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DREF operation update
Zimbabwe: Cholera

International Federation of Red Cross and Red Crescent Societies

DREF operation n° MDRZW005
GLIDE n° EP-2011-000083-ZWE
Update n° 1: 9 September, 2011

The International Federation of Red Cross and Red Crescent (IFRC) Disaster Relief Emergency Fund (DREF) is a source of un-earmarked money created by the Federation in 1985 to ensure that immediate financial support is available for Red Cross and Red Crescent emergency response. The DREF is a vital part of the International Federation's disaster response system and increases the ability of National Societies to respond to disasters.

Period covered by this update: 01 August to 31 August 2011.

Summary: CHF 226,353 was allocated from the IFRC's Disaster Relief Emergency Fund (DREF) on 8 July 2011 to support the National Society in delivering assistance to some 30,000 beneficiaries, or to replenish disaster preparedness stocks.

This operation is expected to be implemented in three months, and completed by 30 September 2011. In line with the Federation reporting standards, the final report (narrative and financial) is due 90 days after the end of the operation (by 31 December 2011).

Beneficiaries receiving non-food items at Chibuwe Clinic/ photo ZRCS

This update summarizes the progress made in the month of August 2011. Cholera is still a major concern in Chipinge district although there have been no new cases. Generally there is low sanitation coverage and poor health and hygiene practices in the two targeted wards. ZRCS continues to work with the Ministry of Health and Child Welfare in training volunteers on health and hygiene education using the Participatory Health and Hygiene Education (PHHE). Emergency stocks comprising soap, water purification tablets, oral rehydration salt (ORS) and jerry cans have been distributed to complement health and hygiene promotion that is currently underway in the two wards. Identification of wells, institutional and household latrine beneficiaries has been done and the communities have started to gather locally available building materials such as bricks and sand while waiting for cement and other materials.

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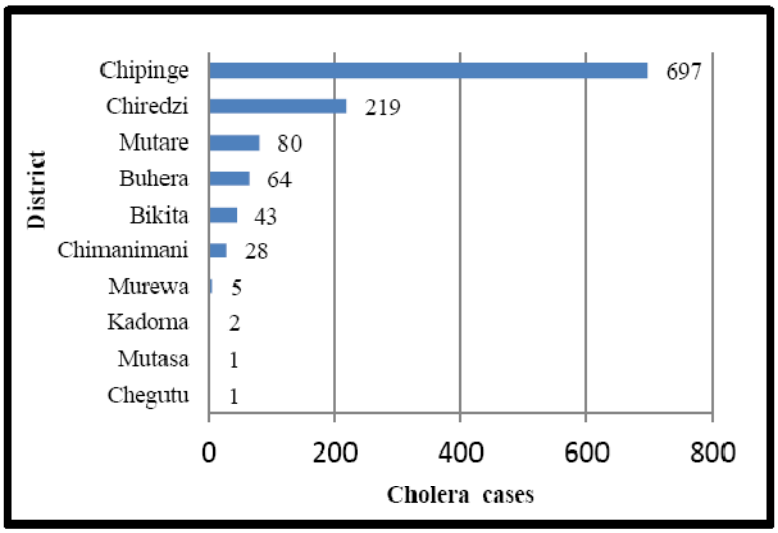
The situation

Following the 2008/2009 cholera outbreak which by its conclusion in June 2009 had affected 55 of 62 districts in Zimbabwe recording 98,531 cholera cases, a case fatality rate of 4.5% and leaving 4,282 dead[1], the National Society with support from the IFRC responded through the deployment of water and sanitation ERUs and mobilisation of trained volunteers in districts throughout the country including Chipinge district. The volunteers further received community-based health (CBHFA) and first aid training and have since been actively involved in health and hygiene

[1] Ministry of Health and Child Welfare (MoHCW) and WHO Epidemiological report for 17 July 2011.

promotion within those communities. From Week 1 to week 25 in 2011, ten out of the 62 districts, namely: Bikita, Buhera, Chegutu, Chimanimani, Chipinge, Chiredzi, Kadoma, Murewa, Mutare and Mutasa, have reported cholera cases. A total of 1140 cholera cases and 45 deaths were reported by the 17th July 2011, giving a crude case fatality rate of 4.0%. Of the total reported cases, 320 were confirmed positive by laboratory tests. Manicaland province reported the majority of cases. 697 (80%) of the 870 (76%) reported cases from Manicaland province were from Chipinge.[2]

Figure 1: Cumulative Cholera cases, Jan – July 2011



Access to safe water supply and basic sanitation in Zimbabwe has worsened over the last few years. Rural communities have been particularly hard hit by the cholera outbreak. WASH cluster partners report that over 60% of boreholes have broken down and sanitation coverage is poor at community level and institutions such as clinics and schools. In schools the WASH situation requires urgent attention in order to protect children from diarrhoeal diseases, including cholera. It is critical to ensure that schools provide a protective and safe environment to children. The underlying causes relate to the lack of safe drinking water, inadequate sanitation and poor hygiene practices. Water and sanitation and good hygiene practices are key barriers to prevention of water borne diseases among them Cholera. The upsurge in the number of infections is an indication that access to these services has been severely compromised. In urban areas, the situation was compounded by a shortage of water treatment chemicals resulting in many areas going without water for extended periods. The flow of effluent in larger cities due to the breakdown of the sewage infrastructure causes cross contamination of piped water and shallow wells. Many households have been forced to resort to use of unprotected contaminated open wells for water for drinking and domestic use.

Coordination and partnerships

An inter-agency coordination committee is operational in the district and province to manage the situation and coordinate the actions of all humanitarian stakeholders. The Provincial Medical Directorate (PMD) continues to give the necessary guidance and support to health structures in responding to the outbreak despite limited financial and material resources. Other relief organisations working in the area are Action Faim and Mercy Corps who have also assisted in the cholera treatment centers (CTCs)

The Red Cross remains a part of the health and WASH cluster. Coordination is crucial for this intervention and the Red Cross is represented and participates in all coordinating forums at provincial and district levels. The ZRCS is coordinating with the MoHCW the health and WASH cluster and other stakeholders at national level. The ZRCS has capacity to carry out community mobilization, water, sanitation and hygiene promotion activities through its network of branches and volunteers. The IFRC through its Southern Africa Regional and Country Representation Offices is following up the situation and provides technical support to the ZRCS

Red Cross and Red Crescent action

Chipinge district in Manicaland is one of the areas where cholera has remained endemic and there is always imminent danger that an outbreak might occur. The operation is targeting 16 wards particularly two wards in

[2] Ministry of Health and Child Welfare (MoHCW) and WHO Epidemiological report for 17 July 2011

St Peters and Chibuwe. These two wards recorded a cumulative case total of 349 of the 554 cases. Zimbabwe Red Cross Society through its trained CBHFA volunteers is involved in health and hygiene promotion at the community level.

The activities were boosted by the injection of DREF funds from the IFRC under which volunteers have been trained in cholera prevention and management. Table 1 below provides a breakdown of non-food items (NFIs) sent to the project site for distribution.

Table 2: Distributed non-food items

Item	Quantity
Soap bars	40,000
Jerry Cans	4,224
Water Purification Tablets	10,800
Oral Rehydration Salts	1,000
Dust bins	4,000
Brooms	1,200
Rolls of barbed wire	3
Water maker sachets	50,000
Windlasses	50
Reinforcing wire	300

2 800 cement bags will be delivered by the second week of September 2011. The supply tender had to be reissued to another supplier as the one who had initially won it failed to deliver. Volunteer training manuals are ready for dispatch.

Progress towards outcomes

Water Supply

Outcome: To improve access to safe water for 30,000 people (6,000 households) by the end of the project timeframe.			
Expected Result: • **Increased use of water amongst the target population** • **Increased use of sanitation facilities by the target population**			
Outputs and activities planned:			
Activities Planned	**Performance indicator /outcomes**	**Progress**	**Remarks**
Emergency repair of 50 shallow wells and 50 boreholes in schools and communities	• Number of people accessing clean drinking water • Water points rehabilitated • People benefitting	Households identified for protection of wells	Identification of beneficiaries was done with the help of environmental health technicians working with water point committees.
Distribution of 10,000 water treatment chemicals (sachets and aqua tabs) for 6,000 households for three months.	• Number of water purification sachets distributed • Households reached	10,800 sachets have been prepositioned at distribution sites i.e. St Peters hospital and Chibuwe clinic.	A total of 540 households benefited.
Distribution of 5,000 jerry cans to households	• Number of jerry cans distributed • Households reached	4,224 jerry cans were distributed.	Each household received one jerry can.
Train community members on household water treatment techniques and safe use of water treatment chemicals.	• Number of households trained on household water treatment techniques and safe use of water treatment chemicals.	Household representatives were trained on the use of water treatment chemicals	Representatives from the 4,224 households were trained during the NFI distribution. This training is being reinforced by PHHE trained volunteers during health and hygiene visits.

Sanitation, and hygiene promotion

Outcome: Improved hygiene practices and awareness for 30,000 people in the targeted cholera affected areas
Expected result: • **The affected population are effectively and efficiently sensitised** • **Improved awareness and uptake of good hygienic practice amongst 90% of the targeted population**
Outputs and activities planned:

Activities Planned	Performance indicator /outcomes	Progress	Remarks
Support the construction of 200 household latrines and 100 latrines in schools.	• Number and location of latrines constructed • People benefiting	• 100 institutional sites and 200 households were identified to benefit from latrine construction support. • Beneficiary institutions and households have started prepositioning aggregates, bricks and sand.	Beneficiaries are awaiting cement and other materials.
Carry out health and hygiene education and promotion among two communities using PHAST in emergency methodology	• People reached by hygiene promotion activities	3,000 people were reached	
Hygiene promoters carry out house to house visits for 2,160 volunteer days.	• Hygiene kits distributed • Households reached	Training on hygiene education is in progress.	
Carry out refresher training for 60 hygiene promoters in the PHAST methodology and ECV manuals and tools	• Number of trainings carried. • Number of HP who received the trained by gender	60 volunteers were trained in PHHE	Facilitation was done by Ministry of Health staff and EHTs.
Print and distribute IEC materials for the prevention of cholera	• Quantity and nature of IEC material produced and distributed • People reached by IEC material.	2,000 pamphlets were distributed to six schools.	The IEC material was taken from health programme stocks
Refresher training for 15 school health facilitators, ten church leaders and 20 village heads	• Number of training • Nature of training • Targeted group by gender	• A meeting was held with 15 school heads • 15 school headmasters were identified and trained	The meeting was to map out training times, venue, selection of cadres and implementation modalities
Promote school health clubs in 15 schools	• Number of school health clubs established. • Gender composition of clubs. • Activities carried out by health clubs.	15 schools were selected and the teachers leading the clubs were trained	Teachers were trained at the end of the second school term holidays.

Distribute soap for hand washing and general hygiene	• Quantity of soap distributed	10,000 bars of soap were distributed.	4,224 households received soap.
Provision of materials for waste disposal (brooms and bins) at two market centres.	• Quantity of materials distributed • People benefiting	100 dust bins and 30 brooms were dispatched to the project area and are awaiting distribution.	

Health and Care

Outcome: To strengthen household level case detection, management and referrals to health facilities.

Expected results:

- **Improved early detection, reporting and referral of suspected cases**
- **Increased use of ORS for the treatment of mild cases**
- **Decrease number of deaths in the two wards at the end of the project timeline**

Outputs and activities planned:

Activities Planned	Performance indicator /outcomes	Progress	Remarks
Train 60 community based volunteers on symptom identification and symptoms of severity using the IFRC ECV manuals for volunteers	• Number of volunteers trained on symptom identification and symptoms of severity using the IFRC ECV manuals for volunteers	60 people were trained	The Training included PHHE approaches.
Establish referral in collaboration with local health authorities.	• Number of referrals established • People referred.	Advocacy meetings conducted	
Train household members on preparation and use of ORS	• Number of household members trained on preparation and use of ORS • Number ORS distributed • Households benefiting	10,000 ORS sachets were distributed and recipients were trained in the preparation of the solution.	

Contact information

For further information specifically related to this operation please contact:

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DREF history:

- This DREF was initially allocated on 8 July 2011 for CHF 226,353 months to assist 30,000 beneficiaries.
- No previous DREF operation updates have been issued.

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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 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 non-violence and peace