OPERATIONAL REPORT 2020

IFRC Organisational Unit: *Heath & Care Department* **Geographic coverage:** *Global*

Manager: *Emanuele Capobianco*

Reporting period: *01 January – 31 December 2020*

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1. Context

Describe key internal or external changes in the operating context that have an impact on the implementation of the activities. Only list the most relevant ones and limit to not more than 5 bullet points.

#	Describe event/change	Impact on operating context
1.	*Pandemic impact reduced normal long term WASH programming in many countries by at least 50% or more. However, WASH capacities for Covid increased exponentially especially for Infection Prevention and Control (IPC) WASH related activities.*	Reduction in regular WASH programming outcomes and significantly increased WASH interventions, guidance, monitoring and coordination for covid 19. .
2.	*IFRC was awarded the role of hosting the Country Support Platform (CSP) for the Global Task Force for Cholera Control (GTFCC) after several months' negotiations with Bill and Melinda Gates Foundation (BMGF).*	CSP related workload increased significantly between June and December 2020
3.	*COVID 19 affected the care in communities, Healthy ageing, NCD, FA and MHPSS programming with several requests to support NS and IFRC field offices to develop, disseminate and build capacities on the tools developed for NS staff and volunteers. This supported NS in providing evidence-based services to the communities.*	Several tools and courses developed using the expertise within and outside the movement for NS enabling them to deliver services.

4.	*Integration of COVID-19 response into EVD has created more demand for personal protective equipment amidst scarce resources, which caused challenges across a number of operations for the IFRC.*	The IFRC continued to monitor the situation and through global and regional logistic units worked to ensure a constant flow of PPE to country offices and operations as required to ensure that staff and volunteers could continue to carry out their essential work with the risk minimised. These efforts continued to be prioritised to ensure the safe working conditions of staff and volunteers.

2. Delivery against priorities: progress and challenges

Comment on key progress and main challenges in relation to activities' delivery. This section of the report is based on the regular activity monitoring. Be analytical and succinct.

P&B Output (AP code)	Progress	Red/Amber/Green Status	
		Q2	Q4
AP021	**Medical Services in Emergencies** Quality Management Framework for Clinical Care The IFRC aims to respond to disasters as rapidly and effectively as possible by mobilising its resources and using its network in a coordinated manner to meet affected communities' needs. The Emergency Response Units (ERUs) are vital in the IFRC's disaster response tools system. They provide specific support or substituting services when local facilities are either destroyed, overwhelmed by the need, or do not exist. An ERU is a team of trained technical specialists, ready to be deployed at short notice, which uses pre-packed sets of standardised equipment. Patient safety is a cornerstone of all high-quality health care. IFRC chairs various working groups and coordinates processes to improve patient safety through Standard Operating Procedures (SOP), smart practices, and quality assured training for staff. Clinical care after disasters is closely linked to other sectors, and patient safety should not be limited to direct health care. With the WHO EMT - an initiative that sets minimum standards for clinical care during disasters - patient safety and quality assurance need to be even more emphasised. Developing a Red Cross Red Crescent Quality Framework for Clinical Care is, therefore, an essential part of improving patient safety within IFRC clinical response to disasters. As an organisation, IFRC commits to core humanitarian standards on quality and accountability. We focus on a strategic approach to improving our health services' quality and bringing measurable improvements by creating and applying the quality assurance framework.		

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	IFRC Quality Team and ICRC Quality Team joined in a collaboration to adapt the existing Quality Management Framework to take account of both organisations' needs and requirements. Extensive consultation took place, and the Quality Management Framework has progressed to become a Movement-wide document. The WHO Emergency Medical Teams (EMT) initiative assists organisations and member states in building capacity and strengthening health systems by coordinating the deployment of quality-assured medical teams in emergencies. When a disaster strikes or an outbreak flares, the more rapid the response, the better the outcome. The IFRC Secretariat Emergency Health team represents its membership in the WHO EMT initiative. It plays a similar role within the IFRC's ERU system (in terms of coordination and quality assurance). This representation includes being a member of the Strategic Advisory Group; attending quarterly remote meetings and the annual face-to-face global meeting. At the WHO EMT Global Meeting held 23-24 June 2019 in Bangkok, IFRC was represented by the Emergency Health Team Leader and the Senior Officer for Emergency Medical Services, and altogether about 15 members of Red Cross Red Crescent National Societies attended. IFRC hosted many sessions and co-hosted an IFRC Asia Pacific regional quality assurance meeting on the side. The IFRC Asia Pacific Emergency Medical Services meeting on quality assurance was held on June 25th in Bangkok convened by the IFRC's Asia Pacific Regional Office with support from the Geneva Emergency Health team. It was attended by nine Red Cross and Red Crescent National Societies, WHO and the Thai Ministry of Public Health. The aim was to encourage engagement and dialogues among National Societies in the Asia Pacific region about the better utilisation and optimisation of resources in Emergency Medical Services. In the Asia Pacific, a growing number of National Societies are requesting assistance from IFRC Secretariat to have well-functioning and well-equipped emergency medical teams, which the National Societies can either deploy domestically or internationally for emergency response. The Red Cross and Red Crescent Health Information System (RCHIS) is an IFRC project designed to support Medical Emergency Response Units (ERUs) and other Red Cross Red Crescent health facilities. The aim is to provide an Electronic Medical Record (individual patient medical records), Health Information System (de-identified reporting and trend analysis for early identification and management of outbreaks at facility level), and health facility management support to improve patient quality of care and medical operational efficiency. RCHIS will be critical in enhancing Red Cross Red Crescent response to epidemics and pandemics, and other disasters.		

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	In addition to improving quality of care and patient safety, RCHIS will be an indispensable tool for National Societies in collecting, sharing, and analysing data. The current capacity to respond will be enhanced, and National Societies will be much better equipped to make data-driven and evidence-based decisions. RCHIS includes: - Electronic Medical Record to facilitate management of patients inside the health ERU and clinical decision-making, to monitor and improve quality of care. - Health Information System (HIS) to support health facility-based surveillance and provide rapid analysis of clinical data allowing for detection of outbreaks. - Health facility management to improve the efficiency of operations - Reporting and accountability to a range of donors (financial) and operational		
AP022	**Epidemic and Pandemic Preparedness** Achieving global health security requires an inclusive and collaborative effort that captures and builds on the critical interdependencies between communities, civil society, the private sector and governments to ensure success. Engagement of communities in epidemic and pandemic preparedness is vital to ensure early response and mitigate impact, including the delivery of normative health services. The IFRC is uniquely placed to support whole-of-society epidemic and pandemic preparedness by leveraging its supporting role to 192 National Red Cross Red Crescent Societies. By working with National Societies and taking advantage of their local reach and auxiliary status with host governments, IFRC ensures they are well placed to help support and facilitate a whole-of-society approach to health threats. To ensure that communities are at the centre of epidemic and pandemic preparedness and play a significant role, the IFRC, under this programme, is utilizing global frameworks including the GHSA and IHR to strengthen and expand on existing country capacities to prevent, detect and respond to infectious disease threats. In collaboration with its National Society network and other partners, the IFRC supports an all-hazard, whole-of-society approach to build the capacity and skills of communities and National Societies themselves, to support and complement government and United Nations' (UN) initiatives aimed at meeting obligations under GHSA and the IHR. IFRC has adapted and developed epidemic and pandemic preparedness community-level training modules and tools that can help communities better prevent, detect, and respond to infectious disease threats, with an emphasis on community health workers and other appropriate local leaders.		

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	The goal of the programme is to strengthen epidemic and pandemic preparedness through a whole-of-society, all-hazard approach. The programme's design is flexible and adaptable – based on the country's priorities, needs, risks and strengths. It builds on the capacity and existing activities of implementing National Societies and the IFRC and identifies synergies with key components of the GHSA and Joint External Evaluation (JEE) action areas. Specific objectives for the three workstreams: To strengthen community resilience against the detrimental effects of epidemics and pandemics To build National Society capacity to prepare and respond to epidemic and pandemic threats To promote private sector, media and other key stakeholder engagement in health security. **Workstream 1** focuses on community preparedness, including community-based surveillance, early community prevention and control activities, and risk communication. **Workstream 2** aims to strengthen National Society capacity to prepare and respond to health emergencies. The IFRC uses the Preparedness for Effective Response (PER) approach, which includes a self-assessment tool, a simulation exercise or an after-action review to assess National Societies' preparedness and to develop a workplan to strengthen their capacity, which can be evaluated the same way in the future (usually 2—3 years later), documenting change over time. **Workstream 3** focuses on collaboration with other key stakeholders. Several activities are available for countries to select from including support in media training, engagement with the private sector, key stakeholder engagement and data readiness. Workstream 1 guides and training tools Building on the core module of Community-Based Health and First Aid (http://ifrc-ecbhfa.org/), CP3 supported the development of complementary primary prevention modules on communicable disease prevention and health in emergencies (http://ifrc-ecbhfa.org/about-ecbhfa/ecbhfa-interventions/).		

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	Over the past years, Partner National Societies have funded the update of the Epidemic Control for Volunteers (ECV) Manual and Toolkit, available at http://ifrcgo.org/ecv-toolkit/, which receives an average of 200 visits each day. Through its partnership agreement with the American Red Cross, CP3 is supporting the development of an Android™ ECV toolkit application, and the release of the Epidemic Control for Response Managers (ECRM) toolkit, which will provide additional technical guidance for Red Cross/Red Crescent National Societies and IFRC staff involved in epidemic and pandemic preparedness and response. The programme draws on the Communication, Accountability and Engagement (CEA) Toolkit and has embedded community communication and feedback mechanisms in the country programmes, for example radio call-in shows for community inputs, WhatsApp lines for feedback and questions. The CP3 training packages were adapted for use by the IFRC Ebola Virus Disease (EVD) response team. An epidemic preparedness training framework developed jointly by CP3 and cholera preparedness in the Africa region is serving as the basis for the model to be rolled out in DRC and preparedness countries. As part of COVID-19 preparedness and response, the CP3 ECV training package was modified for COVID-19 and merged with the Risk Communication and Community Engagement (RCCE) training package, resulting in a combined ECV/RCCE training package for COVID-19 for the Africa region. The updated ECV training package including COVID-19 guidance was also shared with other IFRC regional offices, which translated it into Spanish and Arabic. In the framework of the COVID-19 operation, CP3 has actively contributed to the development and dissemination of guidance notes and practical tools focused on: • Integrating COVID-19 into CBS systems, including guidance on community case definition and triggers • Contact tracing guidance, and how to integrate into MoH systems • How to continue RCCE activities safely in the context of COVID-19 • Guidance for working in crowded settings (urban areas, camps, slums) safely, and how to modify approaches for these settings • Climate-smart disaster risk management during the COVID-19 pandemic • Management of dead bodies ▪ Knowledge-Attitudes-Practices (KAP) survey		

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	The KAP gathers data to serve: (1) as baseline for comparison with the end-line evaluation of impact, and (2) to inform design of programme and content to best target actual needs. Additional surveys had to be put on hold due to the COVID-19 pandemic but are due to resume early 2021. KAP results analysis and visualization is underway. ▪ Information, Education and Communication (IEC) plans IEC plans are adapted by drawing on the results of the KAP survey, enabling staff to tailor health messages to target the specific gaps in the knowledge of people in each community area; to use the right communication channels to more effectively reach people; and to use the most effective forms of communication and languages for great impact of the health awareness activities in CP3. ▪ Community-Based Surveillance (CBS) The CP3 programme developed an Operational CBS Training package and trained trainers in 2018/2019, and then rolled out the training in all CP3 countries but Mali. The passive surveillance system is embedded in routine health promotion activities conducted by community-based volunteers though household visits, mobile cinema, group discussions, school activities and other community sensitization events. The establishment of trust between volunteers and community members encourages the latter to report suspicious batches of illness which may lead to an epidemic. CP3 regularly shares its experience and actively participates in the Red Cross/Red Crescent CBS Technical Working Group. Partner National Societies have funded several activities over the past year, including templates and tools for CBS assessments, protocol development and guidelines on conducting CBS during COVID-19 in the four IFRC official languages, shared through an online CBS website. The Norwegian Red Cross leads the development of the Nyss CBS digital platform. In 2020, COVID-19 was included in CBS activities implemented by CP3 National Societies. A case study on the programme's CBS experience in Indonesia will be released in the first quarter of 2021. Workstream 2 CP3 signed a project agreement with Canadian Red Cross in August 2018, which provides technical support for the implementation of workstream 2, leads Preparedness for Effective Response (PER) processes in three countries and		

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	provides remote PER technical support to other CP3 countries, has developed infection prevention and control (IPC) guidance for small health facilities managed by National Societies, integrates gender and diversity in epidemic and pandemic preparedness tools, and documents key lessons learnt. ▪ Preparedness for Effective Response Since 2017, IFRC has developed the Preparedness for Effective Response (PER) approach. The PER process guides the identification of gaps and the development of a plan of action to strengthen the preparedness of each National Society. It provides a measurable set of indicators to monitor progress over time and ensures harmonization of efforts with other disaster/epidemic preparedness initiatives. A CP3 PER workshop was organized to introduce the approach in 2018, and the programme has supported PER assessments in Uganda (mid-2018), Indonesia (mid-2018), Mali (March 2019), DRC (June 2019) and Guinea (August 2019). Orientation sessions have taken place in Kenya and Sierra Leone, with Guinea and Sierra Leone engaging in a rapid review of their response mechanism in the context of the COVID-19 pandemic. Kenya, Cameroon and Sierra Leone are planning PER assessments in the first semester of 2021. The programme continues to support countries with a selection of activities prioritized in their PER action plans. In close collaboration with the IFRC Disasters, Climate and Crises (Prevention, Response and Recovery) Department, CP3 incorporated epidemic preparedness considerations in the PER assessment tool (currently undergoing revision with the support of Canadian Red Cross), and contributes to the development of the preparedness section of IFRC's disaster management platform (IFRC Go Platform). Over the past year, IFRC has worked on trends analysis of PER assessments carried out in over 45 countries and the analysis of lessons learned from 175 recent response operations funded by the Disaster Relief Emergency Fund (DREF). A catalogue of resources related to each PER component was also made available. This data is now used to better inform the development of training materials and tools to strengthen National Societies' capacities to respond to all types of hazards. A National Society National Response Teams training package has been developed based on agreed global standards, and CP3 contributes to its testing (first pilots took place in Mali and Cameroon in December 2020), finalization and dissemination. Partner National Societies are funding the development of a specialized curriculum on Health in Emergencies for National Response Teams. The CP3 initiative has also actively contributed to the development and dissemination of guidance on National Society Preparedness in the context of the COVID-19		

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	pandemic. This has included the elaboration of a guidance note on National Society preparedness in February 2020, 192 country profiles highlighting hazards and country capacity to respond to COVID-19 and other hazards, a short guide on how to use the PER approach during an emergency, and a review of IFRC contingency planning tools. IFRC's Disaster Law Programme is working on a report on Law and Public Health Emergency Preparedness and Response, using IFRC's lessons learned from the COVID-19 response, and considering a contribution to the Independent Panel set up by WHO, due to submit a report to the next World Health Assembly in May. With the support of a PER technical working group, IFRC is developing a set of videos about the PER mechanism, an e-learning course, and regularly updating PER guidance and training packages. ▪ National Society health facility preparedness Some National Societies where CP3 is being implemented manage health facilities, e.g. Cameroon, Indonesia, Kenya and DRC. The programme supports infection prevention and control (IPC) assessments and frontline staff training. IFRC has developed an IPC and epidemic preparedness checklist for National Red Cross Red Crescent Societies running small primary health facilities. The checklist is based on WHO's Infection Prevention and Control Assessment Framework (IPCAF), taking into account core components of IPC. Where National Societies have larger health facilities and hospitals the IPCAF is used in coordination with WHO and MoH in country; for smaller facilities the IFRC tool is used in partnership with WHO and MoH. Workstream 3 In order to foster external stakeholder engagement in CP3, four main activity areas have been identified under workstream 3: 1. Data readiness 2. Private sector engagement 3. Media engagement and preparedness 4. Religious leaders and other key stakeholder engagement.		

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	The American Red Cross supports IFRC and CP3 National Societies with the development and implementation of data readiness and private sector sensitization activities. BBC Media Action has supported media engagement and preparedness. ▪ Data readiness In conjunction with United Nations Office for the Coordination of Humanitarian Affairs (UN-OCHA) Humanitarian Data Exchange (HDX), IFRC is exploring ways to share/visualize available data for use in health emergencies. Information Management/Geographic Information System (IM/GIS) personnel hired by the CP3 programme in Indonesia, Uganda, DRC, Kenya and Guinea are looking to obtain up to 70 datasets broken down as follows: ▪ Geographic: max. 19 datasets ▪ National Society: max. 3 datasets ▪ Health risk: max. 22 datasets ▪ Socio-cultural: max. 14 datasets ▪ Difficult to obtain: max. 12 datasets. The programme is also conducting remote mapping of geographical locations where CP3 is active using OpenStreetMap. Community mapping has also started in some countries (e.g. Kenya, Guinea), where Red Cross volunteers trained by IM/GIS consultants are collecting points of interest that are of particular relevance for epidemic control (health facilities, water points, markets, burial sites, etc.). Since March 2020, IM/GIS support has particularly focused on supporting National Societies to set up communication and collaboration tools to work remotely during the COVID-19 pandemic, collect information (e.g. about COVID-19 rumours, risk communication activities conducted) and have prepared maps showing points of entry, markets and other key information supporting pandemic preparedness. COVID-19 has brought to the forefront the relevance of maps for food distribution, border screening, installation of handwashing stations, health facilities and metadata (number of hospital beds, capacity of staff, and treatments provided, private/public facility) for instance. The programme is developing a series of case studies to show how data have been used to inform epidemic preparedness and response. ▪ Private sector engagement		

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	Small and medium size enterprises (SME) play a key role in communities' ability to limit the impact and recover from public health events. With the support of CP3, epidemic risk content has been added to the Atlas Ready for Business app, a mobile application developed by the Global Disaster Preparedness Center aimed at preparing small businesses to withstand common crises they might face. American Red Cross also developed "epidemic ready" workshops for SMEs that can be adapted to local contexts and sectors. Some countries have worked with private sector actors in the context of COVID-19, for instance reaching out to taxi and mototaxi drivers and small businesses selling goods in markets. ▪ Media engagement and preparedness A guide for the media on communicating in public health emergencies was developed for the programme and translated into Arabic, Armenian, Azeri, Bahasa, Bangla, Belarusian, French, Georgian, Romanian, Russian, Swahili and Ukrainian by BBC Media Action in 2020. Media landscapes were shared with Indonesia, Kenya, Sierra Leone, and Uganda. A series of two Communication in Emergencies trainings of a duration of two or three days each targeting journalists and humanitarian professionals was organized in Indonesia in February 2020 In September 2020, BBC Media conducted a small study to assess the course, interviewing five participants in each country. Overall feedback from participants about the training was overwhelmingly positive, with people stating it was clear, interesting and engaging and it helped them gain knowledge and practical skills for communicating in emergencies. Participants also stated they have been able to apply learnings from the training through having a better understanding of audience needs and drawing on networks of contacts across sectors. In December 2020, a training for media and Red Cross staff and volunteers was organised in Mali, with the support of Fondation Hirondelle/Studio Tamani. ▪ Religious leaders and other key stakeholder engagement Engagement with religious leaders, traditional healers, teachers and other key stakeholders is key in ensuring trusted channels of communication during a crisis. National Societies have included these actors in their IEC plans and activities. Communication, knowledge sharing and advocacy		

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	The resolution "Time to act: Tackling epidemics and pandemics together" adopted at the 33rd International Conference of the Red Cross and Red Crescent in December 2019 encourages National Societies to work in close coordination with national authorities and other organizations responding to epidemics and pandemics. IFRC's disaster management policy, also adopted in December 2019, encourages National Societies to assess systematically, measure and analyse the strengths, gaps and challenges of their response systems; it recommends increased access to pre-agreed financing ahead of disasters; it promotes response and readiness planning at national and regional levels with key stakeholders; and it encourages National Societies to support their governments in their efforts to assess and strengthen disaster risk management laws, policies, strategies and plans, consistent with the Red Cross Red Crescent's auxiliary role. The IFRC 2030 Strategy highlights the need for a significant investment in epidemic and pandemic preparedness. This includes investing in local actors, networks and volunteers as frontline responders and early risk detectors. IFRC co-convenes the Localization Workstream of the Grand Bargain alongside the Swiss government. CP3 is instrumental in packaging tools and developing approaches for National Societies to further engage in epidemic preparedness and response. The programme has also raised the profile of IFRC's work in epidemic and pandemic preparedness. In October 2020, IFRC's President Mr. Rocca delivered an address at the UN General Assembly WHO side event entitled Sustainable preparedness for health security and resilience: Adopting a whole-of-society approach and breaking the "panic-then-forget" cycle, stressing the importance of investing in community systems and in local actors to support epidemic preparedness. IFRC's Health and Care Director Emanuele Capobianco also raised the importance of risk communication and community engagement at a WHO virtual side event at the 6th GHSA Ministerial Meeting "Bridging Cooperative Action for Global Health Security" entitled Building better for the next Pandemic – Advancing Multisectoral and Whole-of-society Approaches to Health Security Preparedness. In December 2020, CP3's CBS experience was shared at the 8th Global Dialogue Platform on Anticipatory Humanitarian Action, in a session entitled "Catching outbreaks where they start through community-based surveillance". It was also captured in a journal article: "A community-centred approach to global health security: implementation experience of community-based surveillance (CBS) for epidemic preparedness", released in Global Security: Health, Science and Policy.		

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	Countries implementing CP3 are engaged with OneHealth partners to share information and identify synergies with local actors. At global, regional, and country levels, CP3 is coordinating with partners working under GHSA. This includes sharing of resources with Core Group Polio with regards to CBS and IEC materials, Breakthrough Action and John Hopkins University for community level IEC needs and community feedback mechanisms, as well as with READY. IFRC is hosting the Collective Service for Risk Communication and Community Engagement for COVID-19, a partnership between WHO, UNICEF and the IFRC. The CP3 webpages provide a resource for sharing updates and regular material in English and French. A newsletter goes out in English and French to over 300 subscribers. **Public Health in Emergencies** The IFRC's global Emergency Health Team is one of three Teams that make up the IFRC's Health and Care Department, situated in the Programmes and Operations Division of the IFRC Secretariat. The Team is based in Geneva, Switzerland, with emergency health counterparts spread across the IFRC regional offices, all of which act in support of the IFRC's and National Societies' programmes and operations at the country level. The objective of the IFRC's Emergency Health Team is to improve vulnerable people's health and dignity through increased access to appropriate, quality health services and information before and during outbreaks, disasters and other emergencies. Specific areas of focus for the Team include the following: • Infectious hazards management: ensure strategies and capacities are established for priority high-threat infectious hazards in National Societies and communities. • National Society health emergency response readiness: ensure National Society and IFRC capacities are fit-for-purpose for all-hazards emergency risk management. • Health emergency informatics and risk assessments: provide risk assessments and response monitoring for major health events, including support to disease surveillance systems. • Emergency operations: ensure high-quality technical assistance to emergency-affected National Societies and effective mobilization of global health response packages. • Emergency surge services: contribute to effective and rapid staffing of IFRC health emergency response operations. Support received under this grant has made an important contribution to the IFRC's emergency health work, notably through support in enabling the Emergency Health Team to conduct capacity building and training initiatives, as well as supporting the salary of the Team's Senior Officer, Public Health in Emergencies. Implementation strategy:		

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	Key achievements in 2020: 1) Revision and digitalization of the second edition of The Johns Hopkins and IFRC Public Health Guide in Emergencies The IFRC Public Health Guide in Emergencies is a textbook widely used in the classroom and the field, providing guidance in practical terms toward the solution of the many technical and management issues that challenge aid workers following natural and human-made disasters, including complex humanitarian emergencies. The guide captures both the experience of the IFRC and the academic public health perceptions of Johns Hopkins University. This guide was last updated and revised in 2008, and there was a need to continue to update and revise it to capture emerging evidence, along with the rapidity and the extent of changes in humanitarian assistance practices which have occurred since it was last published. In the 2018/19 project cycle, the process began to make this tool digital and modular, to improve usability and accessibility to decision-makers in the field and completed technical updates to the maternal and new-born health sections. The revision of the content was to be accomplished through participatory processes with involvement of various internal and external stakeholders to the International Red Cross Red Crescent Movement and using a phased approach. The key goals of these updates were to identify (and rank, where possible) evidence-based interventions in humanitarian health, and ensure the guidelines are available in a 'toolkit' format, that is rapidly searchable and usable by health coordinators in the field during emergencies. 2) Health leadership training: Emergency Health Coordination (EHC), and Coordination, Assessment and Planning (CAP) Emergency Health Coordinators (EHC) are a strategic tool for the IFRC Global Emergency Health Response; their role lies in health assessment, health risk identification and scenario planning, that are used as the basis for formulating and justifying the IFRC's Emergency Plans of Action. Planning for required resources to adequately and efficiently respond to the situation is a crucial responsibility. The EHCs facilitate and support the implementation and quality assurance of the Red Cross Red Crescent health response. They are required to lead on effective Inter-agency coordination for Red Cross Red Crescent health response and communicate essential information to key stakeholders effectively and promptly. Through the Emergency Health Coordination Training, a 5-7 day residential training run by the IFRC Health and Care Department, participants are expected to build up their competencies to be able to perform their role within the frame of the Red Cross Red Crescent humanitarian crisis response. It is a high-quality training, with problem-based learning methodologies. Trainees are selected through a strict selection application process and are evaluated against the corresponding core and technical competencies. In conjunction with the EHC training, funding was to be used to identify synergies between the existing EHC training and the IFRC's Coordination, Assessment and Planning (CAP) training, and to carry out a joint training, as appropriate. The CAP team is the IFRC's operations tool for assessment of humanitarian needs and coordination of response		

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	following large, complex and slow-onset disasters, anywhere in the world. CAP team members are experienced international disaster managers from National Societies, the IFRC and the International Committee of the Red Cross (ICRC), whose key competencies cover a full range of cross-sectorial expertise in emergency and recovery services. The CAP induction is a two-week intensive residential experience that will provide participants with the core knowledge required to function as an effective member of a Field Assessment and Coordination Team (FACT). The planned training was to be the 26th induction course in a series intended to build and maintain an active roster of trained staff able to deploy to the field at 24 hours' notice to respond to crises and disasters. The funding was to be used to identify and create health-specific modules to effectively bridge between the EHC and CAP trainings. In addition to the EHC and CAP training, there is a significant need for improved and increased distance learning approaches, to ensure health leaders and implementers at RCRC National Societies can continue to improve their technical skills and evidence base, without leaving their countries or National Societies. This project was to work with the Johns Hopkins Center for Humanitarian Health to identify and develop quality distance learning modules, including, for example, massive online open courses (MOOCs), that meet National Societies' health leadership development needs. Funds were to be also be used to ensure that the trainings are accessible to speakers of English, French, Spanish and/or Arabic. This scoping and development of distance learning modules for humanitarian health was to be used also supplement and complement the EHC/CAP trainings, with the updated curriculum reflecting the latest distance learning opportunities. 3) Support for the Health Emergencies global team: This grant's purpose was also to provide funding for the position of Senior Officer, Public Health in Emergencies, a vital role in the Emergency Health Team at the IFRC Secretariat in Geneva. The position leads the development of the IFRC's public health emergency preparedness, response and recovery strategies, tools and approaches. The role provides technical oversight to public health in emergency trainings and development, and quality assurance and operational support for public health responses—including outbreak response and public health response to natural and human-made disasters. This role provides critical support to the regions, gathering, codifying and analysing data to ensure consistency and quality in our humanitarian health response. The Senior Officer is a core member of the Emergency Health team, with a focus on operational excellence and evaluation, looking forwards and backwards, organizational learning, driving the agenda, and leading and supervising operational research to ensure the Movement's volunteers are equipped to provide the most effective emergency health services possible during times of crisis. The position is also the project lead for this grant.		

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	Key achievements: 1. Revision and digitalization of IFRC Public Health Guide in Emergencies: An MOU has been agreed with Johns Hopkins University to facilitate this work. In addition, a scoping of training and learning pathways is underway to better understand gaps, in order to transform modules from the Guide into online courses, interactive modules, massive online open courses (MOOCs), etc. This work is accelerating and will continue into the year 4 timeframe, and is included in the carry-over request. 2. Health leadership training: Emergency Health Coordination (EHC) and Coordination, Assessment and Planning (CAP) Training A pilot five-day Emergency Health Coordination – Coordination Assessment and Planning Training course was held in Geneva, 20-24 January 2020, organised by the IFRC Secretariat Emergency Health Team. After reviewing and comparing both the ECH training and the CAP training, the Emergency Health Team merged the standalone EHC training with the CAP training. To ensure building health capacity for emergency responses, the pilot merged EHC-CAP training was designed with a purely medical / para-medical / public health cohort of students, with the view to ensure the revised CAP training could be conducted with a mixed cohort (health/non-health) in future sessions. This has the added advantage that the training can be replicated as a standalone course for health cohorts, if/when there are significant shortages in trained emergency health coordinators. The combined curriculum allows health coordinators to train within a cross-disciplinary context, which more closely replicates real-world conditions of sudden-onset disasters, while maintaining the health leadership, management, and technical grounding developed through the EHC curriculum, in order to act as standalone technical leads in health emergencies such as outbreaks. The objectives of the training were as follows: 1. To contribute to training National Society staff to provide expert technical support and guidance to their respective National Societies' emergency medical services and public health in emergencies activities. 2. To contribute to the IFRC Secretariat's expert support to the regions and the National Society membership in the area of clinical and public health coordination in emergency response, including health assessment and health intervention planning, and coordination of programming including clinical and public health emergency response units (ERUs) (mobile clinics, field clinics, field hospitals, and various outbreak response ERUs); prehospital care; and management of high-quality health service delivery and outbreak prevention and response in emergencies. There were a total of 25 participants at the training: 13 women and 12 men, and 5 representatives from Africa Region, 4 from Americas, 3 from Asia Pacific, 1 from Middle East and North Africa region, and 12 from Europe Region. There		

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	were three core facilitators (one was the Senior Officer Public Health in Emergencies), 4 mentors, 8 guest facilitators, and four external guests for an external panel from WHO EMT Initiative, UNHCR, GOARN and IFRC. The training was held in Geneva at the ICRC Training Centre, Ecogia. The sessions of the training were the following: IFRC response system, surge process, internal planning, internal coordination, cultural awareness, team dynamics, assessment – secondary data and information management, assessment – analysis and primary data, scenario building, response options, developing an Emergency Plan of Action, ethics, presentation to stakeholders, support services, communications, quality management, lessons learnt from operations, coordination skills, host National Society-Ministry of Health coordination, handover transition and exit. After successful completion of this training, the participants were expected to have improved their skills on: o Assessment and analysis of a humanitarian crisis, identifying health needs, immediate and potential health risks o Development of an Emergency Plan of Action for Health including resource allocation o Provision of technical expert advice, support and quality assurance for Red Cross Red Crescent health responders and use of best practices and international standards o Coordination of Red Cross Red Crescent health response (units, commodities, human resources, field activities) for effective response o Contribution to Inter-Agency coordination and representation o Effectively participate in Red Cross Red Crescent Movement coordination Overall, the feedback from the participants at the end of course evaluation was very positive (overall average score 4.0 out of 5.0). By the end of the training all participants were assessed by their mentors as ready to deploy to an emergency response in some health capacity. Key deliverables of the team included,: • Led the development of the IFRC's Public Health Emergency Response Units (ERUs), which are newly created response modules as part of the IFRC's emergency response surge mechanism. Various National Societies now have dedicated ERUs ready to deploy with specific capacity in community case management of cholera and community-based surveillance, with other modules, including community case management of malnutrition, vaccination, and infection prevention and control, under development. These ERUs allow the IFRC to deploy specialist teams alongside the traditional ERU health clinics and ERU hospitals, which the IFRC has at its disposal. • Coordinated the IFRC's engagement in several academic collaborations for operational research, notably with regards to the ongoing EVD operation in the DRC with the London School of Hygiene and Tropical Medicine.		

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	• Acted as the focal point for the IFRC's involvement with the Global Outbreak Alert and Response Network, where the Senior Officer acts as the IFRC's key technical and coordination link with this important network of response actors. • Led all of the IFRC's public health in emergencies (PHiE) trainings, including the first mid-level PHiE training in the Middle East and North Africa region, thereby delivering on the position's role as a member of the Emergency Health Team's quality assurance and capacity building agenda. • Led the IFRC's production of technical guidance for community-level interventions in health emergencies, notably in the case of the IFRC's EVD response, where the position continues to act as the global technical lead for Safe and Dignified Burials in Viral Hemorrhagic Fever outbreaks, as well as one of the lead authors of the global guidelines produced by an Interagency working group. **DRC Communications that respond to community feedback – risk communication and community engagement (RCCE) – North Kivu and Ituri** Goal: Communities trust Ebola response activities in North Kivu and Ituri and are playing their part in the response to EVD Overall objective: To build, expand and sustain innovative community-driven approaches through a two-fold strategy: 1) Strengthen, localize and systematize an innovative system to analysing and sharing community feedback with decision-makers in real time in order to ensure community insights are translated into action. 2) Strengthen and systematize the process of revising and testing messages to better support Red Cross volunteers and frontline workers in engaging with community members about Ebola and the wider response efforts. Background: Misinformation, mistrust of outsiders and conspiracy theories have spread quickly across the eastern DRC during this Ebola response. There is a general consensus that community-based solutions to stop Ebola in the DRC must be at the forefront of the response, which is also corroborated by the lessons from the response to the Ebola outbreak in West Africa in 2013-16. Nevertheless, at the start of the outbreak there had been a lack of an established mechanism for recognizing and addressing underlying anxieties of communities and responding to their concerns and suggestions. The risk communication and community engagement (RCCE) activities of the Red Cross are implemented by a network of more than 800 local volunteers trained in communication techniques, working as part of the EVD response efforts and the Red Cross feedback collection mechanism, in both North Kivu and Ituri. They have been reaching out to their		

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	own communities, providing vital information on Ebola and the response, answering their questions and addressing rumours and misinformation. More than 1.6 million community members have been reached through household visits as well as mobile cinemas, community meetings, theatre forums and other sensitization activities since the start of the operation. An innovative feedback mechanism has been set up to track community feedback such as rumours, observations, questions and suggestions, and more than 350,000 community feedback comments have been recorded and analysed to date. This has been achieved through collaboration with USCDC technical counterparts, who are providing support to the coding and analysis process. Reports on community insights are shared with partners in the response and an interactive dashboard was developed together with HDX. A community feedback working group was also established under the lead of IFRC, with the goal of supporting the process of translating community feedback into action and therefore contributing to improved community ownership of the response. The project focuses on building on existing efforts and collaborations to bring timely community perspectives to decision-makers, whilst also ensuring a two-way communication channel between the response and communities. Its intention is to ensure community feedback is used in a more systematic way to shape response efforts and therefore contribute to community ownership and higher trust in response efforts. Implementation strategy: Building on the strengths of the innovative system already in place and being realistic and honest about the weaknesses in the system, has allowed the IFRC system to deliver a feedback system that is iterative and focused on translating community feedback into actionable information for decision makers. The key focus is on ensuring a system that allows the response to 'close the feedback loop' and build community ownership across all aspects of the response activities. The Red Cross community feedback data system, and the community-based approaches led by over 1,500 trained volunteers, allow communities to voice their understanding of the response and propose possible solutions to current challenges, thereby building trust and community ownership. Red Cross staff and volunteers have a unique role to play in gathering community intelligence and transforming it into key dialogue points to guide frontline workers, while advocating for social science data to be acknowledged and acted upon in the wider Ebola response.		

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	Specific objectives: 1. Improve and systematize the way community feedback is reviewed and discussed internally by Red Cross technical teams and management, as well as with the different sub-pillars of the broad EVD response, making sure action is taken to respond to community insights. 2. Establish a system to regularly adapt tools, dialogue points and approaches for promoting inclusive dialogue with affected communities and closing the feedback loop, ensuring information provided to communities is adjusted to the changing situation and responding to community feedback. 3. Reinforce Red Cross staff and volunteers' capacity to adapt and test talking points for volunteers and channels used for two-way communication, in order to make sure they are effective, culturally sensitive, and inclusive. 4. Make sure all efforts are linked into the coordination structure and revised talking points and observations are shared with the broader response on the different coordination levels. Key Achievements: • January-March 2020: 807 CEA volunteers reached 2,520,216 people from the target population with door-to-door and community communication activities. • 647,219 community feedback data points were collected during weekly health promotion activities. • These community insights were coded and analysed locally with USCDC support. Almost real-time feedback data informed localized adaptations of Movement activities and were shared with response partners for localization efforts across the broader response. • In the EVD affected zones in Equator Province and in the EVD stricken communities in north Kivu and Ituri, as well as in the EVD preparedness provinces, the IFRC intensified community awareness raising by trained Red Cross volunteers, and activities based on the prevailing realities and of the risks that continue to live with them in all the bases, through community radio shows, information kiosks used as information centres, sound tracks, and house-to-house and focus group exchanges, through community dialogues and educative talks among others, by the Red Cross CEA volunteers who are considered by many local community residents in the operational zones as trusted partners. 14 • Teams also strengthened community involvement through local leaders and other opinion leaders, some of whom were previously associated with community resistance and violence. Following awareness raising activities of the Red Cross, including participation in the radio talk shows, they were recruited as ambassadors to help persuade their fellow community residents to accept and support the work of the response workers. Output 1.1 Red Cross community feedback is translated into concrete action on a regular basis on the local level		

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	During the reporting period, the IFRC actively conducted the following activities under this output: • The capacity of local RCCE focal points, information management (IM) officers and data entry volunteers to analyse feedback and prepare simple presentations was enhanced. The whole process was handed over to the local teams and is fully independent, following dedicated training and capacity building initiatives. • Various internal meetings have been held to improve the feedback collection and analysis. These meetings and exchanges focused on local team capacity building, improving the presentation, reporting and sharing of the feedback collected by the Red Cross volunteers at each level. It is in this sense that a workshop was organized in March in Bunia to allow all volunteers involved in data processing and analysis to better absorb and apply the techniques, to better highlight the community feedback received. • The RCCE focal points regularly produce specific presentations on community feedback relating to their specific communities which are shared with the local sub-coordination and with community stakeholders outside the sub-coordination. • Throughout the reporting period, there were weekly meetings organized in each sub-coordination location by the Red Cross RCCE teams attended by other pillar representatives where teams brainstorm on how to best address the community feedback. • A feedback tracking table allocated actions to team members to follow up on assigned action points. • Team leaders were coached by RCCE supervisors and RCCE focal points in all bases in order to be familiar with the approach in their health areas and local communities where they work. • The field test of the chat-bot with CEA focal points, supervisors and CEA officers in the field was carried out, and the feedback was regularly provided to Translators Without Borders (TWB) for translation and to help improve on the quality of responses to community concerns and questions. Discussions were also held with relevant stakeholders internally and with officials of the Provincial Department of Health to help with the approval of IFRC messages to be integrated in the system. Output 1.2 Red Cross community feedback relevant to each location is shared with all partners and the sub-commissions in all coordination bases During the reporting period, the IFRC actively conducted the following activities under this output: • The Red Cross RCCE team was supporting the community feedback group in Beni, Butembo, Mambasa and Mangina, and other sub-coordinations. • The presentations on community feedback produced by the local RCCE and IM teams for the different bases are shared with the local sub-coordinations and with community stakeholders outside the sub-coordinations.		

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	• After deactivation of the sub coordination at the end of 10th Ebola outbreak declaration, the Red Cross local teams continue to interact with MoH representatives at the provincial division of health and health zones levels to share the community insights. • A document was produced on how Red Cross feedback is collected and analysed and was shared with the RCCE commission and other participants attending for the first time at feedback meetings. • All the feedback analyses produced by the Red Cross team at the general coordination level are available on the google drive of the RCCE commission. • In March 2020, due to Covid-19 restrictions, the regular community feedback meeting that used to take place at the Emergency Operation Centre in Goma was stopped and replaced by an online community feedback meeting with the partners involved in feedback collection and analyses. The IFRC team facilitated this weekly interagency meeting for feedback analysis, with the aim to put together the feedback provided by all the partners and make a joint analysis. Output 2.1 Key talking points for Red Cross volunteers are revised regularly based on community feedback During the reporting period, the IFRC actively conducted the following activities under this output: • The IFRC participated in all activities related to the design and validation of tools, messages and documents used for risk communication and community engagement activities as part of the RCCE commission. An additional platform for inter-agency coordination on community feedback data collection as well as social science research is the EERT Communication Working Group. The feedback analysis was used as reference during the message production process. • During all feedback working group meetings of the different sub-coordinations, a community feedback tracking table for community insights was reviewed and populated together with all pillar representatives. • In all the bases the RCCE teams worked with community stakeholders to discuss community feedback trends and how to address concerns or identify community-led solutions. • Revised and approved messages were always shared with the RCCE field teams in order to ascertain the linguistic and cultural appropriateness and ensure that the translation resonates with the local dialects. • Tested messages were approved and shared with the sub-commission and shared with other partners via email and google drive. Talking points were also shared with identified community influencers to share and discuss information with their communities. Output 2.2 Revised talking points are shared with the broader response During the reporting period, the IFRC actively conducted the following activities under this output: • There was considerable progress in the work to document and store talking points used in the locations by RCCE focal points in collaboration with the sub-coordination commission.		

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	• These community insights are coded and analysed locally, and thanks to the extensive capacity building support, can now be conducted at the local level without the need for support. Almost real-time feedback data informs localized adaptations of Movement activities and were shared with response partners for localization efforts across the broader response. • Through lose collaboration with Internews and weekly media productions, outreach was achieved through a weekly bulletin and broadcast done in collaboration with selected community radio stations to reach out to both community members and local actors and partners. • In March, discussions on how to enter the post-Ebola phase were ongoing, a period that has now arrived and is still ongoing with efforts being reinforced by community engagement and accountability activities, built during the active phase of the outbreak. Volunteers continue to identify diseases that community members are interested in discussing, such as COVID-19, and through these activities, the Red Cross remains as an entity that has worked with the community before Ebola and will continue to be active in providing information and services on health issues affecting them after Ebola has ended. • Various internal meetings have been held to improve the feedback collection and analysis. These meetings and exchanges focused on local team capacity building, improving the presentation, reporting and sharing of the feedback collected by the Red Cross volunteers at each level. It is in this sense that a workshop was organized in March in Bunia to allow all volunteers involved in data processing and analysis to better absorb and apply the techniques to better highlight the community feedback received. • The active participation of the IFRC in all activities related to the design and validation of tools, messages and documents in order to improve risk communication and community engagement continues as well as its collaboration with other CREC members. A platform has been provided also at the Communication Working Group team, which IFRC is a member of, to discuss among entities working in the collection of feedback how to help direct the research, data collection, analysis and dissemination. Challenges: • The fragile security situation continued to challenge activities throughout the reporting period, and subsequent restrictions of movements have made face-to-face trainings and coaching difficult. Although efforts have been made to adapt activities to these realities, including strengthening remoting working modalities and ensuring that local level capacity remains as the focus of capacity building issues, due to their ability to remain active in areas, often even during periods of high tension. • The COVID-19 outbreak has added another layer of complexity to the already challenging situation, especially with regards to the restricted movement of staff and volunteers and the need to adapt activities and reduce instances of		

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	large gatherings for training or RCCE activities for example. A number of adjustments to protocols and processes of the IFRC's work were introduced over the reporting periods to reduce the risk to staff and volunteers, whilst maintain continuity in the delivery of essential activities. These efforts continue. Concluding remarks: • Through the coordination and collaboration with the RCCE sub commission, it was possible to ensure accurate, complete and consistent information was shared by the Red Cross volunteers to the community. It is important to maintain linkage with other stakeholders to ensure harmonization of messages and avoiding duplication of efforts in the same target community. • Collaboration with Translators Without Borders enabled appropriate messaging to the communities using the language and terms that were acceptable and easily understood by them. **Strengthening Ebola preparedness activities in South Sudan – emergency response capacity development** Project Objective: The South Sudan Red Cross Society (SSRC) community-based surveillance (CBS) protocol aims to cover the following objectives: ▪ National Society capacity building for formal CBS integration ▪ Support the Ministry of Health in strengthening epidemiologic surveillance systems and thus contribute to health system strengthening ▪ Support partners in EVD preparedness and community-based surveillance ▪ Ensure community participation in early detection, prevention of potential outbreaks and control of disease for selected priority diseases and health events ▪ Ensure information for decision-making and timely action in tackling outbreaks Outcomes: • National Society's capacity strengthened, and it conducts and participates in overall country epidemiologic surveillance • Community-based volunteers, who are trusted and reside within their communities, are equipped with the knowledge to conduct CBS for the selected priority diseases as well as disseminate key messages and information related to them (community engagement) • National Public Health Surveillance system strengthened and reinforced through active community participation Background:		

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	In response to the threat posed by EVD, the South Sudan Ministry of Health (MoH) activated the Public Health Emergency Operations Centre (PHEOC), as well as reviewing and activating the National Ebola Preparedness plan, alongside instituting four main Sub-Technical Working Groups. Despite the challenging context in the country, the SSRC has continued to actively support government preparedness efforts, coordinated through the national and state level Task Forces led by the MoH and WHO, with SSRC as the lead agency for safe and dignified burials (SDB). SSRC is an active participant in the National Task Force, along with the technical working groups for RCSMCE (risk communication, social mobilization and community engagement), IPC/WASH/Case Management as well as the Psychosocial Support (PSS) Pillar. The risk of EVD spreading from the DRC to South Sudan will remain until the outbreak in the DRC is over. This is due to the proximity of the two countries, the high trade and population movement, the presence of refugees and internally displaced persons (IDP) along the border areas, the weak and fragile health systems and the similarities in the sociocultural context. The South Sudanese government has identified seven locations in Central Equatoria, Eastern Equatoria, Western Equatoria and Western Bahr el Ghazal as being at high risk for EVD transmission due to their proximity to the DRC. The National Ebola Task Force has prioritized infection prevention and control, safe and dignified burials, awareness raising, border screening and surveillance activities, among other preparedness efforts. SSRC, as a neutral and impartial community-based actor in South Sudan, has the unique ability to access communities which are cut-off or affected by armed conflict. In many of these communities, government authorities, including the MoH, are not able to provide services, nor access the communities, in the event of an emergency such as a potential EVD outbreak. It has therefore been critical to maintain, and where appropriate to scale-up, the capacity of SSRC's community volunteers and local branches in at-risk districts to provide critical outbreak response services during this outbreak. The SSRC operates 17 branches nationwide and over 100 units and subunits. The EVD operations fall under the Yambio Branch, Maridi Branch, Nimule Unit and Yei Unit. The geographical operational areas are as follows: Yambio, Nzara and Nabiapai under the Yambio Branch, Maridi and Ibba under the Maridi Branch, Yei, Morobo and Bazi under Yei Unit, Nimule, Abila/Olikwi and Anzara under the Yei Unit. Collectively, the SSRC is thus present in 12 at-high-risk counties. An average of 40 volunteers have been selected from each area; however, the numbers range between 30-50 depending on the need, and the population and size of each area. The SSRC had already trained 180 volunteers on RCSMCE, PSS and SDB in the first phase, and an additional 180 in the second phase, totalling 360 volunteers trained		

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	on all three activities. The project planned to train all the volunteers on CBS as part of expansion of SSRC EVD activities, owing to their presence in communities and the trust of the volunteers amongst the communities. The SSRC is working closely with other partners which will also conduct EVD CBS, namely: CORE Group, Save the Children, Care International, Terre des Hommes and UNICEF, with support from the USCDC. The technical working group had agreed to develop a standardized training package and selected one partner to whom all partners would report, to collect, analyse and respond to the data. Other available information and additional needs would be identified through the CBS assessment coordinated with SSRC along with the other selected partners within the technical working group on epidemiological surveillance. The plan was for the SSRC reporting system to go from the community-based SSRC volunteers to the volunteer supervisors and then to the focal reporting-to partner and/or county health department or state MoH. Since the beginning of the preparedness operations in August 2018, funded by IFRC's DREF funds, SSRC have: • Reached more than 480,000 people with social mobilization and risk communication in areas around 4 high-risk entry points, namely Nimule, Yei, Maridi and Yambio, and Juba. • Mobilized and trained 360 volunteers in the target areas of Maridi, Nimule, Yei, Yambio, and Juba. The volunteers reach people through awareness sessions in communities, schools, places of worship, entertainment centres and markets; public announcements of key messages, house-to-house visits, and mobilization of people at border-crossings for screening by trained volunteers. • Trained over 150 volunteers on SDB and organized them in 15 SDB response teams as part of its EVD preparedness actions in these locations and Juba. The SDB trained volunteers are part of the social mobilization and risk communication team in each location, to keep them engaged. • Procured 5 SDB kits and prepositioned them in the four operational areas. Implementation strategy: The project plan stated that the SSRC will engage in passive surveillance of selected priority diseases. This involves sensitizing communities on identifying and reporting potential alerts to volunteers, who in turn report to their supervisors and from there on to state and county surveillance focal points, thus directly contributing to the country's international disease surveillance (IDSR) system. Importantly, these volunteers are skilled and ready to be deployed and become active during any epidemic or emergency which occurs; they are on standby and active, well-informed, and consensually participant community members. Planned activities:		

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	• Conduct a master training of trainers/supervisors (EVD field officers and volunteer team leads) in cascading down the CBS trainings and activities to the priority areas in coordination with the CBS working group and partners. • The SSRC will roll out a mini-KAP survey to monitor the impact of the RCSMCE activities on the communities with regards to EVD prevention and protection and knowledge of safe and dignified burials, acting as community-based opinion polls, which could further be used to tailor EVD key messaging and dissemination. • SSRC to continue EVD RCSMCE to assure community awareness is maximized and encourage community participation. • Progress monitoring and regular supportive supervision of activity implementation. Key achievements: • SSRC issued its first Community Based Surveillance Protocol and finalised CBS internal reporting forms ensuring alignment with other partners and relevant government ministries. • Revised work plans and budgets for CBS were prepared for 2020; 11 out of 27 counties were prioritized and selected for Phase 3 activities. • 16 key staff and volunteers received a training of trainers/supervisors on community-based surveillance (CBS) for selected priority diseases and public health events (viral hemorrhagic fevers, acute watery diarrhea, measles, polio and cluster human and animal deaths/illnesses). These capacity for the implementation of CBS activities and ensure supervisors are provided with the appropriate level of knowledge, skills and competencies to conduct cascading trainings to field locations. ▪ SSRC conducted a one-day review meeting with the SSRC EVD field officers, which included an overview of CBS integration into EVD preparedness; furthermore, lessons learnt from the meeting will be used for long- and short-term CBS interventions. ▪ The Red Cross team supported the development of a COVID-19 National Emergency Response Risk Communication, Social Mobilization and Community Engagement Strategy (RCSMCE) (April - September 2020). ▪ The Red Cross team developed a training package on risk communication on COVID-19 based on experience and best practice from EVD preparedness ensuring the utilisation of capacity and knowledge built during EVD preparedness activities are being carried forward into the COVID-19 response. ▪ SSRC developed standard operating procedures for the management of the dead during a pandemic, that will be adopted nationwide, and which is adapted from the COVID-19 guidance developed by WHO and IFRC. ▪ The IFRC also developed guidelines to work in confined and crowded places to reduce risk of volunteers' infection to COVID-19. ▪ During the reporting period, a total of 2,538,300 people (1,406,820 female and 1,131,480 male) have been reached country-wide through 8,664 sessions on COVID-19 key messages (house-to-house, street announcements etc.).		

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	DRC: Strengthening Ebola response and preparedness through infection prevention and control Overall objective: Contribute to the reduction in the risk of nosocomial transmission of EVD through improvements to infection prevention and control (IPC) behaviours, practices and facilities in public, private and traditional health facilities in Ebola-affected communities. The main objective of the IPC approach for all health facilities in the epidemic area is to provide a level of protection similar to that observed in Ebola treatment centres. Specific objectives: • Provide ongoing support to 10 health facilities already receiving IPC trainings, equipment and support through the DRC Red Cross • Provide support to scale the Red Cross' IPC approach to 20 new health facilities, which have been identified in conjunction with the IPC commission of the EVD response; in each project facility, focus on: - rapid appropriation of procedures and good practices by personnel working within health structures - the capacity to isolate a patient in a dignified and secure environment for the patient, his/her family and the medical staff, from the time of their arrival, or during their entire stay in the health facilities and until their transfer - the continued use of the protection system over time with a sustained level of vigilance with healthcare personnel • Achieve/surpass and maintain an 80% score on the IPC commission's IPC scorecard in each health facility receiving support Background: Experience from recent EVD outbreaks has shown that the two main modes of transmission were linked to unsafe burials and nosocomial infections in health facilities, and that facilities do not have adequate ways to detect suspected cases and securely isolate them while they are being transferred to a treatment or transit centre. Interventions to protect the health system from contamination during an outbreak are a major challenge in the infection control strategy. They mainly consist of setting up strict procedures for triage of patients and users before they access health facilities and isolating the suspected patient before he or she is transferred by ambulance to an Ebola treatment centre. Triage procedures are set by the MoH and must be applied in all health facilities. The DRC Red Cross and French Red Cross, with the support of the IFRC, is responding to IPC needs in the affected communities, taking into consideration the Movement's capacities, geographical priorities, evolution of the epidemic as well as access constraints. The work undertaken by the Red Cross includes support to health facilities to strengthen IPC practices and behaviours, training on triage; training health care workers on IPC including establishing protocols		

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	for triage in facilities; establishing and/or rebuilding triage centres; the deployment of community-based volunteers to support screening and pre-triage of patients; and deployment of innovative rapid isolation tents to support the humane and rapid isolation of suspected EVD cases in local health facilities. The DRC Red Cross has provided clinical support to health facilities in North Kivu since before the start of the outbreak and maintains an IPC specialist roster at the national level. As such, capacity built at both the health facility and National Society level through this project will continue to impact IPC practices and behaviours during and beyond the timespan of this outbreak. The DRC Red Cross, working with the support of IFRC and the French Red Cross, supports 36 health facilities in Ebola hotspots, wherein DRC Red Cross community volunteers, working with the supported health facilities, have screened more than 300,000 patients seeking care. The Red Cross IPC approach includes an integrated package of interventions: • Hard WASH, including provision and/or rehabilitation of water points, sanitation facilities, and disposal for biohazard and household waste • Training on triage, isolation, case identification/active case finding in wards, and standard IPC procedures, with a focus on adult learning techniques and internalized knowledge and behaviour change • Supportive supervision over a period of months to identify areas for improvement and support lasting behaviour change • Provision of IPC supplies and equipment to support consistent application of IPC best practices • Identification/creation of triage and isolation flows and facilities • Deployment of innovative rapid isolation tents for the humane and safe isolation and provision of basic supportive care to suspect cases awaiting transfer to a testing facility Geographic locations: 40 health facilities were supported with the IPC package and trainings, including 12 in Beni, 4 in Butembo, 4 in Mangina, 5 in Bunia, 2 in Komanda, 3 in Mambasa, 8 in Goma and 2 in Bukavu. In addition, 4 traditional healer centres were supported in Goma (Nyragongo health zone). Implementation strategy and planned activities: In order to achieve these three fundamental goals, three simple interventions are proposed. These interventions are part of the official strategy set by the MoH and WHO and are designed to facilitate their implementation, based on rapid and effective implementation, with a focus on areas of expected high impact. 1. Train health facility personnel (clinical and support) combining a participatory approach, an “in situ” training in the structures, over a short period of time and of all staff		

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	The training of staff in the health facilities is essential for the implementation of protection procedures and to limit the risks of contamination. Good practices must be adopted by all, regardless of the professional category and not just by a few selected people. The training adopts a participatory adult learning pedagogical approach, using card games to facilitate group training workshops. This approach encourages internalized IPC behaviour changes within a health facility by making all personnel, whether cleaners or surgeons, jointly responsible for patient safety. Training within the health facility, where the behaviours and activities will be implemented, takes into account the local realities of that facility and identifies ways to overcome systemic challenges to IPC. In total, 45 training sessions were organized, and reached 286 Red Cross volunteers (126 female and 160 male) and 403 health staff (222 female and 181 male). 2. Install rapid isolation tents The isolation of suspected patients is a key step in the IPC approach. This isolation must be immediate and must allow the risk of contamination to be controlled while awaiting transport to an Ebola treatment centre or transit centre. The time of isolation should allow for medical follow-up of the suspected case, for example by doing a clinical examination or by providing supportive care without exposing the health workers. The use of a tent composed of individual isolation "bubbles" makes it possible to provide quality care, by allowing the patient to be touched, while protecting professionals. The reduced size tent facilitates the installation of the tent within the confines of the health facility, even in an urban context with limited available space. This approach reduces the impact of triage and isolation on existing available space for management of other health needs, which remain pressing in this humanitarian emergency. Likewise, the smaller footprint and discreet set-up of the rapid isolation tents may decrease negative public perceptions of health facilities receiving IPC support, some of which have experienced community resistance due to the misperception that they had been transformed into Ebola treatment centres. 22 health facilities supported out of 40 have benefited from an isolation bubble: 2 in Butembo, 4 in Beni (1 in Mabolio heath structure not supported by Red Cross after the community and MoH's request); 2 in Mangina, 4 in Goma, 3 in Bunia, 3 in Mambasa, 2 in Komanda and 2 in Bukavu. 3. Carry out supportive supervision and simulations over time Frequent and regular training supervision in health facilities make it possible to ensure the persistence of the triage, isolation and IPC systems/behaviours, and to evaluate the continuity of knowledge by health professionals and the respect of official protocols. Supervision allows for continuous improvement in the quality of care over time and the strengthening of health protection. It also helps to restore user confidence.		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
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	As a partner of the Infection Prevention and Control (IPC) Commission, the French Red Cross, DRC Red Cross and IFRC uses MoH-approved standard operating procedures and participates in the IPC Commission at both general coordination and sub-coordination levels. The selection of health facilities (FOSA) that are supported is based on the Commission's priorities and are identified in collaboration with the FOSA staff, IPC Commission and the local community, and are validated by the IPC Commission and relevant sub-coordination before the Red Cross proceeds. IPC teams review the selection criteria, based on lessons learnt regarding the frequentation, category of FOSA, as well as the geographic accessibility. On 5 September 2019, the IPC Commission launched the revised IPC toolbox in Kinshasa and on 18 September in Goma. The Red Cross has been part of its development and incorporated the revised IPC tools into the programme. The Red Cross IPC approach includes an integrated package of interventions. This is based on the MoH's and IPC Commission's IPC package with the objective of ensuring that the priority health facilities attain an IPC score of 80% to reduce the risk of nosocomial infections (MoH/IPC Commission protocols and score card are used). The Red Cross works with the FOSA management and staff on the following interventions: 1. Regular evaluation against the IPC score card with the objective of achieving over 80%. The score card measures the FOSA's performance against designation of focal points and hygiene committees, functional triage area, hygiene, availability of PPE, waste disposal and sterilization, training, suspected case alerting, disinfection and nosocomial transmission exposure to health care workers. IFRC delegates and DRC Red Cross volunteer supervisors who have a health background rotate through the FOSA on a weekly basis. In general, FOSA with scores less than 50% are followed daily, FOSA with scores between 50% and 79% are followed 2 to 3 days a week, and FOSA that have achieved a score over 80% are followed weekly. 2. Regular training, mentoring and formative supervision of health care workers (doctors, nurses, hygienists etc.) based on the FOSA's performance. Including cooperation with the CEA teams to reduce number of incoming patients who refused handwashing by providing supportive information why hygiene is so important. 3. Triage and isolation of suspected cases including the installation of pre-triage, triage and isolation areas, and screening by DRC Red Cross volunteers on rotation 7 days a week. 4. As part of an innovative new system, rapid isolation tents with two individual isolation "bubbles" make it possible to provide quality care for suspected EVD cases, by allowing the patient to be touched, while protecting health professionals during the period from identifying and notifying the suspected EVD case to transport to the Ebola Treatment Centre. Initially 10 units were deployed by French Red Cross with 7 installed at selected FOSA (3 were		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
		Q2	Q4
	provided to General Coordination, 1 for demonstrative purposes with INRB in Kinshasa and 2 for rapid response units). An additional 18 are being produced and sent by French Red Cross to expand the reach. 5. Decontamination of FOSA following a suspected EVD case. 6. Rehabilitation of water, sanitation and hygiene (WASH) infrastructure based on the individual needs of each FOSA (for example the existing supported FOSA have received installation of impluvium's and water tanks to ensure a safe water supply and the construction of incinerators, ash pits, garbage pits, toilets and shower blocks, laundry rooms etc. to improve sanitation). The exact nature of the WASH rehabilitation is based on needs assessments and is done in consultation with FOSA management. 7. Provision of IPC equipment and supplies including chlorine, PPE, thermometers and hygiene supplies. According to the IPC Commission assessments, Red Cross supported facilities that were evaluated have consistently averaged in the mid to high seventy percent for IPC scores. Indeed, the supported FOSA with scores less than 80% were largely due to WASH infrastructure, whereby rehabilitation has been pending due to other funding delays not related to this grant. The Red Cross has several funding sources for IPC that are both earmarked and unearmarked, and that together contribute to the implementation of the complete IPC package. Since the start of the operation, in the 36 FOSA in the IPC project, 118 volunteers have screened 2,033,371 people and completed 1,605 decontaminations, and more than 908 health care workers have been trained. Health facilities supported with IPC approaches have successfully triaged, isolated and referred more than 320 positive Ebola cases, maintaining safe environments for healthcare workers and patients seeking treatment in these community facilities and ensuring rapid and appropriate medical treatment for Ebola patients. Key Achievements: January 2020 Over epidemiological weeks (EW) 2-5, 2020, a total of 206,346 people were screened (58% female, 24% under 18 years) by 151 volunteers: • 16,935 from 10 FOSA in Beni • 98,290 from 4 FOSA in Butembo/ Katwa • 3,607 people from 2 FOSA in Mangina • 62,975 people from 5 FOSA in Bunia • 23,052 people from 5 FOSA in Goma • 1,487people from 3 FOSA in Mambasa		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
		Q2	Q4
	In total, 143 suspected cases were identified, 96 were validated and transferred to an ETC, with no confirmed cases, and 32 suspected EVD deaths were notified. In response, there were 122 decontaminations of FOSA completed. • Out of the 31 FOSA supported, there were 49 performance evaluations (67%) achieving an 80% or above IPC score • 282 health workers from 31 FOSA received supervision • 116 health workers received training and a briefing on IPC protocols and standards • 138 DRC Red Cross volunteers received a briefing • During this period, 10 traditional healers received IPC training in Komanda February 2020 • 32 health facilities were supported with an IPC package, supervision, and training for 155 volunteers 25 • Health facilities supported with IPC approaches successfully triaged, isolated and referred more than 170 positive Ebola cases, maintaining safe environments for healthcare workers and patients seeking treatment in these community facilities, and ensuring rapid and appropriate medical treatment for Ebola patients • 359,035 people were screened including 57% women and 24% under 18 years • The overall results achieved were: ▪ 170 suspected cases notified and validated transferred to ETC for confirmation ▪ 115 suspected deaths notified in health facilities ▪ 224 decontaminations of FOSA realized ▪ 580 health staff, traditional healers and volunteers received training on IPC protocols according standard operating procedures ▪ 473 health workers received supervision or briefings ▪ Out of the 32 FOSA supported, there were 22/30 (73%) EW8 and 20/32 (63%) of performance evaluations greater than or equal to 80% (67%) March 2020 • 36 health facilities were supported with an IPC package, supervision, and training for 155 volunteers • From 1-23 March, 137,480 people were screened, 57% of them were female, 25% screened were children (< 18 years old), as follows: o 8,884 people from 9 FOSA of BENI (1 FOSA: Okapi had temporarily stopped its activities o 59,864 people from 4 FOSA of Butembo o 2,167 from 2 FOSA in Mangina health zone o 23,598 from 6 FOSA of Goma o 31,159 persons from 5 FOSA of Bunia		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
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	o 10,671 persons from 2 FOSA of Komanda o 1,337 persons from 3 FOSA of Mambasa • During EW 10, 15/26 FOSA, supported by the Red Cross scored greater than 80% on their performance score card. While in EW 11, this minimum 80% score card was reached by 20 FOSA representing 77% out of the total of health facilities supported • Most of the FOSA that have not reached the score card of 80% or higher was due to the lack of WASH infrastructure as well as inadequate sterilization equipment; efforts are being undertaken to correct these elements • 40 suspected cases notified and validated were transferred to ETC for confirmation • 37 suspected deaths notified in health facilities • 56 decontaminations of FOSA realized • 267 health staff received training on IPC protocols and standard operating procedures • 237 health workers received supervision or briefings April 2020 • 37 health facilities were supported with the IPC package, supervision, and training for 733 volunteers (one volunteer can receive more than one training session in a month) • 1-30 April, 520,121 people were screened, 55% of them were female, 26% screened were children (< 18 years old), as follows: o 31,820 people from 12 FOSA of BENI (3 traditional healers) o 98,771 people from 4 FOSA of Butembo o 6,539 from 2 FOSA in Mangina health zone o 226,532 from 8 FOSA of Goma and 4 traditional healers o 63,068 persons from 5 FOSA of Bunia o 91,550 persons from 2 FOSA of Komanda o 1,831 persons from 3 FOSA of Mambasa • During the month, 61% of the total health facilities were supported 26 • Most of the FOSA that have not reached the score card of 80% or higher was due to the lack of WASH infrastructure as well as inadequate sterilization equipment; efforts are being undertaken to correct these elements • 63 suspected cases were notified and 33 were validated for the transfer to ETC for EVD confirmation • 15 suspected deaths notified in health facilities • 38 decontaminations of FOSA realized • 267 health staff received training on IPC protocols and standard operating procedures		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
		Q2	Q4
	• 237 health workers received supervision or briefings May 2020 • 39 health facilities were supported with an IPC package, supervision, and training for 502 volunteers (one volunteer can receive more than one training session in a month) • 1-31 May, 612,262 people were screened, 54% of them were female, 26% screened were children (< 18 years old), as follows: o 21,022 people from 12 FOSA of BENI (3 traditional healers) o 118,818 people from 4 FOSA of Butembo o 5,465 from 4 FOSA in Mangina health zone (2 traditional healers) o 252,548 from 8 FOSA of Goma and 4 traditional healers o 114,479 persons from 5 FOSA of Bunia o 36,064 persons from 2 FOSA of Komanda o 70,668 persons from 3 FOSA of Mambasa o 10,198 persons from 3 FOSA of Bukavu • During the month, 77% out of the total health facilities were supported • Most of the FOSA that have not reached the score card of 80% or higher was due to the lack of WASH infrastructure as well as inadequate sterilization equipment; efforts are being undertaken to correct these elements • 61 suspected cases were notified and validated for the transfer to ETC for EVD confirmation • 36 suspected deaths notified in health facilities • 127 decontaminations of FOSA realized • 815 health staff received training on IPC protocols and SOPs (one health staff can receive more than one training session in a month) • 1,133 health workers received supervision or briefings June 2020 • 40 health facilities were supported with an IPC package, supervision, and training for 323 volunteers (one volunteer can receive more than one training session in a month) • 1-30 June, 325,718 people were screened, 56% of them were female, 27% screened were children (< 18 years old), as follows: o 23,709 people from 12 FOSA of BENI (3 traditional healers) o 105,429 people from 4 FOSA of Butembo o 4,579 from 2 FOSA in Mangina health zone (2 traditional healers) o 62,247 from 8 FOSA of Goma and 4 traditional healers		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
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	o 78,466 persons from 5 FOSA of Bunia o 40,004 persons from 2 FOSA of Komanda o 5,993 persons from 3 FOSA of Mambasa o 5,291 persons from 3 FOSA of Bukavu • During the month, 83% out of the total health facilities were supported • 19 suspected cases were notified and validated for the transfer to ETC for EVD confirmation • 32 suspected deaths notified in health facilities • 44 decontaminations of FOSA realized 27 • 619 health staff received training on IPC protocols and standard operating procedures (one health staff can receive more than one training session in a month) • 843 health workers received supervision or briefings Challenges: • Renovation of WASH infrastructures with placenta pits, incinerators, and waste management systems in supported health facilities was challenging throughout the implementation period. Indeed, many FOSA simply lacked appropriate and functional triage buildings and facilities, that were crucial to EVD IPC activities. Indeed, the comparatively lower IPC scores at certain FOSA were overwhelmingly due to the need for improvements and renovation of infrastructure. Correcting these issues were often labour and resource intensive requiring sometimes delayed procurement processes to ensure the necessary quality of materials and work to be done. Every effort was also made to ensure that such work was also done in a sustainable manner, thereby providing long-term structural improvements to supported FOSA that would also be used and valued by the staff working there. • The continuation of EVD IPC activities within the context of COVID-19 also caused a number of challenges during the reporting period. There was a need for further integration to reduce exposure of health workers with adaptions noted as required to account for the specifics of the COVID-19 outbreak. However, improvements on these issues in terms of the integration of both COVID-19 and EVD protocols have been made, which have continued beyond the reporting period and helped by the end of the EVD outbreak. • Challenges were also observed in the enrolment of traditional healers, and their equipping with hand washing items and IPC items. This is an ongoing challenge and something the IFRC was aware of when committing to work with these groups, noting their important role in the local health system and broader community hygiene and IPC practices. Efforts continue to work closely with traditional healers to improve their standards and practices regarding IPC.		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
		Q2	Q4
	• Improvement of score card performance in 80% of supported FOSA, as discussed above, often due to the challenges around infrastructure and renovation requirements. Concluding remarks: • The training of the health staff, volunteers and the traditional healers in IPC procedures was essential in breaking the chain of transmission especially in the most probable locations where potentially sick people would look for support. This work also contributed to improving the skills of health providers, Red Cross volunteers as well as traditional healers. Having the practical sessions ensured improved engagement and increased knowledge retention. The use of MoH IPC guidelines and the use of the FOSA IPC scores system ensured compliance with the government standards, as well as ensuring the MoH participated in the training and monitoring of standards. Ultimately, significant effort has been invested in improving and maintain the knowledge and behaviour change of the health service providers in their daily practice, ensuring their adherence to IPC procedures now and into the future. • The community believes in the use of traditional medicine and often seeks the services of traditional healers when in need of health care. The inclusion of traditional healers in IPC activities was instrumental to reduce the risks of transmission of EVD both for the healers and their patients. In addition to this, the provision of PPE has helped to strengthen their protection as well as that of the users of their services, thus helping to minimize the spread of the virus in the community. • The notable number of people screened at Red Cross supported FOSA has shown the role that the Red Cross can play in these important activities during an outbreak and have contributed significantly to developing further the expertise and experience of the French RC as the IFRC Network's technical lead on IPC. Concurrently, the DRC RC have similarly gained notable expertise and experience in these activities working hand in hand with the French RC on these issues, providing opportunities to continue these types of activities into the future, and notably in supporting adaptions to COVID-19 response activities and broader health 28 system strengthening activities currently ongoing in the DRC as part of post-EVD recovery work. • Another important lesson learned and critical area of work which continues has been efforts to integrate the RCCE and IPC pillars, which has allowed better community acceptance of these interventions, thereby improving their quality and effective use by communities in accordance with required protocols. **EVD emergency response capacity development in unaffected neighbouring countries: Rwanda and Burundi** Rwanda: Emergency Response Capacity Development		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
		Q2	Q4
	Overall objective: To prevent morbidity and mortality that would result from a possible Ebola outbreak in the 15 identified districts, through: continuation of risk communication and sensitization activities; reinforcing the safe and dignified burial teams with capacity building (refresher trainings, drills/exercises); and provision and strategic prepositioning of additional equipment for emergency response, securing temporary bases and planning permanent bases. Background: Following the announcement in August 2018 from WHO declaring Rwanda as a priority one country (based on its shared borders and proximity with the DRC), the Rwanda Ministry of Health (MoH) immediately intensified efforts in strengthening preparedness for prevention and control of a possible EVD outbreak. A coordination forum led by the MoH, Rwanda Bio-medical Centre (RBC) and WHO, was set up to coordinate EVD preparedness activities among partners. Other partners represented in the coordination platform include the Center for Disease Control (CDC), Rwanda Health Communication Centre, University Teaching Hospitals, Directorate General of Immigration and Emigration, National Referral Laboratory (NRL), Rwanda Red Cross, UNICEF, World Food Programme (WFP), OXFAM, UNHCR, FAO, DFID, DG ECHO and various epidemiologists. In July 2019, the first case of Ebola was confirmed in Goma, the biggest city in North Kivu, which borders Rubavu district in Rwanda, sparking fears of cross border spread to Rwanda. The expansion of the outbreak to Mwenge Health Zone in South Kivu in August 2019 further increased the risk of importation to Rwanda. The border area is characterized by high population movement, with an estimated 45,000 - 60,000 people reported to cross daily to either side for trading and private business. In addition, Rwanda has a high population density which increases the risk of a possible EVD outbreak, and Rwanda continues to receive and host refugees and Rwandan returnees from the DRC. Following the declaration of the tenth EVD outbreak in DRC, Rwanda Red Cross has been active in supporting the government's efforts in implementing preparedness activities as per the National Contingency Plan. At the start of the operation, 550 volunteers were trained on community-based surveillance and contact tracing (50 per district); 110 volunteers were trained on safe and dignified burials (SDB) (10 per district), two national SDB teams were formed alongside reserve teams in each of the 11 districts; and 2 starter kits, 3 SDB kits, and 5 PPE kits were procured and pre-positioned. In addition, 55 volunteers (5 per district) were trained on psychosocial support; mobile cinema sessions were conducted and the 550 volunteers have been conducting community sensitization through different meetings, mass sport events, and house-to-house visits, altogether reaching more than 3 million people since September 2018. Initially, awareness on appropriate Ebola prevention measures was low among target communities, volunteers and		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
		Q2	Q4
	health workers as Ebola is not a disease that has affected Rwanda in the past. Continued community sensitization through community meetings and mobile cinema helped to spread awareness of the disease and enable communities to identify signs and symptoms in order to take precautionary measures. Implementation strategy: The Rwanda Red Cross, with the support of IFRC, planned to continue its risk communication and sensitization activities (as behaviour change is a time-based process), across 15 districts most at risk of an outbreak, with an estimated target population of 5,000,000 people (1,000,000 households). Safe and dignified burial teams which are in place, were to be reinforced with refresher trainings, and drills and exercises. In addition, strategic prepositioning of additional equipment for emergency response 30 was to be provided, as well as securing of temporary bases and planning of permanent bases. Overall, these activities were targeted to help strengthen the capacity of Rwanda Red Cross to respond effectively to future epidemics and strengthen the coordination system with the MoH and other partners. Planned activities: Output 1: Community-based disease prevention and health promotion is provided to the target population (Indicators: # of mobile cinema sessions conducted; # of households reached with community engagement and social mobilization; # of information education communication (IEC) materials produced and distributed) Activities: 1. Produce and distribute flyers and posters, IEC materials with Ebola messages to communities 2. Conduct mobile cinema sessions in 15 districts 3. Training of contact tracing teams on the updated case definition form 4. Conduct awareness events at schools 5. Use of interactive radio to engage with affected communities 6. KAP survey (with Kobo data collection) Output 2: Epidemic prevention and control measures carried out (Indicators: # of district branches supported in the planning and implementation of EVD prevention activities; # of contact tracing and community surveillance teams set up; # of trained SDB teams that are ready to deploy; # of drills/ simulation exercises conducted)		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
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	Activities: 1. Procurement of SDB starter kit, SDB training kits, PPE 2. Local procurement of SDB materials (tarpaulins, boots, buckets, trash bins, containers, jerry cans, matches, gasoline) 3. Training of trainers for the frontline SDB teams 4. Drills/simulation exercises for the 2 national SDB teams -"1st line teams" 5. Drills/simulation exercises for the district reserve SDB teams - "2nd line teams" 6. Procurement of first aid kits (medium size) 7. Equipment for contact tracers (bicycles, gloves, disinfectants) 8. Rehabilitation of 2 field warehouses (Rusizi and Rubavu) 9. Procurement of additional hand washing facilities 10. Procurement of calcium hypochlorite chlorine powder for disinfection 11. Procurement of additional spray pumps Output 3: Psychosocial support provided to the target population (Indicator: # of volunteers trained in psychosocial support) Activity: 1. Psychosocial support refresher training for volunteers Key achievements: The following was achieved during the reporting period: • Rwanda Red Cross staff involved in the project included the following: PSS coordinator, Preparedness and DRR coordinator, Communication and CEA/RCCE coordinator, Financial Accountant, Head of Technical department, Logistics and Procurement, PMER Coordinator, 15 National Disaster Response Team (NRDT) supervisors. • Procurement and distribution of 2,396 posters and flyers with EVD messages in 15 districts. • Community mobilization was conducted using mobile cinema: 130 mobile cinema sessions on EVD were conducted between December 2019 and February 2020, reaching an estimated 400,000 people in 13 districts (Rusizi, Nyamasheke, Karongi, Rutsiro, Rubavu, Nyabihu, Musanze, Burera, Gicumbi and Nyagatare, Nyarugenge, Kicukiro and Gasabo). • Conducted 806 community awareness sessions in community meetings, schools, markets between December 2019 and February 2020, reaching over 350,000 people, also via mobile SMS in 13 districts (Rusizi, Nyamasheke, Karongi, Rutsiro, Rubavu, Nyabihu, Musanze, Burera, Gicumbi and Nyagatare, Nyarugenge, Kicukiro and Gasabo). • Procurement and pre-positioning of 1 Ebola starter kit, 5 PPE kits, and 15 SDB training kits during the reporting period.		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
		Q2	Q4
	• Various coordination meetings were attended throughout the reporting period, thereby ensuring the National Society continues to effectively engage in relevant coordination structures at various levels. This work continued now with efforts pivoting towards COVID-19. No activities were implemented under this grant between March and June as the National Society halted all EVD programmes with the onset of COVID-19 response and with authorities requiring EVD messaging and other related activities to stop. Challenges: ▪ As described above, the government took strong positions on the discontinuation of EVD related activities over the course of the reporting period, including more broader preparedness activities and especially risk communication and community engagement (RCCE) messaging. With the arrival of COVID-19 and owing to the change and approval in RCCE messaging to COVID-19, the following activities have been discontinued: mobile cinema sensitization sessions on EVD, community awareness sessions in schools, churches, markets and community events, and distribution of IEC material with EVD messaging. These activities will pivot towards COVID-19 messaging and activities and will conducted in close collaboration with authorities. ▪ In addition, various travel restrictions have been put in place over the course of the COVID-19 outbreak, with complete lockdowns observed early on in the outbreak in Rwanda. These periods of lockdown led to the postponement of the following activities: refresher training and simulation exercises for the SDB teams; rehabilitation of the field warehouses; roll-out of RCCE branch level training in 15 districts; psychosocial support (PSS) and psychological first aid (PFA) training of volunteers planned to be conducted with support from the IFRC's Psychosocial Support Reference Centre (based in Copenhagen, Denmark and acts as a PSS technical and research hub for the IFRC in support of all National Societies); procurement of SDB kit consumables (tarpaulins, boots, buckets, trash bins, containers, jerry cans, matches, gasoline). Concluding remarks: Burundi: Emergency Response Capacity Development Overall objective: To strengthen the existing Burundi Red Cross Society EVD response structures and mechanisms, allowing timely and effective implementation of risk detection, mitigation and response measures in the event of suspected EVD cases in the six provinces of Cibitoke, Bubanza, Bujumbura Rural, Bujumbura Mairie, Rumonge and Makamba, in Burundi. Background:		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
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	The Government of Burundi's National Ebola Taskforce developed an Ebola Virus Disease (EVD) Contingency Plan, with the support of the Burundi Red Cross Society (BRCS). Through this taskforce BRCS has been requested to implement and lead the Safe and Dignified Burials (SDB) pillar of readiness and any eventual response, as well as supporting dissemination of EVD messages through radio spots and mobile cinemas. The BRCS participates in weekly coordination meetings where they report and update on progress in implementation of the SDB and risk communication and community engagement (RCCE) activities. Through the IFRC's DREF1 funding (October 2018 to March 2019), BRCS mobilized and trained staff and volunteers, including 56 people trained in SDB, 84 in RCCE, and 90 in PSS. Mobile cinema activities, door-to-door campaigns and 54 radio shows with messaging on EVD were carried out in at-risk communities reaching 420,000 people. SDB drills were conducted. The DREF-funded operation also enabled the BRCS to procure and pre-position 9 SDB kits and 5 SDB starter kits. However, readiness activities ceased once this funding was exhausted, leaving significant gaps in BRCS's ability to prevent and rapidly respond to a case of EVD. Thankfully, further funding has since been secured, to allow the National Society to continue its work. Implementation strategy: The three main elements of the BRCS implementation strategy are: SDB, psychosocial support (PSS) and dissemination of EVD preventive messages through RCCE activities. BRCS is a member of the National Ebola Taskforce and leads the SDB pillar of the EVD Preparedness Contingency Plan. For two years, BRCS has been a co-leader of the Dead Body Management Committee in the National Platform for Risk Prevention and Disaster Management. As outlined in the National EVD Contingency Plan, BRCS is responsible for SDB activities. Burundi has never experienced an EVD outbreak, thus, there was a need to provide technical support for training for volunteers and staff on SDB. Training of trainers and community educators training on psychosocial support was also required, along with simulation exercises on EVD activities for SDB and PSS. The operation therefore focused on enhancing the capacity of 6 SDB teams to implement SDB activities in the event of an outbreak. Volunteers participating in the response were also to be provided with psychosocial support, as well as the training of staff and volunteers to provide PSS to affected families. RCCE on key Ebola messages, community perceptions and community feedback are important elements of the National Society's social mobilization activities. Similarly, RCCE also includes information on SDB burial protocols to		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
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	ensure at risk communities are aware and prepared to accept and support implementation of SDB in the event of an outbreak. Geographic locations: Six provinces bordering DRC: Cibitoke, Bubanza, Bujumbura Rural, Bujumbura Mairie, Rumonge and Makamba, as designated by the National EVD Contingency Plan. The table below shows targeted provinces and communes for EVD preparedness activities. CIBITOKE BUBANZA BUJUMBURA MAIRIE BUJUMBURA RURAL RUMONGE MAKAMBA 1 DREF, or Disaster Relief Emergency Fund, is the IFRC's version of the UN CERF, allowing for the quick mobilization of funds to kick-start emergency operations and/or address forgotten and ignored humanitarian emergencies. Rugombo Gihanga Ntahangwa Mutimbuzi Muhuta Nyanza-lac Buganda Mukaza Kabezi Rumonge Planned activities: • Provide comprehensive training to SDB teams (including refresher trainings to the 56 people trained through the DREF-funded operation) • Carry out 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 of additional SDB materials (including starter and training kits) • Carrying out awareness sessions in schools and communities including targeting community leaders • Use of mobile cinemas to raise EVD awareness in at-risk communities • Social mobilization through door-to-door campaigns • Training of volunteers and staff in contact tracing • Community engagement and accountability sessions at the community level • RCCE and social mobilization The operation has targeted reaching 834,588 people with key messages on EVD through door-to-door campaigns, radio shows and mobile cinemas. Similarly, BRCS intended to reach community leaders specifically in at-risk communities with key messages on EVD with a particular focus on SDB. Risk communication, social mobilization and community engagement activities were planned to be conducted in 10 communities in 6 provinces bordering the DRC. BRCS also focuses interventions on the travellers at 11 points of entry at the Rumonge, Nyanza-Lac and Mutimbuzi border points.		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
		Q2	Q4
	Key achievements: The following described key achievements since the beginning of the operation in 2018 and are provided to highlight the entirety of the work conducted in Burundi: • 110 people have been trained in SDB and all have benefited from simulations conducted in their respective branches. • 120 people have been trained in RCCE and leading community dialogue to promote behaviour change in their own communities. • 120 staff and volunteers have been trained in psychosocial support (PSS) during the reporting period, and indeed, are cascading the training to their communities and Red Cross branches. • 40 SDB kits have been pre-positioned (8 used in drills and exercises at commune level) over the course of the reporting period • Cumulatively 1,078,540 people sensitized on EVD and COVID-19 between January-June 2020, through risk communication and community engagement activities, which involved working closely with relevant government authorities, the communities themselves and other partners to ensure coherence, consistency and quality of messaging. January: • BRCS staff and volunteers conducted 18 SDB drills across five SDB teams and 40 people were trained. • Four cultural shows were conducted as part of RCCE activities, with 800 people reached. • BRCS used its own resources to deploy 35 tents which were used at 17 entry points by the entry points surveillance teams; and 4 bladders and 34 handwashing facilities were installed at entry points in Ruhwa (in Cibitoke Province), Gatumba (Bujumbura Rural Province), Rumonge and Kabonga (in Nyanza-Lac-Commune). • BRCS worked with the MoH to develop key messages to be printed on 3,000 fliers for distribution, and also worked on the development of key messages in French and Kirundi to be used in radio spots dedicated to awareness raising on EVD. • SDB Standard Operating Procedures (SOP) were reviewed and validated by the National Ebola Taskforce, and which will continue to be a resource should EVD arrive in Burundi in the future. • An IFRC EVD Delegate provided surge support to the country, focusing on implementation and strategic planning along with IFRC and Burundi RC staff and volunteers. February: • 2 SDB drills were conducted in 2 BRCS branches, and 10 local meetings (1 meeting per commune) were conducted with local BRCS volunteers, with participation of 8 volunteers per commune. The meetings addressed key strategic and		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
		Q2	Q4
	planning issues relative to the teams in their defined areas ensuring that preparedness activities were being conducted in good order and to the necessary quality. • An Infection Prevention and Control (IPC) of the BRCS health Center of Kinindo was conducted leading to the development of a Plan of action, to reduce the risks of nosocomial infections and then, to ensure better preparedness to outbreaks and EVD. • Work was also conducted to support BRCS along with the Norwegian Red Cross to finalize and set up a community-based surveillance programme. This involved extensive discussions with MoH and other partners to assess how to implement CBS in Burundi, according to different outbreaks - cholera, measles etc. • A knowledge, attitudes and practices (KAP) evaluation baseline was conducted (training of Data collectors on 27-28 February, and data collection on 2-4 March), with data analysis and final report were validated and shared to the National Ebola Task Force. March: • SDB trainer was deployed to Burundi on 7 March to conduct SDB training of trainers (ToT) and training of volunteers (ToV). From 12-14 March an SDB ToT was conducted in Bubanza province with 28 volunteers trained, increasing to 6 branches the capacities of BRCS in the SDB pillar. From 16-18 March: 10 SDB training sessions of communal volunteers were conducted in 6 BRCS branches with 100 people trained (80 volunteers and 20 community health workers). • Following these trainings, a total of 128 people had been trained in SDB including 108 volunteers and 20 community health workers in the 10 targeted communes of 6 BRCS Branches. • 32 SDB drills were conducted in the 6 targeted BRCS branches. • Development and finalization of SDB revised SOPs, with technical support of SDB Surge – was submitted to MoH for review and approval • 6 coordination meetings were conducted in 6 BRCS branches with volunteers. 35 April: • Two infection, prevention and control (IPC) trainings were conducted for EVD and COVID-19 response resulting in 80 BRCS volunteers trained. • 10 SDB drills were conducted by 10 SDB teams at the commune level. • In April, the BRCS and IFRC Psychosocial Support Reference Centre in Copenhagen initiated the development a BRCS PSS Plan of Action, which focuses on ensuring that the National Society can mainstream psychosocial support services into its activities. This has been identified as a key topic to ensure the National Society can deliver on its duty of care to volunteers and staff for this current operation and into the future.		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
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	• Coordination: recommendation made by the Government (MoH) and National Ebola and COVID-19 National Task Force to all humanitarian actors to include COVID-19 preventive messages in EVD awareness activities, and to adapt also RCCE activities according to COVID-19 preventive measures (mobile cinema, cultural shows and other activities which could gater a lot people were mostly prohibited). May: • Three training sessions on contact tracing were conducted with the MoH for 160 people, including 131 BRCS volunteers and 29 community health workers. • One psychosocial support (PSS) training was conducted for BRCS staff and MoH staff, leading to 18 people trained to manage and lead on PSS activities during outbreaks. • 10 additional SDB teams established and 10 training sessions conducted in SDB for the 6 targeted BRCS branches leading cumulatively to 200 volunteers trained and 20 teams established at commune level (10 communes in 6 BRCS Branches). • 5 SDB drills were conducted by 5 SDB teams at the commune level to ensure continued preparedness, should the teams be required. • 305,325 people were noted as having been sensitized on EVD including COVID-19 preventive messages until April (January, February, March and April) by BRCS volunteers – including 18 trainings of community health workers, and 940 households reached by door-to-door campaigns. • Participation at coordination meetings of the National Ebola National Task Force and COVID-19 Task Force continued. June: • 773,215 people sensitized on EVD and COVID-19 during the months of May and June by BRCS volunteers, reaching cumulatively 1,078,540 people sensitized on EVD and COVID-19 (January-June). • 813 community leaders reached through community sensitization meetings realized for EVD and COVID-19 preventive measures. • 802 road shows conducted for awareness of communities about EVD and COVID-19 preventive messages in the 6 targeted BRCS branches. • 119 awareness sessions for EVD and COVID-19 prevention carried out in schools, reaching 77,354 students. • 480 radio EVD and COVID-19 preventive messages aired on 8 national radios stations. • Finalization of procurements done (bicycles, phones, first aid kits, SDB kits, etc.). • Coordination: participation in regular meetings of National Ebola National Task Force and COVID-19 Task Force. 36		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
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	Challenges: • Large mobilization of BRCS teams and volunteers in the response to COVID-19 pandemic has resulted in some human resource availability challenges, and some EVD activities being changed, postponed or simply reallocated to activities which were adapted to the current context of COVID-19 according to National Task Force & MoH recommendations. • There have been some challenges in the adaptation of RCCE activities and inclusion of COVID-19 awareness messages at the same time as EVD awareness messages were disseminated, as it has been felt that this could have created confusion for targeted groups. Care has however been taken to ensure clear messages and lines of communication with communities on these two issues. Nevertheless, re-, or indeed, de-prioritization by the Burundi Government of some EVD preparedness activities due to the COVID-19 pandemic have become a reality, causing cancellation of many activities where the MoH needs to be involved (such as simulations at province level, establishment of SDB Platform, approval of SDB SOPs, etc.). • Electoral campaigns which began on 27 April 2020 and presidential elections (20 May) limited the ability to conduct missions in the country, as well as to implement some activities. These delays combined with the movement restrictions around COVID-19 have caused delays. Yet, efforts continue to overcome and adapt to this context, noting that COVID-19 will be a lived reality for the foreseeable future for this operation. 37 Project #7: DRC Using mass communication to increase EVD awareness and community engagement Overall objective: Build community trust in the Ebola response and Ebola health information in North Kivu and Ituri provinces, by using trusted and interactive mass communication approaches that respond to peoples' concerns, answer their questions and collect their feedback. Background: While mass communication approaches are critical for reaching large numbers of people with important Ebola prevention and control information, this response has shown that messages and the modality of their dissemination must be contextually and culturally appropriate if they are to be effective in influencing behaviours at an individual and community level on issues related to Ebola symptoms, prevention and treatment. Ebola myths and rumours have flourished at various points throughout the response, which coupled with mistrust in the government and those deemed as outsiders, has led to denial and sparked sometimes fatal community violence towards health care workers and community staff and volunteers. For communities to listen to, and more importantly act on, Ebola prevention and control information, they must first trust those who are sharing that information.		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
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	To build this trust, humanitarian responders need to: • Use community feedback to shape the information shared with communities, rather than continually repeating static key messages. When the information shared by responders is updated regularly and directly responds to the concerns, beliefs and challenges faced in communities it will be more likely to resonate, be trusted and so lead to positive social and behaviour change outcomes. • Provide information to communities about how their feedback is being used to shape the response. • Explain response activities clearly and share information about who we are, what we are doing, and why – in addition to Ebola prevention and control information. This will help to build community trust in responders, which leads to increased trust in the information shared by responders. • Use channels of communication which are trusted by communities and allow for two-way dialogue. Increase the number of trusted and familiar local leaders in community Ebola awareness promotion. • Share information through trusted sources, such as religious leaders, trusted local leaders and local healthcare workers. Indeed, consistent recent Red Cross feedback data shows communities want greater participation of church leaders, local administrators, and youth groups in leading health promotion efforts in the community. • Communicate in local languages and dialects both in written and oral communication. Specific objectives: To build trust in the Ebola response and Ebola information, the Red Cross works to: 1. Respond widely and rapidly to Ebola concerns, misinformation, suggestions, questions and complaints collected through the Red Cross community feedback system through radio, mobile cinema, theatre, social media, community meetings and targeted workshops. 2. Ensure the content used in these activities is culturally and linguistically appropriate. 3. Increase the involvement of trusted local figures and healthcare workers in Ebola risk communication activities by engaging these people in Red Cross radio shows, mobile cinemas, theatre and targeted workshops. 38 4. Provide more regular clear and honest explanations of our activities and respond to community questions and feedback through radio shows, mobile cinemas, theatre and targeted workshops. 5. Increase the capacity of local community structures to provide the key information to their communities in their usual activities. 6. Increase the capacity of DRC Red Cross staff and volunteers to lead risk communication and community engagement activities.		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
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	Geographic locations: Six health zones that have reported cases in recent months and are key in terms of creating acceptance of the Ebola response in North Kivu and Ituri: Kalunguta, Mandima, Mambassa, Oicha, Beni and Mabalako. Implementation strategy: The Red Cross already has extensive experience of delivering radio shows, mobile cinemas, theatre, and community workshops in North Kivu and Ituri, and through this project looks to scale up these activities and improve them through: • Additional training of local DRC Red Cross staff and volunteers to be able to lead these activities in local languages. • Increased involvement of local leaders, health care workers and local community structures (in connection with Project 8). • Increased connection and responsiveness to data collected through the community feedback system, supported by the feedback reports to be produced locally by Red Cross teams as well as the in-depth analysis of this data being carried out with support from USCDC (in connection with Project 3). • Set up a standard process for testing the content used in radio shows, mobile cinemas, theatres and other activities for its cultural and linguistic appropriateness (in connection with Project 3). • Targeting activities such as radio shows, mobile cinema as well as community theatre in areas where there are identified issues with community trust and increases in case numbers. • Making better use of social media, and applications such as WhatsApp. Key achievements: Radio shows • A training package on interactive radio techniques was reviewed, improved and rolled out during the reporting period, providing an important collection of resources that can be used for mass communication purposes through radio channels. • Volunteers in 6 health zones were trained on interactive radio techniques ensuring they can use the package and deliver accurate and timely messaging to communities. • A minimum of 12 radio shows in local languages addressing the community feedback received in the respective areas were produced on a weekly basis. • Discussion with Internews for more collaboration on interactive radio show programmes progressed over the reporting period, highlighting the importance and value of collaboration with partners on this topic. Mobile cinema		

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	• On average, 10 mobile cinema shows were organized per month; the videos used are the story of Ebola, a video produced by the IFRC in Beni on safe and dignified burials2, as well as the testimonials, described below. • Due to Covid-19 preventive measures, this activity was stopped in March 2020 and a new activity was introduced to continue to share information in the community that is called: "Caravane Allo Allo" which aired on sound tracks of pre-recorded public service prevention and control messages, in the targeted communities. Production of testimonials • Twelve testimonials of Ebola survivors have been produced in Butembo, Aloya, Mangina and Beni. These testimonials have been shared with other partners working on the response and used during RCCE activities such as mobile cinemas. Testing on talking points and content for activities • In order to ensure the availability of content in local languages that are accessible and culturally appropriate, the RCCE team have been working closely with Translators Without Borders (TWB). • Through this collaboration various content has been adapted to local languages, including 25 most frequently asked questions, which were translated into local languages by TWB, and which are being used by RCCE teams in their interactions with communities, as appropriate. • A Q&A on the theme of Survival was developed based on community feedback. This document was reviewed and validated at the RCCE commission and shared with all the partners and RCCE team. • A glossary with terms related to the Ebola response was also developed by TWB, which have helped to ensure a consistent understanding of language and the meaning behind the language used amongst key stakeholders. Workshops with key groups • Throughout the reporting period, regular workshops were held with religious leaders, traditional healers, women's associations, youth associations and professional networks such as moto-taxi drivers to plan and organize joint community-based activities and share updates on the epidemic situation. A workshop was also organized with journalists in Bunia to discuss how to best communicate about Ebola and consider RCCE in the way of reporting. Use of social media and WhatsApp • Each health zone has established WhatsApp groups including community members (at the time of writing, the total number of participants is 691) and guidelines for setting up and managing WhatsApp groups have been produced. These groups are used to share information on the epidemiological situation and key messages, as well as to provide the opportunity for community members to ask questions.		

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	Challenges: • The restriction of movement due to the security situation as well as the lockdown imposed because of COVID-19 are causing challenges to activities such as trainings and any face-to-face activity. • Since March 2020, as expected, the most common feedback is on COVID-19, which accelerated an intensified effort to include this topic in communication efforts, and make sure all staff and volunteers are briefed on the disease. Concluding remarks: • The use of radio shows enabled a wider reach of the community with information on EVD while also minimizing risk of spread of infection as volunteers did not have to travel or come into direct contact with the community to share information. Use of films was also crucial in sending out audio-visual information on EVD; however, with the need to implement social distancing measures following the outbreak of COVID-19, resulted in the RCCE teams temporarily stopping the use of mobile cinemas in the eastern part of the DRC. However, the strategy of using mobile trucks playing pre-recorded infection prevention and control messages still enabled the messages to reach the population, highlighting the importance of adaptability of these programmes to the evolving operating context. **DRC Building trust and community ownership of Ebola response activities** Overall objective To build trust and community ownership of Ebola response activities in DRC affected health zones • Outcome 1: Community feedback data and social science research recommendations are regularly used by the response actors to shape approaches and guide interventions that build trust • Outcome 2: Localized strategies and strengthened community capacity to accelerate and improve community-led solutions to prevent and control EVD Background: There is recognition that communities must be central partners in the design, implementation and evaluation of the Ebola response in DRC. Interventions in the response will only be effective if they are relevant and contextually appropriate, co-owned by affected populations, and when two-way trust between providers and affected populations is established and respected. The root causes of mistrust and community frustrations have been extensively captured in social science research, including Red Cross community feedback data collected since the start of the outbreak. Mistrust linked to Ebola treatment centres, vaccination and contact tracing services, is rooted across all affected areas and these issues have been recurrent over time, and often play out in varied, often unpredictable ways.		

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	There is a need for continual granular and localized (at the health zone and heath area level) understanding of behaviour and perception patterns to inform agile response strategies that are rooted in local perspectives. This is particularly true in this phase where the footprint of the epidemic is much smaller, and the virus has been contained in a much smaller geographic area. Cases are particularly happening in rural locations and in a more dispersed way, which requires the response teams to focus and tailor response strategies to very specific localized needs. It is also key to identify trusted interlocutors and engage key influencers to ensure community support for the response, to promote trust and local ownership, to utilize and strengthen existing local capacity, expertise and knowledge, and to improve the effectiveness of communication between responders and communities. Widespread mistrust in the government and response agents have caused examples of denial and sometimes sparked fatal community violence towards health care workers and community staff and volunteers. In response to the rise in community mistrust and violence, the MoH and EVD response partners launched a new community engagement approach across all affected health zones, which is geared towards strengthening community ownership and establishing and/or reinforcing local EVD committees. The Red Cross community feedback system and its large volunteer network is well placed to provide valuable granular insights to guide inclusive and participatory community dialogue, and to contribute to community ownership of the response. To this end, ensuring strong coordination with partners has proven critical for a renewed approach on community ownership to be spearheaded by all responders. The project is therefore building on existing coordination efforts to bring timely community perspectives and social science data to decision-makers to guide responders on how to strengthen community-led approaches, with a focus on SDB and IPC work. Specific objectives: This project aims at coordinating with key response partners and leveraging the current social science research work, including Red Cross feedback data analysis on community insights, UNICEF/London School of Hygiene and Tropical Medicine (LHSTM) and the Social Science Research platform research to: • Support the development of a comprehensive understanding of perceptions, attitudes and beliefs underlying (mis)trust and acceptance regarding health and outbreak services/interventions.		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
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	• Develop strategies and strengthen community capacity to accelerate and improve community-led solutions to prevent and control the Ebola outbreak. Objective 1: Support the development of a comprehensive understanding of perceptions, attitudes and beliefs underlying (mis)trust and acceptance regarding health and outbreak services/interventions Focus will be on ensuring perception and feedback data are routinely compiled and analysed with other social science research findings to provide a comprehensive understanding of the situation and to inform changes in epidemic response efforts. The Red Cross has a unique methodology which offers quality and timely understanding of community insights. These data sets help response efforts to better understand the priorities and perspectives of the at-risk and/or affected populations and can form a baseline to measure the impact and challenges of a response at the community level. Together with the social science field team (CASS), UNICEF and the LHSTM, greater attention is being given to enhancing localized 'good enough' capacity to assess, gather and rapidly analyse community perceptions and community reactions in order to ensure local actors have a regular understanding of communication challenges, health seeking behaviours, power dynamics and trust issues. This ensures response actions and community engagement strategies are sensitive to the context, agile and receptive to change as described in objective 2. Objective 2: Develop strategies and strengthen community capacity to accelerate and improve community-led solutions to prevent and control the Ebola outbreak Focus is on working with local structures, and adjusting interventions over time, based on the feedback and perceptions of affected and at-risk communities and other research findings to enhance Red Cross and other key community actors' capacity to conduct community dialogues and ensure that communities in the most affected areas have access to relevant and useful information, their questions are answered, and messaging is tailored to their current beliefs and concerns. The interventions promote community actions with and through trusted community leaders, influencers and existing community structures. Greater attention is given to enhancing participatory planning of community-led actions and ramping up two-way communication channels to enable strengthened dialogue among local authorities, leaders and communities on key social, political and biomedical issues of concern. SDB and IPC teams are supported to improve community engagement approaches and strengthen local ownership.		

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	Implementation strategy: Community engagement activities are essential at all stages of epidemic preparedness and response and are integrated across all aspects of the Red Cross operations in North Kivu and Ituri. Trusted, clear and effective risk communication and engagement approaches are critical to ensure that community-based solutions to end the Ebola outbreak in the DRC are at the forefront of the response. Ebola myths and rumours spring from entrenched belief systems and decades long socio-cultural practices, in particular, burial practices and care-seeking behaviour. These, combined with widespread mistrust in the government and response partners, cause denial, rejection of response, and spark sometimes fatal community violence towards health care workers and community staff and volunteers. Enhancing the work of local actors and frontline workers, by providing actionable information on issues related to community mistrust and building capacity to be responsive to community perceptions, combined with tailored approaches to community media and containment approaches,is essential for spurring community understanding, engagement and ultimately community-led action. This ensures that all activities are not only accepted by, but progressively owned by, communities and in line with local practices and customs. The Red Cross community engagement efforts align, support and coordinate with the collective interagency approaches supported by UNICEF, USCDC and WHO, among others. The approach aims at constantly evolving and adapting to the needs and concerns of the affected population. The established Red Cross community feedback system in DRC allows communities to voice their understanding of the issues and provide timely and regular feedback on how the response is delivering services. Tracking the perceptions and information needs of communities in almost real-time, enables Red Cross teams in the most affected areas to share relevant information, address key questions and concerns and tailor the operational approach to community needs. This has helped the Red Cross to build trusted community relationships and stronger community-led solutions. The Red Cross SDB protocol has been revised to respond to cultural needs and community feedback at both the macro and micro level of the response. Community engagement volunteers focus on explaining the procedures before the team arrives, and family members are given the opportunity to dress in protective gear and join the burial team through the burial process. These changes have increased acceptance of SDB, and over time fewer concerns have been raised. Similarly, the body bags, which were black and opaque, are now adapted to have a transparent window,		

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	deemed as a crucial feature that allows family members to see their loved ones, whilst maintaining a protective barrier between the deceased and others. However, the greatest challenge during the response has been ensuring that local feedback regularly informs higher-level strategy and operational decision-making across all partners to contain the outbreak. This critical community data, if combined with other social and behavioural sciences data, can help response actors better understand community behaviours and inform coordination, planning, trainings, as well as strategic efforts and programmatic decisions. The project aims therefore at improving the use of social and behavioural sciences to provide timely and valuable community intelligence to inform response actors and their strategies as they engage in sustained and consistent dialogue with affected populations that builds trust with communities (these activities are closely linked to Project 3). In addition, since key stakeholder groups and opinion leaders, including influential and respected community members, play an important role as direct influencers of affected communities, efforts will be escalated to map and engage them more and differently. They are local and traditional authorities, religious leaders (such as pastors, imams, community evangelists etc.) and members of cultural, professional and social groups/associations. They will be engaged as change agents in community mobilization activities. The Red Cross is perceived as a trusted neutral entity in all affected areas and therefore it is best placed to bridge the dialogue gap and enable strengthened community engagement and action. Evidence and experience have indeed shown that approaches that incorporate participatory decision-making and action are more successful, more sustainable, of higher quality and cost-effective over time. The project works towards reinforcing participatory planning approaches in all Red Cross supported interventions. Ultimately through the project, the Red Cross, in close collaboration with UNICEF and other RCCE partners, is working to enhance understanding of perceptions, beliefs and concerns to inform the EVD response activities and guide the effective communication of risks, promote healthy behaviours and enhance community participation in the response. Planned activities: The following activities support and put communities at the centre of all actions; they reinforce people's participation in response efforts and facilitate understanding and interactions with community structures: Outcome 1: Community feedback data and social science research recommendations are regularly used by response actors to shape approaches and guide interventions that build trust Output 1.1 A comprehensive understanding of		

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	community perceptions, beliefs and concerns inform response actions (in collaboration with the social science platform) and community engagement activities Activity Triangulate social science data with community feedback data (including feedback collected by other partners) and produce regular meta-summaries of trends and rationale for underlying community mistrust, resistance and aggression, as well as recommendations for response actors (in closed collaboration with UNICEF, LSHTM research team and CASS) (linked to Project 3) Develop guides and tools for reinforcing local capacity to roll out 'good enough' social science research (formative research, doers/non doers' analysis, focus group discussions, rapid anthropological assessment) to inform strategies, address mistrust and enable better community engagement (in partnership with CASS, UNICEF/LSHTM) Train and support a pool of Red Cross staff and volunteers, with focus on community engagement, SDB/IPC staff, on effective community dialogues based on defined processes and pathways to effectively engage communities (the training is to be informed by regular community feedback and other social science data as well operational guidance from UNICEF/LSHTM) (linked to Project 3). Interactive radio programmes, theatre plays and community cinema approaches (informed by social science data and community feedback) to enhance dialogue in communities, schools, local associations, gatherings organized by churches etc. (linked to Project 7). Reinforce trainings of community engagement volunteers and other front-line workers (in close collaboration with risk communication and community engagement partners) to regularly answer people's questions, address rumours and beliefs in relation to Ebola, ensure timely health seeking behaviours and uptake of the Ebola vaccine (linked to Project 3) Outcome 2 Localized strategies and strengthened community capacity to accelerate and improve community-led solutions to prevent and control EVD Output 2.1: Trusted community members and community structures enable regular dialogue on response actions and recommendations Activity Map key influencers and trusted community leaders/members to inform community-led plans (in close collaboration with UNICEF and based on LSHTM mapping tools)		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
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	Community dialogue sessions led by trusted community leaders and influencers based on dialogue guides and Q&A Mobilize key influencers, community leaders, religious leaders and teachers to join efforts and address stigmatizing attitudes, including through radio, audio-visual material and theatre approaches. Frontline workers and community influencers/champions enhance community understanding and promote action in relation to critical elements of the response, namely health-seeking behaviours, community surveillance, cases detection, contact tracing, towards community-led approaches. Roll out a participatory community planning approach to translate feedback data (and social science research overall) into community solutions (defining roles and responsibilities of different constituencies) and ensure inclusive and participatory community dialogue (piloted in targeted health zones with priority on Mambasa and Mangina affected areas). Enhance community-based approaches to SDB, including in highly insecure areas, which respond to community perceptions and suggestions while ensuring that solutions are both safe and socially acceptable in different contexts within Ebola-affected provinces. Key achievements: Outcome 1: Community feedback data and social science research recommendations are regularly used by response actors to shape approaches and guide interventions that build trust. Output 1.1 A comprehensive understanding of community perceptions, beliefs and concerns inform response actions (in collaboration with the social science platform) and community engagement activities: • Work continued throughout the reporting period to find ways to systematize this process and ensure reporting systems can appropriately capture the nuance and detail in the hyper-local day-to-day adaptions and operational decisions being taken at the various operational bases in response to community feedback. The IFRC's internal evaluation noted there were varying perceptions on this issue, with profiles at regional and global levels noting in some cases a failure to 'close the feedback loop' and ensure this information is informing operational decisions. However, interviews with profiles at the field operational base level offered numerous and consistent hyper-localized, day-to-day examples of how activities were being adapted by response pillar teams following locally acquired feedback through the RCCE teams. The issue seemed to lie in the ability for this information, and the subsequent actions being taken by operational teams, to be systematically recorded, reported and disseminated. The conclusion from the IFRC's		

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	evaluation was that, whilst improvements could be made, the belief that the feedback data was not being used for operational decision making (at the very least by the Red Cross itself) was not accurate in all cases. • The IFRC team participated actively to develop guidelines based on community feedback data and social science research recommendations to support RCCE activities for the 11th EVD epidemic declared in Equateur Province, to ensure better community acceptance and participation in this response through the use of lessons and best practice learned in during the 10th outbreak, and indeed the previous 9th outbreak, also in Equateur. • The IFRC has been working closely with the social science research group (CASS) led by UNICEF to make sure social science data is triangulated with community feedback data – this work has been an important development during this outbreak, with the increased availability and use of social science data and best practice providing important lessons that the IFRC will take forward to future emergency responses. • Importantly, community feedback and social science analyses were presented and used as a basis for discussion at the Ebola Coordination's strategic workshops, including SRP3, SRP4 and SRP4.1 (Strategic Response Plans), of which the IFRC contributed extensively. • Internal and external discussions on how to enter the post-Ebola phase and transition to COVID-19 continue to dominate discussions, noting that community engagement and accountability activities have and will be central over the course of these periods. As described elsewhere in this report, communication messages on COVID-19 have been included in RCCE programming and Red Cross volunteers have been trained on COVID-19, along with the adaption of activities to limit the risk of exposure to both staff and volunteers as well as the communities they are working alongside. Outcome 2 Localized strategies and strengthened community capacity to accelerate and improve community-led solutions to prevent and control EVD Output 2.1: Trusted community members and community structures enable regular dialogue on response actions and recommendations • 319 key influencers and trusted community leaders/members were identified by the local Red Cross teams and recorded in a stakeholder mapping exercise in order to better target RCCE related activities. The identified key influencers were mobilized to join efforts and address stigmatizing attitudes, including through radio broadcasting and audio-visual testimonials. The Red Cross local teams had regular interaction with them to keep them updated on issues and trends. • The community dialogues have made it possible to design simple and accessible solutions at the local level that enable communities to take action themselves for the prevention and control of EVD. One of the examples is the handwashing kit made locally by community members and provided regularly with water and soap. As such,		

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	throughout the response and now moving forward, community-led solutions and participatory planning have been included as a core component of the EVD operation's transition and recovery strategy. Challenges: • UNICEF's strategy has focused on the development of the 'cellules d'animation communautaires (CACs)', of which many are in place, but their operation is noted as not especially efficient, which makes it difficult to support them in the development of action plans at the local level. Nevertheless, the IFRC continues to engage recognising that these community structures offer important points of sustainable engagement with communities into the recovery and post-EVD phase. • In terms of the broader relationship with UNICEF and the social science research activities, late agreement on a joint plan with UNICEF due to uncertainty on research plans in the light of the ending outbreak have hampered some efforts to move forward on this topic, although efforts are being made to address this issue. Concluding remarks: • Community feedback was systematically collated, analysed and presented to stakeholders in the RCCE sub-commissions in all the bases. As a result of the analysis, there was the formulation of '25 frequently asked questions and answers' in September 2019 (updated in March 2020). This tool was developed in USCDC Atlanta from data collected in Beni, and the questions and answers were validated by teams in Goma. Translators Without Borders translated the answers into simple, easy to understand language as some of the content and terminology tended to be clinical and not easily understood by lay persons. To make the content even more accessible, the answers to the frequently asked questions were disseminated via mobile cinema and supported by community demonstrations of IPC (handwashing etc.) and SDB (showing the transparent body bags and burial process) to illustrate the information disseminated. Through regular engagement with the community to get feedback on the operation, it was possible to make changes that enhanced credibility of the organization as a listening partner to the community. The support of and engagement with USCDC technical counterparts were a critical component of this work and the team reiterates its appreciation for the work done through this partnership. It remains as model that the IFRC hopes to take forward to future operations and programmes. **DRC Provision of Ebola capacity – safe and dignified burials** Overall objective: Prevent and reduce morbidity and mortality resulting from the Ebola virus disease in the DRC through provision of safe and dignified burials (SDB), including harm-reduction burials in communities inaccessible to any SDB team.		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
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	Background: The DRC Red Cross SDB teams ensure that every aspect of burials, disinfection and decontamination are conducted in a safe and respectful way, considering cultural understanding and the sensitivity for families and communities. Highly trained DRC Red Cross SDB and disinfection teams, in conjunction with community engagement and psychosocial support (PSS) volunteers, also limit the spread of infection by educating communities about the need for and processes behind disinfection and safe burials. The IFRC/DRC Red Cross EVD response is a highly complex operation, integrating complementary activities across SDB, RCCE, and IPC interventions. Successful implementation within this highly complex and volatile context requires the coordination and smooth operation of these approaches while aligning interventions to the MoH's strategic response plan (SRP), contributing to the evolution of SRP4/SRP4.1, and systematically adapting technical interventions to account for feedback from communities, social science research, and contextual changes. The innovations developed and implemented through this response, including community feedback systems, burials adapted to a conflict context, rapid isolation tents, adult-learning and gaming approaches to IPC training, can only occur within the context of a well-supported operation. Specific objectives: • Safe and dignified burials are attempted for all confirmed and suspected deaths due to Ebola in accessible areas and maintain a success rate at or above 80% • Harm reduction burials are attempted for confirmed and suspected deaths due to Ebola in inaccessible communities with ECUMR (Equipe Communautaire d'Urgence a Moindre Risque) teams • ECUMR teams are established and/or maintained in 67 communities out of reach of SDB services • Communities and families feel engaged and respected in these burials, and standard operating procedures and approaches continue to be adapted based on community feedback and social science research Geographic locations (Health Zones): • 25 existing3 SDB teams in Mandima, Bunia, Komanda, Kamango, Goma, Rutshuru, Kayna, Alimbongo, Katwa, Butembo, Mabalako and Beni • 15 existing4 ECUMR teams in Kalunguta, Katwa, Kayna, Komanda, Lubero • 52 new ECUMR teams across affected and at-risk communities inaccessible to SDB teams Implementation strategy: The Red Cross co-leads the safe and dignified burial (SDB) sub-commission for the EVD response. The Red Cross' SDB approach is the global gold standard for burials of people who are suspected or confirmed to have died of EVD. This		

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	approach, which is also used by the Civil Protection SDB teams (trained by the Red Cross and later by WHO), has resulted in a sustained success rate of over 80% over 28,000 burial alerts since the beginning of the outbreak. Given the challenges with access, acceptance of EVD response activities and community mistrust, this success rate should be viewed as evidence that the SDB approach is well adapted to this challenging context, and an approach that must continue to be supported and expanded across all accessible areas where there is a risk of EVD cases. SDB teams comprise volunteers who live in the affected communities and are able to bring the unique perspective of the needs of their fellow community members. The Red Cross volunteers are known and trusted members of their communities, having provided various support and essential services during previous emergencies and episodes of violence. Increasingly, inaccessible communities are affected by the EVD outbreak, and safe burial of suspected cases in these communities remains key to stopping community-level transmission of the virus. To this end, the Red Cross has led the creation of a community-led emergency harm reduction burial (ECUMR) approach. ECUMR team members are nominated by their communities and work in a much smaller area than SDB teams, ensuring safer burials are available to support families in their communities. The teams are trained in SDB procedures and spend time shadowing standard SDB teams in more secure areas before returning to their own communities. This mentoring approach allows the teams to have both the theoretical and practical knowledge to carry out burials as safely as possible without the supervision and oversight of an SDB expert. To further link the burial team with the local health system and to provide some technical oversight, ECUMR teams are led by the head nurse of the nearest health facility. As with all new approaches adapted to this difficult context, scaling ECUMR requires continuous monitoring of outcomes, challenges and gaps, to ensure both the teams and the communities who nominated them remain as safe as possible. This harm reduction approach has already been successfully implemented in 15 communities that cannot be reached with gold standard SDB activities due to conflict or other dynamics, and is also being implemented by Civil Protection, with support from WHO, in additional communities. While ECUMR is an important component of the response in inaccessible communities and those experiencing violence, traditional SDBs - performed by Red Cross community volunteers from the affected communities - must continue in areas where it is possible and as long as they are needed. The SDB approach has been developed through multiple EVD outbreaks and remains the most evidence-based and safest approach to safer burials during EVD epidemics. SDB protocols focus on the dignity of the deceased and allow for adaptations to the procedures that ensure family and community members feel their cultural, social and religious needs during the burial are met.		

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	This balanced approach -- SDB where possible, ECUMR where necessary -- is a result of an overall Red Cross response that prioritizes community participation in the response, and recognizes the unique challenges posed by this outbreak. Further scale-up, monitoring and quality assurance of this adaptive approach has been used where necessary to ensure all affected communities can reduce the risk of EVD transmission from unsafe burials. The Red Cross continues to monitor and learn from both approaches, and ensures lessons learned in each are applied where possible and useful. SDB activities can have significant impacts on the social and psychological wellbeing of the volunteers on the burial teams, due to repeated exposure to the deceased, bereaved families, resistance, and stigma. Volunteers working in SDBs are under extreme stress and carry out some of the most high-risk tasks related to the outbreak, and they need support. The DRC Red Cross is working alongside the IFRC and other organizations to reduce the psychosocial impact of EVD on volunteers involved in SDB and RCCE activities. For this reason, community volunteers who are in contact with familiesand communities with suspected Ebola cases or deaths are trained in supportive communication and psychological first aid (PFA). The International Red Cross Red Crescent Movement, as a principled-and-values based institution is inclusive of, and engages with, all members of society with priority given to those in need. While responding to the Ebola crisis, the Red Cross utilizes gender-inclusive tools and guidance and all activities are implemented considering “do no harm” principles. To ensure an inclusive and protective EVD response, the IFRC is undertaking the following measures: • Gender-balanced volunteer mobilization, to the extent possible in the context • Collection, analysis, and dissemination of sex- and age-disaggregated data • Protection, gender and inclusion concerns are considered across the assessment and intervention design and implementation with ensuring participation of women, girls and other vulnerable groups through community engagement approaches, including engaging with women’s and youth groups • Training of volunteers on protection, gender and inclusion, including gender analysis, basic prevention and response to sexual and gender-based violence, prevention of sexual exploitation and abuse, and child protection • Support sectoral teams to include measures to address vulnerabilities specific to gender and diversity factors (including people with disabilities) in their planning. Planned activities: The affected population is assisted through safe and dignified burial activities: • Provision of protective equipment and all necessary materials to 25 SDB and 67 ECUMR teams		

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	• Regular refresher training sessions on dressing and proper removal (best practices) of PPE as well as disinfection, every 6 weeks for SDB teams • Conduct quality assurance check of SDB teams by an external partner or supervisors • Conduct regular SDB activity monitoring by DRC Red Cross and IFRC • Train and reinforce SDB focal persons and supervisors' capacity • Train ECUMR focal persons and supervisors on mobile data collection • Graves identification and grave-site management • Provide coffins and graves to bereaved families • Construct decontamination bases at all operational areas • Organization of lessons learnt workshop • Organize SDB training of trainers' sessions for two affected provinces (North-Kivu/Ituri) The affected population is assisted through decontamination activities: • Replace equipment destroyed during disinfection operations with solidarity kits (2 expected disinfections X 4 weeks X 3 months x 12 villages X 1 kit) • IPC training for SDB volunteers • Information management supports epidemiological and operational analysis of SDB data to ensure gaps are quickly identified • Community feedback data is systematically used to enhance and adapt SDB interventions to the local needs • Develop an DRC Red Cross Epidemic Preparedness plan and preposition emergency stocks at the provincial and national level, and ensure standard operating procedures are in place 50 (mobilization, replenishment, roles and responsibilities) as an evolution of the SDB teams during the transition and recovery phases Monitoring, evaluation and quality assurance: 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 complete process includes: • the family has agreed to participate in the SDB • the body has been secured in a body bag and the surrounding area decontaminated • an oral swab has been taken • and for positive (or unknown) cases a safe burial is completed by the SDB team, or		

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	• for a negative result, the body is either returned to the family or for vulnerable families the SDB teams can complete the burial. The principal objective of SDBs in SRP-4 is for an SDB to be successfully carried out for 100% of the deceased. However, given the challenging context this is unrealistic and IFRC has argued for an indicator that is more SMART. The USCDC analysis conducted by Frieden et al in 2015 following the West Africa outbreak, which identified a tipping point at which the epidemic would plateau and decline if enough (i.e., >70%) Ebola patients were isolated effectively and decedents buried safely. Therefore, the IFRC's principal performance benchmark is to surpass this level and maintain at least an 80% SDB success rate, which as presented above has been met throughout all stages of this outbreak. SDB teams report daily in ODK and this is put into the SDB dashboard and shared with key partners on a daily basis. An IFRC staff member is dedicated to SDB quality assurance and works with the personnel responsible for training and ECUMR on the mentoring and supervision of SDB teams. Periodic analysis of SDB failures against community feedback is conducted and used to identify if adjustments to the strategy are required (e.g. as explained above, an early analysis in 2018 indicated that a number of SDB failures were due to communities' dislike of body bags; therefore IFRC developed and implemented body bags with a transparent cover that has reduced resistance and improved SDB success rates). SDB failures are primarily the result of inaccessibility due to insecurity, logistical challenges or community resistance. To reduce community resistance, SDB is not addressed as a stand-alone pillar – it receives strong support from the RCCE pillar and includes a community communicator in every team. Key achievements: From the beginning of the operation (August 2018) through to 14 June 2020, 24,598 (88%) of the 28,056 SDB alerts were successfully completed by 177 teams. Over the course of the implementation period and owing to the reduction in case and also the scale of the operational area with active cases, the IFRC has conducted a phased scale down approach to those areas completing their zero case countdowns. The diagrams below provide an illustrative image of this reduction in the operational area and therefore scale down of certain response activities in these areas. The two colour coded maps below show days since the last confirmed case of EVD by Health Area. The map on the left is dated 12 January 2020. The map on the right is dated 2 June 2020. When analysed alongside the significant fall in cases as shown in the epidemiological curve, the maps provide an illustrative insight into the change in coverage, and subsequent scale, of the IFRC's required response across the operational area from January to June 2020.		

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	▪ 44 ECUMR teams were active and plans were drawn up to expand this to 52 for Q1 2020 ▪ 32 SDB teams were active during January, and almost 800 volunteers were engaged in SDB activities ▪ 87% success of the alerts of possible Ebola deaths ▪ 13% failures of alerts, due to security, family resistance or non-accessibility reasons ▪ During this month, a lot of work was conducted to pilot a n adaption to the feedback system to better include SDB data and ensure SDB teams are responsive and sensitive to the information RCCE teams were receiving on the topic of SDB. This was piloted in Beni specifically during January. 52 ▪ Distribution of 21 SDB kits for the 8 operational bases ▪ Plan with MoH for the transition phase, submitted with the general trend to decrease SDB teams and strengthening the ECUMR teams in capacity and number o The plan was to keep the ECUMR teams, but not only for SDB but to train for the Rapid Response Teams, and for other health related emergencies in the communities. February ▪ Training during this month supported 31 Red Cross teams representing 384 volunteers, 53 teams from Civil Protection and 46 community led ECUMR teams were trained and equipped by the Red Cross ▪ 13% of failures were due to security, family resistance or non-accessibility ▪ The feedback system adaptation for SDBs being piloted in Beni continued during this month, with continued efforts to ensure appropriate synergy between the SDB and RCCE pillars ▪ Due to the epidemiological situation, the SDBs and ECUMRs in all “Green Health Areas” (more than 132 days with no new cases) were stopped, and the plan was for gradually stopping all teams in new Health Areas as they become “green”. This is done in order to allow those communities to resume their cultural and religious burial practices at the earliest opportunity, once it has become clear that it is safe to do so. As a consequence, and from the Red Cross side, both the SDB and ECUMR strategies were noted as scaling down during February, meaning that: ▪ 46 ECUMR teams were still active but on stand-by, with final deactivation from the Red Cross being effective in the green areas 21 days after the area is declared green. The responsibility of the ECUMR teams is then transferred to local health structures (MoH) ▪ The training and equipment of 56 additional ECUMR teams (planned for the first quarter of 2020) has been reduced to 6, these latter belonging to hotspot areas with no access by any partner for geographical or security reasons.		

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	▪ 31 SDB teams were still active and plans were in the pipeline to perhaps transform these teams into multidisciplinary Rapid Response Teams (RRT); the modalities were under discussion and there were 12 RRT in process of being set up at the time. March • Development of disengagement standard operating procedures for all ECUMR teams by 12 April 2020 were developed during this period, noting the continued positive outlook of the epidemiological situation • A number of activities were conducted with regards to the initiation of communication around the ECUMR disengagement process with local authorities • During the period between 2-29 March 2020, the SDB teams recorded 1,670 alerts received while the teams responded to 1,655, including 1,598 (96.55%) successes, and 57 (3.5%) failures; failures were due to security related issues, family refusals (resistance) and a few for delayed response • During this period, and following a period of heightened security tension, progress was made on the relocation of delegates who had previously been evacuated back into the operational bases in order to intensify activities to end the outbreak. Similarly, during this month, there was an intensive period of reflection both internally and externally with partners on the prioritisation of activities to bring about the end of the outbreak. April • During the period between 1 and 29 April 2020, the SDB teams (Red Cross, ECUMR and Civil Protection) received 686 alerts and responded to all the 686 with 663 (97%) successes, and 20 (3%) failures; failures were due to security related issues, family 53 refusals (resistance) and delayed response. The teams conducted 666 swabs including 2 positives. • The SDB activities were reduced at the Goma level and Ituri territory accounting for the lack of cases in those areas. However, active surveillance was implemented through the collection of swab samples from dead bodies in the areas with no cases between 42 and 132 days after the last confirmed case. • 34 ECUMR teams remained active during the reporting period. Work took place to ensure that activities of 12 ECUMR teams would be transferred to local health structures (Minister of Health). May/June • During the period between 1 May and 20 June 2020, the SDB teams (Red Cross, ECUMR and Civil Protection) received 1,594 alerts and responded to all the 1,582 with 1,546 (97.72%) successes, and 48 (3%) failures; failures were once again due to family refusals (resistance) and a few for delayed response. The teams completed 1,546 swabs including noting 1 as positive. It was a child who died at the ETC on 6 May 2020 in Beni.		

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	• During the observed resurgence in the Beni health zone during the period, the SDB activities were implemented in the Beni health zone and the other health zones surrounding Beni to keep surveillance through swab samples on all deaths. the SDB teams were deactivated in the zones surrounding Beni such as Butembo/Katwa, Mangina, Aloya/Byakato, Mandima, etc due to all these areas completing their zero case countdowns. • On 25 June 2020, DRC MoH expected to declare the end of the Ebola epidemic if no cases occurred. i.e. a total of 42 days countdown without new EVD positive case. Thankfully, this countdown was completed and the outbreak in the east was declared over on 25 June. • The IFRC in collaboration with USCDC started discussions on the implementation of the "OraQuick Rapid Diagnostic Test" project in the health areas of the Beni health zone. As of 8 September, discussions are ongoing, but with the likelihood for this project to move to the western outbreak in the DRC. Overall achievements over the course of the reporting period: • 49 community-led emergency harm reduction burial (ECUMR) teams were trained, out of 52 teams planned, to perform safe and dignified burials. In addition to this, they were trained in RCCE and decontamination of houses of EVD deceased people. Members of the ECUMR also did post-mortem sampling (taking specimens) and sent the samples to the nearest laboratories. The Red Cross teams conducted awareness sessions and explained the strategy to both the local authorities and community members. The selection of the members of ECUMR teams was the responsibility of the local authorities and some of the criterion used were their educational background, capacity to learn, nomination by the community and physical fitness (due to the nature of the work). • SDB kits, SDB starter kits and personal protection equipment were distributed to each ECUMR team. In addition, the ECUMR team members benefited from the reimbursement of transport costs incurred in the process of carrying out burial activities and/or the transfer of samples to the laboratories for testing. • ECUMR activities were carried out in line with the local culture, focusing on biosecurity and ensuring community ownership of the activities. This meant that body securing activities were carried out with the same equipment used by the mobile teams but according to customary practices that did not jeopardize the security aspect. Practices that would have jeopardized biosafety were avoided, for example touching the body, kissing the body, etc to express one's attachment to the deceased. 54 • At each burial activity conducted, members of the ECUMR team conducted community sensitization on the process of SDB - why the body bag, why the body should be secured and what decontamination measures will be taken to prevent the spread of Ebola. A total of 1,086 sessions were held during the reporting period. In addition to the sensitization carried out by the ECUMRs during burial activities, for three days a week, the teams carried out door-to-door sensitizations in order to gain the support of the communities and enhance access to accurate information on		

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	the disease. To prevent community resistance to SDB, sessions were organized to show the materials used for SDB and explain the relevance of each material. This was done either when responding to alerts but also during planned mass sensitization campaigns. • Since the health areas for the implementation of the ECUMRs were mostly unsafe and unauthorized locations for international IFRC staff, only IFRC national officers and DRC Red Cross that live and work in these areas had access to these community teams after the training. Monitoring was carried out by the officers according to the number of teams they were in charge of. Some officers managed to hold two meetings per month while others held one meeting. • Initial meetings held with the community involved creating awareness with leaders, community members and head of the health area on the need for ECUMR teams and involved them in identifying these teams. At the meeting, a list of ECUMR team members is developed and approved by the local leaders and given to Red Cross teams. Training of the ECUMR teams was done on site where the community is based and the roles and responsibilities of the ECUMR team laid out in addition to tasks to be done. At the end of the training, the terms of reference of the team is shared with the community as well as with the ECUMR teams commissioned to work in order to ensure clear and open communication on their role and responsibilities and how they would interact with communities, and indeed, what communities could expect from these ECUMR teams. • Monthly meetings were used to monitor performance of the ECUMR teams and general acceptance of their roles by the community. Feedback data was discussed e.g. reasons for failures recorded by certain teams, at a community forum to iron out misunderstandings and advocate for acceptance. Where the team is no longer acceptable to the community (causing resistance), then the ECUMR team is reconstituted afresh. Challenges: • The major challenge in this operation was security. Due to the conflict, it has not been easy to access some places, and this has prompted the spread of EVD and made its control even more difficult. At various points, activities had been stopped, and the IFRC as well as many other actors, had to evacuate all its international teams out of affected localities because of the conflict, which delayed or required adaption of operational implementation. Nevertheless, the focus has and continues to be the building of local level capacity, through DRC Red Cross volunteers and staff, alongside side the prioritisation of their health and safety in carrying out their work in what is a challenging operating environment. Concluding remarks: • The training and equipping of the ECUMR teams strengthened community capacity in conducting safe and dignified burials in difficult to reach areas while also ensuring that this knowledge will be left with the community, thereby		

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	reinforcing their resilience and ability to respond to locaslised outbreaks in the future, requiring the management of the dead. As 55 highlighted above, the focus on ensuring these teams are recruited from and integrated within the health system was an important element of the IFRC's work and one that involved close coordination and collaboration with relevant local authorities and community health leaders. • To further develop the post-EVD recovery and now transition to COVID-19 response strategy, Rapid Response Teams have been trained in the different intervention zones to respond to new eventual outbreaks. This is a strategy for the sustainability of the activities and for strengthening the capacity of the National Society to respond to outbreaks beyond only Ebola and SDBs, by developing multidisciplinary teams consisting of profiles from across all the response pillars. **Increasing capacity of community structures in prevention, preparedness and response to cholera in Malawi and Zambia** Project objective: Reduce morbidity and mortality in cholera hotspot areas of Malawi and Zambia through increasing the capacity of community structures in prevention, preparedness and response to cholera Outcome 1: Branch Rapid Response Teams (BRRT) are trained and equipped in four Red Cross branches and fully integrated into any Government RRT in place and the Red Cross Red Crescent oral rehydration treatment (ORT) preparedness structure able to carry out case follow-up and transmission route interventions in cholera outbreaks Outcome 2: With the full participation of community members, systems are set up to chlorinate rural water supplies in communities identified by the MoH and Red Cross branches, and household water treatment and storage is promoted Implementation strategy: This project strengthens the ability of communities, the National Societies and other partners in two target countries, Malawi and Zambia, to prevent, detect and respond to disease threats and play a significant role in preparing for future cholera outbreaks. The proposed approach is coherent with two critical axes to combat cholera enforced by the Global Task Force on Cholera Control (GTFCC), namely early detection and response and a focus on hotspots. The Red Cross aims to ensure communities have basic information about the spread of diseases and how to prevent them, simple and effective systems to detect outbreaks, and communication mechanisms that ensure timely information sharing and community engagement. The Red Cross is working to strengthen its epidemic preparedness and response capacity,		

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	and at the same time, help National Societies to develop and train networks of volunteers to support early detection and early action to outbreaks. Through its branches and community volunteers, and in line with existing cholera national plans, the IFRC and the National Red Cross Societies of Malawi and Zambia are developing Branch Rapid Response Teams (BRRT) in cholera hotspot areas to be integrated with its ongoing programme to provide training and prepositioned Oral Rehydration Point (ORP) Kits for immediate provision of ORT at community level. Community ORPs offer life-saving treatment and referral, and can collect patient details which can then be used to undertake case tracking and the carrying out of household and neighbourhood interventions to break transmission routes. The BRRT will be fully integrated and coordinated with any Government RRT in place. During non-outbreak periods, the BRRT work with community volunteers to map WASH coverage and key gaps as well as carrying out community chlorination of water supplies and promotion of household water treatment and storage as a prevention measure, either throughout the cholera season or where outbreaks occur in the vicinity. Hygiene promotion campaigns and household visits are carried out during the whole year. Cholera begins and ends in communities. When communities are engaged and trained in cholera prevention, preparedness and response, they become vital contributors to finding and stopping outbreaks, saving lives, restoring services, reducing negative impacts, speeding up recovery and building resilience. The below presents the planned activities as they appeared in the original submission for this project. Readers will note that this project and its activities were designed to be adaptable based on the countries' priorities, needs, risks and capacities. Planned activities: 1. Identification of Red Cross branches and government rapid response team (RRT) capacity in key cholera hotspots and of key hotspot communities within the catchment area of those Red Cross branches. The IFRC ORT model should either already be in place in the chosen branch or will be implemented at the same time. 2. Identification and training of staff and volunteers in case tracking and transmission route interventions (based on findings of GTFCC Working Group); WASH assessment and monitoring; hygiene promotion, basic chlorination systems and household water treatment and safe storage. 3. Formation and equipping of the BRRTs together with existing capacity of the governments' RRTs. The training package, which will be based on the findings of the GTFCC WASH working group on Emergency WASH interventions in		

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	cholera outbreaks and linked into the current ORT preparedness trainings, will be an integral part of the training pathway, and will align to the country Cholera National Plans or any other existing trainings at country level. Key achievements: IFRC has developed a 5-level model which has provision of ORT at its centre. The model is a way of linking global response tools to volunteers living and working in communities, providing a common training pathway, standard operating procedures (SOPs) and standard kits. Level 1 consists of community volunteers living in a community who are trained to diagnose stages of dehydration and can refer and give Oral Rehydration Salt (ORS) treatment. These volunteers are the go-to people in the community and will notice any increase in the number of cases. If there is a significant increase in cases, in agreement with the local health authorities, an Oral Rehydration Point (ORP) may be set up – this is level 2 and is used to scale up response in an outbreak. Level 3 is branch level and is where the ORP kits are prepositioned, the branch supporting several ORPs. Level 4 is headquarters level concentrating on liaising with external partners and looking at cross-border communication and control. Finally, level 5 is the global tool, which consists of the Emergency Response Unit for Community Case Management for Cholera, that is currently being developed by Swiss Red Cross. The current project is working around levels 1 to 3 with the BRRT being branch-based, moving out to ORPs in the communities and using patient line list data to identify concentrations of cases in order to implement interruption of transmission route (predominantly WASH) interventions. The programme is piloting the One WASH M&E toolkit and will provide suggestions for improving it. The toolkit will support staff in planning and designing the projects, in preparing project proposals, in setting up monitoring and reporting systems for One WASH and in evaluation (baseline, end-line and look-back studies) for future WASH-Cholera projects. The Emergency WASH Team training is being developed by the IFRC's East and Southern Africa Platform with contributions from a number of agencies using the MSF 5 tier model and the Context of Transmission models as its core and adhering to the guidelines drawn up by the WASH working Group of the GTFCC. This will be developed over the next two or three months with the inputs of the GTFCC. In the long-term, the aim is that the training would aim to get validation from GTFCC. The aim is to make the training events that will use the curriculum open to all agencies to encourage wider dissemination.		

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	The onset of COVID 19 resulted in all of those involved in the development of the training being pulled into the response. This has meant that the development of the training has been delayed. Two meetings were held with GTFCC to present the training outline which was well received, and it was agreed that it will move ahead when possible. To help move training development forward and also to identify other countries where the training may be expanded to after the initial pilot, a number of Partners National Societies were approached. Support in the training development has been offered from the British, Netherlands and Belgium RCs, who are interested to use the training in Sierra Leone and in Tanzania. In addition, the aim now is that as the training is further developed, that IFRC explores the possibility to put it online but still look for ways to keep a practical element to the content. The target is to have the training draft ready by November. In terms of content the training will be as previously presented, and an outline can be shared. One key discussion point has been the contents of household level kits. Previously these have tended to be family hygiene kits but it has been agreed that the kits prepositioned in the current programme will be for both hygiene and disinfection. Several rounds of discussions have been held with Evidence Action to look at how the chlorine dispenser model they implement can be put in place in some of the hotspots where the current programme will work, and also to look at how some dispensers might be held for emergencies and used as a medium-term solution which links emergency to long-term safe water solutions. An agreement was reached with Evidence Action to pilot 50 chlorine dispenser points in communities linked with each of the two branches in Malawi. However, again, COVID-19 has seen Evidence Action move to respond to the crisis and thus this has not moved forward. The first draft of the WASH baseline survey has been uploaded in KOBO and shared with the National Societies. Due to the travel restrictions the face to face KOBO baseline training was not possible, however trainings online were done for the Information Managers from Zambia and Malawi. Both countries have adapted the baseline to the context and uploaded into the IFRC KOBO account. The purpose of WASH baseline surveys in cholera hotspots is to create baseline estimates for WASH coverage in those hotspots; link to other activities (such as costed cholera plans or OCV coverage surveys); monitor progress in WASH coverage over time as WASH infrastructure is developed; understand the cholera risk factors to develop the hygiene promotion intervention for behavior change and the overal objective is to demonstrate progress on the Cholera Roadmap.		

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	Zambia Zambia Red Cross Society (ZRCS): ZRCS has ten provincial branches, and branches in nearly all districts of Zambia, and an estimated volunteer membership of about 10,000 volunteers. ZRCS has experience in working in cholera outbreaks, specifically in the most recent outbreak in Lusaka. Geographical location: The focus is on the districts of Nsama and Mpulungu, adjacent to the lakes in the north of the country, bordering with Tanzania and DRC. Key achievements during the reporting period to date: • The Oral Rehydration Point training curriculum for ZRCS branch volunteers' level 1 and 2 has been developed and facilitated in the local language. • A total of 45 volunteers (19 female and 26 male) and 5 MoH staff (2 female and 3 male) were trained in level 1 and 2 of the ORP strategy in Mpulungu and Nsumbu (Nsama District). • 10 ORP kits have been prepositioned in Zambia - one in Mpulungu and one in Nsumbu (Nsama district). A new standard kit had been agreed with adapted content; these were procured before the new standard kit had been agreed. Two of the new standard kits have been sent to Zambia, along with the provision of funding so that the existing kits can be upgraded. These will be prepositioned according to plans made in consultation with government. • Two ZRCS staff participated in a ORP Training of Trainers held in Nairobi, Kenya, which ensures they can take these skills and knowledge back to their National Society through cascade training. • The ZRCS plan of action for the implementation of the cholera contingency plan strategy in Lusaka, Mpulungu and Nsama, has been developed in consultation with the Ministry of Health, IFRC Cholera Coordinator and other stakeholders. • A Red Cross branch capacity assessment checklist has been developed and piloted in Mpulungu and Nsumbu Branch. • Consultation with the Department of Health was carried out for the selection of target communities in both districts. • WASH baseline survey online training was done through collaboration between the teams in Geneva and Zambia. WASH baseline survey was adapted and uploaded into the IFRC KOBO account. Malawi Malawi Red Cross Society (MRCS): MRCS is a leading humanitarian organization in Malawi, with an established structure of 28 branches and a network of about 40,000 volunteers down to grass roots level across the country. The MRCS WASH Department has implemented emergency and long-term WASH interventions for more than 20 years, and it has the capacities to implement the proposed activities.		

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	Geographical location: The focus of the project is the district of Karonga in the far north of the country bordering with Tanzania, and one south district, Mangochi, bordering with Mozambique. Key achievements during the reporting period to date: • A total of 55 people have been trained among branch volunteers and two staff (one male, one female) from Karonga, two (one male, one female) from Lilongwe, two (one male, one female) from Chikwawa, 14 (9 male, 5 female) from Salima, and 33 (20 male, 13 female) from Mangochi. • 16 ORP Kits (minimum kits) are already available. New standard kits have been sent to Malawi and funds have been provided to upgrade the existing kits. • Two MRCS staff participated in the ORP Training of Trainers in Nairobi, Kenya. • A Red Cross branch capacity assessment checklist has been developed and piloted in Blantyre and Karonga Branch. A branch assessment has also been carried out in Chikwewa, which will be linked into the programme using existing One WASH funds. • WASH baseline survey online training was completely through collaboration between Geneva and Malawi. WASH baseline survey was adapted and uploaded onto the IFRC KOBO account. Challenges: • There is a need to review the format for recording patients in the line list to make the ORT level 1 and 2 administration more user friendly. • Delays in field visits and trainings due to the COVID-19 situation continued to caused problems for the project. International travel has been delayed, but also domestic travels delays continue to be an issue in both Malawi and Zambia. Indeed, National Society staff travel to the target districts have been postponed, and there has been human resources pressures on the National Society as many have been supporting the MoH in the COVID-19 operation. The However, the project continues to adapt with alternative solutions continuously being explored, whilst the hope will be that the situation will improve in the not too distant future to allow necessary missions to take place. Given the restrictions in travel and shift in priorities due to the COVID-19 pandemic in 2020, in-person trainings were changed to online sessions designed to provide examples, lessons learned and key sessions on specific topics. COVID-19 recorded webinars can be found here (many public health webinar sessions link to tools supported by the Danish Red Cross such as the ECV toolkit and CBS Assessment and Protocol). This includes for instance a session on Community-based surveillance (CBS) needs assessment and introduction to the Red Cross Red Crescent CBS tool Nyss:		

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	Epidemic Control for Response Managers (ECRM) Toolkit. In addition to the Epidemic Control for Volunteers Training Manual and Toolkit, IFRC is working on the development of a toolkit on health emergency management for response managers. The toolkit will be developed in a similar manner as the ECV toolkit, allowing users to search for information according to their profiles, and the disaster/epidemic type they are faced with. Toolkit content is available in English, and funding from the Danish Red Cross allowed the IFRC to translate it into French. IFRC is working with the American Red Cross and the Community Epidemic and Pandemic Preparedness Programme to finalize the toolkit and launch it in 2021. National Response Team harmonized training package The IFRC, together with other components of the International Red Cross and Red Crescent Movement, has a longstanding commitment to developing initiatives and tools aimed at enhancing the response mechanisms and processes of all 192 National Societies worldwide. Strengthening the capacities of the National Response Teams (NRT) is at the core of this process. Investing in NRTs impacts on the wider response preparedness of National Societies, improves emergency response, and which, in turn, may increase the relevance and image of National Societies' services. National Response Teams are one of the critical components of the NS Preparedness for Effective Response approach to conduct an effective and timely emergency response. In addition, in line with the localization agenda, it is critical to strengthen and empower NRTs, who are the first responders at the local level. With the objective of strengthening national, regional, and global response systems through the scaling up of the quantity and quality of response teams, NRT common standards were agreed upon in 2017, to guarantee a certain level of services is provided to affected communities globally. A draft harmonized NRT curriculum was then developed, through consultations with IFRC's regional offices and IFRC's resource centres. The training package was piloted in Cameroon and Mali in the last quarter of 2020. Funding from the Danish Red Cross has allowed the IFRC to review NRT curriculum sessions related to: - Mental Health and Psychosocial Support - Water Sanitation and Hygiene At the start of the COVID-19 pandemic, IFRC developed country profiles with information about risks and capacities of National Societies to engage in COVID-19 response. Country profiles were built upon the questions outlined in the "Guidance for National Society preparedness for COVID-19" and link together information available in various existing global databases. Each country profile provides a brief 2-page summary (per National Society) of the risks and hazards, health system, Red Cross Red Crescent Movement context (IFRC, ICRC, Partner National Societies), National Society context (mandate, resources, medical services, programmes (highlighted: Community Based Health and First Aid		

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	(CBHFA), Community Engagement and Accountability (CEA), and Mental Health and Psychosocial Support (MHPSS), National Society health facilities and National Society capacity strengthening processes), as well as coordination focal points (WHO, Health Cluster, Resident Coordinator / Health Cluster). In Guinea, an information management/GIS consultant used the experience from "Missing Maps" to map Faranah prefecture. In 2019, the Guinean Red Cross, Geo Synapse Guinée and other organizations used satellite imagery available on OpenStreetMap to trace buildings, rivers and roads, and mapped 7,810.96 Km of roads and 79,764 buildings in the sub-prefectures of Faranah. Under the guidance of the information management/GIS consultant, Guinea Red Cross volunteers in Faranah then worked with their communities to ground truth and add key points of interest to the map. They indicated health facilities, community infrastructure, social and education facilities, marketplaces, security services, points of entry, places of worship, cemeteries, communication towers, community radios, guest houses, water facilities, and Red Cross presence. Some key additional information was collected regarding health facilities, which include opening hours, type of health facility and services provided, as per the illustration to the right. See the following blog for further information. In the DRC, an information management/GIS consultant has supported the measles immunization campaign of the DRC Red Cross. In 2019, WHO reported a global resurgence of measles, one of the world's most contagious diseases. In DRC, a measles outbreak was declared by the DRC's Ministry of Health on 10 June 20191, which affected all 26 provinces, with over 250,000 cases and 5,000 deaths in 2019 alone'.2 As summarized by the Outbreak Observatory at Johns Hopkins' University, "*DRC has faced multiple issues that contribute to measles transmission including low immunization coverage, low vaccine supply, poor surveillance, limited logistical means to maintain cold chain needed for vaccines, armed conflict, displacement as well as financial and geographical barriers that impede access to health facilities"*3. Thus, the Red Cross, together with the health authorities, launched a mapping of health facilities using the Open Street Map collaborative platform. As a result, staff and volunteers geolocated existing health facilities or immunization sites in the health zone of Kimpese in Kongo Central and indicated if they had functional vaccine refrigerators or not. The map below was then shared with the DRC Ministry of Health for further analysis and validation. This information was later used to plan immunization activities on the ground. IFRC and the DRC Red Cross also used anonymized information on areas with a higher incidence in immunization refusal in the health zone of Kimpese in order to improve and carry out sensitization visits that can specifically focus on expressed concerns. Community-based Surveillance (CBS) is the systematic detection and reporting of events of public health significance within a community, by community members. Over the past few years, the Red Cross Red Crescent Movement has		

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	developed a methodology (Community-based Surveillance: Guiding principles) and specific tools (NYSS) to support CBS. Complementing this ecosystem, new tools were developed that enable National Societies to assess the need and feasibility of CBS (Community-based Surveillance: Assessment tool), and to develop an implementation protocol for CBS when contextually appropriate (Community-based Surveillance: Protocol template). While CBS has garnered support in the past few years, due to limited in-person trainings, additional resources were developed to facilitate online and remote training on "What is CBS" and the Red Cross Red Crescent methodology for CBS. The training presentations were developed in English and translated into French, Spanish and Arabic to support IFRC's Regional Offices, Country Cluster Support Teams, National Societies and partners, in understanding what CBS is and how it may be integrated with community-based activities in local contexts. Although the CBS Assessment tool has provided guidance to National Societies in assessing whether CBS was appropriate for them, practical tools were needed to facilitate training (especially remote trainings) on how to use the CBS Assessment tool. Thus, a practical presentation and training tool was developed for the CBS Assessment tool in English, French, Spanish and Arabic for National Societies and partners. Specifically, Danish Red Cross financing supported the translation and dissemination of these two documents into French. In addition to the online training presentations, several training and implementation practical tools originally developed in English were translated to share with French-speaking National Societies and partners. In 2021 an "online playlist" of CBS-related training materials is expected to be completed, where these training tools will be shared and linked with existing Training of Trainers and Training of Volunteers tools already available (https://www.cbsrc.org/resources). The CBS Technical Working Group has continued to test Key Performance Indicators (KPIs) and share implementation feedback on how best to incorporate KPIs into programming; and suggested KPIs for CBS have been developed and translated into French and will soon be shared more widely with National Societies. **Internal:** • The Community-based Surveillance Technical Working Group (CBS TWG) is composed of IFRC and National Society representatives advancing CBS methodology, tools, and guidelines. In 2020, this community met virtually bi-monthly to share best practice and collaboratively advance a number of initiatives, including: technology development (NYSS - a custom software platform for data collection and analyses, tailored to the		

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	needs of National Societies for CBS), guidelines and tools for CBS in the context of COVID-19, and general guidance (Key Performance Indicators, etc.). These conversations help to strengthen internal consistency in the Red Cross Red Crescent approach to CBS. All IFRC's CBS work has been discussed with CBS TWG members to ensure CBS technical agreement and support. • The Community Epidemic and Pandemic Preparedness Programme (CP3) has enabled the development of 'model activities and tools' for National Societies and civil society actors for epidemic preparedness. All activities, particularly the achievements noted in Output 1, were conducted in coordination with CP3 colleagues. **External:** • IFRC serves as a member of the Health Cluster and actively participates within two "Task Teams" – the Quality Assurance Task Team (QATT) and the Public Health Information Services Information Management Task Team (PHIS IMTT). The work on the survey design tool is a joint collaboration with the US CDC and is included within the 2020 Health Cluster PHIS IMTT Workplan. Work will continue with US CDC in 2021, to further develop and expand this approach. • IFRC serves as a representative in the World Health Organization (WHO) Early Warning, Alert, and Response System (EWARS) "EWAR in emergencies Technical Working Group" and "Community-based Surveillance in Emergencies Working Group". IFRC's CBS guidelines (Guiding Principles, Assessment Tool, and Protocol Template) have been shared with this community, and the IFRC approach to CBS is often cited. This work further contributes to the PHIS IMTT Workplan.		
AP024	**Immunization** 1. **Support for routine infant immunization in high risk communities:** IFRC and partner National Societies are supporting immunization activities in some of the most challenging operating environments with a focus on reaching zero-dose children in vulnerable settings. In 2020, we developed models to support service delivery at scale in in Afghanistan, the Central African Republic, Nigeria, and Pakistan. A common feature of these models includes support from RC volunteers drawn from the same communities in which they work and who seek to ensure that infants receive the lifesaving vaccines they need early in their lives. Despite intense operational challenges, dedicated teams continue to work in conflict areas and remote mountainous regions that health workers have struggled to reach for years.		

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	The models for reaching zero-dose children have been developed and tailored to operational challenges at the local level. In some contexts, RC teams provide direct vaccination services under government supervision such as in Pakistan. In the Central African Republic, teams are focusing on re-establishment of immunization services in conflict settings with a focus on systems strengthening including microplanning, community engagement, service delivery and capacity-building of the district health team. In Afghanistan, vaccination services are provided anti-government controlled areas as part of a broad package of primary health care services. In Nigeria, volunteers are supporting social mobilization for immunization activities and community-based surveillance for vaccine preventable diseases in hard to reach insecure areas of 3 states in Northern Nigeria. In the course of 2020, Red Cross and Red Crescent staff and volunteers have vaccinated dozens of thousands of children in those underserved communities. As the COVID-19 pandemic posed additional challenges and restrictions, activities were adapted to ensure appropriate social distancing, limiting the number of participants in community meetings, and taking safety measures for staff, volunteers and the communities being served. 2. **Integrated Service Delivery in Afghanistan:** Afghanistan, where a protracted crisis has continued for close to 35 years, is the other remaining polio-endemic country in the world. Children are estimated to make up over 50 per cent of people facing humanitarian needs in the country. In this challenging environment, the IFRC and the Afghanistan Red Crescent Society (ARCS) are providing an integrated package of primary care services through mobile health teams in conflict areas where access is limited. Red Crescent teams are working in the provinces of Paktika and Kandahar, both bordering Pakistan, covering three districts and 184 villages. ARCS is the only humanitarian organization have access in Bermal and Gomal districts of Paktika province. In 2020, the teams have continued to face access challenges, including insecurity and bans on house-to-house vaccinations. Yet, they continue to reach children in need of vaccinations, in particular "missed children" in remote and inaccessible areas. In the course of 2020, the ARCS teams administered the oral polio vaccine to over 7,700 "missed children" under 2 years of age and to over 8,000 "missed children" under 5 years of age living in inaccessible areas. The		

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	ARCS also provided routine immunization services, reaching close to 5,000 children under 1 year of age with the oral polio vaccine, and vaccinating thousands more with additional routine antigens 3. **Building Back Better in the Central African Republic :** In the Central African Republic, 23 per cent of the population must walk for more than one hour to reach a health centre. An estimated 70 per cent of the national territory is under the control of armed groups. The Central African Republic is considered one of the most dangerous operating environments for humanitarian workers, with 424 incidents affecting humanitarian workers recorded in 2020. In this complex operating environment, and since 2018, IFRC and the Central African Red Cross Society (CRCA) are supporting the national routine immunization program in 13 conflict-affected districts, in an area the size of Germany. Red Cross volunteers are present in each of 3,200 villages in some of the hardest-to-reach areas and support microplanning processes and the registration of children with local health centers where they receive vaccination services. Volunteers disseminate key messages and support with community surveillance. Staff are also embedded in the health clinics and at the district health office to support the government-run system. The CRCA is currently supporting 232 health facilities, representing over 25 per cent of functional health centres in the country. Services are being expanded to reach an additional 2,000 villages. In 2020, Red Cross-supported teams vaccinated over 27,000 infants with their third and final dose of the Pentavalent vaccine, protecting them from five major diseases: diphtheria, tetanus, pertussis (whooping cough), hepatitis B and Haemophilus influenzae type b (a deadly bacterium which can cause meningitis, pneumonia and septicaemia) (DTP-hepB-Hib). Red Cross-supported teams reached close to 73 per cent of the estimated total infant population in those districts in the last few months of 2020. In contrast, prior to IFRC and CRCA starting their work in 2018, approximately 50 per cent of infants had been reached with the Penta3 vaccine. IFRC has also continued to scale up its innovative approach to data collection to track and respond to gaps in vaccination access for the most underserved children. In partnership with the Ministry of Health and Population (MoHP), CRCA, the US Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and UNICEF, IFRC has developed an electronic data collection and analysis system used nationwide. This enables health workers to identify not only the number of vaccine doses administered, but also which operational health facilities are offering immunization services. This is crucial in a country in which health centres fall into disuse due to conflict dynamics or lack of supplies. The number of health centres		

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	vaccinating each month of 2020 increased by 96 per cent compared to 2018, almost doubling from 60 to 117 health centres. This also shows the considerable impact of the Red Cross teams in strengthening the health system and ensuring more vulnerable communities can be reached. 4. **Direct Service Delivery in Pakistan:** Pakistan is one of two remaining polio-endemic countries in the world. In some of the most challenging districts of the Balochistan and Khyber Pakhtunkhwa provinces, both bordering with Afghanistan, Red Crescent volunteers, community social mobilisers and vaccinators are directly providing immunization services to underserved and hard to reach communities. Through their work, they are consistently raising coverage for routine vaccines, so more and more children are protected from vaccine-preventable diseases. In Killa Abdullah district of Balochistan, only 9% of targeted children had been receiving their third dose of Pentavalent vaccine in January 2019. As Red Crescent teams began supporting Ministry of Health efforts, vaccination coverage has exceeded monthly targets and increased by over 120% in the last quarter of 2020 compared to 2019, protecting some 16,500 children with Penta3 in the course of 2020. Similarly, by end of 2020, vaccination coverage for Penta3 in the smaller district of Dukki reached 110 per cent, protecting over 2,700 infants. Vaccination coverage has also increased more than 100% for measles and polio vaccinations, providing over 22,000 children with immunization against these potentially fatal diseases in 2020. Certain villages in the tribal belt had not been reached in 15 years, until Red Crescent teams attended those underserved communities with an emphasis on outreach and mobile vaccination sessions at the community level, organized by the community social mobilizers and vaccinators. Part of the teams' success relied on their mobility and motivation to reach remote areas. In 2020, close to 23,000 mobile and outreach sessions were conducted in the districts of Killa Abdullah and Dukki in Balochistan province. The data show a direct correlation between the number of outreach and mobile sessions conducted in communities, and the number of children being vaccinated, with a clear dip during the first wave of the COVID-19 pandemic. 5. **Support for measles mortality reduction:** Despite the availability of an effective vaccine, measles continues to be a major public health problem, accounting for > 140,000 deaths worldwide among children under the		

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	age of five. To ensure widescale protection and population-based immunity, children need 2 doses of measles campaigns. Supplemental immunization activities (SIAs) are often used to ensure children get a second dose of measles, particularly in countries with low second dose coverage. These campaigns provide the opportunity to scale up immunization coverage and thereby improve herd immunity. The IFRC and National Red Cross and Red Crescent Societies are key partners in SIAs in a number of countries and are working to improve vaccination coverage of measles for remote and underserved populations. In the past year, RC NSs supported measles SIAs, in S. Sudan, Nigeria and Central African Republic. 6. **Support for measles campaign in South Sudan** is a conflict-affected country with multiple humanitarian challenges. Therefore, vaccination in South Sudan is fraught with many complications and the country is prone to outbreaks of vaccine preventable diseases. In December 2020, the South Sudan Red Cross Society (SSRC) supported the measles campaign in two very high-risk counties (Fashoda and Maban) of the Upper Nile state. The National Society established connections directly with the health departments in both counties and provided training to volunteers in their own communities. Both counties had large areas which were flooded, complicating community outreach. The SSRC was an integral partner in the campaign along with UNICEF, WHO, World Vision and the county health departments. Across both counties, the SSRC and its 68 volunteers participated in social mobilization efforts which led to the vaccination of approximately **20,000** children with the measles vaccine. This campaign highlighted key challenges of vaccination outreach to underserved populations in geographically remote regions. In addition to personal protective equipment (PPE), volunteers in the flooded communities required access to appropriate footwear and clothing. Learning from vaccination campaigns in such contexts, the IFRC and the Red Cross Red Crescent Movement are able to tailor their strategies to reach under-immunized children in the most geographically isolated communities in the world. SSRC volunteers engaged in social mobilization in Kodok, Fashoda county during the December 2020 measles campaign. 7. **Supporting integrated vaccine campaigns in Nigeria:** The Nigerian Red Cross Society (NRCS) supported the government's "integrated Meningitis A and measles campaign". In October 2020, the NRCS implemented a 10-day social mobilization strategy to support the integrated campaign in Kogi and Niger states with funding from the CDC. The NRCS was a key partner in the planning process which included meetings with government officials and traditional leaders across 46 local government areas. The IFRC/NRCS focal points also served in		

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	the technical teams coordinating the project. In the two states, the NRCS was able to mobilize 725 volunteers to reach over **466,000** children within the target age of nine months to five years. The IFRC/NRCS staff were involved in field supervision and monitoring of the social mobilization exercises. This provided the National Society an opportunity to record, review and analyse the reasons for non-compliance and engage with marginalized communities to address vaccine hesitancy. A key demand from the community was that they needed "food not vaccines". This shows that underserved populations are likely to refuse vaccination when their other needs are not being met and that encouraging vaccine uptake will require an integrated approach to ameliorate economic and social services. Volunteers of the Nigerian Red Cross Society (NRCS) engaged in a social mobilization rally to support an integrated measles and meningitis vaccination campaign. 8. **GAVI MOU**: GAVI and IFRC signed a Memorandum of Understanding to work together on reaching improving access utilization of immunization targeting communities with high numbers of ZD children in June 2020. After signing, IFRC and Gavi conducted a joint mapping exercise, which resulted in the identification of 24 priority Gavi-eligible countries to explore whether Gavi-IFRC collaboration could improve vaccination coverage. The IFRC subsequently proceeded to contact National Societies (NS) in each of the 24 countries and regional teams to orient and introduce them to the MoU. A summary view of the progress includes the following. 1) Of 24 NSs contacted to date, 22 have expressed a willingness and capacity to engage in immunization related activities. 2) A strong capacity and experience of immunization-related activities was evident in 20 NSs including support for the vaccination of children in ZD communities. 3) In 13 out of 23 Gavi priority countries (Afghanistan agreement is signed), the IFRC team and NS focal points have engaged with Gavi teams to discuss collaboration. 4) In 5 countries, the NS has presented at the Gavi-led Multi-stakeholder dialogue and participated in the Full Portfolio Planning process. 5) Apart from Afghanistan, a concrete agreement has not yet been reached for any country. 6) The most common reasons sited for not moving forward with an agreement a) the country does not need additional support b) all the funds have been programed c) It is important for the NS to participate in GAVI processes (FPP and MSD) which is a long process over several months and does not take place every country each year		

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	The IFRC teams have defined the following countries as the highest priority for further engagement due to disease burden and NS capacity to reach ZD communities. Afghanistan, CAR, DRC, Mali, Pakistan, Somalia and Yemen. 9. **CSO Steering committee**: IFRC continues to host the GAVI CSO steering committee. Key accomplishments include support for a new CSO engagement strategy which was presented to the GAVI PPC in May 2021. 10. **IA 2030: Fragile states working group:** IFRC leads the IA2030 working group to support immunization in fragile contexts 11. **ICG**; IFRC staff sit as a member on the Interagency Steering committee that supports review of applications to access the global stockpiles of YF. Cholera. Meningitis and ebola vaccines. **COVID 19 response** **1. Global response to support immunization activities:** In response to the Pandemic, IFRC formed a global task force to support role out of COVID 19 vaccines. The task force includes 2 working groups lead by National Societies ocusing on operational role out of COVID 19 vaccines and a working group on resource mobilization and advocacy. We conducted a global survey of support NSs are providing for immunization activities with the following key results. • 152 out of 192 NSs are involved or planning to be involved in COVID 19 vaccine role out • Societies play a key role in countering vaccine hesitancy, engaging and informing communities, building confidence in vaccines, and ensuring that people have access to vaccines. • The IFRC network identifies and reaches high-risk individuals who may be marginalized • In many last-mile and remote settings, the IFRC network will directly administer vaccines.		

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	1. **Five point plan:** A five pillar plan was developed and endorsed by membership including ICRC which includes the following elements • **Advocate** for equitable and effective access to a COVID-19 vaccine • **Trust:** build community trust and acceptance of COVID-19 vaccines and help manage people's expectations • **Health:** support the distribution and delivery of COVID-19 vaccines in health facilities and during outreach activities • **Reach** the most vulnerable, especially those affected by conflict, violence and disaster, and those living in urban slums and remote rural areas • **Maintain** and strengthen other immunization services such as routine immunization and vaccination campaigns for other vaccine-preventable diseases 2. **Resource mobilization:** A revised appeal was developed and includes support for immunization that targets 500 million people, with a CHF 100 million ask, as part of its global appeal to respond to the COVID-19 pandemic. RC volunteers and staff have supported the vaccination of millions of people in recent months. 3. **Technical support**: IFRC is providing technical support to COVAX through participation in ACT working groups including the IASC and the working group on vaccine buffer stock. **Capacity development**: The Immunization task force is reaching out to membership on a regular basis through webinars addressing key issues of interests to NSs.		
AP025	**Climate and Health** Climate change is one of the greatest threats to public health in the 21st century. Currently climate change already causes an estimated 150,000 deaths annually. The IFRC network is committed to meet the urgency and scale of the climate crisis, which is strongly reflected in IFRC Health and Care Framework 2030 and IFRC Strategy 2030. Reducing the health impacts of climate change is one of the key pillars of the Movement's climate ambitions 2020.		

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	In 2020 through discussions with IFRC Climate Action Task Force and the Reference Group on Global Health, the Health and Care Department and Red Cross and Red Crescent Climate Center established the Heath and Climate Working Group. The Working Group consists of over 30 interested NSs from all five regions, the RCRC Climate Centre and the IFRC Secretariat. The IFRC Health and Care Department in Geneva chairs this WG, in collaboration with the French Red Cross and the RCRC Climate Centre. The WG is linked with both the CATF and RRGH and report back on its activities to both, as appropriate. The group was in instrumental in developing a clear positioning and strategic direction for the IFRC Network on addressing the impact of climate change on health, including on how to scale up relevant activities: 1. With an active engagement of the Working Group, the H&C Department and climate center developed the resource paper for National Red Cross Red Crescent Societies and their partners seeking to address health risks that are aggravated by climate change. The paper outlines the adverse impacts of climate change on human health and seeks to unpack the second pillar of the Movement Ambitions to Address the Climate Crisis, which focuses on reducing the health impacts of climate change. It frames Red Cross and Red Crescent commitments on health and WASH in a changing climate, in particular for the most vulnerable. It explores the urgency of climate action with respect to health and offers examples for action for National Societies and partners. 2. The first step to address the health consequences of climate change is to conduct a risk assessment in order understand hazards, vulnerabilities and exposure within a specific location. In 2020 Health and climate risk assessments were initiated in 11 countries together with respective National Societies - Afghanistan, Pakistan, Nepal, Myanmar, Maldives, Fiji, Mongolia, Timor Leste, Malawi, Ethiopia, Kenya. During the risk analysis focus was given to intersection of the effects of health hazard with any long term change processes related to climate change. 3. Health and Care Department and the Climate Centre developed health section for the Climate Training Kit, an interactive set of materials. This kit is designed to provide innovative tools to trainers and facilitators within the Red Cross Red Crescent Movement and its partners. As with any generic tool, all these products need to be adapted to local context and audience. The Climate Training Kit can be found on the website of the Climate Center 4. During 2020, IFRC extended partnership with WHO and other health organizations to join forces to promote the urgency of climate & health. IFRC is the member of core group to organize regional consultations in 2021 which will discuss together with public authorities regional key health impacts of climate change and make those challenges more central in decision making, so it can get more priority for action. The consultations will lead to Global climate health conference aligned with the COP26 end 2021.		

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	Migrants Health: interactive guide and online training Given the complexity of migration flows and the diversity among international migrants, the relationship between migration and health is complex. For instance, although migration can lead to greater exposure to health risks, it can also be linked to improved health, especially for those seeking safety from harm. Despite this, there are numerous factors surrounding the migration process that can increase a migrant's vulnerability to poor health outcomes, including location (refugee camp versus urban areas). Forcible displacement due to natural disasters or conflict poses immediate and significant health risks to individuals, as do factors within host countries such as discrimination, inadequate healthcare entitlements, poverty, and social exclusion. During 2020, the International Federation of Red Cross and Red Crescent Societies initiated the development of a ''Practical Guidance for Red Cross and Red Crescent on Health and Care for Migrants'', intended to be a resource for National Societies seeking to implement or enhance healthcare for migrants. The format and content are designed to be practically useful for staff and volunteers working on the ground with migrants, while complying with the IFRC's 'Operational framework for involvement in migrant healthcare services'. A second target audience is managers and project officers, whose responsibilities may include programme planning and supervising/training other healthcare providers. In parallel to the guidance, an introductory online course on Health and Migration is also being developed, entitled '' Things You Should Know about Health and Migration''. This 90-minute course is designed primarily for Red Cross and Red Crescent (RCRC) volunteers and staff responding to the needs of migrants, but with no specific expertise on health issues. It can also be a useful resource for non-specialized healthcare practitioners working for RCRC National Societies who are providing primary healthcare to migrants in a range of settings, such as community programming, large-scale movements of migrants and refugee camps. Both tools will be launched during second quarter of 2021 **IFRC and UHC** IFRC's vision is to enable healthy and safe living for all. We seek to reduce preventable death and disease through improved access to health care for underserved communities and the most vulnerable. As highlighted in IFRC Global Health and Care Framework 2030, the activities of the IFRC in health and WASH aims to contribute primarily to SDG3, "Ensure healthy lives and promote wellbeing for all at all ages" and to SDG 6 "Ensure		

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	availability and sustainable management of water and sanitation for all". UHC, by definition, includes access to the full spectrum of services including health promotion, prevention and treatment. All these, and health security, are included in tracking of UHC progress under SDG 3.8.1 (service coverage). In 2020, the IFRC contributed to the State of commitment to universal health coverage (UHC) and provides a multi-stakeholder consolidated view on the state of progress being made towards UHC at country and global levels. The review is country-focused and action-oriented in nature and complements the more technical and global UHC monitoring report focusing on UHC indicators on service coverage and financial protection. The State of UHC Commitment follows the UHC Political Declaration's Key Targets, Commitments and Follow-up Actions and support national accountability and advocacy processes to ensure political leaders are held accountable for their UHC commitments. During 2020 and 2021, the IFRC together with the UHC2030 is engaged in conducting Country Consultations/Focus Groups with local partners at the country level to capture stories, lived experiences, challenges and achievements in UHC from populations that are often left behind. In 2020 IFRC and Norwegian Red Cross - organised a side event "*UHC and COVID-19: Operationalizing Commitments to Leave no one Behind"* during the 75th United Nations General Assembly. The event discussed challenges of communities that are often left behind in line with the Norwegian Red Cross report, "The Last Mile." launched in the beginning of 2020. The report clealry identifies conditions that exacerbate barriers to health, developes a set of indicators, and recommendations to operationalize shared commitments to leave no one behind. The primary recommendation is that Universal Health Coverage should remain a priority in times of crises. IOM and IFRC High-level Virtual Policy Discussion to commemorate UHC Day 2020 was held on the 10th of December 2020, entitled ''Advancing Migrants' Access to Universal Health Coverage in the times of COVID-19''. .		
AP029	**WASH Knowledge and Best Practice.** Progress: WASH Unit continued in leading ERU Technical Working Group; RC\RC WASH Advisors Group; Innovation in fecal sludge treatment; solar and cashless systems for sustainable water supply; research in cholera and for more accessible and female friendly latrine design; participation in the Global WASH Cluster. *65% of planned activities.* Challenges: Covid restrictions in travel, hands-on training, Monitoring and Evaluation missions and field work.		

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	We supported National Societies with a range of technical support. This included a technical note on infection, prevention and control with a focus on the widely carried out but generally ineffective practice of outdoor spraying activities; a series of online trainings for WASH in COVID-19 for National Societies in the Caucasus region; guidance on designs for handwashing facilities in MENA region; and the formation of a network of volunteers to provide direct support and technical advice to NSs on hygiene promotion. While emergency response has been challenging in the pandemic, we have continued to support the most vulnerable in disasters and crisis with access to WASH: In addition to remote support missions, we have also been able to launch traditional WASH emergency response operations, notably in Greece and Honduras, with duty of care to deployed delegates and NS staff and volunteers. In line with the localization agenda we are modifying global tools and using the review of the ERU system to advocate for a more agile approach and increased engagement with NSs from the Global South.		
AP030	**Public Health and Hygiene Promotion.** Progress: Further development and publication of WASH 'software' tools for Emergency and Developmental Hygiene Promotion also translated into other languages especially Arabic took place and similarly with further development on Menstrual Hygiene Management (MHM); very active Community of Practice and on-line MHM group, a new global learning resource with 8 NS MHM case studies. 75% implementation. Challenges: Covid restrictions in travel, hands-on training, Monitoring and Evaluation missions and field work.		
AP054	**Strategy, Advocacy and Policy Development** • Positioned IFRC strongly on the COVID-19 global health ecosystem through a number of high level engagements including: IFRC President & UN Secretary General joint statement on "people's vaccine"; SG attendance to the UN Security Council Meeting • Coordinated advocacy and policy positions with the Members of the Reference Group on Global Health ensuring membership's full ownership of IFRC health agenda. • Organized a meeting on digital health in humanitarian settings as part of the Lancet Financial Times Commission on Digital Health. The meeting brought together digital health and humanitarian experts from several countries to discuss the future of this critical agenda and to provide recommendations for the Commission.		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
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	Partnership and Resource Mobilisation • IFRC won a tender to establish the Cholera Country Support Platform with financing from the Gates Foundation • IFRC, in coordination with WHO and UNICEF, established the Collective Service for Risk Communication and Community Engagement, attracting financing from the Gates Foundation • IFRC was reconfirmed as the host of the Alliance for Malaria Prevention partnership and received additional funding from various donors. • Old partnership with critical donor like USAID and CDC were further strengthened during COVID times, bringing additional large contributions to the		
AP076	**Coordination and convening of partners around insecticide-treated net (ITN) campaign and continuous distribution:** • **AMP Annual Partners Meeting:** The AMP annual Partners' meeting took place on 30 and 31 January 2020, with some 140 participants, including from 14 malaria-endemic countries. The number of participants from malaria- endemic countries (including local implementing organizations) amounted to 34 per cent of all participants, exceeding malaria-endemic country representation in the past three years. • **Maintenance of global ITN campaign tracker:** With increased need for visibility of globally planned ITN campaigns and potential bottlenecks for their planning and implementation, a global ITN campaign tracker was established and updated on a biweekly basis. The tracker was used to identify bottlenecks and communicate these to technical and financial partners to seek resolution. Details were presented to partners during regular meetings. As of mid-January 2021, despite the extraordinary circumstances of the pandemic, an impressive 74 per cent of planned ITNs were successfully distributed in 2020, amounting to 162,233,048 ITNs across 31 countries. • **Chairing of WHO Malaria/COVID-19 taskforce for vector control commodities and supplies -** AMP chaired the ITN/IRS taskforce under the WHO COVID-19 Malaria Workstream for commodities and supplies throughout 2020 and will continue in the role in 2021. Calls with technical, funding and procurement partners were organized weekly (later monthly) and a risk register was developed and circulated to the leadership of WHO and partners for action around critical bottlenecks that could affect sustaining global gains in the fight against malaria. **Development of operational guidance and case studies for better practices:** • **Non-COVID-19 guidance –** While COVID-19 operational guidance consumed most of the year, work continued to complete guidance related to planning and implementation of process evaluations, considerations for effective training and storage of ITNs in containers.		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
		Q2	Q4
	• **COVID-19 guidance -** From March 2020, AMP worked with its global partners, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), the World Health Organization (WHO), the RBM Partnership to End Malaria and the US President's Malaria Initiative (PMI), to rapidly develop initial guidance and recommendations for countries to adapt their ITN campaign strategies to the new COVID-19 context. Subsequently, funding received from the Global Fund allowed for intensive focus on developing guidance for COVID-19 adaptations across thematic areas (strategy, macroplanning, microplanning, social and behaviour change, logistics and supply chain management, data collection, supervision and M&E, etc.) - https://allianceformalariaprevention.com/tools-guidance/covid-19-pandemic/. All guidance developed was translated into French and Portugues, with many documents also made available in Spanish. **Technical assistance for mass and continuous ITN distributions:** • In the course of 2020, AMP technical assistance providers (TA providers) provided 113 technical consultations in support of 26 countries with ITN campaigns. Of the 99 technical consultations provided to African countries in 2020, almost 70 per cent were conducted by TA providers based in Africa, reflecting AMP's continuing commitment to mentor and build a cadre of ITN campaign experts based on the African continent. In 2020, more support was provided outside the African region than in previous years. **Resource mobilization and new partners:** • Bill and Melanie Gates Foundation: In the course of 2020, AMP secured a three-year grant focused on improving ITN campaign efficiency. This work is part of a global movement to more effectively use resources across health programmes using campaign-style delivery strategies. The grant will focus on seven areas identified as priorities by national malaria programmes and their partners and will fund 2.5 positions (two based in Nairobi and one in Geneva) to support the project. • Integrated Vector Control Consortium: As a core partner of the UNITAID-funded New Nets Project, developed to ensure rapid introduction of new ITN technology to address increasing insecticide resistance, funding was provided to AMP for one staff, based in Geneva. • Global Fund: As part of global efforts to ensure that the majority of the planned 225 million ITNs were distributed, AMP received funding to accelerate development of operational guidance for campaign COVID-19 adaptations and ensure its rapid translation into French, Portuguese and Spanish.		

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AP107	**HIV** IFRC is engaged with UNAIDS, in consultation with its 11 co-sponsor organizations to work on a progress report on HIV/AIDS in migrant and mobile populations, as well as refugees and crisis-affected populations. The aim is to provide an update on progress made in the implementation of the AIDS response for those populations since the 2018 Report of the NGO Representative ''People on the Move – Key to Ending AIDS'', in 40 priority countries identified. The NGO Delegation at the UNAIDS Programme Coordinating Board (PCB) prepares a report annually on some area of the AIDS response that needs a higher profile, a more focused policy perspective and a clearer sense of intention and agreement across the UN Joint Programme on HIV/AIDS. This report, expected to be finalized in June 2021, will shed more light on current needs, vulnerabilities, cross-cutting issues affecting mobile populations, presenting best practises, interventions from many different actors on the field and recommendations for the future. Additional information was sought via outreach to countries, civil society, UNAIDS Cosponsors, IFRC, IOM and other actors in the fields of mobility and HIV in the form of questionnaires disseminated through UNAIDS and IFRC regional, cluster and country offices and responses received are numerous. Countries are selected in terms of many factors, such as magnitude of crisis, numbers of migrants and refugees on the ground, presence of focal points, equal representation for different regions, etc. World AIDS day 2020 A ''Webinar to commemorate World Aids Day 2020'' was held on 1st December 2020, organized by the Asian Red Cross and Red Crescent HIV and AIDS Network (ART), the European Red Cross and Red Crescent Network on HIV and Tuberculosis (ERNA), the Red Cross and Red Crescent Network on Substance Abuse and IFRC Health and Care Department. Many examples of interventions and best practices were share from various National Societies around the world. The discussion highlighted common contextual factors and aspects of the risk environment that contribute to the spread of HIV, as well as the importance to focus on vulnerable communities and key populations and their sexual partners, such as people who inject drugs, people in prison and detention settings, migrant communities, etc. The gender factor was also addressed, recognizing the need to target the root causes of sexual and gender-based violence and put an end to gender discrimination. The need for a strong community-led, human rights-based response		

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	was recognized as a key way forward, taking into consideration current constraints imposed by the COVID-19 pandemic. **Substance abuse** The Rome Consensus 2.0 was launched at the 63rd Commission on Narcotic Drugs of UNODC as a multi-partner initiative to promote humanitarian drug policies. The new Consensus seeks to build upon the first Consensus, broadening it out for new signatories from around the world, and providing a reference model for best practices on humanitarian drug policy for the coming decades. Establishing a wider alliance among various actors working in the field and reaching the most vulnerable communities is the goal of this new initiative, reinforcing the Red Cross/Red Crescent Societies' mission, while facilitating access at the community level, and introducing new and more effective ways of working to serve humanity. In the end, it is designed to bring together Civil Society Organizations, leaders, experts and public authorities from across the world to explore ways to effectively combine humanitarian attitude in health, criminal justice, prevention and community responses to addiction. A series of meetings were organized in order to raise awareness, starting from 2020, during a High-level Side Event together with UNODC, WHO, Italian Government, and all the Co-Founders. In this context, The Rome Consensus 2.0 alliance presented a virtual side event at the United Nations 64th Commission on Narcotic Drugs on April 16th, 2021: "Moving beyond the divisions in order to develop humanitarian drug policies: the role of the Rome Consensus 2.0 initiative". The session discussed the issues addressed in the Manifesto, especially on how both programmes and politics can and must overcome the false dichotomies between harm reduction, prevention, treatment and recovery. Best practices from the field were also shared in order to highlight the crucial role of community health workers and volunteers in humanitarian assistance by tackling drug disorders with a health-centered approach, by reducing the harm and stigma at community level, and facilitating the access to treatment.		
AP108	**Care in Communities:** • To scale up the evidence based community health programming using a task shifting and life course approach, a number of tools have been developed with exensive consultation with National Societies, IFRC, ICRC and external stakeholders to support the Membership. These include but are not limited to: the RCRC Network Care in Communities guidelines for National Red Cross Red Crescent Society staff and volunteers; a Joint WHO, UNICEF, and IFRC community based guide for essential health services during COVID-19; CORE group (15 NSOs,		

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	Civil society and IFRC) home-based care reference guide for COVID-19 for community based health workers and volunteers, which has been finalized, published, and disseminated in all 4 IFRC languages as well as Russian. The IFRC Community Health Team worked with IFRC regional and field offices and other actors like WHO and UNICEF, amongst others, to reach staff and volunteers of National Societies and IFRC Offices with the materials through a series of webinars. **Online MOOC e-Learning course for home-based care and support in the context of COVID-19** in English and German launched in partnership with the Austrian Red Cross. **Healthy ageing:** • **Interim guidance for RCRC NSs on working with older people during COVID 19** developed with RCCE, PGI, and IFRC Regional office for Europe. Available in English, Arabic, French, Spanish and Russian languages on all IFRC platforms. The guidance was disseminated through **Interactive webinar on "Working with Older People during COVID-19"** A couple of Webinars conducted for the Asia Pacific, Europe, and Americas with IFRC regional office health & care, PGI, RCCE/CEA and **Global Red Talk on Healthy ageing and COVID-19** organized with Singapore, Serbia RC presenting what their NSs are doing and experiences from an older female volunteer from the Swedish RC • Continued providing technical support was provided to healthy ageing and NCD care and support community-level projects to NS in different regions. • **WHO Steering committee of the Core Group to Combat Ageism:** The IFRC continued working as the WHO's Steering committee member of the Core Group to Combat Ageism. The steering committee aims to develop the vision, goal, and principles that will guide the global campaign to combat ageism in different contexts (i.e. Political, economic, social, technological, legal, and environmental factors likely to have a bearing on the campaign at the international level). • Worked with WHO and 20 other organizations to develop **IASC guidance on the MHPSS needs of older people during COVID-19** as part of a larger guidance document focusing on the MHPSS needs of vulnerable groups. **Non Communicable diseases:** • **IFRC network NCD vision, framework, operational priorities for all contexts (i.e. development, emergencies, and humanitarian crises):** the process to revise and update the existing IFRC NCD vision, framework, and the operational components and priorities for the RCRC Network for all settings (development, emergencies, and protracted crises/ fragile settings). Also initiated the process of developing evidence-based care in communities service delivery packages for community-based management of NCDs and the IFRC position		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
		Q2	Q4
	paper on the role of NS volunteers working as community-based health workers in early diagnosis and screening of NCDs. • **Online eLearning courses on Healthy lifestyle for NCD prevention and control** have been developed and launched in English on the IFRC learning platform. **First Aid:** • Developed and finalized the documents for the **International first aid attestation** process with GFARC. the documents have been finalized after the pilot testing was conducted through a project completed with NS in China, Lebanon, Italy, Costa Rica, and Tanzania. • Developed and launched 3 online courses: **First Aid for Babies and Children, FA for Adults, and FA for older people** on the IFRC e-learning platform. An additional module on first aid considerations for COVID-19 has been developed and included in each course. • **Review of the Global First Aid Reference Centre (GFARC)** was jointly conducted by the IFRC and FRC and completed in February, facilitated by Quartenaire, an independent review, an audit firm. **MHPSS:** • **Roadmap for implementation of Movement wide MHPSS policy and International conference Resolution** adopted at the statutory meetings in 2019 have been finalized with extensive consultations with IFRC different departments, field offices, NS, IFRC PS Center, and ICRC. **The purpose of this roadmap is to help to strengthen the Movement's collective response to mental health and psychosocial needs, in line with these commitments.** • **A series of webinars and online trainings** have been launched to disseminate the movement policy, international conference resolution in multiple languages and to scale up and reach as many staff and volunteers to provide evidence-based community health care including MHPSS services. • A Framework for Mental Health and Psychosocial Support in Radiological and Nuclear Emergencies developed by WHO in close collaboration with IFRC technical experts, OECD NEA, and National Nuclear agencies was launched. **Challenges:** Covid restricted travels, increased number of online meetings		
AP129	**The Collective Service** is a collaborative partnership between the International Federation of Red Cross and Red Crescent Societies (IFRC), United Nations Children's Fund (UNICEF), and the World Health		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
		Q2	Q4
	Organization (WHO), which leverages active support from the Global Outbreak Alert and Response Network (GOARN), and key stakeholders from the public health and humanitarian sectors. It was launched in June 2020, after being endorsed by the Inter- Agency Standing Committee Principals in April 2020. For more information see our website: www.rcce-collective.net. The aim of the Service is to ensure that the strengths of all partners are supported and leveraged to deliver the greatest impact, and to bring together a wide range of organizations involved in RCCE policy, practice and research to provide practical support to those delivering on the ground. Over the last year, all involved in the Service have worked hard to turn this vision into reality, working particularly through dedicated capacity in the hubs established at global and regional level (two regions covered in Africa so far). Significant achievements in those seven months include: **1. We have strengthened common, coordinated approaches which are needs- based and data-driven** • We have established one global Collective Service Secretariat and two regional coordination hubs in West and Central Africa (led by UNICEF) and in East and Southern Africa (led by IFRC) with dedicated coordination, social science, risk communication and information management staff. • We engage regularly over 50 partners globally and regionally through different mechanisms including biweekly calls and regular webinars. According to feedback, 74 per cent of participants found this service 'very useful' particularly the access to partners and resources, and the ability to keep up-to-date on operational information. In the Africa hubs, 100 per cent of partners report that membership of the group benefits their organization. • We have developed and launched the RCCE Global Strategy (Dec. 2020-May 2021), engaging a range of stakeholders in the process. This evidence-based strategy, grounded in community-led approaches, is informing regional and national strategies. • We have strengthened an integrated and coherent approach to RCCE by improving the links between social science and humanitarian coordination structures, including the IASC Results Group Two on Accountability		

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		Q2	Q4
	and Inclusion and social science networks (e.g. Social Science in Humanitarian Action (SSHAP) and SONAR Global). • We have advocated for communities to be central to the roll out of new vaccines, treatments and tests (e.g. 10 steps to community readiness). **2. We have strengthened common, coordinated approaches which are needs- based and data-driven** • We have developed a COVID-19 behaviour change framework with key indicators for RCCE to measure social changes at the population level. This will enable consistent and comparable socio-behavioural data sets, enabling more effective measurement of social and behavioural drivers now and in the future and streamline data collection. • We have developed an online questions bank (available in English, Spanish, French and Arabic) to facilitate the collection of quality data, drawing on existing methods and tools. This tool is informing data collection processes of regional and global partners. • We have contributed to defining the RCCE social science research agenda as well as strengthening and amplifying the use of community feedback, social listening insights, and infodemic data to inform policy and programming (e.g. WHO social listening platform). • We have produced global and regional analyses to identify social-behavioural trends, barriers and enablers (including on vaccines) and supported countries with research design, dissemination, and operationalization of research findings. • We have compiled operational social science approaches, tools, guidelines, and training resources to support the collection, analysis and use of social and behavioural data. **3. We have improved the quality and consistency of RCCE approaches** • We have supported horizontal exchange of experience, sharing of community engagement standards, best practices and knowledge through hosting regular webinars and the global RCCE knowledge hub (www.rcce-		

P&B Output (AP code)	Progress	Red/Amber/Green Status	
		Q2	Q4
	collective.net), a collection of resources, guidance, case studies and data, and dedicated regional libraries (e.g. https://coronawestafrica.info) • We have improved the availability of data from community feedback mechanisms, social listening platforms and polling and survey to ensure community knowledge, risk perceptions, beliefs and needs systematically and regularly inform better decision making and targeted strategy. • We have scaled up regional partnership with media and launched biweekly media webinars to address community feedback on issues from concerns around health service continuity to vaccines. • We have established global, regional and country level partnerships with faith-based leaders to engage with communities and adapting the Six Global Guidelines for Religious Leaders to cover a comprehensive range of topics and ways to approach communities through faith-based work. • We host biweekly global webinars as part of WHO's Information Network for Epidemics (EPI-WIN), bringing together global, regional, and country RCCE experts to share latest information, best practices and emerging challenges engaging over 56,000 participants, from 149 countries and territories until December 2020. **4. We have improved the quality and consistency of RCCE approaches** • We have supported horizontal exchange of experience, sharing of community engagement standards, best practices and knowledge through hosting regular webinars and the global RCCE knowledge hub (www.rcce-collective.net), a collection of resources, guidance, case studies and data, and dedicated regional libraries (e.g. https://coronawestafrica.info) • We have improved the availability of data from community feedback mechanisms, social listening platforms and polling and survey to ensure community knowledge, risk perceptions, beliefs and needs systematically and regularly inform better decision making and targeted strategy. • We have scaled up regional partnership with media and launched biweekly media webinars to address community feedback on issues from concerns around health service continuity to vaccines. • We have established global, regional and country level partnerships with faith-based leaders to engage with communities and adapting the Six Global Guidelines for Religious Leaders to cover a comprehensive range of topics and ways to approach communities through faith-based work.		

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	• We have worked closely with the African Infodemic Response Alliance (AIRA), a WHO-led partnership of public health and communication and educational organizations to better coordinate regional efforts in managing infodemics during health emergencies. We partner to develop and amplify actionable, credible and timely information and shape evidence-based community engagement strategies. • We host biweekly global webinars as part of WHO's Information Network for Epidemics (EPI-WIN), bringing together global, regional, and country RCCE experts to share latest information, best practices and emerging challenges engaging over 56,000 participants, from 149 countries and territories until December 2020.		

3. Progress against targets

Refer to the M&E plan attached to the operational plan and provide on progress against the relevant indicators.

#	Indicator	Indicator Planned	Indicator Actual	Comments	Red/Amber/Green Status	
					Q3	Q4
	Contribute to increasing access to WASH services for vulnerable populations.	3.5 M people	1.0 M people	Reduced by covid pandemic.		
	Contribute to increasing access to appropriate MHPSS services for vulnerable populations.	5 million	9 million	Includes Covid 19 and regular programming		

4. Financial Situation

Refer to the financial report and comment on the income and expenditure situation.

P/G/C Code	Income	Expenditure

G00040	*The budget was fully covered*	*Expenditure in line with approved budget*
G00041	*Income was sufficient to cover all planned and increased activities*	*Expenditure in line with approved budget*
G00185	*Income was sufficient to cover all planned and increased activities*	*Expenditure in line with approved budget*
G00212	*Income was sufficient to cover all planned and increased activities*	*Expenditure in line with approved budget*
G33100	*Income was sufficient to cover most of the planned activities, while others were pushed to early in 2021 due to the pandemic*	*Expenditure in line with approved budget*
G33500	*Income was sufficient to cover all planned and increased activities*	*Expenditure in line with approved budget*
G33501	*Income was sufficient for planned WASH Unit requirements.*	*Expenditure was in line with validated budget (no over or under expenditure).*
G00401	*Income was sufficient to cover all planned and increased activities*	*Expenditure in line with approved budget*
G00425	*Income was sufficient to cover all planned and increased activities*	*Expenditure in line with approved budget*

Click here to go directly to the financial report.

5. Learning

Please list any major learning points from the reporting period. Make sure to provide hyperlinks to the reports, studies you are referring to.

Source or event that prompted the learning	Key learning points	Owner/contact
Covid Pandemic reinforced WASH needs in pandemics and epidemics.	WASH in relation to Infection Prevention and Control (IPC) activities such as provision of hand washing facilities and consumables; hygiene and dignity kits; disinfection materials and guidance; PPE for target populations and staff\volunteers; safe disposal of medical waste including sharps as vaccination efforts increase. Guidance and tools developed and translated. On-line COVID - WASH training facilitated for Europe and other regions and playlist created in the eLearning platform with more than 1600 learners from different regions.	WASH Unit Geneva. Wash.geneva@ifrc.org

Source or event that prompted the learning	Key learning points	Owner/contact
	The Global MHM and WASH network Community of Practice continues to be an effective platform for sharing resources and experiences between many internal and external partners (500 members and 1600 members). Everyone is welcome to join! IFRC MHM global case study collection from 8 RCRC National Societies was developed and uploaded at the IFRC WASH website. This learning document is a collection of experiences that capture key results and lessons learnt from different National Societies' MHM work. A webinar series (5) was launched to present the compilation of global menstrual hygiene management experiences.	
Health for migrant's interactive guide	During 2020, the International Federation of Red Cross and Red Crescent Societies initiated the development of a ''Practical Guidance for Red Cross and Red Crescent on Health and Care for Migrants'', intended to be a resource for National Societies seeking to implement or enhance healthcare for migrants.	Lasha Goguadze
Addressing Substance Abuse	Online training for Red Cross and Red Crescent Societies on Substance Abuse was launched on IFRC's learning platform. The training is available in different languages. It provides basic knowledge to Red Cross Red Crescent staff and volunteers how to plan and implement activities addressing needs of People Who Use Drugs.	Lasha Goguadze

6. Upcoming events

Date	What	Where	Recommended participation