DREF Operation

Democratic Republic of Congo Cholera Epidemic 2026

Kinshasa, distribution of buckets and soap

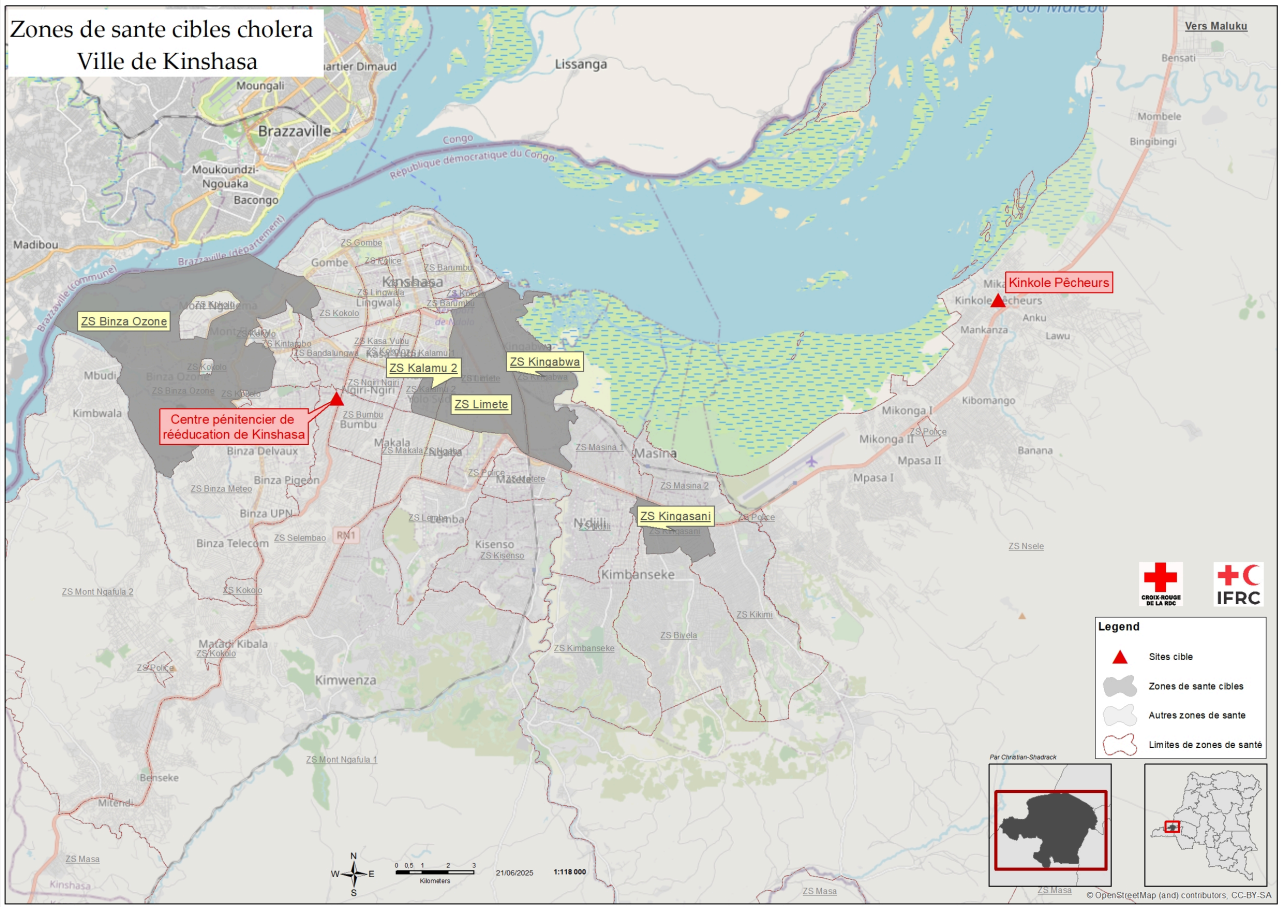
Appeal: **MDRCD049**	Hazard: **Epidemic**	Country: **Democratic Republic of Congo**	Type of DREF: **Response**
Crisis Category: Orange	Event Onset: **Sudden**	DREF Allocation: **CHF 372,524**	
Glide Number: -	People Affected: **751,000 people**	People Targeted: **37,550 people**	
Operation Start Date: **06-03-2026**	Operation Timeframe: **4 months**	Operation End Date: **31-07-2026**	DREF Published: **13-03-2026**

Targeted Regions: **Kinshasa**

Description of the Event

Date of event

22-02-2026



Targeted zones

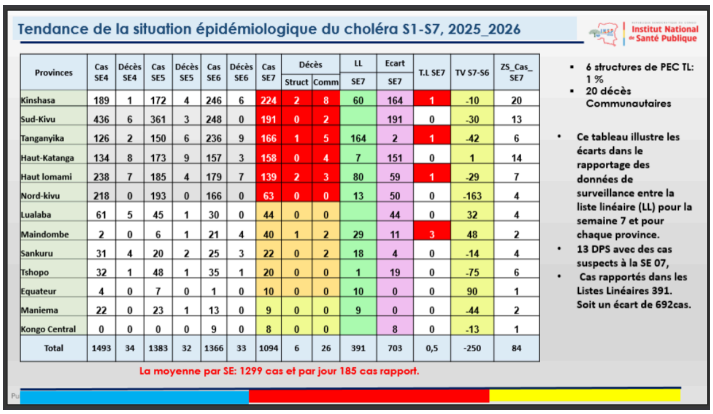
What happened, where and when?

A cholera epidemic is currently ongoing in the Democratic Republic of Congo (DRC), with a geographical expansion and a recent increase in the number of reported cases and deaths during epidemiological week 7 of 2026 (EW7_2026) compared with previous years, epidemiological week 7 of 2026, 1,094 suspected cases and 26 deaths had been reported, including 6 deaths in health facilities and 20 community deaths, representing an overall case fatality rate of approximately 1%.

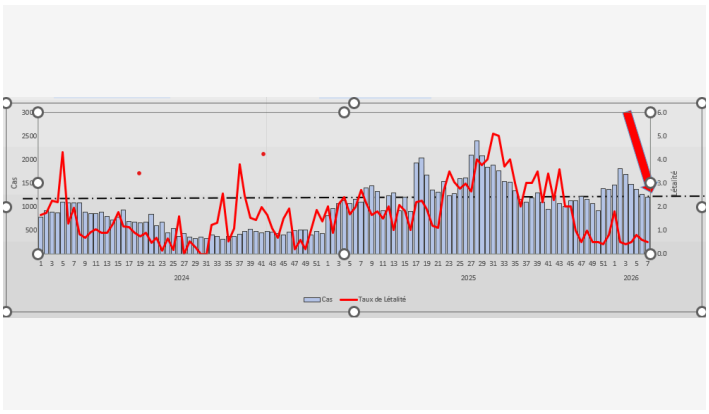
The epidemic shows an increasing trend in case reporting compared with certain previous weeks, with a similar number of cases but a higher number of deaths than in 2024 and 2025. This situation indicates a concerning trend in terms of disease severity and access to healthcare services.
The high number of community deaths (occurring outside health facilities) is particularly alarming and suggests difficulties in accessing healthcare services, delays in seeking care, or late case management.

Currently, the epidemic affects a large part of the country. By epidemiological week 7 of 2026, 13 provinces and 84 health zones had reported at least one suspected cholera case.
The most affected provinces include: Kinshasa, South Kivu ,Tanganyika ,Haut-Katanga , Haut-Lomami , North Kivu Lualaba.
Other provinces, although less affected, have also reported cases and sometimes deaths, including: Mai-Ndombe , Sankuru , Tshopo , Équateur , Maniema and Kongo Central.

This distribution highlights a multi-focal epidemic, with major hotspots in the eastern and south-eastern parts of the country, as well as in Kinshasa, while also spreading to provinces historically less affected by cholera such as Mai-Ndombe, Équateur, and Kongo Central.



Tendances Cholera avec Pic a la S7



Tendances Cholera

Scope and Scale

The cholera epidemic in the Democratic Republic of Congo is already having a significant impact on human lives, livelihoods, and well-being, and the situation may worsen due to the numerous challenges identified.

From a public health perspective, recent data clearly demonstrate the severity of the situation. By epidemiological week 7 of 2026, a total of 1,094 suspected cases had been reported nationwide, with 26 deaths, including 6 deaths in health facilities and 20 deaths occurring within communities, corresponding to an overall case fatality rate of around 1%.
This situation occurs within a context of persistent transmission. For comparison:
- In EW7_2024, 996 cases and 6 deaths were reported (CFR 0.6%, across 6 provinces).
- In EW7_2025, 1,097 cases and 26 deaths were reported (CFR 2.3%, across 10 provinces).

Over the past three years, the number of cases around epidemiological week 7 has remained relatively stable at around 1,000 cases, but the number of affected provinces has increased from 6 to 13, demonstrating a clear geographical expansion of the epidemic. The large proportion of community deaths (20 out of 26 deaths in EW7_2026) indicates that many patients do not reach healthcare facilities in time, increasing the likelihood of preventable deaths.

A provincial analysis further illustrates the scale of the impact. In recent weeks, provinces such as South Kivu, Tanganyika, Haut-Lomami, Haut-Katanga, and Kinshasa have reported several hundred cases each. For example, during epidemiological week 7 alone: South Kivu reported 191 cases , Kinshasa reported 224 cases , Tanganyika reported 166 cases , Haut-Katanga reported 158 cases , Haut-Lomami reported 139 cases
Other provinces with lower numbers remain affected, including: North Kivu , Lualaba (44 cases) , Mai-Ndombe (40 cases, compared with only 2 cases in week 4) , Sankuru (22 cases) , Tshopo (20 cases) , Équateur (10 cases)
Maniema (9 cases), Kongo Central (8 cases)

These figures represent not only a direct impact on human lives, but also significant socio-economic consequences. Each week, more than 1,000 people fall ill, leading to temporary inability to work, increased healthcare expenses, and disruption of household livelihoods.

In areas where poverty levels are already high, even temporary loss of income or the death of a productive household member can push families into greater food insecurity and vulnerability.

Moreover, the large number of affected health zones (84 health zones reporting at least one case) indicates extensive geographical coverage of the epidemic, meaning that tens of thousands of people are currently living in areas at constant risk of cholera exposure.

Source Name	Source Link
1. UNICEF – RDC	https://www.unicef.fr/article/rdc-la-pire-epidemie-de-cholera-observee-depuis-25-ans/
2. OMS Afrique	https://www.afro.who.int/fr/countries/democratic-republic-congo
3. Médecins Sans Frontières (MSF)	https://www.msf.fr/communiques-presse/rdc-une-epidemie-de-cholera-de-plus-en-plus-preoccupante-a-travers-le-pays

4. Congo quotidien /OMS	https://www.congoquotidien.com/2026/03/05/epidemie-cholera-kinshasa-2026-oms/

Previous Operations

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

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

-

Lessons learned:

Previous epidemic response operations in the DRC have highlighted several recurring challenges, including delays in deploying teams to hotspot areas, insufficient early community activities, and logistical constraints for patient supervision and transfer. These lessons have been taken into account in the design of the current operation in order to mitigate similar difficulties.

Early deployment and micro-planning, along with the rapid development of micro-plans in priority areas, enable an early and much more targeted response.

WASH–Health–CEA–PGI integration is an integrated approach that will be systematically applied to reduce the risk of transmission, improve community acceptability, and ensure inclusive and gender-sensitive assistance.

Better coordination with health authorities and Movement partners avoids duplication and optimizes available resources.
Thus, the current operation builds directly on previous experiences to improve the speed, quality, and impact of the response.

Did you complete the Child Safeguarding Risk Analysis in previous operations, what was risk level?	**Yes**
What was the risk level for Child Safeguarding Risk Analysis?:	**high**

Current National Society Actions

Start date of National Society actions

17-01-2026

Health	In Kinshasa and South Kivu province, the DRC Red Cross has mobilized 200 volunteers and is implementing community awareness activities aimed at promoting good hygiene practices in public spaces. As part of the UNICEF-funded program in North Kivu province, the DRC Red Cross is mainly involved in community prevention and response to cholera and other

	epidemics. The actions carried out are as follows: - Raising awareness among households about good hygiene practices (hand washing, water treatment, sanitation). - Door-to-door activities and community mobilization to prevent the spread of cholera. - Identification and reporting of suspected cholera cases in the community. - Support for health teams to quickly refer patients to treatment centers.
Water, Sanitation And Hygiene	Raising awareness among households about good hygiene practices (hand washing, water treatment, sanitation) in North Kivu. Disinfection of households and sanitary facilities. Support for water chlorination and disinfection of water points. Disinfection of latrines and households in at-risk areas.

IFRC Network Actions Related To The Current Event

Secretariat	The International Federation of Red Cross and Red Crescent Societies (IFRC) is present in the Democratic Republic of Congo. Within the framework of this DREF operation, IFRC will provide operational, technical, and strategic support, in coordination with national authorities (Ministry of Health, National Institute of Public Health – INSP) and other partners (WHO, UNICEF, MSF, etc.). IFRC supports the Red Cross of the Democratic Republic of Congo (CRRDC) in actively participating in national cholera coordination mechanisms, including crisis cells, clusters, and thematic working groups on WASH, health, and RCCE/SBC. IFRC also assists the CRRDC in aligning its community-based interventions (SBC activities, community surveillance, Oral Rehydration Points – ORP, and support to Cholera Treatment Centers/Units – CTC/UTC) with national and provincial response priorities. In the event of a further escalation of the epidemic (increase in the number of cases or geographical expansion to new provinces), IFRC may also mobilize regional surge capacity, including specialists in WASH, community health, epidemiology, and operations management, to temporarily support the CRRDC in the most affected areas. Several support functions are provided by the IFRC delegation to assist the CRRDC and strengthen the cholera response: - PMER & Information Management (IM): support for data collection and analysis, production of situation reports, and documentation of lessons learned. - Finance: establishment and monitoring of financial management mechanisms related to the DREF (emergency budgets, expenditure tracking, and donor reporting). - Administration: support for administrative procedures required for the implementation of activities (contracts, administrative support to CRRDC branches, and document management). - Security: monitoring of the security situation in operational areas, development and implementation of security plans for CRRDC staff and volunteers, and operational guidance (field movements, access to unstable health zones, and work in displacement sites or urban peripheries). This support is particularly critical in provinces affected by conflict and population displacement. - Logistics: support for the procurement, supply, and distribution of response items required for the operation.
Participating National Societies	The following Participating National Societies (PNS) are present in the Democratic Republic of Congo, but are not yet directly involved in the implementation of the response to this specific cholera outbreak. These include the Belgian Red Cross, Spanish Red Cross, German Red Cross, Swedish Red Cross, and French Red Cross.

ICRC Actions Related To The Current Event

The International Committee of the Red Cross (ICRC) is present in the Democratic Republic of Congo. However, for this specific cholera outbreak response, the ICRC does not provide direct support within the framework of this emergency. Its current activities focus mainly on the protection of victims of armed conflict, support to detention facilities, humanitarian transfers, and improving access to water and hygiene services in contexts of violence, and therefore do not extend to the epidemiological response to cholera.

Nevertheless, in the context of this emergency, the ICRC will maintain close collaboration with the International Federation of Red Cross and Red Crescent Societies (IFRC) and the Red Cross of the Democratic Republic of Congo (CRRDC) on security-related aspects. This collaboration includes the sharing of information and analysis on the security situation in operational areas, as well as providing guidance on safe access to sensitive locations—particularly in the eastern part of the country and around specific sites such as detention facilities or conflict-affected areas.

This coordination aims to ensure that CRRDC and IFRC staff and volunteers can implement cholera response activities under optimal security conditions.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	The national authorities of the Democratic Republic of Congo, under the leadership of the Ministry of Public Health (MoH) and the National Programme for Cholera Elimination and Control of Other Diarrhoeal Diseases (PNECHOL-MD), have implemented several actions to respond to the cholera outbreak. The Ministry of Health coordinates national epidemiological surveillance through the National Institute for Surveillance and Prevention (INSP), with regular publication of SITREP bulletins detailing suspected cases, deaths, and case fatality rates by province and health zone. PNECHOL-MD leads priority interventions including early detection of cases, rapid response within a radius of 100–250 metres around index cases, strengthening of Cholera Treatment Centres and Units (CTC/UTC), distribution of treatment kits, water chlorination, and community awareness activities. Authorities have also activated multisectoral emergency response mechanisms, including collaboration with provincial authorities to deploy investigation teams to high-incidence areas. They also coordinate oral cholera vaccination (OCV) campaigns and WASH interventions (improving access to safe drinking water and sanitation facilities), in partnership with OCHA, WHO, and UNICEF, as demonstrated by the anticipatory activation on 9 February 2026 in the Butuma health zone (Haut-Lomami). Despite these efforts, several challenges remain. Reports highlight insufficient government funding, weaknesses in rapid response mechanisms, shortages of personnel and vaccines, as well as logistical and security constraints that limit access to affected areas.
UN or other actors	The United Nations and its humanitarian partners play a central role in the response to the cholera outbreak in the Democratic Republic of Congo, complementing the efforts of national authorities. OCHA coordinates the overall humanitarian response and activated the anticipatory action framework for cholera on 9 February 2026 in the Butuma health zone (Haut-Lomami), following the crossing of predefined alert thresholds.

WHO and UNICEF are implementing activities funded by the Central Emergency Response Fund (CERF), including early detection and rapid response to cholera alerts, medical treatment of infected cases, improvement of sanitation conditions (WASH), and community awareness activities aimed at containing the outbreak before it worsens.

WHO also supports essential health services and strengthens epidemic preparedness in conflict-affected eastern provinces, where 7.5 million people are estimated to require urgent humanitarian assistance in 2026.

However, these actors highlight major gaps in the response, including critical underfunding of WASH services, overburdened health workers, supply shortages, and difficulties in accessing treatment centres, in the context of the worst cholera outbreak in the country in the past 25 years (more than 1,300 suspected cases and 35 deaths reported since January 2026).

Are there major coordination mechanism in place?

The main coordination mechanism is the Multisectoral Strategic Plan for Cholera Elimination (PMSEC) 2023–2027, launched in October 2023 by the Government of the Democratic Republic of Congo, with the objective of eliminating cholera by 2027. This plan mobilizes more than 22 key ministries, with a dedicated pillar focused on coordination and advocacy.

Needs (Gaps) Identified

Health

The epidemiological situation of cholera in the Democratic Republic of Congo remains concerning. During the week of 16 to 22 February, nearly 1,500 suspected cases and 43 deaths were reported nationwide. Kinshasa alone accounts for approximately 30% of the national burden, with 431 cases and 14 deaths, confirming the central role of the capital in the current dynamics of the epidemic.

Transmission is particularly concentrated in certain urban health zones. According to available analyses, five health zones—Limete, Kingabwa, Kalamu II, Binza Ozone, and Kingasani—account for more than 80% of the cases recorded in the city. These areas therefore represent the main transmission “hotspots”, characterized by high population density, inadequate sanitation conditions, and limited access to safe drinking water in several neighborhoods.

The situation is further aggravated in highly congested settings, where the risk of transmission is particularly high. This is notably the case in Makala Central Prison, which faces severe overcrowding and persistent challenges related to access to water, hygiene, and sanitation. Similarly, at the Kinkole displacement site, precarious living conditions may facilitate the rapid spread of the disease.

In addition, early case detection and rapid referral to treatment facilities remain major challenges in some densely populated neighborhoods of the capital. Weak community surveillance mechanisms, combined with sometimes limited knowledge of cholera prevention measures at the household level, contribute to delays in case management and increase the risk of transmission within communities.

In this context, it is essential to strengthen targeted community interventions in the most affected health zones, particularly through hygiene promotion and community-based surveillance, in order to rapidly reduce transmission and prevent the emergence of new epidemic hotspots in the capital.

Water, Sanitation And Hygiene

The WASH situation in Kinshasa remains a major factor contributing to the transmission of cholera. In several urban neighborhoods characterized by high population density, rapid urbanization, and limited access to basic services, many households do not have regular access to safe drinking water sources or adequate sanitation facilities.

The health zones of Limete, Kingabwa, Kalamu II, Binza Ozone, and Kingasani, identified as the main transmission hotspots in the capital, present particularly concerning WASH conditions. In many neighborhoods within these zones, water points are insufficient or unprotected, household water treatment practices remain limited, and access to functional latrines is inadequate, which contributes to environmental contamination and the spread of waterborne diseases.

As a result, unmet needs in the WASH sector remain significant and directly contribute to the continued transmission of cholera in the city. The main gaps include:

Insufficient water chlorination activities and hygiene promotion at community level in high-risk neighborhoods.

Limited availability of household water treatment solutions and community awareness activities, restricting the adoption of essential practices such as household water treatment, handwashing, and proper use of latrines; Insufficient disinfection activities for sanitation facilities in areas where cases are regularly reported.

The risks are even higher in highly congested settings, particularly in Makala Central Prison. At the Kinshasa Penitentiary and Rehabilitation Centre (CPRK), a recent outbreak was recorded with 141 suspected cases and 7 deaths within two weeks. The prison context, marked by severe overcrowding, limited access to safe drinking water, and an insufficient number of latrines, creates conditions conducive to the rapid spread of the disease within the facility and also poses a risk of transmission to surrounding communities.

The situation is also of concern at the Kinkole displacement site, located in the N'sele health zone, where approximately 10,000 people live in extremely precarious conditions, characterized by overcrowding and very limited access to WASH infrastructure. Across the entire site, only three latrines and two functional water points are available, which is far below humanitarian standards. During the recent reporting period, 12 suspected cholera cases were recorded, exposing the population to a high risk of disease spread.

In this context, rapid strengthening of targeted WASH interventions including water chlorination, sanitation facility disinfection, hygiene promotion, and improved access to sanitation infrastructure is essential to reduce cholera transmission in the most affected health zones of Kinshasa.

Protection, Gender And Inclusion

Several vulnerable groups in Kinshasa are highly exposed to the risk of cholera, yet their specific needs are often insufficiently considered in prevention and response interventions. In the most affected health zones—Limete, Kingabwa, Kalamu II, Binza Ozone, and Kingasani—precarious living conditions, high population density, and limited access to WASH services increase the vulnerability of certain population groups.

Children under five years of age, older persons, persons living with disabilities, and female-headed households face particular difficulties in accessing prevention information, appropriate hygiene facilities, and health services when symptoms occur. These barriers may lead to delays in seeking care, increasing the risk of complications or death.

In highly congested environments, such as Makala Central Prison and the Kinkole displacement site, the risks are even higher. Overcrowding, limited access to sanitation facilities, and constraints related to mobility or security may prevent some individuals—particularly women, older persons, and persons with disabilities—from easily accessing water points, latrines, or health services.

Furthermore, inequalities in access to information and participation mechanisms may limit the ability of these groups to express their needs and concerns. The absence of systematic approaches integrating protection, gender, and inclusion considerations may also increase the risk of exclusion or marginalization in access to cholera prevention and response services.

Community Engagement And Accountability

Accountability and community engagement mechanisms remain largely insufficient, which contributes to community resistance to cholera response interventions. Very few formal feedback mechanisms—such as complaint and feedback systems, systematic collection of community perceptions, or adaptation of communication messages—are documented in newly affected health zones.

In the absence of these mechanisms, tens of thousands of people do not have regular access to information adapted to their context, nor do they have safe channels to express their concerns or misunderstandings. This situation fuels mistrust, rumors, and sometimes refusal to participate in prevention and case management activities.

In closed settings, such as Makala Prison in Kinshasa, as well as in displacement sites, cholera-related CEA activities remain limited or nonexistent, despite the fact that hundreds of people live there in conditions of high overcrowding.

The lack of targeted information, continuous dialogue, and responses to the specific concerns of these groups increases their vulnerability and the risk of rejection or non-adherence to recommended measures, such as the use of chlorination points, acceptance of referrals to Cholera Treatment Centers/Units (CTC/UTC), or compliance with recommended hygiene practices.

Any identified gaps/limitations in the assessment

Several limitations and gaps emerge from the current assessment of the cholera situation in the Democratic Republic of Congo, despite the availability of a significant amount of quantitative data (more than 1,000 suspected cases per week around epidemiological week 7, 26 deaths in EW7_2026, and 13 provinces and 84 health zones affected).

First, some essential needs remain unmet or only partially addressed.

In the health sector, case management remains uneven. In several Cholera Treatment Units and Centres (UTC/CTC)—notably Itombwe, Ruzizi, and Lemera in South Kivu—the treatment protocol is not consistently followed. This contributes to a relatively high number of deaths (26 deaths reported in EW7, including 20 occurring in the community), even though cases are theoretically managed within organized health structures.

In the WASH sector, the situation regarding water supply and sanitation facilities remains severely degraded in some areas, yet these conditions are only partially documented in epidemiological reports, despite being key drivers of ongoing transmission.

In addition, in closed or high-risk settings such as Makala Prison in Kinshasa, other detention facilities, and displacement sites—specific needs related to water, sanitation, and rapid access to healthcare services are only partially reflected in the initial assessment.

These unmet needs are further compounded by resource shortages. Several critical gaps have been reported, including a complete stock-out of Rapid Diagnostic Tests (RDTs) in several health zones, insufficient availability of Cary Blair transport media for laboratory samples, lack of updated tools (case management registers and oral rehydration point registers), and insufficient training of healthcare providers for case and death investigations.

Regarding community surveillance, it is estimated that approximately 200 community-based surveillance actors (SBC) are needed per health zone, yet these numbers are far from being reached. This significantly limits early case detection and timely reporting.

Financial resources also remain constrained. The capacity to maintain a sustained response across 13 provinces and 84 health zones, with more than 1,000 cases reported per week, is limited by the availability of funding, essential supplies, and qualified personnel.

Operational Strategy

Overall objective of the operation

The IFRC DREF operation aims to reduce cholera-related morbidity and mortality in the city-province of Kinshasa (Democratic Republic of Congo), particularly in the health zones of Limete, Kingabwa, Kalamu II, Binza Ozone, and Kingasani, by providing integrated and life-saving health and WASH services, strengthening community surveillance, Community Engagement and Accountability (CEA), and ensuring the integration of Protection, Gender and Inclusion (PGI) considerations.

The intervention will also pay particular attention to high-risk settings, such as Makala Central Prison and the Kinkole displacement site, while ensuring inclusive, protective, and accountable assistance over a four-month implementation period.

Operation strategy rationale

The cholera outbreak in Kinshasa occurs in a context of persistent urban vulnerabilities, including insufficient access to safe drinking water and sanitation services in several neighborhoods, high population density, rapid and sometimes unplanned urbanization, and limitations in the health system in certain peripheral areas. The presence of highly frequented and sometimes closed or overcrowded spaces (such as markets, schools, detention facilities, and other collective environments) may also facilitate disease transmission when hygiene and sanitation conditions are inadequate.

These factors contribute to a high incidence of cases, rapid spread of outbreaks, and an increased risk of mortality, particularly among children under five years of age and other vulnerable groups.

This DREF operation aims to respond to the most urgent needs of targeted communities while combining prevention activities, early case management, transmission risk reduction, and strengthened community participation.

The DRC Red Cross (CRRDC) strategy is based on an integrated approach combining Health, WASH, Community Engagement and Accountability (CEA), and Protection, Gender and Inclusion (PGI), supported by strong coordination mechanisms in order to maximize impact within a limited timeframe and with constrained resources.

1. Health
To address these needs, the DREF will focus on the following interventions Establishment of Oral Rehydration Points (ORPs).

Oral Rehydration Points (ORPs) managed by trained volunteers will be established in close collaboration with Ministry of Health structures.

In coordination with Health Zones, local committees and Red Cross branches, the National Society teams will identify the most affected areas and strategic locations, including markets, transport corridors, displacement sites, and communities located far from health centers.
Based on this mapping, ORPs will be installed or strengthened close to high-risk communities. Each ORP will be linked to a reference health structure (health center or CTC/CTU) to ensure medical supervision, regular ORS resupply , rapid information reporting .
Volunteers assigned to ORPs will receive practical training covering recognition of cholera symptoms , oral rehydration protocols , hygiene and infection prevention and referral procedures.

They will provide initial management of suspected cases by immediately administering oral rehydration solution (ORS) and assessing severity based on simplified criteria established with health personnel. Moderate and severe cases will be systematically referred to CTCs/CTUs or health facilities using standardized referral forms. Targeted health facilities will receive additional support to strengthen continuity of care.

The Red Cross will also provide ORS kits for household distribution, targeting households with confirmed or suspected cases, neighboring households and high-risk contacts.

During home visits or patient discharge, volunteers will distribute ORS sachets and provide clear instructions on correct preparation, administration frequency, and warning signs requiring immediate consultation.

The project will also train and deploy community volunteers and community relays (RECO) to detect suspected cases early, report alerts promptly, refer cases rapidly to CTC/CTU or health centres, and conduct community awareness on cholera signs, early treatment, and the importance of rehydration.

A network of volunteers and community relays will be deployed in targeted neighborhoods and villages.
These volunteers, recruited from the communities themselves, will be trained on: early detection of acute watery diarrhea, household actions while awaiting treatment , community-level health communication.
They will conduct household visits and group awareness sessions, explaining cholera symptoms and encouraging communities to seek care quickly at ORPs or health facilities.
To further reduce delays in access to treatment and limit mortality, the project will support community referral mechanisms by procuring stretchers for patient transport and providing ambulance services for severe cases requiring rapid evacuation to Cholera Treatment Centers (CTCs).

2. Water, Sanitation and Hygiene (WASH)
As cholera is a waterborne disease, reducing transmission primarily requires , access to safe drinking water ,adequate excreta and waste management ,strong hygiene promotion, particularly handwashing and water treatment. CRRDC volunteers will identify key water points used by communities (public taps, wells, reservoirs, etc.) and install or strengthen chlorination systems.
These systems will be regularly monitored to ensure effective disinfection while maintaining user acceptability.
Personal protective equipment (PPE) will be provided to volunteers to reduce contamination risks.
Aquatabs will be distributed to households along with practical demonstrations on correct use.
This distribution will be complemented by jerrycans to promote safe water storage and prevent post-treatment contamination.
Regular water quality monitoring will be conducted at household and community water points to assess treatment effectiveness.
Handwashing stations with soap will be progressively installed in high-traffic locations, including health facilities , markets , schools, places of worship ,cholera treatment centers supported by the operation.
These stations will be regularly monitored, maintained and replenished to ensure continuous functionality.

A community-based management and accountability mechanism will be established to maintain facilities, prevent supply shortages, and promote sustained hygiene practices.
In parallel, intensive hygiene promotion campaigns will be conducted through awareness sessions ,practical demonstrations ,posters and visual tools , radio messaging , community mobilizers.
Key messages will focus on critical handwashing moments ,correct household water treatment and storage ,safe management of excreta and household waste and appropriate actions in case of acute watery diarrhea.

3. Community Engagement and Accountability (CEA)
A CEA strategy will be implemented to ensure that the intervention effectively responds to the needs, priorities, and constraints of affected populations.
At the start of the operation, meetings will be held with community leaders , women and youth associations , representatives of vulnerable groups (persons with disabilities, displaced households, minorities).

These consultations will present the DREF objectives, activity timeline and beneficiary selection criteria, while collecting community perceptions and expectations.
The operation will also provide community awareness tools such as picture boxes for health messaging , cholera awareness posters.

Particular attention will be given to the use of local languages to ensure accessibility for women, men, youth, elderly persons, and persons with disabilities.

Community feedback and complaints mechanisms will be established, potentially including suggestion boxes at health facilities and distribution sites, phone or WhatsApp numbers managed by trained volunteers.
All feedback will be recorded, analyzed, and addressed within clearly communicated timelines, with systematic feedback provided to communities on actions taken.
Volunteers will be trained in active listening, confidentiality, respectful engagement in order to build trust and encourage open expression without fear of retaliation.

4. Protection, Gender and Inclusion (PGI)
PGI considerations will be mainstreamed throughout the intervention.
Before and during implementation, a rapid protection and gender risk analysis will be conducted with communities and local actors. This analysis will consider gender differences in access to water and sanitation , barriers faced by older persons and persons with disabilities , constraints faced by female-headed households and minors , risks of gender-based violence in contexts such as queues, water collection, or access to health services.
The results will inform the location of chlorinated water points and handwashing stations (safe and accessible locations), distribution schedules , volunteer team composition with balanced gender representation.

Awareness activities will also include messages on prevention of gender-based violence and promotion of dignity and respect.

The National Society will ensure that all staff and volunteers sign and comply with the Code of Conduct, including a zero-tolerance policy for Sexual Exploitation and Abuse (PSEA). Teams will be trained on safe identification and referral of protection cases.
Special attention will be given to ensuring that WASH distributions, awareness sessions, and sanitation activities remain accessible to all, including persons with reduced mobility. The operation also includes the procurement and distribution of dignity kits for 500 vulnerable households, targeting women and adolescent girls, particularly in high-risk environments such as detention facilities and displacement sites.
These kits will contribute to improved personal hygiene, preservation of dignity, reduced vulnerability to waterborne diseases including cholera.

5. Coordination
The implementation of the intervention will rely on close coordination between the National Society, local authorities, government technical services, health facilities, community organizations, and other humanitarian actors operating in the targeted areas.

Targeting Strategy

Who will be targeted through this operation?

This operation will primarily target populations most exposed to the risk of cholera infection and least able to prevent and cope with the disease in the affected health zones of the Democratic Republic of Congo (DRC).

The intervention will specifically focus on households located in the health zones of Limete, Kingabwa, Kalamu II, Binza Ozone, and Kingasani, as well as in particularly vulnerable settings such as Makala Central Prison and the Kinkole displacement site.

Targeting these households aims to rapidly reduce transmission by improving access to safe drinking water, promoting hygiene practices, and supporting safe case management at community level.

In addition to groups traditionally considered vulnerable in cholera responses, special attention will be given to children over five years of age, particularly children living or working on the streets, as well as homeless populations. In the urban context of Kinshasa, these groups face increased vulnerability due to limited access to safe water, sanitation facilities, and health services, as well as frequent exposure to unsanitary environments and precarious living conditions.

Explain the selection criteria for the targeted population

To ensure equity, transparency, and accountability, targeted communities in the health zones of Limete, Kingabwa, Kalamu II, Binza Ozone, and Kingasani will participate in the validation of the selection criteria and in identifying the most vulnerable individuals.

Particular attention will also be given to high-risk settings, such as Makala Central Prison and the Kinkole displacement site, where overcrowded living conditions and challenges related to access to water, hygiene, and sanitation may increase the risk of cholera transmission.

The selection criteria will combine areas presenting the highest cholera risk (based on epidemiological data and WASH conditions) with individuals least able to prevent and cope with the disease (based on socio-economic vulnerability and PGI considerations). This approach will ensure that vulnerable and marginalized groups are explicitly targeted, including women and girls, children, persons living with disabilities, older persons, and populations living in highly vulnerable contexts.

Priority will systematically be given to:
• Female-headed households.
• Households with children under five years of age.
• Persons living with disabilities and elderly persons living alone.
• Populations living in overcrowded conditions or with limited social support, particularly those in displacement sites and other collective environments.

Total Targeted Population

Women	**11,800**	Rural	**70%**
Girls (under 18)	**8,000**	Urban	**30%**
Men	**10,200**	People with disabilities (estimated)	**15%**
Boys (under 18)	**7,550**		
Total targeted population	37,550		

Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	**Yes**
Does your National Society have prevention of sexual exploitation and abuse policy?	**Yes**
Does your National Society have child protection/child safeguarding policy?	**Yes**
Does your National Society have whistleblower protection policy?	**Yes**
Does your National Society have anti-sexual harassment policy?	**Yes**

Please analyse and indicate potential risks for this operation, its root causes and mitigation actions.

Risk	Mitigation action
The operation does not follow the planned timeline (delays in distributions, health, WASH, cash activities, etc.), or the quality of services is insufficient, thereby reducing the impact for the communities..	Establish close monitoring mechanisms (monthly progress reviews, dashboard with key indicators, and rapid adjustments to the operational plan). Develop a realistic operational plan and timeline, validated by the logistics, finance, and program teams.
Exposure of staff, volunteers, and partners to security risks (violence, intimidation, accidents, theft, harassment), which may lead to injuries or psychological trauma.	Update and disseminate the National Society's security plan for this operation (context analysis, risk mapping, movement rules, and incident management procedures). Train staff and volunteers on personal security, appropriate

	behavior in sensitive areas, and the proper use of the Red Cross emblem. Ensure mandatory security briefings prior to any deployment, with regular updates depending on changes in the context. Coordinate with local authorities and other humanitarian actors to share security information.
Safeguarding risks, including the risk of sexual exploitation and abuse (SEA), harassment, or abuse of power, which may occur during interactions between response teams and communities.	Raise awareness and provide briefings to volunteers and staff on safeguarding principles, the Code of Conduct, and the Protection from Sexual Exploitation and Abuse (PSEA) policy. Establish and communicate safe and accessible feedback and complaints mechanisms for communities. Ensure regular supervision of field activities. Promote an inclusive and respectful community approach, taking into account gender, age, and vulnerability dynamics.

Please indicate any security and safety concerns for this operation:

The operation will take place in the city-province of Kinshasa, a dense urban environment characterized by a high population concentration and varying security challenges depending on municipalities and neighborhoods. In some targeted areas such as Limete, Kingabwa, Kalamu II, Binza Ozone, and Kingasani, teams may face urban crime risks (theft, burglary, robbery), crowd movements in markets and public spaces, as well as access difficulties linked to poor road conditions or seasonal flooding.

Specific intervention contexts, such as Makala Central Prison and the Kinkole displacement site, also present particular constraints, including overcrowding, restricted access, and institutional sensitivity, which may require strengthened access procedures and coordination with the relevant authorities. In addition, sporadic social demonstrations or political tensions may disrupt traffic and affect the movement of teams in the field.

Furthermore, health and environmental risks remain significant, particularly due to recurring epidemics, poor hygiene conditions in some neighborhoods, and climatic hazards that may cause flooding and complicate access to communities. Staff and volunteers may also be exposed to psychosocial risks related to operational stress.

To mitigate these risks, the operation will implement a security analysis and security plan adapted to the Kinshasa context, including clear movement rules, communication and evacuation procedures, and mandatory security briefings for all staff and volunteers.

Strict movement rules will be applied (daytime travel only, pre-assessed routes, and limited transport of cash and valuables), with the use of well-maintained vehicles equipped with communication means and first aid kits.

The operation will also seek to strengthen community acceptance through community engagement and close coordination with local authorities and community leaders.

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

Planned Intervention

Health

Budget: CHF 66,372
Targeted Persons: 37,550

Indicators

Title	Target

# of Oral Rehydration Points (ORPs) established or strengthened in the targeted areas.	80
# of joint supervision visits between ORPs and health facilities conducted during the operation.	120
# of suspected cholera cases who received oral rehydration treatment at ORPs supported by the DRRC.	2,000
# of households that received ORS sachets along with a demonstration on preparation and use	2,000
# of volunteers / community relays (Reco) trained on early detection, initial household case management, and referral of suspected cholera cases.	250
# of people reached (disaggregated by sex and age) through awareness activities (household visits and group sessions)	10,000
% of community alerts of suspected cases validated/investigated by health facilities.	80
# of group awareness sessions conducted	200
% of community alerts investigated within 24 hours	80
# of people reached (disaggregated by sex and age) through awareness and health promotion activities	37,550

Priority Actions

- Identify and establish / strengthen Oral Rehydration Points (ORPs).
- Conduct regular supervision visits of the ORPs.
- Distribute ORS sachets to households with suspected or confirmed cases, neighboring households, and high-risk contacts, with clear explanations on correct use.
- Train 250 volunteers / community relays (Reco) on cholera, early detection, and case referral.
- Conduct group awareness sessions and community outreach communication.
- Establish or strengthen the community-based early warning system.
- Increase community knowledge on cholera signs and appropriate actions to take.

Water, Sanitation And Hygiene

Budget: CHF 88,483
Targeted Persons: 37,550

Indicators

Title	Target
# of handwashing facilities installed (with soap available)	100
% of people practicing handwashing at critical times (before meals, after using the toilet).	75
# of households that receive Aquatabs.	2,000

% of targeted sanitation facilities effectively disinfected	100
# of latrines and showers disinfected in high-risk settings	500
# of high-risk sites where disinfection activities were carried out.	2
% of volunteers using PPE during activities.	100
% of handwashing stations regularly supplied with water and soap.	100
# of volunteers or committee members trained on WASH monitoring.	60
# of people reached with WASH awareness sessions	37,550

Priority Actions

• Mobilize DRRC volunteers to identify main water points (public taps, wells, reservoirs) and install or reinforce water chlorination systems, with regular monitoring to ensure appropriate disinfection levels and community acceptability.
• Distribute Aquatabs to 2,000 households, with practical explanations on their correct use.
• Provide two jerrycans per household to 2,000 of the most vulnerable households to enable safe storage of treated water and prevent recontamination.
• Install 100 handwashing stations and distribute soap and hydro-alcoholic gel in high-traffic locations such as health facilities, markets, schools, places of worship, and cholera treatment centers.
• Promote good practices for the management of excreta and household waste.
• Disinfect latrines and showers in high-risk environments.
• Conduct awareness sessions and practical demonstrations, using communication materials on key handwashing moments, water treatment and storage, and safe management of excreta and waste.
• Carry out regular water quality testing (residual chlorine and contamination) at household level and at community water points, while ensuring maintenance of community handwashing stations in high-risk areas.
• Ensure continuous supply of water and soap for handwashing facilities.
• Train 60 community volunteers as WASH focal points to monitor WASH facilities.
• Establish a community monitoring and accountability system for the management and maintenance of WASH facilities.
• Conduct regular supervision and monitoring visits by WASH teams and volunteers.
• Provide personal protective equipment (PPE) to volunteers.

Protection, Gender And Inclusion

Budget: CHF 53,938
Targeted Persons: 37,550

Indicators

Title	Target
# of rapid PGI assessments conducted	1
% of women, men, youth, and vulnerable persons participating in PGI consultations.	50
% of PGI recommendations integrated into the project planning.	80
% of emergency water points/latrines accessible to persons with reduced mobility.	30
# of awareness sessions integrating a PGI/GBV module.	200

# of people sensitized on GBV and non-discrimination (disaggregated by sex, age, and disability).	37,550
# of community committees or WASH committees trained on PGI/GBV.	40
% of staff and volunteers who have signed the PSEA Code of Conduct.	100
Percentage of staff/volunteers trained on PGI and PSEA.	100
% of protection cases identified and safely referred to appropriate services	100

Priority Actions

• Conduct a rapid analysis of protection risks and gender inequalities in each intervention area, with community participation.
• Adapt WASH infrastructure to specific needs (access ramps, clear signage, and privacy conditions for women).
• Integrate messages on the prevention of gender-based violence (GBV), respect, dignity, and non-discrimination into all WASH and health awareness sessions.
• Train and support WASH/community committees to include protection and gender equality considerations in their activities (including alert and support mechanisms).
• Ensure that all staff and volunteers sign the Code of Conduct, including the zero-tolerance policy on Sexual Exploitation and Abuse (PSEA).
• Train staff and volunteers on PGI principles, GBV and PSEA, including identification of protection cases, handling sensitive feedback, safe referral procedures, and respectful and ethical communication with communities.
• Establish collaboration and coordinate activities with local Organizations of Persons with Disabilities (OPDs) to ensure that the specific needs of persons living with disabilities are considered in the planning and implementation of the intervention.
• Provide information and awareness messages in accessible formats (visual materials, simple language, adapted communication) and facilitate the active and inclusive participation of persons with disabilities in community cholera prevention activities.

Community Engagement And Accountability

Budget: CHF 73,619
Targeted Persons: 37,550

Indicators

Title	Target
# of community meetings held during the project	24
% of participants belonging to vulnerable groups (women, IDPs, persons with disabilities, minorities).	40
% of participants reporting that they understand the project objectives and the beneficiary selection criteria.	80
# of community discussion / awareness sessions conducted	60
# of participants in community discussion sessions (disaggregated by sex and age).	48
# of radio broadcasts aired on cholera prevention.	48
# of IEC materials (posters, leaflets) produced and displayed.	250

% percentage of respondents able to cite at least three key messages on cholera prevention and water treatment.	80
# of volunteers and staff trained on Community Engagement and Accountability (CEA).	250
# of operational feedback mechanisms (suggestion boxes, phone/WhatsApp numbers, etc.)	3

Priority Actions

• Hold regular community meetings to share information, collect feedback, and adjust activities accordingly.
• Organize community discussion sessions / educational talks on cholera prevention and case management, handwashing practices, and safe water treatment and storage.
• Conduct household visits to relay key messages and respond to community questions and concerns.
• Produce and display visual communication materials (posters, banners, and flyers) in local languages at key locations such as water points, health facilities, markets, and schools.
• Train 250 Red Cross volunteers and staff on Community Engagement and Accountability (CEA), including active listening, complaint management, confidentiality, respect for dignity, and inclusive communication sensitive to gender and disability.
• Establish at least one community feedback mechanism in each neighborhood or village to collect and address community concerns.

Secretariat Services

Budget: CHF 31,128
Targeted Persons: 500

Indicators

Title	Target
# of volunteers insured	500
# of monitoring missions conducted.	8

Priority Actions

• Provide insurance coverage for volunteers.
• Organize field monitoring missions.

National Society Strengthening

Budget: CHF 58,984
Targeted Persons: 283

Indicators

Title	Target
# of planning meetings organized.	4
# of volunteers who received protective equipment and visibility items	250

# of lessons learned workshops organized.	1
# of launch meetings organized	1

Priority Actions

• Organize a launch meeting with the authorities.
• Organize a planning meeting with the Kinshasa branch.
• Provide volunteers with PPE, bibs, and vests to ensure visibility and safety during activities.
• Organize a lessons learned workshop at the end of the operation.

About Support Services

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

The operation will mobilize a total of 283 volunteers and staff members, including 250 community volunteers, 25 supervisors, and 8 key staff members at national and provincial levels.

The 250 volunteers will be deployed in the targeted health zones of Limete, Kingabwa, Kalamu II, Binza Ozone, and Kingasani, as well as in high-risk settings such as Makala Central Prison and the Kinkole displacement site. They will conduct community-based activities including hygiene promotion, door-to-door awareness raising, community surveillance, support to WASH distributions, CEA activities, as well as identification and referral of suspected cases.
The 25 supervisors will provide technical oversight to volunteers, ensure quality control of field activities, compile data, and provide regular reporting to the operational coordination team.

The operation will be coordinated by an Operations Manager, responsible for the overall management, strategic coordination, and monitoring of the implementation.
At the provincial level, a Provincial Supervisor will oversee activities in the targeted health zones and ensure liaison with health authorities, prison authorities for interventions at Makala Central Prison, as well as with local authorities and partners operating in the field.

The team will also be reinforced by:
• A PMER Officer (Planning, Monitoring, Evaluation and Reporting) responsible for monitoring indicators, ensuring data quality, and producing reports.
• A Finance Officer, responsible for budget management, expenditure control, and financial compliance.
• An Information Management (IM) Officer, responsible for data management, consolidation of operational information, and analysis of trends.

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

Efforts have been made by the DRC Red Cross (CRRDC) to ensure that volunteer teams reflect, as much as possible, the diversity in terms of gender, age, and cultural background of the affected populations in the targeted provinces.

The National Society prioritizes the recruitment and deployment of volunteers from the local communities, which facilitates communication in local languages, strengthens the understanding of cultural dynamics, and improves community acceptance. This approach helps build trust, facilitates access to households, and increases the effectiveness of activities.

Particular attention is given to the participation of female volunteers, especially in areas where women and girls are particularly exposed or where sociocultural norms limit interactions with male volunteers. Female volunteers play a key role in household hygiene promotion, engagement with women's groups, and identification of protection-related concerns.

However, in some areas, female representation remains lower than that of men. In addition, the participation of youth and persons living with disabilities within volunteer teams remains limited.

To address these gaps, the operation will:
- Promote the targeted inclusion of women and youth among the selected volunteers.
- Encourage the participation of volunteers from minority or marginalized groups.
- Strengthen the capacity of all volunteers on Protection, Gender and Inclusion (PGI).

These measures aim to ensure that the response provides inclusive, dignified, and context-appropriate assistance to affected communities.

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

Procurement under this operation will be carried out jointly by the National Society and the IFRC, in accordance with the established procedures and procurement thresholds.

The National Society will be responsible for local purchases below CHF 50,000, in compliance with its internal procedures and IFRC standards.

The IFRC will handle international procurement as well as any purchases exceeding CHF 50,000. This includes specialized items not available locally or procurements for which international sourcing ensures better quality, compliance, and optimal use of resources. The IFRC will ensure that all processes follow its standard tendering and contracting procedures.

How will this operation be monitored?

Monitoring of this operation will combine close supervision, community monitoring, coordination meetings, and standard reporting mechanisms.

At the operational level, field teams and supervisors will ensure daily monitoring of the activities implemented, including awareness-raising, disinfection activities, and distribution of WASH supplies.

Data will be collected using harmonized tools (data collection forms, household monitoring forms, and weekly activity reports).

IFRC monitoring visits will be organized regularly, depending on the security and logistical context. These missions will help verify the quality of implementation and provide technical support to the teams.

Please briefly explain the National Societies communication strategy for this operation

The National Society will implement a coordinated communication strategy, both internally and externally, to ensure timely, transparent, and consistent information sharing throughout the operation.

Internal communication will be ensured through regular coordination meetings at national and provincial levels, weekly situation reports, operational updates from branches, as well as the use of dedicated communication channels. These arrangements will ensure effective coordination between the headquarters, provincial committees, volunteers, and technical teams involved in the activities.

External communication will aim to maintain close coordination with health authorities, partners, donors, and the media. The National Society will share key information through situation reports, coordination meetings, and information-sharing platforms. Communication materials will highlight the progress of the intervention, operational needs, and impact on communities, while ensuring compliance with data protection and ethical communication principles.

Budget Overview

IFRC

DREF OPERATION

MDRCD049 - DRC RED CROSS
Cholera Outbreak

Operating Budget

Planned Operations	**282 412**
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	66 372
Water, Sanitation & Hygiene	88 483
Protection, Gender and Inclusion	53 938
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	73 619
Environmental Sustainability	0
Enabling Approaches	**90 111**
Coordination and Partnerships	0
Secretariat Services	31 128
National Society Strengthening	58 984
TOTAL BUDGET	**372 524**

all amounts in Swiss Francs (CHF)

Click here to download the budget file

Contact Information

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

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Click here for the reference