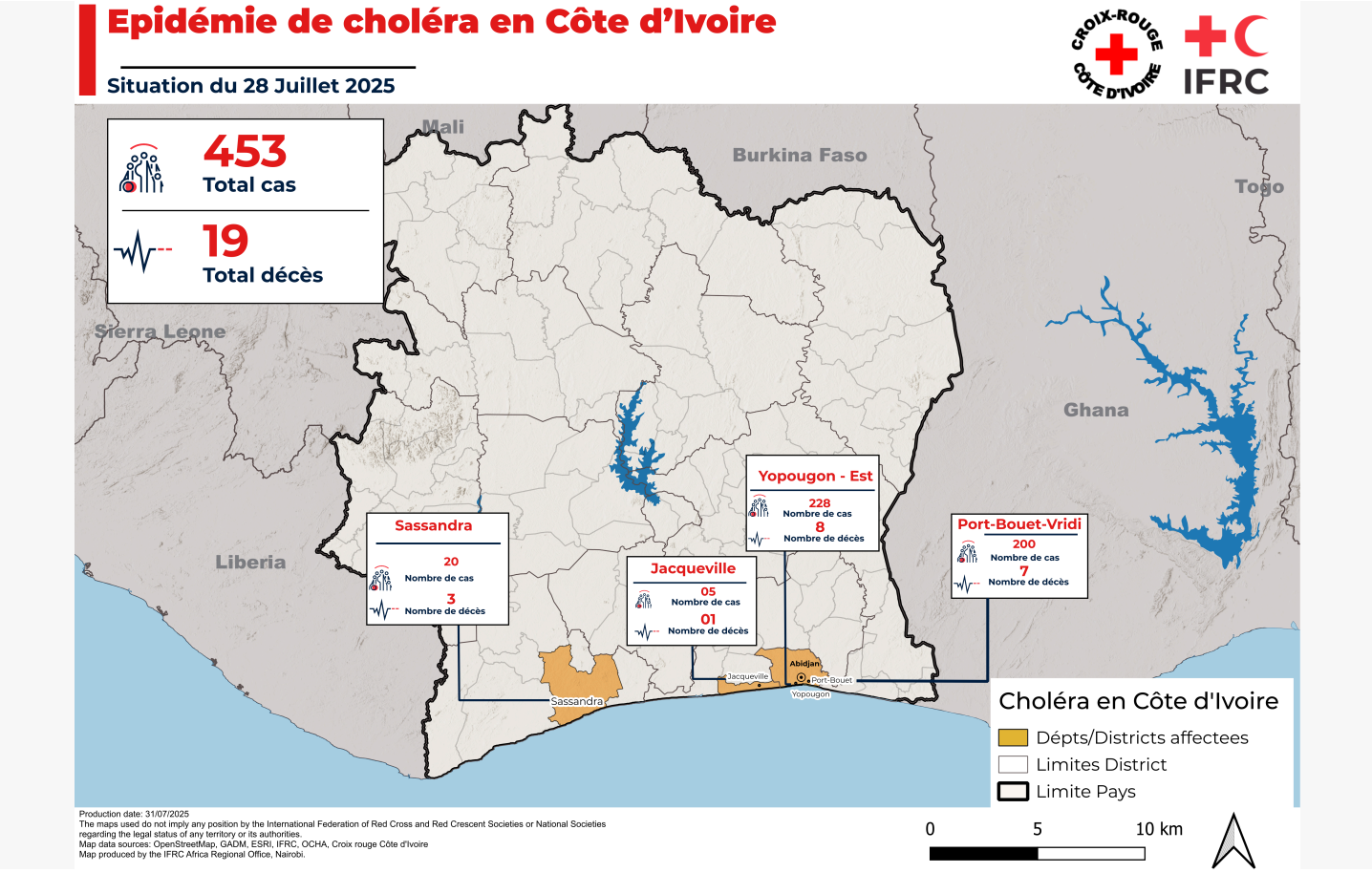
DREF Operational Update

Ivory Coast_Cholera

Sensibilisation of volunteers in Port-Bouet

Appeal: **MDRCI018**	Total DREF Allocation: **CHF 489,424**	Crisis Category: **Yellow**	Hazard: **Epidemic**
Glide Number: **-**	People at Risk: **1,131,706 people**	People Targeted: **169,755 people**	
Event Onset: **Slow**	Operation Start Date: **16-06-2025**	New Operational End Date: **31-12-2025**	Total Operating Timeframe: **6 months**
Reporting Timeframe Start Date: **16-06-2025**		Reporting Timeframe End Date: **02-08-2025**	
Additional Allocation Requested: **329,509**		Targeted Regions: **District Autonome D'Abidjan, Gbokle, Grands Ponts, San Pedro, Sud-Comoe**	

Description of the Event



Date when the trigger was met

01-08-2025

What happened, where and when?

On May 25, 2025, health authorities confirmed a cholera outbreak in the village of Ako Brakré, located in the Port-Bouët/Vridi health district in Abidjan, Côte d'Ivoire. This area, home to approximately 19,800 residents—mainly fishing families and migrants—has historically been vulnerable to cholera due to poor sanitation, limited access to safe drinking water, and frequent flooding.

The outbreak quickly spread beyond its initial epicenter. Cases have now been reported in five other health districts: Yopougon Est, Yopougon Ouest, Koumassi, Jacqueville, and Sassandra. The epidemic affects both urban and peri-urban coastal areas, as well as a concerning hotspot in a detention center in Abidjan, where overcrowding and poor sanitation increase the risk of transmission. The outbreak has been ongoing for nine weeks, with two observed peaks and newly confirmed transmission hotspots in Yopougon East and Sassandra. The presence of Vibrio cholerae O1 has been confirmed in stool samples.

During a coordination meeting organized by the Ministry of Health on August 1, the National Institute of Public Hygiene (INHP) presented alarming data, indicating a significant worsening of the situation:

- Total number of cases: 453, including 19 deaths
- Port-Bouët/Vridi District: 200 reported cases (including 17 residing in Yopougon East), 7 deaths, case fatality rate: 3.5%
- Yopougon Est: 228 cases (presumptive positive alerts), 8 deaths, case fatality rate: 3.5%
- Sassandra: 20 cases, 3 deaths, case fatality rate: 15%
- Jacqueville: 5 cases, 1 death, case fatality rate: 20%

Many cases are severe, including in Port-Bouët, where of the 200 recorded cases, 109 are considered severe and 169 have been hospitalized.

Cases are widely dispersed across 20 localities in the Port-Bouët district.

Several nationalities are affected: Beninese (2), Burkinabe (110), Ghanaian (117), Ivorian (50), Liberian (1), Malian (8), Nigerien (5), Togolese (4).

The most affected populations are mainly Ghanaian nationals in Ako Brakré and Yopougon East. The most vulnerable groups include fishermen, traders, students, and unemployed youth. Community concerns, lack of awareness of cholera-related hygiene practices, and misinformation continue to hamper the effectiveness of the response.

The August 1 coordination meeting marks a turning point in managing this outbreak. The newly shared data calls for an urgent scale-up of response activities. In this context, the Red Cross of Côte d'Ivoire, with the support of the International Federation, will initiate a request for an additional DREF fund allocation to:

- Strengthen epidemiological surveillance;
- Scale up case management;
- Expand risk communication and community engagement activities;
- Support interventions in high-risk settings, especially closed environments.

This operational scale-up is essential to contain the spread of cholera, protect the most exposed populations, and prevent the emergence of new hotspots in surrounding areas. The situation remains evolving and requires immediate and reinforced mobilization.

Disinfection of boats

Sensibilisation

Hygiene promotion

Supervision and monitoring

Scope and Scale

The cholera outbreak is severely impacting the health and livelihoods of communities across Abidjan and the surrounding coastal districts. With 453 reported cases, including numerous severe infections requiring hospitalization, the epidemic is placing significant strain on local health services and highlighting critical gaps in water, sanitation, and hygiene infrastructure.

The most vulnerable populations are those living in overcrowded and underserved areas, particularly fishing communities, informal traders, students, and unemployed youth. A large proportion of affected individuals are Ghanaian nationals residing in Ako Brakré and Yopougon Est. Factors such as limited access to clean water, poor sanitation, and crowded living conditions increase their susceptibility to infection.

Additional high-risk groups include detainees in the overcrowded detention center of Abidjan where inadequate sanitation heightens transmission risks. Historically, these populations have borne the brunt of cholera outbreaks due to structural inequalities and limited healthcare access.

Community concerns, misinformation, and insufficient awareness of preventive hygiene practices continue to hinder effective response efforts. The situation remains dynamic and demands urgent scaling up of surveillance, case management, and risk communication to contain the outbreak and protect those most at risk.

Summary of Changes

Are you changing the timeframe of the operation	**Yes**
Are you changing the operational strategy	**Yes**
Are you changing the target population of the operation	**Yes**
Are you changing the geographical location	**Yes**
Are you making changes to the budget	**Yes**
Are you requesting an additional allocation?	**Yes**

Please explain the summary of changes and justification:

This update to the DREF reflects the rapid spread of the cholera epidemic and the need to extend the response beyond Greater Abidjan to other health districts, including Sassandra, Tabou, San Pedro, Grand Lahou, Assinie, Adiaké, Aboisso, and Jacqueville. This scaling up is motivated by the confirmation of new cases, the emergence of new epidemic foci, and a growing risk in densely populated and coastal areas. As of 1 August, 453 cases have been confirmed by the authorities and 19 deaths. However, during the implementation of the first phase of the response, community feedback suggests that the number of cases is underestimated due to a lack of information about the disease and limited access to health centres. At the coordination meeting with health authorities on 1 August, it was announced that a new health district would be affected and that there were risks associated with the resumption of the fishing season after a month-long hiatus. This two-month extension, until 31 December 2025, with an increase in the budget to CHF 329,509, is due to the evolution of the epidemiological situation in the country (several health districts are experiencing an epidemic). This new extension will enable the implementation of a response strategy based on anticipation and mobility in line with the evolution of the epidemiological situation in the various areas of intervention. The response will be coordinated and complementary to the actions of the authorities and other partners in the field, who are calling for the continuity and increase of the CRCI's response.

The next phase of the operation will involve strengthening the Branch Outbreak Response Team (BORT) strategy in order to be mobile and reach remote or vulnerable communities and provide assistance in managing the epidemic. 250 volunteers (including 125 who have already been trained and mobilised) will be trained and made available quickly to implement this approach. In this context, community surveillance (SBC) will be activated in certain areas, enabling community volunteers to report early warnings and support epidemic control efforts. The approach will remain mobile and adaptable, targeting areas that are difficult to access or experiencing rapid transmission.

The response will be based on a coordinated multisectoral approach led by WASH (water, sanitation and hygiene), public health, and community engagement and accountability (CEA) teams:
- The health component will focus on BORT and SBC (community-based surveillance) approaches in emergency situations, including awareness-raising, first aid through the distribution of ORS (oral rehydration salts) and referral to health facilities.
- The WASH component contributes to both BORT and SBC approaches, as well as the distribution of hygiene kits, household disinfection, the promotion of hygiene adapted to local contexts and the installation of latrines,
- The CEA approach will emphasise proactive community engagement, including awareness-raising during the implementation of CBS, coordination with local leaders, monitoring and responding to rumours, and collecting and analysing community feedback to adapt the response.
- Communication activities combine mass media and interpersonal interaction through community radio, home visits, and the use of tools adapted to the local context.
In line with the evolution of the epidemic and the national cholera control strategy, the operation will remain flexible and ready to activate the ORT (oral rehydration therapu) module in areas with high transmission, if necessary. These adjustments aim to ensure a rapid, community-centred, risk-based response across all newly affected areas.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC delegation based in Niamey (Burkina Faso, Mali, Niger, and Côte d'Ivoire) provides close support to the Red Cross of Côte d'Ivoire through various technical staff

	members, including a program manager, a health coordinator, a PMER specialist, an NSD specialist, and financial specialists. The IFRC also has an office in Côte d'Ivoire, currently hosting a Finance Coordinator and a Finance Officer. An NSD Delegate is being recruited. To support this response, the IFRC has deployed three Surge staff, including 1 Ops Manager, 1 Public Health in Emergencies Officer, and 1 CEA Officer to assist the CRCI in implementation. The Cluster Logistics Officer also conducted a support mission in Côte d'Ivoire and assisted the CRCI logistics team in various procurement processes. With the expansion of the response, IFRC (Surge) support will be extended.
Participating National Societies	The Netherlands Red Cross (NLRC) provides technical and financial support to the CRCI, with a focus on preparedness as part of the RP3 (Response Preparedness) project, which will run until July 2025 and be transferred to the IFRC in August 2025. This project strengthens the CRCI's response capacity by focusing on auxiliary roles, logistics, financial preparedness, emergency health and emergency response teams. Thanks to this project, a Crisis Modifier fund has been made available to enable a rapid response to crises and disasters. Following the cholera alert, the CRCI was able to implement the initial response thanks to this fund of €49,999. The main activities carried out for 50 volunteers on the BORT approach included awareness-raising activities over two months and the purchase of WASH kits. The Dutch Red Cross continues to support the CRCI and the IFRC in the implementation of this DREF through technical support. The Monaco Red Cross (MRC) supports the CRCI, in particular through the implementation of a WASH and protection project in the Daloa region. For this response, the MRC is providing financial support to the CRCI for volunteer training activities and the purchase of equipment (kits, handwashing facilities and protective equipment). The MRC has a country representative available to support the response, particularly the WASH component.

ICRC Actions Related To The Current Event

The ICRC supports the CRCI through its regional delegation based in Abidjan, which covers Côte d'Ivoire, Guinea, Ghana, Togo and Benin. This support is mainly focused on operations to assist displaced populations and host communities in the northern regions of the country. In addition, the ICRC contributes to strengthening branches, improving communication capacities and supporting security management in emergency situations.

For this response, the ICRC is supporting the CRCI by providing WASH supplies to carry out activities in the Abidjan prison complex, as well as joint training for staff and inmates on disinfection and awareness-raising activities, and supervision of disinfection and awareness-raising sessions for trained inmates. Strengthened coordination and cooperation with Movement partners has been put in place for the response.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	Since the beginning of the response, the Ministry of Health has played a central role in the fight against cholera. It is responsible for investigating cases, laboratory confirmation, case management and official notification of cases at the national and international levels. The Ministry leads the overall coordination of the health response and ensures compliance with national protocols and international standards. Currently, a government response plan is being developed with the overall objective of containing the cholera epidemic. Priority actions include coordinating response interventions at the district and central levels; epidemiological surveillance and investigations; drinking water supply; sanitation and environmental hygiene measures;

	case management; community outreach and engagement. However, this plan has financial gaps and requires support from partners, particularly the CRCI. The CRCI is part of this national response, working closely with the Ministry of Health at the operational and strategic levels. It has actively participated in the development of the national response plan and the updating of prevention and awareness messages to be disseminated in high-risk communities. The CRCI's support has been officially requested by the health authorities, and the National Society is systematically called upon to support several components of the national response in all affected areas, including active case finding, awareness-raising activities and disinfection operations – which fully justifies this operational update of the DREF.
UN or other actors	WHO, UNICEF and MSF are actively involved in the fight against cholera alongside the health authorities and the CRCI. These organisations are supporting the main aspects of the response, including surveillance, treatment, risk communication and WASH interventions. MSF supports patient care through donations of equipment and supplies to health districts, training volunteers, constructing, equipping and disinfecting tents for hospitalising patients (currently for three cholera treatment centres in affected areas), and has reinforced medical teams to care for patients. This disinfection activity in the prison system has been transferred to the CRCI. From the outset of the epidemic, UNICEF has donated supplies to health authorities and conducted community awareness activities through U-Reports. UNICEF has also donated 10,000 Aqua tabs to the CRCI. It is now working on the ground through an NGO that mainly carries out community awareness activities in the village of Ako Braké (Port Bouet Vridi). CRCI is coordinating with this NGO for community awareness activities.

Are there major coordination mechanism in place?

Coordination meetings are regularly held with COUSP, INHP, health districts, WHO, MSF, and other operational partners in the field. This joint effort aims to avoid duplication, strengthen the effectiveness of the response, and maximise the impact on the most vulnerable communities.

Since the beginning of the epidemic, the Ministry of Health has systematically sought the support of the CRCI, particularly for rapid needs assessments in Ako Braké and Vridi 3 (Zimbabwe neighbourhood), as well as for all response activities: community awareness-raising, early case detection and referral to health facilities, WASH activities, and support for the coordination of the Ministry's interventions.

In addition, the CEA team has set up an external coordination mechanism dedicated to managing community feedback. Collaborative meetings are held regularly with the CRCI, Movement partners, external partners (including UNICEF, health districts, and INHP), and the Ministry of Health. These meetings enable collective processing of feedback, harmonisation of messages, and coordination of responses to community concerns.

Needs (Gaps) Identified

Health

As of 30 July 2025, according to data from the National Institute of Public Health (INHP), 453 cases of cholera have been recorded, including 19 deaths, spread across four health districts: Port-Bouët, Yopougon Est, Koumassi, Yopougon Ouest in Abidjan, Jacqueville and Sassandra health districts. While there has been a decrease in cases in the initial epicentre, new areas are now affected, including certain islands that are difficult to access and prisons.
Given the epidemic dynamics, the time required to consolidate data and the observed mortality rate, the true extent of the epidemic at the community level appears to be underestimated. It is likely that cases are not being reported and that community transmission is going unnoticed in some cases. The number of deaths occurring outside healthcare facilities suggests that the disease is more widespread than official figures indicate. It is therefore urgent to continue deploying volunteers to ensure active community surveillance and collect

real-time data on the true extent and progression of the epidemic.

Fifteen years after the last epidemic, there is a significant knowledge gap within communities regarding the symptoms, modes of transmission and prevention measures for cholera. Persistent misinformation and lack of access to clear public health messages limit the adoption of good hygiene practices. It is therefore crucial to intensify awareness campaigns, distribute hygiene kits, and set up oral rehydration points in areas where access to healthcare remains limited.

Health workers also warn of major constraints: low early detection of cases, reluctance of patients to go to treatment centres (often due to fear or lack of resources), and critical shortages of essential supplies such as oral rehydration salts, intravenous fluids and disinfectants. These shortcomings seriously compromise the response capacity of health facilities.

Needs assessments and the CAP survey conducted by the Côte d'Ivoire Red Cross (CRCI) revealed an urgent need to strengthen community presence. This involves increasing the deployment of volunteers for active case finding, referring suspected cases to treatment facilities, and disinfection operations. Significant capacity-building needs have also been identified, both for health workers and volunteers, particularly in relation to cholera transmission, home risk assessment, and the dissemination of appropriate prevention messages.

In addition, the fishing season resumed on 1 August, which could lead to a significant increase in cases in several countries due to exchanges between fishermen from Ghana, Togo and Benin. According to health authorities, the 2015 epidemic intensified sharply and spread rapidly after the reopening of the fishing season, with fishermen among the groups most affected by cholera.

Finally, the long interval since the last epidemic means that capacities need to be upgraded. Targeted training must be provided to health workers and volunteers to ensure an effective and coordinated response. Strengthening these capacities is a fundamental pillar of the CRCI's response to this public health crisis.

Water, Sanitation And Hygiene

Community feedback, the CAP survey and needs assessments conducted by the Ivorian Red Cross (CRCI) have highlighted persistent difficulties in accessing drinking water and basic hygiene products.

In several affected areas, a large proportion of households do not have latrines or use poorly maintained latrines. Access to handwashing facilities with soap and water near latrines remains very limited. Certain behaviours increase health risks, including open defecation, placing utensils directly on the ground, lack of cleaning products in households, and washing soiled laundry near water sources. In addition, many unsealed latrines are located in close proximity to water sources, posing a high risk of environmental contamination. Most available water sources are unsafe, often located near the sea or lagoons, and highly exposed to pollution.

The rainy season exacerbates these vulnerabilities by promoting water stagnation, which is conducive to the spread of cholera. The lack of effective drainage systems and poor waste management further aggravate the situation. Contamination could quickly spread to other urban areas if control measures are not strengthened. Although unprotected surface water is rarely used, safe wells and boreholes remain underused. Certain everyday practices facilitate transmission, such as direct contact of hands or containers with pumps, or the sharing of containers between several households.

The sale of beverages prepared with untreated water is common, while basic hygiene measures are rarely applied by vendors, posing a significant risk to public health. Concerns have also been raised about the accumulation of rubbish and the persistent practice of open defecation.

Finally, frequent exchanges—whether commercial, professional, or related to fishing activities—between rural and urban areas significantly increase the risk of cholera transmission.

Protection, Gender And Inclusion

Community feedback gathered during the first weeks of the response in Côte d'Ivoire highlighted significant challenges in terms of social cohesion, perceptions of fairness and inclusion in efforts to combat the epidemic. In some areas, misunderstandings or misinterpretations emerged regarding the origin of the disease and how aid was distributed. These perceptions can affect community trust, limit collaboration with response teams, and complicate early case detection.

It is therefore essential to continue promoting transparent, inclusive and locally contextualised communication, relying on trusted community actors and accessible channels. Community dialogue must be strengthened in order to better explain the roles of the various

actors, the targeting criteria and the public health objectives pursued.

Furthermore, discussions with certain groups, particularly women, highlighted the need to better involve end users in the design and location of WASH infrastructure. A lack of consultation can result in low acceptance of facilities or limit their optimal use.

In light of these findings, the following priorities have been identified:

- Strengthen the dissemination of clear, appropriate public health messages that promote values of equity and solidarity.
- Ensure active participation by different segments of the community, particularly women, in decisions regarding the location and use of sanitation facilities.
- Consolidate community listening mechanisms to enable regular feedback on perceptions, concerns and suggestions, thereby allowing for continuous adjustment of interventions.

Adopting an inclusive approach based on participation and listening will help build trust, improve the effectiveness of the response, and root actions in the reality of the communities concerned.

Community Engagement And Accountability

Initial feedback from communities in Ako Brakré and surrounding areas highlighted significant needs in terms of information, communication and community participation. Several people expressed the need to better understand the role of the various actors involved in the response, as well as a desire to be more involved in decisions that affect them, particularly with regard to access to services and prevention activities.

Communities also emphasised the importance of a visible response tailored to local conditions, particularly in areas where health and environmental conditions are poor. Clear, understandable and locally adapted messages are needed to build trust, correct misperceptions and encourage preventive behaviour.

In some areas, the mechanisms enabling people to ask questions, raise concerns or give their opinions are not sufficiently well known or accessible. There is a clear need to strengthen two-way communication, promote trusted community channels (such as local radio stations, community or religious leaders) and make feedback mechanisms more visible.

The main needs identified in terms of community engagement and accountability include:

- Clarify the role of Red Cross volunteers and partners involved in the response.
- Improve access to information on selection criteria and decision-making processes related to services (distribution, sanitation, awareness-raising, etc.);
- Strengthen localised communication through culturally appropriate messages, disseminated via reliable and accessible channels.
- Promote community dialogue and feedback mechanisms, including through the green line and community committees.
- Monitor and address perceptions, concerns and rumours to better guide the response and promote adherence to preventive measures.
- Support social cohesion by promoting inclusive messages and ensuring equitable access to services for all affected persons, including mobile or marginalised populations.

These priorities will help build community trust, promote meaningful participation, and ensure that the response to the epidemic is perceived as fair, appropriate, and rooted in community realities.

Environment Sustainability

The response to the cholera epidemic in vulnerable neighbourhoods such as Vridi highlights critical environmental needs. The widespread use of single-use plastic materials, the lack of adequate waste management systems for distributed items (packaging, disinfectant residues, etc.), and the risks of soil and groundwater contamination from improperly dosed chemicals raise significant environmental concerns.

The main environmental needs identified are as follows:

- The use of sustainable or biodegradable WASH materials to limit the environmental impact of the response.
- The implementation of safe and responsible management of waste related to distributed items, in particular plastic packaging and disinfectant residues.
- The use of approved, environmentally friendly disinfectants, applied in appropriate doses to prevent environmental contamination.

Any identified gaps/limitations in the assessment

The assessment highlights several gaps and limitations, including unmet needs in sectors such as shelter and mental health, particularly for displaced households and communities in unsanitary conditions. There are shortages of hygiene supplies, trained personnel, and funding, which constrain the scale and speed of the response. Operational challenges, such as difficult access to Ako Brakré due to its lagoon geography and seasonal flooding, further delay interventions. Coordination at the local level remains uneven, with gaps in planning and information sharing among actors. Additionally, the specific needs of vulnerable groups such as the elderly, persons with disabilities, and single-parent households may not have been fully captured during the initial assessment.

Operational Strategy

Overall objective of the operation

Limiting the spread of cholera in Abidjan and other high-risk areas in Côte d'Ivoire through the strengthening of the response using the BORT (Branch Outbreak Response Team) approach. The intervention will aim to anticipate the evolution of the epidemic and adapt actions based on the mobility of cases.

The number of mobilized volunteers will increase from 125 to 250 to ensure broader and more responsive coverage. These volunteers will be engaged in activities such as household-level data collection and needs assessment, identification and referral of suspected cases, initial emergency response, and household water treatment.

The response will be centered on an anticipatory, flexible, and community-based approach, aimed at curbing transmission in existing hotspots while preventing the emergence of new cases.

Operation strategy rationale

Achievements to date:

As part of the response to the cholera outbreak, the CRCI, with support from the DREF, implemented a series of activities. A total of 125 volunteers were trained in the BORT approach, which included modules on WASH, as well as CEA. These volunteers carried out awareness activities on the signs of cholera, prevention measures, and case referrals, reaching over 10,000 people across nearly 7,600 households, with more than 100 cases referred.

In terms of WASH, the CRCI disinfected 64 homes and 400 community sites such as schools, places of worship, and public latrines. It also installed six handwashing stations and deployed spraying and protective equipment for its volunteers. One WASH assistant and 15 volunteers were mobilized in the priority area of Vridi Ako.

Additionally, the CRCI procured 100 NFI kits that will soon be distributed and is preparing to install latrine blocks in collaboration with the beneficiary communities. At the same time, community engagement efforts were strengthened through the collection of over 1,000 community feedback responses, the organization of focus groups, targeted consultations (particularly with women), meetings with local leaders, and the dissemination of prevention messages through various channels.

To support these efforts, the IFRC deployed a multidisciplinary technical team to assist the CRCI on logistical, operational, strategic, and financial aspects. This support helped strengthen coordination, planning, budget monitoring, and operations management, with regular supervisory visits by regional officials.

So far, the response enabled rapid case detection, limited the spread of cholera in affected areas, and strengthened both the CRCI's capacities and community involvement.

New strategy:

As part of the continued response to the cholera outbreak, the extension of this DREF will enable the CRCI to scale up its actions in support of the efforts led by national health authorities. The intervention will maintain an integrated approach focused on health, WASH, as well as CEA.

The strategy being implemented is based on proven Red Cross Movement approaches, notably the mobile interventions of the BORT, CBS, ORP, and logistical support for transporting patients when necessary. These approaches will be adjusted in line with the evolving epidemiological situation and carried out in close coordination with local health authorities.

To strengthen the impact of the response, 125 new volunteers will be recruited and trained, in addition to the 125 already mobilized, bringing the total to 250 volunteers. Supervised by experienced coordinators, they will operate in affected areas to raise household awareness on prevention measures, distribute aqua tabs, disinfect contaminated locations, administer ORS in cases of moderate dehydration, and refer severe cases to health facilities. In areas not yet affected but considered at risk, volunteers will conduct community-based surveillance, report suspected cases using the KoBo tool and carry out prevention activities.

Oral rehydration points will be set up in hard-to-reach neighborhoods or isolated zones, including islands. These fixed community structures will allow for a rapid response to moderate dehydration cases, facilitate referrals to treatment centers when needed, and disseminate prevention messages to the population. Their installation will be coordinated with local health districts based on identified priorities.

In parallel, WHO has secured approval for 76,000 doses of vaccine from the Global Stockpile, with delivery expected on August 12. Volunteers will be trained on vaccine safety and efficacy and will carry out community mobilization activities to encourage wide participation in the campaign.

This community-based and proximity-driven response aims to strengthen early detection of cases, break chains of transmission, and promote adoption of preventive behaviors. Volunteers will receive in-depth training on cholera prevention, response protocols, risk communication, and information reporting. Capacity-building sessions will also be organized for CRCI teams to ensure a quality, accountable, and sustainable response.

Drawing lessons from the first six weeks of response, the operational structure has been adjusted to anticipate challenges and ensure effective interventions. The plan includes strengthened logistics, increased coordination with partners, enhanced technical support from the IFRC to ensure compliance with standards, and the mobilization of additional volunteers dedicated to community health activities. Two technical officers will support implementation, monitoring, and supervision, with further support from the National Society to manage key staff.

This strengthened, mobile, and inclusive approach will allow for effective containment of the cholera outbreak and adaptation of the response to local realities throughout the intervention period.

Targeting Strategy

Who will be targeted through this operation?

- Confirmed, suspected, or probable cholera cases, as well as their direct contacts within households and communities.

- Mobile populations, including fishermen, seasonal workers, and itinerant traders.

- Food handlers such as street food vendors, small restaurant operators, and producers, who often work in precarious sanitary conditions.

- Transport workers (taxi drivers, minibus drivers, boat operators, etc.), who are highly exposed due to their mobility and frequent daily interactions.

- Vulnerable groups: pregnant women, children under five, the elderly, and individuals living with comorbidities.

- Households living in overcrowded, informal, or underserved neighborhoods, where lack of sanitation, limited access to safe drinking water, and poor waste management contribute to the spread of cholera.

- Men, who represent the majority of reported cases in several affected areas (88% in Port-Bouët, 75% in Yopougon, 55% in Ako Brakré).

- Incarcerated individuals in detention centers where cases have been reported, due to critical sanitary conditions and overcrowding.

- Students, particularly in areas with high school density, due to shared facilities and close quarters in dormitories or on campuses.

Explain the selection criteria for the targeted population

The selection of target groups is based on a risk-based approach that combines several determining factors: epidemiological surveillance, local environmental conditions, mobility patterns and community feedback.

Cases and their direct contacts are targeted to immediately limit transmission. Mobile populations, such as fishermen and transporters, are identified because of their high interregional mobility, which increases the risk of cholera spreading. Street food vendors, restaurant owners and market traders handle sensitive products in high-risk environments, which warrants special attention.

Precarious neighbourhoods, often characterised by a lack of latrines, open defecation, inadequate waste management and the use of unsafe water, are conducive to rapid community transmission. Men are targeted because they are overrepresented among reported cases, which may be explained by specific behavioural or occupational factors.

Finally, prisons and educational facilities with high population densities (such as boarding schools or campuses) present high risks of transmission in closed environments, while people who are vulnerable in terms of health (pregnant women, young children, the elderly, or people with chronic illnesses) are at increased risk of serious complications.

By closely linking risk profiles with local dynamics, this targeting strategy enables a response that is effective, equitable and tailored to the specific contexts of the affected areas.

Total Targeted Population

Women	**45,844**	Rural	**-**
Girls (under 18)	**37,336**	Urban	**-**
Men	**47,682**	People with disabilities (estimated)	**-**
Boys (under 18)	**38,893**		
Total targeted population	169,755		

Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	**Yes**
Does your National Society have prevention of sexual exploitation and abuse policy?	**Yes**
Does your National Society have child protection/child safeguarding policy?	**No**
Does your National Society have whistleblower protection policy?	**No**
Does your National Society have anti-sexual harassment policy?	**No**

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

Risk	**Mitigation action**
Risk of non-acceptance of cholera prevention measures and public health information, which could hinder community buy-in and reduce the effectiveness of response efforts.	Strengthen community engagement through messages tailored to the local culture, involve local leaders and trusted communicators, and establish feedback mechanisms to ensure that community concerns are heard and addressed.
The stigma associated with cholera can lead affected individuals or families to conceal symptoms, avoid seeking treatment, or resist community interventions, thereby increasing the risk of transmission.	- Integrate anti-stigma messages into all communication and awareness campaigns. - Involve community leaders and health workers in promoting solidarity and understanding. - Ensure confidentiality and respect for dignity in case

	management and contact tracing. - Highlight stories of recovery and concrete facts to reduce fear and misinformation.
The context of the upcoming elections could have an impact on the operating environment, particularly due to a shift in local priorities, effects on community gatherings, or reduced availability of civil servants and community leaders, which could delay or complicate response activities.	Collaborate with local authorities and community leaders to align activities with the electoral calendar, ensure flexibility in implementation timelines, and prioritise low-visibility, community-led approaches that preserve neutrality and avoid interference in the electoral process.
Risk of drowning (main access route via the lagoon). The rainy season can not only accelerate the spread of the epidemic by promoting the stagnation of contaminated water, but also make certain areas difficult to access, thus complicating response operations.	- Use of life jackets (already purchased). - Awareness of hygiene and sanitation measures.
Risk for staff and volunteers of contracting cholera or other diseases related to the conditions of the intervention.	- Provide personal protective equipment (gloves, disinfectant gel, boots, masks). - Train volunteers on cholera prevention measures. - Ensure access to drinking water and ORS. - Raise awareness about self-monitoring of symptoms.
Risk of work overload or exhaustion due to prolonged shifts or difficult conditions.	- Establish a fair rotation system and regular rest periods. - Limit the number of working hours per day. - Actively monitor the workload and physical condition of teams.
Risk of emotional stress, anxiety, or psychological distress related to exposure to illness, death, or social pressure.	- Organize regular psychosocial briefings with the support of the PSS team. - Set up a safe space for listening and expressing emotions. - Encourage breaks, team discussions, and peer support
Operational and legal risks Difficult access to certain areas and a lack of resources can delay activities. Certain interventions, such as disinfection or data collection, require authorizations; failure to obtain these can lead to blockages or legal risks.	-Ensure compliance with national procedures and applicable laws. -Work in coordination with local authorities. -Ensure that all volunteers sign informed consent forms/liability waivers before deployment.
Risk of Sexual Exploitation and Abuse and child safeguarding.	- Training of CRCI staff and volunteers in - PGI and PEAS response. - Continuous assessment of protection risks. - Establishment of sensitive feedback mechanisms.

Please indicate any security and safety concerns for this operation:

The operation is not expected to face any major security threats, but localised risks such as petty crime, health risks and limited access due to seasonal flooding could affect the safety of staff, volunteers and affected communities. To mitigate these risks, standard security protocols will be applied, including regular briefings, coordination with local authorities, and basic security measures to protect staff and volunteers in the field.

Has the child safeguarding risk analysis assessment been completed?	No

Planned Intervention

Health

Budget: CHF 103,726

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

Indicators

Title	Target	Actual
Number of trainers trained on BORT/PRO	27	0
Number of volunteers trained on BORT/PRO/Vaccination	250	50
Number of people reached by awareness-raising activities	45,109	10,219
Number of people referred to health centers	200	100
% trained volunteers active in the response	80	0

Progress Towards Outcome

As part of the response to the epidemic, several health activities were implemented with support from the DREF and crisis funding from the Netherlands Red Cross. One hundred and twenty-five community volunteers were trained in the Branch Outbreak Response Deployment (BORT) approach during a three-day training course, which included additional modules on WASH and Community Engagement and Accountability (CEA). Of these volunteers, the training of 50 was funded by the DREF. These volunteers carried out awareness-raising activities on the signs and prevention measures for cholera, active case finding, hygiene promotion, and referral of symptomatic individuals to treatment centers. These actions enabled early detection of cases, rapid treatment, and a reduction in the number of deaths. Between June 23 and July 15, 7,594 households were reached, reaching 10,219 people (including 4,784 men, 5,435 women, and 3 people with disabilities), with 100 cases referred to healthcare facilities.

Water, Sanitation And Hygiene

Budget: CHF 167,373
Targeted Persons: 21,354
Targeted Male: 10,890
Targeted Female: 10,464

Indicators

Title	Target	Actual
Number of WASH kits purchased and distributed.	5,600	0
Number of people who have benefited from latrine	50	0
Latrine blocks built	1,200	0
Number of people reached by handwashing demonstrations.	21,354	12,284
Number of households or public spaces disinfected using the BORT approach	650	0
Number of treated water sources	41	0

Number of CDRTs trained in WASH	25	0

Progress Towards Outcome

WASH activities were carried out in close coordination with health facilities and consisted of disinfecting the homes of cases, means of transport (canoes, pinasses, vehicles), public places (schools, places of worship, public and family latrines), as well as setting up and monitoring six handwashing stations. Between June 23 and July 17, 15 WASH volunteers and one assistant disinfected 64 homes and more than 400 community sites in the Vridi Ako neighborhood, helping to limit the spread of the disease in densely populated areas. These actions were supported by the use of spraying equipment, PPE, and disinfectants such as 0.2% bleach and HTH chlorine.

In addition, 100 NFI kits have been procured and are scheduled for distribution next week. The procurement process for the construction of latrine blocks has also been finalized with the support of the IFRC. Their installation is planned for this week, following consultation meetings with communities to identify the most appropriate locations.

Protection, Gender And Inclusion

Budget: CHF 6,971
Targeted Persons: 45,109
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
Number of volunteers trained on PGI during BORT training	250	0
Number of staff trained in PGI in the response	14	0

Progress Towards Outcome

PGI has been mainstreamed so far in the response, but with no dedicated budget. With the operational update and dedicated PGI budget, activities will be scaled up.

Community Engagement And Accountability

Budget: CHF 30,967
Targeted Persons: 45,109
Targeted Male: 23,005
Targeted Female: 22,104

Indicators

Title	Target	Actual
Number of volunteers trained in CEA during the BORT training	250	50
Number of people reached through home visits, group discussions in markets, transport stations and schools.	45,109	12,284
Community Feedback Mecanism	0	1

Number of Feedback collected	2,500	1,000
% Percentage of feedback processed and incorporated into the response	80	40
Community meetings organised	16	2

Progress Towards Outcome

- Awareness-raising sessions were held door-to-door, in markets, stations and schools in Ako Brakré and neighbouring areas. More than 1,000 responses were collected between 18 and 28 June. The number of people reached by the awareness-raising activities, broken down by gender, is approximately: 2,323 women and 1,884 men.

- A consultation with women in Caillou (11 July 2025 with 48 participants in the Caillou area (Ako Brakré), including representatives of local leadership on the construction of latrines planned by the CRCI.

- A session to update the FAQ and key messages with external partners (INHP, DSCP, UNICEF, Health District), NLRC, IFRC.

- Preparation of feedback summary and sharing for SitRep.

- Volunteer debriefings and field observations were conducted, and key messages were shared for possible feedback.

- For the distribution of hygiene kits, a discussion was held with community leaders to provide information on the distribution process and the criteria for targeting households to be assisted.
- Focus group discussions provided a better understanding of community concerns and helped spread prevention messages.
- Capacity strengthening for 125 additional volunteers from local committees in Yopougon, Songon, Jacqueville, Dabou, Abobo, and Grand-Bassam on the CEA/RCCE approach.
- Finalisation of a SOP for the Community Feedback Mechanism (Response to cholera).
- Conduct an initial CAP survey in the Vridi Ako area.

Secretariat Services

Budget: CHF 107,367
Targeted Persons: 5
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
Surge deployment	3	2
Support visits	6	1
Support lessons learned workshop	1	0

Progress Towards Outcome

The IFRC provided significant support to the Red Cross Society of Côte d'Ivoire in this operation, with the aim of strengthening its operational capacities and improving coordination, planning, budget management and relations with the Ministry of Health and other humanitarian actors.

Since the response began, several resources have been mobilised, including the deployment of an IFRC health officer, an operations Manager since 1 July, and a public health surge team on the same date. The cluster's logistics have also been strengthened by a four-week

mission, in addition to the ongoing support of the IFRC finance officer based in Abidjan.

In addition, strategic visits were made, including one by the Regional Director and Head of Delegation, as well as a mission by the cluster programme coordinator. The IFRC's Senior Regional Communications Officer also carried out a support mission.

These various interventions have enabled the National Society to ramp up its response and structure its internal mechanisms. Additional missions are planned for August, particularly in the areas of security and PMER.

National Society Strengthening

Budget: CHF 73,020
Targeted Persons: 250
Targeted Male: 130
Targeted Female: 120

Indicators

Title	Target	Actual
Trained, equipped, and insured volunteers	250	50
Capacity-building session for the Red Cross of Côte d'Ivoire in PMER, logistics, finance, and operational management	8	4
Briefing volunteers on safety, security, and protection against cholera	10	4
Training of trainers on the BORT approach	25	0
Lessons Learned Workshop	1	0

Progress Towards Outcome

As part of the development of the Red Cross in Côte d'Ivoire, this operation is an opportunity to strengthen its operational capacities. Several actions have been carried out, including awareness-raising sessions on budget management and expenditure justification, training for BORT teams, and support on the use of the DREF mechanism.

The delegation also benefited from high-level visits, including that of the IFRC Regional Director and Head of Delegation, as well as a support mission from IFRC health staff based in Burkina Faso and the Cluster Program Coordinator. Logistical support was provided to the National Society to strengthen its logistics department. In addition, as part of this DREF operation, 50 volunteers were trained.

About Support Services

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

As part of its overall response to the cholera epidemic, the Red Cross of Côte d'Ivoire will mobilise 20 staff members and 250 volunteers, 125 of whom will be specifically trained and supported under this DREF. The volunteers, trained in cholera prevention, risk communication, rumour management and community surveillance (PROC), will carry out awareness-raising activities, conduct home visits, monitor contacts and contribute to the early detection of cases within affected communities.

The personnel mobilised will include specialists in health, water, sanitation and hygiene (WASH), focal points in protection, gender and inclusion (PGI) and community engagement and accountability (CEA), as well as logistics and finance managers and branch coordinators.

The response will be coordinated by the CRCI's operations and programmes coordinator, with support from an CEA coordinator, a WASH

manager and a health coordinator, who will provide technical guidance, operational coordination and supervision of all activities in the field.

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 volunteer team is inclusive and representative, reflecting a diversity of gender, age and culture in line with the target communities. It includes women and men, young people and adults, many of whom come from the areas of intervention and are fluent in the local languages. This composition promotes culturally appropriate engagement, greater community acceptance and effective local communication with the affected populations.

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

Given the challenges faced by the CRCI in responding to this epidemic, the National Society is requesting the deployment of three surge teams to support the implementation of the operation. These surge teams will provide technical and operational support throughout the cholera response. The mandate of the operations manager will be extended for a total of four months, as will that of the public health reinforcement. A surge alert will also be issued for the recruitment of a specialist in Community Engagement and Accountability for two months. Considering that IFRC will be responsible for the procurements, a logistics surge will be deployed as well for two months.

These profiles are essential to ensure effective coordination of the response and provide targeted technical support. They will work closely with the National Society to support the planning, implementation and monitoring of activities, while strengthening the capacities of staff and volunteers at the national and local levels.

Their responsibilities will include:

- Supporting the development and implementation of an appropriate health and WASH strategy to effectively contain the epidemic.
- Strengthening the integration of PGI (Protection, Gender and Inclusion) and CEA aspects into all community interventions.
- Developing feedback mechanisms and two-way communication with affected communities.
- Facilitating data-driven decision-making and ensuring compliance with quality standards.
- Contributing to coordination with Movement and external partners to ensure a harmonised response.

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

The supply of 100 NFI kits and two latrine blocks was carried out during the first phase by the CRCI, with support from the IFRC. Given the significant scale of the expansion and changes in the National Society's human resources, it was agreed between the IFRC and the CRCI that, for the extension phase, the National Society would continue the procurement process, but that payments would be made directly by the IFRC to suppliers. Close collaboration will be maintained throughout the process to ensure compliance with procurement procedures and to strengthen the capacities of the CRCI.

How will this operation be monitored?

The operation will be monitored using a rigorous system combining field supervision by the Côte d'Ivoire Red Cross and technical support from the IFRC. A PMER (planning, monitoring, evaluation and reporting) focal point appointed within the National Society will coordinate the monitoring of activities in close collaboration with the heads of the Health, WASH, CEA and PGI sectors. Standardised tools will be used to collect quantitative and qualitative data, ensuring accurate, regular monitoring at the community level.

The results will be measured using clear indicators: number of people made aware of cholera prevention, hygiene kits distributed, volunteers mobilised, community feedback received and incorporated. Periodic reviews will enable implementation to be adjusted in line with changing needs and strengthen accountability to the affected populations.

The IFRC delegation in Abidjan will support the initiative through technical follow-up visits and joint field missions. Additional support through emergency deployments may be mobilised if necessary. Post-distribution monitoring and a capitalisation workshop will enable the impact of the operation to be assessed and lessons to be learned for future interventions. This mechanism will ensure an effective, high-quality response focused on the needs of communities.

Please briefly explain the National Societies communication strategy for this operation

The communication strategy of the CRCI as part of this operation aims to ensure a transparent, inclusive and participatory response. Its objective is to strengthen community trust, counter misinformation and promote essential preventive behaviours through multi-channel communication. This will be based on door-to-door awareness campaigns, interactive radio programmes, the distribution of printed materials and megaphone announcements, all in the main local languages to ensure widespread understanding and acceptance.

Budget Overview

IFRC

DREF OPERATION

MDRCI018 - CROIX ROUGE COTE D'IVOIRE
DREF CHOLERA

Operating Budget

Planned Operations	**309 037**
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	103 726
Water, Sanitation & Hygiene	167 373
Protection, Gender and Inclusion	6 971
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	30 967
Environmental Sustainability	0
Enabling Approaches	**180 388**
Coordination and Partnerships	0
Secretariat Services	107 367
National Society Strengthening	73 020
TOTAL BUDGET	**489 424**

all amounts in Swiss Francs (CHF)

Internal 06/08/2025 #V2022.01

Click here to download the budget file

Contact Information

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

National Society contact: Dr Yapi, Head of Health department, gym20021967@gmail.com

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

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

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

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

Click here for the reference