DREF Final Report

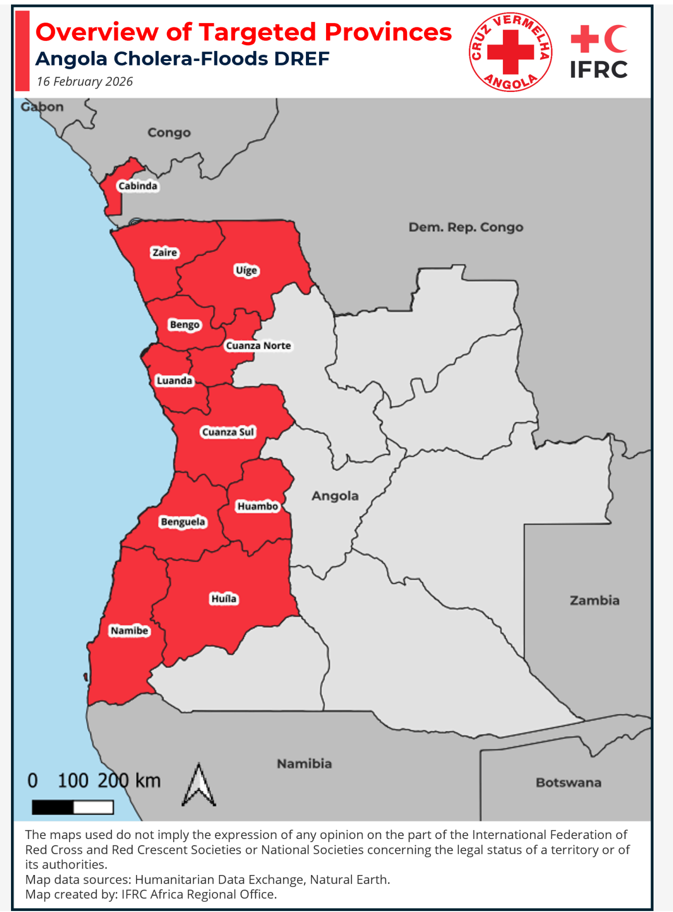
Angola - Cholera & Floods Response

CVA Volunteers setting up Safe Water Points for the Cholera Response

Appeal: **MDRAO011**	Total DREF Allocation: **CHF 627,608**	Crisis Category: **Orange**	Hazard: **Epidemic**
Glide Number: **-**	People Affected: **7,200,000 people**	People Targeted: **720,000 people**	People Assisted: **880,229 people**
Event Onset: **Sudden**	Operation Start Date: **21-01-2025**	Operational End Date: **31-10-2025**	Total Operating Timeframe: **9 months**
Targeted Regions: **Bengo, Benguela, Cabinda, Cuanza Norte, Cuanza Sul, Huila, Huambo, Luanda, Namibe, Uige, Zaire**			

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



Targeted Provinces for the Cholera-Floods Operation

Date of event

07-01-2025

What happened, where and when?

Angola experienced a Cholera Outbreak since 7th January 2025, which remained active until October 2025 , significantly affecting several regions of the country. By October 2025, a total of 27,728 Cholera cases were reported nationwide, with 776 deaths recorded. Of these fatalities, 341 (44%) occurred outside health facilities, while 435 (56%) occurred within health facilities, affecting individuals aged between 2 and 85 years. The high proportion of community (extra-hospital) deaths highlighted persistent challenges related to timely access to healthcare services, early recognition of symptoms, and appropriate health-seeking behaviour among affected populations. The outbreak had its greatest impact in the provinces of Luanda, Bengo, Benguela, Cuanza Norte, Cuanza Sul, Uíge and Zaire, where limited access to safe drinking water, inadequate sanitation, poor hygiene practices and high levels of vulnerability created conditions conducive to rapid disease transmission. These risk factors were further exacerbated by the rainy season, which intensified environmental contamination and increased exposure to waterborne diseases.

Bairro Paraíso, Municipality of Cacuaco, Luanda Province, registered 25 suspected cases of Cholera on 7th January 2025, of which 5 died. BY 8th January 2025, more than 30 suspected cases were recorded. On 8th January 2025, the Ministry of Health held a meeting to launch the 2025 National Response Plan to Control Cholera, requesting partners, including Angola Red Cross, to support with the planned response. By 28th June 2025, cases had increased to 27,008, with 759 deaths and a Case Fatality Rate of 2.8%. The situation improved, with a reduction of 47% in cases reported in the last week of June 2025 only in 10 provinces (out of 18 that reported cases at some point of the outbreak).

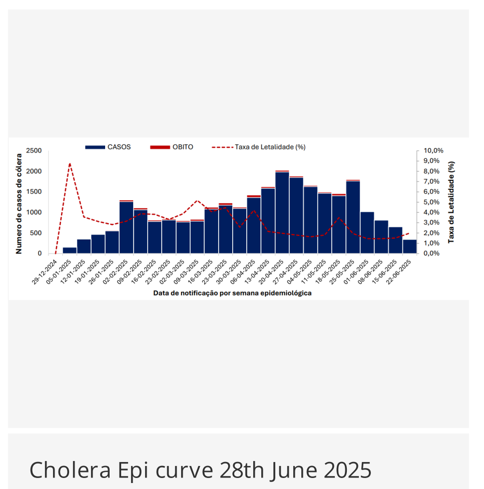
The start of year 2025 was characterised with the rainy season in Angola, with documented flooding across numerous provinces of the country. Combined with heavy rainfall, poor sanitation and limited access to clean water, there was an increase of risk in Cholera outbreaks and other waterborne diseases, especially in children. From the start of the year, multiple risk alerts for imminent flooding

were issued on the Disaster Alert Platform across various provinces, including Luanda and those at higher risk of diseases outbreak. Flooding risk according to IFRC Risk Watch, remained through May 2025 for Angola. Reports from the Provincial Government indicated multiple impacts of floods including lives and livelihoods lost or damaged, as well as houses and public infrastructure across various provinces. While these provincial reports did not have disaggregated data by date of flooding event, but covered seasons across years, they still showed impacts of the floods.

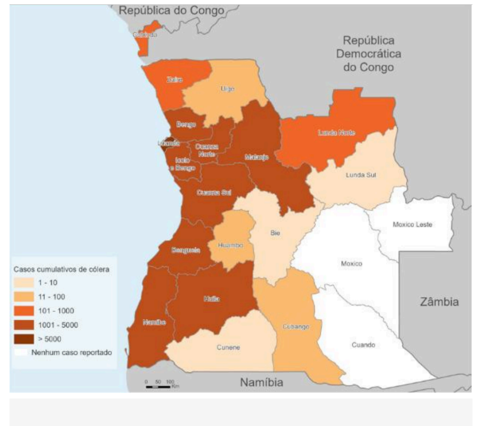
On 7th May 2025, Angola Red Cross submitted a qualitative assessment carried out by the National Society (NS) with support from this DREF operation on the vulnerabilities and risks of people affected by floods and Cholera across 6 provinces. The assessment report was accompanied by official government data (where available and with various time periods). The qualitative assessment from the NS indicated that due to heavy downpours, there were significant loss of livelihoods in communities, and an increased risk of disease outbreaks. The most reported needs were those of reinforced shelter as homes were built with weak materials, household items such as Mosquito nets, health and hygiene items such as soap and clean water, and food (given loss of agricultural inputs and ongoing food insecurity across Angola). Data from the Government indicated that there were deaths and injuries and thousands of houses damaged or destroyed. However, the impacts were not linked to one specific event, but to entire seasons of flooding. While the impacts of the floods could not be linked to a single flooding event, the 7th May 2025 Report from the NS, was the official request for support for the impact of the floods and continued Cholera Response because floods worsened the Cholera Outbreak. By end of June 2025, most of flooded areas had dried, while households returned to their settlements, needs were still high due to the loss and the impact of floods.

In response to the flood emergency, the Angola Red Cross, with support from the IFRC, conducted a rapid market assessment in 3 most affected provinces most by the combined impacts of heavy rainfall, flooding and Cholera transmission. Based on the findings, targeting criteria were established, beneficiaries were identified, and cash assistance was distributed to eligible households in a timely, dignified and flexible manner, while simultaneously supporting local markets. This complemented the ongoing WASH and Health activities, as key interventions for under both Cholera and flood responses.

The primary funding for the Angola Red Cross Cholera Response was provided by the International Federation of Red Cross and Red Crescent Societies (IFRC) through the DREF, designed as an integrated and multisectoral intervention. The response was structured around the core pillars of Health, Water, Sanitation and Hygiene (WASH), Community Engagement and Accountability / Risk Communication (CEA/RCCE), Protection, Gender and Inclusion (PGI), and Planning, Monitoring, Evaluation and Reporting (PMER), ensuring a coordinated, community centered and standards based humanitarian approach. Water Sanitation and Hygiene (WASH) achievements under this operation were significantly enhanced through strong complementarity with ongoing partner initiatives. In Cuanza Norte, a UNICEF-supported project contributed to critical WASH interventions, including water chlorination, soap distribution, and hygiene awareness campaigns. In parallel, a complementary donation from the French Red Cross reinforced these efforts by enabling the procurement and distribution of additional Aqua tabs, thereby expanding household level water treatment coverage. A total of 17,060 people received Aquatabs through the French Red Cross support. Together, these complementary interventions strengthened the overall effectiveness, reach, and sustainability of the WASH response, ensuring more comprehensive and well coordinated support to vulnerable populations.



Cholera Epi curve 28th June 2025



Map total acumulated cholera cases at 28th June 2025

Flooding in Cacuaco, Cholera hotspot April 2025

Scope and Scale

Cacuaco Municipality was considered the epicenter of Cholera transmission in Luanda Province. Due to the high mobility of the population and the movement of goods, all of Luanda's municipalities were classified as High-risk areas for the spread of Cholera. Furthermore, Bengo, Benguela, Cuanza Norte, Cuanza Sul, Huila, Icolo e Bengo, Malanje, and Namibe emerged as provinces where number of cases exceed the thousands. Other provinces as Bie, Cabinda, Cubango, Cunene, Huambo, Lunda Norte, Lunda Sul, Uige, and Zaire also presented cases. Cholera and other acute diarrheal diseases were significant public health challenges, with a high potential for causing epidemics and mortality, especially when they are not treated in a timely manner.

Flooding deteriorates sanitation conditions in communities, increasing the risk of cholera. Floods have been reported in over six provinces of Angola in the first quarter of 2025. With the exception of Moxico and Cuando Cubango, other provinces affected by floods

already had confirmed cholera cases. Preliminary data from the Government was incomplete but reported on damages from floods to lives and livelihoods, beyond the spread of disease. The NS conducted a qualitative assessment to assess the risks and vulnerabilities of people at risk (or already affected) by floods and cholera. The assessment took place across six provinces: Luanda, Bengo, Kuanza Sul, Kuanza Norte, Huila and Huambo. The qualitative assessment from the NS indicated that across the rainy season, there has been significant loss of livelihoods in communities, and an increased risk of disease outbreaks. The most reported needs according to the NS assessment were those of reinforced shelter as homes are built with weak materials, household items such as mosquito nets, health and hygiene items such as soap and clean water, and food (given loss of agricultural inputs and ongoing food insecurity across Angola).

The geographical scope of the operation covered the provinces most affected and at highest risk, namely Luanda, Bengo, Benguela, Cuanza Norte, Cuanza Sul, Uíge and Zaire, with flood-related interventions prioritised in Bengo, Cuanza Sul and Huambo. These areas were characterised by high population density, limited access to safe water, inadequate sanitation infrastructure, poor drainage systems and recurrent flooding, all of which significantly increased vulnerability to cholera transmission and other waterborne diseases. Densely populated cities in Luanda posed a high risk for rapid spread, due to crowded areas and lack of adequate sanitation infrastructure. Rural communities that also lacked access to washing materials and safe water were also at high risk.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC Country Cluster Delegation (CCD) for Mozambique and Angola, based in Mozambique supported the Angola Red Cross in their response plan in alignment with the Angola Ministry of Health Cholera Response Plan. The CCD also networked with external stakeholders to assist the National Society (NS) in strengthening its presence in health coordination mechanisms and platforms as well as established new partnerships with UNICEF. The IFRC supported the NS with the creation of communications materials that promoted NS actions and enhanced fundraising. The IFRC CCD also continued offering technical, reporting, and operational support to the response. The IFRC 3 Months Finance Surge and 3 weeks Water Sanitation and Hygiene (WASH) Lead/Public Health in Emergencies Coordinator (PHiECO) also offered Angola Red Cross in country support.
Participating National Societies	The response received the support from Swedish Red Cross, and German Red Cross through Surge deployments, the WASH Coordinator and the Public Head in Emergencies respectively.

Other Actors Actions Related To The Current Event

Government has requested international assistance	No
National authorities	The Ministry of Health, through the Luanda Provincial Health Office, immediately activated the appropriate measures recommended by the World Health Organization for these cases. In coordination with other related institutions, it began disinfection in contaminated areas, the identification and tracking of contacts, as well as in-depth epidemiological and laboratory investigation to confirm suspected cases. In addition, the Government worked with partners including Angola Red Cross to map and mobilize volunteers for a home to home information campaign and distribution of Information, Education and Communication (IEC) material and calcium hypochlorite (bleach) mother solution to allow families to disinfect their drinking water at home, as well as latrines and toilets. The Municipal and Provincial Government shared information on impacts of the rainy season on people's lives and livelihoods. However, the data was not disaggregated by year or by flooding episode.

UN or other actors	The World Health Organization (WHO) and United Nations International Children's Emergency Fund (UNICEF) were requested to support with the organization of vaccination campaign under the Ministry of Health Response Plan. OCHA called a taskforce with WHO, UNICEF, World Vision, and CVA/IFRC on 17th January 2025, to discuss the response plans. The application for OCV to ICG was approved for 948,500 doses. A second round of vaccination was approved. For the floods, the Government had been collecting data over the years on different flooding events. However, formal reports for a few selected provinces were shared with the NS in April 2025.

Are there major coordination mechanism in place?

Provincial coordination meetings were led by the government but at the national level, there was a challenge with coordination. On 7th January 2025, the United Nations Office for the Coordination of Humanitarian Affairs (UN-OCHA) convened a taskforce with WHO, UNICEF, World Vision, and CVA/IFRC to discuss the response plans. Ad-hoc provincial meetings were conducted with Government and stakeholders for key activities such as vaccination campaigns.

Needs (Gaps) Identified

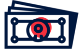
Shelter Housing And Settlements

Government data and field assessments confirmed the significant impact of flooding across several provinces during the 2024/2025 rainy season. In Cuanza Norte Province, data covering the period from 2023 to 2025 indicated that 1,294 houses were destroyed, 1,549 houses were damaged, and 593 houses were flooded, affecting a total of 15,593 people. In Huambo Province, data from August 2024 to 31 March 2025 showed that 955 houses were destroyed and 442 houses were damaged, affecting 1,397 families, equivalent to approximately 6,985 people, with 167 deaths and/or injuries reported. In Moxico Province, data from January and February 2025 indicated that 97 houses were destroyed, 151 houses were damaged, and five houses were flooded, leaving approximately 1,155 people without adequate shelter, while an estimated 3,015 additional people remained at risk.

A qualitative assessment was conducted in six provinces which include Bengo, Luanda, Huambo, Cuanza Norte, Cuanza Sul and Huíla and which highlighted the widespread structural vulnerability and socio-economic impacts. In Bengo Province, households reported recurrent flooding of homes, with some communities resorting to cutting baobab trees for shelter construction, a negative coping mechanism with long-term environmental consequences that may further increase exposure to droughts and flooding. Across all assessed provinces, community focus group discussions consistently identified damage to houses and infrastructure, loss of income and livelihoods, and contamination of water sources as the most pressing challenges.

The assessment also revealed that most houses were self-built using fragile materials, including adobe blocks, scrap metal, untreated wood and Aluminum sheets, particularly in urban informal settlements. Many homes were located close to rivers or water sources, increasing their exposure to flooding. These construction methods and locations leave households highly vulnerable to repeated rainfall and floods, with structures unable to withstand multiple rainy seasons. During flood events, affected families often relocate temporarily to schools or churches used as improvised shelters, which generally lack adequate sanitation facilities to safely accommodate large numbers of people.

With the exception of Bengo Province, where some communities relocated permanently to Mabubas, most households interviewed were not displaced at the time of the assessment. However, respondents consistently reported that their priority needs included rehabilitation of damaged housing, food assistance, and basic household and hygiene items, underscoring the need for integrated support addressing both immediate and recovery related needs.



Multi purpose cash grants

Multi-purpose cash assistance was implemented as a key response modality to address the immediate and diverse needs of households affected by flooding and cholera. The intervention aimed to provide flexible and dignified support, enabling affected families to prioritise their most urgent needs, including food, hygiene items, basic household goods, shelter/house rehabilitation and livelihood recovery, according to their specific circumstances.

The cash assistance intervention was informed by a viability assessment conducted in the most affected provinces, which confirmed the availability and functionality of local markets and banks despite the floods. Based on the assessment findings, targeting criteria were established, vulnerable households were identified in coordination with local authorities and community leaders, and cash assistance was delivered to 1,500 selected beneficiaries. This approach supported immediate household recovery, strengthened household coping

capacity, and contributed to local market stimulation, while ensuring a timely, dignified and accountable response aligned with IFRC cash and voucher assistance standards.

Health

By April 29th, 2025, 16,719 Cholera cases (45% male and 55% female) were confirmed, amongst them 558 deaths. New hotspots emerged including the original hotspot in Luanda, followed by Belguela, Bengo, Cuanza Norte, and Icolo e Bengo. Oral Rehydration Points (ORPs) and Cholera Treatment Centres (CTCs) were set up and managed by the Government.

The Knowledge Attitude Practice (KAP) Survey highlighted a mixed level of Cholera awareness. While most respondents recognized Cholera as a personal risk, only 34% viewed it as a problem in their community, and over half had not received Cholera related information recently. Preventive knowledge was limited, and although most participants said they would seek medical help for Cholera, 15% said they would do nothing. Awareness of the Oral Cholera Vaccine (OCV) was particularly low, with many respondents unaware of its existence or how it is administered, emphasizing the urgent need for public education and vaccine campaigns.

The Ministry of Health noted the immediate need for:
For the vaccination campaign support, doses of vaccines were approved by ICG and WHO followed by planning vaccination campaigns. Six vaccination campaigns were conducted. The key challenges included limited vaccine availability and gaps in Risk Communication and Community Engagement (RCCE) to inform communities about the vaccination, to increase uptake, and to manage expectations of communities that were not prioritised. The National Society (NS) was requested to support future vaccination efforts, through community mobilisation, RCCE activities and vaccination delivery.

Another critical gap identified in the response was household level surveillance and early detection of Cholera symptoms. While Angola Red Cross volunteers actively conducted household visits, referring suspected cases to health facilities and sharing data with local health centres, there was no formal and integrated surveillance system linking community level data with municipal, provincial and national health information systems. As a result, in some cases daily Cholera bulletins reflected incomplete information, although volunteers continued to use available data to monitor trends, including case fatality rates over time.

Risk Communication and Community Engagement (RCCE) was the cornerstone of the response, particularly in addressing misinformation and rumours related to Cholera transmission and vaccination. Strong community engagement was essential to reinforce prevention behaviours, promote early care seeking, and building trust in health interventions, especially in the context of OCV campaigns.

Flooding further compounded health risks in affected communities. Findings from the National Society's qualitative assessment indicated that floods increased the likelihood of disease transmission, particularly in areas where Cholera cases were already confirmed prior to flooding. Focus group discussions revealed that access to health facilities was limited, not only due to distance but also because of lack of transport and intermittent shortages of medicine at health centres. These barriers posed significant challenges, particularly when Cholera cases worsened, and complicated referral pathways, given that Cholera treatment was exclusively provided by the Government.

Water, Sanitation And Hygiene

As Cholera quickly spread due to poor sanitation conditions, worsened by the floods, the Ministry of Health identified immediate needs which ensured populations at risk had:
1) Access to safe water (distribution of water purification to households). According to the Knowledge Attitude Practice (KAP) survey conducted on Cash and Voucher Assistance (CVA), only 16% of the respondents had piped water in their housing/dwellings.
2) Access to sanitary facilities by setting up latrines and handwashing stations.
3) Good hygienic practices for disease prevention including on non-open defecation and on food preparation. As Cholera can spread quickly, Ministry of Health identified the need for rapid scale-up of sensitization materials, in particular education about risks, prevention and treatment.
4) Disinfectants at household level to decrease spread of disease
5) No stagnant water even in drains to avoid further spread and minimize impacts of potential floods from the rainy season
6) For rural communities' safe water guaranteed by treating water from wells with chlorine or by boiling.

Overall, in Angola, the Ministry of Health estimated that 26% of all deaths were linked to water and sanitation (contaminated water, inadequate sanitation practices, and others). A study from World Bank in 2021 estimated that in Angola, 6 million people practiced open defecation. Another 42% of the population didn't have access to handwashing stations, while 66% reported having access to safe drinking water. The WHO risk assessment indicated that flood-prone provinces were at heightened risk of Cholera due to contamination of water sources.

According to the Government, flood impacts included:
1) Two water points damaged in Cuanza Norte Province (not disaggregated by year including data from 2023 through 2025) damaged and not functional in 2025.

2) One septic tank damaged in Huambo Province (data from August 2024 to 31 March 2025, shared in April 2025).

Findings of the qualitative assessment conducted by Angola Red Cross in 6 provinces:
Bengo particularly, with a flat topography surrounding Dande , had flooded and houses were empty. Open drainage channels were full (not draining) and children used them for washing and play. Still water was full of garbage. This is the area that had high concentration of Cholera. People who lost homes moved to a nearby area allocated by the Government and remained there. However, there was no electricity, and they only got water from the nearby host community. There was one water point in the reallocated area. The Government had set up water reservoirs, but the community said they were mostly empty. This was one area in need of aqua tab distributions.

Other provinces covered by the qualitative assessment included: Lunada, Hambo, Kuanza Norte, Kuanza Sul, and Huila. The highest mentioned issue by community focus groups was contaminated water and increased diseases. The focus groups reported that there was accumulation of rubbish in stagnant water points, lack of potable water for use and lack of basic sanitation infrastructure and urban drainage systems. The needs reported by communities were cleaning, having safe water, and having hygiene items such as soap.

The KAP survey in 8 communities of Bengo, Cuanza Norte, Cuanza Sul, Huambo, Huila, Luanda, Uige, and Zaire confirmed significant gaps in access to safe water, sanitation, and hygiene. While public taps and piped water were the main sources of drinking water, a large portion of rural and urban households reported occasional water shortages, and only 42% treated their water properly.

There was a concern on sanitation where 47% of respondents shared toilet facilities, which is risk factor for Cholera transmission and many households had toilets located dangerously close to water sources. Additionally, 33% had toilets inside their homes, and over half had never emptied their latrines.

Protection, Gender And Inclusion

During the DREF Operation, vulnerable groups including women, children, the elderly, and persons with disabilities faced limited access to information and resources, making them more susceptible to exploitation and abuse. To address these concerns, protection and inclusion were prioritised to ensure that the specific needs of these groups were effectively met. Targeted awareness campaigns were necessary to raise awareness about issues related to gender-based violence and discrimination.

Additionally, staff and volunteers were briefed on the Code of Conduct and the protocols for preventing and responding to sexual exploitation, abuse, and child protection as they responded to the Cholera-flood Emergency. This response ensured that all National Society (NS) staff, International Federation of Red Cross and Red Crescent Societies (IFRC) personnel, and volunteers sign the Code of Conduct. All training sessions included dedicated segments on Protection, Gender, and Inclusion (PGI) to reinforce its implementation.

Community Engagement And Accountability

There was need to set up two-way communication channels to share and receive critical information as well as feedback mechanisms for communities to express their needs. The focus group discussions conducted during the Angola Red Cross Qualitative Assessment, found that women, young people, and people with disabilities had limited engagement in decision making at local levels, and that they did not have an identified space to engage in community dialogues and participate in discussions on prevention and response to emergencies as part of the community. In response, a feedback collection mechanism was established, which included focus group discussions and the Post Distribution Monitoring (PDM) Kobo-collect Tool.

Operational Strategy

Overall objective of the operation

This DREF operation aimed to reduce the risk of cholera transmission and improve the health and well-being of people affected by floods and cholera in Luanda, Bengo, Huambo, Cuanza Sul, Cuanza Norte, Zaire, Benguela, and Uige provinces. This was planned to be achieved by reaching to at least 720,000 people with health promotion, safe water access and early detection, while of these, 7,500 people (1,500 households) were targeted to receive cash assistance to mitigate the double burden of floods and Cholera.

Operation strategy rationale

Cholera is an acute, rapidly spreading infectious disease, strongly associated with poor sanitation, limited access to safe water and inadequate living conditions. These risk factors are significantly exacerbated by flooding, which contaminates water sources, damages

sanitation infrastructure and displaces communities. Angola experienced a heavy rainy season during the first quarter of 2025, resulting in multiple floods and creating ideal conditions for the rapid spread of cholera.

At the same time, Luanda, the country's capital and main population hub, was facing an active cholera outbreak, making a rapid, coordinated and multisectoral response a public health priority for national authorities and humanitarian actors, including the Angolan Red Cross (CVA). Confirmed cholera cases were reported in 17 provinces, with the highest risk and transmission observed in Luanda, Zaire, Uíge, Bengo, Cuanza Norte, Cuanza Sul and Benguela.

This operation was designed to support an integrated response to cholera and floods, fully aligned with the Ministry of Health (MoH) National Cholera Response Plan (2025) and coordinated through national and provincial stakeholder platforms involving MoH, WHO, UNICEF and other partners. All activities implemented under this operation directly contributed to the Government-led response, complementing existing capacities and filling critical gaps at community level.
The strategy prioritised prevention, early detection, community engagement and immediate household recovery, focusing on four mutually reinforcing sectors: Health, WASH, Community Engagement and Accountability (CEA/RCCE), and Multi-Purpose Cash Assistance (MPCA).
Health – Cholera Response

The health component focused on early detection, referral and prevention, recognising that delayed care-seeking and weak community surveillance contribute to high case fatality rates. CVA volunteers strengthened community-based epidemiological surveillance by identifying and referring suspected cases to Government-run Oral Rehydration Points (ORPs) and Cholera Treatment Centres (CTCs), while supporting health authorities with community-level data.

The operation also supported Oral Cholera Vaccination (OCV) campaigns, following the approval of over 900,000 vaccine doses by the International Coordinating Group (ICG). While the MoH and WHO led vaccination planning and implementation, CVA volunteers played a critical role in community sensitisation, RCCE, post-vaccination monitoring, registration and vaccine administration when requested. Despite two vaccination rounds being completed, challenges remained related to limited vaccine availability and community misinformation, reinforcing the need for strong community engagement. Continuous coordination with MoH, WHO and partners ensured alignment of activities and responsiveness to evolving epidemiological trends.

Community Engagement and Accountability (CEA/RCCE): Strong risk communication and community engagement were central to the strategy. The operation established two-way communication mechanisms, including focus group discussions and Kobo Collect, to address rumors, misinformation and community concerns related to cholera transmission, vaccination and flood response. Special attention was given to ensuring that information was accessible in local languages and appropriate formats, and that women, young people and persons with disabilities were actively included in dialogue and feedback mechanisms.

WASH – Cholera and Floods Response
The WASH component aimed to reduce disease transmission through a combination of health and hygiene promotion, safe water access and environmental sanitation. CVA volunteers supported community mobilisation activities on hygiene practices, safe water use and sanitation, under the coordination of local authorities and health services. These efforts were reinforced through mass communication campaigns, radio messaging and dissemination of IEC materials in multiple local languages.
CVA supported Government-run ORPs with cleaning supplies and safe water, while distributing Aquatabs to households most at risk. The operation also included community clean-up campaigns targeting contaminated water sources, particularly after flooding, and the installation of handwashing stations in key public and community locations to promote sustained hygiene practices.

Multi-Purpose Cash Assistance: Flooding caused varying levels of household losses, including damage to shelters, loss of food stocks, household items and income. Given the diversity of needs and functioning local markets, multi-purpose cash assistance was identified as the most effective, flexible and dignified response.
The operation planned to support 1,500 floods- and cholera-affected households through a one-time cash transfer of AOA 86,000 (approximately CHF 80–89) per household of five people, covering approximately one month of basic needs. The transfer value was based on previous operations and minimum market costs, and was to be confirmed through a rapid market assessment. CVA's cash readiness and experience enabled rapid implementation, avoiding delays associated with procurement and logistics of in-kind assistance.

Community-based targeting ensured that the most vulnerable households were prioritised, with strong involvement of community leaders and local structures.
Cross-Cutting Approaches and Implementation Capacity
Protection, Gender and Inclusion (PGI) and CEA were integrated across all sectors, recognising that floods and cholera disproportionately affect individuals with limited access to health services, water points and infrastructure, particularly women, children, persons with disabilities and remote rural communities. The operation aimed to reduce risk without placing undue responsibility on affected populations, through collective community actions such as clean-up campaigns and inclusive decision-making.

The operation was implemented through trained CVA volunteers, many of whom had previously received training in CBHFA/EPiC, health and hygiene promotion, OCV readiness, cash and voucher assistance, PGI and CEA. Existing provincial delegations and health posts further strengthened response capacity, ensuring rapid scale-up when the outbreak worsened.

Overall, the strategy aimed to deliver timely, coordinated and community centered humanitarian assistance, addressing immediate needs while strengthening community resilience and preparedness beyond the DREF timeframe.

Targeting Strategy

Who was targeted by this operation?

The National Society's (NS) targeting strategy was implemented in close coordination with the Angolan Government's Civil Protection and Fire Services (SPCB). Although the crisis affected nearly the entire country, the NS prioritised intervention in areas identified as most vulnerable, based on the severity of flooding, active cholera transmission, emerging hotspots and existing gaps in assistance. The operation therefore focused on provinces with a high overlap between flooding and cholera risk, namely Luanda, Bengo, Zaire, Uíge, Cuanza Norte, Cuanza Sul, Huambo and Benguela.

Within these provinces, the municipalities at highest risk have been identified with the Government. Within municipalities, risk assessments were done to determine which communities were targeted for the door-to-door communication and hygiene and health activities. Other activities such as information dissemination through radios and social media had broader reach. The Angola Red Cross aimed to mobilize 450 volunteers in the 7th initial provinces with the following household reach, with volunteers reaching 8 houses a day, 2 days a week for 5 months. This equals 64 houses per volunteer per month for a total of: 144,000 HH (720,000) people targeted for health & hygiene promotions activities.

No. of Volunteers per Province

1	Luanda	150
2	Zaíre	50
3	Uíge	50
4	Bengo	50
5	Cuanza Sul	50
6	Cuanza Norte	50
7	Benguela	25
8	Huambo	25
Totals		450

In addition, 425 volunteers were trained on ORC, OCV and data collection, 45 volunteers were engaged in beneficiary registration and cash distribution activities in the provinces of Bengo, Huambo and Cuanza Sul. Furthermore, 62 neutral volunteers were trained on Post-Distribution Monitoring (PDM) practices and deployed to collect monitoring data in Bengo, Cuanza Sul, Huambo, Luanda and Cuanza Norte, supporting accountability, learning and evidence-based adjustments to the response.

Beneficiary selection for cash distribution, followed clearly defined vulnerability criteria, validated through field assessments and consultations with affected communities, and coordinated with local authorities to avoid duplication and ensure complementarity with Government assistance. Priority was given to households whose homes were destroyed or damaged by flooding and who lost their means of subsistence, leaving them unable to meet basic needs without external support.

The following selection criteria were applied:
Socio-economic vulnerability
- Households with low or no income, including families living below the poverty line.
- Total loss of livelihoods, such as destroyed crops, lost agricultural tools, or livestock deaths.
- Unemployment or underemployment exacerbated by flooding.

Household composition and protection risks
- Female-headed households, particularly those caring for young children.
- Persons with disabilities, chronic illnesses or reduced mobility.
- Older people living alone or dependent on others.
- Households with a high number of dependents, including children, elderly persons or chronically ill members.
- Pregnant and lactating women within the household.

Impact of flooding
- Partial or total destruction of housing.
- Loss of essential household assets, including clothing, cooking utensils and food stocks.
- Forced displacement, including households temporarily hosted by relatives or living in collective shelters.

Geographic vulnerability
- Hard-to-reach communities that may have received limited assistance.
- Areas with the highest levels of damage, as confirmed through rapid assessments.

Exclusion Criteria (to prevent duplication and fraud)
To ensure efficient use of resources and avoid overlap, the following households were excluded:
- Families that had already received similar assistance from other organisations.
- Households with demonstrated recovery capacity, such as access to savings, insurance or other reliable support mechanisms.

The target population for the Aquatabs distribution consisted of low-income households living in communities identified as cholera hotspots, particularly in rural and hard-to-reach areas. These households typically lacked access to safe drinking water and rely on untreated water sources, such as wells, rivers, tanks and other unsafe supplies.

The following selection criteria were applied:
- Low-income households living in communities identified as cholera epicentres.
- Households residing in rural and hard-to-reach areas.
- Households without access to safe drinking water, relying on wells, rivers, tanks or other untreated water sources.
- Low-income households with more than five members.
- Low-income households headed by older persons or children.
- Low-income households with children, pregnant women or persons with disabilities.
- Communities without access to basic sanitation services.
- Households without access to latrines.
- Households with members who have contracted cholera.

This targeting approach ensured that households at highest risk of waterborne disease transmission were prioritised, while maximising the public health impact of the water treatment intervention.

Beneficiary selection and targeting was coordinated with local authorities and community leaders, affected communities and working with community stakeholders to identify the most affected people. The CEA staff members accompanied the process to ensure that the most vulnerable members of the community have been prioritized.

Explain the selection criteria for the targeted population

There were environmental, population and service factors that were considered when defining and delimiting risk areas, which impacted the targeting strategy. Targeting initially concentrated on case households and areas impacted by both floods and cholera before any consideration of any other factors. These were the places known to have had the disease and floods that have increased the risk of disease spread.

Angola Red Cross aligned further with the targeting criteria of the Ministry of Health which defines high-risk areas and populations as those that with:
- Impacted by floods with absence, deficiency or intermittency of drinking water supply.
- Inadequate disposal and treatment of feces.
- Absence or deficiency in the disposal and treatment of solid and liquid waste.
- Low and waterlogged soils that allow water contamination by fecal materials (especially in areas with flood and drought cycles).
- High population density.
- Low socio-economic income of populations.
- Communities with very low coverage of water, sanitation and hygiene services.
- Isolated communities and especially those historically prone to cholera.
- Inadequate personal hygiene habits that lead to oral contamination through feces.
- Communities with difficult access to information (can create rumors and misconceptions about the disease).

The selection of the targeted population for cash assistance and Aqua tabs distribution was based on a vulnerability- and risk-based approach, informed by rapid assessments, epidemiological data and community consultations, and coordinated with local authorities to avoid duplication and ensure complementarity with Government support.

For cash assistance, priority was given to households most severely affected by flooding and the cholera outbreak, particularly those whose homes were partially or totally destroyed and who experienced loss of livelihoods or income as a result of the floods. Selection criteria focused on low- or no-income households, families that lost agricultural production, tools or livestock, and households facing unemployment or underemployment exacerbated by the floods. Additional priority was given to households with heightened protection risks, including female-headed households, older people living alone, persons with disabilities or chronic illness, pregnant or lactating women, and households with a high number of dependents. Households that had already received similar assistance from other actors or demonstrated sufficient recovery capacity were excluded to prevent duplication.

For Aqua tabs distribution, targeting focused on households at highest risk of waterborne disease transmission, particularly in cholera hotspot communities. Priority was given to low-income households living in rural and hard-to-reach areas with limited or no access to safe drinking water, who relied on untreated water sources such as wells, rivers and tanks. Households without access to basic sanitation or latrines, larger households, and those with members who had contracted cholera were also prioritised. Special consideration was given to households with children, pregnant women, older people and persons with disabilities, who faced higher health risks from unsafe water.

Total Assisted Population

Assisted Women	-	Rural	-
Assisted Girls (under 18)	-	Urban	-
Assisted Men	-	People with disabilities (estimated)	-
Assisted Boys (under 18)	-		
Total Assisted Population	880,229		
Total Targeted Population	720,000		

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
The rainy season brings the risk of flooding, which has exacerbated the spread of the epidemic.	Integration of key messages of flooding into social communications, monitoring situation, trainings for volunteers. Inclusion of a risk and vulnerability analysis for floods and cholera in the initial DREF application to start getting data on floods to be able to scale up the operation as necessary.
Health risk for the NS staff in the field.	Personal Protective Equipment Training Volunteer insurance.

Please indicate any security and safety concerns for this operation:

Contamination of NS staff is a major risk. Infected persons can become sources of transmission in their community. A further operational risk related to cholera exposure among National Society staff and volunteers, as infected personnel could inadvertently contribute to community transmission. This risk was mitigated through the provision of appropriate personal protective equipment (PPE) tailored to assigned tasks, alongside targeted training on infection prevention and control (IPC) measures.

Stigmatization of staff involved in the cholera response (misunderstanding of the disease by the population, rumors and fears), which could lead to violence against them. This risk was mitigated through strong Risk Communication and Community Engagement (RCCE) activities, aimed at improving community understanding of cholera transmission and prevention, promoting trust, and reinforcing the protective role of volunteers within their communities.

While major road infrastructure linking Luanda to provincial capitals continues to improve, poor driving standards and variable road conditions remained a significant risk. Travel outside major towns often requires convoys of two or more four-wheel-drive vehicles. In rural and remote areas, the presence of landmines and unexploded ordnance continued to pose a safety hazard, with contamination reported on roads, bridges, verges, in abandoned buildings and across the countryside. Due to these factors, Lunda and Cabinda provinces were classified as high-security risk areas by the IFRC.

Angola presents a complex security environment, characterized by high levels of crime, particularly in urban centers. Crimes of opportunity, including armed robbery, constituted the primary security threat to both local populations and expatriates, especially in Luanda. In addition, armed assaults and premeditated home invasions have been increasing in the capital. Violent incidents, including sexual abuse and harassment, homicide and kidnapping, were also reported, affecting both Angolan nationals and expatriates, particularly in the province of Cabinda. To mitigate the risk of personnel exposure to crime, violence and road hazards, robust risk mitigation measures were implemented throughout the operation. These included continuous situation monitoring, strict adherence to minimum security standards, and application of IFRC security plans to all IFRC personnel involved in the response.

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

Implementation

Multi Purpose Cash

Budget: CHF 156,199
Targeted Persons: 7,960
Assisted Persons: 7,960
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
#HH receiving cash assistance	1,500	1,500

Narrative description of achievements

In response to the floods, the Angola Red Cross implemented multi-purpose cash assistance aimed at supporting vulnerable families affected by the disaster in Bengo, Cuanza Sul and Huambo provinces. The National Society successfully reached 100% of its total target. A total of 1,500 families (500HH in Bengo, 500HH in Cuanza Sul and 500HH in Huambo). Approximately, 7,960 people, received financial support after being identified as in need. Each household was given 86,000 Kwanzas (Approximately 73 CHF) to allow them to address their immediate needs and invest in their recovery.

This assistance was conducted in coordination with the local government, such as the Department of Risk Reduction and Disaster Management, Civil Protection and Fire Services, Social Action, and community leaders. Beneficiary selection was conducted in collaboration with the community and the Government, using selection criteria established by the Government, the National Society, and

the community members. After agreeing on these criteria, the community supported the National Society in identifying the most vulnerable groups within their population.

Traditionally, the Angola Red Cross (CVA) provided support to communities through direct cash assistance. However, for this operation, a different approach was adopted. Given that the majority of community members possessed the necessary identification documents, it became feasible to implement a Cash Transfer Programme (CTP) through the formal banking system. This modality allowed for a more structured, secure, and scalable delivery of assistance, while remaining aligned with the recipients' preferences, protection standards, and the operational context of the response.

Angola Red Cross conducted a market assessment in 2025 where multiple factors were analysed, including the capacity of local markets, community acceptance, access to financial services, protection risks, and the level of local authorities' engagement. The assessment conducted in the provinces of Cuanza Sul, Huambo, and Bengo demonstrated that minimum conditions existed for the implementation of cash assistance programmes, with the possibility of complementary in-kind support where necessary. Overall, community acceptance was high, local authorities showed openness to collaboration, and local markets demonstrated the capacity to absorb increased demand.

For cash and voucher assistance, a total of 49 members (including staff, volunteers, community focal groups and partners) were trained in preparations for the cash distribution exercise. The beneficiary registration was done through kobo collect, with a form that was already structured in the system ready to be used by the volunteers. During cash distribution a satisfaction and feedback survey was done on 10% of the beneficiaries.

Additionally, 62 volunteers (15 in Bengo, 10 in Huambo and 20 in Cuanza Sul) received specialized training in Post Distribution Monitoring (PDM), to enhance the operation's effectiveness. The PDM, reported high levels of satisfaction with the cash distribution process, with 94% of participants indicating that the support helped meet their basic needs. Beneficiaries emphasized that the assistance was vital in restoring dignity and providing their families with resources to rebuild their houses.

Lessons Learnt

The operation demonstrated that multi-purpose cash assistance is an effective and dignified modality for responding to floods and health-related shocks when local markets are functional. PDM results showed high levels of beneficiary satisfaction with both the cash value and the delivery process, confirming that cash enabled households to prioritize their most urgent needs, including food, health, education and shelter rehabilitation.

The intervention also highlighted the critical importance of strong Community Engagement and Accountability (CEA). While a majority of beneficiaries were informed about the cash value and distribution dates, gaps in communication were observed, with a significant proportion of beneficiaries reporting limited understanding of selection criteria and complaint mechanisms. This underlines the need to systematically communicate eligibility criteria and feedback channels, using multiple formats and local languages, before and during implementation.

The PDM identified isolated cases (3%) of community-level interference and informal payments, particularly linked to local committees or individuals involved in beneficiary identification. The National society conducted several investigations to verify the issues raised. Include verification check with the bank, which provided satisfactiry evidence that the NS has adequately addressed the issue, and is committed to strengthening CEA in operations to mitigate future risks.

Although these incidents did not undermine the overall credibility of the operation, they reinforced the lesson that robust integrity safeguards, clear messaging that assistance is free of charge, and early sensitisation of community leaders and volunteers are essential to prevent misuse and protect trust. Following the PDM, a Community Engagement and Accountability (CEA) inquiry was conducted at community level to better understand community perspectives on the findings. The communities demonstrated a high level of openness and willingness to engage, and clearly expressed their appreciation for CVA's active involvement of community members at all stages of the programme. This reinforced the importance of early, continuous, and meaningful community participation in improving programme relevance, ownership, transparency, and the overall effectiveness of humanitarian interventions.

Operationally, the average waiting time during cash collection was acceptable but highlighted opportunities for improvement. Future operations would benefit from staggered payment schedules, improved identity verification processes and closer coordination with financial service providers to reduce waiting times and beneficiary fatigue, particularly in urban and high-density areas.

Finally, the operation reaffirmed that cash assistance alone is insufficient in complex emergencies such as floods combined with cholera. The integration of cash, health, WASH and RCCE activities proved critical in reducing public health risks, addressing misinformation and strengthening community resilience. Sustained investment in preparedness, volunteer training, CEA systems and inter-institutional coordination is essential to improve the effectiveness and accountability of future responses.

Challenges

The implementation of the DREF Cholera and Floods Operation faced several operational, contextual and coordination challenges, inherent in a complex emergency combining public health risks and climate-related shocks. These included:

1) Communication and information dissemination at community level. A The Post-Distribution Monitoring (PDM) findings showed that not

all recipients were consistently informed about distribution dates, cash values, selection criteria and complaint mechanisms. These gaps caused confusion, unnecessary movements of beneficiaries and, in some cases, fueled rumors and perceptions of exclusion. This highlighted the need to further strengthen Community Engagement and Accountability (CEA) mechanisms.

2)Understanding and transparency of the selection criteria also posed challenges. While many recipients reported understanding why they were selected, a notable proportion did not clearly understand the eligibility criteria. This created tensions between recipients and non-recipients and increased the risk of mistrust at community level, particularly in areas with limited coverage.

3)The operation also faced access constraints, particularly in remote and hard-to-reach communities. Difficult access during the flooding period caused delays in team mobilization, and monitoring of activities, increasing operational complexity and affecting the timeliness of some interventions.

4)Integrity and accountability risks were also observed, including isolated cases of informal payments, community-level interference and partial payments reported during the PDM. Although limited in scale and without significant impact on the overall credibility of the operation, these incidents highlighted the need for stronger safeguards, closer supervision of volunteers and continuous messaging that assistance is free of charge. An inquiry was done and the issue was well solved with the community members, leaders and bank reconciliation.

5)Operational constraints during cash distribution further challenged implementation. Average waiting times of approximately 1 hour and 45 minutes, particularly in urban and densely populated areas, were linked to manual identity verification, high recipient volumes and limited banking staff capacity. These delays affected recipients experience and highlighted the need for improved scheduling and coordination with financial service providers.

Health

Budget: CHF 93,116
Targeted Persons: 720,000
Assisted Persons: 87,258
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
number of volunteers trained in ORP and OCV and data collection	400	487
number of chosueholds visits by volunteers for early detection	76,800	87,258
# of government-led OCV campaigns supported	3	2
number of early detection cases referred to health cetners	-	504

Narrative description of achievements

A total of 487 volunteers, surpassing the initial target of 120, were trained on ORC, OCV, data collection, and health promotion, which equipped them with essential skills to respond to health challenges effectively. The increase in trained volunteers was possible due to the availability of additional volunteers, who then train more individuals to keep them prepared and updated for potential situations, such as the need for replacements. This expanded training capacity enhanced the readiness and resilience of the response team.

The volunteers conducted activities three times per week over a period of nine months, completing a total of 58,235 household visits dedicated to early detection.

Volunteers submitted data to the Government on a weekly basis during coordination meetings that were conducted at the Provincial Level. This data that was submitted by volunteers, enabled the Government to systematically review progression of the epidemic as well as implementation progress.

The Cholera Outbreak continued to escalate due to poor sanitation, limited access to clean water, and high population density in affected

areas. In response, the International Coordinating Group for Vaccine Provision allocated 978,000 doses of the Oral Cholera Vaccine (OCV) to Angola. To support the National Cholera Response, the Angola Red Cross contributed to the Oral Cholera Vaccination (OCV) campaign in high-risk provinces, while promoting hygiene practices and raising community awareness to reduce transmission and protect vulnerable populations. Across the three phases of OCV, the volunteers directly supported the administration of 97,470 doses, representing approximately 3.2% of the national total.

Vaccination activities were carried out at fixed posts (health centers, schools, churches, markets) and through mobile outreach teams that travelled to remote and underserved communities. In parallel, CVA volunteers and partners led Risk Communication and Community Engagement (RCCE) efforts to raise awareness on Cholera symptoms, safe hygiene practices, and the importance of early treatment, thereby strengthening both the reach and the impact of the vaccination campaign.

Lessons Learnt

• The operation confirmed that early detection of cholera cases at community level is critical to reducing transmission and case fatality rates. The presence of trained volunteers within communities enabled timely identification of suspected cases and prompt referral to Government-managed Oral Rehydration Points (ORPs) and Cholera Treatment Centers (CTCs), demonstrating the added value of community-based epidemiological surveillance in complementing formal health systems.
• The health interventions further demonstrated the effectiveness of integrated health and hygiene promotion strategies in preventing and containing disease outbreaks. Community workshops and health education campaigns proved effective in increasing awareness of waterborne diseases, promoting preventive behaviors and reinforcing key public health messages at household and community levels.
• The response highlighted gaps in the integration of community-level surveillance data into official health information systems, which limited the timeliness and completeness of epidemiological analysis at national level. While volunteers supported data collection and case referral at local health facilities, the absence of a formal, bidirectional reporting mechanism reduced opportunities for real-time decision-making and trend analysis, underscoring the need to strengthen structured linkages between community surveillance and national health systems.
• Close collaboration with local health authorities was a critical enabler of the response, strengthening coordination, ensuring alignment with Government-led interventions and enhancing the overall effectiveness of health activities. This collaboration facilitated joint planning, improved referral pathways and supported the implementation of vaccination, surveillance and prevention activities.
• Experience from the Oral Cholera Vaccination (OCV) campaigns underscored the importance of community mobilization and expectation management, particularly in contexts of limited vaccine availability and phased geographic prioritization. Strong Risk Communication and Community Engagement (RCCE) was essential to address rumors, build trust and maintain community acceptance of vaccination efforts.

Challenges

The health response faced several challenges that affected the timeliness, coverage and effectiveness of interventions.
1) Limited access to remote and flood affected communities, particularly during heavy rainfall. Flooded roads and damaged infrastructure delayed the deployment of health teams, restricted supervision and monitoring activities, and complicated referrals of suspected Cholera cases to health facilities.
2) Gaps in community level disease surveillance and information flow also posed challenges. While volunteers actively identified and referred suspected cases, the absence of a formal, integrated surveillance system linking community data with municipal, provincial and national health information systems limited the completeness and real time use of epidemiological data. This affected the ability to rapidly identify trends and adjust interventions accordingly.

Water, Sanitation And Hygiene

Budget: CHF 116,398
Targeted Persons: 720,000
Assisted Persons: 400,518
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
number of handwashing station built	60	43
number of people reached with health & hygiene promotion	720,000	400,518

information		
number of aquatabs distributed	468,000	486,453
number of clean-up campaigns	6	6

Narrative description of achievements

The WASH programme played a critical role in mitigating the public health and hygiene impacts of flooding in affected communities that were affected by Cholera. During the response period, a total of 400,518 people were reached through health and hygiene promotion activities, contributing to the prevention of Cholera and other waterborne diseases.

To strengthen access to safe household water, 486, 453 Aqua tabs (water purification tablets) were distributed directly to most at risk households. Trained volunteers conducted door-to-door sensitisation, awareness campaigns in public spaces, and Focus Group Discussions (FGDs) on Cholera prevention and broader disease risk reduction.

The training of 487 volunteers in basic hygiene and sanitation aimed to significantly strengthen community level capacity to adopt and sustain healthier practices. Volunteers conducted household visits to promote good personal and collective hygiene behaviours, while additional teams facilitated small-group sessions in high-density locations such as markets, streets and neighbourhood gathering points, delivering key WASH messages and demonstrating proper water treatment, storage and management practices.

To expand outreach and reinforce behaviour change, Information, Education and Communication (IEC) materials, megaphones and radio broadcasts were utilised, enabling the dissemination of consistent and culturally appropriate messages to a wider audience. These combined approaches aimed at equipping communities with the knowledge and practical skills needed to make informed decisions and reduce health risks associated with flooding and water contamination.

The WASH achievements under this operation were significantly enhanced through strong complementarity with ongoing partner initiatives. In Cuanza Norte, a UNICEF-supported project contributed to critical WASH interventions, including water chlorination, soap distribution, and hygiene awareness campaigns. In parallel, a complementary donation from the French Red Cross reinforced these efforts by enabling the procurement and distribution of additional Aquatabs, thereby expanding household-level water treatment coverage. A total of 17,060 people received Aquatabs through the French Red Cross donation. This complementarity enhanced well-coordinated support to vulnerable populations and as well as effectiveness, reach and sustainability of the response.

The six cleaning campaigns facilitated by the volunteers in targeted areas raised awareness and encouraged healthy practices. Approximately 400,518 people were reached with mass health promotion campaigns. The campaigns included conducting sensitization sessions at markets, bus stops and door to door visits in communes across all three provinces. These health promotion sessions focused on educating communities about safe water storage, treatment, and hygiene practices to prevent the spread of Cholera. The volunteers also utilized IEC materials, including posters, and megaphones to disseminate information during the community visits. Extensive radio broadcasts disseminated vital health messages nationally, reaching a wide audience and informing communities about the Cholera prevention.

Lessons Learnt

• It became evident that a door-to-door approach led by trained volunteers significantly increased understanding and adoption of safe hygiene and household water treatment practices. Practical demonstrations on the correct use of Aquatabs, safe water storage and handwashing were more effective than information-only messages.
• The operation demonstrated that the distribution of water treatment supplies must always be accompanied by continuous sensitisation to ensure correct and consistent use. In communities with low literacy levels, visual and verbal reinforcement proved essential to prevent incorrect use or underutilisation of Aquatabs.
• Awareness-raising activities in high-density public spaces, such as markets and densely populated neighbourhoods, enabled rapid outreach to large numbers of people with key WASH messages, extending the impact of the response beyond households reached through door-to-door visits.
• The training of a large number of local volunteers in hygiene and sanitation strengthened community capacity and supported the sustainability of promoted practices. Volunteers drawn from the communities themselves were more readily accepted, fostering trust and increasing adherence to WASH messages.

Challenges

It was observed that despite receiving guidance on the correct use of Aquatabs, some community members continued to use the product incorrectly or in inappropriate quantities. This highlighted the need for continuous reinforcement of sensitization and hygiene education activities, including repeated practical demonstrations and follow-up, to ensure correct and consistent use of water treatment products.

Community Engagement And Accountability

Budget: CHF 29,041
Targeted Persons: 720,000
Assisted Persons: 384,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# opportunities for community participation to help guide the response	27	28
% of complaints and feedback recieved and responded to by the NS	100	100

Narrative description of achievements

The Community Engagement and Accountability (CEA) framework facilitated effective communication and feedback mechanisms within the affected communities. A total of 487 volunteers were trained in community engagement and accountability, enabling them to conduct focus group discussions on health and hygiene promotion activities. Focus group discussions were conducted with the purpose of analysing, consulting, and planning activities. Mediators between the volunteers and the community were selected based on the criteria of diversity in terms of age, ethnicity, and gender, including religious and traditional leaders as well as the youth. These meetings assessed the impact of the implemented activities and evaluate whether the actions effectively reached and benefitted the communities.

Other feedback mechanisms included an internal telephone line from the NS and suggestion boxes, established to enhance transparency and responsiveness during the operation, and kobo collect forms, particularly for cash and Aquatabs distribution. Although the telephone line was set up for community feedback, no complaints were received, as community members preferred to address issues directly with focus groups or by visiting the provincial offices. The suggestion boxes were positioned in all distribution centers to allow community members to present their feedback

Volunteers also collected and addressed feedback while conducting community mobilization. Some concerns were redirected to the appropriate authorities, who, along with volunteers returned to the community to clarify these matters. An example of a common concern raised was related to beneficiary registration. Many non-beneficiaries expressed frustration over not being registered to receive support, making this the most it the most frequent issue throughout the response. These cases were reported to local leaders and the provincial delegation for further review and clarification. According to volunteer records, community feedback indicated a 100% response rate to feedback, demonstrating the commitment to listening to and addressing the concerns of communities.

Challenges

1) Despite efforts to engage communities, some groups felt excluded from the decision-making process, leading to dissatisfaction.
2)Coordinating feedback collection and addressing community concerns in a timely manner proved challenging, particularly in areas with limited access to communication channels.
3) Enhancing transparency and continuous engagement were identified as areas requiring improvement.

Secretariat Services

Budget: CHF 117,448
Targeted Persons: 5
Assisted Persons: 6
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
number of surge deployed	6	6
number of techincal and monitoring visits	4	8

Narrative description of achievements

The IFRC supported deployment of an operations manager (2 rotations) who worked with the volunteers and also supported field monitoring of the operations. One finance officer surge, one WASH coordinator surge, and one PhiE surge (2 rotations) supported the operation scale-up, refresher trainings on logistics and financial administration, reporting and monitoring.

The IFRC operations manager from the Cluster, IFRC WASH Lead from Geneva, IFRC finance officer from the cluster, and IFRC security officer conducted field visits at various times during the operational timeframe to provide ongoing technical support and monitor the progress of the activities being implemented but also provided guidance on areas requiring improvements such as timely submission of reports and returns. A French RC delegate also accompanied one of the distributions in the field, as the French Government supported the Cholera response through a complementary donation of Aquatabs for distribution.

All (487) volunteer insurance was paid while they supported the operation.

Lessons Learnt

• The operation highlighted the critical value of timely and sustained surge support in strengthening National Society capacity during scale-up phases. The deployment of IFRC technical and operational staff across operations management, finance, WASH, PHI, and security significantly improved field monitoring, technical quality, and overall coordination, while refresher trainings contributed to reinforcing CVA systems in logistics, financial administration, reporting, and monitoring. Regular field visits by cluster and Geneva-based IFRC technical leads enabled real-time problem-solving and constructive feedback, underscoring the importance of close accompaniment and hands-on support, particularly in large-scale and fast-evolving responses.
• The operation also demonstrated the added value of strong Movement and partner complementarity, as exemplified by the French Red Cross contribution, which enhanced operational reach and visibility through in-field accompaniment.

Challenges

1) Increases in bank rates and delays with payments, as well as external factors such as changes in purchasing power, drastically impacted the operation and required constant re-evaluation and work planning to ensure the goals of the operation were met. In this sense, support from IFRC staff and surge deployments were essential in order to support NS to navigate these changes and support finding solutions to mitigate the impact of the changes on the operation.

National Society Strengthening

Budget: CHF 115,406
Targeted Persons: 472
Assisted Persons: 487
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
number of coordination meetings attended	60	84
number of monitoring visits	15	18

Narrative description of achievements

Weekly coordination meetings were conducted with the MoH and UNICEF at the provincial level to ensure continuous oversight and alignment among stakeholders. During these sessions, updated data were formally submitted to the Government, enabling timely analysis of key indicators. Progress against targets, operational challenges, and corrective actions were systematically reviewed and discussed to strengthen implementation and accountability.

The actual number of staff and volunteers who received capacity building exceeded the original target. This larger than expected turnout was a result of effective mobilization efforts, increased interest from local volunteers, and a strong recognition of the critical role capacity building plays in enhancing the overall operation. Furthermore, the NS extended capacity-building opportunities to community mediators, and key partners. This broader inclusion aimed to have many stakeholders equipped with the necessary skills and knowledge to support the intervention effectively.

The intervention was closely monitored by branch officials, ensuring consistency and accountability throughout the operations. The number of reports produced doubled the initial target, driven by the need for more detailed and frequent updates to enhance transparency and accountability. This approach aimed, as much as possible, to ensure that operational issues, challenges, and other factors that could potentially have a negative impact on the operation were identified, communicated, and addressed promptly.

Lessons Learnt

Including a broad range of stakeholders in capacity building efforts proved highly effective in increasing acceptance, transparency, and the overall impact of the operation. By extending training opportunities beyond the Red Cross team to include community mediators and key partners, the National Society ensured that all participants were aligned with program objectives and equipped with the skills necessary to support the intervention.

Challenges

1) The fund transfer process at the bank in Angola experienced delays, leading to necessary adjustments in the activity schedule.

Financial Report

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Selected Parameters			
Reporting Timeframe	2025/1-2026/3	Operation	MDRAO011
Budget Timeframe	*	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

Prepared on 05/May/2026

All figures are in Swiss Francs (CHF)

MDRAO011 - Angola - Cholera Response

Operating Timeframe: 21 Jan 2025 to 31 Oct 2025

I. Summary

Opening Balance	**0**
Cash Contributions	**15,345**
French Red Cross	15,345
Funds & Other Income	**627,608**
DREF Response Pillar	627,608
Expenditure	**-555,881**
Closing Balance	**87,072**

II. Expenditure by planned operations / enabling approaches

Description	Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items			**0**
PO02 - Livelihoods			**0**
PO03 - Multi-purpose Cash	146,666	156,199	**-9,533**
PO04 - Health	88,365	82,145	**6,220**
PO05 - Water, Sanitation & Hygiene	109,294	96,198	**13,096**
PO06 - Protection, Gender and Inclusion			**0**
PO07 - Education			**0**
PO08 - Migration			**0**
PO09 - Risk Reduction, Climate Adaptation and Recovery	38,305	772	**37,533**
PO10 - Community Engagement and Accountability	27,269	46,168	**-18,899**
PO11 - Environmental Sustainability			**0**
Planned Operations Total	**409,898**	**381,482**	**28,416**
EA01 - Coordination and Partnerships			**0**
EA02 - Secretariat Services	110,280	120,400	**-10,120**
EA03 - National Society Strengthening	107,427	53,999	**53,428**
Enabling Approaches Total	**217,707**	**174,398**	**43,308**
Grand Total	**627,605**	**555,881**	**71,724**

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Please explain variances (if any)

The operation closed with total expenditure of CHF 555,881 against an approved budget of CHF 627,605, resulting in a total underspend of CHF 71,724 on the DREF allocation. This balance largely reflects the final PFA tranche that was not transferred, which remains available for return to the DREF due to delayed reporting by the National Society. This balance will be returned to the DREF pot while pledge appearing under the report will be removed/corrected and should not be considered part of the DREF allocation.

Variance explanations on the execution of the DREF allocation.

1) Multi-purpose Cash (PO03) Overspend are mainly due to higher implementation costs, including reallocation of volunteer incentives shared across operational areas, initially planned under other budget lines.
2) Health (PO04) Savings were achieved through efficiencies in procurement and implementation of planned health activities.
3) Water, Sanitation and Hygiene (PO05) Savings result from complementary funding received from partners, which reduced reliance on DREF resources for the WASH activities and help on reducing the costs initially planned.
4) Risk Reduction, Climate Adaptation and Recovery (PO09)
Savings of CHF 37,533 as several planned activities were either scaled down or not fully implemented due to shifting operational priorities and reduced needs over time.
5) Community Engagement and Accountability (PO10) Overspend are linked to increased engagement activities and community outreach requirements, including additional communication and feedback mechanisms.
6) On the Enabling approaches
•Overspend of CHF 10,120 under Secretariat Services is due to expenses such as car rental and operational support costs being charged under this category, although initially budgeted under other lines.
•Savings of CHF 53,428 on National Society Strengthening are mainly resulting from the final PFA tranche not being transferred to the National Society, as reporting requirements for the previous tranche were not met on time. These funds will be returned to DREF.

Contact Information

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

National Society contact:
Catarina Laurinda, NSD and Health Coordinator, catarina.laurinda@cruzvermelha-angola.org, +244 911 871 658

IFRC Appeal Manager: John Roche, Head of Delegation, john.roche@ifrc.org, +258850115141

IFRC Project Manager: Rachel Fowler, Manager - IFRC Mozambique & Angola, rachel.fowler@ifrc.org, +258850109601

IFRC focal point for the emergency: Rachel Fowler, Manager - IFRC Mozambique & Angola, rachel.fowler@ifrc.org, +258850109601

Media Contact: Edgardo Ricardo, Senior Communications Officer, Edgardo.RICARDO@ifrc.org

Click here for reference