



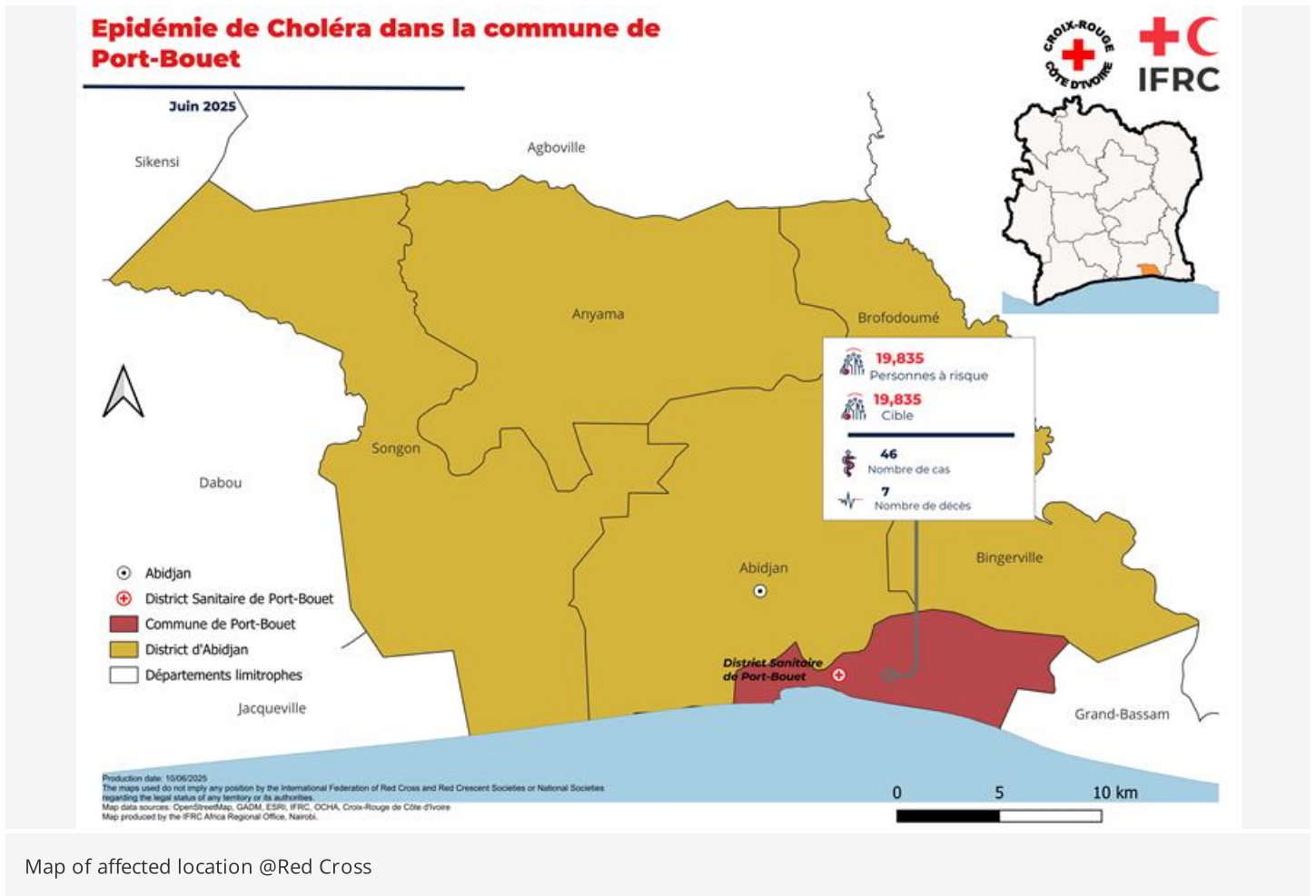
A volunteer supervising hand washing by a community member

Appeal: MDRCI018	Total DREF Allocation: CHF 489,424	Crisis Category: Yellow	Hazard: Epidemic
Glide Number: -	People Affected: 1,131,706 people	People Targeted: 169,755 people	People Assisted: 143,307 people
Event Onset: Slow	Operation Start Date: 16-06-2025	Operational End Date: 31-12-2025	Total Operating Timeframe: 6 months

Targeted Regions: **District Autonome D'Abidjan, Gbokle, Grands Ponts, San Pedro, Sud-Comoe**

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



Date when the trigger was met

01-08-2025

What happened, where and when?

On 5 June 2025, health authorities confirmed a cholera outbreak in the village of Vridi Ako (also referred to in some early alerts as Ako Brakré), located in the Port-Bouët Vridi health district of Abidjan, Côte d'Ivoire. The area, home to approximately 19,800 inhabitants—mainly fishing communities and migrants—has long been vulnerable to waterborne diseases due to poor sanitation, limited access to safe drinking water, and recurrent flooding.

While the first confirmed cases were reported in early June in Vridi Ako, retrospective epidemiological investigations indicated that alert signals and suspected cases had already emerged in late May, explaining the discrepancy in reported start dates across different reports and surveillance updates.

Following confirmation of the outbreak in Vridi Ako, the situation evolved rapidly from a localized outbreak into a multi-district epidemic. Within days, additional cases were reported beyond the initial epicentre, first spreading to nearby peri-urban and coastal areas, and subsequently extending to five additional health districts: Yopougon Est, Jacquerville, Sassandra, Fresco, and San Pedro. This marked a clear transition from a concentrated outbreak in Port-Bouët Vridi to a wider geographic spread affecting both urban and coastal peri-urban settings.

The epidemiological curve showed two distinct phases of transmission intensity. The first peak occurred in June, concentrated in Vridi Ako, reflecting rapid local transmission driven by environmental contamination and high population mobility. A second and more geographically dispersed peak followed in July, associated with the emergence of new transmission hotspots in Yopougon Est and

Sassandra, indicating secondary spread and establishment of additional foci outside the initial epicentre. A particularly high-risk cluster was also identified in a detention centre in Abidjan, where overcrowding and inadequate sanitation conditions accelerated transmission dynamics.

This escalation from a single-community outbreak to a multi-district epidemic required a corresponding scale-up of the response. As an auxiliary to public authorities, the Red Cross Society of Côte d'Ivoire initially supported rapid needs and situation assessments during the first alerts in late May and early June, leveraging pre-positioned volunteers in Vridi Ako. As the outbreak expanded geographically and intensified during the July peak, the National Society scaled up operations across affected districts, reinforcing its WASH activities, health interventions, and risk communication and community engagement (RCCE) to address both containment in the original hotspot and prevention of further spread in newly affected areas.

Despite continued transmission over several months, the outbreak gradually declined after the second peak. On 1 December 2025, the Ministry of Health and Public Hygiene officially declared the end of the outbreak across all six affected health districts. In total, 556 cases and 24 deaths were reported over the course of the epidemic.

By the end of the operation, no new cholera cases were being reported, and the Ministry of Health and Public Hygiene officially declared the end of the outbreak on 1 December 2025. Transmission had been interrupted across all six affected health districts.

However, important vulnerabilities remained in the affected communities, which continue to face overcrowding, recurrent flooding, inadequate sanitation, and limited access to safe water. Communities also expressed continued socio-economic needs and requested sustained support beyond the emergency phase.

While health facilities resumed normal operations, many still faced shortages of medical supplies and equipment. To support preparedness, first-contact health centres in all affected districts were provided by CRCI with essential medical and hygiene supplies, including chlorine and soap during this operation to ensure sustainability of interventions beyond the outbreak.

As part of the exit strategy, trained teams in the Abidjan detention centre remained operational and continued implementing disinfection activities using equipment provided by CRCI and the ICRC.

In addition, recognizing the socio-economic impact of the epidemic, CRCI mobilized complementary funding to provide cash assistance to vulnerable households in Vridi Ako in February 2026, ahead of the Lent and Ramadan periods.



Disinfection of boats



Awareness-Raising



Hygiene promotion



Supervision and monitoring



Scope and Scale

Extent of Impacts

The cholera epidemic had significant negative effects on human lives, livelihoods, well-being, and health infrastructure. Local health services were severely strained, exposing persistent structural gaps in access to safe drinking water, hygiene, and sanitation. The impact was reflected in the rapid spread of the disease following the first confirmed cases in Vridi Ako, the overburdening of health facilities across affected districts, and the deterioration of already precarious living conditions in the most affected communities.

As the outbreak evolved from initial alerts in late May 2025 to confirmation in early June 2025, the situation worsened with progressive geographic expansion beyond the original epicentre. This evolution reinforced existing inequalities in access to essential WASH services and highlighted pre-existing vulnerabilities in coastal and peri-urban settlements.

Most Exposed Populations and Location

The groups most affected included fishermen, informal sector traders, students, and unemployed youth. These populations primarily reside in overcrowded and underserved coastal and peri-urban areas, where access to safe drinking water is limited and sanitation infrastructure is insufficient. In several neighbourhoods, the absence or insufficiency of latrines has contributed to open defecation practices, sometimes occurring near water points or directly in the lagoon, significantly increasing exposure to contamination and disease transmission.

As the outbreak expanded beyond Vridi Ako to districts such as Yopougon Est, Jacqueville, Sassandra, Fresco, and San Pedro, similar vulnerability patterns were observed in both urban informal settlements and rural coastal communities, indicating that structural WASH deficiencies were a key driver of sustained transmission.

Reasons for Vulnerability

Vulnerability was driven by a combination of structural, environmental, and behavioural factors:

- Overcrowding and precarious housing conditions in high-density informal settlements.
- Limited physical access to healthcare services in certain coastal or lagoon-access communities, in some cases reachable only by small boats (pinasses), delaying timely care.
- Low awareness of preventive hygiene practices, compounded by misinformation and inconsistent risk communication in the early phase of the outbreak.
- Persistent structural disparities in WASH access, with significantly higher access to safe water in urban areas (approximately 88%) compared to rural areas (around 58%), and low sanitation coverage (estimated between 22–32% nationally).
- Environmental exposure linked to flooding and contamination of water sources during the rainy season, which facilitated rapid transmission.

Specific High-Risk Groups

Beyond the general affected populations, detainees in the Abidjan PPA detention centre were identified as a particularly high-risk group due to severe overcrowding, inadequate ventilation, and extremely limited sanitation facilities, which created ideal conditions for rapid transmission.

Children, older persons, and people with disabilities were also disproportionately affected due to increased dependence on caregivers and community-based services, which were often overstretched during the peak of the epidemic.

Historical Information

National data show that nearly 28% of the population still practices open defecation, and fewer than 20% have adequate handwashing facilities. Historically, these structural vulnerabilities have facilitated the spread of waterborne diseases, including cholera, leading to recurrent outbreaks and a significant proportion of diarrheal diseases linked to inadequate access to water and sanitation (UNICEF & WHO, JMP).

Situation at the End of the Operation and Remaining Risks

By the end of the outbreak, following the official declaration of the end on 1 December 2025, transmission had been interrupted across all six affected health districts. Health facilities had gradually returned to normal levels of activity, and no new confirmed cases were reported in the final epidemiological weeks.

However, significant residual risks remained. Structural WASH deficits - particularly in informal settlements and coastal fishing communities - persisted, leaving these areas highly vulnerable to potential future outbreaks. Surveillance systems, while strengthened during the response, required continued reinforcement to ensure early detection of any resurgence. Seasonal flooding, population mobility between coastal districts, and overcrowding in informal and institutional settings (including detention facilities) continued to represent ongoing risk factors for re-emergence.



Overall, while the immediate epidemic was contained, some vulnerabilities and needs persist and sustained investment in water, sanitation, hygiene infrastructure, and community-level prevention was identified as essential to reduce the likelihood of recurrence.

National Society Actions

Have the National Society conducted any intervention additionally to those part of this DREF Operation?	No
---	----

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC, through its Niamey Cluster covering Burkina Faso, Mali, Niger, and Côte d'Ivoire, provided substantial support to the Red Cross Society of Côte d'Ivoire. This included the deployment of three surge personnel—an Operations Manager, a Public Health in Emergencies specialist, and a CEA/PGI specialist—for a period of two months. In addition to these surge deployments, several technical support missions were carried out: • Programmatic support: four missions by the Cluster Coordinator, one mission by the Cluster Manager, two PMER missions, and two CEA/PGI missions. • Support services: two missions by the logistics officer to assist the National Society's logistics team in various procurement processes, as well as one security mission. • The IFRC country office also mobilized a Finance Coordinator and a Finance Officer, who facilitated the verification of supporting documents and the timely transfer of funds.
Participating National Societies	The Netherlands Red Cross (NLRC) provided both technical and financial support to the Red Cross Society of Côte d'Ivoire (CRCI) through a Crisis Modifier mechanism. This emergency fund, amounting to EUR 49,999, was made available to the CRCI to initiate response activities prior to the allocation of DREF funding. This early financial support enabled the National Society to implement the initial phase of the response, including the training of 50 volunteers on the BORT approach and the rollout of risk communication activities over a two-month period. The Monaco Red Cross (MRC) also contributed to the response by financing selected activities with a contribution of EUR 15,000. These funds supported the procurement of essential hygiene materials (including kits, handwashing facilities, and protective equipment) as well as the training of 25 volunteers in Sassandra on the BORT approach.

ICRC Actions Related To The Current Event

As part of this response, the ICRC provided both technical and financial support to DREF operations by facilitating the participation of the Red Cross Society of Côte d'Ivoire (CRCI) in tripartite coordination meetings involving government partners, MSF, and Movement partners. These coordination platforms ensured clarity of roles and responsibilities among stakeholders in the implementation of response activities. Within this framework, the CRCI was responsible for the disinfection of all sites within the Abidjan Penitentiary Centre (Pôle
--



Penitentiary Abidjan – PPA), as well as for training staff and peer educators among detainees to support the implementation of activities. The ICRC further supported these interventions by providing the CRCI with essential hygiene, disinfection, and protective equipment, including chlorine, sprayers, and full sets of personal protective equipment (PPE).

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	Since the beginning of the response, the Ministry of Health has played a central role in the cholera outbreak response. It was responsible for epidemiological investigations, laboratory confirmation of cases, patient management, and the official reporting of cases at both national and international levels. The Ministry ensured overall coordination of the health response and compliance with national protocols and international standards. In terms of risk communication, the Ministry of Hydraulics, Sanitation and Hygiene, through the National Agency for Waste Management (ANAGED), installed several awareness-raising billboards on good hygiene practices within affected communities. In addition, five blocks of latrines were constructed in some neighbourhoods of Vridi Ako, contributing to a reduction in open defecation practices. It is also important to note that the Ministry of Health systematically requested the support of the CRCI to conduct rapid needs assessments in Vridi-Ako and Vridi 3 (Zimbabwe neighbourhood) at the onset of the health crisis. The findings of these assessments were shared with the health authorities. The CRCI worked in close collaboration with the Ministry of Health at both operational and strategic levels. It contributed to the development of the national response plan and supported the updating of prevention and awareness messages targeting high-risk communities. The authorities also requested the CRCI's support in several components of the national response across all affected areas, particularly in community sensitization activities and the disinfection of public spaces and households of confirmed cases. Furthermore, the CRCI was officially requested to support social mobilization during cholera vaccination campaigns.
UN or other actors	WHO, UNICEF, and MSF actively supported the cholera response alongside the national health authorities and the CRCI. From the onset of the response, coordination and collaboration meetings were initiated by the CRCI and the IFRC with UNICEF and MSF to ensure effective coordination and strengthened partnership. These organizations contributed to key pillars of the response. MSF supported case management and treatment in health facilities, while WHO provided support to vaccination activities. UNICEF focused on risk communication and cholera prevention messaging. In addition, MSF supported the CRCI's BORT activities through the donation of 1,000 sachets of oral rehydration salts (ORS). UNICEF also contributed by donating 10,000 Aquatab tablets to the CRCI to support household water treatment activities.



Are there major coordination mechanism in place?

Weekly coordination meetings were held every Wednesday with the Public Health Emergency Operations Centre (COUSP), based at the National Institute of Public Hygiene (INHP), as well as with health districts, WHO, MSF, and other operational partners in the field. These coordination meetings helped to avoid duplication of activities among partners, strengthen the effectiveness of the response, and maximize impact on the most vulnerable communities.

Since the beginning of the outbreak, all response activities, including community sensitization, early case detection and referral to health facilities, as well as household disinfection of confirmed cases—were implemented in a coordinated manner between Ministry of Health teams and MSF at treatment centres.

The CEA team established an external coordination mechanism dedicated to managing community feedback. Regular collaborative meetings were organized with the CRCI, Movement partners, and external stakeholders including UNICEF, health districts, the Community Health Directorate, and INHP. These meetings supported the processing of community feedback, the development of frequently asked questions (FAQs), and the harmonization of key risk communication and awareness messages

Needs (Gaps) Identified



Health

Despite successfully controlling the outbreak in both the initial epicenter and newly affected areas, the true level of risk at the community level was underestimated. It is likely that some cases went unreported and that community transmission occurred undetected in certain instances. The number of community deaths recorded during the outbreak suggests that the disease had a greater impact than reflected in official figures. This underscores the need for continuous community-based surveillance to generate real-time data on the actual progression of the outbreak.

Health facilities in affected areas also faced significant challenges. While the overall number of cases remained manageable, rural health centers around Abidjan lacked the capacity to handle a large influx of patients due to limited bed space and insufficient supplies of oral rehydration salts (ORS) and other critical medical inputs.

Furthermore, fifteen years after the last outbreak, community knowledge of cholera symptoms, transmission routes, and prevention measures was found to be low or, in some cases, nonexistent. Persistent misinformation and limited access to clear public health messaging hindered the adoption of appropriate hygiene practices, making sustained risk communication essential. Health professionals also reported difficulties in implementing community-based surveillance for early case detection.

Needs assessments and Knowledge, Attitudes, and Practices (KAP) surveys conducted by the Red Cross Society of Côte d'Ivoire (CRCI) highlighted an urgent requirement to strengthen community presence. This called for greater volunteer engagement to support early detection and referral of suspected cases to health facilities.

Capacity gaps were also identified among both health workers and volunteers, particularly in relation to cholera knowledge and household-level risk assessment.

Finally, the significant resumption of fishing activities increased the risk of transmission due to population movement and interactions between fishermen from Ghana, Togo, Benin, and Côte d'Ivoire. Fishermen were among the most affected groups during the outbreak.

At the end of the 2025 cholera epidemic, several needs remained. Health facilities in affected areas continued to face capacity constraints, including gaps in medical equipment, supplies, and infrastructure required to effectively manage epidemic-prone diseases. In addition, there is a continued need to strengthen community knowledge and understanding of public health threats, including cholera as well as other vector- and water-borne diseases such as malaria and dengue fever. Sustained health promotion and community awareness efforts are therefore required to improve prevention practices, early health-seeking behavior, and overall preparedness for future outbreaks.



Water, Sanitation And Hygiene

The Knowledge, Attitudes and Practices (KAP) survey and needs assessments conducted by the Red Cross Society of Côte d'Ivoire (CRCI) had highlighted persistent challenges in access to safe drinking water and basic sanitation infrastructure (latrines, waste pits, etc.).



In several affected areas, a large proportion of households did not have access to latrines. Open defecation continued to be practiced by some communities due to the lack of sanitation facilities, resulting in a high health risk.

Most of the available water sources were unsafe and highly exposed to contamination.

The rainy season during the outbreak period exacerbated these vulnerabilities by causing water stagnation, which was conducive to the spread of cholera and other diseases. The sale of beverages prepared with untreated water was common, while basic hygiene practices were rarely observed by vendors, representing a significant public health risk.

Finally, frequent exchanges, whether commercial, occupational, or related to fishing activities, between rural and urban areas had significantly increased the risk of cholera transmission.

At the end of the operation, significant needs persisted in WASH. Access to adequate sanitation facilities remained limited, with latrine coverage still insufficient, particularly in the event of population increases or higher density in affected communities. Continued investment in sanitation infrastructure is therefore required to reduce reliance on unsafe practices such as open defecation. In addition, sustained efforts are needed to improve hygiene practices at community level, including handwashing and safe water handling, to reinforce behaviour change and reduce the risk of disease transmission.



Protection, Gender And Inclusion

Community feedback collected by the CRCI during the first weeks of the response highlighted significant challenges related to social cohesion, as well as perceptions of equity and inclusion in the response to the outbreak. In some areas, misconceptions about the origin of the disease and the stigmatization of certain communities undermined trust and limited collaboration with response teams. It was therefore essential to continue promoting transparent, inclusive, and context-appropriate communication, relying on trusted community actors and accessible communication channels. Community dialogue was strengthened to improve social cohesion. People with disabilities had expressed the need for continued involvement in all community-based activities.

In addition, discussions with certain groups, particularly women, had highlighted the need for their involvement in the design and siting of water, sanitation, and hygiene (WASH) infrastructure, as the lack of consultation could have led to low acceptance and utilization of facilities.

Considering these findings, the main identified needs were as follows:

- Strengthened, clear, and context-appropriate communication promoting equity, solidarity, and prevention, to address misconceptions and reduce stigma.
- Increased and meaningful participation of different community segments, particularly women and persons with disabilities, in the design, location, and use of WASH infrastructure.
- Establishment and reinforcement of community feedback and listening mechanisms to ensure better consideration of the concerns and feedback of affected populations.
- Systematic adoption of an inclusive, participatory, and community-centred approach to strengthen trust, improve acceptance of interventions, and ensure that the response was grounded in local realities.

These findings also point to persisting vulnerabilities linked to marginalisation, particularly in Vridi Ako, the first affected district. Its highly diverse composition, including multiple nationalities, ethnic groups, and socio-economic backgrounds, continued to influence levels of access to information and participation in the community. This is highlighting the need for sustained efforts to ensure equitable access to services, inclusive communication, and meaningful participation of all community groups in future responses.



Community Engagement And Accountability

Community feedback in Vridi-Ako and other affected areas had highlighted significant needs in terms of information, communication, and community participation. Several individuals have expressed a need for a better understanding of the roles of the different actors involved in the crisis response, as well as a desire to be more involved in decisions affecting them, particularly regarding access to services and prevention activities.

Communities had also emphasized the importance of a visible response adapted to local realities, especially in areas where sanitary and environmental conditions were fragile. Clear, understandable, and context-appropriate messaging had been necessary to build trust, correct misconceptions, and encourage preventive behaviors.

In some affected areas, mechanisms enabling citizens to ask questions, raise concerns, or provide feedback were insufficiently known or accessible. It had therefore been necessary to strengthen two-way communication, promote trusted community channels (such as local



radio, community leaders, and religious leaders), and make feedback mechanisms more visible.

The main needs identified in terms of community engagement and accountability were as follows:

- Clarification of the role of Red Cross volunteers and partners involved in the response, in order to strengthen community understanding and trust.
- Improved access to information on decision-making processes related to services, particularly regarding the distribution of items, sanitation activities, and awareness-raising interventions.
- Strengthening of local communication through culturally appropriate messages disseminated via reliable, accessible, and appropriate channels.
- Consolidation of community dialogue and feedback mechanisms, including the use of hotline systems and community committees.
- Systematic monitoring of perceptions, concerns, and rumors in order to effectively guide the response and promote the adoption of preventive measures.
- Strengthening of social cohesion through inclusive messaging and equitable access to services for all affected populations, including mobile and marginalized groups.

Towards the end of the operation, although some improvements were observed in information sharing and community engagement through volunteer-led activities, the above needs remained partially unmet and continued to require sustained efforts to strengthen trust, accessibility of information, and community participation in future interventions.



Environment Sustainability

The cholera outbreak response in vulnerable neighborhoods such as Vridi-Ako highlighted critical environmental concerns. The widespread use of single-use plastics, the absence of adequate waste management systems (including packaging and disinfectant residues), and the risk of soil and groundwater contamination due to improperly dosed chemical products raised serious environmental issues.

The main environmental needs identified were as follows:

- The use of sustainable or biodegradable water, sanitation, and hygiene (WASH) materials to limit the environmental impact of the response.
- The implementation of safe and responsible management of waste generated by distributed items, particularly plastic packaging and disinfectant residues.
- The use of approved, environmentally friendly disinfectants applied at appropriate dosages to prevent any environmental contamination.

Operational Strategy

Overall objective of the operation

In this response, the objectives of the CRCI were to:

- Limit the spread of cholera in Abidjan and other high-risk areas of Côte d'Ivoire, while adapting interventions based on case mobility.
- Contribute to breaking the chain of cholera transmission in affected health districts and neighboring districts.

The response was based on a proactive, flexible, and community-centre approach aimed at slowing transmission in existing outbreak hotspots while preventing the emergence of new cases.

Operation strategy rationale

Achievements to date:

As part of the cholera outbreak response, and with the support of the IFRC DREF Fund, the Netherlands Red Cross Crisis Modifier, and funding from the Monaco Red Cross, the Red Cross Society of Côte d'Ivoire (CRCI) implemented a wide range of activities to strengthen community protection. A total of 250 volunteers were trained on the BORT approach and subsequently carried out awareness-raising sessions on cholera symptoms, prevention measures, early case detection, and referral of suspected cases to health facilities. Through



these efforts, more than 68,072 people across 17,018 households were reached, and 235 suspected cases were referred for treatment, enabling early detection and limiting community transmission.

In the field of Water, Sanitation and Hygiene (WASH), CRCI disinfected 279 households and 1,053 community sites, including schools, places of worship, and public latrines, while also installing handwashing facilities at strategic locations. Volunteers were equipped with spraying and protective equipment to ensure safe and rapid interventions. To further reduce household-level transmission, Non-Food Item (NFI) kits were distributed to vulnerable families, and latrine blocks were constructed in the most affected communities in collaboration with beneficiaries, helping to curb open defecation—a major driver of cholera spread.

However, increased population mobility toward coastal areas for trade and cross-border fishing activities led to the spread of the outbreak to new localities starting in August. During a coordination meeting organized by the Ministry of Health, updated epidemiological data highlighted the urgent need to reinforce response activities. In this context, CRCI, with IFRC support, requested and received an additional allocation of CHF 389,424 from the DREF Fund to extend and scale up operations. This funding allowed for a more flexible and rapid response to rising case numbers across different areas.

The reinforced BORT approach combined health interventions, WASH activities, community surveillance, and social mobilization during vaccination campaigns. Volunteers, equipped with Aquatabs, ORS, mineral water, and assessment forms, conducted household visits where they carried out risk assessments, provided tailored health education, chlorinated water, and administered ORS to suspected cases before referral to health facilities. These combined interventions helped break the chain of transmission and contributed to containing the outbreak across all affected health districts.

Targeting Strategy

Who was targeted by this operation?

This operation primarily targeted populations most exposed to the risk of cholera transmission, considering epidemiological factors, living conditions, and mobility patterns. Attention was given to high-risk groups in terms of infection, transmission, and complications, in order to maximize the impact of prevention, early detection, and response activities.

The priority target groups included:

- Confirmed, suspected, or probable cholera cases, as well as their direct household and community contacts.
- Mobile populations, including fishermen, seasonal workers, and itinerant traders.
- Food handlers, such as street vendors, small restaurant operators, and producers, who often worked in precarious sanitary conditions.
- Transport personnel (taxi drivers, minibus drivers, boat operators, etc.), who were highly exposed due to their mobility and frequent daily interactions.
- Vulnerable groups, including pregnant women, children under five years of age, older persons, and individuals with comorbidities.
- Households living in overcrowded, informal, or underserved neighborhoods, where poor sanitation, limited access to safe drinking water, and inadequate waste management contributed to cholera transmission.
- Men, who represented most reported cases in several affected areas (88% in Port-Bouët Vridi and 75% in Yopougon).
- Incarcerated people in detention centers where cases had been reported, due to critical sanitary conditions and overcrowding.
- Pupils and students, particularly in high-density school areas, due to shared facilities and close living conditions in universities and campuses.

Explain the selection criteria for the targeted population

The selection of target groups was based on a risk-informed approach combining several key determinants: epidemiological surveillance data, local environmental conditions, mobility patterns, and community feedback.

Confirmed cases and their direct contacts were subject to targeted follow-up to immediately limit further transmission. Mobile populations, such as fishermen and transport workers, were prioritized due to their high inter-regional mobility, which increased the risk of cholera spread. Street vendors, restaurant operators, and market traders handling food products in high-risk environments also received particular attention.

Precarious neighborhoods, often characterized by the absence of latrines, open defecation practices, inadequate waste management, and the use of unsafe water sources, had contributed to rapid community transmission. Men were specifically targeted as they were overrepresented among reported cases, which was associated with certain behavioral and occupational factors.



Finally, prisons and high-density educational settings (such as boarding schools and university campuses) presented a high risk of transmission in closed environments, while medically vulnerable groups (pregnant women, young children, elderly persons, and individuals with chronic diseases) were at increased risk of severe complications.

By closely linking risk profiles with local dynamics, this targeting strategy enabled an effective, equitable, and context-appropriate response.

Overall, the target populations were reached, largely thanks to the BORT approach, which allowed teams to access hard-to-reach areas predominantly inhabited by the most vulnerable populations.

Total Assisted Population

Assisted Women	51,167	Rural	-
Assisted Girls (under 18)	25,700	Urban	-
Assisted Men	42,703	People with disabilities (estimated)	-
Assisted Boys (under 18)	23,737		
Total Assisted Population	143,307		
Total Targeted Population	169,755		

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?	No
Does your National Society have whistleblower protection policy?	No
Does your National Society have anti-sexual harassment policy?	No
Please analyse and indicate potential risks for this operation, its root causes and mitigation actions.	
Risk	Mitigation action



Risk of work overload or exhaustion due to prolonged shifts or difficult conditions.	- The number of working hours per day has been limited. - The workload and physical condition of the teams have been monitored.
Risk of emotional stress, anxiety, or psychological distress related to exposure to illness, death, or social pressure.	- Regular psychosocial information sessions were organized with the support of the psychosocial support team. - A safe space was created where people could be heard and express their emotions.-
Operational and legal risks Difficult access to certain areas and a lack of resources can delay activities. Certain interventions, such as disinfection or data collection, require authorizations; failure to obtain these can lead to blockages or legal risks.	- National procedures and laws were followed. - All operations were carried out in coordination with local authorities. - Volunteers signed an informed consent form and a liability waiver prior to their deployment.
Risk of Sexual Exploitation and Abuse and child safeguarding.	- CRCI staff and volunteers have been trained in PGI and PEAS interventions. - Ongoing assessment of protection risks. - A feedback mechanism has been established and adapted. .
Risk of non-acceptance of cholera prevention measures and public health information, which could hinder community buy-in and reduce the effectiveness of response efforts.	Community engagement was strengthened through messages tailored to the local culture and the involvement of community leaders. Feedback mechanisms were also put in place to ensure that community concerns were addressed.
The stigma associated with cholera can lead affected individuals or families to conceal symptoms, avoid seeking treatment, or resist community interventions, thereby increasing the risk of transmission.	Messages combating stigma had been incorporated into all communication and awareness campaigns; community leaders and health professionals had been involved in promoting solidarity and understanding, confidentiality and respect for dignity were ensured in case management and contact tracing, and stories of recovery as well as concrete facts were highlighted to reduce fear and misinformation.
The context of the upcoming elections could have an impact on the operating environment, particularly due to a shift in local priorities, effects on community gatherings, or reduced availability of civil servants and community leaders, which could delay or complicate response activities.	Collaboration with local authorities and community leaders made it possible to align activities with the electoral calendar, ensure flexibility in implementation timelines, and prioritize low-key, community-led approaches, thereby preserving neutrality and avoiding any interference in the electoral process.
Risk of drowning (main access route via the lagoon). The rainy season can not only accelerate the spread of the epidemic by promoting the stagnation of contaminated water, but also make certain areas difficult to access, thus complicating response operations.	The volunteers were equipped with life jackets made as part of the project during the crossings The life jackets that had already been purchased had been used, and hygiene and sanitation measures had been implemented.
Risk for staff and volunteers of contracting cholera or other diseases related to the conditions of the intervention.	Personal protective equipment such as gloves, hand sanitizer, boots, and masks had been provided; volunteers had been trained in cholera prevention measures; access to safe drinking water and sanitation facilities had been ensured; and awareness campaigns on self-monitoring for symptoms had been conducted.



Please indicate any security and safety concerns for this operation:

The operation did not face any major security threats, but localized risks such as petty crime, health risks, and limited access due to seasonal flooding affected the safety of staff, volunteers, and the communities involved. To mitigate these risks, standard security protocols were implemented, including regular briefings, coordination with local authorities, and basic security measures to protect staff and volunteers in the field.

Has the child safeguarding risk analysis assessment been completed?

No

Implementation



Budget: CHF 103,726
Targeted Persons: 45,109
Assisted Persons: 68,072
Targeted Male: 34,850
Targeted Female: 33,222

Indicators

Title	Target	Actual
Number of trainers trained on BORT/PRO	27	30
Number of volunteers trained on BORT/PRO/Vaccination	250	250
Number of people reached by awareness-raising activities	45,109	68,072
Number of people referred to health centers	200	235
% trained volunteers active in the response	80	80

Narrative description of achievements

• As part of the cholera outbreak response, the Red Cross Society of Côte d'Ivoire (CRCI), with support from the IFRC through the DREF and funding from partners such as the Netherlands Red Cross, the Monaco Red Cross, and the ICRC, implemented a wide range of health activities aimed at strengthening community resilience and reducing mortality. A total of 30 staff members and volunteer supervisors were trained on the PROC and BORT approaches, followed by the training of 250 community volunteers. These sessions included complementary modules on Water, Sanitation and Hygiene (WASH) and Community Engagement and Accountability (CEA), ensuring that volunteers were equipped not only with technical knowledge but also with the skills to engage communities effectively.

Through these efforts, 68,072 people were reached, including 33,222 women, 34,850 men, and 153 persons with disabilities. The establishment of a community-based surveillance mechanism proved critical, enabling the referral of 235 suspected cases to treatment centres and thereby significantly reducing cholera-related mortality. Volunteers also played a central role in vaccination campaigns, receiving training on vaccine effectiveness to counter misinformation and support community mobilization. Their involvement contributed to a 62% vaccination coverage rate, with 45,001 individuals vaccinated out of 72,630 targeted.



As part of CRCI's exit strategy, nine primary health centres in Vridi Ako, Port Bouët, Yopougon, Jacqueville, Sassandra, and San Pedro were supplied with essential hygiene materials to reinforce local capacity for future prevention. These supplies included liquid soap, bleach, waste bags, pedal bins, brushes, powdered soap, buckets, gloves, and brooms—items that are vital for maintaining hygiene standards and preventing the resurgence of waterborne diseases. Together, these interventions illustrate a comprehensive response that combined immediate outbreak control with long-term capacity building, ensuring that communities are better prepared to face future health emergencies.

Lessons Learnt

- Maintain contingency stocks of essential cholera supplies, including Aquatabs and oral rehydration salts (ORS), to enable a rapid and effective response to waterborne disease outbreaks.
- Strengthen coordination mechanisms among key stakeholders from the outset of the response to better anticipate community needs and ensure timely and complementary interventions.
- Incorporate geographical and distance analyses into preparedness and response planning to accurately estimate transportation requirements and associated costs, thereby improving logistical efficiency and resource allocation.

Challenges

• Several operational challenges emerged during the implementation of the BORT strategy in response to the cholera outbreak. Ensuring the consistent availability of essential supplies such as Aquatabs and oral rehydration salts (ORS) was critical to enabling volunteers to carry out household-level interventions effectively. Rapid mobilization of volunteers was also necessary to support cholera vaccination campaigns, which required strong coordination and timely deployment. However, guaranteeing the safety of volunteers during home visits in very remote areas posed significant difficulties, particularly in communities with limited infrastructure. Appropriate transportation was another challenge, as reaching hard-to-access zones demanded reliable logistical arrangements. Finally, the regular payment of per diems to volunteers was essential to maintain motivation and commitment, yet it required careful financial planning and management to avoid delays or disruptions. Together, these challenges highlight the importance of robust supply chains, effective volunteer management, and strong logistical support in ensuring the success of community-based outbreak response strategies.



Water, Sanitation And Hygiene

Budget: CHF 167,373
Targeted Persons: 21,354
Assisted Persons: 25,000
Targeted Male: 12,650
Targeted Female: 12,349

Indicators

Title	Target	Actual
Number of WASH kits purchased and distributed.	5,600	5,600
Number of people who have benefited from latrine	50	26,800
Latrine blocks built	1,200	3
Number of people reached by handwashing demonstrations.	21,354	25,000
Number of households or public spaces disinfected using the BORT approach	650	1,053
Number of treated water sources	41	0

Narrative description of achievements

Located between the sea and the Ebrié Lagoon, Vridi Ako in the Port-Bouët Vridi health district and Ossibissa in the Yopougon Est health district had no sanitation network, and more than 90% of households lacked access to latrines. As a result, communities practiced open defecation along lagoon banks and in waste disposal areas. Most households also relied on shallow, unprotected traditional wells as their primary water source.

With financial support from the IFRC, the CRCI implemented a range of WASH interventions, including the construction of latrines in high-vulnerability neighborhoods and the distribution of WASH kits to households living in high-risk hygiene conditions. The construction of latrines was preceded by community consultations led by the CEA team, resulting in agreement on the designated construction sites. Communities and traditional leaders actively contributed to implementation, monitoring, and conflict resolution throughout the construction process.

Despite implementation delays linked to the rainy season, the transport of materials via small boats (pinasses), and limited regular monitoring of construction sites, the activities resulted in the construction of 3 blocks of 8 emergency latrines: 1 block of eight latrines in Vridi Ako (Port-Bouët health district) and 2 blocks of eight latrines in Ossibissa (Yopougon Est health district).

Regarding hygiene kit distribution, beneficiary selection was based on health facility consultation records for confirmed cases. For at-risk households, volunteers conducted targeted assessments under the supervision of PMER staff using the Kobo Collect tool to assess household hygiene vulnerabilities. This process led to the selection of 5,600 households to receive WASH kits.

The kit included: one 23-litre handwashing bucket with tap, one 23-litre covered water storage bucket, two rolls of paper towels, six bottles of chlorine solution (Sur Eau), three bottles of 12° bleach, and two bars of soap. Multiple distribution rounds were conducted across all affected localities, resulting in the distribution of 5,600 kits across Vridi Ako (2,000), Port-Bouët including Anani, Jean Folly and Vridi 3 (2,100), Ossibissa (500), Sassandra (400), Jacquenville (400), and San Pedro (200).

Household disinfection activities covered transport means (canoes, pinasses, vehicles), public spaces (schools, places of worship, public and household latrines), as well as 279 households and more than 1,053 community sites, contributing to limiting disease transmission. Handwashing stations were installed in high-traffic areas and managed by volunteers, significantly reinforcing hygiene promotion efforts. Through these activities, approximately 25,000 people were reached through handwashing demonstrations, strengthening preventive practices and contributing to reducing the spread of the disease to unaffected localities.

For the number of persons who benefitted from the utilization of the latrines, the target was erroneously put at 50 yet should have been 25,000. This explains the overreach.

In addition, 25 CDRT volunteers were trained in WASH to carry out water source treatment-related activities. This strengthened local capacity by ensuring the availability of trained resource persons within community committees, thereby enhancing the ability of volunteers to support WASH interventions. Water source treatment activities were ultimately implemented by the Public Health Hygiene Services of the National Institute of Public Hygiene (INHP), rather than by the CRCI as initially planned.

Lessons Learnt

- Establish and maintain framework agreements with pre-qualified suppliers and service providers prior to outbreaks to enable rapid procurement and timely delivery of essential WASH and response supplies during cholera emergencies.
- Systematically activate CRCI emergency logistics procedures at the onset of each DREF operation to accelerate procurement, transportation, and distribution processes and minimize delays in the implementation of life-saving activities.
- Mobilize and train Community Disaster Response Teams (CDRTs) at the early stages of the response to ensure that volunteers possess the technical skills required to support cholera prevention and control activities, including hygiene promotion, disinfection, and community-based surveillance.

Challenges

- Pre-positioning of kits in hard-to-reach areas
- Availability of kits within the required timeframe
- Handover of latrines to communities within the required timeframe



Protection, Gender And Inclusion

Budget: CHF 6,971

Targeted Persons: 45,109

Assisted Persons: 68,072

Targeted Male: 34,581

Targeted Female: 33,491

Indicators

Title	Target	Actual
Number of volunteers trained on PGI during BORT training	250	250
Number of staff trained in PGI in the response	14	25

Narrative description of achievements

• As part of PGI (Protection, Gender and Inclusion) activities, a multi-stakeholder workshop was held, which enabled the validation of informed consent forms for the cholera DREF operation, as well as informed consent forms for other National Society programmes and the associated usage guidelines. These measures ensured that each volunteer was clearly informed of the risks related to their participation, that their free and voluntary consent to field activities was obtained, and that compliance with safety rules and preventive measures was promoted.

To strengthen the National Society's capacity and ensure the integration of protection, gender, and inclusion considerations, 16 staff members (9 men and 7 women) were trained on PGI minimum standards in emergency settings. It should also be noted that 1,500 PGI posters were produced to raise awareness on the respect of the dignity of vulnerable people and the prevention of abuse, exploitation, and sexual harassment.

To ensure compliance with PGI minimum standards during the cholera DREF operation, an assessment was conducted. The results showed that:

- 100% of people reached felt respected and reported having been sufficiently informed about cholera.
- Community members indicated that volunteers carried out their work properly, did not engage in inappropriate relationships with community members, and maintained appropriate conduct.
- Volunteers were perceived as respectful and were not reported to have solicited money from community members.

Lessons Learnt

- Ensure the early and continuous engagement of PGI focal points throughout the response to facilitate the systematic integration of minimum Protection, Gender, and Inclusion (PGI) standards into community-based interventions and to promote safe, inclusive, and accessible services for all affected populations.

Challenges

- Delayed integration of PGI into the response: One of the key challenges was the late integration of Protection, Gender and Inclusion (PGI) considerations into the implementation of the response, which limited their systematic inclusion during the early phases of activities and required adjustments during implementation.
- Collection and management of sensitive information: The collection, processing, and management of sensitive information represented a significant challenge, particularly due to the need to ensure confidentiality, data protection, and the ethical use of information in an emergency response context.



Community Engagement And Accountability

Budget: CHF 30,967

Targeted Persons: 45,109



Assisted Persons: 45,109
Targeted Male: 23,005
Targeted Female: 22,104

Indicators

Title	Target	Actual
Number of volunteers trained in CEA during the BORT training	250	250
Number of people reached through home visits, group discussions in markets, transport stations and schools.	45,109	68,072
Community Feedback Mechanism	0	1
Number of Feedback collected	2,500	12,284
% Percentage of feedback processed and incorporated into the response	80	71
Community meetings organised	16	15

Narrative description of achievements

Community Engagement and Accountability (CEA) activities were a central pillar of the cholera DREF response. In this framework, 12,284 pieces of community feedback were collected through various channels, including door-to-door outreach, markets, transport hubs, and schools, conducted by CRCI volunteers.

The CEA mechanism was structured around an integrated internal and external coordination system involving the CRCI, Movement partners, UNICEF, health districts, the Community Health Directorate, and the National Institute of Public Hygiene (INHP). These regular coordination meetings enabled the processing of community feedback, the development of Frequently Asked Questions (FAQs), and the harmonization of key risk communication messages to ensure coherent and context-appropriate communication.

Community feedback was collected using standardized forms completed by volunteers, then entered into the KOBO Collect platform and submitted to the CEA team for processing. The data were subsequently consolidated into a feedback matrix, allowing for analysis, coding, and prioritization. Processed feedback was systematically integrated into Situation Reports (SITREPs), ensuring its consideration in operational response monitoring.

The results of this analysis were operationalized through the development of FAQs, jointly prepared with technical services of the Ministry of Health, Movement partners, and community stakeholders. These FAQs were then used by volunteers as a reference tool to provide standardized and consistent responses to community concerns.

In the specific context of latrine construction in Vridi Ako and Ossibissa, CEA played a key role in community consultation and engagement. Inclusive meetings were organized with women, community leaders, religious authorities, and local associations to identify and validate construction sites. Recommendations from these consultations were taken into account, validated by traditional authorities, and formally approved prior to the start of construction. This participatory approach strengthened community ownership and facilitated local monitoring and conflict resolution throughout implementation.

In addition, community meetings were held ahead of hygiene kit distributions to inform populations about targeting criteria and distribution processes. These engagements helped address community concerns and strengthened transparency throughout the intervention.

Community feedback played a tangible role in shaping operational decisions during the response, ensuring that activities were better aligned with local needs and preferences.

In the case of latrine construction, consultations were conducted with women, including women's associations in the Caillou sector, to determine appropriate installation sites. While an initial location had been suggested by local leadership, community members



particularly women expressed concerns related to safety and accessibility, indicating that the proposed site was not suitable for their use. In response to these concerns, CRCI adjusted the final location of the latrines to better reflect community preferences and ensure safe access for all users.

Similarly, during vaccination activities, the Ministry of Health initially planned a fixed-site approach for vaccine delivery. However, feedback collected by CRCI volunteers highlighted a clear community preference for door-to-door services, rather than requiring people to travel to designated sites. This feedback was communicated to the relevant health authorities, who subsequently adapted the strategy and implemented a door-to-door vaccination approach.

These examples demonstrate how community feedback mechanisms contributed to improving the relevance, accessibility, and acceptance of key interventions.

Finally, through this DREF operation, the CRCI finalized and validated Standard Operating Procedures (SOPs) for the community feedback mechanism, thereby consolidating gains in CEA and reinforcing accountability to affected populations. . . .

Lessons Learnt

- Systematically integrate community engagement and participation mechanisms throughout cholera responses to ensure that affected populations are actively involved in the design and implementation of interventions, thereby strengthening community ownership, acceptance, and the effectiveness of response activities.
- Maintain a strong community presence through volunteers and local structures close to affected populations to enable timely information and feedback collection, supporting better decision-making and a more effective response to outbreaks.

Challenges

- Collection of feedback through the hotline (green line): The collection of community feedback through the hotline (green line) represented a major challenge due to its lack of operational functionality during the implementation period. This limitation reduced its use as a two-way communication channel and required the strengthening of alternative community-based mechanisms to ensure the effective collection and reporting of feedback.



Budget: CHF 107,367
Targeted Persons: 5
Assisted Persons: 4
Targeted Male: 3
Targeted Female: 1

Indicators

Title	Target	Actual
Surge deployment	3	2
Support visits	6	6
Support lessons learned workshop	1	1

Narrative description of achievements

- In line with the National Society, IFRC support to this operation was structured to ensure coordinated, effective, and closely monitored implementation. This support was deployed through a combination of operational, technical, and coordination mechanisms aimed at strengthening the overall response capacity of the CRCI.



A dedicated country-based team was established to provide operational oversight, technical guidance, and coordination support. This was complemented by the deployment of surge personnel, including an Operations Manager, as well as public health in emergencies and CEA surge delegates, to reinforce field-level implementation and coordination.

Operational, PMER, logistics, and finance support missions were conducted to strengthen the National Society's capacities. PMER support focused on improving planning, monitoring, evaluation, and reporting systems, including data collection, analysis, consolidation, and the production of progress and final reports for donors and partners. Logistics support missions contributed to strengthening procurement and supply chain processes, while financial oversight ensured compliance with procedures, quality control of expenditures, and accountability requirements.

Regular coordination meetings and working sessions were held on a monthly basis to ensure effective communication and alignment among all stakeholders. Through these engagements, continuous capacity strengthening of the National Society was ensured across key functional areas identified as critical during previous response experiences.

Operational management support was primarily provided by surge teams and the Operations Manager, focusing on planning, coordination, and field monitoring, including volunteer management, logistics coordination, and implementation tracking. Financial management was ensured by the IFRC finance focal point in-country, while PMER functions supported overall data management and reporting processes.

Lessons Learnt

- The deployment of surge personnel, combined with regular coordination, monitoring, logistics, finance, and PMER support, proved essential in reinforcing the National Society's capacity and improving accountability and data management. Future responses should therefore ensure the early deployment of surge personnel and maintain regular coordination and support mechanisms throughout the operation to maximize effectiveness and sustainability.

Challenges

• Ensuring the continuous motivation and protection of volunteers during cholera outbreak responses remains a critical challenge. While volunteers are central to household-level interventions, vaccination campaigns, and community mobilization, their safety in remote areas, access to adequate transportation, and timely provision of per diems are often difficult to guarantee. Addressing these issues requires stronger logistical planning, reliable financial management, and robust safety protocols to sustain volunteer engagement and effectiveness in future emergency operations.



National Society Strengthening

Budget: CHF 73,020

Targeted Persons: 250

Assisted Persons: 250

Targeted Male: 130

Targeted Female: 120

Indicators

Title	Target	Actual
Trained, equipped, and insured volunteers	250	250
Capacity-building session for the Red Cross of Côte d'Ivoire in PMER, logistics, finance, and operational management	8	4
Briefing volunteers on safety, security, and protection against cholera	10	4
Training of trainers on the BORT approach	25	25
Lessons Learned Workshop	1	1



Narrative description of achievements

• In the framework of the development of the Red Cross Society of Côte d'Ivoire, this operation provided a significant opportunity to strengthen the National Society's operational capacities. Several structured actions were implemented to this effect. Training sessions were conducted for 30 staff members on the BORT and PROC approaches, as well as for 250 volunteers, to enhance operational skills and better prepare the National Society for potential health emergencies. These training courses were complemented by coaching sessions on the use of the DREF mechanism, contributing to improved emergency response management. In addition, a lessons learned workshop was organized to capitalize on the experience gained from the cholera response. This workshop helped consolidate key achievements and formulate recommendations aimed at improving future interventions, particularly in the areas of training, logistics, community coordination, and operational management. Furthermore, the response enabled the acquisition of essential equipment to strengthen the institutional and operational capacities of the National Society. In this regard, 60 tablets were procured to enhance the digitalization of PMER activities. In addition, a multifunction camera was acquired to strengthen documentation and visibility of interventions, along with three laptops to facilitate reporting and activity monitoring by staff.

Lessons Learnt

- Ensure that all National Society staff and volunteers have a clear and shared understanding of the operation, roles, and planned activities from the outset to strengthen coordination, facilitate implementation, and ensure the timely delivery of results.

Challenges

• While the operation provided valuable opportunities to strengthen the operational capacities of the Red Cross Society of Côte d'Ivoire, sustaining these gains remains a challenge. Ensuring that the skills acquired through training on BORT, PROC, and DREF mechanisms are consistently applied in future emergencies requires ongoing coaching and refresher sessions. Similarly, the effective use of newly acquired equipment—such as tablets for PMER digitalization, laptops for reporting, and cameras for documentation—depends on continuous technical support and maintenance. Another challenge lies in translating lessons learned into long-term institutional improvements, particularly in logistics, community coordination, and operational management, so that the National Society can move beyond short-term capacity building and achieve lasting resilience.



Financial Report



DREF Operation

Draft Report (CHF)

Date from: 16 Jun 2025 to 30 Jun 2026

MDRCI018 - Côte d'Ivoire - Cholera

Operating timeframe: *Start date: 16-Jun-2025 End date: 31-Dec-2025*

Appeal launch date: *17-Jun-2025*

I. Summary

	Actual (CHF)
Opening Balance	0
Funds & Other Income	489,424
DREF Response Pillar	489,424
Expenditure	-432,911
Closing Balance	56,513

II. Expenditure by planned operations / enabling approaches

Description	Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items			
PO02 - Livelihoods			
PO03 - Multi-purpose Cash			
PO04 - Health	97,395	139,724	-42,329
PO05 - Water, Sanitation & Hygiene	157,158	142,754	14,404
PO06 - Protection, Gender and Inclusion	6,545	-43	6,588
PO07 - Education			
PO08 - Migration			
PO09 - Risk Reduction, Climate Adaptation and Recovery	29,871	404	29,467
PO10 - Community Engagement and Accountability	29,077	11,174	17,903
PO11 - Environmental Sustainability			
Planned Operations Total	320,046	294,013	26,033
EA01 - Coordination and Partnerships	0	1,953	-1,953
EA02 - Secretariat Services	100,814	85,021	15,793
EA03 - National Society Strengthening	68,564	51,925	16,639
Enabling Approaches Total	169,378	138,899	30,479
Total	489,424	432,911	56,512

III. Expenditure by budget category & group

Prepared on 20-Jul-2026

Page 1 of 2

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

Please explain variances (if any)

PO04 – Health (43% Over-expenditure): The overspending is due to the fact that all volunteer per diems, regardless of the activities supported, were charged to the health sector.

PO05 – Water, Sanitation and Hygiene (9% Under-expenditure): Underspending is linked to the fact that several WASH activities initially planned were ultimately taken over by other partners:



- The treatment of water sources was not carried out, as it was fully implemented and funded by the INHP;
- Disinfection activities in prison settings were funded by the ICRC;
- Aquatabs were provided by UNICEF.

In addition, WASH activities mainly consisting of procurement generated significant balances due to procurement procedures and complementary external funding.

Per diem payments for volunteers who supported the implementation of WASH activities were charged to PO04 Health.

PO06 Protection, Gender and Inclusion (100% Under-expenditure): Underspending is linked to the fact that almost all PGI activities were embedded in other sectors including Health, WASH and CEA.

PO09 – Risk Reduction, Climate Adaptation and Recovery (98% Under-expenditure): Although the DRR line appears in the budget, this is due to an ERP coding issue where the PSSR was incorrectly mapped under AP104 instead of AP107 (where the e-contract is registered). No expenditure was actually incurred under DRR, which is consistent with implementation.

PO10 – Community Engagement and Accountability (61% Under-expenditure): The CEA budget included a significant number of planned community meetings; however, actual costs were minimal as many community engagement activities required limited financial resources. Feedback collection, partner coordination meetings, and other CEA activities were largely implemented directly by the CRCI CEA focal point supported by the IFRC CEA Surge, resulting in limited expenditures. In addition, several CEA activities were integrated into Health interventions, contributing to both CEA under-expenditure and Health over-expenditure. Per diem payments for volunteers who supported the implementation of WASH activities were also charged to PO04 Health.

Planned radio broadcasts were initially budgeted across all targeted districts but were ultimately implemented only in three districts (Port-Bouët, Yopougon, and Sassandra) due to limited availability of community radio stations in the other affected areas. Finally, the budget for communication materials and promotional tools was overestimated.

EA02 – Secretariat Services (18% Under-expenditure): Several operations and projects were underway during the same period of implementation including the Elections DREF, the Mpox Emergency Appeal, the Floods sEAP and the Response Preparedness project. As a result, some of the IFRC's costs were charged to other operations.

EA03 – National Society Strengthening (13% Under-expenditure)

The variance in NSD is linked to an overestimation of monitoring mission costs. The budget included missions from both CRCI and IFRC staff under this category, while some of these costs were also budgeted under Secretariat Services. In practice, CRCI staff missions were conducted in a more integrated and efficient manner, combining multiple activities and staff within single missions, which reduced overall costs compared to initial planning.



Contact Information

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

National Society contact: Dr Aka Bavieba Monique Ehounou, Head of Health department, bavieba.aka@croix-rougeci.org

IFRC Appeal Manager: Papa Moussa Tall, Head of Cluster Delegation Niamey, papemoussa.tall@ifrc.org

IFRC Project Manager: Dorien Dolman, Coordinator Operations, Niamey Delegation, Dorien.DOLMAN@ifrc.org

IFRC focal point for the emergency: Dorien Dolman, Coordinator Operations, Niamey Delegation, Dorien.DOLMAN@ifrc.org

Media Contact: Susan Nzisa Mbalu, Senior officer communication, susan.mbalu@ifrc.org

[Click here for reference](#)



MDRCI018 - Côte d'Ivoire - Cholera

Operating timeframe: *Start date: 16-Jun-2025 End date: 31-Dec-2025*

Appeal launch date: *17-Jun-2025*

I. Summary

	Actual (CHF)
Opening Balance	0
Funds & Other Income	489,424
DREF Response Pillar	489,424
Expenditure	-432,911
Closing Balance	56,513

II. Expenditure by planned operations / enabling approaches

Description	Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items			
PO02 - Livelihoods			
PO03 - Multi-purpose Cash			
PO04 - Health	97,395	139,724	-42,329
PO05 - Water, Sanitation & Hygiene	157,158	142,754	14,404
PO06 - Protection, Gender and Inclusion	6,545	-43	6,588
PO07 - Education			
PO08 - Migration			
PO09 - Risk Reduction, Climate Adaptation and Recovery	29,871	404	29,467
PO10 - Community Engagement and Accountability	29,077	11,174	17,903
PO11 - Environmental Sustainability			
Planned Operations Total	320,046	294,013	26,033
EA01 - Coordination and Partnerships	0	1,953	-1,953
EA02 - Secretariat Services	100,814	85,021	15,793
EA03 - National Society Strengthening	68,564	51,925	16,639
Enabling Approaches Total	169,378	138,899	30,479
Total	489,424	432,911	56,512

III. Expenditure by budget category & group

Date from: 16 Jun 2025 to 30 Jun 2026

Description	Budget	Expenditure	Variance
Operational Forecasting		0	0
Services items		0	0
WatSan items	89,210	78,902	10,308
Relief items, Construction, Supplies	89,210	78,902	10,308
Computers & Telecom	8,170		8,170
Medical Equipment	2,908		2,908
Land, vehicles & equipment	11,078		11,078
Transport & Vehicles Costs	1,265	883	382
Logistics, Transport & Storage	1,265	883	382
International Staff	78,358	36,953	41,405
National Staff		11	-11
Volunteers	1,563	1,183	380
Personnel	79,921	38,147	41,774
Workshops & Training	6,179	432	5,747
Workshops & Training	6,179	432	5,747
Travel	14,977	37,907	-22,930
Information & Public Relations	4,325		4,325
Office Costs	3,780	4,209	-429
Communications	872	283	589
Financial Charges		139	-139
General Expenditure	23,954	42,538	-18,584
National Society Expenditure	247,948	240,784	7,164
Contributions & Transfers	247,948	240,784	7,164
Programme & Services Support Recovery	29,871	26,422	3,449
Indirect Costs	29,871	26,422	3,449
Shared Office and Services Costs		4,803	-4,803
SOSC Allocations		4,803	-4,803
Total	489,424	432,911	56,515