DREF Operation

Congo Cholera outbreak 2026

Coordination meeting with MOH and Partners in Brazzaville

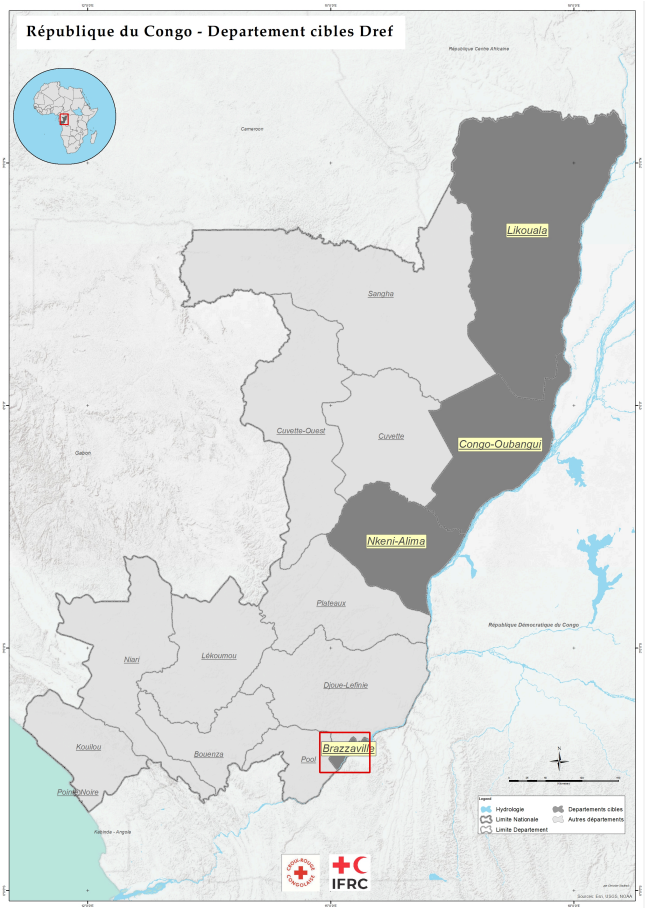
Appeal: **MDRCG028**	Hazard: **Epidemic**	Country: **Congo**	Type of DREF: **Response**
Crisis Category: Yellow	Event Onset: **Slow**	DREF Allocation: **CHF 199,226**	
Glide Number: -	People Affected: **50,000 people**	People Targeted: **15,000 people**	
Operation Start Date: **06-04-2026**	Operation Timeframe: **5 months**	Operation End Date: **30-09-2026**	DREF Published: **09-04-2026**

Targeted Regions: **Brazzaville, Likouala**

Description of the Event

Date when the trigger was met

26-04-2026



targeted Departement

What happened, where and when?

The Republic of Congo is currently experiencing an ongoing cholera outbreak that began in July 2025 and remains active as of March 2026, characterized by sustained transmission and a high case fatality rate. While cholera cases have been reported since last year, the current situation represents a new resurgence, characterized by a recent peak in cases and deaths, as highlighted in SITREP 36, as well as a persistently high case fatality rate (8.5%), significantly above emergency thresholds.

As of 26 March 2026, a cumulative total of 1,074 cases (998 suspected and 76 confirmed) and 91 deaths have been reported, corresponding to a case fatality rate of 8.5%, significantly exceeding the emergency threshold of 1%.

During the most recent reporting period from 12 to 26 March 2026, 33 new suspected cases and 4 deaths were recorded, confirming that the outbreak is ongoing and not yet under control and indicating a new resurgence. The outbreak affects several departments, including Congo-Oubangui (particularly Mossaka–Loukolela, the most severely impacted area), Brazzaville (notably Île Mbamou and Talangaï), Likouala, and Nkeni-Alima, with recent cases reported in Mossaka (16 cases and 4 deaths) and Île Mbamou (17 cases).

The high proportion of deaths occurring at community level, combined with persistent transmission and inadequate WASH conditions, highlights a serious public health emergency and underscores the urgent need for immediate intervention to reduce mortality and prevent further spread.

Sanitization in Ile Mbamu /Brazza Departement

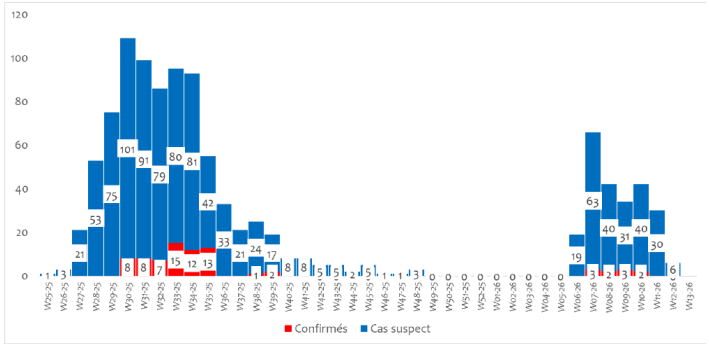


Figure 1 : Répartition des cas confirmés et suspects de choléra dans les départements touchés, République du Congo de S25-2025 à S13 de 2026

Distribution of confirmed and suspected cholera cases in affected departments

Scope and Scale

The ongoing cholera outbreak in the Republic of Congo represents a severe and rapidly evolving public health emergency, with significant impacts on morbidity and mortality, particularly among vulnerable and hard-to-reach populations.

As of 26 March 2026, a total of 1,074 suspected cases and 91 deaths have been reported, resulting in a high case fatality rate (CFR) of 8.5%, which is well above the WHO emergency threshold of 1%. This elevated lethality indicates critical gaps in timely access to life-saving treatment, delayed care-seeking behavior, and limited availability of adequate health and WASH services.

Importantly, cholera is not endemic in the Republic of Congo, and outbreaks tend to occur sporadically, often linked to seasonal shocks such as flooding and deterioration of WASH conditions. As a result, the current outbreak is placing additional strain on a health system not routinely equipped for sustained cholera response, contributing to the observed high fatality rate and rapid spread.

According to the latest epidemiological updates from the Ministry of Health, particularly SITREP 36 published on 27 March 2026, the situation shows a clear peak in both reported cases and deaths, marking a significant deterioration of the outbreak dynamics. This peak confirms an intensification of transmission, as well as a shift from a protracted situation to an acute phase requiring immediate scale-up of response efforts.

In addition, a continued upward trend and geographic expansion has been observed, particularly in Brazzaville and Likouala departments, including the health districts of Mossaka and Loukolela (Congo-Oubangui). The outbreak is no longer limited to initial hotspots and is increasingly affecting high-risk and hard-to-reach areas, further complicating response efforts.

The situation is further exacerbated in peri-urban densely populated areas such as Île Mbamou (Brazzaville) and remote riverine and flood-prone zones, where communities rely heavily on untreated surface water and face significant logistical barriers to accessing health services. These conditions contribute to late detection of cases, delays in treatment, and high levels of community-based mortality.

Vulnerability is particularly pronounced among:
- Children under five, who represent a significant proportion of cases and are more susceptible to severe dehydration.
- Older adults, who show higher mortality rates.
- Women, due to their roles in water collection and caregiving, increasing exposure risks.
- Persons with disabilities and isolated populations, who face barriers in accessing information and services.

Furthermore, while data on population movements remains limited, mobile and underserved populations are likely to be disproportionately affected, as observed in similar outbreaks in the region.

Historically, cholera outbreaks in the Republic of Congo follow seasonal patterns linked to flooding and poor WASH conditions, often resulting in rapid escalation of cases and high fatality rates when response is delayed. However, the current epidemiological peak, high lethality, geographic expansion, and non-endemic context indicate that this outbreak has exceeded expected patterns.

Without rapid action to strengthen community-based surveillance, improve access to safe water and sanitation, and ensure timely case management, there is a high risk of further escalation, sustained transmission, and additional loss of life.

Source Name	Source Link
1. Organisation mondiale de la Santé (OMS) – Bureau Afrique (AFRO)	https://www.afro.who.int/
2. OMS – Cholera Global & Regional Updates	https://www.who.int/emergencies/disease-outbreak-news

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?	**Yes**
Did the National Society request funding form DREF for that event(s)	**Yes**
If yes, please specify which operation	MDRCG025

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:

While cholera outbreaks have been reported periodically in the region, it is important to note that cholera is not considered endemic in the Republic of Congo, and occurrences are typically linked to seasonal or contextual risk factors such as flooding, population movements, and gaps in WASH conditions, rather than sustained transmission. However, the current outbreak should not be considered a routine or predictable recurrence.

The ongoing epidemic is characterized by sustained transmission, a high case fatality rate of 8.5%, well above the acceptable emergency threshold and a recent surge in both cases and deaths. In addition, the outbreak has expanded geographically beyond initial hotspots, affecting multiple departments simultaneously, including hard-to-reach riverine areas such as Congo-Oubangui and densely populated peri-urban settings like Île Mbamou in Brazzaville. This expansion significantly increases both the scale and operational complexity of the response.

Furthermore, the high proportion of deaths occurring at community level reflects critical gaps in early detection, timely referral, and access to care, which are not consistent with a controlled or expected outbreak pattern. While underlying structural vulnerabilities persist, the trigger for this DREF is the acute escalation of the epidemiological situation, rather than pre-existing preparedness gaps.

The situation is further compounded by concurrent public health challenges, including Mpox, placing additional strain on already limited health system capacities. Taken together, the recent peak in cases and deaths, high lethality, geographic expansion, and non-endemic context demonstrate that the magnitude and severity of the current outbreak exceed expected thresholds and justify the use of DREF to enable a timely, targeted, and scaled-up response aimed at reducing mortality and preventing further spread.

Lessons learned:

Lessons learned from the previous operation have been carefully integrated into the design and implementation of the current response in order to address operational gaps and enhance effectiveness.

Challenges related to limited motivation and irregular participation of coordination team members, previously linked to insufficient logistical support and competing priorities, are being mitigated through strengthened coordination mechanisms, including more regular follow-up with partners, flexible meeting modalities, and improved information sharing through alternative communication channels to ensure continuity in decision-making. Similarly, the limited access to smartphones among community-based surveillance volunteers, which previously delayed alert transmission, is being addressed by reinforcing alternative reporting pathways through supervisors, community focal points, and health facilities, while increasing supervision visits and refresher orientations to maintain the efficiency of the surveillance system.

The experience of concurrent health emergencies, such as Mpox, has also informed the current operation by promoting closer coordination between health authorities, the National Society, and partners to ensure integrated planning and avoid disruptions in cholera response activities despite competing priorities.

In addition, successful approaches from the previous response are being scaled up, including community-led environmental sanitation campaigns in public spaces and markets to ownership, the distribution of jerrycans combined with practical household demonstrations on water treatment methods, and hygiene promotion sessions in schools to reinforce sustainable behavior change. These measures aim to strengthen community engagement, improve early detection and response, and ultimately reduce transmission and mortality in the ongoing outbreak.

Did you complete the Child Safeguarding Risk Analysis in previous operations, what was risk level?	No

Current National Society Actions

Start date of National Society actions

19-03-2026

Health	In response to the ongoing cholera outbreak in Brazzaville, the Congolese Red Cross (CRC) has scaled up its community-based health interventions to support early detection, prevention, and response efforts. A total of 25 trained volunteers have been deployed in the most affected areas, including Île Mbamou, to conduct door-to-door awareness campaigns aimed at promoting key hygiene practices, early care-seeking behavior, and community engagement in cholera prevention. Through these household visits, volunteers provide targeted health education on handwashing, safe water handling, and recognition of cholera symptoms, thereby contributing to reducing transmission risks at community level. In parallel, the volunteers are actively engaged in community-based surveillance, focusing on the identification and prompt alerting of suspected cholera cases. This approach strengthens early warning systems and facilitates timely referral of cases to health facilities. As of today, a total of 67 alerts have been reported by CRC volunteers, demonstrating the critical role of community networks in improving detection and response. These alerts are communicated through established coordination channels with local health authorities to ensure rapid verification and follow-up. Overall, the engagement of CRC volunteers at community level has been instrumental in bridging gaps between affected populations and the health system, particularly in hard-to-reach and underserved areas, while reinforcing risk communication, early detection, and timely response to the outbreak.
Coordination	At coordination level, the CRC is actively participating in regular coordination meetings organized by the Ministry of Health, ensuring alignment of its activities with the national response strategy and contributing to information sharing, joint planning,

	and harmonization of interventions. This engagement enhances collaboration with partners and supports a more effective and coordinated response.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC has a country delegation based in Kinshasa, which provides coverage and support to the Republic of Congo through its cluster approach. In the context of the ongoing cholera outbreak, the IFRC is providing technical, operational, and strategic support to the Congolese Red Cross (CRC) to ensure an effective and coordinated response. At the strategic and coordination level, the IFRC supports the CRC in aligning its interventions with national response priorities and Movement partners, while ensuring coherence with Ministry of Health coordination mechanisms. The IFRC also facilitates engagement with partners and contributes to strengthening domestic coordination through regular follow-up and technical guidance. In terms of technical support, the IFRC provides guidance on health and WASH interventions, community engagement and accountability (CEA), and epidemic preparedness and response, including support to community-based surveillance and risk communication activities. Overall, the IFRC plays a key role in supporting the CRC through a combination of technical expertise, coordination, and operational support, ensuring that the response is timely, efficient, and aligned with Movement standards.
Participating National Societies	At present, no Participating National Societies (PNS) are permanently present in the Republic of Congo. As such, the response to the ongoing cholera outbreak is primarily led by the Congolese Red Cross (CRC).

ICRC Actions Related To The Current Event

The International Committee of the Red Cross (ICRC) does not have a direct operational role in the current cholera response in the Republic of Congo. No specific support has been mobilized by the ICRC for this emergency operation.

Should the situation evolve and require additional Movement support, coordination mechanisms remain in place to ensure complementarity and avoid duplication of efforts.

Other Actors Actions Related To The Current Event

Government has requested international assistance	No
National authorities	The national authorities, through the Ministry of Health and Population, are leading the response to the cholera outbreak in the Republic of Congo. An Incident Management System (IMS) has been activated to coordinate the response, including regular coordination meetings, production of situation reports, and revision of the incident action plan to adapt to the evolving situation. Surveillance activities have been

	strengthened at both community and health facility levels to ensure early detection and reporting of suspected cases. Case management capacities have been reinforced through the provision of treatment services in health facilities and the planned establishment of oral rehydration points in affected areas. Laboratory capacity has also been strengthened through the use of rapid diagnostic tests and sample analysis to confirm cases. The government is further working with partners to mobilize resources, improve logistics in hard-to-reach areas, and ensure the availability of essential supplies for the response.
UN or other actors	United Nations agencies and other humanitarian partners are supporting the national cholera response in coordination with the Ministry of Health and Population. The World Health Organization (WHO) is providing technical support in surveillance, case management, and coordination, including support to the Incident Management System, data analysis, and laboratory activities. Overall, UN agencies and partners are working closely with national authorities and the Congolese Red Cross to ensure a coordinated, multisectoral response aimed at reducing transmission, improving early detection, and minimizing mortality.

Are there major coordination mechanism in place?

Coordination of the cholera response in the Republic of Congo is led by the Ministry of Health and Population through the Incident Management System (IMS) at national level, which serves as the primary coordination platform for all response actors. Regular coordination meetings are held to review the epidemiological situation, share updates, and guide strategic decision-making. At sub-national level, coordination is ensured through district health authorities (District Sanitaires), particularly in affected areas such as Mossaka, Loukolela, and Brazzaville (Île Mbamou), where local coordination meetings support operational planning, case management and surveillance activities.

UN agencies, including WHO , as well as other partners, actively participate in these coordination platforms, providing technical and operational support aligned with national priorities.

The Congolese Red Cross (CRC) is fully integrated into these coordination mechanisms at both national and local levels. The National Society regularly participates in coordination meetings led by the Ministry of Health, contributing to information sharing, planning, and implementation of community-based interventions, particularly in risk communication, community engagement, and surveillance. While the CRC does not hold a formal lead or co-lead role within the coordination structure, it is recognized as a key operational partner, especially at community level, where it plays a critical role in bridging the gap between affected populations and health authorities.

Some coordination challenges have been identified, including occasional delays in information sharing, limited logistical resources, and competing priorities due to concurrent health emergencies, which may affect the regularity of meetings and timely decision-making.
In addition, gaps remain in reaching hard-to-access riverine areas, where coordination and service delivery are more complex. Despite these challenges, ongoing efforts to strengthen communication and collaboration among stakeholders are contributing to improved alignment and response effectiveness.

Needs (Gaps) Identified

Health

Despite ongoing efforts, significant gaps remain in the health response, particularly in early detection, referral, and case management. As of 26 March 2026, a total of 1,074 cases and 91 deaths have been reported, with a case fatality rate of 8.5%, far above the acceptable threshold of 1%, clearly indicating delays in access to timely and appropriate treatment as well as gaps in community-level detection and response. The fact that over 80% of deaths occurred at community level further highlights critical weaknesses in early case identification, referral systems, and health-seeking behaviors, as many patients are not reaching health facilities in time to receive life-saving treatment.

At community level, surveillance systems remain insufficiently strengthened, with limited coverage and capacity of community-based volunteers to promptly identify and report suspected cases. This contributes to delays in alert generation and case investigation, allowing transmission to continue within households and communities. In addition, the absence or limited number of oral rehydration points (ORPs) in affected areas reduces opportunities for early treatment at community level, which is critical in preventing severe dehydration and deaths.

At health facility level, only a limited number of facilities are adequately equipped and prepared to manage cholera cases, with gaps in essential supplies, trained personnel, and infection prevention and control (IPC) measures. This affects the quality and timeliness of care provided to patients. Furthermore, access to healthcare remains a major challenge, particularly in riverine and hard-to-reach areas such as Mossaka and surrounding localities, where transportation is limited and often dependent on boats, causing delays in patient referral and access to treatment centers.

Logistical constraints, including limited availability of transport means, weak supply chain systems, and difficulties in pre-positioning medical supplies, further hinder rapid response and continuity of care. These challenges are compounded by the geographic dispersion of affected communities and the presence of concurrent health emergencies, which place additional strain on already limited health resources.

Overall, these gaps significantly contribute to the persistence of transmission and elevated mortality, underscoring the urgent need to strengthen community-based surveillance, expand access to early treatment through ORPs, improve referral systems, and reinforce the capacity of health facilities to effectively manage cholera cases.

Water, Sanitation And Hygiene

Critical gaps in WASH services continue to be a major driver of cholera transmission in the affected areas. While more than 101,000 water purification tablets have been distributed and over 1,300 households reached, these efforts remain insufficient compared to the scale and geographic spread of the outbreak. A large proportion of the population in affected districts, particularly in riverine and flood-prone areas such as Mossaka and surrounding localities, continues to rely on untreated surface water for drinking and domestic use, significantly increasing the risk of contamination and disease transmission.

Access to safe and reliable water sources remains limited, and existing infrastructure is often insufficient or not adequately maintained. Although some water points have been treated, the overall number remains low relative to needs, and very few chlorination points have been established, limiting access to safe water at community level. In addition, the distribution of water treatment products is not yet systematic, and follow-up on proper usage at household level remains limited, reducing the effectiveness of these interventions.

Significant gaps also exist in sanitation infrastructure, particularly in access to safe and functional latrines. Many households in affected communities lack access to improved sanitation facilities, leading to open defecation practices or the use of poorly constructed or shared latrines that do not meet hygiene standards. In flood-prone and riverine environments, existing latrines are often damaged, submerged, or unusable, further increasing environmental contamination and the risk of fecal-oral transmission. The lack of adequate latrines in public spaces such as markets and schools also contributes to the spread of the disease.

Hygiene practices remain suboptimal, with limited access to handwashing facilities, soap, and hygiene materials. Although sensitization activities are ongoing, behavior change remains inconsistent, particularly in high-risk settings such as markets, schools, and densely populated areas. Overcrowded living conditions, combined with poor environmental sanitation, further exacerbate transmission risks.

Overall, these WASH gaps including limited access to safe water, insufficient chlorination, and critical shortages in adequate latrine coverage continue to sustain cholera transmission, underscoring the urgent need to scale up integrated WASH interventions to reduce exposure and protect vulnerable populations.

Protection, Gender And Inclusion

The response continues to face significant challenges in adequately addressing the needs of vulnerable and at-risk groups, with limited integration of Protection, Gender and Inclusion (PGI) considerations across interventions. Epidemiological data indicates that children under five account for approximately 16.9% of cases, highlighting their heightened exposure and vulnerability due to weaker immunity and dependence on caregivers for hygiene and care practices. At the same time, mortality is disproportionately higher among older age groups, particularly those aged 45 years and above, reflecting increased risk of severe outcomes and potential delays in accessing appropriate treatment.

In addition, men account for 72.5% of deaths, suggesting gender-related differences in exposure, health-seeking behavior, or access to care, which are not yet fully understood or addressed through targeted interventions. Despite these disparities, the response currently lacks sufficiently tailored strategies to address the specific needs and barriers faced by different demographic groups.

People living with disabilities, the elderly, and individuals in remote or hard-to-reach communities face significant physical, social, and informational barriers in accessing prevention messages, healthcare services, and referral systems. Communication materials and approaches are not always adapted to their needs, and mobility constraints further limit their ability to seek timely care. Similarly, women and girls, who are often responsible for water collection and caregiving, may face increased exposure to cholera risks while also encountering barriers related to access to information and decision-making.

Furthermore, community engagement and response strategies do not yet systematically incorporate inclusive and gender-sensitive approaches, such as disaggregated data use, targeted outreach, or safe and accessible feedback mechanisms. This limits the ability of the response to identify and address protection risks, including exclusion, stigma, or unequal access to services.

Overall, these gaps highlight the need to strengthen the integration of PGI across all sectors of the response, ensuring that interventions are inclusive, equitable, and responsive to the specific needs of vulnerable populations, thereby improving access to services and reducing morbidity and mortality among the most at-risk groups.

Community Engagement And Accountability

While sensitization efforts are ongoing, important gaps remain in effectively reaching all at-risk populations with accurate, timely, and actionable information. Although more than 133,000 people have been sensitized, the continued reporting of new cases and the high proportion of deaths occurring at community level indicate that awareness has not sufficiently translated into sustained behavior change, particularly in relation to early care-seeking, safe water handling, and hygiene practices.

Risk communication activities are still limited in coverage and consistency, especially in remote, riverine, and hard-to-reach communities where access to information channels is constrained. In these settings, populations often rely on informal sources of information, increasing the risk of misinformation, misconceptions, and low risk perception. This contributes to delayed health-seeking behaviors and inadequate adoption of preventive measures.

In addition, community engagement remains insufficiently structured, with limited mechanisms in place to systematically collect, analyze, and respond to community feedback. Existing feedback channels are not consistently used or accessible to all groups, particularly vulnerable populations such as women, the elderly, and people living with disabilities. As a result, community concerns, rumors, and socio-cultural barriers influencing behavior are not adequately identified or addressed in a timely manner.

There is also a need to strengthen two-way communication approaches to ensure that communities are not only informed but actively engaged in the response. Current approaches remain largely one-directional, focusing on message dissemination rather than dialogue, which limits community ownership and reduces the effectiveness of interventions.

Furthermore, frontline volunteers and community actors require additional support, tools, and harmonized messaging to ensure consistent communication across affected areas. Without strengthened coordination and capacity in CEA, the response risks failing to address key behavioral drivers of transmission.

Overall, these gaps reduce the effectiveness of risk communication and community engagement efforts, underscoring the need to enhance community-centered approaches, strengthen feedback and accountability mechanisms, and promote sustainable behavior change to effectively control the outbreak.

Any identified gaps/limitations in the assessment

Despite ongoing assessment efforts, several limitations and gaps remain that affect the comprehensiveness of the analysis and the ability to fully respond to identified needs.

Key needs in health, WASH, CEA, and PGI remain only partially addressed. While initial interventions have been implemented, the scale of the response is not yet sufficient to match the magnitude and geographic spread of the outbreak. Critical gaps persist in early detection and referral of cases, access to safe water and sanitation, and effective community engagement to promote behavior change.

The response is constrained by limited financial, human, and material resources, affecting the ability to scale up interventions. There are shortages in trained personnel, community volunteers' support, essential supplies (including WASH and health materials), and logistical means to sustain operations, particularly in remote areas. These limitations reduce coverage and delay the implementation of key response activities.

Significant operational constraints have been identified, particularly in hard-to-reach and riverine areas, where access is limited and often dependent on boats or irregular transport systems. These challenges affect the timely delivery of assistance, supervision of activities, and referral of patients to health facilities. In addition, competing public health priorities and limited infrastructure further strain response capacity.

While coordination mechanisms are in place under the leadership of the Ministry of Health, challenges remain in ensuring timely information sharing, regular participation of all stakeholders, and harmonization of interventions. Competing schedules, limited logistical support, and multiple ongoing health priorities occasionally lead to delays in decision-making and uneven coverage of response activities across affected areas.

The needs of certain vulnerable groups may not have been fully captured or adequately addressed during the assessment. These include

children under five, the elderly, people living with disabilities, and populations in remote or underserved communities, who face additional barriers in accessing information, healthcare, and WASH services. In some areas, socio-cultural factors and limited engagement mechanisms may also restrict the participation of women and marginalized groups, leading to gaps in inclusive response planning.

Operational Strategy

Overall objective of the operation

The overall objective of this four-month DREF operation is to contribute to the rapid reduction of morbidity and mortality associated with the ongoing cholera epidemic in the Republic of the Congo, with a targeted focus on the most affected areas reaching at least 15,000 people , particularly Brazzaville and the hardest-hit health districts of Congo-Oubangui through a rapid, prioritized, and community-based response.

Given the recent spike in cases and deaths, the high case-fatality rate, and the concentration of cases in certain clusters, the operation will emphasize early detection, alerting, and referral of suspected cases, as well as strengthening community-based surveillance in the most affected areas. It will also support targeted WASH interventions to reduce immediate transmission risks in high-incidence and hard-to-reach areas.

The operation will further aim to strengthen risk communication and community engagement (CEA) to remove barriers to early care-seeking and improve acceptance of key interventions, including vaccination. Protection, Gender, and Inclusion (PGI) aspects will be integrated to ensure safe, equitable, and dignified access to services for vulnerable groups in the most affected areas.

This targeted approach aims to maximize impact in the most affected areas, while supporting the efforts of national authorities and strengthening the supporting role of the Congolese Red Cross in implementing an effective response to contain the epidemic and reduce preventable deaths.

Operation strategy rationale

The operational strategy of this DREF is designed to address the most urgent needs identified in the ongoing cholera outbreak, notably the recent peak in cases and deaths, high case fatality rate, ongoing community-level transmission, and delayed access to care, as well as critical gaps in WASH, community engagement, and inclusive approaches.

In line with the revised objective, the strategy adopts a highly targeted approach focusing on the most affected areas, particularly Île Mbamou in Brazzaville and Mossaka and surrounding localities in Congo-Oubangui, where the burden of cases, community deaths, and structural vulnerabilities are the highest. The approach prioritizes rapid reduction of mortality and interruption of transmission through intensified, community-based interventions, adapted to hard-to-reach and high-risk settings.

A total of 100 volunteers will be mobilized and strategically deployed across the targeted areas to maximize impact in identified hotspots.

1) Health
The strategy focuses on strengthening community-based surveillance and early warning systems in the most affected areas to address delays in case detection and referral, which are key drivers of mortality.
The Congolese Red Cross will deploy 45 volunteers (approximately 25 in Brazzaville and 20 in Congo-Oubangui), trained in epidemic control, to conduct active case finding through household visits and community networks in high-incidence areas. These volunteers will identify suspected cases, raise alerts, and facilitate rapid referral to health facilities through established coordination mechanisms.

Given the high proportion of deaths occurring at community level, particular emphasis will be placed on early identification of danger signs, immediate referral, and follow-up of suspected cases to ensure timely access to treatment and reduce preventable deaths, especially in remote and riverine settings where access to health facilities is delayed.

2) Water, sanitation and Hygiene (Wash)
In the WASH sector, the strategy aims to rapidly reduce cholera transmission in the most affected areas, particularly in Île Mbamou (Brazzaville) and Mossaka (Congo-Oubangui), through a combination of targeted household-level interventions and community-based sanitation improvements.

The response will prioritize improving access to safe drinking water at household level by supporting approximately 2,500 households with water treatment solutions over a period of three months. This will be complemented by continuous engagement with communities to promote the correct use of water treatment products and safe water handling practices, recognizing that improper use remains a key driver of transmission.

To further reduce contamination risks, households will also be supported with appropriate water storage solutions, alongside hygiene promotion efforts aimed at strengthening safe hygiene practices and environmental cleanliness within homes and surrounding areas. The

provision of cleaning and disinfection products will contribute to reducing the risk of household-level transmission, particularly in settings where overcrowding and limited sanitation facilities increase exposure.

At community level, the strategy will focus on addressing critical sanitation gaps in high-risk locations, including densely populated neighborhoods and flood-prone areas, where inadequate or damaged infrastructure contributes to the spread of cholera. Efforts will be made to improve access to sanitation through the construction and rehabilitation of essential facilities, while ensuring that these are functional, accessible, and appropriately used by communities.

Overall, the WASH strategy is designed to deliver focused, practical, and community-driven interventions that directly address the main drivers of cholera transmission in the most affected areas, while contributing to a rapid reduction in cases and supporting broader outbreak control efforts.

3) Community Engagement and Accountability (CEA)
The CEA strategy will focus on intensive, localized, and two-way communication in the most affected communities, to address persistent barriers to behavior change and care-seeking. A total of 20 volunteers (around 10 per zone) will be dedicated to CEA activities, working closely with community leaders and local structures to:
• Deliver targeted and harmonized messages.
• Collect and analyze community feedback.
• Identify and address rumors and misconceptions, including low vaccine acceptance.
This real-time feedback will allow continuous adaptation of messages and approaches to improve effectiveness and community trust.

4) Protection, Gender et Inclusion
The PGI strategy will ensure that all interventions are inclusive, safe, and responsive to the specific needs of vulnerable groups, including children, older persons, persons with disabilities, and survivors of gender-based violence (GBV), particularly in the most affected areas. PGI will be mainstreamed across all sectors, with a strong focus on prevention, risk mitigation, and response to protection concerns in a context marked by increased vulnerability due to the outbreak.

To support this, a one-day training/refresher on PGI will be provided to staff and volunteers across all sectors, strengthening their capacity on key areas such as Protection from Sexual Exploitation and Abuse (PSEA), child protection, GBV, survivor-centered approaches, and safe referral pathways. This will ensure that PGI principles are consistently applied throughout the response and that frontline actors are equipped to identify and respond appropriately to protection risks.

A network of 50 trained volunteers, including PGI/CEA focal points, will be mobilized to conduct regular community-based sensitization activities (2 days per week over a period of 4 months) in the most affected communities. Through sustained engagement, these volunteers will promote key protection messages, raise awareness on GBV and PSEA, and support the identification of vulnerable individuals, while facilitating access to available services.

Prevention efforts will be reinforced through the development and dissemination of adapted IEC materials on GBV and PSEA, integrating psychosocial support (PSS) aspects. These tools will support community understanding of protection risks and promote safer behaviors, while ensuring that messaging is accessible and culturally appropriate.

The strategy will support the provision of basic assistance and referral for survivors, ensuring that individuals affected by GBV or other protection concerns receive confidential, safe, and timely support in line with a survivor-centered approach. Where needed, referrals will be made to specialized services available within the existing system.

Additionally, dignity and hygiene kits will be procured and distributed, particularly targeting women and girls, to address their specific needs, enhance dignity, and reduce protection risks in the context of the outbreak
Overall, the strategy aims to deliver a coordinated, multisectoral, and community-centered response that complements the efforts of national authorities and partners, while maximizing the comparative advantage of the Congolese Red Cross in accessing and engaging vulnerable communities.

This strategy aims to deliver a targeted, high-impact, and community-centered response, focusing resources on the most affected areas to rapidly reduce mortality and transmission, while complementing national efforts and reinforcing the auxiliary role of the Congolese Red Cross.

Targeting Strategy

Targeting Strategy Supporting Document

Who will be targeted through this operation?

This operation will primarily target populations affected by and at risk of cholera transmission in the most impacted areas, in Brazzaville and Congo-Oubangui, where vulnerability is heightened due to limited access to safe water, inadequate sanitation, and constrained

access to healthcare services, particularly in hard-to-reach and riverine settings.

The targeting approach is guided by recent epidemiological data, which highlights a peak in cases and deaths, a high case fatality rate, and continued community-level transmission, with a significant proportion of deaths occurring outside health facilities. This underscores the need to prioritize high-burden hotspots where rapid, community-based interventions can have the greatest impact on reducing mortality and transmission.

The operation will focus on approximately 2,500 households in high-risk communities, particularly those living in densely populated, flood-prone, peri-urban, or underserved environments, where exposure to contaminated water and poor sanitation conditions remains high. Priority will also be given to communities with limited access to health services and delayed care-seeking behaviors, which are key drivers of preventable deaths.

Special attention will be given to vulnerable groups, including children under five, who represent a significant proportion of cases, and older adults, who face a higher risk of severe outcomes and mortality. Women and girls will be specifically targeted due to their roles in water collection, caregiving, and household hygiene, which increase their exposure, as well as their specific protection needs. In addition, persons with disabilities, elderly individuals, and populations in remote or isolated areas will be prioritized, given the barriers they face in accessing information, services, and referral mechanisms.

Explain the selection criteria for the targeted population

The selection of the targeted population is based on a combination of epidemiological data, vulnerability analysis, and access constraints, with the objective of prioritizing those most at risk of cholera infection and related mortality. Geographic targeting focuses on the most affected areas, particularly Brazzaville (Île Mbamou) and Congo-Oubangui (Mossaka and surrounding localities), where the highest number of cases and deaths have been reported and where transmission remains ongoing. Priority is given to communities with limited access to safe water, sanitation, and healthcare services, as these conditions are key drivers of cholera transmission and severity.

At the household level, selection criteria include exposure to high-risk environments, such as proximity to contaminated water sources, living in flood-prone or riverine areas, and residing in densely populated or underserved neighborhoods. Households with limited capacity to adopt preventive measures, due to economic or structural constraints, are also prioritized.

Particular attention is given to vulnerable groups who face increased risk of infection, severe outcomes, or barriers to accessing services. These include children under five, who are more susceptible to dehydration; older persons, who experience higher mortality; and women and girls, who may have increased exposure due to their roles in water collection and caregiving. In addition, people living with disabilities, the elderly, and individuals in remote or hard-to-reach communities are specifically targeted due to mobility constraints, limited access to information, and challenges in reaching health services.

The selection process also considers social and inclusion factors, ensuring that marginalized or less visible groups are not excluded from assistance. Community-based targeting approaches will be used, involving local leaders and volunteers to identify those most in need, while applying inclusive criteria to ensure equitable access to services and support.

Total Targeted Population

Women	**4,500**	Rural	**60%**
Girls (under 18)	**3,500**	Urban	**40%**
Men	**4,000**	People with disabilities (estimated)	**10%**
Boys (under 18)	**3,000**		
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
limited access to affected areas, particularly in riverine and hard-to-reach zones such as Mossaka and surrounding localities. This is mainly due to geographical constraints, poor transport infrastructure, and dependence on waterways. Such limitations could delay the delivery of assistance, supervision of activities, and referral of suspected cases, thereby affecting the timeliness and overall impact of the response	The operation will prioritize community-based approaches, and rely on locally based volunteers to ensure continuity of activities. Additional logistical planning and coordination with local authorities will also be strengthened.
Low community engagement and resistance to behavior change, driven by misinformation, rumors, and low risk perception. This could undermine the effectiveness of prevention measures, including hygiene practices and early care-seeking, ultimately sustaining transmission.	Strengthening Community Engagement and Accountability (CEA) approaches, promoting two-way communication, engaging community leaders, and systematically collecting and addressing feedback to adapt interventions accordingly.
Occurrence of concurrent health emergencies, such as Mpox or other outbreaks, which may divert attention and resources from the cholera response. This could lead to reduced coordination, delayed response, and overstretched health systems.	Involve strengthening coordination with health authorities and partners, ensuring integration of activities where possible, and maintaining flexibility in planning to adapt to evolving priorities.

Please indicate any security and safety concerns for this operation:

The operation will take place in Brazzaville and Kongo-Oubangui, where the overall security context is relatively stable. However, certain areas may present localized risks, including petty crime and challenges related to access, particularly in remote or riverine communities.

The flood-affected environment presents several safety risks for staff, volunteers, and communities. These include damaged infrastructure, unstable ground, and the presence of stagnant and contaminated water, increasing the risk of waterborne diseases such as cholera and other public health concerns. In Kongo-Oubangui, limited accessibility, including reliance on river transport, may also pose additional logistical and safety challenges.

There is also a potential risk of community tensions during the distribution of assistance, particularly in areas where needs are significant and resources are limited.

To mitigate these risks, the Congolese Red Cross, with the support of the IFRC, will implement standard security and safety measures. These will include adherence to Movement security protocols, regular security briefings for staff and volunteers, coordination with local authorities and community leaders, and continuous monitoring of the security situation. Appropriate personal protective equipment (PPE) will be provided, and movement tracking procedures will be applied to ensure safe access to operational areas.

Has the child safeguarding risk analysis assessment been completed?	No

Planned Intervention

Health

Budget: CHF 32,748
Targeted Persons: 15,000

Indicators

Title	Target
% of volunteers reporting into CBS system	100
#of suspected cases identified and referred	300
#of people (desagreted by age and sex)reached with health messages	15,000
% of alerts reported within 24 hours	95
% of alerts investigated/validated by health authorities	80
% of suspected cases referred within 24 hours	100
% of community members able to identify at least 3 key cholera symptoms	70
% of community members aware of where to seek treatment	80
% of volunteers reporting into CBS system (your target should be between 95-100%)	100
# of confirmed cased detected via CBS mechanism	-

Priority Actions

• Deploy trained volunteers for community-based surveillance and active case finding.
• Conduct referral and follow-up of suspected cases.
• Deliver health promotion sessions on cholera prevention and early care-seeking.

Water, Sanitation And Hygiene

Budget: CHF 39,949
Targeted Persons: 15,000

Indicators

Title	Target
#of households receiving Aquatabs	3,000
#of households receiving jerrycans	3,000
# of latrine constructed	30
# showers constructed	25
#of community sanitation campaigns conducted	20
% of targeted households practicing safe water treatment and storage (using Aqua tabs and jerrycans) at the time of PDM	80

Priority Actions

• Distribute Aqua tabs and demonstrate correct use.
• Distribute jerrycans for safe water storage.
• Construct emergency latrines and showers in priority areas.
• Conduct environmental sanitation campaigns.
• Conduct a PDM.

Protection, Gender And Inclusion

Budget: CHF 18,154
Targeted Persons: 15,000

Indicators

Title	Target
# of volunteers trained on PGI (GBV/PSEA)	30
% of activities integrating PGI considerations	100
% of vulnerable individuals reached	4,500

# of referral pathways identified and functional per zone	2
# of staff and volunteers trained on PGI (PSEA, GBV, child protection)	120
% of staff and volunteers who signed the Code of Conduct/PSEA	100
# of people reached through PGI sensitization (disaggregated by sex, age, disability)	15,000
# of community theatre sessions conducted	16
% of survivors receiving support (PSS and/or referral services)	100

Priority Actions

• Train volunteers on GBV, PSEA, PSS and safe referral pathways.
• Integrate PGI into all sectoral activities.
• Ensure inclusive communication and access to services.
• Establish safe and accessible feedback mechanisms.
• Ensure Code of Conduct and PSEA commitments are signed and understood by all staff and volunteers.
• Integrate PGI key messages across all sectors (WASH, Health, etc.).
• Provide specific training for PGI/CEA focal points on safe and confidential complaint mechanisms (including SEA).
• Establish safe, accessible, and confidential feedback mechanisms (complaint boxes, hotline, community channels).
• Map and strengthen referral pathways (health, psychosocial, legal services).
• Conduct targeted sessions for at-risk groups (women, adolescent girls, persons with disabilities).
• Carry out regular PGI supervision and quality monitoring visits.
• Ensure accessibility measures are integrated into services (physical access, inclusive communication).
• Distribute dignity and hygiene kits alongside awareness messages on protection and safe use.

Community Engagement And Accountability

Budget: CHF 28,512
Targeted Persons: 15,000

Indicators

Title	Target
#of people reached with CEA activities	15,000
#of feedback/rumors collected and addressed	100
#of community sessions conducted	50
% of people demonstrating improved knowledge on cholera prevention	75
% of feedback responded to within 48 h	80
% of feedback integrated into response adaptation	60
% of identified rumors addressed through adapted messaging	80
% of community members aware of how to provide feedback	70

# of volunteers trained on CEA and feedback mechanisms	45

Priority Actions

• Conduct door-to-door awareness sessions.
• Organize community dialogue sessions.
• Collect and analyze community feedback and rumors.
• Disseminate key messages through local channels (schools, leaders, churches,etc.).

Secretariat Services

Budget: CHF 18,716
Targeted Persons: 3

Indicators

Title	Target
#of technical support missions/engagements provided	5
#of financial monitoring/review sessions conducted	2
#of volunteers Insured	500

Priority Actions

• Provide technical support to the National Society in planning, implementation, and monitoring of the operation
Support PMER functions, including development of DREF documents, reporting, and data analysis.
• Provide financial management and compliance support, including budget monitoring and financial reporting.
• Support logistics and procurement processes, ensuring compliance with IFRC standards.
• Provide security guidance and risk management support to ensure safe implementation.
• Support communication and visibility, including development of communication materials and alignment with IFRC standards.
• Provide National Society Development (NSD) support, including coaching and strengthening of systems and structures.
• Ensure overall coordination and quality assurance of the operation through regular follow-up and technical guidance
• Support to Insurance of volunteers.

National Society Strengthening

Budget: CHF 48,988
Targeted Persons: 9

Indicators

Title	Target
# of kick- off meeting with authorities organized	1
#of supervision visits conducted	20
# of lessons learned workshop conducted	1

Priority Actions

• Organize a kick- off meeting with authorities.
•Strengthen coordination and operational management capacities at national and branch levels.
• Support supervision and coaching of volunteers during implementation.
• Strengthen PMER systems, including data collection, analysis, and reporting tools.
• Provide operational support (communication, transport, visibility materials) to ensure effective implementation.
• Conduct a lessons learned workshop at the end of the operation to capture best practices and areas for improvement.

About Support Services

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

The implementation of this operation will rely primarily on the mobilization of Red Cross volunteers, supported by a limited number of staff at both national and branch levels to ensure effective coordination, supervision, and technical oversight.

A total 120 volunteers will be engaged across the targeted areas, including Brazzaville (Île Mbamou) and Congo-Oubangui (Mossaka and surrounding localities). These volunteers will be distributed across sectors, with roles in community-based surveillance, health promotion, WASH activities, community engagement and accountability (CEA), and support to Oral Rehydration Points (ORPs). They will conduct door-to-door sensitization, identify and report suspected cases, support referrals, facilitate hygiene promotion sessions, and assist in the implementation of WASH interventions, including distribution activities and environmental sanitation campaigns.

In addition to volunteers, 8 staff members from the Congolese Red Cross will be involved in the operation, including key positions such as a Project Coordinator, Health Officer, WASH Officer, and PMER/Reporting Officer, supported by administrative and finance staff. These staff members will be responsible for overall coordination, technical supervision, planning, monitoring, reporting, and ensuring compliance with operational and financial procedures.

At field level, team leaders or supervisors will be designated among volunteers in each operational area to oversee daily activities, ensure quality implementation, and maintain communication with branch and national coordination teams.

The operation will also benefit from technical guidance and remote support from the IFRC, particularly in areas such as PMER, finance, and operational strategy. Overall, this structure is designed to ensure a well-coordinated, community-based response, with clear roles and responsibilities to support effective implementation and accountability.

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?

The composition of the volunteer team reflects, to a large extent, the gender, age, and cultural diversity of the targeted communities, particularly as volunteers are recruited from within the same operational areas, including Brazzaville (Île Mbamou) and Congo-Oubangui. This community-based approach facilitates trust, acceptance, and effective communication, as volunteers are familiar with local languages, cultural norms, and community dynamics.

Efforts have been made to ensure a balanced representation of men and women within the volunteer teams, recognizing the importance of gender-sensitive approaches in the cholera response. Female volunteers play a critical role in engaging with women and children at household level, particularly in discussions related to hygiene practices, caregiving, and health-seeking behaviors. In addition, the inclusion of volunteers from different age groups supports broader outreach, including engagement with youth and community leaders.

However, some gaps remain, particularly in ensuring sufficient representation of women in all operational areas, as well as the inclusion of volunteers with specific skills related to engaging vulnerable groups, such as people living with disabilities or elderly populations. In certain remote or hard-to-reach areas, the availability of trained and diverse volunteers is also limited.

To address these gaps, the operation will promote inclusive volunteer recruitment and deployment, with particular attention to increasing female participation and ensuring representation from different community groups. In addition, volunteers will receive training on Protection, Gender and Inclusion (PGI), including gender-sensitive communication, cultural awareness, and approaches to reach vulnerable and marginalized populations.

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

Procurement activities for this operation will be primarily carried out by the Congolese Red Cross (CRC), with technical guidance and oversight from the IFRC Secretariat, in line with IFRC procurement standards and procedures. This approach aims to ensure timely acquisition of goods while strengthening the National Society's operational capacity.

Procurement will mainly involve local suppliers, particularly for WASH items (Aquatabs, jerrycans, soap), construction materials for latrines and handwashing facilities, and basic equipment required for community-based activities. Local procurement is prioritized to ensure cost-effectiveness, faster delivery, and support to local markets, while also considering availability and quality standards. In case certain items are not available locally or do not meet required standards, alternative sourcing options will be explored in coordination with IFRC.

The procured items will be used primarily for distribution to targeted households and communities, as well as for the implementation of activities (e.g., ORPs, hygiene promotion, sanitation infrastructure). The procurement process will follow standard competitive procedures, and the tendering process is expected to take approximately 2 to 4 weeks, depending on the type and volume of items.

How will this operation be monitored?

The operation will be monitored through a combination of routine data collection, field supervision, and regular reporting, ensuring that activities are implemented as planned and that progress toward expected results is effectively tracked. A structured PMER (Planning, Monitoring, Evaluation and Reporting) system will be applied throughout the operation.

At field level, volunteers and team leaders will collect data on daily activities, including the number of households reached, suspected cases identified and referred, WASH items distributed, and community sessions conducted. This information will be compiled at branch level and consolidated at national level on a regular basis. Standardized data collection tools and reporting templates will be used to ensure consistency and quality of data.

Monitoring of the operation will be overseen by the CRC Operation/Project Coordinator, with technical support from the PMER officer, who will be responsible for data analysis, tracking of indicators, and preparation of internal and external reports, including DREF updates. Regular field supervision visits will be conducted by CRC staff to ensure quality implementation, provide on-site guidance to volunteers, and verify reported data.

The IFRC will provide remote technical support and monitoring oversight, including regular review of reports and progress updates. Where feasible, IFRC monitoring visits may be conducted during the operation to support quality assurance, provide technical guidance, and ensure compliance with DREF requirement.

Please briefly explain the National Societies communication strategy for this operation

The Congolese Red Cross (CRC) will implement a communication strategy that supports both operational coordination and community engagement, ensuring timely, accurate, and consistent information flow throughout the operation.

Internally, communication will be facilitated through regular coordination meetings, field reports, and direct communication channels (phone, messaging platforms) between volunteers, team leaders, branch staff, and national headquarters. This will ensure effective information sharing, timely reporting of activities, and rapid identification of challenges requiring action.

Externally, the CRC will coordinate closely with the Ministry of Health and partners to ensure that all public messaging is aligned with national guidelines and response strategies. Communication with affected communities will be primarily conducted through community-based approaches, including door-to-door sensitization, community meetings, and engagement with local leaders and structures. These channels will ensure that information is accessible, culturally appropriate, and adapted to local languages and contexts.

To ensure transparency and accountability, the CRC will integrate Community Engagement and Accountability (CEA) mechanisms, including feedback collection through volunteers and community focal points. This will allow communities to express concerns, ask questions, and provide input, enabling the response to be continuously adapted to their needs.

In terms of external visibility, the CRC may utilize media and digital platforms, including radio messaging, social media updates, and the development of communication materials (such as posters and key messages), to raise awareness and share information on the response. Where relevant, press releases or updates may be issued in coordination with national authorities and partners.

The IFRC will provide technical support in communication, including guidance on visibility, messaging, and alignment with Movement communication standards. IFRC may also support the development of communication products and ensure coherence in external messaging at regional and international levels.

Budget Overview

IFRC

DREF OPERATION

- Congo Red Cross
Congo Cholera Outbreak 2026

Operating Budget

Planned Operations	**127,122**
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	34,877
Water, Sanitation & Hygiene	42,546
Protection, Gender and Inclusion	19,334
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	30,365
Environmental Sustainability	0
Enabling Approaches	**72,104**
Coordination and Partnerships	0
Secretariat Services	19,932
National Society Strengthening	52,172
TOTAL BUDGET	**199,226**

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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