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Emergency Plan of Action Operations Update:

Democratic Republic of the Congo (DRC)
Ebola virus disease outbreak

International Federation of Red Cross and Red Crescent Societies

One International Appeal n° MDRCD026	**GLIDE n°** EP-2018-000048-COD EP-2018-000129-COD
EPoA update n° 3; date of issue: 11 July 2019	**Timeframe covered by this update: 15 months**
Operation start date: 21 May 2018	**Operation timeframe: 6 months, end date 21 February 2020**
Overall operation budget: CHF 31.5million	**DREF amount initially allocated: CHF 500,000 + CHF 300,000 (Uganda)**
N° of people to be assisted: 15,426,970 people (2,572,000 households)[1]	
Partners in the Red Cross and Red Crescent Movement continue to be actively involved in the response to Ebola disease: In addition to the Red Cross of the Democratic Republic of Congo, there is also the International Federation of Red Cross and Red Crescent Societies (IFRC), the International Committee of the Red Cross (ICRC) and the French Red Cross. Alongside these movement partners, other national and international organizations are directly involved in the response to the Ebola epidemic. These include the Ministry of Health of the Democratic Republic of Congo, WHO, UNICEF, MSF, Oxfam, PVH, SAD Africa, AMEF, ASEBO, MND, Humanitarian Action, EPSP, Border Hygiene, IMC, ALIMA, IRC, Caritas, Mercy Corps, FHI 360, etc.	
Summary of the major revision of the EPoA Given the persistence of the disease, it is crucial to maintain the efforts made so far and to increase efforts to stop the spread of this outbreak in other areas not yet affected by the epidemic. In this perspective, this 4th update of the operation extends the operational deadline by six months (new deadline: 21 February 2020) and focuses attention on the community-led response at the core of the response across each of the pillars in the operation. This ensures alignment with the Ministry of Health and the WHO National Plan as well as SRP4 for the response to the Ebola virus outbreak in DRC as well as updated discussions at national level across Uganda, Rwanda, Burundi and South Sudan. This operation update also notes the response activities in DRC and now Uganda (which is highlighted across the relevant sectors below) as well as preparedness activities and the extension of activities to other health areas in cities, provinces and countries not yet declared as part of the epidemic.	

[1] The average household size is 6 people

1. SITUATION ANALYSIS

1.1. Description of the disaster

The ninth outbreak of Ebola virus disease (EVD) was reported by the DRC Ministry of Health on 8 May 2018 in the Bikoro and Iboko health zones (Equateur province). This epidemic had caused the death of 33 people out of 38 confirmed cases out of 54 suspected cases reported.

Shortly after the declaration of the eradication of the ninth Ebola epidemic in Equateur province on 25 July 2018, another outbreak was discovered in the Mabalako health zone in Beni territory, in North Kivu province, leading to the tenth round of this epidemic in the DRC.

This tenth epidemic quickly spread to the village of Mandima in the neighbouring province of Ituri. Ituri province was subsequently declared affected by the virus after a case was confirmed on August 13, 2018.

Figure 1: A Red Cross Safe and Dignified Burial team responding to an Ebola alert in Beni. IFRC-Maria Santto/June 4th 2019.

Between the beginning of the outbreak on 1 August 2018 and 16 June 2019 there have been a total of 2,168 Ebola Virus Disease (EVD) cases (2,074 confirmed and 94 probable) with 1,449 deaths (1,355 confirmed) and 590 survivors for a total case fatality rate of 66%.

The tenth EVD outbreak in DRC has so far been characterised by three epidemiological waves; the first wave in Mabalako (North Kivu) and Mandima (Ituri) through to 19 August 2018, then expansion into Beni (North Kivu) through to November 2019 and is now into the third phase expansion to the other health zones with hotspots in Butembo and Katwa. So far 137 health areas within 22 health zones of North Kivu and Ituri have been affected[2]. The tenth outbreak is considered the second deadliest in history after West Africa epidemic in 2013 -16[3] and is considered the worst in DRC. It has been made more complex by being a public health emergency within a wider humanitarian emergency characterized by active armed conflicts, displaced populations, community resistance and other disease outbreaks (Cholera, Measles)[4]. Furthermore, it is the first outbreak in North Kivu and Ituri Provinces which have high population density (6,655,000 and 3,650 000, respectively), large population movements and cross-border activity, particularly with Uganda and Rwanda.

While the WHO Emergency Committee met on 14 June 2019 and recommended that the EVD outbreak is a health emergency in DRC and the region it does not meet the criteria for a Public Health Emergency of International Concern (PHEIC)[5]. However, despite the collective efforts of the Ebola response, in the event that the epidemic continues to expand, and more cases are reported in neighbouring countries this position may be reconsidered.

[2] WHO Situation report on the Ebola outbreak in North Kivu #46 18 June 2019 https://www.who.int/ebola/situation-reports/drc-2018/en/ accessed 24/6/2019
[3] The index patient was identified in Guinea in December 2013 and WHO declared the EVD epidemic in West Africa a Public Health Emergency of International Concern Guinea on 24 March 2014 and lifted it on 29 March 2016. A total of 28,616 Ebola cases were reported in Guinea, Liberia and Sierra Leone, with 11,310 deaths. See http://apps.who.int/gho/data/view.ebola-sitrep.ebola-summary-latest?lang=en
[4] DR Congo Humanitarian Response Plan 2019 https://www.humanitarianresponse.info/en/operations/democratic-republic-congo/document/rd-congo-plan-de-réponse-humanitaire-2019 accessed 24/6/2019
[5] https://www.who.int/news-room/detail/14-06-2019-statement-on-the-meeting-of-the-international-health-regulations-(2005)-emergency-committee-for-ebola-virus-disease-in-the-democratic-republic-of-the-congo accessed 26/6/2019

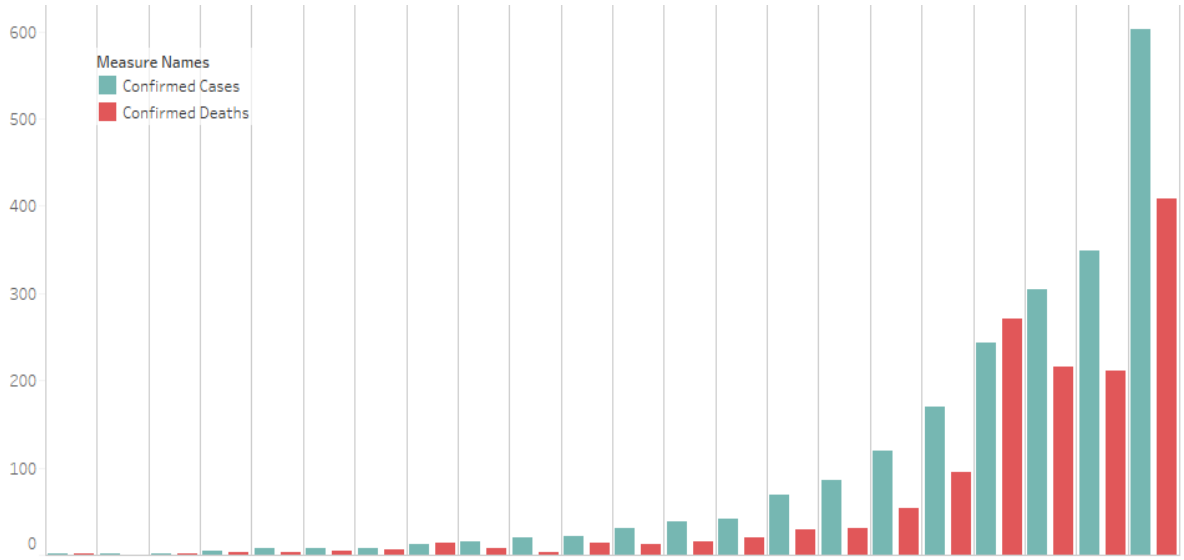

Figure 2: Total confirmed Ebola cases evolution (August 2018 – June 2019)

On 11 June 2019, the Ministry of Health of Uganda Republic reported a first confirmed case of Ebola virus disease in Bwera in the western part of the country (bordering the Democratic Republic of Congo).

It was a 5-year-old child whose family reportedly attended the funeral of a family member who died in DRC and who was confirmed to have EVD. The child and his family entered Uganda through Bwera Border post and sought medical care at Kagando hospital where health workers identified Ebola as a possible cause of illness[6]. The child was then transferred to Bwera Ebola Treatment Unit for management. This was the first confirmed case on Ugandan soil; three cases have been confirmed in total with two deaths, on Ugandan soil, followed by one on the way back to Beni. Following this confirmed case, the Ugandan authorities have activated measures to fight the epidemic. The remaining family members of the deceased boy were repatriated to the DRC on 13 June 2019. To date, Uganda has had no other confirmed cases of Ebola virus disease, but the country still remains in the "Ebola response" mode.

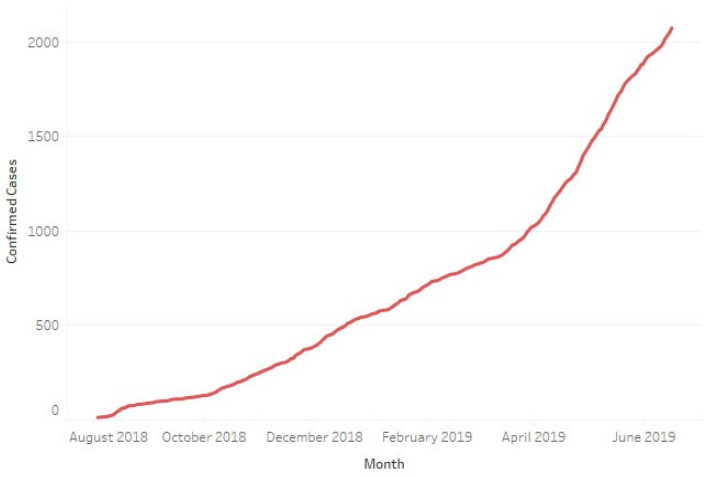

Figure 3: Confirmed cases evolution DRC (August 2018 – June 2019)

Other countries bordering the DRC, namely Rwanda, South Sudan, and Burundi also remain on high alert due to the high risk of cross-border cases. Red Cross teams continue undertaking preparedness activities such as point of entry screening, community risk communication and engagement, training of Safe and Dignified Burial teams as well as prepositioning SDB supplies (see 1.3).

[6] WHO, *Confirmation of case of ebola virus disease in Uganda,* 2019
https://www.afro.who.int/news/confirmation-case-ebola-virus-disease-uganda

1.2. Summary of current response

1.2.1. Overview of Host National Society

9th Outbreak - Equateur

As of 12 May 2018, the International Federation of Red Cross and Red Crescent Societies had allocated funds under its Disaster Relief Emergency Fund (DREF) of CHF 216,168 for an immediate response developed a three-week action plan in Equateur jointly with the National Society. The response in Equateur Province spanned 11 weeks until the epidemic was declared over on 25 July 2018.

The IFRC and DRC Red Cross intervention beyond this period focused mainly on the transition to early recovery in order to ensure the sustainability of the response and to maintain community monitoring mechanisms (CBS). Our response was in coordination with Ministry of Health and WHO.

Key results achieved to date
• A total of **266,490** people reached with the risk communication and community engagement sessions including in schools and religious sites • Training of **445** volunteers in different areas including 300 in risk communication and community engagement, 108 in Safe and Dignified Burials and disinfection techniques, and 37 in PSS; • **36** Safe and Dignified Burials have been carried out and 70 households disinfected by Red Cross volunteers in Itipo, Bikoro and Mbandaka; • Support to **13** health centres and hospitals in Mbandaka with Infection Prevention and Control and capacity building activities, 920 health professionals and hygienists trained on IPC

1.2.1.1.

The transition phase in Equateur

When the EVD emergency response period came to an end, all stakeholders decided that a 3-month transition phase was necessary to ensure sustainability of the intervention in the affected communities. Following an MoU signed between IFRC and WHO, the implementation was granted an amount of CHF 1,706,140 to strengthen capacities of the existing health system through reinforced community-based surveillance in target communities.

The implementation plan also included activities aimed at building the capacities of the Ministry of Public Health (MSP) to carry out IPC (Infection Prevention and Control) activities in 5 key pre-identified Health Zones at high risk of contamination. In these areas the initial plan was to build 5 triage units but due to timeframe constraints, only one simplified unit was set up in Bikoro General Hospital.

Moreover, the transition phase includes the maintenance of other important programmes, such as Community Engagement and Accountability (CEA) and Psychosocial Support (PSS) for Ebola survivors and affected communities in order to fight stigma, discrimination and trauma associated with Ebola false beliefs and rumours.

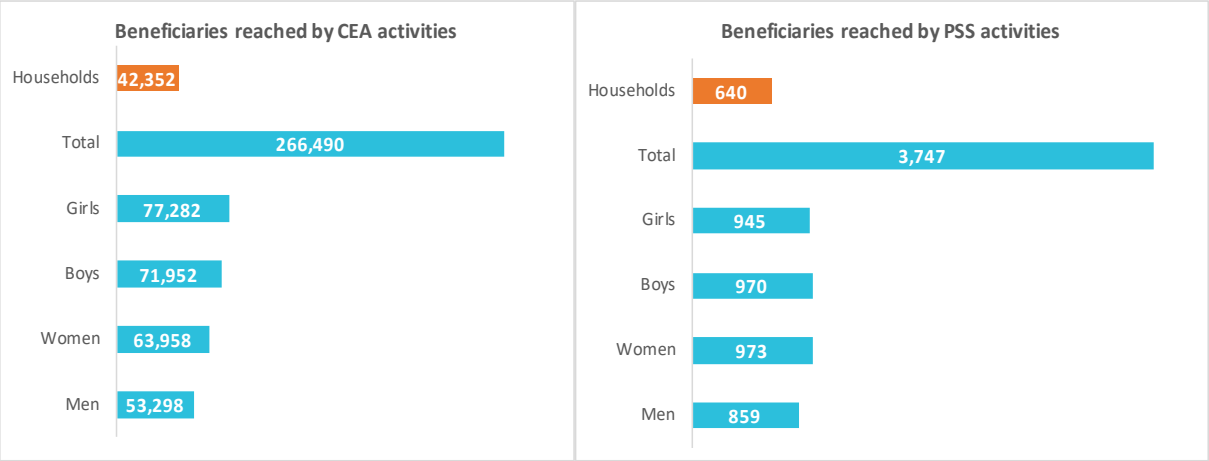

Figure 4: People reached by CEA and PSS activities (May-Dec 2018 Equateur)

During the same period, 18 radio shows were conducted. The purpose of the radio shows was to establish a continued communication flow and deliver key messages to the affected communities through guest speakers or Red Cross volunteers. Amongst other themes, key topics of discussion included ‘’Non-stigmatization”, “Good hygiene”, “Safe and Dignified Burials techniques”. Between August and October, 38 calls and 16 SMSs were received as part of the communities’ feedback and participation mechanism.

A community-based surveillance framework was developed and joint assessment with BCZ (Bureau Chef Zone) was conducted in Bikoro, Itipo/Iboko, Mbandaka and Wangata health zones. CBS activities will be implemented by 322 volunteers in 5 health areas Bikoro, 7 health areas in Mbandaka and 6 health areas in Itipo/Iboko.

In regard to the IPC pillar, an IPC triage base in durable material is under construction in Bikoro general referral hospital. Once finalised, this triage base will be equipped with existing prepositioned material available at IFRC.

In collaboration with IFRC and Canadian Red Cross, 30 DRC volunteers from 3 provinces (Equateur, Tshuapa and Sud-Ubangi) were trained to setup 3 Emergency Response Teams (ERT) and equipped with a contingency stock (SDB kits).

In terms of national society capacity building, the Mbandaka provincial office and the volunteer training centre have been rehabilitated and WASH infrastructures have been improved. Full radio (HF and VHF) equipment installed and operational in Mbandaka.

Since 30th June 2019 all the activities in Equateur have been completed except for the construction of an incinerator in Bikoro referral hospital which will be completed Mid-July. The handover of assets and equipment to the NS is ongoing and will be completed by July 2019. The last activity which has been planned will be the final evaluation of the project in Equateur, scheduled to take place in the latter half of 2019.

1.2.1.2. 10th Outbreak - North Kivu & Ituri

Key results achieved to date

- **80%** of the **7,110** SBD alerts have been successfully completed by 107 Safe and Dignified Burials teams (31 Red Cross, 26 Civil Protection, 13 community-led harm reduction burial teams (ECUMR) trained by the Red Cross and 37 community burials teams trained by Civil Protection)
- **807** CEA volunteers have reached **1,311,234** of the target population with door-to-door and mass sensitization activities
- **298,156** community feedback data points have been collected from community members
- **14** health facilities are being supported with an IPC package, supervision, training and 68 volunteers who have screened **779,436** people (9% under 18 years), referred 368 suspected cases (32 confirmed cases), completed 194 decontaminations and trained more than 130 health care workers
- PSS teams have reached **9,208** staff and volunteers with 1,600 PSS activities and trained 87 volunteers on Psychosocial First Aid
- **10** DRC RC branches provided with support in addressing the Ebola Outbreak
- **1,398** volunteers and **75** supervisors from DRC Red Cross registered as operational for the response

Following the announcement of the 10th outbreak on 1 August 2018, staff and equipment from the 9th outbreak in Equateur Province were quickly deployed to North Kivu and Ituri provinces to support the response, arriving 4 August and by 5 August several Safe and Dignified Burials (SDB) teams were operational on the ground. This was followed by the implementation of CEA, IPC and PSS pillars. In November 2018 the Movement held the first EVD reflection workshop to identify how to scale-up the operation to meet ongoing needs. By 7 December the operation had over 50 International staff, 13 National Society staff and more than 400 volunteers. In total for 2018, 60 Field Assessment Coordination Team (FACT), 68 Regional Disaster Response Team (RDRT), and 5 Head of Emergency Operations (HEOps) deployments had been secured to respond to the 9th and 10th outbreaks in DR Congo. As such, surge deployments for epidemic response accounted for 46% of all IFRC surge deployments in 2018.

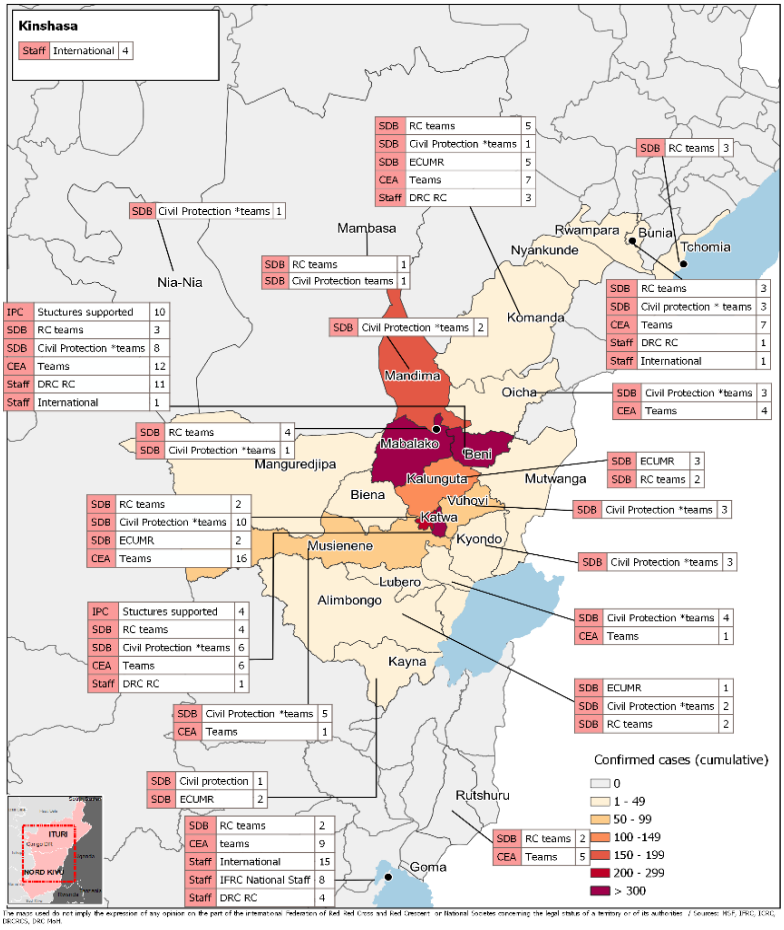

Figure 5: Movement Presence North Kivu and Ituri EVD Outbreak

However, in December and January threats directed to the Red Cross staff and volunteers were received resulting in the relocation of expatriate response personnel from key operational bases. At the same time, hostility directed towards humanitarian responders and health care personnel in the provinces grew. Ebola treatment centres were attacked, set alight and in extreme cases, lives were lost. This included attacks on MSF Ebola treatment Centres in Katwa (23 February) Butembo (28 February). The cumulative effect of these constraints at community level continues to hinder the international response to the Ebola crisis.

By the 14 March 2019, the operation had scaled up and the main operational hub had moved from Beni to Goma in line with the MoH revised strategic coordination that had shifted from Beni to the Emergency Operations Centre (EOC) in Goma. By 30 March the Red Cross had 1,398 volunteers and 75 supervisors and focal points registered as operational for the response and supported by 45 international IFRC delegates/RDRT, 21 national IFRC staff and 23 DRC RC staff and technical support volunteers across 6 operational bases located in Beni, Bunia, Butembo, Komanda, Mangina (Mabalako) and Goma. To date a total of 84 CEA teams, 14 IPC teams, 25 Red Cross and 32 Civil Protection traditional' SDB teams and 14 Red-cross trained ECUMR and 17 Civil Protection community SDB teams are active across 21 health zones including active zones (Beni, Bunia, Tchomia, Butembo, Katwa, Komanda, Lubero, Masereka, Vuhovi, Kirumba, Kyondo, Musienene, Kitshombero, Kipese, Mabalako, Mandima, Oicha, and Kalunguta) and preparedness zones (Goma, Rutushuru and Mambassa) supported by 6 PSS teams (20 volunteers, 6 supervisors and 3 focal points). In addition, ICRC has a dedicated team of experts and national staff focusing on IPC in prisons and security and logistical support for the operation under the L3 agreement with IFRC. Ongoing insecurity continues with periodic attacks by armed groups in epidemic hot spots (Beni Butembo, and Katwa), population displacement and targeted attacks on Ebola responders and infrastructure that resulted in the assassination of Dr Richard Valery Mouzoko Kiboung, a WHO epidemiologist in Butembo on 19 April. DRC RC field teams continued to be active and were supported remotely by IFRC delegates.

Following the second operational review workshop of 14 and 15 March, based on the security context and epidemiological trends, the Movement is working towards a National Society led operation over the coming months. However, this period had a number of challenges, including the ending of contracts of existing staff and a lack of available funds for extension of contracts and new recruitment of delegates and national staff. By 27 May there were 23 delegates (from 60+ at the peak of the operation) and by 15 June the operation was down to 15 delegates and 10 national staff. Meaning that without national staff in place and adequate time to transition, the technical team is reduced to one CEA field delegate and CEA team leader, SDB team leader, three IPC staff on loan from French Red Cross and no PSS delegate. With the arrival of new funds, the recruitment of 5 delegates[7] to support transition and recruitment of 18 national staff is currently in progress.

During this period the epidemiological trend was showing an acceleration from 8 April (EW 15) averaging close to 100 cases per week for the next 10 weeks, particularly in 'hot spot' areas of Beni, Butembo and Mabalako. Despite the significant challenges, the DRC RC field teams continued to operate across all targeted zones and at the same time, the epidemic continues to evolve. Bunia and surrounding areas had not seen a confirmed case for over the 42 day clearance period.[8] However, almost 3 months clear of cases, new EVD cases were confirmed in the Ituri Health Zones of Rwampara on 7 June (after 115 days of no case) and Bunia and Komanda on 16 June (88 days clear). At the same time the first case was confirmed in Uganda. As a result, the teams are continuously adapting to the epidemiological trends, and this challenge becomes more difficult without necessary staff and flexible/contingency funds to adapt to the outbreak.

The third Movement workshop was held in Kinshasa on 7 and 8 June 2019 to review and reflect on the operational objectives, to strengthen inter-movement coordination and prepare for the review of third strategic response plan (SRP3) and the development of the fourth (SRP4). The commitment of the Movement partners to continue until the end of the 10th epidemic was reiterated and it was recognised that an operational 'reset' was required to not just respond to Ebola but to address the wider needs of the affected communities and strengthen links to the immediate, medium, to long-term development objectives. As we enter the development phase of SRP4, it is clear that the EVD

[7] SDB, CEHRBU, PSS, and CEA profiles
[8] Health zones are considered non-active over the 42 day clearance period

response is struggling to contain the outbreak not just as a result of conflict but also due to community resistance and trust, with people refusing vaccines, concealing symptoms and attacking treatment centres. Further, the social fabric/community structures have been disrupted by parallel Ebola structures and a 'monetized' community action in a context where traditionally communities have led their own response to recurrent risks and vulnerabilities. The Red Cross Movement is calling for the EVD response to better owned and co-led by the community, the response must refocus on ensuring that the community must be at the centre of the response and that we need to focus on 'localization', knowledge sharing and monitoring. In this regard we are planning operational research to evaluate SDB, CEA and ECUMR for effectiveness and appropriateness.

The below summarize the recommendations of the third Movement workshop:

1. Fast-track hiring of highly qualified national staff to fill both functional support and leadership technical roles to ensure the succession of qualified NS volunteers with on-the-job mentoring (over a period of 3 months) by delegates according to the organigram. This should be actioned by DRC RC and IFRC.
2. Train and support DRC RC in security management by strengthening its security structure with clear operational standard safety management procedures from the base to the central level. This should be actioned by ICRC and IFRC.
3. Improve communication between Movement partners in the response operation (DRC RC, ICRC, PNS and IFRC) to enable timely problem-solving within the operation and wider context (including mobilization of resources). This should be presented by a Movement-wide approach by benefitting and taking into account the actions taken by other partners in the response. This should be coordinated by IFRC with support from DRC RC, ICRC and PNS at country level.
4. Review recommendations weekly on how to improve operations at base-level by operationalizing community feedback received. This should be coordinated by DRC RC/IFRC at base-level with attendance from ICRC.
5. Share recommendations into external coordination structures at country level via co-chairing of the feedback group. This should be coordinated by DRC RC/IFRC.
6. Contribute to the drafting of SRP4 using our added value and data analysis to support the recommendations. This should be coordinated by DRC RC/IFRC with input from ICRC and PNS at country level. Advocacy should be enacted at RO and GVA level to support uptake of the recommendations in the wider humanitarian strategy.

Safe and Dignified Burials (SDB)

Traditional burial practices are a significant source of transmission of EVD, with those preparing the bodies for burial and family and community members who participate in funerals all at risk of contracting the disease. Safe and dignified burials (SDB) are a key intervention to prevent the spread of the outbreak. The below provides highlights as well as recommendations from the strategic workshop and to be shared into the SRP4 preparations.

Highlights

- As of 16 June 2019, the SDB teams (53% Red Cross, 44% Civil Protection and 3% ECUMR) have recorded a total of 7,057 SBD alerts, of which 5,685 (just over 80%) were successfully completed, 1,372 (19%) failed or incomplete[9], and 8 pending or a false alert.

[9] An SDB is considered a success when less than 72 hours passes between the SDB team receiving the validated death alert and the completion of the SDB. This includes that the family has agreed to participate in the SDB, the body has been secured in a body bag and the surrounding area decontaminated, the swab has been taken and for positive (or unknown) cases a safe burial is completed by the SDB team or for a negative result the body is either returned to the family or for vulnerable families the SDB teams can complete the burial.

- SDB teams enter the data directly into ODK, the Information Management (IM) team then cleans, analyses and visualises it on an online dashboard that is shared with response partners daily[10].
- Mapping for SDB teams for SRP4 has identified 107 teams currently in place (31 Red Cross representing 372 volunteers, 26 Civil Protection, 13 ECUMR and 37 Civil Protection community teams[11]) with 141 new teams planned for SRP4 (2 Red Cross SDB, 9 Civil Protection SDB, 52 ECUMR and 78 Civil Protection community teams).
- The Red Cross is co-leading the SDB sub-commission with Civil Protection.
- An analysis of 1,169 failed SDB by health areas found that 54% of failures were from community deaths (42% health facility and 3% Ebola treatment centres). When a failure occurred, it was recorded as being the result of community resistance (33%), security (9%), logistical issues (6%), or no specific reason recorded (52%).
- This analysis also identified certain health areas within the health zones are responsible for the most failures.[12]

Recommendations

- The successful piloting of the community-based harm-reduction burial (ECUMR) teams for use in inaccessible and/or insecure areas has been important for expanding access to safer burials in communities where gold-standard SDB approaches cannot reach. This strategy must be scaled up to ensure adequate safer burial coverage and reduce the risk of community-based transmission in these hard-to-reach communities. A further 52 ECUMR teams are planned for the next phase. Where traditional SDB teams are not best placed to respond, and to reduce failures due to security and access, ECUMR teams need to be systematically planned in health areas with difficult access.
- To help reduce community failures of SDB the process of communication between surveillance, SDB and laboratory need to be strengthened. This includes strengthening community-based surveillance to improve the reporting of death alerts and strengthening the link with the laboratory commission to ensure swab results are returned in a timely manner and the results recorded in the SDB database.
- To reduce community resistance, we cannot address SDB as a stand-alone pillar. We need to revise the communication strategy and strengthen community engagement, sensitization and communication tools and address rumours in the communities, increase training and involvement of health care workers, traditional practitioners and community leaders. This includes continued analysis of SDB-related community feedback and SDB failures to better adapt practices and messaging to the local context.
- To reduce failures due to logistics, it will be important to reduce the waiting time for laboratory test results by improving logistical capacity, ensure that all times have 2 cars for SDB teams and motorbikes for ECUMR teams.
- Encourage healthcare providers to collect post-mortem samples before SDB (this will help reduce resistance after deaths in health facilities).
- For hotspot and affected health zones continue systematic SDB including oral swabbing of all validated death alerts with the understanding that for negative test results, the body can be buried by family members.
- For at-risk areas (not yet affected) and where health zones have exceeded 42 days without new confirmed cases continue systematic oral swabbing, but do not necessarily proceed to burial.

The Movement has trained and equipped 31 burial teams based on the proven, evidence based IFRC SDB protocols, and trained Civil Protection to provide SDB in some inaccessible areas. However, many affected and at-risk communities remain out of reach of gold standard SDB operations. While the SDB approach has been key to preventing EVD transmission in this and

[10] Red Cross SDB Dashboard https://app.powerbi.com/view?r=eyJrIjoiMmQ3ODg3N2UtNDM3OC00OTZjLWI5YTItOTQ1ZWZkY2RiODcyIiwidCI6ImEyYjUzYmU1LTczNGUtNGU2Yy1hYjBkLWQxODRmNjBmZDkxNyIsImMiOjh9

[11] Red Cross teams are under the supervision of Red Cross supervisors and have 12 members including a focal point for community engagement. Civil Protection traditional teams are under the supervision of Civil Protection and have 8 members. ECUMR teams are trained by Red Cross, but are under the supervision of the Head Nurse at each FOSA and are composed of 10 members (including community engagement). Civil Protection community team are trained/supported by WHO, under the supervision of the Head Nurse at each FOSA and are composed of 8 members.

[12] Specifically the health area of Kanzulinzuli (28% of Beni failures), Masuli (18% of Katwa failures) and Muchanga (13% failures in Katwa), Kyangike (17% failures in Butembo), Nzenga (37% failures in Mutwanga) and Bulongo (20% in Mutwanga).

previous epidemics, the challenging context in North Kivu and Ituri has led the Red Cross to develop and support a community-led emergency harm reduction burial approach (ECUMR by its abbreviation in French) in insecure areas where SDB teams are not able to operate. In this approach, community-nominated volunteers, including the head nurse of the nearest health facility, are brought to accessible areas to be trained in SDB and to job shadow existing SDB teams, before returning to their inaccessible communities and being provided with the equipment necessary to carry out safer burials. To date, ECUMR teams have carried out more than 222 safer burials for suspected EVD cases that could not have otherwise been provided. This adaptation to the particularly challenging context of North Kivu requires significant investment to scale up and continue to provide safer burials to all affected communities, regardless of conflict dynamics. This balanced approach -- SDB where possible, ECUMR where necessary -- is a result of an overall Red Cross response that prioritises community participation in the response, and adaptation of proven best practices to rise to the unique challenges posed by this outbreak. Community engagement approaches are also a key part of the SDB approach and trainings have been provided to both SDB and ECUMR teams. A member of each burial team is dedicated to engaging with families and communities during the burial. Further scale-up, monitoring and quality assurance of this adaptive approach is necessary to ensure all affected communities are able to reduce the risk of EVD transmission from unsafe burials.

Expected result by 21 February 2020: Maintain an SDB success rate of at least 80%

Expected result by 21 February 2020: Train and equip 52 ECUMR teams

Community Engagement and Accountability (CEA)

Misinformation, mistrust of outsiders and conspiracy theories have spread quickly across North Kivu and Ituri during this Ebola response. Community-based solutions to beat Ebola in DRC must be at the forefront of the response supporting community ownership. The Community Engagement and Accountability (CEA) approach fits within the Risk Communication and Community Engagement (RCCE) commission of the response. The below provides highlights as well as recommendations from the strategic workshop and to be shared into the SRP4 preparations.

Highlights

- As of 16 June 2019, the CEA volunteers have reached 1,311,234 individuals (54% of the total reporting as 'female'; 55% of the total reporting as 'under the age of 18 years'). This comprises of 976,320 (55% female, 55% under 18 years) through door-to-door outreach and 334,914 (52% female, 53% under 18 years) people through various mass sensibilisation activities such as education sessions with various community groups, faith-based organisation and school groups, community forums, events, mobile cinema and theatre targeting various. Messages are guided by RCCE and adapted based on community feedback and include vaccination, Call the EVD hotline, SDB, Hygiene/Handwashing, EVD signs and symptoms, contact tracing and are adapted based on community feedback. In addition, 34 interactive radio shows have been rolled out in Beni with planned expansion to 6 other bases.
- The community feedback mechanism for EVD is the largest that Red Cross has implemented in an operation. The CEA volunteers systematically collect information and report on complaints, feedback and rumours in their daily community engagement activities. A team of IM volunteers then help to clean and code the data, it is then sent to a team of analysts at the US Centres for Disease Control analyse the data, the IM team then uploads it on the humanitarian data platform HDX[13]. Weekly reports are made available to the Strategic Coordination, RCCE commission and sub-commissions and sub-coordination at field level and presented at the weekly community feedback working group that is co-lead by IFRC and Internews. To date over 298,156 community feedback data points (codes) have been collected in the system and it has allowed the teams to adapt and respond to the needs of the community.
- The Red Cross is a key partner in the Risk Communication and Community Engagement Commission and is co-leading the community-feedback inter-commission working group with Internews.

[13] https://ebola-feedback.ml/login

Recommendations

- The Movement will join efforts with key partners to ensure increased attention towards creating local capacity of community members and front-line workers and enhanced harmonisation of knowledge sharing and capacity building approaches.
- Greater engagement of key influencers and communities: multiple influencers from each community should be mapped and engaged, leveraging the neutral, independent and recognized role of the Red Cross in DRC.
- Strengthen the utilization of community feedback data. Currently the coordination system is still fragmented and despite several attempts, each pillar is not yet held accountable for course correction based on evidence. The feedback group should be implemented in all the sub coordination and needs to have more support from the Coordinator (Emergency Operations Centre (EOC) and sub coordination level) to make sure the participation of all the sub commission and make them accountable of the recommendations.
- It is necessary to ensure that EVD messaging works to 'normalize' and de-dramatize the disease moving towards a health wide response that is beyond EVD. Community engagement approaches, if harmonized and strengthened, can be an entry point for local actors, communities and platforms to address broader health issues.
- Internally, the Movement must increase internal coordination for coherence amongst pillars to ensure quality and an appropriate approach is being operationalized by listening and acting on community feedback received. These discussions need to be led by a community-led approach and thus discussed at base-level.

Expected result by 21 February 2020: Reach at least 2 Million people through risk communication and community engagement activities

Expected result by 21 February 2020: Collect at least 500,000 community feedback data points and strengthen the analysis, localisation and two-way communication with communities

Infection Prevention and Control (IPC)

As of 16 June, there have been 119 confirmed EVD cases amongst health care workers, and many people continue to be infected with Ebola while seeking care for other illnesses in health facilities across the affected area. The Red Cross is supporting the Prevention Commission to strengthen IPC measures in targeted health facilities to reduce the risk of nosocomial transmission and strengthen IPC capacity in targeted health facilities. This is through supporting the screening and rapid isolation of suspected cases and creation of triage areas, provision of IPC supplies and equipment, strengthening the utilisation of standard operating procedures through training and formative supervision and, where necessary, rehabilitating water and sanitation infrastructure to ensure that supported facilities attain an IPC score of at least 80% on the response-wide IPC scorecard. The below provides highlights as well as recommendations from the strategic workshop and to be shared into the SRP4 preparations.

Highlights

- As of 16 June, the OIA is supporting 14 health facilities (FOSA) with an IPC package, supervision and training. 68 volunteers have screened 779,436 people (9% under 18 years); referred 368 suspected cases, including 32 confirmed cases; completed 194 decontaminations and the IPC teams has trained more than 130 health care workers in IPC measures.
- Rehabilitation works are ongoing and have been slowed by insecurity and destruction of items at several the health facilities. However, to date the following have been completed: 5 semi-durable pre-triage and triage areas; drinking water supplies with impluvium systems for 7 health facilities; construction of 4 laundry facilities, 8 incinerators, septic tanks, placenta pits and toilets; and shower blocks for 2 health facilities. An additional 6 health facilities are being identified, bringing the 20 the total number of facilities supported with the IPC package.

- As part of strengthening triage, the French Red Cross team is the process of deploying 10 isolation tents with two individual isolation "bubbles" that make it possible to rapidly and safely isolate a suspected case and provide quality supportive care, by allowing the patient to be touched, while protecting professionals until they can be transferred to a treatment centre. With the support of MOH, this approach is being piloted in hotspots such as Beni, Butembo/Katwa and Mabalako and in Goma as a preparedness measure.

Recommendations

- Continue to align all interventions with the Ministry of Health's SOPs and SRP4 based on community ownership while maintaining minimum package of IPC interventions (triage, decontamination, awareness against other diseases, etc.);
- Support the strengthening of the multimodal (ring strategy) strategy around positive cases with community engagement and involvement and ensure that health facilities integrate the complete package and have reached the 80% score;
- Support the strategy to strengthen training and SOPs amongst traditional healers to improve IPC practices.

Expected result by 21 February 2020: Support 20 Health facilities to achieve an IPC score of at least 80%

Psychosocial Support (PSS)

Providing psychosocial support (PSS) to staff and volunteers is a critical element to supporting health and wellbeing of the EVD response teams. It is particularly important in the current conflict and highly complex response. The below provides highlights as well as recommendations from the strategic workshop and to be shared into the SRP4 preparations.

Highlights

- As of 16 June, a team of 20 volunteers, 6 supervisors and 3 focal points are providing psychosocial support (PSS) to staff and volunteers across the 6 operational bases of Beni, Butembo, Goma, Mabalako and Mandima, Bunia, and Komanda. As of 16 June more than 9,200 staff and volunteers have received support through 1,600 PSS activities, including; 1,714 people reached by individual sessions, 3,850 by psychosocial support sessions, 3,012 by focus group discussions, 545 people by debriefings and 87 people trained in psychological first aid (PFA), see Table 1.

Recommendations

- Support PSS programme to ensure appropriate coverage of PSS activities across the six bases.
- Continue to build the psychosocial support network in North Kivu and Ituri by training volunteers, capacity building and technical support from the Psychosocial Support Reference Centre.
- Explore options to continue PSS programme post Ebola.

Expected result by 21 February 2020: At least 15,000 staff and volunteers are reached with psychosocial support activities

NS Capacity Building and Preparedness

The risk of spread of current outbreak within DRC and neighbouring provinces is high. The operation is planning to engage in preparedness, contingency planning and risk communication activities in neighbouring provinces and strategic locations within DRC to prevent further extension of the outbreak to communities. Strong preparedness will also ensure that the impact on individuals and communities is reduced with a timely and effective response, thus allowing the affected to gain stability quicker and to start rebuilding their lives and communities.

Capacity building is an essential component in the next phase of the implementation of the OIA, once both epidemics will be declared as over to assure the autonomy of the National Society to respond fast and efficiently to subsequent EVD outbreaks. Through links with the on-going USAID funded community epidemic pandemic preparedness (CP3) initiative in Kinshasa and Kongo Central province platform for more longer-term epidemic preparedness and response is created. The resources and capacity mobilized through the emergency appeal operation will be carefully translated into overarching contingency plan, operational plan and coordination strategies to play RC mandate in complex health context focusing on preparedness actions at National, Provincial and branch level to be more proactive in dealing with health crisis and other recurring hazards.

IFRC's National Society Development (NSD) framework describes a well-performing National Society as 'an organization that consistently delivers, through volunteers and staff, relevant country-wide services to vulnerable people sustained for as long as needed and that contributes to the strength of IFRC and the Movement". NSD is not a goal in and of itself. The intention of NSD work is to enable a National Society to have a lasting impact on the individuals and communities it serves. The primary responsibility of National Society Development lies with National Society leadership, but external actors can provide valuable support to NSD.

The objective of National Society Development (NSD) is to ensure that the National Society has the necessary legal, ethical and financial foundations, systems and structures, competencies and capacities in place. This includes:

- Supporting the implementation of financial and operational support services;
- Developing the capacity for NS security management;
- Various trainings and support for 1,398 volunteers (29% female) operational in the response;
- Appointment of sectoral counterparts by pillar for each pillar team, hiring national programme staff to build technical capacity and provide mentoring support through delegates.

Highlights

- A preparedness plan has been developed for 11 health zones in North Kivu/Ituri
- SDB teams are operational in Goma (3 teams) and Rustshuru (2 teams) while more than 100 CEA volunteers are implementing activities in Goma since December 2018.
- 12 DRC RC volunteers trained on security in May 2019 and NS security SOP under development
- Logistics training conducted for 12 volunteers (North Kivu and Ituri) and a warehouse set up at Goma Provincial branch

Recommendations

- Fundraise and implement the EVD provincial preparedness plan in North Kivu/Ituri and neighbouring high-risk provinces.
- Support the NS to appoint pillar counterparts for the EVD operation to allow an adequate transfer of skills especially related to SDB, CEA, IPC and PSS.
- Support the NS to develop the capacity building plan for the EVD operation

1.3. Summary of current regional containment activities

1.3.1. Regional preparedness

1.3.1.1. Regional Coordination

In terms of regional coordination, the 9th and 10th outbreak operations have been coordinated and given strategic, technical, financial, and operational support and direction through the IFRC Nairobi Regional Office.
Highlights of the coordination and support activities include:

- Establishment and maintenance of an Ebola team at the IFRC Africa Regional Office, at ICRC HQ and at Kinshasa level, as well as ERU/RDRT from NSs, to support multi-country response coordination and country-specific preparedness activities;
- Rapid response for the recent Ebola outbreak in Uganda,

- Completion of the Regional EVD Strategic Plan and Regional Contingency Plan;
- Facilitation of numerous surge deployments to DRC, Burundi, Rwanda, Uganda and South Sudan and including in the areas of Operations, Health, RCCE, IM, Finance, PRD and Communications;
- Establishment of a qualitative measure for the standard assessment of SDB and CEA preparedness, with application in Uganda, Rwanda, South Sudan, and Burundi, to enhance SDB and CEA readiness;
- Review, harmonization and standardization of training packages, operational guidelines, guidance for NSs and SOPs on SDB and RCCE;
- Establishment of an information management platform for the regional containment strategy on to enhance coordination between operations and support external communications;
- Technical support of SDB Alerts & Activity Dashboard which compiles data of alerts for all SDB actors. This is the basis of all the SDB data-driven planning, at Red Cross and ECUMR also commission and coordination levels;
- Reorientation and re-operationalization DRC operation based on recent declaration of WHO the wide scale up and activation of infectious disease response.
- Technical support to community feedback mechanism. Feedback data, which are coded in DRC and analysed with CDC support, are visualized and shared among partners and responders through an online dashboard excel dashboard with more granular data by health area. This data is used weekly RCCE activities, including training of volunteers on usage;
- Establishment of an exchange strategy and platform for EVD for the Red Cross Movement;
- Strategic oversight supported through Internal coordination amongst IFRC and Movement players, while represented in a united vision externally;
- Problem solving support to field teams and backfill as needed;
- Various situation reports and maps on an ongoing basis.

The DREF operations for Burundi, Rwanda, South Sudan and Uganda were coordinated and given strategic, technical financial and operational support and direction through the East Africa Country Cluster office in Nairobi.

1.3.1.2. Burundi

Through DREF funding BRCS has mobilised staff and volunteers who have been trained in various thematic areas, including:

- 56 people have been trained in SDB and are conducting simulation exercises in their respective branches.
- 84 people have been trained on risk communication, social mobilisation and community engagement who are helping in promoting messages and behaviour change in their own communities
- 90 staff and volunteers have been trained in PSS, and are cascading the training to their communities
- 4 SDB kits were procured and used to train the volunteers in SDB
- Mobile Cinemas were developed and implemented in at-risk communities (2 sessions per week in the concerned provinces)
- Key messages were developed to be used on fliers for distribution as well as in radio spots. These key messages are broadcasted each day on national radio and television before the news in the national language, French, Swahili and English, and BRCS conducted its own 1-hour radio shows on EVD.

With its own resources the NS contributed **35 tents which were deployed to 17 points of entry (PoE)** and are being used by the entry point surveillance teams. The National Society also installed **4 bladders and 34 hand washing facilities at entry points** in Ruhwa (in Cibitoke Province), Gatumba (Bujumbura Rural Province), Rumonge and Kabonga in Nyanza-Lac Commune. BRCS deployed three of its staff (PMER, IM and RCCE) to support the 9th EVD outbreak in the DRC and their experience in the response is being used to enhance the NS preparedness activities. The

National Society also has emergency stocks available including soap, jerry cans, aqua tabs, tarpaulins and family tents used for temporary shelter.

1.3.1.3. Rwanda

Through the DREF and other funds the following key results have been achieved;

- With support from MoH and DREF, **550 volunteers (50 per district in 11 districts, which includes Kigali) were trained as trainers on community surveillance and contact tracing, and 110 on SDB (10 per district),** where they form teams of 10 persons. From these teams, 20 were selected to form 2 national frontline teams that are trained to be the first responders. The 550 volunteers are conducting community sensitization activities, through different meetings, school visits, mass sport events, house to house, and cascading information to other volunteers.
- **55 volunteers (5 in 10 districts and 5 in Kigali) were trained as ToTs on PSS**. The volunteers are expected to conduct cascade training to the 550 volunteers.
- All districts have volunteers trained on mobile cinema, and **175 mobile cinema sessions have been conducted in 13 districts, reaching 672,822 people directly. In total, 3,364,113 people were sensitized** through different channels of communication.
- Procurement and prepositioning of **10 PPE kits, 2 Ebola starter kits, 3 SDB kits and 60 body bags.**
- Ebola prevention messages from Rwanda MoH have been shared with all local branches to inform the volunteers and community, and flyers and posters have been revised to include SDB messages.

Support from PNSs was also received for preparedness activities:

- Through support from Belgian RC-FI, **150 NDRTs were trained on community surveillance and contact tracing and SDB**, and handwashing facilities were purchased, along with the printing of 2,000 flyers and 1,000 posters.
- With support from Belgian RC- Fr, **7 mobile cinema sessions** were conducted in Karongi, Rutsiro, Nyabihu (bordering DRC), and Ngororero and Gakenke, and 2,000 flyers and 1,000 posters were printed.
- Through support from Danish RC, **community sensitization and 7 mobile cinema sessions** in Musanze, Burera and Gicumbi (districts bordering Uganda) took place, with further support planned for training of SBD teams.

RRCS has 12 staff (district coordinators and focal points) coordinating activities and volunteers. 3 RRCS HQ staff are also supporting the project (Health, Chief Finance and PMER), 2 CEA staff, and 4 NDRT members were mobilized to assess the activities' impact and train volunteers on EVD and the reporting system

1.3.1.4. South Sudan

Through the DREF the following key results have been achieved;

- Mobilized and trained **180** volunteers in four high-risk locations in Yei, Maridi, Nimule and Yambio. The volunteers were trained on EVD Risk Communication, Social Mobilization and Community Engagement knowledge - RCSMCE, prevention/protection and behavioural change to carry out social mobilization and community engagement.
- **86** volunteers were trained on safe and dignified burials - SDB. Established and fully equipped 6 SDB teams in all four high-risk areas including Juba Capital, as part of the mobile and rapid response SDB teams ready to be deployed in the event of an EVD outbreak.
- **119** of the same volunteers were trained on psychosocial support – PSS.
- **5** full and **5** starter SDB kits as well as **200** body bags procured and prepositioned; one in each of the four high-risk locations (Maridi, Nimule, Yambio and Yei). Each kit is enough to carry out 20 safe and dignified burials. The remaining kits and body bags are positioned in Juba for use by the mobile and rapid response team if need arises and or to replenish the prepositioned SDB kits in the four high-risk locations.
- SSRC reached over **240,418** people (aggregated) in the four operational locations through awareness sessions in communities, schools, places of worship, entertainment centers and

markets; public announcements of key messages, house-to-house visits and mobilization of people at border-crossing for screening.
- SSRC established functional EVD Movement Task force -MTF, which draws participants from its technical departments (WASH, Protection, Health, DM and Support Services), in-country PNs, IFRC and ICRC. Externally, SSRC and IFRC are active participants in the National Task Force - NTF, members of the Social Mobilization and Risk Communication technical working group -TWG, and co-lead of the Safe and Dignified Burial TWG as well as Case Management and WASH-TWG. SSRC also coordinates with various partners at operational level.

In total, SSRC trained **180** volunteers on RCSMCE, SDB, and PSS. These volunteers are all currently engaged in risk communication and social mobilization activities while those trained on SDB remain active and engaged until they are ready to be deployed. Importantly, the SDB team timely and effectively responded to two alerts of suspected EVD cases in Yei and Yambio, of which collected samples from the deceased tested negative for Ebola.

IFRC deployed two EVD technical surge to support the SSRC for SDB preparedness in planning, training implementation and coordination. The MoH South Sudan seconded an experienced health staff to support the SSRC on RCSMCE.

1.3.1.5 Uganda

In spite of preparedness efforts, Uganda remained at very high risk for EVD, due to its proximity to the border and affected area in DRC. On 11th June 2019, The Ugandan Minister of Health made an official statement of an EVD outbreak in Kasese district, in South West Uganda. Kasese is one of the districts categorized as most at risk, where Uganda Red Cross Society had been implementing preparedness activities.

The index case was a 5-year-old male who returned to Uganda from DRC with his family on 9th June 2019 after attending a burial of the grandfather who had succumbed to EVD. The child and his family entered Uganda through Bwera Border post and sought medical care at Kagando hospital. The grandmother and 3-year-old brother also started presenting signs of EVD, both tested positive and have also succumbed to EVD.

On June 12th, a cross border meeting took place with DRC and Uganda representatives of the MoH, UNICEF, WHO and IOM. The DRC delegation requested to be allowed to return the cases to the ETU in Beni for further care as the DRC offers investigational therapeutic treatments that may offer some benefit to the patients which Uganda does not do. On June 13th, the DRC team successfully repatriated five people.

A total of 108 contacts have been identified and are being monitored, none of the contacts have developed symptoms. 1,900 vaccine doses have been received in Uganda from WHO and DRC with vaccinations on-going in Kasese district with a cumulative 846 people vaccinated as at 23rd June 2019, as per MoH SitRep #12.

Following the EVD outbreak, Uganda is now implementing activities using a dual approach of response and preparedness. URCS scaled up its preparedness activities with an initial DREF loan.

Through the initial DREF operation from September to March 2019, URCS achieved the following:
- Immediately following the declaration of the outbreak in DRC, URCS developed an **EVD Plan of Action** and rapidly mobilized volunteers through the branches in Bundibugyo, Kasese, Kabarole, Kisoro and Rukungiri/Kanungu to support border screening and risk communication interventions.
- **360 volunteers have been conducting sensitization activities at community level** (increased from 180 through funds from UNICEF). These volunteers provide facts on Ebola to allay fears and anxiety, raised in occasion of suspected cases, identify individuals with psychosocial needs, provide psychological first aid, and make appropriate referrals if required
- **184 volunteers have been conducting screening at PoE's** through support from WFP and the DREF.

- Community volunteers support passive health surveillance in all districts of intervention, referring people to health structures, using the established referral paths.
- An **operational meeting was organized between URCS and DRC RC, with the objective to strengthen cross border collaboration** through sharing information and lessons learned.

Two URCS Head Quarter Health Department staff, the Health Director and the Emergency Preparedness and Response (EPR) Manager, are part-time engaged in the EVD Preparedness operation, overseeing the operation and providing technical guidance. Additional operational support is provided by branch managers operational and support staff and National Disaster Response Team (NDRT) members. Nevertheless, URCS acknowledges the need to strengthen its coordination and technical capacities both at HQ and field level. Therefore, along with the revision of its contingency plan, URCS elaborated a HR structure specifically to EVD operations. Some of this is funded through external Movement channels, but sustainability of the activities require support through the OIA.

Uganda EVD preparedness operation has been funded by IFRC DREF, IFRC USAID, UNICEF, WFP, IOM and WHO. From September 2018-April 2019, the operation was fully funded. However, funding reduced significantly after April 2019, with the following impact:

- Risk communication, community engagement and sensibilization on EVD is currently not being implemented in 5 out of 7 districts targeted since September 2018 and urgently need to be re-started;
- URCS continued screening at 39 PoEs although since May 2019, there has not been any budget to support volunteers' incentives in 16 points of entry located in Bundibudgyo, Kasese and Ntoroko. In addition, there is an urgent need to strengthen surveillance in additional point of entry, mainly unofficial ones.
- Withdrawal of humanitarian actors is seen by communities as an end to the Ebola crisis, with most exercising less care in health practices.
- URCS is not SDB prepared: only 1 Training of Trainers for 26 people was conducted in December 2018. As result, there are no teams trained, equipped and ready for direct response. SDB preparedness is an urgent need and priority activity to be supported through the training of 3 teams.

1.3.1. Provincial preparedness in DRC

The preparedness activities aim to prevent the propagation of outbreak in surrounding health zones in North Kivu and Ituri. In the last EPoA as revised in March 2019, 6 high risk zones were identified for being supported with preparedness activities with an entry point to CEA activities. In addition, 3 ERT (mobile teams) could be activated to conduct SDB activities in the areas. These activities were designed to meet 342,386 people with the health and preparedness activities though have been delayed in some areas due to lack of funding. These activities are currently being re-assessed to align with the current disease trends and coordination discussions for at-risk areas.

Key ongoing and future activities include:

- Support to DRCRC in prevention and immediate interventions in high risk health zones and priority neighbouring provinces;
- Training of volunteers and their deployment in the field for risk communication and community engagement (CEA), for safe and dignified burials (SDB) and for Psychosocial Support (PSS);
- The capacity building of DRCRC to respond effectively in the future to any possible outbreak and strengthen the coordination system with the Ministry of Health and other partners.

Given the risk of the epidemic spreading to neighbouring areas with the number reached so far but also the flow of population movements in North Kivu and Ituri and with neighbouring countries, it would be crucial to extend these activities to other high-risk health areas.

1.4. Overview of Red Cross Red Crescent Movement in DRC

The DRC Country Office of the International Federation of Red Cross and Red Crescent Societies (IFRC) has been strengthened through the deployment of regional and global surge capacity and hiring of staff to support the NS and the response effort for both outbreaks. Five partner National Societies (Belgium Red Cross, Canadian Red Cross, French Red Cross, Spanish Red Cross and Swedish Red Cross) have long standing programs with the National Society. The International Committee of the Red Cross (ICRC) is present in 10 provinces of the country with programmes responding to the protection and assistance needs of the population affected by armed conflict and other situations of violence.

The Red Cross of the DRC (DRC RC) is present in all provinces and territories of the country. While the response for the 9th outbreak in the non-conflict area of Equateur was carried out under the co-leadership of IFRC and RCDRC, the 10th outbreak, being in a conflict area, is under ICRC lead for operational access, including security management. This was confirmed during a Mini-Summit held on 02 August in Kinshasa. For this new epidemic and due to the specificity of the location, the IFRC and the ICRC developed together a joint approach where clear roles and responsibilities have been agreed upon through multi-level and daily coordination.

The ICRC has a deep understanding of the affected area (including an office in Beni since 2008) allowing it to help communities affected by armed conflict and violence.

Several Movement coordination mechanisms have been put in place at provincial level (Equateur, North Kivu and Ituri), national (Kinshasa), regional (Nairobi) and headquarters level (Geneva) between the DRC RC, the IFRC and the ICRC in order to ensure smooth implementation of the different activities. Tripartite meetings are also regularly organised for operational and strategic discussion. It will be critical to have a whole Movement approach moving forward in this operation, particularly during the end transition phase outside of the EVD OIA. This is noted and agreed by PNS, ICRC, IFRC and DRC RC in the above recommendations from the strategic workshop held in Kinshasa on June 7-8.

1.5. Overview of non – RCRC actors in country

There are currently more than 60 national and international organizations (including local authorities) involved in the ongoing EVD response in North Kivu and Ituri provinces. In addition, there are 166 humanitarian actors registered on the 2019 Humanitarian Response Plan[14], outside of the EVD response although there are a number of partners that are active in both domains.

The organigram for the EVD response was revised in April 2019 and clearly defines the roles and responsibilities and interaction of the various EVD partners across the five response levels;

1. The National Coordination Committee in Kinshasa presided by MSP, with the Representatives of UN agencies involved in the EVD response, the Secretary General for Health and the Inspector General for Health, Representation from other Ministers (Education, Defence, Finance), Presidents of the commissions and representatives of partners, co-leads and civil society. This is supported by;
    - National Secretariat (lead MSP, Co-lead WHO-OCHA)
    - Information Management and analysis cell (lead MSP, Co-lead CDC-WHO)
    - Head of Ebola Emergency Operation (lead SD-DGLM, Co-lead WHO)
    - Monitoring and evaluation cell (Lead DEP-MSP, Co-lead WHO-OCHA)
2. General Coordination Goma
    - Leadership by the General Coordinator (MSP), with Heads of Divisions, Provincial Health Inspector, UN EVD Coordinator, WHO Incident Manager, OCHA Ebola team lead, Partner representatives (including The Red Cross Movement), small strategic

[14] https://www.humanitarianresponse.info/en/operations/democratic-republic-congo/document/rd-congo-plan-de-réponse-humanitaire-2019

committee (of the General Coordination Team) and representatives from other Provincial Ministers
    - Secretariat (MSP)
    - Information management and analysis cell (MSP/CDC/UNICEF/WHO)
    - Monitoring and evaluation cell (MSP/WHO/OCHA)
    - Operational Manager and Coordinator of the commissions (MSP)
        - Security Commission (MSP/MONUSCO/WHO)
        - Logistics (MSP/WFP/WHO)
        - Surveillance (MSP/WHO)
        - Infection Prevention and Control (MSP/WHO/UNICEF)
        - **Safe and dignified burials sub-commission (MSP/Red Cross)**
        - Risk Communication and Community Engagement (MSP/WHO/UNICEF)
        - Medical care (MSP/WHO)
        - Psychosocial care (MSP/UNICEF)
        - Laboratory and research (MSP/WHO)
        - Contact tracing, vaccination, Point of Entry/ Point of Control
    -
3. Operational Sub-Coordination at Field Level (Beni, Butembo, Katwa etc) with Chief Zone Medical Officer, UN field EVD coordinator, WHO field Coordinator, OCHA Field Humanitarian Affairs Officer, sub-commissions, Sub-commissions, co-leads, response partners and civil society, community leaders.
4. Health Zone Support Teams with Chief Zone Medical Officer, local emergency coordination committee, WHO sub-head lead, representatives from local authorities and local health facilities, community leaders and local response partners. In high risk areas also supported by an Integrated Support team (senior epidemiologist, alert focal point, contact tracing, Communication and Community engagement, IPC/WASH, psychosocial support)
5. Health Area Intervention Teams with integrated response team (surveillance, Communication and Community engagement, IPC/WASH)

Though we are noted as co-chair for SDB, the Movement is represented across all five levels.
In recognition of the need for high level political support David Gressly was appointed as the new UN Emergency Ebola Response Coordinator on 23 May 2019. Under this direction the scope of SRP4 will be broadened to include the wider humanitarian infrastructure through 5 pillars.

1. Strengthening public health response in support of the Ministry of Health;
    a. Risk Communication and Community Engagement (UNICEF)
    b. Surveillance, Contact tracing and vaccination (WHO)
    c. Laboratories (WHO)
    d. Clinical Management and isolation (WHO)
    e. Infection Prevention and Control (WHO/UNICEF)
    f. Safe and Dignified Burials (IFRC)
    g. Psychosocial Support (UNICEF)
    h. Operational Readiness in at risk provinces (WHO)
2. Strengthening political engagement, security and operational support (UN Emergency Coordinator/ EERC)
    a. Safe work environment and security (MONUSCU/UNDSS)
    b. Enhanced political engagement (SSRG/EERC)
    c. Common support services (WFP)
3. Strengthened support to communities affected by Ebola (EERC)
    a. Community works (World Bank)
    b. Community ownership and essential services (UNICEF)
    c. Multi-sectoral coordination for humanitarian response (OCHA)
4. Strengthened financial planning, monitoring and reporting (World Bank)
5. Strengthened preparedness for surrounding countries (WHO/OCHA)

1.6 Regional Preparedness: Overview of Host National Society, Red Cross Red Crescent Movement, and non – RC actors in country

Burundi

While the Government of Burundi does not have an EVD prevention policy, it has established a National Ebola Taskforce, which the Burundi Red Cross Society (BRCS) is part of, which developed an EVD Contingency Plan. Through this taskforce BRCS has been requested to implement and lead the SDB pillar of the EVD Preparedness Contingency Plan as well as supporting dissemination of EVD messages through radio spots and mobile cinemas. In addition, BRCS is represented in 6 technical commissions: Coordination, Operations (ETC and a Laboratory), PMER, Finances and Logistics, Prevention and Infections Control and RCCE. The NS would like to continue to participate in National Coordination meeting on EVD as well as in joint monitoring missions to assess preparedness in the high-risk provinces. BRCS is an active member of the National Platform in charge of the coordination of humanitarian actors, which is managed under the Ministry of Security. The IFRC has a Country Cluster Support Team (CCST) Office for Eastern Africa and a Regional Office for Africa, in Nairobi. It has deployed 2 surge staff to Burundi to support the NS enhance its SDB capacities as well as coordination at country level. The NS also hosts and receives support from in-country Movement partners including the ICRC and Partner National Societies (PNSs) which are the Belgium-Flanders and Francophone, Finnish, Luxemburg, Netherlands, Norwegian and Spanish Red Cross Societies.

Rwanda

The Rwanda Red Cross Society (RRCS) is part of the National Rapid Response Team (NRRT). The NRRT is the national level coordination team and is composed of the Ministry of Health (MoH)/Rwanda Bio-Medical Centre, and major NGO and UN partners. Weekly meetings are held to update and coordinate the response strategies. RRCS was tasked with community surveillance/contact tracing, risk communication/ social mobilization and community engagement, SDB/Decontamination, as well as PSS. A partners coordination forum, where pertinent issues in areas of coordination, case management, infection prevention and control, surveillance, laboratory capacities and other relevant issues in EVD preparedness are discussed regularly, was established. The National Contingency plan is currently being reviewed by the NRRT and technical working groups. A 72-Hours National Response Plan has also been developed.

IFRC is assisting through the Eastern Africa CCST as well as through the Africa Regional Office. There is regular contact with IFRC Nairobi Operations and Health teams and RRCS has been updating on coordination meetings and preparedness action plans. Surge FACT support was also deployed in January 2019 to assist with coordination and ensure that the requirements for SDB readiness are in place. RC partners in-country include the Danish RC, Belgian-Fl, Belgian Fr, Spanish RC and Austrian RC, some of whom have supported preparedness activities for EVD including mobile cinema, SDB and community sensitization. The initial contingency plan focused on 10 districts (bordering DRC and Uganda) and Kigali city. During a review led by MoH, three other districts were added to the list following a review meeting in January 2019: Nyabihu (which was initially overlooked), Nyanza and Bugesera (both host refugee transit centres).

South Sudan

The South Sudan Red Cross (SSRC) is an active member of the National Task Force (NTF), and two Technical Working Groups; Risk Communication, Social Mobilization & Community Engagement (RCSMCE) and Safe and Dignified Burial (SDB) Technical working groups. The SSRC is one of the implementing partners engaged in RCSMCE activities in the four operational areas (high-risk border towns and points of entry), namely; Nimule, Yei, Maridi and Yambio, thus complementing the efforts of the Ministry of Health and other partners in behavioural change communication with regards to EVD.

IFRC is providing technical support to SSRC for training on SDB, RCSMCE, Coordination of the EVD Preparedness at Regional, National and State levels and resource mobilization. Surge FACT support was deployed to assist with coordination and ensure that requirements for SDB

preparedness and readiness are in place. In addition, a RDRT Surge was deployed to support with the training and setting up of 6 SSRC's volunteers SDB teams in the target high-risk locations.
At the country level, SSRC with support of IFRC, coordinates the EVD preparedness operation in close cooperation and support of ICRC, and 9 Partner National Societies (PNSs). IFRC is monitoring the development of the situation in DRC through the regional coordination mechanism. Through this mechanism, IFRC is facilitating information sharing with at-risk neighbouring countries.

Uganda

The MoH has been coordinating the Ebola preparedness actions in country, through central and district level Joint Task Forces. Following the confirmation of the outbreak, MoH has maintained lead role in coordinating response activities, National and District Taskforces (NTF and DTF) were activated with a focus on response. The Ugandan Ministry of Health has also activated the Public Health Emergency Operations Centre (PHEOC). The NTF developed a 3 months EVD Response Plan (June to August) which has been validated and guides the implementation of EVD activities in Uganda. After this period, in line with the development of the situation in DRC preparedness activities will continue under the guidance of the MoH.

The Uganda Red Cross Society (URCS) has been participating in the MoH led National Taskforce meetings and engaged in national preparedness activities such as reviewing EVD contingency plan, surveillance on cross border population movement and mobilization of people for a potential response. URCS also participated in the development of the National EVD Response Plan and URCS activities and resources mobilised are complementing and contributing to the achievement of the National Response Plan activities/targets. As of 22nd June, URCS received from the MoH a letter acknowledging and introducing the National Society to the districts as main partner to implement SDB, among other interventions.

Two URCS Head Quarter Health Department staff, the Health Director and the Emergency Preparedness and Response (EPR) Manager, are part-time engaged in the EVD Preparedness operation, overseeing the operation and providing technical guidance. Additional operational support is provided by branch managers operational and support staff and National Disaster Response Team (NDRT) members. Nevertheless, URCS acknowledges the need to strengthen its coordination and technical capacities both at HQ and field level. Therefore, along with the revision of its contingency plan, URCS elaborated a HR structure specifically to EVD operations.

At the country level, URCS works together with the IFRC, ICRC, and Partner National Societies (PNSs) including, the Netherlands Red Cross, German Red Cross, Belgium Red Cross-Flanders, Austrian Red Cross, Icelandic Red Cross and the Canadian Red Cross. Movement partners work together with URCS in the areas of WASH, community-based health and care, protection, livelihoods, preparedness and National Society Development. The variety of interventions and their extensive geographical coverage guarantee an added value in terms of technical and logistical support to the Ebola preparedness operation as well as resource mobilization coordination.

IFRC has been supporting URCS with the development of the URCS EVD Plan of Action and the revision of IFRC Contingency plan, as well as with the EVD Preparedness DREF implemented between September 2018 and March 2019. IFRC has an in-country team supporting the EVD operation, consisting of 1 Programme Coordinator overseeing the full IFRC portfolio in Uganda and 1 Finance Delegate.

At the aftermath of the outbreak declaration in Uganda, the IFRC deployed:

- 1 DM Delegate/DHEOPs from the EACCST between 14th and 23rd June;
- 1 Communication Officer from the EACCST, supporting content gathering and CEA activities, between 13th and 21st June.

In addition to that:

- 1 FACT Team Leader will be deployed for an initial period of 5 weeks, between June 26th and July 17th for supporting coordination at national level, strategic development of the operation and resource mobilization. This was funded through the Regional Coordination for EVD OIA;
- 1 Operations Manager alert was raised to support the implementation of the DREF operation and coordination at field level.
- 1 SDB technical surge alert will be raised with support from external funding

Additional surge capacity will be considered based on needs and development of the situation.

2. NEEDS ANALYSIS AND SCENARIO PLANNING

2.1. Needs analysis

DRC:
Given the high number of health zones (HZ) involved (23 as of 7 July), the 10th outbreak is recorded as having the largest geographic spread in the history of EVD outbreaks in DR Congo and also the largest number of cases (nearly 2,500 to date) and fatalities (more than 1,500, 67% lethality). While Mabalako health zone (Mangina) was initially the most affected area, the epicentre and areas with the most intense transmission have continued to shift, affecting both new and previously affected health zones. At various times, Mabalako, Beni, Butembo/Katwa have each been the epicentre of the outbreak, with the epicentre shifting back to Beni at the time of writing. Throughout the epidemic, the most active transmission and most cases have occurred within the Mabalako-Beni-Butembo/Katwa triangle.

In North Kivu and Ituri provinces, access challenges in several affected areas, along with community resistance, represent two major hindrances of the emergency operation, affecting greatly the reach and the coverage of the programmed activities. Limited knowledge of EVD within the population and among health personnel remains a key barrier to behaviour change at the household and health systems levels.

According to the findings of community surveys, awareness about EVD risks and prevention has increased. Nevertheless, there are significant gaps in understanding about Ebola Treatment Centres (ETC), signs and symptoms and what to do in case a person is sick or dies after experiencing EVD symptoms. Further, communities are not effectively informed about the progression of or response to the outbreak, which is critical to build trust and overall knowledge. There are key sociocultural, political and economic issues that are fuelling the epidemic and hindering community engagement efforts. While the socio-political context in the affected areas is very complex, more needs to be done to inform and engage communities and adapt to communities identified needs and priorities.

To inform the operation, the Red Cross community feedback mechanism captures essential community views on EVD and the response. By regularly gathering and analysing community rumours, beliefs, observations, questions and suggestions using an interdisciplinary approach and novel tools, field teams and decision-makers are provided with useful insights that inform risk communication and community engagement approaches across the response. These localised community insights must also be systematically used both within the Red Cross and across the broader response to inform adaptations to the technical approaches of the response itself.

Some of the main findings of community feedback relate to community mistrust of the government and organizations engaged in the EVD response; however, they also highlight communities willingness to understand more and protect themselves. Further undermining trust and cohesion, Ebola is often perceived to be a political scheme, or a lucrative business. Doubts and concern are also raised about the vaccination approach and safe and dignified burials.

Communities consistently demonstrate their need for comprehensive information that goes beyond the repetition of basic messaging. They demand more information about vaccines, Ebola effects and outcomes, and more broadly about the operation itself. The main themes of communities' requests are the following: to better explain 1) what Ebola is, 2) where it comes from, 3) what can be done to prevent it, and 4) requests to be more meaningfully involved in the response and to allow community members to influence their neighbours to change behaviours and stop the spread of EVD. Drawing lessons learned

from DRC, the Regional Office and Cluster Office are investigating how to integrate these community feedback approaches into existing response and community structures, particularly those already existing for CEA, across the containment countries in Uganda, Burundi, Rwanda and South Sudan.

In terms of primary health services, many health facilities (FOSA) do not have the required infrastructure, materials, or knowledge of infection prevention and control (IPC) practices and behaviours—including case identification, triage and isolation—to prevent transmission of the virus within health facilities[15]. Many health workers have been infected (almost 130 to date) because of lack of basic knowledge about IPC. It is also common to have poor (or no) surveillance in health facilities and to mistake EVD for malaria or other diseases. IPC measures and training of staff is therefore an important activity to detect suspected cases early and to limit the spread of EVD from one patient to the other or from an infected patient to medical personnel. IPC activities need to be intensified across the affected areas and in areas at risk of transmission or importation.

Safe and dignified burials (SDB) are critical to preventing transmission of the virus, particularly for people who died in the community without knowing they were infected. Red Cross volunteers, working alongside Civil Protection members originally trained by the Red Cross, lead this sector. In urban areas like Beni and Butembo, both Red Cross and Civil Protection SDB teams are highly operational. Civil Protection teams have played a critical role in SDB activities in high-risk areas (often using armed paid police escorts), which complements the ongoing RC SDB response.

Given the nature of their tasks and the challenging environment, PSS support to the SDB volunteers is essential. SDB teams face grieving families and communities daily, and they have encountered resistance and experienced animosity and both verbal and physical attacks from community members.

In support of the above, and in line with IFRC's National Society Development (NSD) framework, the operational needs should be addressed by continuing to support a well-performing National Society, both in its staff and volunteer capacity, to have a lasting impact on the individuals and communities it serves, standing longer than the current operational timeframe of the EVD outbreak.

Uganda:

Since the beginning of the outbreak the MoH has been receiving alerts of suspected cases which are being isolated and tested. Given the number of alerts received, as well as continued movement between DRC and Uganda through both official and unofficial entry points, there is a high risk of EVD cases crossing the border, as happened in June 2019. There is therefore a need to continue ensuring vigilance and scaling up the Ugandan RC response and preparedness actions in at-risk districts, including those bordering DRC. To ensure rapid detection of cases there is a need to scale up community-based surveillance activities, risk communication, and screening at points of entry and points of control. Following the importation of cases from DRC, implementation of social mobilization activities will also aim to reduce tensions in communities. Risk communication and community engagement and screening at entry points are essential to quickly identify and isolate cases, while limiting negative social impacts on people associated with the outbreak. Given the likelihood of new cases, there is a need to ensure enough capacity to perform SDB in the at-risk districts. Early community engagement and acceptance are essential to raise awareness on safe burial protocols.

Cross border population movements for trade, family, religious, health and education related services increases the risk of more EVD cases to be identified in Uganda. In addition, since January 2018, Uganda is experiencing a high influx of Congolese refugees due to the security situation in North Kivu and Ituri provinces, which are both affected by the current EVD outbreak. As of 31st May 2019, there were nearly 350,000 DRC refugees in Uganda[16].

In addition to the refugee influx there is a considerable number of people crossing the Uganda-DRC border through:

- Entebbe International Airport with daily flights between Entebbe, Kinshasa and Goma;

[15] A recent inspection determined that out of 305 FOSA in the Beni Health Zone, only 24 are state owned and following official MoH guidelines, while many of the others are purely commercial structures unaware of even the most elementary norms.

[16] Uganda Refugee Response, May 31, 2019

- Unofficial land border crossings which may represent many more border crossing points than there are official border entry points. An estimated 57 approved entry points are used daily;
- Numerous bus terminals with daily links between Kampala and major towns in the Eastern DRC.

2.2. Scenario planning

2.2.1. 9th Outbreak

Following the official declaration of the conclusion of the EVD 9th outbreak, the intervention strategy changed, and priorities were re-oriented towards recovery and preparedness.
While 3 scenarios[17] were envisaged during the initial emergency planning, scenario one ''No other case of EVD is reported'' prevailed. The planning and intervention were focused on Post EVD transition phase and was characterized by a significant downward scaling of the activities and the phasing out of several actors involved in the response. Community surveillance, risk communication, PSS, WASH and IPC activities were maintained under the transition phase in Equateur at least for 90 days beyond the official period of end of Ebola.

2.2.2. 10th Outbreak

The response to this 10th Ebola outbreak has many challenges, as a public health emergency within a wider complex humanitarian response involving multiple armed groups it faces ongoing insecurity and a difficult social and political context. This has produced an environment of mistrust within the affected communities and has led to the reluctance, refusal and resistance of some communities to the EVD response.

There are many incidents or threats that directly, or indirectly, affect the teams involved in the response. Since the beginning of the epidemic, several cases of security incidents have been recorded by INSO teams, with at least two deaths, including an international staff from Cameroun working for WHO. Discussions have already been held at several levels with the authorities at local, national and international level to calm people's minds, but much remains to be improved in this regard.

This situation has had very significant impacts on the intervention in the region, especially in the Butembo and Katwa health zones.
Added to this, the repeated fighting events between the regular army of the Democratic Republic of Congo (FARDC) and the numerous armed groups (AG) on the one hand, and attacks by AG (ADF, Mai Mai among others) on the population on the other hand, which make it difficult to respond.

On 7 May 2019, following the death of one motorcycle taxi driver killed in an accident involving an NGO vehicle, Mai Mai groups attacked FARDC and police positions around Butembo and downtown. Following these clashes, eight persons were killed.

Since 10 June 2019, violent inter-ethnic clashes between two communities have erupted in the Djugu territory, Ituri province. At least 160 people were reportedly killed[18] and houses burnt down, forcing people to flee their homes and seek refuge in Bunia and around the town. Activities had to be temporarily suspended in the affected area due to increased insecurity.
With this situation of insecurity making some areas inaccessible and community resistance, the epidemic has surpassed 2'300 confirmed cases and 1'530 deaths and is the most deadly of the ten Ebola epidemics in the history of DRC. In recent weeks, some health zones such as Rwampara or Bunia that had not recorded other cases of MVE for more than 40 days have seen new cases.

[17] The 3 scenarios were: (1) No other case of EVD is reported, (2) One or several cases of EVD are reported from a remote site and (3) One or several cases of EVD are reported from a larger urban center such as Mbandaka.
[18] https://observers.france24.com/fr/20190620-rd-congo-messacres-ituri-nombreux-corps-pourrisent-encore-brousse

In this context, the current scenario is such that the risk of contamination and spread of the epidemic is still high, and the disease in the affected area remains difficult to control as some contact cases still show resistance or disappear. The fragility of surveillance at border crossings with neighbouring countries also worsens the epidemic's export risk beyond the borders of the DRC.

2.2.3. Scenario analysis for North Kivu and Ituri Provinces and Uganda

The scenarios have been updated to reflect the situation as of 16 June 2019. The updated operational plan and budget is based on the revised scenario 1. This scenario has several planning assumptions which will continue to be monitored throughout the operation. Contingency planning is also occurring with triggers identified to inform a scale up of relevant activities. The current Movement strategy is based on responding to this scenario and being ready to activate the contingency plan. The operation has also in place provisions for ensuring continuity of services to vulnerable people in case of a deterioration of the security situation in the country.

SCENARIO	ASSUMPTIONS	KEY ELEMENTS OF RESPONSE
Scenario 1	Outbreak is largely contained to the 22 health zones that have so far been affected and remains mostly in North Kivu and Ituri Provinces with single cases or small clusters in other neighbouring zones and/or export to neighbouring countries without ongoing transmission (such as Uganda cluster of 12 June). Average EVD caseload remains at or below 100 cases per week without significant acceleration or geographical expansion On average 50% of cases are unknown contacts, suggesting that there are many potential unknown transmission chains driving the epidemic. This is driven by risk factors such as delayed time between symptoms and isolation/seeking of treatment, high movement of contacts and an increased number of community deaths Risk of potential spread of cases to neighbouring provinces but PoE control is working effectively able to detect suspected cases reducing the risk. Security situation allows continuity of response Timeframe 6 months	• Movement interventions focus on 5 key pillars in North Kivu and Ituri provinces with a DRC RC and nationally led response • The response remains supported by the L3 agreement, whereby "IFRC has the operational expertise for programmatic response especially in Safe and Dignified Burials (SDB), Community Engagement and Accountability, Psychosocial Support, Surveillance and IPC while the ICRC is leading the operation, mainly in terms of security (including movements, deployment capacity, accommodation, etc.) and field expertise in the area, especially regarding the response in detention facilities • Security situation allows effective response despite access constraints • Close coordination with partners across all pillars for an effective response • Increase logistics and material supplies to support the operational plan • Maintain the support/liaison office in ICRC Sub-Delegation of Goma for the IFRC • Increase HR structure to support the operational plan • Volunteers mobilised and trained for effective response • Communities are engaged and provided with needed information, messaging is tailored to beliefs, concerns and questions tracked by community engagement volunteers • Preparedness/ contingency planning activities by DRC RC in Health Zones at risk as security allows as well as nationally • Preparedness activities by National Societies of the neighbouring at risk countries with population movement/ transportation links with affected area • Legal preparedness through IDRL and advocacy to facilitate the entrance of international humanitarian assistance in the UN system-wide activation • Flexibility and revision of the plans as needed based on the evolution of the epidemic • Anticipation of the next phase with preparation of a Transition & Preparedness Plan

Scenario 2	Major surge in cases (over 100 cases per week) in North Kivu and Ituri, expansion into non-affected health zones, including areas with access restrictions Appearance of cases in urban centres (including Goma) Spill over to neighbouring provinces Spill over of cases to neighbouring countries with local transmission (not only imported cases) A Public Health Emergency of International Concern is declared as the number of cases increases weekly, exceeding 500 and cases reported regionally Timeframe 12 months	• Revision of operational plan to scale up in all pillars in affected areas in close coordination with ICRC, DRC RC and IFRC and still supported by the L3 agreement • Scale- up from preparedness to active response in neighbouring affected provinces and neighbouring countries • Scale-up of offices in each affected province • Deployment of further surge to support the operation at provincial, national and regional level • Establishment of Regional Ebola Hub • Training and mobilizing additional volunteers from all targeted areas • Communities are engaged and provided with needed information, messaging is tailored to beliefs, concerns and questions tracked by community engagement volunteers • Close coordination with other stakeholders • Revision of the OIA and EPoA • Adding case management as new pillar for response as needed • Increase of supply chain and logistics capacity to match the size of the operation • Prevention and Preparedness activities in additional at-risk provinces and additional at-risk countries (regional) • Regional legal preparedness to facilitate the coordination of international humanitarian assistance • Flexibility and revision of the plans as needed based on the evolvement of the epidemic.

Three possible scenarios have been identified for the response in the at-risk countries:

Best case scenario	Most likely scenario	Worst case scenario
The EVD outbreak is contained within DRC through effective identification and isolation of cases, and other control interventions including point of entry and point of control screening, IPC and vaccination.	Isolated cases such as those that occurred in Uganda continue to cross the border to one or more neighbouring countries. Effective contact tracing, point of control screening, risk communication and IPC at health facilities near the border, and interagency communication rapidly identify suspect cases and isolate them with limited onwards transmission.	Isolated cases crossing the border are not identified in a timely way, or at all, and people with EVD die in previously unaffected communities in one or more neighbouring countries. This results in onwards transmission due to unsafe care in the community and unsafe burials. Cases are not identified until after this onwards transmission has occurred, and an outbreak is declared in a neighbouring country.

2.3. Operation Risk Assessment

DRC:

On 15 November, heavy fighting involving the Armed Forces of the Democratic Republic of Congo (FARDC), the United Nations Organization Stabilization Mission in the DRC (MONUSCO) and the Allied Democratic Forces (ADF) North of Beni resulted in the death of 7 peacekeepers. Other attacks to the MONUSCO base occurred later in the week with collateral damages in the surrounding of the MONUSCO compound and the nearby houses, where many UN staff are being located. Beyond the impacts on the operation, the civilian population had to bear much of the impact of the conflict, which necessitates constant vigilance in ensuring humanitarian action.

In addition, the high prevalence of rumours and misinformation linked to Ebola outbreaks has affected how communities perceive and respond to Red Cross staff and volunteers, which can increase the risk of violent incidents. In Butembo, a team of the Red cross was attacked and injured in October (Press Release), and two Congolese health workers supporting the response were killed on 20 October.

During the current operation, security incidents were identified at different dates. In a non-random way we can quote:

- In April 2019, an Ebola health centre was attacked by a self-defence militia resulting in the killing of an international organisation (OMS) doctor.
- In June 2019, a group of hopeless and jobless youth attacked the RC SDB team at a family graveyard, harming the vehicle driver slightly and stealing telephones of the team after breaking the vehicle windscreen.
- Still in June, clashes between two long standing rivalry ethnic groups in Djugu Territory resulted in dozens of killings (>160), houses burnt down and tens of thousands IDPs.
- Community resistance to Ebola responders is still active in several communities within our operational bases, though its space is less wide compared to what it used to be in the beginning of year 2019.

As part of the response, the Movement is implementing activities with different risk levels. Many of the activities carry low level risk like RCCE and IPC support whereas the SDB process carries the highest risk if not performed correctly. Based on this, the operation has developed a risk management strategy for security and risks. This includes multi-scenario planning with security and health triggers, and related evacuation protocols for ensuring the safety of personnel. In addition, the operation developed an internal risk register to prevent fraud and corruption and trained 12 Security Focal Points to serve in 5 operational bases in North Kivu and Ituri Provinces. Security Standard Operating Procedures are being developed along with Risk mitigation measures so as to effectively and safely implement operational activities.

Moreover, a plan has been designed to define the main strategic and operational priorities as well as the minimum set-up, this to be able to continue activities and overcome unpredicted events throughout the end of the year 2019.

Fears of increased insecurity after the general elections of December 2018 did concretize. The post-election period was by and large relatively calm despite claims for victory by one frontrunner presidential candidate. The new DRC President has designated a Prime Minister in May 2019, who did not form his cabinet so far.

Main opposition leaders have been active protesting against the results of the presidential elections and have presently a joint agenda aiming at destabilizing the regime through street political protests. The recent invalidation of provincial assembly representatives by the Constitutional Court is a motive for repeated attempts to disturb law and order.

Such political factors combined with the already volatile and precarious security context in North Kivu are leading to a change of the set-up. In line with the ICRC strategy, the IFRC reviewed its current set-up and restricted field trips while ensuring sustainability of the activities and the continuation of the EVD response.

Analysis and scenarios planning are ongoing to ensure risks such as described above are well taken into consideration and measures are developed to mitigate their impact on the operation.

Uganda:

The following are related to the risk assessment for the response in Uganda:

1) Volunteer protection:
URCS has a duty of care towards volunteers who will be involved in high risk activities and/or areas of operation, including Points of Entry (PoE) screening and SDB. The risk for EVD infection of staff and volunteers is being mitigated through MoH, WHO and Red Cross orientations and trainings on screening and Infection Prevention and Control (IPC) as well as through the procurement of appropriate protective gears (PPEs). However, all volunteers do have gaps in knowledge and procedures in IPC as well as in usage of PPE, which brings a substantial risk of infection and therefore there is a need of strengthen IPC/PPE knowledge of volunteers in the field.

To mitigate the risk among URCS volunteers, the IFRC Operations Manager will conduct routine orientation sessions for volunteers at PoEs. SDB drills and simulations will also reinforce skills and improve safety, specifically for the SDB teams. All volunteers are insured and, URCS will constantly keep volunteers informed on EVD vaccination campaigns organized by MoH and will facilitate their participation in case of interest. To cope with stress as result of resistance of community members to EVD messages and efforts of preventing discriminatory actions towards DRC communities. all volunteers will participate in 1 PSS session/district, led by URCS PSS officer.

2) Increase in refugee influx:
The influx from DRC might further increase due to ongoing instability in the neighbouring districts in DRC and fear of Ebola in DRC. The Office of the Prime Minister (OPM) for refugees, UNHCR and Ministry of Lands have already identified new locations in Isingiro District to settle refugees, when Kyaka II refugee settlement's capacity is exhausted. Additional refugees arriving from North Kivu, increased population movement exposes Uganda to a higher risk of EVD importation. The risk is being mitigated through the engagement of OPM and UNHCR who coordinate screening activities in transit and reception centres for all newly arriving refugees.

3) Increase/escalation of tensions/violence:
There is a potential risk that tensions/violence between Ugandan host communities and refugees increase and/or escalate. Given the EVD outbreak and deaths in Uganda the local communities may become hostile to Congolese due to fear of further cases/infection. Tensions may also occur at points of entry particularly the unofficial points with people resisting the screening exercise.

4) Spread of rumours on Ebola affecting URCS' access and security:
Rumours continue to be present in communities. This risk is being mitigated through the community sensitization activities supported through this response plan, rumours are tracked and followed up and communities are informed on Ebola symptoms, prevention and treatment.

3. OPERATIONAL STRATEGY

3.1. Proposed strategy

The vision is to support a community-led response by the National Societies across DRC, Uganda, Rwanda, Burundi and South Sudan with support of the Movement to end the EVD outbreak while also supporting the National Societies to be better prepared to respond to future epidemics with more autonomy.

This new vision has been developed while considering key elements in its design including security context, epidemic trends, analysis of available data internally and externally, shifts in humanitarian context (i.e. system-wide activation), financial mobilization and available capacity. The secondary goal is to lay foundations for health resilience where relevant at the community level by engaging support from our Movement partners while enacting the above vision.

3.2. Overall Operational objective

Contribute *to preventing and reducing morbidity and mortality resulting from the Ebola virus disease in the DRC, through focusing on:*

- Reinforcing the DRC RC response for immediate lifesaving interventions in the affected areas
- Roll out prevention and response activities in the affected and at-risk areas
- Coordinated response with the authorities/Ministry of Health, WHO and other key actors
- Engaging the affected people throughout the entire process and adapting our activities to meet communities' expressed needs.
- Strengthening the capacity of the National Society to respond to epidemics

The overall operational strategy with a focus on DRC RC and national response is proposed as below for DRC:

Plan:

- **Phase 1:** Transfer of knowledge through key indicators for EVD operations management and extension of activity implementation from delegates to DRC RC and IFRC national staff.
- **Phase 2:** Transfer of knowledge through key indicators for EVD operations management and extension of activity implementation from IFRC national staff to DRC RC staff and/or volunteers where hiring is not possible. Ongoing support from key delegate positions remains during this phase.

3.2.1. 9th Outbreak

Since 1st August 2018, the operation in Equateur has been engaged in the planning and implementation of the Post Ebola transition phase. The aim of the transition phase is twofold: (1) to strengthen the capacities of the health system in IPC and CBS and (2) maintain a proper preparedness mechanism through Risk communication (CEA) and PSS to affected communities. In this regard, IPC focuses on the construction and equipment of 5 triage facilities, plus training of medical staff who run the IPC facilities in 5 health zones of Equateur. At the same time, CBS will focus on maintaining surveillance of community diseases in the same health zone. Implementation of surveillance will be conducted by 30 well trained individuals composed of 60% Red Cross volunteers and 40% medical staff from the MoH. CEA, IPC, PSS and Surveillance activities will also continue through dedicated support staff in Equateur.

As the 9th epidemic has been declared over, the main thrust of the Equateur operation is on the transition to early recovery and implementation of preparedness activities at provincial and national level. This preparedness and transition plan focus on readiness, "epidemic surveillance" and early action. All the planned activities in the transition and preparedness plan fall under the crucial pillar of reinforcing the capacities of the NS, to assure an organizational readiness at national, provincial and committees' level in remote areas to deal with a potential new EVD outbreak. One important component is the scaling-up of surveillance activities as well as good community engagement capacity with the DRC RC. Despite the declaration of the 10th epidemic, such preparedness activities need to continue to be implemented. In fact, the 10th epidemic is a drastic reminder on the need to reinforce the capacities of response in DRC to face such outbreaks.

The Equateur operation will support the DRC RC in operational and institutional capacity building activities through:

- Setting up a multidisciplinary team to respond to epidemics in line with the activities outlined in the various pillars
- Strengthening capacities for efficient and transparent management, including training on financial management systems

- Improving the DRC RC offices in Bikoro, Itipo and Mbandaka
- Improving the DRC RC offices in North Kivu and Ituri (durable refurbishment for essential office structures)
- Training National Society teams in Mbandaka on warehousing (procedures and protocols) and on procurement procedures

As part of the preparedness component; a rapid response team will also be formed. This team will consist of staff for SDB and disinfection as well as support staff and will be equipped to deploy when needed. They will be supported with equipment for SDB and disinfection, vehicles, equipment for the construction of emergency operational bases, and other items required for rapid response. These teams will be deployed alongside the teams of the Ministry of Health.

3.2.2. 10th Outbreak

The 10th outbreak of EVD in North Kivu and Ituri provinces was declared by the Ministry of Public Health (MSP) on August 1, 2018. The Movement plan for this response is in line with the Government's Strategic Response Plans (SRPs). The initial strategic response plan (SRP-1) covered the period to October 2018, the second (SRP-2) up to January 2019 and the third (SRP-3) to July 2019. The SRP3 has just been reviewed and the fourth (SRP-4) through to December 2019 is currently being developed with the response partners.

The SRP3 was based on responding as a Public Health Emergency led by the (MSP)[19] and UN co-lead WHO. It was centered around 13 axes: coordination mechanisms, surveillance, capacity building of mobile laboratories, establishment of points of control, reinforcement of prevention measures and infection control, risk communication - social mobilization and community engagement, psychosocial care, support to the gratuity of health services, preparation of health zones and provinces adjacent to the epidemic outbreak, operational support and logistics, food distribution and security of human and material resources acquired for the response. Significant gains were made in treatment (increased number of Ebola Treatment Centres and Transit Centres, implementation of treatment cubes, a clinical trial of new treatment protocol), reinforced laboratory testing, strong ring vaccination protocol for contacts, increased Point of Entry (PoE) and Point of Control (PoC) monitoring, development of local Ebola committees and the piloting of community-led harm reduction SDB. However, there were a number of deficits, primarily the soloing of the response and a lack of integration with the wider humanitarian context and response to communities needs outside of Ebola. With the ongoing insecurity and the underlying social and political context there continues to be community mistrust, reluctance, refusal and resistance to the EVD response. The lack of a conflict resolution strategy for reported security incidents and the need for a clear strategy for managing community resistance was required. This was coupled with coordination challenges between the strategic coordination, sub-coordination and technical commissions, the weak follow up of contacts (on average at least 50% of cases were either unknown contacts or contacts lost to follow up), challenges in information management and fragmented database (no unique identification number), deficits in IPC at health facilities (protocols, infrastructure, training and knowledge of health care workers), ongoing challenges with community perceptions and resistance and insufficient preparedness capacity in high-risk health zones not yet affected by the epidemic.

The Movement has had strong participation in the development of the SRPs and is the co-lead of the SDB sub-commission with Civil Protection. The DRC RC and IFRC are recognized for their prominent role in risk communication and community engagement, particularly the community feedback as co-lead of the inter-commission community feedback working group and is considered a strong partner in support of IPC in the targeted health facilities. The ICRC is the primary partner on EVD preparedness and response for detention sites.

3.2.3. Protection, Gender and Inclusion

The IFRC as a principles-based and values-driven organization is inclusive of and engages with all members of society, with a priority for those most marginalized. It seeks to protect human dignity and promotes a culture of non-violence and peace. While responding Ebola Crisis, the IFRC utilizes

[19] https://www.who.int/emergencies/crises/cod/DRC-revised-plan-19october2018-en.pdf

the gender inclusive tools and guidance such as the Minimum Standard Commitments to Gender and Diversity, the IFRC Strategic Framework on Gender and Diversity issues, the Child Protection Action Plan and the Movement-wide Strategic Framework on Disability Inclusion. To ensure gender inclusive EDV response, IFRC undertakes following practical measures:

- Gender-balanced volunteer mobilization
- Collect, utilize and disseminate sex- and age-disaggregated data
- Gender and diversity concerns are considered across the assessment and intervention design and implementation with ensuring participation of women and girls and other vulnerable groups through community engagement approaches.
- During community consultations and awareness sessions, special effort is made to ensure women and people with disabilities are also included and feel comfortable to share their concerns and feedback
- The activity is implemented considering “do no harm” principles
- The protection activities endeavour to prevent family separation and are built in community mobilisation and support – with opportunities for women’s equal participation – to counter Ebola survivors stigmatisation and to assist in their integration into their communities. Close attention is also paid to the protection needs of children, women and girls in Ebola affected communities, building on the strengths and capacities of existing women’s and girls’ groups.
- A PSEA focal point has been appointed and the Code of Conduct has been translated into Swahili and is being distributed to volunteers.
- The ICRC continues its traditional activities around the armed conflict. It monitors the conduct of hostilities and the behaviour of the armed groups that could affect the Ebola responders (Health Care in Danger). Linked to other detainee’s population support activities: ICRC provides access to water, improvement of hygiene conditions, increase in cooking capacity and improvement of sanitation priority intervention of the Water and Habitat strategy. The following activities were or are being achieved.

- In Beni Prison, police and FARDC (camps and prison cells): IPC sensitisation and washing works + hygiene material donations and prison food
- In Butembo prison, police and FARDC: IPC sensitisation and washing works + hygiene equipment donations + food for prison
- In Bunia Prison, police and FARDC: IPC awareness and washing works + donations of hygiene equipment
- ICRC is equally providing food assistance to the detainees in the prisons of Beni and Butembo
- In Goma Prison: IPC sensitisation and washing works

3.2.4. Regional Preparedness

3.2.4.1. Overall Operational Objective

Although the strategies for each of the surrounding countries differ depending on the particular situation, threat level and coordination mechanisms/strategy of the respective national governments, the activities in all four countries aim to strengthen the respective National Society’s preparedness, response structure and mechanisms to implement timely and effective risk mitigation, detection and response measures in the event of a suspected EVD case. Ultimately, the goal is to prevent morbidity and mortality resulting from EVD. To do so, all four countries will build on the activities already completed using DREF funds and are aligned with the Regional EVD Strategic Plan.

3.2.4.2. Burundi

If adequate funding is received, the Appeal operation will focus on five key pillars around which the intervention is organized:

1. Risk Communication and Community Engagement (RCCE)
2. Infection prevention and control (IPC),
3. Safe and Dignified Burials (SDB)
4. Psychosocial support (PSS)

5. Community surveillance and contact tracing
6. National Society capacity strengthening

The preparedness operation will enable continuation and scaling up of the following activities that were initiated during the DREF operation:

- Provision of comprehensive training to SDB teams (including refresher trainings) – with new training of 76 staff and volunteers
- Set up of additional SDB teams in at-risk locations and the capital, Bujumbura
- Carrying out of periodic drills and simulations to ensure enhanced capacity of the SDB teams
- Procurement and pre-positioning of personal protective equipment (PPE) kits for volunteers involved in activities
- Procurement and prepositioning of SDB kits and body bags
- Training of staff and volunteers in RCCE, and subsequent carrying out of RCCE and community awareness sessions in schools and communities, including targeting community leaders
- Use of mobile cinemas to raise EVD awareness in at-risk communities
- Social mobilisation through door to door campaigns
- Training and equipping of volunteers and staff in contact tracing and community surveillance
- Training staff and volunteers in PSS
- Training of staff and volunteers in mobile data collection
- Security Training for NS staff and volunteers

Risk communication, social mobilization and community engagement activities will be conducted the following communities in 4 provinces which border the DRC: Rugombo and Buganda in Cibitoke province, Mutimbuzi, Kabezi, Ntahangya and Mukaza in Bujumbura rural and Bujumbura Mairie; Muhuta and Rumonge in Rumongo province and also in Nyanza lac which is located in Makamba province.

BRCS will also focus the interventions on the travellers at the Rumonge, Nyanza-Lac and Mutimbuzi border points. In total, the NS will target 20% (166,588) of the total population in the targeted areas through its planned activities.

In addition to technical support, the IFRC will also release PPE stocks from Sierra Leone. PPE stocks were previously deployed to Burundi, but these were all utilized and will thus be replenished. BRCS will also locally procure other essential materials for SDB teams. SDB materials will be pre-positioned in strategic locations as well as some stocks being retained in the National Warehouse ready to be deployed.

3.2.4.3. Rwanda

If adequate funding is received, the Appeal operation will focus on the below key pillars:

1. Risk communication and community engagement (RCCE)
2. Psychosocial support (PSS)
3. Infection prevention and control (IPC)
4. Safe and Dignified Burials (SDB)
5. Community surveillance and contact tracing
6. National society capacity strengthening

Considering that the 1st EVD case could be a community case and appear in any part of the country (as Rwanda is a country with easy and free population movement), RRCS decided to prioritize training of national frontline teams in SDB. There are two categories of SDB burial teams:

A. Frontline SDB teams

These teams will be re-trained and equipped and provided with a regular drill/simulation schedule. They will be “ready to go” with short (hours) notice. They will also be qualified as trainers for the reserve teams. Each team is composed of trained volunteers from each of the target districts.

B. Reserve SDB teams

These teams will be “dormant” in each of the most at-risk districts. They can be mobilized in case the outbreak affects their district. The reserve teams will be ready to operate after a refresher training provided by the “frontline” teams. The volunteers from these teams will participate in risk communication activities during preparedness phase. Each team is made up of 10 trained SDB volunteers and 5 PSS volunteers.

The frontline teams will work together with the Rapid Response Team in the affected districts, should an outbreak occur.

In addition, there will be two more priority activities:
- Provision and strategic prepositioning of additional equipment for emergency response, securing temporary bases and planning permanent bases;
- Continuation of risk communication and community engagement activities, as behaviour change is a time-based process.

A one-day training of 300 volunteers on community surveillance and contact tracing, and 100 volunteers on SDB took place with support from MoH. An additional 250 volunteers were trained in risk communication, social mobilization and community engagement, including mobile cinema and 10 volunteers from Kigali were trained on SDB using the DREF funds. Overall, the 550 volunteers are conducting cascade trainings to other community volunteers involved in sensitization activities. This will strengthen the volunteers’ capacities, allowing them to reach more people and improving the sustainability of the behaviour change process. 55 volunteers (5 per district in 11 districts) were trained on PSS and will cascade the trainings to other volunteers so that even contact tracers will be able to perform PSS as well.
Considering the importance of the role played by RRC volunteers in the preparedness activities, the appeal will support to keep the interventions ongoing. There will be a need of more funds especially for SDB team capacity building, social mobilization activities and more materials (PPE) to keep doing drills/ exercises to the burial teams, more IEC materials and for emergency stock.

The total estimated population (indirect beneficiaries) of the 13 districts at risk is approximately 5,000,000 people (1,000,000 households). RRCS will conduct activities in 63 sectors across the 13 districts which are considered at greatest risk for the outbreak. The total population in these sectors (direct beneficiaries) is estimated at 2,250,000 people (450,000 households).

3.2.4.4. South Sudan

The appeal operation has been and will continue to focus on the following key areas:
1. Social Mobilization, Risk Communication and Community Engagement.
2. Support EVD screening at ground Points of Entry (PoEs).
3. Psychosocial support training for volunteers.
4. Safe and Dignified Burials (SDB).
5. National Society Capacity Strengthening
6. Strengthening of Coordination and Communication

The aim is to strengthen the SSRC EVD preparedness, response structure and mechanisms at all levels (HQ and branch levels) for timely and effective implementation of risk mitigation, detection and response measures in the event of suspected Ebola cases in the four main target areas (Nimule, Yei, Yambio and Maridi), and to expand the coverage to eight areas in the same geographical locations including, Morobo, Nzara, Nabiapai, and Bazin. The appeal will focus on the following preparedness readiness activities to complement other actors’ actions to date:

- Additional training of 180 volunteers to expand the social mobilization, risk communication and community engagement in 4 new locations within the operational areas.
- Training of 40 new volunteers on community-based surveillance and contact tracing. This will be bundled up with RCSMCE and carry out simultaneously in the target areas. The SSRC trained

volunteer network is seen by CDC/UNICEF as added value for CBS and CT in the target communities.
- Training of additional 104 SDB volunteers to scale up the number of SDB teams from 6 to 18 in line with the MoH/WHO South Sudan updated National EVD Preparedness Plan
- Establish feedback mechanisms to understand community perceptions of and beliefs in relation to Ebola and training for community volunteers on how they can engage with communities (CEA) around Ebola.
- Develop key messages and approaches on EVD, such as addressing the myths and rumours around Ebola for acceptance by the communities
- Engage and work closely with community and opinion leaders, including religious leaders, traditional healers, women's groups, youth, etc.
- Establish a feedback system for tracking, analysing and responding to community rumours, perception of SSRC intervention in delivering key EVD messages – this is a big issue for Ebola and can impact the effectiveness of social mobilization and overall Ebola response.
- Training of trainer of SSRC Staff and NDRT on safe and dignified burials and maintaining the skills of staff and volunteers through regular drills and simulations; to transfer skills, knowledge and empower SSRC to take on the SDB training and preparedness activities with less external or with remote technical support.
- Simulation exercises on EVD activities, especially on SDB and PSS with staff and volunteers
- Training of SSRC SDB volunteers on handling of unidentified EVD deceased linked to ICRC missing persons file and develop or amend the SDB SoPs/manual to guide SSRC SDB activities.
- Use of innovative approaches to social mobilization, using radio talk shows, jingles and mobile announcement in public places and house to house visits.
- Training and equipment of staff and volunteers on mobile data collection for community feedback and reporting.
- Procurement and prepositioning of more PPEs; procurement and distribution of visibility materials for volunteers; production of key messages on prevention on leaflets, posters, and other items as per the Movement Communication SOPs.
- Ensure that all SSRC frontline (SDB) volunteers are vaccinated.

3.2.4.5 Uganda

The appeal operation has been and will continue to focus on the following key areas:
1. Risk communication, community engagements and sensitization;
2. Community-based surveillance at community level;
3. Screening at point of entry (PoE);
4. Provision of psychosocial support (PSS);
5. Implementation of infection prevention and control (IPC) measures
6. Safe and Dignified Burials (SDB)

The aim is to strengthen the existing URCS EVD response structures and mechanisms to implement timely and effective risk mitigation, detection and response measures in the event of suspected and confirmed EVD cases, including community preparedness in Kasese, Kabarole, Bunjangabo, Ntoroko, Kisoro, Kanungu, Bundibugyo districts in Uganda.

The objective of the URCS response is aligned to the following objectives of the National EVD Response Plan of Uganda;
- Objective 1: Mobilize partners and resources for effective EVD response and enhanced preparedness in high risk districts
- Objective 3: Raise public awareness on the threat of EVD and galvanize community support for prevention and early treatment seeking.
- Objective 4: Enhance capacity for appropriate EVD case management, safe and dignified burials and psychosocial support in outbreak and high-risk districts.

These priority activities are fully aligned with IFRC regional EVD strategic plan. IFRC/URCS activities strictly follow WHO regulations and standards for preventing and controlling the spread of Ebola virus.

In particular through this operation URCS aims at scaling up the following actions:

- **Point of Entry Screening**:
  - realization of screening activities in 12 PoE in Kisoro and Kanungu for a period of 4 months (September-December 2019) as continuum of IOM support ending in August 2019, though the support of 78 volunteers;
  - realization of screening activities in 17 PoE in Kasese, Bundibugyo and Ntoroko for a period of 7 months (June-December 2019) through the support of 106 volunteers;
  - realization of screening activities in additional 50 PoE in Kasese, Bundibugyo, Kanungu, Kisoro and Ntoroko though the engagement of 3 volunteers/PoE for a total of 150 volunteers for a period of 7 months (June-December 2019);
  - replenishment / procurement of equipment and NFI, such as battery for thermometers, water tanks, chloride for setting up PoE and conducting IPC activities;
  - replenishment / procurement of protective gears and visibility materials for volunteers at PoE.
- **Risk communication and social mobilization:**
  - continuation of risk communication and social mobilization activities, CBS and contact tracing though the re-engagement of 60 volunteers/district for a period of 6 months (July-December 2019) in Kasese, Bundibugyo and Ntoroko, for a total of 180 volunteers, as complementary to the support received/to be received by other partners for Kisoro, Kanungu, Bunjangabo and Kabarole;
  - realization of 2 days orientation on Community Based Surveillance and contact tracing for 60 volunteers/district for a total of 420 volunteers over 7 districts;
  - realization of 1-day orientation sessions on community engagement and accountability approaches, including rumour tracking and feedback mechanism for a total of 420 volunteers over 7 districts;
  - realization of door to door visits and community sensitization sessions, including mobile cinema sessions drama shows, radio talk shows and dissemination of messages in Kasese, Bundibugyo and Ntoroko;
  - engagement of religious, traditional, local leaders, teachers and transporters on dialogue on acceptance of SDB practices and dissemination of behavioural change information in Kasese, Bundibugyo and Ntoroko;
  - procurement of IEC materials;
  - replenishment and procurement of protective gears and visibility materials for volunteers.
- **Provision of PSS:**
  - Procurement of 50 discharge kits for suspected and confirmed cases, in addition to the 49 prepositioned kits;
  - realization of 1 PSS sessions for 420 volunteers by URCS PSS Officer.
- **Safe and Dignified Burials:**
  - realization of 3 SDB cascade trainings aimed at forming 3 SDB teams;
  - realization of 1 simulations/team over the 6 months as completion of additional drill and simulation exercises supported by different sources of funding;
  - procurement of SDB kits and equipment.

4. PROGRESS TOWARDS OUTCOMES

4.1. Progress outcomes for the 9th outbreak (Equateur)

Health Outcome 1: The immediate risks to the health of affected populations are reduced through awareness raising about EVD and early detection		
Indicators	Final	Target
Number of Red Cross branches provided with support in addressing the Ebola Outbreak	4	7
Health Output 1.1: Improved early detection mechanisms of resurgence of Ebola through integrated community-based health interventions		
Indicators	Final	Target
# of health areas covered by RC CBS activities	18	5
# of health areas respectively covered by RC case finding teams	23	6
# of community leaders trained on early case finding by RC	30	231
# volunteers trained on Ebola early case finding procedure	322	140
% of people reached by active case finding that belong to minorities and/or vulnerable groups	35%	65%
# of radio messages promoting active case finding behaviour change & use of Hotline	18	N/A
Health Output 1.2: Social mobilization, risk communication and community engagement and accountability activities are conducted to limit the spread and impact of Ebola		
Indicators	Final	Target
# people OR % target population reached with community engagement activities	266490	N/A
% of SDB volunteers trained on CEA	100%	100%
# of Ebola survivors and SDB families involved in our campaigns	324	324
% of questions raised on SDB during radio program out of the total questions raised	N/A	N/A
# OR % of staff and volunteers trained on community engagement approach	300	300
# of system/protocols in place to collect, analyse, verify and respond to community feedback received	3	5
Health Output 1.3: Identify and prepare communities to respond to the outbreak in potentially high-risk areas of the country		
Indicators	Final	Target
# of new volunteers trained	N/A	N/A
# of people reached by community engagement activities	266490	N/A
Health Outcome 2: Targeted health facilities with improved IPC practices and protocols to reduce infection of EVD		
Indicators	Final	Target
Number of health facilities provided with RC support to improve IPC practices and protocols:	13	50
Health Output 2.1: IPC activities conducted in 50 targeted health facilities in affected zone or at-risk zone in Mbandaka, North Kivu and Ituri (20)		
Indicators	Final	Target
# of local health facilities supported by IFRC and ICRC	13	18
# of assessments conducted based on IFRC standards	1	1

# of health facilities triage established	13	18
# of people IPC in detention sites carried by the ICRC	1	1
Health Output 2.2 The targeted health facility staff have better capacity to provide safe patient care during EVD outbreak including triage, early detection of cases and early management		
Indicators	Final	Target
# of volunteers and health practitioners trained in epidemic control	950	1000
Health Outcome 3: PSS. The psychosocial effect of the epidemic is reduced through direct support for SDB volunteers and communities affected.		
Indicators	Final	Target
Number of people reached by psychosocial support	9,208	TBD
Health Output 3.1: Preserving or restoring the psychosocial well-being of SDB volunteers directly or indirectly affected by the EVD		
Indicators	Final	Target
# of group sessions conducted to reduce stress and anxiety for SDB team	60	60
# of volunteers trained for PFA	108	108
WASH Outcome 1: The spread of Ebola is limited by disinfection of affected houses and safe burial of the dead under optimal cultural and security conditions		
Indicators	Final	Target
Number of contaminated houses/areas disinfected	70	N/A
Percentage of Safe and dignified burials carried out by an IFRC trained and equipped team out of the total number of SDB	64%	100%
WASH Output 1.1: The affected population is assisted through safe and dignified burial and decontamination activities		
Indicators	Final	Target
# of implemented SDB	36	120
# of volunteers trained in infection prevention and control as well as in SDB	920	180
WASH Output 1.2: Other areas (potential Haemorrhagic fever affected) are well prepared (contingency) for SDB activities		
Indicators	Final	Target
# of SDB teams trained in area at risk	8	N/A
# of SDB starter kit preposition in at risk area	8	N/A

4.2. Progress outcomes for the 10th outbreak (North Kivu and Ituri)

Health Outcome 1: The immediate risks to the health of affected populations are reduced through awareness raising about EVD and early detection		
Indicators	Actual	Target
Number of Red Cross branches provided with support in addressing the Ebola Outbreak	10	10
Health Output 1.2: Social mobilization, risk communication and community engagement and accountability activities are conducted to limit the spread and impact of Ebola		
Indicators	Actual	Target

# people reached by RCCE activities in hotspots in active areas.	965,909	2,362,650
# of interactive radio shows	72	100
# of vulnerable people and/or minority groups reached by RCCE activities	136,732	N/A
% of SDB volunteers trained on RCCE	100%	100%
# of Ebola survivors and SDB families involved in our campaigns	7	50
% of questions raised on SDB during sensitization activities	31%	N/A
# OR % of staff and volunteers trained on community engagement approach	886	TBD
# of system/protocols in place to collect, analyse, verify and respond to community feedback received	1	1
% questions, complaints and rumours discussed in the feedback group and followed up by action	TBD	N/A
# of community feedback data points collected	292,414	120,000
Health Output 1.3: Identify and prepare communities to respond to the outbreak in potentially at high-risk areas of the country		
Indicators	Actual	Target
# of new volunteers trained through cascade trainings across all pillars in high risk areas	N/A	220
# of people reached by RCCE activities in high-risk areas	1,311,234	NA
# of refusals in door to door awareness activity	430	NA
Health Outcome 2: Targeted health facilities with improved IPC practices and protocols to reduce infection of EVD		
Indicators	Actual	Target
Number of health facilities provided with RC support to improve IPC practices and protocols:	14	20
% of supported health facilities with a score of 80% or higher in the IPC scorecard	29%	100%
Health Output 2.1: IPC activities conducted in 20 targeted health facilities in affected zone or at-risk zone in North Kivu and Ituri		
Indicators	Actual	Target
# of local health facilities supported by IFRC	14	20
# of assessments conducted based on MoH standards	N/A	30
# of supported health facilities with triage and isolation established	14	20
# of IPC in detention sites carried by the ICRC	5	6
% of active trainers trained on IPC guidelines and protocol	64%	100%
# of health workers trained on IPC guidelines and protocol (cascade training)	327	500
% of people sent to triage over the number of patients screened (suspected cases)	368	N/A
% of suspected validated cases send to ETC	9%	100%
# of Health facilities supported by French Red Cross IPC approach	6	10

Health Output 2.2 The targeted health facility staff have better capacity to provide safe patient care during EVD outbreak including triage, early detection of cases and early management		
Indicators	Actual	Target
# of volunteers and health practitioners trained in epidemic control	734	300
Health Outcome 3: PSS. The psychosocial effect of the epidemic is reduced through direct support for SDB volunteers and communities affected.		
Indicators	Actual	Target
Number of people participating in psychosocial support activities	9208	1000
# of PSS activities	1600	N/A
Health Output 3.1: Preserving or restoring the psychosocial well-being of SDB volunteers directly or indirectly affected by the EVD		
Indicators	Actual	Target
# of volunteers trained in PFA	87	12
WASH Outcome 1: The spread of Ebola is limited by disinfection of affected houses and safe burial of the dead under optimal cultural and security conditions		
Indicators	Actual	Target
% of houses/areas disinfected out of all SDB alerts	78%	100%
Percentage of Safe and dignified burials carried out by Red Cross teams out of the total number of SDBs	50%	N/A
WASH Output 1.1: The affected population is assisted through safe and dignified burial and decontamination activities		
Indicators	Actual	Target
% of implemented SDB with success	81%	80%
# of persons trained in SDB	372	150
# of Red Cross SDB teams trained and equipped in hotspot areas	21	21
# of Red Cross SDB teams trained and equipped in active areas	5	5
# of ECUMR teams trained and equipped	14	52
Wash Output 1.2: Other at-risk areas are well prepared (contingency) for SDB activities		
Indicators	Actual	Target
# of Red Cross SDB teams trained and equipped in at-risk areas	5	5
PGI Outcome 1: Communities identify the needs of the most vulnerable and particularly disadvantaged and marginalised groups, as a result of inequality, discrimination and other non-respect of their human rights and address their distinct needs		
Inclusion and Protection Output 1.1: NS programmes improve equitable access to basic services, considering different needs based on gender and other diversity factors.		
Indicators	Actual	Target
Number of volunteers trained on the respect of gender and others diversity factors and the minimum Standard commitment.	15	200
Number of people reached with the awareness raising on preventing and responding to SGBV in all community outreach activities.	N/A	TBD
SFI1.1: National Society capacity building and organizational development objectives are facilitated to ensure that the National Society has the necessary legal, ethical and financial foundations, systems and structures, competencies and capacities to plan and perform		
Output S1.1.6: The National Society has the necessary corporate infrastructure and systems in place.		

Indicators	Actual	Target
# of DRC Red Cross volunteers trained in mobile phone-based data collection	22	100
SFI2.2: The complementarity and strengths of the Movement are enhanced.		
Output S2.2.1: In the context of large-scale emergencies the IFRC, ICRC and NS enhance their operational reach and effectiveness through new means of coordination		
Indicators	Actual	Target
# of Movement meetings (tripartite meetings at provincial and national level, movement meetings at national level)	Twice a week on Provincial Level, Bimonthly national level	Twice a week on Provincial Level, Bimonthly national level
Outcome S3.1: The IFRC secretariat, together with National Societies uses its unique position to influence decisions at local, national and international levels that affect the most vulnerable		
Output S3.1.1: IFRC and NS are visible, trusted and effective advocates on humanitarian issues		
Indicators	Actual	Target
# of sub-commissions created and chaired by the NS	1	1
Outcome S4.1: The Movement enhances its effectiveness, credibility and accountability		
Output S4.1.3: Financial resources are safeguarded; quality financial and administrative support is provided, contributing to efficient operations and ensuring effective use of assets; timely quality financial reporting to stakeholders.		
Indicators	Actual	Target
Percentage of narrative reports submitted in time	99%	100%
Percentage of financial reports submitted in time	99%	100%

4.3. Provincial preparedness activities 10th outbreak (Tshopo, Haut-Uele, Maniema, South Kivu)

*The preparedness strategy is still being refined to align with SRP4

Provincial Preparedness Outcome 1: Integrated training and mobilization of volunteers on community engagement and accountability (CEA), safe and dignified burial (SDB), psycho-social support (PSS) and Infection Prevention and Control (IPC).	
Provincial Preparedness Output 1.1: Provinces and health zones are well prepared (contingency) for SDB activities.	
Indicators	Target
# of volunteers per health zone receiving basic integrated training on CEA, IPC, SDB, CBS and PSS	24
# of trained and equipped as Epidemic Rapid Response Teams (1 team per province, 10 people per team)	4
Provincial Preparedness Output 1.2: Social mobilization, risk communication and Community Engagement and community-based surveillance activities are conducted to limit the spread and impact of Ebola	
Indicators	Target
# Meetings with community leaders (district and cell chiefs, religious leaders etc.), influencers (youth leaders, women, artists, motorbike riders, etc.)	TBD
# of people reached through RCCE activities	TBD
# of information functional kiosks set up	TBD

Provincial Preparedness Output 1.3: Improved capacity of communities to control and prevent the spread of infections	
Indicators	Target
# of hand washing stations set up	TBD
# hygiene promotion sessions delivered	TBD
Provincial Preparedness Outcome 2: *Train and equip the DRC Red Cross with didactic tools, state-of-the-art equipment and a specialized team to manage and respond to epidemic emergencies.*	
Indicators	Target
# of people trained in code of conduct, fraud prevention and control and financial management software	TBD
Provincial Preparedness Output 2.2: The National Society has the necessary corporate infrastructure and systems in place.	
Indicators	Target
# DRC RC Epidemic Preparedness plan and SOPs at the province level	1
# of DRC RC managers trained in inventory management	5
# of simulations conducted for RRTs per month	1

4.4. Progress outcomes for the Regional Preparedness activities

4.4.1. South Sudan

Health Outcome 1: The immediate risks to the health of affected populations are reduced		
Health Output 1.3: Community-based disease prevention and health promotion is provided to the target population		
Indicators	Actual	Target
# of awareness sessions carried out	90	192
# number of people sensitised on EVD	192,997	360,800
# of community leaders sensitized	In progress	300
# of radio shows on EVD conducted	12	180
# of households reached through door to door sessions	15,000	28,000
# of SSRC/IFRC staff trained on safety and security	In progress	15
Health Output 1.4: Epidemic prevention and control measures carried out.		
Indicators	Actual	Target
# of additional volunteers trained in SMRCCE	90	180
# of SSRC Staff and NDRT trained as SDB TOT	13	20
# of additional volunteers trained on SDB (additional 12 teams, 8 volunteers / team to trained and setup)	40	96
# of SDB refresher training, drills and simulations carried out	3	75
# of drills carried out by 5 SDB teams	10	60
# of bicycles procured and deployed to the 4 target areas (40 procured but only 10 has been deployed)	40	80
# of locations with materials and equipment for disinfection	5	8
# of vehicles deployed	1	4

# of vehicles prearranged for SDB	2	4
# of SDB bases established and ready for operation *(Bases identified, but yet to be ready in Yambio and Maridi. SBD materials prepositioned)*	2	4
# of NTF, TWG and MTF Coordination meeting held	17	54
# of people reached on Key Messages on EVD	240,418	600,000
Health Output 1.5: Psychosocial support provided to the target population		
Indicators	Actual	Target
# of volunteers trained in psychosocial support	119	180
Outcome S1.1: National Society capacity building and organizational development objectives are facilitated to ensure that National Societies have the necessary legal, ethical and financial foundations, systems and structures, competences and capacities to plan and perform		
Indicators	Actual	Target
# of volunteers insured	400	360
Output S1.1.7: NS capacity to support community-based disaster risk reduction, response and preparedness is strengthened		
Indicators	Actual	Target
# reviews done on NS epidemic contingency/preparedness	In progress	1
# of staff recruited/contracted and actively supporting EVD preparedness operation at HQ and branch levels	6	14
SSRC EVD Contingency plan developed and used	1	1
EVD PMER tools and system fully functional and supporting the operation	In progress	1
# of local review/assessment of the EVD Preparedness operation	1	2
# of EVD SMRCCE impact KAP Survey conducted in the 4 locations (Yei, Maridi, Yambio and Nimule)	In progress	2
# of supportive supervision/monitoring visits provided by SSRC HQ relevant sectorial heads for the EVD preparedness operation	4	12
# of EVD related reports produced and shared with relevant stakeholders (weekly, monthly & Quarterly)	12	24
Outcome S2.1: Effective and coordinated international disaster response is ensured		
Output S2.1.1: Effective response preparedness and NS surge capacity mechanism is maintained		
Indicators	Actual	Target
# of missions conducted by IFRC staff	1	6

4.4.2. Burundi

Health Outcome 1: The immediate risks to the health of affected populations are reduced		
Health Output 1.3: Community-based disease prevention and health promotion is provided to the target population		
Indicators	Actual	Target
# of community leader trainings conducted	12	12
# number of people sensitised on EVD	420,000	166,558
# of awareness sessions carried out in schools	In progress	84

# of cultural shows disseminating EVD messages	In progress	30
# of radio shows on EVD conducted	5	24
# of volunteers refreshed on CEA	117	117
# of volunteers trained on CEA	In progress	120
# of households reached through door to door sessions	83,000	10,000
Health Output 1.4: Epidemic prevention and control measures carried out.		
Indicators	Actual	Target
# of drills carried out by 6 SDB teams	In progress	36
# of SDB refresher trainings carried out	In progress	12
# of SDB kits procured	In progress	10
# of SDB starter kits procured	In progress	10
# of SDB training kits procured	In progress	6
# of bicycles procured	In progress	60
# of staff and volunteers trained	160	200
Health Output 1.5: Psychosocial support provided to the target population		
Indicators	Actual	Target
# of staff and volunteers trained in PSS	84	20
# of PSS sessions provided	In progress	N/A
Outcome S1.1: National Society capacity building and organizational development objectives are facilitated to ensure that National Societies have the necessary legal, ethical and financial foundations, systems and structures, competences and capacities to plan and perform		
Output S1.1.4: National Societies have effective and motivated volunteers who are protected		
Indicators	Actual	Target
# of volunteers insured	In progress	200
# of security trained staff and volunteers	In progress	20
Output S1.1.7: NS capacity to support community-based epidemic risk reduction, response and preparedness is strengthened		
Indicators	Actual	Target
# reviews done on NS epidemic contingency/preparedness	In progress	1
Outcome S2.1: Effective and coordinated international disaster response is ensured		
Output S2.1.1: Effective response preparedness and NS surge capacity mechanism is maintained		
Indicators	Actual	Target
# of missions conducted by IFRC staff	In progress	6

4.4.3. Rwanda

Health Outcome 1: The immediate risks to the health of affected populations are reduced		
Health Output 1.3: Community-based disease prevention and health promotion is provided to the target population		
Indicators	Actual	Target
# of people reached with community-based epidemic prevention and control activities	3,364,113	2,500,000
# of mobile cinema sessions conducted	189	290

Health Output 1.4: Epidemic prevention and control measures carried out.		
Indicators	Actual	Target
# of trained frontline SDB teams that are ready to deploy	2	2
# of trained reserve SDB teams that are ready to deploy	11	13
# of simulation exercises conducted (attended)	3	N/A
Health Output 1.5: Psychosocial support provided to the target population		
Indicators	Actual	Target
# of volunteers trained in psychosocial support	55	10
S1.1: National Society capacity building and organizational development objectives are facilitated to ensure that National Societies have the necessary legal, ethical and financial foundations, systems and structures, competences and capacities to plan and perform		
Output S1.1.7: NS capacity to support community-based disaster risk reduction, response and preparedness is strengthened		
Indicators	Actual	Target
# of NS contingency and preparedness plans updated	1	1
# of RCCE orientation sessions conducted	31	30
Outcome S2.1: Effective and coordinated international disaster response is ensured		
Output S2.1.1: Effective response preparedness and NS surge capacity mechanism is maintained		
Indicators	Actual	Target
# of people reached with community-based epidemic prevention and control activities	3,364,113	2,250,000
# of trained frontline SDB teams that are ready to deploy	2	2
# of trained reserve SDB teams that are ready to deploy	11	13
Outcome S3.1: The IFRC secretariat, together with National Societies uses their unique position to influence decisions at local, national and international levels that affect the most vulnerable.		
Output S3.1.2: IFRC produces high-quality research and evaluation that informs advocacy, resource mobilization and programming.		
Indicators	Actual	Target
# of evaluation and lessons learned reviews conducted	4	*1*

4.3.4. Uganda

Health Outcome 1: The immediate risks to the health of affected populations are reduced		
Health Output 1.3: Community-based disease prevention and health promotion is provided to the target population		
Indicators	Actual	Target
# of people reached by NS with services to reduce relevant health risk factors	9,798,306	7,068,060
# of volunteers conducting risk communication, social mobilization activities in 7 districts for 3 months	360	360
# of CEA mechanisms established	2	2
# of HH reached with EVD messages on prevention, identification and referral though risk communication activities (188.724 HH//month x 3 months)	368,725	566,171
# of people reached with EVD messages on prevention, identification and referral though risk communication activities (1,321,066 people/month x 3 months)	1,442,795	3,936,200
# of community/group meetings held on EVD prevention, identification and referral (2,620 community groups/months x 3 months)	14,647	7, 860
# of people taking part in community/group meetings held on EVD prevention, identification and referral (142.221 people/month x 3 months)	1,067,178	426,663

# of people reached with EVD prevention messages through mobile cinema sessions (150 people/sessions x 105 sessions); 4,400 people reached with EVD prevention messages through drama sessions, target: (100 people/session x 44 sessions).	16,075	15,750
# of mobile cinema sessions conducted	133	180
# of volunteers trained on surveillance and contact tracing	420	420
Health Output 1.4: Epidemic prevention and control measures carried out.		
Indicators	Actual	Target
# of SDB trainings from health partners supported by URCS facilitators	26	13
# of volunteers conducting screening activities at 28 PoE for 3 months	196	334
# of people screened at PoE crossing the border for trade, family, religious, health and education reasons in 3 months (946.662 people/month);	8,094,404	2,839,986
# of people crossing the border to seek refuge in 3 months, (89 people/day)	N/A	N/A
# of SDB drills conducted by 3 SDB teams,	In progress	15
# of SDB simulations conducted by 3 SDB teams	2	15
# of joint MoH and URCS quality control missions on SDB simulations conducted	In progress	3
Health Output 1.5: Psychosocial support provided to the target population		
Indicators	Actual	Target
# of volunteers providing PSS in 7 districts for 3 months	360	360
# of discharge kits procured	In progress	50
Outcome S1.1: National Society capacity building and organizational development objectives are facilitated to ensure that National Societies have the necessary legal, ethical and financial foundations, systems and structures, competences and capacities to plan and perform		
Output S1.1.4: National Societies have effective and motivated volunteers who are protected		
Indicators	Actual	Target
# of National Society contingency and preparedness plan adopted, including SDB SOPs	In progress	1
# of volunteers insured	In progress	517
# of people which have received PSS	360	586
Output S1.1.6: National Societies have the necessary corporate infrastructure and systems in place		
Indicators	Actual	Target
# of monitoring missions conducted by HQ staff	20	5
Outcome S2.1: Effective and coordinated international disaster response is ensured		
Output S2.1.1: Effective response preparedness and NS surge capacity mechanism is maintained		
Indicators	Actual	Target
# of NDRTs deployed	2	3
Output S2.1.4: Supply chain and fleet services meet recognized quality and accountability standards		
Indicators	Actual	Target
# of emergency procurement procedures reviewed	In progress	1
# of motor-vehicles deployed to the field to support the operation	In progress	9
# of URCS logistic support staff fully dedicated to the operation	In progress	1
Output S2.1.6: Coordinating role of the IFRC within the international humanitarian system is enhanced		
Indicators	Actual	Target
# of NTF and DTF attended	96	All

Output S2.2.1: In the context of large-scale emergencies the IFRC, ICRC and NS enhance their operational reach and effectiveness through new means of coordination.		
Indicators	Actual	Target
# of Regional Strategic Documents on EVD preparedness drafted	1	1
# of National task forces attended at National level per month	12	24
# of Movement in country coordination meetings	3	3
# of Lessons learnt workshops conducted	In progress	1
Output S2.2.5: Shared services in areas such as IT, logistics and information management are provided		
Indicators	Actual	Target
# of laptops procured	In progress	2
Outcome S3.1: The IFRC secretariat, together with National Societies uses their unique position to influence decisions at local, national and international levels that affect the most vulnerable.		
Output S3.1.1: IFRC and NS are visible, trusted and effective advocates on humanitarian issues		
Indicators	Actual	Target
# of press releases launched	In progress	3
# of communication materials developed	In progress	6
# of communication missions conducted	In progress	2
Output S3.1.2: IFRC produces high-quality research and evaluation that informs advocacy, resource mobilization and programming.		
Indicators	Actual	Target
# of lesson learnt report drafted and disseminated	In progress	1
Outcome S3.2: The programmatic reach of the National Societies and the IFRC is expanded.		
Output S3.2.1: Resource generation and related accountability models are developed and improved		
Indicators	Actual	Target
# of RCCE frameworks developed	In progress	1
# of RCCE strategies for EVD response drafted	In progress	1
Outcome S4.1: The IFRC enhances its effectiveness, credibility and accountability		
Output S4.1.2: IFRC staff shows good level of engagement and performance		
Indicators	Actual	Target
# of surge deployed	3	4
Output S4.1.3: Financial resources are safeguarded; quality financial and administrative support is provided contributing to efficient operations and ensuring effective use of assets; timely quality financial reporting to stakeholders		
Indicators	Actual	Target
# of finance and logistic staff directly supporting the operation, (1IFRC finance delegate, 1 URCS finance staff, 1 URCS logistic staff)	3	3
# of IFRC staff support finance admin	1	1
Output S4.1.4: Staff security is prioritised in all activities		
Indicators	Actual	Target
IFRC country security plan updated	In progress	1

5. BUDGET

Disaster Response Financial Report

MDRCD026 - DR Congo - Ebola Virus Disease Outbreak

Timeframe: 12 May 18 to 21 Aug 19

Appeal Launch Date: 21 May 18

Annual Report

Appeal Code	Appeal.Appe
MDRCD026	5/12/18

Selected Parameters			
Reporting Timeframe	2018/1-2019/5	Programme	M
Budget Timeframe	2018/1-2019/5	Budget	A
Split by funding source	n	Project	*
Subsector:	*		

All figures are in Swiss F

I. Funding

		Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Defer Inco
A. Budget			191,392	16,927,703			17,119,095	
B. Opening Balance								
Income								
Cash contributions								
American Red Cross	M1812012			248,194			248,194	
Austrian Red Cross	M1810008			109,482			109,482	
Belgian Government - Flanders	M1812046			154,829			154,829	
British Red Cross	M1807011			235,541			235,541	
British Red Cross	M1809026			126,995			126,995	
British Red Cross	M1905086			317,001			317,001	
China Red Cross, Hong Kong branch	M1810010			25,569			25,569	
Danish Red Cross	M1806054			100,000			100,000	
European Commission - DG ECHO	M1804036			154,717			154,717	
European Commission - DG ECHO	M1812073			2,253,084			2,253,084	
Icelandic Red Cross	M1810021			400,000			400,000	
Italian Government Bilateral Emergency Fund	M1906019			562,395			562,395	
Japanese Red Cross Society	M1807027			89,554			89,554	
Norwegian Red Cross	M1806079			389,060			389,060	
Red Cross of Monaco	M1807029			17,401			17,401	
Swedish Red Cross	M1905085			466,841			466,841	
Swiss Red Cross	M1905017			227,000			227,000	
The Canadian Red Cross Society	M1805076			52,456			52,456	
The Canadian Red Cross Society	M18GK026			651			651	
The Netherlands Red Cross	M1806012			149,900			149,900	
The Netherlands Red Cross	M1806080			404,897			404,897	
The Netherlands Red Cross	M1905047			112,701			112,701	
Turkish Red Crescent Society	M1905016			35,000			35,000	
United States Government - USAID	M1806032			709,006			709,006	
United States Government - USAID	M1811069			673,098			673,098	
United States - Private Donors	M1803026			1,897			1,897	
Western Union Foundation	M1811057			9,484			9,484	
WHO - World Health Organization	M1806078			1,669,689			1,669,689	
WHO - World Health Organization	M1811015			3,153,583			3,153,583	
C1. Cash contributions				***12,872,028***			***12,872,028***	
Inkind Goods & Transport								
The Canadian Red Cross Society				10,018			10,018	
C2. Inkind Goods & Transport				***10,018***			***10,018***	
Other Income								
DREF Allocations			150,000	350,000			500,000	
Write off & provisions				-76,965			-76,965	
C4. Other Income			***150,000***	***273,035***			***423,035***	
C. Total Income = SUM(C1..C4)			**150,000**	**13,155,082**			**13,305,082**	
D. Total Funding = B +C			**150,000**	**13,155,082**			**13,305,082**	

Disaster Response Financial Report

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Selected Parameters			
Reporting Timeframe	2018/1-2019/5	Programme	MDRCD026
Budget Timeframe	2018/1-2019/5	Budget	APPROVED
Split by funding source	n	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

II. Movement of Funds

	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Deferred Income
B. Opening Balance							
C. Income		150,000	13,155,082			**13,305,082**	**979,543**
E. Expenditure		-189,351	-13,042,506			**-13,231,857**	
F. Closing Balance = (B + C + E)		-39,351	112,576			**73,225**	**979,543**

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Budget Timeframe	2018/1-2019/5	Budget	APPROVED
Split by funding source	n	Project	*
Subsector	*		

All figures are in Swiss Francs (CHF

III. Expenditure

Account Groups	Budget	Expenditure						Variance
		Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/ RC work	Joint working and accountability	TOTAL	
	A						B	A - B
BUDGET (C)			**191,392**	**16,927,703**			**17,119,095**	
Relief items, Construction, Supplies								
Shelter - Relief	7,882			9,596			9,596	-1,714
Construction - Housing	201			201			201	0
Construction - Facilities	112,460			66,640			66,640	45,820
Construction Materials	32,587			56,174			56,174	-23,587
Clothing & Textiles	26,371			32,334			32,334	-5,962
Food	21,521			29,903			29,903	-8,382
Water, Sanitation & Hygiene	122,655			136,595			136,595	-13,941
Medical & First Aid	246,253			451,951			451,951	-205,698
Teaching Materials	54,269			17,263			17,263	37,006
Utensils & Tools	5,045			5,404			5,404	-359
Other Supplies & Services	160,306			103,134			103,134	57,172
ERU	21,868			21,868			21,868	0
Total Relief items, Construction, Sup	811,417			931,062			931,062	-119,645
Land, vehicles & equipment								
Vehicles	29,594			18,711			18,711	10,883
Computers & Telecom	182,495		1,336	126,923			128,260	54,235
Office & Household Equipment	18,529			22,090			22,090	-3,561
Medical Equipment	2,279			2,419			2,419	-140
Total Land, vehicles & equipment	232,896		1,336	170,143			171,479	61,417
Logistics, Transport & Storage								
Storage	143,701			164,260			164,260	-20,559
Distribution & Monitoring	145,488			198,602			198,602	-53,114
Transport & Vehicles Costs	786,322		96	644,029			644,125	142,197
Logistics Services	37,085			46,627			46,627	-9,542
Total Logistics, Transport & Storage	1,112,595		96	1,053,518			1,053,614	58,982
Personnel								
International Staff	2,937,005		79,251	3,119,286			3,198,536	-261,531
National Staff	349,433			369,574			369,574	-20,141
National Society Staff	156,705			135,099			135,099	21,606
Volunteers	2,253,610			1,322,746			1,322,746	930,864
Total Personnel	5,696,753		79,251	4,946,705			5,025,956	670,797
Consultants & Professional Fees								
Consultants	101,780			21,365			21,365	80,416
Professional Fees	62,816			69,637			69,637	-6,821
Total Consultants & Professional Fe	164,596			91,002			91,002	73,595
Workshops & Training								
Workshops & Training	457,308		19,780	285,346			305,126	152,183
Total Workshops & Training	457,308		19,780	285,346			305,126	152,183
General Expenditure								
Travel	1,040,424		42,626	945,845			988,472	51,952
Information & Public Relations	118,864			71,667			71,667	47,197
Office Costs	308,938		1,741	328,795			330,536	-21,598
Communications	188,268		1,894	178,037			179,931	8,337

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Selected Parameters			
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Budget Timeframe	2018/1-2019/5	Budget	APPROVED
Split by funding source	n	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

III. Expenditure

Account Groups	Budget	Expenditure					Variance
		Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/ RC work	Joint working and accountability	TOTAL	
	A						B	A - B
BUDGET (C)			**191,392**	**16,927,703**			**17,119,095**	
Financial Charges	80,994		1,556	105,614			107,170	-26,176
Other General Expenses	24,443			21,947			21,947	2,496
Shared Office and Services Costs	296,513		26,480	293,764			320,244	-23,731
Total General Expenditure	2,058,444		74,298	1,945,668			2,019,966	38,478
Contributions & Transfers								
Cash Transfers National Societies	554,601			353,788			353,788	200,813
Cash Transfers to 3rd Parties	1,768,380			2,165,862			2,165,862	-397,482
Total Contributions & Transfers	2,322,981			2,519,650			2,519,650	-196,669
Operational Provisions								
Operational Provisions	3,275,166		3,034	380,062			383,096	2,892,071
Total Operational Provisions	3,275,166		3,034	380,062			383,096	2,892,071
Indirect Costs								
Programme & Services Support Recove	933,646		11,557	660,239			671,796	261,850
Total Indirect Costs	933,646		11,557	660,239			671,796	261,850
Pledge Specific Costs								
Pledge Earmarking Fee	46,428			49,385			49,385	-2,957
Pledge Reporting Fees	6,863			9,726			9,726	-2,862
Total Pledge Specific Costs	53,291			59,111			59,111	-5,820
TOTAL EXPENDITURE (D)	**17,119,095**		**189,351**	**13,042,506**			**13,231,857**	**3,887,238**
VARIANCE (C - D)			**2,041**	**3,885,197**			**3,887,238**	

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Budget Timeframe	2018/1-2019/5	Budget	APPROVED
Split by funding source	n	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

IV. Breakdown by subsector

Business Line / Sub-sector	Budget	Opening Balance	Income	Funding	Expenditure	Closing Balance	Deferred Income
BL2 - Grow RC/RC services for vulnerable people							
Disaster management	191,392		150,000	150,000	189,351	-39,351	
Subtotal BL2	191,392		150,000	150,000	189,351	-39,351	
BL3 - Strengthen RC/RC contribution to development							
Health	16,927,703		13,155,082	13,155,082	13,042,506	112,576	979,543
Subtotal BL3	16,927,703		13,155,082	13,155,082	13,042,506	112,576	979,543
GRAND TOTAL	**17,119,095**		**13,305,082**	**13,305,082**	**13,231,857**	**73,225**	**979,543**

Reference documents

Click here for:

Previous Appeals and updates

Emergency Plan of Action (EPoA)

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

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How we work

All IFRC assistance seeks to adhere to the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief and the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere**) in delivering assistance to the most vulnerable. The IFRC's vision is to inspire**, encourage, facilitate and promote at all times all forms of humanitarian activities** by National Societies, with a view to **preventing and alleviating human suffering**, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.