DREF Final Report

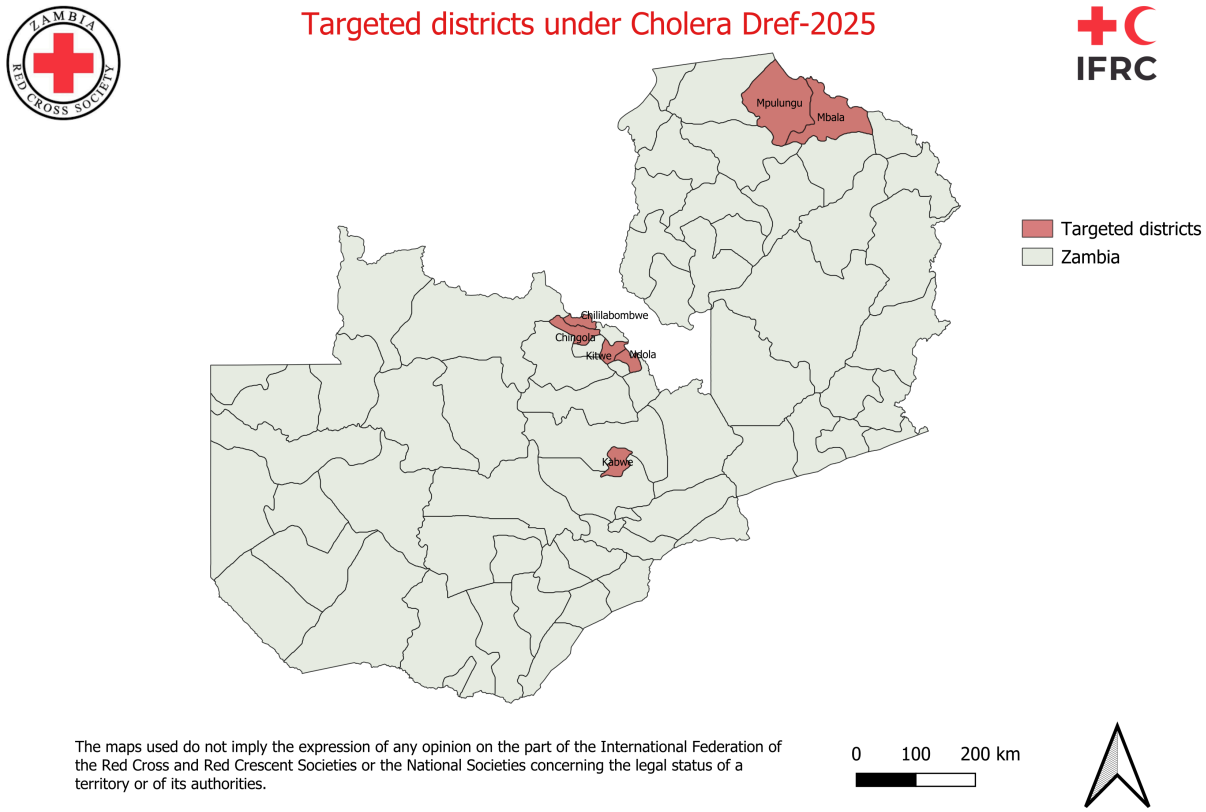
Zambia Cholera Response

ZRCS staff and volunteers setting up ORPs in Kabwe District

Appeal: **MDRZM024**	Total DREF Allocation: **CHF 275,765**	Crisis Category: Yellow	Hazard: **Epidemic**
Glide Number: **-**	People Affected: **1,917,978 people**	People Targeted: **1,917,978 people**	People Assisted: **1,543,751 people**
Event Onset: **Sudden**	Operation Start Date: **03-03-2025**	Operational End Date: **31-08-2025**	Total Operating Timeframe: **5 months**

Targeted Regions: **Central, Copperbelt, Northern**

Description of the Event



Districts of operations under Cholera Dref-Zambia 2025

Date of event

07-02-2025

What happened, where and when?

The outbreak was first declared on 24th December 2024 in Nakonde District (border of Tanzania), Muchinga Province, while on the Copperbelt cholera cases were reported on 18th Jan 2025, in Chililambombwe district (bordering DRC) with no epidemiological linkage with Nakonde cases. Later on, sporadic cases were recorded in Solwezi and Kalumbila in North-western and Ngabwe in Central Province. Kabwe district recorded 68 cases on 26th March 2025, the epidemiological data link the cases to contamination of a water source （borehole） at a school.
The cholera situation reached its peak in late January 2025, with a sharp increase in cases and deaths, particularly on the Copperbelt province affecting Chililabombwe, Chingola, Kitwe and Ndola. According to a situational report by Zambia National Public Health Institute (ZNPHI) dated 13th May 2025, the country recorded a total of 496 confirmed cases and 9 deaths （7 occurring in the community and 2 in a health facility） had been reported. The outbreak had an overall case fatality rate of CFR of 1.9%.

In response to the trend of cases, the Government swiftly initiated control measures, including the launch of an Oral Cholera Vaccination (OCV) campaign in Chililabombwe, Copperbelt Province, which began on February 7, 2025. Approximately 129,000 vaccine doses were allocated for the district. The Zambia Red Cross Society （ZRCS）, as a key local partner, had been called upon to play a crucial role in reaching communities, complementing the National Society's ongoing efforts in cholera prevention and response.

ZRCS had consistently contributed to cholera control efforts over the years, including during the country's most severe outbreak from October 2023 to 2024. However, surge in cases especially in Chililabombwe had not been observed in the other affected districts. The spike was largely attributed to factors such as inadequate water and sanitation infrastructure, poor hygiene practices, and the start of the rainy season, which had further fueled the spread of the disease. With rains continuing, there was potential for the situation to escalate further.

However, On 5th August 2025, Mpulungu district reported seven suspected cholera cases from Chipwa Health Post, the suspects were presenting with acute watery diarrhoea and vomiting, including a 2-year-old child (index case) and her mother, both from Kasisi village, Tanzania. By 10th August, 20 suspected cases were recorded from Kasisi, Kipwa (Tanzania), and Chipwa (Zambia), all along Lake Tanganyika.

On 12th August, Mbala District confirmed a cholera case in a patient with recent travel to Kasisi, Tanzania, for a funeral and fish trading. The outbreak was epidemiologically linked to cholera transmission in Tanzania's Kalambo region, with clear evidence of cross-border spread.

With the rise in cases of cholera, ZRCS utilizing DREF funds in collaboration with Cholera County Support Platform (CSP) in country supported the response in Mpulungu and Mbala district with the focus on RCCE, WASH and Health pillar.

It's worth noting that during implementation of the DREF, ZRCS supported Kabwe, Ndola, Kitwe, Chingola, Chililabombwe, Mpulungu and Mbala districts. These changes were influenced by the evolution of the epidemic during the implementation period.

Challenges:
As of later September 2025, the outbreak spread to other districts in Northen Province such as Mpika, Nsama, Nsenga hill districts. The affected districts are receiving limited supported to contain the outbreak in their districts. Noted gaps are: limited number of CBVs conducting sensitization, lack of supplies to implement the CATI approach among others.

Sample ORC functioning

During Door to Door Sensitization

During Volunteer Training

Chlorine Distribution

Scope and Scale

Cholera Outbreak evolution from case 1.
December 27, 2024: Two additional cholera cases—a son and a domestic worker from the initially affected household in Nakonde—were confirmed by laboratory testing. This brought the total confirmed cases in Nakonde to seven (7), all caused by Vibrio cholerae.
January 12, 2025: Nakonde's cumulative confirmed cases increased to 22.
January 18, 2025: Copperbelt Province reported its first case at Kasumbalesa market in Chililabombwe, with no epidemiological link to the ongoing outbreak in Muchinga.
January 22, 2025: Chililabombwe District confirmed 13 cases, still with no direct link to Nakonde cases.
January 28, 2025: Both affected provinces activated their Incident Management Systems (IMS), and the national IMS was activated in response to the growing scale of the outbreak.
January 30, 2025: Chililabombwe reported 57 cases and five deaths.
End of January 2025: Zambia had a total of 96 cases across six districts in three provinces, with Chililabombwe accounting for 70 cases and Nakonde 21 cases.
February 1, 2025: Reported cases rose to 123 with seven deaths, resulting in a case fatality rate (CFR) of 8%.
February 3, 2025: The cumulative number of cases increased to 158 with eight deaths (seven community and one facility death), yielding a CFR of 5.1% (facility CFR of 0.6%).
Case distribution:
Copperbelt Province: Chililabombwe (121), Chingola (3), Kitwe (7), Ndola (2)
Lusaka Province: Matero (1)
Muchinga Province: Nakonde (24)
Most affected age groups:
20–29 years (72 cases)
30–39 years (64 cases)
40–49 years (31 cases)
15–19 years (19 cases)
50–59 years (17 cases)
0–4 years (10 cases)
5–14 years (7 cases)
60–69 years (2 cases)
February 4, 2025: Cases increased to 168 with eight deaths, including nine new cases in Chililabombwe and one in Chingola.
February 20, 2025: Total cases reached 269 with nine deaths (seven community and two facility deaths). Case distribution:

Chililabombwe (215), Chingola (14), Kitwe (10), Ndola (2), Matero (1), Nakonde (27).
Impact on Population
In Chililabombwe, the outbreak had disproportionately affected males (66% of cases), particularly cross-border truck drivers and traders.

Risk Factors and Scope of the Emergency
The outbreak in Chililabombwe was driven by several factors:
- Prolonged waiting times for truckers at the border, leading to extended stays in areas with inadequate sanitation.
- Reliance on food from informal vendors with poor hygiene standards.
- Overcrowding and destruction of sanitation facilities due to congestion, with queues of trucks extending up to 50 kilometers.
Severity of the Situation:
- Chililabombwe had experienced a severe escalation of cases, epidemiologically linked to Nakonde and spreading to neighboring districts like Chingola. Chililabombwe's high CFR compared to Nakonde reflects significant challenges in early case detection, timely treatment, and overall healthcare response. This highlighted the urgent need for:
- Increased medical supplies and treatment access.
- Strengthened disease surveillance.
- Expanded Water, Sanitation, and Hygiene (WASH) interventions.
- Enhanced community engagement and health education.
Underlying Challenges:
The outbreak continued to thrive in areas with:
- Inadequate access to safe water.
- Poor sanitation and waste management.
- Limited WASH infrastructure, especially in border towns with high population mobility.
While the Zambia Red Cross Society (ZRCS) had been actively engaged in cholera prevention and response including through the Emergency Appeal (EA) the outbreak had affected districts that were not prioritized in the 2023/2024 EA. Of the six districts now reporting cases, only two received limited support under the EA. The other four districts—Chingola, Ndola, Matero, and Nakonde accounted for over 95% of current cases.

Vulnerability of Chililabombwe:
Historically, Chililabombwe had not faced large-scale cholera outbreaks, although sporadic cases were recorded during the 2023–2024 national outbreak, which affected 72 out of Zambia's 116 districts. The outbreak had a trend of steadily increasing cases highlighted in Chililabombwe's growing vulnerability and the need for sustained public health interventions.

Cross-Border and Regional Concerns:
Nakonde and Chililabombwe are high-risk border towns, which had :
- Nakonde sharing a border with Tanzania.
- Chililabombwe bordering the Democratic Republic of Congo (DRC).
Both towns were key trade hubs with heavy cross-border movement, increasing the risk of regional spread. Poor drainage, inadequate WASH services, and widespread use of unsafe water sources (such as open shallow wells) exacerbate the situation. Chililabombwe, home to 260,000 people and a transit point for travelers from multiple neighboring countries—including Zimbabwe, Tanzania, South Africa, Mozambique, Namibia, Rwanda, and Burundi—faced a heightened threat of rapid cholera transmission.

Wider Impact Scenarios:
If not urgently contained, the outbreak could have lead to:
- Increased morbidity and mortality, particularly among vulnerable groups such as children, the elderly, persons with disabilities, internally displaced persons, and mobile populations.
- Overburdened health facilities, straining available resources, beds, and medical staff.
- Co-infection risks, with diseases like Mpox compounding the public health burden.
- Heightened vulnerability for marginalized communities, such as those living in informal settlements like PPZ compound.
- Misinformation and panic, creating stigma and undermining risk communication and community cooperation.

Cholera Outbreak evolution from case 2.
In the 3rd month of the outbreak Nakonde Stopped recording cases for 3 weeks straight showing that the cases were being contained while in Kabwe district cases started to arise Kabwe which has a total population of 288,598 was not spared by this disease which could have resulted in many fatalities if there is poor management of cases as well as swiftness in combating continuation of new infections. On 27th March 2025, an outbreak of cholera was reported from David Ramushu Secondary School which had an enrollment of 2876, the index being a Teacher presented with AWD at Kasanda Health Facility, as of 31st March 2025, a cumulative total of 74 cases have been reported in Kabwe. The Main hotspot being Magandanyama alongside Mukululu, Nakoi, kasanda and Mine Areas. 7 culture confirmed positive . Just after recording the confirmed cholera case, the District Health Office quickly activated its epidemic response plan. Two Cholera treatment centers were quickly set at Kasanda and Makululu Urban facilities. Cholera intervention activities at community level like well chlorination and other health promotion activities were commenced. Zambia Red Cross Society also joined forces and helped in conducting of community engagement meetings, focused group discussions, setting up of ORPs as well as the Information by funding the cholera radio programs, providing IEC materials for distribution and paying the volunteer allowance to the volunteers conducting door to door RCCE shifting from Nakonde to Kabwe with the cholera DREF response Funding.
The interventions implemented under the DREF operation, including door-to-door sensitizations, community meetings, chlorine distribution, establishment of Oral Rehydration Points (ORPs), and strengthened coordination with key stakeholders, collectively contributed to reducing cholera transmission and improving community health outcomes. Through timely health education and hygiene

promotion, households were empowered with knowledge and resources to adopt preventive behaviors such as safe water handling and handwashing. The distribution of chlorine ensured continued access to safe drinking water, while ORPs provided immediate treatment and reduced the risk of severe dehydration and fatalities. Moreover, community engagement platforms fostered trust and encouraged early reporting of suspected cases, enhancing surveillance and response efficiency. Overall, these integrated efforts significantly mitigated the outbreak's impact and improved community resilience against future cholera occurrences.
There was also a second intervention, On 5th August 2025, Mpulungu district reported seven suspected cholera cases from Chipwa Health Post, the suspects were presenting with acute watery diarrhoea and vomiting, including a 2-year-old child (index case) and her mother, both from Kasisi village, Tanzania. By 10th August, 20 suspected cases were recorded from Kasisi, Kipwa (Tanzania), and Chipwa (Zambia), all along Lake Tanganyika.

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Source Information

Source Name	Source Link
1. UNICEF	https://www.unicef.org/zambia/stories/protecting-zambias-children
2. Media	https://english.news.cn/africa/20250130/18c3387eff024909bf278c3f7ca4ab80/c.html
3. MDRZM021 Zambia cholera Emergency appeal documents	https://www.ifrc.org/emergency/zambia-cholera-outbreak
4. MDRZM021 Zambia cholera 6 month update	https://www.ifrc.org/fr/appeals?date_from=&date_to=&search_terms=&search_terms=&appeal_code=MDRZM021&search_terms=&text=
5. Situation Report - MOH 27 January 2025	https://www.moh.gov.zm/?p=4152&utm_source
6. Press Briefing by Minister of Health	https://www.lusakatimes.com/2025/02/03/government-orders-shallow-wells-closure-to-combat-cholera-in-kasumbalesa-and-chililabombwe/
7. 30 December 2024 MoH press statement on Cholera	https://www.moh.gov.zm/?p=4152

National Society Actions

Have the National Society conducted any intervention additionally to those part of this DREF Operation?	Yes
Please provide a brief description of those additional activities	With support from UNICEF, ZRCS contributed to the cholera response in Muchinga Province, Nakonde district, on the Copperbelt Province (Chililambombwe, Chingola, Kitwe and Ndola districts). The support covered a duration of 2 month from February to March2025. the response focused on the following interventions 1. RCCE (Door to door sensitizations and use of megaphones in marketplace, distribution of IEC, training of volunteers and teachers on cholera prevention) 2. WASH (Distribution of chlorine and hygiene kits) targeting the affected areas. 3. Community Case Management (deployment of skilled staff and volunteers in management of ORPs) There was also a second intervention, On 5th August 2025, Mpulungu district reported seven suspected cholera cases from Chipwa Health Post, the suspects were presenting with acute watery diarrhoea and vomiting, including a 2-year-old child (index case) and

her mother, both from Kasisi village, Tanzania. By 10th August, 20 suspected cases were recorded from Kasisi, Kipwa (Tanzania), and Chipwa (Zambia), all along Lake Tanganyika.

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With the rise in cases of cholera, ZRCS in collaboration with CSP in country supported the response in Mpulungu and Mbala district with the focus on RCCE, WASH and Health pillar.

RCCE Pillar,
ZRCS team rapidly conducted an orientation of volunteers on hygiene promotion, social behave communication and Community Engagement and Accountability. Trained volunteers have been deployed to conducted door to door sensitizations, distribution of IEC materials and use of PA system to reach out to markets.

WASH Pillar,
ZRCS supported the distribution of WASH supplies procured from the DREF and CSP such as chlorine, multipurpose soap, ORS, buckets, The team are using the CATI approach in responding to the outbreak. Donated 2000 cholera kits in Mupungu and Nsama district, through the Provincial Health Office.

Health Pillar,
Through the CSP, ZRCS has trained MOH staff on CATI approach at provincial, district and health facility level, the strengthened capacity has helped the province to be more ready to respond to the outbreak.

Challenges:
As of later September 2025, the outbreak spread to other districts in Northen Province such as Mpika, Nsama, Nsenga hill districts. The affected districts are receiving limited supported to contain the outbreak in their districts. Noted gaps are: limited number of CBVs conducting sensitization, lack of supplies to implement the CATI approach among others.

IFRC Network Actions Related To The Current Event

Secretariat

• The IFRC secretariat, provided technical and financial support to ZRCS through IFRC Harare country cluster delegation. The IFRC played an essential role in ensuring effective coordination within and outside the Movement.
• The technical support was also provided through the existing capacity at delegation level but also at regional level. IFRC office in Zambia hosts two staff: Cholera Country Support Platform (CSP) delegate, and a CEA Officer.
The IFRC Secretariat provided support for a range of health and WASH activities that have significantly contributed to cholera prevention efforts in Zambia and strengthened ZRCS's capacity to fulfill its mandate in responding to public health emergencies related to cholera. Notably, the support had included initiatives such as the Country Support Platform (CSP) program, which stands out as one of the key outcomes and added value of IFRC's assistance.
The CSP helps countries affected by cholera to develop and implement their National Cholera Plans (NCPs). The CSP is part of the Global Task Force on Cholera Control (GTFCC). In Zambia, the CSP actions are supported by several back donors including The Foreign, Commonwealth and Development Office and Swiss Development Cooperation include. Among the retained capacity from that program, there has been;
- The Zambia Red Cross Society continued to provide technical support in the running of the Incident Management System (IMS), it also supported the successful roll-out of the Case Area Targeted Interventions (CATI) strategy in Lusaka, Chililabombwe, Kitwe, and Nakonde districts. This included the procurement and distribution of CATI supplies, as well as the engagement of volunteers to strengthen implementation in

	targeted areas. In addition, the Society provided technical support to the Ministry of Health in the successful emergency application of the Oral Cholera Vaccine (OCV) in Kabwe, Chililabombwe, and Kitwe. All these activities had complemented and reinforced the proposed DREF interventions, ensuring a coordinated, timely, and community-centered cholera response. Further to the above, the ZRCS benefited from a Federation Wide Emergency appeal launched for the 2023/2024 outbreak. [SOURCE 5]. Among the targeted districts of that appeal, it included the following districts. - Lusaka Province: Lusaka, Kafue, Chilanga, Chongwe, Rufunsa, Luangwa, - Copperbelt Province: Kitwe, Ndola, Chililabombwe, - Central Province: Kabwe, Mumbwa - Eastern Province: Chipata, - Southern Province: Sinazongwe, Chikankata, Chirundu, Siavonga, Shangombo The MDRZM021 emergency appeal, funded by several donors including the UK and Scottish Governments achieved significant milestones in combating Zambia's cholera outbreak. The NS mobilized and capacitated over 1,782 volunteers with skills in cholera response, including ORT, contact tracing, the RCCE, PGI, IPC. They supported a comprehensive response to cholera, contributing to curb the outbreak by implementing activities such as sensitization to 3.7M people; establishmented of 55 ORP; supported OCV that reached 795,452 people; supported access of water and hygiene including water reticulation in 13 water points, 20 boreholes drilled and solarized, and 15 waterborne toilets constructed. The response efforts summarized above had been instrumental to address the previous outbreak, but the distribution of the assistance was proportionate to priorities per districts based on outbreak evolution and National response plan. Therefore, it was critical to highlight that: - Of the 6 districts that were reporting the outbreak, only two received limited support from the EA. However, the four were not part of the EA and contributed to over 95% cases in the current outbreak. WASH, Health gaps on the outbreak needed dedicated resources to enhance the capacity of the NS to respond to outbreak in the targeted districts. - The retained capacity from the above response was leveraged and contributed to this intervention. The IFRC also deployed a Field Coordinator for six weeks with support from British red Cross who supported in coordination of the operation. By the end of the operation, coordination mechanisms established between the Zambia Red Cross Society (ZRCS), IFRC Secretariat, and key stakeholders remained active, ensuring a smooth transition and sustained engagement beyond the operational period. The Incident Management System (IMS) continued to function under the Ministry of Health's leadership, with ZRCS providing ongoing technical and volunteer support at district and provincial levels. The Case Area Targeted Interventions (CATI) and RCCE coordination structures also remained operational, with responsibilities gradually transferred to district health teams to maintain continuity. The Country Support Platform (CSP) framework continued to guide collaboration under the National Cholera Plan, reinforcing multisectoral coordination through regular review meetings and technical working groups. An exit coordination plan was implemented to consolidate lessons learned, ensure the handover of key activities to local authorities, and maintain linkages between the IFRC, government ministries, and humanitarian partners for continued cholera prevention and response readiness. During the response, IFRC supported NS society in responding to Cholera outbreak, the response reached over 1,543,751 people across the districts of intervention, with 1 200,000 people reached with radio programs and 343751 reached during door-to-door sensitizations.
Participating National Societies	Netherlands Red Cross (NLRC) was the only PNS in country that supported ZRCS in Cholera preparedness activities in Lusaka through training of volunteers in RCCE. volunteers were deployed to support preparedness activities, including hygiene promotion. NLRC was part of the IMS coordination at National level through meetings for the Cholera operation. They provided technical guidance to the operation through its in-country delegates.

ICRC Actions Related To The Current Event

During the response there was no support received from ICRC

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	The Ministry of Health together with Zambia National Public Health Institute (ZNPHI) and DMMU supported the Provincial and District Health teams in Copperbelt and Muchinga Provinces through. 1. Activation of emergency coordination mechanisms such as District Public Health1 Emergency Operation Centers and Incident Management System, District Epidemic Preparedness, prevention Control, and Management Committee meetings. 2. Intensified surveillance activities, including risk assessment, outbreak investigation, active case search, community surveillance, and contact tracing, Isolation, Case management, and IPC 3. Data Management-deployment of Cholera tracker/EIMS and providing of situational report daily/periodic according to the evolution of the epidemic. 4. Enhanced Risk Communication and Community sensitization, activities in coordination with other stakeholders. 5. Deployment of skilled human resource from National and Provincial level to support the response at district level. 6. WASH interventions that aimed at provision of safe drinking water in Chililabombwe district in Kasumbalesa area and distribution of in the affected communities, Cleaning of public places and promotion of hygiene practices. 7. Declaration of the outbreak to facilitate involvement of other partners into the response.
UN or other actors	UN and other actors were part of the cluster system that had been activated helped the Government in resource mobilization, conducting of needs assessments, surveillance and provision of supplies. They were part of the IMS and cluster coordination. The following were some of the organizations and roles they played: - UNICEF - provision of WASH services and supplies, supported ZRCS to respond in Nakonde district and Copperbelt province - SN NAME OF STAKEHOLDER ROLES 1 UNICEF -RCCE/CASE MANAGEMENT 2 ZNPHI -Risk Communication and Community Engagement/WASH/IPC/CASE MANAGEMENT/ Surveillance/ OUT BREAK INVESTIGATION 3 ZRCS -RCCE/CASE MANAGEMENT/WASH 4 Africa CDC-WASH/RCCE/CASE MANAGEMENT 5 Disaster Management and Mitigation Unit (DMMU) - Water Sanitation and Hygiene (WASH) 6 Zambia News and Information Services (ZANIS) - Media and broadcasting 8 Chililabombwe Council-Sanitation and Hygiene/Surveillance/RCCE 9 Kasumbalesa Business Community-WASH/Transportation (FUEL) 10 24 Market Associations-RCCE/disinfection 11 District Education Board-RCCE/Mobilization 12 Trade Kings Association- Sanitation and Hygiene 13 Reload Logistics-Transportation (Fuel) 14 Hungry Lion-RCCE 15 Church Association-RCCE

Are there major coordination mechanism in place?

The Ministry of health activated Incident Management Systems (IMS) at district, provincial and national level to coordinate the response.
ZRCS is part of the Multisectoral Cholera response mechanism at national and subnational levels, coordinated by MOH/ZNPHI. This helped to avoid duplication of efforts and improve management and coordination of the Cholera outbreak response operation by maintaining a shared information and collaboration in that coordination system with key partners.
other coordination mechanisms that were in place are sector specific such as WASH, HEALTH and RCCE cluster meetings which ZRCS is an active member. The number of people reached was achieved through the efforts and resources mobilized under the DREF operation. Other stakeholders, such as UNICEF, CATI-CSP, and the Ministry of Health (MoH), provided technical and coordination support to complement the intervention.

Needs (Gaps) Identified

Health

The government rolled out the Oral Cholera Vaccination （OCV） campaign in Chililabombwe and Mpulungu Districts, which took place in February and August respectively. This intervention, called for an urgent need to scale up outreach and Risk Communication and Community Engagement （RCCE） efforts to maximize vaccine coverage and uptake. In high-risk areas such as Chililabombwe, Ndola, kabwe, Kitwe, Chingola, Mpulungu and Mbala there was a shortage of trained volunteers to support RCCE and health promotion activities. This gap severely limited the reach and effectiveness of WASH (Water, Sanitation, and Hygiene) interventions, making it challenging to reinforce proper hygiene practices, improve sanitation, and curb the spread of cholera. Most of the affected districts are transit towns, with high population mobility in these areas especially among traders and truck drivers, this further increases the risk of transmission, making robust community engagement critical to controlling the outbreak.

The elevated case fatality rate （CFR） pointed to significant weaknesses in timely case detection, access to treatment, and overall healthcare response capacity. This underscored the urgent need for increased medical supplies, enhanced disease surveillance, improved WASH services, and intensified community mobilization to prevent additional deaths and contain the outbreak.

In Chililabombwe and other district with high recorded cases of cholera, the district health authorities faced several challenges in managing the surge of cholera cases. Including but not limited to; Limited human resources and logistical constraints, contact tracing, a key component of outbreak control, was particularly under-resourced, with health teams unable to monitor most individuals exposed to confirmed cases. This gap increased the risk of unchecked transmission within the community.

Another major challenge was the absence of dedicated Health Promotion Focal Point Persons (HPFPP) in health facilities, which had weakened coordination of community awareness and education initiatives. Additionally, the potential of local media platforms, such as radio, remained underutilized due to technical failures and funding shortages, hindering the dissemination of critical public health information.

The effectiveness of health promotion was also being compromised by the inadequate Information, Education, and Communication (IEC) materials in key local languages such as Bemba and Lamba. There was also a critical shortage of inclusive materials designed for people with hearing impairments, further limiting access to lifesaving information. Without culturally appropriate and accessible IEC tools, communities faced challenges in adopting prevention measures and sustaining behavioural change.

Furthermore, limited involvement of influential community leaders, including traditional authorities and religious figures, had weakened community mobilization and message uptake. The lack of basic tools such as megaphones was also restricting outreach efforts, particularly in densely populated or high-risk areas. Additionally, the volunteer workforce remained insufficient relative to the size of the population in need, further stretching response capacities.

To close these gaps, it was essential to strengthen partnerships with key stakeholders, allocate additional resources, expand volunteer recruitment and training, and improve the distribution of health promotion materials. Enhancing contact tracing through community volunteer support which was crucial to breaking transmission chains, protecting vulnerable populations, and reducing the pressure on health facilities in Chililabombwe Kabwe, Kitwe Chingola Ndola, Mpulungu and Mbala

Towards the end of the operation, several improvements were made such as the recruitment of additional community volunteers and increased engagement of traditional leaders. Persistent challenges in contact tracing, media utilization, and accessibility for people with hearing impairments improved. Monitoring tools such as daily RCCE activity reports, WASH coverage checklists, and volunteer deployment logs were used to track progress and inform adaptive strategies. while gaps remained, including insufficient volunteer coverage in high-risk districts and limited availability of IEC materials in local languages. Exit plans included strengthening local partnerships and transferring responsibilities for community engagement to district health teams to sustain gains beyond the operational period.

Water, Sanitation And Hygiene

Overcrowding in many communities where houses are built on small plots size of 20x20 meters, with water sources and latrines positioned less than 30 meters apart, poses a significant risk of water and food contamination. Overcrowding and unplanned settlements also limits adequate space for setting up proper sanitation, hygiene facilities and provision of WASH services to underserved communities by the water utility companies, this, further increased the risk of disease outbreaks and transmission. Most public institutions and places such as schools, health facilities and markets face challenges, such as inadequate access to safe and clean drinking water, poor sanitation and hygiene facilities, making it difficult to maintain best hygiene standards. Public places also have a challenge of inadequate infrastructure, with a shortage of domestic waste, leading to indiscriminatory waste disposal and further environmental contamination. Compounding these issues, schools experienced an erratic supply of soap for handwashing, reducing the effectiveness of hygiene promotion efforts. Additionally, there was an insufficient supply of chlorine to adequately cover target communities, limiting access to safe water and increasing the risk of the spread of cholera outbreaks. Addressing these challenges was critical to improving public health and preventing the spread of cholera.
Households in high-risk communities, particularly in Chililabombwe, Ndola, Kabwe, Kitwe, Chingola, Mpulungu and Mbala districts required urgent support with chlorine distribution and access to safe communal water collection points to prevent the spread of waterborne diseases. Latrine emptying had become a critical intervention to avoid contamination of drinking water sources, as flooding increased the risk of fecal matter seeping into groundwater and surface water supplies. Kabwe as an example is characterized by inadequate water and sanitation services, poor hygiene practices, and a drainage system that exacerbates the spread of waterborne diseases.

Communities, especially those in high density compounds, required access to suitable and sustainable latrine designs to improve sanitation and reduce open defecation. Without proper infrastructure, the risk of cholera and other diarrheal diseases remained high. Additionally, waste collection by local authorities remained poor, leading to the accumulation of garbage, which contributed to unhygienic conditions and increased the presence of scavengers. The lack of proper waste disposal further fueled the public health risks, which made it essential to strengthen waste management systems, sanitation services, and hygiene promotion efforts in these districts. Informed by lessons from the Emergency Appeal, the intervention design emphasized on sustainable solutions for the Water, Sanitation, and Hygiene (WASH) factors contributing to cholera in Zambia. Considering that these were the underlying challenges to the outbreak.

By the end of the operation, progress had been made in addressing several key WASH-related challenges identified at the outset. Initial needs included urgent access to safe and clean water, limited chlorine supplies, inadequate sanitation facilities, overcrowding in high density communities, and poor waste management systems in Chililabombwe, Ndola, Kabwe, Kitwe, Chingola, Mpulungu and Mbala. At closure, chlorine distribution and access to communal water points had improved in most targeted communities, and some households received support for latrine emptying and improved sanitation. Hygiene promotion efforts in schools were strengthened, with more consistent soap supplies in certain areas. However, persistent gaps remained, including overcrowding and insufficient space for proper sanitation in high density settlements, limited access to sustainable latrine designs, and inadequate waste collection systems by local authorities. These residual challenges continued to pose risks for disease transmission and highlighted the need for ongoing interventions to maintain public health standards. Monitoring tools, such as WASH coverage checklists, community feedback mechanisms, and routine site visits, were used to track improvements and identify remaining gaps, ensuring that lessons learned could inform future interventions and support a smooth transition to local authorities for sustainability.

Protection, Gender And Inclusion

Non-Inclusivity of translated materials posed a challenge for differently abled individuals such as the visually impaired, hearing-impaired persons. Additionally, most sanitary facilities did not accommodate People with Disabilities. Inadequate Information, Education, and Communication (IEC) materials on cholera prevention remained a significant challenge, particularly with the translation gap. Communities in Chililabombwe, required cholera prevention messages that are culturally appropriate and accessible to ensure better understanding and adoption of hygiene practices.

t the start of the operation, significant gaps existed in ensuring inclusivity of cholera prevention information and WASH facilities. IEC materials were largely inaccessible to differently-abled individuals, including the visually and hearing-impaired, and most sanitary facilities did not accommodate people with disabilities. Communities in Chililabombwe required culturally appropriate, translated, and accessible messages to support adoption of hygiene practices. By the end of the operation, some improvements were made, awareness sessions increasingly considered accessibility needs, reaching more community members. However, persistent gaps remained, including the limited availability of fully inclusive materials for people with hearing or visual impairments, and sanitary facilities in many public spaces and households still lacked accommodations for persons with disabilities. Recommendations were made to local authorities and community leaders to sustain inclusive messaging and improve accessibility in WASH facilities beyond the operational period.

Community Engagement And Accountability

The response faced significant challenges due to inadequate systems for closing feedback loops, limiting the ability to address community concerns effectively. Additionally, there were no deliberate plans from stakeholders to support Community Engagement and Accountability (CEA) activities, which weakened efforts to build trust and encourage participation. Furthermore, community-led solutions were not fully adopted, reducing local ownership and sustainability of interventions. Strengthening feedback mechanisms, securing stakeholder commitment to CEA, and fully integrating community-driven approaches were essential for enhancing the effectiveness and long-term impact of response efforts.

At the outset of the operation, community engagement and accountability (CEA) faced significant gaps, including inadequate feedback mechanisms, limited stakeholder support for CEA activities, and low adoption of community led solutions, which hindered local ownership and trust in response efforts. By the end of the operation, some progress had been achieved: community driven solutions such as marketers in Chililabombwe received their cleaning materials, basic feedback channels were established, select community concerns were addressed, and stakeholders were more actively involved in supporting CEA activities. Despite these improvements, persistent gaps remained, and insufficient stakeholder commitment to fully integrate CEA into routine response activities. Monitoring tools, such as community feedback forms, participatory focus group discussions, and weekly coordination meetings, were used to track the effectiveness of engagement efforts and identify outstanding needs. Lessons learned were documented to inform future interventions, emphasizing the importance of sustained stakeholder engagement and community led approaches to ensure trust, participation, and sustainability beyond the operational period.

Operational Strategy

Overall objective of the operation

The IFRC-DREF operation aimed to support over 1,917,978 people in order to reduce the health, social, and economic impacts of the cholera outbreak for communities in Chililabombwe, Chingola, Kitwe, Ndola, Kabwe, Mpulungu and Mbala affected by the ongoing cholera epidemic, by providing Health, WASH, Protection, Gender and Inclusion (PGI), and Mental Health and Psychosocial Support (MHPSS) interventions and ensuring protection, dignity, and resilience over a period of five months.

There was a switch from Nakonde to Kabwe which did not result in the cessation of interventions in Nakonde. At the request of the National Society, Kabwe was added as an additional district, and existing programmes were integrated to address the identified needs in Kabwe. The CCD clearly informed the National Society that any budget variation exceeding 10% would require an operational update; however, no such request was submitted as the adjustments remained within the approved budget lines and did not surpass the 10% threshold. Furthermore, although Kabwe was added without a formal DREF operational update, all activities implemented remained consistent with and within the scope of those originally approved under the DREF.

Operation strategy rationale

Based on the situation reports, update meetings and lessons learnt from previous operations, ZRCS' response was focused on increasing awareness on prevention and control through Risk Communication and Community Engagement, WASH intervention with the hygiene promotion, provision of safe water in collaboration with MoH, local authorities, and other actors like UNICEF, Africa CDC, Churches Association, DMMU, ZANIS, Konkola Radio, 24 Market Association, Kasumbalesa business community, Ministry of Education, Trade Kings Association, Reload Logistics, hungry Lion , and Water Aid Zambia. The National Society response was based on the identified gaps through situation report from MOH and ZNPHI, based on the focus sectors for the response such as HEALTH, WASH, RCCE, CEA, PGI. This helped to be more focused with the planned interventions in affected and high-risk districts.

ZRCS conducted a needs assessment in the target districts to verify and guide on quality programming for the Cholera response activities. Furthermore, to ensure strengthened capacity of existing branches, ZRCS conducted trainings of volunteers in Epidemic Control for Volunteer (ECV), supported contact tracing, Protection Gender and Inclusion (PGI), MHPSS/PFA, Community Engagement and Accountability (CEA), Risk Communication and Community Engagement (RCCE), Red Cross and Red Crescent Movement (RCRC) and signing of volunteer code of conduct .

1. Prevention and Control

ZRCS Supported hygiene promotion activities at household level through risk communication and community engagement. This was accomplished by deploying volunteers 3 times a week for 4 months (as the outbreak evolved). An OCV was concluded in Chililabombwe District and it wasnt not extended to other districts. The NS also provided IPC materials for volunteers and staff who were supporting contact tracing. ZRCS volunteers were trained in contact tracing to support the MOH initiatives as the outbreak evolved. The trainings were facilitated by the MOH staff following their guidelines.

Oral rehydration points/Centres (ORPs/ORCs)

To enhance case management, interventions included training of volunteers and establishment and management of Oral rehydration points/Centres (ORPs/ORCs).

The strategic placement of Oral Rehydration Points (ORPs) and Oral Rehydration Centers (ORCs) in Kabwe districts was essential for

ensuring timely access to treatment, reducing severe cases, and preventing fatalities. The selection of locations for these facilities was guided by several key factors such as High-burden areas with frequent cholera cases and historical outbreaks were prioritized through utilization of materials left from EA. Additionally, high-risk populations, including those in peri-urban and high-density settlements with poor sanitation and limited water access, were targeted. Mobile populations such as truck drivers, cross-border traders, and market vendors, who were more likely to spread the disease, were also considered through placing ORC near truck park.
Communities relying on contaminated water sources, inadequate latrines, and poor drainage systems were also prioritized, as these conditions heightened the risk of cholera transmission. Public spaces like markets, schools, and bus stations that lack proper sanitation and handwashing facilities were also considered. Furthermore, accessibility to these facilities was critical; ORPs were set up within walking distance of affected households, while ORCs was placed near health centers for seamless referral of severe cases. Hard-to-reach areas were also covered to ensure no community was left out.
Finally, health system capacity was assessed, with ORPs and ORCs established in areas where health facilities were overwhelmed due to limited staff, medical supplies, or infrastructure. Previous locations where ORP/ORC setups were effective were leveraged for continuity especially those support during the EA. The management of these ORP/C were done by volunteers and MoH staff from the local health facilities. The branch leadership was oriented on the Cholera response and their roles during implementation.

Active case finding:
To interrupt the transmission at community level, trained volunteers focused on active case search and contact. volunteers were equipped with the necessary skills and resources to enable timely identification of suspected cases, prompt referrals, and targeted interventions. This approach enhanced early isolation efforts, improveed community awareness through health education, and ensured that sanitation supplies reached vulnerable households.

2. Improve hygiene condition and access to safe water.
Distribution of WASH supplies such as liquid chlorine to households in selected communities was done together with orientation on how to use the supplies. The NS with support from local Authorities, conducted water quality testing and residue chlorine monitoring at household level and chlorination at source. A post-distribution Monitoring was carried out for the WASH Non-Food Items (NFIs) distributed to establish compliance on the use and information given.

3. RCCE and Social mobilization
In order to enhance knowledge, and uptake of hygiene practices and behavior necessary to prevent and control cholera, volunteers sensitized communities through door-to-door visits and distributed IEC materials. Other techniques included radio. The NS supported printing of IEC materials and other important orientation on review of messages sessions which enabled stakeholders update information as the outbreak evolved.
The NS procured visibility materials (T-Shirts, Bibs, Jackets, caps) with cholera messages for volunteers and ZRCS personnel. ZRCS periodically obtained data on the current situation from MoH/ZNPHI through daily updates, and volunteer field reports which were used to guide the operation team in decision making as well as sharing with key stakeholders. NS engaged media fraternity to update, disseminate and orient them on the Cholera response.

4. Community Engagement and Accountability CEA/ PGI
The National Society based its response on the Community Engagement and Accountability (CEA) principles and ensured that community interactions and feedback was incorporated and mainstreamed.
ZRCS continued to set up feedback mechanism in all the affected districts. The feedback received by NS CEA focal persons analyzed and shared with pertinent stakeholders through various committees, such as the CEA committee, community meetings and focus group discussions. Community representatives, such as civic leaders, women's organizations, religious leaders, and youth organizations, the elderly and the persons with disability were involved in the social mobilization campaigns and community sensitization.
To enhance Risk Communication and Community Engagement (RCCE) efforts, a mixed-method approach was used in districts like Chililabombwe, where diverse populations, including truck drivers, cross-border traders, and high-density communities, require tailored messaging. Radio programs, drama performances, and roadshows were integrated into RCCE activities to effectively reach different community groups. Radio discussions provided wide coverage.

5. PSS coordinated within the CEA and PGI strategy
To address the discrimination risk for cholera cases or in cholera affected communities, the National Society (NS) prioritized efforts to raise awareness and promote social acceptance through Risk Communication and Community Engagement (RCCE) initiatives. Volunteers were engaging communities in open discussions, storytelling, and education campaigns to dispel myths and reduce discrimination.

Additionally, the NS provided Mental Health and Psychosocial Support (MHPSS) to cholera victims and their families. Trained volunteers offered emotional support, counseling, and community reintegration programs to help those affected cope with the psychological impact of the outbreak. By combining awareness campaigns with direct psychosocial support, the NS aimed to foster compassion, reduce stigma, and encourage collective responsibility in the fight against cholera.

5. Coordination and Partnerships
ZRCS was part of the Multi sectoral Cholera response mechanism at national and subnational levels, coordinated by the MOH/ZNPHI. This helped to avoid duplication of efforts and improve management and coordination of the Cholera outbreak response operation. Maintaining a shared information and collaboration with key partners like (WHO, ZNPHI, UNICEF, Africa CDC, World Vision, Zam Health and others) helped to streamline efforts and maximizing resource utilization.

6. Membership Coordination within the movement
The IFRC secretariat, which provides technical and financial support to ZRCS through IFRC Harare country cluster delegation, played an

essential role in ensuring effective coordination within and outside the Movement.
IFRC supported ZRCS launch an emergency appeal for Cholera in January 2024 when the country experienced one of the worst outbreaks. Through the appeal, ZRCS supported the Government reduce morbidity and mortality reaching to over 3.7Million people through emergency response and long-term preparedness interventions including provision of access to clean water and sanitation facilities. The appeal which closed in December 2024 is undergoing reporting.
The DREF application availed funds to ZRCS to conduct lifesaving emergency response in the districts affected by the outbreak. ZRCS utilized the available preparedness supplies from the appeal to reach out to these new communities.
The PNS in the country, NLRC, provided bilateral support to ZRCS since the response started. It participates in coordination meetings held in the country and contributes its expertise to this response

To ensure sustainability beyond August 2025, ZRCS developed a transition strategy in collaboration with local authorities, community leaders, and health facilities. This strategy includes handing over maintenance of WASH infrastructure, continued community engagement through trained volunteer networks, and integration of cholera prevention messaging into routine public health activities. Schools, markets, and community health committees are supported to continue hygiene promotion, feedback collection, and risk communication efforts after the formal response phase.

The National Society utilized a range of monitoring and reporting tools to guide the operation and ensure accountability. These included Kobo Toolbox for household and community assessments, daily volunteer field reports, feedback forms from CEA mechanisms, and post distribution monitoring checklists for WASH supplies. Data collected through these tools informed decision making, resource allocation, and reporting to both IFRC and key stakeholders throughout the response.
In the 3rd month of the outbreak Nakonde Stopped recording cholera cases for 3 weeks straight indicating that the cases were being contained. While Kabwe district had reported cholera cases and they were increasing rapidly. On 27th March 2025, an outbreak of cholera was reported from David Ramushu Secondary School which has an enrolment of 2876, the index being a teacher presented with AWD at Kasanda Health Facility, as of 31st March 2025, a cumulative total of 74 cases has been reported in Kabwe. The Main hotspot being Magandanyama alongside Mukululu, Nakoi, kasanda and Mine Areas. 7 cultures confirmed positive. Just after recording the confirmed cholera case, the District Health Office quickly activated its epidemic response plan. Two Cholera treatment centers were rapidly set at Kasanda and Makululu Urban facilities.
On 5th August 2025, Mpulungu district reported seven suspected cholera cases from Chipwa Health Post, the suspects were presenting with acute watery diarrhoea and vomiting, including a 2-year-old child (index case) and her mother, both from Kasisi village, Tanzania. By 10th August, 20 suspected cases were recorded from Kasisi, Kipwa (Tanzania), and Chipwa (Zambia), all along Lake Tanganyika.
While in Mbala, the district confirmed a cholera case in a patient with recent travel to Kasisi, Tanzania, for a funeral and fish trading on 12th August. The outbreak was epidemiologically linked to cholera transmission in Tanzania's Kalambo region, with clear evidence of cross-border spread.
With the rise in cases of cholera, ZRCS utilizing DREF funds in collaboration with Cholera County Support Platform (CSP) in country supported the response in Mpulungu and Mbala district with the focus on RCCE, WASH and Health pillar.
Cholera Outbreak evolution interventions
Cholera intervention activities at community level like well chlorination and other health promotion activities were commenced. Zambia Red Cross Society also joined forces and helped in conducting of community engagement meetings, focused group discussions, setting up of ORPs as well as the Information by funding the cholera radio programs, providing IEC materials for distribution and paying the volunteer allowance to the volunteers conducting door to door RCCE shifting from Nakonde to Kabwe with the cholera DREF response Funding.
The interventions implemented under the DREF operation, including door-to-door sensitizations, community meetings, chlorine and cholera kit distribution, establishment of Oral Rehydration Points (ORPs), and strengthened coordination with key stakeholders, collectively contributed to reducing cholera transmission and improving community health outcomes. Through timely health education and hygiene promotion, households were empowered with knowledge and resources to adopt preventive behaviours such as safe water handling and handwashing. The distribution of chlorine ensured continued access to safe drinking water, while ORPs provided immediate treatment and reduced the risk of severe dehydration and fatalities. Moreover, community engagement platforms fostered trust and encouraged early reporting of suspected cases, enhancing surveillance and response efficiency. Overall, these integrated efforts significantly mitigated the outbreak's impact and improved community resilience against future cholera occurrences. With this intervention an estimated of 17,500 (F=9000, M=8500) people where reached.

It's worth noting that during implementation of the DREF, ZRCS supported Kabwe, Ndola, Kitwe, Chingola, Chililabombwe, Mpulungu and Mbala districts. These changes were influenced by the evolution of the epidemic during the implementation period.

Targeting Strategy

Explain the selection criteria for the targeted population

The cholera response strategically targeted Kabwe, Ndola, Kitwe, Chingola, Chililabombwe, Mpulunga and Mbala districts due to the outbreak and the high-risk factors associated with these districts. These areas were characterized by high population mobility, primarily driven by mining activities and cross-border trade with neighbouring countries such as the Democratic Republic of Congo (DRC) . The constant movement of people, particularly traders, transporters, and truck drivers, had increased the risk of cholera transmission both

within Zambia and to other regions. Additionally, surveillance data indicated that many reported cases in other areas were linked to Chililabombwe, reinforcing the need for focused interventions in high risk zones.
There was a switch from Nakonde to Kabwe which did not result in the cessation of interventions in Nakonde. At the request of the National Society, Kabwe was added as an additional district, and existing programmes were integrated to address the identified needs in Kabwe. The CCD clearly informed the National Society that any budget variation exceeding 10% would require an operational update; however, no such request was submitted as the adjustments remained within the approved budget lines and did not surpass the 10% threshold. Furthermore, although Kabwe was added without a formal DREF operational update, all activities implemented remained consistent with and within the scope of those originally approved under the DREF.

Special attention was given to the elderly, children, persons with disabilities, and pregnant and lactating mothers, particularly during the distribution of WASH non-food items (NFIs). These groups often faced challenges in accessing healthcare, clean water, and adequate sanitation, which increased their vulnerability to cholera and its severe complications. To protect these at-risk populations, the distribution of essential WASH NFIs including soap, water treatment products was prioritized to strengthen their resilience and reduce the risk of disease transmission.

Total Assisted Population

Assisted Women	**663,813**	Rural	**60%**
Assisted Girls (under 18)	**123,500**	Urban	**40%**
Assisted Men	**648,375**	People with disabilities (estimated)	**2%**
Assisted Boys (under 18)	**108,063**		
Total Assisted Population	**1,543,751**		
Total Targeted Population	1,917,978		

Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	**Yes**
Does your National Society have prevention of sexual exploitation and abuse policy?	**Yes**
Does your National Society have child protection/child safeguarding policy?	**Yes**
Does your National Society have whistleblower protection policy?	**Yes**
Does your National Society have anti-sexual harassment policy?	**Yes**

Please analyse and indicate potential risks for this operation, its root causes and mitigation actions.

Risk	Mitigation action
Increased infection through cross boarder movement affecting	Cross boarder coordination with neighboring countries and

other districts	intensification of messages in boarder areas was done.
Poor access to affected communities due to poor road infrastructure.	There was engagement of more local volunteers and engagement of local community leaders as change agents.
Staff and volunteers get infected.	Staff and volunteers were vaccinated and provided with PPES and insurance.
Inflation was driving up the price of commodities	Budgeting in international currencies with frequent revision of budgets was done.

Please indicate any security and safety concerns for this operation:

Zambia's security environment remained stable throughout the cholera response operation. The Zambia Red Cross Society (ZRCS) closely monitored the situation in the targeted districts Kitwe, Kabwe, Chingola, Chililabombwe, Ndola, Mpulungu and Mbala to ensure that volunteers, staff, and partners operated in safe conditions. No major security incidents were reported during the implementation period.

In line with established protocols, the IFRC security officers provided ongoing guidance and technical support, particularly regarding international deployments linked to the response. This ensured that all activities adhered to both national and IFRC security standards. By integrating risk monitoring and security oversight into the operation, ZRCS maintained an enabling environment for the effective and uninterrupted delivery of cholera interventions.

Has the child safeguarding risk analysis assessment been completed?	**Yes**

Implementation

Health

Budget: CHF 127,661
Targeted Persons: 1,917,976
Assisted Persons: 1,543,751
Targeted Male: 756,438
Targeted Female: 787,313

Indicators

Title	Target	Actual
#of needs assessments done	1	1
# of IEC materials printed and distributed	1,000	700
# of radio/ TV programmes conducted	15	24
# of people in the target communities sensitized on cholera through door-to-door visits on cholera awareness, increased risk perception, health-seeking behaviours, and prevention.	144,000	343,751
# of people in target population reached with social mobilization and	1,917,978	1,543,751

RCCE activities		
# of volunteers trained in RCCE, PGI, MHPSS, CEA, ECV, active case search and d Basic sign language	150	150
# of volunteers and staff trained on ORP management	204	182
# of functional ORPs in the target communities	20	7
# of people reffered to health facilities or ORP	100	8
# of people served (that received assistance in the ORP)	100	1,532
% of people referred by ZRCS team that received assistance in ORP	100	8

Narrative description of achievements

During the cholera response in the seven affected districts (Kitwe, Kabwe, Chingola, Chililabombwe, Ndola, Mpulungu and Mbala), the Zambia Red Cross Society (ZRCS) successfully implemented a series of health-focused interventions that strengthened community capacity, improved prevention, and enhanced case management.

Volunteer Trainings and Orientation
A total of 150 volunteers were trained across the five districts in Risk Communication and Community Engagement (RCCE), Community Engagement and Accountability (CEA), Epidemic Control for Volunteers (ECV), Protection, Gender and Inclusion (PGI), Mental Health and Psychosocial Support (MHPSS), and active case identification with a strong focus on contact tracing. These trainings equipped volunteers with practical skills to support surveillance, early detection, and referral of cholera cases. In addition, 150 and 50 Branch leader /volunteers received orientation on the Red Cross Red Crescent Movement
(RCRC) principles and signed the volunteer code of conduct, reinforcing accountability and ethical standards in their response work.

Risk Communication and Community Engagement (RCCE)
Volunteers conducted door-to-door household visits across the five districts, reaching over 100857 households with health education on cholera prevention, hygiene promotion, and safe water practices. Through this approach, communities received timely and accurate information, while volunteers simultaneously collected household feedback that was fed into the CEA dashboard. In addition, 24 radio programs were conducted in partnership with local stations such as Konkola Radio in Chililabombwe, Rooster in Ndola,Chingola radio raise Fm, spice radio in Kabwe and radio YourAnthem in Kitwe . District health staff were engaged for these radio programs inconjuction with ZRCS branch leaders and volunteers. These programs helped extend the reach of cholera prevention messages to thousands of listeners, including truck drivers, market vendors, and peri-urban households in at-risk areas. These programs reached 1,543,751 people across the districts of operation

Psychosocial and Community Support
As part of the PGI and MHPSS strategy, volunteers carried out community outreach activities to raise awareness on common psychosocial and physical reactions to cholera. Through door-to-door psychosocial support visits, more than 1,200 individuals were counseled and reassured, particularly in high-incidence areas of Chililabombwe and Chingola.

• Following the training, seven (7) ORCs were established and operationalized in Kabwe, which was identified as one of the high-burden districts requiring immediate community-level support. These ORCs were strategically mounted in hotspots with high case reporting, especially peri-urban and densely populated areas where access to health facilities was limited or delayed. A total of 1,532 people received assistance from the Oral Rehydration Points (ORPs). Of these, 8 individuals were referred to health facilities due to worsening conditions; all of them fully recovered within 2–3 days after receiving treatment at the health facilities

The ORCs provided lifesaving first aid care to suspected cholera patients by ensuring:
Early initiation of rehydration before referral to health facilities.
Continuous community presence and visibility, which increased community trust in the response.
Health education opportunities where patients and caregivers were sensitized on safe water use, handwashing practices, and food hygiene while receiving care.

• To reinforce cholera prevention messages at community level, the Zambia Red Cross Society (ZRCS) produced and distributed 700 Information, Education, and Communication (IEC) materials during the outbreak response. These materials, which were all Social and Behavior Change Communication (SBCC) tools, contained clear, practical messages on maintaining clean environments, safe water usage, food hygiene, and handwashing practices.

The IEC materials were distributed equally across the five affected districts Kabwe, Chingola, Chililabombwe, Kitwe, and Ndola. Volunteers, who had already been trained in Risk Communication and Community Engagement (RCCE), conducted the distribution strategically in markets, schools, and health facilities/clinics. These were identified as key gathering points where large segments of the population could regularly view the posters and reinforce life-saving messages.
The visual nature of the materials ensured that even community members with low literacy levels could understand and adopt the preventive practices. By being displayed in public spaces, the posters also created constant reminders for communities to uphold hygiene practices throughout the outbreak period.
• To ensure data quality of health indicators, PMER conducted data quality audits to check the consistency, reliability and timeliness of data that was being collected by the volunteers as well as ensure that key indicators align with MOH and ZNPHI.

Lessons Learnt

• A key lesson was that multi-thematic training strengthened volunteer effectiveness, as they were able to integrate health, psychosocial, and protection considerations during household visits. However, more time is needed for refresher trainings, as some volunteers initially struggled to apply newly acquired technical skills in fast-changing outbreak settings.
• Door-to-door outreach combined with radio programs significantly improved community awareness and reduced misinformation. The main lesson was that local media partnerships amplified reach and trust, particularly in Chililabombwe and Chingola, where cross-border populations relied heavily on radio.
• Integrating MHPSS into health activities was essential in reducing stigma and addressing anxiety linked to cholera. The establishment of psychosocial support desks at CTCs provided visible spaces where patients and families could seek help, which normalized psychosocial care in the community

Challenges

•Despite the use of radio programs and door-to-door visits, misinformation and rumors persisted in some communities, particularly around the causes of cholera and the safety of health interventions. In border areas like Chililabombwe, the high mobility of truck drivers and traders made consistent messaging difficult.
• Long distances for volunteers to reach scattered communities
Language barrier in delivering messages
Widespread misconceptions and myths. Some households believed cholera was caused by witchcraft or contaminated medicines rather than poor sanitation and unsafe water.
Competing community priorities
where households focused more on daily survival needs (food, income) than on attending sensitization sessions.

Water, Sanitation And Hygiene

Budget: CHF 22,508
Targeted Persons: 1,917,976
Assisted Persons: 1,543,751
Targeted Male: 756,438
Targeted Female: 787,313

Indicators

Title	Target	Actual
#of people reached with appropriate knowledge about cholera and health/hygiene protective behaviours	1,917,978	1,543,749
# of households reached with liquid chlorine and multi-purpose soap distribution	51,708	16,800
# Handwashing stations distributed	20	0
# of chlorine bottle procured	17,300	16,800

Narrative description of achievements

16,800 bottles of liquid chlorine were procured and distributed in the risk communities against a target of 17,300. The discrepancy was in the changes of prices and type of chlorine bottles procured. The chlorine was distributed door-to-door reaching an equivalent number of households has one chlorine was distributed per HH. ZRCS conducted household-level hygiene promotion three times a week through trained volunteers, focusing on handwashing, safe water handling, and food hygiene.
A strong hygiene promotion component was implemented alongside chlorine distribution. Volunteers conducted door-to-door hygiene education sessions focusing on handwashing with soap, safe food preparation, proper waste disposal, and household water storage practices. Hygiene messages were contextualized in local languages to ensure wider acceptance and understanding. Demonstrations on handwashing techniques were conducted at household and community level, reinforcing practical behavior change. These activities reached thousands of households, building awareness and promoting sustained hygienic practices critical in breaking cholera transmission chains.

The planned installation of 20 handwashing stations was not achieved due to the prioritization of emergency chlorine distribution during the peak of the outbreak. The decision to redirect resources was made in consultation with district health authorities to focus on immediate containment measures, ensuring the provision of chlorine and soap to high risk households and public facilities. Handwashing promotion was instead conducted through community sensitization sessions and school based hygiene campaigns using existing facilities. Plans to establish handwashing stations had been deferred to the recovery phase of the response.

Water quality testing was already conducted by the Ministry of Health team before the Dref and the results were that 42% of samples from community boreholes and shallow wells showed fecal contamination, making them unsafe for consumption.
58% of samples from treated communal taps and kiosks met safe water standards, though chlorine residual levels were low (0.1–0.2 mg/l) in some areas due to irregular chlorination.

Based on these findings, ZRCS intensified chlorine distribution, household water treatment demonstrations, and hygiene promotion messages to reduce the risk of cholera transmission.

Lessons Learnt

Delivering 16,800 bottles of liquid chlorine directly to households ensured greater reach and uptake compared to facility-only distribution. Households appreciated direct access to chlorine without transportation costs.
• Conducting household-level hygiene promotion three times a week created consistency, reinforced messages, and led to visible improvements in handwashing, safe water handling, and food hygiene practices.
• Using health facilities as secondary distribution points boosted trust, as communities associated the intervention with formal health systems
• Follow-ups ensured chlorine was being used correctly and consistently, helping identify knowledge gaps early and allowing volunteers to provide refresher guidance

Challenges

• Conducting hygiene promotion three times a week was resource- and time-intensive, leading to volunteer fatigue and high demand for refresher support.
• Poor sanitation infrastructure in markets and border communities sometimes undermined efforts, as behavior change alone could not fully compensate for structural gaps.
• Post-distribution monitoring required significant manpower and coordination, making it difficult to track every household consistently.

Protection, Gender And Inclusion

Budget: CHF 6,970
Targeted Persons: 1,917,976
Assisted Persons: 1,543,751
Targeted Male: 756,438
Targeted Female: 787,313

Indicators

Title	Target	Actual
# of volunteers and MOH staff trained	204	152

# of child friendly key messages and information about cholera distributed	200	0

Narrative description of achievements

• During the cholera response in the targeted districts of Kitwe, Kabwe, Chingola, Chililabombwe, Ndola, Mpulungu and Mbala, the Zambia Red Cross Society (ZRCS) prioritized inclusion and protection as cross-cutting elements in all interventions. Trainings for volunteers were conducted with a focus on:

123 Volunteers and 29 Environmental Health Technologists (TOT's) were trained by the PGI focal point person in Identifying and responding to GBV and SGBV cases during emergencies, recognizing the heightened risks faced by women and girls in times of crisis.
Biding by the volunteer Code of Conduct to ensure accountability, ethical behavior, and protection of affected populations. Volunteers and TOTs reached out to people living with disabilities, ensuring they were not left behind in cholera prevention and response activities by mainstreaming the PGI into the door-to-door sensitizations and radio programs reaching over 1,543,751
• Zambia Red Cross Society (ZRCS) ensured that PGI principles were mainstreamed across all cholera response interventions, particularly in hygiene promotion and risk communication sessions. Volunteers were sensitized on inclusion and non-discrimination, ensuring that outreach efforts targeted vulnerable groups such as women, children, the elderly, and persons with disabilities.

Cholera often triggered community discrimination against affected individuals and their families, leading to social stigma, exclusion, and psychological distress. To mitigate this, volunteers were trained to deliver stigma reduction messages and promote community solidarity during outreach. Misinformation and fear that previously led to victim-blaming were addressed through CEA and PGI-integrated messaging, encouraging early health-seeking behavior and reintegration of recovered individuals. These combined efforts contributed to improved trust, increased reporting, and a reduction in social exclusion at community level.

Lessons Learnt

• Training responders on PGI created greater sensitivity to the diverse needs of men, women, children, and persons with disabilities during cholera interventions.
• Anti-discrimination sensitization helped cholera victims reintegrate without shame, leading to increased acceptance of health services.

Challenges

• Despite sensitization, some community members continued to discriminate against cholera victims or dismiss SGBV discussions due to cultural taboos
• Although awareness was raised, survivors often hesitated to report due to fear of stigma, lack of confidentiality, or weak referral systems in some districts.

Community Engagement And Accountability

Budget: CHF 15,942
Targeted Persons: 1,917,976
Assisted Persons: 3,224
Targeted Male: 1,200
Targeted Female: 2,024

Indicators

Title	Target	Actual
% of community members who agree they have adequate information about cholera outbreak and how to protect themselves	-	343,751
#number of community meeting conducted	30	34
#number of community feedback received & responded.	1,000	2,284

Narrative description of achievements

Community Engagement and Accountability (CEA) was a central component of the cholera response, ensuring that interventions were designed and implemented with active participation of the communities in Kitwe, Kabwe, Chingola, Chililabombwe, Ndola, Mpulungu and Mbala.
A total of 34 community meetings were conducted across affected districts bringing together 940 community leaders including civic leaders, traditional chiefs, religious figures, women's group representatives, youth leaders, and representatives of people with disabilities. Chililabombwe was supported with cleaning material for drainages such as hoes slashers and racks including bins for proper waste management and disposal of wate materials in efforts to reduce on the out breaks in market places. In addition, a CEA dashboard was developed and utilized to consolidate real-time data collected by volunteers during door-to-door household visits. This system allowed for systematic documentation of feedback, concerns, and questions raised by households, which were then analyzed and used to adapt messaging and interventions. The dashboard served as a critical tool for tracking rumors, identifying misinformation, and addressing gaps in community knowledge about cholera prevention and treatment.
These sessions provided platforms for dialogue between Zambia Red Cross Society (ZRCS), local authorities, and community members on cholera prevention, case management, and water and sanitation issues.

Throughout the operation, 2,284 feedback entries were collected through door-to-door visits, community meetings, and feedback boxes. The main themes that emerged included:

1. Concerns over inadequate access to clean water and sanitation facilities (38%)
2. Requests for more information on cholera prevention, treatment, and safe burial practices (27%)
3. Reports of stigma and misinformation surrounding cholera cases (20%)
4. Operational and logistical complaints, such as delayed delivery of chlorine and hygiene materials (15%)

In response, ZRCS worked with health authorities to improve information dissemination, clarify misinformation, and ensure chlorine supplies were prioritized in the most affected areas. Volunteers conducted rumor tracking sessions to address myths around cholera transmission, particularly those linking it to witchcraft or contaminated relief items.

Although no formal perception survey was conducted, qualitative feedback gathered during community meetings indicated that most participants appreciated the responsiveness of Red Cross volunteers and their consistent presence in communities. Communities expressed satisfaction with the improved communication on cholera prevention and response, noting increased confidence in seeking treatment early and participating in hygiene promotion sessions.

Despite these achievements, gaps remained in systematically closing the feedback loop, particularly at district level. Moving forward, ZRCS aims to strengthen data analysis, reporting, and two-way communication mechanisms to enhance accountability and trust with the affected communities.•

Lessons Learnt

• Providing Chililabombwe with cleaning materials for drainage and waste management directly addressed environmental risk factors, showing that combining community engagement with practical support strengthens outbreak prevention
• he CEA dashboard enabled systematic documentation of household feedback, helping volunteers and program managers quickly identify misinformation, rumors, and gaps in knowledge, allowing interventions to be adapted promptly.
• Organizing 34 community meetings across five districts engaged 940 community members and leaders from diverse backgrounds, fostering community ownership of cholera interventions and increasing acceptance of prevention measures.

Challenges

• Despite the dashboard, tracking and countering all rumors proved challenging, particularly in hard-to-reach communities or where misinformation was deeply rooted.
• Volunteers faced challenges in collecting, entering, and analyzing feedback in real time, which sometimes caused delays in action or follow-up.
• Some areas, especially drainage channels and markets, required more structural support than could be provided, limiting the effectiveness of waste management interventions.

Coordination And Partnerships

Budget: CHF 4,486
Targeted Persons: 1,917,976
Assisted Persons: 1,543,751
Targeted Male: 756,438
Targeted Female: 787,313

Indicators

Title	Target	Actual
#number of coordination and partnership meetings attended	5	5

Narrative description of achievements

• The cholera response benefited from strong coordination at all levels, ensuring that interventions were harmonized and aligned with national strategies. The HQ team as well as the NDRTs actively participated in national, provincial, and district Incident Management System (IMS) meetings according to the Ministry of Health schedule, contributing to planning, reporting, and strategic decision-making. In addition, engagement in health, WASH, and RCCE cluster meetings strengthened multi-sector collaboration, facilitated information sharing, and allowed timely identification of gaps and needs. These coordination efforts enhanced the efficiency and effectiveness of cholera interventions across all targeted districts. Each District NDRT attended district level coordination meetings to ensure the reponse was well aligned with the government's efforts

Lessons Learnt

• Participation in national, provincial, and district IMS meetings ensured that interventions were consistent with Ministry of Health strategies and priorities.
• Regular interaction with MoH and other stakeholders fostered trust, creating stronger partnerships for both immediate and future outbreak responses.

Challenges

• Coordinating attendance across multiple districts and levels sometimes caused delays, particularly when key stakeholders were unavailable or meetings overlapped
•

Secretariat Services

Budget: CHF 21,451
Targeted Persons: 165
Assisted Persons: 30
Targeted Male: 14
Targeted Female: 16

Indicators

Title	Target	Actual
# of monitoring mission organised	3	2
# of operational and technical call/meetings with NS	5	5
# of operation & technical personnel mobilized & supported under this operation	2	1

Narrative description of achievements

• The Harare Cluster Delegation provided full support across Operations Coordination, WASH, Finance, Logistics, Information Management, Security, and communication.
• IFRC office in Zambia hosts three staff: Cholera Country Support Platform (CSP) delegate, National Implementation Officer and a CEA

Officer who closely provided technical support to the NS.
• Presence of CSP funding in Zambia, continuously supported the NS integrate with the Cholera Operation.
• The IFRC also deployed a Field Coordinator for six weeks with support from British red Cross who supported in coordination of the operation.

Lessons Learnt

• There is need to have frequent coordination calls with the NS to support swift decision making in the face of changing epidemiological trends that affect the operations rationale.

Challenges

• None

National Society Strengthening

Budget: CHF 76,746
Targeted Persons: 165
Assisted Persons: 153
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of branches oriented on cholera response	5	5
#Orientation of volunteers on the RCRC movement	150	150
# of lesson learnt workshops conducted	1	1

Narrative description of achievements

A total of 50 branch executive members were oriented on the cholera response channels and their specific roles in supporting the interventions. All volunteers engaged as responders received orientation on the history of the Red Cross Movement, ensuring that new volunteers gained a comprehensive understanding of the organization's mission and values.

In total, over 150 volunteers were trained, and insurance coverage was provided through IFRC to safeguard them in case they contracted cholera while actively responding to the outbreak.

To consolidate experiences and strengthen preparedness for future outbreaks, the Zambia Red Cross Society (ZRCS) convened a Lessons Learnt Workshop in Ndola, one of the five affected districts. The workshop brought together a wide range of key stakeholders, ensuring that perspectives from both operational and community levels were represented.
Participants included Health and Care Department staff from Headquarters, members of the National Disaster Response Team (NDRT) deployed across Kitwe, Ndola, Chingola, Chililabombwe, and Kabwe, Ministry of Health officials, and branch leaders from the affected districts. The presence of the IFRC Project Manager further enriched the discussions, as they provided valuable technical guidance and global insights on best practices in cholera response.
The workshop served as an interactive platform where participants openly shared their field experiences, successes, and challenges faced during implementation. It allowed stakeholders to reflect on the effectiveness of interventions, including volunteer training, WASH activities, RCCE, and PGI integration, while also exploring opportunities for scaling up successful approaches.
Key best practices highlighted included the use of community-driven approaches, the establishment of feedback mechanisms through CEA dashboards, and the strategic use of local media for risk communication. Meanwhile, challenges such as logistical delays, resource constraints, and volunteer fatigue were discussed candidly, with participants proposing practical solutions for improvement.

Lessons Learnt

•Training 50 branch executive members on response channels clarified their roles and improved coordination, ensuring they could provide effective support to interventions.
• The lessons learnt workshop in Ndola created an important platform for shared experiences across stakeholders, leading to identification of best practices and innovative ideas for future responses.
• Providing insurance coverage through IFRC reassured volunteers of their safety, boosting morale and willingness to serve in high-risk environments.

Challenges

• The lessons learnt workshop, while valuable, was constrained by time, limiting deeper analysis of cross-district challenges and opportunities.

Financial Report

Selected Parameters			
Reporting Timeframe	2025/03-2025/11	Operation	MDRZM024
Budget Timeframe	2025/03-2025/08	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

Prepared on 05/Feb/2026

All figures are in Swiss Francs (CHF)

MDRZM024 - Zambia - Cholera Response

Operating Timeframe: 03 Mar 2025 to 31 Aug 2025

I. Summary

Opening Balance	**0**
Funds & Other Income	**275,765**
DREF Response Pillar	275,765
Expenditure	**-241,410**
Closing Balance	**34,355**

II. Expenditure by area of focus / strategies for implementation

Description	Budget	Expenditure	Variance
AOF1 - Disaster risk reduction	16,831		**16,831**
AOF2 - Shelter			**0**
AOF3 - Livelihoods and basic needs			**0**
AOF4 - Health	119,870	116,022	**3,848**
AOF5 - Water, sanitation and hygiene	21,135	22,509	**-1,374**
AOF6 - Protection, Gender & Inclusion	6,545	6,970	**-425**
AOF7 - Migration			**0**
Area of focus Total	**164,381**	**145,501**	**18,879**
SFI1 - Strenghten National Societies	83,142	82,818	**324**
SFI2 - Effective international disaster management			**0**
SFI3 - Influence others as leading strategic partners	4,212	4,486	**-274**
SFI4 - Ensure a strong IFRC	24,030	8,604	**15,426**
Strategy for implementation Total	**111,384**	**95,908**	**15,476**
Grand Total	**275,765**	**241,410**	**34,355**

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Please explain variances (if any)

From the allocation of CHF 275,765received, CHF 241,410 was spent and the balance of CHF 34,355 will be returned to the DREF pot following the closure of this DREF. There were no significant variances to be explained except the variance observed only under AOF1 and is primarily attributable to PSSR and pledge coding fees, which are automatically generated within the Work Breakdown Structure (WBS) budgets. However, the actual expenditure reflects that PSSR costs were allocated across multiple output codes rather than being charged solely to AOF1. In addition, under SF14, the Harare CCD leveraged resources from other ongoing programmes and operations to cover travel and supervision costs. This cost-sharing approach resulted in overall savings for this operation.

Contact Information

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

National Society contact: Jack Bbabbi Mukulu, Director of Programmes, jackbbabbi.Mukulu@redcross.org.zm, +260972138665

IFRC Appeal Manager: Kopano Masilo, Head of Delegation, kopano.masilo@ifrc.org, 263772128648

IFRC Project Manager: VIVIANNE JEPKOECH KIBON, Operations Coordinator, Vivianne.kibon@ifrc.org, 263776138832

IFRC focal point for the emergency: VIVIANNE JEPKOECH KIBON, Operations Coordinator, vivianne.kibon@ifrc.org, 263776138832

Media Contact: Susan Mbalu, Communications Manager, susan.mbalu@ifrc.org, +254 733 827 654

National Societies' Integrity Focal Point:
Jack Bbabbi Mukulu, Director of Programmes, jackbbabbi.Mukulu@redcross.org.zm, +260972138665

Click here for reference

Selected Parameters			
Reporting Timeframe	2025/03-2025/11	Operation	MDRZM024
Budget Timeframe	2025/03-2025/08	Budget	APPROVED

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MDRZM024 - Zambia - Cholera Response

Operating Timeframe: 03 Mar 2025 to 31 Aug 2025

III. Expenditure by budget category & group

Description	Budget	Expenditure	Variance
Logistics, Transport & Storage	**10,109**	**4,731**	**5,378**
Transport & Vehicles Costs	10,109	4,731	5,378
Personnel	**5,400**	**2,806**	**2,594**
International Staff	5,400	81	5,319
National Staff		2,725	-2,725
General Expenditure	**18,630**	**5,273**	**13,357**
Travel	13,591	3,267	10,324
Office Costs	3,743		3,743
Financial Charges	1,296	195	1,101
Shared Office and Services Costs		1,812	-1,812
Contributions & Transfers	**224,795**	**213,866**	**10,929**
Cash Transfers National Societies	224,795	213,866	10,929
Indirect Costs	**16,831**	**14,734**	**2,097**
Programme & Services Support Recover	16,831	14,734	2,097
Grand Total	**275,765**	**241,410**	**34,355**