

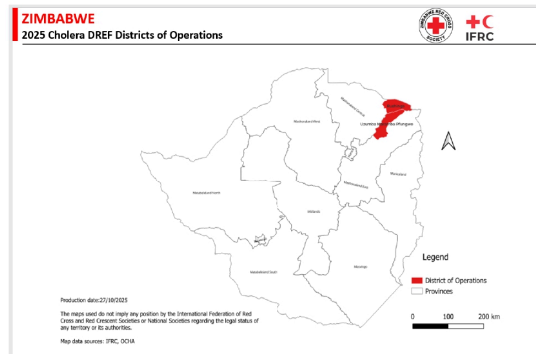


Women fetching water a Tausi Borehole which was rehabilitated in Rushinga

Appeal: <b>MDRZW024</b>	Total DREF Allocation: <b>CHF 289,726</b>	Crisis Category: <b>Yellow</b>	Hazard: <b>Epidemic</b>
Glide Number: -	People Affected: <b>309,019 people</b>	People Targeted: <b>309,019 people</b>	People Assisted: <b>685,859 people</b>
Event Onset: <b>Sudden</b>	Operation Start Date: <b>20-03-2025</b>	Operational End Date: <b>31-08-2025</b>	Total Operating Timeframe: <b>5 months</b>

Targeted Regions: **Mashonaland Central, Mashonaland East**

# Description of the Event



Public

Cholera DREF Districts of Intervention

## Date of event

10-03-2025

## What happened, where and when?

Zimbabwe recorded a surge in cholera cases, which reached critical levels, necessitating urgent interventions. Harare reported its first case on December 6, 2024, in the Belvedere squatter camp. The outbreak, also reported on December 19, 2024, in Mazowe District, Bindura, Kariba, Mt Darwin, Uzumba Maramba Pfungwe (UMP), Beitbridge, Chiredzi, and Hwedza, has escalated rapidly, with cumulative cases reaching 579 and 13 fatalities recorded as of March 12, 2025.

This cholera outbreak was so alarming due to its unprecedented spread into areas that were previously unaffected by the disease, such as Hwedza and UMP. Historically, cholera outbreaks in Zimbabwe have been concentrated in urban centers and known hotspot districts with fragile water, sanitation, and hygiene (WASH) infrastructure. However, the current outbreak breached these traditional patterns, affecting both rural and peri-urban areas that had not previously reported cases, signaling a worrying shift in disease dynamics.

The scale of this outbreak was also significantly above normal thresholds, with case numbers rising at an accelerated rate. The widespread geographic distribution of cases, coupled with the high transmission rate, suggested deeper systemic challenges in WASH access and public health preparedness. Contributing factors included increasing pressure on already overstretched health services, erratic water supply, and limited sanitation infrastructure in newly affected areas.

The affected regions required urgent interventions, including increased access to clean water, enhanced disease surveillance, improved case management, strengthened community awareness, and intensified coordination among health authorities and response partners.

Province	Cumulative Suspected Cases (New)	Cumulative RDT+ for Screening (New)	Cumulative Culture Confirmed (New)	Cumulative Recovered Cases (New)	Cases (In-Care)	Cumulative Culture Deaths (New)	Cumulative Suspected Deaths (New)
Bulawayo	0(0)	0(0)	0(0)	0(0)	0	0(0)	0(0)
Chiranganda	0(0)	0(0)	0(0)	0(0)	0	0(0)	0(0)
Harare	3(0)	2(0)	2(0)	2(0)	0	0(0)	1(0)
Manicaland	1(0)	1(0)	1(0)	1(0)	0	0(0)	0(0)
Mash Cent	324(8)	319(8)	62(0)	302(9)	16	6(1)	2(0)
Mash East	75(17)	64(4)	23(0)	6(13)	9	3(0)	0(0)
Mash West	138(0)	68(0)	3(0)	127(0)	0	0(0)	1(0)
Masvingo	23(0)	23(0)	13(0)	23(0)	0	0(0)	0(0)
Mtsh North	0(0)	0(0)	0(0)	0(0)	0	0(0)	0(0)
Mtsh South	0(0)	0(0)	0(0)	0(0)	0	0(0)	0(0)
Midlands	0(0)	0(0)	0(0)	0(0)	0	0(0)	0(0)
<b>Total</b>	<b>579(25)</b>	<b>493(21)</b>	<b>118(0)</b>	<b>338(23)</b>	<b>25</b>	<b>9(1)</b>	<b>4(0)</b>

Cholera Cases 10 March 2025. MoHCC



A woman enjoying clean and safe water at Musvaire village borehole



ZRC Team and IFRC media profiling at Tagarika Rehabilitated borehole .



Construction of disability and girlfriendly latrines

## Scope and Scale

The surge in cholera cases in specific hotspots like Mashonaland Central, Mashonaland West, Masvingo, Manicaland, and Harare was indicative of new and unusual patterns of disease transmission. The evolving dynamics of the outbreak, with new cases emerging over the past few months and spreading to previously unaffected areas such as Hwedza and Uzumba Maramba Pfungwe (UMP), underscored the urgent need for a timely response. This escalation in regions with weak healthcare infrastructure and limited access to basic services constituted an emergency that necessitated a focused and multi-sectoral response.

### Timeline of the Epidemic:

- November 4, 2024: The outbreak began in Gatchegatche, Kariba District, Mashonaland West Province, with sporadic suspected and confirmed cases reported.
- February 4, 2025: The outbreak in Gatchegatche was declared over after 28 days without new cases.
- As of March 11, 2025 the situation was as follows:
  - o Cumulative suspected cases: 579
  - o Confirmed cases: 114
  - o Deaths: 13 (9 confirmed institutional, 4 suspected community deaths).
  - o Recovery rate: 94% (23 cases under care).
  - o Rapid diagnostic tests: 579 conducted, 493 positive (85% positivity).
  - o New Cases: 8 suspected cases reported today, with 4 laboratory confirmed results.
  - o Culture tests: 140 conducted, 114 positive (81% positivity).

The affected provinces experienced increasing morbidity and mortality, with rural communities at heightened risk due to inadequate healthcare infrastructure, weak disease surveillance, and limited access to clean water and sanitation. Below is the case Distribution:

- Mashonaland Central: 332 suspected (6 new), 62 confirmed, 308 recovered.
- Mashonaland East: 75 suspected, 25 confirmed, 65 recovered.
- Mashonaland West: 130 suspected (2 new), 7 confirmed, 129 recovered.
- Harare: 3 suspected, 2 confirmed, 2 recovered.

The reliance on unsafe water sources in these regions exacerbated the outbreak, making immediate intervention critical.

Beyond direct health effects, the cholera outbreak threatened to disrupt local economies, increase household poverty, and hinder development efforts. Farming communities in affected districts faced reduced productivity due to illness, while households experienced financial strain from medical expenses and lost income. The psychological toll of repeated outbreaks further degraded community well-being, increasing stress and mental health challenges.

The attack rate calculated used the risk population of 309,019 people. An attack rate of 1.81% indicates that approximately 2 out of every 100 people at risk have developed cholera, suggesting moderate transmission. With 19 districts affected and sporadic cases reported, this



attack rate underscored the need for sustained surveillance, WASH interventions, and oral cholera vaccine (OCV) campaigns to prevent further spread. Additionally, the high rapid diagnostic test (RDT) positivity rate of 85% and culture positivity rate of 81% confirmed ongoing transmission, highlighting the continued emergence of cases in affected areas.

From March 1 to March 11, 2025, confirmed cholera cases increased by 42.5%, from 80 to 114. Case Fatality Rate (CFR) increased from 2.0% to 2.2%. This indicated a significant rise in confirmed cases, highlighting ongoing transmission, while the CFR increase suggested a slight worsening of case severity or delays in treatment. These trends called for intensified surveillance, case management, and WASH interventions. The transmission rate was calculated using Basic Reproduction Number (is the average number of secondary infections generated by one infected person. A rough estimate can be made using cases and recoveries, the calculated transmission rate is 0.8.

The cholera outbreak in Zimbabwe has been influenced by several critical risk factors: Limited access to clean water and poor sanitation infrastructure. The rapid spread in border areas, inadequate disease surveillance, and limited hospital capacity exacerbated the crisis.

The cholera epicurve for Zimbabwe as of 17 March 2025 illustrated the outbreak's progression, showing trends in case numbers over time. The curve helped determine whether the outbreak is point source, continuous, or propagated based on its shape. If there was a sharp rise and fall, it would have suggested a single exposure event, while a prolonged plateau indicated ongoing transmission, possibly through contaminated water sources. A wave-like pattern would suggest person-to-person spread. The peak of cases highlighted when the outbreak was most severe, and any decline would indicate the effectiveness of interventions such as improved WASH measures, community awareness, and case management.

See attached epi-curve and refer to [https://public.tableau.com/app/profile/mohcc.zimbabwe/viz/WCOCholeraUpdate\\_/Dashboa](https://public.tableau.com/app/profile/mohcc.zimbabwe/viz/WCOCholeraUpdate_/Dashboa)

## Source Information

Source Name	Source Link
1. Sitreps	<a href="https://drive.google.com/drive/folders/1fMQj9qs9-vMYdNjM4X2epCIA4uNhnc-R">https://drive.google.com/drive/folders/1fMQj9qs9-vMYdNjM4X2epCIA4uNhnc-R</a>
2. Mazowe Mission Report	<a href="https://docs.google.com/document/d/1LMt1TZGw9sDFj3dFkXjIpe1S_Wad1cyOBhNbWQSV40A/edit?usp=sharing">https://docs.google.com/document/d/1LMt1TZGw9sDFj3dFkXjIpe1S_Wad1cyOBhNbWQSV40A/edit?usp=sharing</a>
3. MOHCC response to ongoing Cholera outbreak	<a href="https://www.zbcnews.co.zw/mash-central-battles-recurring-cholera-outbreak/?fbclid=IwZXh0bgNhZW0CMTEAAR3GYM6P_Rru6gpZwKEhftXsfq2fS_RRgBDf17YBP44OyybCuDLvux8Z25A_aem_g2J4gy57ev2kCWs8W0oiyw&amp;sfnsn=wa">https://www.zbcnews.co.zw/mash-central-battles-recurring-cholera-outbreak/?fbclid=IwZXh0bgNhZW0CMTEAAR3GYM6P_Rru6gpZwKEhftXsfq2fS_RRgBDf17YBP44OyybCuDLvux8Z25A_aem_g2J4gy57ev2kCWs8W0oiyw&amp;sfnsn=wa</a>
4. Cholera Sitrep dated 11 March 2025	<a href="https://zimbabweredcrosssociety-my.sharepoint.com/:b:/g/personal/moyoc_redcrosszim_org_zw/EZi9kho8bdxMuED03yVMSpMB0tJAiT8NXN9LVOR1WEJnlge=6leGcG">https://zimbabweredcrosssociety-my.sharepoint.com/:b:/g/personal/moyoc_redcrosszim_org_zw/EZi9kho8bdxMuED03yVMSpMB0tJAiT8NXN9LVOR1WEJnlge=6leGcG</a>
5. Bindura Cholera assesments and training reports	<a href="https://zimbabweredcrosssociety-my.sharepoint.com/:w:/g/personal/moyoc_redcrosszim_org_zw/EdnM92aVl8JNgWl6g9gAu84B3oiwxcTlea_byeAV2vjA1g?e=hcQK0j">https://zimbabweredcrosssociety-my.sharepoint.com/:w:/g/personal/moyoc_redcrosszim_org_zw/EdnM92aVl8JNgWl6g9gAu84B3oiwxcTlea_byeAV2vjA1g?e=hcQK0j</a>
6. Mazowe training reports	<a href="https://zimbabweredcrosssociety-my.sharepoint.com/:w:/g/personal/moyoc_redcrosszim_org_zw/ESMArg2mobhAnXcEGYvsb9MBu2n3BYgAh593_EHMOTvgTge=NyFivD">https://zimbabweredcrosssociety-my.sharepoint.com/:w:/g/personal/moyoc_redcrosszim_org_zw/ESMArg2mobhAnXcEGYvsb9MBu2n3BYgAh593_EHMOTvgTge=NyFivD</a>
7. MOHCC Zimbabwe Cholera dashboard	<a href="https://public.tableau.com/app/profile/mohcc.zimbabwe/viz/WCOCholeraUpdate_/Dashboa">https://public.tableau.com/app/profile/mohcc.zimbabwe/viz/WCOCholeraUpdate_/Dashboa</a>
8. Prepositioned Cholera appeal stocks	<a href="https://zimbabweredcrosssociety-my.sharepoint.com/:x:/g/personal/moyoc_redcrosszim_org_zw/EW_ClwkletNqSaSjk4xfssBe1d673LcJLVw518EFP_yPA?e=xhfJf">https://zimbabweredcrosssociety-my.sharepoint.com/:x:/g/personal/moyoc_redcrosszim_org_zw/EW_ClwkletNqSaSjk4xfssBe1d673LcJLVw518EFP_yPA?e=xhfJf</a>
9. Epi-curve	<a href="https://zimbabweredcrosssociety-my.sharepoint.com/:w:/g/personal/moyoc_redcrosszim_org_zw/EXzfg7k-CXxFo0XKA2vSzkwBVnZpxuuKyZY0rNE5oP3P3w?e=WAJMaA">https://zimbabweredcrosssociety-my.sharepoint.com/:w:/g/personal/moyoc_redcrosszim_org_zw/EXzfg7k-CXxFo0XKA2vSzkwBVnZpxuuKyZY0rNE5oP3P3w?e=WAJMaA</a>



10. Zimbabwe Population Census	<a href="https://www.citypopulation.de/en/zimbabwe/admin/">https://www.citypopulation.de/en/zimbabwe/admin/</a>
11. ZIMLAC REPORT	<a href="https://www.unicef.org/zimbabwe/media/11516/file/2024%20ZimLAC%20Rural%20Livelihoods%20Assessment%20Report.pdf">https://www.unicef.org/zimbabwe/media/11516/file/2024%20ZimLAC%20Rural%20Livelihoods%20Assessment%20Report.pdf</a>
12. ZIMBABWE GENDER ASSESSMENT REPORT	<a href="https://documents1.worldbank.org/curated/en/099062823005513984/pdf/P179911142c466021906b1a5f4a115199d.pdf">https://documents1.worldbank.org/curated/en/099062823005513984/pdf/P179911142c466021906b1a5f4a115199d.pdf</a>
13. UNICEF ZIM RCCE BRIEF	<a href="https://www.unicef.org/zimbabwe/media/9571/file/Cholera%20Risk%20Communications%20and%20Community%20Engagement%20(RCCE)%20BRIEF%20#1.pdf">https://www.unicef.org/zimbabwe/media/9571/file/Cholera%20Risk%20Communications%20and%20Community%20Engagement%20(RCCE)%20BRIEF%20#1.pdf</a>

## National Society Actions

Have the National Society conducted any intervention additionally to those part of this DREF Operation?	No
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## IFRC Network Actions Related To The Current Event

<b>Secretariat</b>	<p>The IFRC secretariat, provided technical and financial support to ZRCS through the Harare Country Cluster delegation. It played an essential role in ensuring the 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.</p> <p>The IFRC Secretariat provided support for a range of health and WASH activities that have significantly contributed to cholera prevention efforts in Zimbabwe and strengthened ZRCSs capacity to fulfil its mandate in responding to public health emergencies related to Cholera.</p> <p>ZRCS benefitted from a Federation wide emergency appeal to respond to the Cholera outbreak of 2023/2024. With funding from donors including the UK Foreign, Commonwealth &amp; Development Office (FCDO), Norwegian Red Cross, the British RedCross, ECHO, Swiss Red Cross, Netherlands Red Cross, and Japanese Red Cross Society provided critical support for cholera response efforts in 12 districts of Zimbabwe reaching over 832,000 people. Through the EA, 27 Oral rehydration kits were procured, deployed and later decommissioned for subsequent use after the cases went down. The ORP kits assisted 11,000 ORP patients.</p> <p>The response built on the capacity established by the Emergency Appeal (EA) in 2024, which ensured that previously established systems, resources, and expertise were leveraged for the current outbreaks. The EA significantly enhanced the National Society's operational readiness through trained rapid response teams, pre-positioned WASH and health supplies, and improved surveillance mechanisms. These resources were then utilized in the cholera response, as well as the management of other public health threats.</p> <p>Moreover, the deployment of Emergency Response Units (ERUs) in 2024 provided critical technical support in case management, risk communication, and community engagement, leaving behind enhanced coordination structures and data management systems. These existing capacities facilitated a more efficient scale-up of interventions, reducing response time and ensuring continuity in outbreak control efforts.</p>
<b>Participating National Societies</b>	<p>The crisis modifier under the ECHO-funded project, implemented through the Finnish and Danish Red Cross, provided crucial support for the cholera response in October in Belvedere Harare by enabling rapid and flexible deployment of resources to affected areas. This funding facilitated the distribution of emergency WASH supplies, including water purification tablets, hygiene kits, and sanitation materials, to curb the spread of cholera in vulnerable communities. It also supported the deployment of response</p>



teams to conduct hygiene promotion, risk communication, and community engagement activities aimed at raising awareness about cholera prevention and treatment.

## ICRC Actions Related To The Current Event

ICRC don't have a physical presence in Zimbabwe, however, ZRCS, partners and IFRC coordinate with the ICRC regional office in Pretoria.

## Other Actors Actions Related To The Current Event

<p><b>Government has requested international assistance</b></p>	<p>Yes</p>
<p><b>National authorities</b></p>	<p>The Ministry of Health, in collaboration with the National Society, supported Provincial and District Health teams in Zimbabwe through several key initiatives to address the cholera outbreak. These included:</p> <ul style="list-style-type: none"> <li>-Activation of National Public Health Emergency Operation Centers and the Incident Management System.</li> <li>-Intensified surveillance activities, including risk assessments, outbreak investigations, active case searches, community surveillance, and contact tracing to identify and manage cases effectively.</li> <li>-Deployment of data management systems, such as the Information Management System to enhance data collection and analysis.</li> <li>-Enhanced Risk Communication and Community Engagement activities to raise awareness about cholera prevention and treatment in affected communities.</li> <li>-Advocacy and stakeholder engagement to mobilize resources and support for the response efforts.</li> <li>-Isolation and case management protocols, along with infection prevention and control measures, are being implemented in healthcare facilities.</li> <li>-National and Provincial teams have been deployed to provide on-the-ground support for responses in areas like Hwedza and UMP where Cholera is not endemic.</li> <li>-Cleaning of public spaces and promotion of hygiene practices to reduce the risk of cholera transmission.</li> <li>-Provision of chlorine to affected communities to ensure access to safe drinking water.</li> <li>-Early detection of cholera cases is being facilitated through Community-Based Surveillance (CBS), Event-Based Surveillance (EBS), and active case-finding systems through local EHTs and Community health volunteers.</li> </ul> <p>Additionally, the Ministry of Health intensified surveillance efforts, conducted contact tracing for individuals exposed to confirmed cases, distribution of NFIs, setting up of CTCs chlorinated water sources, and disinfected homes affected by cholera. These coordinated actions which were governed through weekly National Cholera Coordination meetings aimed to mitigate the spread of the outbreak and protect the health of communities across Zimbabwe.</p>
<p><b>UN or other actors</b></p>	<p>The United Nations and other humanitarian actors have been actively engaged in the response to the cholera outbreak in Zimbabwe, providing critical support across various areas. The World Health Organization (WHO) has collaborated closely with the Ministry of Health and Child Care (MoHCC) and the Zimbabwe Red Cross Society (ZRCS) to offer technical guidance, enhance disease surveillance, and coordinate health interventions. WHO has also assisted with supply chain management, ensuring the timely delivery of essential medications and sanitation materials, including Oral Rehydration Solutions (ORS) and personal protective equipment (PPE) for frontline health workers.</p> <p>UNICEF has played a vital role in supporting vaccination campaigns, particularly for</p>



cholera, and has been involved in health education initiatives aimed at improving hygiene practices and disease prevention in affected communities. The agency has also contributed to water, sanitation, and hygiene (WASH) interventions by ensuring that clean water supplies are made available in affected areas and by conducting safe water handling and sanitation awareness campaigns.

In addition to UN agencies, non-governmental organizations (NGOs) and humanitarian organizations such as Médecins Sans Frontières (MSF) and Welthungerhilfe (WHH) have been instrumental in providing transportation, non-food items (NFIs), and mental health support in Mazowe, Bindura, UMP. They also supported disease surveillance and rapid response teams in rural and remote areas, where access to healthcare services was often limited.

#### Are there major coordination mechanism in place?

There were major coordination mechanisms in place to ensure an effective and unified response to the ongoing health crises in Zimbabwe. The ZRCS works closely with the Ministry of Health and Child Care (MoHCC) and other government agencies, as well as UN agencies (such as WHO and UNICEF), NGOs, and local authorities. ZRCS was an active participant in the National Task Force for Disease Outbreaks, National Expanded Program of Immunization Task Force, Health cluster and RCCE thematic working group which facilitated the coordination of resources, information, and response efforts across all actors. Additionally, multi-sectoral coordination meetings were held regularly to ensure that the response is well-coordinated, ensuring that resources are allocated effectively, and gaps are addressed in real-time. ZRCS also collaborated with local communities, health workers, and volunteers to ensure that interventions were culturally appropriate, context-specific, and community-driven. The use of shared communication platforms i.e. RCCE dashboard, social media platforms and regular situation updates helped to keep all stakeholders informed, promoting a cohesive and timely response across affected regions. This coordination was vital for managing the ongoing outbreaks and ensuring that the response is scalable and responsive to emerging needs.

## Needs (Gaps) Identified



To effectively address the ongoing cholera outbreak in Zimbabwe, there was focus on several critical health needs, supported by the latest statistics from the situation report (SitRep) dated March 11, 2025. These needs were vital for mitigating the outbreak's impact and ensuring community safety.

One of the most pressing needs was strengthening outreach and community engagement. Risk Communication and Community Engagement (RCCE) efforts were enhanced, particularly in high-risk areas such as Bindura, UMP and Hwedza. As of March 11, 2025, there were eight new suspected cases, contributing to a cumulative total of 579 suspected cases. Community awareness campaigns were intensified to address the ongoing outbreak, especially with 23 isolated cases currently under treatment.

The shortage of trained volunteers hampered the effectiveness of Water, Sanitation, and Hygiene (WASH) interventions. Expanding this workforce was crucial to sustaining health promotion activities in affected communities. With ten new recoveries recorded, ongoing engagement was done to reinforce hygiene practices and prevent further infections. Deploying additional trained volunteers enhanced community-based interventions and ensured wider outreach.

Strengthening disease surveillance was critical for timely case detection and response. 593 Rapid Diagnostic Tests (RDTs) were conducted, with an 85% positivity rate (493 positive). This high positivity rate underscored the urgent need for proactive monitoring, effective contact tracing, and strengthened reporting mechanisms to curb the spread of the disease. Without robust surveillance, new cases may have gone undetected, contributing to further transmission.

The availability of medical supplies remained a critical concern. There was immediate need for additional supplies, including Oral Rehydration Solutions (ORS) and antibiotics, to manage cholera cases effectively. Stockpiling and timely distribution of medical resources improved case management and reduced cholera-related complications.

Improving access to safe water and sanitation services was fundamental in controlling the outbreak. The recent Oral Cholera Vaccine (OCV) campaign reached 4,923 people. Refurbishing water supply systems in affected communities and promoting proper hygiene practices significantly reduced the spread of cholera and improve long-term public health resilience.

Effective health promotion required culturally appropriate Information, Education, and Communication (IEC) materials. Given that 19 districts have reported cases, developing and distributing culturally sensitive IEC materials enhanced health literacy and promoted behavior change necessary for cholera prevention.

In the operational districts, approximately 40 healthcare facility focal persons (HPFPP) received training in Infection Prevention and



Control (IPC). This cohort included both Environmental Health Technicians and facility Nurses. Of those trained, 19 were females, with the remaining individuals being males. This initiative aimed to strengthen IPC practices within these healthcare settings, crucial for public health and patient safety. The training programs were designed to equip participants with the knowledge and skills necessary to implement and monitor effective IPC measures, thereby reducing the risk of healthcare-associated infections. The inclusion of both Environmental Health Technicians and facility Nurses underscores a comprehensive approach to IPC, recognizing the diverse roles involved in maintaining a safe healthcare environment.

Local media platforms played a crucial role in disseminating health information. With cholera cases still being reported in multiple districts, increasing the use of local radio, newspapers, and social media helped reach populations with limited access to formal healthcare services. Enhancing local media communication ensured timely updates and reinforced public awareness efforts.

Community leaders were instrumental in mobilizing populations to adopt preventive measures. Traditional and religious leaders, in particular, had strong influence and helped drive community participation in health initiatives.

Finally, addressing population mobility was essential to prevent further transmission. High population movement, particularly in affected districts like Hwedza and Beitbridge where there was movement of truckers, increased the risk of cholera spread.

By addressing these critical health needs, Zimbabwe enhanced its cholera response and safeguard the well-being of its communities. With a coordinated approach, sustained public health interventions, and strengthened community engagement, the country effectively mitigated the impact of the outbreak and prevented future occurrences.



## Water, Sanitation And Hygiene

Zimbabwe was facing a severe cholera outbreak, with 579 suspected and 114 confirmed cases as of March 11, 2025, resulting in 13 fatalities and a case fatality rate of 2.2%. The most affected province, Mashonaland Central, accounted for 332 suspected and 62 confirmed cases. The crisis was exacerbated by limited access to clean drinking water, inadequate sanitation, and poor hygiene practices, particularly in regions such as Hwedza, UMP, Kariba, Mazowe, Belvedere, and Chiredzi. Many communities relied on unprotected water sources such as wells, rivers, and streams, which increased the risk of contamination. Additionally, 40% of healthcare facilities in rural areas lacked clean water and basic sanitation, severely hampering effective outbreak response efforts. In Hwedza mining areas, 49% of the population lacked proper sanitation, which contributed to widespread open defecation and further contaminated water sources.

In response to the outbreak, efforts such as the Oral Cholera Vaccine (OCV) campaign in Glendale, Mazowe District, which reached over 4,923 people, were crucial in containing the disease. However, these measures had to be complemented by sustainable interventions that addressed the root causes of cholera transmission. Overcrowding in temporary shelters, inadequate waste management, and safety concerns particularly for women and children continued to deter the use of public sanitation facilities, which increased the risk of disease spread. The strain on the healthcare system was further exacerbated by limited resources, which increased morbidity and mortality rates, especially among vulnerable populations such as children and the elderly. Without urgent action, Zimbabwe risked prolonged outbreaks and escalating public health and economic crises.

To mitigate the impact of cholera and prevent future outbreaks, a multi-sectoral approach was required. Investments in water, sanitation, and hygiene (WASH) infrastructure, including the provision of safe drinking water, improved sanitation facilities, and hygiene promotion, were essential. Strengthening healthcare facilities with access to clean water and sanitation enhanced disease response efforts and reduced cross-contamination risks. Additionally, targeted community awareness campaigns on handwashing, safe water storage, and proper waste disposal helped curb the transmission of cholera in areas like UMP and Hwedza, where 56% of the population used unsafe water sources (ZIMLAC 2024 Report). Addressing these systemic challenges through coordinated efforts not only controlled the outbreak but also built long-term resilience against future health emergencies.



## Protection, Gender And Inclusion

According to the ZIMLAC Report, Gender-Based Violence (GBV) was reported as a shock by 2.8% of households nationally in 2024, with the highest reporting in Mashonaland East (3.7%) and Mashonaland West (4.0%). About 3.5% of households had at least one person living with a disability, highlighting the need for inclusive health strategies. A critical need had been to ensure safe access to health services. Vulnerable populations, including women, children, and persons with disabilities, had to be able to access cholera treatment and vaccination without fear of violence or discrimination. For instance, in Bindura and Mazowe where 23 cholera cases were in care protective measures established at health facilities helped address potential risks, ensuring that individuals felt safe when seeking medical assistance.

Health communication strategies also had to be gender-sensitive. Messaging addressed the specific needs and concerns of women and girls, particularly in high-risk areas such as Hwedza, Beitbridge, and UMP, which had reported new cases. This entailed providing clear information on hygiene practices, disease prevention, and access to services in ways that respected cultural norms and recognised gender roles. For example, workshops tailored for women were organised to discuss hygienic practices and cholera prevention, ensuring that they could share knowledge within their households.



Active involvement of women and marginalised groups in community engagement initiatives was crucial for the effectiveness of outreach efforts. In Glendale, Mazowe District where 4,923 people received the Oral Cholera Vaccine (OCV) during a four-day reactive campaign engaging local women's groups enhanced the reach of health interventions. Their participation not only empowered these groups but also ensured that health initiatives were relevant and sensitive to the needs of all community members.

Protecting vulnerable populations was another essential aspect of the response. Special attention was given to groups living in informal settlements, elderly individuals, and persons with disabilities. For instance, in Mashonaland Central Province—which recorded 332 suspected cholera cases and 62 confirmed cases—targeted support such as mobility aids and accessible information materials ensured that these individuals were included in health programs and could participate in sanitation and hygiene practices.

The cholera outbreak also exacerbated vulnerabilities to Gender-Based Violence. Measures to monitor and respond to GBV incidents were implemented, particularly in densely populated areas like Harare and Chitungwiza. Harare recorded three suspected cases and one suspected death, emphasising the need for protection mechanisms. According to the Zimbabwe Gender Assessment Report (2023), only 39% of women who experienced GBV sought help, which highlighted the need for stronger confidential reporting mechanisms. Training health workers to recognise and address signs of abuse created an environment where victims felt safe seeking help. Establishing confidential reporting mechanisms within health facilities also encouraged individuals to come forward without fear of stigma.

Developing culturally appropriate Information, Education and Communication (IEC) materials was vital for effective health promotion. These materials were made accessible to all community members, including those with disabilities. For example, producing IEC materials in local languages such as Shona and Ndebele, and ensuring they were available in formats suitable for individuals with hearing impairments, enhanced their effectiveness.

Engaging community leaders, including traditional and religious figures, further strengthened community mobilisation around gender and inclusion issues. Their support was crucial in promoting equitable access to health services and resources. In districts where cholera cases were reported such as UMP, Bindura, and Hwedza leveraging the influence of these leaders encouraged community members to participate in health initiatives and adhere to hygiene practices.

Providing psychosocial support services to individuals affected by cholera was essential, particularly for those who may have experienced trauma or loss due to the outbreak. This support was culturally sensitive and accessible to all, regardless of gender or background. Establishing support groups in affected areas provided a safe space for individuals to share their experiences and receive emotional support.

It was also vital to establish mechanisms for monitoring and evaluating the effectiveness of gender and inclusion strategies within the cholera response. Collecting disaggregated data helped assess the impact of interventions on different demographic groups. For example, tracking the participation rates of women and marginalised populations in health programs informed future strategies and resource allocation. Through these efforts, Zimbabwe enhanced its cholera response and ensured that all community members particularly the most vulnerable were supported in a manner that respected their rights and dignity.



## Community Engagement And Accountability

Zimbabwe's ongoing cholera outbreak, alongside broader challenges related to climate change, highlighted significant gaps in Community Engagement and Accountability (CEA) that hindered the effectiveness of health interventions. Many health and climate adaptation initiatives were implemented without proper consultation with affected communities, resulting in limited local ownership and engagement. This lack of involvement undermined the effectiveness of critical initiatives such as vaccination campaigns, sanitation improvements, and disease surveillance efforts.

Structural barriers further exacerbated these challenges. Only 35% of the population had access to safe water, while 40% still practised open defecation, significantly increasing cholera transmission risks. Health messages often failed to consider local contexts, languages and cultural practices, leading to misunderstandings and non-compliance with health guidelines. Communities reported concerns about the quality of city water and unlicensed vendors selling untreated water at busy markets, which further complicated cholera prevention efforts.

Misinformation also persisted, particularly among religious sects. Some Apostolic communities, for example, resorted to home remedies such as mixing Coca-Cola with salt or drinking water mixed with ash as perceived treatments for cholera. The absence of strong community feedback mechanisms led to a diminished sense of accountability from authorities and organisations. This gap fostered rumours and distrust, making it harder to engage communities in health initiatives. Fear of stigma also prevented timely healthcare-seeking behaviour, with many cholera patients delaying treatment, assuming initial symptoms were mild or fearing judgment from their communities.

According to the ZRCS RGA preliminary report, CEA gaps disproportionately impacted vulnerable groups, including women, children, the elderly, persons with disabilities, and informal workers such as vendors and artisanal miners. Inadequate consideration of accessibility issues meant that elderly individuals and persons with disabilities struggled to use sanitation facilities, limiting their ability to practise safe hygiene. Similarly, children in high-density suburbs such as Dilibadzimu in Beitbridge where frequent sewer bursts occurred were at high risk of exposure to cholera as they played in contaminated environments. (UNICEF CEA report is available if needed.)



# Operational Strategy

## Overall objective of the operation

This response aimed at assisting 309,019 at risk people in high-risk areas including Beitbridge, Bindura Hwedza, UMP and any other emerging districts which were not covered in the previous responses by addressing the urgent health challenges posed by ongoing outbreaks of cholera, in Zimbabwe while simultaneously building long-term resilience in these stated vulnerable communities for 5 months.

The response strategy prioritized a multi-sectoral, community-centered approach that combined emergency health interventions, risk communication, and community engagement while addressing underlying vulnerabilities related to WASH, food security, and healthcare access. By enhancing coordination among stakeholders, strengthening health infrastructure, and empowering local communities with preventive knowledge and resources, the strategy aimed to contain the current outbreaks and fortify Zimbabwe's capacity to manage future public health threats effectively.

## Operation strategy rationale

In response to the ongoing cholera outbreak in Zimbabwe, the Zimbabwe Red Cross Society (ZRCS) implemented a comprehensive strategy that focused on increasing awareness of prevention and control measures, enhancing water, sanitation, and hygiene (WASH) interventions, and facilitating community engagement. This strategy was executed in collaboration with the Ministry of Health and Child Care, local authorities, and various partners including UNICEF, WHO, IMC, WHH and community organizations. By addressing these critical areas, ZRCS aimed to mitigate the impact of cholera and promote long-term health resilience in affected communities, particularly in regions such as Beitbridge, Hwedza, UMP, and Bindura.

### Risk Communication and Community Engagement (RCCE):

The primary objective of the RCCE component was to raise community awareness about cholera prevention and control. To achieve this, ZRCS deployed trained volunteers three times a week for four months to conduct door-to-door visits, distribute Information, Education, and Communication (IEC) materials, and engaged in community dialogues in affected areas. This direct engagement helped clarify misconceptions about cholera and encouraged preventive behaviors. Furthermore, local media channels, including radio programs and social media platforms, were utilized to disseminate tailored messages that resonated with diverse populations, such as truck drivers and market vendors. By organizing community events, including drama performances and roadshows, ZRCS promoted hygiene practices and cholera awareness, particularly in high-density areas like Belvedere in Harare, where the risk of transmission was elevated.

### WASH Interventions:

Improving access to safe water and sanitation facilities was critical for controlling cholera transmission. ZRCS rehabilitated boreholes and installed handwashing stations in public places, especially in densely populated areas like Belvedere in Harare and Hwedza mining area in Mashonaland East. These interventions not only provided immediate access to safe water but also encouraged proper hygiene practices among community members. Additionally, WASH supplies, including liquid chlorine, was distributed to households in affected communities, such as those UMP and Hwedza, accompanied by training on proper usage to ensure that families understand how to effectively treat their water. Regular water quality testing and chlorine residual monitoring was conducted at the household level to guarantee the safety of drinking water, thereby reducing the risk of cholera transmission. BORT was prioritized.

### Active Case Finding:

Interrupting cholera transmission at the community level is essential for controlling the outbreak. ZRCS equipped volunteers with the skills and resources necessary for active case searches and contact tracing to quickly identify and refer suspected cases. This proactive approach enhanced community awareness through health education sessions that promoted early reporting of symptoms, thereby facilitating timely interventions. By reducing stigma associated with cholera, the initiative encouraged affected individuals in regions like Mashonaland Central and East to seek help without fear of discrimination.

### OCV campaign support:

Currently MOHCC has not communicated any plans on OCV campaigns however in February, an OCV campaign was done in Mazowe which targeted 4200+ people therefore which justifies having a contingency plan. The cholera vaccination response strategy involved a multi-faceted approach focusing on community mobilization, risk communication, and effective vaccination support. Trained community volunteers led awareness campaigns, including door-to-door outreach, community meetings, and radio broadcasts, to encourage OCV uptake and counter misinformation. In parallel, information materials on cholera prevention were distributed, and local influencers, including religious leaders and community heads, were engaged to advocate for the vaccine.

### Community Engagement and Accountability (CEA):

To ensure that community feedback was integrated into response efforts, ZRCS established feedback mechanisms in all affected districts. This allowed the organization to capture community concerns and suggestions effectively. Involving community representatives from regions such as Bindura, and UMP including women's organizations and local leaders, in social mobilization campaigns ensured that diverse perspectives were considered. This inclusive approach fostered a sense of ownership among community members and reinforces the importance of collective action in combating cholera.



#### Coordination and Partnerships:

Streamlining response efforts and maximizing resource utilization was critical for an effective cholera response. ZRCS actively participated in the multi-sectoral cholera response mechanism coordinated by the MoH and ZNPHI, which helped avoid duplication of efforts.

#### Monitoring and Evaluation:

Assessing the effectiveness of interventions and adapting strategies as needed is vital for sustained impact. ZRCS conducted regular monitoring of WASH Non-Food Items (NFIs) distributed to ensure compliance and effectiveness. Data gathered from volunteers and community reports in affected areas informed decision-making and improved operational strategies, ensuring that the response remained relevant to the evolving situation.

#### Psychosocial Support (PSS):

Addressing the psychological impact of cholera on affected communities was an important aspect of ZRCS's response. The organization will provide Mental Health and Psychosocial Support (MHPSS) to cholera victims and their families through trained volunteers.

#### Conclusion:

This detailed strategy aimed to address the immediate needs arising from the cholera outbreak in Zimbabwe while building the capacity of communities to prevent future outbreaks. By integrating WASH interventions, community engagement, and effective coordination, ZRCS sought to enhance the overall health outcomes for affected populations in regions such as Hwedza, UMP, Bindura and Beitbridge, fostering resilience against cholera and other waterborne diseases. Through these concerted efforts, ZRCS was committed to improving public health and ensuring that communities have the resources and knowledge to protect themselves from cholera.

## Targeting Strategy

### Explain the selection criteria for the targeted population

The selection criteria for the targeted population as stated above was based on several key factors that prioritize those most at risk of infection, severe health outcomes, and barriers to accessing essential services. The primary criterion was epidemiological data, which identifies hotspot areas with high disease burden, such as districts reporting the highest number of cholera cases, including Bindura, Hwedza, Beitbridge and UMP. Population vulnerability was another critical factor, with a focus on marginalized groups such as children under five, pregnant women, the elderly, and persons with disabilities who are more susceptible to severe health complications and have limited access to healthcare. Socio-economic conditions, including poverty levels, food insecurity, and inadequate access to clean water and sanitation, are also considered, as these factors increase exposure to waterborne and zoonotic diseases. Furthermore, geographical accessibility was taken into account, ensuring that remote and hard-to-reach communities. The selection process also prioritized areas with weak health infrastructure and limited capacity to respond to outbreaks effectively. Lastly, the potential for community engagement and collaboration with local stakeholders was factored in to ensure sustainable and community-led interventions that enhance long-term resilience.

## Total Assisted Population

Assisted Women	188,323	Rural	75%
Assisted Girls (under 18)	170,378	Urban	25%
Assisted Men	171,758	People with disabilities (estimated)	5%
Assisted Boys (under 18)	155,400		
Total Assisted Population	685,859		
Total Targeted Population	309,019		



# 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
Disease Spread Beyond Targeted Areas	Strengthen disease surveillance and early warning systems in neighbouring districts. Conduct widespread risk communication and community engagement to promote preventive behaviours.
Increased demand for healthcare services due to multiple concurrent outbreaks may strain health facilities and personnel	Provide personal protective equipment (PPE) and mental health support for front-line workers. Establish temporary treatment centres to manage case surges efficiently.
Economic challenges and political factors may impact operational efficiency and stakeholder cooperation.	Engage with government authorities at all levels to ensure alignment with national response plans. Monitor the socio-political landscape and adapt strategies accordingly.

**Please indicate any security and safety concerns for this operation:**

The political environment was stable and allowed the operation to go on smoothly. The Mpox DREF and other projects in operation had paid volunteer insurance for all volunteers engaged. The NS addressed the security and safety of volunteers and staff, especially considering the high risk of infection in outbreak settings. If a volunteer or staff member became infected, there were clear protocols in place to ensure immediate medical attention, containment, and prevention of further spread. These protocols included the identification of designated healthcare facilities for treatment, rapid referral systems, and immediate isolation if required. Additionally, there was a comprehensive plan for contact tracing and monitoring of those who might have been exposed. The safety protocols also included protective equipment (PPE) requirements, proper hygiene practices, and training for staff and volunteers on infection prevention and control measures. Furthermore, psychological support and counselling services were available for staff and volunteers dealing with the stress and trauma of working in high-risk environments. It was important to confirm that these protocols were already in place, well communicated, and regularly updated in response to evolving risks.

Has the child safeguarding risk analysis assessment been completed?	No
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# Implementation



**Budget:** CHF 117,328  
**Targeted Persons:** 309,019  
**Assisted Persons:** 685,868  
**Targeted Male:** 327,158  
**Targeted Female:** 358,710

## Indicators

Title	Target	Actual
# of oral rehydration points installed.	20	0
# of volunteers trained and deployed to do early detection, reporting, and response to cholera outbreak	200	200
% of people referred by ZRCS team that received assistance in ORP	100	0
# of people referred from ZRCS manned ORP to CTC	-	0
# 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.	309,019	186,603
#of RCCE (Risk Communication and Community Engagement) dashboard to visualize community feedback in real time and guide evidence-based decision-making	1	1
# of people reached with key health messages on cholera, through at least three communication channels (radio, social media, and community meetings) Disseminated.	309,019	186,604
# of trained volunteers conduct culturally appropriate, community-led public health education sessions on cholera prevention, Sessions will be conducted twice a week.	200	200

## Narrative description of achievements

• Healthcare workers training on Cholera, Case Management and IPC was done in the two districts. 20 health workers were trained in Rushinga which comprised of 12 Males 8 Females and 20 health workers were trained in UMP which comprised of 9 Males and 11 Females .The participants included EHTs, nurses from the affected areas.

• 9 Community dialogues on community feedback collection and establishment of community feedback and Rapid gender analysis was done in Rushinga and UMP reaching to 49 people which comprised of 28 Males and 21 Females of Ward 18 Karira Area, Ward 4 Bopoma, Ward 16 Rusambo.

The community dialogues conducted in Rushinga with regards to the cholera outbreak along Mazowe River highlighted several issues related to poor Water, Sanitation, and Hygiene (WASH) practices. Total is at 115 Females and 96 Males.

Rapid gender analysis was carried out in UMP district with the assistance of Ministry of Women Affairs as well as the District HPO at 2 stations. In Mutawatawa they interviewed 9 females and 9 females were also interviewed in Dindi.



- Volunteer Training on Cholera, PFA and BORT As part of the cholera Disaster Response Emergency Fund (DREF) response in Uzumba Maramba Pfungwe (UMP) and Rushinga districts, 200 (150 females/50 males) Zimbabwe Red Cross Society (ZRCS) volunteers and Village Health Workers (VHWs) were trained on key areas including cholera prevention and control, Psychological First Aid (PFA), and Basic Oral Rehydration Therapy (BORT).

All the trained volunteers were deployed and became frontline agents in the community for cholera detection, education, and early treatment, vastly improving the reach and effectiveness of the response. Volunteers equipped with BORT skills helped reduce severe cholera cases by providing timely oral rehydration guidance and ensuring prompt referral to health facilities for critical cases, contributing to lower mortality. Incorporation of PFA enabled volunteers to address the mental health and psychosocial needs of affected individuals, particularly those who lost family members or faced stigma, promoting community resilience and trust. Knowledgeable volunteers conducted door-to-door sensitization, risk communication, and mobilization activities, which led to better community adherence to cholera prevention practices such as safe water use and hygiene behaviors.

- Development of community surveillance and household visit monitoring tool with IFRC and MoHCC to be used at national level. ZRCS, IFRC and MoHCC collaborated in developing a data collection tool that will be utilised by any organisation that will be involved in the Cholera response in Zimbabwe. The tool will utilise DHIS2 capture to feed into the main MoHCC DHIS2 platform. The tools were developed in two phases, one for the volunteers and village health workers and one for the facility level to be used by health workers. 200 volunteers (100 in Rushinga and 100 in UMP) have received training for the tool. EHTs were also trained on how to use the same tool at facility level.

The main objective of developing this tool was to develop a standardized digital tool for community-level cholera surveillance and household monitoring to enhance early detection, timely reporting, and informed response at the national level. The tool is designed to link directly with the national health information system, improving data flow from the community to district and provincial levels.

The tool was piloted in cholera hotspot districts identified through previous epidemiological data and hotspot mapping exercises that is, Rushinga and UMP.

- Training of Health Care Workers on data collection tools (dhis2 and kobo collect) In a strategic initiative to strengthen cholera response and disease surveillance, Zimbabwe Red Cross Society (ZRCS), supported by partners, conducted targeted training for Health Care Workers (HCWs) in Rushinga and UMP districts on the use of mobile-based data collection tools—DHIS2 and Kobo Collect. 20 health care workers in UMP and 40 in Rushinga were trained to be competent in using these tools.

The training equipped HCWs with the skills to use DHIS2 and Kobo Collect platforms effectively, ensuring accurate real-time data entry and reducing errors associated with manual data collection. This improvement is vital for timely identification and response to cholera cases and emerging hotspots. Trained HCWs play a crucial supervisory and mentorship role for ZRCS volunteers involved in field data collection and community health activities. They provide technical guidance on accurate data input, troubleshooting tool usage, and ensuring data integrity.

- Training of ZRCS volunteers and Village Health workers in data collection mobile based tools ( DHIS2 and Kobo collect). 200 volunteers ( 100 in Rushinga and 100 in UMP) were trained on data collection using mobile based data collection tools. DHIS2 community monitoring and disease surveillance tool was developed to be adopted at national level, whilst the kobo collect community feedback tool is for feedback collection in areas of intervention. The community health workers were trained before they start doing the door-to-door RCCE activities.

Training in DHIS2 and Kobo Collect equipped 200 Zimbabwe Red Cross Society (ZRCS) volunteers and Village Health Workers (VHWs) with the skills to collect and submit cholera surveillance data electronically via mobile devices. This significantly improved the timeliness and accuracy of case reporting from community and facility levels during the cholera DREF response in UMP and Rushinga.

- During the implementation period, the number of recorded cases was insufficient to justify the establishment of ORPS therefore, no ORPS were set up during the project cycle. However, the available tool facilitates systematic community surveillance by enabling Community Health Volunteers (CHVs) and local health workers to record real-time data on cholera symptoms and cases identified during household visits. Reliable, high-quality data enhanced situational awareness for health authorities and partners, informing data-driven decisions on resource mobilization, risk communication, and deployment of treatment supplies such as Oral Rehydration Salts (ORS) and water purification products.

## Lessons Learnt

**Comprehensive Training is Critical:** Training healthcare workers, volunteers, and community health workers on cholera case management, Infection Prevention and Control (IPC), Psychological First Aid (PFA), and Basic Oral Rehydration Therapy (BORT) proved essential for effective response. Well-trained volunteers were key frontline agents for early case detection, education, and treatment referral, reducing severe cases and mortality.

**Importance of Community Engagement:** Community dialogues and feedback collection, including gender analysis, enabled understanding of local issues such as poor Water, Sanitation, and Hygiene (WASH) practices, guiding tailored interventions. Risk communication and community engagement enhanced adherence to preventive measures.

**Use of Digital Tools for Surveillance:** Developing and implementing standardized digital tools (DHIS2 and Kobo Collect) for community and



facility-level data collection improved real-time cholera surveillance, early detection, and data accuracy, enabling timely public health responses.

**Collaboration and Partnerships:** Coordination among Zimbabwe Red Cross Society (ZRCS), Ministry of Health and Child Care (MoHCC), IFRC, and community structures increased the reach and effectiveness of the cholera response, ensuring resource sharing, training, and monitoring.

**Decentralization of Care:** Village Health Workers VHWs were equipped with BORT skills, which helped reduce severe cholera cases by providing timely oral rehydration guidance and ensuring prompt referral of critical cases to health facilities. This contributed to lower mortality. Community members who were not feeling well would first seek assistance from these VHWs, which helped decentralize care to the community level and improved access to basic health services.

**Psychosocial Support:** Integrating PFA into volunteer training addressed mental health needs of affected individuals, fostering resilience and reducing stigma within communities.

## Challenges

• **Response Fatigue Among Healthcare Workers:** Prolonged outbreak response led to occupational fatigue, impacting staff motivation and performance.

**Data Flow and Reporting Barriers:** There were barriers related to data flow and reporting. Despite the availability of digital tools, challenges persisted in transmitting data from Volunteers/VHWs to the central health information systems. This was largely due to difficulties in using the DHIS2 platform, mainly caused by network limitations, resulting in delayed reporting and data gaps.

**Infrastructure and Accessibility Issues:** Rural settings faced challenges such as poor road networks, transport limitations, and distance to health facilities affecting access to care and timely reporting.

**WASH-Related Risks Remain High:** Community dialogues revealed persistent poor WASH practices, highlighting the need for sustained WASH interventions alongside health response.

**Need for Continued Supervision and Mentorship:** Health care workers trained on digital data tools required ongoing technical support to maintain data quality and tool usage proficiency.

**Limited Resources for Scaling-Up:** National level scale-up and sustainability of digital surveillance tools and comprehensive training require ongoing funding and technical capacity building.



## Water, Sanitation And Hygiene

**Budget:** CHF 29,426

**Targeted Persons:** 309,019

**Assisted Persons:** 685,868

**Targeted Male:** 327,158

**Targeted Female:** 358,710

## Indicators

Title	Target	Actual
# of boreholes rehabilitated.	10	18
# of schools equipped with disability and girlfriendly latrines.	4	2
# of people practicing safe hygiene practices and household water treatment after receiving hygiene kits and attending hygiene promotion sessions	309,019	685,868



## Narrative description of achievements

• Hygiene Kits were distributed during awareness campaigns, and some were distributed at health care facilities, UMP district hospital and Rushinga District Hospital. Household water testing equipment to support UMP district.

On mensural hygiene kits, these were distributed, 50 per district to support 2 schools, Mungari school, in UMP and the other one in Rushinga to support the girl child' 2 schools were selected instead of 4 because of budgetary constraints. The 2 most in need were then selected.

During the Cholera response ZRCS ensured to collaborate and work with DWSC department in Rushinga and UMP to identify and improve WASH conditions in affected areas to curb cholera. During rapid gender analysis WASH issues were identified to be of paramount importance and were considered a priority area. ZRCS identified and assessed boreholes in Rushinga and UMP which required immediate attention for provision of clean and safe water to residents in hotspot areas. Boreholes were identified and ZRCS managed to rehabilitate 18 boreholes in UMP and Rushinga after consultation with the DDC, MoHCC and DWISK department. Water committees were identified in all villages that had their boreholes rehabilitated under Cholera DREF and were trained in water point management.

Mungari primary in UMP and Musvaire primary were identified as priority schools that needed disability and girlfriendly latrines. Musvaire only had 5 squat holes for girls for ecd upto grade 7 and 5 squat holes for boys from ecd to grade 7 level and total enrolment is at 367. Mungari primary was better compared to Musvaire but did not have a disability and girlfriendly latrines and could not afford to build one.

• Water Point Committee Training of four WPCs (Two in Rushinga District Tausi and Garikai and two in UMP District Nyakusamwa and Kawerenga 2) 5 Males 13 Females (Rushinga) The WPC training was facilitated by three stakeholders; from Ministry of Women Affairs, Ministry of Health and Child Care and Min of Housing. The councillor welcomed all the participants to the workshop who were a total of 18.

14 WPC members were trained in UMP from the two water points facilitated by RIDA, Ministry of Health and Ministry of Women Affairs(3 M 11 F).

• 9 Boreholes rehabilitated in Rushinga urban) Rushinga. 9 Boreholes rehabilitated in UMP (

Zimbabwe Red Cross Society (ZRCS) successfully rehabilitated 9 boreholes in Rushinga Urban and 9 boreholes in Uzumba Maramba Pfungwe (UMP) districts. This critical intervention aimed to restore access to clean and safe water sources, directly supporting water, sanitation, and hygiene (WASH) activities during the cholera response.

-Tausi Borehole – 50 Households

-Westview/Garikai – 460 Households

-Kapishe Borehole -75 Households

-Mukoka – 120 Households

-Kararira – 270 Households

-Musvaire- 70 Households

- Rushinga urban- 200 Households

-Chaparapata 43 households

-Kawerenga 2 Village 134 households

-Sose Village 100 households

-Kawerenga 1 Village 120 households

-Nyakusamwa Village 90 households

-Jeke1borehole 500 households

-Jaji1borehole 230 households

-Nyandoro village borehole 180 households

-Nyabarura Borehole 161 households plus Mungari Primary School

• Construction of Girl friendly latrines at Musvaire Primary and Mungari.

Musvaire Primary School (16.70752°S, 31.88313°E) were selected to benefit from the construction of an inclusive, girl-friendly and disability-friendly BVIP latrine with five squat holes. A community sensitization meeting was held, and the Environmental Health Technician (EHT) successfully pegged the squat holes to enable the community to begin excavation work. Musvaire has an enrolment of 364 pupils.

Mungari Primary School in ward 4 of UMP has an enrolment of 900 pupils was selected to be the recipient of the girl-friendly toilet. Work on the toilet was initially slow as they took some time to dig the holes that had been pegged by the EHT.

## Lessons Learnt

• Multi-stakeholder Collaboration is Key:

Working closely with the DWSC, Ministry of Women Affairs, MoHCC, community water committees, and local leadership helped to identify priority WASH needs and ensured coordinated planning and implementation, improving effectiveness.

Community Participation Drives Sustainability:

Identifying and training Water Point Committees (WPCs) empowered local communities to manage and maintain rehabilitated boreholes, fostering ownership and enhancing the sustainability of water sources.

Targeted Infrastructure Rehabilitations Impacted Many Households:

Rehabilitation of 18 boreholes across key hotspots immediately restored access to clean water for thousands of households, directly addressing one of the crucial cholera transmission pathways.

Inclusive Sanitation Facilities Address Vulnerable Groups' Needs:



Prioritizing girl-friendly and disability-friendly latrines in schools (Musvaire Primary and Mungari Primary) promoted equity in access, encouraging female and differently abled children's continued attendance and dignity, which are critical during outbreaks.

**Community Sensitization Facilitates Acceptance and Participation:**

Holding sensitization meetings and involving Environmental Health Technicians (EHTs) for technical support enhanced community buy-in and ensured proper technical standards in construction and maintenance.

**Gender Considerations Improve WASH Outcomes:**

Applying rapid gender analysis helped highlight the specific WASH needs of women, girls, and marginalized groups, ensuring that interventions were relevant and culturally appropriate.

## Challenges

• **Slow Construction Progress Due to Community Capacity:**

At Mungari Primary School, excavation and construction of latrines were slow, reflecting potential limitations in local skills, labor availability, or competing community priorities.

**Resource Limitations for WASH Infrastructure:**

Both schools identified the need for disability and girl-friendly latrines but lacked internal resources to build them, highlighting the reliance on external funding and potential delays in intervention.

**Maintenance and Sustainability Risks:**

Despite training WPCs, ongoing maintenance may face challenges if committee members lack incentives or if adequate replacement parts and technical support are unavailable over time.

**Geographical Dispersion of Boreholes:**

Boreholes are spread across many villages, which may complicate regular monitoring, logistic support, and rapid repairs in case of breakdowns.

**Integrating WASH Improvement with Behaviour Change:**

While infrastructure was improved, sustained cholera prevention depends on continuous behavior change communication around safe water use and hygiene, which may require ongoing effort beyond borehole rehabilitation.

**Balancing Multiple Priorities During Outbreak:**

The cholera response context required rapid action, but some WASH infrastructure works such as latrine construction faced delays, showing the tension between immediate outbreak control and longer-term facility improvements.



## Protection, Gender And Inclusion

**Budget:** CHF 19,211

**Targeted Persons:** 10,000

**Assisted Persons:** 48,980

**Targeted Male:** 23,357

**Targeted Female:** 25,623

## Indicators

Title	Target	Actual
# of schools equipped with inclusive hygiene promotion facilities that meet the needs of women, children, people with disabilities, and other vulnerable groups as informed by Rapid Gender Analysis (RGA).	4	2
# of gender-based violence (GBV) prevention and response messages disseminated into public health campaigns in cholera-affected areas	100	192
% increase of dis-aggregated data by gender, age, and disability across 75% of intervention sites to better understand the needs of affected populations	75	75



## Narrative description of achievements

• During the cholera response in Uzumba Maramba Pfungwe (UMP) and Rushinga districts, Zimbabwe Red Cross Society (ZRCS) and partners prioritized inclusive hygiene promotion and gender-sensitive approaches to ensure equitable access and protection for vulnerable populations. Guided by insights from Rapid Gender Analysis (RGA), the response focused on equipping schools with hygiene facilities designed to meet the specific needs of women, children, people with disabilities, and other vulnerable groups. Out of the targeted 4 schools, 2 primary schools Musvaire and Mungari were successfully provided with girl-friendly and disability-inclusive sanitation facilities. These upgraded facilities enhanced dignity, accessibility, and hygiene promotion for all learners, positively impacting school attendance and well-being during the outbreak. In efforts to address Protection, Gender, and Inclusion (PGI) priorities, a total of 48,980 individuals (23,357 males and 25,623 females) were reached through the project.

Recognizing the heightened risk of gender-based violence in crisis contexts, the response integrated GBV prevention and response messages into cholera public health campaigns. More than 196 messages were disseminated, significantly exceeding the target of 100, reflecting a strong commitment to raising awareness about GBV risks and available support services. This integration ensured that cholera interventions addressed not just physical health needs but also psychosocial safety and protection concern of affected populations.

Further strengthening the response's inclusiveness, data collection and reporting were enhanced through systematic disaggregation by gender, age, and disability status in 75% of intervention sites, fully meeting the target set. This granular data allowed program managers to better understand the diverse needs and vulnerabilities within the communities, informing adaptive strategies and resource allocation tailored to different population groups.

Together, these integrated activities of infrastructure improvement, gender-sensitive messaging, and data-driven programming underpinned an equitable and holistic cholera response, strengthening community resilience, protection, and health outcomes amidst the outbreak.

## Lessons Learnt

### • Inclusion Enhances Effectiveness:

Providing hygiene facilities tailored to vulnerable groups, such as girls and persons with disabilities, significantly improved accessibility and uptake, supporting equitable health and education outcomes during health crises.

### Multi-dimensional Interventions Are Critical:

Addressing both health and protection (GBV) within cholera response campaigns creates a safer environment and holistic support for affected communities, especially marginalised populations.

### Data Disaggregation Drives Responsive Programming:

Collecting and analysing disaggregated data by gender, age, and disability enables targeted interventions that better meet the unique needs of all groups, improving the relevance and impact of response activities.

### Community and Stakeholder Engagement Facilitates Uptake:

Integrating insights from Rapid Gender Analysis and involving stakeholders in planning ensures that interventions are culturally appropriate and accepted by the community.

### Targets Are Achievable with Adequate Planning and Resources:

Successfully surpassing the GBV message dissemination target shows the benefit of prioritizing communication efforts and leveraging multiple channels during emergency responses.

## Challenges

### • Partial Achievement of Inclusive Facility Targets:

Only 2 out of 4 targeted schools received inclusive hygiene facilities, due to resource constraints and logistical challenges that limited full coverage in outbreak settings.

### Sustaining Behavior Change and Facility Maintenance:

Upgrading infrastructure is essential, but ongoing hygiene promotion and maintenance of facilities require continued investment and community ownership beyond the emergency phase.

### Ensuring Quality and Depth of GBV Messaging:

While message quantity exceeded targets, ensuring consistent quality, culturally sensitive delivery, and reach to the most vulnerable remains a challenge.

### Data Collection Limitations:

Although disaggregation targets were met, completeness and accuracy of disability data can be difficult to ensure, requiring ongoing training and support for data collectors.

### Gender and Protection Integration in Health Emergencies is Complex:



Coordinating across sectors (health, protection, education) and securing dedicated resources for integration demands strong leadership and collaboration, which may face bureaucratic or operational hurdles.



## Community Engagement And Accountability

**Budget:** CHF 34,111  
**Targeted Persons:** 309,019  
**Assisted Persons:** 685,868  
**Targeted Male:** 327,158  
**Targeted Female:** 358,710

### Indicators

Title	Target	Actual
# of community feedback received & responded.	-	10,616

### Narrative description of achievements

- RCCE Dashboard was formulated, and to reinforce it, the DHIS2 dashboard with the MoHCC was also formulated.
- RCCE van messaging campaign, the campaign employed a van-based messaging strategy, utilizing Ministry of Health and Child Care van truck equipped with loudspeakers to broadcast cholera awareness messages throughout four growth points Borera, Chikuwa/ Katiyo, Dindi and Maramba. In total, the project reached 685,868 (327,158M/358,710F) through RCCE activities. These growth points were the cholera hotspots in Uzumba, Maramba Pfungwe. RCCE dashboard was informed and updated based on the data that was collected and submitted by the trained 200 volunteers (100 Rushinga and 100 in UMP). The collaboration significantly enhanced the visibility and effectiveness of RCCE efforts. Communities demonstrated increased knowledge and adoption of cholera prevention measures, contributing to more robust outbreak control.

### Lessons Learnt

- Integrated Data-Driven RCCE Improves Response Efficiency:  
The formulation of the RCCE dashboard, complemented by the DHIS2 dashboard developed by MoHCC, enabled real-time data collection, visualization, and analysis. This integration enhanced coordination, evidence-based decision-making, and timely updates during the response.

Community-Led Messaging Enhances Outreach and Impact:

Utilizing a van equipped with loudspeakers to disseminate cholera awareness messages across key growth points effectively expanded coverage, reaching approximately 150,000 people in hotspot areas. This strategy was instrumental in engaging hard-to-reach populations.

Trained Volunteers are Crucial for Data Collection and Message Dissemination:

Having 200 trained volunteers conducting door-to-door household visits and submitting data through digital tools ensured high-quality, grassroots-level information feeding into the RCCE dashboard. Their involvement reinforced community trust and improved message uptake.

Collaboration with Government Enhances Credibility and Reach:

Partnership with the Ministry of Health and Child Care (MoHCC) through joint efforts like the RCCE dashboard and van campaign reinforced authority, fostering community acceptance of health messages.

Dynamic Feedback Mechanisms Support Adaptive Communication:

Continuous data submission and dashboard updates allowed rapid identification of misinformation, information gaps, and emerging community concerns, enabling tailored and timely RCCE interventions.

### Challenges

- Sustaining Engagement in Remote and Diverse Communities:  
Despite wide reach, maintaining consistent, repeated messaging and follow-up in geographically dispersed and culturally diverse growth points remains challenging, risking message fatigue or gaps.

Technology and Connectivity Limitations:



Digital data collection and dashboard updating depend on reliable network connectivity and volunteers' technical capacity, which may be inconsistent in rural settings, leading to delays or incomplete data submission.

#### Resource Constraints for RCCE Activities:

Van-based campaigns and continuous volunteer engagement require ongoing financial and logistical support, which may strain budgets during prolonged outbreaks.

#### Measuring Behavior Change Impact:

While increased knowledge was reported, quantifying actual behavior change and linking it directly to RCCE activities is complex, requiring robust monitoring and evaluation frameworks.

#### Language and Literacy Barriers:

Broadcasting messages via loudspeakers demands careful adaptation to local languages and cultural contexts to ensure comprehension across diverse populations, which can be resource-intensive.



## Coordination And Partnerships

**Budget:** CHF 1,218

**Targeted Persons:** 5

**Assisted Persons:** 4

**Targeted Male:** 2

**Targeted Female:** 2

### Indicators

Title	Target	Actual
# of coordination meetings conducted.	3	3
# of donor engagement meetings attended.	3	3

### Narrative description of achievements

- The IFRC team (IM, PMER and PHIE) were part of the Cholera response from the time of inception till project closure. ZRCS developed a community surveillance and door-to-door data collection tool in conjunction with the MoHCC, whilst IFRC IM and PHEC were part of the process.
- During data collection trainings for volunteers and health care workers, the IFRC team, ie PMER and IM, were co-facilitators, and this made the training easier and effective.

### Lessons Learnt

- The involvement of IFRC PMER, IM, and PHEC provided crucial guidance for coordination, planning, and data-driven decision-making. This ensured that interventions were timely, well-targeted, and adjusted as the outbreak evolved, enhancing the overall efficiency and effectiveness of the response.
- The teams maintained active disease surveillance and case management throughout the outbreak. Rapid response teams facilitated early case detection and isolation, which curtailed further spread. The technical support from IFRC strengthened these systems, improving outbreak control.
- The disciplines of monitoring, evaluation, and information management ensured that the response was adaptive and evidence-based. Lessons from previous cholera outbreaks were integrated, such as targeting vaccinations and WASH (Water, Sanitation, and Hygiene) improvements in vulnerable hotspots. This led to increased resilience in areas repeatedly affected.
- Trainings and capacity strengthening of local healthcare workers and volunteers elevated the health system's ability to manage cholera and other emergencies better in the future, contributing to a more resilient health infrastructure.

### Challenges

There were no significant challenges worth reporting.





## Secretariat Services

**Budget:** CHF 20,583  
**Targeted Persons:** 15  
**Assisted Persons:** 15  
**Targeted Male:** 11  
**Targeted Female:** 4

### Indicators

Title	Target	Actual
# of field missions by IFRC	4	5

### Narrative description of achievements

- IFRC deployed a Public Health in Emergencies Coordinator for three months who was instrumental in the achievement of this operation. The coordinator was instrumental in supporting the development of the Malaria DREF Operation during this period, and she supported the two operations (cholera & Malaria).
- The Cluster PMER, Finance, Operations and Communications team provided routine supervision including finance verification, field monitoring of activities, documenting the activities and communicating the interventions in numerous media platforms. A total of 5 monitoring visits were conducted.

### Lessons Learnt

- Strong collaboration and support from IFRC significantly contributed to the successful implementation of activities.

### Challenges

- There were no significant challenges encountered.



## National Society Strengthening

**Budget:** CHF 67,848  
**Targeted Persons:** 200  
**Assisted Persons:** 200  
**Targeted Male:** 50  
**Targeted Female:** 150

### Indicators

Title	Target	Actual
# of internal policies and frameworks review and update meetings conducted to align with international standards and best practices for humanitarian health responses	5	5
# of volunteers and staff trained in public health education, WASH interventions, and PGI	1	200
% Increase in volunteer recruitment and achieve a retention rate	15	15



## Narrative description of achievements

During the cholera response in Uzumba Maramba Pfungwe (UMP) and Rushinga districts, Zimbabwe Red Cross Society (ZRCS) demonstrated strong commitment to aligning its humanitarian health interventions with international standards and best practices. This was evidenced by the conducting one internal policy and framework review meeting that aimed at updating organizational guidelines to better reflect current global humanitarian health frameworks. Although the target was five, this crucial step ensured that operations remained technically sound, accountable, and coordinated within a wider standards-based context.

- A major milestone was the training of 200 (150 females/50 males) volunteers and staff in areas critical to cholera prevention and response, including public health education, Water, Sanitation, and Hygiene (WASH) interventions, and Protection, Gender, and Inclusion (PGI). The comprehensive training enhanced the capacity of frontline responders to deliver inclusive, effective, and context-appropriate health and WASH services, while ensuring vulnerable and marginalized populations were adequately considered and supported.
- Furthermore, ZRCS consistently engaged with key stakeholders to maintain coordination and synergy in response efforts, demonstrated through attendance at 36 coordination meetings. These meetings facilitated information sharing, resource mobilization, harmonization of interventions, and alignment with broader governmental and partner strategies, enhancing the efficiency and impact of the cholera response.
- Key stakeholders, including the Ministry of Health and Child Care, the Ministry of Youth and Development, the Rural Infrastructure Development Agency (RIDA), the District Development Coordinator (DDC), and the Environmental Management Agency (EMA), played crucial roles in the implementation of the project and were actively involved in conveying meetings. Their collective involvement ensured a multi-sectoral approach to project planning and execution, leveraging their respective mandates and expertise to address various facets of the initiative.

## Lessons Learnt

- Policy Alignment is Foundational but Requires Sustained Effort:

Regular review and update of internal policies ensure compliance with evolving international humanitarian standards; however, achieving full review cycles required dedicated time and resources.

- Comprehensive Training Builds Capacitated and Motivated Teams:

Investing in broad-based training that covers technical, WASH, and PGI aspects equips volunteers and staff to deliver holistic, inclusive interventions that address diverse needs in outbreak settings.

- Volunteer Recruitment and Retention Need Targeted Strategies:

While increases in recruitment and retention are positive, maintaining motivation and engagement beyond initial training is essential to sustaining response capacity over time.

- Frequent Coordination Strengthens Partnerships and Reduces Duplication:

Regular participation in multi-stakeholder meetings promotes information sharing and coordinated action, leading to a more unified and efficient outbreak response.

- Integrated Approaches Enhance Impact:

Combining health, WASH, and protection training ensures volunteers and staff can address multiple dimensions of cholera prevention and control, improving outcomes.

## Challenges

There were no significant challenges worth reporting.



# Financial Report

## DREF Operation

FINAL FINANCIAL REPORT

Selected Parameters			
Reporting Timeframe	*	Operation	MDRZW024
Budget Timeframe	*	Budget	APPROVED

Prepared on 28/Jan/2026

All figures are in Swiss Francs (CHF)

### MDRZW024 - Zimbabwe - Cholera

Operating Timeframe: 20 Mar 2025 to 31 Aug 2025

#### I. Summary

<b>Opening Balance</b>	<b>0</b>
<b>Funds &amp; Other Income</b>	<b>289,726</b>
DREF Response Pillar	289,726
<b>Expenditure</b>	<b>-288,211</b>
<b>Closing Balance</b>	<b>1,515</b>

#### II. Expenditure by area of focus / strategies for implementation

Description	Budget	Expenditure	Variance
AOF1 - Disaster risk reduction			0
AOF2 - Shelter			0
AOF3 - Livelihoods and basic needs			0
AOF4 - Health	270,399	137,600	132,799
AOF5 - Water, sanitation and hygiene		24,558	-24,558
AOF6 - Protection, Gender & Inclusion		16,068	-16,068
AOF7 - Migration			0
<b>Area of focus Total</b>	<b>270,399</b>	<b>178,227</b>	<b>92,173</b>
SF11 - Strengthen National Societies		90,211	-90,211
SF12 - Effective international disaster management			0
SF13 - Influence others as leading strategic partners			0
SF14 - Ensure a strong IFRC	19,327	19,773	-446
<b>Strategy for implementation Total</b>	<b>19,327</b>	<b>109,984</b>	<b>-90,657</b>
<b>Grand Total</b>	<b>289,726</b>	<b>288,211</b>	<b>1,515</b>

[Click here for the complete financial report](#)

## Please explain variances (if any)

The budget variance resulted from a system synchronization error. A revised version of the financial report will be issued once the budget lines are correctly aligned with the WBS, and the variances will be clearly explained.



# Contact Information

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

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[Click here for reference](#)



# DREF Operation

FINAL FINANCIAL REPORT

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Budget Timeframe	*	Budget	APPROVED

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SFI2 - Effective international disaster management			0
SFI3 - Influence others as leading strategic partners			0
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FINAL FINANCIAL REPORT

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## MDRZW024 - Zimbabwe - Cholera

Operating Timeframe: 20 Mar 2025 to 31 Aug 2025

### III. Expenditure by budget category & group

Description	Budget	Expenditure	Variance
<b>Logistics, Transport &amp; Storage</b>	<b>6,168</b>	<b>8,874</b>	<b>-2,706</b>
Transport & Vehicles Costs	6,168	8,874	-2,706
<b>Personnel</b>	<b>10,000</b>	<b>8,644</b>	<b>1,355</b>
International Staff	4,400	7,319	-2,919
National Staff	5,600	1,325	4,274
<b>General Expenditure</b>	<b>6,160</b>	<b>7,248</b>	<b>-1,088</b>
Travel	3,520		3,520
Office Costs	880		880
Communications	880		880
Financial Charges	880		880
Shared Office and Services Costs		7,248	-7,248
<b>Contributions &amp; Transfers</b>	<b>249,717</b>	<b>245,836</b>	<b>3,881</b>
National Society Expenditure	249,717	245,836	3,881
<b>Indirect Costs</b>	<b>17,683</b>	<b>17,609</b>	<b>74</b>
Programme & Services Support Recover	17,683	17,609	74
<b>Grand Total</b>	<b>289,726</b>	<b>288,211</b>	<b>1,515</b>