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Emergency Plan of Action Operations Update:

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

International Federation of Red Cross and Red Crescent Societies

One International Appeal n° MDRCD026	**GLIDE n°** EP-2018-000049-COD
EPoA update n° 3; date of issue: 7 December 2018	**Timeframe covered by this update:** 6 months
Operation start date: 21 May 2018	**Operation timeframe:** 12 months, end date 21 May 2019
Overall operation budget: CHF 9,143,195	**DREF amount initially allocated:** CHF 216,168
N° of people to be assisted: 800,000 people (134,000 households)[1]	
Red Cross Red Crescent Movement partners currently actively involved in the operation: International Federation of Red Cross and Red Crescent Societies (IFRC), International Committee of the Red Cross (ICRC), French Red Cross, Canadian Red Cross, Swedish Red Cross, Spanish Red Cross	
Other partner organizations actively involved in the operation: Ministry of Health, WHO, UNICEF, MSF, Oxfam, PVH, SAD Afrique, AMEF, ASEBO, MND, Action Humanitaire, EPSP, Hygiene Frontière, IMC, ALIMA, IRC, Caritas	
Summary of Major Revision to the EPoA This operation updates seeks a three-month extension of the operational timeframe (new end date 21 May 2019) to ensure alignment with the Ministry of Health (MOH) and the WHO National plan for the Response to the Ebola virus disease epidemic.	

A. SITUATION ANALYSIS

Description of the disaster

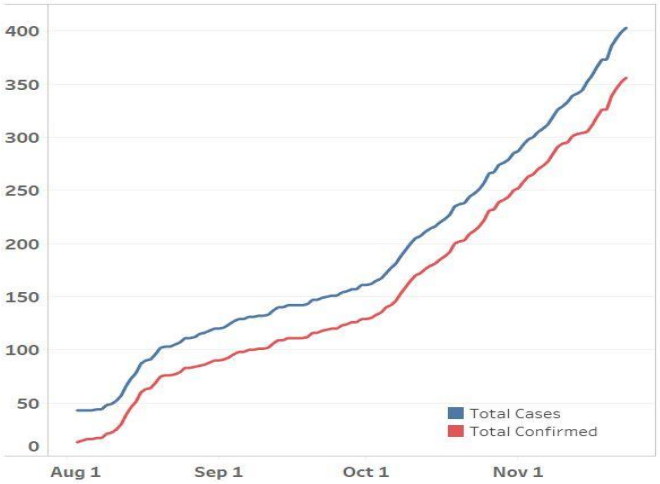
On 8 May 2018, the Ministry of Health (MoH) of the Democratic Republic of the Congo (DRC) officially declared a new outbreak of Ebola virus disease (EVD) in Equateur province, the 9th outbreak in the country's history. The two affected health zones within Equateur Province (Bikoro and Iboko) were remote with limited communication and transportation infrastructure. The third affected health zone, Wangata, was more urban and included the capital of Equateur province, Mbandaka, which is an important port city with over 1.5 million inhabitants and active transportation connections to the Republic of Congo, Central African Republic (CAR), and Kinshasa.

Red Cross Safe and Dignified Burials team, DRC
Photo by DRC RC/Communications Department

[1] The average household size is 6 people

Since the declaration of the 9th outbreak, 54 cases of the Ebola Virus Disease (EVD) were registered, including 38 confirmed cases. 33 persons died during this epidemic including two health personnel while 21 people survived. The 9th epidemic was declared over on 25 July 2018 after 42 days (two incubation periods) without a new confirmed case[2]. However, shortly after, on 1 August and some 2,500km from Equateur, a new cluster of EVD cases were detected and confirmed in North Kivu resulting in the declaration of the 10th EVD outbreak in DRC's history. The EVD cases were reported in Mabalako Health Zone, Beni territory in North Kivu province, where four samples collected from patients suffering from an 'unknown disease' tested positive for the virus. After a confirmed case on the 13th of August, Ituri Province was also included in the viral infection outbreak. To date, nearly 412 EVD cases[3] (365 confirmed and 47 probable) have been registered, including 236 deaths, resulting in a global Case Fatality Rate (CFR) 57%. The epicenter of the epidemic, initially in the town of Mangina, moved after three months to the much larger and more densely populated city Beni, which now accounts for 51% of the confirmed cases. An alarming trend is also registered in Butembo area, where the number of confirmed cases keeps increasing. To date, 14 health Zones in North Kivu and Ituri provinces have reported – confirmed or probable – cases, and the global numbers of cases are steadily on the rise.

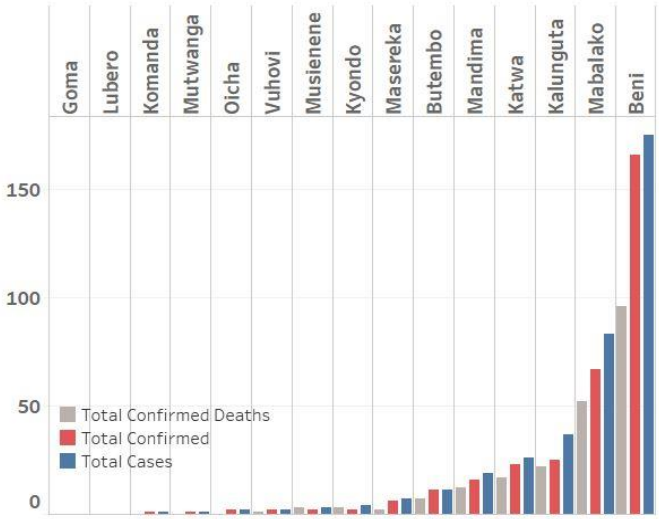
Figure 1 Number of cases since start of the outbreak



With 8 million inhabitants, North Kivu is one of the most densely populated provinces of the country. It is home to many who have been displaced by the conflict and shares borders with both Uganda and Rwanda. As such, cross border movements due to trade and other activities are frequent. North Kivu is also the site of a long-standing active military conflict with several armed groups present, creating a very volatile security situation and restricting access to several areas. Furthermore, poor road conditions in North Kivu and Ituri, coupled with a prolonged rainy season, largely renders roads impassable from September to January, which hinders humanitarian access and forces heavy reliance on air transport[4].

The presidential, provincial and legislative elections, set to take place in December 2018, represent further hazards to the already taense political climate and are expected to exacerbate the already high level of insecurity in the region[5].

Figure 2 Number of cases per Health Zone



Summary of current response

Overview of Host National Society

9th Outbreak - Equateur

Since the declaration of the outbreak, the DRC Red Cross has been coordinating its activities with the Ministry of Health. In-country IFRC personnel provided the necessary technical support and together with the National Society, deployed pre-positioned Personal Protective Equipment (PPE) kits to the affected areas and trained volunteers on Ebola awareness, surveillance, Safe and Dignified Burials (SDB) and disinfection procedures. On 12 May 2018, the IFRC

[2] https://au.int/en/pressreleases/20180726/statement-chairperson-african-union-commission-end-ebola-outbreak-democratic
[3] DRC Ministry of Health daily Sitrep ; Situation épidémiologique dans les provinces du Nord-Kivu et de l'Ituri – 26 Novembre 2018
[4] ACAPS; DRC: Ebola outbreak in Nord Kivu. Available at:
https://www.acaps.org/sites/acaps/files/products/files/20180807_acaps_start_briefing_note_drc_ebola_nord_kivu_0.pdf
[5] https://reliefweb.int/sites/reliefweb.int/files/resources/2018_07_forecast.pdf

allocated CHF 216,168 from its Disaster Relief Emergency Fund (DREF) for immediate response and, together with the National Society, developed a three-week plan of action. The responses in Equateur continued for 11 weeks until the outbreak was declared over on July 25. The IFRC and DRC Red Cross' intervention beyond this was primarily dedicated to the transition to early recovery in order to ensure the sustainability of the response and maintain Community Based Surveillance (CBS) mechanisms.

As of October 30, the Equateur operation has its main coordination structure in Kinshasa and in Mbandaka. To ensure an efficient response two field offices have been established in Itipo and Bikoro.
During the emergency phase of the response (8 May – 25 July 2018) the following achievements have been reached:

- **228,421** people reached through the response to the 9th outbreak
- Training of **300** volunteers in different areas including 163 in CEA and Ebola sensitization, 108 in SDB and disinfection techniques, and 29 in PSS.
- **36** Safe and Dignified Burials conducted
- Support to **13** health centres and hospitals in Mbandaka with Infection Prevention and Control and capacity building activities

In addition, preparedness activities and contingency planning in Kinshasa and the four neighbouring provinces of Equateur were implemented to ensure an adequate EVD response in case of a possible outbreak or spread of the diseases in these areas.

The transition phase in Equateur
When the EVD emergency response period came to an end, all stakeholders decided that a 3-month transition phase was necessary to ensure sustainability of the intervention in the affected communities. Following an MoU signed between IFRC and WHO, the implementation was granted an amount of CHF 1,706,140 to strengthen capacities of the existing health system through reinforced community-based surveillance (CBS) in target communities.
The implementation plan also consists in building capacities of the MoH to carry out IPC (Infection Prevention and Control) activities in 5 key pre-identified Health Zones at high risk of contamination. In these areas, 5 new triage facilities will be built and equipped with proper IPC kits in compliance with WHO standards. They will be installed in the Hospitals of Mbandaka, Wangata, Ntondo, Iboko and Bikoro and works are expected to start the 3rd week of November 2018.
Moreover, the transition phase includes the maintenance of other important programmes, such as Community Engagement and Accountability (CEA) and Psychosocial Support (PSS) for Ebola survivors and affected communities in order to fight stigma, discrimination and trauma associated with Ebola false beliefs and rumours.

Table 1: People Reached through CEA and PSS activities (Aug-Oct. 2018 Equateur)

Pillar	Men	Women	Boys	Girls	Total	Households
CEA	1,640	1,948	2,202	2,396	8,186	1,327
PSS	340	408	446	534	1,728	328

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

10th Outbreak - North Kivu & Ituri
Immediately after the announcement of the 10th epidemics, staff and equipment from the 9th outbreak in Equateur were quickly deployed to North Kivu and Ituri provinces to support the response.
As of 5 August, several Safe and Dignified Burials (SDB) teams were operational on the ground and had the relevant equipment's and logistics support to respond.
Currently, the Movement in North Kivu and Ituri provinces has 5 operational bases located in Beni, Mangina, Bunia, Butembo and Tchomia with the main operational hub in Beni, where the overall coordination of the operation is taking place.
An IFRC support and liaison office has also been set in Goma with help from the ICRC. Due to security constraints for maintaining international staff in Beni, the Goma office hosts several support functions as needed that can operate from Goma with short terms visits to the operational areas. This office is also supporting the communication, coordination and logistics components of the ongoing response.

In total over 30 International staff, 13 National Society staff and more than 400 volunteers are currently working for the EVD response operation. Each sectoral pillar of the RC response has a NS focal points, branch coordinators and volunteers responding to the outbreak. The ICRC also deployed a dedicated team composed by 4 International Staff and over 25 Resident Staff to allow an important scale up of the EVD response.

To date, **21 SDB teams (12 Red Cross, 9 Civil Protection) are fully operational in Beni, Mangina, Bunia/Tchomia and Butembo, with 194 volunteers trained**. Several trained SDB teams are also in place in Goma and Mambasa for preparedness in case of diseases spillover. The number of SDB teams is dynamic and in line with the evolution of the outbreak.

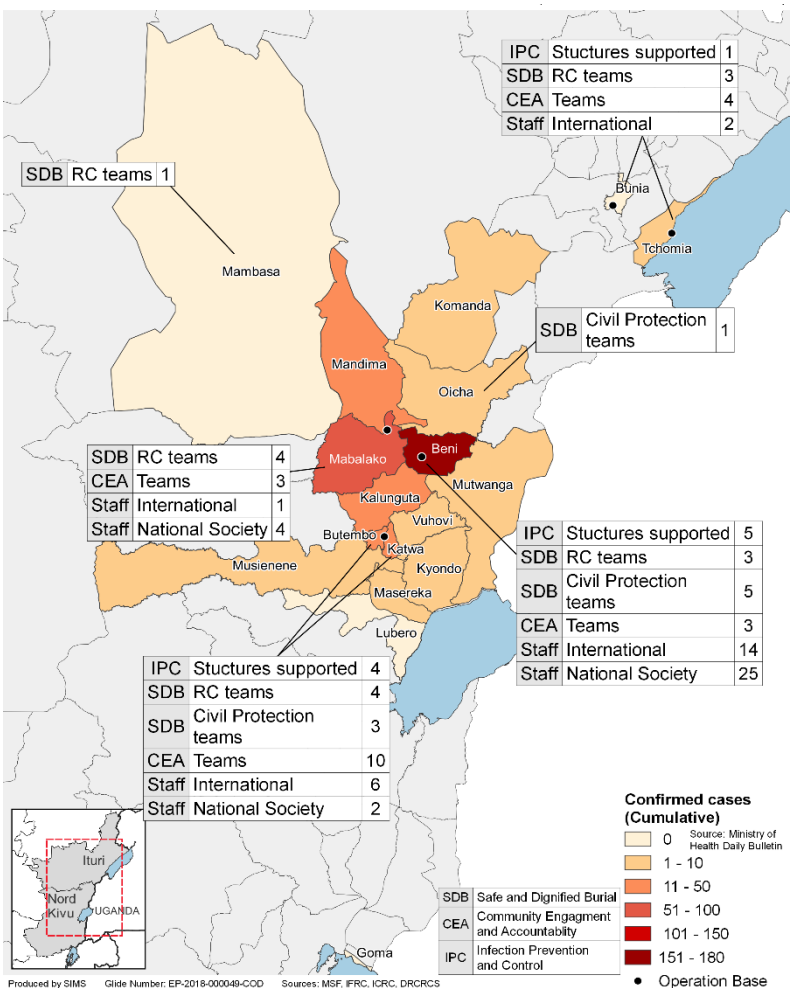
As of 26 of November **573 (or 85%) successful SDBs were conducted**, 35 (or 5%) were incomplete and 42 (or 6%) of them were unsuccessful due to security conditions or population's resistance to welcome SDB teams. SDBs were conducted by both, DRC RC teams and by the Civil Protection. Indeed, Civil Protection teams have been trained to respond to SDB in areas where Red Cross cannot access due to security constraints and when the movements of the Red Cross are limited.

In total, Red Cross has trained 9 SDB teams among the Civil Protection. 5 teams were trained in Beni, 3 in Butembo and 1 in Oicha and 4 additional teams (2 Red Cross and 2 Civil Protection) will be formed in Butembo by late November.

Community engagement approaches are also a key part of the SDB approach and trainings have been provided to SDB teams. A member of each SDB team is dedicated to engaging with families and communities during an SDB.

Red Cross has also trained more than 400 community volunteers to do risk communication and community engagement activities in Beni (from 17 health areas), Mangina (from 8 health areas), Butembo, Bunia and Oicha (town). A community feedback system to keep track of community beliefs, questions and suggestions has been established and **as of 26 November more than 13,000 complaints, feedback and rumours were registered through this mechanism.**

Figure 3 Movement Presence in North Kivu and Ituri



Produced by SIMS, Sources: MSF, IFRC, ICRC, DRCRC.
The maps used do not imply the expression of any opinion on the part of the International Federation of Red Cross and Red Crescent Societies or National Societies concerning the legal status of a territory or of its authorities.

In terms of IPC at health facilities, IFRC has supported 5 Health facilities in Beni (trainings, provision of structures like pre-triage, triage, isolation area, incinerators depending on the Health Facility), and supervised the implementation of protocols. 5 additional facilities have been identified for support according to needs expressed by the IPC commission in Beni. In Butembo, 3 health facilities have been supported (one of them is a hospital) with same services as above. 4 additional facilities are planned to be supported. IPC work in health facilities have been implemented with the support of the Canadian Red Cross through provision of key IPC materials. Thanks to the support of the ICRC, IPC activities are also being carried in 3 detentions sites in Beni and 2 In Butembo.

Furthermore, since September 2018, the PSS pillar has been focusing on targeted interventions such as focus group discussions, self-support groups led by local practitioner psychologists.
To date, 110 SDB volunteers from Beni, Mangina and Butembo have been reached through PSS activities.
To reinforce the PSS pillar and to ensure an active and effective presence, 12 PSS focal points have received a specific training on Psychological First Aid (PFA) in emergency and risky settings and already more than 200 volunteers from the 5 Operational bases have been exposed to PFA concepts and practices.

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

The Red Cross of the DRC (RCDRC) is present in all provinces and territories of the country. While the response for the 9th outbreak in the non-conflict area of Equateur was carried out under the co-leadership of IFRC and RCDRC, the 10th outbreak, being in a conflict area, is under ICRC lead for operational access, including security management. This was confirmed during a Mini-Summit held on 02 August in Kinshasa. For this new epidemic and due to the specificity of the location, the IFRC and the ICRC developed together a joint approach where clear roles and responsibilities have been agreed upon through multi-level and daily coordination.
The ICRC has a deep understanding of the affected area, and has had an office in Beni since 2008, allowing it to help communities affected by armed conflict and violence.

Several Movement coordination mechanisms have been put in place at provincial level (Equateur, North Kivu and Ituri), national (Kinshasa) and headquarters level (Geneva) between the DRC RC, the IFRC and the ICRC in order to ensure smooth implementation of the different activities. Tripartite meetings are also regularly organised in Beni for operational and strategic discussion.

Overview of non-RCRC actors in country
There are currently more than 60 national and international organizations (including local authorities) involved in the ongoing response in North Kivu and Ituri provinces. These organizations are active in one or more of the following components of the response: coordination; surveillance, communication, prevention, case management, psycho-social support (PSS), laboratory, logistic, vaccination and information management. The Ministry of Health leads the general coordination of the response (called “riposte”) supported by WHO and other partners. WHO is directly involved in implementation of IPC support, surveillance, PSS support to families and investigation of suspected cases. MSF, IMC and Alima are also active in the treatment of Ebola in affected areas. Oxfam and UNICEF are active in Risk Communication and community engagement and IPC.

The response strategy at field level is established around 11 different commissions and the DRC RC, with support of the IFRC, is actively engaged in 4 of them (SDB, Prevention, Communications, PSS) to ensure the Movement engagement with partners and to contribute to the operational strategy. Moreover, the Movement has successfully advocated for the creation of an SDB sub-commission to ensure essential visibility to the SDB component within the overall response and enhance coordination with other key commissions involved in the SDB process. In addition, ICRC represents the Movement response in the Strategic Committee held on a daily basis in Beni. Participation is also ensured in all Humanitarian Country Team (HCT) meetings held in Kinshasa.

The Movement is also well included in the National Strategic Response Plan with a recognized prominent role in risk communication and community engagement, SDB as well as IPC at community and/or health facility level, and detention sites.

Needs analysis and scenario planning

Needs analysis
The 9th EVD outbreak took place in three health zones in Equateur province (Wangata, Bikoro and Iboko). Approximately 2 Million people reside in the health zone (which includes the city of Mbandaka with a population of 1.5 million). Surveillance, contact tracing, infection prevention and control, capacity building in health facilities, risk communication, social mobilization and community engagement, psychosocial support and safe and dignified burials were identified as needs which informed the Red Cross response planning for Equateur. The planning process in Equateur was proportionally guided by the extent of the epidemics and the needs in the field.

As part of the global Response Strategic Plan, together with other partners, IFRC’s implementation focused on strengthening Infection Prevention and Control (IPC) measures in selected health facilities in Mbandaka and Bikoro. IFRC also led the Safe and Dignified Burials (SDB) activities in these zones. Community surveillance mechanisms were implemented as well. These two major pillars were complemented by cross-cutting PSS and CEA interventions.

Given the high number of health zones involved, the 10th outbreak is recorded as having the largest geographic spread in the history of EVD outbreaks in DR Congo. Mabalako health zone (Mangina) was initially the most affected area, in the following months the epidemic epicentre shifted to Beni and Butembo, several cases were reported in Ituri, Mandima, Komande and Tchomia. Some cases were also registered in Oicha, Kalunguta and Masareka (NK).

In North Kivu and Ituri provinces the access restriction in several affected areas, the so called "no-go areas", along with community resistance represent the two major hinderances of the emergency operation affecting greatly the reach and the coverage of the programmed activities. Limited knowledge of EVD within the population and among health personnel remains the main source of community resistance.

According to the findings of recent community surveys, awareness about EVD risks and prevention has increased, however Butembo still registers very low level of knowledge with women being relatively less informed. Llimited is also the knowledge about the Ebola Treatment Centre (ETC) and what to do in case a person presents symptoms, is sick or dies under suspicious circumstances. Further, fewer are informed about the outbreak situation and state of the response, which is critical to build trust and overall knowledge. There are key sociocultural, political and economic issues that are fuelling the epidemic and hindering community engagement efforts. In particular, the socio-political context in the affected areas is influencing how the EVD is perceived by communities.

To inform the operation, the Red Cross has established a community feedback mechanism that captures essential community information related to Ebola. By regularly gathering and analysing community beliefs, observations, questions and suggestions using an interdisciplinary approach and novel tools, field teams and decision-makers are provided with useful insights that inform risk communication and community engagement approaches across the response.

Some of the main findings relate to community mistrust against the government and organizations engaged in the EVD response but also highlights the community willingness to understand more and protect themselves.. To further undermine trust and cohesion there is the misperception of the role played by key actors of the response in contributing to the EVD propagation. This creates a fertile ground for rumours and misinformation in the community. In fact, first findings[6] suggest that Ebola is strongly perceived to be a political scheme to affect the election or as a lucrative business. At the same time, the risk of instrumentalization[7] of the outbreak and the response in advance of the upcoming elections is greatly undermining the quality and scale of the EVD response action.

Doubts and concern are also raised against the vaccination program and safe and dignified burials. Communities consistently demonstrate their need for comprehensive information that goes beyond the repetition of basic messaging. They demand more information about vaccines, Ebola effects and outcomes and the more broadly about the operation.

In terms of health facility needs, several FOSA (Formation Sanitaire) have limited infrastructure and materials for standard medical examination and triage. Several health workers have been infected because of lack of proper knowledge, equipment and tools. It is also common to have poor surveillance in health facilities and to mistake EVD for Malaria or other diseases. Infection and Prevention Control (IPC) and training of staff is therefore an important activity to detect the suspected cases early and to limit the spread of EVD from one patient to the other or from the patient to the medical personnel.

The Movement has identified Safe and dignified burials (SDB) as key activity for the response of the Outbreak in North-Kivu and Ituri provinces. Red Cross, and more lately Civil Protection members trained by the Red Cross, are the only actors operating in this sector. In urban areas like Beni and Butembo, both Red Cross and Civil Protection SDB teams are highly operational. Civil Protection teams have played a critical role in SDB activities in high-risk areas, which complements the ongoing RC SDB response.

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

[6]Th Red Cross feedback system where the Red Cross has been able to collect over 30,00 feedback between August and November 2018 Rapid qualitative analysis performed with the support the Centres for Disease Control and Prevention (CDC)

[7] IFRC DRC – Ebola Red Cross community feedback system: - "Ebola does not exist, it's a political scheme", "Ebola has been created by humanitarians to benefit the employees.", "The vaccine leads directly to death." Etc.

Scenario planning

9th Outbreak

Following the official declaration of the conclusion of the EVD 9th outbreak, the intervention strategy changed, and priorities were re-oriented towards recovery and preparedness.

While 3 scenarios[8] were envisaged during the initial emergency planning, scenario one ''No other case of EVD is reported'' prevailed. The current planning and intervention focus on Post EVD transition phase and its characterized by a significant downward scaling of the activities and the phasing out of several actors involved in the response. Community surveillance, risk communication, PSS, WASH and IPC activities will be maintained under the transition phase in Equateur at least for 90 days beyond the official period of End of Ebola.

10th Outbreak

For the ongoing outbreak in North Kivu and Ituri, the situation is highly concerning. In line with the context analysis, the current scenario is of a geographically contained outbreak with high risk of spread, with new cases confirmed on a daily basis and some without clear epi link combined with deteriorating security situation and severe access constraints (scenario 1 below). It is expected that the number of cases will continue to increase in the coming days and weeks. However due to the lack of clear epidemiological and demographic data with cases reported without clear epidemiological link, it remains difficult to estimate the full scope of this 10th outbreak.

Considering the risk of the spread of the outbreak regionally; National Societies, including Uganda RC, Rwanda RC, South Sudan RC, and Burundi RC have engaged in national level preparedness activities, including surveillance on cross-border population movement and updating contingency plans. Surge support to Uganda, South Sudan, and Burundi is currently underway. Additionally, as the risk of spread within DRC and neighbouring provinces is high, the operation will engage in preparedness, contingency planning and risk communication activities in neighboring provinces within DRC to prevent further extension of the outbreak to communities.

Scenario analysis for North Kivu and Ituri Provinces

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

SCENARIO	ASSUMPTIONS	KEY ELEMENTS OF RESPONSE
Scenario 1	✓ Outbreak is contained to Mabalako, Beni, Bunia and Butembo Heath Zones and potentially single cases in other neighbouring HZ. ✓ Cases continue to be reported for the next 2-3 months but still many suspected cases turn out negative ✓ Risk of potential spread of cases to neighbouring provinces but PoE control is working effectively able to detect suspected cases reducing the risk. ✓ Security situation allows continuity of response ✓ Timeframe 6 months	✓ Movement interventions focus on 5 key pillars in North Kivu and Ituri provinces ✓ Movement coordination is led by ICRC under its operational modalities, including logistics and security ✓ Security situation allows effective response despite access constraints ✓ Close coordination with partners across all pillars for an effective response ✓ Increase logistics and material supplies to support the operational plan ✓ Maintain the support/liaison office in ICRC Sub-Delegation of Goma for the IFRC ✓ Increase HR structure to support the operational plan ✓ Volunteers mobilised and trained for effective response ✓ Communities are engaged and provided with needed information, messaging is tailored to beliefs, concerns and questions tracked by community engagement volunteers ✓ Preparedness/ contingency planning activities by DRC RC in Health Zones at risk as security allows as well as nationally ✓ Preparedness activities by National Societies of the neighbouring at risk countries with population movement/ transportation links with affected area ✓ Legal preparedness through IDRL and advocacy to facilitate the entrance of international humanitarian assistance ✓ Flexibility and revision of the plans as needed based on the evolution of the epidemic ✓ Anticipation of the next phase with preparation of a Transition & Preparedness Plan

[8] The 3 scenarios were: (1) No other case of EVD is reported, (2) One or several cases of EVD are reported from a remote site and (3) One or several cases of EVD are reported from a larger urban center such as Mbandaka.

Scenario 2	✓ Major surge in cases in N Kivu and Ituri in several HZs including insecure areas with access restrictions ✓ Appearance of cases in urban centres (including Goma) ✓ Spill over to neighbouring provinces ✓ Spill over of cases to neighbouring countries ✓ A Public Health Emergency of International Concern is declared as the number of cases increases weekly, exceeding 500 and cases reported regionally ✓ Timeframe 12 months	✓ Revision of operational plan to scale up in all pillars in affected areas in close coordination with ICRC RCDRC and IFRC and still under the lead of ICRC for operational modalities ✓ Scale- up from preparedness to active response in neighbouring affected provinces and neighbouring countries ✓ Scale-up of offices in each affected province ✓ Deployment of further surge to support the operation at provincial, national level and regional level ✓ Establishment of Regional Ebola Hub ✓ Training and mobilizing additional volunteers from all targeted areas ✓ Communities are engaged and provided with needed information, messaging is tailored to beliefs, concerns and questions tracked by community engagement volunteers ✓ Close coordination with other stakeholders ✓ Revision of the OIA and EPoA ✓ Adding case management as new pillar for response as needed ✓ Increase of supply chain and logistics capacity to match the size of the operation ✓ Prevention and Preparedness activities in additional at-risk provinces and additional at-risk countries (regional) ✓ Regional legal preparedness to facilitate the coordination of international humanitarian assistance ✓ Flexibility and revision of the plans as needed based on the evolvement of the epidemic.

Operation Risk Assessment

The operational risk assessment for the Movement EVD response in DRC is assessed as **high** given the geography and types of activities to be carried out. Learnings from the 2014 Ebola operation in West Africa are being applied to this response planning and operational risk assessment to enhance mitigation measures. Equateur Province is reasonably stable in comparison to other areas in the country. However, the security situation in North-Kivu and Ituri is volatile and unpredictable.

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

In addition, the high prevalence of rumours and misinformation linked to Ebola outbreaks has affected how communities perceive and respond to Red Cross staff and volunteers, which can increase the risk of violent incidents. In Butembo, a team of the Red cross was attacked and injured in October (Press Release), and two Congolese health workers supporting response were killed on 20 October.
Additionally, the security situation could deteriorate with the upcoming presidential elections planned for the 23rd of December. Analysis and scenarios planning are ongoing to ensure risks are well taken into consideration and measures developed to mitigate their impact on the operation.

As part of the response; the Movement is implementing activities with different risk levels. Many of the activities carry low level risk like RCCE and IPC support whereas SDB process carries the highest risk if not performed correctly. Based on this, the operation has developed a risk management strategy for security and biohazard risks. This includes multi-scenario planning with security and health triggers, and related evacuation protocols for ensuring safety of personnel. In addition, the operation developed an internal risk register to prevent fraud and corruption. Risk mitigation measures are being identified and implemented along with the operational activities of the operation

Moreover, a Business Continuity Plan has been designed to define the main strategic and operational priorities as well as the minimum set-up throughout the end of the year/beginning of new year. This period will be characterised by two important factors with distinctive impacts: the Christmas season, normally highly correlated with a significant increase of the criminality rate, and the provincial and national election set to take place on the 23rd of December.
Such factors combined with the already volatile and precarious security context in North Kivu is leading to a change of the set-up. In line with the ICRC strategy, the IFRC will review its current set-up and restrict field trips while ensuring sustainability of the activities and the continuation of the EVD response.

B. OPERATIONAL STRATEGY

Proposed strategy

The proposed strategy supports preparedness, response, and national society development action in two distinct geographic areas—Equateur province and North Kivu and Ituri provinces—to address critical humanitarian needs associated with the 9th and 10th outbreaks of the Ebola Virus Disease in the Democratic Republic of Congo. Within 3 months, DRC RC has faced two major Ebola epidemics, which highlights the need to scale up response efforts but also invest in the longer-term capacity building of the DRC RC to respond to these crises in the future. The Red Cross response plan is for 12 months, with most response activities in Equateur being already implemented and the activities in North-Kivu and Ituri ongoing (and potentially scaled up). This is aligned with the MoH and WHO operational timeframe for North Kivu.

B. Operational strategy

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

- ✓ Reinforcing the DRC RC response for immediate lifesaving interventions in the affected areas
- ✓ Roll out prevention and response activities in the affected and at-risk areas
- ✓ Coordinated response with the authorities/Ministry of Heath, WHO and other key actors
- ✓ Engaging the affected people throughout the entire process
- ✓ Strengthening the capacity of the National Society to respond to epidemics

9th Outbreak
Since 1 August 2018, the operation in Equateur has been engaged in the planning and implementation of the Post Ebola transition phase. The aim of the transition phase is twofold: (1) to strengthen capacities of the health system in IPC and CBS and (2) maintain a proper preparedness mechanism through Risk communication (CEA) and PSS to affected communities. In this regard, IPC focuses on the construction and equipment of 5 triage facilities, plus training of medical staff who run the IPC facilities in 5 health zones of Equateur. At the same time, CBS will focus on maintaining surveillance of community diseases in the same health zone. Implementation of surveillance will be conducted by 30 well trained individuals composed of 60% Red Cross volunteers and 40% medical staff from the MoH. CEA, IPC, PSS and Surveillance activities will also continue through dedicated support staff in Equateur.

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

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

- Setting up a multidisciplinary team to respond to epidemics in line with the activities outlined in the various pillars
- Strengthening capacities for efficient and transparent management, including training on financial management systems
- Improving the DRC RC offices in Bikoro, Itipo and Mbandaka
- Improving the DRC RC offices in North Kivu and Ituri (durable refurbishment for essential office structures)
- Training National Society teams in Mbandaka on warehousing (procedures and protocols) and on procurement procedures

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

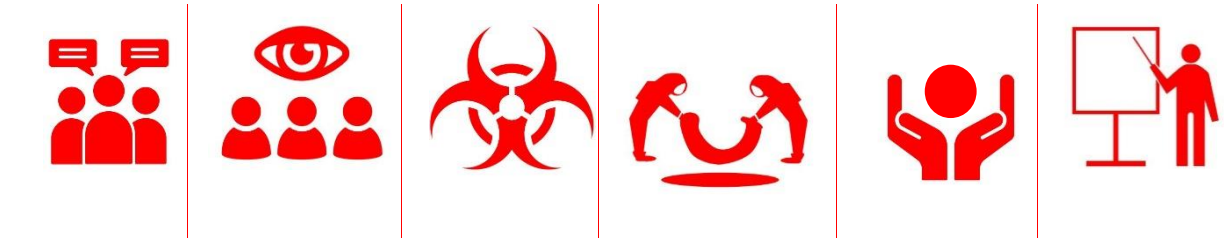
10th Outbreak
The Movement plan for the response to the 10th Outbreak is in line with the Revised National Strategic Plan developed by the MOH[9] with support from WHO.
The response strategy is articulated around 13 axes: coordination mechanisms, surveillance, capacity building of mobile laboratories, establishment of points of control, reinforcement of prevention measures and infection control, risk communication - social mobilization and community engagement, psychosocial care, support to the gratuity of health services, preparation of health zones and provinces adjacent to the epidemic outbreak, operational support and logistics, food distribution and security of human and material resources acquired for the response.
Essential activities refer to:

- Detection of all suspected cases and take samples for biological confirmation;
- Identification and contact tracing;
- Organization of medical treatment and psychosocial care (including food security vulnerabilities);
- Reduction of transmission within the communities;
- Reinforce infection prevention and control measures;
- Increase surveillance in all Health Areas, taking into consideration displacements;
- Risk communication, social mobilization and community engagement: to ensure a better understanding of risks and engagement of communities to ensure ownership and inform effective response and control approaches;
- Vaccination of exposed and at-risk people (heath personnel, contacts, etc.);
- Support treatment of malnutrition.

The Movement is well included in the National Response Plan with a recognized prominent role in risk communication and community engagement, SDB as well as IPC at community and/or health facility level, as well as detention sites.

Specific objectives and outcomes

The overall strategy combines five response pillars, and one pillar related to NS capacity building and preparedness for epidemic response. With two EVD outbreaks within three months, there is a crucial need for a longer-term approach that consists in building the capacity of the communities and the DRC RC:



1. Risk communication and Community engagement

Community engagement is essential at all stages of epidemic preparedness and response and is integrated across all aspects of the operations in Equateur, North Kivu and Ituri. Trusted, clear and effective risk communication and engagement approaches are critical to ensure the distribution of correct and relevant information in order to prevent fear, panic and rumours to undermine the response efforts. Community engagement is supporting the operation to gain an insight into the perceptions and behaviours of different groups, to develop effective and targeted messaging as well as to make informed programmatic changes. It is important to note that community engagement works in support of all pillars and is mainstreamed in the activities of all volunteers, with a special emphasis on SDB activities. Through various

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

tools and approaches, risk communication and community engagement can promote inclusive dialogue with affected communities, ensuring their adherence to preventive measures while supporting better preparedness and resilience for future crises.

Community resistance to changes of entrenched socio-cultural practices, in particular burial practices or consumption of bush meat, fuelled by mistrust in the government, have been hindering prevention and control efforts and could cause future outbreaks. At the same time, rampant rumours circulating within communities are causing considerable resistance to prevention and containment efforts. Risk communication and community engagement efforts therefore adopt a two-pronged approach, through enhancing understanding about the Red Cross and its EVD response activities while continuing to communicate risks, promote healthy behaviours and scale up community participation in the response.

In North Kivu and Ituri, the risk communication and community engagement interventions continue to be scaled up as the outbreak spreads. More than 360 volunteers have been trained in Community Engagement and Accountability (CEA) and activities are carried out in Beni, Mangina, Bunia, Tchomia and Butembo. Those volunteers are visiting households in their communities, providing them with information about Ebola and its prevention. In addition to household visits, mass sensitization, focus group discussions, community meetings, mobile cinemas, interactive radio shows as well as the use of social media reinforce everyone's participation in awareness-raising efforts and facilitate interactions with all the structures within the villages. Influencers in the communities are identified and targeted, such as community and religious leaders, women's and youth groups as well transportation providers and motorcyclists. Community power structures are considered and vulnerable groups such as pigmy communities and handicapped people targeted specifically. Volunteers in the off-limit health zone of Oicha have been trained to conduct mass sensitization activities as well as household visits of minority groups. ICRC efforts in supporting the CEA activities focuses on sensitization of armed and security forces and contributes to mass-sensitization activities and Community leaders' sensitization.

Tracking the perceptions and information needs of communities ensures that households in the most affected areas have access to relevant and useful information, their questions are answered, and messaging is tailored to the current[10] beliefs and concerns. For this purpose, a community feedback mechanism has been established and feedback from communities is collected systematically during household visits and mass sensitization activities. This community feedback is being analysed and shared internally as well as with partners, informing both programmatic decisions and messaging. Working with local volunteers is essential for making sure that all activities are accepted and in line with local practices and customs.

The 9th epidemic response in Equateur has entered a transition phase, with a focus on the development and systematic usage of standardized approaches, including data collection and reporting tools for community engagement activities and development of standardized training packages tailored to disease prevention activities. Diversified approaches have been adopted and are implemented in targeted areas, including adapting sensitization tools to local realities and needs, using key informants to reach people and influence their ways and practices.For example an anthropological study will be commissioned to research the cultural customs and believes of the Batwa population in Equateur. Response efforts are also being extended to localities and villages that were not affected but remain exposed to the outbreak.

2. Surveillance and Active case finding

At the start of the 9th outbreak operation, volunteers were encouraged to alert if they encountered any unusual community illness or community deaths during their community-based risk communication and community engagement activities. Now for the transition and preparedness phase in Equateur, focus has shifted to support the MoH's community-based surveillance program in health areas throughout four health zones which are most in need of reinforcement, and where the DRC RC has trained volunteers. The approach will rely on a cascade training in the field. In Equateur the Red Cross is currently in discussions with the MoH and WHO to conduct joint surveillance trainings which will be supplemented by Red Cross-specific trainings (e.g. CEA and ECV) for those not already trained. The cascade training would involve Master trainers conducting training of trainers for the Health Area-level supervisors and branch management structures, who would in turn train the community-level volunteers.

As a result of the challenging security situation in North Kivu and Ituri, surveillance and active case finding are not part of the Movement's response strategy for the 10th outbreak. However, the Red Cross Movement is supporting affected communities by providing alert numbers and by verifying the compliance to the alert process.

[10] Evidence from the previous epidemics shows that local practices and believes are not static but shift and evolve in response to immediate conditions.

3. Infection Prevention and Control (IPC) and triage

IPC is crucial in containing the spread of EVD. Robust IPC measures and practices need to be in place at all health facilities. IPC aims to stop the spread of infectious diseases to other patients as well as health care workers by rapid isolation of suspected cases; creation of isolation areas that ensure correct patient flow and keep suspect patient away from others seeking usual care; and availability of appropriate facilities and materials for hand washing, waste management, cleaning and disinfection as well as PPE for health workers. It is also important that facilities have trained staff in triage and early detection of suspected EVD cases.

For the 9th epidemic in Equateur, 13 facilities have been supported through the set-up of temporary triage facilities, improving IPC measures and the training of 920 health personnel in the Equateur province. These activities were mainly implemented by the ERU HR focusing on IPC/Triage at the facility level. One triage center will be constructed and equipped in Bikoro referral hospital A similar approach has also been taken by the ICRC at Mbandaka prison by ICRC.

For the on-going epidemic in North Kivu and Ituri IPC remains critical. IFRC, ICRC and the DRC RC are responding to IPC needs taking into consideration the Movement capacities, geographical evolution of the epidemic as well as the access constraints. As of October 18th, five health facilities in Tamende Health Area in Beni and two major hospitals and a health facility in Butembo have been supported by Movement IPC interventions. Additional health areas and facilities have been identified, as well as detention sites in which the IPC models and activities are planned to take place depending on the Movement capacities. ICRC will continue implementing IPC activities in detentions sites (Beni, Butembo and Bunia) as well.

ICRC will promote training and the use of personal protection equipment by surgical personnel of the hospital in N'Dosho (Goma). Likewise, it will provide support to hospitals in Grand Nord which refer wounded patients to Ndosho and Bikavu hospitals.

4. Safe and Dignified Burials (SDB) and disinfection

Traditional burial practices present high-risk of infection in EVD outbreak, as family and friends often wash and touch the corpse. The DRC RC SDB teams ensure that every aspect of burials, disinfection and decontamination is conducted in a safe and respectful way, considering cultural understanding and the sensitivity for families and communities at this difficult time. Highly trained DRC RC SDB and disinfection teams, in conjunction with community engagement and PSS volunteers, limit the spread of infection by conducting SDB and disinfection when needed and educating communities about the need for and processes behind disinfection and safe burials. Red Cross has been recognized as the main actor in safe and dignified burials by the authorities for both 9th and 10th *o*utbreak in DRC. Activities planned under this pillar will continue until the official declaration of the end of the 10th epidemic.

The IFRC has supported the training of a group of 108 SDB volunteers for the 9th epidemic. At the end of 9th epidemic in Equateur province, the DRC RC and the IFRC had 8 SDB teams: 2 in Mbandaka, 2 in Bikoro, 3 in Itipo and 1 in Iboko. One trained SDB team from Mbandaka with required materials was deployed to North Kivu at the beginning of the 10th outbreak as rapid response mechanism to respond to immediate SDB needs and support training of local capacity.

For the epidemic in North Kivu and Ituri, the IFRC and DRC RC use a complementary approach with the Civil Protection to ensure operational continuity in high security areas inaccessible by Red Cross teams. 21 operational SDB teams are present in Beni, Butembo, Mangina, Bunia and Tchomia. In addition, there are trained teams in Goma and Mambasa ready to be activated if need arises. Red Cross is supporting the capacity building of Civil Protection through training and provision of materials and equipment as needed. Trained Civil Protection teams will help to access areas which Red Cross cannot access due to security constraints, as well as to improve the reliability and speed of SDB. To speed up the intervention, the Beni sub-coordination requested all SDB teams to be based close to the BCZ (Health Zone Office). Instruction has been given to establish a platform to dispatch alerts between the Red Cross and the Civil Protection SDB teams. The aim is to ensure that SDBs are done even in the event of limitation of movements for the Red Cross team. In addition to the previous, Red Cross SDB rapid response teams are planned to be established with capacity to respond to SDB needs in potential new areas where no SDB capacity yet exists.

SDB is considered crucial part of epidemic response to prevent the transmission and will continue to be so even after the declaration of the end of the EVD outbreak. It is a key intervention strategy to effectively contain a new EVD outbreak in case it occurs. Thus, institutional preparation through discussions with the Ministry of Health (MoH) is planned to draft possible pre-agreement determining the roles and responsibilities of the DRC RC for future epidemics. This will give DRC RC a unique role in country during and after the epidemics as an auxiliary service to the MoH. The IFRC and ICRC support the DRC RC to establish a national response unit for the management of corpses in epidemics, including Ebola and other diseases with epidemic potential, and during disasters as part of the national multidisciplinary team. This

comes with an establishment and maintenance of a national contingency stock for the management of corpses in case of epidemics.

Even with the strategy of complementing the SDBs activities with Civil Protection, SDB Teams (both RC's and CP's) are still facing significant resistance from the communities and some areas are still off-limits. In this context and in order to reduce the risk of spreading of Ebola virus in hard-to-reach communities while performing burials, a new Community Based Approach is being developed. The approach consists in the training and provision of adequate material to inaccessible communities in order to enable them to perform harm-reduction burials. This Community Based Approach is essential to ensure that communities living in areas where RC SDB teams and CP SDB have limited or no access, are aware of the risks related to traditional burials and are equipped with adequate material to perform safer burials. Furthermore, the community element of this approach is useful and necessary not only to understand the specific needs of a community, but also to integrate them as part of the design and development of the response.

IFRC and ICRC will continue to contribute towards equipping areas for decontamination for operational SDB teams with tools and equipment. The IFRC and DRC RC are also looking at prepositioning knowledge and not only stocks. As a lesson learned from the response, the DRC RC is adapting its modalities to provide SDB to communities with specific needs or culture. Thus, IFRC aims to develop a guide on knowledge and practices on some specific communities, as well as to commission an Anthropological study on safe and dignified burials.

5. Psychosocial support

The DRC RC is working alongside the IFRC and other organizations to reduce the psychosocial impact of the Ebola Virus Disease on the affected communities and on the volunteers involved at various levels in the response but especially in SBD and CEA activities.For this reason, community volunteers who are in contact with families and communities with suspected Ebola cases or deaths are trained in supportive communication and psychological first aid. As SGBV prevalence has been proven to increase in contexts of emergencies, with additional strain being put on already weak health structures a training component on responding to the psychosocial needs of SGBV survivors is also integrated into the PSS pillar of the response. Alongside the training of volunteers, the coordination with other actors able to provide services for survivors will be strengthened to ensure the availability of referral pathways.

In North-Kivu and Ituri, MoH has the lead on supporting family and affected patient, therefore our activities will focus more on the support to SDB volunteers. Volunteers working in Ebola response and especially in high risk activities like SDB are under extreme stress and carry out some of the most high-risk tasks related to the outbreak and need support. It is critical teaching volunteers and staff about stress management and peer support, as well as setting up support systems to help them deal with their situation without engaging in risk-taking behaviour. Continuing and complementing the activities already being carried out during both EVD responses will mainly aim at strengthening National Society preparedness in the area of psychosocial support for them to be ready to better respond to subsequent epidemics. A team of trainers in psychosocial support will be set up within DRC RC and it will be able to carry out awareness activities and trainings for both the staff and volunteers involved in epidemics response, including EVD.

6. Cross-cutting: National Society capacity building and preparedness for effective response for the potential spread of current outbreak and future outbreaks

The risk of spread of current outbreak within DRC and neighbouring provinces is high. The operation is planning to engage in preparedness, contingency planning and risk communication activities in neighbouring provinces and strategic locations within DRC to prevent further extension of the outbreak to communities.

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

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

The capacity building includes the support to:

Knowledge transfer and learning	Infrastructure and equipment	Visibility and respect of the emblem
• Volunteer and staff capacity building activities • Leadership support and training • On the job training	• Improvement of branch office and equipment.	• Support for visibility materials • Organization of meetings to improve respect of the emblem. • Monitoring impact of SDB knowledge on community acceptance of RC action.

7. Protection, Gender and Inclusion

The IFRC as a principles-based and values-driven organization is inclusive of and engages with all members of society, with a priority for those most marginalized. It seeks to protect human dignity and promotes a culture of non-violence and peace. While responding Ebola Crisis, the IFRC utilizes the gender inclusive tools and guidance such as the Minimum Standard Commitments to Gender and Diversity, the IFRC Strategic Framework on Gender and Diversity issues, the Child Protection Action Plan and the Movement-wide Strategic Framework on Disability Inclusion. To ensure gender inclusive EDV response, IFRC undertakes following practical measures:

- Gender-balanced volunteer mobilization
- Collect, utilize and disseminate sex- and age-disaggregated data
- Gender and diversity concerns are considered across the assessment and intervention design and implementation with ensuring participation of women and girls and other vulnerable groups through community engagement approaches.
- During community consultations and awareness sessions, special effort is made to ensure women and people with disabilities are also included and feel comfortable to share their concerns and feedback
- The activity is implemented considering “do no harm” principles
- The protection activities endeavour to prevent family separation and are built in community mobilisation and support – with opportunities for women’s equal participation – to counter Ebola survivors stigmatisation and to assist in their integration into their communities. Close attention is also paid to the protection needs of children, women and girls in Ebola affected communities, building on the strengths and capacities of existing women’s and girls’ groups.

Protection

The ICRC continues its traditional activities around the armed conflict. It monitors the conduct of hostilities and the behaviour of the armed groups that could affect the Ebola responders (Health Care in Danger). Linked to other detainee’s population support activities: ICRC provides access to water, improvement of hygiene conditions, increase in cooking capacity and improvement of sanitation priority intervention of the Water and Habitat strategy. The following activities are planned:

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

Progress towards outcomes:

9th outbreak

Health Outcome 1: The immediate risks to the health of affected populations are reduced through awareness raising about EVD and early detections		
Indicators	Actual	Target
Number of Red Cross branches provided with support in addressing the Ebola Outbreak	4	7
Health Output 1.1: Improved early detection mechanisms of resurgence of Ebola through integrated community-based health interventions		
Indicators	Actual	Target
# of suspected cases detected by Red Cross community volunteers.	0	N/A
# of health areas covered by RC CBS activities	5	5
# of health areas respectively covered by RC case finding teams	6	6
# of community leaders trained on early case finding by RC	30	231
# volunteers trained on Ebola early case finding procedure	18	140
% of people reached by active case finding that belong to minorities and/or vulnerable groups	35%	65%
# of radio messages promoting active case finding behaviour change & use of Hotline	N/A	N/A
# of dissemination material made available in adequated support for blind and deaf people	N/A	N/A
Health Output 1.2: Social mobilization, risk communication and community engagement and accountability activities are conducted to limit the spread and impact of Ebola		
Indicators	Actual	Target
# people OR % target population reached with community engagement activities	266,490	N/A
# people OR % who are knowledgeable about recommended practices (based on KAP done with partners if any)	N/A	N/A
# of vulnerable people and/or minority groups reached by door-to-door sensitization	N/A	N/A
# of community engagement material made available in adequate support for blind and deaf people and minority groups	N/A	N/A
% of SDB volunteers trained on CEA	108	108
# of Ebola survivors and SDB families involved in our campaigns	324	324
% of questions raised on SDB during radio program out of the total questions raised	N/A	N/A
# OR % of staff and volunteers trained on community engagement approach	300	300
# of system/protocols in place to collect, analyse, verify and respond to community feedback received	3	5
# of complaints, feedback and rumours received, including per area of work	N/A	N/A
# of feedback received per area of work	N/A	N/A
# of teenagers (14-18 years old) engaged in community- based activities	N/A	N/A
Health Output 1.3: Identify and prepare communities to respond to the outbreak in potentially high-risk areas of the country		
Indicators	Actual	Target
# of new volunteers trained	N/A	N/A
# of people reached by community engagement activities	N/A	N/A
# of young people participating to focus groups/presentation on SDB	N/A	N/A
# of messages targeting vulnerable and/or minority groups during radio shows	N/A	N/A
# of refusals in door to door awareness activity	N/A	N/A
% of feedbacks (complaints, questions, suggestions) followed by concrete response	N/A	N/A
Health Outcome 2: Targeted health facilities with improved IPC practices and protocols to reduce infection of EVD		
Indicators	Actual	Target

Number of health facilities provided with RC support to improve IPC practices and protocols: 50	13	50
Health Output 2.1: IPC activities conducted in 50 targeted health facilities in affected zone or at-risk zone in Mbandaka, North Kivu and Ituri (20)		
Indicators	Actual	Target
# of local health facilities supported by IFRC and ICRC	13	18
# of assessments conducted based on IFRC standards	1	1
# of health facilites triage established	8	18
# of people IPC in detention sites carried by the ICRC	1	1
Health Output 2.2 The targeted heath facility staff have better capacity to provide safe patient care during EVD outbreak including triage, early detection of cases and early management		
Indicators	Actual	Target
# of volunteers and health practitioners trained in epidemic control	920	1000

Health Outcome 3: PSS The psychosocial effect of the epidemic is reduced through direct support for SDB volunteers and communities affected.		
Indicators	Actual	Target
Number of people reached by psychosocial support	266,490	266,490
Health Output 3.1: Preserving or restoring the psychosocial well-being of SDB volunteers directly or indirectly affected by the EVD		
Indicators	Actual	Target
# of group sessions conducted to reduce stress and anxiety for SDB team	60	60
# of volunteers trained for PFA	108	108

WASH Outcome 1: The spread of Ebola is limited by disinfection of affected houses and safe burial of the dead under optimal cultural and security conditions		
Indicators	Actual	Target
Number of contaminated houses/areas disinfected	248	600
Percentage of Safe and dignified burials carried out by an IFRC trained and equipped team out of the total number of SDB	44%	100%
WASH Output 1.1: The affected population is assisted through safe and dignified burial and decontamination activities		
Indicators	Actual	Target
# of implemented SDB	36	120
# of volunteers trained in infection prevention and control as well as in SDB	92	180
WASH Output 1.2: Other areas (potential Haemorrhagic fever affected) are well prepared (contingency) for SDB activities		
Indicators	Actual	Target
# od SDB trained in area at risk	N/A	N/A
# of SDB starter kit preposition in at risk area	N/A	N/A

10th outbreak

Health Outcome 1: The immediate risks to the health of affected populations are reduced through awareness raising about EVD and early detections		
Indicators	Actual	Target
Number of Red Cross branches provided with support in addressing the Ebola Outbreak	10	10
Health Output 1.1: Improved early detection mechanisms of resurgence of Ebola through integrated community-based health interventions		
Indicators	Actual	Target
# of suspected cases detected by Red Cross community volunteers.	0	0
# of health areas covered by RC CBS activities	NA	NA
# of health areas respectively covered by RC case finding teams	NA	NA
# of community leaders trained on early case finding by RC	NA	NA
# volunteers trained on Ebola early case finding procedure	NA	NA
% of people reached by active case finding that belong to minorities and/or vulnerable groups	NA	NA
# of radio messages promoting active case finding behaviour change & use of Hotline	NA	NA
# of dissemination material made available in adequate support for blind and deaf people	0	2
Health Output 1.2: Social mobilization, risk communication and community engagement and accountability activities are conducted to limit the spread and impact of Ebola		
Indicators	Actual	Target
# people OR % target population reached with door-to-door and mass sensitization activities	280.000	2.362.650
# of interactive radio shows	25	100
# people OR % who are knowledgeable about recommended practices (based on KAP done with partners if any)	85%	95%
# of vulnerable people and/or minority groups reached by door-to-door sensitization	300	1000
# of community engagement material made available in adequate support for blind and deaf people and minority groups	0	8
% of SDB volunteers trained on CEA	79%	100%
# of Ebola survivors and SDB families involved in our campaigns	33	50
% of questions raised on SDB during sensitization activities	4%	1%
# OR % of staff and volunteers trained on community engagement approach	82%	90%
# of system/protocols in place to collect, analyse, verify and respond to community feedback received	1	1
# of complaints, feedback and rumours received, including per area of work	13.398	120.000
# of teenagers (14-18 years old) engaged in community- based activities	6	20
Health Output 1.3: Identify and prepare communities to respond to the outbreak in potentially high-risk areas of the country		
Indicators	Actual	Target
# of new volunteers trained	In progress	220
# of people reached by community engagement activities	In progress	NA
# of young people participating to focus groups/presentation on SDB	In progress	NA
# of messages targeting vulnerable and/or minority groups during radio shows	In progress	NA
# of refusals in door to door awareness activity	In progress	NA
% of feedbacks (complaints, questions, suggestions) followed by concrete response	In progress	NA
Health Outcome 2: Targeted health facilities with improved IPC practices and protocols to reduce infection of EVD		
Indicators	Actual	Target
Number of health facilities provided with RC support to improve IPC practices and protocols:	9	13

Health Output 2.1: IPC activities conducted in 20 targeted health facilities in affected zone or at-risk zone in North Kivu and Ituri		
Indicators	Actual	Target
# of local health facilities supported by IFRC and ICRC	9	13
# of assessments conducted based on IFRC standards	16	30
# of health facilities triage established	9	13
# of IPC in detention sites carried by the ICRC	5	5
Health Output 2.2 The targeted heath facility staff have better capacity to provide safe patient care during EVD outbreak including triage, early detection of cases and early management		
Indicators	Actual	Target
# of volunteers and health practitioners trained in epidemic control	214	300
Health Outcome 3: PSS The psychosocial effect of the epidemic is reduced through direct support for SDB volunteers and communities affected.		
Indicators	Actual	Target
Number of people reached by psychosocial support	59	107
Health Output 3.1: Preserving or restoring the psychosocial well-being of SDB volunteers directly or indirectly affected by the EVD		
Indicators	Actual	Target
# of group sessions conducted to reduce stress and anxiety for SDB team	11	17
# of volunteers trained for PFA	12	12

WASH Outcome 1: The spread of Ebola is limited by disinfection of affected houses and safe burial of the dead under optimal cultural and security conditions		
Indicators	Actual	Target
Number of contaminated houses/areas disinfected	159	600
Percentage of Safe and dignified burials carried out by RC trained and equipped team out of the total number of SDB	86%	100%
WASH Output 1.1: The affected population is assisted through safe and dignified burial and decontamination activities		
Indicators	Actual	Target
# of implemented SDB	594	693
# of volunteers trained in infection prevention and control as well as in SDB	0	0
Wash Output 1.2: Other areas (potential Haemorrhagic fever affected) are well prepared (contingency) for SDB activities		
Indicators	Actual	Target
# of SDB teams trained in area at risk	4	4
# of SDB starter kit preposition in at risk area	0	3
PGI Outcome 1: Communities identify the needs of the most vulnerable and particularly disadvantaged and marginalised groups, as a result of inequality, discrimination and other non-respect of their human rights and address their distinct needs		
Inclusion and Protection Output 1.1: NS programmes improve equitable access to basic services, considering different needs based on gender and other diversity factors.		
Indicators	Actual	Target
Number of volunteers trained on the respect of gender and others diversity factors and the minimum Standard commitment.	0	200
Inclusion and Protection Output 1.1: NS programmes improve equitable access to basic services, considering different needs based on gender and other diversity factors.		
Indicators	Actual	Target
Number of people reached with the awareness raising on preventing and responding to SGBV in all community outreach activities.	0	NA

S1.1: National Society capacity building and organizational development objectives are facilitated to ensure that the National Society has the necessary legal, ethical and financial foundations, systems and structures, competencies and capacities to plan and perform.		
Output S1.1.4.: The National Society has effective and motivated volunteers who are protected.		
Indicators	Actual	Target
Number of volunteers involved in the operation who are motivated and protected	819	1000
Output S1.1.6: The National Society has the necessary corporate infrastructure and systems in place.		
Indicators	Actual	Target
# of people who can be served with the emergency stock prepositioned	0	50
# of DRC Red Cross volunteers trained in mobile phone-based data collection	3	100

S2.1: Effective and coordinated international disaster response is ensured.		
Output S2.1.1: Deployment of surge capacity		
Indicators	Actual	Target
Number of Surge people deployed to support the operation (disaggregated by area of specialization)	77	8
Outcome S.2.2: The complementarity and strengths of the Movement are enhanced.		
Output S2.2.1: In the context of large scale emergencies the IFRC, ICRC and NS enhance their operational reach and effectiveness through new means of coordination		
Indicators	Actual	Target
# of Movement meetings (tripartite meetings at provincial and national level, movement meetings at national level)	Twice a week on Provincial Level, Bimonthly national level	Twice a week on Provincial Level, Bimonthly national level
Outcome S3.1: The IFRC secretariat, together with National Societies uses its unique position to influence decisions at local, national and international levels that affect the most vulnerable		
Output S3.1.1: IFRC and NS are visible, trusted and effective advocates on humanitarian issues		
Indicators	Actual	Target
# of sub-commissions created and chaired by the NS	1	1
Outcome S4.1: The Movement enhances its effectiveness, credibility and accountability		
Output S4.1.3: Financial resources are safeguarded; quality financial and administrative support is provided, contributing to efficient operations and ensuring effective use of assets; timely quality financial reporting to stakeholders.		
Indicators	Actual	Target
Percentage of narrative reports submitted in time	99%	100%
Percentage of financial reports submitted in time	99%	100%

D. BUDGET

Disaster Response Financial Report

MDRCD026 - DR Congo - Ebola Virus Disease Outbreak

Timeframe: 12 May 18 to 21 Feb 19

Appeal Launch Date: 21 May 18

Interim Report

Selected Parameters			
Reporting Timeframe	2018/4-10	Programme	MDRCD026
Budget Timeframe	2018/4-2019/2	Budget	APPROVED
Split by funding source	Y	Project	*
Subsector	*		

All figures are in Swiss Francs (CHF)

I. Funding

	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Deferred Income
A. Budget			6,039,447			6,039,447	
B. Opening Balance							
Income							
Cash contributions							
Austrian Red Cross (from Austrian Government)*			*109,196*			*109,196*	
British Red Cross			*362,536*			*362,536*	
China Red Cross, Hong Kong branch			*25,500*			*25,500*	
Danish Red Cross			*100,000*			*100,000*	
European Commission - DG ECHO			*154,717*			*154,717*	
Icelandic Red Cross			*400,000*			*400,000*	
Japanese Red Cross Society			*89,554*			*89,554*	
Norwegian Red Cross			*48,173*			*48,173*	
Norwegian Red Cross (from Norwegian Government)*			*66,525*			*66,525*	
Red Cross of Monaco			*17,401*			*17,401*	
The Canadian Red Cross Society			*651*			*651*	
The Canadian Red Cross Society (from Canadian Government)*			*52,456*			*52,456*	
The Netherlands Red Cross (from Netherlands Government)*			*554,797*			*554,797*	
United States Government - USAID			*611,030*			*611,030*	*80,263*
WHO - World Health Organization			*1,531,692*			*1,531,692*	*1,815,233*
C1. Cash contributions			*4,124,229*			*4,124,229*	*1,895,497*
Inkind Goods & Transport							
The Canadian Red Cross Society			*10,018*			*10,018*	
C2. Inkind Goods & Transport			*10,018*			*10,018*	
C. Total Income = SUM(C1..C4)			4,134,248			4,134,248	1,895,497
D. Total Funding = B +C			4,134,248			4,134,248	1,895,497

* Funding source data based on information provided by the donor

II. Movement of Funds

	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Deferred Income
B. Opening Balance							
C. Income			4,134,248			4,134,248	1,895,497
E. Expenditure			-2,858,665			-2,858,665	
F. Closing Balance = (B + C + E)			1,275,583			1,275,583	1,895,497

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Budget Timeframe	2018/4-2019/2	Budget	APPROVED
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

III. Expenditure

Account Groups	Budget	Expenditure						Variance
		Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/ RC work	Joint working and accountability	TOTAL	
	A						B	A - B
BUDGET (C)				6,039,447			6,039,447	
Relief items, Construction, Supplies								
Shelter - Relief	465			465			465	0
Construction - Facilities	19,949			13,949			13,949	6,000
Construction Materials	10,715			10,715			10,715	0
Clothing & Textiles	651			651			651	0
Food	635			635			635	0
Water, Sanitation & Hygiene	528,027			43,665			43,665	484,362
Medical & First Aid	496,385			142,577			142,577	353,808
Teaching Materials	23,238			10,988			10,988	12,250
Utensils & Tools	4,222			4,222			4,222	0
Other Supplies & Services	9,528			9,528			9,528	0
ERU	417,664			22,664			22,664	395,000
Total Relief items, Construction, Sup	1,511,478			260,059			260,059	1,251,420
Land, vehicles & equipment								
Vehicles	65,627			29,627			29,627	36,000
Computers & Telecom	67,446			37,192			37,192	30,254
Office & Household Equipment	12,342			2,188			2,188	10,154
Total Land, vehicles & equipment	145,415			69,007			69,007	76,408
Logistics, Transport & Storage								
Storage	34,105			32,605			32,605	1,500
Distribution & Monitoring	24,974			46,094			46,094	-21,120
Transport & Vehicles Costs	542,001			254,147			254,147	287,854
Logistics Services	23,048			7,852			7,852	15,196
Total Logistics, Transport & Storage	624,128			340,698			340,698	283,430
Personnel								
International Staff	1,054,531			530,462			530,462	524,069
National Staff	111,424			88,224			88,224	23,200
National Society Staff	129,199			30,436			30,436	98,763
Volunteers	766,590			210,015			210,015	556,575
Total Personnel	2,061,744			859,137			859,137	1,202,607
Consultants & Professional Fees								
Consultants	15,008			15,008			15,008	0
Professional Fees	4,566			4,566			4,566	0
Total Consultants & Professional Fe	19,574			19,574			19,574	0
Workshops & Training								
Workshops & Training	285,598			61,164			61,164	224,434
Total Workshops & Training	285,598			61,164			61,164	224,434
General Expenditure								
Travel	347,493			334,841			334,841	12,652
Information & Public Relations	48,948			32,948			32,948	16,000
Office Costs	190,600			53,636			53,636	136,964
Communications	122,592			42,155			42,155	80,437
Financial Charges	37,836			13,054			13,054	24,782
Other General Expenses	24,568			13,768			13,768	10,800
Shared Office and Services Costs	127,876			85,346			85,346	42,531
Total General Expenditure	899,913			575,746			575,746	324,167
Contributions & Transfers								

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Budget Timeframe	2018/4-2019/2	Budget	APPROVED
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

III. Expenditure

		Expenditure						
Account Groups	Budget	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/ RC work	Joint working and accountability	TOTAL	Variance
	A						B	A - B
BUDGET (C)				6,039,447			6,039,447	
Cash Transfers National Societies				94,475			94,475	-94,475
Cash Transfers to 3rd Parties	102,852							102,852
Total Contributions & Transfers	102,852			94,475			94,475	8,377
Operational Provisions								
Operational Provisions				381,297			381,297	-381,297
Total Operational Provisions				381,297			381,297	-381,297
Indirect Costs								
Programme & Services Support Recov	368,229			172,975			172,975	195,254
Total Indirect Costs	368,229			172,975			172,975	195,254
Pledge Specific Costs								
Pledge Earmarking Fee	14,359			20,204			20,204	-5,845
Pledge Reporting Fees	6,156			4,327			4,327	1,829
Total Pledge Specific Costs	20,515			24,532			24,532	-4,016
TOTAL EXPENDITURE (D)	6,039,447			2,858,665			2,858,665	3,180,782
VARIANCE (C - D)				3,180,782			3,180,782	

Reference documents ↘

Click here for:

- Previous Appeals and updates
- Emergency Plan of Action (EPoA)

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

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For In-Kind donations and Mobilization table support:

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For Performance and Accountability support (planning, monitoring, evaluation and reporting enquiries)

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How we work

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

The IFRC's work is guided by Strategy 2020 which puts forward three strategic aims:

Save lives, protect livelihoods, and strengthen recovery from disaster and crises.

Enable healthy and safe living.

Promote social inclusion and a culture of non-violence and peace.