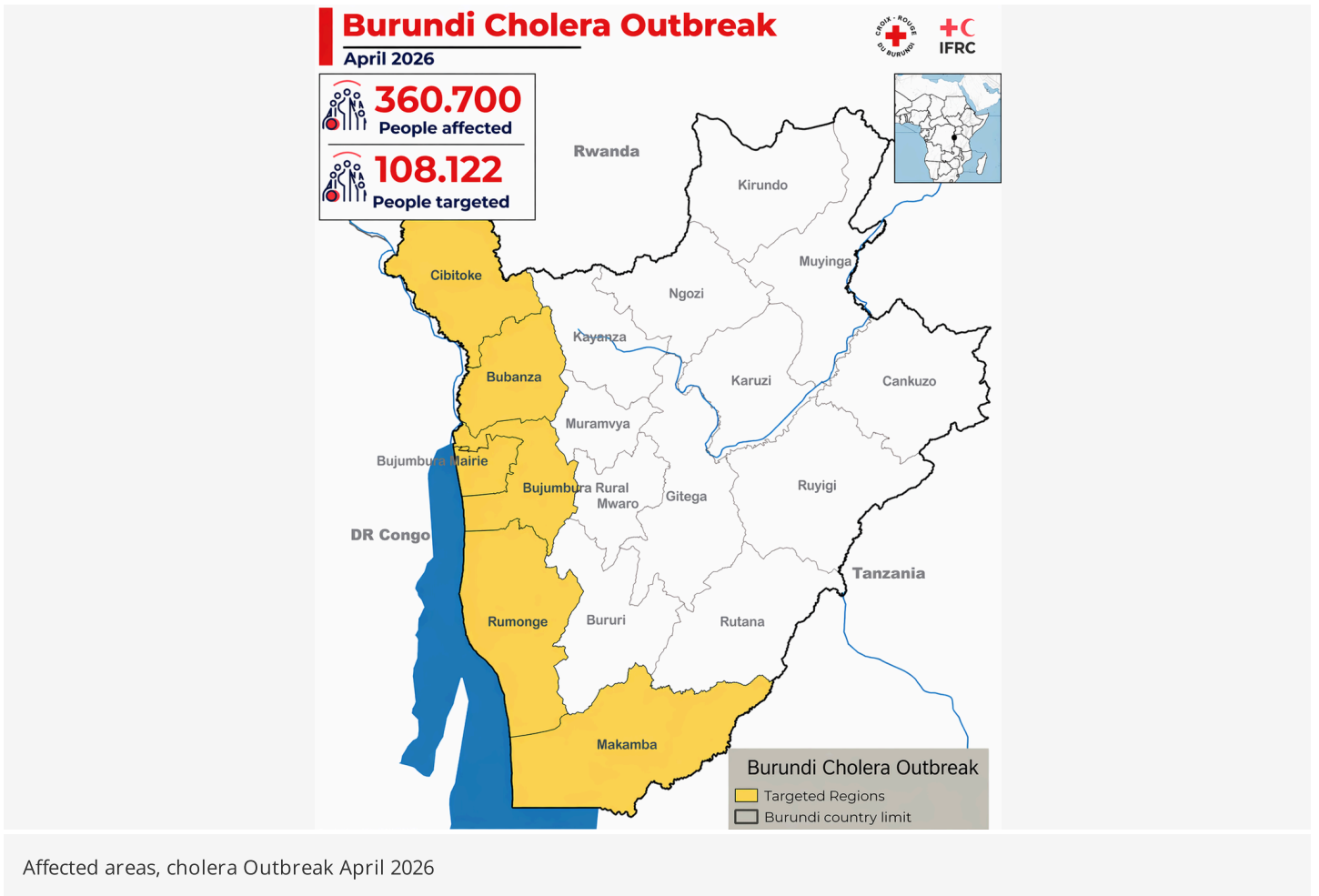




NS and the Civil Protection together for Household disinfection at Bwiza Quarter

Appeal: MDRBI024	Total DREF Allocation: CHF 499,999	Crisis Category: Yellow	Hazard: Epidemic
Glide Number: -	People Affected: 360,700 people	People Targeted: 108,122 people	
Event Onset: Sudden	Operation Start Date: 12-12-2025	New Operational End Date: 30-06-2026	Total Operating Timeframe: 6 months
Reporting Timeframe Start Date: 01-12-2025		Reporting Timeframe End Date: 30-06-2026	
Additional Allocation Requested: 124,999		Targeted Regions: Bubanza, Bujumbura Mairie, Bujumbura Rural, Makamba, Rumonge	

Description of the Event



Affected areas, cholera Outbreak April 2026

Date of event

07-12-2025

What happened, where and when?

Since early 2025, cholera has reappeared in Burundi after several years without an outbreak. This is due to the lack of clean drinking water in the region, which has forced the population to fetch water from Lake Tanganyika and runoff. This situation is exacerbated by poor hygiene and inadequate sanitation, with schools lacking proper latrines. While the initial outbreaks in the north and center (Cibitoke, Bubanza, Bujumbura, and Rumonge) were relatively contained, transmission has surged in recent weeks in the Lake Nyanza health district, where the number of daily cases now frequently exceeds 50.

On 27 November, the first case of cholera was identified in the Lac Nyanza health district, specifically in the Sangtaire area. From that point, the outbreak has taken another turn with an increase in cases as shown in the MoH SITREP of 7 December 2025. Between 27 November and 07 December, the cholera outbreak has continued to expand, intensifying in recent weeks, especially since late November. Between late November and early December 2025, with cumulative cases rising from 2,689 on 29 November to 2,968 on 7 December, indicating 279 new cases within one week. The epicentre remains Nyanza-Lac, which consistently reports the majority of new cases and active caseloads in all SITREPs.

The escalation is compounded by flooding and deteriorating water and sanitation conditions, heightening the risk of further spread among vulnerable communities. Furthermore, given the significant population movement from the DRC into Burundi, the risk of cross-border spread of cholera remains high. This recent surge is further aggravated by flooding caused by heavy rains during the 2025–2026 agricultural season, which contaminates water sources, worsens sanitation conditions, and thereby facilitates the rapid spread of the disease among the most vulnerable communities.

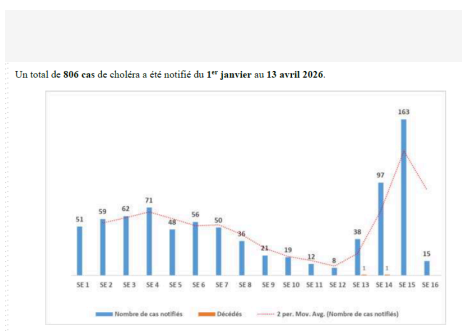
As of April, 12th, 2026, following the combined efforts of various stakeholders, particularly the Regional Health Commission (CRB), the



outbreak declared in the Nyanza Lac Health District was quickly brought under control. However, an increase in cases was observed in the Mukaza, Kamenge, and Mutimbuzi Health Districts within the Bujumbura Municipality. According to the Ministry of Health (MoH) situation report published on April 13, 2026, there is a cumulative total of 806 cases, including 37 active cases. Among the 37 active cases, 15 are new cases from Mutimbuzi (7 cases from the Tenga neighborhood), Kamenge (4 cases from the Buterere and Uwinterekwa neighborhoods), and Mukaza (4 cases from the Bwiza and Buyenzi neighborhoods).

Situation épidémiologique du 01 Janvier au 13 Avril 2026		
CUMUL DES CAS PAR DS	Cumul des Cas	Reçus Nouveaux ds
MUTIMBUZI	336	
MUKAZA	137	
NYANZA	97	
KAMENGE	58	
RUMONGE	49	
RUYIGI	38	
RUZIBA	36	
CIBITORE	27	
NDAYA	12	
MPANDA	9	
KABEZI	4	
BUGARAMA	3	
806		Nouveaux guéris : 12
		Cumul des guéris : 767
CAS ACTIFS	NOUVEAUX CAS	Origine des nouveaux cas
37	15	Mutimbuzi : 07 Cas
		Mukaza : 04 Cas
		Kamenge : 04 Cas

Epidemic situation



Epidemic cuve



Chlorine distribution and RCC at Nyanza



Decontamination at Mukaza (Bwiza)

Scope and Scale

The cholera situation has deteriorated sharply in recent weeks. Approximately 2,030 cases were reported between 1 January and 19 October 2025, but more than 600 additional cases were recorded between 30 September and the end of November 2025, according to health authorities. Since late November, daily notifications have shown dozens of new cases per day, frequently exceeding 50 new cases per day. In total, a total of 2,968 cholera cases were reported between 1 January and 7 December 2025, with 50.3% male and 49.7% female. The most affected age groups are 11–20 years (22.3%), 21–30 years (19.7%), and children under 5 years (18.1%), indicating that adolescents, young adults and very young children are particularly at risk. As of 19 October 2025, some 1,933 patients had recovered, 6 deaths were recorded and 91 cases were still active, giving an overall Case Fatality Rate (CFR) of about 0.3% (6/2,030). Although this CFR is relatively low, it remains a concern in a context of chronic water shortages, overcrowded treatment centres and limited access to timely care; any further increase in cases risks overwhelming the fragile health system and pushing the CFR upwards.

This rapidly rising caseload, together with the wide geographic spread, high-risk WASH conditions and the structural vulnerability of affected communities, confirms a clear surge in transmission in the Nyanza-Lac area and along the shores of Lake Tanganyika (MoH SitRep, 7 December 2025). Without immediate and large-scale action, there is a real risk of further increases in incidence, more severe disease and higher mortality, with cascading impacts on livelihoods and well-being.

A rapid needs assessment conducted by the National Health Service showed that, due to the lack of access to safe drinking water, most households fetch water directly from Lake Tanganyika, which is already contaminated. This reliance on unsafe water, combined with inadequate hygiene and sanitation practices (lack of adequate latrines, no facilities for handwashing with soap and clean water, poor solid-waste management), creates an environment that is highly conducive to sustained cholera transmission. In such conditions, each new case can easily lead to multiple secondary infections, especially in crowded settings where people share few, poorly maintained latrines and no safe water points.

The outbreak trend and risks are particularly critical in Nyanza-Lac and along the shores of Lake Tanganyika, where households have no viable alternative but to draw water from the lake for drinking, cooking, washing and fishing-related activities. At the main fishing points, especially in Mvugo, Kabonda and Muguruka, there is severe overcrowding and very poor hygiene and sanitation conditions (no safe drinking water on site, no adequate latrines, no handwashing facilities). Fishermen and their families, as well as communities living on the



hills surrounding these fishing ports, are therefore among the most exposed groups, as they are in constant contact with potentially contaminated water and environments. However, because water and markets are shared, all hills in the plain are now generally at risk, and all socio-economic groups in the affected area—men, women, children, farmers, petty traders—are exposed to the disease.

Several categories are particularly vulnerable to the negative impacts of this outbreak:

- Children under 5 years and adolescents/young adults (11–30 years), who represent the largest share of reported cases and are more prone to severe dehydration if not treated promptly.
- Elderly people and people with chronic illnesses or disabilities, who may have reduced mobility and face difficulties accessing treatment centers or safe water points, increasing the risk of complications and death.
- Poor households, including those living in informal settlements along the lake and in the Ruzizi plain, who lack financial means to pay for transport, treatment-related costs or alternative water sources.
- Fisherfolk and lake-dependent communities, whose livelihoods depend on daily exposure to the lake, and who - often live in precarious housing without adequate WASH infrastructure.
- Internally displaced persons (IDPs) and other mobile populations along the Burundi–DRC border, who may live in overcrowded conditions with very limited access to basic services, and are highly exposed both to infection and to the socio-economic impacts of movement restrictions or market disruption.

Historically, communities in Burundi’s “cholera belt” and along Lake Tanganyika have experienced recurrent cholera outbreaks, often linked to the same underlying drivers: dependence on unsafe surface water, insufficient investment in WASH infrastructure, high population density in fishing and market areas, and intense cross-border movements with eastern DRC where cholera is endemic. These past outbreaks have repeatedly resulted in preventable deaths, loss of income for fishing and trading households, school absenteeism among children, and increased pressure on an already fragile health system. The current outbreak, with its recent rapid escalation and spread to multiple districts, risks reproducing and amplifying these negative impacts on lives, livelihoods, well-being, and essential services if not urgently contained.

While the cholera epidemic was under control in the Nyanza Lac Health District, there has been an increase in cases in the Bujumbura Mairie Health Districts, namely Mukaza, Kamenge, and Mutimbuzi. According to the situation report published by the Ministry of Public Health on April 12, 2026, an increase in cases was observed starting in week 14 (with 97 new cases) and was more pronounced in week 15 (with 163 new cases), along with two deaths.

Since January 1, 2026, 806 cumulative cases have been reported in 12 health districts: Cibitoke, Ndava, Mpanda, Mutimbuzi, Kamenge, Mukaza, Ruziba, Kabezi, Bugarama, Rumonge, Nyanza, and Ruyigi. Among them, two deaths were reported during WE 13 and 14.

While the cholera epidemic, which had been raging for several months in the Nyanza health district, appeared to be under control, a worrying resurgence of cases has been observed in the Mutimbuzi, Ntahangwa, and Mukaza health districts. This resurgence demonstrates the continued circulation of the cholera bacterium in urban and peri-urban areas, despite the response efforts already underway.

Since April, more than 200 cases have been reported, with a marked acceleration of transmission. The situation worsened particularly during epidemiological week 14, which recorded 97 new cases, before peaking during week 15 with 163 new cases reported. This rapid evolution indicates active spread of the disease and a high risk of further spread if immediate and reinforced measures are not implemented.

Several structural factors explain this outbreak. Insufficient access to safe drinking water in some neighborhoods forces people to rely on unsafe water sources, thus increasing the risk of contamination. This is compounded by particularly precarious hygiene and sanitation conditions: a lack of adequate latrines, poor waste management, and in some cases, the direct disposal of excreta in the streets. These practices promote environmental contamination and accelerate the transmission of cholera, especially in densely populated areas.

Furthermore, the high population density in these districts, combined with still insufficient awareness of good hygiene practices (handwashing, water treatment, proper latrine use), contributes to maintaining a high level of risk. Population movements between affected areas and other localities could also facilitate the spread of the disease. As of 13 April, 2026, there is a cumulative of 806 cases and 2 new deaths. Among those 806 cholera cases already reported from January to April, 53.1% are male, and 46.9% are female. The most affected age groups are: 11 to 20 years (24.9%), 21 to 30 years (23.2%), and children under 5 (14.8%).

Source Information

Source Name	Source Link
1. National workshop with the First Lady to discuss cholera	https://www.iwacu-burundi.org/burundi-cholera-un-bilan-alarmanant/#:~:text=Le%20chol%C3%A9ra%20s%C3%A9vit%20au%20Burundi,et%206%20d%C3%A9c%C3%A8s%20sont%20enregistr%C3%A9s.
2. Cholera in NyanzaLac	https://www.rpa.bi/index.php/actualites/8sante/epidemie-de-



Summary of Changes

Are you changing the timeframe of the operation	Yes
Are you changing the operational strategy	No
Are you changing the target population of the operation	Yes
Are you changing the geographical location	No
Are you making changes to the budget	Yes
Are you requesting an additional allocation?	Yes

Please explain the summary of changes and justification:

The resurgence of cholera cases in Burundi since January 2026 is occurring within a context already marked by structural vulnerabilities in the health system and precarious living conditions in several localities. The rapid increase in the number of cases is leading to the saturation of cholera treatment centers, which are struggling to accommodate and care for all patients under optimal conditions. For the population, the direct effects are manifested by an increase in morbidity and mortality, exacerbated by particularly precarious hygiene conditions in the affected areas. The lack of adequate latrines, combined with the poor use of existing ones, contributes to environmental contamination. This is compounded by limited access to drinking water, forcing many households to rely on unsafe water sources. In some urban areas, such as Bujumbura, poor practices, particularly the dumping of toilet waste into gutters, worsen the spread of the disease by facilitating the contamination of water and public spaces. Furthermore, the lack of partners involved in the fight against cholera limits the scope and effectiveness of the response, slowing down the implementation of essential interventions, particularly in the areas of water, hygiene, and sanitation.

As on April 12th 2026, there has been an increase in cases in the Bujumbura Mairie Health Districts, namely Mukaza, Kamenge, and Mutimbuzi. According to the situation report published by the Ministry of Public Health on April 12, 2026, an increase in cases was observed starting in week 14 (with 97 new cases) and was more pronounced in week 15 (with 163 new cases), along with two deaths.

IFRC Network Actions Related To The Current Event

Secretariat

The IFRC, through its Country/Cluster Delegation covering Burundi, Rwanda, DRC and Congo is actively supporting the Burundi Red Cross in this response at both operational and strategic levels.

In terms of domestic coordination, IFRC is working closely with the Burundi Red Cross to ensure that the National Society is fully integrated into the national coordination mechanisms (health sector meetings, cholera coordination commissions, WASH and RCCE working groups). IFRC provides technical support for the analysis of epidemiological data, the design of community-based interventions (WASH, RCCE, and surveillance) and the development of operational plans and budget for this DREF. As of April 2026, the IFRC is providing financial support to the National Society(SN) with DREF funds for the response in the Nyanza District. In addition, the IFRC provided technical support and, most importantly, resource mobilization.



Participating National Societies	<p>With funding from the HIP 2025 Crisis Modifier project, the Burundi Red Cross, in collaboration with the Finnish Red Cross, is implementing a package of WASH and RCCE activities. These include the provision of safe drinking water, household disinfection/spraying in areas where cholera cases are detected, and risk communication and community engagement (RCCE) through roadshows and community outreach.</p> <p>These activities are currently being carried out in the communes of Ntakangwa, Cibitoke, Bukinanyana and Mpanda.</p>
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ICRC Actions Related To The Current Event

The ICRC has an office in the country. However, it has not provided direct support to the cholera response so far. Its contribution has focused on the broader population movement context, notably through the provision of 47 PPE items to support the response to population movements, but not specifically to this cholera operation.

Other Actors Actions Related To The Current Event

Government has requested international assistance	No
National authorities	<p>The Government continues to ensure case management in the various cholera treatment centres (CTCs). As shown by the MoH's SitReport published on April 13th 2026, the following activities are currently being implemented:</p> <ul style="list-style-type: none"> -Admission of 15 new cases, including 11 cases at the CPLR CTC and 4 cases at the Rubirizi CTC; -Management of 37 active cases, including 26 cases at the CPLR CTC, 10 cases at the Rubirizi CTC, and 1 case at the Rugombo CTC; -Redeployment of a COUSP team to support the CPLR CTC; -Nutritional care for patients and healthcare workers at the CTCs; -Receiving calls from the public via the call center (toll-free number 117); -Broadcasting of radio spots on symptoms, modes of transmission, prevention measures, and procedures to follow in the event of a suspected case of cholera; -Development and daily sharing of SITREPs (Integrated System for Risk Assessment and Prevention). -Supply of cholera treatment centers (CTCs) with necessary inputs for patient care; -Household disinfection coupled with awareness campaigns on cholera prevention measures. - Dissemination of a video spot in Kirundi on online platforms. - Preparation and dissemination of daily situation reports (SITREPs). -A regular supply of treatment centres with essential medical inputs and supplies is needed for case management.
UN or other actors	Médecins Sans Frontières (MSF) is supporting at the CTC.



Are there major coordination mechanism in place?

Through the COUSP (National Coordination Unit for Public Health), a national coordination mechanism for epidemic response is in place and fully operational, under the leadership of the Ministry of Health. At the national level, cholera is coordinated through a multi-stakeholder task force and technical working groups (health, WASH, RCCE), chaired by the Ministry of Health and involving UN agencies, NGOs and the Burundi Red Cross (BRC).

At the operational level, coordination is led by the Health Districts, which oversee planning and implementation of response activities in their catchment areas. The Burundi Red Cross participates in all levels of coordination, both nationally (COUSP, national cholera task force and technical commissions) and at district/local level (health district meetings, and sectoral coordination platforms).

The National Society does not currently hold a formal lead or co-lead role in any sector, but is recognized as a key operational partner, particularly for community-based activities (surveillance, WASH, RCCE) and is regularly invited to strategic and technical meetings. Occasionally, high-level coordination meetings are convened by the Prime Minister's Office or the Office of the First Lady to review the evolution of the outbreak and the overall response; the BRC is systematically invited to these meetings and contributes with updates on its activities and community feedback.

While overall coordination is functioning, some gaps and overlaps persist, notably in the systematic inclusion of community-level actors and clearer delineation of roles for RCCE and WASH at community level, where the BRC could play an even stronger role as an auxiliary to the public authorities.

Needs (Gaps) Identified



Health

Community-based surveillance remains limited due to an insufficient number of community health workers deployed in the field. This shortage reduces the capacity to rapidly detect suspected cases, follow up on alerts, and conduct local awareness campaigns. Consequently, community coverage is incomplete, increasing the risk of silent disease transmission and delaying the implementation of control interventions.

In the Nyanza-Lac health district, the lack of a functional isolation facility is a major weakness in case management. The shortage of tents exacerbates this situation, limiting the capacity to establish triage, isolation, or safe care areas. Furthermore, a portion of the population continues to consume untreated water from Lake Tanganyika, which represents a significant risk factor for the transmission of waterborne diseases, particularly cholera. The lack of alternative drinking water solutions further intensifies this vulnerability.

In several Cholera Treatment Centers (CTCs), a lack of nutritional support for hospitalized patients has been observed. This deficiency compromises the nutritional recovery of patients, particularly children and vulnerable individuals. Furthermore, associated chronic conditions—such as hypertension, diabetes, or other conditions requiring monitoring—are not systematically addressed. This situation exposes patients to additional complications and limits the overall effectiveness of medical care.

The management of cholera cases is hampered by a significant shortage of essential medical supplies and equipment. Stocks of rehydration solutions, equipment, disinfectants, and other vital supplies are insufficient to meet demand, especially during periods of high consumption associated with an outbreak. This shortage limits the capacity of healthcare facilities to provide adequate, rapid, and safe care, thereby increasing the risk of complications and mortality.

As of April 2026, the health actions implemented in the Nyanza Health District are also relevant in the Bujumbura Health Districts affected by the cholera epidemic. While the volunteers in Bujumbura have been trained in epidemic management as part of the MPOX response, they need to be equipped in terms of training on cholera, equipment, and motivation.



Water, Sanitation And Hygiene

Within the community, there is a shortage of safe drinking water across all 19 hills affected by the epidemic. More broadly, access to drinking water in Burundi remains a major structural challenge. Despite efforts by various stakeholders to strengthen water infrastructure, many communities still travel several kilometres to access water, and this water is often not treated. Along Lake Tanganyika, all 19 lakeshore hills draw their water directly from the lake, which is already polluted and microbiologically unsafe, creating ideal conditions for the spread of cholera and other diarrheal diseases among the nearly 3,000 cholera cases (2,968) reported between 1 January and 7 December 2025.

WASH conditions are particularly poor in fishing communities, who often lack adequate latrines at landing sites and in surrounding



settlements. Open defecation or the use of rudimentary, overflowing or poorly maintained latrines near the lake contributes to the contamination of surface water. This situation disproportionately affects fisherfolk and their families living along the lakeshore, and households in the 19 hills that depend directly on the lake for drinking, cooking, washing and Hand hygiene.

In Burundi, only 6% of households have access to a handwashing facility with both soap and water, a rate far below the sub-Saharan African average of 25%. This means that millions of children and adults in Burundi cannot practice effective handwashing at critical times, even though this is one of the simplest and most cost-effective measures to prevent diarrheal and respiratory diseases. Historical survey data (2010) showed that only 38% of women washed their hands with soap before preparing meals, 40% before caring for babies, and 50% after using the toilet. These low adoption rates, combined with the current outbreak context, significantly increase the risk of transmission within households and communities, especially in crowded settings with shared latrines and limited water.

The WASH gaps are particularly alarming at a time when the country is facing multiple health crises, including cholera and monkeypox, as well as population displacement linked to the El Niño phenomenon, which further strains existing services. In this context, the fact that 19 cholera-affected hills rely on one contaminated lake as their main source of water, only 6% of households have functional handwashing facilities with soap and water; and cholera has already affected over 3000 households in less than a year, clearly demonstrates the urgency of scaling up WASH interventions.

In April 2026, in the municipality of Bujumbura, there is a high population density, creating overcrowding and limited access to and use of water and sanitation infrastructure. In some neighborhoods, there may be approximately 10 households with over 100 inhabitants sharing a single latrine on their property or sharing it with another property. Access to water is a very serious problem in Bujumbura. As a result, REGIDESO (the national water utility) can no longer meet the city's needs, and some neighborhoods are forced to use surface water such as water from Lake Tanganyika, rivers, sewage, and rainwater, which promotes the spread of waterborne diseases. Indeed, the WASH actions implemented in the Nyanza Health District are also relevant in the Bujumbura Health Districts affected by the cholera epidemic.



Protection, Gender And Inclusion

The fight against cholera in Burundi requires an approach that fully integrates gender and social inclusion, as the disease disproportionately affects already vulnerable groups. Inequalities in access to safe drinking water, sanitation, and health services result in increased exposure for women, girls, people with disabilities, the elderly, and poor households. In a context where cholera spreads primarily through contaminated water, these inequalities become key risk factors.

Access to safe drinking water clearly illustrates these disparities. Women and girls, responsible for collecting water, often travel long distances, increasing their exposure to health, social and GBV risks while limiting their educational and economic participation. People with disabilities and the elderly face significant physical barriers to reaching water points, while poor households struggle to pay for water or treatment products. To reduce these vulnerabilities, it is essential to ensure access to nearby, safe, accessible, and affordable water points.

Sanitation and hygiene issues also exacerbate inequalities. Insufficient, unsafe, or inadequate latrines disproportionately affect women and girls, who need privacy and security, particularly for managing menstrual hygiene. People with reduced mobility are often unable to use unsuitable facilities, further exposing them to the risk of infection. Therefore, gender-segregated, well-lit, inclusive, and accessible infrastructure is essential, along with hygiene practices tailored to the needs of each group.

Finally, access to health services and community participation play a central role in an effective cholera response. Distance, cost (transportation fees), and social norms often limit the ability of women and marginalized groups to reach treatment centers quickly. At the same time, their underrepresentation in decision-making bodies limits the effectiveness of proposed solutions. Inclusive communication, accessible in local languages and adapted to different literacy levels, along with the active participation of women, youth, and people with disabilities, are essential to strengthening prevention and ensuring an equitable and sustainable response. Oversights may occur during response operations, requiring reminders to response teams regarding protection considerations.

During the treatment period for sick individuals, visits from relatives are not permitted, and family members are distressed when they don't know the progress of their loved ones' health. Furthermore, those living near a household with a confirmed case remain fearful of the risk of being infected and the members of HH with confirmed cases are stigmatized and are mentally affected.

As of April 2026, the PGI actions implemented in the Nyanza Health District are also relevant in the Bujumbura Health Districts affected by the cholera epidemic.



Community Engagement And Accountability

In the context of the fight against cholera, several gaps persist in terms of community engagement and accountability, which limits the effectiveness of interventions. First, knowledge of the epidemic remains insufficient in many communities. Many households do not clearly understand the modes of cholera transmission, the warning signs, or the appropriate actions to take in case of suspected



infection. This lack of knowledge leads to misconceptions, rumors, and sometimes a minimization of the risk, which complicates the implementation of prevention measures. The absence of information adapted to different literacy levels and local languages further exacerbates this difficulty.

At the same time, non-compliance with preventative measures constitutes another major challenge. Even when communities have heard about recommended practices—handwashing, water treatment, latrine use, isolation of suspected cases—their adoption remains limited. Several factors explain this situation: lack of access to necessary resources (water, soap, and chlorine), socioeconomic constraints, and also poor understanding and application of prevention messages. When recommendations are not perceived as realistic, culturally appropriate, or co-created with communities, they are rarely implemented sustainably.

Another significant gap concerns the under-utilization of community communication channels. While community meetings, religious gatherings, dialogues with local leaders, and village governance structures are valuable spaces for disseminating reliable information, they are not sufficiently utilized. This under-utilization deprives interventions of a crucial channel for reaching the most remote or marginalized populations. It also limits opportunities to gather community concerns, feedback, and suggestions, thereby undermining the accountability of humanitarian and health actors.

As of April 2026, the risk communication and community engagement actions implemented in the Nyanza Health District are also relevant in the Bujumbura Health Districts affected by the cholera epidemic.

Any identified gaps/limitations in the assessment

According to the MoH SitRep published on April 13th, 2026, here bellow the urgent needs

- Precarious hygiene conditions in some localities affected by the epidemic.
- Many patients still arrive late at the CTC/CTU, which increases the risk of severe dehydration and death. There is a need to strengthen community-based disease management, including early identification of cases, home use of ORS, and prompt referral.
- While multiple communication channels exist (radio, meetings, posters, hotline), the scale of the outbreak shows that behavior change and trust gaps remain. There is a need to reinforce two-way communication and feedback systems and ensure that community feedback (especially from vulnerable groups) systematically informs adjustments to the response.
- Insufficient adequate latrines and poor use of existing ones in the affected localities.
- Insufficient access to drinking water in the affected areas.
- Insufficient number of partners committed to supporting the cholera response.
- Poor practices in Bujumbura, such as dumping toilet waste into gutters.

The following is recommended:

- Strengthen access to drinking water for populations living in the affected localities.
- Continue raising awareness among households about the construction and proper use of latrines, as well as avoiding the consumption of untreated lake water.
- Continue community awareness campaigns on the clinical signs of cholera, preventive measures, the appropriate course of action in the event of a suspected case, and the importance of promptly seeking treatment at cholera treatment centers (CTCs) using safe channels.
- Continue the provision of water via bladders installed in the Bukirasazi neighborhood.
- Continue surveillance at points of entry, in refugee camps, and at transit sites.
- Continue mobilizing financial resources to support the cholera response.
- Ensure holistic patient care.
- Strengthen the Administration's involvement in cholera prevention through the strict enforcement of measures prohibiting the dumping of toilet waste into gutters.
- While multiple communication channels exist (radio, meetings, posters, hotline), the scale of the outbreak shows that behavior change, and trust gaps remain. There is a need to reinforce two-way communication and feedback systems and ensure that community feedback (especially from vulnerable groups) systematically informs adjustments to the response.
- Provision of WASH kits to households (containers for water transport and storage, jerrycans, buckets, soap and basic hygiene items).
- Use of LMS kits, in addition to water trucking, is essential to provide potable water in areas that are not connected to water networks or are difficult to access.
- Decontamination (household and public-place disinfection) remains essential for epidemic control, but coverage is still incomplete; volunteers need to continue and scale up decontamination to reach all 19 lakeshore hills.

Operational Strategy

Overall objective of the operation

Through this 6-month DREF operation, the Burundi Red Cross aims to reduce cholera transmission in the Nyanza-Lac, Ntahangwa, and Mukaza Health District and surrounding high-risk areas by implementing integrated WASH, Health, and CEA interventions. The operation will provide direct WASH and health support to 18,035 households and reach approximately 108,210 people with targeted



risk communication and community engagement activities, to improve access to safe water, strengthen early case management, and promote life-saving hygiene and prevention practices.

Operation strategy rationale

To achieve its objective, the National Society's strategy will be structured around four main sectors, such as WASH, Health, PGI and CEA. In line with this, the overall operational strategy for this 6-month DREF operation is to deploy an integrated package of WASH, Health, PGI and CEA interventions implemented by trained Burundi Red Cross volunteers in close collaboration with the Ministry of Health and district health authorities to rapidly reduce cholera transmission in Nyanza-Lac and the surrounding high-risk areas while strengthening community-based prevention and early case management.

1) Health

With the support of the Ministry of Health and using the IFRC EpiC (Epidemic Control for Volunteers) manual as a reference, the Burundi Red Cross will implement a structured training programmed for volunteers. This training will first strengthen their ability to quickly recognize the signs and symptoms of cholera so they can detect suspected cases early within their communities. It will also cover early case management at community level, including the correct use of oral rehydration salts (ORS) and the provision of basic advice to families to limit dehydration before patients reach a treatment centre.

Volunteers will be trained on the procedures for rapid referral to government cholera treatment centers and units (CTC/CTU), enabling them to guide patients efficiently towards appropriate care and reduce delays in accessing treatment. An important component of the training will focus on infection prevention and control (IPC), so that volunteers adopt and promote safe practices to protect both households and themselves during awareness-raising, household visits and support to health facilities. Trained volunteers, working closely with health centers and the Medical Officers of Health (MCZs), will carry out a range of community-based activities. They will conduct door-to-door visits in the 19 hills and in other high-incidence areas to rapidly identify suspected cases, share prevention messages and respond to household concerns. They will also lead educational talks focusing on the warning signs of cholera, the correct use of oral rehydration salts (ORS) stem and the importance of going quickly to the cholera treatment centre (CTC) as soon as symptoms appear. To address delays in access to care and reduce mortality, the National Society will implement a community-based ORS distribution system.

These volunteers will help disseminate official messages validated by the Ministry of Health, ensuring that information shared across all targeted areas is harmonized, reliable and fully aligned with national guidelines.

If the existing CTC becomes saturated, and upon request from the Ministry of Health, the Burundi Red Cross will support the expansion of treatment capacity. This will include installing additional tents to serve as CTC/CTU structures, as well as setting up emergency latrines and handwashing facilities around the centre to ensure adequate infection prevention and control. All works will be carried out under the technical supervision of the relevant MoH services (hospital directorate/cholera unit), with the Burundi Red Cross providing logistical support and manpower through its network of volunteers.

The National Society will establish and/or strengthen a Community-Based Surveillance (CBS) system in cholera-affected and high-risk areas with the following components:

- Early detection and reporting of suspected cholera cases, deaths and other relevant events at the community level.
- Rapid linkage between community alerts and the formal health system to support timely investigation, response and referral.
- Improve community awareness and trust in cholera prevention, early care-seeking and outbreak control measures.

2) WaSH

In coordination with the Ministry of Health and the district health authorities, the Burundi Red Cross (BRC) will organize training sessions for volunteers and technical teams (National Society staff and health authorities). These sessions will cover household and public-place decontamination protocols, water management (use of LMS treatment kits, chlorination, and safe storage) and the promotion of good hygiene and sanitation practices. All training sessions will be aligned with national WASH/cholera guidelines and validated by the relevant government technical services.

Working jointly with the district health authorities and local water services, the BRC will then put these skills into practice on the ground.

For household and public-place decontamination, trained volunteer teams will be deployed across the 19 hills along the shores of Lake Tanganyika. Routes and priorities (hills, markets, schools, places of worship) will be defined together with the Medical Officers of Health (MCZs) and local WASH focal points. The teams will carry out spraying and disinfection of households of confirmed cases, latrines and communal water points, in close coordination with government teams.

To improve access to safe drinking water, and in collaboration with the technical water services, the BRC will support water trucking to priority areas agreed with the authorities, and will install and operate LMS water-treatment kits at strategic locations to treat lake water and produce safe drinking water. In more remote communities, BRC volunteers and community health workers will jointly distribute Aquatabs or other household water-treatment products and demonstrate their correct use.

For household-level WASH support, and in coordination with health zones/districts, the BRC will target 3,000 vulnerable households (on lists validated jointly with the authorities) to receive WASH kits, including containers for collecting and storing water (jerrycans, buckets with lids) and soap and basic hygiene consumables. Each distribution will be accompanied by short awareness-raising sessions delivered in pairs by a BRC volunteer and a Ministry of Health staff member or community health worker, to reinforce key messages on safe water handling, hygiene and cholera prevention and Post Distribution Monitoring.



3) Protection, Gender and Inclusion

In collaboration with the Ministry of Health's Health/WASH coordinators, the Burundi Red Cross will organize PGI briefings for all personnel involved in the operation, and for key volunteers in each target area. These sessions will cover core "do no harm" principles, emphasize the importance of taking into account the specific needs of women and girls, older people, persons with disabilities and displaced people, and address the prevention of sexual exploitation and abuse (PSEA). The aim is to ensure that everyone engaged in the response understands how to deliver assistance in a safe, inclusive and dignified manner.

For the implementation of specific activities on dignity and menstrual hygiene, the BRC will work in coordination with maternal health services and local structures (health centers and specialized NGOs) to identify the most vulnerable women and adolescent girls within the 3,000 targeted households. These beneficiaries will receive dignity kits (including sanitary pads, underwear, soap and a bucket), together with simple counselling on menstrual hygiene management, delivered in a way that fully respects their privacy and dignity.

PGI will also be integrated transversally across all field activities. During household visits, distributions and WASH/health interventions, volunteers will pay particular attention to ensuring that services are physically and socially accessible and safe for everyone, for example by considering paths, timing, queues and the specific needs of people with reduced mobility. Any protection incident or risk identified in the community will be reported promptly to the designated MoH/BRC focal points, so that appropriate follow-up and support can be organized.

4) CEA

Community engagement and accountability (CEA) activities will be implemented through a combination of communication channels and feedback mechanisms, in close coordination with local health and administrative authorities. The Burundi Red Cross will support the dissemination of information via radio programmes in local languages, the use of loudspeakers and megaphones during targeted campaigns, and the organization of community meetings and focus group discussions with community leaders, women, youth and other key groups. These approaches will help ensure that accurate, consistent messages on cholera prevention, safe water, hygiene and access to care reach a wide audience and are discussed openly within communities. In the areas affected, Kirundi is the main language with other local languages that will need to be prioritized for the IEC supports and mass communication, while volunteers selected at local level will be able to deliver the message in local language if required during the door-to-door visits, community meetings.

The National Society will also reinforce the CRB hotline (109) as a key two-way communication tool. This will involve training call operators, aligning call scripts with Ministry of Health guidance, and strengthening referral mechanisms. Through this hotline, the population will be able to obtain answers to their questions, report suspected cholera cases or problems in accessing water and health services, and share concerns that will be relayed to the Ministry of Health and the relevant coordination bodies for follow-up.

At the beginning and throughout the operation, the Burundi Red Cross will conduct perception surveys to assess how well communities understand cholera-related risks and to gauge the level of trust in the actors and services involved in the response. The findings from these surveys will be used to adjust messages, channels and approaches as needed, so that CEA activities remain responsive to community feedback and effectively support behavior change and uptake of services.

5) Coordination

Coordination with the government will be continuous and iterative throughout the operation. The overall strategy will be jointly developed and regularly adjusted during national coordination meetings (COUSP, national cholera task force) and during district and health-zone meetings led by the Medical Officers of Health (MCZs). Activity plans, including detailed micro-plans by hill and catchment area, will be validated jointly by the Ministry of Health and the Burundi Red Cross. This joint planning process is intended to avoid duplication, fill existing gaps and ensure that the highest-risk areas are systematically prioritized in the response.

Volunteers involved in the activities will be briefed on various areas of intervention to ensure they are better prepared and equipped. There will be rotations to prevent fatigue and ensure proper coordination of activities. Furthermore, they will receive allowances and travel expenses based on the distances they will travel to reach the different activity locations.

The activities to be conducted in Bujumbura will help raise community awareness about cholera prevention. The distributed WASH kits will facilitate proper water storage. Advocacy will be undertaken with the government to ensure that the installed reservoirs are connected to the REGIDESO water network.

Natural Sciences (NS) is also collaborating with the Ministry of Health (MOH) to carry out these activities, and trained volunteers will continue to implement prevention and response activities within the community.

Targeting Strategy

Who will be targeted through this operation?

Under this DREF, NS will aim to reach at least 18,035 households, approximately 108,212 people. Some activities, such as water trucking and awareness campaigns, may reach a larger number of people as they will target the entire



community in the affected areas. By contrast, household decontamination will first be prioritized for homes where cholera cases have been reported and will then be progressively extended to cover all 19 affected hills and all HH in the affected quarters of Bujumbura (Health Districts Mukaza, Kamenge, and Mutimbuzi). For distributions, the most vulnerable households will be identified and selected based on agreed vulnerability criteria and in coordination with local authorities and health services.

Explain the selection criteria for the targeted population

The primary geographic focus of the operation is the 19 hills along the shores of Lake Tanganyika in the Nyanza-Lac Health District and the affected health Districts in Bujumbura (Mukaza, Kamenge, and Mutimbuzi), which currently concentrate a large share of the reported cholera cases and where dependence on contaminated lake water and poor WASH conditions create a particularly high risk of transmission. These areas have therefore been prioritized as the initial target area. However, as the epidemic is dynamic, other neighboring hills or health areas may be added to the intervention if surveillance data show a spread of cases beyond the currently affected locations. Where resources allow, additional high-risk sites outside the Nyanza-Lac Health District will also be supported, in agreement with the Ministry of Health.

Within these geographical areas, the operation will focus on vulnerable households who are least able to protect themselves from cholera and to cope with its impacts. Distributions of WASH kits, hygiene kits and dignity kits will therefore not be blanket, but will target households selected according to agreed vulnerability criteria developed with local authorities and health services.

These criteria include:

- Households headed by elderly persons who may have difficulties collecting water, accessing latrines or reaching health facilities;
- Widows/widowers and single-headed households with limited income and support;
- Households caring for orphans or unaccompanied children;
- Households where a child or adolescent is the head of household, often with very limited resources and exposure to protection risks;
- Other socially and economically marginalized families identified by community leaders and health workers.

By prioritizing these categories, the operation aims to ensure that limited resources reach those most at risk of infection and least able to adopt protective behaviors (e.g. buying soap, fetching water from safer sources, paying for transport to CTCs). This targeting logic is intended to reduce inequities, strengthen the protection of particularly exposed groups, and maximize the humanitarian impact of the response in the context of a rapidly evolving outbreak.

Total Targeted Population

Women	48,172	Rural	64%
Girls (under 18)	10,796	Urban	36%
Men	38,347	People with disabilities (estimated)	2.7%
Boys (under 18)	10,807		
Total targeted population	108,122		

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?	No
Does your National Society have anti-sexual harassment policy?	Yes
<p>Please indicate any security and safety concerns for this operation:</p> <p>The operation will be implemented in a border area with the DRC, where frequent population movements and a concentration of vulnerable communities can create specific security and safety risks for staff, volunteers and beneficiaries.</p> <p>From a security perspective, some parts of the intervention zone are exposed to:</p> <ul style="list-style-type: none"> - Cross-border tensions and informal movements, which can generate mistrust or tension between groups; - Heightened petty crime and theft, particularly around busy water points, markets and distribution sites; - Possible localized unrest linked to perceptions of unequal assistance or rumors around cholera and its treatment. <p>There are also important safety and health risks including the volunteers and staff may have to travel on poor-quality roads or paths, especially in the rainy season, which increases the risk of accidents. They are also exposed to health hazards such as cholera infection itself and other water-borne or vector-borne diseases.</p> <p>To address these risks, security measures will be reinforced throughout the operation. All personnel and volunteers will receive briefings on the context and security environment in the border area; basic personal security rules (movement in teams, avoiding high-risk areas, safe behavior at night); infection prevention and control (IPC), including the correct use of PPE, hand hygiene and safe decontamination practices.</p> <p>The National Society will apply IFRC and national security protocols, including:</p> <ul style="list-style-type: none"> • Ensuring that movement plans are validated by the district health authorities and local administration; • Maintaining regular communication and check-in systems for teams in the field; • Providing appropriate visibility items (bibs, badges) so volunteers are clearly identified as humanitarian actors. • Given the sensitive context, the National Society will also reinforce social cohesion and peaceful coexistence activities within communities, in close collaboration with local leaders and authorities. • Particular attention will be paid to transparent communication on targeting and selection criteria for assistance (e.g. for WASH and dignity kits), so that communities understand who is being assisted and why. <p>This will help to reduce tensions, prevent potential conflicts linked to perceived favoritism or exclusion, and protect both beneficiaries and volunteers from backlash.</p>	
Has the child safeguarding risk analysis assessment been completed?	Yes

Planned Intervention



Budget: CHF 69,012
Targeted Persons: 108,210
Targeted Male: 49,240
Targeted Female: 58,959

Indicators

Title	Target	Actual
# of people reached by Community Based Surveillance activities	50,000	15,462



(include trained volunteers and contact tracing)		
# of people reached by RCCE activities through trained volunteers	108,210	24,340
# of households in the 19 lakeshore hills that received ORS at community level	500	500
# of volunteers trained-briefed on EPiC	100	50
% of alerts investigated within 24 hours	80	0
% of suspected cases referred within 24 hours	100	0
% of volunteers reporting into CBS system	100	0

Progress Towards Outcome

Progress

- Training of 50 volunteers on Community Based Surveillance (CBS). The trainers were from the Red Cross BRC) and the Ministry of Public Health, specifically from the Bujumbura Regional Health Coordination Unit (COUSP) and the Nyanza Health District.
- Deployment of these volunteers for awareness campaigns. In total, 15,462 people have already been reached by CREC health-related activities while 24,340 people have been reached by RCCE activities through trained volunteers.
- Training of volunteers on oral rehydration therapy (ORT), and 500 kits were purchased and distributed to 500 households. Thanks to CREC actions and community surveillance, the epidemic was quickly brought under control in the Nyanza Lac Health District.
- In Bujumbura, decontamination of premises began immediately upon the appearance of cholera cases.

For the extension areas, the following activities will be implemented:

- Briefing of Bujumbura volunteers on EPiC (20 volunteers from Bwiza, 20 from Buyenzi, 20 from Kamenge);
- Briefing of volunteers on SBC, focusing on cholera.
- Purchase of community rehydration kits for Bujumbura.
- Deployment of SBC volunteers in Bujumbura.



Water, Sanitation And Hygiene

Budget: CHF 229,581

Targeted Persons: 36,071

Targeted Male: 17,555

Targeted Female: 18,515

Indicators

Title	Target	Actual
# of HH decontaminated	9,000	2,972
# of HH reached by WASH Kits	2,000	1,500
# of bladders installed	5	5
# of sessions of PHASTER training	2	2

% of surveyed people satisfied with WASH distribution	90	0
# of plastic tanks installed	5	0

Progress Towards Outcome

Progress

Disinfection of 1,500 households with one or more cholera cases

Purchase of 5 Bladders

Installation of Bladders

Water Trucking

Construction of 5 latrine blocks

Construction of 2 shower blocks

Installation and commissioning of the LMS Kit

Purchase of 5 drums of granular chlorine

Purchase of 500 WASH Kits

Purchase of 200 sprayers

Purchase of 100 handwashing stations for schools and public facilities

Purchase of 150 cartons of soap for schools and public facilities

Purchase and distribution of 1,500 WASH Kits to households

Training of volunteers on the CHASTER in emergency situations

Activities extended

Purchase of 3000-liter plastic tanks

Extending Water access: Installation of plastic tanks in areas without access to drinking water; filling of plastic tanks. Truck movement to receive fuel needs, truck maintenance, driver and volunteer allowances.

Purchase of Aquatabs tablets

Distribution of Aquatabs tablets

Purchase and distribution of WASH kits

Chlorination



Protection, Gender And Inclusion

Budget: CHF 54,922

Targeted Persons: 108,210

Targeted Male: 49,240

Targeted Female: 58,960

Indicators

Title	Target	Actual
% of the deployed staff and volunteers briefed on PGI	100	100
# of people reached by PGI activities	36,071	15,500
# of people reached by hygiene kit	1,350	1,350
# of safe, accessible and culturally appropriate reporting mechanisms put in place	2	2



Progress Towards Outcome

Progress

Training of staff and volunteers from all sectors on IGP (PSEA, child protection, GBV, IGP survivor-centered approach, and case referral).
Increased use of GBV/PEAS awareness-raising tools integrating PSS aspects (posters, picture boxes).
Setting up and equipping a listening center.
Promoting the Red Cross hotline.
Implementation of IGP/PEAS mechanisms.
Community awareness-raising through theatrical performances.
Purchase of 1,350 hygiene/dignity kits.
Briefing of volunteers on PEAS aspects and DAPS principles.
Community awareness-raising on GBV cases.

For this extension request, the following activities are planned:

- Briefing of volunteers on PEAS aspects and DAPS principles
- Community awareness-raising on cases of gender-based violence



Community Engagement And Accountability

Budget: CHF 46,158

Targeted Persons: 108,210

Targeted Male: 49,240

Targeted Female: 58,960

Indicators

Title	Target	Actual
# of radio broadcasted	8	8
# of community feedback received	100	75
% of community received and responded to	80	80
# of students reached through school sensitization activities	5,000	0

Progress Towards Outcome

Progress

Purchase of IEC materials, including 60 megaphones and 1,110 cholera posters;
A PDM survey is underway in Nyanza District.

A community trust index survey is underway nationwide. Thirty-seven volunteers identified across the country have been trained to collect data from at least 1,510 households in 13 communes.

Community awareness campaigns on cholera are being conducted through mass awareness sessions, door-to-door canvassing, radio broadcasts, etc.

Extension priorities

- Extension will scale up the dissemination of key messages about cholera through radio (radio shows).
- The feedback management will continue to feed and inform decision making.
- Collection of Success Stories.
- Monitor Community Trust Index.



Secretariat Services

Budget: CHF 24,515



Targeted Persons: 503
Targeted Male: 275
Targeted Female: 228

Indicators

Title	Target	Actual
# of joint field missions	1	1
# of Kick-off meetings	1	1
# of volunteers insured	500	500

Progress Towards Outcome

Meetings have been organized and a lesson learned is organized and field missions have been organized jointly with the IFRC.

Priorities for the extension

- Monitoring and string oversight will continue from Secretariat.
- Delegation ensures regular missions and technical calls to oversee the quality of the intervention.
- Ensure reporting spot checks are conducted.



National Society Strengthening

Budget: CHF 75,810
Targeted Persons: 500
Targeted Male: 275
Targeted Female: 225

Indicators

Title	Target	Actual
# of field mission	3	3
# of coordination meetings	3	3
# of lesson Learned organized	1	0
# of national surge deployed	1	0

Progress Towards Outcome

Staffs were deployed on the field.

Preparatory meeting was organized.

Lesson learned workshop is going to be conducted at the closure of the intervention.

Priorities in this extension is to maintain strong coordination, monitoring and reporting: -

- Logistical support for transporting items and handling/storage for the spot check on procurement and proper documentation consolidation.
- HR mobilized for the DREF are providing support and ensure regular check on the progress at various technical, operational and



financial level: DM, PMER, Logistics, 2 WASH Engineers, 3 Drivers, Finance.

- Monitoring missions.
- Monthly progress reports and final report consolidation is overseen and delivered within KPI.
- Coordination with stakeholders integrated at district and provincial level.

About Support Services

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

The following people will be mobilized: The DM Director, Program Director, Health Coordinator, PMER, CEA, Logistics, National Surge, Field Colleagues (Provincial Coordinator, Branch Coordinator, Provincial Accountants, Drivers, and 500 Volunteers).

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 National Society (NS) has the tools and data collection methods to disaggregate data by sex, age, and disability. The PMER (Project Management and Emergency Response Team) will update these tools and deploy them in the field so that the operation can have up-to-date and disaggregated data.

Will surge personnel be deployed? Please provide the role profile needed.

BRC will recruit a national Surge for this operation to ensure the effective management of this operation's response

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

Purchases will be made by the National Society through its procurement department, using the NS's procurement manual. However, the fuel will be purchased by the International Federation of Red Crescent Societies (IFRC) to circumvent shortage problems in the country.

How will this operation be monitored?

The team will conduct a field mission to monitor the implementation. A database will be set up for this operation, and with the data flow, the NS will be able to regularly monitor achievements. As the NS will continue monitoring the event, the field report will be regularly updated. The NS will develop and submit operations updates and a final report. The IFRC team will also join the monitoring field missions. At the end of the operation, the NS will conduct a lessons learned workshop capture the challenges and the lessons learned.

Please briefly explain the National Societies communication strategy for this operation

The NS has a communication team that will regularly develop and share SitReps of the operation as well as the events updates.



Budget Overview



DREF OPERATION

MDRBI024 - Burundi Red Cross Cholera Outbreak 2025

Operating Budget

Planned Operations	399 673
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	69 012
Water, Sanitation & Hygiene	229 581
Protection, Gender and Inclusion	54 922
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	46 158
Environmental Sustainability	0
Enabling Approaches	100 326
Coordination and Partnerships	0
Secretariat Services	24 515
National Society Strengthening	75 810
TOTAL BUDGET	499 999

all amounts in Swiss Francs (CHF)

Internal

21/04/2026

#V2022.01

[Click here to download the budget file](#)



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