Emergency Plan of Action Final Report

Zimbabwe: Cholera Outbreak

International Federation of Red Cross and Red Crescent Societies

DREF Operation	**Operation n°: MDRZW013 / PZW032**
Date of Issue: 24 June 2019	**Glide number: EP-2018-000150-ZWE**
Date of disaster: 05 September 2018	
Operation start date: 18 September 2018	**Operation end date: 18 December 2018**
Host National Society: Zimbabwe Red Cross Society	**Operation budget: CHF 208,367**
• **Number of people affected: 10,208 cases of which 9,939 were suspected and 269 confirmed. This includes 55 deaths (CFR 0.54%) as per *MoHCC/WHO Sitrep on* 23 November 2018.** • **Total number of people living in the affected area: 250,000 people** • **Total number of people at high risk of contamination: 100,000 people** • **Total population of Harare: 2,253,747 people**	**Number of people assisted: 15,000 people (3,000 HH)**
N° of National Societies involved in the operation: 4 (Zimbabwe Red Cross Society (ZRCS), British RC, Finnish RC, Danish RC)	
N° of other partner organizations involved in the operation: 10 (IFRC, ICRC, Oxfam, UNICEF, WHO, MSF, Care International, Harare City Council, MoHCC, National Civil Protection)	

The major donors and partners of the Disaster Relief Emergency Fund (DREF) include the Red Cross Societies and governments of Belgium, Britain, Canada, Denmark, German, Ireland, Italy, Japan, Luxembourg, New Zealand, Norway, Republic of Korea, Spain, Sweden and Switzerland, as well as DG ECHO and Blizzard Entertainment, Mondelez International Foundation, and Fortive Corporation and other corporate and private donors. The IFRC, on behalf of Zimbabwe Red Cross Society, would like to extend thanks to all for their generous contributions. To note, the Canadian Government through its National Society, as well as ECHO contributed to replenishing the DREF for this operation.

A. SITUATION ANALYSIS

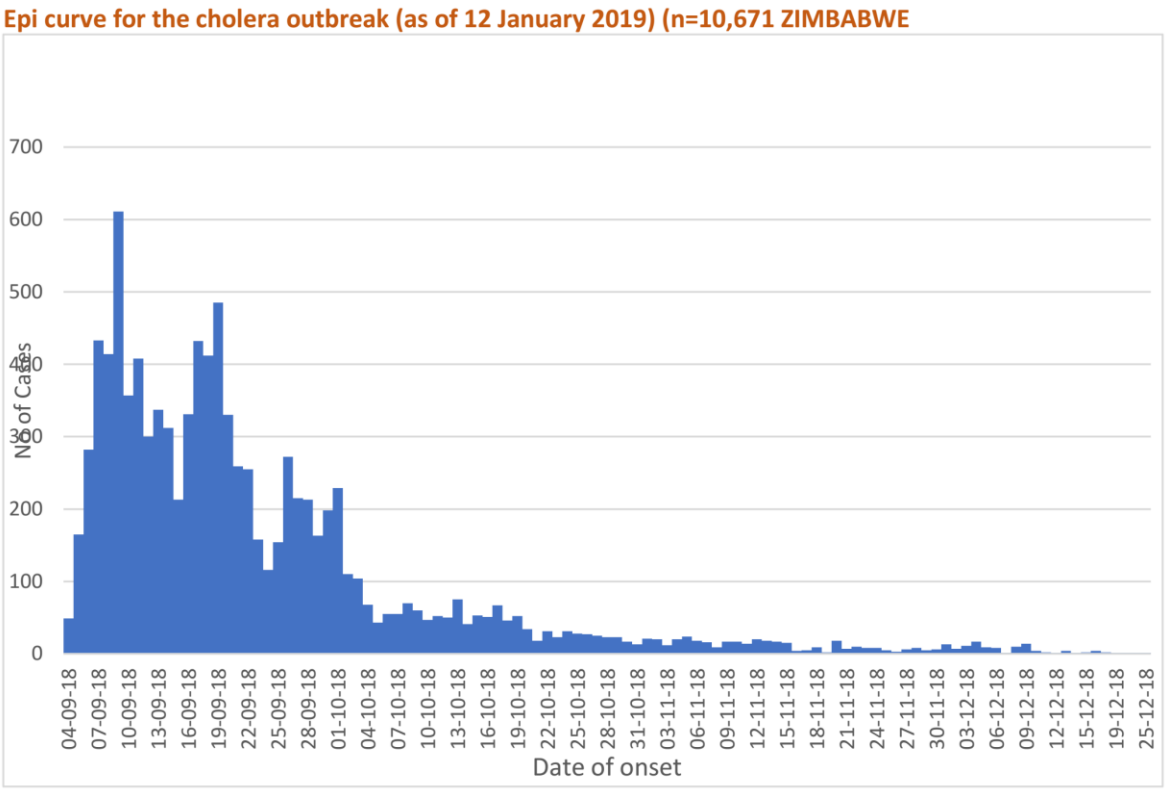
Description of the disaster

On 5 September 2018, 25 patients were admitted at Beatrice Road Infectious Disease Hospital (BRIDH) presenting symptoms which included diarrhoea and vomiting. Ten (10) of these patients were referred from Harare Central Hospital, and the other 15 used various modes of transport to reach BRIDH. Most cases came from Glenview 8, 3, Budiriro 1 and 2. A 25-year-old woman who was brought in collapsed and died on the same day -- 5th of September 2018. A sample from the woman was positive for V. cholera, Ogawa. All the patients had typical cholera symptoms like excessive vomiting and diarrhoea with rice watery stools and dehydration. During the night of 5 September 2018, more patients were admitted. By early morning of 6 September, some 52 suspected cholera cases had been admitted. On 6 September -- 11 cases were confirmed by RDT to be positive of Vibrio cholerae. Some 39 stool samples were taken for culture and sensitivity, and of these, 17 were confirmed positive for Vibrio cholerae type Ogawa species. Contaminated water sources including boreholes and wells were suspected to be the source of the outbreak. Sewage was seen flowing on the ground all over the affected areas due to blocked & damaged sewer pipes.

- On 6th September 2019, the then Minister of Health and Child Care Dr. David Parirenyatwa visited BRIDH. With the information at hand, he declared a cholera outbreak in Harare City.

- The new Minister of Health, Dr O Moyo, toured the cholera epicenter immediately after he was sworn in as Minister on 11th September 2018. He subsequently visited the epicenter virtually daily with other very high-level Government officials.
- The Head of State declared the cholera as a state of disaster, in line with sub-section (1) section 27 of the Civil Protection Act on 12th September 2018 and the First Lady visited the epicenter on 18th September 2018 and donated essential supplies through the Angel of Hope Foundation. MoH received these supplies on behalf of the Beatrice Road Infectious Disease Hospital. The Head of State, together with his two Vice Presidents, visited the epicentre in Harare on 19th September 2018.

Figure 1: Harare Cholera Epi-curve from September to December 2018 showing Declaration of Cholera Outbreak.



On 18 September, Zimbabwe Red Cross Society was granted a DREF allocation of 208,367 swiss Francs in response to the outbreak. These funds were directed to support NS in conducting activities including improved surveillance for early case detection, timely response and effective case management to curb the rising trend of the outbreak and contribute to preventing further cholera outbreaks in the target population. Through a combination of strategies such as improved surveillance, timely alerts and responses, soft WASH activities, case referral and sustained social mobilization by ZRCS volunteers, the National Society contributed significantly to controlling the outbreak.

Although not over yet, the outbreak has considerably slowed down with minimal cases being reported at the various treatment centres. The government managed to carry out a massive campaign in administering the Oral Cholera Vaccine to the most affected suburbs in greater Harare with a view to curb further spread. A lot has been going on in the epicenter of the disease to rehabilitate sewer and water works. Initially there was fear that the rains would further heighten the situation, but the rains were delayed and only started end of November, giving more time for the operation implementation to continue.

Summary of response

Overview of Host National Society

The Zimbabwe Red Cross Society (ZRCS) has been fully involved in responding to this cholera outbreak. As of 5 September 2018, when information on the Cholera outbreak was shared by the City of Harare and the Ministry of Health, the Director of the Civil Protection (DCP) requested the support of the Red Cross in the response to this epidemic. ZRCS took part in the crisis meeting chaired by the DCP on the strategic response plan for this outbreak. As part of the initial response, the National Society deployed 160 volunteers from its roster of community disaster response team. During the coordination meetings, to which ZRCS was represented in the WASH and Health Promotions sub committees, the following gaps were presented:

- ✓ Rapid assessment/ situation analysis to determine the predisposing factors for appropriate messaging

- ✓ Community stakeholder sensitization meetings
- ✓ House to house hygiene promotion, point of use water treatment
- ✓ Active case finding and referral to clinic
- ✓ Street campaigns
- ✓ Road shows
- ✓ School health promotion – teachers and students
- ✓ Health education – churches, crèches, market places, public transports, industrial areas
- ✓ IEC material distribution
- ✓ NFI distribution- water guard, aqua tabs, tapped buckets, soap.

Following the Harare cholera outbreak in Glen View and Budiriro areas, a multi stakeholder meeting was held at City of Harare - Rowen Martin Offices and another meeting was subsequently held at the Ministry of Health and Child Care Head Office. In both meetings the NS attended and was tasked among other things to provide support to Cholera Treatment Centres by providing volunteers. As a result of the request Zimbabwe Red Cross Society deployed 70 volunteers to Beatrice Hospital, Glen View Poly clinic and Budiriro Clinic.

ZRCS response teams started on the 11th of September up to the 31th of January 2019, with 160 volunteers performing different tasks -- most of them were deployed to treatment centres, where they conducted the following activities: The number of volunteers involved in the operation increased from 120 to 160 due to the expansion of the coverage area.

- Cleaning wards and toilets
- Emptying vomitus and any other dirty
- Giving water, food and any support to patients as per request
- Spraying at the gate (point of entry)
- Disinfecting beds, wards and soiled places
- Helping nurses by taking temperature and screening patients
- Washing linen and blankets.
- Cooking

Some 40 volunteers carried out health and hygiene promotion in the communities using drama plays, targeting schools and shopping centres in the affected areas. These volunteers were mobilised from Kadoma (Mashonaland West) to help with social mobilisation and was actively involved in carrying out Road Shows in the affected areas. The group supported by an HQ surge team visited the following suburbs: Highfield, Glen Norah Glen View, Budiriro, Mufakose, Dzivarasekwa, Hatcliffe, and Epworth. The other suburbs face similar conditions to Glen View and Budiriro and have potential of erupting. During the campaigns, the group provided key messaging using a public address (PA) system and at shopping and business centres through dance and drama, provided awareness sessions which culminated in the distribution of fliers and posters. The mobile road shows proved effective in constantly reminding the public on what to do in the event of cholera affecting them. The road shows also targeted education institutions and reached in total 43 schools. After discussing with District Education Officers, the team was advised on which schools to visit. At the schools, the volunteers would perform sketches and songs with key messaging on hygiene promotion. After performing, volunteers distributed NFIs such as buckets and soap for hand washing to the school authorities. The volunteers also set up the hand washing points and distributed posters bearing hand washing and general cholera messaging.

The 40 volunteers provided community-based support complementing community health workers on community-based surveillance (CBS). They covered various schools including Glen View 6 Primary School which has 2,333 children and 64 teachers, Glen View 8 Primary School which has 1,733 children and 79 teachers and Glen View 5 Primary School was still closed down since the Headmaster had died of cholera. Overall, a total of 43 schools where visited reaching 67,831 learners. A ZRCS national review workshop was held in October 2018 to conduct an after-action review of the cholera operation considering supplementary funding from the Italian Embassy and the Danish Red Cross. The meeting sought to bring Provinces all to one table as they presented state of affairs in their respective province, activities that they have realized and/or should undertake to curb the Cholera spread in the various provinces, before the onset of the rainy season. Plans of action where presented and some of the activities led to the re-adjustment of activities in the DREF operation.

Some 120 Red Cross volunteers were involved in the management of Cholera Treatment Centres providing critical surge support to the three main health centres. The situation by 31 January 2019, one month after the end of the DREF operation, was as follows:

- The last case was reported on 26 December 2018.
- The cumulative total for Harare was 9,971 cases of which 216 were positive, 9,755 were suspects and 46 deaths.
- The cumulative total countrywide was 10,716 cases, of which 10,406 were suspects and 310 were confirmed in the first few weeks of the outbreak. Some 69 deaths were recorded in total (CFR 0.64%) as at beginning of February 2019.

Overview of Red Cross Red Crescent Movement in country

ZRCS activated its internal emergency response mechanism and an operation meeting was held internally. All ZRCS Provincial structures put on high alert since the spread had gone national with cases being reported in all the provinces. Community disaster response team members in Harare were activated through the roster system. Emergency Steering Committee meetings involving Movement partners were periodically held and minutes and updates shared accordingly.

In country PNSs managed to support the NS to initiate initial responses through the activation and deployment of volunteers. The British Red Cross provided USD 26,000, Finnish RC supported the response with Euro 10,000 and Danish Red Cross supported with USD 68,800 for the extended Cholera Response outside the DREF. An Echo Crisis Modifier was also activated and USD 10,000 was utilised from it.

IFRC Southern Africa CCST and Africa Region provided ZRCS the needed support to submit a proposal to the Italian Embassy for Euro 200,000. This contribution supported the NS with a cholera toolkit and allowed the NS to scale up the operation to other affected areas countrywide.

Overview of non-RCRC actors in country

The coordination of response activities among National Authorities and main stakeholders (UN, INGOs, ZRCS) was activated through two main mechanisms, the National Civil Protection Committee and the UN clusters (WASH and Health). ZRCS took part in both coordination mechanisms and the DREF EPoA was developed to complement the proposed National Consolidated Action Plan in order to avoid gaps and overlaps.

Needs analysis and scenario planning

With the onset of the rainy season, the outbreak was exacerbated. A population of more than 2,253,747 persons living in the urban areas of Harare became highly vulnerable to cholera. High risk communities included those living in Harare suburbs with limited or no access to water and sanitation services, people utilising public facilities including open markets, schools and religious institutions. Also, people attending social gatherings such as weddings, funerals and those dining in restaurants were particularly vulnerable. It is important to add that as at 12 September 2018, Harare City Council had banned all public gatherings. Other provinces were affected as anticipated. Manicaland Province was worst hit with Buhera district affected due to religious beliefs shared by apostolic sects in the area.

Stakeholder meetings held between 1 and 10 September 2018, highlighted the extent and trends of the outbreak. DCP coordination meetings at the national level helped to outline the gaps that required partners attention and for coordinated response to the outbreak. Key among the identified gaps were:

- Inadequate access to basic social services in the areas where the outbreak occurred;
- Inadequate funding and logistic/supplies for rapid response to the outbreak;
- Inadequate coordination between the Health Cluster and the Ministry of Public Health;
- Inadequate community-based surveillance in place for early waring information to assist investigations and responses;
- Insufficient capacity of staff in case management;
- Need to scale up WASH interventions to increase common access to safe water.

This DREF operation provided the NS with requested support to effectively respond to the outbreak in the most affected districts.

Operation Risk Assessment
The risk of outbreak spreading to other parts of the country was high. However, due to preventive measures put in place through awareness campaigns, the spread was not catastrophic as initially anticipated. Besides poor drainage networks in the affected areas; there was generally weakness of community-based surveillance of disease information.

Community perception of water treated with chlorine or Aqua tabs could have equally affected the successful implementation of planned interventions under this DREF operation. Generally, the community have some hesitation in drinking water treated with Aqua tabs with the complaint that the natural taste is lost. Sustained community sensitization in weighed heavily on the derived benefits from chlorinated water changed community perception to treat water with chlorine or Aqua tabs.

To counter some of these externalities, the proposed action included community engagement and accountability mechanisms. Continuous feedback, through ZRCS volunteers, was collected and analysed in order to improve service delivery to the target beneficiaries. A help desk was set up to provide information on activities the NS was implementing and to also give the community an opportunity to ask questions and contribute to project activities in ways that helped meet the humanitarian needs.

In addition to the above, the national markets suffered an unexpected dive in the inflation rate. This had implications on household in terms of capacity to meet daily needs compromising own basic healthy and sanitary needs i.e. soap, toilet papers and safe drinking water. This therefore resulted in spiralling of prices and shortage of basic commodities. Fuel challenges where experience as of ending September 2018. The price hike led to increase in the cost of budgeted procurement items.

The coverage of activities by other partners also led the NS to relook at the operational plan to cater for areas outside the target four suburbs and beyond Harare Metropolitan provinces. NS played its role in Health awareness and social mobilisation of communities including WASH initiatives. However, needs were highlighted in the provinces and the need to initiate responses outside of the target four areas. Cases reported in the provinces where directly related to the epicentre hence, the need to focus on tracing the cases and covering the affected provinces.

B. OPERATIONAL STRATEGY

This DREF operation aimed at implementing lifesaving interventions including improved surveillance for early case detection, timely response and effective case management to curb the rising trend of the outbreaks and contribute to preventing further outbreaks of cholera in the target population. Through a combination of strategies such as improved surveillance, timely alerts and responses, soft WASH activities, case referral and sustained social mobilization by ZRCS volunteers, the National Society contributed significantly to controlling the cholera outbreak and promoting healthy living among the target population.

Proposed strategy

As outlined in the EPoA, in accordance with the IFRC's response and preparedness strategy for epidemic countries in the region, aimed at supporting ZRCS through staff and volunteer training, awareness raising, dissemination of information, production of education and communication materials, community-based epidemiological surveillance, communication of key messages for the preparedness and prevention of Cholera epidemic outbreaks.

In addition, through this operation, ZRCS conducted social mobilisation to reduce the risk of further spread of cholera, as well as improving prevention activities, in collaboration with the MoHCC and City of Harare Municipality. To reach the at-risk population, ZRCS utilized its network of existing community volunteers to enhance Oral Rehydration Points (ORP). The activities below were implemented with respect to WHO and Sphere Standards:

- Some 80 volunteers were trained by ZRCS trainers with co-facilitation from the MoHCC on Participatory Health and Hygiene Education (PHHE), including some Community Engagement and Accountability (CEA) components and the Epidemic Control for Volunteers (ECV) manual, specifically linked to the risks related to cholera outbreaks (two-days training). A Supplementary 70 volunteers who were deployed into Cholera Treatment centres also underwent training so in total 150 ZRCS volunteers received training.

- Social mobilization was undertaken together with other stakeholders and partners in the targeted areas. Other organisations such as UNICEF through Oxfam also conducted a series of sessions in the target areas. However, all activities where coordinated through the WASH cluster and the Emergency Strategic Advisory Group – ESAG. ZRCS implemented door to door campaigns and mass media awareness sessions, using megaphones and distributing information, education and communication (IEC) materials in public places (churches, mosques and schools). Throughout the implementation of activities, volunteer collected feedback and tracked community perceptions and rumours about cholera and the response. Most of the feedback highlighted the good work that organisations where inputting in addressing the situation especially in schools. However, concerns were also raised in the way that sometimes people were made to gather during roadshows which could have a negative effect as people gathering could lead to cholera spread. This feedback helped NS to ensure that it resorted to 5 to 10 minutes maximum awareness sessions at a point.

From the feedback NS also identified the need for psychosocial support for families that had lost their loved ones. This area was not particularly being addressed. Organisations that were involved in case management would trace a case back to the household and then disinfect without giving due attention to the bereaved family. As Red Cross, NS advocated for this need to be covered through the respective authorities during the stakeholder meetings.

- Cholera mass education was provided to 2,783HHs and 66,048 school children in 43 schools.

- ZRCS trained volunteers reached out to 11 families and provided Psychosocial support and brief benevolence messages.

- Community-Based Surveillance (CBS) including monitoring/referral by volunteers at community level, as well as participation by the ZRCS in information/coordination meetings. This was done at community level by the volunteer network. Through the 80 trained volunteers in CBS, 63 referrals were made.

- As concerns community-based management, ZRCS set up eight (8) ORPs for the community-based management of cholera especially in the four affected areas (2 per target area) where there were no health facilities, for the distribution of household water treatment (Aqua tabs / Water guard) for at least 3,000 affected families and the most at-risk people. These ORPs served as points for the distribution of ORS. The 40 volunteers and 4 supervisors engaged in CBS were at the same time, engaged in managing the ORPs and ensured referral of suspected cases to the health facilities. The CBS and ORP management were conducted in the target areas assigned for NS response under the lead of UNICEF (for WASH) and WHO (health) as agreed during the coordination meetings.

    - The NS managed to procure only 5,600 ORS sachets, because health facilities indicated they had enough stock. It was then agreed to buy 34 more ORP kits, which were found to be more useful, instead to serve the affected population. An ORP training for volunteers was conducted with 24 participants. After monitoring, some volunteers were found not to have ORP administration skills and the training was therefore found to be of importance in that area. This was a ToT training with participants being expected to cascade to other volunteers within their communities. The training had the following content:
        1. Cholera overview of ORP
        2. Kit components.
        3. Practical: The filter
        4. Setting up ORP
        5. Operational ORP.
        6. Social mobilization, behavioural change
        7. Fear, stigma& PSS in cholera

    - The NS procured 576 Water guard which covered, one water guard bottle purifies 20 by 20 litres. In total 100 bottles were used for bucket chlorination at water points and this benefitted 2,000 households, while 476 were distributed to 476 households, and this brings the total to 2,476 households that have benefitted from this support. In addition, the NS managed to secure a donation of 110,000 bottles of Water guards from Latter Day saints Charities, these were distributed to public institutions mostly clinics and some to directly to households. During the distribution, ZRCS volunteers demonstrated the use of the Water guard and fliers were distributed accordingly indicating use. The supplier of Water guard also provided fliers and posters on Cholera and WASH.

    - During one of the visits by delegate from ECHO, Pool testing of chlorine was recommended as part of ensuring that households where chlorinating water.

- The four (4) Health Centres in the affected areas were provided with 8 tins (45kg each as planned) calcium hypochlorite (HTH) for the preparation of chlorine solutions for different uses (disinfection of vomit surfaces, faeces, urine and other biological fluids).

- As a contribution to improving hygiene and sanitation, 40 backpack sprayers were procured for the treatment of eight (8) community/public latrines and 300 household latrines. Disinfection remained ongoing through community-based volunteers.

- Community engagement in the response was enhanced by providing training on social mobilization to volunteers on how to collect feedback, including rumours and complaints, from the communities. This information was used to update messages and social mobilization approaches. Through door to door, and community awareness campaigns, feedback was received on beneficiary satisfaction and guided the intervention.

- Provision of 3,000 WASH related NFI kits to the most vulnerable households (soap (5 per household), buckets with lids (1 per household) and jerry cans (1 per household)). An additional 100 pieces of soap was procured for training purposes. All distribution was coordinated under the lead of UNICEF (WASH lead agency to avoid gaps and duplications).

- The initial response phase was supported with production of IEC materials with key messages on cholera put in place by the Ministry of Health and Child Care for community-based awareness sessions. The Finnish RC and Echo Crisis modifier supported production of fliers and posters which were distributed in institutions and households for WASH and Cholera awareness.

- One hundred (100) hand washing devices were produced and positioned at health centres, ORPs and other public places with chlorinated water for hand disinfection. Volunteers demonstrated hand washing techniques with soap. Procurement was done for replenishment of handwashing buckets which were distributed in the schools as handwashing points where set up. A total of 430 hand washing buckets were distributed and 215 hand washing points with two buckets each set up. 860 pieces of soap were also distributed to the schools to aid the handwashing facilities.

- Some 43 HP sessions were carried out in schools and 12 in the communities in and around the epicentre. One community radio broadcast was carried out in an outdoor setting. About 48 additional sessions were carried out on hygiene promotion in other targeted areas outside Harare (1 session per week per target area for a period of 3 months). This activity was conducted by the 20 social mobilization volunteers and 4 supervisors (trained on PHHE) in coordination with other stakeholders to avoid gaps and duplication and complemented by IEC materials provided. Volunteers were in charge of demonstration sessions on safe use of water treatment products and handwashing techniques, as well as disinfection of 240 latrines in strategic locations including schools, homes, health centres and public places.

- 140 personal protective equipment (PPE) were purchased and distributed to 120 volunteers and 20 supervisors including masks, work suits, boots, hand disinfectant and hand gloves to prevent contamination of volunteers by the disease.

C. DETAILED OPERATIONAL PLAN

Health

People reached: 80,666 people

Male:

Female:

Health Outcome 1: Vulnerable people's health and dignity are improved through increased access to appropriate health services.		
Indicators:	**Target**	**Actual**
% of people with access to appropriate health services	100%	60%
Health Output 1.1: Communities are provided by NS with services to identify and reduce health risks		
Indicators:	**Target**	**Actual**
# of people reached by the NS with services to reduce health risks	15,000	80,666 (12,835 people plus 66,048 school children)
# of assessments conducted	2	2
# of volunteers trained on the ECV / cholera control	120 volunteers and 20 Supervisors	140
# of community leaders trained on the ECV / cholera control	60	70
# of volunteers retrained on the CBS by MoHCC	40 volunteers	80

	and 4 Supervisors	
# of IEC material produced	40 boxes 1,000 posters 3,000 leaflets	40 boxes 1,000 posters 3,000 leaflets
# of visibility material produced and distributed to volunteers and NS staff	150 T-shirts, 150 caps and 150 bibs	150 T-shirts 150 caps
# of tents procured and distributed to HCs for isolation of affected cases	4 tents (1 per health centre)	2
# of volunteers and supervisors trained on the use of ORP and ORS	120 volunteers and 20 supervisors	120 volunteers, 20 supervisors and 4 staff members
# of monitoring missions conducted	12 (3 per month)	20
# of lesson learnt workshop organised	1	1
Health Output 1.2: Communities are supported by the NS to effectively detect and respond to infectious diseases outbreak		
Indicators:	**Target**	**Actual**
# of ORS procured and distributed	11,200	5,600
# of people reached with ORS	800 patients	1,400 patients
# of volunteers deployed to high risk areas	120 volunteers and 20 supervisors	160 volunteers
# of ORPs set up	8	42
# of people served at ORPs	800	3,000
# of radio broadcasts	90	1
# of road shows conducted	12	17
% of community feedback or complaints responded to through the help desk	80%	100%
Health Output 1.3: Community-based disease prevention and health promotion is provided to the target population		
Indicators:	**Target**	**Actual**
# of people reached with community-based awareness sessions	15,000	19,600 general public plus 66,048 school kids
# of information and coordination meetings held	12	40
# of community monitoring committees set up/enhanced for cholera surveillance	8	10
# of volunteers actively reporting surveillance cases (Target: 40 volunteers)	40	80
Case fatality rate (CFR) change	>1	0.64%
% of suspected cases identified and referred to the treatment centres	100%	100%

Narrative description of achievements

- The 100% target on increasing access to health was ambitious as it did not consider the unavailability of health facilities in some affected areas, therefore limiting access by the affected people. Therefore, in terms of increasing access to health for the affected population it is estimated that 60% of the affected population, had easy access to health services.

- Through assessments the NS was able to identify thematic areas, full extent of cholera spread and engage the communities on planned interventions. In addition, the national society through assessments managed to

understand the role of other actors, which helped mapping out the service areas and avoid duplications.

- The operation reached a total of 80,666 people with cholera response material and awareness services --these included 12,835 people reached with awareness messages in homes and 66,048 children in schools. More people than planned were reached due to coverage of new areas outside Harare.
- 140 volunteers were trained in Epidemic Control for Volunteers, Community based surveillance and PHHE. Out of these 140, some 70 were deployed at the CTCs while the rest were community based and supporting health authorities with CBS in their communities.
- In total, 80 volunteers were given refresher on CBS, given the additional areas NS operated in and the strategic importance of this theme, 36 more volunteers were added, and among these were 10 members of governance board at district level, whom the National Society considered key in epidemic control.
- 20 volunteer supervisors and 120 volunteers and 4 members of staff were trained on ORP and ORS and reached 1,400 patients with ORS services. 4 staff, 2 from head and 2 from branches were included in the training to enhance the quality of monitoring and supervision.
  The skills gained through the training provided volunteers with the feeling of safety and confidence to carry out their work.
- More people were reached as the ORP were set up at public centres which were easily accessible to affected population. OPR set up has increased the visibility of the NS, then secondly the ORP points were also used as the distribution points for IEC materials.
- The distributed IEC materials motivated the volunteer's engagement, promoted the understanding of messages. Most of the IEC materials were distributed in schools and children carried the prevention messages to their homes further reinforcing messages.
- Radio broadcasts were under budgeted, so the NS could only manage one broadcast, however five more road shows were done in other affected areas outside Harare.
- Visibility materials were all not bought as planned as money was not sufficient, currency exchange loss affected the prices and purchasing prices of the planned items.
- Community engagement and accountability was integrated into the operation and allowed for 100% of complaints reported to be addressed. Complaints/feedback were given suggestion boxes placed at strategic locations during mobilisations sessions. Suggestion boxes were opened by community stakeholders including community leaders, local government staff. Feedback was given publicly during the sessions. The national society anticipated to get more complaints/complaints which the case was however not and therefore managed to attend to all feedback/queries given immediately. Most of the feedback was appreciating the work of the NS and mainly seeking clarification of operational aspects.
- ZRCS volunteers are now actively involved in the national clean-up campaign called by the Government scheduled for every first Friday of the month. This is a country wide programme.
- Monitoring by staff and volunteers increased to accommodate additional areas not initially planned. The monitoring ensured harmonisation of approaches and maintenance of quality across the operation.
- Community monitoring committees were set up to enhance cholera surveillance, additional two were set up. One committee was set up at RC Centre and second one at the college to mitigate the potential outbreak at these institutions.
- Although 40 volunteers were assigned to be actively doing surveillance and report cases, the number increased to 80 as some of the volunteers that were involved in the Cholera Treatment centres, had also been reporting cases of cholera they detected in their neighbourhoods.
- All identified through active surveillance by the volunteers were referred, this could be attributed to high level of community awareness and good volunteer training.

Challenges

- Deterioration of the economy affected prices of goods and some of the procurements, in some cases NS procured less than planned.
- Poor WASH infrastructure in the affected areas predisposed at-risk community to high chances for recurrence.
- The usual delayed application process for DREF was not the case this time around, unlike in previous emergencies. The turnaround time between application and disbursement to the National Society was much shorter compared to previous applications, although for a fast spreading outbreak of this nature, there remains rooms for improvement.

Lessons Learned

Zimbabwe Red Cross Society held a two-days Lessons learnt workshop of the DREF operation from the 11th to the 12th of December 2018. The lessons learnt workshop aimed at reviewing progress of the DREF activities and then looking at the gaps or challenges in the operation and what could be learned from the operation. As part of the workshop, the Africa Cholera framework was also presented as a way of introducing a new way of looking at Cholera responses in Africa. Participants at the Workshop were drawn from the Red Cross provinces and HQ. Participants included Provincial Programme Managers, Volunteer supervisors at the centre of the operation; ZRCS programme staff, PNS reps and IFRC Africa Region representative.

Overall recommendations:

- The framework on Cholera was seen as a sound way of dealing with outbreaks as it tries to look at the root causes and address them way before an outbreak is proclaimed.
- Targeting the mapped hotspots allows us to focus on the traditional epicentres and thus improve systems for surveillance, prevention and response.
- In collaboration with the Ministry of Health's Surveillance department, the National Society could explore mechanisms to strengthen Early Warning/Early Action for quicker response and ensure outbreaks are contained effectively.
- Community engagement and accountability could further be strengthened not to focus on monitoring but rather have a proper system for complaints and feedback with a view to improve the operation and keeping the communities at the centre of activities.
- To continuously improve ZRCS volunteers' capacities through trainings and have a proper database to capture their various skill sets.
- Boost visibility of the organisation and volunteers.
- Improve ZRCS participation in key stakeholder meetings so as to have more say and influence in those meetings.

It is important to be quick in sourcing the DREF funding. Forecast-based Financing could be a remedy to ensure the NS is not late in its response to disease outbreaks. The DREF was only released a bit later after confirmation on the 18th of September, while the cholera epidemic started on the 5th of September. Funding was received by the NS a week later. A 24/48hr system is what is required if NS is to remain relevant in comparison with other partners. In that period, a lot would have happened and NS relevance in coordination will become increasingly redundant as NS may have nothing to offer whilst other organisations release funds for operations within 24/48hrs.

Prepositioning of response materials or having an emergency fund present to kickstart operations should always be encouraged as health emergencies need quick response.

Water, sanitation and hygiene

People reached: 15,000 people (2,567 households)

Male:

Female:

WASH Outcome1: Vulnerable people have increased access to appropriate and sustainable water, sanitation and hygiene services

Indicators:	Target	Actual
% of reduction of cholera cases in the target areas	0 case	

WASH Output 1.1: Communities are provided by NS with improved access to safe water

Indicators:	Target	Actual
# of hygiene promotion and awareness sessions conducted	48	55
# of people who have access to potable water	15,000	Over 50,000 people
# of people reached with water purification tablets	15,000	Over 50,000
# of people reached with chlorine solutions	15,000	15,000
# of HTH procured and distributed to health centres	8 tins	8 tins
# of latrines treated/disinfected	240	300
# of key hand washing moments demonstration sessions conducted	3,000	3,022
# of safe water treatment use sessions held	144	152
Quantity of WASH related NFIs procured and distributed (Target: Soap: 15100, bucket with lids: 3,000, Jerry can: 3,000, Backpack sprayer: 40)	Soap 15,100, buckets 3,000, jerry cans 3,000, backpack sprayer: 40	12,835 soaps, 2,567 jerry cans, 2,567 buckets and 35 backpack sprayers

Narrative description of achievements

- The overall reach of this sector exceeded the target due to support mobilised from local partners and the additional geographical coverage.
- The hygiene awareness sessions reached more areas than initially planned due to additional geographical areas covered by the NS.
- The NS procured 576 water guards; one water guard bottle purifies 20 by 20 litres. In total 100 bottles were used for bucket chlorination at water points and this benefitted 2,000 households, while 476 bottles were distributed to 476 households, and this brings the total to 2,476 households that have benefitted from this support. In addition, the NS managed to secure a donation of 110,000 bottles of Water guards from Latter Day saints Charities, these were distributed to public institutions mostly clinics, and some directly to households, it is estimated that over 50,000 people benefitted from the support.
- The four (4) Health Centres were provided with 8 tins (45kg each as planned) calcium hypochlorite (HTH) for the preparation of chlorine solutions for different uses (disinfection of vomit surfaces, faeces, urine and other biological fluids). The tins distributed helped improve general sanitation and availability of portable water at health centres.
- 300 latrines in schools and public places were disinfected by trained volunteers in Glen View and Budiriro. The local donations received by the NS resulted in additional 60 toilets chlorination from o
- 152 sessions to disseminate water treatment use were held in the communities and schools, the achievement is higher than planned due to additional geographical areas.
- 12,835 Soap, 2,567 jerry cans, 2,567 buckets and 35 backpack sprayers were procured and distributed. Fewer soaps, jerry and buckets were purchased due unexpected increase in prices.

Challenges

Poor WASH infrastructure in the affected areas predisposed at risk community to high chances for recurrence
Some NGOs who distributing water treatment tablets had challenges with community perception towards it, distributed water guards and chlorine for toilets disinfection.

Lessons Learned

NS needs to have non-expiring NFIs always available for such emergencies.

D. THE BUDGET

The overall grant for this operation was CHF 208,367, of which CHF 198,943 (95.47%) were spent. A balance of CHF 9,424 will be returned to the DREF pot.

Explanation of variances:

- **Shelter:** Variance of CHF 2,129, this was a budget error as expenditure was budgeted as transitional shelter instead of relief.

- **Clothing & Textiles**: Variances of bought overalls which was used by the volunteers engaged in WASH activities.

- **Water sanitation and Hygiene**: The under expenditure of CHF 37,850 (includes Buckets and Jerry Cans) was reported under Utensils and Tools

- **Medical and First Aid:** Over expenditure of CHF 3,892**,** more ORP bought as they were identified as a huge gap, critically required in the operation more than the ORS which was abundantly provided by other actors.

- **Utensils and Tools**: Over expenditure of CHF 28,634, due to costs being budgeted under Water, Sanitation and Hygiene.

- **Transport Vehicle Costs:** Over expenditure of CHF 3,533 because vehicle service cost more than planned. More fuel was required to cater for response drives in other areas outside Harare. This also included HQ monitoring and distribution drives.

- **Logistics Services:** Spent CHF 2,500 which was not budgeted due, this was procurement/service charge by Dubai Procurement for the NFIs procured through IFRC.

- **National Society Staff:** Over expenditure of CHF 19,673 is related to **ZRCS** staff costs during monitoring to other areas affected by cholera outside Harare. These were not budgeted but became necessary in the interventions due to sporadic outbreaks in other provinces.

Contact information

Reference documents ↘

Click here for:

- Emergency Plan of Action (EPoA)

For further information, specifically related to this operation please contact:

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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 Humanitarian 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 non-violence and peace

DREF Operation

FINAL FINANCIAL REPORT

Selected Parameters			
Reporting Timeframe	2018/09-2019/05	Operation	MDRZW013
Budget Timeframe	2018/09-2018/12	Budget	APPROVED

Prepared on 18/Jun/2019

All figures are in Swiss Francs (CHF)

MDRZW013 - Zimbabwe - Cholera Outbreak

Operating Timeframe: 18 Sep 2018 to 18 Dec 2018

I. Summary

Opening Balance	**0**
Funds & Other Income	**208,367**
DREF Allocations	208,367
Expenditure	**-198,943**
Closing Balance	**9,424**

II. Expenditure by area of focus / strategies for implementation

Description	Budget	Expenditure	Variance
AOF1 - Disaster risk reduction			**0**
AOF2 - Shelter			**0**
AOF3 - Livelihoods and basic needs			**0**
AOF4 - Health	102,325	117,456	**-15,131**
AOF5 - Water, sanitation and hygiene	71,919	68,470	**3,449**
AOF6 - Protection, Gender & Inclusion			**0**
AOF7 - Migration			**0**
Area of focus Total	**174,245**	**185,926**	**-11,682**
SFI1 - Strenghten National Societies	11,012	9,956	**1,056**
SFI2 - Effective international disaster management	23,111	3,038	**20,072**
SFI3 - Influence others as leading strategic partners			**0**
SFI4 - Ensure a strong IFRC		22	**-22**
Strategy for implementation Total	**34,123**	**13,016**	**21,106**
Grand Total	**208,367**	**198,943**	**9,424**

DREF Operation

FINAL FINANCIAL REPORT

Selected Parameters			
Reporting Timeframe	2018/09-2019/05	Operation	MDRZW013
Budget Timeframe	2018/09-2018/12	Budget	APPROVED

Prepared on 18/Jun/2019

All figures are in Swiss Francs (CHF)

MDRZW013 - Zimbabwe - Cholera Outbreak

Operating Timeframe: 18 Sep 2018 to 18 Dec 2018

III. Expenditure by budget category & group

Description	Budget	Expenditure	Variance
Relief items, Construction, Supplies	**67,930**	**68,956**	**-1,026**
Shelter - Relief		2,129	-2,129
Shelter - Transitional	2,000		2,000
Clothing & Textiles		6,040	-6,040
Food		183	-183
Water, Sanitation & Hygiene	55,730	17,880	37,850
Medical & First Aid	5,200	9,092	-3,892
Utensils & Tools	5,000	33,634	-28,634
Logistics, Transport & Storage	**20,830**	**18,307**	**2,523**
Distribution & Monitoring	10,300	1,743	8,557
Transport & Vehicles Costs	10,530	14,063	-3,533
Logistics Services		2,500	-2,500
Personnel	**69,930**	**71,956**	**-2,026**
National Society Staff	1,800	21,473	-19,673
Volunteers	68,130	50,484	17,646
Workshops & Training	**10,180**	**8,057**	**2,123**
Workshops & Training	10,180	8,057	2,123
General Expenditure	**26,780**	**19,524**	**7,256**
Travel	3,000	251	2,749
Information & Public Relations	17,780	14,769	3,011
Office Costs	2,250	1,479	771
Communications	2,400	2,061	339
Financial Charges	1,350	965	385
Indirect Costs	**12,717**	**12,142**	**575**
Programme & Services Support Recover	12,717	12,142	575
Grand Total	**208,367**	**198,943**	**9,424**