www.ifrc.org
Saving lives, changing minds.

Emergency Plan of Action operation update

Tanzania: Cholera Outbreak

International Federation of Red Cross and Red Crescent Societies

Revised Emergency Appeal n° MDRTZ018	**Glide n°** EP-2015-000058-TZA
Operations update n° 3	**Timeframe covered by this update:11 Nov 2015 – 11 May 2016**
Operation start date: 26th, October, 2015	**Expected timeframe:** 9 months (31st , July, 2016)
Overall operation budget: CHF 1,290,421 (including CHF 188,505 DREF "start-up" loan)	
Number of people affected: 2,000,000	**Number of people to be assisted:** 226,000 estimated in Arusha, Dar el Salaam, Mwanza and Tanga
Host National Society presence (n° of volunteers, staff, branches): 480 Volunteers, 4 Regional Coordinators, 1 National Staff at the Headquarter, **4 Regions**: Dar es Salaam, Tanga, Arusha and Mwanza	
Red Cross Red Crescent Movement partners actively involved in the operation : International Federation of Red Cross and Red Crescent Societies	
Other partner organizations actively involved in the operation: Ministry of Health Community Development Gender Elderly and Children (MoHCDGEC), UNICEF, WHO, MSF Spain, CDC, Water Aid, PSI and DAWASCO/DAWASA	

Summary of major revisions made to emergency plan of action: The Revised Emergency Appeal seeks an extension to the end of July 2016 for the appeal to be a total of 9 months instead of the original 6 months, in order to ensure that all the activities are completed. Delay in implementation is attributed to the fact that the geographical areas that need to be covered are vast, causing a time lag in the implementation of various activities. The communities live in remote and distant areas and thus a significant amount of time is spent on transportation (by road, ferry and boat). In addition, some of the activities had to be approved by the Tanzania Ministry of Health to include community based surveillance and Child Hygiene and Sanitation Transformation before implementation, causing a further delay.

There are no alterations to budget.

A. Situation analysis

Description of the disaster

- **15 August, 2015**: First cholera outbreak case was reported in Dar es Salaam's Kinondoni district before spreading throughout the Dar es Salaam region and the following twelve other regions of the country: Morogoro, Kigoma, Dodoma, Geita, Mwanza, Mara, Arusha, Tabora, Tanga, Shinyanga, Singida and Coast, and the island of Zanzibar.
- **May, 2015**: Cholera outbreak declared in Nyarugusu refugee camp on the Tanzanian/Burundi border, home to around 175,000 Burundian refugees with 4,833 cases and 40 deaths reported. The outbreak was contained through a vaccination campaign, provision of safe water and health education.
- **3 November, 2015**: A total of 7,155 cumulative cholera cases reported, with 96 deaths. Although the figures of the outbreak are lower than those of previous years, the rapid increase of cases (from 5,973 on 31 October to 7,155 on 3 November), with almost 20% of overall cases occurring in just 4 days, indicates that a sharp and rapid increase in cases is highly likely.

Fig 1: Handwashing demonstration in Arusha region

- **11 November, 2015**: IFRC launches Emergency Appeal seeking 941,146 Swiss francs for 226,000 people, with 188,505 Swiss francs allocated from the IFRC's Disaster Relief Emergency Fund (DREF) as start-up support.
- **18 December, 2015**: IFRC revised Emergency Appeal to seek 1,290,421 Swiss francs (increased from 941,146 Swiss francs) to support the Tanzania Red Cross Society (TRCS) scale-up the response n to the growing cholera outbreak for some 226,000 people.
- **January - March 2016**: New regions began to experience cholera transmission, include Iringa, Manyara and Mbeya. There was an increase in new cholera cases in Morogoro, Mwanza, Mara, Dodoma, Singida, Arusha and Simiyu. The Ministry of Health, Community Development Gender Elderly and Children (MoHCDGEC), sent rapid response and assessment teams to these regions to support the Council Health Management Teams in implementing cholera response interventions.
- **April-May 2016:** Currently new Cholera cases are still being reported in regions across Tanzania mainland, there is a reduction in the new cholera cases and deaths in the hot spot regions.

Table 1: Epidemiological Data on Cholera Cases and Related Deaths in Tanzania Mainland (May 2016)

	CUMULATIVE CASES	CUMULATIVE DEATHS	CFR %
DAR ES SALAAM	5067	45	0.9%
MOROGORO	2346	32	1.4%
IRINGA	667	1	0.2%
PWANI	388	5	1.3%
KILIMANJARO	531	6	1.1%
KIGOMA	573	14	2.4%
DODOMA	1042	36	3.5%
GEITA	391	14	3.6%
MWANZA	1943	36	1.9%
ARUSHA	1300	11	0.8%
MARA	2111	54	2.6%
SHINYANGA	96	2	2.1%
TABORA	54	1	1.9%
SINGIDA	1206	22	1.8%
TANGA	1617	17	1.1%
LINDI	205	11	5.6%
RUKWA	105	4	3.8%
MANYARA	937	6	0.6%
KAGERA	191	5	2.6%
KATAVI	78	0	0.0%
MBEYA	363	10	2.8%
SIMIYU	364	6	1.6%
MTWARA	2	0	0.0%
GRAND TOTAL	21577	338	1.6%

To date cholera has been reported in 22 out of 30 regions, as shown in Table 1. A total of 109 districts have been affected by the Cholera outbreak. The most affected districts include Kinondoni, Morogoro (M), Iringa (v),Same, Uvinza, Dodoma Mjini, Chato, Ukerewe, Ilemela, Arusha Mjini, Musoma (v), Singida (v), Korogwe (DC), Handeni (DC) and Simanjiro. Various regions have been identified as hot spots, which are characterised by high transmission rates these include Mwanza, Dodoma, Mara and Manyara. As of 18 May 2016 the cumulative cases were 21,577. A total of 338 cholera related mortalities have been reported in 70 districts. The cumulative case fatality rate, is 1.6%.

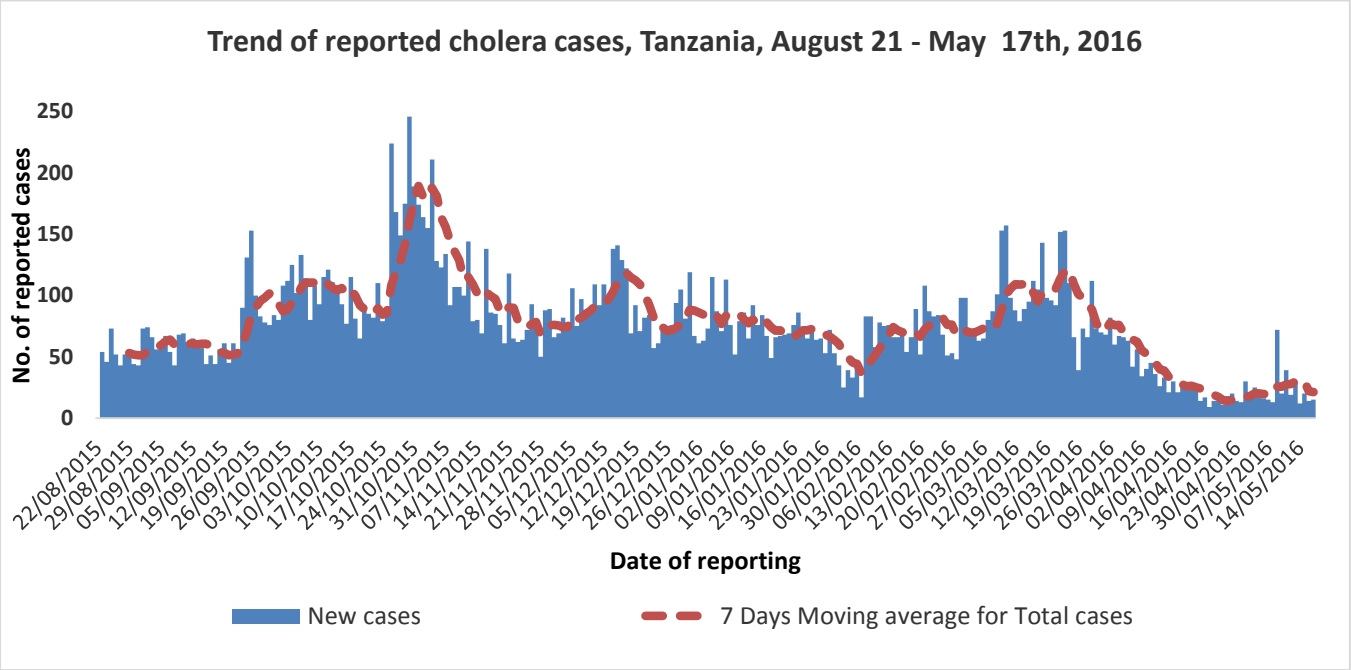


Fig 2: Trend of Cholera in Tanzania Mainland

The outbreak in Tanzania mainland; has had numerous waves in transmission as shown in Figure 2 , these were witnessed in October 2015, December 2015 and March 2016. Currently there is a reduction in the number of new cholera cases reported in the various regions. The MoHCDGEC attributes the cholera outbreak to lack of sufficient safe water and poor hygiene and sanitation practices compounded by the lack of or poor condition of sanitation facilities.

Situation of Cholera in TRCS Regions of the Cholera Operation

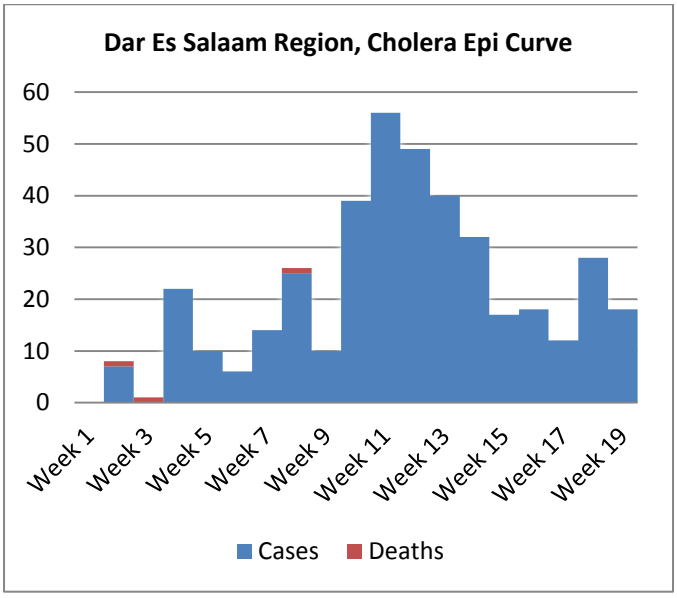
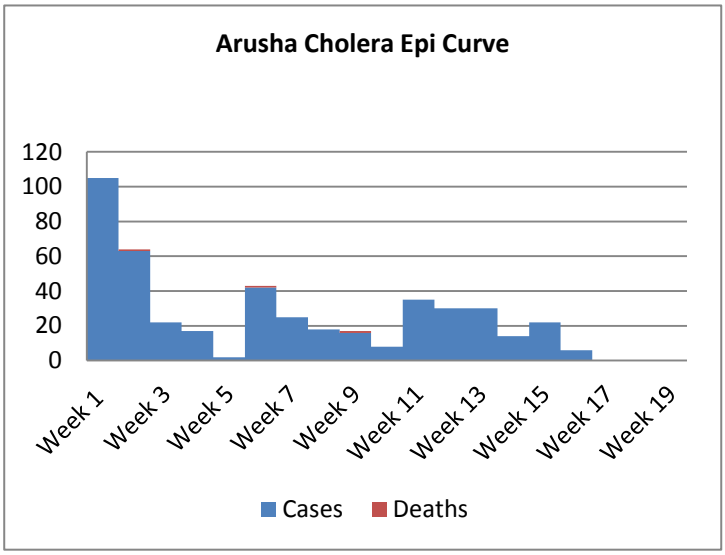


Fig 3:Trend of Cholera in Dar es Salaam Region

In Dar es Salaam Region there have been multiple upsurges in cholera cases. In 2016 this was mostly observed in the month of March. A slight increase in cases was observed following the heavy downpour that was experienced in April following the El Niño phenomenon. All the districts in the region have been affected by the Cholera outbreak. The highest number of cases has been observed in Kinondoni district with a cumulative case load of 2,326. From the onset of the outbreak in August 2015, the Dar es Salaam region has reported 45 cholera related deaths. High and fast transmission rates were observed in this region due to the high population density which is characteristic of the region.



In Arusha region an upsurge of cases was observed in the months of January, February and March 2016. The region has been zero reporting for cholera cases in the month of May 2016. The most affected districts include Arusha mjini (726 cases) and Arusha DC (346 cases). Cases of Cholera have also been reported in hard to reach wards in Monduli and Karatu districts. The transmission of cholera in Arusha region is attributed to water scarcity and poor sanitation.

Fig 4: Trend of Cholera in Arusha Region

In Mwanza Region, the most affected districts include Ukerewe (669 cases), Ilemela (562 cases) and Sengerema (282 cases). An upsurge of cases was observed in the months of January to March, 2016. In the months of April and May 2016 there was a reduction of reported cholera cases. The transmission of cholera in Mwanza region is attributed to the use of the contaminated lake water and the lack of proper latrines. In Ukerewe island high transmission is associated with the migration of fishermen to the numerous islands or fishing camps which are characterised by poor sanitation and the lack of safe drinking water.

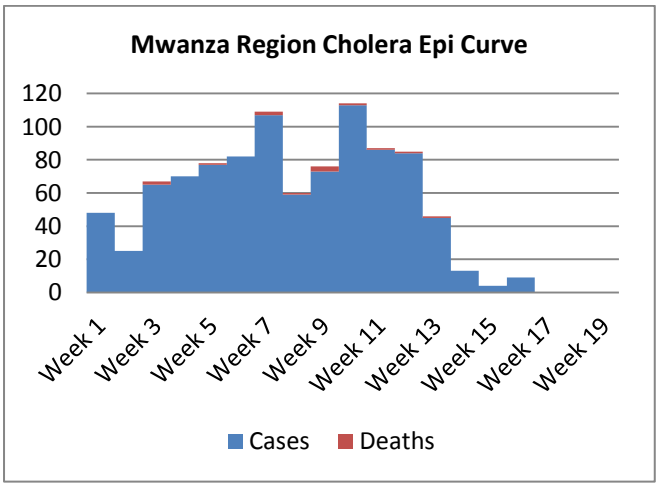


Fig 5:Trend of cholera in Mwanza Region

The Tanga region experienced an upsurge of cases in the mid –March and April 2016. The region had been zero reporting for cholera cases in mid-January and February 2016. The districts mostly affected include Korogwe DC (442) and Handeni DC (574).

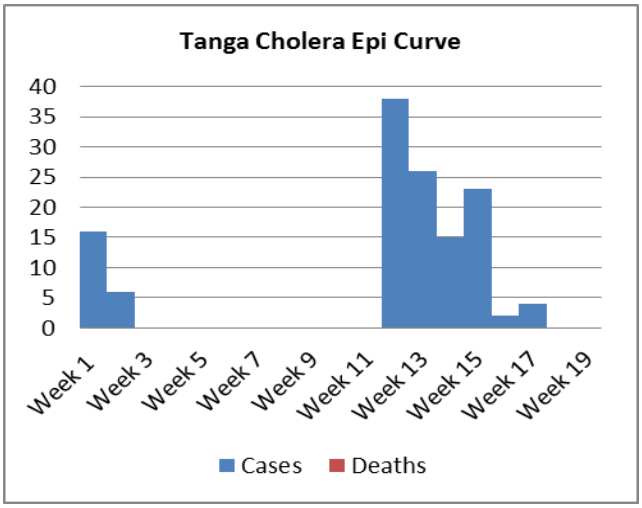


Fig 5:Trend of cholera in Tanga Region

Summary of current response

Overview of Host National Society

Following the Cholera outbreak a detailed assessment was carried out that identified that there was an urgent need for hygiene promotion and cholera awareness activities at both regional, district and community levels in all affected regions. To address these needs TRCS requested for an emergency appeal allocation, whereby CHF 188,505 was provided as a start-up loan. TRCS is responding to the Cholera outbreak in Dar es Salaam, Tanga, Arusha and Mwanza regions. TRCS personnel involved in the cholera response include; regional coordinators (4) volunteer supervisors (80) and community based volunteers (400).

At the time of this report, it is estimated that 75% of the agreed activities have been completed as per the emergency plan of action whose summary is as follows:

- Trainings on cholera awareness, hygiene promotion and social mobilization have been cascaded to 400 volunteers in the respective regions.
- The volunteers are involved in various community based WASH interventions to include targeted household distribution of chlorine tablets and education on their use. A total of 782,338 chlorine tablets have been distributed.
- A total of 107,816 households and 345,933 beneficiaries have been reached with cholera awareness and hygiene promotion messages.
- Mass sensitization is being carried out through the use of mobile cinemas and school hygiene promotion sessions in wards reporting new cholera cases.
- A total of 25,000 Information, Communication and Education (IEC) materials (developed by MoHCDGEC and UNICEF) have been printed and distributed during the household visits and mass sensitization sessions.

Fig 7: TRCS volunteers, preparing for a mobile cinema session at Longido, district, Tinga Tinga village

- Support has been provided to Cholera Treatment Centres, whereby 40 cholera beds were procured and 10 were each distributed to the respective operational regions.

TRCS is a member of the activated Cholera Response Taskforce forum and various sub-committees to include social mobilization, WASH and Surveillance at both the National and Regional levels. TRCS participates in the various meetings held by these sub-committees. In addition TRCS collaborates with other partners on other responses towards the control of the cholera outbreak. The National Society is also collaborating with UNICEF and CDC, to carry out Community based WASH interventions in Iringa, Mwanza, Mara and Dodoma regions.

Overview of Red Cross Red Crescent Movement in country

The IFRC provides assistance through its East Africa and Indian Ocean Islands (EAIOI) operations unit, and Africa region (formerly Zone) office, which are based in Nairobi, Kenya; and have been in regular contact with the National Society since the onset of the cholera outbreak, to agree on the response required.

On 26th October 2015, the IFRC deployed a Field Assessment and Coordination Team (FACT) and in collaboration with TRCS staff and volunteers (and in coordination with other actors, e.g. MoHCDGEC), conducted a rapid assessment in Arusha, Mwanza, Singida and Tanga. In addition the FACT members contributed to the development of an initial Emergency Plan of Action for the Emergency Appeal.

On 11th November 2015, the IFRC launched an Emergency Appeal, which sought CHF 941,146 to support the Tanzania Red Cross Society (TRCS) to address the needs of 226,000 people identified as being at risk to the cholera outbreak in 11 districts in the country. IFRC released CHF 188,505 from its Disaster Relief Emergency Fund (DREF) as a start-up loan to the operation.

In November IFRC deployed an interim Operations Manager for 2 months to support the NS. From January to date, TRCS has a dedicated Operations Manager who is a staff on loan from the Kenya Red Cross Society. The Operations manager will support the NS until the end of the operation in July 2016.

The IFRC EAIOI operations unit is also supporting the National Society to closely monitor and prepare for any expected effects of El Niño, as excessive flooding is likely to exacerbate the cholera outbreak. Four (4) of the regions currently experiencing the cholera outbreak, including Arusha, Dar es Salaam, Shinyanga and Tanga, are also at risk of increased flooding following El Niño.

Overview of non-RCRC actors in country

The response of non-RCRC actors remains as per the original Emergency Appeal, with a few additions which is as follows:

- **MOHCDGEC** :
  - Activated National Cholera Task Force and seven sub-committees to include Case Management, Laboratory, Surveillance, Social Mobilisation, WASH, Logistics and Coordination meet weekly.
  - The National Cholera Response plan has been completed and is ready for endorsement.
  - Emergency Operations Centre (EOC) is operational. Daily and weekly sitreps are compiled and disseminated to partners through the EOC.
  - Regional and district Task Forces have also been activated chaired by Regional Medical Officers and District Commissioners respectively.
  - Cholera Treatment Centres (CTCs) have been opened in various wards.
  - The main partners of the MOHCDGEC on the cholera response are: WHO, CDC/USAID, UNICEF,TRCS/IFRC and PSI.
  - Distribution of the Cholera story DVD to the transport sector through TABOA, to enable dissemination of the key messages on cholera control and prevention, on ferries and buses to people on transit.

- **WHO:**
  - Rapid Response Teams comprising of technical staff have been sent on 3 mission to various hot spot regions to support the Regional Health Management Teams (RHMTs) and Council Health Management Teams (CHMTs) in cholera response.
  - WHO has also provided financial support for case management, laboratory services, surveillance and social mobilization activities.

- Provided support towards strengthening water quality monitoring systems in regions in Tanzania
- In Mara and Mwanza regions there are plans to construct demonstration improved pit latrines and to drill bore holes.

- **UNICEF :**
  - Community sensitization through TRCS and water quality monitoring
  - Printing of Universal Cholera Flip chart
  - Assistance in the production of 'The Story of Cholera' video
  - Conducted SMS and PUSH messaging campaign for Cholera
  - Provided IEC and water purification tablets to provide support to Zanzibar
  - Plans to engage PSI in social marketing of Oral Rehydration Salts and water purification tablets.
  - Provides technical expertise for WASH C4D and WASH Emergencies

- **Centre for Disease Control (CDC):**
  - In Collaboration with UNICEF and MOHCDGEC, CDC is providing technical support in the implementation of a pilot project in Dar es Salaam and Morogoro regions, on bulk water chlorination targeting water vendors in the selected wards.

- **Ministry of Water and Irrigation (MOWI)**
  - The MOWI coordinates the Water Sector Development Program (WSDP) 2006-2025 which includes rural water and sanitation program. The Ministry is responsible for the provision, treatment and distribution of water for human use.
  - Involved in the development of guidelines for drinking water chlorination and chlorination of shallow wells and bore holes

- **National Institute for Medical Research (NIMR)**

  - Provides technical input with regards to WASH related interventions.

  - Planning to carry out social marketing for water treatment products and storage options in Mwanza, Morogoro, Dodoma and Mara Regions.

- **Local Government Authorities (LGAs)**
  - In collaboration with the Health Management Teams and with the local water authorities in the districts efforts have been directed to explore the feasibility of drilling protected deep wells in selected most affected wards.
  - Involved in targeted distribution of water purification tablets and conducting cholera awareness campaigns

Needs analysis and scenario planning

Following the development of the Emergency Plan of Action for the original Emergency Appeal, a rapid assessment was conducted by the FACT between 4 – 11, November 2015 in, Arusha, Mwanza, Singida and Tanga regions. The findings of the assessment (issued in FACT SitRep No.4), reports from the MoHCDGEC, other partners and ongoing in process monitoring have contributed to the following assumptions, main findings, identified gaps and recommendations, which are summarised below:

Table 2: Risk Analysis

Area	Main findings	Identified Gaps	Recommendations
Surveillance	• Initial assumption: There is a need for and feasibility of implementation of community-based surveillance; community-based surveillance is the preferred approach for enhanced surveillance as it will be coordinated by MOHCDGEC, WHO and CDC • Health authorities in all districts reported conducting rapid response to households of new cholera cases • In the regions outside Dar es Salaam cases appear to be too scattered for a successful implementation of community-based surveillance. • Active case finding is not taking place in the regions due to the wide geographical spread of transmission	• Irregular routine testing of suspected cases to confirm whether cholera transmission is still active and/or changing. • Low adherence to case definition for screening and reporting. • Lacking the means to submit real-time comprehensive data. • Under reporting of cases and deaths at the community and health facility levels . • Line lists are submitted late, inaccurate and incomplete • Ineffective contact tracing and reports on numbers of contacts and action taken not routinely available.	• Implement routine testing in all facilities; RDTs to be made available if culture tests cannot be done . • Training of clinical staff in case definition, screening and importance of surveillance. • Train and equip staff with standard forms/line list books to ensure data is complete with dates and cholera status. • Ensure facilities have the means to report real time, complete and comprehensive data. • Active case finding to be included in house to house visits/social mobilisation in all regions . • Involvement of RC volunteers in surveillance at the health facilities. • Use of community-based surveillance to provide data on new cholera cases and cholera related mortalities.
Case Management	• Initial assumption: Red Cross volunteers will not be involved in clinical case management, patient transport, referrals or diagnosis. • There is a high risk of cross transmission and spreading of cholera from facilities to communities due to poor IPC at the CTCs.	• Unsatisfactory IPC measures and waste management within CTCs. • Inadequate IPC equipment and supplies. • Inadequate water supply for washing, cleaning and drinking at CTCs. • Lack of proper triage and classification of patients • Lack of hygiene promotion at CTCs. • Under-resourced in terms of HR, equipment, beddings, food, consumables, drugs and rapid diagnostic test (RDT) kits, and electricity supply • Non-adherence to case management guidelines • Delays in seeking care • CTCs are inaccessible because of long distance	• Implement and train staff in standard protocols for Infection Prevention and Control (IPC) • Ensure adequate stocks of IPC materials are made available to CTCs • Ensure sufficient water supply and satisfactory safe water storage at CTCs • Ensure sufficient safe drinking water is provided for patients and staff in CTCs • Ensure patient flow from low to high risk and adhere to flow protocol at all times for patients, staff and visitors • Involvement of RC volunteers in IPC support in CTCs • Involvement of RC volunteers in hygiene promotion and cholera awareness in CTCs

Cholera knowledge and beliefs	• Initial assumption: Mass sensitisation is the preferred approach for cholera prevention • Red Cross volunteers' limited knowledge about cholera was indicative of the general population • Women are primarily responsible for the collection of water, preparation of food and management of household waste	• Widespread lack of cholera awareness and understanding on transmission and prevention measures • Myths, misconceptions, and beliefs around cholera transmission, chlorine tablets use, latrine use and use of boiled water for drinking	• Conduct entry and exit health and hygiene promotion talks for all patients, accompanying family members and visitors. • Disseminate consistent messages about transmission, prevention, recognition and treatment of cholera to the general population • Conduct mass sensitisation campaigns through mobile cinemas and radio spots
Water and sanitation	• Initial assumptions: Water source close to ORP locations; water source available at schools • The lack of sufficient clean and safe water is a major contributory factor in the on-going cholera outbreak • Unplanned settlement and overcrowding in most urban ward.	• Rural Areas :Unregistered shallow wells and bore holes are not tested or treated • Urban areas: Water authorities not effectively chlorinating water • Communities without latrines practice open defecation in or near water sources • Communities members with access to latrines choose to or have a tradition of practising open defecation • Inadequate water quality monitoring system • Unsanitary condition of pit latrines • Inadequate knowledge and practise on handwashing	• Provide bucket chlorination at water points, ensuring households understand importance of separating drinking water from water used for bathing and cleaning • Rehabilitate or construct latrines in areas of high risk • Advocate for the use of existing low cost technologies for hand washing e.g. use of the tippy tap • Conduct hygiene promotion campaigns

The largest cholera outbreak recorded in Tanzania occurred in 1997, with more than 40,000 cases. The current outbreak is the largest since 2006, and few cases have been reported annually since then. Cholera transmission appears to be concentrated in urban areas, where population density, mobility and poverty are high, whilst sanitation facilities are inadequate and unsafe water sources plural. Furthermore, anecdotal reports from Dar es Salaam suggest people mistake cholera for 'normal diarrhoea' and stay at home and/or self-medicate with inappropriate drugs, rather than seeking health care - all of which will fuel the outbreak and put more people at risk. In the regions assessed by FACT most cholera deaths occurred at the facilities following late arrival.

Beneficiary Selection

The priority beneficiaries are those directly affected or exposed to cholera in the household or the immediate community, school children in targeted districts, and patient visitors at CTCs. Given regional and district variations in terms of attack rate and longevity of transmission, projections of the number who are at risk of infection are hard to make. However, given the available and historical trends for Tanzania and the El Niño phenomenon, we can expect up to 40,000 people to be infected with cholera if there are no interventions.

The rapid assessment highlighted the benefit of targeting school children; this group quickly understand key messages and often encourage their families to adopt safer hygiene practices. Gender specific focus group discussions have also showed that women and men have different hygiene practices; therefore messages with

suggested improvements to these will be different for men and women. In some communities men will be specifically targeted where their hygiene practices heighten the risk of transmission for the wider community. Future focus group discussions will continue to be gender specific, and will continue to inform community engagement strategies.
As women are almost exclusively responsible for collecting water, preparing food and managing waste for the household, they will be reached predominantly in the household in urban areas, and at water collection points and community meeting areas in rural areas.

Risk Analysis

As community-based Red Cross volunteers do not have any medical or environmental health background, and their protection and safety must be ensured, more efforts will be focused on activities outside CTCs. Though some volunteers after receiving, adequate training will assist in the selected CTCs in undertaking required Infection Prevention Measures. Please refer to the above table of the risk analysis.

Scenario planning

Without an adequate response, the high transmission in urban areas and the continued spread in rural areas and to other regions is likely to continue and cause excess morbidity and mortality. Complex social structures, bylaws and norms may limit possibilities for robust surveillance, social mobilization and good hygiene practices. Stigma and fear may stop people from accessing treatment, thus increasing risk of dying and exposing others to transmission.

The Tanzania Meteorological Agency, continue to issue climate outlooks which warn of heavy rains in many parts of the country due to the anticipated El Niño phenomenon effect. The regions that are most at risk include Dar es Salaam, Coastal, Kagera, Kigoma, Mara, Shinyanga, Tanga, Kilimanjaro, Arusha, Manyara, Morogoro, Pemba and Unguja. Many of these regions already have confirmed cholera cases, and this appeal will target 4 of these same regions. In addition to cholera response activities (prevention and treatment) in 4 regions, TRCS also aim to prepare for a likely response in neighbouring regions in case of severe flooding and a further spread of the cholera outbreak. These preparedness activities will include the training of an additional 30 volunteers in hygiene promotion, as well as the procurement of prepositioned equipment (such as megaphones). These prepositioned resources and personnel can be dispatched at short notice to areas affected by flooding or a sudden surge in the cholera outbreak. TRCS will also ensure that the agreements put in place with suppliers and other partner will easily allow TRCS to broaden the scope of their response (ensuring that the chosen suppliers have relevant and sufficient prepositioned stock).

Cholera is unlikely to spread into the refugee camps as an outbreak was successfully contained earlier this year. The majority of the camp population has been vaccinated, but ongoing large scale population movement in the region also increases the risk of transmission.

B. Operational strategy and plan

Overall Objective

To contribute to cholera prevention by breaking the chain of transmission through reaching 226,000 people in 16 districts of Arusha, Dar el Salaam, Mwanza, and Tanga with community mobilization and hygiene and health interventions in support of the Ministry of Health Community Development, Gender ,Elderly and Children.

Proposed strategy

The Revised Emergency Appeal will use a community-based approach to strengthen community based surveillance and social mobilization over a period of 9 months, to ensure that high risk households and communities are provided with information on how to protect themselves from cholera and are mobilized to take action to reduce the risk of cholera.
Activities planned include the following:

- Conduct an **initial rapid assessment** in the 4 priority regions (Dar es Salaam, Tanga, Arusha and Mwanza); note that this has been completed and informs the Revised Emergency Appeal; however further assessments will be carried out if the outbreak spreads to new areas, and will be included

- Establish 100 **community based ORPs**, which will be located in rural/urban areas that have been identified as being particularly high risk. Each ORP will be equipped with materials, including: basins, buckets, chlorine, disinfectant, garbage bins, jugs, oral rehydration sachets, chlorine tablets and soap (dish wash and hand wash. In total, 200 volunteers will receive training on how to set up and run the ORPs as well as refer/report suspected cholera cases using standard case definitions. Data collection and referral mechanisms will be established between the ORPs and CTCs and existing health facilities. Each volunteer will be mobilized for four days per week for three months (52 days approx.), receive a daily volunteer allowance and be issued with protective equipment (boots, rain coats, sanitizer etc.). Please note that the number of ORPs and volunteers may be revised as the cholera outbreak evolves, and more assessment information is available – as such 40 ORP kits will be retained to enable them to be set up in hot spots as they are identified. *There is a change of this strategy- where by Oral rehydration intervention has been incorporated into social mobilization and cholera awareness. ORS sachets are distributed during household visitation and school hygiene sessions this is in line with the proposed strategy by the MoHCDGEC and other partners.*
- **Community and household sensitization and hygiene promotion** focused on the prevention, control and response to the cholera outbreak. Please note that hygiene promotion for the urban and rural contexts will be guided by assessments (gender sensitive focus group discussions) to identify community perception and behaviours related to cholera (both those which may increase the risk of transmission and to provide a protective factor). In total 832 volunteers will receive training on cholera awareness, health and hygiene promotion, and be deployed to carry out community and household level sensitization including through mass media (e.g. mobile cinema, radio and TV etc.), of which 400 will be mobile, and used to scale up activities within 48 hours in areas identified as hot spots through CTCs, ORPs or health facilities surveillance. In addition, 32 volunteers will selected from two branches outside of the regions targeted by the Revised Emergency Appeal, which will be on standby for any required scale up of the response, as a result of the anticipated flooding from El Niño It is expected that these will be from branches identified as most at risk, which are neighbouring the regions targeted by the Revised Emergency Appeal. During the sensitization activities, the volunteers will disseminate key messages on the risk of cholera and its transmission routes to ensure that people know how to prevent it and what actions can be taken if they or their family members get sick, as well as promote household level safe water treatment and storage practices (e.g. through the demonstration and distribution of items for bucket chlorination at water sources etc.), and the importance of environmental sanitation (e.g. safe disposal of excreta.)
- Procurement of projector and speakers for mobile cinema (1 kit per region), megaphones for **mass sensitization** (four per region and two for prepositioning to scale up the response due to El Niño-affected flooding – see below.) has already been carried out. Materials for bucket chlorination at household level (buckets, cloths, chlorine tablets, cups, funnels, jerry cans, salt, sugar and soap), ORS, as well as MoHCDGEC IEC materials (brochures, posters, stickers etc.) have also been procured and distributed to the various regions.
- **Establish handwashing points in 100 schools** and other hot spot areas identified following the completion of further assessments. Each handwashing point will be equipped with materials, including: jerry cans and soap. It is also intended that teachers will receive training on how to chlorinate water, and school children will be issued with IEC materials and soap to take home. TRCS staff that receives the ToT (see below) will provide teachers in the 100 schools with training on how to chlorinate water and carry out Child Hygiene Sanitation Transformation (CHAST).

- **Procurement/loan of equipment to MOHCDGEC CTCs** and regional authorities in hot spot areas (e.g. cholera beds), which will then be returned to the National Society at the end of the cholera outbreak
- **Trainer of Trainers (ToT) for 60 staff on cholera awareness, health and hygiene promotion** to strengthen the capacity of the National Society. The ToT will provide an improved and expanded social mobilisation curriculum suitable for urban and rural communities, and allow the National Society to increase the number.

Operational support services

Human resources

Through the Revised Emergency Appeal, the following staff will be supported (partially or fully) to enable the effective implementation of the operation:

- A National Society Operations Manager, who will be recruited for a period 9 months and be responsible for coordinating the implementation of the activities planned in the operation, as well as liaising with the IFRC Operations Manager.
- Partial salary support for National Society Regional coordinators (4) for a period of 3 months and a National Society finance staff (1) for a period of 6 months; as well as per diem support for volunteers (400 volunteers x 52 days) and supervisors (80 supervisors). In addition, dedicated drivers will be provided to support the operation in each of the targeted regions, and will be receive a daily allowance.
- An IFRC operations manager, who will be recruited for a period of 9 months and will be responsible for supporting the National Society counterpart with the implementation of the activities planned in the operation, as well as ensuring compliance of IFRC policies and procedures, and the transition from the FACT mission.
- An IFRC finance delegate will support the operation for a period of 9 months.

Logistics and supply chain

- Procurement plans – the majority of commodities are available in-country, either through existing TRCS suppliers or from MoHCDGEC/WHO/UNICEF. TRCS will ensure that suppliers are selected based partially on their capacity to enable TRCS to quickly scale up their response, ensuring that the chosen suppliers have relevant and sufficient prepositioned stock to support a rapid scale up.
- Warehouse and storage plans – TRCS headquarters and branch storage capacity are sufficient
- Transport and fleet needs – Branch vehicles will be used for the field activities and monitoring. As part of the contribution to running costs, this operation will fuel and service these vehicles. In NS headquarters, an additional 2 vehicles will be hired or loaned from East Africa and Indian Ocean office for local running and support supervision.

Information technologies (IT)

Volunteer supervisors will require mobile phone credit to provide daily updates.

Communications

TRCS is working in close collaboration with MoHCDGEC national, regional and district structures. There is regular sharing of information through existing sub-committees both at the national and regional levels and with other partners. The visibility of TRCS volunteers is ensured through the use visibility materials such as identification bibs and feedback to various forums.

Security

Security Regulations and medical evacuation procedures for the IFRC Mission Tanzania have been developed and disseminated. Moreover, all staff working in the IFRC field operations are required to successfully complete and register the “Stay safe – IFRC Personal security” e-learning course, and in addition, anybody with a managerial

responsibility must also complete and register the “Stay safe – IFRC Security Management” e-learning course. In light of an increased global threat of violent extremism and militancy, including in East Africa region, RCRC personnel must enhance their vigilance and security preparedness in order to reduce the risk of falling victim to violence. Personnel should be particularly careful in public or crowded places and in public transport. Personnel should also monitor the overall and security environment on a continuous basis.

Planning, monitoring, evaluation, & reporting (PMER)

The TRCS Disaster Management and Health departments work closely with the branches in the affected areas to ensure proper delivery of humanitarian assistance to affected communities. TRCS is charged with the overall monitoring role to ensure accountability, timely and quality response. Updated reports received from the regions are shared with IFRC. Two (2) emergency operational updates have already been published on the IFRC website. With technical support from Emergency PMER delegate, a monitoring and evaluation framework was designed for the Emergency Plan of Action. The Ops Managers from IFRC and TRCS have undertaken several field visits for purposes of monitoring and to provide technical inputs to the ongoing operation. They also ensure timely submission of reports as per the IFRC reporting frequency; make cash request and accompanying liquidation of the same. A joint monitoring field visit was also carried out by TRCS, IFRC and ECHO. Following the visit various recommendations were suggested to enhance response in the targeted wards. The IFRC EAIOI regional operations unit intends to carry out monitoring missions to provide assurance over the effective implementation of the operation (4 missions over the 9 months).

Administration and Finance

TRCS is on a working advance system and financial returns are reported according to the National Society accounting system. The accounting journals are sent to the regional office for verification and accounting. Financial procedures and monitoring have been put place to ensure proper reporting and accountability. The IFRC EAIOI regional representation’s finance unit provides technical support to the TRCS to ensure the activities are reported in accordance with the budget. The Revised Emergency Appeal also support costs related to the overall running of the NHQ to enable effective management of the operation through contribution to costs related to salaries, office utilities, stationery, vehicle maintenance, communication and travel.

C. Detailed Operational Plan

Early warning & emergency response preparedness

Early warning, referral, monitoring disease trends			
Outcome 1 Early detection and consistent monitoring of disease trends and community case management of cholera saves lives	**Outputs**		**% of achievement**
	Output 1.1 A network of community ORPs provides early detection and referral of cholera cases.		80%
	Output 1.2 Daily aggregated data is analysed for early warning, alert and response.		80%
Activities	**Is implementation on time?**		**% progress (estimate)**
	Yes (x)	**No (x)**	
1.1.1 Identify and map CTC & CTUs, vulnerable areas and current gaps	x		100%
1.1.2 Conduct assessment of affected and high risk districts to be targeted for community based ORPs	x		100%

1.1.3 Identify resource needs for the ORPs including supplies, data collection materials, supervisions	x		100%
1.1.4 Train 200 volunteers to set up and run ORPs and report suspected cholera cases using standard case definitions	x		100%
1.1.5 Procure / despatch ORP kits (chlorine tablets and ORS nationally, other items locally)	x		75%
1.1.6 Establish 100 ORPs in target areas	x		80%
1.1.7 Establish a data collection and referral system at ORPs	x		100%
1.2.1 Receive information from MOHCDGEC and other actors and monitor and analyse outbreak trends	x		80%
1.2.2 Share information on the implementation with MOHCDGEC and other actors	x		80%
1.2.3 Map cumulative cases weekly to better target areas for cholera containment activities	x		80%
1.2.4 Train volunteers to undertake community based surveillance in targeted districts and wards having high transmission.		x	0%
1.2.5 Active cholera case identification through community based surveillance in targeted wards at risk of high transmission of Cholera.		x	0%

Progress towards outcomes

1.1.1 Assessments have been completed in the 4 regions and a total of 32 CTCs have been identified for Infection Prevention Support. Dar es Salaam (3) Tanga (9), Arusha (5) and Mwanza (6). It should be noted some of the regions do not have designated CTCS but there is the setup of an isolation ward/corner to allow for the management of the cholera cases.

Current gaps have been identified to include; lack of IPC supplies and equipment. Plans are currently underway for the procurement of these items and distribution to the selected CTCs/ CTUs . A total of 38 Community Based Volunteers have been recruited for the purpose of assisting the selected CTCs with infection prevention support and social mobilization through the provision of education to the care givers and patients.

1.1.2- 1.1.7 The strategy to set up static ORPS sites was modified to integration of mobile rehydration with other interventions that is social mobilization and household visitation. A total of 18,269 have been distributed during household visitation and school hygiene sessions.

1.2.1 The MoHCDGEC through the Emergency Operations Centers shares daily Sitreps with the partners. From this data various analysis are carried out to determine the cholera trends and hence inform the implementation of the interventions. At the regional level the Coordinators also receive cholera epidemiological data.

1.2.2 TRCS shares information with the MoHCDGEC through the various sub-committees and task force forums both

at the National and Regional levels.

1.2.3 Mapping was carried in the targeted 4 regions and 15 districts and 107 wards were identified to have high transmission of cholera. Various interventions have been carried out in the identified wards and response is still ongoing.

1.2.4. The initial 400 volunteers with an additional of 110 volunteers (who have been recruited) will be trained on Community Based Surveillance through facilitation from the MoHCDGEC. Currently the MoHCDGEC is finalizing on the curriculum which will soon be available for use.

1.2.5 Community Based Surveillance was an intervention incorporated into the revised appeal. It is planned that the volunteers who were undertaking the household visits for cholera awareness and hygiene promotion; will also be required to incorporate the aspect of community based surveillance into their service delivery. This intervention will begin as soon as the training is completed.

Preventing and reducing risk of cholera transmission

Preventing and reducing risk of cholera transmission			
Outcome 2. The transmission of cholera is eliminated or contained **.**	**Outputs**		**% of achievement**
	Output 2.1 Mass sensitization on the risk of cholera and its transmission routes is carried out		90%
	Output 2.2 The chain of transmission is broken where cluster cases have been identified		80%
	Output 2.3. School children in targeted areas have access to hand washing facilities with soap and water .		45%
Activities	**Is implementation on time?**		**% progress (estimate)**
	Yes (x)	**No (x)**	
2.1.1 Conduct gender sensitive focus group discussions to inform community and household sensitization and hygiene promotion	x		100%
2.1.2 Produce and disseminate MoHCDGEC Information, Education and Communication materials	x		30%
2.1.3 Train 400 volunteers on cholera awareness, health and hygiene promotion and the use of Information Education Communication materials	x		100%
2.1.4 Mobilize volunteers to provide community and household	x		75%

sensitization and hygiene promotion on prevention, control and response to the cholera outbreak			
2.1.5 Dissemination of cholera prevention and control messages through mass media (e.g. mobile cinema, radio and TV etc.) and at community gatherings/meetings, schools and at CTCs etc.	x		80%
2.2.1 Conduct assessment of TRCS branch resources	x		100%
2.2.2 Procurement of materials for bucket chlorination, household water purification tablet distribution and hygiene promotion.	x		80%
2.2.3 Train 400 volunteers on cholera awareness, health and hygiene promotion and the use of IEC materials to respond within 48 hours of an outbreak of new cases	x		100 %
2.2.4 Mobilize volunteers to provide community and household sensitization and hygiene promotion on prevention, control and response to the cholera outbreak within 48 hours in hot spot areas.	x		100%
2.2.5 Ensure safe drinking water through targeted distribution of water purification tablets in areas experiencing high cholera transmission.	x		40%
2.2.6 Train 100 volunteers on how to carry out bucket chlorination in targeted water collection points in districts and wards experiencing high transmission.	x		100%
2.2.7 Mobilise volunteers to undertake bucket chlorination at targeted water points in high transmission districts and wards.		x	0%
2.2.8 Support targeted Cholera Treatment Centres with Infection Prevention Control measures	x		25%
2.3.1 Conduct assessment of water sources and sanitation facilities in schools in high transmission areas and surrounding districts	x		100%
2.3.2 Distribute MOHCDGEC Information, Education and Communication materials to 100 schools in high transmission areas and surrounding districts		X	75%
2.3.3 Establish hand washing points at 100 schools, and other areas identified during assessments		X	0%
2.3.4 Train teachers on Child Hygiene Sanitation Transformation, and how to chlorinate water ;in 100 schools in high transmission districts and wards.		X	0%

2.3.5 Roll out CHAST exercise in 100 targeted primary schools in high transmission areas and surrounding districts .		X	0%
2.3.6 Conduct hygiene promotion sessions in 100 schools in areas reporting high number of cholera cases.	x		100%

Progress towards outcomes

2.1.1 During the assessment phase, data on the populations' knowledge and beliefs about cholera was collected through Focus Group Discussions (FGDs) having participants include men, women and school children. A total of 5 FGDs were conducted, with consideration of 2 communities in Arusha region, 1 community in Tanga region and 2 communities in Mwanza region.

2.1.2 Within the period under review, a total of 25,000 IEC materials were printed and distributed during mass sensitisation and household visitation sessions.

2.1.3 A total of 400 community based volunteers have been trained on cholera awareness, health and hygiene promotion.

2.1.4 Within the period under review, a total of 107,816 households have been visited and provided with messaging on cholera control and prevention.

2.1.5 Mass sensitisation awareness has been carried out through mobile cinemas using the beneficiary communication approach, a total of 83 sessions have been conducted. Plans are underway to air MoHCDGEC cholera messages through local radio stations in the 4 targeted regions.

2.2.1 During the FACT mission an assessment of the branch resources, in the targeted operational regions, was carried out and the details are provided in the FACT situational report.

2.2.2 A total of 777,000 water purification tablets, and materials for the demonstration were procured.

2.2.3 A total of 400 volunteer have been trained on cholera awareness and hygiene promotion and appropriate use of the IEC materials for rapid response to an outbreak.

2.2.4 In the targeted regions volunteers have been mobilised to respond in the event of a upsurge in new cholera cases.

2.2.5 A total of 782,338 water purification tablets have been distributed during the household visitation sessions and education on their use was also provided.

2.2.6 Plans are currently underway to facilitate the training of volunteers who will carry out the bucket chlorination at selected water points in wards and districts reporting high cholera transmission.

2.2.7 A total of 110 volunteers have been recruited to participate in bucket chlorination at selected water points. A total of 95 bucket chlorination sites have been identified in Tanga, Mwanza and Arusha regions. Dar es salaam region has no ideal water points where bucket chlorination can be undertaken, hence in this region the volunteers will concentrate on targeted household distribution of water purification tablets.

2.2.8 CTCs in the targeted regions have been supported with 40 Cholera beds. Plans are currently underway to procure hygiene and sanitation supplies and equipment for distribution to CTCs. A total of 32 CTCs have been identified in the targeted regions and will be supported with handwashing stations, calcium hypochlorite (HTH) for disinfection, detergents and waste disposal equipment. In addition a total of 38 TRCS volunteers have been recruited to support the CTCs with IPC and to provide education on cholera and hygiene promotion to care giver and the patients.

2.3.1 An assessment of water sources in schools has been carried out in 100 targeted institutions which will be supported with storage tanks, jerry cans, buckets and drinking water stations.

2.3.2 Plans are currently underway to procure IEC materials for distribution in schools.

2.3.3 Technical and material support will be provided to 100 schools in the targeted regions to set up tippy taps for handwashing stations.

2.3.4. Training on CHAST facilitation for 100 Teachers (school health club patrons) will be carried for 100 schools in the targeted regions; Arusha (35), Dar es salaam (25), Tanga (25) and Mwanza (15).

2.3.5 A total of 8 CHAST sessions per school club have been planned, these session shall be facilitated by the trained school health club patrons under the supervision of TRCS volunteers.

2.3.6 During the reporting period a total of 105 school hygiene promotion sessions were conducted in both primary and secondary schools in wards reporting high cholera transmission.

National Society capacity building

National Society capacity building				
Outcome 3 Increased Red Cross knowledge, awareness and capacity in cholera and emergency response	**Outputs**			**% of achievement**
	Output 3.1 Red Cross volunteers mobilized in areas of high transmission			70%
	Output 3.2: Regular coordination with MOHCDGEC and other actors contributing to the cholera response			90%
	Output 3.3: Preparedness for future cholera outbreaks			60%
Activities		**Is implementation on time?**		**% progress (estimate)**
		Yes (x)	**No (x)**	
3.1.1 Conduct assessment of TRCS branches in regions reporting a high number of cholera cases		X		100%
3.1.2 Conduct ToT for 60 supervisors on cholera awareness, health and hygiene promotion		X		100%
3.1.3 Support roll-out of health and hygiene promotion training to 1,000 community-based volunteers: ORPs, bucket chlorination, hand washing and use of ORS		X		75%
3.1.4 Provide equipment and IEC materials to community-based volunteers		X		75%
3.1.5 Monitor number of households/communities reached		X		50%
3.1.6 Measure social mobilization activities against MoHCDGEC cholera situation reports			x	0%
3.2.1 Attend weekly National Cholera Task Force meetings in Dar es Salaam		X		80%
3.2.2 Input into Surveillance, Social Mobilisation and Coordination sub-committee meetings in Dar es Salaam		X		80%
3.2.3 TRCS Regional Coordinators attend regional Cholera Task Force meeting		X		80%
3.2.4 Daily internal coordination meetings for all departments at TRCS headquarters		X		80%

3.2.5 Share assessment and monitoring information with other partners through the MoHCDGEC Cholera Emergency Operations Centre	X		80%
3.3.1 Procurement of ORS, aqua tabs, cholera beds, protective clothing, buckets, jerry cans, training and IEC materials	X		80%
3.3.2 Dispatch of training and IEC materials to regions for ToT and social mobilisation training, retain excess in Dar es Salaam TRCS warehouse for new outbreak areas	X		75%
3.3.3 Retention of 40 ORP kits for outbreaks in new areas or emergency stocks		x	0%
3.3.4 Loan 40 cholera beds to MoHCDGEC for CTCs (returning to warehouse once cleaned and disinfected for emergency stocks)	X		100%

Progress towards outcomes

3.1.1 Assessment of the TRCS branch resources was carried out during the FACT mission and this information was incorporated in the FACT situation Report.

3.1.2 TOT training on Cholera awareness and health and hygiene promotion has been conducted for 80 Volunteer supervisors in the four targeted regions.

3.1.3 A total of 400 volunteers have been trained on proper handwashing etiquette and use of ORS to control dehydration following a diarrhoea episode. Further trainings on bucket chlorination (110), community based surveillance (510), infection prevention at cholera treatment centres (38) are planned.

3.1.4 TRCS Volunteers involved in the cholera outbreak response have been provided with 500 flip charts (job aids), 400 pairs of gum boots and rain coats, 400 back packs and 25,000 IEC materials. To enhance the visibility the volunteers were provide with identification bibs (300), T-shirts and baseball caps with cholera prevention messaging (300 of each).

3.1.5 -3.1.6 Monitoring protocols and tools have been developed and approved by the MoHCDGEC; a house to house KAP survey is planned to evaluate a set of indicators and determine the quality of the household visits undertaken by the TRCS volunteers.

3.2.1 TRCS and IFRC regularly attend the weekly Cholera National Taskforce meetings held at Dar es Salaam.

3.2.2 Varied inputs have been provided to the surveillance, social mobilisation and coordination sub-committees to include developed reporting tools, monitoring protocols and implementation approaches.

3.2.3 The 4 Regional Coordinators regularly attend the Cholera Regional Taskforce meetings held in their respective regions.

3.2.4 Regular briefings on cholera outbreak operational response are held at the TRCS headquarter level.

3.2.5 Assessment report (FACT situational report) has been shared with the MOHCDGEC Emergency operation Centre for circulation to other partners.

3.3.1 The following items have already been procured to include ORS sachets (60,000), water purification tablets (777,000), Cholera beds (40), gum boots and rain coats (400), buckets fitted with outlets (1000). Plans are currently underway to procure an additional items to include 320 cholera beds,

3.3.2 A total of 500 flip charts on cholera awareness, have been dispatched to the regions. Plans are currently underway to produce an additional 100 flip charts and 30400 IEC materials.

3.3.3 Procurement plans have been drawn to enable emergency stock to be placed at the regional level. The following items will be procured; ORS sachets, water purification tablets, buckets, jerry cans and Personal Protective clothing (washable plastic aprons, gum boots). This will allow for prompt response in the event of future upsurge in new cholera cases or new cholera outbreak.

3.3.4 A total of 40 cholera beds have been loaned to various CTCS within the targeted regions, these will be returned to the warehouse at the end of the outbreak to contribute towards the emergency stocks.

Contact Information

For further information specifically related to this operation please contact:

- **In Tanzania:** Joseph Kimaryo, Disaster Management Director, Tanzania Red Cross National Society; phone +255 713 325 042; email: utouh2009@yahoo.com
- **IFRC Regional Representation**: Finnjarle Rode; Regional Representative for East Africa; Nairobi; Phone: +254 20 28 35 000; Email: finnjarle.rode@ifrc.org
- **IFRC Disaster Management Unit**: Farid Aiywar; Head of Unit. Nairobi; Phone: +254 (0)731 067 469; email: farid.aiywar@ifrc.org
- **In Geneva:** Christine South, Senior Quality Assurance Operations Officer, office phone: +41.22.730.4529, email: christine.south@ifrc.org
- **IFRC Africa Logistics:** Rishi Ramrakha; mobile phone: +254 733 888 022/ Fax +254 20 271 2777; email: rishi.ramrakha@ifrc.org

For Resource Mobilization and Pledges:

- Fidelis Kangethe, Partnerships and Resource Development Coordinator; Nairobi; Phone: +254 731 984117; Email: fidelis.kangethe@ifrc.org
  Please send all pledges for funding to zonerm.africa@ifrc.org

For Performance and Accountability (planning, monitoring, evaluation and reporting):

- **In IFRC Zone:** Robert Ondrusek, PMER Coordinator; mobile phone: +254 731 067 277; email: robert.ondrusek@ifrc.org

How we work

All IFRC assistance seeks to adhere to the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief and the Humanitarian Charter and Minimum Standards in Disaster Response (Sphere) in delivering assistance to the most vulnerable.

The IFRC's vision is to inspire, encourage, facilitate and promote at all times all forms of humanitarian activities by National Societies, with a view to preventing and alleviating human suffering, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

The IFRC's work is guided by Strategy 2020 which puts forward three strategic aims:

1. Save lives, protect livelihoods, and strengthen recovery from disaster and crises.
2. Enable healthy and safe living.
3. Promote social inclusion and a culture of nonviolence and peace.

Find out more on www.ifrc.org