**ORP Preparedness Programme**

1. **Introduction**

This paper argues that community actions with a core response based around community case management (CCM) should be the added value of RCRC in any cholera response. CCM would not be undertaken in isolation, but combined with other community level interventions: sensitization, mobilization, rumour management, transmission route interventions and support of OCV campaigns.

The rationale for concentrating in this area is given and a model of intervention presented with justifications for the different levels. Key characteristics of the proposed intervention are also described. The basis of the paper is IFRC Africa Cholera Framework, but it is also informed by reports from various responses.

1. **Background and Rationale**

The IFRC Africa Cholera Framework of April 2017 profiles cholera on the continent and considers the effectiveness of response actions, where the emphasis of RCRC responses has traditionally been in Emergency Appeals and DREFs and gives ideas on ways forward.

At the outset any RCRC cholera programme needs to recognize that there are many partners involved in the fight against cholera, each having its unique strengths. There is a need to both recognize the strengths and comparative advantages of our own organization whilst at the same time recognizing where others do things better than us. To be involved in every element of cholera prevention and response is to spread limited resources too thinly.

The idea is not necessarily that RCRC should only do CCM, but rather that if RCRC only does one thing, it should be CCM – not only because we are better positioned – but also because this is the first and most important element of a response and no agency is currently doing it. This focussed response can certainly be widened, but there is a pressing need to focus on CCM.

The Africa Cholera Framework reviewed 30 EA and DREFs for cholera between 2012 and 2017 with a total of CHF 11.4 million spent. In these 30 cases, 46 types of activity in 9 categories were identified, suggesting that whilst the RCRC movement is a key responder, it does not have a clear idea of what that response should consist of nor a common idea of a core area of competence. WASH and Community sensitization and mobilization are present in all the cases, the latter suggesting that RCRC does recognize its relative strength in communities.

This recognition of having comparative strength in the community, is not only a self-realization but also something recognized by other agencies. Encapsulated, this comparative advantage is that the RCRC through both its community volunteers and its branches has, to varying degrees, a permanent presence in communities. This is important in response but perhaps even more so if the emphasis of RCRC turns more towards ***preparedness***.

A key finding of the framework is the slowness of a full response. Often it seems to be the case that a NS will carry out minor preliminary responses on the announcement of an outbreak, but that the main response is hindered by the NS not wanting to commit to actions without funds being present and the process usually involved in both getting the funds in place and the training and procurement which needs to be done once the funds arrive. The recent case of the outbreak in Zimbabwe, which might be considered quite efficient is interesting to consider. The first case was identified on 5.9.18 and the outbreak announced the next day. ZRCS immediately prepared a DREF which was sanctioned by the 18th when the main response started. The funds arrived at the end of the month and ZRCS were able to rely on some funds between the 6th and the 30th of September from PNSs and an ECHO crisis modifier fund. Training and procurement were then undertaken, the latter proving to be problematic in-country and creating further time delays.

Well thought out preparedness programmes can prevent such delays, by identifying funding which can be immediately mobilized, training volunteers and staff outside of response periods and pre-positioning key items in identified high risk areas. The permanent presence of branches, staff and volunteers gives RCRC an opportunity to do preparedness, unavailable to other agencies. The emphasis of this preparedness should be in communities and branches that are in ‘hotspot’ areas and based around actions that can be taken in the communities.

Whilst community sensitization and mobilization were present in all responses reviewed a perhaps more important community action, that of community case management was only present in 17% of responses, though ORS distribution was carried out in 43% of cases. It is worth noting that while oral rehydration is considered an essential measure, the way ORS sachets are distributed and to whom, is important as they should only be given to dehydrated people and not as a ‘cure’ through blanket distribution, as ORS does not prevent you from being infected.

The treatment of people in the community with ORS saves lives and reduces the movement of population who may be infected with the disease. Done effectively and at scale, such actions can reduce the severity and impact of an outbreak.

RCRC should concentrate on ***preparedness*** as this will result in quicker and less costly responses, and also on ***community-based actions*** which will contribute to the speed of response and also play to the strengths of RCRC. Whilst mobilization and sensitization of communities is important, it has been shown that the way to save most lives is to have capacity for case management at community level. For RCRC to play a meaningful part in the fight against cholera it must increase the capacity of volunteers, branch staff and branches to concentrate on community level actions with its core intervention being community case management – ORT.

1. **ORP Preparedness Programme**

**3.1 ORS Community Case Management (CCM) and Safe Referral**

The use of Oral Rehydration Salts in suspected cholera cases in order to treat dehydration has been shown to promote recovery in 80% of cases. The sooner such treatment is available to those who are moderately or severely hydrated, the greater their chances of survival are. It therefore makes sense to move the treatment as close to the end user as possible, which essentially means having the awareness, skills and consumables at community level.

The added advantage of having such treatment available in the communities is that it deters people who may have cholera from moving to Community Health Centres in an unsafe manner – if further treatment is needed, they can be safely referred. Cholera is a disease which thrives on people’s movement and congregation and administration of ORS at community level can go some way to reducing exposure of communities which are, as yet, unaffected. Additionally, in most of the communities where CCM preparedness will be implemented, there are many types of diarrhoea which can also be treated with ORS, thus the model prevents community deaths from other sources of diarrheal disease.

Whilst from a health perspective the model makes great sense and can have a huge impact, it does create issues from the logistical standpoint. It raises questions of ownership, integrity, stock control and stock movement, the proper use of items and the likelihood that there will be cases of misuse or selling consumables on the local market. As the detail of the model is developed and it is piloted, these issues need to be tackled with strong systems and checks and balances.

Another issue is with regard to the situation in the 20% of cases where further treatment is required and a means of safe referral is required to ensure the disease remains isolated. Wherever ORS community case management (CCM) is undertaken, some sort of safe referral system should be in place so that a care continuum is provided and those in a community are not left in a situation where they are dealing with a serious case that they have no capacity to attend to nor means to move the patient to a community health facility in a safe manner.

**3.2 The Problem with the ORP Kit as a Response Tool**

The idea of Community Case Management (CCM) is the basis for the use of ORP Kits as a response mechanism in cholera outbreaks. It has been used effectively as a response device in several African countries, most recently in Somaliland in 2017 and Mozambique in 2019. Typically, one or two-day trainings are carried out with community members in areas where there has been a high number of reported cases. The kits are brought in and made operational with the community volunteers.

Even where such a response is commenced at speed there remains a time lag whilst teams and equipment are brought in and moved to the field and the training carried out. The current strategy outlined here would argue that kits already be prepositioned at branches in hotspot areas and that communities would be trained and would thus be ready to become operational much sooner.

However, it can also often be the case that ORP kits are not the solution in some outbreaks such as is pointed out in the DRC Population movement EA Update No 2. Dec.2018:

***Due to the relatively low case load and the geographical spread of cases, ORPs are not considered necessary in the response.***

On the operational side there are financial and time costs to be paid when setting up an ORP – per diems will need to be paid and the support costs of monitoring, so in cases like the DRC situation cited above there is little point to set up where the case load is small and spread out. However, the need to treat *in situ* and to prevent movement from the community are still needed in these geographically spread locations and are imperative if the severity of the outbreak is to be limited in hard to reach and insecure areas.

Capacity is needed in each community in the high risk (hotspot) areas, but the cost of prepositioning large numbers of ORP kits would be prohibitive both in terms of the items and the training needed.

It is clear a ‘lighter’ solution is needed; lighter in terms of both cost and being ‘low maintenance’. The Blue Flag Volunteer system used in Sierra Leone can perhaps offer a way forward here (Annex: references to the BFVs) whereby communities have ‘go to’ persons.

In each community a volunteer would be known to all community members as the person to go to in cases of severe diarrhoea – they become the “Ms/Mr Rehydration” of that community. This person would be able to recognize the different stages of dehydration and have the training and resources to administer ORS treatment and refer severe cases. The volunteer would treat all cases of serious diarrhoea, not only cholera. Through treating all diarrhoea cases this individual would be aware of any significant increase of diarrhea cases in the community (or recognise the rice watery diarrhea often associated with cholera) and would immediately alert the health authorities. Such a set-up would result in both immediate treatment and early warning.

Again, issues are raised when putting in such a system: how to keep the volunteers motivated and ensure knowledge remains in the community; how to fit the system into/in parallel with existing health structures; how to move to scale with training and ensure the supply chain for consumables. Equally, there is a need to increase awareness and knowledge regarding ORS – studies have shown that this creates demand and is one element of successful and sustainable ORS systems..

**3.3 Strategy**

3 levels of preparedness for ORP CCM and Support

**Level 1 passive ORP** – This will follow the Blue Flag Volunteer (BFV) model as was used in Sierra Leone and will be a quantitative approach in terms of trying to have `go to ` persons in communities which are in hotspot areas – preferably in each community. Passive refers to the fact that a full ORP as such will not be set up, but one or two people will be trained to recognize symptoms and give treatment and will have the resources to do so. These volunteers will also be an early warning system who can give an alert if they experience a spike in cases. Because level one is essentially a quantitative exercise, a way needs to be found where large numbers of community volunteers can be trained and equipped. A cascade training model needs to be developed along with an informal supply chain. For instance, the NS should identify what items are available in remote villages and how those items get there, with a view to piggybacking such routes. The aim would be to develop a partnership with UNICEF (or/and WHO) where they might provide the ORS.

**Level 2 active ORP** – This would involve the set-up of ORPs in communities where there is an obvious need in terms of number of cases with support from the nearest branch which would hold a number of ORP Kits in stock. This training would review the Level 1 training and then be based around the ORP manual and training slides which have been developed. The learning from Somaliland suggests that there would need to be some emphasis on both logging visitors to the ORP and stock management. Cheat Sheets should be an integral part of the kit allowing the volunteers points of quick reference. Kits would sit with and be mobilized by the branches in coordination with the local health authorities.

**Level 3 Branch ORP Support** – This will be done at different levels, in different countries, but will essentially link the branch to support communities where ORPs are set up whilst also linking up with the main health facility and ensuring safe referral from community to that facility. The training at this level will be about how to support up to 10 ORPs and both scale up quickly and scale down in an ordered manner. Again, logistics and admin will be a keyas will be the support of a public health / epidemiologist to determine quickly where to set up new ORPs or when to close down, based on a dynamic epidemiological analysis.

**3.4 ORP Kit Contents and Procurement**

The ORP Kit currently exists in two forms – the basic Kit used in emergencies and a more comprehensive kit developed by IFRC EA CC Office in 2015 which considers the wider operational issues in a kit’s use in a community. The different items that comprise the kit can be divided into 3 different groups. The main items are stationary and plastic/wooden cutlery and jugs, cups etc. There are then, what might be called the quality or more expensive items (more of these exist in the kit devised by the EA CC) this includes solar lighting, sanitation platforms, water filters and tarpaulins). The final category are the consumable items – the ORS sachets, zinc tablets and water treatment sachets. Currently in emergencies it is often the case that IFRC is sending out kits from Europe which mainly comprise of category 1 items, that is, sending items which can easily be procured locally and cheaply. The costs of kits can be significantly reduced if local procurement is undertaken for these items. With the second group - quality items – standard products for each will be agreed eg. standard solar light, standard water filter and these would either be transported in or bought locally, whichever is cheaper. For the consumable items RCRC will start to develop agreements with other in-country agencies which can provide these products – the key here is the monitoring of expiry dates.

One possibility is to use existing IFRC pre-positioned hubs in Zimbabwe, Cameroon, Niger (planned) and Senegal. Movement of the stocks through West and South Africa is not an issue, while East Africa is more problematic and will thus require a different strategy.

Simply put, medical items and consumables should be prepositioned locally (in-country with NS/ Regional level); NFIs and plastic items could either be ordered locally or prepositioned regionally as a part of IFRC pre-stock strategy.

One major logistical issue regarding items needed in a kit is around the provision and prepositioning of chlorine. Currently RCRC have to order chlorine from Europe for responses due to issues around quality.

As mentioned, the kit should include cheat cards or graphical descriptions of actions – quick reference points for the volunteers as standard items.

**3.5 Logistics and Admin**

At all levels of training there is a need for logistical input on stock management, replenishment, understanding lead-in times and expiry dates. The comment from the assessment of the Somaliland response is a salutary reminder of why this is necessary.

***`The monitoring and supervision of the ORPs requires more focus. With the stock management and SMS reporting, there was a disconnect between what should be and what was. The ORP kit re-stocking was not well managed and more than 50% of kits could not be accounted for.`***

***Somaliland Cholera Response Assessment***

Levels one and two would involve training in the logging of cases and consumables used, storage and management of stock and communicating when replenishment is needed. At level 3, the branch would be dealing with storage and supply chain management. Branches and HQ should be interlinked – with a centralized stock management system - so that stocks can be mobilized from neighbouring branches or from the NS central stock if needed. The key here will be to have strong systems which rely more on their own robustness than the persons involved in using them. Clear and simple paperwork needs to be developed and if this is standardized will allow support personnel form other NSs or the ERU CCM to join an operation seamlessly.

**3.6 ORP Preparedness and the ERU PHE CCM**

There is a need to ensure that the strategy for ORP preparedness and the proposed ERU PHE CCM, which the Swiss RCS is developing are aligned and that trainings, equipment, systems, paperwork, SoPs and ToRs are standard to both. The use of ORPs up until now has been in responses, usually into a response which has started, but comprises of the traditional activities of RCRC in cholera response – namely WASH and Community Mobilization. The fact that both the ERU PHE CCM and the ORP Preparedness model are new concepts, offers an opportunity to ensure the two are aligned and deployment of the former can fit seamlessly into the latter. Obviously, the move to ORP preparedness will not be done overnight, thus it will be important that Africa Region keep the ERU developers in the loop as to the status of the countries which fall under the ORP Preparedness Programme.

Those developing the ERU need to look carefully at what its added value would be in an ongoing response where an ORP Preparedness programme has been undertaken. Essentially this comes down to whether the ERU offers a quantitative or qualitative addition to what is already there, bearing in mind that other agencies will probably be involved in the response as well and that the underlying rationale for RCRC is to concentrate on community level intervention.

At this stage key elements might be: the ability to train, equip and support large numbers of volunteers to carry out level 1 and level 2 actions where this has either not yet been done or where there is a need to scale up the capacity available; and the ability to support branches in carrying out their admin, logistics, support to ORPs and safe referral responsibilities.

1. **Implementation**

The ORP Preparedness Programme will initially be rolled out in 2019 with a limited budget provided by the Norwegian RCS. Below are several suggested characteristics of the programme

**Targeting –** The hotspot mapping exercise being carried out by UNICEF allows for the identification of hotspots within a country. This then allows RCRC to target branches within those areas. Thus, the preparedness programme will only work where such a mapping has been undertaken or where it is ongoing. The targeting will also aim to build ‘clusters’ of countriesso that cross border initiatives can be undertaken, where cholera outbreaks tend to be influenced by cross-border transmission. Finally, the programme will aim to go hand-in-hand with the One WASH initiative so that prepared response capacity is available in any areas where prevention activities are being undertaken.

**PNS involvement –** whilst IFRC will look for opportunities for support from PNSs at a higher level, their involvement at country level is perhaps even more important. Limited resources mean that the current initiative will not be looking to set up programme infrastructure, but where possible would look to ‘piggy-back’ ongoing long-term programmes. This provides an opportunity for PNSs too, in that, the training and prepositioning which can be supported by IFRC can provide an extra dimension to existing programmes.

**Opportunistic –** the programme will look totake advantage of opportunities which arise as it is implemented, using PNSs and other agencies as a means to piggy back in to areas. The aim is to keep the funding light so that structures that are put in place can become more sustainable.

**Linking with ERUs –** The link with the ERU PHE CCM is discussed above, but offers opportunities which may be beneficial to NSs and the ERU. A case in point might be ERU staff to be trained coming into the field on an annual basis to carry out trainings which allows them to get familiar with the contexts and practice training whilst at the same time increasing the capacity of the NS.

**Active Partnership –** it is all very fine to have numerous partnership agreements on paper, but if they are not utilised, then they remain just that. The current programme will look to develop partnerships with other agencies and use them to the fullest degree. It is sometimes the case that partnerships drawn at a high level are not even known about in the field and thus cannot be put to good use, thus it is important to ensure such information is passed both ways.

**Retention –** Keeping the interest of volunteers and ensuring they are carrying out what is asked of them is a key part to the model. The feeling of having an important role in the community and an area of expertise are Important here as is the idea of training progression discussed below. It does however need to be recognized that often, more tangible reward is necessary. The idea of supporting community volunteers to become agents of franchise has been mooted, whereby they are demonstrators and vendors of health-related products which can be beneficial to the standard of life of households whilst also having a health impact. The use of per diems needs to be limited as a tool where possible.

**Training pathways –** one key method to promote the retention of volunteers is to provide a clear training pathway with opportunities for ever greater responsibilities. The development of 3 levels of training in Q1 can be the basis for this and offer a standardized pathway common to all volunteers and staff. Training quality is key and reinforcement (through refresher trainings) especially at the commencement of the cholera season should be realized. Understanding the ‘whole’ response and their part in it is also a key motivator.

**Proof of concept and evidence-based initiatives –** the programme aims to develop a new modality of response through preparedness and being new will need adjustments and should be prepared to admit when something is not working. Developing a strong evidence base around a proof of concept is the means by which RCRC might then explore additional funding opportunities once the concept is refined.

1. **Way Forward**

Much of the training material needed for level 1 and level 2 is already in place from a number of ORP trainings that have been undertaken. This will need to be modified based on the three-level system and additional materials added mainly around logs and admin for the ORP Kit. The main work to be done will be around the training at level 3 for branch support. In addition, systems, SOPs and documents will also be prepared. A consultant is already working with IFRC Africa Regional Office to develop further the training packages with the objective to have these ready in Q1 of 2019. A review group from NSs and PNSs will be put together to review and comment on the materials as they are developed.

Three clusters of countries have initially been identified to be included in the initial run of the training. By clustering, the hope is to create a common method of response amongst countries which are neighbours and that this will create opportunities for cross border cooperation. These countries have either already been mapped for hotspots by UNICEF or the process of mapping is ongoing in 2019. One WASH projects are planned in Malawi, Rwanda and Uganda.

**Southern:** Malawi, Mozambique, Zambia and Zimbabwe

**Eastern:** Burundi (through NorCross), Kenya (through NorCross), Rwanda, Tanzania and Uganda

**Lake Chad:** Cameroon (under CP3), Chad,Niger, Nigeria,

In implementing the above IFRC wishes to work as closely as possible with the NSs in order to understand how the model can fit in their existing context and how training can be cascaded down. Assistance will be given to help NSs to network and collaborate with other key agencies under the GTFCC. In-country PNSs will also be approached to consider how existing programmes in the country might support the roll out of the ORP Preparedness Programme.

1. **Methodology**

The aim will be to cover 20 branches in up to ten countries in the first year and the focus of training events, where possible, will be in the branches rather than in HQs. For each branch up to 40 communities will be covered with a volunteer equipped and trained to level 1. Obviously, this number will vary given the geographical spread of the communities and what is possible logistically, from the branch’s side. Here the branch needs to think realistically about what is possible to cover in an outbreak.

Initially, the aim will be to carry out the training in one branch in each country with the view to exposing the concept and model in as many countries as possible, though if opportunities arise through other funding  the NS has or through in-country programmes being supported by PNSs, then the programme would support this technically and where possible with its training team.

The training team will initially comprise of the lead consultant, a second consultant where and when required and staff from IFRC Africa Regional team. As more trainings are carried out the aim will be to put in place a regional training team – one Francophone and one Anglophone from those identified as good trainers and strong responders.

As well as leading the training teams the lead consultant will oversee the revision of training materials based on feedback from trainings and any guidance issued from GTFCC, so that the training remains premised on current thinking and aligns with the work of external organizations. Equally the consultant will ensure the evolution of the training remains aligned with the Africa Cholera Framework.

**Pre-training: Conditions to have in place**

* National Society agrees to the idea and model
* In-country PNSs have the model presented to them to get buy in and possibly support the creation of a ‘crisis modifier’ fund to support mobilization in responses.
* Ongoing discussions with UNICEF to identify support around provision of consumables (ORS, Water treatment sachets, zinc, soap etc)
* Ongoing discussions with main in-country cholera partners
* Buy-in of National Government and Local Health Authorities where the branches are situated.
* Branches chosen are in proven hotspots according to UNICEF past or current mapping.
* Branches identify most efficient and sustainable supply chain routes to the communities.

**Training Roll Out**

All training events will be done at Branch level or lower, depending on the set-up of the NS in the country. Training events at the HQ will be avoided except where security dictates otherwise. As previously stated, initially one branch will be focused on and left to carry out one further ORP Kit training (2 day) and 2 sets of training for level one volunteers (2 x 1 day). Once these trainings are completed and the system is set up and functional the Regional Training Team will be informed. Plans will then be made to return to the country with a view to monitoring set-up and volunteers trained in Branch 1 and its communities and then to carry out the training 1 at Branch 2 with the support of key persons from Branch 1. This way roll-out only moves ahead once the model is successfully in-place in the first branch.

Where possible the current model will aim to utilize training staff and rollout strategies already in place, through for example a FA or CBHFA programme, but this will only be done if it can fit with the approach here described.

**Training 1**

(4-5 days) Branch 1 – carried out by the Regional Training Team

This will focus on branch staff, stronger volunteers situated and working from the branch and selected stronger volunteers from the satellite communities. Those selected should have response experience and show leadership and trainer qualities.

The training will cover the responsibilities of the branch in supporting the Level 1 community volunteers; supporting up to 10 ORPs in an outbreak and ensuring timely set up of, decommissioning or movement of ORPs based on epidemiological and PHE advisories.

Also included, will be an accelerated training on the set up and operationalization of an ORP kit and how the duties carried out at an ORP link in with those at branch level. Finally, there will be a ToT part to the training where those chosen train in how to give the one-day level 1 training and the two-day level 2 training.

Another part of this training will involve the development and scheduling of a roll out strategy and its costing – this roll out consists of Training 2 and Training 3 below.

**Training 2**

2 x Level 1 trainings (1 day each) carried out by those identified to be trainers in Training 1

This training will provide general knowledge of cholera and the model being set up and the responsibilities of the Level 1 volunteers on a day to day basis and in a response. The volunteer will be able to recognize stages of dehydration and malnutrition and give appropriate treatment. They will be able to prepare ORS with safe water and administer it in a hygienic way. They will have contacts and be able to refer patients and be able to identify and communicate spikes in numbers of cases. They will understand the need to hygiene in the home and have the knowledge and materials to advise those in their communities with regard to hygiene and home water treatment. They will have a stock of water treatment tablets/sachets and will know how to use and show others how to use these where the community experiences a spike in diarrhoea cases. Finally, they will be able to keep a record of diarrhoea cases and the stock they have and understand how to replenish stock.

**Training 3**1 x Level 2 training (2 days) carried out by those identified to be trainers in Training 1

Those trainees identified as more able in the level 1 trainings will be asked to join the level 2 training for ORP Kit set up and operationalization. This training will give them the skills to set up a functional ORP in an outbreak, treating and referring patients and carrying out actions in the community to block transmission routes. They will be able to log and report cases and also keep records of stock and know how and when to restock.

**Monitoring, Assessment and Adjustment**

Once trainings 2 and 3 have been implemented by the branch staff and volunteers the Regional Training Team will be informed. Depending on what is possible a single member of the team may go into monitor the setup and give the go-ahead to proceed with the second branch, or the full team will go in to do this and carry out the same training schedule in the second branch.

1. **Key Issues**

This paper does not purport to have all the answers and raises a number of issues which will need to be considered further, not least those around retention and motivation of volunteers and worries around questions of ownership, integrity, stock control and stock movement, the proper use of items and the likelihood that there will be cases of misuse or selling consumables on the local market. However, these concerns are not unique to the current programme and should not be a reason to not attempt what can be a fundamental shift in the way RCRC prepares for and responds to cholera outbreaks.

1. **Conclusion**

The RCRC movement has committed itself under the GTFCC to be an active and key player in the fight against cholera. To do this effectively, it needs to recognize its main strengths and develop a core area of response that plays to these strengths. Self-perception and that of other key agencies recognizes this strength as being the RCRC movement’s permanent presence through its branches and community-based volunteers. It therefore makes sense to concentrate on activities at this level and the permanent presence means it is a lot easier to do preparedness work. RCRC responses have, to some extent exploited its strength in previous outbreaks through community mobilization and sensitization, however, RCRC has not engaged in CCM to any great extent thus far even though it is recognized that ORS treatment at community level can have a profound impact on any cholera outbreak.

At the Cholera Interagency Meeting in Nairobi in December 2018 it was agreed that IFRC should lead on ORPs and safe referral given its comparative advantage in communities, with technical and logistical support from other agencies, most notably MSF, UNICEF and WHO. IFRC Africa Office will concentrate efforts to develop ORPs as the core of a community-based preparedness programme. Other elements will be developed over time such as rumour management, OCV mobilization campaign support and transmission route interventions but the core will be ORP. This way the movement can develop a clear area of competence across many countries through risk informed preparedness; an area which is key in reducing cholera’s impact.