SIMPLIFIED EARLY ACTION PROTOCOL

Zimbabwe | Cholera

Figure 1 Zimbabwe Red Cross Volunteer at Oral Rehydration Point under DG ECHO funded Cholera Preparedness Project

sEAP №: **sEAP2025ZB02**	Operation №: **MDRZW026**	Total Budget **CHF 219,282**	Readiness: **CHF 81,413**	
			Prepositioning: **CHF 22,368**	
			Early Action: **CHF 115,501**	
People targeted: **61,780 People**	sEAP approved: **16/10/2025**	sEAP timeframe: **2 Years**	sEAP lead time: **1 Month**	Operational timeframe: **9 months**

Prioritized geographical areas:

Tier 1 Urban cholera hotspots in Harare: Budiriro, Hopley, Glenview, Kuwadzana, Dzivarasekwa, Mbare, Rutsanana and Highfields.

Tier 1 and 2 Rural Hotspots: Two locations as affected

RISK ANALYSIS AND EARLY ACTION SELECTION

Prioritized hazard and its historical impact.

Prioritised Hazard

The Zimbabwe Red Cross Society (ZRCS) initiated Forecast Based Actions (FBA) programming in 2018 through a scoping study and a subsequent Roadmap for FBA in Zimbabwe (Annex 1) which provides guidance towards the phased progression of hazards which could be addressed by FBA in Zimbabwe, based on historical impacts, forecast availability and feasibility. Informed by these assessments the roadmap recommended that drought, cholera and flooding be addressed sequentially, supported by a planned capacitation of ZRCS anticipatory action capacities. During 2019-2022 ZRCS successfully developed a full Early Action Protocol (EAP) for Droughts which was approved by the IFRC Validation Committee in December 2022. In line with the recommendations of the Roadmap the ZRCS began to address anticipatory action programming for cholera in 2023, with the support of a DG ECHO funded cholera preparedness project. This process coincided with a large regional outbreak of cholera during 2023-2024 which seriously affected Zimbabwe and required a significant intervention by the ZRCS focused on community level interventions, which were based on the Red Cross Red Crescent Movement Branch Outbreak Response Team (BORT) and Oral Rehydration Point (ORP) approaches. Lessons from this intervention and ongoing cholera preparedness programming have informed the development of this simplified Early Action Protocol, its trigger methodology and the Early Actions which have been included in this Protocol.

During 2023-2024 the country was affected by the largest cholera outbreak since 2008, which has affected all of the country's 10 provinces and 62 districts and resulted in 34,549 cases and 631 deaths. The outbreak was declared over in August 2024, however new outbreaks of cholera have emerged in multiple hotspot districts around the country since November 2024.The growth of poorly serviced peri-urban informal settlements, with insufficient water, sanitation and solid waste management *sustains* the potential for future largescale outbreaks, particularly in the Cities of Harare, Mutare and Chitungwiza. These three cities along with the rural districts of Manicaland Province accounted for 78% of the suspected cholera cases during 2023-2024. The infrastructural interventions required to address these challenges are limited by underinvestment and outpaced by population growth and urban densification, ensuring that the risk of outbreaks will persist.

The approach and actions included in this sEAP recognize that unplanned urban growth in Zimbabwe will continue to outpace the required expansion of infrastructure in the foreseeable future, exposing both urban and rural populations to conditions conducive for cholera. Addressing this requires a flexible and scalable approach that is aligned with Government of Zimbabwe's (GoZ) capacities. Additionally, the sEAP recognizes the risk of regional transmission of cases and the need for strengthened and proactive monitoring, coordination and the adoption of regionally applicable anticipatory actions.

An important consideration in the risk analysis of cholera is the impact of climate change. Zimbabwe is expected to have an increased likelihood of both flooding and droughts[1], both of which have correlations to increased cholera risk, which can be seen in the previous large scale outbreaks.

Drought: There is a clear, though often indirect, correlation between drought conditions and cholera outbreaks in Zimbabwe[2], primarily driven by reduced access to safe water, sanitation and shifts in population behavior. The 2008–2009 cholera outbreak, which recorded over 98,000 cases and more than 4,000 deaths, coincided with a multi-year drought period (2007–2009). Similar patterns were observed during the 2018–2019 outbreak, centered again in Harare, where cholera cases surged following dry spells and extensive sewer system failures.

[1] climate_variability_climate_change_and_its_risks_in_zimbabwe_charity_denhere.pdf

[2] Drought-related cholera outbreaks in Africa and the implications for climate change: a narrative review

Zimbabwe was experiencing a significant meteorological drought in 2018, with below-average rainfall affecting safe water availability and sanitation services, particularly in informal urban settlements. More recently, in 2023, the worst recent drought conditions in Zimbabwe coincided with the largest cholera outbreak since 2008, It can be reasonably expected then that as climate change intensifies the frequency and severity of droughts, the risk of cholera will also increase, especially in contexts of weak public health systems, informal urban growth, and poor WASH service coverage.

Flooding: Zimbabwe is also predicted to be increasingly affected by condensed seasonal rainfall patterns, where periods of heavy rainfall will be followed by prolonged dry spells. The heavier rainfall, combined with poor drainage infrastructure results in increased urban flooding, particularly of semi formal peri urban areas, which overlap cholera hotspots[3]. The heavy rainfall can increase contamination of informal water sources and also increases the demands on wastewater treatment infrastructure prior to its entry to lake Chivero, the City's main reservoir, a significant contributor to the large-scale outbreak in 2008.

Historical Impact

A protracted socio- economic crisis in Zimbabwe, combined with high levels of rural to urban migration has eroded existing urban water, sanitation and health infrastructure, significantly increasing the risk of cholera transmission. Most cholera outbreaks in Zimbabwe have been historically concentrated in hotspot areas, recent years have shown both increasing frequency of outbreaks and expanding geographical spread beyond the traditional hotpots. According to the Zimbabwe Multi Sectoral Cholera Elimination Plan (2018-2028), cholera is endemic in the country and all districts are vulnerable to outbreaks, however there are distinct hotspot areas which have exhibited persistent and/ or regular outbreaks, as identified in Cholera Elimination Plan. The existing hotspot mapping is currently being updated through the Priority Areas for Multisectoral Intervention (PAMI) process, which expands beyond the GTFCC epidemiological approach used in the Cholera Elimination Plan by incorporating additional vulnerability factors to create a more comprehensive vulnerability index for targeting intervention. However, at the time of submission for the sEAP the process has not yet completed and as such the information in this document is based on the existing Elimination Plan and the recent outbreak data, which will be updated in subsequent versions of the sEAP.

Beyond the immediate and individual effects of the disease, cholera outbreaks have diverse impacts and consequences for communities and the broader society.

- **Morbidity and loss of life:** Cholera outbreaks have resulted in significant loss of life, particularly in areas where there is low health facility coverage and limited knowledge of community/ household case treatment. The 2008-2009 outbreak was particularly severe, with over 4,000 deaths and nearly 100,000 cases. During 2023-2024 the country was affected by the largest cholera outbreak since 2008, which affected all of the country's 10 provinces and was reported in 62 districts, resulting in 34,549 cases and 719 deaths[4]. The Case Fatality Ratios (CFR) reported in Zimbabwe are typically above the WHO maximum acceptable thresholds of 1%, indicating inadequate treatment access or quality. According to the WHO the overall CFR for the 2023-2024 outbreak was 2.1% countrywide, with significant geographic disparities. Some rural districts in Manicaland reported CFRs higher than 5% while urban areas such as Harare maintained a lower CFR of 1.2% potentially attributable to better healthcare access and the targeted ZRCS response interventions in these areas.

[3] Satellite Based Assessment of Hydroclimatic Conditions Related to Cholera in Zimbabwe | PLOS One

[4] Cholera_SitRep__15_June__2025 (1).pdf

- **Strain on Healthcare Systems**: The recurring outbreaks have severely strained Zimbabwe's healthcare system, which is already under-resourced and not fully able to meet basic demands. Large outbreaks, such as the 2023-2024 one, overwhelm healthcare facilities, leading to shortages of medical supplies and personnel.
- **Loss of Income**: Cholera outbreaks disrupt economic activities in affected areas, particularly for households reliant on the informal sector, which accounts for 75 % of employment in the country. The informal sector is very susceptible to shocks and is particularly affected by interventions which seek to limit the spread of outbreaks, for example the closure of markets and banning of food vending. On an individual level, households may experience a significant loss of income when a breadwinner is unable to work, or when markets and food vending are prohibited[5].Cholera can also impose unexpected and unaffordable critical health expenditures on vulnerable households which can eliminate savings and force negative economic coping mechanisms. The economic burden of cholera, including healthcare costs and loss of income, exacerbates poverty levels in affected communities.
- **Disruption of Education:** Outbreaks have disrupted education, particularly in vulnerable communities. Schools often close to prevent the spread of the disease, affecting children's education. According to UNICEF, 94% of rural schools were closed in 2009, and national attendance dropped dramatically from over 80% to just 20%, disrupting the education of thousands of children. Cholera has both direct and indirect impacts on education. Firstly, access to education is affected for children who become sick or who have to care for sick family members. According to UNICEF approximately 31 per cent of cases of cholera in Zimbabwe are children aged below 15 years, and 14 per cent are children under five years[6]. More indirectly, the economic impacts of cholera on the household economy can affect access to education through loss of income for school fees and other educational expenses7.
- **Competing Government Spending**: Responses to cholera pose a significant financial burden on public authorities and during large outbreaks can require the allocation of funds and human resources towards response rather than ongoing health services.[8] An estimate of the funding requirements for the response to the recent cholera outbreak stands at over 8 million USD, highlighting the significant resource burden of large outbreaks on the country. On a broader scale, financial losses for the region are estimated to be as high as 156 million USD per year[9]

An important consideration in the analysis of the impact of cholera in Zimbabwe is the geographic location of the outbreak, as vulnerabilities and risk profiles of populations differ significantly between urban and rural areas.

Urban and peri urban areas: Urban Zimbabwe is increasingly characterized by high population densities, prevalent environmental hazards and a highly mobile population, which contributes to increasing transmissibility of water borne diseases and makes outbreaks of cholera in urban areas a particular concern. This is particularly true in semi-formal peri-urban areas, where rapid population growth and urbanization have outpaced the expansion of public health infrastructure. A critical lack of adequate WASH services and public health services in

[5] A Perspective on the 2023 Cholera Outbreaks in Zimbabwe: Implications, Response Strategies, and Policy Recommendations - PMC
[6] Cholera Outbreaks Disrupt Education, Health in Southern Africa
[7] A Perspective on the 2023 Cholera Outbreaks in Zimbabwe: Implications, Response Strategies, and Policy Recommendations | Journal of Epidemiology and Global Health
[8] A Perspective on the 2023 Cholera Outbreaks in Zimbabwe: Implications, Response Strategies, and Policy Recommendations | Journal of Epidemiology and Global Health
[9] https://pmc.ncbi.nlm.nih.gov/articles/PMC2691726/

these areas drive the spread of cholera outbreaks, as evidenced by the very high case-loads appearing in peri urban Harare and Chitungwiza which accounted for the majority of the cases in 2023-2024. The Multi Sectoral Cholera Elimination Plan indicates that 69.5 % of the cases reported nationwide were located in Harare prior to 2020 and the high risk of cholera transmission in these areas is evidenced by the fact that 10 of the 13 Tier one cholera hotspots are located in Harare. The hotspot classification within Harare is further informed by the 2023 study, A Stitch in Time (Ayling et al, 2023), which clearly shows the close connection between degraded urban infrastructure, in particular sewerage bursts, with urban cholera caseloads[10]. The high density areas of Harare (Budiriro, Hopley, Glenview, Kuwadzana, Dzivarasekwa, Mbare, Glen Norah and Highfields) are particularly prone to outbreaks of cholera and will be prioritized for intervention during activations of this protocol.

Though there are much higher caseloads in urban areas, the population generally has better access to public health infrastructure and affected households are more easily able to seek emergency health services and support when required. There is additionally easier access to products and information that are essential for case management and the mitigation of spread (Oral Rehydration Solution, WaterGuard, risk communication materials). This results in a generally lower CFR when compared to the more remote rural areas of Zimbabwe. Though Harare has historically recorded the majority of cases, it has recorded a much lower portion of the deaths, with an official CFR for the 2023-2024 outbreak of 1.2%. This figure is based on confirmed cases, which are limited by a low testing capacity in country and as a result the actual CFR for urban Harare is likely lower.

Rural areas: Rural Zimbabwe is similarly affected by a deteriorated public health service and infrastructure, however there is a generally lower concentration of environmental hazards that are conducive to the spread of cholera than in urban areas. This is matched by lower population densities in rural areas which further reduces the caseloads that are generated during rural outbreaks. Despite comparatively lower caseloads rural populations have a much higher vulnerability to the acute impacts of cholera outbreaks due to the limited availability of life saving products and the long distances to emergency health services, such as Cholera Treatment Centres (CTC) and ORPs. This results in a comparatively high CFR in rural Zimbabwe, where most of the deaths from outbreaks have been recorded. The protocol aims to limit the transmission of high caseloads in Harare to vulnerable rural areas.

Explain which risks have been selected for this protocol and why

The Early Actions in this sEAP aim to reduce the risk of cholera by firstly anticipating and limiting its geographic spread in urban areas and secondly ensuring that lifesaving services are available to respond to small scale rural outbreaks.

Limit geographic spread: The strategic priority of limiting the geographic spread addresses a consistent epidemiological pattern observed across multiple outbreaks in Zimbabwe: high-density urban transmission followed by a spread to rural areas where mortality impacts are more severe. The actions included in this sEAP recognize that the highest concentration of cholera cases are located in urban areas, however, the most pronounced vulnerabilities are in rural areas. This is reflected in the proposed interventions, which use early detection and targeted containment measures in urban areas, limiting the spread to rural areas.

The target areas to limit geographic spread will be the Tier 1 Hotspot areas of Harare, particularly the high-density urban settlements and peri urban informal settlements in the south and west of the city.

Reduce Case Fatality Rates: Consistently elevated CFRs in rural districts indicate critical gaps in timely access to appropriate treatment. While acknowledging data limitations in CFR calculations due to insufficient testing

[10] A stitch in time: The importance of water and sanitation services (WSS) infrastructure maintenance for cholera risk. A geospatial analysis in Harare, Zimbabwe - PubMed

capacity at primary healthcare facilities, the consistently elevated CFRs are a concerning pattern. The CFRs which sit consistently above the WHO maximum thresholds of 1% additionally highlight the increased hazard exposure, vulnerabilities and coping capacities of populations in the different districts.

This sEAP will target rural areas countrywide where sporadic cholera outbreaks, despite generating fewer total cases, result in disproportionately high fatalities. This will be achieved through targeted capacity building interventions and the deployment of NFI and ORP kits to communities which are chronically underserved by emergency health services reducing critical time between symptom onset and effective treatment.

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

Response Approach

The sEAP utilizes investigations and case data from the region and in country to anticipate case spread, aiming to implement interventions which will limit cholera spread though:

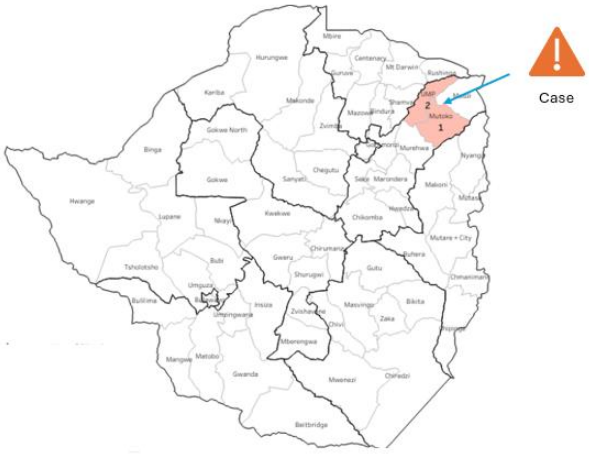
1) ***Flexible assessment and investigation measures*** to address small scale outbreaks over a wide geographical coverage
2) ***Scalable, trigger based anticipatory actions*** in densely populated urban hotspot areas, to reduce mortality and limit further onward spread to the rest of the country.
3) ***Foundations for further scale up*** through the trigger-based development of DREF applications informed by surge team deployments, prepositioned equipment and materials and enhanced coordination.

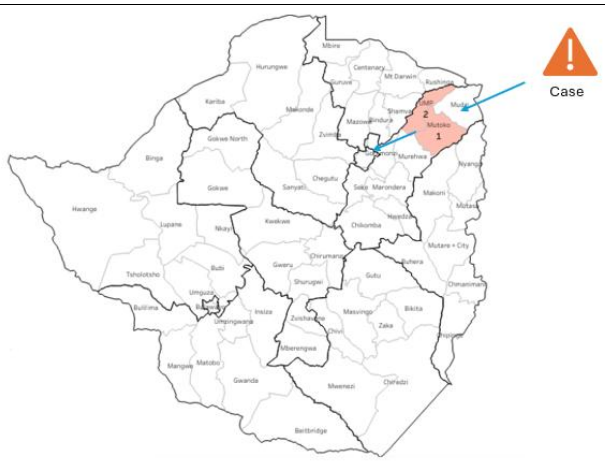
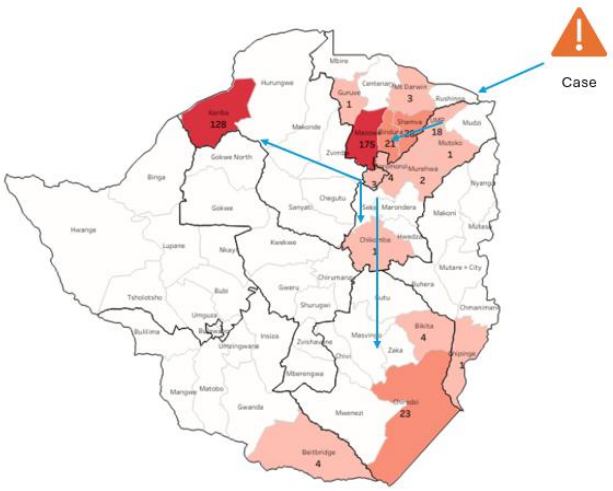
As a flexible anticipatory measure, the protocol will equip and support a mobile Surge Team of BORT and Government Rapid Response Team (RRT) trainers to support rapid investigations of small outbreaks in rural areas around the country. The results of these investigations will be further informed by Ministry of Health Situation Reports to further inform action. In addition to the investigations the Surge Teams will provide standardised BORT trainings to provincial and district level staff to support their capacity to respond. The teams will be equipped with materials to kickstart their interventions (NFI kit, Rapid Diagnostic Test kits (RDT), fuel coupons, transport allowance and assessment forms), which will assist the trained district teams to conduct immediate assessments of cases and provide basic community level interventions to reduce the potential impact and spread.

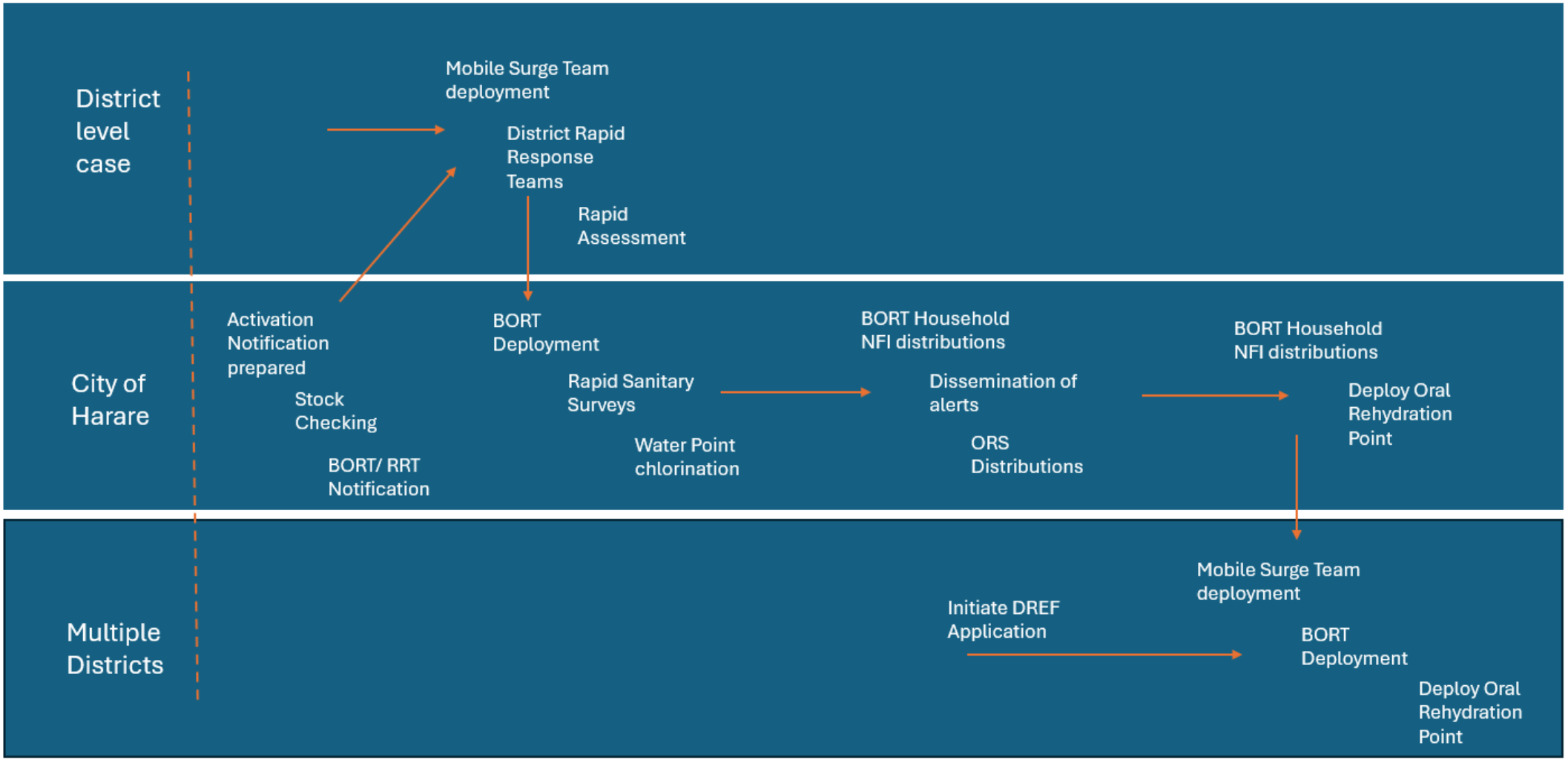
The findings from the Surge Team deployment will activate the Phase 1 trigger as defined in the framework initiating anticipatory actions in the Tier 1 urban hotspots of Harare. Key indicators from these assessments that will determine activation include case proximity to Harare (within neighbouring provinces and districts), and evidence of urban to rural transmission patterns. These actions will anticipate spread from identified districts to Harare and will implement AA to limit transmission to and within the Harare hotspots and prevent onward spread to more vulnerable rural districts.

With the support of the protocol, ZRCS will maintain an established presence of 300 volunteers in the hotspot urban areas of Harare. These volunteers will undertake trigger-based anticipatory actions to prevent the large case numbers generated by urban outbreaks. Upon receipt of an alert, the urban volunteer teams will utilize the BORT approach to deliver household cholera awareness messaging and to conduct quick assessments of chlorine residuals at water points in the hotspot areas. Inline chlorination interventions will be implemented, improving broad access to treated water supplies. If potential cases are identified in Harare, the protocol will support Rapid Response Team deployments, with the same RRT Kickstarter kits, to assess, identify index cases, likely transmission routes and to inform further mitigating interventions to be conducted by further BORT deployments.

Finally, if an outbreak is established in Harare the BORT deployments will be scaled up through the distribution of household hygiene and water treatment kits and ORS, increased bucket chlorination and the deployments of Oral Rehydration Points. During this phase the mobile Surge Team will maintain its capacity to deploy to an extended geographic location to support the assessments of new outbreak areas, deliver BORT and RRT trainings and provide NFIs and establish ORPs where necessary. This budget ceiling of this protocol does not allow for sufficient funding to conduct a large scale multi district response, however, to address anticipated needs the Action in the protocol include the anticipatory development of a DREF/EA application which will be informed by the assessments conducted by the mobile Surge Teams under phase 3 of the project. The Surge teams will provide detailed information on District outbreaks beyond Harare informing targeting and anticipating the requirements for the development of further interventions which will be supported by the DREF.

Readiness Phase: No suspected cases in the region or country **Harare:** BORT Trainer of Trainers training Reorientation of the BORT teams. ZRCS to hold readiness meetings with PNS and IFRC. Develop Inline chlorinator framework contracts and IEC materials	
Readiness Phase: Confirmed Case in Region (2 Months leadtime) **Harare:** Alerts disseminated within ZRCS through meetings of the AA Working Group. Activation Notification is prepared, stocks checked and BORT and RRT members are notified.	
Activation Phase 1: Confirmed Case in District Outside Harare **Affected District:** The surge RRT and BORT ToTs will be deployed with Kickstarter kits to train initial assessment and conduct interventions in the affected district. **Harare:** Based on the alert from the neighbouring district community level surveillance and BORT are deployed in Harare to support community level chlorination and Risk Communication and Community Engagement (RCCE) in Tier 1 hotspot areas.	

Activation Phase 2: Confirmed Case in City of Harare **Harare:** The protocol will continue the targeted deployment of BORTs, increasing to include the distribution of household NFI kits in affected areas, informed by community surveillance. Concurrent to this the protocol will continue to support City of Harare Health Department (CoHHD) RRTs with Kickstarter kits to enable increased testing and localized rapid assessments.	
Activation Phase 3: Confirmed Case + Community Transmission (Harare and multiple districts) **Harare:** BORT deployments with household hygiene kits to conduct widespread HH awareness raising**.** The protocol will support the establishment of Oral Rehydration Points based on thresholds provided by clinics. Additionally, a referral support mechanism will be established. **Countrywide:** The mobile Surge Team and BORT deployment for assessment and training in additional districts. Basic BORT deployments will conduct widespread HH awareness raising and ORPs will be established where necessary.	



Readiness	Phase 0	Phase 1	Phase 2	Phase 3
0 Cases	Outbreak in Region	Outbreak in any district	Case Confirmed Harare	Harare and National Outbreak

EARLY ACTION INTERVENTION

Overall objective of the intervention	**Objective:** To use early actions and early detection to reduce the risk of cholera transmission and reduce the number of cholera cases and deaths before and during the initial phase of an outbreak **Approach:** The ZRCS has been a lead actor in cholera outbreak responses nationwide supporting interventions that bridge national level coordination with field level interventions. With the support of RC Movement partners, the ZRCS has developed its cholera preparedness and anticipation capacities, adopting approaches that align with the strengths of the Red Cross Movement. During 2023-2024 ZRCS, responded to outbreaks in 15 districts, utilizing 996 trained volunteers to deliver support to over 800,000 beneficiaries. This response helped define the interventions, materials and capacities required for effective interventions, which have been adopted by the ZRCS in a standardized package of actions. This response approach is based on the BORT, developed by the IFRC which utilizes prepositioned stocks and trained volunteers to deliver RCCE at household level and Oral Rehydration Therapy in a systemized fashion at community level, distribute NFIs and support the referral of severe patients to health facilities. This approach is well suited to flexible responses to clusters of cases, reducing spread of cases and reducing mortality amongst affected people. In areas where cholera outbreaks become significant the BORT approach can be further strengthened through the deployment of standardized Oral Rehydration Points, which serve as focal points for community level case management (For all case management references in this document we refer to community level support provided by the BORT and ORP teams which relates to ORT, referral advice to a health facility and reporting to the CoHHD structures.) A rapid intervention to interrupt the spread of cases, particularly in urban areas, can significantly reduce caseloads and case fatalities in both rural and urban areas. The sEAP will position the NS to support anticipatory responses to cholera through: **Readiness:** The sEAP will be used to maintain ZRCS cholera readiness and anticipation capacities, oversee the existing trained BORT members and prepositioned stocks. The protocol will additionally support continued engagement with Red Cross-National Societies in the region, key stakeholders and the CoHHD to support activations. **Activation:** When activated, the sEAP will support the proactive deployment of volunteers and cholera materials to contain cholera cases, limit mortality and prevent spread to additional districts. The activation will run in three distinct phases in multiple target areas. The triggering process will be supported by the deployment of a mobile surge team to districts outside of Harare where cases are suspected.

	This will initiate the deployment of BORT teams in Harare and NFIs to implement anticipatory actions in the target hotspot areas of Harare.
Potential geographical high-risk areas that the simplified EAP would target	The sEAP focuses its intervention on cholera hotspots areas informed by the caseloads and case fatalities reported during the 2023-2024 outbreak and guided by the National Cholera Elimination Plan and ongoing identification of Priority Areas for Multisectoral Intervention. A specific focus will be placed on the urban hotspots of Harare where high population densities and greater exposure to environmental risk factors drive high caseloads and sustained community level transmission. Activities here will aim to reduce transmission from urban hotspots to the vulnerable rural areas, which exhibit significantly higher CFR due to lower access to health care services. Concurrently, the sEAP will build the capacities of both rural and urban populations to manage and deliver lifesaving ORS treatments to communities in hotspot areas. Importantly, the sEAP maintains the flexibility to respond to outbreaks that appear in non-traditional hotspot areas. The infrastructural interventions required to address these challenges are limited by underinvestment and outpaced by population growth and urban densification and the risk of outbreaks will persist. Transmission of cases from these urban areas pose an increased risk to rural populations, where the impacts of outbreaks have been worsened by a critical lack of equipment and human resources. The rural health care system is constrained and in remote areas is unable to scale up services to mitigate outbreaks. This is worsened by access challenges, where distances to health facilities and limited access to transport or referral services result in delayed treatment and increased mortality. This is highlighted by the CFR which greatly exceed those reported in urban areas. According to the WHO the CFR reported countrywide for the 2023-2024 outbreak was 2.1%, however there are wide variances with some rural districts in Manicaland reporting CFRs higher than 5%.
Who will be assisted through this operation and what criteria will be used for their selection?	**General** This EAP will target persons who are living in areas that are prone to the spread of cholera based on the hotspot locations identified in the Zimbabwe Cholera Elimination Plan (2018-2028) and evidence of the most recent cholera outbreak in Zimbabwe. The Cholera Risk Elimination Plan identifies cholera hotspots as "a geographically limited area…where environmental, cultural and/or socioeconomic conditions facilitate the transmission of the disease and where cholera persists or re-appears regularly." [11] The Plan further classifies the hotspots into Tiers, one to four, based on the mean annual incidence, persistence and population, This sEAP targets eight of the eleven Tier 1 Hotspots that are identified in the plan. The targeting within the sEAP is further informed by considerations of environmental hazards within communities and proximity to active/ recent cases. Broadly the intervention follows the Case Area Targeted Intervention (CATI) approach which is described in detail below under Readiness and Activation. **Readiness:** **National Society:** The readiness phase will primarily assist ZRCS and volunteers in the target areas, who have been trained in the BORT and ORP

[11] ZIMBABWE-MULTI-SECTORALCHOLERA-ELIMINATION-PLAN_1.pdf

	approach, will receive refresher trainings and simulations to ensure that they are prepared for rapid anticipatory interventions if required. Early Action Notifications will be predeveloped by the ZRCS to ensure that they can be rapidly submitted. Where necessary engagement with the Ministry of Health and Child Care (MoHCC) and other actors involved in the activation process will be conducted to ensure access to required information. ZRCS will coordinate the Protocol through the internal Anticipatory Actions working group for the RC Movement partners in country which was established during the EAP for Drought development. **BORT/ ORP Members:** The ZRCS has developed a strong foundation of BORT and ORP trained volunteers, supported by experienced Trainer of Trainers. During the 2023-2024 cholera outbreak response, the NS trained close to 1,000 volunteers in the BORT and ORP approach, 300 of who are based in the target wards of Harare. All of the Harare volunteers have practical experience and have been deployed as both BORT and ORP members over the past two years. The ZRCS maintains a database of these volunteers which details their experience and trainings received. The protocol will further develop the capacities of 300 volunteers, providing them with refresher trainings to ensure that they are able to provide accurate *RCCE* and to rapidly establish ORPs in anticipation of need. Further building on the experiences of the recent outbreak, the location of the ORPs will be informed by an agreed criteria which is informed by caseloads, community engagement, water availability and sanitation access. Accessibility for vulnerable or disabled populations will be an important criterion, as will safety and security, Where possible the location of ORPs will be informed by previous experience and agreements with community leaders. **<u>Activation:</u>** The persons who will most directly benefit from the activation will be the members of most at risk communities, the households and neighbours of recent/ active cases and the actual cases themselves. Finally, the District RRT/ clinic staff in the target areas will be provided with a short refresher training focused on case management, reporting and messaging. There are four main categories of beneficiaries under the sEAP for cholera which informs their selection and the subsequent type of support that they will receive during an activation. These categories will be informed by geographical location, history of close or direct contact with cases or those cases who are currently affected by cholera. **Persons who reside in cholera hotspot areas:** These beneficiaries will be residents of locations that are historically affected by cholera, and which have conditions that are conducive to the spread of water borne disease. These are typically high-density or informal settlements which have poor access to safe water supplies and sanitation facilities and which are located in areas with a high-water table or poor drainage. Persons residing in these areas will receive a combination of RCCE services which highlight the location of ORPs, CTCs and information around cholera prevention strategies and home treatment options. This same level of support will be provided to households who do not live in the above-described areas, but which have recently experienced a case or cluster. In Harare there are 9 hotspot areas which have been identified by the Cholera Risk Elimination Plan. At this level the sEAP will additionally target the distribution of community level water treatment supplies and engage with

	Water Point Committee (WPC) members to provide training on chlorination and water treatment. This will be supported through the dissemination of IEC materials and cholera treatment messaging. **Persons who have been in close or direct contact with cases:** Family members and immediate neighbours of recent or active cases will be provided with support from BORT members during targeted household visits. The support will focus on providing cholera prevention messaging and identification and elimination of possible transmission routes. Training on the preparation and use of ORS will be provided along with ORS, soap and water treatment products, allowing them to quickly support any additional cases which appear in the household. This will be further supported by the provision of IEC materials that clearly indicate symptoms, household treatment options and referral pathways. Any active cases that are identified by the BORT members will be recorded and reported on to the EHT/ ORP for collation before being further shared with the EHTs and clinics. The records of the patients will be kept confidential and will be maintained by the BORT members for subsequent follow up. **Persons who are currently affected by cholera**: Any cases actively identified by BORT household visits will be provided with ORS at home or, where necessary, will be assisted with referral. Cholera cases may also refer themselves to the established ORP services where they will be provided with support and ORS and where necessary provided referral on to the nearest CTC/*clinic*.
Trigger(s) statement	Due to the complex risk factors that impact the likelihood of onwards transmission of cholera, The sEAP adopts a staged intervention which uses separate triggers to initiate three consecutive phases of action. **Phase 1: Trigger:** A confirmed cholera case in any district of the country will trigger: • In the affected district mobile Surge Team will be deployed to support rapid investigations, provide BORT trainings and support Rapid Response Team (RRT) capacity. • In Harare: BORT teams will be deployed to disseminate community level cholera messaging and surveys to inform targeting (environmental hazards and Free Chlorine Residual (FCR) tests) **Phase 2: Trigger** A case confirmed in Harare will trigger: • Rapid Response Teams investigations which will be supported in target areas • Branch Outbreak Response Team deployment with NFI's to support targeted distributions and continued cholera awareness information dissemination • The distribution of inline chlorinator tablets to areas identified by the assessments under Phase 1 • ZRCS begin developing DREF document to anticipate needs and actions outside of Harare **Phase 3: Trigger** Evidence of community transmission in Harare and spread to additional districts • BORT members deployed with NFI and ORPs • Surge Team continue to support a limited capacity to respond to outbreaks countrywide, preparing for more sustained interventions
Trigger threshold justification	**Case and outbreak definitions**

	In 2025 the MoHCC updated its cholera case and outbreak definitions to reflect the case patterns experienced in recent outbreaks. For clarity and alignment these updated case and outbreak definitions have been adopted by the protocol as below:
	• **Suspected cholera case:**
	  ○ In areas where a cholera case has not been declared: Any patient aged two years and older presenting with acute watery diarrhea and severe dehydration or dying from acute watery diarrhea.
	  ○ In areas where an outbreak is declared: Any person presenting with or dying from acute watery diarrhea
	• **Probable cholera case:** Clinical case identified using cholera definition and RDT positive.
	• **Confirmed cholera case** A suspected case with Vibrio Cholerae 01 or 0139 by culture or PCR
	• **Cholera outbreak:** An outbreak is defined by the occurrence of at least one confirmed case of cholera and evidence of local transmission. An outbreak can only be declared by Government of Zimbabwe.

Next steps – For National Societies that intend to develop a full EAP (Optional)	The ZRCS has established an internal multi-disciplinary AA working group which is meeting regularly to guide the planning, development and implementation of AA work within the ZRCS. The ZRCS has successfully developed and activated a full EAP for Drought, which was validated in 2022 and activated in 2023. The EAP for Droughts is currently undergoing review and will be resubmitted in 2025. This experience with the development and activation of EAPs will be used to further develop this sEAP into a full EAP. The development of a full EAP will require the building of volunteer capacity to implement Community and Events Based Surveillance approaches, which will be refined through the implementation of the sEAP activations. Proof of concept and evidence generation during the activations will provide insights into the critical areas that require development to scale up to a full protocol. The sEAP includes a review process which will be facilitated by the AA working group, with the support of stakeholders.

PLANNED OPERATIONS

	**Water, Sanitation and Hygiene**	**Budget**	**77,645**
		No. people targeted	59,250
Indicator:	**# of people with access to improved water quality**	**Target:**	31,250
Indicator:	**# of people reached with cholera messaging to reduce spread**	**Target:**	28,000
Readiness activities:	1. **Readiness meetings:** Meetings will be held immediately following the validation of the Protocol to ensure there is a		

	good awareness of the activities and responsibilities of the HNS, IFRC and PNS in country. The meeting will be chaired by the ZRCS Operations Director, with members of the internal AA working Group. Focused update meetings will be held at regular intervals throughout the project with CoHHD/ MoH to ensure the project is informed on trends related to communicable disease, water supply and sanitation infrastructure issues which may indicate outbreaks susceptibility. 2. **Develop Framework contracts with inline chlorinator provider:** To provide rapid improvements to community level coverage of chlorinated water sources the ZRCS will engage with inline chlorinator suppliers and develop a framework contract to support the immediate installation, refill or rehabilitation of urban in-line chlorinators. The framework contract will significantly reduce the timeframes for water treatment activities. 3. **BORT/ RRT training of trainers:** Following the initiation of the protocol trainings will be provided to volunteers, CoHHD staff and national level Rapid Response Team members. The trainings will be based on the existing BORT and RRT manuals and will ensure that there is a core of trained personnel able to mobilize for additional trainings. 4. **Design/print general cholera IEC materials:** Standardized IEC materials which have been developed to support the BORT approach ready for use in case of cholera emergency. The Protocol will support the development of 'BORT Bulletins' which will contain short relevant updates for BORT members and Red Cross Staff which will be sent out on a regular basis.
Pre-positioning activities:	**1. Procurement and pre-positioning WASH**: The prepositioning of materials included in this protocol has been supported by the DG ECHO funded Cholera Preparedness Project and with Disaster Response Funding from the Finnish Red Cross. During the readiness phase the protocol will assess the stocks to identify gaps, expiration dates and arising needs. The protocol maintains a contingency fund which can be utilised to purchase additional materials, specifically: a. BORT household hygiene kits and b. Water treatment commodities for inline chlorination c. ORP Kits: The DG ECHO funded Cholera Preparedness Project has supported the purchase and prepositioning of 15 ORP kits to support responses to cholera. Of these 12 remain available for deployment and 5 will be specifically linked to the sEAP to support the proposed interventions in the protocol. In the readiness phase the NF's and Hygiene kits will be prepacked to ensure that they are ready for rapid distribution to households. The procurement of chlorine products (aqua tabs, HTH, water guard) will be supported by framework agreements to limit the need for storage of items with a limited shelf life. Procurement

	agreements with service providers will be put in place with delivery of the materials agreed on an as needed basis.
Prioritized Early Actions:	1. **Activation meeting:** chaired by ZRCS Operations Director including ZRCS, PNS and IFRC. The meeting will define and agree the scope of interventions and initiate the deployment of the surge team and initiate Early Actions in Harare. 2. **Rapid assessment of FCR:** Following the activation of the protocol and deployment of the national Surge Team to the affected district, the sEAP will initiate actions in Harare to identify and improve water quality in the target hotspots. This will be conducted through a rapid assessment of communal water points to gauge the presence of FCR at water points. 3. **Point of collection and point of use chlorination:** Based on the data gathered by the rapid assessment the sEAP will activate its framework contract with water quality services providers to improve access to chlorinated water in targeted areas through the distribution of inline chlorinator recharge tablets and the installment of incline chlorination points where necessary. In line chlorinator tablets will provide >1 month of treated water at community points which will be further enhanced through the targeted distribution of household water treatment products during Phase 2 BORT deployments. The protocol will support the installation of 25 inline chlorinators which will benefit 250 households at an average of 5 persons each, providing improved chlorination to 31,250 beneficiaries. 4. **Increased community level assessments** Volunteers will support the CoHHD to conduct rapid community level assessments to identify environmental hazards in the target areas for example sewer bursts and other sources of contamination to improve targeting. This will inform BORT messaging and deployments. 5. **BORT orientation/refresher training and simulation exercises:** 300 ZRCS volunteers have been trained in the BORT approach in Harare since 2023 and all of these volunteers have participated in BORT/ ORP deployments to cholera. In order to strengthen these teams and their collaboration with stakeholders the protocol will support targeted refresher trainings. 6. **Targeted BORT deployment in Harare:** Based on the anticipation of cases in the hotspot areas and the information generated by the community level surveillance the sEAP will deploy BORT members to provide anticipatory RCCE and promote the adoption of protective behaviours and practices to reduce the chances of cholera outbreak. The Protocol will support two deployments (5 days each) in Rural areas which report outbreaks, in preparation for additional DREF/ EA funding. Based on previous interventions the BORT deployments can reach 5,600 households, or 28,000 beneficiaries.

Phase 2 Early Actions	1. **Expanded BORT deployment:** If a case is reported in Harare the sEAP will support the expanded deployment of BORT teams, which will include the targeted distribution of pre purchased BORT household hygiene kits. The hygiene kits will prioritize household water treatment products, soap and disinfectant and will be distributed to the surrounding community of suspected/ confirmed cases following the BORT/ CATI approach. This will be accompanied by continued cholera prevention messaging and enhanced reporting of suspected cases to CoHHD RRTs.
Phase 3 Early Actions	1. **Deployment of the Surge Team to target district:** The Surge Team will be deployed immediately to affected districts outside of Harare to conduct rapid assessment in areas with suspected cases in coordination with CoHHD and MoHCC. The team will be composed of national RRT members and BORT Trainer of Trainers who will support district level structures to investigate the cases. The teams will be equipped to support rapid assessments, including RDT kits to allow for quick confirmation of results

	Health & Care	**Budget**		**40,144**
		No. people targeted		2,130
Indicator:	**#of people trained in ORP approach**		**Target:**	380
Indicator:	**# of people covered by Oral Rehydration Points**		**Target:**	1,750
Readiness activities:	1. **Development of IEC and RCCE strategy:** The RCCE strategy will be informed by the rapid assessment survey findings to ensure that the approach is appropriate, evidence based and community driven. Targeted cholera awareness messaging will be developed to support effective RCCE interventions by the BORT/ ORP teams. A key component of the messaging will focus on ORS and highlight the availability of the ORP within the target areas once deployed. 2. **Community feedback mechanism:** The establishment of effective feedback mechanisms will be planned prior to any community engagement. This will primarily support confidential feedback from beneficiaries on the services provided and allow for adjustments. A further consideration is the identification of rumours and other barriers to effective health seeking behaviour, which can be addressed through CEA and messaging informed by historical KAP surveys and RCCE activities. The sEAP will include procedures for the identification and addressing of rumours and procedures to support the engagement of religious leaders and local leaders. 3. **Coordination:** The ZRCS will maintain active participation in relevant national and local coordination forums, particularly			

	the Emergency Sanitation Action Group and the Agencies Cholera Technical Working Group, both of which are the recognized WASH and Cholera coordination platforms. Further to this the ZRCS can participate in the following cholera related coordination platforms: a. Risk Communication and Community Engagement (RCCE) Pillar b. National Health Cluster c. Cholera Task Force TWG 4. **Support ORP simulation exercises**: Aligning with the BORT refresher trainings the sEAP will support simulation exercises to build familiarity with the establishment of ORPs. This will support the agreement of reporting roles between ZRCS and stakeholders and will agree criteria to guide the safe location of ORPs in communities. 5. **Development of SOP for ORPs:** Informed by the simulation exercise the sEAP will support the development of internal Red Cross SOPs to guide the deployment and decommissioning of ORPs. This will assist with the definition of thresholds for stakeholders to request the deployment of ORPs. Thresholds for the deployment of ORPs will be further developed by the ZRCS during this and subsequent cholera preparedness programming, through collaboration with stakeholders and partners. 6. **Data review meetings:** After the activation of the sEAP the deployment of ORPs will be informed by thresholds identified by target health facilities based on historical caseloads. To prepare for potential deployments the sEAP will engage with stakeholders to ensure that the required data has been assessed and reviewed and is available to inform deployments.
Prepositioning activities:	1. **Procurement of investigation materials**: The protocol will support the purchase of essential materials to support rapid investigations of cases by the mobile Surge Team. The materials will be prepacked and will include RDT Kits, investigation forms, fuel coupons and training materials. These kits will be prepositioned with the NS and available to use by the Surge Team as needed. 2. **Oral Rehydration Point Kits:** The pre-positioning of ORP kits under this protocol is supported by the DG ECHO funded Cholera Preparedness Project which has supported the procurement of 15 ORP kits which are stocked in the ZRCS national warehouse and available for rapid deployment. Five of these kits are available for deployment under this protocol, with the remainder in place and available if the situation requires. The ORP kits are supplemented by HTH stocks, NFIs and ORS necessary to run the ORPs at community level. The ZRCS maintains additional community cholera management materials which were purchased in December 2024 through funding from the IFRC. These additional 27 ORPs provide an increased capacity for scale up responses where necessary.

	3. **Printing of IEC materials:** The protocol will support the printing of the standard BORT and ORP simulation materials and IEC Materials developed by the IFRC. 4. **Procure visibility materials**: Visibility for volunteers who will staff the ORPs will be procured and prepositioned along with relevant Personal Protective Equipment (PPE) that is not already included in prepositioned ORP kits.
Phase 1 Early Action	1. **Deployment of the Surge Team to target district:** The Surge Team will be deployed immediately to affected districts outside of Harare to conduct rapid assessment in areas with suspected cases in coordination with CoHHD and MoHCC. The team will be composed of national RRT members and BORT Trainer of Trainers who will support district level structures to investigate the cases. The teams will be equipped to support rapid assessments, including RDT kits to allow for quick confirmation of results.
Prioritized Early Actions phase 3:	2. **Phase Activation meeting:** Following the activation of Phase 3 Early Actions the ZRCS Operations Director will chair a meeting with NS, PNS and IFRC. This meeting will inform the scope of deployment required, initiate the release of required materials and notification of BORT volunteers. 3. **Targeted deployment of ORPs (City of Harare):** The sEAP maintains the capacity to deploy 5 ORPs to target areas based on caseloads and thresholds communicated by the CoHHD clinics. The ORP kits will primarily target Harare, however, will be available to support outbreaks in districts around the country, supported by the mobile Surge Team. The locations for ORP deployments will be informed by criteria which considers need, safety and accessibility and will be positioned with the support of local authorities, local leadership and community consultation. 4. **Targeted deployment of ORPs (multiple Districts)** If an outbreak has spread to multiple districts beyond Harare the protocol has the capacity to deploy a further 2 prepositioned kits will be deployed, subject to the availability of additional funding not covered by this protocol. Based on previous responses each ORP can expect to serve 250 persons over a 2-week period, bringing the expected number of beneficiaries to 1,750 for the ORP intervention.

ENABLING APPROACHES

	Secretariat services	**Budget**	**18,313 CHF**	
		No. People targeted		
Indicator:			**Target:**	
Readiness activities:		a. Contribution of Salary to CCD Ops Mgt		

	b. Bank Charges Year 1
Prepositioning activities:	**1.** *Insert more lines as required*
Prioritized Early Actions:	c. Bank Charges EA d. Contribution of Salary to CCD Ops Mgt **e.** Travel costs for cluster supervision

	National Society Strengthening	**Budget**	**79,983 CHF**
		People targeted	380
Indicator:	# of Standard Operating Procedures developed and approved by the NS for cholera	**Target:**	2
Indicator:	# of staff and volunteers trained in anticipatory approaches to cholera	**Target**	380
Readiness activities:	**1. *Cholera Preparedness Project Coordinator 50%:*** The Project Coordinator will provide ongoing support to the development of preparedness capacities in the NS and will maintain continued coordination with stakeholders and partners. The development of framework contracts, planning and training of readiness capacities will be covered by this position during non-activation years.		
Prepositioning activities:	**1. *NA***		
Prioritized Early Actions:	**1.*Cholera Preparedness Project Coordinator 50%:*** The project coordinator will guide the activation process, ensuring that required data is shared from the target districts, notifications are developed and submitted and that planning, funding and implementation of interventions are conducted according to the agreed schedule of the sEAP. ***2. Mobile District Field Officer 100%:*** During an activation the NS will allocate a DFO to support the assessments, trainings and activities under the early action segments. The DFO will need to be allocated to the protocol rapidly to ensure that actions are implemented according to the planned schedule. ***3. Finance Assistant 40%*** The Finance assistant will support all financial processes during the activation period. ***4. PMER Officer 20%*** The PMER officer will support monitoring of all project activities following an activation, ensuring the protocol achieves its set goals and objectives		

	Partnership and Coordination	**Budget**	**3,196 CHF**
		People targeted	20
Indicator:	# of coordination meetings held by the AAWG during the project	**Target:**	8
Readiness activities:	**1.** During the readiness phase of the project ZRCS will maintain regular coordination meetings regarding Anticipatory Action through the AA WG with representatives of the IFRC and PNS's. The AA WG meetings are currently scheduled to be held monthly chaired by ZRCS and will serve as a platform for the discussion of: 1) Validation and Initiation of the protocol 2) Planning and implementation of the readiness activities 3) Monitoring, activation and submission of activations 4) Coordination and the development of supplemental actions (DREF/ EA)		
Prepositioning activities:	**1.** *NA*		
Prioritized Early Actions:	**1.** ***Development of DREF submission package:*** Informed by the activation of phase two early actions (confirmation of cases in Harare) ZRCS will call a meeting to inform the IFRC of their intention to develop a DREF which will address outbreaks which occur outside of Harare. The DREF document will be informed by the findings of the mobile Surge Teams deployments in additional districts and will leverage the existing prepositioned stocks. The DREF document will support the sustained interventions which will be required as a result of a multi- district cholera outbreak. **2.** ***Lessons learned workshop:*** Following the completion of the Early Actions the ZRCS AA Working Group will host a lessons learned workshop which will assess the effectiveness and appropriateness of the trigger and actions undertaken in the EAP and will support resubmission and informing lessons for the development of a full EAP.		

CONDITIONS TO DELIVER THE EARLY ACTION

Experience and/or capacity to implement the early actions. *Assumptions or minimum conditions needed to deliver on the early actions*	The Zimbabwe Red Cross has staffed provincial offices representing the National Society in each of the 8 rural provinces and the 2 urban provinces of Zimbabwe. The NS has 25,000 volunteers around the country, almost 1,000 of whom have been trained in the BORT and ORP approach (300 in Harare and 700 in Manicaland, Masvingo, Mashonaland East, Midlands and Mashonaland West). During the 2023-2024 outbreak, the Zimbabwe Red Cross was able to quickly mobilize and train volunteers to respond to outbreaks in both rural and urban areas. The Zimbabwe Red Cross has strong working relations with all Government of Zimbabwe structures and is the only Non- Governmental Organisation with a

(including issues to be resolved)	permanent seat at the Department of Civil Protection, strengthening its capacity to coordinate with Government stakeholders in provinces and districts across the country. During the 2023-2024 cholera outbreak the ZRCS conducted repeated deployments of BORT volunteers in both rural and urban settings within days of the receipt of an alert. This capacity has been further developed through the cholera preparedness and response programming that has been implemented during 2023-2025. The anticipation of outbreaks in Zimbabwe is particularly important given the high impact of historical outbreaks of cholera and current low coping capacity of the GoZ to respond to large scale outbreaks. It is especially important that the protocol anticipates the spread of cholera to Harare, as this is an identified springboard for national level outbreaks. As such the protocol maintains the capacity to rapidly scale interventions where anticipated, or to maintain interventions at a sustained level. Due to the possibility of cases re-emerging or going undetected this sEAP does not include a traditional stop mechanism, however, the phased approach adopted in this sEAP allows for a scale down mechanism employed in cases where outbreaks are contained by interventions or do not spread beyond their initial geographic location. The scale down options is present at each of the phases of intervention which will allow the sEAP to conserve resources in order to respond to future cases and outbreaks. **Phase 1:** The initial interventions employed during Phase 1 of the sEAP rely on capacity building and light BORT deployments focused on RCCE. In the event that no further spread of cases to neighbouring districts is identified the phase 1 activities can be tapered off. **Phase 2:** Secondary interventions under Phase 2 scale up enhance the BORT deployments to include NFIs, which again can be sustained to address cases without the need to proceed to the final phase. **Phase 3:** Finally, Phase 3 will utilize thresholds generated by local clinics to determine whether ORP deployments will be necessary. If thresholds are not met, or if there is no specifically identified need, the sEAP will not proceed to this stage.
Red Cross Red Crescent Movement partners, Governmental / other agencies consulted/involved on this simplified EAP	This protocol has been developed with significant engagement with RC Movement partners in the region, through sEAP focused meetings guided by the IFRC Africa Cholera Coordinator. This has shaped the approach and actions identified in the protocol. The protocol has been developed with technical support from the FRC through the DG ECHO funded Cholera Preparedness project and is based on learnings from the responses to outbreaks conducted during this project. The protocol leverages capacities and prepositioned stocks that were developed and procured during the DG ECHO project and is further aligned with FRC supported cholera preparedness programming. The design of the protocol has also taken into account the increased capacities of the ZRCS to conduct cholera responses through prepositioned stocks that have been procured by the IFRC through the 2023-2024 Cholera Emergency Appeal. The stocks made available through the Emergency Appeal will be utilized during any necessary scale ups that exceed the capacities of the sEAP, particularly for outbreaks outside of Harare. The protocol includes the development of a DREF/ Appeal which will utilise these stocks and mobilise further funding for the NS.

	Engagement with actors across the development and humanitarian spheres, as well as coordination with government authorities ensures that the sEAP is well aligned with ongoing development and humanitarian programmes. Moreover, the unique position of ZRCS as the only non-governmental agency with a permanent presence in the country allows it to sustain a community-centred approach and a resilience lens bridging humanitarian and development objectives. ZRCS in coordination with UN and Non-Governmental Organisations established the FBA/AA COP in 2019, which has been meeting under a rotating chair, on a monthly basis. Through the COP, ZRCS coordinates with a wide range of humanitarian and development actors working on Anticipatory Action in Zimbabwe towards early warning messaging and standardized early responses to hazards in the country. At present the CoP comprises Welthungerhilfe, WFP, Mercy Corps, UNDP and UNESCO, along with representatives from Government departments including Scientific Industrial Research and Development Centre (SIRDC), Department of Civil Protection (DCP) and Meteorological Services Department (MSD). The development of this sEAP has been based on meetings with the CoHHD throughout the 2023-2025 period. These engagements have been facilitated by the DG ECHO funded Cholera Preparedness project which has supported the development of this protocol. Meetings with the CoHHD have been conducted at both field and management level, specifically to identify and define approaches and interventions to support AA programming in Harare and Zimbabwe.

BUDGET

Early Action Protocol Summary

EAPcode - Zimbabwe Red Cross Society
Cholera

Operating Budget	Readiness	Pre-Pos Stock	Early Action	TOTAL
Planned Operations	**23,568**	**22,368**	**71,853**	**117,790**
Shelter and Basic Household Items	0	0	0	**0**
Livelihoods	0	0	0	**0**
Multi-purpose Cash	0	0	0	**0**
Health	10,292	1,127	28,725	**40,144**
Water, Sanitation & Hygiene	13,276	21,241	43,128	**77,645**
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	**57,845**	**0**	**43,648**	**101,493**
Coordination and Partnerships	0	0	3,196	**3,196**
Secretariat Services	8,452	0	9,861	**18,313**
National Society Strengthening	49,393	0	30,591	**79,983**
TOTAL BUDGET	**81,413**	**22,368**	**115,501**	**219,282**

all amounts in Swiss Francs (CHF)

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