DREF Final Report

Cholera Outbreak

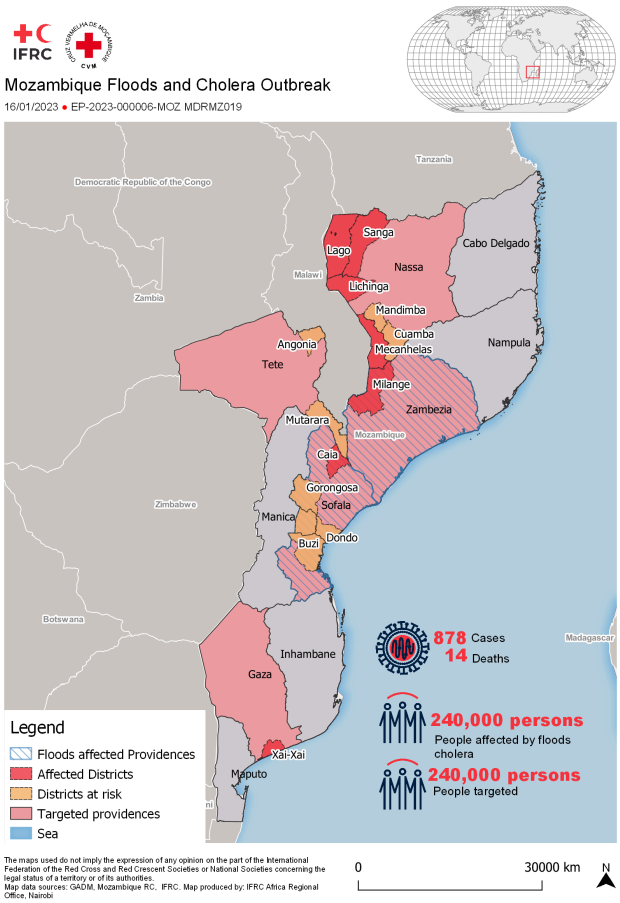
The Mozambican Red Cross successfully distributed hygiene kits to affected families in Praia Grande, Sofala province.

Appeal: **MDRMZ019**	Total DREF Allocation: **CHF 476,331**	Crisis Category: Yellow	Hazard: **Epidemic**
Glide Number: **EP-2023-000006-MOZ**	People Affected: **240,000 people**	People Targeted: **240,000 people**	People Assisted: **-**
Event Onset: **Slow**	Operation Start Date: **20-01-2023**	Operational End Date: **31-07-2023**	Total Operating Timeframe: **6 months**

Targeted Areas: **Gaza, Inhambane, Niassa, Sofala, Tete, Zambezia**

The major donors and partners of the IFRC-DREF include the Red Cross Societies and governments of Australia, Austria, Belgium, Britain, China, Czech, Canada, Denmark, German, Ireland, Italy, Japan, Luxembourg, Liechtenstein, Malta, Norway, Spain, Sweden, Switzerland, Thailand, and the Netherlands, as well as DG ECHO, Mondelez Foundation, and other corporate and private donors. The IFRC, on behalf of the National Society, would like to extend thanks to all for their generous contributions.

Description of the Event



Cholera and floods risk areas

Date when the trigger was met

08-01-2023

What happened, where and when?

On 8 January 2023, the Ministry of Health's (MoH) Niassa Daily Cholera Bulletin reported an alarming increase in cholera cases in Niassa Province, which borders Malawi and was already experiencing a cholera outbreak. Niassa Province initially recorded 629 confirmed cholera cases and eight deaths in Lago and Lichinga districts. Within six days, the number had risen to 878 confirmed cases and 14 deaths. Overall, in January, Mozambique saw an 80% increase in the number of cases recorded since December 2022. At the start of the DREF, the outbreak stood at 878 cases with 14 deaths in 5 provinces and 14 districts in Niassa with 819 cases: Sofala, Tete, Gaza and Zambezia for the rest. By March, 9,060 cases and 55 deaths had been recorded. By 27 June, the latest MoH update, the outbreak had spread to 45 districts in 11 provinces, with 33,017 cases and 141 deaths. The hotspots are now in a decreasing order: Zambezia with 12 districts affected and 13,370 cases/38 deaths, Sofala 7,507 cases/30 deaths, Niassa 3,501 cases/25 deaths, Tete with 2,966 cases/19 deaths, Nampula 2,217 cases/3 deaths; Manica 1,669 cases/9 deaths and Cabo Delgado with 1,012 cases/3 deaths, Inhambane with 313 cases/8 deaths. The remaining cases are in Maputo and Gaza, with less than a hundred cases. New provincial hotspots since the start of the DREF are Nampula, Manica and Cabo Delgado.

According to WHO, a total of 33,544 cases have been confirmed and 141 deaths have been reported in the country as of July 2023, with a case fatality rate of 0.4% in recent months. In total, 62 districts in 11 provinces were affected by the infection, and by July 2023 only two provinces, Cabo Delgado and Nampula, still had active cases. As the number of cases continued to rise, and with the expected flood season approaching, the Mozambican Red Cross (CVM) declared a high risk of the cholera situation worsening until the end of the rainy and cyclone season. It was reported that the CTCs were overcrowded and that checking on affected family members was a challenge due to a lack of human resources.
Due to Tropical Cyclone Freddy, many sites were inaccessible or reported infrequently, making it difficult to obtain or validate accurate reporting figures from all districts, leading to the assumption that the total number of cases is significantly higher than reported. As predicted, the two landfalls of Tropical Cyclone Freddy, on 28 February and 12 March, severely affected the country and exacerbated the

pre-existing health and WAS situation in the country. Extensive flooding left families homeless, affected water supplies and reduced access to many communities. Oral rehydration points (ORPs) were vandalised, and community members expressed concern about an increase in cholera cases at ORP sites.

CVM volunteer supporting patient care at the CTC in Quelimane

CVM Volunteers pulverizing in a CTC, Quelimane

Scope and Scale

Beneficiaries in low-lying areas were at increased risk due to flooding during the rainy season and the repeated landfalls of Tropical Cyclone Freddy. People living in transitional shelters, where conditions may be overcrowded and WASH facilities may be overstretched, were also at increased risk of contracting cholera. Extensive flooding in Tete, Niassa, Sofala and Zambezia provinces exacerbated the cholera situation as rising water levels affected water sources and latrines. Cholera outbreaks also occurred among IDPs in accommodation centres in Zambezia province. These centres were closed during the project period, leaving many people without shelter, limited resources and access to clean water, oral rehydration salts (ORS) and sanitation facilities.

There were also cholera outbreaks among beneficiaries in IDP centres in Zambezia Province. These centres were closed in May 2023, leaving many people homeless and with limited resources and access to clean water, oral rehydration salts (ORS) and sanitation facilities.

CVM conducted an initial assessment and identified the need for community engagement and accountability (CEA) to raise awareness of cholera transmission, safe health and hygiene practices, and community participation in decision-making.

At the end of the DREF response, there were still active cholera cases in Nampula (Erati, Nacala velha, Nacala Porto, Memba and Namialo districts) and Sofala (Nhamatanda district). There were still isolated cases of acute diarrhoea in Tete and Zambezia provinces.

National Society Actions

Have the National Society conducted any intervention additionally to those part of this DREF Operation?	Yes

Please provide a brief description of those additional activities	The initiative was expanded beyond the provinces initially covered by the cholera DREF to address the outbreak in Nampula and Manica provinces reaching out around 39,183 people with Hygiene campaigns. With support from the Swiss Agency for Development and Cooperation (SDC), the National Society successfully trained 150 volunteers in critical areas such as Oral Cholera Vaccination (OCV), Emergency Preparedness and Incident Command (EPIC), Community-Based Health and First Aid (CBHFA), Public Health Guidance (PGI), Risk Communication and Community Engagement (RCCE) and Community Engagement (CE). The comprehensive support package included logistics and transport services, distribution of hygiene kits, provision of water purifiers to affected communities, use of awareness-raising tools, production of visibility materials, development of information, education and communication (IEC) materials, broadcasting of radio spots and provision of incentives for volunteers. This multi-faceted approach was designed to meet the urgent needs of the cholera outbreak and ensure a holistic and effective response to the health crisis in both Nampula and Manica provinces.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC Delegation in Maputo, together with the Nairobi Regional Office, worked closely with the Mozambique Red Cross (CVM) to provide technical support in operational planning. The IFRC also provided strategic support to enable the integration of flood preparedness elements into the cholera response, as the floods could exacerbate the cholera situation if not properly managed, and to ensure proper coordination between the two responses. The IFRC supported CVM in the implementation of the project, in particular through training in all provinces, procurement of supplies, and coordination and monitoring of activities. In addition, the IFRC worked with CVM to conduct a multi-sectoral assessment and planning, provide technical support and liaise with external and Movement partners. Finally, the IFRC worked with CVM on PMER efforts. IFRC liaised with external partners on behalf of CVM to strengthen relationships with external partners and share strategies to coordinate efforts. The IFRC supported CVM by coordinating and developing partnerships with UNICEF and SDC. Canadian RC provided 3 public Health coordinators (in rotation) staff on loan who have been supporting the operations. IFRC provided an operations Manager through the surge support system.
Participating National Societies	With financial support from CDC, and material contributions, the National Society was able to train a larger number of volunteers, scale up operations across affected provinces, and ensure faster, broader outreach to communities in need. This support facilitated timely distribution of hygiene kits, water treatment supplies, and awareness campaigns, particularly in remote and underserved areas. As a result, communities were better informed, equipped, and empowered to adopt life-saving hygiene practices, contributing to the reduction in transmission rates and improved access to essential health and WASH services.

ICRC Actions Related To The Current Event

There is an ICRC Delegation in Maputo, which was informed of the DREF operation but did not provide support to the response.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	The Ministry of Health of Mozambique through its structures supported the affected districts with the following actions: - Contact tracing. - Distributing water purification tablets (Certeza). - Conducting home-based visits. - Conducting monitoring activities and holding regular meetings with community leaders. - Raising community awareness through media. - Building capacity of local health committees and holding regular coordinating meetings. - Supporting CTCs. - Supporting OCV implementation. Several rounds of oral cholera vaccination campaigns in response to outbreaks have been conducted, and these efforts reached approximately 2,484,412 people, including 554,918 children under 5 years old.
UN or other actors	First and foremost, the IFRC received CHF 220,000 in funding from the Swiss Agency for Development and Cooperation (SDC) to provide additional support to this DREF operation. Through this funding mechanism, the IFRC decided to implement additional activities in the provinces of Nampula and Manica, as well as to strengthen existing activities within the geographical area defined in the original DREF. Outside of the DREF operation, WHO, UNICEF and MSF strengthened surveillance in the area. UNICEF also worked with CVM in Niassa, Tete and Sofala through focus group discussions (FGDs), in Zambezia on needs assessment and intervention planning, and with IFRC to develop ideas for feedback mechanisms. WHO supported all actors through coordination, messaging and networking. CVM volunteers also supported the MoH and MSF-led CTCs. Through these combined efforts, those actors managed to support over 2.4 million people with oral cholera vaccinations and other preventive measures.

Are there major coordination mechanism in place?

Movement coordination was also frequent, to ensure that the Red Cross Movement could adapt its activities in border areas affected by or at risk of cholera outbreaks, but also to discuss how CVM could provide integrated and efficient assistance in this cholera response.

The CVM Emergency Operations Team (GODE) was activated at the start of the operation and at least 30 GODE meetings were held. These GODE meetings included daily debriefs, situation monitoring and decision making for the ongoing operation.

In addition, CVM worked in close coordination with the MoH through the National Health Cluster, which held monthly meetings. Participants in the national cluster included UNICEF, MSF and WHO, with the MoH taking the lead. At the provincial level, health cluster meetings were held daily at the beginning of the outbreak and were the main coordination platform. The coordination mechanism remained active until the end of the DREF and continued to operate even after its closure, as new cholera cases were still emerging in certain areas of the country, particularly in regions where heavy rains persisted, creating favorable conditions for the spread of the disease.

The IFRC leads all technical meetings to support all CVM branches in the cholera response.

Needs (Gaps) Identified

Shelter Housing And Settlements

At least 450,000 people were at risk from the effects of the heavy rains predicted by INAM. A large percentage of the population living in coastal areas are vulnerable to the effects of flooding and strong winds due to the structure of their shelters, which are made of sticks and mud with thatched roofs. CVM carried out an assessment to identify the most vulnerable families in need of support to reduce their vulnerability to flooding. Poverty prevented some of the most vulnerable families from reinforcing their structures, leaving them more vulnerable to flooding and health problems. With water in the houses at the onset of heavy rains, the families were completely exposed, making it more difficult to maintain good hygiene conditions. The planned assistance aimed to provide families with risk materials to repair roofs and walls. However, during the implementation of this DREF, Mozambique was hit twice by Tropical Cyclone Freddy. As a DREF was launched for that emergency, all activities under shelter were reallocated to that DREF.

Livelihoods And Basic Needs

As Mozambique is 80% rural, living conditions remain poor. Due to poverty, communities face challenges in accessing safe food and water as they live in poor environmental, housing and sanitation conditions, which are factors in disease transmission. The districts are rural communities with a high prevalence of nutritional problems.

During the operation, CVM focused its support on rural areas with lower incomes or people living with a lack of basic needs.

Health

The launch of the Disaster Relief Emergency Fund (DREF) in response to the cholera outbreak in Mozambique marked the beginning of efforts to address the escalating crisis. Initially, the outbreak was reported at 878 cases with 14 deaths across five provinces. By March, the numbers had risen to 9,060 cases and 55 deaths. In particular, new hotspots emerged in Nampula, Manica and Cabo Delgado.

A visit to the Manjune peripheral health centre in Zambezia confirmed that no cases had been registered for more than two weeks. The few patients who had come presented with moderate diarrhoea, often associated with malaria. Outpatient treatment was provided, and volunteers actively followed up on cases, with an emphasis on health education. Visits to the main health centres were positive, with a reduction in cholera admissions and the possibility of tents being dismantled.

In July 2023, a rapid assessment in Nampula Province highlighted ongoing concerns, including active cholera cases, insufficient PPE in community treatment centres (CTCs), and a lack of resources such as megaphones and batteries for community engagement. While the number of cases showed a downward trend, the withdrawal of supporting partners raised alarm bells. Red Cross volunteers remained the only support after WHO's support ended on 30 June, leaving a potential vacuum in the management of the situation.

The lack of trained volunteers, the vacancy of key positions such as the national health coordinator, and the need for comprehensive training in cholera and health promotion strategies underlined the urgency of recruitment and leadership in the field. Adding to the challenges, Mozambique faced flooding from the rainy season and the impact of Tropical Cyclone Freddy, which increased the risk of cholera spreading. Outbreak hotspots included Beira, Marromeu, Chimoio and Quelimane. A new DREF was launched in response to Tropical Cyclone Freddy, focusing on Zambezia and Sofala, where flooding and damage to the health system exacerbated cholera cases. Coordination between the two DREFs aimed to complement efforts.

Quelimane, which was severely affected by the cyclone, faced challenges with damaged health centres, making it difficult to collect information on cholera and other health needs. Despite these hurdles, the collaborative approach between local and international organisations sought to address the multifaceted crisis and mitigate the impact of the cholera outbreak in Mozambique.

The comprehensive assessment identified several challenges, including limited access to potable water, lack of water purification in critical areas, and inadequate environmental sanitation. The situation was exacerbated by deaths attributed to cholera, as well as challenges in mobilising volunteers for field work due to a lack of financial and material resources.

Water, Sanitation And Hygiene

The unavailability of safe drinking water in some rural areas and urban slums was a major concern in areas affected by the cholera outbreak. The main areas of concern identified by the IFRC were:
- Limited access to drinking water for vulnerable communities, leading to poor hygiene and sanitation in the affected areas.
- Unavailability of water purification agents and appropriate storage containers.
- Unavailability of hygiene items such as soap to promote hygiene.

Heavy rainfall led to flooding and contaminated grey water in these areas. Similarly, latrines were submerged by floodwaters, and water pipes in urban areas broke, cutting off the supply of water to taps for domestic use. Most people living in rural areas and rural communities did not have access to good sanitation and continued to rely on unsafe water sources. Many rural communities did not have access to soap and Certeza for water purification. The floods exacerbated this situation by disrupting supply chains. Unless provided through programming, many people did not have the money to buy these items themselves. Handwashing facilities were not available or accessible in rural communities. Some communities continued to use rivers and lakes as water sources despite the outbreak and continued to use them for washing and bathing.

The planned operation focused on door-to-door visits to households on water chlorination, food preparation and handwashing. CVM disseminated messages on cholera outbreak prevention and safe WASH practices throughout the affected communities. CVM also distributed essential WASH supplies such as chlorine tablets. Finally, CVM worked to construct or rehabilitate latrines in key communities throughout Mozambique.

Protection, Gender And Inclusion

During disease outbreaks, female-headed households, orphans, the elderly and people with disabilities or chronic illnesses were most affected. For waterborne diseases in particular, women and children were more at risk because they often had more contact with water through activities such as washing, cooking, fetching water and cleaning. People with chronic diseases lost access to medication when access to health facilities was cut off, leaving them vulnerable to worsening illnesses.

Multiple shocks also reduced the coping capacities of groups such as orphans and female-headed households, which may lead them to adopt negative coping mechanisms. In addition, during an emergency, evacuation centres are likely to have separate sleeping and sanitary facilities for men and women, exposing women and girls to sexual harassment.

The planned operation focused on the most vulnerable. Measures were taken to ensure that female-headed households, orphans, the elderly and people with disabilities or chronic illnesses were included in appropriate interventions to meet their needs.

Risk Reduction, Climate Adaptation And Recovery

The heavy rainfall season was forecast by INAM for the months of January to March in the provinces of Maputo, Gaza, Inhambane, Manica, Sofala and the south-eastern districts of Tete province and the south-western districts of Zambezia province. The floods caused loss of life and community assets due to a lack of anticipatory action. The operation planned to conduct monitoring and disseminate early warning information materials to raise community awareness, particularly in communities previously affected by flooding or cholera outbreaks.

Community Engagement And Accountability

The lack of effective RCCE/CEA to control and contain cholera outbreaks in communities was a key challenge. Identifying key entry points such as community leaders or other key influencers was one of the critical approaches to controlling cholera outbreaks. Addressing rumours and myths was also considered and addressed through the establishment of two-way feedback mechanisms.

CVM and IFRC identified the lack of community feedback mechanisms during activities as a key area for improvement. While CVM found that provincial offices currently receive and act on community feedback, the mechanism needs to be formalised.

The needs assessment was in line with the PGI minimum standards. In addition, the volunteers carrying out the activities were trained in PGI and CEA elements, allowing for better needs assessment and dissemination of relevant information to the communities.

A CVM-coordinated feedback mechanism is not currently in place throughout the country. Feedback comments were collected by volunteers, but not formally documented and addressed. Mozambican government agencies and the UN have a feedback mechanism through the Linha Verde.

UNICEF was interested in a formal partnership with CVM to address RCCE needs. CVM did not have a focal point for RCCE.

Operational Strategy

Overall objective of the operation

The objective of this operation was to support the Government's efforts to stop the ongoing cholera outbreak by improving community hygiene and health behaviours, interrupting the chain of transmission, increasing access to case management, and informing communities about the upcoming flood season to prevent its impact and potential worsening of the outbreak.

As the context evolved throughout the duration of the DREF, the DREF adapted to the evolving situation across the country. In particular, the landfall of Tropical Cyclone Freddy affected the population and the pre-existing cholera outbreak, and CVM responded by creating a separate DREF to address the impact of the tropical cyclone.

The operation targeted 240,000 people (48,000 families) and was launched for a period of five (5) months but was extended to six months. It was implemented in Gaza, Inhambane, Niassa, Sofala, Tete, Zambezia, Manica and Nampula through a comprehensive community-based approach including health, risk communication and community engagement (RCCE) and water, hygiene and sanitation (WASH). So far, the operation reached more than 380,000 people through RCCE engagement.

The cholera DREF was completed on time, but cholera cases continue, albeit at relatively low levels. Diarrhoea continues and active cholera cases have now been confirmed in five provinces, with an upward trend in the central and northern regions of the country. While future needs remain, the DREF deadline has already passed.

Operation strategy rationale

To address the needs of the target population, the operation implemented a two-pronged strategy to stop the ongoing outbreak and to support disease prevention activities to reduce the health risks associated with the cholera outbreak. The implementation plan covered both areas with confirmed cases and areas considered at risk. In particular, the health and WASH sectors were priority areas for intervention, and it was expected that the health situation for cholera would deteriorate, depending on the vulnerability of other sectors, if not addressed in advance.

This operation successfully expanded to reach a larger population than originally planned, particularly in health, WASH, and community engagement efforts with more volunteers trained, more CTCs supported and expanded outreach. However, challenges in community feedback collection, misinformation management, and gender-sensitive sanitation in displacement centers remain key areas for improvement in future operations. The response demonstrated effective partnerships, especially with UNICEF & SDC and strong adaptability, as shelter & Livelihoods support deprioritized to focus on cholera containment rapid scale-up. Nevertheless the need for improved community inclusion, structured feedback systems, and long-term resilience planning were highlighted.

1. Health Response
The health response contributed to reduce cholera transmission through expanded support to 35 Cholera Treatment Centers (CTCs), far exceeding the originally planned five. Cholera cases surged to 33,544 with 141 deaths, requiring a rapid scale-up of health interventions. The Mozambique Red Cross (CVM) distributed Oral Rehydration Salts (ORS), chlorine, hygiene kits, and protective equipment to CTCs and affected communities. A major component of the response was the training of 767 volunteers in community-based surveillance (CBS), risk communication (RCCE), oral cholera vaccination (OCV), and outbreak control strategies such as Branch Transmission Intervention Teams (BTIT). Additionally, 55 supervisors were trained to oversee cholera prevention efforts.
To strengthen health education, volunteers conducted 64,356 door-to-door visits, and 12 radio stations broadcasted cholera prevention messages, reaching over 718,000 people—a significant expansion from the five stations initially planned. The operation also adjusted its strategy to address new outbreak hotspots in Cabo Delgado, Nampula, and Manica, reallocating resources to these provinces as cases continued to emerge.

2. Water, Sanitation & Hygiene (WASH)
The water, sanitation, and hygiene (WASH) response played a crucial role in controlling the outbreak. The intervention included household water chlorination campaigns through door-to-door visits, the distribution of hygiene kits (soap, buckets, chlorine tablets), and the construction and rehabilitation of latrines in high-risk areas. Volunteers conducted disinfection campaigns using chlorine

spraying, targeting both community spaces and CTCs. Hygiene materials were provided in all 35 supported CTCs, including soap, water purifiers, and cleaning supplies.
However, there were several challenges:
- Severe flooding from Tropical Cyclone Freddy worsened water contamination, making it difficult to ensure access to safe drinking water, thus increasing cholera risk.
- Many rural communities continued relying on unsafe sources such as rivers and lakes, despite efforts to promote hygiene awareness.
- Limited availability of water purification agents further complicated the response, disrupting supply chains and requiring additional efforts to procure resources.

3. Risk Communication & Community Engagement (CEA/RCCE)
Community Engagement and Accountability (CEA/RCCE) efforts were significantly expanded, focusing on risk communication, misinformation management, and community outreach. The number of radio stations broadcasting cholera messages increased from 5 to 12, ensuring wider reach with up to 718,017 people reached. Volunteers were involved in risk communication and community engagement as an essential aspect of epidemic control and to promote safety. They actively conducted door-to-door sensitization, reaching 64,356 people, and worked to counter misinformation at the community level. They distributed IEC (Information, Education & Communication) materials to reinforce key messages. Focus Group Discussions (FGDs) were held in Niassa and Tete in partnership with UNICEF, helping to assess public perceptions of the outbreak. Through those various channels, volunteers gathered misinformation & rumors to counteract public fears.
The main challenge was that a formal community feedback mechanism was never fully established, limiting structured responses to concerns and rumors. Although volunteers collected public concerns informally, there was no centralized system to track and analyze feedback at a national level. Also, it was noted that misinformation persisted, particularly in remote areas.

4. Protection, Gender & Inclusion (PGI)
The PGI approach was integrated into the operation, recognizing that certain groups—such as women, children, the elderly, and persons with disabilities—faced heightened risks during the outbreak. 150 volunteers were trained in PGI strategies, with a focus on addressing the specific hygiene needs of women and girls, who are often responsible for water collection and household sanitation.
However, challenges remained, particularly in displacement centers, where gender-sensitive sanitation facilities were lacking, increasing the vulnerability of women and children to health risks and gender-based violence.

5. Shelter, Housing & Settlements
Initially planned? shelter and housing assistance was not implemented, as funds were reallocated to health and WASH interventions due to the severity of the outbreak. The cholera response had originally included provisions for shelter reinforcement, targeting 450 households, but these activities were deprioritized after the launch of a separate Tropical Cyclone Freddy DREF operation, which took over responsibility for addressing shelter-related needs.

6. Climate Risk & Disaster Preparedness
While climate risk and disaster preparedness were considered in response planning, no standalone climate adaptation program was developed. The intervention included flood early warning messaging, as Mozambique faced seasonal heavy rains and flooding, which contributed to cholera spread. However, despite initial plans to integrate disaster risk reduction (DRR) activities, efforts remained focused primarily on cholera prevention rather than long-term resilience building.

7. Coordination & Partnerships .
Strong coordination and partnerships played a crucial role in the success of the operation. The Mozambique Red Cross worked closely with the Ministry of Health (MoH), IFRC, UNICEF, WHO, MSF, and the Swiss Agency for Development and Cooperation (SDC). Additional SDC funding allowed operations to expand into Nampula and Manica, covering new outbreak hotspots. Coordination was maintained through 30 Emergency Operations Team (GODE) meetings, which provided regular updates on the situation. CVM actively participated in national and provincial health cluster meetings, ensuring alignment with government and humanitarian partners. Movement coordination was also strengthened, allowing the Red Cross to adapt its activities in affected areas and work alongside external partners such as WHO and UNICEF.
The challenge here was that the outbreak spread rapidly and there were delays in the availability of funding.

Human resources and capacity development:
CVM has a pool of approximately 880 volunteers trained in a variety of areas, including health, food and non-food distributions, and WASH. To ensure that trained volunteers were available to support operations in all affected areas, the operation prioritised building volunteer capacity in health and hygiene promotion, community-based surveillance, oral cholera vaccine delivery and epidemic control. Volunteers were trained to support the Ministry of Health in a wide range of cholera response activities, including community-based health care, provision of oral rehydration salts, distribution of oral cholera vaccine, community health and hygiene promotion, case referral and early detection, and work in cholera treatment centres. Volunteers were also trained in community engagement and accountability, recognising the importance of addressing community rumours about epidemics.

Coordination & PMER:
CVM HQ and branches implemented the response with the support of their volunteers, PNSs and the IFRC surge team. Daily status

meetings were held and HQ and IFRC monitoring visits were carried out in the provinces. At the provincial level, where a Health District Officer was not available, CVM appointed a focal point to provide updates on the response and the situation in the field. CVM coordinated closely with external stakeholders and the health cluster to organise the response across the country.

Training & Capacity Building:
767 volunteers trained in Community-Based Surveillance (CBS), Risk Communication (RCCE), Oral Cholera Vaccine (OCV), and Branch Transmission Intervention Teams (BTIT).
55 supervisors trained in cholera outbreak management.

A key lesson from this DREF could be emphasized on the fact that the response had to adapt to challenges such as floods, road inaccessibility, and shifting outbreak hotspots. Flexibility in planning and resource allocation was critical to maintaining effectiveness.

AS cholera cases declined, CVM, in coordination with the Ministry of Health and partners, scaled down emergency operations while maintaining key prevention activities in high-risk areas. Volunteers continued to support cholera awareness, hygiene promotion, and disease surveillance even after the DREF operation ended.

Additionally, the intervention laid the groundwork for future preparedness by strengthening local capacities, such as training community volunteers, supporting the functionality of Cholera Treatment Centers, and improving coordination mechanisms.

Targeting Strategy

Who was targeted by this operation?

The DREF targeted approximately 240,000 people (15,000 people in each district), approximately 10% of the people living in affected districts and districts at risk of cholera. The districts targeted include Lichinga, Lago, Senga, Mecanhelas, Cuamba, and Madimba in Niassa Province; Cala, Buzi, Dondo, Gorongoza, and Nhamatanda in Sofala; Angonia and Mutarara in Tete; Xai-Xai and Chilaulene in Gaza; and Milange in Zambezia.

Direct targets receiving material support included the most vulnerable families in communities where cholera cases had been recorded or were at risk. The operation targeted 12,000 people (2,400 HHs) in the highest hotspot districts.

Explain the selection criteria for the targeted population

The population of Niassa, Gaza, Zambezia, Sofala, Tete, Manica, and Nampula provinces were affected as per cholera reports confirmed by the Ministry of Health. CVM targeted the most vulnerable families with no access to basic items to prevent and protect themselves and their families. This included:
- Vulnerable groups in the communities such as pregnant and lactation women, persons living with disabilities and older people, children, as well as people suffering from chronic diseases.
- Priority was given to the most exposed communities from districts with ongoing outbreaks which were also at risk of experiencing floods this season.
- Vulnerable groups as above but specific groups living on the border areas of Malawi such as the fishing communities and fishermen; people living in flood-prone areas and along the basins, Lake Niassa and Zambeze River.
- The families with high numbers of members, who also share housing with minors, the elderly, lactating mothers, and people who are ill.
- Community-based targeting was used to ensure the most vulnerable ones were supported. Communities decided with CVM provincial offices, based on the cholera statistics, prioritizing hotspots.

Total Targeted Population

Women	**106,404**	Rural	**70%**
Girls (under 18)	**18,396**	Urban	**30%**
Men	**96,052**	People with disabilities (estimated)	**2.6%**
Boys (under 18)	**19,148**		
Total targeted population	240,000		

Risk and Security Considerations

Please indicate about potential operation risk for this operations and mitigation actions

Risk	Mitigation action
Natural disasters: The recurrence of disasters increasing as well as the number of affected people was a concern. Other extreme weather events were possible throughout the project implementation period as well.	Monitoring weather updates from INAM and ensure security briefings would be given to volunteers and operation team.
Procurement challenges in rural areas.	Procurement would need to be done in Maputo and budgeted accordingly.
Migration: Niassa shares border with other countries including Zimbabwe, Zambia and Malawi, which was experiencing a cholera outbreak. High migratory movements have been reported, which could increase the risk of the cholera contamination.	Deployment of volunteer to work on awareness raising with communities living in those areas, through house-to-house community awareness and RCCE.
Distribution challenges in rural areas.	Establishment of accessible distribution points, mapping roads, and working with community leaders to ensure all community members awareness of the distribution.

Please indicate any security and safety concerns for this operation

Conflict: Mozambique is experiencing conflict in the province of Cabo Delgado, caused by armed groups' violent actions targeting government structure and officials, with an impact on the civilian population as well as growing concern about IDP in some districts of Niassa.

The National Society ensured continuous security monitoring in partnership with ICRC, government, and other NGOs. Weekly security briefings of staff by the security officer were done. Risks were monitored, and volunteers received a briefing for individual security. Protection equipment was also planned for the engaged staff and volunteers.

Implementation

Shelter Housing And Settlements

Budget: CHF 27,247
Targeted Persons: 2,250
Assisted Persons: 0

Indicators

Title	Target	Actual
Number of volunteers who completed training in emergency shelter	50	0
Number of people reached with shelter kits to support reinforcement of shelter	2,250	0
Number of HH who confirmed the shelter materials have helps them reinforced their houses	450	0

Narrative description of achievements

• Shelter activities were not implemented during this DREF.

Lessons Learnt

• During the implementation of the Cholera DREF, Mozambique was hit twice by Tropical Cyclone Freddy. As a DREF was launched for that emergency, all activities were reallocated to that DREF. The funds originally allocated to shelter activities within the Cholera DREF were re-prioritized to scale up the health, WASH and RCCE activities.

Health

Budget: CHF 79,735
Targeted Persons: 240,000
Assisted Persons: 718,017

Indicators

Title	Target	Actual
Number of districts covered by assessment	16	18
Percentage of targeted communities with active CBS volunteer	100	100
Number of ToT/ Supervisors trained in CBS/RCCE/OCV	36	55
Number of volunteers trained in CBS	360	767
Number of people reached through radio awareness messages	302,000	718,017
Number of people confirming they received health messages through door to door	12,000	64,356
Number of people reached with health awareness messages	240,000	382,276
Number of radios that disseminated cholera prevention messages	5	12
# of CTC´s supported in cholera response	5	35
#of hygiene kits distributed within CTC´s	200	252

Narrative description of achievements

A key Success of this operation is that overall, implementation exceeded plans, particularly in:
- Volunteer training numbers more than doubled, improving outreach capacity (767 instead of 360)
- Radio awareness campaigns (12 radio stations contracted instead of 5).
- CTC support covering 35 centers instead of 4, due to the outbreak's spread.
- House-to-house sensitization reached more people than planned (64,356 people instead of 48,000)

1) Prevention and interrupt chain of transmission with community- based health:
• CVM conducted rapid needs assessments in 18 districts of Zambezia (3), Niassa (5), Manica (5) and Sofala (5) to better understand the needs and community perception of cholera. In Gaza and Tete, CVM did not conduct separate assessments, as those provinces coordinated their needs assessments with the Ministry of Health (MoH). The general assessment concluded the unavailability of access to drinking water, lack of water purifiers in the hotspots market and poor environmental sanitation. Cases of deaths due to cholera and difficulties in activating volunteers to carry out field work due to lack of financial and material resources.

• In terms of supervisor training, CVM conducted Training of Trainers (ToT) sessions for 55 individuals (46 men and 9 women) on key community health topics, including Community-Based Surveillance (CBS), Risk Communication and Community Engagement (RCCE), and Oral Cholera Vaccine (OCV) awareness. These sessions were carried out across five provinces: Niassa (16), Zambézia (20), Sofala (9), Manica (6), and Tete (4). This represents 153% of the original target of 36 supervisors. The increase was due to the inclusion of additional provinces, which were not part of the initial operational plan. The expansion responded to the rapid evolution of the outbreak, requiring more supervisors to ensure greater coverage and effective implementation of activities in newly affected areas.
• Similarly to the Training of Trainers (ToT), the training of volunteers also exceeded initial targets, with a total of 767 volunteers trained (469 men and 298 women) against a target of 360, representing 213% achievement. This increase was driven by the same rationale as the ToT expansion, namely the rapid spread of the outbreak and the inclusion of additional provinces not originally planned in the intervention. To ensure effective community-level response and coverage, more volunteers were mobilized and trained accordingly. The training covered critical topics such as Community-Based Surveillance (CBS), Risk Communication and Community Engagement (RCCE), Oral Cholera Vaccine (OCV), EPIC (Emergency Preparedness and Incident Command), BTIT (Branch Transmission Intervention Teams), hygiene promotion, and data collection methods. The breakdown by province was as follows: Niassa (134), Zambézia (120), Sofala (237), Tete (79), Nampula (60), and Manica (137).
• For awareness messaging, CVM developed and disseminated messages covering cholera prevention, safe water handling, hygiene promotion, and Infant and Young Child Feeding (IYCF/ANJE). Messages were delivered through radio, house-to-house visits, and megaphone announcements to ensure maximum reach, and reached 64,356 people. IEC materials were also printed and distributed to support awareness-raising.
• Radio campaigns were significantly expanded. While originally planned for 5 radio stations, CVM broadcasted messages on 12 stations, with one station each in Manica, Niassa, Sofala, and Tete, and three stations each in Zambezia and Nampula.
• CVM produced and distributed IEC materials, including banners, pamphlets, and brochures, to support community health activities in raising awareness about cholera prevention.
• To raise awareness and educate the community on cholera prevention, CVM developed and disseminated messages and jingles in local languages through various channels. Messages covered health education, hygiene practices, early warning for floods, and breastfeeding (IYCF/ANJE).
• CVM broadcasted awareness messages and jingles on 12 radio stations across the country, exceeding the original plan of five stations. This included one radio station each in Manica, Niassa, Sofala, and Tete, and three stations each in Zambezia and Nampula.
• IEC materials such as banners, pamphlets, and brochures were produced and distributed to support community health education and cholera prevention efforts, in all districts targeted for the operation.
• House-to-house information dissemination visits were conducted in the affected provinces, sensitizing communities on the early signs of cholera, prevention methods, case management, handling of safe drinking water, hygiene practices, and safe food preparation. 64,356 individuals were reached through these door-to-door visits. Additionally, volunteers conducted group sensitization sessions (10-15 people per session) and used megaphones attached to vehicles with recorded messages to expand outreach.
• Volunteers worked with MoH CBS teams to conduct community-based surveillance (CBS), supporting case detection and referrals in cholera-affected districts. CBS was fully integrated into volunteer activities, though specific details on frequency and paper-based reporting were not provided.
• CVM procured and distributed PPE and hygiene materials to volunteers, including gloves, sanitizers, and chlorine for health and hygiene safety.

2) Support case management and treatment:
• The support to Cholera Treatment Centers (CTCs) far exceeded the original plan, expanding from 4 CTCs to 35. Instead of just Niassa, Sofala, and Gaza, the response covered CTCs in Gaza (2), Nampula (2), Sofala (4), Tete (5), Manica (6), Zambezia (7), and Niassa (9). This expansion was necessary due to the rapid spread of the outbreak, which led to the activation of additional CTCs and isolation points in various districts and provincial hospitals.
• CVM provided ORS, granulated chlorine, PPE, hygiene kits, jerrycans, and sanitizers to CTCs. Additionally, 252 hygiene kits were distributed in Sofala and Zambezia to improve sanitation at treatment centers. Volunteers assisted in managing cases at CTCs, implementing BTIT strategies (Ban the Infectious Agent, Treat the Ill, and Improve WASH), facilitating referrals, and ensuring proper hygiene and safety measures.
• For community-based healthcare, CVM procured and distributed soaps, buckets, PPE, hygiene kits (laundry powder and sanitary pads), cholera tablets, and ORS across impacted provinces.

3) First aid and PSS to affected communities:
• Finally, CVM volunteers provided Psychosocial Support (PSS) to affected communities in hotspot districts. However, there was no specific reporting on the planned First Aid training for 50 volunteers.

Lessons Learnt

• Conducting rapid needs assessments in affected districts was crucial for understanding community needs and perceptions during the outbreak, and coordination with the Ministry of Health (MoH) and partners to avoid duplications.
• Initially it was planned to support 4 Cholera Treatment Centers (CTCs) in Niassa, but the outbreak's extent required a significant increase

in the number of supported CTCs. Therefore, the flexibility in scaling up operations was vital to address the support needed in the various provinces.

Challenges

• Cholera spread rapidly throughout the country during the DREF operation. This forced CVM to constantly be shifting and adapting its operational plan to adjust to the needs on the ground and be in coordination with other government agencies.
• As cholera spread rapidly throughout the country, including remote areas, this presented a challenge for CVM to reach remote communities in the appropriate amount of time. CVM encountered delays and difficultly with procurement for those areas.

Water, Sanitation And Hygiene

Budget: CHF 96,873
Targeted Persons: 240,000
Assisted Persons: 321,778

Indicators

Title	Target	Actual
# emergency latrines constructed	50	13
# of houses/places pulverized	5,000	2,062
PDM conducted	1	1
Number of families that receives water supply material	2,400	1,337
Number of families that receives hygiene material	2,400	3,325
Number of handwashing stations set up	200	53
Number of households reached with hygiene promotion	48,000	64,356

Narrative description of achievements

During the project implementation, CVM worked to integrate the WASH intervention into key health activities to avoid the continuation of the cholera outbreak. Due to context constraints and challenges encountered throughout the DREF (such as delayed supplier availability or limited transport equipment), hygiene promotion and distribution of hygiene material were prioritized over the construction of latrines, boreholes and handwashing stations. This prioritization was based on the multi-sectoral needs assessment findings.

The key achievements include, but are not limited to the below:
• To enhance the strategy for blocking the outbreak, additional support for care at Cholera Treatment Centers (CTC), donations of supplies, indoor spraying, and backing the oral cholera vaccination campaign were incorporated reaching out 41% of the targeted houses to be pulverized. Nevertheless, some tasks, such as rehabilitating water wells and constructing latrines for the physically disabled, remain outstanding with only 26% of the target achieved for latrines. These activities necessitate a procurement process, which, when combined with limited access to transport equipment, contributed to delays.
The intervention did not include specific activities related to the establishment of community committees for the management and monitoring of boreholes and latrines, as originally planned. Instead, the focus was redirected toward hygiene promotion, support to Cholera Treatment Centers (CTCs), and door-to-door awareness due to emerging priorities and operational challenges.
• Due to the high amount of hygiene kits distributed in Zambezia, a Post-Distribution Monitoring (PDM) exercise was conducted in Quelimane district, Zambézia Province, to assess the relevance, effectiveness, and beneficiary satisfaction following the distribution of hygiene kits under the cholera DREF operation. A total of 61 households (representing 23% of total beneficiaries in the area) were surveyed using digital data collection tools. The findings revealed that all respondents confirmed receiving the hygiene kits, and the vast

majority expressed satisfaction with the registration process and the quality of the items received. However, only 79% were fully satisfied with the quantity of items, particularly in larger households where needs exceeded the kit content.
Distributions were primarily conducted at the beneficiaries' homes, which improved accessibility. While 61% of respondents reported receiving prior information about the distribution, many were unaware of the specific items they would receive. A key gap identified was the limited awareness and use of complaints and feedback mechanisms.
• 1,337 (56%) affected families throughout all the outlined provinces, except Niasssa, were provided with WASH items including containers, water purification tablets, bottles, and services to families in the most vulnerable communities in the 16 districts following the initial multi-sectoral needs assessment results.
• 2,758 affected families were provided with hygiene kits including 10L jerrycans and soaps for three months. These kits were distributed in Gaza, Sofala, Tete, and Zambezia.
• Against the initial target of 200 handwashing stations, a total of 97 stations were established, representing a 49% achievement. This total includes 44 handwashing stations constructed by CVM in key public health locations across the affected provinces: Niassa, Sofala, Tete, and Zambézia, and 53 additional stations that were installed or maintained in Cholera Treatment Centres (CTCs) with the support of CVM volunteers, in close coordination with the Ministry of Health. The prioritization of installations in CTCs and health facilities was a strategic decision, aimed at reducing the risk of infection in high-transmission areas and ensuring hand hygiene in spaces where cholera patients and caregivers were present. This focus allowed for more targeted use of resources and effective supervision by CVM teams. The distribution of handwashing stations across the provinces was as follows: Niassa-9, Sofala- 9, Manica- 9, Tete- 12, Zambézia- 14. Although the number of stations fell short of the original target, the intervention was still impactful due to its strategic focus on CTCs and high-risk areas, helping to strengthen infection prevention and control efforts during the cholera outbreak.
• CVM reached in total 64,356 households (321,778 People, of those 41% female, 30% male and 29% were childrens) with hygiene promotion information through door-to-door visits.
• At the beginning of the cholera outbreak, CVM also assisted the MoH with spraying cholera-affected households with chlorine to prevent the further spread of the disease. CVM sprayed: 112 households in Gaza, 697 households in Niassa, 318 households in Sofala, 615 households in in Tete, 233 households in Zambezia, 87 households in Nampula
• In flood-prone areas of Sofala Province, early warning messages were actively disseminated as part of the preparedness and response strategy during the cholera outbreak. Working closely with local authorities and community leaders, trained Red Cross volunteers conducted door-to-door awareness campaigns and used community radios and megaphones to broadcast early warning messages related to flood risks and associated health threats, including cholera. These messages focused on preventive measures, such as the safe use and storage of water, proper handwashing practices, and what to do in case of rising water levels. The use of local languages and culturally adapted content helped ensure greater community understanding and engagement.

Lessons Learnt

• The project demonstrated the importance of adaptability in prioritizing interventions. Context constraints and challenges led to prioritizing hygiene p of households with hygiene promotion and the distribution of materials over infrastructure projects like latrine construction and handwashing stations.
• Door-to-door visits and community engagement initiatives were successful in reaching a large numeration information. This highlights the effectiveness of grassroots-level communication in disseminating critical health information.
• Conducting post-distribution monitoring visits, as exemplified in Quelimane City, is essential to evaluate the effectiveness of interventions, gather feedback, and make adjustments based on real-time needs and challenges.
• The project's ability to enhance the strategy for blocking the outbreak by incorporating additional support for Cholera Treatment Centers (CTCs), donations of supplies, and indoor spraying demonstrates the importance of strategic decision-making in response to evolving situations.
• Identified challenges in rehabilitating water wells and constructing latrines, such as procurement processes and limited access to transport equipment, highlight the need for streamlined logistics and contingency planning for unforeseen obstacles.
• The identification of outstanding tasks, like water well rehabilitation and latrine construction, emphasizes the importance of realistic planning and accounting for potential delays. Future projects can benefit from advanced procurement strategies to mitigate such challenges.

Challenges

During implementation, CVM faced many delays related to the supplier of the latrines. CVM originally identified Niassa as the designated province for the latrines, but the supplier had difficulty transporting supplies to the province and the cholera outbreak had spread at that time to outside of Niassa. Instead, CVM pivoted to provide latrines in Gaza but still faced delays from the supplier.
• Another challenge between IFRC and CVM was the lack of CVM staff availability during the DREF implementation. Due to competing priorities with other projects or trainings, CVM staff were often occupied with other tasks.
• CVM had difficulty procuring the goods for the handwashing stations leading to multiple delays in certain provinces. In turn, CVM and IFRC prioritized activities such as hygiene kit distribution. While CVM did try to mitigate procurement challenges where possible, it ultimately led to fewer hand washing stations being established.
• In some affected communities, there was initial resistance to the use of chlorinated water at handwashing stations. The word 'chlorine' was misunderstood by some community members as being associated with cholera itself, leading them to believe that the washing points

were actually spreading the disease. As a result, three handwashing stations were vandalized in Zambézia Province, which was the epicentre of the outbreak at the time. This incident forced CVM to temporarily suspend implementation of certain activities in the area.

Protection, Gender And Inclusion

Budget: CHF 0
Targeted Persons: 12,000
Assisted Persons: 64,356

Indicators

Title	Target	Actual
Percentage of feedbacks linked to protection concerns that are managed	100	0
Number of briefings in the intervention on PGI	5	0
% of volunteer trainings that include a PGI briefing	100	97

Narrative description of achievements

The operation aimed to ensure the promotion and participation of men and women, including persons with disabilities. Staff and volunteers would be briefed on the Code of Conduct and on prevention and response to sexual exploitation and abuse and child safeguarding as they implemented Cholera interventions. Ensure that all NS, IFRC, PNS staff, and volunteers involved had signed the Code of Conduct. All trainings carried out with dedicated sessions on PGI to ensure PGI and its application reinforced.
• IFRC and CVM tried to implement PGI activities where possible ensure the promotion and participation of men and women including persons with disabilities, however this data disaggregated is undisclosed from the information gathered.
During volunteer trainings, CVM briefed them on PGI topics, such as an introduction to Protection, GBV, and PSEA, and points of concern volunteers may encounter while out with the community. All provinces, except for Gaza implemented this.
• Specific training was done for volunteers in these provinces.

Lessons Learnt

• CVM did not track or report on the "number of briefings in the intervention on PGI" as this was not a suitable indicator based on the PGI activities and therefore this indicator was reported as zero. Instead, CVM tracked and reported on the indicator "% of volunteer trainings that include a PGI briefing" as this more accurately represented the type of PGI activities conducted during the DREF. And so far, the 20 (3%) volunteers from Gaza province did not receive any briefing prior to the activities.

Challenges

• CVM had difficulties implementing a community feedback mechanism in all affected provinces which inhibited them from collecting and addressing protection concern feedback. Instead, they used informal channels which IFRC and CVM are working to formalize in the next DREF operation.

Community Engagement And Accountability

Budget: CHF 5,509
Targeted Persons: 240,000
Assisted Persons: 328,279

Indicators

Title	Target	Actual
Percentage of feedback collected which is addressed	100	100
Number of volunteers trained on CEA	396	596

Narrative description of achievements

During the DREF implementation CVM engaged the communities in a different approach and implemented feedback mechanisms trough community mobilizations, focus group discussions, collection of rumors, perception surveys and door-to-door visits, and it can be estimated that approximately 328,279 people were reached within the scope of Community Engagement and Accountability (CEA).

CVM trained 596 volunteers across the seven (this is inclusive to the 2 additional provinces supported by CDC) provinces on topics including, but not limited to, RCCE and CEA strategies. Furthermore, following the distribution of goods in Sofala and Zambezia, CVM conducted door-to-door outreach to receive feedback on the distribution. The intention was to obtain feedback from the beneficiaries regarding the distribution process and assess their level of satisfaction with the project. For this purpose, a questionnaire was used to collect the beneficiaries' satisfaction with the received products and their overall perception of the implementation process. So far, 92% of the interviews referred to be satisfied with the distribution process and 100% said they were satisfied with the products received.

In Sofala province, a total of 38 pieces of feedback were collected, primarily related to cholera prevention methods. Trained volunteers, well-prepared through their sessions, were able to respond immediately to most questions and concerns raised by community members, thereby reinforcing trust and improving health practices on the ground. However, four of the collected feedback items were referred to the health team, as they involved resistance from some community members in accepting the use of ORPs (Oral Rehydration Points). These cases required more technical or targeted engagement to overcome misinformation or reluctance. Moreover, in collaboration with UNICEF, focus group discussions were conducted in Niassa province to further understand community perceptions and strengthen communication and engagement approaches. These efforts contributed to improving the design and delivery of health messages and interventions during the cholera response.

From the total feedback collected, CVM ensured that 100% of the issues raised were addressed. Whenever possible, concerns were resolved immediately by trained volunteers in the field. For those requiring further technical input, such as the four cases related to resistance to ORPs, the feedback was promptly referred to the appropriate health authorities.

In the RCCE activities, volunteers were also trained on how to address rumors or feedback specifically related to misconceptions about cholera and disease transmission.

During the operation, CVM also worked with the UN in Mozambique on the UN-run Linha Verde feedback mechanism which was part of the wider country-wide response. This feedback mechanism was reported on a bi-monthly basis and was done country-wide.

Lessons Learnt

•Training volunteers on topics such as RCCE and CEA strategies equipped them to effectively engage with communities. This approach facilitated two-way communication and ensured that volunteers could address rumors and feedback related to cholera misconceptions and disease transmission.
• Incorporating beneficiary satisfaction assessments into the feedback process, using tools like questionnaires, allowed for a quantitative measure of the community's satisfaction with the distribution process and received products.
• Collaborating with partners, such as UNICEF, in conducting focus group discussions showcased the importance of engaging in partnerships to enhance the depth and reach of feedback mechanisms.

Challenges

• Unfortunately, CVM was unable to implement formal feedback mechanisms in the remaining provinces due to a combination of, time constraints, and competing operational priorities during the height of the emergency response. Despite the absence of structured systems, CVM volunteers and staff maintained active engagement with community members, providing real-time clarifications and responses to concerns raised during outreach and awareness activities. However, these interactions were not formally documented, as the teams prioritized immediate response and life-saving interventions. Moving forward, there is a recognized need to strengthen and standardize feedback collection processes to ensure community voices are consistently captured and used to inform programming.

• Adequate resources, including financial, human, and logistical, were necessary for the successful execution of comprehensive community engagement strategies.

Secretariat Services

Budget: CHF 50,496
Targeted Persons: 4
Assisted Persons: 6

Indicators

Title	Target	Actual
Number of coordination meetings organised with IFRC participation	10	10
Number of mission from IFRC to support CVM	4	6

Narrative description of achievements

• Within the TC Freddy response DREF a one-month finance deployment also supported the Cholera DREF's accountability to ensure the clarity of this process by working directly with the CVM Finance Director. The Canadian Red Cross also contributed to the deployment of three surge delegates in the capacity of public health officers and a coordinator. They supported CVM with field deployments for needs assessments, capacity building, strategic partnerships and reporting. IFRC DM and Health and Care Officer also deployed in key moments of the outbreak, mainly to the most affected provinces of Niassa and Zambezia.
• All the Cholera response coordination meetings were led by the IFRC Health and Care department.
• PMER team initially provided support remotely. However, throughout the period, it was noted that the National Society (SN) faced challenges in sharing information due to the lack of allocation of focal points in the intervention areas to manage the flow of information. This resulted in the need to deploy the Federation PMER staff to the field to provide on-site technical support, as the National Society (SN) has only one PMER officer at the national level.

Lessons Learnt

• The inclusion of a one-month finance deployment within the TC Freddy response DREF to support the Cholera DREF's accountability was a valuable strategy. This practice enhanced transparency and ensured clear financial processes, ultimately contributing to effective resource utilization.
• The deployment of surge delegates, including public health officers and a coordinator from the Canadian Red Cross, demonstrated the effectiveness of collaborative efforts in responding to complex emergencies. They played a key role in field deployments, needs assessments, capacity building, strategic partnerships, and reporting.
• Alongside identification, designated focal points should undergo comprehensive training to ensure they are well-equipped to handle PMER responsibilities. This training can cover data collection methods, ITT utilization, and other relevant skills.
• It is necessary to develop clear protocols and guidelines for PMER activities within the context of DREFs. This includes delineating responsibilities, timelines, and communication channels to streamline the process.
• In the next DREFs, PMER focal points should be identified in advance to avoid the difficulties experienced at the beginning of the specific DREF regarding data collection.

Challenges

• Field data updates were difficult to obtain, and the hierarchical system of CVM, as well as the lack of designated personnel for data management, constituted limiting factors for accessing information. This often resulted in delays in updating implemented activities.
• Remote PMER support proved not to be very effective, mainly because the delegations did not have designated and trained focal points to conduct this activity. There was a need to visit all provinces covered by the DREF to guide the belatedly identified focal points and to collect existing data in the field to feed into the ITT.

National Society Strengthening

Budget: CHF 58,060
Targeted Persons: 452
Assisted Persons: 767

Indicators

Title	Target	Actual
Number of coordination meetings attended by the Health cluster and MoH	20	113
Number of coordination meetings organised within the Movement	10	18
Number of coordination meetings held in GODE	20	30
Number of months of deployment for the Rapid Response Team member (Surge)	3	4
Number of provincial response focal point mobilised and trained	5	7
Supervision report completed at districts level that are shared with coordinator	20	42
Number of missions to be conducted by HQ	4	3
Number of volunteers trained who are mobilised	446	767

Narrative description of achievements

• CVM attended 113 coordination meetings with the Ministry of Health and the Health cluster, specifically in Gaza, Niassa, and Tete, either at the national or the provincial level. The coordination meetings took place with the MoH, UNICEF and MSF before CVM went to the field to carry out activities. In Niassa, the meetings took place every weekday (five times a week) except on public holidays from January 12 to May 14, 2023.
• GODE and Cholera technical meetings were developed since the very beginning of the outbreak. The GODE meetings included the participation of the CVM authorities (Secretary General and Programs Directors) and coordinators, PNSs representatives, CVM provincial delegations and IFRC coordinators. and took place 30 times throughout the beginning of the operation. The 18 technical meetings were Movement-wide and were held by the ones that were aimed at discussing specific topics related to the cholera impact and intervention strategy.
• Due to operational needs and with the support of the Uruguayan Red Cross, the Operations Manager deployed extended its mission from 3 to 4 months to ensure the continuity of key coordination actions, including reporting and accountability.
• The provincial response focal points participated in the training of trainer's sessions in Niassa, Sofala, and Tete with 7 trainers done in total were held jointly and everyone took part. Provincial focal point was responsible for collecting, collating and sharing data on activities with the central office and took part in all the training sessions with his colleagues.
• 767 (469 men, 298 women) volunteers received Health and Hygiene training from CVM HQ staff, training topics included those listed above in the health section. The number of volunteers ended up surpassing the estimated target because the initial plan anticipated a small number of intervention sites. However, as the situation escalated, there was a need to cover more areas, resulting in an increase in volunteers. Furthermore, with the support of CDC funds, it was possible to train a larger number.
• Some distribution of visibility items and PPE/equipment have been distributed to all volunteers (767)
• 42 supervisor reports were completed at the district level: 12 in Gaza, 17 in Sofala and 13 in Zambezia. In Sofala, 2 reports were made in Nhamatanda, 13 in Beira, one in Marromeu, and 1 in Chemba. Beira had more reports because it had ORPS, CTCs and mobilization. In Zambezia 13 were conducted in Quelimane.
• Ensurance has been provided to all.

Lessons Learnt

• The GODE meetings were appropriately coordinated and involved the participation of national, provincial, and partner technicians, fostering effective coordination among them and with the Ministry of Health (MoH).
• The training of volunteers enabled them to be well-prepared to address the needs of preventive intervention in communities, fostering significant acceptance and credibility among the community members.

• To address gaps in data collection and sharing management, a WhatsApp group was created. In this group, focal point volunteers were selected and received training for collecting and compiling field data. This ensured an improvement in the flow and circulation of information.

Challenges

• The lack of trained volunteers for data collection and management, coupled with frequent changes in information collection tools, posed a limiting factor for the flow of information. This hindered the timely updating of information about the activities being implemented in the field.

Financial Report

Selected Parameters			
Reporting Timeframe	2023/01-2024/12	Operation	MDRMZ019
Budget Timeframe	2023/01-2024/12	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

Prepared on 28/Feb/2025

All figures are in Swiss Francs (CHF)

MDRMZ019 - Mozambique - Cholera Outbreak and Floods Readiness

Operating Timeframe: 20 Jan 2023 to 31 Jul 2023

I. Summary

Opening Balance	**0**
In-Kind Personnel	**37,110**
The Canadian Red Cross Society	37,110
Funds & Other Income	**476,331**
DREF Response Pillar	476,331
Expenditure	**-295,431**
Closing Balance	**218,010**

II. Expenditure by area of focus / strategies for implementation

Description	Budget	Expenditure	Variance
AOF1 - Disaster risk reduction	0		**0**
AOF2 - Shelter	27,247	10,265	**16,982**
AOF3 - Livelihoods and basic needs			**0**
AOF4 - Health	151,141	79,735	**71,406**
AOF5 - Water, sanitation and hygiene	165,623	96,873	**68,750**
AOF6 - Protection, Gender & Inclusion	0		**0**
AOF7 - Migration			**0**
Area of focus Total	**344,012**	**186,874**	**157,138**
SFI1 - Strenghten National Societies	100,743	58,060	**42,683**
SFI2 - Effective international disaster management			**0**
SFI3 - Influence others as leading strategic partners			**0**
SFI4 - Ensure a strong IFRC	31,576	50,496	**-18,920**
Strategy for implementation Total	**132,319**	**108,557**	**23,763**
Grand Total	**476,331**	**295,431**	**180,900**

Click here for the complete financial report

Please explain variances (if any)

As mentioned above, shelter activities were not implemented due to the reallocation of funds to WASH and Health. The shelter budget was no longer prioritized because Tropical Cyclone Freddy made landfall twice in the country, leading to the launch of a new DREF operation to respond to shelter emergency. Consequently, the funds originally allocated for Shelter in the Cholera DREF were reallocated.

The health and WASH expenditure was significantly lower than the budget due to additional funds received from the SDC to complement the Cholera operation. The SDC funds allocated to the Cholera response covered activities in health and WASH, providing savings under

the DREF.

Additionally, the procurement of items such as Certeza and hygiene items was cheaper than budgeted, resulting in further savings.

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Click here for reference