DREF Final Report

Congo Cholera Epidemic 2025

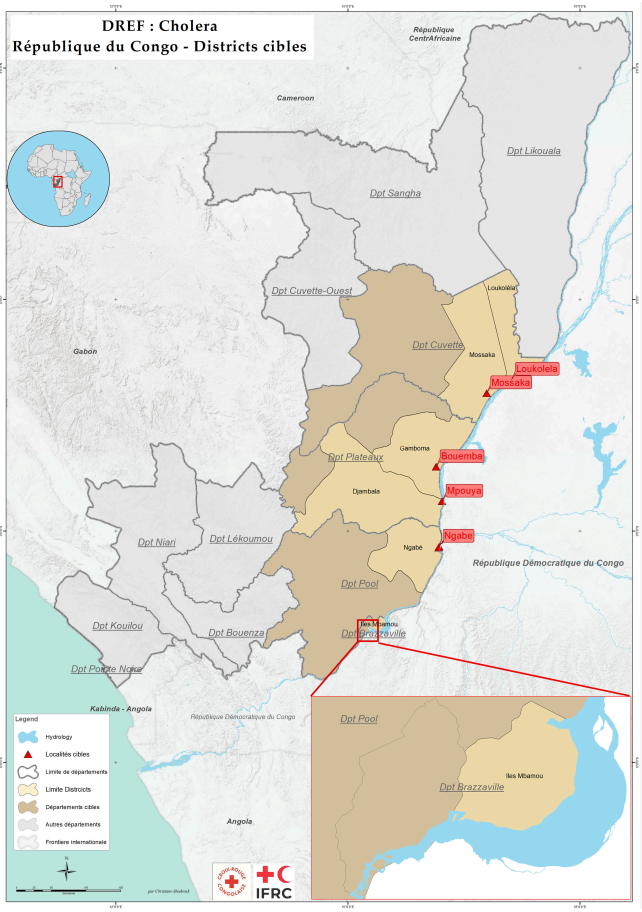
EpiC training Brazza

Appeal: **MDRCG025**	Total DREF Allocation: **CHF 431,534**	Crisis Category: Yellow	Hazard: **Epidemic**
Glide Number: -	People Affected: **150,000 people**	People Targeted: **15,000 people**	People Assisted: **15,000 people**
Event Onset: **Slow**	Operation Start Date: **04-08-2025**	Operational End Date: **31-12-2025**	Total Operating Timeframe: **4 months**

Targeted Regions: **Brazzaville**

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 Areas

Date when the trigger was met

26-07-2025

What happened, where and when?

The Ministry of Health was informed on July 10, 2025 of the appearance of several cases of diarrhea in the health district of Ile de Mbamou, Brazzaville department, clinically accompanied by the following signs: Fever, vomiting, emission of liquid stools.
The Ministry of Health, in collaboration with WHO, deployed a team for a thorough investigation. After sampling and analysis of 3 samples at the Laboratoire National de Santé
Publique in Brazzaville, 2 were found to be positive for Vibrio cholerea serogroup and 1 for Ogawa serotype.

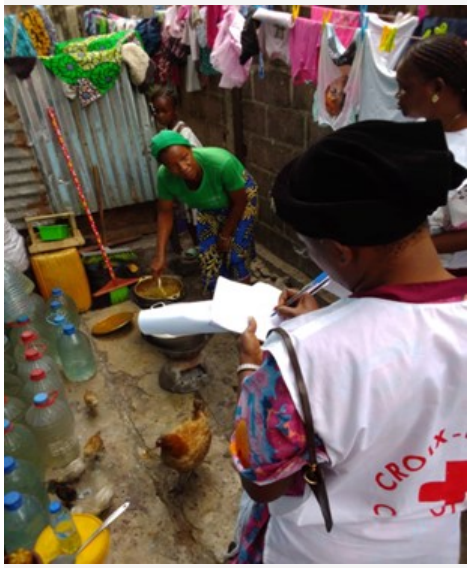
Following the declaration of the cholera outbreak by the Ministry of Health and Population on 26 July 2025 and the activation of the Incident Management System (IMS), the Government of the Republic of the Congo initiated a coordinated response to contain the epidemic. According to SITREP No. 30 published on 15 November 2025, covering the period from 03 to 14 November 2025, a cumulative total of 822 cholera cases had been reported since the start of the outbreak, including 756 suspected cases and 66 laboratory-confirmed cases, with 67 deaths, corresponding to a case fatality rate (CFR) of 8.2%.

The outbreak affected mainly three departments: Brazzaville, Congo-Oubangui, and Nkeni-Alima, with the highest burden observed in the Congo-Oubangui department (Mossaka–Loukolela health district). Over the course of the epidemic, the number of reported cases increased progressively, reaching a major peak during epidemiological week 30 of 2025, before gradually declining following the implementation of response measures. By mid-November 2025, the epidemiological situation had stabilized, with only seven new suspected cases reported between 03 and 14 November 2025 in the Île-Mbamou health district of Brazzaville, and no active cases remaining under treatment.

Although the situation appeared to be under control in the affected departments, the continued proximity of these areas to active

cholera hotspots in neighboring Democratic Republic of the Congo required sustained vigilance and continued surveillance efforts to prevent resurgence.

Sanitization at entry point /Brazza Beach



HH visit

Correct Hands Washing demonstration at Mossaka school

Volunteers training in Brazzaville

Scope and Scale

Brazzaville, like many other cities and countries in Africa, was affected by a cholera outbreak in 2025. The outbreak in the Republic of the Congo occurred within a regional context marked by the resurgence of cholera in neighbouring countries, notably Angola, where cases had been confirmed in Kabinda Province, and the Democratic Republic of the Congo, where cases had been reported in Kinshasa and in Equateur Province.

The epidemiological situation in the Democratic Republic of the Congo had posed a significant risk for the Republic of the Congo, given the strong links between the two countries and their shared vulnerabilities, including intense population movements, porous borders, fragile health systems, and precarious sanitation conditions. Brazzaville and Kinshasa, two twin cities separated only by the Congo River, had experienced frequent cross-border movements, which had increased the risk of cross-border transmission of cholera.

The situation reported for the period from 21 June to 31 July 2025 was summarized as follows:
- On 23 June 2025, the index case (deceased) was reported in the village of Sinoa, in the Ile-Mbamou health district of the Brazzaville department.
- On 25 July 2025, the National Public Health Laboratory in Brazzaville confirmed two positive cases of Vibrio cholerae serogroup O1 and one case of the Ogawa serotype.
- On 26 July 2025, the Minister of Health and Population officially declared the cholera outbreak.
- On 30 July 2025, three additional cases were confirmed in the same health district of Ile-Mbamou in Brazzaville.
- By the end of July 2025, 220 cases had been reported across two departments, Brazzaville and Congo-Oubangui, including 24 deaths, representing a case fatality rate (CFR) of 10.9%. Not all cases had been laboratory confirmed, mainly due to limited availability of sampling kits.
- The epicenter of the outbreak was located in the Ile-Mbamou health district in Brazzaville, which had reported 188 suspected cases, including six confirmed cases, and 13 deaths, corresponding to a CFR of 7.8%. The Congo-Oubangui department had reported 32 cases and 11 deaths, resulting in a CFR of 34%, the highest among the affected areas.

- Analysis of the first two Situation Reports (SITREPs) indicated that symptoms of the index case had begun on 21 June 2025. On average, five suspected cases had been recorded per day, with peaks observed on 14 July and 19 July 2025, when 15 and 16 cases were reported respectively.
Epidemiological analysis showed that the most affected age group was 15–24 years (20.0%), followed by individuals aged 50 years and above (16.8%). The average age of cases was 29.8 years, with the youngest case aged six months and the oldest 82 years. Children under five years old represented 11.8% of reported cases.

Regarding mortality, the highest case fatality rate was observed among the 25–29 age group (19.0%), followed by the 15–24 age group (15.9%). Among children under five years old, the CFR was estimated at 3.8%. Men were more frequently affected in the 20–29 and 30–39 age groups, while among women the most affected groups were 15–24 years and individuals aged 50 years and above.
Although cholera had not been endemic in the Republic of the Congo, several factors had increased the risk of rapid deterioration of the situation. During a coordination meeting convened by the Ministry of Health and Population with technical and financial partners, several key challenges were identified, highlighting the need for external support.

Source Information

Source Name	Source Link
1. MINISTERE DE LA SANTE ET DE LA POPULATION DELA REPUBLIQUE DU CONGO	https://sante.gouv.cg/declaration-de-lepidemie-de-cholera-dans-le-district-sanitaire-de-lile-mbamou-departement-de-brazzaville/#:~:text=Le%20minist%C3%A8re%20de%20la%20sant%C3%A9,L'%C3%A9mission%20des%20selles%20liquides.

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 Congolese Red cross benefited from the technical support of the delegation of the International Federation of Red Cross and Red Crescent Societies based in the Democratic Republic of the Congo for the planning and implementation of activities activities.
Participating National Societies	No PNS is present in the country at the moment.

ICRC Actions Related To The Current Event

The International Committee of the Red Cross has an office in Kinshasa and was closely monitoring the situation, but no action had yet been taken.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	- The Ministry of Health of the Democratic Republic of the Congo deployed a multidisciplinary team to conduct a thorough investigation. - An epidemic management unit was set up at national and departmental levels. - The Ministry ensured the availability of health services to care for cholera patients, with the mobilization of medical teams. - The Ministry worked closely with the World Health Organization and other partners to strengthen the response to cholera. - Material and human resources were mobilized to support efforts to combat the epidemic.
UN or other actors	- The World Health Organization stepped up cholera surveillance, notably by deploying rapid response teams to affected areas, conducting epidemiological surveys, and training health personnel in case management. - 6 Vaccination campaigns were organized by the World Health Organization, with doses of oral cholera vaccine (OCV) distributed in at-risk areas. - The World Health Organization supported capacity-building in the health sector, notably by providing medical equipment and training health personnel in cholera case management. - The World Health Organization promoted coordination among the various stakeholders involved in the fight against cholera, including UN agencies, ministries, non-governmental organizations, and the private sector.

Are there major coordination mechanism in place?

- A coordination mechanism was established at all levels in collaboration with the United Nations system and relevant humanitarian partners.
- Daily coordination meetings (two per day) were organized at the departmental level, in which the Red Cross actively participated.

Needs (Gaps) Identified

Health

The cholera outbreak in the Republic of the Congo placed significant pressure on the health system, particularly during the early stages of the epidemic. The Ministry of Health and Population received the first alert of suspected cholera cases in the Île-Mbamou health district in Brazzaville on 10 July 2025. By 16 July 2025, the Ministry had already reported 103 suspected cases and 12 deaths, indicating a rapidly evolving outbreak that required an urgent response.

The situation occurred within a broader regional context of cholera resurgence, particularly in the Democratic Republic of the Congo, where more than 35,000 cases had been reported in 2025, including confirmed transmission in Kinshasa, which shares intense population movements with Brazzaville. This cross-border dynamic increased the risk of importation and sustained transmission of cholera in the Republic of the Congo.

Over the course of the outbreak, the epidemic affected three departments: Brazzaville, Congo-Oubangui, and Nkeni-Alima. According to the latest epidemiological data available at the end of the operation (14 November 2025), a cumulative total of 822 cases (756 suspected and 66 confirmed) and 67 deaths had been reported, corresponding to a case fatality rate (CFR) of 8.2%. A significant proportion of deaths (83.6%) occurred in the community, suggesting delays in accessing health services or barriers to timely care-seeking.

During the peak of the outbreak, health facilities in affected areas experienced increased pressure due to the limited number of facilities capable of managing cholera cases and the shortage of trained personnel, medical supplies, and logistical resources. In some locations,

health facilities were required to manage both cholera and non-cholera patients simultaneously, which further stretched the available capacity.

Challenges were also identified in terms of epidemiological surveillance and laboratory capacity, including limited availability of sampling kits and rapid diagnostic tests, as well as constraints in transporting samples from remote areas. In addition, geographical barriers and weak communication infrastructure in some riverine areas complicated the timely reporting of alerts and case management.

Community-level barriers also contributed to the spread of the disease. In some cases, reluctance to seek care at health facilities, limited awareness of symptoms, and delays in referral contributed to suspected cases remaining within communities and moving between localities, increasing the risk of further transmission.

Throughout the response, strengthening early detection, referral systems, and case management capacity at health facility and community levels remained a priority. Community demonstrations on the preparation and use of oral rehydration solutions (ORS) and awareness campaigns were important measures to support early management of dehydration while facilitating referral to health facilities.

At the end of the operation, although the outbreak had been brought under control, important needs remained in strengthening health system preparedness, including improving epidemiological surveillance, strengthening laboratory capacity, ensuring the availability of cholera treatment supplies, and building the capacity of health workers in case management and infection prevention and control (IPC). These measures remain essential to prevent future outbreaks and improve the overall resilience of the health system.

Water, Sanitation And Hygiene

Water, sanitation and hygiene (WASH) needs remained significant throughout the cholera outbreak in the Republic of the Congo and continued to represent a key risk factor for the transmission of waterborne diseases. Limited access to safe drinking water, inadequate sanitation facilities, and poor hygiene practices in some communities contributed to the spread of cholera during the early stages of the outbreak.

In several affected areas, particularly in vulnerable communities in Brazzaville and riverine districts such as Mossaka–Loukolela in the Congo-Oubangui department, populations relied on untreated water from rivers and other unsafe sources due to the limited availability of improved water points. These conditions increased exposure to waterborne and faecal-oral diseases and highlighted the structural WASH challenges faced by many communities.

During the response, WASH interventions focused on reducing immediate transmission risks and promoting safer hygiene practices. According to the latest available data, more than 25,000 water purification tablets were distributed to communities, reaching 2,500 households.

Despite these efforts, important gaps remained in access to safe water and sanitation infrastructure. In several locations, the lack of adequate sanitation facilities and the continued practice of open defecation near water sources increased the risk of contamination of rivers and wells. These challenges were particularly acute in remote and riverine areas where access to improved WASH infrastructure remained limited.

Seasonal factors also contributed to the vulnerability of communities. The rainy season increased the risk of flooding and contamination of water sources, which could facilitate the spread of cholera and other waterborne diseases. In addition, population movements between Brazzaville, Kinshasa, and other departments of the country represented an additional risk for disease transmission along major transport routes.

At the end of the operation, strengthening sustainable access to safe drinking water, improving sanitation infrastructure, and promoting long-term hygiene behaviour change remained critical priorities to reduce the risk of future cholera outbreaks. Continued investments in community-based WASH interventions and preparedness measures will therefore remain essential to strengthen resilience and protect vulnerable populations.

Protection, Gender And Inclusion

The cholera outbreak in the Republic of the Congo disproportionately affected vulnerable populations living in precarious conditions, including people with disabilities, elderly persons, children under five years old, and households headed by women or children. These groups often faced additional barriers in accessing health services, safe water, sanitation facilities, and cholera prevention information.

According to the epidemiological data reported during the outbreak, children and young adults represented a significant proportion of the reported cases, while higher case fatality rates were observed among older age groups. In addition, a large proportion of deaths occurred at the community level (83.6%), suggesting potential delays in seeking care, limited access to health services, or barriers related

to information and awareness.

In several affected areas, particularly in remote and riverine communities such as Mossaka–Loukolela, geographical isolation, limited health infrastructure, and weak communication networks further increased the vulnerability of certain population groups. Social factors such as stigma, local beliefs, and misinformation about cholera also posed challenges to timely care-seeking and community acceptance of response activities.

People with disabilities and socially marginalized groups were particularly at risk of exclusion from prevention and response services due to physical, social, and informational barriers. Similarly, women and girls could face increased risks of discrimination, exclusion, or protection concerns when accessing water points, sanitation facilities, or health services.

To address these risks, it remained essential to integrate Protection, Gender and Inclusion (PGI) considerations throughout the response. This included ensuring equitable access to cholera prevention information, community awareness activities, and WASH services, as well as promoting inclusive community engagement approaches that reached vulnerable and marginalized groups.

At the end of the operation, strengthening community-based approaches that promote inclusive participation, improve access to information for all population groups, and address stigma and discrimination remained important to reduce vulnerabilities and ensure that future preparedness and response activities are inclusive and accessible to all.

Community Engagement And Accountability

Community engagement played a critical role in the response to the cholera outbreak in the Republic of the Congo. Given the importance of early detection, rapid referral, and prevention behaviors in controlling cholera transmission, the response emphasized strengthening community participation and awareness throughout the operation.

During the outbreak, community-based approaches were essential to support the identification of suspected cases, the rapid notification of alerts, and the promotion of preventive behaviors at household and community levels. Community volunteers and community health workers supported the dissemination of key messages on cholera prevention, including handwashing practices, safe water use, early care-seeking behaviour, and the importance of reporting suspected cases and deaths occurring in the community.

According to the latest available data, more than 24,000 people were reached through community awareness activities, with the support of 281 community health workers and volunteers, and 14,708 households were sensitized during the response. These activities contributed to strengthening community understanding of cholera symptoms, transmission routes, and prevention measures, as well as encouraging timely referral of suspected cases to health facilities.

Community engagement also supported the early identification and reporting of suspected cases through community-based surveillance systems. This helped improve alert mechanisms and strengthened collaboration between communities and health authorities.

However, the response also highlighted several challenges related to community engagement, including misinformation, stigma associated with the disease, and certain local beliefs that sometimes hindered timely care-seeking behaviors or adherence to preventive measures. In remote areas, limited communication infrastructure and difficult geographical access also affected the timely flow of information between communities and health services.

At the end of the operation, continued investment in community engagement remained essential to sustain prevention behaviors, strengthen trust between communities and health actors, and ensure effective community-based surveillance. Strengthening accountability mechanisms and ensuring that communities have access to timely, clear, and culturally appropriate information will remain important to improve preparedness and response to future outbreaks.

Operational Strategy

Overall objective of the operation

This DREF operation aimed to support the response to the cholera epidemic on Mbamou Island in the Brazzaville department and in the Congo-Oubangui area, while also implementing prevention activities in the departments of Loukolela, Mossaka, Ngabé, Mpouya and Bouemba.

Over the four months of implementation, key interventions were carried out in the areas of health, water, sanitation and hygiene (WASH), as well as risk communication and community engagement, in order to curb the spread of the disease and strengthen early detection and case management.

Overall, the operation contributed to strengthening the national response to the cholera outbreak and improving community awareness

of prevention measures. Through community-based interventions, more than 24,000 people were reached with cholera prevention and awareness activities, while 14,828 households were sensitized on hygiene practices and early care-seeking behaviors. WASH interventions also supported risk reduction through the distribution of more than 25,000 water purification tablets, reaching 2,500 households,

Among the key achievements of the operation were the mobilization of community volunteers to strengthen community-based surveillance, the expansion of community awareness and risk communication activities, and the promotion of safe water and hygiene practices in affected communities. These actions contributed to improving early detection and referral of suspected cases and supporting community-level prevention of cholera transmission.

However, the operation also faced several challenges, including difficult access to some remote riverine communities, logistical constraints related to transportation and communication infrastructure, and persistent gaps in WASH infrastructure in certain areas. In addition, community reluctance to seek care at health facilities and misinformation about cholera occasionally slowed the early reporting of suspected cases.

Operation strategy rationale

The NS's strategy was to combat the cholera epidemic.
The NS's response capacity through this DREF was deployed to help reduce cholera transmission, strengthen hygiene promotion and teach community members how to prepare homemade ORS as the main support for case management at community level.

The intervention was implemented according to the following strategy:

1) Capacity-building for volunteers was essential to create a workforce for surveillance and case detection, epidemic control and hygiene promotion, which were key both for response and preparedness. A total of 200 volunteers were trained and deployed for 4 months, 3 days per week. Volunteers and the branch were also briefed on personal protection measures. In this regard, the provision of personal protective equipment and training in its use were very important.

2) Reducing the risk of transmission
Surveillance in health centers and communities was strengthened, with their full participation (identification, alerts, contact follow-up).
The surveillance system put in place under the leadership of WHO, the Ministry of Health and the NS helped improve the system at community level. WHO drew up the list of contacts and, on this basis, volunteers monitored these contacts. Using the community case definition, volunteers also reported alerts and participated in case investigation under the lead of the health authorities.

3) Case management at community level was ensured through:
• Stocks of ORS that were procured and made available at handwashing points only on Mbamou Island, supplied as needed and managed by volunteers in coordination with the Ministry of Health, which provided dedicated community health workers.
• Volunteers being trained in oral rehydration therapy and homemade ORS solutions, and in turn cascading this training to communities.
• The NS organizing demonstration sessions for households on the use of ORS, using part of the purchased stock. Guidance was provided on where to obtain ORS at the various NS pharmacies and handwashing points. Efforts were also made to involve communities through door-to-door household visits and group discussions with women and young people on homemade rehydration solutions, their storage and administration.
• Psychosocial support being provided to affected communities and patients.
• Door-to-door awareness-raising activities carried out in the community . Volunteers, who had already been deployed, disseminated awareness messages aligned with those of the Ministry of Health and continued to work in collaboration with community relays (Ministry of Health teams) to spread prevention messages.
• Several WASH interventions also contributed to interrupting disease transmission, including:
- supporting the distribution of household detergents/disinfectants to communities where suspected and confirmed cases had been reported;
- improving WASH conditions by setting up and monitoring handwashing facilities in public places and health centers;
- providing safe drinking water to households through the distribution of Aquatabs and treatment containers (jerrycans);
- the NS organizing demonstration sessions for households on how to use the various products distributed, how to treat water with Aquatabs tablets and how to use disinfectants correctly;
- deploying human resources to ensure systematic monitoring of handwashing facilities at all entry points to the affected towns/localities, in order to sensitize and mobilize communities on the importance of WASH practices such as handwashing, food hygiene, personal hygiene and environmental hygiene;
- closely ensuring systematic monitoring of handwashing facilities at all entry points to the affected cities/localities to further strengthen community sensitization and mobilization.

4)Coordination
All NS interventions were carried out in close coordination with the Ministry and other partners. The CRC took part in all coordination meetings organized as part of this response.

Targeting Strategy

Who was targeted by this operation?

The target areas were the affected island of Mbamou and the districts of Loukéla, Mossaka, Ngabé, Mpouya and Buemba, which were considered at high risk due to their proximity to the DRC.

A total of 15,000 people (approximately 2,500 households) were targeted for assistance. Within this population, 10% of households received direct humanitarian support to improve their water, hygiene and sanitation (WASH) conditions and sanitation facilities.

The selection of these groups followed a vulnerability-based logic. The targeted areas are border or riverine localities with frequent population movements and limited access to basic services, which increases exposure to health and WASH-related risks. Within these areas, the most vulnerable households were identified using criteria such as low income, poor access to safe water and sanitation, presence of young children, female-headed households, people with disabilities, and those living in informal or high-risk settlements.

Particular attention was paid to vulnerable groups, including migrants, displaced people and other marginalized households who often have limited access to information and services. Community-based mechanisms (community leaders, volunteers and local committees) were used to identify and reach these groups, ensure their inclusion in activities, and prioritize them for direct WASH support where needs were greatest.

Explain the selection criteria for the targeted population

The choice of sites and targets was guided by the evolution of the epidemic and the Ministry's declaration. Thus, the NS's priority was the cholera-affected areas of Mbamou, but the targeting also took into account other areas surrounding and close to the DRC, notably Loukolela, Mossaka, Ngabé, Mpouya and Buemba.

Total Assisted Population

Assisted Women	**4,500**	Rural	**31%**
Assisted Girls (under 18)	**3,500**	Urban	**69%**
Assisted Men	**4,000**	People with disabilities (estimated)	**18%**
Assisted Boys (under 18)	**3,000**		
Total Assisted Population	**15,000**		
Total Targeted Population	15,000		

Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	**No**
Does your National Society have prevention of sexual exploitation and abuse policy?	**No**

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
Sexual Exploitation and Abuse during door-to-door awareness campaigns.	During the implementation of door-to-door awareness and community outreach activities, the risk of sexual exploitation and abuse (SEA) was identified as a potential concern, particularly given the close interaction between volunteers and community members during household visits. To mitigate this risk, the National Society implemented several preventive measures throughout the operation. Volunteers and staff involved in the response were sensitized on the Prevention of Sexual Exploitation and Abuse (PSEA) principles and the expected code of conduct when engaging with communities. Clear guidance was provided to ensure respectful, safe and inclusive interactions with all community members during awareness activities. Team leaders also monitored field activities to ensure compliance with these standards. Throughout the implementation of the operation, no cases of sexual exploitation or abuse were reported in relation to the activities carried out. However, mechanisms were in place to allow community members and volunteers to raise concerns or report incidents if they occurred. These measures contributed to promoting accountability and safeguarding within the operation. The integration of PSEA considerations helped reinforce safe programming practices and ensured that prevention measures were systematically considered during community engagement activities.
Rain season	The rainy season had been identified as a potential risk factor that could aggravate the cholera situation due to flooding, contamination of water sources, and increased difficulties in accessing certain communities. These conditions also had the potential to disrupt response activities and increase the vulnerability of affected populations. During the implementation of the operation, the National Society intensified community awareness activities on hygiene practices, safe water use, and early reporting of suspected cholera cases, particularly in areas vulnerable to flooding and poor sanitation conditions. These preventive measures aimed to reduce the risk of further transmission of waterborne diseases during the rainy season. However, significant flooding was reported in December 2025 in Brazzaville and Pointe-Noire, which affected several communities and increased humanitarian needs. In response to this new situation, the National Society requested a DREF allocation to support emergency response activities related to the floods.

	Although these flooding events occurred towards the end of the cholera operation, the preparedness and community awareness activities implemented during the cholera response contributed to strengthening community knowledge of hygiene and prevention measures, which remained relevant in the context of flood-related public health risks.
The epidemic is spreading to areas outside the island of Mbamou, as well as to surrounding towns. The health system is overwhelmed by the increase in cases. This situation is leading to saturation of the health system, with an increase in cases and deaths; the epidemic is becoming difficult to control. Collaboration between communities and personnel involved in the response, both at community level and in health centers, is inadequate.	During the early phase of the outbreak, the epidemic spread beyond Mbamou Island to surrounding areas and neighbouring localities. This rapid expansion of cases placed considerable pressure on the health system, which faced significant challenges in managing the increasing number of suspected and confirmed cases. The rise in cases and deaths during the peak of the outbreak led to a temporary saturation of available health services in the affected areas, making the epidemic more difficult to control. Limited coordination and collaboration between communities and response actors at both community and health facility levels also contributed to delays in case reporting and referral. In response to the evolving situation, the Congolese Red Cross (CRC), in coordination with national health authorities and the IFRC, adapted its operational approach to strengthen community-based surveillance, risk communication, and hygiene promotion activities in affected areas. Throughout the operation, the National Society closely monitored the epidemiological situation and maintained readiness to scale up its response if necessary, with the support of the IFRC delegation and partners.

Please indicate any security and safety concerns for this operation:

Security risks in the targeted departments were assessed as moderate throughout the operation. To mitigate potential risks related to crime, violence or road hazards, several practical measures were implemented during the response.

Prior to deployment, all volunteers and staff received safety briefings covering operational security, road safety, cultural sensitivity and the Red Cross Red Crescent Code of Conduct. These briefings helped ensure that teams clearly understood the security context and the expected behaviour while working in communities.

Minimum security requirements were strictly respected during field activities. Volunteers operated in teams and during daylight hours, and movements to field locations were coordinated with local Red Cross supervisors and community leaders to ensure safe access to intervention areas.

To reduce exposure to risks, volunteers and supervisors were provided with visibility equipment such as Red Cross vests and bibs, allowing them to be easily identified by communities and local authorities. This contributed to strengthening acceptance and reducing the likelihood of misunderstandings or security incidents.

In addition, regular communication was maintained between field teams, CRC headquarters and local authorities to monitor the security situation and ensure that any emerging risks could be addressed promptly. No major security incidents affecting volunteers or staff were reported during the operation.

Has the child safeguarding risk analysis assessment been completed?	No

Implementation

Health

Budget: CHF 50,192
Targeted Persons: 15,000
Assisted Persons: 14,828
Targeted Male: 5,965
Targeted Female: 8,863

Indicators

Title	Target	Actual
# of people (disaggregated by sex, age and disability) affected by the cholera response.	15,000	14,828
# of volunteers and supervisors trained in epidemic control and community-based surveillance (CBS)	200	200
% of community-based surveillance (CBS) alerts responded to by public health action within 48 hours.	80	69
# of active CBS volunteers	200	200
# of contacts identified	500	375
% of contacts referred and tested for cholera with volunteer support	100	68
% of contacts investigated within 24 hours	80	61
# of staff (disaggregated by gender, age and disability) and volunteers trained in Community Involvement and Accountability (CEA) and CREC.	200	200
# of people (disaggregated by gender, age and disability) reached by risk communication and community engagement activities (in support of health and hygiene promotion)	15,000	14,828
% of respondents who say they received useful and usable information.	80	72

Narrative description of achievements

A multisectoral needs assessment was conducted at the early stage of the operation to better understand the needs of affected communities and guide the response strategy. The assessment covered key sectors including health, water, sanitation and hygiene (WASH), community engagement, and epidemic surveillance. Data were collected by 40 trained volunteers of the Congolese Red Cross using the KOBO data collection platform, enabling rapid compilation and analysis of information from targeted communities.

The findings revealed important gaps in community awareness of cholera symptoms and prevention practices. Approximately 65% of surveyed households reported limited knowledge of the early signs and symptoms of cholera, while nearly 60% indicated that they were

not familiar with the correct preparation and use of Oral Rehydration Solution (ORS). In addition, around 45% of respondents reported that suspected cases were often initially managed at home, contributing to delays in seeking care at health facilities and increasing the risk of transmission within communities.

The assessment also highlighted significant WASH-related vulnerabilities. Nearly 70% of households reported relying on untreated water sources, including river water, while approximately 55% indicated that they did not have consistent access to improved sanitation facilities. These conditions significantly increased the risk of water-borne and faecal-oral disease transmission in the affected communities.

In terms of surveillance, the assessment showed that about 40% of communities experienced delays in reporting suspected cases to health facilities, mainly due to limited communication tools, lack of transport, and geographical barriers, particularly in riverine and hard-to-reach areas. Limited access to smartphones among community-based surveillance volunteers further slowed the transmission of alerts to Integrated Health Centers (CSI), which contributed to delays in case investigations in some communities.

Based on these findings, the response prioritized strengthening community awareness, surveillance and early case management. A total of 200 volunteers and supervisors were trained in epidemic control and community-based surveillance, achieving the planned target. These volunteers supported community-level detection and reporting of suspected cases and contributed to maintaining 200 active community-based surveillance volunteers throughout the operation.

Through community outreach and surveillance activities, volunteers identified 375 contacts of suspected or confirmed cases, compared to the planned target of 500 contacts. This lower number is mainly explained by the progressive decline in cholera cases during the response period, which reduced the number of contacts generated through case investigations.

Among the identified contacts, 68% were referred and tested for cholera with volunteer support, compared to the target of 100%. This gap was partly due to reluctance among some community members to visit health facilities, mobility of certain contacts, and logistical challenges related to transport and access to testing services in remote areas.

Similarly, 61% of contacts were investigated within 24 hours, compared to the target of 80%. This delay was mainly linked to geographical barriers, transportation constraints and delayed notification of suspected cases, particularly in riverine areas where access depended on river transport.

Despite these challenges, community-based surveillance remained functional. 69% of alerts were responded to by public health action within 48 hours, slightly below the target of 80%, mainly due to logistical constraints and the limited availability of transport for rapid investigations in some areas.

Capacity strengthening of volunteers was also a key component of the operation. In addition to the EPiC training, 200 volunteers and staff were trained in Community Engagement and Risk Communication (CREC), fully meeting the planned target. These trainings strengthened volunteers' ability to communicate prevention messages, address community concerns and support behavior change.

Risk communication and community engagement activities enabled volunteers to reach 14,828 people with cholera prevention and hygiene promotion messages, slightly below the target of 15,000 people. The small difference is mainly explained by population movements and accessibility challenges in some communities during the response period.

Community feedback collected during the operation indicated that 72% of respondents reported receiving useful and usable information, compared to the target of 80%. While the majority of respondents found the information helpful, some community members indicated that more frequent sessions and additional communication channels such as local radio broadcasts would further improve access to information.

The response also supported ORS distribution and awareness sessions on its proper use, particularly in affected communities on Mbamou Island. Through active case finding and household visits, volunteers helped identify suspected cases early and ensured follow-up of contacts, contributing to improved community-based surveillance and earlier referral of cases to nearby health facilities.

Despite operational challenges such as limited communication tools among volunteers, difficult access to riverine areas and the concurrent response to other health emergencies such as Mpox, the operation contributed to strengthening community awareness, surveillance and early detection mechanisms in the affected communities.

Surveillance activities were further reinforced at key entry points to Brazzaville and other targeted localities, where volunteers were deployed at checkpoints alongside Ministry of Health staff. These teams supported temperature screening, installation and management of handwashing facilities, and the distribution of ORS, helping reduce the risk of disease transmission along major population movement routes.

In addition, household-level demonstration sessions were organized to show community members how to correctly prepare and use ORS, using part of the procured stock. At the same time, health promotion campaigns were conducted on cholera and other epidemic-prone and water-borne diseases, as well as on hygiene practices. These campaigns used multiple communication channels, including door-to-door visits, broadcasts through local radio stations, and awareness activities in public spaces, places of worship, markets and schools. These activities helped reinforce key prevention messages, improve community knowledge of cholera symptoms and transmission, and promote safer hygiene behaviors across the targeted areas.

Overall, these community-based interventions contributed to strengthening community awareness, improving early detection and referral of suspected cases, and promoting preventive hygiene behaviors, thereby supporting efforts to limit the spread of cholera in the affected communities.

Post-distribution monitoring (PDM) was conducted to assess the use and effectiveness of the distributed materials. The findings indicated that the majority of beneficiary households reported using the water treatment products as recommended, and many respondents demonstrated a good understanding of safe water storage and hygiene practices. The PDM also highlighted that community sensitization conducted by volunteers played an important role in improving knowledge and encouraging the adoption of safer water treatment practices. However, some households reported challenges related to the taste of treated water and irregular access to water containers, which may have affected consistent use in a few cases.

Lessons Learnt

• Limited motivation of coordination team members. The motivation of coordination team members was negatively affected by the limited operational support provided to participants involved in the Incident Management System (IMS), including constraints related to logistical support and competing professional responsibilities. This situation, combined with conflicting schedules among stakeholders, led to frequent postponements or irregular attendance of coordination meetings, which sometimes slowed decision-making and information sharing. To mitigate this challenge, the National Society and health authorities strengthened communication through regular follow-up with partners, shared updates through alternative channels, and encouraged greater coordination between field teams and health authorities to maintain operational continuity.

• Limited access to smartphones among community surveillance volunteers. Most volunteers involved in community-based surveillance did not have access to smartphones or reliable communication tools, which delayed the transmission of alerts and suspected case notifications to Integrated Health Centers (CSI). This limitation affected the speed of reporting and follow-up of suspected cases in some communities. To mitigate this challenge, volunteers relied on alternative communication methods, including direct reporting through supervisors, community focal points, and in-person notification at nearby health facilities. Additional sensitization and supervision visits were also conducted to strengthen the alert system and maintain community-based surveillance activities.

• High transportation costs and difficult access to riverine areas. Health facilities (FoSa) experienced delays in conducting rapid investigations of alerts, particularly in remote riverine areas where transportation costs were high and access depended on river transport. These logistical constraints sometimes slowed case investigations and the implementation of response measures in affected villages. To address this challenge, coordination with local authorities and community actors was strengthened to facilitate information sharing, and response teams prioritized high-risk areas to ensure timely follow-up of alerts when resources allowed.

• High proportion of deaths occurring at community level. A higher proportion of deaths occurred and were reported at community level compared to health facilities. Out of the 67 deaths reported during the outbreak, 56 (83.6%) occurred in the community, compared to 11 (16.4%) in health facilities. This was mainly due to limited knowledge of cholera symptoms, local beliefs, stigma associated with the disease, and delays in seeking care. To address this challenge, the response strengthened community engagement and risk communication activities, including door-to-door awareness campaigns, hygiene promotion sessions, and community sensitization on early care-seeking behaviors and the importance of rapid referral of suspected cases to health facilities.

• Concurrent health emergencies complicating the response. The presence of Mpox cases in the same localities further complicated the response to the cholera outbreak, as health authorities and response teams had to address multiple public health priorities simultaneously. This situation placed additional pressure on already limited health resources and required the coordination of parallel surveillance and response activities. Coordination between health authorities, partners, and the National Society was therefore strengthened to ensure that cholera response activities continued alongside other public health interventions.

Challenges

• The motivation of coordination team members was negatively affected by the limited support provided to participants under the incident management system. This, combined with conflicting schedules, led to frequent postponements of meetings.

• Most volunteers dedicated to surveillance did not have access to smartphones, which hampered the timely transmission of alerts to Integrated Health Centers (CSI).

• Health facilities (FoSa) faced delays in conducting rapid investigations of alerts due to high transportation costs in certain riverine areas.

• A higher proportion of deaths occurred and were reported at community level compared to health facilities. Out of the 67 deaths reported during the outbreak, 56 (83.6%) occurred in the community, compared to 11 (16.4%) reported in health facilities. This was mainly due to limited knowledge of the disease, compounded by local beliefs and stigma, which undermined community acceptance and timely health-seeking behavior.

• The presence of Mpox cases in the same localities further complicated the response to the cholera outbreak.

Water, Sanitation And Hygiene

Budget: CHF 215,644
Targeted Persons: 15,000
Assisted Persons: 14,838
Targeted Male: 5,965
Targeted Female: 8,863

Indicators

Title	Target	Actual
# of people (disaggregated by sex, age and disability) reached by WASH actions as part of the Cholera response	15,000	14,838
# of people (disaggregated by gender, age and disability) benefiting from effective water treatment materials and promotional activities (2,500 households)	3,750	2,500
# of communities/sites benefiting from WASH actions (including handwashing facilities) as part of emergency response (Cholera response)	100	100
# of households benefiting from environmental sanitation activities implemented (target of 30 sanitation campaigns organized)	2,500	2,500
# of volunteers trained in IPC	200	200

Narrative description of achievements

• A total of 200 volunteers were trained in community Infection Prevention and Control (IPC), strengthening their capacity to support WASH and hygiene promotion activities in the affected areas. As part of the response, handwashing facilities were installed at key entry points to Brazzaville, at health centers and in communities reporting cholera cases. Volunteers ensured the proper functioning of these facilities by maintaining a regular supply of water and soap and monitoring their use. Field monitoring indicated that approximately 75% of the installed handwashing stations were regularly used by community members and travelers, particularly at major entry points and health facility entrances.

• Community-level sanitation campaigns were organized to encourage environmental clean-up in the affected neighborhoods. These campaigns mobilized communities to remove waste and improve environmental hygiene, thereby reducing the risk of fecal contamination and cholera transmission. In addition, the operation supported household hygiene through the distribution of disinfectant bottles to 2,500 households. For this activity, the target was intended to be 2,500 households, not 3,750 people. The figure of 3,750 was entered in error. Practical demonstrations were conducted during the distributions to ensure that households understood how to correctly use disinfectants and apply basic hygiene and disinfection practices within their homes.

• A large-scale hygiene promotion campaign focusing on handwashing, safe water handling and environmental sanitation was conducted in markets, schools and other public gathering areas. These sessions included demonstrations on proper handwashing techniques and safe water storage practices. Food and water vendors were specifically targeted, as they play a key role in preventing contamination and transmission of water-borne diseases in busy public areas.

•To improve access to safe drinking water at household level, Aquatabs were distributed to 2500 households for a three-month period. Prior to distribution, trained volunteers conducted awareness sessions to explain the correct dosage, use and storage of water treatment products. Jerrycans were also distributed to support accurate dosing of Aquatabs and promote safer household water storage.

• Post-distribution monitoring (PDM) conducted towards the end of the operation showed encouraging results. Approximately 82% of households reported regularly using Aquatabs for water treatment, while around 78% indicated that they had improved their handwashing practices after the awareness sessions. In addition, about 85% of surveyed households reported that the distributed WASH items were useful and easy to use. Community feedback highlighted that the demonstrations conducted by volunteers were particularly

helpful in improving understanding of water treatment and hygiene practices.

• Throughout the operation, volunteers also maintained the handwashing facilities installed at key entry points and monitored their use. Close coordination between WASH and health teams enabled the identification of cholera clusters and the prioritization of hygiene promotion and disinfection activities in the most affected areas.

• Overall, these interventions contributed to strengthening community awareness of hygiene practices, improving household water treatment practices, and promoting safer sanitation behaviours, thereby reducing the risk of cholera transmission in the targeted communities.•
•

Lessons Learnt

• Organizing environmental sanitation campaigns in public spaces and municipal markets proved effective in encouraging affected communities to take ownership of cleaning and improving their surroundings.

• The distribution of jerrycans, together with household-level demonstrations on water treatment using Aquatabs and boiling, was well received and appreciated by targeted households.

• Hygiene promotion sessions in schools provided an excellent opportunity for pupils to understand that the prevention of diarrhea diseases starts with proper handwashing and the use of latrines.

Challenges

Hygiene conditions in several communities were poor, characterized by the absence of latrines and boreholes and widespread open defecation, thereby increasing health risks and complicating the implementation of WASH interventions.

Protection, Gender And Inclusion

Budget: CHF 3,033
Targeted Persons: 15,000
Assisted Persons: 14,838
Targeted Male: 5,966
Targeted Female: 8,862

Indicators

Title	Target	Actual
# of staff and volunteers trained in ERP and PEAS, including referrals to other services.	200	200

Narrative description of achievements

As part of the operation, two-day training sessions on Protection, Gender and Inclusion (PGI) minimum standards and Prevention of Sexual Exploitation and Abuse (PSEA) were organized for volunteers involved in the response. These trainings strengthened volunteers' understanding of safeguarding principles, do-no-harm approaches and inclusive programming, enabling them to integrate protection considerations into all cholera response activities and to identify potential protection concerns within communities.

Volunteer recruitment also prioritized diversity and representation of different community groups, including women, men and youth from different localities. As a result, 45% of the mobilized volunteers were women, which helped facilitate engagement with female community members and ensure that activities were accessible to different groups within the communities.

Protection and inclusion messages were systematically integrated into community engagement and awareness sessions, with a particular focus on reducing stigma towards cholera patients and promoting safe and respectful behaviors within communities. Volunteers facilitated community discussions and focus group sessions, providing spaces for community members to share concerns and perceptions related to cholera prevention, access to services and protection risks. Feedback collected during these discussions indicated that 70% of participants reported improved understanding of cholera prevention and early care-seeking behaviours, while many participants noted that the sessions helped reduce fear and misconceptions surrounding the disease.

Special attention was also given to early identification and reporting of protection risks, including gender-based violence (GBV). Volunteers were sensitized on how to recognize potential protection concerns and inform community members about available referral pathways. Throughout the operation, no GBV cases directly linked to the response activities were formally reported. However, volunteers remained vigilant and ensured that community members were informed about existing support services and mechanisms for reporting protection concerns when needed.

To ensure that children were also reached with appropriate information, the National Society promoted the use of child-friendly communication tools during awareness sessions conducted in schools and community spaces. These tools helped children better understand hygiene practices and cholera prevention messages in an accessible and engaging way.

Community feedback collected during monitoring visits showed a generally positive perception of the operation. 80% of community members consulted reported that the activities were inclusive and respectful of different social groups, and many participants highlighted that the presence of trained volunteers from the same communities helped build trust and improve participation in the response.

Overall, the integration of PGI approaches contributed to reducing stigma, strengthening community participation, and ensuring that vulnerable groups could access prevention messages and services, thereby supporting a more inclusive and community-centered cholera response

Lessons Learnt

• Involving men in community meetings helped challenge prevailing stereotypes suggesting that men are opposed to gender equality.
• Sensitizing men on shared responsibility proved to be an effective strategy, contributing to changes in men's attitudes towards women and leading to tangible improvements in women's living conditions and those of their communities, thereby helping to prevent gender-based violence.

Challenges

• During community engagement sessions and focus group discussions, several male participants expressed concerns regarding the Congolese Gender and Inclusion protection law ("Mouebara"), which some perceived as primarily designed to protect women. According to feedback collected during these discussions, many men felt that their own experiences of violence or family conflicts were not sufficiently recognized, which sometimes led to reluctance in participating in protection-related discussions. Volunteers acknowledged these concerns and facilitated open dialogue sessions to clarify the objectives of gender and protection policies, emphasizing that GBV prevention and protection mechanisms are intended to protect all individuals, regardless of gender. These discussions helped reduce misunderstandings and encouraged more inclusive participation in community activities.

• The operation also highlighted limited ownership of local initiatives aimed at integrating gender and inclusion considerations, particularly at community leadership level. While awareness activities were generally well received, the sustainability of these initiatives remained a challenge, as some community actors viewed gender and protection activities as externally driven interventions rather than locally owned priorities. To address this issue, volunteers engaged community leaders, religious authorities and local committees during sensitization sessions to encourage stronger community involvement and promote dialogue on gender and protection issues within existing community structures.

• Another important challenge identified during the response was that GBV cases were often managed informally within families, mainly due to fear of stigma and social repercussions for survivors within the community. This practice discouraged formal reporting and limited survivors' access to appropriate support services. Volunteers therefore incorporated specific messages on early reporting of GBV cases and available referral pathways during community awareness activities. They also emphasized confidentiality, survivor-centered approaches and the importance of seeking support from trained service providers when needed.

Overall, these challenges highlighted the need for continued community dialogue, engagement with male community members, and stronger collaboration with local leaders to improve understanding of gender and protection issues, reduce stigma surrounding GBV, and promote safer and more inclusive reporting mechanisms within communities.

Community Engagement And Accountability

Budget: CHF 48,789
Targeted Persons: 15,000
Assisted Persons: 14,839
Targeted Male: 5,967
Targeted Female: 8,863

Indicators

Title	Target	Actual
The National Society has an operational feedback mechanism for the entire organization.	1	1

Narrative description of achievements

• A total of 120 volunteers were trained at CREC through the EPIC training programme, including a dedicated module on community feedback and two-way communication. Through this training, volunteers strengthened their capacity to collect, analyse and respond to feedback from communities, enabling a more community-centred cholera response. Existing feedback tools were reviewed and adapted to the cholera context to ensure that they were simple, culturally appropriate and easy to use in community settings.

Before the feedback system was established, consultations were held with community members to understand their preferred channels of communication and feedback. This participatory process helped ensure community ownership of the system and increased trust and willingness to share concerns, questions and suggestions throughout the operation.

To support awareness-raising and two-way communication, 60 image boxes (10 per district) were produced and distributed. These visual tools allowed volunteers to deliver clear and accessible messages on cholera prevention, water-borne diseases and hygiene practices, particularly among populations with low literacy levels, and helped facilitate more interactive discussions during community sessions.

Health promotion campaigns were conducted across all affected areas through house-to-house visits, local radio broadcasts and awareness sessions in markets, schools, places of worship and other public spaces. These activities enabled volunteers not only to disseminate prevention messages but also to collect a significant volume of feedback from community members, including questions, rumours, concerns and suggestions related to cholera transmission, treatment and prevention measures.

To ensure that community perspectives were integrated into the response, weekly consultation meetings were organized with community leaders and existing community platforms. On average, 20–30 participants attended these meetings, including community leaders, volunteers, health representatives and local authorities. These discussions provided an opportunity to share updates on the response, review feedback collected during the week and identify appropriate responses to community concerns.

During the early phase of the operation, several rumors and misconceptions were reported by volunteers and community members. These included beliefs that cholera was caused by poisoning or witchcraft, fears that treatment centers were places where people went to die, and concerns that chlorinated water was unsafe to drink. Through targeted community dialogues, radio messages and demonstrations on water treatment and hygiene practices, volunteers and health partners addressed these rumors and clarified misconceptions.

Over the course of the operation, the feedback collected showed a positive shift in community perceptions and behaviors. At the beginning of the response, many questions and concerns were related to the causes of cholera and the safety of treatment and prevention measures. By the later stages of the operation, feedback increasingly reflected better understanding of cholera transmission, improved acceptance of chlorinated water and greater willingness to seek treatment early.

Overall, the feedback mechanism enabled the operation to remain responsive to community needs and concerns, strengthened trust between communities and responders, and contributed to improved adoption of key cholera prevention practices.

Lessons Learnt

•Involving community members before implementing the feedback mechanism fostered ownership, active participation, and trust in the intervention.
• Weekly consultations helped build trust, reduce rumors, and improve acceptance of activities.
• In some areas, linguistic diversity and local beliefs related to cholera have sometimes limited understanding or acceptance of prevention messages.
• The spread of rumors about cholera and health interventions required additional efforts in terms of communication and community engagement.

Challenges

• Although the tools were adapted to the context, consolidating, analyzing, and systematically integrating community feedback into operational decision-making proved challenging, particularly given the volume and diversity of the information collected
• Maintaining a consistent level of competence among the 120 trained volunteers required regular monitoring, particularly in light of staff turnover, varying availability, and high workloads during the response.

Secretariat Services

Budget: CHF 30,900
Targeted Persons: 500
Assisted Persons: 202
Targeted Male: 103
Targeted Female: 98

Indicators

Title	Target	Actual
# of monitoring missions organized	2	2

Narrative description of achievements

• Monthly monitoring missions were organized to follow up on the implementation of activities in the field, assess progress against the plan, and identify any operational challenges. During these visits, staff provided technical support and guidance to volunteers, verified the quality of interventions, and collected data and feedback to inform decision-making and any necessary adjustments to the response.
• In addition, insurance coverage was provided for all volunteers involved in the operation. This measure ensured that volunteers were protected against potential risks related to their deployment, reinforcing the National Society's duty of care and contributing to the safety and well-being of frontline personnel throughout the response.

Lessons Learnt

The organization of monthly monitoring missions proved effective for closely tracking implementation, providing on-site technical support to volunteers and rapidly addressing operational issues, which contributed to maintaining the quality and continuity of activities.

Challenges

No major challenges were reported

National Society Strengthening

Budget: CHF 82,976
Targeted Persons: 200
Assisted Persons: 200
Targeted Male: 102
Targeted Female: 98

Indicators

Title	Target	Actual
# of kick-off meetings held	1	1
The National Society has a risk management framework.	1	1
# of monitoring missions organized	6	6

# of lesson-learning workshops organized	1	1
# of lunch meeting held	1	1

Narrative description of achievements

A kick-off coordination meeting was organized with the Ministry of Health, IFRC and key partners involved in the cholera response to jointly plan and harmonize response activities. During this meeting, partners clarified their respective roles and responsibilities, identified priority intervention areas and agreed on common approaches for community engagement, surveillance support and health promotion. This coordination helped avoid duplication of activities and ensured complementarity between CRC volunteers and government health teams working in affected districts.

Throughout the operation, the IFRC conducted regular support missions to the field to assist the Congolese Red Cross (CRC) in implementing activities and ensuring alignment with agreed operational standards and procedures. These missions also provided an opportunity to review progress, identify operational challenges and strengthen coordination with local health authorities and other humanitarian actors involved in the response.

In addition, five part-time CRC regional staff were deployed to support volunteers in the targeted areas, contributing to close supervision and continuous monitoring of activities. Regular follow-up and supervisory visits were conducted throughout the operation to track progress, address operational challenges and provide technical guidance to volunteers and field teams.

A lunch meeting involving CRC, IFRC, the Ministry of Health and other partners was organized following the workshop to facilitate more informal exchanges. This meeting provided a space to deepen discussions initiated during the workshop, clarify remaining operational issues and explore opportunities for strengthening collaboration and preparedness for future outbreaks.

Personal protective and visibility equipment, including vests and bibs, were procured and distributed to 200 volunteers and supervisors involved in the response. This support contributed to improving volunteer safety, visibility and recognition within communities. Logistics support, including the transport, handling and storage of materials and supplies, was centrally coordinated by CRC headquarters to ensure timely delivery of operational materials to the field.

A lessons-learned workshop was organized at the end of the operation bringing together CRC staff and volunteers, IFRC , Ministry of Health officials and operational partners. The objective was to review the implementation of the response, identify good practices and challenges, and draw recommendations to strengthen preparedness and response to future outbreaks.
Key lessons and recommendations from the workshop included:
- Strengthening community engagement and feedback mechanisms, as community dialogue and two-way communication were critical in addressing rumors and improving acceptance of prevention measures.
- Enhancing coordination with local health authorities, which proved essential for aligning community outreach activities with government surveillance and case management efforts.
- Investing in volunteer training and supervision, as well-trained and well-supported volunteers significantly improved the quality and reach of community-based interventions.
- Improving preparedness measures, including the pre-positioning of materials and strengthening coordination mechanisms to allow for faster deployment in future outbreaks.
Overall, the workshop contributed to documenting operational experiences and strengthening CRC's institutional learning, while also supporting improvements to the organization's risk management and emergency response systems.

The Congolese Red Cross operates under an established risk management framework which guides the identification, mitigation and monitoring of operational risks. During the cholera response, this framework supported the implementation of appropriate safety measures for volunteers and staff and contributed to strengthening institutional preparedness for future emergency responses.

Lessons Learnt

• The multifaceted support provided by IFRC to CRC field activities created valuable opportunities for experience-sharing and collaboration among staff from the different pillars of the response.
• The inclusion of the CRC logo in national SITREPs demonstrated official recognition of CRC's contribution to the cholera response by the Government, and in particular by the Ministry of Health.

Challenges

• No difficulties reported in this sector.

Financial Report

Please explain variances (if any)

Overall, the operation achieved a high level of financial implementation, with total expenditure of CHF 430,379 against a budget of CHF 431,534, resulting in a closing balance of CHF 1,155 which will be returned to the DREF pot. The observed variances across budget lines are mainly explained by an operational reprioritization in response to the evolving cholera situation.

1) Significant variances were observed in the following sectors:
• PO04 – Health recorded significant overspending. This was attributed to an intensified cholera response, including an increase in cases, expanded logistical needs, increased team deployment, and the prioritization of life-saving activities.
• PO05 – Water, Sanitation and Hygiene showed underspending. This underconsumption is linked to an indirect reallocation of priorities toward health interventions.
• PO09 – Risk Reduction, Climate Adaptation and Recovery activities were not implemented due to the emergency nature of the operation. This may also be attributed to a potential data entry error, specifically the use of an incorrect output code.
• PO10 – Community Engagement and Accountability (CEA) recorded overspending (CHF -31,949). This is attributed to the increased need for community outreach and enhanced risk communication related to the cholera outbreak.

2) Variances under Enabling Approaches
• EA03 – National Society Development (NSD) recorded overspending due to increased support to national teams, as well as additional coordination needs and operational capacity requirements.
• EA02 – Secretariat Services showed underspending (+5,168 CHF), reflecting minor savings resulting from cost optimization.

3) Additional Financial Adjustments
Some variances are also linked to accounting and allocation issues:
• A wrong nominal account code was used for an expense related to office equipment (office desk).
Fuel costs for vehicles were charged under this operation but were partially used for other programmes due to shared vehicle usage.
• A misclassification of expenses occurred, where some costs initially recorded under incorrect accounts actually relate to medical expenses for local staff.
A workshop initially categorized under another line was conducted in relation to monitoring activities.

4) Conclusion
The variances observed were mainly due to the operational shift toward urgent cholera response activities, combined with some minor budget reallocation and accounting adjustments. These changes reflect the need to adapt resources to emerging priorities while ensuring continuity of essential interventions.

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Click here for reference

Selected Parameters			
Reporting Timeframe	2025/8-2026/2	Operation	MDRCG025
Budget Timeframe	2025/8-2025/12	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

Prepared on 24/Mar/2026

All figures are in Swiss Francs (CHF)

MDRCG025 - Republic of Congo - Cholera

Operating Timeframe: 04 Aug 2025 to 31 Dec 2025

I. Summary

Opening Balance	**0**
Funds & Other Income	**431,534**
DREF Response Pillar	431,534
Expenditure	**-430,379**
Closing Balance	**1,155**

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			**0**
PO04 - Health	47,132	143,210	**-96,078**
PO05 - Water, Sanitation & Hygiene	202,495	89,553	**112,942**
PO06 - Protection, Gender and Inclusion	2,848	3,033	**-185**
PO07 - Education			**0**
PO08 - Migration			**0**
PO09 - Risk Reduction, Climate Adaptation and Recovery	26,339		**26,339**
PO10 - Community Engagement and Accountability	45,808	77,757	**-31,949**
PO11 - Environmental Sustainability			**0**
Planned Operations Total	**324,623**	**313,554**	**11,069**
EA01 - Coordination and Partnerships			**0**
EA02 - Secretariat Services	29,017	24,018	**4,998**
EA03 - National Society Strengthening	77,911	92,807	**-14,896**
Enabling Approaches Total	**106,928**	**116,825**	**-9,897**
Grand Total	**431,551**	**430,379**	**1,172**

DREF Operation

FINAL FINANCIAL REPORT

Selected Parameters			
Reporting Timeframe	2025/8-2026/2	Operation	MDRCG025
Budget Timeframe	2025/8-2025/12	Budget	APPROVED

Prepared on 24/Mar/2026

All figures are in Swiss Francs (CHF)

MDRCG025 - Republic of Congo - Cholera

Operating Timeframe: 04 Aug 2025 to 31 Dec 2025

III. Expenditure by budget category & group

Description	Budget	Expenditure	Variance
Land, vehicles & equipment		**192**	**-192**
Office & Household Equipment		192	-192
Logistics, Transport & Storage	**4,560**	**243**	**4,317**
Transport & Vehicles Costs	4,560	243	4,317
Personnel	**15,085**	**15,613**	**-528**
International Staff		1,268	-1,268
National Staff	15,085	14,345	740
Workshops & Training		**6,702**	**-6,702**
Workshops & Training		6,702	-6,702
General Expenditure	**9,372**	**8,810**	**562**
Travel	8,731	7,537	1,194
Communications		1,273	-1,273
Financial Charges	641		641
Contributions & Transfers	**376,195**	**372,552**	**3,643**
National Society Expenditure	376,195	372,552	3,643
Indirect Costs	**26,339**	**26,267**	**72**
Programme & Services Support Recover	26,339	26,267	72
Grand Total	**431,551**	**430,379**	**1,172**