



Photo taken by ERCS during Community discussion about the cholera sEAP

sEAP №: sEAP2025ET03	Operation №: MDRET038	Total Budget: CHF 219,961		Readiness: CHF 75,875
				Prepositioning: CHF 38,827
				Early Action: CHF 105,259
People targeted: 12,500 People	sEAP approved: 12/08/2025	sEAP timeframe: 2 Years	sEAP lead time: Drought – 3 months Epidemiological – 7 days	Operational timeframe: 6 months (including 3 months lead time)

Prioritized geographical areas:

- **Afar Region:** Amibara, Assaita, Dubti
- **Amhara Region:** Abergele, Telemt, Wegera woredas
- **Oromia Region:** Berbere, Gelana, Goro Bale, Moyale woredas
- **Somali Region:** Gursum, Erer, Hudet, Kelafo, Moyale (Somali), Dolo Ado woredas
- **South Ethiopia Region:** Dasenech woredas
- **Tigray Region:** Dega Temben, Tahtay Adiyabo woredas

RISK ANALYSIS AND EARLY ACTION SELECTION

Prioritized hazard and its historical impact.

Cholera is an acute diarrheal disease caused by consuming food or water contaminated with the *Vibrio cholerae* bacteria. This highly infectious illness can lead to severe acute watery diarrhoea, with symptoms appearing anywhere from 12 hours to five days after exposure. It affects both adults and children and can be fatal within hours if left untreated.

Cholera which disproportionately impacts poor countries and the most vulnerable continues to affect at least 47 countries across the globe, resulting in an estimated 1.3 – 4 million cases, and 21,000 - 143,000 deaths per year worldwide. [WHO Cholera fact sheet, December 2024.](#)

Eighteen countries including Ethiopia were impacted by the cholera outbreak in the WHO African Region in 2024.

Since the beginning of the year 2024, the number of cholera cases and deaths reported to the WHO Regional Office for Africa (AFRO) as of 30 November was 149 820 and 2 744 respectively, with a case fatality ratio of 1.8%. The Democratic Republic of the Congo (DRC), Ethiopia, Nigeria, Zambia, and Zimbabwe account for 75.9% (113 688) of the total cases and 85.5% (2 344) of total deaths reported this year. ([Monthly Regional Cholera Bulletin: November 2024 | WHO | Regional Office for Africa](#)).

Cholera was a major epidemic disease in traditional Ethiopia, causing high mortality and social disruption. According to literatures Cholera arrived in Ethiopia from India as part of global epidemics. Ethiopian records provide rare insights into pre-19th-century outbreaks. While royal chronicles often lack detail, two accounts from 1634, during Emperor Fasiladas' reign, describe an epidemic called *fangal*, later used for cholera. A Portuguese visitor, Diego de Matteos, reported its spread in Tigray. This outbreak likely extended from a 1629 epidemic in Java, highlighting Ethiopia's role in documenting historical cholera outbreaks ([The history of cholera in Ethiopia - PMC](#)).

Between January 2001 and November 2023, there were 215,205 reported cases of cholera/AWD and 2,355 deaths, with a cumulative case fatality rate (CFR) of 1.10%. The mean annual incidence rate was 8.9 per 100,000 people. Two significant cholera epidemic surges occurred in the past two decades, with mean attack rates of 20.57 per 100,000 from 2006 to 2010 and 14.83 per 100,000 from 2016 to 2020. Another outbreak resurgence happened between 2021 and 2023, with a mean attack rate of 8.63 per 100,000. The national cholera CFR peaked at 3.13% in 2022 ([Retrospective Analysis of Cholera/AWD in Ethiopia From 2001 To 2023](#)).

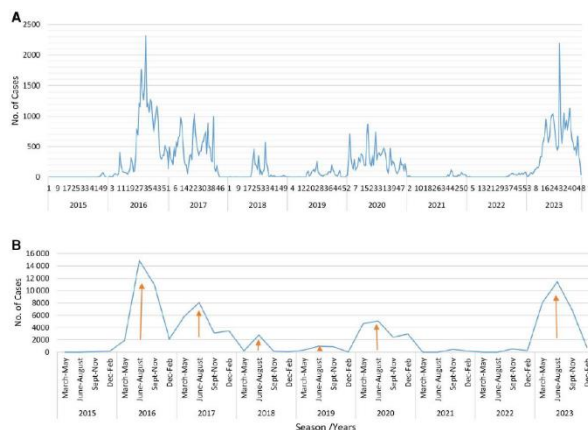


Figure 1. Cholera epidemic curves and seasonal patterns in Ethiopia. A, Successive cholera epidemic waves in Ethiopia every year from 2015 to 2023. The presented epi-weeks exhibit the magnitude and persistence of cholera outbreaks in the country. B, Seasonal pattern of cumulative cholera case counts reported by the major seasons in Ethiopia from 2015 to 2023.

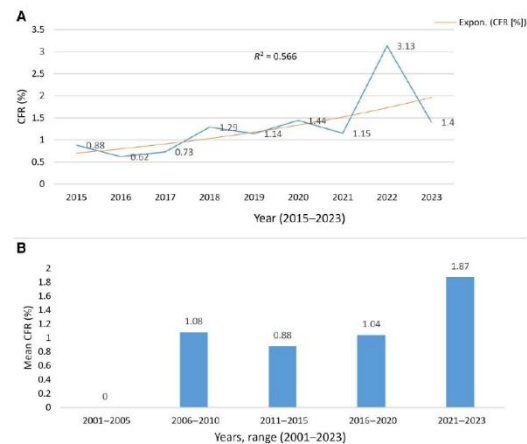


Figure 2. Annual and mean cholera case fatality rate in Ethiopia. A, Annual trends of cholera case fatality rate (CFR) in Ethiopia during 2015–2023. R^2 is the coefficient of determination and the best trendline determined using Expon. (CFR [%], exponential trendline). B, Trend of mean cholera CFR per 5-year period during 2001–2023 in Ethiopia.

Retrospective Analysis of Cholera/AWD in Ethiopia From 2001 to 2023

Currently Ethiopia is under an ongoing cholera outbreak which started in late 2022. In the past four years, Ethiopia reported 60,299 cholera cases and 778 deaths, resulting in a case fatality rate of 1.29%. Cholera outbreaks have affected multiple regions and woredas (districts) across Ethiopia, including Oromia, Somali, Amhara, Central Ethiopia, South Ethiopia, Dire Dawa, Benishangul-Gumuz, Sidama, and Tigray. Oromia remains the hardest-hit region, reporting 17,917 cases and 232 deaths, with a case fatality rate (CFR) of 1.29%. The Somali region follows with 15,183 cases and 150 deaths (CFR 0.99%), while Amhara ranks third with 9,903 cases and 150 deaths (CFR 1.57%). Benishangul-Gumuz has reported the fewest cases (480) but the highest CFR at 4.58%, with 22 deaths. (EPHI internal Power BI Report, cited 2025 Mar 19, [Microsoft Power BI](#)).

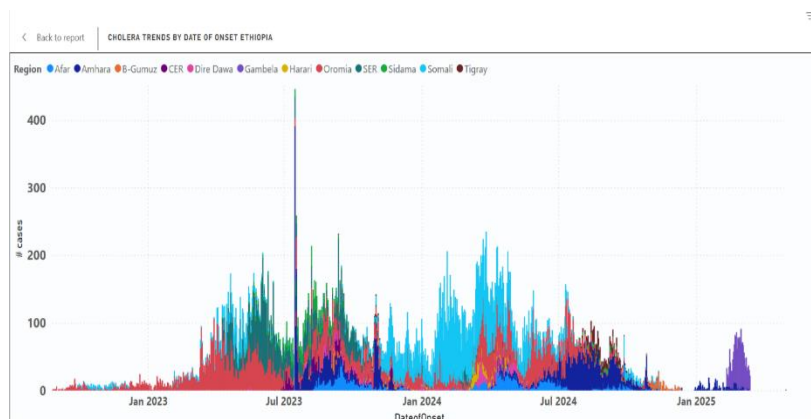


Figure 2: Cholera trend by date of onset and by region, Ethiopia

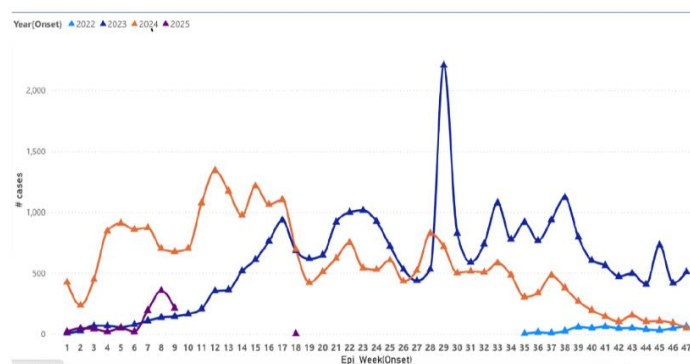


Figure 3: Cholera outbreak by year Ethiopia 2022-2025

Cholera is a significant public health challenge in Ethiopia due to a combination of factors, including poor sanitation, limited access to clean water, overcrowded living conditions, and weak healthcare infrastructure. These conditions create an environment where *Vibrio cholerae*, the bacterium that causes cholera, can spread rapidly, particularly during drought causing water shortage ([Multi Sectorial Cholera Elimination Plan Ethiopia 2022 2028 V2.pdf](#))

Droughts significantly influence the incidence and severity of cholera outbreaks in Ethiopia. Drought exacerbate cholera transmission through mechanisms like water scarcity, which forces reliance on unsafe water sources and reduces hygiene practices. The 2017 cholera epidemic occurred amidst a regional drought, with approximately 5.6 million Ethiopians requiring emergency food aid. In the Somali Region, severe drought compelled pastoralist communities to travel long distances for water, often gathering at unprotected sources, leading to 75% of suspected cholera cases being reported from this area. ([Spatiotemporal dynamics of cholera epidemics in Ethiopia: 2015–2021 - PMC](#)).

A broader study across sub-Saharan Africa from 1990 to 2010 found that cholera outbreaks began during 30% of registered droughts. The incidence rate of cholera outbreaks during drought periods compared with drought/flood-free periods was also found to be 4.3 times higher. The prolonged duration and extensive impact of droughts may explain the higher proportion of cholera outbreaks during these periods [Am. J. Trop. Med. Hyg.+1PubMed+1](#).

Beyond the immediate health impacts, cholera outbreaks have far-reaching economic and social consequences. Families affected by cholera often face high medical costs and loss of income due to illness or death. Outbreaks also disrupt education, as children may be unable to attend school during epidemics. Furthermore, the stigma associated with cholera can lead to social isolation for affected individuals and communities ([Influences of community engagement and health system strengthening for cholera control in cholera reporting countries | BMJ Global Health](#)).

These statistics and patterns underscore the persistent and severe impact of cholera in Ethiopia, these highlighting the critical need for enhanced cholera Anticipatory, preparedness and response strategies in Ethiopia, with special consideration to the increasing frequency of extreme weather events due to climate change.

Explain which risks have been selected for this protocol and why

Cholera poses great risk to communities and health and wellbeing. For this simplified EAP three major risk are prioritized. The first primary risk is in ability to prevent an uncontrolled spread of the outbreak through a multitude of factors such as inadequate knowledge on the disease and its prevention, poor hygiene and sanitation practices, poor water and food safety practices and poor access to safe water. The second priority risk is inability to reduce morbidity due to factors such as limited capacity to timely recognize cases and referral, not interrupting the transmission chain with IPC/WASH measures, and not having proper surveillance systems set up to prevent an outbreak escalation. The third priority risk is inability to prevent Mortality due to delay in seeking medical help, and unavailability of basic flood replacement treatment through timely ORS Provision quickly leading to shock or even death.

The first primary risk is the inability to prevent cholera outbreaks, stemming from factors such as inadequate knowledge about the disease and its prevention, poor hygiene and sanitation practices, unsafe water and food handling, and limited access to clean water. In Ethiopia, 60% to 80% of health problems are due to communicable diseases attributable to unsafe water supply and unhygienic waste disposal.

Additionally, major risk factors for cholera infection have been linked to drinking water and latrine hygiene. ([UNICEF](#), [Frontiers](#)).

The second primary risk is the limited capacity to reduce morbidity, which is influenced by not promptly recognizing and referring cases, failure to interrupt the transmission chain through effective Infection Prevention and Control (IPC) and Water, Sanitation, and Hygiene (WASH) measures, and inadequate surveillance systems to prevent outbreak escalation. Effective case management and IPC measures require a robust preparedness plan to capacitate the healthcare system, establish clear referral pathways, and implement effective IPC measures to mitigate disease spread ([gtfcc.org](#)). If cholera is not treated early, it can lead to several severe health impacts beyond death. One of the most immediate concerns is severe dehydration, as the disease causes rapid loss of fluids through diarrhoea and vomiting. This can result in extreme thirst, dry mouth, sunken eyes, and decreased urine output (<https://www.who.int/news-room/fact-sheets/detail/cholera>).

Alongside dehydration, there is a significant risk of electrolyte imbalance, which can cause muscle cramps, weakness, irregular heartbeat, and even seizures. The rapid fluid loss can also lead to hypovolemic shock, where there isn't enough blood flow to the organs, potentially causing organ failure including kidney failure (<https://www.niaid.nih.gov/diseases-conditions/cholera>).

The third primary risk is difficulty in preventing mortality in cholera affected individuals due to delays in seeking medical help and the unavailability of basic rehydration treatment which can quickly lead to shock or death. Delayed healthcare-seeking behaviour contributes to ineffective management of infectious diseases like cholera, potentially leading to preventable deaths. Decentralizing access to ORS and establishing Oral Rehydration Points (ORPs) can reduce delays in treatment initiation and prevent cholera-related deaths ([PMCgtfcc.org](#)).

Describe the selected early actions and explain how they will address the risks and lead to the intended outcome

Based on the prioritized risks, the Technical Working Group (TWG) convened multiple meetings to identify and select early actions aimed at preventing and mitigating cholera risks. The selection process incorporated several key steps:

- **Workshops with Stakeholders:** The TWG conducted brainstorming sessions to determine the timing of impacts relative to the rainy season and to identify feasible early actions with adequate lead time for drought situations, drawing from the experiences of participating organizations. These expert insights were then prioritized using pair-wise ranking, considering time and budget constraints.
- **Local level stakeholder and Community Consultations:** Focus group discussions and key informant interviews were held with local sectoral decision-makers and local communities to gather grassroots perspectives on effective early actions.
- **Literature Review:** An extensive review of existing literature was undertaken to assess previously implemented actions and their outcomes.

Early actions were selected for two prioritized risk sectors: Water, Sanitation, and Hygiene (WASH) and Health. The selection criteria included:

- **Evidence of Effectiveness:** Actions demonstrating a proven impact in reducing the identified risks.
- **Organizational Capacity:** The national society's ability and prior experience in implementing the

selected actions.

- **Strategic Alignment:** Consistency with the mandates of the Ethiopian Red Cross Society (ERCS), plans and strategies of the Ethiopian Public Health Institute (EPHI), national policies, and international standards such as those set by the Global Task Force on Cholera Control (GTFCC).
- **Health System and Community Benefit:** Relevance of actions to strengthen the health system and benefit communities, while considering the potential scenario of acting in vain.
- **Implementation Feasibility:** The practicality of executing these actions within the available lead time.

Through this simplified Early Action Protocol (sEAP), three prioritized risks were identified, and corresponding early actions were selected:

1. **Limited Capacity to Prevent Outbreaks:** To address this, planned early actions include risk communication, hygiene promotion, and the provision of hygiene non-food items (NFIs) and safe water, in collaboration with the Ministry of Water and Energy. These measures aim to tackle the predisposing factors of cholera, enabling vulnerable communities to build capacity for disease prevention.
2. **Limited Capacity to Reduce Morbidity:** Selected early actions encompass strengthening basic surveillance measures such as community-based surveillance, active case finding, referral systems, and linkage with health facilities. Additionally, household and facility disinfection will be conducted to enhance the health system's capacity to interrupt transmission chains, thereby flattening the epidemiological curve and reducing case numbers.
3. **Difficulty in Preventing Mortality:** Interventions will focus on early detection and treatment of cholera cases. This includes awareness campaigns to improve health-seeking behaviour and the provision of Oral Rehydration Salts (ORS) at health facilities and decentralized Oral Rehydration Points (ORPs). These efforts aim to enable cholera patients to replace lost fluids and electrolytes promptly, preventing dehydration and significantly decreasing the risk of death.

By implementing these targeted early actions, the initiative seeks to effectively prevent and mitigate the impacts of cholera outbreaks within the community.

EARLY ACTION INTERVENTION

Overall objective of the intervention	The overall objective of this protocol is to prevent and mitigate cholera outbreaks by enhancing community resilience through targeted actions that address the primary risks associated with the disease. This includes improving capacities to prevent an uncontrolled spread of an outbreaks, reduce morbidity, and prevent mortality through coordinated efforts in risk communication, hygiene promotion, surveillance strengthening, and provision of timely treatment.
Potential geographical high-risk areas that the simplified EAP would target	Due to budgetary constraints within this sEAP, implementing interventions across all 118 cholera-prioritized woredas and those affected by cholera in the past four years was not feasible. Consequently, a selection of 20 high-priority woredas from six regions in Ethiopia was made, as follows: • Afar Region: Amibara, Assaita, Dubti • Amhara Region: Abergele, Telemt, Wegera • Oromia Region: Berbere, Gelana, Goro Bale, Moyale

	• Somali Region: Gursum, Erer, Hudet, Kelafo, Moyale (Somali), Dolo Ado • South Ethiopia Region: Dasenech • Tigray Region: Dega Temben, Tahtay Adiyabo The selection process employed multiple criteria: 1. Cholera Hotspot Identification: All chosen woredas are among the 118-cholera hotspot woredas (PAMIs) identified by the Ethiopian Public Health Institute. 2. Drought Susceptibility: Given that initial trigger is based on drought occurrence, woredas with in the cholera hotspot list and experiencing recurrent droughts were prioritized, utilizing data from existing drought s/EAPs and current trends from the Ethiopian Disaster Risk Management Commission (EDRMC). 3. Recent Cholera Incidence: to further narrow down the list Woredas identified by the above two criteria's and additionally with reported cholera cases and significant caseloads in the past three years were further prioritized, acknowledging that the Ethiopian Public Health Institute's cholera hotspot designations were established over three years ago. 4. Multisectoral Hotspot Classification: To finalize the selection, the remaining woredas were assessed using the EDRMC's multisectoral hotspot classification, which evaluates factors such as WASH infrastructure, health systems, nutrition, education, agriculture, protection, and market conditions, categorizing woredas into priority levels 1, 2, and 3. This comprehensive approach ensures that the limited resources are allocated effectively to areas with the highest risk and need. Attached as Annex 1 is the list of woredas with the rating from each criterion.
Who will be assisted through this operation and what criteria will be used for their selection?	The groups to be targeted by this sEAP will be selected based on who is more exposed to the prioritized risks and it also takes into consideration the levels of vulnerability, coping capacities and social parameters, with attention to particularly vulnerable and/or most-at-risk groups: 1. Individuals with suspected cholera cases and their families 2. Facilities with reported suspected cholera cases 3. People who are in a 200-meter radius (based on CATI) as first priority and sharing water sources if there is still more items to distribute with Cholera suspected cases 4. People are facing water scarcity due to drought (based on past experiences and WASH assessment that will be conducted). 5. People who are located more than 1hr walking distance from health facilities 6. People living in congested living conditions such as slum areas, IDPs, refugees, etc

	The selection of the specific households from the target groups would then prioritize: • Households with suspected cholera cases • Listed Low-income households by the woreda/district (this is regularly done by all woredas) • Female or child headed household • Large households with 3 or more children. • Households with children under 5 years. • Households with elderly members • Households who are listed as food insecure by the woreda/district The targeting will be community centered through their existing committees and will be refined by volunteers when mobilized for the early actions, it will build on the CEA work and will also be pre-informed by the targeting selection criteria mentioned above. Moreover, since there is continuous coordination with the government and other stakeholders any available data that becomes available at the time of the intervention will be reviewed and adopted where appropriate.
Trigger(s) statement	Scenario 1: When trigger 1 and 2 are activated sequentially Trigger 1: ERCS will activate the first trigger of the sEAP • When the monthly EDRMC disaster report confirms the occurrence of drought affecting 32000 people in any of the 20 identified woredas, with a 3-month lead time. EDRMC issues a monthly disaster incidence report by collecting information from all woreda's who has experienced any disaster within the month, this report is shared with all relevant stakeholders who work on humanitarian settings, ERCS will be among the ones who will be receiving this report. The ERCS focal person will review this report monthly to see the occurrence of drought (due to its slow onset nature drought incidents are reported on the monthly disaster report). Trigger 2: ERCS will activate the second trigger of the sEAP when • one confirmed case is reported by EPHI in a neighboring woreda/district of the 20 identified woredas/districts, within the same country or in a neighboring district of bordering country with a 7-day lead time, or • five suspected cases that qualify the clinical case definition of EPHI are identified within a week in the 20 selected woredas/district with a 7-day lead time. Suspected cholera case: any person aged 2 years or more presenting with acute watery diarrhea and severe dehydration or dying from acute watery diarrhea as reported by EPHI. Confirmed cholera case: A suspected case in which <i>Vibrio cholera</i> O1 or O139 has been isolated from their stool as reported by EPHI.

	The Ethiopian Public Health Institute (EPHI) issues weekly disease surveillance reports based on WHO epidemiological weeks. To facilitate timely access to this information, the Ethiopian Red Cross Society (ERCS) and EPHI have established an agreement whereby EPHI includes ERCS in the distribution list for these weekly reports, specifically for trigger monitoring purposes. The designated ERCS focal person will review these reports weekly to determine if any triggers have been met. For the trigger concerning confirmed cholera cases in neighbouring areas, ERCS and EPHI have agreed that ERCS will be notified via email whenever a confirmed case is identified in the country. The ERCS focal point will assess the location of these confirmed cases to ascertain if they are in woredas adjacent to the 20 prioritized woredas. If such cases are identified, the focal point will determine if the established triggers have been reached. The activation procedure for all triggers is detailed in Annex 2. Scenario 2: When Trigger 2 is activated independently ERCS will activate the second trigger of the sEAP when • one confirmed case is reported by EPHI in a neighbouring Woreda/district of the 20 identified woredas/districts within the same country or in a neighbouring district of bordering country with a 7-day lead time, or • five suspected cases that qualified clinical case definition of EPHI are identified within a week in the 20 selected Woredas/districts with a 7-day lead time.
Trigger threshold justification	Droughts significantly exacerbate cholera outbreaks in Ethiopia and other regions. Droughts reduce water availability, compromising hygiene practices and forcing reliance on unsafe water sources. Since Ethiopia frequently experiences drought, which is among the country's most recurrent natural hazards, we based one of the triggers on occurrence of this hazard. Regarding epidemiological triggers, one of the triggers is based on suspected cholera case confirmation rates, while specific data for Ethiopia is limited, similar protocol from Cameroon—a country with similar cholera challenges—suggest an 80% probability of confirming a single positive case among five suspected cases. The TWG has decided this would be sufficient evidence to base our trigger on. For the trigger involving a confirmed case in a neighbouring area, implementing cholera prevention activities in areas neighbouring confirmed cases is a standard and essential public health strategy to curb the spread of the disease. Cholera is highly contagious, and proximity to affected regions significantly increases the risk of transmission. By proactively enhancing prevention efforts in adjacent areas, we aim to prevent potential outbreaks in that specific woreda.
Next steps – For National Societies that	The current protocol employs triggers based on amplifying factors such as drought, along with proxy epidemiological indicators. In the future, the Ethiopian Red Cross Society (ERCS) aims to collaborate with the Ethiopian Public Health Institute (EPHI), the Ministry of Health (MOH), and other

intend to develop a full EAP (Optional)	pertinent national and international partners to develop a predictive model for cholera outbreaks. This initiative seeks to expand the simplified Early Action Protocol (sEAP) into a full Early Action Protocol (EAP). Should modelling prove not feasible, ERCS plans to engage stakeholders interested in this domain, incorporate lessons learned from the current sEAP, and work towards formulating a full EAP that considers additional amplifying factors such as nutritional status and population movement. Furthermore, ERCS will endeavour to secure additional funding from both Movement and non-Movement partners to enhance the efforts undertaken by the Disaster Relief Emergency Fund's Anticipatory Action pillar.
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PLANNED OPERATIONS

	Health & Care	Budget	85,728CHF	
		No. people targeted	12,500 People	
Indicator:	1. # trained on Epidemic Preparedness and Response in Communities training aligned with (CBS, RCCE, IPC, and CBCM) 2. # of job aids and IEC/BCC materials distributed. 3. # of PPE materials procured. 4. # of ORP established. 5. # of volunteers deployed for disinfection and awareness creation.	Target:	1. 50 2. 2000 3. 500 4. 2 5. 250	
Readiness activities:		1. Conduct sEAP familiarization workshop with Woreda health office and branch ERCS team and integrate with existing woreda systems including developing activation plan, Mapping, Health/WASH resources, stakeholders, and plans to coordinate and Sensitize them using existing coordination mechanisms. 2. Conduct training for NS and Govt staff on Surveillance and Case Notification (CBS) Implementation. 3. Participate in relevant national and local coordination and preparedness platforms as per MoU. 4. Develop MoUs with EPHI for cholera specific response activities, data sharing and reporting. 5. Design/print job aids, IEC/BCC materials specific to cholera.		
Prepositioning activities:		1. Procurement of PPE relevant for cholera activities. 2. Procurement of ORP kits. 3. Procurement of ORS with a shelf life of at least 2 years.		

Prioritized Early Actions:

Scenario 1: When Trigger 1 and 2 are activated Sequentially

Trigger 1

1. Establish local-level community feedback mechanism and promote the existing EPHI 8335 toll-free line to collect alerts for suspected cases and rumours.
2. Provide Epidemic Preparedness and Response in Communities training for cholera prevention aligned with government packages (community bases surveillance, RCCE, IPC, and Community based case management) for volunteers to conduct early actions.
3. Deploy volunteers to conduct cholera risk communication, active case search through HH visits, community meetings, and by engaging community leaders such as traditional/religious leaders to lead cholera prevention measures at community's level.
4. Enhance readiness of health facilities to effectively manage referred suspected cases.
5. Provide field level technical support to deployed teams by national technical working group to drought affected woredas and facilities for cholera activation.
6. Identify, map and engage traditional healers, CHWs, religious and local leaders to lead community mobilization efforts for cholera prevention.

Trigger 2

1. Activation of cholera stakeholder rapid response team and Task force.
2. Provide half day refresher training on the selected cholera prevention health packages (Community based Surveillance, RCCE, Community Case management, and IPC) for 250 Community health workers and volunteers.
3. Deploy volunteers to conduct intensive community-based surveillance RCCE, and community case management using Case-Area Targeted Interventions (CATI) approach.
4. Distribution of Oral Rehydration Salts (ORS) to notified alert cases, their families and close neighbours following the CATI approach (then referral to the management structures).
5. Disinfection of households (patient beds, toilets and kitchens) where a suspected case(s) have been reported.
6. Disinfection (school, markets, public services, etc.) where one or more suspected cases have been reported.

	7. Conduct awareness creation using audio mounted cars/town criers. 8. Set up and operationalize ORP on areas with high number of suspected cases. 9. Strengthening timely rumours notification and registration at hot spot Woreda. 10. Support hot spot Woredas to conduct active case searching, contact tracing, follow-up and referral of suspected cases to health facility following the CATI approach. 11. Transport suspected cases of cholera to health facilities. Scenario 2: When Trigger 2 is activated Independently 1. Activation of cholera stakeholder rapid response team and Task force. 2. Provide one day training on the selected cholera prevention health packages (Community based Surveillance, RCCE, and Community Case management,) for 250 Community health workers and volunteers. 3. Deploy volunteers to conduct intensive community-based surveillance, RCCE and community case management using Case-Area Targeted Interventions (CATI) approach. 4. Conduct awareness creation using audio mounted cars/town criers. 5. Establish local-level community feedback mechanism and promote the existing EPHI 8335 toll-free line to collect alerts for suspected cases and rumours. 6. Enhance readiness of health facilities to effectively manage referred suspected cases. 7. Identify, map and engage traditional healers, CHWs, religious and local leaders 8. Support hot spot Woredas to conduct active case searching, contact tracing, follow-up and referral of suspected cases to health facility following the CATI approach. 9. Set up and operationalize ORP on areas with high number of suspected cases. 10. Disinfect households with suspected and confirmed cholera cases. 11. Disinfection (school, markets, public services, etc.) where one or more suspected cases have been reported. 12. Distribution of Oral Rehydration Salts (ORS) to notified alert cases their families and close neighbours following the CATI approach (then referral to the management structures). 13. Transport suspected cases of cholera to health facilities.
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	Water, Sanitation and Hygiene	Budget	77,201 CHF	
		No. people targeted	12,500 People	
Indicator:	1. # of WASH Assessment conducted. 2. # of hygiene committee established or revitalized. 3. # of trained volunteers deployed to provide cholera hygiene promotion and support handwashing facilities installation. 4. # of HHs received NFI kits. 5. # of facilities received hand washing facilities. 6. # of population addressed with key message.		Target:	1. 1 2. 12 3. 250 4. 1500 5. 10 6. 12,500
Readiness activities:		1. Initiate existing woreda RRT/sectoral meetings monthly/quarterly based on previous experience. 2. Conduct WASH assessment in specify cholera hotpots Woredas including effectiveness, preference and availability of water treatment chemicals, costume NFI needs, key messages, and methods of communicating with beneficiaries.		
Pre-positioning activities:		1. Procurement of WASH/NFI package (customized based on assessment) considering protective container compatibility and using standard NaDCC treatment doses for water treatment. 2. Preposition 5000 L water containers (Roto). 3. procurement and pre-positioning of chlorine for disinfection. 4. Procurement of WASH kits (boots, gloves, goggles, sprays etc.) 5. Procurement of handwashing devices.		
Prioritized Early Actions:		Scenario 1: When Trigger 1 and 2 are activated sequentially Trigger 1 1. Activate hygiene committees in the high-risk areas of target woredas to support community early actions. 2. Provide cholera WASH training integrating CATI- based module for volunteers to be deployed in the targeted woredas to conduct WASH early actions. 3. Deploy Community Health workers and volunteers to supply handwashing facilities, provide cholera hygiene and sanitation messages and mobilize communities for cholera prevention emphasizing household water treatment and safe storage.		

4. support the implementation of the developed WASH cholera action plan and resource mapping in coordination with EPHI/MoH, MoWE, and other stakeholders at the targeted Woredas.
5. Advocate for the provision of safe and adequate water supply (healthcare facilities, schools, public gathering: -market, religious places, IDPs) in affected settings of the targeted Woredas by liaising with MoWE and its lower structures.
6. Install the water container(roto) in the selected public facilities with poor water access.

Trigger 2

1. Provide half day refresher cholera WASH training referencing to the CATI based module for volunteers to be deployed in the targeted woredas to conduct WASH early actions.
2. Deployment of these volunteers to provide cholera hygiene and sanitation messages and mobilize communities for cholera emphasizing on household water treatment and safe storage. prevention. following the CATI approach.
3. Distribute NFI kits (Water treatment chemicals, soap.) for HHs following the CATI approach
4. Disinfection of communal Water sources in the affected area following the CATI approach.
5. Awareness raising for population of targeted communities on effective utilization of distributed NFI kits at HH level
6. Conduct residual chlorine test
7. Advocate for the provision of safe and adequate water supply for vulnerable communities and facilities and provide water supply for selected few public facilities (healthcare facilities, schools, public gathering: -market, religious places, IDPs) in affected settings of hotspot Woredas by liaising with MoWE and its lower structures.

Scenario 2: When Trigger 2 is activated Independently

1. Conduct consultative meetings with Kebele leaders, HEWs, Kebele sectoral heads, and DAs on what and how to implement the early actions within the lead time.
2. Provide half day training to water and sanitation committee at kebele level and engage them in mobilizing communities to implement WASH cholera prevention practices emphasizing on household water treatment and safe storage.
3. Advocate for provision of safe and adequate water supply for vulnerable communities and facilities and provide water supply for selected few public facilities (healthcare facilities, schools, public gathering: -market, religious places, IDPs) in affected settings of hotspot Woredas by liaising with MoWE and its lower structures.

	4. Provision of Water treatment chemicals for HHs in hotspots following the CATI approach with education on household water treatment and safe storage. 5. Provide a 1-day cholera WASH training integrating CATI- based module for volunteers to be deployed in the targeted woredas to conduct WASH early actions 6. Deployment of these volunteers to provide cholera hygiene and sanitation messages and mobilize communities for cholera prevention. following the CATI approach emphasizing on household water treatment and safe storage. 7. Support the implementation of the developed WASH cholera plan during readiness. 8. Distribute NFI kits (Water treatment chemicals, soap.) for HHs following the CATI approach. 9. Disinfection of communal Water sources in the affected area following the CATI approach. 10. Awareness raising for population of targeted communities on effective utilization of distributed NFI kits at HH level. 11. Conduct residual chlorine test. 12. Install the water container(roto) in the selected public facilities with poor water access.
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ENABLING APPROACHES

	Secretariat services	Budget	19,937 CHF	
		No. People targeted		
Indicator:			Target:	
Readiness activities:	1. IFRC staff salary. 2. Technical and operational support readiness (mission). 3. Transport & Vehicles Costs contribution (vehicle lease, running cost...).			
Prepositioning activities:				
Prioritized Early Actions:	1. IFRC Early Action Technical and operational support (mission) 2. IFRC support with reporting and lessons learned for (mission)			

	National Society Strengthening	Budget	37,095 CHF	
		People targeted		
Indicator:	1. # of Lessons learned workshop conducted. 2. # of PDM conducted.		Target:	1. 1 2. 1
Readiness activities:		1. Salary for health expert. 2. Admin support for the national society (5%).		
Prepositioning activities:				
Prioritized Early Actions:		1. Conduct PDM. 2. Conduct post Activation Lessons learned workshop. 3. Transport and Logistics service. 4. Volunteer Insurance for 250 volunteers.		

CONDITIONS TO DELIVER THE EARLY ACTION

Experience and/or capacity to implement the early actions.	This sEAP will be stopped if any of the following conditions are met • If confirmed cholera cases were identified during any of the triggers within the activated area, • If 5 suspected cholera cases were not identified within a week at the end of the lead time of (any week in the lead time) of Trigger 1 for drought, • During Drought Trigger 1 Activation, if there is no indication of a decline in the surface water resources one month after the start of the drought season, as compared to the normal season based on Ministry of Water and Energy monitoring, then the sEAP activation will be stopped. EDRMC is the one who takes the lead and the responsible authority to signal the stop mechanism with close consultation with TWC. Ethiopia faces several disasters, both natural and human-made, including disease outbreaks, floods, droughts, stormy rains, landslides, population movements, pest infestations, fires, and accidents. In response to these disasters, the Ethiopian Red Cross Society (ERCS) has been utilizing the International Federation of Red Cross and Red Crescent Societies (IFRC) global tools over the years. These tools include the Disaster Relief Emergency Fund (DREF) and emergency appeals for large-scale disasters such as cholera, drought, population movements, and floods. ERCS has also received surge support in various thematic areas to aid their operations.
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	ERCS is one of the key actors in the country in the areas of Health and Water, Sanitation, and Hygiene (WASH). The NS has supported the government in managing disease outbreaks, such as cholera epidemics, in the past. ERCS has extensive experience in implementing activities identified in this Early Action Protocol (EAP). In addition, the National Society conducted the Preparedness for Effective Response (PER) assessment in June 2019 and 2024. The objective of this assessment was to evaluate the preparedness and response capacity of ERCS during an actual emergency using a post-operational method. Based on the findings, ERCS identified priority areas in risk management, community-based disaster risk reduction, the Emergency Operations Center (EOC), and resource management. A work plan was developed and implemented, and another evaluation of the work plan's implementation was conducted in 2024. Further plans were developed to improve areas that had not shown sufficient progress. A feasibility study conducted in 2018 indicated that Forecast-based Financing (FbF) is feasible in Ethiopia, and the National Society has the basic capacities to implement FbF. Several capacities in different thematic areas and at all levels of the society's structures have been enhanced to guide the implementation of the findings. The National Society has implemented several activations of EAPs for flood and drought with funding from DREF and other sources, gaining advanced experience in implementing anticipatory action activities.
Red Cross Red Crescent Movement partners, Governmental / other agencies consulted/involved on this simplified EAP	During the development of this sEAP, several movement and non-movement stakeholders were consulted. We organized three workshops. On this workshops partners such as the Italian Red Cross, Netherlands Red Cross, Norwegian Red Cross, and the Climate Center were involved to provide critical insights on the protocol. From the government side, we consulted the Ethiopian Public Health Institute (the technical wing of the Ministry of Health managing public health emergencies), the Ethiopian Disaster Risk Management Commission, the Ethiopian Meteorological Institute, the Ministry of Water and Energy, and the Ministry of Agriculture. Non-movement partners including OCHA, UNICEF, Resolve to Save Lives, Save the Children, and World Vision were also consulted during the protocol development. Additionally, we organized a field mission, the field mission was particularly crucial as it involved direct engagement with local authorities and communities. This engagement allowed us to gather firsthand insights and feedback from those who are most affected by disasters. Local authorities provided valuable information on the existing preparedness and response capacities, infrastructure, resources, community level actions and challenges faced in cholera prevention and control. Communities shared their experiences, needs, and suggestions for improving the cholera preparedness and response. This collaborative approach ensured that the sEAP was tailored to the specific context and needs of the local population. The contributions of all parties involved were invaluable, and the government along with all partners are committed to facilitating the implementation of this protocol.

BUDGET

Early Action Protocol Summary

- Ethiopian Red Cross Society
Cholera

Operating Budget

	Readiness	Pre-Pos Stock	Early Action	TOTAL
Planned Operations	35,022	38,827	89,080	162,929
Shelter and Basic Household Items	0	0	0	0
Livelihoods	0	0	0	0
Multi-purpose Cash	0	0	0	0
Health	33,228	10,799	41,701	85,728
Water, Sanitation & Hygiene	1,794	28,028	47,379	77,201
Protection, Gender and Inclusion	0	0	0	0
Education	0	0	0	0
Migration	0	0	0	0
Risk Red., Climate Adapt. and Recovery	0	0	0	0
Community Engagement and Accountability	0	0	0	0
Environmental Sustainability	0	0	0	0
Enabling Approaches	40,853	0	16,179	57,031
Coordination and Partnerships	0	0	0	0
Secretariat Services	17,445	0	2,492	19,937
National Society Strengthening	23,408	0	13,686	37,095
TOTAL BUDGET	75,875	38,827	105,259	219,961

all amounts in Swiss Francs (CHF)

Contact information

For further information, specifically related to this simplified EAP please contact:

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Annex 1: list of identified 20 woreda's and their rating based on criteria's.

Cholera sEAP identified 20 Implementation Woredas							
Sr. No.	Region	Zone	Woreda	Drought	Recent Cholera outbreak	Cholera case load starting from 2022	EDRMC Multi-sectoral Hot Spot woreda
1	Afar	Zone 3	Amibara	Yes	Yes	124	2
2	Afar	Zone 1	Assaita	Yes	Yes	44	2
3	Afar	Zone 1	Dubti	Yes	Yes	344	2
4	Amhara	Waghimera	Abergele	Yes	Yes	1	1
5	Amhara	North Gonder	Telemt	Yes	No	0	1
6	Amhara	Central Gondar	Wegera	Yes	Yes	64	1
7	Oromia	Bale	Berbere	Yes	Yes	726	1
8	Oromia	West Guji	Gelana	Yes	Yes	886	1
9	Oromia	Bale	Goro Bale	Yes	Yes	816	1
10	Oromia	East Hararge	Gursum	Yes	Yes	127	1
11	Oromia	Borena	Moyale	Yes	Yes	753	1
12	SE	South Omo	Dasenech	Yes	No	0	1
13	Somali	Liban	Dolo Ado	Yes	Yes	15	1
14	Somali	Sitti	Erer (Somali)	Yes	Yes	1028	1
15	Somali	Fafan	Gursum	Yes	Yes	632	2
16	Somali	Dawa	Hudet	Yes	Yes	123	1
17	Somali	Shebele	Kelafo	Yes	Yes	582	1
18	Somali	Dawa	Moyale (Somali)	Yes	Yes	546	1
19	Tigray	Southeast Zone	Dega Temben	Yes	No	0	1
20	Tigray	Northwest Zone	Tahtay Adiyabo	Yes	Yes	2	1

Annex 2: Activation procedure

