



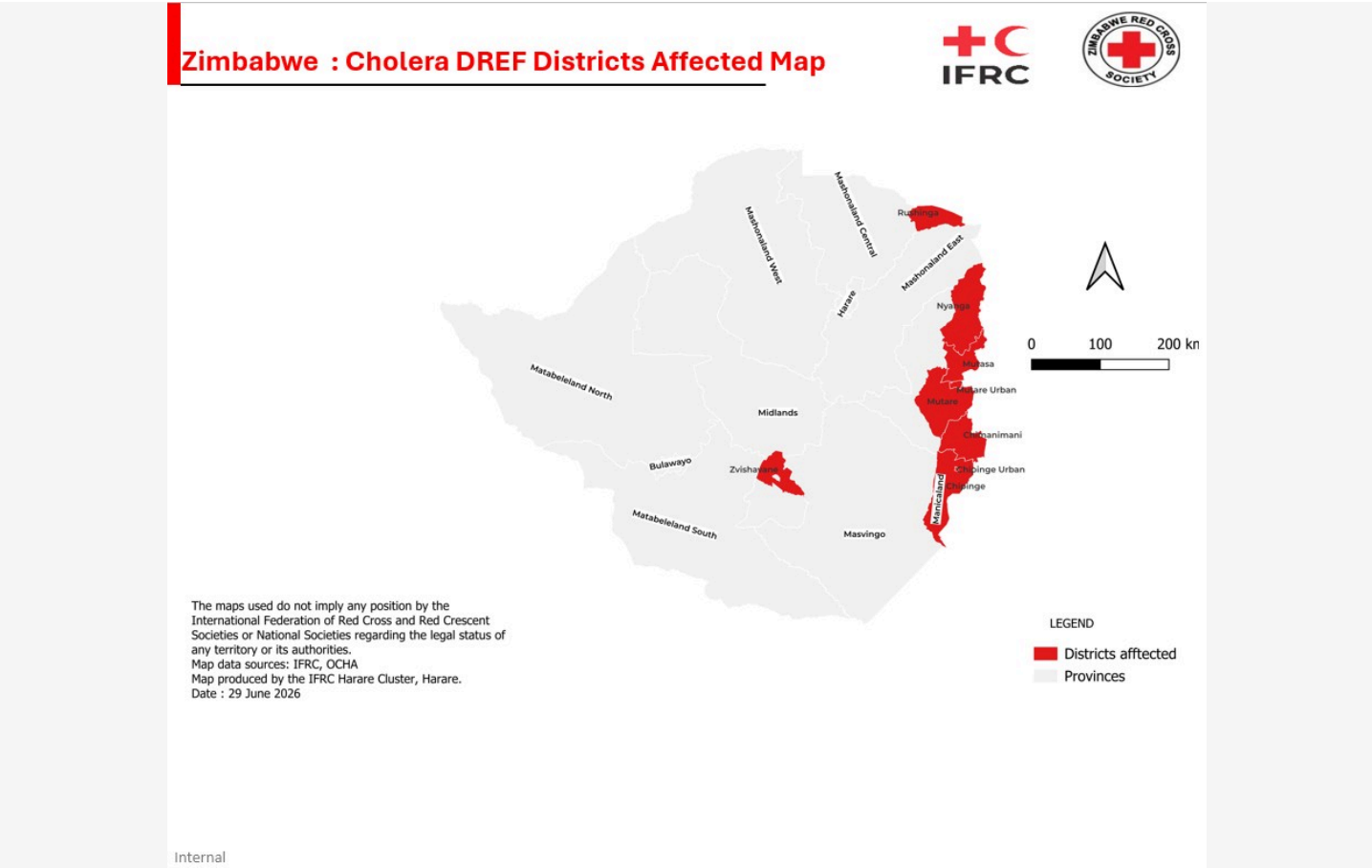
Zimbabwe Red Cross Volunteer Conducting Bucket Chlorination at source in Harare

Appeal: MDRZW029	Hazard: Epidemic	Country: Zimbabwe	Type of DREF: Response
Crisis Category: Yellow	Event Onset: Sudden	DREF Allocation: CHF 244,436	
Glide Number: -	People Affected: 347,959 people	People Targeted: 88,200 people	
Operation Start Date: 20-07-2026	Operation Timeframe: 6 months	Operation End Date: 31-01-2027	DREF Published: 22-07-2026
Targeted Regions: Manicaland, Midlands			

Description of the Event

Date of event

02-07-2026



Zimbabwe Cholera Districts

What happened, where and when?

Zimbabwe is experiencing a renewed cholera outbreak less than two years after controlling its largest cholera epidemic in more than a decade. During the previous outbreak, which occurred between February 2023 and June 2024, Zimbabwe recorded 34,549 suspected cases and 718 deaths, with transmission spreading from Chegutu District to all ten provinces and reaching its peak during June–July 2023. Following a coordinated multisectoral response, cholera cases declined, and the outbreak was officially declared over on 9 August 2024, after the last reported case was recorded on 30 June 2024. After approximately twelve months without sustained local transmission, cholera re-emerged in 2026, marking the start of a new outbreak.

The current outbreak began on 22 January 2026 in Rushinga District, Mashonaland Central Province, and has since spread to multiple geographically distinct locations across Zimbabwe. Confirmed outbreaks have been reported in Nyanga, Mutasa, Mutare City, Chipinge, and Chimanimani districts in Manicaland Province, as well as Zvishavane District in Midlands Province. The outbreak is unusual because it is occurring during the winter period (May–July 2026) where environmental survival and spread of *Vibrio cholerae* is reduced. This is outside the traditional rainy-season cholera transmission period when higher temperatures, rainfall, and flooding typically increase contamination of water sources and facilitate disease transmission. The persistence of transmission during the dry season indicates that other drivers, including population mobility, and chronic WASH services deficiencies, are sustaining the outbreak.

The emergence of winter transmission therefore represents a shift in the epidemiology of cholera in Zimbabwe. There is a high likelihood that the outbreak will persist into the next rainy season starting in the next 3 months from October, when environmental conditions become more favourable for accelerated transmission. Also, the outbreak has been affecting mainly non traditional rural hotspots, which



increases risk of transmission to neighbouring traditional major hotspots like Harare and Buhera, the major epicentre of the 2023-2024 cholera outbreak where 44 people died from about 2 223 suspected cases recorded. Historical data has shown that once an outbreak reaches major hotspots like Harare, it quickly spreads all over the country. Sporadic outbreaks may thus continue to emerge in geographically distinct districts through repeated importation of cases. This pattern has already been observed since January 2026, with outbreaks successively occurring in Rushinga, Nyanga, Zvishavane and multiple districts within Manicaland Province

In Zvishavane District, Midlands Province, the outbreak began on 9 May 2026 in a mining setting. By 28 June 2026, a total of 42 suspected cases had been reported, including 13 cases positive by Rapid Diagnostic Test (RDT) and 10 culture-confirmed cases. In Manicaland Province, the outbreak was reported from 14 June 2026, with 24 cases reported by 25 June 2026, including five culture-confirmed cases and one death. Since then, additional cases have been reported in Mutare City (4 cases), Chipinge (1 case), Chimanimani (1 case), and Mutasa (11 cases), demonstrating continued geographical expansion within the province.

The 2026 outbreak is no longer limited to isolated communities but is increasingly concentrated in high-risk, historically recurrent cholera hotspots located along population mobility corridors and border areas with Mozambique. The outbreak dynamics are strongly influenced by population movement associated with cross-border trade, artisanal mining, informal economic activities, and seasonal livelihoods. In Manicaland, epidemiological investigations indicate that transmission is particularly concentrated in the Penhalonga artisanal mining area, where 19 of 26 suspected cases (73%) are epidemiologically linked. The settlement is characterised by inadequate access to safe water, poor sanitation facilities, overcrowding, and high population mobility, creating conditions favourable for sustained cholera transmission. A case reported in Chipinge District has also been linked to cross-border transmission from Mozambique, highlighting the continued risk of disease introduction and spread through population movement.

The outbreak presents additional transmission risks due to large-scale population gatherings and mobility events. From 6 July 2026, approximately 100,000 pilgrims are attending the Marange Apostolic Faith annual regional conference in Manicaland Province. The event attracted participants from across the SADC region, including countries experiencing active cholera transmission. Increased population movement, shared accommodation, communal food preparation, and pressure on sanitation facilities during the 14-day gathering create conditions that may facilitate transmission and increase the risk of cases spreading to other districts and neighbouring countries as participants return to their communities.

Since the onset of the outbreak, the Government of Zimbabwe, through the Ministry of Health and Child Care (MoHCC) and other relevant ministries, has coordinated the national response through established emergency mechanisms, including the Public Health Emergency Operations Centre (PHEOC), Incident Management System (IMS), and provincial and district response structures. Also, MoHCC has led the response by strengthening surveillance, laboratory confirmation, case management, IPC, water quality monitoring, and risk communication. However, the continued spread of the outbreak into mining, border and rural communities has exposed gaps in rapid response capacity. Through this DREF operation, the ZRCS will complement Government efforts by training and deploying trained volunteers to strengthen community surveillance, early case detection and referral, hygiene promotion, household water treatment, RC-CATI, and community engagement in the affected districts.

Through the Cholera Simplified Early Action Protocol (sEAP), the Zimbabwe Red Cross Society (ZRCS) activated early action following the outbreak in Rushinga on 10 February 2026, enabling volunteer training, prepositioning of emergency supplies, and initial community preparedness activities. While these early actions were effective in reducing immediate risks and strengthening preparedness, they were not sufficient to interrupt transmission or prevent the geographical expansion of the outbreak. Population mobility has been one of the principal factors limiting the effectiveness of localized control measures. Epidemiological investigations indicate that the outbreak is being sustained by continuous movement of artisanal miners, informal traders, transport operators, seasonal agricultural workers and cross-border travellers between Zimbabwe and Mozambique. In Penhalonga and Zvishavane, miners frequently move between mining sites and their home communities, while informal trading networks connect affected communities with neighbouring districts and provinces.

This high level of mobility allows new infections to be introduced into previously unaffected communities faster than localized interventions can interrupt transmission. Consequently, while RC-CATI and household-level interventions successfully reduced transmission around identified cases, they could not prevent repeated reintroduction of cholera into other high-risk communities through population movement. Subsequent outbreaks in Nyanga, Zvishavane, and Manicaland emerged beyond the anticipated geographical scope and capacity of the cholera sEAP. The expansion of transmission into additional high-risk districts, particularly mining and border communities, demonstrates the evolving nature of the outbreak and the need for scaled-up response capacity to support government efforts in containing further spread. The MoHCC requested the ZRCS in its uxilliary function, to support govenment-led response to the cholera outbreak (see ANNEX 1 attached).





Penhalonga artisanal mining context



Delivery of Hygiene kits in Penhalonga



Field assessment in Penhalonga artisanal mine

Scope and Scale

The current cholera outbreak is affecting multiple high-risk districts in Manicaland and Midlands Provinces, with active transmission reported in Mutasa, Mutare City, Chipinge, Chimanimani and Zvishavane. In Manicaland, the outbreak is concentrated in Penhalonga artisanal mining communities and border areas with Mozambique, while in Midlands transmission is centred in Zvishavane mining communities. These areas are characterised by inadequate water and sanitation services, overcrowding and high population mobility, which increase the risk of sustained transmission and geographical spread. Although the number of confirmed cases remains relatively low, the continued occurrence of epidemiologically linked cases across multiple districts indicates ongoing community transmission that requires an immediate scale-up of community-based interventions.

The cholera outbreak is currently affecting six districts across Manicaland and Midlands Provinces, with a cumulative 66 suspected cases reported to date. Zvishavane District in Midlands Province remains the most affected district, accounting for 42 suspected cases, including 15 RDT-positive cases and 10 culture-confirmed cases. In Manicaland Province, a cumulative 24 suspected cases have been reported across Mutasa (Penhalonga) (11), Mutare City (6), Mutare Rural (4), Chipinge (2), and Chimanimani (1), with 19 RDT-positive cases, 15 culture-confirmed cases, and one reported death (CFR: 1.6%). The concentration of cases in Penhalonga, an artisanal mining settlement, together with ongoing transmission in Zvishavane, demonstrates that mining communities remain the principal hotspots of the outbreak. In Manicaland, for example, analysis of the available line list shows that females account for the majority of reported cholera cases, representing 13 of the 21 cases (62%), while males account for 8 cases (38%). The age distribution indicates that the outbreak is predominantly affecting economically active adults. The 20–30 years and 31–40 years age groups each reported 6 cases (28.6%), together accounting for 12 of the 21 cases (57.1%). This is consistent with epidemiological investigations linking transmission to artisanal mining communities, where the workforce largely comprises young and middle-aged adults engaged in mining, trading and transport activities that involve frequent movement.

While WHO classifies Zimbabwe's cholera situation as being in the "readiness" phase, the continued detection of epidemiologically linked cases across multiple districts indicates sustained community transmission rather than isolated importations. As such, the cholera situation is beyond the scope of preparedness hence the move to response. The request by the MoHCC ZRCS demonstrates that the geographical expansion of the outbreak and increasing operational demands have exceeded available preparedness capacities. The outbreak is being driven by high population mobility associated with artisanal mining, cross-border movement with Mozambique, and informal trade, coupled with inadequate access to safe water, sanitation and hygiene (WASH) services. These factors increase the risk of further escalation to neighbouring districts and provinces, particularly as movement between mining communities and surrounding rural and urban areas continues.

The outbreak is expected to have significant impacts on lives, livelihoods, health and community well-being. Cholera can cause severe dehydration and death within hours if treatment is delayed, particularly among vulnerable populations. Beyond its direct health effects, the outbreak is likely to reduce household incomes as sick individuals are unable to work, disrupt artisanal mining and informal trading activities, increase household expenditure on healthcare and transport, and place additional pressure on already overstretched health system. Fear of infection may also reduce market activity, restrict population movement and interrupt access to essential health, education and social services.

The proposed operation will target 88,200 (approximately 17,640 households) living in the highest-risk cholera hotspots, including Zvishavane, Mutare-Sakubva, Penhalonga, Chipinge Town, Chimanimani Town, and Marange Wards in Mutare Rural. These areas have

been prioritised using Ministry of Health and Child Care surveillance data, PAMIS cholera hotspot mapping, and population estimates based on the 2022 population census. The target population includes households surrounding confirmed cholera cases, communities sharing contaminated water sources, artisanal mining settlements, high-density residential areas, schools, markets, transport hubs, and health facility catchment populations where the risk of transmission is highest. The intervention will follow the Red Cross Case Area Targeted Intervention (RC-CATI) approach, which extends preventive measures beyond affected households to neighbouring households and shared exposure sites to rapidly interrupt transmission.

Women and girls are particularly vulnerable because they are primarily responsible for collecting water, caring for sick family members and maintaining household hygiene, increasing their exposure to infection. Children under five years of age are at heightened risk of severe dehydration and death due to their lower body fluid reserves, while pregnant and lactating women, older persons, people living with disabilities and individuals with chronic illnesses often face additional immunity challenges. Urban, peri-urban and informal settlements are disproportionately affected because they are undeserved and frequently experience interrupted water supplies, poor sanitation infrastructure, and low coverage in healthcare services, increasing delays in diagnosis and treatment.

Historical experience demonstrates the potential severe consequences if outbreaks are not rapidly contained. Zimbabwe's 2008–2009 cholera epidemic resulted in more than 98,000 reported cases and over 4,000 deaths, while the 2023–2024 outbreak recorded 34,549 suspected cases and 718 deaths, spreading from Chegutu to all ten provinces. These outbreaks caused widespread illness and loss of life, disrupted livelihoods, education and essential services, overwhelmed health facilities, and imposed substantial economic costs on households and government. Manicaland has consistently been identified as one of Zimbabwe's highest-risk provinces because of its extensive cross-border movement with Mozambique, artisanal mining settlements and chronic WASH deficiencies. The current outbreak is following similar transmission pathways but with the additional concern of sustained winter transmission, reinforcing the need for immediate, targeted interventions to interrupt transmission before the onset of the rainy season accelerates disease spread.

Source Name	Source Link
1. Manicaland cholera situation as of 30 June 2026	https://1drv.ms/b/c/26fbe9cf42503b18/IQDupCcxCd2RS5IG8P60k7RrAZnRSI2Zxy-HTnA_vE09Moc?e=sro2lB
2. Zimbabwe Cholera SitRep 01/07/2026	https://1drv.ms/b/c/26fbe9cf42503b18/IQCODPUljON8TJJlE-84de5oAc6KoPA1KskpcLU1dCxjiFo?e=ekaTNm

Previous Operations

Has a similar event affected the same area(s) in the last 3 years?	Yes
Did it affect the same population group?	Yes
Did the National Society respond?	Yes
Did the National Society request funding form DREF for that event(s)	No
If yes, please specify which operation	-

If you have answered yes to all questions above, justify why the use of DREF for a recurrent event, or how this event should not be considered recurrent:

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Lessons learned:

The proposed operation builds on key lessons from the previous ECHO-supported cholera response (Strategy for Cholera Risk Elimination and Mitigation phase I and II projects), which demonstrated that rapid deployment of response activities is critical to interrupt transmission before outbreaks escalate. Delays in mobilising volunteers, supplies and operational resources were found to increase the risk of widespread community transmission. Consequently, this DREF operation prioritises a short turnaround time by leveraging anticipatory action measures, including the pre-positioning of non-food items (NFIs), Oral Rehydration Point (ORP) kits, volunteer training and preparedness planning in cholera-prone areas. These measures will enable immediate implementation of early actions once transmission is detected, reducing morbidity and preventing further spread.

Experience from previous responses also highlighted the importance of recruiting and deploying local volunteers who are trusted members of communities, particularly within drug-hesitant religious groups. Volunteers who share the same beliefs, language and social networks were significantly more effective in promoting health-seeking behaviour, facilitating referrals and encouraging the adoption of cholera prevention practices. The current operation will therefore prioritise the engagement of community-based volunteers, while strengthening collaboration with traditional leaders, religious leaders and other influential community figures to address misinformation, improve risk communication and encourage behaviour change among high-risk populations. Another key lesson was that the Red Cross Case Area Targeted Intervention (RC-CATI) approach proved highly effective in rapidly containing cholera transmission. Areas where RC-CATI teams were promptly deployed experienced marked reductions in reported cases, demonstrating that geographically targeted interventions are more efficient than blanket approaches. Accordingly, this operation will focus RC-CATI activities around reported cases and identified transmission hotspots through active case finding, contact tracing, household visits, hygiene promotion, water treatment promotion and community surveillance to rapidly interrupt chains of transmission.

The previous operation further highlighted the importance of cross-border collaboration in managing population movement and reducing the risk of cross-border transmission. The current operation will therefore strengthen coordination with neighbouring Red Cross National Societies and Government Ministries like the Ministries of Health to enhance information sharing, harmonise surveillance and risk communication, and coordinate preparedness and response activities in border communities. This approach is particularly relevant given the continued movement of populations across borders and the risk of importing or exporting cholera cases.

Lessons learned from the implementation of the Cholera sEAP will be systematically captured through the planned cholera SEAP Lessons Learned exercise in August 2026, followed by an operational review focusing on the anticipatory action component. The findings from the initial months of ZRCS intervention, including the effectiveness of RC-CATI deployment, community engagement approaches, coordination mechanisms, operational challenges, and factors influencing transmission dynamics, will be documented and used to inform the implementation of the cholera DREF. Key recommendations will be incorporated through adaptive management processes.

Did you complete the Child Safeguarding Risk Analysis in previous operations, what was risk level?

Yes

Current National Society Actions

Start date of National Society actions

29-06-2026

Health

Since receiving outbreak alerts in Penhalonga, Mutare City, and Zvishavane, the ZRCS conducted rapid needs assessment. Based on needs, the ZRCS rapidly reoriented and deployed 96 RC-CATI volunteers to support community-based cholera response activities. Volunteers are conducting door-to-door hygiene promotion and risk communication and community engagement (RCCE) activities to improve awareness and encourage adoption of protective hygiene behaviours. They are also distributing household water treatment products, promoting safe water practices, and supporting early identification and referral of suspected cases to health facilities. In addition, ZRCS is actively participating in coordination meetings with the MoHCC and other



	stakeholders to strengthen collaboration, share response updates, identify emerging needs, and ensure alignment of interventions with the wider cholera response. If the DREF application is approved, ZRCS will enable the scale-up of the already ongoing activities.
Coordination	The ZRCS participated in an Emergency Strategic Advisory Group (ESAG) meeting convened by the Department of WASH to receive updates on the cholera situation and to share priority response actions and plans. During the meeting, Government highlighted the severity of the outbreak in Manicaland Province and urged partners to prioritise the area with urgent WASH and health interventions to contain further spread. It was noted that ZRCS was the only organisation that immediately indicated its intention to deploy to the field to initiate response activities.
Assessment	The ZRCS engaged the MoHCC in Manicaland province to assess the situation in the affected districts prioritising districts which have recorded positive and suspected cases that include Mutare city, Penhalonga (Mutasa) and Mutare rural. The rapid assessment led to joint development of a response plan drawing from the gaps and priority needs of the districts. The MoHCC recommended the following immediate actions: • Refresher volunteer training and mentorship in preparation for RC-CATI deployment. • Refresher training and mentorship of healthcare staff to improve case management, community surveillance, and contact tracing • Procurement and installation of two 5,000-litre water storage tanks in Penhalonga. • Daily water trucking to affected artisanal mining communities. • Establishment and operationalization of 2 Oral Rehydration Points in Penhalonga. • Distribution of hygiene kits and non-food items to food vendors to promote safe food preparation, handling and handwashing with soap. • Provision of aquatabs for point of use water treatment. • Installation of strategic handwashing stations at health facilities, schools and public places. • Support for temporary sanitation facilities in Penhalonga artisanal mining settlement. • Door to door hygiene promotion and risk communication in communities and villages that have recorded suspected cholera cases and those surrounding • Active case finding, contact tracing and household surveillance. • Strengthening community-based disease surveillance working with local leaders and volunteers. • Provision of IPC materials, PPE and disinfectants in CTCs. • Increased water quality monitoring and testing in Penhalonga. • Refresher training and mentorship for health workers to improve case management

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC has an in-country presence in Zimbabwe and has been providing strategic, technical, and operational support to the ZRCS since the escalation of the cholera outbreak. Upon notification of the evolving emergency, the IFRC Country Delegation, together with the IFRC Africa Regional Office and Headquarters, convened a coordination meeting with ZRCS to review the implementation status of the Cholera Seasonal Emergency Action Plan (SEAP) and assess the rapidly evolving outbreak situation, particularly in Zvishavane and Manicaland provinces. Based on the assessment, IFRC advised ZRCS to immediately utilise available resources under the SEAP to initiate life-saving response activities in Manicaland while
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	simultaneously preparing a DREF application to scale up operations. This guidance enabled the National Society to make timely operational decisions, including the rapid deployment of surge personnel to the affected areas and the prepositioning of emergency supplies. Throughout the response, the IFRC has continued to provide Secretariat support through strategic coordination, operational planning, PMER guidance, finance and administrative oversight, logistics support for the mobilisation of relief items, National Society Development (NSD) support, and technical assistance in health, WASH, and emergency operations to ensure the response is timely, coordinated, and aligned with IFRC standards.
Participating National Societies	The Finnish Red Cross is the primary Participating National Society (PNS) supporting this operation in Zimbabwe. Through the Integrated Strategy for Cholera Risk Elimination and Mitigation (ISCREM) Phase II project, which builds on Phase I supported by ECHO, the Finnish Red Cross has supported cholera preparedness in Manicaland Province, particularly in Mutare Rural, Mutare City, and Buhera District. Preparedness activities included the prepositioning of one Oral Rehydration Point (ORP) kit and capacity building for 360 Zimbabwe Red Cross volunteers and 90 healthcare workers on Red Cross Case Area Targeted Interventions (RC-CATI). The trained volunteers are being mobilised for immediate deployment in the field. Following the escalation of the outbreak in Manicaland, the Finnish Red Cross approved approximately USD 10,000 under the ISCREM project to support the early response. These funds are being used to enable the rapid deployment of volunteers, establishment of ORPs, and implementation of community-based cholera control interventions, complementing the broader response being coordinated by the Zimbabwe Red Cross Society and IFRC.

ICRC Actions Related To The Current Event

ICRC is not in country and has not directly supported the response, but they have an RFL programming in Beitbridge which could assist should there be need for retracing initiatives.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	Since the confirmation of the cholera outbreak in Manicaland Province, the MoHCC has led a multisectoral response through the Public Health Emergency Operations Centre (PHEOC), Provincial and District Rapid Response Teams (RRTs), and the District Civic Protection Committee. Rapid response teams were deployed to Penhalonga to support outbreak investigations, coordinate field operations, and strengthen logistical support in the affected districts. The Provincial RRT provided technical support to district teams, while the District Civic Protection Committee convened coordination meetings to review the evolving outbreak and guide response priorities. Government health authorities intensified surveillance through active case finding, contact tracing, and monitoring of contacts, while laboratory testing was strengthened to confirm suspected cases. Case management services were enhanced through the establishment of Cholera Treatment Centre in Penhalonga and Marange Hospital to

	ensure timely treatment of severe and suspected cases. In response to the high-risk mining communities in Penhalonga, health authorities conducted rapid field assessments to identify priority interventions, including suitable locations for additional ORPs and emergency water supply. Risk communication and community engagement activities were intensified through community sensitisation of artisanal miners, engagement with mines leadership. However, the MoHCC expressed overwhelming shortage of resources to fully contain the outbreak on its own.
UN or other actors	Following the cholera outbreak in Manicaland, the response has been coordinated by the MoHCC, with partners participating in coordination meetings at provincial and district levels. Mercy Corps has indicated that it has non-food items (NFIs), including essential hygiene supplies, available for distribution to affected and at-risk communities. However, according to the MoHCC, the Zimbabwe Red Cross Society (ZRCS) is currently the only humanitarian partner with an active operational presence on the ground supporting the response

Are there major coordination mechanism in place?

Zimbabwe has an established multi-sectoral cholera preparedness and response coordination mechanism led by the Ministry of Health and Child Care (MoHCC) through the Public Health Emergency Operations Centre (PHEOC) and the National Incident Management System (IMS). The IMS provides overall leadership and coordination across national, provincial, district and community levels, ensuring harmonised implementation by government and humanitarian partners. As a member, the Zimbabwe Red Cross Society (ZRCS) attend PHEOC meetings to provide updates on preparedness and response activities.

At national level, operation of agencies is coordinated through the Emergency Strategic Advisory Group (ESAG), comprising MoHCC, Civil Protection Department, WHO, UNICEF and partners, to provide strategic oversight. ZRCS participates in ESAG and technical coordination meetings, contributing operational updates and aligning response activities with national priorities. At provincial level, Provincial Rapid Response Teams (PRRTs), led by the Provincial Medical Director, coordinate outbreak investigation, surveillance, case management and supervision of district response. ZRCS will participate in provincial meetings, providing operational updates on preparedness and response actions.

At district level, District Rapid Response Teams (DRRTs) lead case detection, contact tracing, laboratory confirmation and establishment of treatment CTCs and ORPs in communities. The District Civil Protection Committee (CPC), chaired by the District Development Coordinator, provides broader multi-sectoral coordination. ZRCS, as a CPC member, will support contingency planning, preparedness activities, simulation exercises and pre-positioning of supplies in high-risk areas.

Needs assessment observed that Emergency Preparedness and Response (EPR) plans exist at health facility level, but are often not fully operational due to limited updating, weak prepositioning of supplies and insufficient resources. Where activated, EPR plans support IPC strengthening, surveillance reporting and establishment of cholera treatment services, in close coordination with DRRTs.

Community coordination is led by MoHCC through environmental health officers, nurses and Village Health Workers, working with local authorities and partners. RCCE relies on traditional leaders, councillors, church leaders and community volunteer. However, field needs assessments in Manicaland indicate inconsistent engagement, particularly in rural areas such as Mutare. In several districts, cholera case definitions were not consistently displayed, limiting community awareness and early detection. Although coordination structures remain functional and active in Manicaland, the project will support strengthening of district and sub-district coordination, including regular meetings and improved operational follow-up. ZRCS will support volunteer deployment, hygiene promotion, household water treatment and case management in affected districts.

Cholera cases in Chipinge are epidemiologically linked to cross-border transmission with Mozambique, highlighting the need to strengthen surveillance and coordination at both formal and informal points of entry and along the border. While a cross-border WhatsApp platform exists for sharing alerts and SitReps between Zimbabwe and Mozambique, it remains informal and limited in scope. There are currently no formal joint cross-border cholera response operations. Strengthening structured cross-border coordination, joint surveillance and harmonised response activities is therefore critical to reduce further spread.

Needs (Gaps) Identified



Health

The current cholera outbreak has exposed critical gaps in health system preparedness and response capacity at both health facility and community levels. While the MoHCC has activated cholera response mechanisms, the rapid expansion of the outbreak into new districts has overwhelmed available resources, particularly in high-risk transmission areas such as Penhalonga, Marange and Mutare City. Immediate support is required to strengthen case management capacity, improve infection prevention and control (IPC), and enhance community-level case management to reduce cholera morbidity and mortality.

At the health facility level, cholera case management is constrained by shortages of essential medical supplies and equipment. Health facilities report inadequate stocks of Oral Rehydration Salts (ORS), intravenous fluids, cholera beds, personal protective equipment (PPE), disinfectants, chlorine products, IPC consumables, and other critical supplies required for effective case management. Existing supplies are insufficient to meet increased demand during peak outbreak, limiting the ability of facilities to provide timely and quality care and increasing the risk of severe dehydration, complications and preventable deaths.

Human resource capacity is also inadequate. Assessment findings indicate that healthcare workers from eight health facilities serving the Penhalonga catchment area have not received formal training in cholera case management. Several frontline health workers reported lacking confidence in managing cholera patients, noting that they had never previously managed a cholera outbreak, while others are newly recruited staff with limited emergency response experience. This skills gap affects adherence to standardised cholera treatment protocols, IPC practices, and patient management, highlighting the urgent need for refresher training, mentorship and supportive supervision.

At the community level, early detection and management of cholera cases need strengthening. In Penhalonga, only five Village Health Workers (VHWs) have received a one-day orientation by the MoHCC, which provided limited theoretical knowledge and practical skills on Case Area Targeted Interventions (CATI), Oral Rehydration Point (ORP) management, referral pathways and community surveillance. This limited capacity reduces the effectiveness of community-based early response and delays referral of suspected cases to health facilities.

Although twelve Oral Rehydration Points (ORPs) have been established by the MoHCC in Penhalonga, these are largely managed by food vendors or food handlers rather than trained community volunteers. There are only 5 trained community health workers in Penhalonga. The ORPs consist mainly of basic buckets fitted with taps for handwashing, water storage containers and limited supplies of ORS. They lack essential equipment, PPE, IPC materials and standardized operating procedures required for safe cholera management. There are 200 food handlers in Penhalonga. Food vendors face competing responsibilities between operating their businesses and providing ORS to suspected cholera patients, reducing the effectiveness and reliability of the ORPs. In addition, food safety and hygiene standards are inadequately observed within the densely populated artisanal mining communities, further increasing the risk of ongoing transmission. The food vendors currently managing the ORPs will be integrated into the training and field deployment of Red Cross RC-CATI volunteers. This approach will promote cross-learning, strengthen collaboration, and ensure a common understanding of cholera prevention, case identification, referral pathways, and community engagement.

Community volunteers also lack the minimum resources required to support cholera prevention and response. Hygiene kits comprising buckets with taps, jerry cans, handwashing soap, detergent, aquatabs and other household water treatment supplies are unavailable, limiting household-level infection prevention and safe water practices. Strengthening community case management, equipping and training community volunteers, improving ORP functionality, and ensuring adequate medical and IPC supplies at health facilities are therefore critical priorities to interrupt transmission and reduce cholera-related morbidity and mortality.



Water, Sanitation And Hygiene

The cholera outbreak continues to be driven by critical water, sanitation and hygiene (WASH) deficiencies across affected districts. Limited access to safe water, poor sanitation coverage, inadequate water quality monitoring and weak household hygiene practices are sustaining transmission, particularly in high-risk communities such as Penhalonga in Mutare District. These conditions require urgent investment in emergency WASH interventions alongside longer-term community engagement to reduce cholera risk.

Access to safe water remains a major challenge at both community and health facility levels. In Mutare District, one of the outbreak hotspots, access to improved sanitation is estimated at 39%, characterised by widespread open defecation, while access to safe water is only 67%. In Penhalonga, with an estimated population of approximately 8,000 people, there is currently no reliable source of safe

drinking water. Municipal piped water supplies were disconnected because of non-payment, while sections of the water distribution network have reportedly been damaged by artisanal mining activities. Groundwater sources are unsuitable for consumption due to contamination from gold-processing chemicals such as mercury and cyanide, as well as faecal contamination resulting from open defecation. Reports indicate that some artisanal miners defecate inside underground mine shafts and consume water from the same environment, significantly increasing the risk of faecal-oral disease transmission. Immediate solutions include emergency water trucking, installation of large water storage reservoirs, and restoration of the municipal piped water supply.

Water shortages are also affecting health service delivery. At Zvipiripiri Clinic, the solar-powered water system has been non-functional for more than two weeks following damage to the pump control box, leaving the facility without a reliable water supply. As a result, a patient with severe diarrhoea and vomiting could not be admitted on 30 June 2026 and had to be referred approximately 20 km to Marange Hospital, where she arrived in a severe dehydrated state, increasing delays in treatment and the potential risk of disease transmission during transport. Healthcare workers are currently relying on water obtained from a nearby private household, compromising infection prevention and control (IPC) measures and the safe management of suspected cholera cases.

Household water treatment practices remain very limited, while routine water quality surveillance is constrained by shortages of laboratory reagents and mobile water testing kits. This limits the ability of health and WASH authorities to monitor water safety, identify contaminated sources and implement timely corrective actions. At the household level, access to essential hygiene items is also inadequate, reducing communities' ability to safely store, treat and use water.

Sanitation remains another major driver of transmission. Low sanitation coverage and widespread open defecation continue to contaminate the environment and water sources, particularly in informal settlements and artisanal mining communities. Increasing sanitation coverage will require intensified community engagement, sanitation marketing and behaviour change interventions to motivate and support households to construct and consistently use improved toilets. Strengthening hygiene promotion, and expanding access to safe water, are therefore priority WASH interventions required to interrupt cholera transmission.



Community Engagement And Accountability

Community engagement and accountability remain insufficient to support effective cholera prevention and control in the affected districts. Field assessments found limited community dialogue sessions, inadequate engagement with traditional, religious and community leaders, and a lack of school-based cholera awareness activities to reinforce prevention behaviours. These gaps are particularly critical in Marange ahead of the July 2026 Apostolic gathering, where large numbers of pilgrims from cholera-affected neighbouring countries are expected.

In addition, shortages of Information, Education and Communication (IEC) materials, weak risk communication targeting mobile mining communities and religious groups, and limited mechanisms for collecting and responding to community feedback have reduced the effectiveness of behaviour change interventions. Strengthening trusted community engagement platforms, faith-based engagement, school outreach, rumour management and two-way communication will be essential to improve early health-seeking behaviour, counter misinformation and reduce the risk of widespread cholera transmission during and after the mass gathering.

Any identified gaps/limitations in the assessment

The assessment identified significant unmet needs across health, WASH, Protection, Gender and Inclusion (PGI), and Community Engagement and Accountability (CEA). Health facilities face shortages of essential cholera treatment supplies, including ORS, intravenous fluids, PPE, chlorine products, disinfectants, cholera beds, and IPC materials. Human resource capacity is also limited, with many healthcare workers and community volunteers lacking adequate training in cholera case management, RC-CATI, surveillance, and ORP management. Community-based response is further constrained by inadequately equipped ORPs and a lack of hygiene kits and household water treatment supplies.

Critical WASH gaps continue to drive transmission. Access to safe water remains inadequate in hotspot areas such as Penhalonga due to damaged water infrastructure, contaminated groundwater, and low sanitation coverage characterised by widespread open defecation. Water shortages at health facilities compromise infection prevention and case management, while limited laboratory reagents and water quality testing kits reduce the capacity to monitor water safety and respond to contamination.

The response is further limited by resource and operational constraints, including inadequate funding, shortages of fuel and airtime for surveillance, active case finding and contact tracing, insufficient IEC materials, and limited PHHE tools. Weak communication channels reduce the ability to reach mobile artisanal mining communities and remote populations with timely risk communication and behaviour change messages, while inadequate handwashing facilities increase the risk of continued transmission.

Assessment findings also highlighted important coordination and community engagement gaps. Limited community dialogue sessions, insufficient engagement with traditional and religious leaders, weak community feedback mechanisms, and inadequate coordination meetings have reduced the effectiveness of risk communication and community ownership of the response. These gaps are particularly concerning ahead of the large Apostolic gathering in Marange, where thousands of pilgrims are expected from cholera-affected neighbouring countries.

Several vulnerable groups require additional attention, including artisanal miners, food vendors, residents of informal settlements, women, children, older persons, persons with disabilities, and members of the Apostolic sect in Marange, where low health-seeking behaviour and vaccine and treatment hesitancy increase the risk of delayed case detection and ongoing transmission. The outbreak disproportionately affects vulnerable groups, including women and girls, who face increased exposure through caregiving, food preparation, and water collection. Women and girls often face higher exposure because they are typically responsible for water collection, food preparation, and caregiving for sick family members. Children, particularly those who are unaccompanied, street-connected, or out of school. Persons with disabilities face communication barriers and that they often remain invisible in assessments and response planning.

Also, people with chronic illnesses, who are at greater risk of severe outcomes. Children also face heightened protection risks, including caregiver illness or loss, disrupted education, increased caregiving responsibilities, and psychosocial distress. These vulnerabilities highlight the need for an inclusive response that ensures equitable access to information, services, referrals, and community-based support for all at-risk populations. Current response efforts have limited capacity to provide appropriate and inclusive services for these high-risk populations.

[Assessment Report](#)

Operational Strategy

Overall objective of the operation

To reduce cholera transmission and prevent cholera-related deaths among 88200 people in affected and high-risk communities in Manicaland and Midlands Province through timely and coordinated health, WASH, and community engagement interventions that support outbreak containment and promote sustained cholera prevention practices.

Operation strategy rationale

To address the needs of the targeted population, this DREF operation will support an integrated, community-centred cholera response aimed at interrupting transmission, reducing cholera-related morbidity and mortality, and preventing further geographical spread of the outbreak in Manicaland and Midlands provinces. ZRCS will adopt a hybrid and integrated implementation strategy that combines Health, Water, Sanitation and Hygiene (WASH), Protection, Gender and Inclusion (PGI), and Community Engagement and Accountability (CEA) throughout the operation. The proposed operation will target 88,200 people (approximately 17640 households) living in the highest-risk cholera hotspots, including Zvishavane (32,500 people), Mutare-Sakubva (50,700), Penhalonga (5,000). These areas have been prioritised using MoHCC surveillance data, PAMIS cholera hotspot mapping, and population estimates based on the 2022 population census.

Rather than implementing these sectors as separate activities, volunteers will be trained and deployed to deliver integrated interventions at household and community level, ensuring communities receive coordinated, people-centred support that addresses the multiple drivers of cholera transmission. A hybrid approach will be used for volunteer capacity strengthening, combining theory-based training with practical field exercises, mentoring, on-the-job coaching, and digital communication platforms where feasible. This approach enables rapid deployment of volunteers while reinforcing learning through supervised field implementation. Refresher sessions and regular debriefings will be conducted throughout the operation to address emerging challenges, share lessons learned, and adapt interventions as the epidemiological situation evolves.

The operation will utilize the Red Cross Case Area Targeted Intervention (RC-CATI) approach as the primary community response model. Volunteers will conduct household visits around confirmed and suspected cholera cases, integrating health promotion, hygiene education, community surveillance, and referral into a single household interaction. This integrated approach maximizes the impact of each household visit, minimizes community fatigue from multiple visits by different teams, and improves operational efficiency.

MoHCC in Manicaland and Zvishavane reported that all confirmed and suspected cholera cases were identified through passive surveillance, with patients presenting themselves at health facilities after developing symptoms. This suggests that the current case counts



may underestimate the true extent of transmission, as individuals with mild symptoms, limited access to healthcare, or those reluctant to seek treatment may remain undetected within the community. The absence of active community case finding increases the risk of silent transmission, delayed treatment, continued environmental contamination, and further spread of cholera to neighbouring households and communities. Strengthening community-based surveillance through trained community volunteers will therefore be critical to support early identification and referral of suspected cases, timely reporting of alerts, and rapid implementation of RC-CATI to interrupt transmission before the outbreak escalates.

Health interventions will focus on strengthening community-based surveillance, early detection and referral of suspected cholera cases, promotion of prompt health-seeking behaviour, support to Oral Rehydration Points (ORPs) when deployed, dissemination of cholera prevention messages, and monitoring of community transmission. Volunteers will reinforce recognition of cholera danger signs, demonstrate preparation and use of Oral Rehydration Solution (ORS), hand hygiene and facilitate rapid referral of suspected cases to designated health facilities.

WASH interventions will be delivered simultaneously during household visits. These will include promoting and demonstration of household water treatment using aquatabs or other approved disinfectants, promotion of safe water storage, handwashing with soap at critical times, food hygiene, environmental sanitation, cleaning and disinfection of households where cholera cases have been identified, and identification of unsafe water sources requiring further technical intervention. Volunteers will also conduct simple sanitary surveys/observations and report WASH risks to relevant authorities for follow-up. Contaminated communal water points identified during assessments shall be targeted for chlorination at source through installation of inline chlorinators to ensure access to safe drinking water.

To strengthen health facility technical capacity, healthcare staff will be oriented in cholera case management targeting new staff. Zimbabwe's health sector continues to experience a high turnover of healthcare workers due to migration, hence several recruitment of newly qualified graduates. As a result, many frontline staff currently deployed in health facilities have limited or no practical experience in cholera detection, clinical management, IPC, case reporting, and outbreak response. Reorientation training is therefore essential to build and standardize the technical competencies of these new staff, ensuring they can rapidly identify suspected cases, provide appropriate treatment according to national and WHO guidelines, and implement IPC measures to prevent healthcare-associated transmission. Strengthening the capacity of health facility staff will not only improve the quality of case management but will strengthen support and supervision of volunteers in the field.

Protection, Gender and Inclusion (PGI) considerations will be mainstreamed across all activities to ensure that assistance is safe, dignified, accessible and responsive to the needs of different population groups. Volunteers will be trained to identify and address barriers faced by women, children, older persons, persons with disabilities, people living with chronic illnesses, and other vulnerable groups. Household visits and community engagement activities will be designed to ensure equitable participation, confidentiality, respect for cultural practices, and protection from stigma and discrimination associated with cholera. Referral pathways for protection concerns identified during community activities will be strengthened in collaboration with local authorities and other sector service providers.

Community Engagement and Accountability (CEA) will underpin the entire operation by placing affected communities at the centre of decision-making and response implementation. Rather than relying solely on one-way health messaging, volunteers will facilitate two-way dialogue with community members to understand local perceptions, rumours, concerns and barriers to adopting preventive behaviours. Community feedback will be systematically collected through household visits, perception surveys, community meetings, suggestion boxes where appropriate, and engagement with community leaders. Feedback and rumours will be analysed regularly and used to adapt risk communication messages and operational strategies throughout the response. This continuous feedback loop will strengthen community trust, improve acceptance of interventions, and promote community ownership of cholera prevention activities.

The integrated strategy also recognizes that cholera transmission is influenced by multiple social and environmental factors. Consequently, volunteers will promote behaviours that simultaneously improve health outcomes, reduce WASH risks, strengthen community resilience, and encourage timely health-seeking practices.

The ZRCS will implement the operation in close coordination with the MoHCC, which is leading the national cholera response through the Public Health Emergency Operations Centre (PHEOC), and provincial and district response structures. Coordination with the MoHCC, local authorities, Environmental Health Technicians, community leaders and other humanitarian partners will ensure consistent messaging and avoid duplication of activities. At national, provincial and district levels, ZRCS will actively participate in health, WASH, Risk Communication and Community Engagement (RCCE), and Emergency Services Action Group (ESAG) coordination meetings to ensure that interventions are aligned with national priorities, avoid duplication, and complement government and partner efforts. RCS will work closely with District Health Executives, Environmental Health Officers, Health Promotion Officers, and local authorities to jointly plan and implement community-based surveillance, RC-CATI, risk communication, hygiene promotion, household water treatment, and referral of suspected cases. Coordination will also be maintained with UN agencies, the International Federation of Red Cross and Red Crescent Societies (IFRC), Partner National Societies, non-governmental organizations, and community-based organizations supporting the cholera response to facilitate information sharing, harmonization of technical approaches, joint monitoring, and efficient use of resources. Regular sharing of surveillance data, operational updates, community feedback, and lessons learned will enable evidence-based decision-making and adaptive management throughout the operation while strengthening the collective effectiveness of the national cholera response.



By integrating Health, WASH, PGI and CEA into every stage of volunteer training and community implementation, the operation will maximize the effectiveness of limited resources, strengthen community trust and participation, improve early detection of cases, reduce transmission risks, and build sustainable community capacity for cholera preparedness and response beyond the lifetime of the DREF operation.

DREF activities will build on achievements and lessons from the ongoing Cholera Simplified Early Action Protocol (SEAP). The ZRCS activated its Cholera Simplified Early Action Protocol (sEAP) to implement anticipatory and early action measures, including hotspot mapping, prepositioning of cholera response supplies, RC-CATI preparedness, volunteer training and reorientation, and coordination with the MoHCC. These investments have significantly strengthened the National Society's readiness and enabled the rapid deployment of trained volunteers and response teams following the emergence of outbreaks in Rushinga and Nyanga. The proposed DREF operation therefore builds directly on the foundations established through the sEAP by scaling up RC-CATI activities in the newly affected hotspots of Mutare city, Penhalonga and Zvishavane. While the sEAP remains active until August 2026, the remaining activities will focus primarily on sustaining preparedness functions, coordination, and monitoring, complementing the DREF's expanded response interventions. Recognising that cholera transmission may continue beyond the DREF implementation period, the operation is designed to strengthen sustainable community and institutional capacities through trained volunteers, improved household water treatment practices, hygiene behaviours, and enhanced coordination with the MoHCC and local authorities. An exit strategy will be implemented through the gradual integration of surveillance, RC-CATI, and RCCE activities into routine MoHCC programming and government-led cholera preparedness and response systems, ensuring that gains achieved through the cholera SEAP and DREF are sustained beyond the operation while supporting a seamless transition to longer-term preparedness and resilience interventions if transmission persists.

The operation strategy is organised around five mutually reinforcing pillars of Health; WASH in emergencies; Protection, Gender and Inclusion; Community engagement and accountability, coordination, monitoring, evaluation and learning, as described below.

1. Health

In collaboration with the MoHCC, ZRCS will strengthen community-based cholera prevention, surveillance and early response through its trained volunteer network using the Red Cross Case Area Targeted Interventions (RC-CATI) approach and national cholera guidelines. Volunteers will receive refresher training on community cholera case definitions, community-based surveillance, Case Area Targeted Interventions (CATI), infection prevention and control (IPC), oral rehydration therapy, safe referral pathways and risk communication. Special emphasis will be placed on ensuring CATI is initiated within 48 hours of case notification to rapidly interrupt household and community transmission.

Through RC-CATI, ZRCS volunteers will conduct active case finding, household follow-up, health education and deploy Oral Rehydration Points (ORPs) where needed and referrals when cases continue to rise as guided by the MoHCC. The operation will strengthen community-level oral rehydration by training community volunteers, providing essential supplies and standard operating procedures, and improving referral linkages with health facilities. HTH 70% chlorine shall be procured for emergency water treatment interventions during the cholera response. The chlorine will be used for both community-level water source disinfection and preparation of stock solutions for IPC in the management of ORPs. Other NFIs and supplies to be procured include handwashing soap, disinfectants, PPE, and visibility materials (volunteer T-shirts, bibs, hats). Community-based surveillance will be strengthened to improve early detection, reporting and rapid response to suspected cases and deaths. The intention of ZRCS is not only to train volunteers but to support the standardization, strengthening, and quality improvement of ORP services in coordination with the MoHCC and local health authorities. This will include identifying priority locations based on outbreak risk and health facility access, supporting the provision of essential ORP supplies and IPC materials, orienting designated personnel and volunteers on ORP management protocols, strengthening referral pathways and reporting mechanisms, and conducting regular supervision and quality assurance visits. Where existing ORPs are not required or cannot meet minimum standards, ZRCS will work with MoHCC to rationalize their operation and ensure that community rehydration support is provided through safer and better-coordinated mechanisms.

2. Water, Sanitation and Hygiene (WASH) in emergencies

ZRCS will implement emergency WASH interventions aimed at reducing environmental transmission of cholera and improving access to safe water in affected communities. Volunteers and technical teams will be trained/oriented on household disinfection, water quality monitoring, chlorination, safe water handling, hygiene promotion and community-led sanitation approaches in accordance with national cholera response protocols rehabilitation of 2 communal latrines in 2 selected communities in Mandawa suburb in Zvishavane in communities affected by open defecation, inadequate sanitation coverage, and high population concentration. The purpose of these facilities is to reduce environmental contamination and interrupt faecal-oral transmission pathways while longer-term sanitation solutions are being addressed by relevant authorities and partners.

Working alongside local authorities and district WASH teams, ZRCS will support chlorination of communal water sources, emergency water storage and distribution where required. This will also include household water treatment through aquatabs and chlorine products, and routine water quality surveillance in high-risk communities. Reagents for water quality testing will be purchased to assist local authorities to conduct bacteriological tests. Low WASH infrastructure improvements will be targeted for high impact. These include repair/rehabilitation of communal water points, improving water supply service level to solar powered piped water supply, and repair of communal latrines especially in urban areas. Communal water points recording positive water quality results will be targeted and



prioritised. Hygiene kits containing buckets with taps, jerry cans, soap, detergent and water treatment products will be distributed to vulnerable households, accompanied by practical demonstrations on safe water treatment, storage and handwashing.

To reduce environmental contamination, volunteers will undertake household disinfection around confirmed cases and promote sanitation improvements through community mobilisation, hygiene education and behaviour change campaigns. Support will also be provided to improve WASH services in health facilities and Oral Rehydration Points where gaps have been identified, including restoration of functional handwashing facilities and strengthening infection prevention and control.

3. Protection, Gender and Inclusion (PGI)

Protection, Gender and Inclusion will be integrated throughout the operation to ensure that assistance is safe, accessible, equitable and responsive to the needs of all population groups. All staff and volunteers will receive orientation on IFRC PGI minimum standards, safeguarding, Prevention of Sexual Exploitation and Abuse (PSEA), confidentiality and the "Do No Harm" approach before deployment. The intervention will include Psychological First Aid (PFA) as the core MHPSS intervention. However, MHPSS considerations will also be integrated through community engagement activities that address fear, stigma, and anxiety related to cholera, as well as through volunteer well-being measures, including supportive supervision and debriefing.

MHPSS messages will be embedded within Risk Communication and Community Engagement (RCCE) activities, promoting positive coping strategies, social support, stigma reduction, and timely help-seeking. Clear referral pathways will be established for individuals experiencing severe psychological distress, pre-existing mental health conditions, protection concerns, or who are survivors of sexual and gender-based violence (SGBV), ensuring they receive appropriate specialized services. Psychosocial indicators will also be integrated into assessments and monitoring systems to identify and respond to MHPSS needs alongside public health priorities. Measures will be put in place to integrate child protection and psychosocial support into response activities, promote continuity of education where feasible, and use schools as platforms for hygiene promotion and cholera prevention messaging when safe and appropriate. In addition, the operation will prioritize the wellbeing of Red Cross staff and volunteers through supportive supervision, regular debriefing, peer support, and stress management measures, recognizing that responder wellbeing is essential for maintaining an effective and sustainable outbreak response

The operation will prioritise vulnerable groups including women, children, older persons, persons with disabilities, mobile mining populations and marginalised religious groups with low health-seeking behaviour. The overall child safeguarding risk for this operation is assessed as Medium. Although the response does not involve activities specifically targeting children, cholera outbreaks disproportionately affect children, particularly those under 15 years of age, who are at greater risk of infection, school disruption, psychosocial distress, and loss or illness of caregivers. Girls may also assume increased caregiving responsibilities, while unaccompanied, separated, street-connected, and homeless children face heightened risks of neglect, exploitation, abuse, and family separation during the outbreak. To mitigate these risks, the ZRCS will ensure that all staff and volunteers receive child safeguarding orientation and adhere to the Red Cross Code of Conduct and Child Safeguarding Policy. Volunteers conducting household visits and community engagement will work in pairs, avoid being alone with children, and use age-appropriate communication during hygiene promotion activities. Where child protection concerns are identified, volunteers will follow established referral pathways to the MoHCC, the Department of Social Welfare, and relevant child protection actors.

4. Community Engagement and Accountability (CEA)

Community Engagement and Accountability will underpin all aspects of the response to ensure communities are informed, listened to and actively involved in controlling the outbreak. ZRCS will work closely with MoHCC, traditional leaders, school authorities, faith leaders, mining associations, Village Health Workers and local authorities to deliver consistent cholera prevention messages using trusted communication channels.

Community engagement activities will include door-to-door awareness campaigns, community dialogue sessions, small group discussions, and public announcements. Local radio programmes will help broadcast key messages. Interpersonal communication and targeted messaging in mining settlements, border communities and high-risk religious gatherings will also be done. Particular attention will be given to addressing misinformation, rumours and vaccine or treatment hesitancy through evidence-based messaging and engagement with influential community leaders. Feedback and complaints mechanisms will be strengthened through community feedback desks, suggestion boxes, complaints desks, hotline platforms and volunteer reporting systems to ensure community concerns inform operational decision-making. Regular perception surveys, Knowledge, Attitudes and Practices (KAP) assessments and rumour tracking will be conducted throughout the operation to adapt communication strategies, improve service delivery and strengthen community trust.

5. Coordination

ZRCS will continue to support the Government-led cholera response through active participation in the national, provincial and district coordination mechanisms led by the Ministry of Health and Child Care under the Public Health Emergency Operations Centre (PHEOC) and Incident Management System (IMS). The operation will align with national cholera preparedness and response plans and complement the activities of WHO, UNICEF and other humanitarian partners.

Operational planning, volunteer deployment and micro-planning will be undertaken jointly with Provincial and District Rapid Response



Teams to ensure resources are directed towards the highest-risk communities and duplication is avoided. ZRCS will maintain close coordination with District Civil Protection Committees, Environmental Health Officers, Village Health Workers, Red Cross volunteers and local authorities to facilitate surveillance, Case Area Targeted Interventions and WASH activities.

Recognising the importance of cross-border transmission, the operation will strengthen collaboration with Mozambique through existing surveillance information-sharing mechanisms and support improved coordination at formal and informal points of entry. The operation will also invest in volunteer management through refresher training, supervision, psychological First Aid, duty rotations and appropriate logistical support to maintain an effective and sustained emergency response. Continuous monitoring, joint field supervision and operational reviews with MoHCC will ensure that interventions remain evidence-based, adaptive and responsive to the evolving epidemiological situation. The epidemiological situation remains dynamic, requiring continuous surveillance and coordination with the MoHCC and neighbouring National Societies in the region.

6. Monitoring, Evaluation and Learning

Monitoring, evaluation and learning activities will be integrated throughout the operation to assess implementation quality, accountability and outcomes. Zimbabwe Red Cross Society (ZRCS) will conduct routine field monitoring, joint monitoring visits with the Ministry of Health and Child Care (MoHCC) and IFRC, and regular supervision of volunteers to track progress against planned activities and indicators.

Perception surveys and community feedback mechanisms will be used to assess community acceptance of interventions, identify rumours or concerns, and inform adaptive programming. Post-distribution monitoring (PDM) will be conducted to determine whether hygiene kits and water treatment products reach the intended beneficiaries, are used correctly, and contribute to improved hygiene practices. Monitoring will also assess the adoption and sustainability of key protective behaviours, including handwashing with soap, household water treatment and safe water storage.

At the conclusion of the operation, After-Action Reviews (AARs) and lessons-learned workshops will be conducted with ZRCS, MoHCC, IFRC and other key stakeholders to document good practices, operational challenges and recommendations for strengthening future cholera preparedness and response. Findings from monitoring and learning activities will be used to improve ongoing implementation and inform future epidemic preparedness and response operations.

7. National Society Development

This will focus on strengthening the National Society's capacity to respond to the current outbreak and future public health emergencies. This will include training of 180 volunteers, coaching and mentorship, supporting NS contingency planning, volunteer wellbeing and insurance, lesson learning and documentation. ICT equipment including computers for the Coordinator and District Field Officer shall be procured internet connectivity services required to support the effective management and implementation of the cholera response. These resources are intended to strengthen operational coordination, data management, reporting, communication, and monitoring functions throughout the DREF implementation period.

Targeting Strategy

[Targeting Strategy Supporting Document](#)

Who will be targeted through this operation?

The operation will directly target approximately 88,200 people (17,640 households) living in cholera-affected and high-risk communities in Manicaland (Penhalonga, Mutare city) and Midlands (Zvishavane) Provinces. Targeting will be guided by epidemiological surveillance data, vulnerability assessments, and the Red Cross Case Area Targeted Interventions (RC-CATI) approach to ensure that resources are directed to communities and households at the highest risk of infection and transmission. While the MoHCC Situation Report indicates that most reported patients had recovered, the proposed operation is not based solely on the number of active cases. The targeting is informed by the ongoing risk of transmission, continued reporting of new cases, the expansion of the outbreak into new districts, and the presence of persistent risk factors. The DREF therefore targets populations at highest risk of infection rather than only those currently ill, with the aim of interrupting transmission, preventing further spread, and supporting Government-led containment efforts.

Priority will be given to households with suspected or confirmed cholera cases and their immediate neighbours, who will receive rapid integrated interventions including health education, household water treatment, hygiene kits, household disinfection where required, and referral of suspected cases for early treatment. The operation will also prioritise artisanal miners in Penhalonga and other mining settlements, food vendors and traders operating in high-risk environments, and households living in areas with inadequate access to safe drinking water and sanitation, including communities affected by contaminated water sources, sewer blockages, overflowing sanitation systems, and poor waste management.



Recognising the disproportionate impact of cholera on vulnerable populations, the operation will target women, girls, children and household caregivers, who play a central role in water collection, food preparation, childcare and caring for sick family members, thereby increasing their exposure to infection. Special attention will also be given to older persons, persons with disabilities, chronically ill individuals, and other vulnerable people who face difficulties accessing Oral Rehydration Points (ORPs), Cholera Treatment Centres (CTCs) or health facilities, ensuring that services are accessible, equitable and responsive to their needs.

The operation will further support poor and socially vulnerable men and women who have limited resources to access safe water, sanitation facilities and hygiene supplies. School children will form another important target group because of the high risk of transmission in crowded learning environments. School-based health education and hygiene promotion activities will reinforce protective behaviours and contribute to reducing transmission within schools and surrounding communities.

Recognising that community acceptance is critical for successful cholera control, the operation will actively engage traditional leaders, community leaders, faith leaders, mining associations, Village Health Workers, teachers and other influential community members to promote positive health behaviours, counter misinformation and encourage early health-seeking behaviour. Particular attention will be given to vaccine- and treatment-hesitant groups, including sections of the Apostolic religious community, through culturally appropriate risk communication and community dialogue aimed at increasing trust and improving uptake of cholera prevention and treatment services.

The operation will also strengthen the capacity and safety of frontline healthcare workers, Environmental Health Technicians, Village Health Workers and Zimbabwe Red Cross volunteers, who are at increased occupational risk while delivering cholera response activities. They will receive training, supervision and appropriate infection prevention and control (IPC) supplies to safely deliver community surveillance, RC-CATI, WASH and case referral interventions.

Targeting the populations at greatest epidemiological and social risk, the operation aims to maximise the public health impact of the response, interrupt community transmission, and improve timely access to life-saving services.

Explain the selection criteria for the targeted population

The operation will prioritise cholera-affected and high-risk communities in Mutare city, Zvishvaane and Penhalonga and will potentially expand to new districts recording new cases. These areas have been selected based on epidemiological surveillance data, rapid field assessments and risk analysis, which indicate sustained transmission, poor water and sanitation conditions, high population mobility, and frequent cross-border movement with Mozambique. Furthermore, these districts are recognised as traditional cholera hotspots and are classified under Priority Index 10–11 in Zimbabwe's Priority Areas for Multisectoral Interventions (PAMI), reflecting the highest levels of vulnerability and the need for intensified preparedness and response interventions.

Particular emphasis will be placed on Penhalonga, where the majority of confirmed cases have been reported. The area hosts an estimated 8,000 highly mobile artisanal miners living and working in overcrowded settlements characterised by inadequate access to safe water, sanitation and hygiene facilities. Population mobility, informal food vending, environmental contamination and limited access to healthcare create conditions that facilitate rapid cholera transmission. Marange will also receive priority attention because of its large population of drug- and treatment-hesitant Apostolic communities. In July 2026, Marange is expected to host an annual Apostolic religious gathering attracting approximately 100,000 pilgrims from Zimbabwe and neighbouring SADC countries, including Mozambique, Malawi and Zambia, where cholera transmission remains active. This mass gathering presents a substantial risk of amplification and cross-border spread of cholera, making early preventive interventions essential. As the outbreak evolves, the operational footprint will remain flexible, enabling resources to be redirected rapidly to newly affected districts or emerging hotspots based on MoHCC surveillance data and epidemiological trends.

Within these priority geographical areas, the operation will target households and individuals who are both most exposed to cholera infection and least able to prevent or cope with its effects. Given the limited resources available through the DREF, assistance will be risk- and vulnerability-based rather than universal, ensuring that life-saving interventions reach those with the greatest need and highest potential to contribute to interrupting transmission. Beneficiary selection will be undertaken jointly by community leaders, health authorities and ZRCS volunteers using transparent vulnerability criteria and the RC-CATI methodology.

Priority will therefore be given to households with suspected or confirmed cholera cases and neighbouring households, where rapid interventions can break household and community transmission chains. Households identified through community assessments as having limited access to safe drinking water, sanitation facilities and hygiene services, including those living near contaminated water sources, sewer blockages or overflowing sanitation systems will also be prioritised because of their heightened exposure to infection.

The operation recognises that cholera disproportionately affects vulnerable groups. Consequently, women, girls and household caregivers will be prioritised because they are primarily responsible for collecting water, preparing food, maintaining household hygiene and caring for sick family members, increasing both their exposure to infection and their influence on household hygiene practices.



Children, particularly school-going children, will be targeted through school-based hygiene promotion because schools are high-density environments where diseases can spread rapidly and children can act as effective agents of behaviour change within their families.

The operation will specifically engage artisanal miners, food vendors, traders in Penhalonga and other highly mobile populations, whose occupational and living conditions increase exposure to contaminated environments and facilitate the spread of disease across communities. Likewise, traditional leaders, religious leaders, teachers, Village Health Workers, mining associations and other community influencers will be targeted because they are trusted sources of information and play a critical role in promoting behaviour change, countering misinformation and encouraging timely health-seeking behaviour. Particular attention will be given to drug- and vaccine-hesitant groups, especially within Marange Apostolic communities, through culturally sensitive dialogue and engagement designed to improve acceptance of cholera prevention and treatment services.

Finally, the operation will support frontline healthcare workers, Environmental Health Technicians, Village Health Workers and Zimbabwe Red Cross volunteers, who are at increased occupational risk due to their direct involvement in cholera response activities. Strengthening their knowledge, skills, supervision and access to infection prevention and control (IPC) supplies will improve the quality and safety of the response while protecting the health workforce.

Total Targeted Population

Women	24,700	Rural	94%
Girls (under 18)	21,270	Urban	6%
Men	21,230	People with disabilities (estimated)	1.6%
Boys (under 18)	21,000		
Total targeted population	88,200		

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
Continued or expanded cholera transmission: Root causes: - High population mobility (artisanal miners, cross-border movement) - Poor WASH infrastructure in hotspots (Penhalonga, Marange, Mutasa, Chipinge) - Delayed health-seeking behaviour and low community awareness in some groups - Large upcoming Apostolic gathering in Marange (~100,000 pilgrims)	- Scale up RC-CATI within 48 hours of case notification - Prioritise hotspot-focused interventions (Penhalonga, Marange, border communities) - Strengthen ORPs and rapid referral systems - Pre-position WASH supplies in high-risk areas ahead of mass gatherings - Intensify targeted risk communication before and during gathering
Ongoing contamination of water sources due to sewer blockages especially in urban areas	Emergency chlorination of water points and household water treatment (Aquatabs, chlorine) Distribution of hygiene kits and safe storage containers Routine water quality monitoring in hotspot areas Sanitation campaigns and rapid environmental clean-ups
Low uptake of prevention and treatment services especially among drug hesitant apostolic groups	Use trusted community messengers, including volunteers recruited from within the affected populations, such as Marange faith worshippers, to enhance acceptance, trust, and uptake of key cholera prevention and response messages.
Access constraints in mining and informal settlements	Engagement with mining associations and community leaders Use of locally trusted volunteers
Delays in delivery of supplies and field implementation	Framework agreements with suppliers for rapid procurement
Sexual exploitation, abuse, or harassment (SEA/H), including misuse of power by volunteers, staff, or partners during household visits, distributions, or service provision	Ensure all staff and volunteers receive PSEA training and sign Codes of Conduct before deployment. Establish confidential reporting mechanisms and communicate these to communities. Conduct regular supervision and monitoring of field teams
Please indicate any security and safety concerns for this operation: The security risk for this operation is assessed as low to moderate, with no conflict-related threats anticipated in the operational areas. However, several occupational risks may affect staff, volunteers and beneficiaries. The operation will be implemented in artisanal mining communities such as Penhalonga, where overcrowding and hazardous mining activities may present access and safety challenges. There is also a risk of road traffic accidents during field deployments to remote communities and difficult-to-reach areas, particularly during adverse weather conditions. The greatest safety risk is exposure to cholera infection among frontline volunteers, healthcare workers and staff. Fatigue and stress among volunteers responding to a prolonged outbreak may also affect staff well-being and performance.	
Has the child safeguarding risk analysis assessment been completed?	Yes

Planned Intervention



Budget: CHF 93,708



Targeted Persons: 6,000

Indicators

Title	Target
# of RC-CATI training of trainers trained	90
% of ORPs reporting uninterrupted operation during the response period	80
% of community alerts investigated within 24 hours.	100
# of Volunteers re-oriented on RC CATI	180
# of HCW to receive cascaded RC CATI Training	90
# of after-deployment reviews conducted.	3

Priority Actions

1. Conduct RC-CATI Training of Trainers (ToT) for 90 Rapid Response Teams 30 per district, strengthening the quality of existing and new ORP services through supportive supervision, regular mentorship and joint monitoring with the MoHCC. Training will target volunteers from the newly affected operational areas who have not previously received RC-CATI training under cholera SEAP, while providing a focused refresher for a limited number of experienced volunteers who will serve as trainers and mentors.
2. Conduct RC-CATI volunteer orientation, refresher training and simulation exercises for 180 volunteers for 3 days 60 per district
3. RC-CATI training cascaded to Health facilities for 90 healthcare workers and Rapid Response Teams for 3 days. (The training is intended to orient frontline healthcare workers on the RC-CATI approach, so they understand the community-based surveillance, referral, and follow-up system being implemented by ZRCS volunteers. This shared understanding strengthens coordination between health facilities and RC-CATI teams, improves referral pathways, ensures timely information sharing)
4. Support standardization of ORPs, job aids and reporting tools developed through the MoHCC to ensure consistency and compliance with MoHCC standard operating procedures (SOPs)
5. Deploy 30 volunteers to Oral Rehydration Points (ORPs) and communities for 10 days
5. Conduct 3 after-deployment reviews for adaptation and learning
7. Conduct 3 sanitary surveys and strengthen community surveillance
9. Conduct 4 supportive supervision, monitoring, and deployment visits and reviews



Water, Sanitation And Hygiene

Budget: CHF 39,722

Targeted Persons: 88,200

Indicators

Title	Target
# of people reached with handwashing promotion and hygiene education.	88,200
# of health facilities supplied with chlorine, ORS and PPE.	15
# of Kickstart kits pre-positioned for rapid outbreak response.	55



# of districts with surge teams deployed within 24–48 hours of outbreak notification.	3
# of communal latrines repaired/rehabilitated	2
% of households correctly treating drinking water after volunteer engagement.	60
# of identified environmental risk factors addressed following sanitary surveys.	5

Priority Actions

1. Procure and deploy 1000 buckets with tapes for hand-washing promotion in high-risk settings
2. Conduct 3 water quality monitoring and sanitary surveys for 4 days each
5. Installation of 10 inline chlorinators at communal water points
6. Procurement of WASH supplies and NFIs for pre-positioning, preparedness and response
7. Deploy 3 surge response teams to outbreak hotspots
8. Repair/rehabilitate 2 non-functional communal latrines in 2 selected communities of Mandawa in Zvishavane
9. RC-CATI door to door hygiene education to discourage open defecation, promote point of use water treatment and hand hygiene to mitigate further spread of the disease.



Protection, Gender And Inclusion

Budget: CHF 1,678

Targeted Persons: 88,200

Indicators

Title	Target
# of volunteers trained on PGI, and trust building	180
# of community perception and feedback surveys conducted in targeted communities.	1
% of community feedback, rumours and complaints documented and acted upon within the agreed timeframe.	80
# of PGI IEC packages developed and approved.	4
# of people reached through community awareness sessions	88,200

Priority Actions

1. Rapid gender, protection, and disability inclusion analysis to inform response planning.
2. Mapping and strengthening SGBV, child protection, MHPSS, and safeguarding referral pathways.
3. Community awareness on GBV/SGBV risks, child protection, PSEA, available services, and cholera prevention
4. Train 180 volunteers for 2 days on Protection, Gender and Inclusion (PGI), trust building and risk communication. These trainings to be coupled with equipping traditional leaders and influencers from existing community structures to drive cholera prevention and response.
5. Conduct community perception and feedback survey for 2 days.
6. Develop a Risk Communication and Community Engagement (RCCE) strategy for cholera
7. Design, print and disseminate PGI Information, Education and Communication (IEC) materials.





Community Engagement And Accountability

Budget: CHF 11,076

Targeted Persons: 88,200

Indicators

Title	Target
# of people reached with SGBV prevention and response and Child protection messages	88,200
# of services assessed and mapped per location Activities:	5
# of stakeholders mapped	5
% of community members who feel the aid provided by the operation currently covers their needs	80
% of operation complaints and feedback received and responded to by the National Society	85
% of community members, including marginalized and at-risk groups, who know how to provide feedback about the operation	80

Priority Actions

1. Train 180 volunteers and staff for 2 days on CEA (To be integrated with PGI).
2. Establishment of safe feedback, complaints, and referral mechanisms, including sensitive feedback handling.
3. Inclusive community engagement through participation of women, girls, children, and persons with disabilities using accessible communication approaches.
4. Map out key stakeholders, including local businesses, faith-based organizations, traditional leaders, government agencies, and NGOs, and identify how cholera prevention aligns with their existing priorities



Coordination And Partnerships

Budget: CHF 29,144

Targeted Persons: 300

Indicators

Title	Target
# of inception and stakeholder engagement meetings conducted.	3
# of joint monitoring and supervision visits conducted.	2
# of monitoring and evaluation review meetings completed.	2

of lessons learnt workshops conducted.

1

Priority Actions

1. Conduct inception meetings and stakeholder engagement sessions.
2. Conduct joint monitoring and supervision visits.
3. Conduct monitoring, evaluation and learning (MEL) review meetings.
4. Organise a project lessons learnt workshop.
5. Document and disseminate lessons learnt and recommendations



Secretariat Services

Budget: CHF 14,199

Targeted Persons: 7

Indicators

Title	Target
# of IFRC CCD monitoring visits conducted and field reports shared	4
# of Kick off meeting held within 7 days of DREF approval	1

Priority Actions

- Ensure overall operational coordination in line with IFRC DREF standards and policies.
- Convene a kickoff meeting within one week of approval and conduct monthly operational coordination meetings thereafter
- Cover salary costs for essential strategic positions required for effective operation delivery. PMER Officer and Project Officer
- Provide technical and coordination support through the IFRC Country Cluster Delegation (CCD), including PMER, finance, and logistics, in compliance with DREF and IFRC policies.



National Society Strengthening

Budget: CHF 54,910

Targeted Persons: 180

Indicators

Title	Target
# of volunteers insured	180

Priority Actions

- Volunteer insurance
- Volunteer IEC Materials
- Salary costs at Level of Effort for Project Coordinator, District Field Officers, Finance Officer, and PMER Officer.
- Vehicle costs
- ICT Costs; computers and Printers



About Support Services

How many staff and volunteers will be involved in this operation. Briefly describe their role.

1. Project Coordinator: Overall management of the operation and reporting to IFRC
2. District Field Officers: Coordinate and supervision of field implementation and coordination with district authorities
3. CEA/PGI Focal Person: Ensures community engagement, inclusion, safeguarding and accountability standards
4. Logistics Officer: Procurement, warehousing and distribution of emergency supplies
5. Finance Officer: Financial tracking, reporting and compliance
6. PMER Officer: Monitoring implementation, data collection, feedback systems and reporting
7. The operation will train 180 volunteers who will serve as the frontline responders, implementing RC-CATL activities, and will collect community feedback, identify protection concerns and WASH risks, and work closely with the MoHCC to strengthen early detection, interrupt transmission

Does your volunteer team reflect the gender, age, and cultural diversity of the people you're helping? What gaps exist in your volunteer team's gender, age, or cultural diversity, and how are you addressing them to ensure inclusive and appropriate support?

The ZRCS volunteer structure is designed to reflect the gender, age, and cultural diversity of the communities being served. The current volunteer base includes both male and female volunteers across youth, adult, and older age groups, drawn directly from the affected communities, including rural, peri-urban, artisanal mining and religious group settings. A total of 180 volunteers will be engaged during the operation. A deliberate effort will be made to ensure gender balance, with women actively represented in community-based surveillance, hygiene promotion, and Community Engagement and Accountability (CEA) activities. This is particularly important given that women, girls and caregivers are among the most affected groups and are often more accessible for household-level interventions. Male volunteers will also be engaged to ensure access to male-dominated spaces such as artisanal mining sites and some religious group settings.

Cultural and linguistic diversity will also be reflected in the team composition, with volunteers recruited locally to ensure familiarity with Shona-speaking mining communities, Apostolic faith groups in Marange, and cross-border populations in Mutare and Chipinge. This helps strengthen trust, improve acceptance of messages, and reduce resistance to cholera prevention and response activities.

If there is procurement, will it be done by National Society or IFRC?

Procurement for this operation will be led by the ZRCS in accordance with the National Society's procurement procedures and the IFRC Procurement Manual. Most items required for the response—including hygiene kits, buckets with taps, jerry cans, soap, aquatabs, chlorine (HTH), ORS, PPE, and other operational supplies—will be procured locally where markets have the capacity to meet the required specifications, quality standards and delivery timelines. Local procurement will facilitate timely delivery of life-saving assistance while supporting local markets.

Competitive procurement methods will be applied in line with IFRC and ZRCS regulations. For items intended for distribution, the tendering and supplier selection process is expected to take approximately 1–2 weeks, depending on the procurement value and availability of suppliers. Close coordination between ZRCS Logistics, IFRC and programme teams will ensure that procurement is completed efficiently and in compliance with quality, transparency and accountability standards

How will this operation be monitored?

The cholera response operation will be monitored through a structured, multi-level Monitoring, Evaluation, Accountability and Learning system led by the ZRCS in close coordination with the MoHCC and supported by IFRC. Monitoring will combine routine field supervision by volunteers and ZRCS staff, standardized reporting tools. Community feedback mechanisms such as feedback desks, hotlines, and



perception surveys will also be used to capture community perceptions, rumours, and complaints/compliments to improve accountability and responsiveness.

Oversight will be provided through a layered structure involving PMER officers, field and national staff, MoHCC, and IFRC technical staff, ensuring both operational and technical quality assurance. Progress will be measured using key health, WASH, community engagement, PGI, and coordination indicators, including case detection within 48 hours, number of ORPs functional, households reached with hygiene kits, water quality improvements, and community awareness levels. IFRC will conduct regular joint monitoring visits with ZRCS and MoHCC, including field supervision missions, technical support visits, and end-of-operation reviews, complemented by weekly and monthly reporting, dashboards, and epidemiological trend analysis to guide adaptive management of the response.

Please briefly explain the National Societies communication strategy for this operation

In line with the IFRC Communication Framework and Community Engagement and Accountability (CEA) approaches, the operation will implement a comprehensive communication strategy to ensure timely, accurate and accessible information reaches all at-risk and vulnerable populations. Communication activities will be tailored to local contexts and use multiple channels to maximize coverage, particularly among hard-to-reach communities, mobile populations, artisanal miners, and religious groups.

Key communication activities will include the production and distribution of culturally appropriate Information, Education and Communication (IEC) materials in relevant local languages, radio messaging through national and community radio stations, community dialogues, interpersonal communication by trained Red Cross volunteers, and the use of mobile public address systems where appropriate. The operation will also maintain regular engagement with local and national media to disseminate verified public health information, promote accurate reporting, and share operational updates with government, humanitarian partners and other stakeholders. Communication products, including human-interest stories, photographs, videos and success stories, will be developed to document the response, capture lessons learned and showcase the impact of the operation, while contributing to organizational learning and accountability.



Budget Overview



DREF OPERATION

MDRZW029 - Zimbabwe Red Cross Society
Cholera Response 2026

Operating Budget

Planned Operations	146,184
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	93,708
Water, Sanitation & Hygiene	39,722
Protection, Gender and Inclusion	1,678
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	11,076
Environmental Sustainability	0
Enabling Approaches	98,252
Coordination and Partnerships	29,144
Secretariat Services	14,199
National Society Strengthening	54,910
TOTAL BUDGET	244,436

all amounts in Swiss Francs (CHF)



Contact Information

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[Click here for the reference](#)

