



Multisectoral Response to a Nationwide Cholera Outbreak in Mozambique

SUMMARY

From September 2022–June 2023, Mozambique experienced one of the biggest cholera outbreaks in recent history with 32,265 reported cases in all 11 provinces.¹ The outbreak began escalating from mid-January and spread quickly in March 2023 following Cyclone Freddy, reaching some districts that had not reported cholera cases for more than five years and as a result, were not well-prepared to respond. In March 2023, the World Health Organization (WHO) categorized the outbreak as a multi-region Grade 3 Public Health Emergency requiring a major response.

Mozambique's cholera response followed the WHO Global Strategic Preparedness, Readiness and Response Plan (SPRRP).² The UNICEF Mozambique Country Office led the response on risk communication and community engagement (RCCE); water, sanitation, and hygiene (WASH); and infection prevention and control (IPC) at the community and cholera treatment centre (CTC) levels. UNICEF was also actively involved in other response activities led by WHO including leadership, coordination, planning and monitoring, case management and vaccination.

This Field Note contributes to current knowledge on cholera outbreak interventions by highlighting some recurring challenges faced and corresponding solutions applied during the implementation of the 2022–2023 cholera response. Based on lessons learnt, the Mozambique Country Office offers specific actions to be taken during low transmission periods and when an acute watery diarrhoea (AWD) or cholera outbreak is declared to ensure an efficient response in future outbreaks.

Background

Cholera is endemic in Mozambique and outbreaks are reported nearly every year during the summer

rainy season (December–March) mainly in Nampula, Cabo Delgado, Sofala and Tete provinces. These provinces are more vulnerable due to their poor WASH indicators and

¹ While few confirmed cases were still being reported by June 2023 (dry season), the outbreak was never officially declared over, and the country continued counting cholera cases until 30 September 2023. At the time this note was finalized (30 November 2023), a new count is ongoing, and cases are reported as part of a 'new' outbreak cycle.

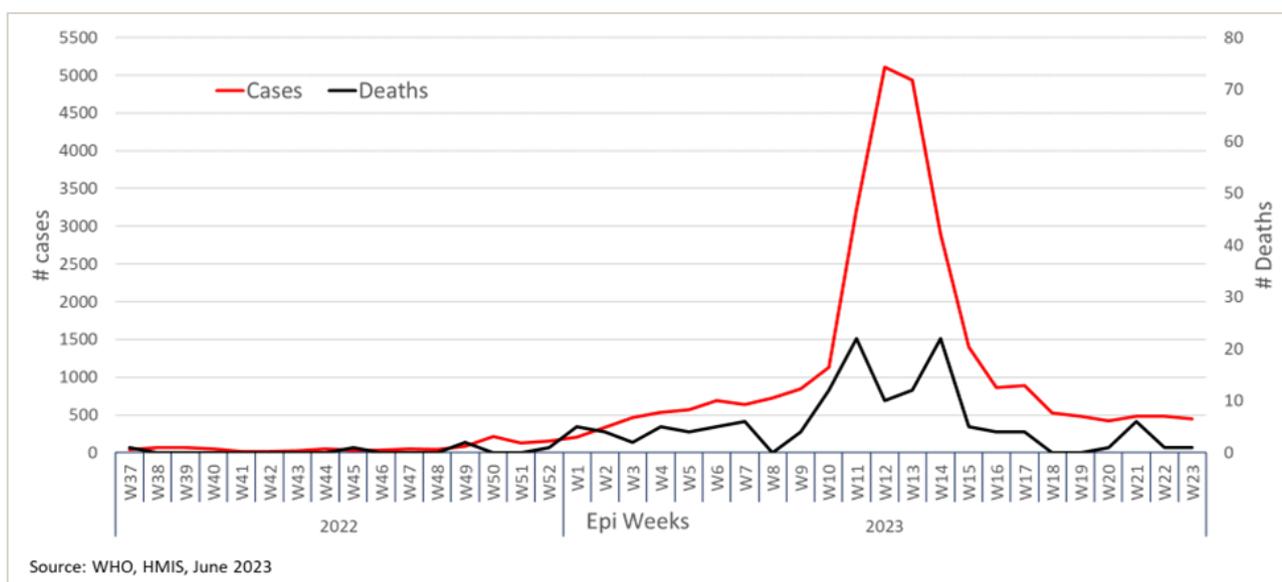
² According to the [WHO Global Strategic Preparedness, Readiness and Response Plan \(SPRRP\) for Cholera \(April 2023–April 2024\)](#), a response structure consists of ten inter-related pillars: (1) Leadership, coordination, planning and monitoring; (2) Risk communication and community engagement (RCCE); (3) Surveillance and outbreak investigation; (4) Water, sanitation and hygiene (WASH); (5) Laboratory diagnostics and testing; (6) Infection prevention and control (IPC); (7) Case management; (8) Operational support and logistics (OSL); (9) Continuity of essential health and social services; and (10) Vaccination.

susceptibility to heavy flooding. In recent years, cholera outbreaks have been relatively small and localized. However, a localized outbreak reported in September 2022 in Niassa Province quickly evolved into a nationwide outbreak. From 14 September 2022–11 June 2023, there were 32,265 confirmed cases and 141 deaths [case fatality ratio (CFR) 0.4%]. Such a prolonged outbreak affecting all provinces – including the capital city of Maputo – confirmed sustained disease transmission.

region Grade 3 public health emergency requiring a major response.

Zambezia, Sofala, Tete and Niassa provinces were the most affected, and there was a spike in cholera cases reported in March 2023 due to a change in the case definition to include mild cases. Following the peak, the number of cases started decreasing, mainly related to the end of the rainy season and the oral cholera vaccine (OCV) campaigns conducted in affected locations (see Figure 1).

Figure 1: Cholera cases and deaths by week (14 September 2022 – 11 June 2023)



Source: UNICEF Mozambique

To add fuel to the fire, Cyclone Freddy struck Mozambique in February–March 2023, causing widespread flooding, population displacement, and interruption of basic services including WASH. The cyclone affected an extensive geographical area leaving at least 750,000 people with poor sanitation and inadequate water treatment and hygiene, which exacerbated the cholera outbreak. Some of the affected provinces had not reported cholera cases for more than five years prior to this and as a result, the health system – including many health workers – was ill-prepared to respond. By March 2023, the outbreak was categorized by WHO as a multi-

A combination of factors contributed to the exponential spread of cholera in Mozambique:

- A fragile health system, together with an overstretched health workforce that was simultaneously responding to multiple disease emergencies (polio, cVDPV2, monkey pox, measles, COVID-19).
- Limited WASH-RCCE response in communities at the onset of the outbreak coupled with poor WASH service coverage.
- The impact of Cyclone Freddy.
- Weak surveillance (late reporting and under-reported cases).

- Lack of essential cholera commodities pre-positioned.
- Global shortage of OCV.
- Frequent movements between districts and borders experiencing cholera outbreaks.

UNICEF Response

UNICEF led the RCCE, WASH and IPC components of the cholera response at the community and CTC levels. The Country Office was also strongly involved in leadership,

coordination, planning and monitoring, as well as case management and vaccination. The main activities are presented below according to the WHO SPRRP pillars.

Pillar 1: Leadership, coordination, planning and monitoring

UNICEF contributed to the response coordination, planning and monitoring as WASH Cluster lead at both national and subnational levels, and through active participation in national and sub-national Health Clusters. UNICEF also led coordination for RCCE activities.

meetings were conducted at national and provincial levels. A WASH Cluster 5W matrix was established where all partners – both governmental and non-governmental – reported on weekly progress.

Bi-weekly WASH Cluster progress updates were developed and shared with all cluster members, and at the peak of the response, weekly cluster

WASH and Health Clusters developed a joint Cholera Response Plan at national level, as well as in several provinces, although not systematically in all of them.

Pillar 2: Risk Communication and Community Engagement (RCCE)

Photo 1: Grupo de Teatro o Retratista - Molumbo, Mercado da vila de Molumbo



Source: © M Lemos/ UNICEF

- Critical RCCE interventions were designed and implemented based on available and compiled evidence on the main social and behavioural outbreak drivers with the aim of reinforcing the adoption of preventive practices. Messages focused on hygiene, safe water consumption and care-seeking behaviour among affected populations.
- The interventions were implemented in conjunction with the Case-Area Targeted Interventions (CATI) approach in communities with identified and registered cases and in the surrounding communities that were at risk of the disease.
- Social mobilization and community engagement efforts were carried out such as multimedia mobile units, community radio, community theatre groups, and utilizing the role of religious leaders to reach a broad range of people, particularly in hotspot areas.

- UNICEF also produced and broadcasted a series of videos featuring young artists and influencers, addressing the main factors that hindered the adoption of preventive practices, particularly among youth and adolescents who were among the most affected age groups in

provinces like Zambezia. A page on UNICEF's *Internet of Good Things* provided key information about cholera symptoms, prevention, and care-seeking, reaching nearly 2 million people nationwide.

Pillar 4: Water, Sanitation and Hygiene (WASH) + Pillar 6: Infection Prevention and Control (IPC)

The UNICEF WASH response focused on the following key strategic areas:

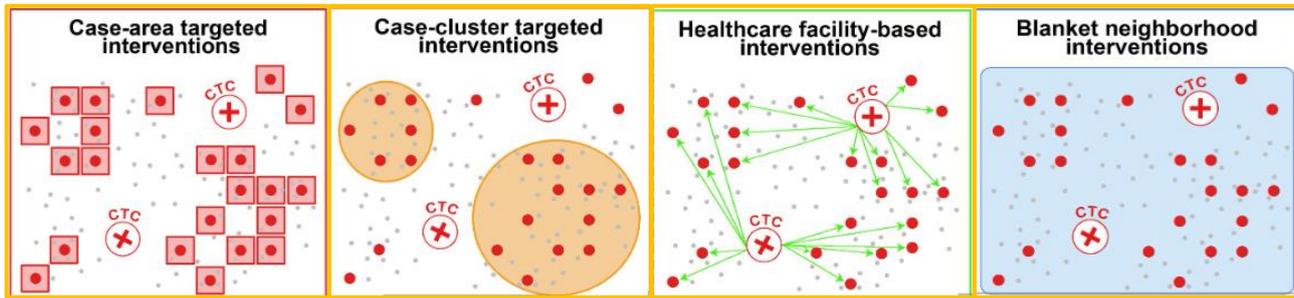
Photo 2: Installation of a water tank in Barrio Sanjala, Lichinga



Source: © UNICEF J. Nhaule, March 2023.

- **Ensuring access to safe water in affected communities, in health care facilities (HCFs) and in CTCs.** From January–June 2023, UNICEF, in partnership with Government institutions and at least five NGO partners, reached a total of 378,550 people with safe water through water trucking, installation of tanks, distribution of water treatment chemicals, and disinfection of water points. UNICEF supported the Provincial Directorates of Public Works and water supply service provider (FIPAG) with water treatment chemicals in all affected provinces. A total of 1.3 million litres of safe water were trucked to CTCs as part of the response.
 - UNICEF supported 46 CTCs and 56 schools and HCFs with **WASH IPC materials and sanitation infrastructures**. A total of 198 emergency latrines were constructed in CTCs as part of the response.
- **Implementing different modalities of community-based cholera prevention and control – see text box below – according to the context** reaching over 976,086 people from January–June 2023. These interventions included targeted distribution of WASH supplies, hygiene awareness, decontamination of surfaces, and water

Box 1: Delivery mechanisms used for cholera prevention and control in communities



Case-area or case-cluster targeted interventions (CATI) approaches were used at the beginning of the outbreak when cases were relatively few and could be tracked in provinces such as Niassa and Tete.

Health workers and volunteers led by health technicians visited hospitalized patients' households and provided sensitization talks, distributed water purification products and other WASH items and installed bucket chlorination.

In some contexts, the sensitization and distribution of kits were done at the CTCs.

This approach was mainly used by MSF (Medecins Sans Frontieres) in CTCs managed by them.

In contexts such as Quelimane and Beira cities with an important number of cases, the delivery modality used was 'blanket neighborhood interventions' including door to door or community sensitization activities, blanket distribution of water purification products and chlorination of water points.

Pillar 7: Case Management + Pillar 10: Vaccination

Case management and vaccination were led by WHO, and UNICEF supported the following activities:

Photo 3: Distribution of WASH and Health supplies in Quelimane hospital less than 48 hours after outbreak declaration



Source: © UNICEF, March 2023.

- **Training and deployment of community health workers (CHWs).** From January–June 2023, at least 478 CHWs were trained to conduct health promotion, cholera prevention, case referral and follow-up.
- **Technical support on CTC management.** As the outbreak lingered beyond the typical period and spread to new non-hotspot districts, UNICEF, in coordination with WHO and the United States Centers for Disease Control and Prevention (CDC), strengthened the referral system between communities and health facilities by supporting logistics, providing supplies, and participating in needs assessments to new districts reporting cholera outbreaks and/or increasing cases of AWD.
- **Procurement of vaccines and implementation of OCV campaigns.** UNICEF provided technical and financial support for four rounds of OCV campaigns between March–October 2023, reaching almost 3 million people with one dose of the vaccine. About 60 per cent of the total reached were children <15 years (48 per cent of them female).
- **Installation of community oral rehydration points (ORP).** At least 21,000 people benefited from 106 ORPs from January–June 2023.
- **Procurement and delivery of supplies for cholera treatment centres (CTCs).** Equipment included cholera beds, tents, personal protective equipment, cleaning materials and catheters for a value of around US\$3 million.

Challenges and Implemented Solutions

While responding to the nationwide cholera outbreak, UNICEF faced external and internal challenges that were identified during internal lessons learnt sessions and an after-action review workshop led by MoH held in August 2023. Highlights are summarized below.

Pillar 1– Leadership, coordination, planning and monitoring + Pillar 3 – Surveillance and outbreak investigation³

Main challenges	Implemented solutions
External	
<ul style="list-style-type: none"> ▪ The Government never activated the Cholera Emergency Operations Centre which made coordination difficult between the Government and key non-governmental partners. 	<ul style="list-style-type: none"> ▪ A multi-agency group with main partners (WHO, UNICEF, MSF) was created to prioritize, harmonize, and coordinate interventions.
<ul style="list-style-type: none"> ▪ Multi-sectoral cholera task forces were activated at provincial level led by MoH but with little commitment and/or space left for other sectors to actively participate, particularly water and sanitation sector counterparts. 	<ul style="list-style-type: none"> ▪ Advocacy messages were sent to all levels of the WASH-related ministry to boost their involvement in the response and capacity to coordinate. Similar messages were also sent to MoH to facilitate multi-sectoral coordination.
<ul style="list-style-type: none"> ▪ Once the peak of the outbreak passed and after OCV campaigns ended, coordination became more challenging due to a loss of momentum around the response. 	<ul style="list-style-type: none"> ▪ UNICEF and WHO advocated at national and provincial levels to ensure coordination and surveillance during and after the outbreak. Partnerships with NGOs were extended to ensure surveillance and preparedness during the low-transmission period between the two rainy seasons (May–October 2023).
<ul style="list-style-type: none"> ▪ A National Cholera Response Plan was outlined by the Government but never finalized or shared with partners which made it difficult for partners to understand geographical priorities and respond to and evaluate identified needs and gaps. 	<ul style="list-style-type: none"> ▪ UNICEF attempted to influence provincial authorities to design provincial/district response plans, but it was not always effective. ▪ The WASH and Health Clusters updated the common response plan twice, but it was mainly used for fundraising (review of Flash Appeal and Humanitarian Response Plan).

³ Although UNICEF did not intervene in Pillar 3, which was led by WHO, UNICEF offer recommendations linked to successful implementation of CATI.

<ul style="list-style-type: none"> ▪ The WASH and Health Clusters developed a common response plan by pillar, but the plan lacked a results framework and detailed budget. 	
<ul style="list-style-type: none"> ▪ Official outbreak declarations in affected zones often happened late, delaying responders' capacity to intervene. ▪ Cholera cases and deaths were underreported because cases were only registered in CTCs as inpatient admitted cases. Mild cases were reported only from March when the case definition changed, and cases from remote HCFs were never reported. As a result, lack of and/or unreliable data did not allow for tailoring the response package according to the transmission contexts. 	<ul style="list-style-type: none"> ▪ Strengthened coordination with MSF and WHO facilitated epidemiological data analysis, information sharing on increased AWD cases, and quick mobilization of teams. ▪ UNICEF trained implementing partners on the use of data to guide the response.
Internal	
<ul style="list-style-type: none"> ▪ An integrated response plan for the Mozambique Country Office and clear leadership was missing at the onset of the response and the initial interventions operated mainly in silos at both national and provincial levels. ▪ Weeks after the beginning of the outbreak, a multi-sectoral response plan with targets and budgets was developed at national level including disaggregation by provinces, but it was mainly a top-down exercise. Field offices did not develop their own multi-sectoral response plan to orientate their response. 	<ul style="list-style-type: none"> ▪ A Cholera Working Group was created at the beginning of the response, consisting of all members of the Emergency Management Team and met weekly, but proved inefficient as it was too large and lacked clear accountabilities and reporting lines. Several months after the onset of the outbreak (April 2023), a Cholera Task Force led by the Emergency Section was created with dedicated staff from each of the key sections involved in the response [Health, WASH, Social and Behaviour Change (SBC)]. The objective of the task force was to advise and guide the work of field teams according to epidemiological analysis. ▪ Some intents to develop provincial response plans were done although not consistently in all provinces. ▪ The need for a UNICEF Cholera Coordinator to lead the preparedness and response interventions was identified and a staff member recruited.
<ul style="list-style-type: none"> ▪ There were significant gaps in human resources at the beginning of the outbreak since the office was still recruiting for the new Country Programme Management Plan (CPMP). 	<ul style="list-style-type: none"> ▪ Several recruitment processes for local consultants were launched, as well as a surge plan. The UNICEF Regional Office and Headquarters' support were critical to cover the gaps. Despite these efforts, the challenges remained since, although short-term missions were useful for

<ul style="list-style-type: none"> ▪ The loss of institutional memory and low capacity of staff to deal with a cholera response after five years without a major cholera outbreak impacted staffs' ability to efficiently address the emergency. 	<p>advising and training, they caused challenges for coordination, partnership building, and monitoring of partners and interventions.</p>
<ul style="list-style-type: none"> ▪ The Country Office faced delays in developing partnerships given the roll-out of the new e-Program Document platform. ▪ During the first months of the response, partnership agreements to implement community activities (mainly CATI/CLUSTI) were developed separately by WASH, SBC and Health sections. Despite a Humanitarian Programme Document (HPD) template that included harmonized indicators, the final signed HPDs still had some inconsistencies which impacted the office's capacity to monitor and collect data on indicators in a centralized manner. 	<ul style="list-style-type: none"> ▪ Simplified emergency procedures like the 'start-up' letters were crucial to provide partners with capacity for quick mobilization. ▪ Having some pre-identified partners with an active partnership document on cholera response was proved helpful. ▪ Indicators were agreed with partners and integrated across amended HPDs, allowing harmonization of response indicators, and facilitated reporting. ▪ For CATI, a single data collection tool using mobile phones and the KoboCollect application open source was put in place.
<ul style="list-style-type: none"> ▪ The extent of the outbreak, which affected provinces where UNICEF does not have field offices and/or with very limited implementing partners' capacity, limited UNICEF's operational response e.g., unprepared for flexible disbursement procedures in this context, no long-term agreements (LTAs) for car rentals and other services, petty cash, absence of phone/internet service providers. 	<ul style="list-style-type: none"> ▪ UNICEF field offices in or close to affected provinces provided critical support to staff deployed in the field (i.e., Nampula Field Office supported colleagues on mission in neighbouring Niassa Province). ▪ Although it took time to sort out and learn the procedures, the Country Office managed to set up and utilize purchasing cards (p-cards⁴) for staff travelling to provinces outside of UNICEF's operating areas.

Pillar 2 – Risk Communication and Community Engagement (RCCE)

Main challenges	Implemented solutions
<ul style="list-style-type: none"> ▪ UNICEF and WHO did not activate a cholera RCCE technical working group at the onset of the response since both agencies were busy leading and implementing their sector-related response activities. 	<ul style="list-style-type: none"> ▪ At central level, UNICEF supported the MoH Health Promotion Department to organize coordination meetings with the participation of representatives from the affected provinces. Although meetings were not regularly scheduled, the coordination of different actors improved.

⁴ A p-card is a type of pre-paid debit card that allowed UNICEF staff to charge goods and services locally without the need for pre-approval and eliminated the need for petty cash.

<ul style="list-style-type: none"> Some provinces conducted frequent RCCE technical working group meetings, but attendance/representation by all partners was not always sufficient. 	
<ul style="list-style-type: none"> Limited RCCE assessments were conducted, therefore interventions were mainly blanket RCCE approaches due to lack of knowledge on context-specific drivers and perceptions of risks amongst populations at risk. Interventions commenced too late – after the declaration of the outbreak rather than in response to the first reported cases. Preparedness measures for at-risk communities were not promoted due to lack of epidemiological data on hotspots. 	<ul style="list-style-type: none"> Rapid qualitative data collection was conducted in some provinces and social and behavioural assessments were integrated into partnership agreements and harmonized across the different implementing partners. The “<i>Ficha de Pesquisa Rápida</i>” (Rapid Research Fiche) was adapted to collect data to inform RCCE interventions. Evidence review of socio-cultural practices for cholera prevention and care seeking was commissioned to inform RCCE based on available data, challenges, and lessons from past outbreaks in the country.
<ul style="list-style-type: none"> Mistrust towards government interventions caused incidences of persecution and aggression against health workers and local leaders who were supporting cholera response interventions. 	<ul style="list-style-type: none"> UNICEF supported community engagement activities to build trust in the cholera response and to address misinformation.
<ul style="list-style-type: none"> Limited partners’ capacity to collect behavioural data and community feedback made it difficult to monitor the outcome of the RCCE response on prevention and care seeking practices and to address misinformation. 	<ul style="list-style-type: none"> Active HPDs with partners set during the response (January-June 2023) were extended to ensure continuity of services during low transmission periods, focusing on awareness-raising around AWD/cholera prevention. Data gathering was integrated into partnership documents and a standardized feedback collection tool for all partners was piloted.

Pillar 4 – Water, Sanitation and Hygiene (WASH) + Pillar 6 – Infection Prevention and Control (IPC)

Main challenges	Implemented Solutions
Cholera prevention and control in communities (CATI, CLUSTI, etc.)	
<ul style="list-style-type: none"> Weak capacity of partners to plan and implement WASH interventions guided by epidemiological data and in coordination with other sectors. Different delivery mechanisms of cholera prevention and control in communities were implemented either late or incompletely by health 	<ul style="list-style-type: none"> Updated Cholera prevention and control in communities (CATI, CLUSTI, etc.) guidelines and training materials and massive training of government and non-governmental partners on it.

authorities and partners. While a good deal of knowledge about the approach was found amongst health authorities and partner responders, successful implementation was undermined by the fact that interventions were carried out after patient discharge rather than on admission.⁵

- Lack of vehicles or fuel to transport the teams, lack of incentives for volunteers, delays in obtaining patients' data from the CTCs.
- In a few cases, these activities' implementation was affected by reluctance of patients' families and communities to receive and accept the response teams given stigmatization of cholera in some communities.
- Incomplete epidemiological data and absence of a centralized database limited the capacity to accurately analyse, tailor, guide and assess the impact of the response.
- When these activities were implemented by government health authorities or health partners – which was mainly the case – the water-related component (disinfection, chlorination, water quality testing) was often missing, incomplete or conducted incorrectly.

- Technical and financial support was provided to health authorities to ensure capacity for community response e.g., for rental cars, fuel, incentives.
- Coordination with Social Behaviour Change partners to reinforce communication on cholera risks and prevention to increase acceptability of CATI/CLUSTI teams by families and communities.
- Expedited mobilization/contracting of partners using contingency Programme Documents (PDs) or modified existing HPDs.
- CATI/CLUSTI indicators and targets (i.e., % of admitted cases being followed up by CATI/CLUSTI teams within 48h after admission in CTCs) were standardized for all partners intervening in the response.
- Community outreach and mobilization was done by the health promotion technicians and local community leaders to increase acceptance of CATI/CLUSTI teams.

Water Supply and Sanitation (hard component)

- In terms of water supply, there was a heavy reliance on household water purification products, particularly by health authorities. As a result, disinfection, and reinforced chlorination of water sources, as well as bucket chlorination, were neglected by both health and water supply and sanitation authorities and almost only done when supported by partners. A few interventions were also done in high transmission areas such as markets and bus stations.

- UNICEF was efficient in procuring and delivering water purification products (about 16,450 kg of calcium hypochlorite (65-70%), 8,200 kg of aluminium sulphate and 201,781 bottles of household water purification products delivered between January–June and partnering with government-owned public utilities to improve the quality of piped water and to deliver water by truck, particularly to HCFs and CTCs.
- To mitigate problems with chlorination of water sources, UNICEF partnered with NGOs active in affected areas who were more effective than government counterparts in monitoring water quality and

⁵ The success of CATI aims for 80 per cent of all reported cases to be followed-up within 48 hours.

<ul style="list-style-type: none"> ▪ Regular monitoring of water quality was challenging due to inadequate technical capacity and equipment to conduct tests; therefore, it could not always be used to guide interventions. ▪ Sanitation-related activities were largely neglected by water supply and sanitation authorities as cholera was perceived to be a water-related disease. Most sanitation activities were done in CTCs, but almost nothing was done at the community level and in public spaces. 	<p>implementing chlorination and/or rehabilitation of water sources. However, the limited capacity or non-existence of WASH partners in some areas made it difficult to ensure full coverage. As an alternative solution, direct engagement with district authorities appeared to be more efficient for community interventions.</p> <ul style="list-style-type: none"> ▪ Sanitation and environmental cleaning in communities were mainly conducted by NGO partners. UNICEF also tried to mobilize Community-led Total Sanitation (CLTS) partners to conduct emergency sanitation and hygiene interventions with positive results.
<ul style="list-style-type: none"> ▪ Extremely dire conditions of HCFs where CTCs were set up in terms of access to WASH facilities and waste management, with some locations also having been affected by Cyclone Freddy. 	<ul style="list-style-type: none"> ▪ Setting up of p-cards as a petty cash modality with UNICEF Headquarters' support for staff in the field, as well as use of start-up letters to transfer funds to partners, were extremely useful to procure needed IPC items and products for CTCs (i.e., 1,000 buckets and 3,000 soaps procured by Quelimane field office for the CTC in less than 24 hours using the p-card).

Pillar 7 – Case Management + Pillar 10 – Vaccination

Main challenges	Implemented solutions
<ul style="list-style-type: none"> ▪ Limited human resource capacity to cover all the CTC needs as well as limited medical and IPC supplies. 	<ul style="list-style-type: none"> ▪ UNICEF procured and delivered IPC supplies to provincial and district authorities.
<ul style="list-style-type: none"> ▪ Limited capacity to implement ORPs and since ORPs were a new implementation strategy, communities were not aware of the approach and associated materials. 	<ul style="list-style-type: none"> ▪ Worked with partners and SBC and communication teams to increase capacity to implement and accept ORPs, also linking these more closely with health facilities.
<ul style="list-style-type: none"> ▪ Incomplete guidance on case management for pregnant and breastfeeding women, severely wasted and/or HIV positive. 	<ul style="list-style-type: none"> ▪ Supported the development of guidance on how to manage specific groups.

<ul style="list-style-type: none"> ▪ Global supply shortage of OCV. 	<ul style="list-style-type: none"> ▪ Conducted global advocacy with Gavi and other to prioritize Mozambique for the implementation of a one-dose OCV emergency campaign.
<ul style="list-style-type: none"> ▪ Changing epidemiological context – By the time the OCV request for Tete Province was accepted and vaccines sent to Mozambique, the needs had shifted to Zambezia Province. 	<ul style="list-style-type: none"> ▪ Performed active logistics oversight to swiftly re-direct vaccines in view of changing patterns of the outbreak severity levels.
<ul style="list-style-type: none"> ▪ Access to remote areas during the rainy season and in the context of Cyclone Freddy. 	<ul style="list-style-type: none"> ▪ Partnered with local NGOs and government organizations to reach populations in remote areas.

Lessons learnt: key actions on cholera preparedness and response

This challenging nationwide cholera outbreak allowed UNICEF Mozambique Country Office to identify several **critical actions** to be undertaken during low transmission periods in terms of

preparedness and during the response phase once an acute watery diarrhoea (AWD) or cholera outbreak is declared.

Preparedness Phase – low transmission periods

Pillar 1 – Leadership, coordination, planning and monitoring + Pillar 3 – Surveillance and outbreak investigation

At country/provincial/district level (external)

- Support the designated MoH Incident Manager to develop a standard response coordination mechanism and ensure it is functioning at least monthly. The coordination mechanism should be co-led by MoH and the relevant ministry dealing with WASH, with active participation of other key ministries.
- Support and contribute to the development, implementation and monitoring of multi-sector preparedness plans that include capacity building, supply pre-positioning and logistics management, prevention activities.
- Promote and support cholera/AWD provincial readiness meetings with health and WASH authorities and NGO partners.
- Support review of the outbreak declaration protocol.
- Promote and support monthly AWD surveillance in the absence of a declared outbreak at provincial level.
- In high-priority hotspots, support training of health and WASH authorities and partners on quick multisectoral coordination,

epidemiological data analysis, case investigation and case management protocols.

- Support active surveillance in non-CTC health centres, prioritizing peripheric districts to detect pockets of residual cholera, including engaging with traditional healers and religious leaders.
- Clarify roles and responsibilities of Health Cluster coordination at subnational level with WHO.

At UNICEF Country Office level (internal)

- Maintain the multi-sectoral Cholera Task Force with a staff member from each of the key sections (WASH, Health, SBC) led by the Cholera Coordinator who reports to the Chief of Emergency and continue joint field visits.
- Develop and disseminate a response plan template to be used by national and provincial teams.
- Set aside Regular Resources for rapid response.
- Ensure contingency partnerships are in place with NGOs present in hotspot

districts with key health, WASH, SBC cholera actions.

- Finalize an agreement with the International Federation of the Red Cross (IFRC) to take advantage of the reach of the Mozambican Red Cross, map its capacity in hotspot districts, and contribute to sustaining RCCE actions.
- Preposition critical supplies in high-risk areas.
- Support training on cholera outbreak management at provincial and district levels.
- Create a roster of consultants and/or create an LTA with a third-party institution for contracting consultants to avoid deployment of colleagues in short-term

missions that are more appropriate for advising and training, while coordination, partnership building, and monitoring of partners and interventions should be conducted by national staff with contracts for at least six months.

- Support logistics capacity assessments and procure and preposition supplies in UNICEF and/or partners' warehouses to treat at least 5,000 cholera cases.
- Review and/or develop LTAs for key supplies, vehicle rentals and transport mechanisms for supplies.
- Ensure all rapid fund disbursement mechanisms (petty cash, LTAs, P-Cards) are known by UNICEF colleagues and ready to be activated.

Pillar 2 – Risk Communication and Community Engagement (RCCE)

- Establish and activate a RCCE coordination group under MoH composed of UNICEF, WHO and key NGO partners to mobilize all local RCCE partners in high-priority provinces and at-risk districts.
- Collect, analyse, and use social and behavioural data to identify key population groups with high risk of exposure and transmission; identify key practices and behaviours, as well as their drivers; identify communities' and health case seeking behaviours concerns, vulnerabilities, perceptions and barriers related to adopting desired practices.
- Map trusted actors, channels and platforms for communication and feedback related to health and WASH-related issues.

- Review/co-create and pre-test RCCE key messages and behaviours to be promoted with local groups, community-based organizations (CBOs) and other stakeholders. Map the most trusted platforms, actors and networks and prepare agreements for possible collaboration.
- Maintain active programmes and spots on community radios, multi-media mobile units, and theatre group activities.
- Support municipalities to implement systematic actions in markets, bus stations, and school communities maintaining minimum conditions of hygiene and sanitation.
- Engage food vendors into local solutions to food protection.

- Establish or re-mobilize local partners (NGOs, CBOs) and local leaders (religious, traditional) to launch preventive activities at local level and prepare for coordinated responses.
- Ensure behavioural indicators and community feedback are systematically collected by partners and reported monthly.

Pillar 4 – Water, Sanitation and Hygiene + Pillar 6 – Infection Prevention and Control

- Review (provincial and district level) lessons learnt and recommendations from the implementation of cholera prevention and control in communities.
- Support MoH in the elaboration and approval of a reviewed CATI/CLUSTI booklet to be disseminated at provincial and district levels.
- Ensure tools for adequate monitoring of the response are in place and known by partners.
- Identify high priority hotspots and support health and WASH authorities to use the WASH costing tool (currently under development) to map:
 - Main food markets and transport hubs to assess WASH conditions, make quick improvements, get contacts of persons responsible to engage with during outbreaks.
 - Water points and water systems, to enable quick chlorination in affected neighborhoods when an outbreak starts.
- Support training of WASH authorities at provincial and district levels on WASH sector coordination and WASH in public health emergencies.
- Support WASH authorities and water supply systems managers to boost chlorination monitoring and maintain appropriate free residual chlorine level along distribution systems, at least at the onset of the rainy seasons.
- CLTS (Community Led Total Sanitation) in emergency or market-based sanitation approaches could be used to boost sanitation coverage in affected areas.
- Support the development of consolidated supply plans, procurement, and proper warehousing of supplies.
- Support health and WASH authorities at provincial and district levels in assessing WASH IPC in active CTCs and readiness of HCFs that would serve as CTCs or cholera treatment units (CTUs) during an outbreak.
- Review the IPC checklist for CTCs with MoH and WHO.

Pillar 7 – Case Management + Pillar 10 – Vaccination

- Support establishment of guidance for setting up ORPs by adapting Global Task Force on Cholera Coordination (GTFCC), including minimum kit of materials to be easily assembled for pre-positioning.
- Support training of health and WASH technicians at provincial and district levels about setting-up CTC/CTUs and ORPs, data management, IPC assessment.
- Ensure finalized and validated case management protocols for vulnerable

groups i.e., pregnant, and lactating women, children affected by severe wasting, people living with HIV.

- Support preparation and advocacy for Mozambique to be considered for preventive cholera vaccination approach.
- Ensure capacity of cold chain and vaccine management within the health system.

Response Phase – onset and during of Acute Watery Diarrhoea or Cholera outbreak declaration

Pillar 1 – Leadership, coordination, planning and monitoring + Pillar 3 – Surveillance and outbreak investigation

At Country/provincial/district level (external)

- Support MoH for the activation of a National Cholera or Public Health Emergency Operations Centre at the onset of the outbreak and ensure the WASH-related ministry is actively involved.
- Within the Operations Centre, support and contribute to the development of multi-sectoral national response plans that could be replicated at provincial level.
- At provincial and district levels, advocate and support WASH and health authorities to quickly set-up a cholera coordination taskforce.
- At partner level, support the creation of a cholera multi-agency task force – comprised of at least WHO, UNICEF, MSF - to ensure alignment and common approaches.
- Organize joint quick assessment missions with WHO/MSF in declared areas.
- After the first acute phase, quickly advocate for and support active surveillance teams in surrounding neighbourhoods / districts and health centres.
- Support CHWs and volunteers to deliver cholera kits to patients with AWD outside of CTCs and to patient's relatives at admission.
- Activate agreed subnational Health Cluster coordination responsibilities.
- Develop a cholera response plan (national and provincial) using pre-set templates, including key immediate actions by each UNICEF section, roles, and responsibilities of different staff, estimated budgets and supplies needed.
- Quickly activate partnerships and ensure quick cash transfers using the start-up letter procedure.
- Identify and support key staff to participate in a rapid assessment mission conducted with MoH and WHO at onset of outbreak.
- Support the development of a human resource plan for the response.
- Activate both the roster of consultants and the LTA with a third-party institution for contracting consultants.

- Support the mobilization of ‘frontliners’ and stretch assignments from other country offices.
- Ensure all mechanisms and procedures for rapid response are made available for response teams i.e., quick, and local procurement, use of flexible disbursement arrangements, activation of pre-set LTAs.
- Supply colleagues should accompany response teams during the first missions to

understand challenges and take necessary measures.

At UNICEF Country Office level (internal)

- Activate UNICEF’s internal cholera taskforce at national and provincial levels to:
 - Conduct daily short meetings at outbreak onset; and
 - Clearly identify who leads and coordinates the UNICEF multisector response.

Pillar 2 – Risk Communication and Community Engagement (RCCE)

- Support activation of the MoH RCCE coordination group to plan a response guided by the epidemiological situation.
- Ensure establishment of provincial and district level RCCE groups or that RCCE is part of multi-sectoral teams with WASH and Health.
- Ensure disaggregated data analysis to highlight emerging issues in population groups (e.g., adolescents and youth, young children, people with disabilities, displaced people, female-headed households) and quick analysis of epidemiological data.
- Set up mechanisms to systematically collect community feedback to address questions, concerns, complaints and/or suggestions that communities raise to realign/readjust the response.
- Put mechanisms in place to monitor and identify sources of rumours to act accordingly, preferably using community platforms and actors.
- Focus RCCE interventions on potential hotspot areas (not solely where cases are registered) – including those with no cases – to ensure individual and community awareness and prevention.

Water, Sanitation and Hygiene (Pillar 4) and Infection Prevention and Control (Pillar 6)

- Reinforce the links between epidemiological data and the WASH and community-based response needs by ensuring data is available and systematically analysed.
- Establish an agile system to collect data from patients in CTCs and make it available to the CATI/CLUSTI teams for a timely response.
- Clarify intervention protocols for CATI/CLUSTI teams that includes both “soft” and “hard” activities regardless of who is leading – whether health or WASH partners.
- Monitor water quality regularly and ensure disinfection and reinforced chlorination of water sources and systems, as well as bucket chlorination, together with promoting household water treatment

modalities. In case of distribution of water purification products, ensure proper post-distribution monitoring to ensure actual use and adequate dosage by health, water supply and sanitation authorities.

- Identify high transmission areas such as markets and bus stations and ensure their

inclusion in the response (not only affected communities).

- Prioritize handwashing and sanitation-related activities in communities and public spaces (e.g., disinfecting public toilets in markets, emptying full pits/septic tanks in public institutions and markets).

Pillar 7 – Case Management + Pillar 10 –Vaccination

- Support setting-up CTC/CTUs, ORPs and other case management activities under leadership of WHO.
- Activate ORPs guided by epidemiological data.
- Support utilization and application of tools and protocols developed for quality assurance.

- Support transportation of vaccines into the country.
- Support campaign activities including vaccine and cold chain management (cold rooms, transport) and community engagement/awareness.

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About the Series

UNICEF's water, sanitation and hygiene (WASH) country teams work inclusively with governments, civil society partners and donors, to improve WASH services for children and adolescents, and the families and caregivers who support them. UNICEF works in over 100 countries worldwide to improve water and sanitation services, as well as basic hygiene practices. This publication is part of the UNICEF WASH Learning Series, designed to contribute to knowledge of good practice across UNICEF's WASH programming. In this series:

Discussion Papers explore the significance of new and emerging topics with limited evidence or understanding, and the options for action and further exploration.

Fact Sheets summarize the most important knowledge on a topic in few pages in the form of graphics, tables and bullet points, serving as a briefing for staff on a topical issue.

Field Notes share innovations in UNICEF's WASH programming, detailing its experiences implementing these innovations in the field.

Guidelines describe a specific methodology for WASH programming, research or evaluation, drawing on substantive evidence, and based on UNICEF's and partners' experiences in the field.

Reference Guides present systematic reviews on topics with a developed evidence base or they compile different case studies to indicate the range of experience associated with a specific topic.

Technical Papers present the result of more in-depth research and evaluations, advancing WASH knowledge and theory of change on a key topic.

WASH Diaries explore the personal dimensions of users of WASH services, and remind us why a good standard of water, sanitation and hygiene is important for all to enjoy. Through personal reflections, this series also offers an opportunity for tapping into the rich reservoir of tacit knowledge of UNICEF's WASH staff in bringing results for children.

WASH Results show with solid evidence how UNICEF is achieving the goals outlined in Country Programme Documents, Regional Organizational Management Plans, and the Global Strategic Plan or WASH Strategy, and contributes to our understanding of the WASH theory of change or theory of action.

COVID-19 WASH Responses compile lessons learned on UNICEF's COVID-19 response and how to ensure continuity of WASH services and supplies during and after the pandemic.

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