



Emergency Plan of Action Final Report

Democratic Republic of the Congo (DRC), AFRICA | Ebola Virus Disease epidemic

Appeal No: n° MDRCD026	Date of issue: 15 January 2024	Timeframe covered by this Report: 41 months (May 2018 –September 2021)
	Operation start date: 21 May 2018	Operation timeframe: 41 months (12 May 2018 –30 September 2021)
Glide No: EP-2018-000049-COD EP-2018-000129-COD EP-2020-000151-COD EP-2021-000014-COD	Funding Requirements: CHF 56 million Funding Coverage: CHF46,634,067 Total Income: CHF47,439,415 Expenditure: CHF48,437,409	DREF amount allocated: CHF800,000

Number of people assisted: 8,7 million people (target)

Red Cross Red Crescent Movement partners involved in the operation: In addition to the Democratic Republic of Congo Red Cross (DRC RC), the International Federation of Red Cross and Red Crescent Societies (IFRC), the International Committee of the Red Cross (ICRC), French Red Cross and other in-country partner National Societies (Belgium Red Cross, Spanish Red Cross and Swedish Red Cross) and other Partner National Societies who made financial contributions (American, British, Canadian, Finnish, Icelandic, Norwegian, Swedish, Swiss). The preparedness actions taken in Priority 1 Host National Society, namely Burundi Red Cross Society (BRCS), Rwanda Red Cross Society (RRCS), South Sudan Red Cross, Uganda Red Cross Society (URCS)

Other partner organizations actively involved in the operation: Alongside these Movement partners, other national and international organizations directly involved in the response to the Ebola epidemic include the Ministry of Health of the Democratic Republic of Congo, WHO, UNICEF, MSF, Oxfam, Personnes vivant avec Handicap (PVH), Soutien action pour le développement de l'Afrique (SAD Africa), AMEF, ASEBO, MND, Humanitarian Action, Ministry of Primary and Secondary Education (EPSP), Border Hygiene, IMC, The Alliance for International Medicine Action (ALIMA), IRC, Caritas, Mercy Corps, FHI 360, Africa CDC, CDC Atlanta, Foreign, Commonwealth and Development Office (FCDO formerly DFID), OIM USAID and the World Bank.

A. SITUATION ANALYSIS

Description of the disaster

Since the first epidemic of Ebola Virus Disease (EVD) identified in Yambuku province in 1976, until 30 September 2021 (the end of this operation), the Democratic Republic of Congo (DRC) had reported 12 epidemics of EVD. The epidemics have affected a total of 10 of the country's 26 provinces.

The Disaster and Red Cross Red Crescent response to date

8 May 2018: 9th EVD epidemic was declared by the DRC MoH in Equateur province which marked IFRC response in the country. Others Key dates for the 9th, 10th , 11th and 12 th epidemics can be found in [previous operation updates](#).

1 August 2018: 10th EVD epidemic was declared shortly after the declaration of the end of the ninth EVD epidemic in Equateur following cases confirmed in the Mabalako health zone in Beni territory in North Kivu province. Red Cross response teams from the 9th epidemic were immediately deployed to North Kivu.

21 August 2018: 2nd OIA Revision - response to the new EVD epidemic in North Kivu and continued with actions in Equateur.

28 September 2018: WHO revised its risk assessment for the epidemic and elevated the risk from high to very high

10 December 2018: IFRC issued a [6 Month Operation Update](#) extending the timeframe until 21 May 2019, to ensure alignment with the Strategic Response Plan (SRP).

17 March 2019: IFRC issued the [3rd OIA Revision](#) which scaled up operations in North Kivu and Ituri; and included epidemic preparedness in surrounding health zones; as well as epidemic preparedness in priority one countries.

19 July 2019: [4th revision of the OIA](#) - activities timeframe was extended to 21 February 2020

18 December 2019: [The OIA is revised for the 5th time to extend the timeframe to December 2020](#) and make provision for transition and recovery activities. Budget increases from CHF 43m to CHF 61m.

1 June 2020: 11th EVD epidemic declared: While the operation was preparing for a transition from the response to the recovery phase, new EVD cases were reported in the town of Mbandaka in Equateur Province, the same area that had experienced the 9th epidemic, and the DRC MOH declared an EVD epidemic (the 11th in the history of the DRC).

25 June 2020: End of 10th EVD epidemic: This epidemic infected 3,470 people and killed 2,287, leaving 1,171 survivors. This epidemic had a case fatality rate of more than 65%.

24 September 2020: [The OIA is revised for the 6th time to extend the timeframe to 30 June 2021](#) and Budget decreased from CHF 61m to CHF 56m

18 November 2020: End of 11th EVD epidemic declared by the DRC Ministry of Health. A total of 130 cases (119 confirmed and 11 probable) and 55 deaths were recorded since the beginning of the epidemic. IPC is being conducted in 11 locations including 9 health centres (FOSA), DRC RC premises and Mbandaka Prison. PSS for volunteers is also continuing.

7 February 2021: 12th EVD epidemic declared, the Minister of Health of the Democratic Republic of the Congo declared an epidemic of Ebola Virus Disease (EVD) after the laboratory confirmation of one case, an adult female was reported in Biena Health Zone in the territory of Butembo, North Kivu Province.

31 March 2021: [The OIA is revised for the 7th time](#) to extend the timeframe to 30 September 2021. This gave a minimum surveillance period required even if the transmission was quickly ended

30 April 2021: IFRC issued [the 9th Operation Update](#) to ensure alignment with the OIA strategy and showed achievements of Emergency Plan of Action Final

3 May 2021: End of 12th EVD epidemic declared by the DRC Ministry of Health. A total of 12 cases confirmed and 6 deaths were recorded since the beginning of the epidemic. This came just three months after the first case was recorded.



Figure 1: DRC Red Cross's Volunteers, getting ready to preform Safe and Dignified Burials (SDB)- Photo DRC RC

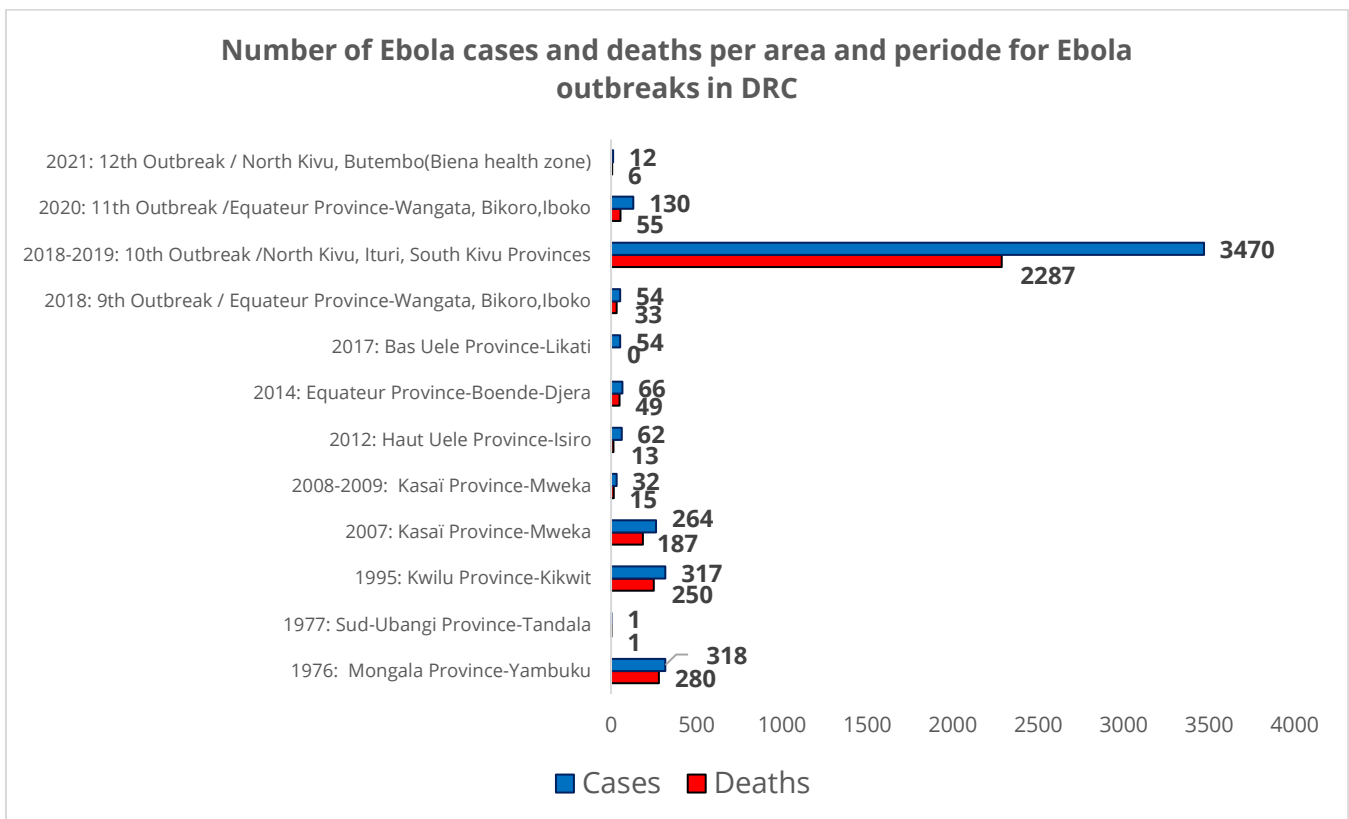


Figure 2: History of EVD in DRC

Summary of response

Overview of Host National Society

9th epidemic - Equateur

Key results achieved.



36 Safe and Dignified Burials were carried out and 70 households disinfected by Red Cross volunteers in Itipo, Bikoro and Mbandaka.



266,490 people reached with risk communication and community engagement sessions including in schools and religious sites



13 health centres and hospitals in Equateur supported with Infection Prevention and Control and capacity building activities, 920 health professionals and hygienists trained on IPC.

10th epidemic - North Kivu, Ituri and South Kivu

Key results achieved.



25,847 (88%) of the **29,357** SDB alerts have been completed successfully Safe and Dignified Burials teams including 32 Red Cross, 26 Civil Protection, 48 community-led harm reduction burial teams (ECUMR) trained by the Red Cross and 37 community burials teams trained by Civil Protection)



981 CEA volunteers have reached **3,993,291** of the target population with door-to-door and mass sensitization activities.

1,636,923 community feedback data points have been collected from community members, analysed and informed decision making across pillars. This is one of the largest feedback platforms developed by the Red Cross Red Crescent Movement in the world



55 health facilities have been supported with an IPC package, supervision, training. 333 volunteers have screened **4,909,533** people (23% under 18 years; 53% female), referred 1,450 suspected cases (86 cases were confirmed following the laboratory test), completed 2,204 decontaminations and trained more than 403 health care workers (including 222 women)



PSS teams have reached staff and volunteers with **91,451** participations through **11,155** PSS activities.

11th epidemic – Equateur

Key results achieved.



261 (56%) of the **465** SDB alerts have been completed successfully by Red Cross teams. The SDB teams carried out 282 swabs out of which 17 were tested positive.



528 CEA volunteers reached **290,160** people (58% under 18 years and 55% women) with door-to-door sensitization.

143,533 community feedback data points were collected from community members, analysed and used to informed decision-making across pillars.



9 health facilities were supported with an IPC package and **456,491** people were screened.



PSS teams implemented **2,992** activities that benefited both RC staff and volunteers.

12th epidemic North Kivu Key results achieved.



Red Cross teams received **239** SDB alerts, of which **224 (93,72%)** were successfully responded to



180 CEA volunteers reached **15,010** people during community mobilisation activities.



Assessment of **10 health facilities** and support with an IPC package in Biena, Katwa and Butembo and revival of hygiene committees

Overview of Red Cross Red Crescent Movement in DRC

+C IFRC



**CROIX-ROUGE
DE LA RDC**



ICRC

The Red Cross of the Democratic Republic of the Congo (DRC RC) is present in all provinces and territories of the country with an extensive and deep network of 209,000 active volunteers (2021) organised through 1,787 local branches. All activities within the framework of this Appeal were implemented in complete partnership with DRC RC.

The DRC Country Delegation of the 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 all epidemics.

Coordinated the response to epidemics through coordination with Disaster & Crisis Prevention, Response & Recovery and Health units including global surge mechanisms on human resources; support to the Operations team in Goma and information management activities as well as support of preparedness activities in RoC given the high risk of spill over. There was staff recruitment at regional level staff to support in planning, monitoring, evaluation, and reporting on the EVD operation, human resources, and other sectors like programs, logistic etc.

Four Partner National Societies (Belgium Red Cross, French Red Cross, Spanish Red Cross, and Swedish Red Cross) have long-standing programs with the National Society. The Luxembourg Red Cross initiated a program to support Panzi Hospital in South Kivu. 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.

Eastern DRC is an armed conflict area thus DRC RC, IFRC and the ICRC developed a joint approach where clear roles and responsibilities were agreed upon through multi-level and regular coordination. The ICRC provides security management for movements of all international staff operating in eastern DRC under an agreement known as L3 agreement. It will continue to be adapted as needed through discussions between ICRC and IFRC.

In addition, in response to the 10th outbreak, the ICRC supported EVD prevention activities to the particularly vulnerable populations of detainees and war wounded in the four major prisons and four major hospitals in North Kivu and Ituri as well as in Bukavu central prison and Uvira prison (South Kivu).

Within the implementation of this Appeal, PNS were welcome to contribute to the Movement effort, in areas where they have expertise and interest. There is a strong and ongoing partnership built with French Red Cross which was leading the IPC programming. French Red Cross has specialized and technical know-how in Ebola response especially in IPC and health, earned during the 2015 West African outbreak as well as during 9th DRC outbreak in Equateur. These assets have proved extremely valuable to build the capacity of the DRC RC, support the EVD response structure and the overall value of our collective intervention.

The Democratic Republic of Congo Red Cross (DRC RC) is present in all provinces and territories of the country. While the response for the 9th and 11th epidemics in the non-conflict area of Equateur was carried out under

the co-leadership of IFRC and DRC RC, the 10th epidemic, being in a conflict area, was under ICRC lead for operational access including security management.

Several Movement coordination mechanisms were put in place at the provincial level (Equateur, North Kivu and Ituri), national (Kinshasa), regional (Nairobi) and headquarters level (Geneva) between the DRC RC, the IFRC and the ICRC to ensure smooth implementation of the different activities.

In the DRC, the ICRC promotes respect for international humanitarian law in the treatment of civilians and detainees and helps those adversely affected by conflict and internal violence to survive and become self-sufficient. The ICRC also improves water supply and sanitation, strengthens health care for the wounded and sick, including those affected by sexual violence, and reunites families in DRC. Direct EVD+ response was managed by the NS with the support of the IFRC and security and access managed by ICRC.

Overview of non-RCRC actors in country

Overall, there were more than 60 national and international organizations (including local authorities) involved in the response in the affected provinces in the country (in particular the 10th epidemic). These organizations were 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 led the general coordination of the response (called “riposte”) supported by WHO and other partners. WHO was directly involved in implementation of IPC support, surveillance, PSS support to families and investigation of suspected cases. MSF, IMC and Alima were also active in the treatment of Ebola in affected areas. Oxfam and UNICEF were active in Risk Communication and community engagement and IPC. During the different resurgences, the response strategy at field level was generally established around 11 different commissions and the DRC RC, with support of the IFRC, was 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 represented the Movement response in the Strategic Committee. Participation was also ensured in all Humanitarian Country Team (HCT) meetings in Kinshasa. The Movement was 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.

The recovery from epidemics aimed also at ensuring the DRC RC continued to be a national partner of choice that can support DRC health authorities and also coordinate with humanitarian mechanisms in place such as the UN-led Cluster system. The Appeal provided the DRC RC with the technical and logistical capacity to respond to the extreme humanitarian needs in the areas affected, including the response to future epidemics through early warning and early response systems, coordinated with national, provincial and local authorities, as well as the entire humanitarian community present DRC.

For more details, please refer to [the 2019 Humanitarian Response Plan](#) or [the Update 3 Emergency Plan of Action Operation](#) and other [updates](#).

Summary of regional containment activities

Regional preparedness and coordination

The IFRC regional office provided oversight and coordination to the EVD operations since the 9th epidemic. This included strategic orientation and technical support, ensuring a holistic implementation and quality benchmarks across different activities and countries including peer-to-peer exchange of best practices and consolidation of learnings, such as the “chronological review” of IFRC’s response to Ebola, that reinforced IFRC preparedness and readiness to respond to epidemics. In addition to these technical and strategic elements, the Regional Coordination team provided grant compliance, Information Management (IM),

Community Engagement and Accountability (CEA), financial, logistics, security, and HR support to the operation.

Regrettably, the COVID-19 travel restrictions impacted the direct support to the field teams towards the end of the Appeal, but remote mechanisms were put in place and allowed maintaining regular communication, follow-up and support. Hence, the Regional Office continued supporting the operations in DRC and Priority 1 countries (Uganda, Burundi, Rwanda, and South Sudan) in the planning, integration and operationalization of preparedness, readiness and response activities for COVID-19 in the EVD program, as well as planning and preparation to resume and complete the planned EVD activities. In the priority 1 countries and DRC, the readiness transition strategy was rolled out, including:

- Readiness in tools (Rapid Response SOPs, Information Management Toolkit, CEA and Health Training Package);
- Readiness in staff (setting up, equipping and training rapid response teams);
- Readiness in IM, CEA, and health technical expertise, supported by regional missions to P1 countries.

A Lessons Learnt Review (LLR) was done that permitted a deep dive into the IFRC experience working with and working for DRC Red Cross to combat EVD throughout the 9th and 10th epidemics was completed and a webinar shared information with teams in November 2020. The webinar presented learnings and discussed the recommendations for Operations and Health managers handling similar elements in future epidemic responses. The results of this webinar were used to inform the management and guide IFRC decision-makers and operational teams responding to the following EVD and other epidemics across the African continent and globally.

Highlights of the coordination and support activities include:

- Continued support to DRC and Priority 1 countries in the operational management of the appeal,
- Provided strategic, technical, financial and operational support and direction to CAR (Central African Republic) and Republic of Congo (RoC) through the East Africa Country Cluster office in Nairobi and Central Africa Cluster (Yaoundé) in driving two coordinated EVD preparedness DREF interventions amongst IFRC and Movement partners including for the 11th epidemic ([RoC EVD preparedness DREF Operation Final Report](#) / [CAR EVD preparedness DREF Operation Final Report](#))
- Ensured smooth functioning and availability of regional surge members (rapid response personnel) to support multi-country response coordination and country-specific preparedness activities.
- Updated Regional EVD Contingency Plan
- Reviewed and harmonized training packages, operational guidelines, guidance for NSs and Standard Operating Procedures on Safe and Dignified Burials (SDB) and Risk Communication and Community Engagement (RCCE)
- Established an IM platform for the regional containment strategy to enhance coordination between operations and support external communications.
- Cross-border information sharing, cross-border SDB experience sharing, lessons learned, and data analysed from the feedback system in DRC.
- Developed tools including the IM toolkit for SDB and SDB training materials.
- Supported P1 countries to adjust and reorient some activities to respond to the epidemics of COVID-19 in their respective countries, including the redevelopment of work plans and budgets, according to restrictions and lockdowns measures established by national governments.
- Provided technical guidance and financial support to National Societies to ensure duty of care and safety of staff and volunteers throughout the COVID-19 pandemic.
- Coordinated the response to the 11th epidemic in Equateur through coordination with Africa regional DCPRR and Health units including global surge mechanisms on human resources; support to the Operations team in Goma and information management activities as well as support of preparedness activities in RoC given the high risk of spill over.
- Recruited regional level staff to support in planning, monitoring, evaluation and reporting on the EVD operation, human resources, and other sectors like programs, logistic etc.
- Provided technical support to community feedback mechanisms. Feedback data, which are coded in DRC and analysed, are visualized and shared among partners and responders through an online excel

dashboard with more granular data by health area. This data is used weekly for the RCCE activities, including training of volunteers on its use.

- Facilitated cross-program coordination between COVID-19 and EVD responses in all five countries.
- Facilitated logistical support for international procurements and provided back-up logistics.

Transition Strategy and EVD+

The transition strategy for the regional coordination team revolved around building on the lessons learned and capacities developed during the previous EVD epidemics in the DRC to contribute to the longer-term strengthening of preparedness of the DRC Red Cross, the Red Cross Societies of P1 countries as well as CAR and RoC, Equateur's neighbouring countries, to respond quickly and effectively to future public health emergencies.

In the effort to enable the organization to truly implement the lessons learned from EVD in future operations, the above-mentioned chronological review was carried out and completed. The dissemination, as well as technical webinar of the chronological review, aimed at outlining the key strategic and operational decisions that must be taken by the IFRC working with and working for DRC Red Cross to support future epidemic responses in complex contexts to ensure operational efficiency and effectiveness as well as validating the results and developing a roadmap to implement the recommendations.

A "readiness" strategy was rolled-out in DRC and Priority 1 countries (Rwanda, Burundi, South Sudan and Uganda), which entailed the preparation of tools (Rapid Response SOPs, IM Toolkit, CEA Toolkit and Health training package), set-up of Rapid Response Teams (RRTs), Community Based Surveillance (CBS) in Uganda including capacity building in key technical elements and equipment as well as the development of technical guidelines. Integration of Ebola operations capacities into the country plan was sustain over 2 years of a continuous response and maintain a presence in Eastern DRC where are major DRC humanitarian needs.

Overview of P1 Host National Society, Red Cross Red Crescent Movement, and other actors in-country.

South Sudan

The South Sudan Ministry of Health activated the Public Health Emergency Operations Centre (PHEOC), reviewed, and activated the National Ebola Preparedness plan, and instituted sub-Technical Working Groups.

Despite the challenging context in the country, the South Sudan Red Cross (SSRC) was actively supporting government preparedness efforts, coordinated through the national and state level Task Forces led by MoH and WHO, with SSRC as the lead agency for Safe and Dignified Burials (SDB). SSRC was an active participant in the National Task Force, along with the technical working groups for risk communication, social mobilization, and community engagement (RCSMCE), IPC/WASH/Case Management as well as the PSS (psychosocial Support) Pillar.

The SSRC was one of the implementing partners engaged in risk communication activities in the six operational areas (high-risk border towns and points of entry), namely Nzara, Yambio, Maridi, Yei, Morobo and Magwi, thus complementing the efforts of the Ministry of Health and other partners in behavioural change communication with regards to EVD.



Figure 3: EVD Preparedness areas in South Sudan

At the country level, SSRC continued to coordinate the EVD preparedness and COVID-19 response operation closely with the IFRC, ICRC, and 7 in-country PNSs including, Danish Red Cross, Netherlands Red Cross, Swedish Red Cross, Norwegian Red Cross, Finnish Red Cross, Canadian Red Cross and Turkish Red Crescent.

- In total, **SSRC trained 510 volunteers on RCSMCE, SDB, and PSS**. These volunteers were all engaged in risk communication and social mobilization activities while those trained on SDB remained active and engaged until they were needed to be deployed. Importantly, the SDB team timely and effectively responded to **13 alerts of suspected EVD cases** in Yei and Yambio, during which they collected samples from the deceased, all of which tested negative for Ebola. On **8 occasions they performed Safe and Dignified Burials**. IFRC deployed two EVD technical surge to support the SSRC for SDB preparedness in planning, training implementation and coordination. The MoH South Sudan seconded an experienced health staff to support the SSRC on RCSMCE.
- **SSRC reached over 455,776 people** in the six operational locations 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-crossing for screening. For more details refer to [the Operation Update 7](#) and South Sudan - Ebola Virus Preparedness [DREF Operation Final Report](#).

Uganda

At the country level, Uganda Red Cross Society (URCS) worked together with the IFRC, ICRC, and PNSs including, the Netherlands Red Cross, German Red Cross, Belgium Red Cross - Flanders, Austrian Red Cross, Icelandic Red Cross and the Canadian Red Cross in the areas of disaster management, WASH, community-based health and care, protection, livelihoods and National Society development. The variety of interventions and their extensive geographical coverage guaranteed a benefit in terms of technical and logistical support to the Ebola preparedness operation as well as resource mobilization coordination.

IFRC supported URCS with the implementation of the URCS EVD Plan of Action and revisions of IFRC Contingency Plan. IFRC had an in-country team supporting the EVD operation, consisting of one Programme Coordinator overseeing the full IFRC portfolio in Uganda and one Finance Delegate. From the start of the operation, URCS was an active member of the National and District Task Forces. The National Society continued to work in the target districts under the EVD operation, integrating COVID-19 response through implementation of community sensitization activities/RCCE, CBS and screening at Points of Entry (PoE).

Preparedness efforts were critical in Uganda, which was at very high risk for EVD due to its proximity to the border and affected area in DRC. On 11 June 2019, the Ugandan Minister of Health made an official statement of an EVD epidemic in Kasese district, in Southwest Uganda, where the Uganda Red Cross Society had been implementing preparedness activities. The index case was a 5-year-old male who returned to Uganda from DRC with his family on 9 June 2019 after attending a burial of the grandfather who had succumbed to EVD. The child and his family entered Uganda through Bwera Border post and sought medical care at Kagando hospital. The grandmother and 3-year-old brother also started presenting signs of EVD, both tested positive and succumbed to EVD. Following the confirmation of a positive case, 108 contacts were identified and monitored. 1,900 vaccine doses were received in Uganda from WHO and DRC and used to vaccinate front line workers in Kasese district. URCS implemented EVD Response and Preparedness activities in line with the Uganda Government's EVD Response and Preparedness Strategy.

- **In total, 480 volunteers conducted risk communication and social mobilization activities**. They were trained also on Community Based Surveillance (CBS) and deployed to conducted passive community-based disease surveillance and send through weekly reports to the CBS command centre in Kampala.
- **10,868,958 people were reached** by NS with services to reduce relevant health risk factors, particularly by screening at 63 Point of entry (PoEs) in the following districts: Kasese, Ntoroko, Bundibugyo, Kisoro and Kanungu. For more details refer to [the Operation Update 7](#) and Uganda - Ebola Virus Preparedness [DREF Operation Final Report](#).

Burundi

The Burundi Red Cross Society (BRCS) was represented in five National technical commissions: Coordination, Operations (Ebola Treatment Centre (ETC) and a Laboratory), Logistics, Infection Prevention and Control (IPC), and RCCE. The NS participated in National Coordination meetings on public health emergencies (EVD and COVID-19) as well as in joint monitoring missions to assess preparedness in the high-risk provinces. BRCS is an active member of the National Disaster Management and Reduction Platform in charge of the coordination of humanitarian actors, which is managed under the Ministry of Public Security.

The IFRC has a Country Cluster Support Team (CCST) Office for Eastern Africa and a Regional Office for Africa, in Nairobi. The BRCS also hosted and received support from in-country Movement partners including the ICRC and partner National Societies (PNSs) which are the Belgium-Flanders and Francophone, Finnish, Luxemburg, Norwegian and Spanish Red Cross Societies. Following COVID epidemic, the Government recommended to immediately integrate prevention messages on COVID-19 virus. EVD RCCE activities were therefore also useful for COVID-19 response. In May 2020, the Government suspended all EVD preparedness activities to only focus on COVID-19 epidemic.



Figure 4: EVD Preparedness areas in Burundi

- In total **2,234,231 people were sensitized on EVD**
- **228 people were trained in SDB** and conducted simulation exercises in their respective branches. For more details refer to [the Operation Update 7](#) and Burundi - Ebola Virus Preparedness [DREF Operation Final Report](#).

Rwanda

The Rwanda Red Cross Society (RRCS) is part of the National Rapid Response Team (NRRT), the national level coordination team composed of the Ministry of Health (MoH)/Rwanda Bio-Medical Centre, and major NGO and UN partners. At the beginning of the response, weekly coordination meetings were convened to update and coordinate response strategies. RRCS was tasked with community surveillance/contact tracing, risk communication/social mobilization and community engagement, SDB/Decontamination, as well as PSS. A 72-Hours National Response Plan was also developed. The coordination platform has since then been converted into the national taskforce for COVID-19 response coordination.

IFRC supported RRCS through the Eastern Africa CCST as well as through the Africa Regional Office and there was regular contact with IFRC Regional Operations and Health teams. RC partners in-country include the Austrian RC, Belgian-FI, Belgian Fr, Japanese RC, and Spanish RC some of whom supported preparedness activities for EVD in the initial phases of the response including mobile cinema, SDB and community sensitization.



Figure 5: EVD Preparedness areas in Rwanda

Rwanda Red Cross carried out preparedness activities since 2018, focusing on risk communication, health and hygiene promotion across 15 districts at high risk. SDB rapid response and localised teams were trained and provided with equipment. EVD risk communication activities were discontinued in March 2020 following the beginning of the COVID-19 pandemic as public health messaging by the government was shifted to focus on the pandemic. Nevertheless, the National Society continued to work in the 15 districts targeted under the EVD operation to conduct refresher training of rapid response teams and to strengthen their capacities in CEA, PSS and SDB.

Through the DREF operation, Rwanda Red Cross supported the government's efforts in implementing the preparedness activities as per the National Contingency Plan. The DREF operation was carried out from September 2018 to March 2019, in 11 districts. The National Contingency plan was revised again in 2019 with 15 target districts: Rusizi, Nyamasheke, Karongi, Rutsiro, Rubavu (bordering DRC); Musanze, Burera, Gicumbi Nyagatare and Nyabihu (bordering Uganda); Bugesera and Nyanza (both host a refugee transit centre); Kigali (comprised of 3 districts: Nyarugenge, Kicukiro and Gasabo). Additional funding to continue preparedness activities was received through the Appeal in October 2019.

- In total **4,514,113 people were reached with community-based epidemic prevention and control** activities
- There were also 15 SDB teams, including 1 rapid response team based in Kigali.
- **305 mobile cinema sessions were conducted.** For more details refer to [the Operation Update 7](#) and Rwanda - Ebola Virus Preparedness [DREF Operation Final Report](#)

Needs analysis and scenario planning.

For information on the operation, including on "**Needs analysis, risk assessment and scenario planning**"; please refer to the Emergency Plans of Action (MDRCD026) launched on 14 May 2018 and different revisions. This information can be accessed via IFRC website, [Appeals link](#). A summary is provided below.

DRC 9th Epidemic (Equateur)

The 9th EVD epidemic took place in three health zones in Equateur province (Wangata, Bikoro and Iboko). Approximately 2 million people reside in the health zones (which includes the city of Mbandaka with a population of 1.5 million). This was the first known Ebola epidemic in Equateur province and therefore knowledge of Ebola was limited within the population. There were issues that complicated understanding of Ebola such as people questioned whether or not Ebola was real, how it was transmitted, and the risks of vaccination, and resistance to changing behaviours that can contribute to EVD spread, such as cultural burial practices or consumption of bushmeat. There was a clear need to share clear, factual information in ways that make the information accessible to communities and collect and address rumours and misinformation, so they do not undermine epidemic response efforts.

The major means of transportation in the region is by road during the dry season. Waterway transportation is also a very prominent means of movement - the waterway transport runs along the border with the Republic of Congo and Central African Republic, from Brazzaville and Kinshasa to Bangui, traversing many communities along the river. These movements constituted a potential risk for spread considering the number of people who use such means of transport daily, creating the risk of long-distance seeding of the virus into far-flung communities.

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 Strategic Response 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. DRC RC also led the Safe and Dignified Burials (SDB) activities in these zones with the support of IFRC. The IPC and SDB activities were complemented by cross-cutting PSS and CEA interventions.

A DRC RC and IFRC joint team was deployed to Equateur province in north-western DRC, bringing with them essential stocks of life-saving equipment and supplies to reduce and eventually stop the spread of EVD. Contacts were established with the DRC RC local branch in Bikoro and constant coordination was ensured with local health authorities and key humanitarian stakeholders. Over 100 local Red Cross volunteers were mobilized to support affected communities. In addition, an IFRC global and regional surge team reinforced DRC RC's response capacities.

MOH and WHO identified a need to deploy medical teams with experience in IPC as well as early management of clinical cases. The deployment of such medical teams was required to work in existing health facilities to strengthen IPC, to facilitate early detection of EVD cases and to provide initial care to patients with suspected EVD while awaiting transfer to a designated Ebola treatment centre (ETC) and accompany patients during transfer. This response included support from other Red Cross and Red Crescent partners through the deployment of medical surge teams to provide IPC support to health facilities in the affected areas. The DRC RC had targeted persons in the affected area by training and mobilizing volunteers for risk communication and community engagement activities, including rumour tracking and collection of community feedback. The DRC RC supported the government in SDB activities by training, equipping and mobilizing SDB teams in affected areas as well as disinfection of homes and health facilities where cases had spent time while ill. PSS was provided by trained Red Cross volunteers to affected people. Community engagement approaches focused on establishing systems that allowed communities to voice their needs and assist in reducing fear and rumours and raise awareness.

Following the official declaration of the conclusion of the 9th EVD epidemic, the intervention strategy changed, and priorities were re-oriented towards recovery and preparedness. The planning and intervention focused on post EVD transition and was characterized by a significant downward scaling of the activities and the phasing out of several actors involved in the response. Risk communication, PSS, WASH, and IPC activities continued under the transition phase in Equateur for a minimum of 90 days beyond declaration of the end of the epidemic.

DRC 10th epidemic (North Kivu, Ituri, South Kivu)

Given the high number of health zones (HZ) involved (29), the 10th epidemic is recorded as having the largest geographic spread in the history of EVD epidemics in DR Congo and also the largest number of cases (3,470) and fatalities (2,287, 66% case fatality). While Mabalako health zone (Mangina) was initially the most affected area, the epicentre and areas with the most intense transmission shifted throughout the epidemic, affecting both new and previously affected health zones. At various times, Mabalako, Beni, Butembo/Katwa were each the epicentre. Throughout the epidemic, the most active transmission and most cases occurred within the Mabalako-Beni-Butembo/Katwa triangle.

In North Kivu and Ituri provinces, access challenges in several affected areas, along with community resistance, presented two major hindrances of the emergency operation, affecting the reach and the coverage of the programmed activities. Limited knowledge of EVD within the population and among health personnel was a key barrier to behaviour change at the household and health systems levels. According to the findings of community surveys, awareness about EVD risks and prevention increased throughout the epidemic. Nevertheless, there were significant gaps in understanding about Ebola Treatment Centres (ETC), signs and symptoms and what to do in case a person is sick or dies after experiencing EVD symptoms. Further, communities were not effectively informed about the progression of or response to the epidemic, which is critical to build trust and overall knowledge. There were key sociocultural, political and economic issues that were fueling the epidemic and hindering community engagement efforts. While the socio-political context in the affected areas were very complex, greater investment was needed to inform and engage communities and adapt to communities' identified needs and priorities. To inform the operation, the Red Cross community feedback mechanism captured essential community views on EVD and the response. By regularly gathering

and analysing community rumours, beliefs, observations, questions and suggestions using an interdisciplinary approach and novel tools, field teams and decision-makers were provided with useful insights that inform risk communication and community engagement approaches across the response.

In terms of primary health services, many health facilities (FOSA) do not have the required infrastructure, materials, or knowledge of infection prevention and control (IPC) practices and behaviours to prevent transmission of the virus within health facilities or prevent transmission between patients or care providers inside the health facility. Many health workers were infected because of lack of basic knowledge about IPC, or due to lack of IPC equipment and facilities. It was also common to have poor (or no) surveillance in health facilities and to mistake EVD for malaria or other diseases. IPC measures and training of staff was therefore an important activity to detect suspected cases early and to limit the spread of EVD from one patient to the other or from an infected patient to medical personnel. IPC activities were intensified across the affected areas and in areas at risk of transmission or importation.

Safe and dignified burials (SDB) were critical to preventing transmission of the virus, particularly for the loved ones of people who died in the community without knowing they were infected. Red Cross volunteers, working alongside Civil Protection members originally trained by the Red Cross, led this sector. In urban areas like Beni and Butembo, both Red Cross and Civil Protection SDB teams were operational. Civil Protection teams played a critical role in SDB activities in high-risk areas (often using armed paid police escorts), which complemented the RC SDB response. SDB required constant adaptation to meet local cultural and social needs.

Given the nature of their tasks and the challenging environment, PSS support to the SDB volunteers was essential. SDB teams faced grieving families and communities daily, and they have encountered resistance and experienced animosity and both verbal and physical attacks from community members. In support of the above, and in line with IFRC's National Society Development (NSD) framework, the operational needs were addressed by continuing to support a well-performing National Society, both in its staff and volunteer capacity, to have a lasting impact on the individuals and communities it serves, standing longer than the operational timeframe of the EVD epidemic.

DRC 11th epidemic (Equateur)

Despite experiencing a recent previous EVD epidemic, the systemic challenges experienced during the 9th epidemic remained relevant to the 11th. Health and surveillance systems remained weak, understaffed and under resourced, and there was continued low population knowledge of EVD and its means of transmission and prevention. New communities were affected by this epidemic, which had very low knowledge of the virus. In the interagency response coordination meeting, the DRC RC was identified as a key responder in the affected communities.

IPC knowledge, practices and capacities were very low or impossible due to lack of resources in clinical health facilities. IPC interventions were critical to reduce the risk of nosocomial transmission of the virus, to increase case detection capacity from within existing patient populations, to maintain confidence in the health system and mitigate the reduction in care-seeking behaviour that is frequently seen in epidemics. In that perspective, despite the epidemic being declared over on 18 November 2020, the Red Cross continued to maintain its commitment towards MoH and population in Equateur by supporting and rehabilitating nine health centres. That support included training health workers on EVD detection, symptoms, means of transmission and methods to prevent it.

It was important that community members contribute to the response and can impact the way response activities occur in their communities. It was equally important for the community's acceptance to ensure that response activities are integrated into the responses to needs identified by communities. Failure to address communities' needs also contributes to perceptions that Ebola and other major epidemics were driven by financial or political imperatives, rather than health or humanitarian ones.

Recovery and Preparedness

The 10th epidemic in eastern DRC left communities very vulnerable. Humanitarian needs in eastern DRC are massive. By December 2020, 21.8 million people were considered in need in DRC with the biggest proportion in the East. In 2021 there are 5.2 million displaced persons, mainly because of armed conflict, another 19.6 million people facing severe food insecurity between January and June 2021 with more than 3.4 million children under five suffering from acute malnutrition. People of DRC are routinely vulnerable to epidemics of contagious diseases such as Ebola as well as measles, cholera, etc. Coupled with this, DRC is also hit by COVID-19. The humanitarian consequences of these communicable diseases are compounded by insecurity, food insecurity, displacement, and lack of basic services.

In such fragile communities, the humanitarian consequences of epidemics are dramatically amplified, thus the relevance of our strategy to strengthen DRC RC capacity for early warning and early response for any emergency with a focus on health emergencies. The fragility of communities in eastern DRC had two immediate humanitarian consequences that were been tackled by this Appeal:

- 1) **Early warning/early action:** Conflict, lack of essential services and huge humanitarian needs made it challenging for the DRC health authorities to detect and respond to new epidemics in a timely way. In April 2018, in Mangina (NK), it was only after several deadly weeks that the 10th EVD epidemic was identified by health authorities. This led to unnecessary deaths, including health workers, and an initial head-start of the disease unchecked. Both could have been limited with an effective early warning system. The DRC RC has a very dense network of volunteers, present in every community, where they are known and trusted. Properly trained and supported, the DRC RC volunteers warned of possible epidemics upon the first signs.
- 2) **DRC Red Cross's Auxiliary role in humanitarian response is vital:** The capacity of authorities to respond to epidemics when identified is stunted by conflict and chronic challenges to build efficient state institutions in eastern DRC, along with distrust between communities and authorities. The DRC Red Cross is the main local humanitarian actor in the country, and it is expected by communities to respond to epidemics and other emergencies. The Appeal improved the preparedness of DRC Red Cross to respond to epidemics in eastern DRC, strengthening the capacity of communities to face these out-breaks quickly and effectively.

In DRC, health capacity and resources are considerably strained, and additional burdens were put on the national health system with the COVID-19 pandemic and other health emergencies currently experienced in the DRC. It was therefore important to have measures in place for early detection, reporting and response of potential health risks with epidemic potential in communities to allow for quick response mobilisation. The appeal aimed to strengthen and sustain the capacity of the DRC RC to maintain early warning and early response systems for future epidemics.

DRC 12th epidemic

The resurgence of EVD cases came as the EVD operation was in recovery mode and scaling down and handing over activities and equipment to the DRC RC. The resurgence led to the revision of the Appeal in March 2021, with an extension of the end date from June 30 to September 2021.

Insecurity in North Kivu province was a major concern as there was frequent violence by armed elements, resulting in deaths and population movements. This limited access to high-risk areas for Ebola and complicated the monitoring of the epidemic dynamics that could evolve rapidly and unpredictably to new areas, including hard-to-reach rural areas.

The IFRC in collaboration with local DRC RC branches aimed to provide an operational CBS mechanism to complement the national surveillance mechanism, especially during and after the EVD epidemic to prevent spread and to detect a new cluster earlier through a strong network of volunteers available and well trained

on Epidemic control for volunteers (ECV) Community-based health first aid (CBHFA) in the communities and prevent epidemics.

P1 countries (Uganda, Rwanda, South Sudan, Burundi)

Scenario planning

The scenarios were updated regularly to reflect the different epidemics. This generally involved two planning assumptions that would continue to be followed until the end of the operation. Emergency planning was done with identified contingency triggers to inform an intensification of relevant activities. The operation also put in place arrangements to ensure continuity of services to vulnerable people in the event of a deterioration of the security situation in the country.

As of December 2020, Republic of Congo and Central African Republic were no longer considered at risk of spread of any current EVD epidemic, though they remained at risk of a new epidemic due to presumed endemicity of the Ebola virus in bat populations and the ever-present risk of a new zoonotic crossover event.

There was also regular updating of human resource plans and gaps in addition to Logistics preparedness. The security context was regularly analyzed to guide decision-making and team protection. There was constant coordination at all levels for the implementation of the key elements of response mentioned in the scenarios.

Risk Analysis

DRC:

The following were the risks that affected implementation:

There were security risks due to protracted, multi-centred conflict, leading to security and access challenges; further risks of humanitarian access being hindered for Red Cross staff and volunteers if communities continued to deny the existence of Ebola; distrust of responders due to widespread community perceptions of "Ebola-business" due to the perceived monetization of response activities; risks related to remote management (both from Goma to the field after evacuation, and in general for ECUMR teams and all activities in "red zones") and a risks related to conflict in general, not specific to targeting of EVD workers

- **Insecurity and increase in active conflict and potential targeting of EVD responders.**

There were incidents of violence targeted at Ebola volunteers, especially SDB teams. The IFRC continued to follow ICRC security rules for all staff and use CEA activities and community feedback mechanisms to measure community acceptance. IFRC Minimum Security Requirements were in place. Situation was monitored and security assessments were carried out to enable the operation to implement risk management measures considering the evolving situation. This is also a risk during the current COVID-19 epidemic in Congo. The IFRC has learned lessons from EVD programming that enabled CEA to include COVID-19 messaging into EVD activities to continue to build a trusting relationship between communities and the DRC Red Cross.

- **Mismanagement of financial and procured assets through fraud and corruption.**

Strong internal control is in place to ensure compliance with IFRC procedures and donor requirements. Recurrent workshops on the Code of Conduct and Prevention of Fraud and Corruption to all Staff and Partners involved in the EVD operation in DRC. These workshops aimed to make everyone aware and accountable for ethics rules and the organization's principles and values. Internal Audit was conducted on December 2019 and External Audit by KPMG was conducted in March 2020 to ensure quality control and review of compliance measures. To mitigate risks for potential cases of Ghost volunteers for per diem payments, preventive measures have been took using a new method replacing physical attendance lists with electronic data collection (using biometry/GPS) and control has been experienced in Beni field basis, which also improved the overall volunteer management through an up-to-date Database. Volunteers and staff were trained, sensitized

and encouraged to report allegations of fraud and corruption via the safe call number **47 22 22**. They were also reassured of the strict confidentiality of the reporting process. Finally, we noticed a good improvement of the gender balance during the last trainings in Equateur with at least 30% of participants being women.

- **Sexual Exploitation and Abuse**

The hotline 47 22 22 was operationalised and has been displayed in all IFRC and DRC RC premises and vehicles. This had an aim to enhance community feedback and reporting of sensitive information especially those related to SEA. The community was informed through CEA activities to report any suspicion of sexual exploitation or abuse through the hotline immediately. Staff as well as volunteers were informed through the code of conduct trainings on how to report any suspicion of violation of this code of conduct. The IFRC still ensures that an effective anonymous and confidential complaint mechanism exist. The complaint mechanism or hotline is accessible for all communities' members around DRC and is easy and safe for the community to use. This hotline is still operational. The staff manning the hotlines had been trained in handling sensitive complaints. There is a plan for sustainability of hotline with ICRC support and DRC RC.

- **Staff and volunteer health and wellbeing, stress and burnout (especially due to COVID 19 travel restrictions)**

Staff and volunteers have been working in high-stress environments with risk of other health issues (cholera, malaria, etc), security incidents and general cumulative stress. To mitigate these risks, 37 psychosocial support volunteers have been deployed to all of the bases offering psychosocial support activities (psychosocial first aid, education sessions, focus group discussions, debriefings after incidents, recreational activities etc). R&R has been suspended due to COVID-19 travel restrictions. The IFRC has been exploring other options for staff well-being and stress reduction and this remains a high priority task for the IFRC management. Some examples included taking R&R in country until some degree of international travel is possible.

- **COVID-19 in DRC and its humanitarian consequences**

The IFRC in working with and working for DRC Red Cross to combat EVD has learned lessons through this operation that enabled us to include COVID-19 information into EVD activities to continue to limit the humanitarian consequences of COVID-19 and maintain the trust and relationship between communities and the DRC Red Cross by showing that we respond to their concerns and not only to the EVD risk.

South Sudan

- **Volunteer protection**

The risk for EVD and COVID-19 infection of staff and volunteers was mitigated through internal measures taken by the SSRC. The measures were tailored to the ones given by the South Sudan Government with consultation from Medical Advisory Panel (MAP). The SDB Volunteers were also trained to safely manage COVID-19 deaths in case of mass casualties. SSRC Volunteers in all the 17 branches and 102 units were oriented on ways of protecting themselves and their community members.

- **Increase/escalation of tensions/violence**

The situation remained stable during the reporting period and under the Transitional Government of National Unity, the risk of resumption of fighting remained moderate. Those risks which were not directly related to the conflict remained relevant to RCRC operations in South Sudan such as the risk of criminality which has continued to increase across the country and in big urban cities like Juba and cattle rustling especially in areas inhabited by pastoralist communities.

Regular risk assessments were conducted by ICRC which maintained the lead in terms of security management whereby mitigation measures are implemented, and security advisories are being provided to the respective RCRC partners operating in the said areas. To reduce the risk of RCRC personnel falling prey to crime or violence, all RCRC personnel actively involved in the operations were mandated to complete the

respective IFRC security e-learning courses (i.e., Stay Safe Personal Security, Security Management, or Volunteer Security). Related to safer access concern, one of the main benefits of the SSRC is the nationwide recognition of the National Society which facilitated the relationship with community heads, leaders and most importantly the community themselves.

- **COVID-19 pandemic**

In South Sudan, the COVID-19 epidemic has shifted the focus on the risk communication messaging by the government from EVD to COVID-19. The National Steering Committee on EVD was transformed to be the same one in charge of COVID-19 response. As such, South Sudan RC has also shifted risk communication to COVID-19 to be in line with government efforts.

- **Fragile Health System**

The overall health system across South Sudan remains fragile and the protracted crisis has seriously affected health service delivery. Health services delivery infrastructure were heavily destroyed in most parts of the country during the crises that occurred over the past few years. Factors for increased likelihood of EVD as well as COVID-19 cross-border spread to South Sudan include a very porous border with DRC, informal trade between the two countries, regular cross-border market activities, unregulated movements, and the fact that communities on both sides of the border share language, culture and beliefs.

Uganda

- **Volunteer protection**

The risk for EVD infection of staff and volunteers was mitigated through MoH, WHO and Red Cross orientations and trainings on screening and IPC as well as through the procurement of appropriate personal protective equipment/gears (PPEs). All volunteers also participated in one PSS information session per district led by URCS PSS officer. In the context of COVID-19, additional PPE (face masks and hand sanitizer) were procured to ensure all deployed volunteers have access to face masks and sanitizers during deployment.

- **Increase/escalation of tensions/violence**

There was a potential risk that tensions/violence between Ugandan host communities and refugees increase and/or escalate. Given the current COVID-19 pandemic and fear of the same, the local communities could become hostile to Congolese refugees due to fear of exposure/infection.

- **The spread of rumours on Ebola affecting URCS access and security**

Rumours continue to be present in communities, both on Ebola as well as COVID-19. The fear of Ebola also increased fear towards the COVID-19 pandemic, with many misconceptions on the same causing fear and stigma. This risk was being mitigated through the community sensitization activities supported through this response plan, rumours were tracked and followed up and communities informed on Ebola and COVID-19 symptoms, prevention and treatment.

Burundi

- **COVID-19 pandemic affected the ability of the NS to implement EVD preparedness activities.**

BRCs continued to participate as a member of the National Ebola Task Force which later became the National Ebola and COVID-19 Task Force and was requested by Ministry of Public Health to support the following response pillars: Surveillance and contact tracing, RCCE, IPC with WASH in community and SDB, health care with psychosocial first aid (PFA)/PSS activities and more recently, Points of Entry (PoEs). Due to the occurrence of COVID-19 epidemic inside the country, more focus went to COVID-19 preparedness and response activities. Consequently, some EVD activities were cancelled in May 2020 due to the changed focus of Ministry of Public Health and Partners, but also to the recommendations of National Ebola and COVID-19 Task Force limiting implementation of EVD activities.

The BRCS response plan involved both financial and technical support from the Movement and external partners inside the country. Some EVD activities were reallocated to ensure better response to COVID-19. In addition, COVID-19 preventive messages have been integrated into EVD sensitization activities as recommended by National Ebola and COVID-19 Task Force in April 2020.

- **Political instability related to elections in 2020.**

The NS worked on an Election Preparedness response plan – funded by IFRC and other Movement partners. EVD activities were affected by the elections as there was limited access to the field in some targeted branches. According to the security risk assessment conducted with ICRC support, some activities were prioritized to be continued and others postponed and implemented after the elections. During the elections, staff were mobilized across the country to ensure rapid response activities, such as first aid in case of electoral and post-electoral violence. In addition, ambulances were pre-positioned in each RC branch of the country for evacuation of wounded in case of violence. After the election process, the death of the former President H.E Pierre Nkurunziza temporarily halted implementation of activities during the funeral period.

Rwanda:

- **Accessibility**

Some of the districts along the borders were not easily accessible due to poor road infrastructure and the hilly topography. In addition, the area is prone to floods and landslides which affects the Western districts during the annual rainy seasons, making access more difficult.

- **Refugee influx**

The political situation in neighbouring DRC led to an influx of refugees in the border districts. In addition, Rwandan detainees held in Ugandan detention centres were released following talks between the two governments and transported through the road border posts. This population movement from neighbouring countries carried the risk of both EVD and COVID-19 transmission.

- **COVID-19 pandemic**

In Rwanda, the COVID-19 pandemic shifted focus on the risk communication messaging by the government from EVD to COVID-19 since March 2020. The National coordination committee on EVD was transformed to be the same one in charge of COVID-19 response. As such, Rwanda RC has also shifted risk communication to COVID-19 to be in line with government efforts limiting messaging on EVD.

B. OPERATIONAL STRATEGY

Strategy

The overall objective of this operation was to contribute to preventing and reducing morbidity and mortality resulting from Ebola virus disease in the DRC and strengthen priority 1 countries' preparedness for EVD by supporting activities that build sustainable EVD detection and response capacity. At the same time, the longer-term strategy focused on supporting resilient health systems and tools of the National Society to ensure response readiness in DRC.

Overall, RC's operational strategy was based on four operational priorities:

- 1) **Maintain EVD at zero:** In former EVD-affected areas, provide high quality, humanitarian and community-based epidemic control activities, and keep Ebola at zero in places that have ended the epidemic, by maintaining the needed level of risk communication and IPC measures in place to rapidly detect and contain any new emergence of the disease in Equateur, South Kivu, North Kivu and Ituri where the population has paid an immense toll to Ebola.

- 2) Mobilize DRC RC branches in affected areas for early response, according to the defined four pillars of intervention (IPC, SDB, RCCE and PSS), integrating the multidimensional threats that affect communities, such as health (including COVID-19).
- 3) Provide the DRC Red Cross in Equateur, North Kivu, Ituri and South Kivu with the capacity to respond to emergencies, including epidemics of Ebola or other infectious diseases.
- 4) While focused on preventing a new epidemic of Ebola in eastern DRC, the operation also aimed to contribute to limit the humanitarian impact of COVID-19 in the parts where DRC RC operates.

In Equateur, the strategy was adapted to the context and the features of the 11th epidemic. The epidemic was characterised by geographic spread that resulted in many affected areas separated by significant distances. Equateur is a very remote and poor province, even by DRC standards. Most of Equateur province is neither accessible by car nor it is served by phone networks. There is no centrally provided electricity in the province. RC teams deployed to very hard to reach areas by using pirogues (canoes), UN provided helicopters, motor-cycles, etc. The 11th epidemic required Red Cross to design an agile response to be able to deploy quickly to newly hit areas and work hard to stop the epidemic before it spread further. For that purpose, we designed a strategy based on four operational priorities:

- **A locally led response:** The **9th epidemic** of Ebola had hit Equateur in 2018. The local branches of the DRC RC had therefore gained experience in responding to Ebola. In addition, we leveraged the experience gathered by DRC RC in eastern DRC by deploying local staff and volunteers from eastern DRC to Equateur. Key community groups were engaged to ensure the response was accepted and owned by local communities.
- **A light and agile operational footprint approach:** The 11th epidemic evolved differently from the 9th (also in Equateur), spreading in harder-to-reach areas. This required teams to be agile and be able to deploy to areas newly hit quickly and decisively by Ebola to swiftly set up the required response. As an example of this agile approach, the Equateur part of the operation featured Rapid Deployment Teams of six staff and volunteers who, upon a confirmed case in a new health area, could hop in helicopter or pirogue, reach the area, and start responding with local DRC RC volunteers in a matter of a few days.
- **Implementing lessons learned from 10th epidemic:** From the onset of the Equateur response (11th epidemic), teams implemented the lessons learned from the eastern DRC response. They learned through the course of this operation that key components such as proper management of volunteers, support to local sections of DRC Red Cross, as well as systematic collection of and action based on community feedback yield better results if started early.
- **Transitioning to recovery** based on community health and linkages with existing programmes such as community-based health and first aid (CBHFA), epidemic control for volunteers (ECV), integrated readiness, and community-based surveillance (CBS).

At the end of the EVD epidemics covered by this Appeal, there was a process of staff reduction, reducing the number of IFRC international delegates and national staff. Thus, with the declaration of the end of the **12th EVD epidemic** in North Kivu province on 3 May 2020, only a reduced number of staff was maintained to provide support when needed.

The Red Cross Red Crescent Movement's community-led vision was designed considering key elements such as the security context, internal and external analysis of available data and shifts in humanitarian context. Maintaining regular discussions with local structures and communities has been also key; RC teams adjusted interventions over time by updating our protocols 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 can participate in the response, by accessing relevant and useful information, and their questions are answered.

For the P1 countries, the vision was to support a community-led response by the National Societies across DRC, Uganda, Rwanda, Burundi, and South Sudan with support of the Movement to support the National Societies to be better prepared to respond to future epidemics (including EVD+ which includes COVID-19

response measures) with more autonomy. Given the 11th EVD epidemic in Equateur Province in DRC, the other two neighbouring countries, Central African Republic and the Republic of Congo's preparedness measures and readiness to recompense capabilities were strengthened.

Operational Support

Information Management (IM)

IM coordinated with pillars and external partners towards improving data collection and analysis processes. IM was a key tool to strengthen the ability to have a data-driven operation and bolster this culture within the DRC RC. In addition, there was focus on transferring and strengthening the capacity of the DRC RC to collect, analyse and utilise data for decision-making, ensure the volunteer database was continuously updated, that Red Rose is deployed in all bases and NS staff and volunteers are trained on its usage. IM teams:

- supported CEA and trained the NS in data coding and analysis.
- Ensured use of standard data management tools.
- Supported data analysis to operational decision making.
- Strengthened DRC RC capacity and knowledge transfer as part of preparedness.

Community Engagement and Accountability

Established a wide range of RCCE strategies and activities which included working with key local stakeholders and use of available and effective traditional channels of interactive community engagement activities and working with key influencers in the communities. Capacity building through knowledge and skills transfer of DRC RC on community feedback management systems, including quality assurance, analyses, documentation, and use of data were done. The teams focused on strengthening community confidence around the mistrust of Red Cross response teams that surfaced prominently in the community feedback, advocate for and encourage discussions on safer, healthier, and sustainable hygiene practices in communities.

Communication

There was continued communication about operation's action and the plea of communities as well as tailor regional communications resources and assets toward the context of the country and the National Society. DRC RC's capacity to communicate effectively about humanitarian needs and the response to these needs was strengthened. The strategic focus in communication was to amplify the voice of volunteers and communities.

Security

Security assessments were carried out to enable the operation to implement risk management measures considering the evolving situation. ICRC and IFRC security monitored the security environment and provided technical advice. IFRC and DRC RC security focal points were in close coordination with partners and stakeholders to provide advice to colleagues involved in the response – this includes areas such as mobility, risks and close contact during implementation of activities. Security incidents were closely tracked, monitored and managed in close coordination with ICRC and DRC RC security personnel and leadership.

Logistics

The working structure for logistics was improved by the right sizing of the human resources and the increase of the level of competence. New digital tools were developed to improve controls and reduce the risk of fraud. Tons were imported and cleared without any difficulty/delay with customs clearance. These improvements significantly strengthened our capacity to timely and efficiently respond to the Equateur epidemic.

To respond to the Emergency Plan of Action, the following key areas were programmed to ensure effective logistics support:

- Secured optimal human resources.
- Strengthened the logistics capacity of the Federation and Red Cross staff and volunteers by implementing new specialized trainings conducted by the Logistics Capacity Building Delegate
- Improved and developed digital tools to improve warehouse and fleet management and reporting key performance indicators, service quality and lead times.

Finance

Challenges faced regarding swift processing of payments while respecting all needed safeguards were addressed. What was at stake here was crucial at three levels. First, ensuring the operation was not mired by delays in processing payments. Second, the integrity of finance processes was paramount. Third, and equally important, setting up a system that worked efficiently in DRC while maintaining the required level of integrity, this was a crucial step for our preparedness and responses efforts. Preparedness consisted of capacity to respond to needs and this response needs to be compliant with our finance standards. So, building a finance system that worked transparently and efficiently in DRC supported the operation and at the same time boosted DRC RC capacity to respond to future emergencies.

Planning, Monitoring, Evaluation and Reporting (PMER)

The core PMER team consisted of PMER delegate and PMER officer, national staff. Opportunities were explored as part of NS strengthening in PMER to have focal points identified for capacity enhancement in PMER. Preceding this, a PMER capacity self-assessment exercise was done at the national DRC RC offices. The focus included:

- Close collaboration with IM in refinement of data collection tools to capture periodic monitoring data for indicators.
- Regularly drafting and reviewing donor reports
- Carried out field monitoring visits to gauge progress and support field teams identify and document case studies on the impact of the operation.
- Supported IFRC and DRC RC staff in HQ and field bases with a capacity building plan based on a self-assessment and built upon capacities and possibilities.

Human Resources

Ensuring proper presence and management of human resources remained a priority for the operation. We have made significant progress in setting up an HR management system that is stable and adapted to needs. Strengthening the HR set-up of the DRC RC was our priority. We had identified key positions that were crucial to our operation and the response capacity of the DRC RC.

Regional Preparedness

Overall Operational Objective


The surrounding P1 countries (Rwanda, Burundi, South Sudan, and Uganda) focused on the EVD+ interventions as follows:

1. Risk Communication and Community Engagement (RCCE)
2. Infection prevention and control (IPC)
3. Safe and dignified burials (SDB)
4. Psychosocial support (PSS)
5. Community-based surveillance and contact tracing (in limited contexts)
6. National Society capacity strengthening

In addition, the readiness plan was rolled out, including the development of Standard Operating Procedures for epidemic response activation, coordination and information management tools, a CEA toolkit and health technical package.

C. DETAILED OPERATIONAL PLAN

Achievements for the 9th epidemic (Equateur)

	<p>Health</p> <p>People reached: 266,490 (42,352 HHs) Male: 125,250 Female: 141,240</p>	
<p>Health Outcome 1: The immediate risks to the health of affected populations are reduced through awareness raising about EVD and early detection</p>		
<p>Indicators</p>	<p>Actual</p>	<p>Target</p>
<p>Number of Red Cross branches provided with support in addressing the Ebola epidemic</p>	<p>4</p>	<p>4</p>
<p>Health Output 1.1: Improved early detection mechanisms of resurgence of Ebola through integrated community-based health interventions</p>		
<p>Indicators</p>	<p>Actual</p>	<p>Target</p>
<p># of health areas covered by RC case finding teams</p>	<p>23</p>	<p>6</p>
<p># of community leaders trained on early case finding by RC</p>	<p>30</p>	<p>231</p>
<p># Volunteers trained on Ebola early case finding procedure</p>	<p>322</p>	<p>140</p>
<p>% of people reached by active case finding that belong to minorities and/or vulnerable groups</p>	<p>35%</p>	<p>65%</p>
<p># of radio messages promoting active case finding behaviour change and use of Hotline</p>	<p>18</p>	<p>N/A</p>
<p>Health Output 1.2: Social mobilization, risk communication and community engagement and accountability activities are conducted to limit the spread and impact of Ebola</p>		
<p>Indicators</p>	<p>Actual</p>	<p>Target</p>
<p>% of SDB volunteers trained on CEA</p>	<p>100%</p>	<p>100%</p>
<p># of Ebola survivors and SDB families involved in our campaigns</p>	<p>324</p>	<p>324</p>
<p># OR % of staff and volunteers trained on community engagement approach</p>	<p>300</p>	<p>850</p>
<p># of system/protocols in place to collect, analyse, verify, and respond to community feedback received</p>	<p>3</p>	<p>5</p>
<p>Health Output 1.3: Identify and prepare communities to respond to the epidemic in potentially high-risk areas of the country</p>		
<p>Indicators</p>	<p>Actual</p>	<p>Target</p>
<p># of people reached by community engagement activities</p>	<p>266,490 (13%)</p>	<p>N/A</p>
<p>Health Outcome 2: Targeted health facilities with improved IPC practices and protocols to reduce infection of EVD</p>		
<p>Indicators</p>	<p>Actual</p>	<p>Target</p>
<p># of health facilities provided with RC support to improve IPC practices and protocols</p>	<p>13</p>	<p>50</p>
<p>Health Output 2.1: IPC activities conducted in 18 targeted health facilities in affected zone or at-risk zone in Mbandaka, North Kivu and Ituri (20)</p>		
<p>Indicators</p>	<p>Actual</p>	<p>Target</p>
<p># of local health facilities supported by IFRC working with and working for DRC Red Cross to combat EVD and ICRC</p>	<p>13</p>	<p>18</p>
<p># of assessments conducted based on IFRC standards</p>	<p>1</p>	<p>1</p>
<p># of health triage facilities established</p>	<p>13</p>	<p>18</p>
<p>Health Output 2.2 The targeted health facility staff have better capacity to provide safe patient care during EVD epidemic including triage, early detection of cases and early management</p>		
<p>Indicators</p>	<p>Actual</p>	<p>Target</p>
<p># of volunteers and health practitioners trained in IPC</p>	<p>950</p>	<p>1000</p>

Narrative description of achievements

- When the epidemic started, IFRC supported the deployment of 2 DRC RC staff (1 disaster management (DM) and 1 water, sanitation and hygiene (WASH)) to Equateur province for assessment of the situation and identification of needs. The National Society (NS) team was accompanied by the IFRC Cholera Operations Manager who was in country at that time. During the operation, IFRC and Movement partners supported the DRC RC branches in Bikoro, Bolenge, Iboko, Mbandaka and Wangata HZs in addressing the Ebola epidemic. 300 DRC RC volunteers were trained in community engagement approach and reached 266,490 people with CEA activities.
- 100% SDB volunteers have been trained on CEA and 324 Ebola survivors and members of families that had experienced an SDB were involved in our campaigns.
- Among volunteers, 60 have been trained specifically in safe and dignified burials (SDBs), 20 in Mbandaka, 20 in Bikoro and 20 in Itipo (Iboko HZ).
- Planned Infection Prevention and Control (IPC) activities were carried out by the Emergency Response Unit (ERU) health team deployed to Equateur province. There were 2 rotations of ERU teams were deployed. The ERU team built 13 triage and temporary isolation centres in 13 health facilities. The team had also equipped these centres with hygiene materials. In addition, ERU has provided IPC training to 950 volunteers and health practitioners in Mbandaka and Wangata HZs.
- The International Committee of the Red Cross (ICRC) also supported IPC activities in the same health facilities, in close collaboration with the IFRC-deployed ERU team. ICRC support was mainly targeting maternity units in those health facilities. In this regard, ICRC has supported the maternity units of the Mbandaka and Wangata general reference hospitals by training health personnel in EVD prevention, hygiene practice and waste management in child delivery rooms of the 2 reference hospitals, in close collaboration with the provincial Health Directorate and WHO.
- An Ebola preparedness operational plan has been developed and implemented in close collaboration with DRC RC and interested partner NS (PNSs) (Swedish Red Cross, Canadian Red Cross, Spanish Red Cross)
- At the beginning, the host National Society did not have an Ebola focal person. With IFRC support, this position has now been filled and the person, who is the NS counterpart to the IFRC's Head of Emergency Operations (HeOps), had been working with DRC RC counterparts with ERU, IFRC surge and PNS staff in the field. This has contributed to strengthening the operational capacities of the host NS for subsequent epidemic response. ICRC teams have been providing EVD awareness to the police, the army and judicial authorities.

Challenges

- Difficult access to intervention areas due to poor infrastructure. The major means of transportation to the epicentre of the outbreak from Mbandaka to Bikoro town was by 4x4 vehicles during the dry seasons; however, during rainy seasons, the roads become impassable and thus the only means of accessing the area was with the use of motorcycles and helicopters. UN had rerouted its helicopter programme to allow helicopter flights from Mbandaka to Bikoro. Water way transportation was also a very prominent means of movement. ICRC offered an ambulance boat to the provincial branch of M'Bandaka

Lessons learned/ Key drivers/enablers of success.

- Good collaboration/participation of French Red Cross in the deployment of ERU and then delegates. French Red Cross under the lead of IFRC supported the DRC Red Cross for the implementation of IPC activities with the main objective of supporting the prevention and control of infections in health facilities in order to avoid nosocomial infections or to avoid the contamination of patients, nursing staff and other users of the services of the health structure.

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	9,208	N/A

Health Output 3.1: Preserving or restoring the psychosocial well-being of SDB volunteers directly or indirectly affected by the EVD

Indicators	Actual	Target
# of group sessions conducted to reduce stress and anxiety for SDB team	60	60
# of volunteers trained in PFA	108	108
Narrative description of achievements <ul style="list-style-type: none"> Overall, 9,208 people have been reached by psychosocial support and 60 group sessions conducted to reduce stress and anxiety for SDB team. 		
Challenges <ul style="list-style-type: none"> It has not been easy to mobilise psychosocial support (PSS) surge capacity for this operation. Nevertheless, the French Red Cross deployed its PSS specialist who conducted an assessment in the field and drafted a list of PSS needs to be covered. 		
Lessons learned/ Key drivers/enablers of success. <ul style="list-style-type: none"> The programme of capacity building in PSS for committee members in Equateur and Kinshasa was important for the success of the operation. The PSS planned creative and recreational activities to relieve stress from the beneficiaries were very successful in the 4 health zones activated, namely: Mbandaka; Bolenge; Wangata and Bikoro 		
Health Outcome 4: The spread of Ebola is limited by disinfection of affected houses and safe burial of the dead under optimal cultural and security conditions		
Indicators	Actual	Target
# of contaminated houses/areas disinfected	70	N/A
Health Output 4.1: The affected population is assisted through safe and dignified burial of suspect and confirmed EVD deaths		
Indicators	Actual	Target
# of SDB alerts responded to by SDB teams	36	NA
# of volunteers trained in infection prevention and control as well as in SDB	180	180
% of SDB alerts successfully responded to by SDB teams	64%	>80%
Health Output 4.2: Areas at risk of EVD importation are well prepared for SDB activities		
Indicators	Actual	Target
# of SDB teams trained in area at risk	8	N/A
# of SDB starter kit prepositioned in at risk area	8	N/A
Narrative description of achievements <ul style="list-style-type: none"> In the 9th epidemic, the Red Cross received 81 alerts of deceased people who were suspected of having EVD. Out of the 81 alerts, the Red Cross performed 36 safe and dignified burials (SDB). The remaining alerts were either buried by relatives before the information could get to the Red Cross or refused SDB. The refusals were mostly associated with cultural beliefs. Trained Red Cross volunteers disinfected 70 houses where suspected EVD cases had spent time. In addition to SDB and disinfection activities, DRC RC volunteers supported by IFRC-deployed surge staff conducted hygiene and sanitation work, reaching 18,838 households and an average of 125,058 people with safe hygiene and sanitation messages, with focus on Ebola prevention and protection messages. The messages prepared in French were also translated into Lingala to facilitate communication with vulnerable people. ICRC conducted health and WASH activities at the Mbandaka prison. Activities implemented include the following: <ul style="list-style-type: none"> - Training of the health team of the prison in EVD risks - Distribution of 30 hand-washing devices and thermometers - Distribution of hygiene tools to the health centre at the prison, including soap, buckets, hand-washing devices, chlorine, detergent, boots, household gloves, medical thermometers and basic dressing kits - Training of prisoners in hygiene and disinfection practices - Donation of hygiene materials to prisoners, including buckets, plastic cans, hand-washing devices and soap - Strengthening access to water in the prison by improving 2 water wells, installing 6 big containers and downpipes - Improving the system for evacuating waste waters 		


Challenges

- Challenges to adapt SDB minimum requirements to make them culturally acceptable.
- It was challenging to build SDB capacities at the beginning of the 9th outbreak and to cover the scale and reach of SDBs, while maintaining quality in the 10th outbreak, particularly given the issues of access and the initial lack of materials and training for volunteers. Technical support from Geneva and experienced West African delegates meant the IFRC was able to build capacities over time. The RCRC was able to maintain more than an 80% success rate throughout the response under difficult conditions, , and DRC RC volunteers and branches gained skills and capacities in SDB and were able to take on more responsibility.

Lessons learned/ Key drivers/enablers of success.

- The training of SDB volunteers in CEA has enabled them to be more effective. Community Engagement and Accountability (CEA) was recognized as a “gold standard” for CEA for the IFRC. It was vital given the context and the high levels of community resistance. CEA was also an integral part of the security system in DRC and played an important role in understanding and reassuring communities. The CEA pillar adapted well to changes on the ground and there is evidence it was used to inform changes in the other pillars, particularly SDB (e.g., the “clear-view” window body bag so families could see the body) and reduce community resistance. The pillar developed its data gathering and analysis capacity over the duration of the response and developing a comprehensive rumor-tracking mechanism that is recognized and used by other organizations. This work was noted as having put IFRC at the heart of the response. Indeed, the IFRC did a lot to raise the profile of CEA – the dashboard, data sets, and deep dives were all made available via the Community Feedback Commission - however, it was challenging to engage other actors and even the RCRC management to ensure the information was fully used to improve delivery and crucially inform operational decision making. Nevertheless, extensive work was conducted, notably through collaboration with the IFRC CEA and IM functions in the DRC along with technical support from USCDC, to build the CEA and IM capacity of volunteers at the branch level.

Achievements for the 10th epidemic (North Kivu, Ituri and preparedness in South Kivu, Tshopo, Maniema, Haut-Uele)

	<h3 style="color: red;">Health</h3> <p>People reached: 4,909,533. Male: 2,307,481 Female: 2,602,052</p>	
Health Outcome 1: The immediate risks to the health of affected populations are addressed through scaled up community engagement and early detection approaches		
Output 1.1: CEA activities are conducted to limit the spread and impact of EVD, COVID and other co-occurring health risks		
Indicators	Actual	Target
# Red Cross branches provided with support in addressing the Ebola epidemic	10	10
# of people reached in affected communities that are supported by the operation to effectively detect and respond to the EVD epidemic in DRC	3,993,291	4,400,000
Health Output 1.2: Community feedback mechanisms are in place and feed into programming		
Indicators	Actual	Target
# of people reached in affected communities with RCCE activities to identify and reduce health risks of Ebola in Democratic Republic of Congo	3,993,291	4,400,000
# of feedback data points collected and analysed from comments shared by the community during CEA activities and systematically added to the Red Cross Community Feedback Database	1,636,923	1,500,000
% of community feedback received by DRC RC volunteers as comments of appreciations or encouragements to the Red Cross and the response in general	17%	20%
Narrative description of achievements		

➤ North Kivu and Ituri Provinces Achievement

- RCCE activities were conducted in all communities across the eastern DRC using different approaches to facilitate community feedback analysis, community-based activities, specifically house visits, community dialogues, educational talks, community meetings and focus group discussions. In total, 981 CEA volunteers have reached 3,993,291 of the target population with door-to-door and mass sensitization activities. 1,636,923 community feedback data points have been collected from community members, analysed and informed decision making across pillars. This is one of the largest feedback platforms developed by the Red Cross Red Crescent Movement in the world.
- The RCCE activities were complemented by interactive radio programming and intensified different group engagements including local opinion leaders, community leaders, local health workers, traditional healers, community animation cells (CAC), motor taxi associations, women's groups, and youth associations. This has strengthened community participation, ownership, and enhanced community access e.g., strengthening community involvement through local leaders and other opinion leaders, some of whom were previously associated with community resistance and violence. Now these leaders were involved in the awareness raising activities of the Red Cross, including participation in the radio programs to help mobilize their own community and support the work of Ebola plus. Volunteers in the different operational bases continued to use social media, especially WhatsApp platforms that were created to facilitate exchange of information on EVD and COVID-19 and to inform their communities, collect feedback and return to communities with appropriate responses and solutions to analysed community feedback.
- The CEA team shared most prominent weekly community feedback collected during community mobilization with Internews for use to produce the weekly *"Tulivyo Sikia"* bulletin which is shared widely with IFRC and DRC Red Cross and other stakeholders/partners present in the communities after analysis and recommendation. This also helps to increase the coverage of the people and institutions reached with regularly analysed community feedback. The volunteers were briefed on daily basis with answers from the bulletin to respond to community feedback. After the declaration of end of the 10th Ebola epidemic, the CEA teams continued community mobilization activities to build community capacity to prevent and prepare for disease epidemics. This period also marked the full deactivation of CEA activities in Eastern DRC for the 10th Ebola virus epidemic.

➤ Former Preparedness Provinces

- EVD+¹ activities carried out in the South Kivu Province where DRC Red Cross volunteers intensified community awareness sessions despite various challenges in the field. This was important in view of the rising cases of COVID-19 that required adaption of the EVD prevention messages to include symptoms, methods of transmission and prevention for the two diseases. As per other preparedness areas such as Tshopo and Maniema, RC volunteers collected community feedback including concerns, rumours, beliefs, observations, questions, suggestions, and thanks that helped adapt EVD response activities and awareness messages to meet the needs of communities. Responding to this feedback allowed the communities to realise that their points of view were considered by the Red Cross and increasingly generated a mark of confidence towards the Red Cross.
- In addition, the community feedback was shared both internally and externally mainly with the risk communication sub-commissions headed by the health divisions of the provincial Ministry of Health. This helped facilitate strategic discussions and decisions making. For instance, after receiving feedback that the population did not understand the COVID-19 protocol applicable to schools and considering the start of the 2020-2021 school year was near and all the risks associated with this virus in South-Kivu province, the provincial Ministry of Health made the decision to participate in the Red Cross radio broadcasts on awareness raising against the epidemics in order to clearly explain this protocol to communities and respond to various concerns and questions of the listeners.
- As a result of the feedback shared, other partners were able to develop appropriate community engagement approaches that aimed to further reduce anxiety and fear amongst communities and addressed rumours as

¹ EVD plus activities include information on preventing and spread of Ebola virus disease and other diseases of epidemic potential, in this case including COVID-19

well different cultural perceptions about Ebola and COVID-19 diseases. Moreover, the feedback guided the local Red Cross of South-Kivu, Maniema and Tshopo in developing tailored capacity building sessions for focal points, supervisors and team leaders involved in CEA activities on the management and analysis of community feedback data. Such sessions allowed above mentioned staff to better analyse and visualize community feedback on a regular basis and produce information products such as regular community feedback reports, updates on trends among others.

➤ Radio programmes

- The radio programmes were developed to reach as many people as possible, mostly those who are in remote and unreachable areas. Three community radios were selected namely RTNC (Radio Télévision Nationale Congolaise), Radio Maendeleo and RTCM of Minova. A total of 60 broadcasts and over 67 radio spots have been produced so far (two broadcasts per week and 10 spots per month for each radio). It is projected that these programmes have reached approximately 6.5 million people in South-Kivu province and its surroundings. Themes discussed were inspired from feedback collected by Red Cross volunteers during their door-to-door sensitization. Experts and local speakers made their contribution to respond and clarify community feedback. The radio programmes helped communities to better prepare for epidemics (with a particular attention on Ebola and COVID-19), change risky behaviour and develop safe practices. Based on their achievement, the RTNC in November 2020 granted the Red Cross a bonus of 40 free broadcasts to meet the increasing demand of its listeners who appreciated the programs and wanted much more. A single broadcast on the radio costs \$60, that means the Red Cross benefited a sum of \$ 2,400 in surplus value. Nevertheless, the contracts with all the radios expired at the end of December 2020.



Figure 6: Radio broadcast to raise awareness on Ebola Prevention-Photo DRC RC

- Volunteers **Engaged:** The Red Cross relied on its dynamic network of volunteers for CEA activities to respond to information dissemination of EVD plus. In the South-Kivu province, 133 volunteers were involved of whom 43 were women, Maniema: 38 volunteers of whom 12 were women and Tshopo: 70 volunteers of whom 20 were women.
- Information **kiosks:** Information Kiosks are small pavilions set up on the sidewalks where people come to learn about epidemics. In the province of South Kivu, there were four of which three were in the city of Bukavu and one in Minova. They were operational three times a week from 10 a.m. to 2 p.m. operated by two volunteers per day. Each Kiosk had a sound kit that was used to play educational songs. One volunteer inside the kiosk had tally cards, leaflets to hand out and a megaphone with which to launch messages. This created an interest among passers-by who, out of curiosity, approached the kiosks to try to understand message being projected giving an opportunity to educate them. The volunteer outside the Kiosk, explained to people about the posters pasted on the Kiosk and guided them to the hand washing point placed right next to the Kiosk and was responsible for collecting feedback from visitors to the Kiosk and providing answers to their concerns to the extent of his skills. Before the advent of COVID-19, this volunteer approached people to encourage them to follow the messages at Kiosk. It was expected that all information kiosks will remain operational despite the deactivation of volunteers end of November 2020 in order to keep communities informed and prepared about epidemics.

Key drivers/enablers of success


- Acceptance of the DRC RC in the community, capacity building of the CEA volunteers and the integration of the CEA in the RRT and other pillars created synergy and smooth implementation of activities.
- The use of the hotline by community members to report alerts (deaths of family members, suspected COVID cases and other communities' issues) showed community participation and engagement in community-based surveillance and prevention of diseases.
- Good collaboration with other partners such as the Ministry of Health.
- Support from the local radios including getting free airtime to further spread reach of messages.
- Support from the RCCE Commission.

Challenges

- Some churches and schools do not follow COVID-19 preventive measures such as wearing masks and physical distancing during services or classes. Following this observation, the CEA volunteers organized educational talks with religious leaders and teachers to increased awareness of the existence of COVID-19 and invited them to participate in the radio show. The full deactivation of CEA volunteers had an impact the COVID-19 community mobilization. IFRC CEA team continued de provide minimal technical support and assistance to the DRC RC CEA team as needed.
- All CEA volunteers involved in the 10th epidemic were deactivated on November 30th, 2020. Due to lack of funding, the information kiosks were not given to the local National Society of Beni, Mangina and Butembo as planned for this period.

Lessons learned/ Key drivers/enablers of success.

- Engaging communities and responding to feedback were essential in building trust between communities and the Red Cross to ensure effective risk communication, community engagement and collaborative action. Therefore, rapid and frequent regular collection of community feedback from activities such as house visits, community dialogues and meetings have been very helpful to adapt messages based on community needs and priorities and increased adoption of healthy practices at all stages of the response. Sharing them with the government-led communication commissions in different epidemic locations allowed common understanding and facilitated coordination amongst partners intervening in RCCE.
- Increased awareness activities tailored to the context would be the best way to reduce high-risk behaviours as they are directly conducted within the community. These can be either door-to-door or as a group with the full participation of the very community members, who also many times proffer local solutions that are very sustainable.
- Some of the communities mainly in South-Kivu area felt that Ebola and COVID-19 were getting so much attention when there were other serious health issues such as malaria and cholera. To address this feedback, Red Cross volunteers included messages on how to prevent both malaria and cholera in their RCCE activities. This approach enhanced acceptance among the community of the awareness messages on Ebola/COVID-19 carried by Red Cross volunteers.
- Engaging with the community before/after any epidemic and involving them in decisions are keys milestones to increase community acceptance, to promote healthy practices and to understand the community's cultural and social norms. RCCE work should continue even after the epidemic ends, as a means of helping communities develop their own strategies to fight the Ebola and other epidemic diseases such as the current COVID-19 epidemic.
- The hotline number played the role of phone alert system for rapid notifications of persons suspected of having COVID-19, car accidents and flooding in the communities. The CEA team used feedback from the hotline as formative evaluation data, drawing from the communities needs to adapt messages, improve quality of services, improve outreach and social mobilization awareness on disease prevention and improve community-based surveillance for Ebola and COVID-19. CEA teams also worked in collaboration with other pillars such as RRT, SDB, IPC and PSS to improve quality of services and acceptance in the community especially the RRT.

Health Outcome 2: Infection risk to the affected populations is reduced through infection prevention and control measures		
Indicators	Actual	Target
# of local health facilities supported to effectively detect and respond to infectious disease epidemics -during the Ebola operation in the Democratic Republic of Congo	55	40
# of people screened in communities in local health facilities supported to effectively detect and respond to infectious disease epidemics	4,909,533	5,400,000
Health Output 2.1: Targeted health facilities (including traditional healers) are better protected through improved IPC practices		
Indicators	Actual	Target
% of Red Cross supported health facilities having obtained an IPC score greater than or equal to 80% to reduce the risk of nosocomial transmission	70%	70%
% of Red Cross supported health facilities having an IPC package in line with MoH standards and protocols to improve IPC practices and protocols and reduce the risk of nosocomial transmission of EVD	67%	100%
# of temporary isolation spaces converted to permanent structures	30	20
Narrative description of achievements		
	<p>In total 55 health facilities have been supported with an IPC package, supervision, training. 333 DRC RC volunteers have screened 4,909,533 people (23% under 18 years; 53% female), referred 1,450 suspected cases (86 cases were confirmed following the laboratory test), completed 2,204 decontaminations and trained more than 403 health care workers (including 222 women).</p>	
<p>Figure 7: An isolation tent in use - Photo DRC RC</p>		
<p>Challenges:</p> <ul style="list-style-type: none"> • The security events in Bunia and Beni prevented in-person follow-up with the facilities in this area. This also slowed down implementation of some activities. IFRC had limited understanding of the security / risk environment and was reliant on the ICRC for all security/risk analysis and decision-making. This increased IFRC's risk exposure. Security and access were primary determinants in the prolongation of the crisis and a stronger understanding of the evolving operating environment would have allowed for better contingency and operational planning. IFRC did have security input from the RO and some in-country security support, however, it would have been important to enhance the IFRC's security role and engagement with ICRC, particularly around analysis. This was rectified in late 2019, when a virus risk analysis tool was created in Goma, however it was arguably added too late in the response to have supported it in a major way. This lack of understanding likely contributed to the IFRC not defining an 'acceptable risk threshold' for eastern Congo. No red line was ever established as a trigger for IFRC to evacuate/ relocate its staff and structures. This remained under the ICRC guidance in the L3. As ICRC has a different risk threshold given its mandate, it is critical for the IFRC to define its own organizational red lines based on its acceptable risk appetite. • Difficulty experienced to finish the hard WASH constructions on time. • Limited source of water - improve access to water and sanitation on giant incinerator sites by constructing latrines and water supply systems. 		
<p>Lessons learned/ Key drivers/enablers of success.</p> <ul style="list-style-type: none"> • Improvement in the score of the health facilities through the completion of the WASH works in the health facilities contributed to efforts to slow the spread of EVD and COVID-19 in the operation areas. 		

- Improvement access to water and sanitation through installation of giant incinerator sites, construction of latrines and water supply systems in health facilities contributed to efforts to slow the spread of EVD in the operation areas.
- Training of volunteers and HCs staff in the use of giant incinerators and WASH structures was a key element in DRC RC capacity building.
- Activation of the hygiene committees in the FOSA was essential in the effectiveness of IPC activities.
- The donation of IPC items to the FOSAs, training the focal points of the hygiene committee in use and management of items is essential for the implementation of IPC pillar.

Health Outcome 3: Transmission of diseases of epidemic potential is reduced

Indicators	Actual	Target
% of SDB alerts successfully responded to by SDB teams	88%	80%

Health Output 3.1: Red Cross RRT are set up to conduct patient transfer activities to allow safe access to health care services

Indicators	Actual	Target
# of multisectoral RRT trained and equipped	78	72
% of active multisectoral RRT out of the total trained	28%	25%
# of cases of illness among RRT personnel	0	0
# of volunteers identified and trained to form CBS teams Target: 240	0	240
% of patient transport requests that resulted in RRT transportation	92%	100%

Narrative description of achievements

- Activities were implemented only at the end of the epidemic, during recovery. In total, 25,847 (88%) of the 29,357 SDB alerts have been completed successfully by Safe and Dignified Burials teams including 32 Red Cross, 26 Civil Protection, 48 community-led harm reduction burial teams (ECUMR) trained by the Red Cross and 37 community burials teams trained by Civil Protection. Overall, 53% of alerts were responded to by the Civil Protection, 41% were responded to by the Red Cross and 6% of alerts responded to by ECUMR teams. Then 87% of successful SDBs were carry out without community resistance (Target: 90%)
- During the 10th Ebola epidemic, the DRC Red Cross mobilized a total of 915 volunteers in mobile SDB teams and ECUMRs. These teams were spread across the three affected provinces (North and South Kivu as well as Ituri) and in 29 health zones and 211 affected health areas.
- On the material side, in order to protect the community, to protect itself and to fight against the spread of the Ebola virus disease, the Red Cross and Red Crescent movement had equipped all the bases working in the SDB pillar with covered Pickup vehicles (Canopy) to transport hygienic materials as well as the transport of bodies, but also a long chassis vehicle to transport the interveners (teams).
- Rapid response teams (RRTs) were set up to be operational and replace SDB teams so that once the Ebola epidemic was declared over, they would be involved in provision of first aid services, securing bodies of people suspected to have died of contagious diseases to minimise post-mortem spread and safe transfer of patients to health facilities. In the whole operation, there have been 78 RRTs trained and equipped to give support to the communities where they come from as needed. Data collection forms for RRT have been designed to enable the capture of types of services given by the RRTs. The RRT strategy has been instrumental in enabling the community and other stakeholders view the Red Cross as not being an Ebola only actor.
- The rapid response teams received 666 alerts. This included 386 alerts of suspected or confirmed COVID-19 cases, 209 alerts for first aid interventions, 33 suspected Ebola alerts and 36 alerts due to other diseases. RRT responded to these alerts, in cases of patient transfers to health facilities.
- Belgian Red Cross deployed a CBS specialist to conduct evaluation on CBS in Ebola affected areas. The report of this evaluation was shared and disseminated to movement partners and MoH. After Evaluation mission on CBS, a plan was proposed to pilot CBS and Nyss in North Kivu, Ituri, Equateur and South Kivu. In this regards a ToT was organized on ECV. In December 2020, 20 RC volunteers were trained as master trainers on epidemic control for volunteers (ECV). Next steps was the CBS training and Nyss. But unfortunately, these activities did not happen due to lack of fund mainly.
- The RRTs were deactivated in January 2021 for South Kivu and North Kivu Provinces; however, they remained activated in Ituri Province for EVD and COVID-19 activities around the IDP site of the ISP (Institut Supérieur Pédagogique).

- With the 12th epidemic declared in North Kivu Province, the IFRC reactivated four rapid response teams trained during the 10th epidemic in the health zones of Butembo and Katwa. These teams were reinforced by three other teams trained in SDB, decontamination and patient transport in the Biena and Musienene health zones. These are two teams of six volunteers each for Biena and one team for Musienene.
- The rapid response teams in Ituri and Equateur remained active in securing the bodies of people suspected of having died from EVD or Covid-19, and the safe transfer of patients to health facilities. For North Kivu, starting February 7, 2021, the rapid response teams focused on conducting SDB, transporting patients in general and decontaminating the households of EVD patients and health facilities that received confirmed or suspected EVD cases. During this period, the rapid response teams responded to 1,198 EVD and Covid-19 alerts out of the 1,534 received. These included 202 alerts for SDB, 551 for patient transport, and 445 for decontamination.



Figure 8: SDB training in Goma- Photo IFRC



Figure 9: Conducting SDB- Photo DRC RC



Figure 10: Preparation of a team volunteers in Ebola operation -Photo DRC RC

Challenges

- Unavailability of funds for the IFRC to continue supporting the activities of the rapid response teams and to implement planned CBS activities at the end of the 10th epidemic (June 2020).
- Insecurity in some areas of intervention in North Kivu, which has led to the restriction of humanitarian movements.
- The COVID-19 context disrupted the implementations of activities in all targeted areas. However, the DRC/IFRC RC teams monitored activities remotely. The main challenges were difficulty of accessibility of some project areas due to movement restrictions in the COVID-19 situation and the state of emergency decreed by the DRC government in March 2020. Another challenge was the transport of contingency stocks to the field (e.g., the case of Isiro which took 1 month on the road by land). All these factors delayed the implementation of activities in Haut-Uélé provinces and some areas of Maniema. When the state emergency was lifted on 15th August, activities were rescheduled.

Lessons learned/ Key drivers/enablers of success.

- RRTs were needed to improve acceptance of SDB by embedding it in other health activities that communities really wanted, and then to move to a multi-epidemic response capacity.

<ul style="list-style-type: none"> RRT established by RC were involved in sensitization and spread of key messages on COVID-19 prevention and feedback collected from communities. These working closely with MoH surveillance teams played a big role in COVID-patient transfer in Bukavu, Goma and Bunia. 		
Health Output 3.2: Capacity to detect, report and respond to diseases with epidemic potential is strengthened		
Indicators	Actual	Target
# of SDB volunteers retrained to conduct post-mortem surveillance	70	70
# and % of deceased suspect cases responded to with RDT-based post-mortem surveillance during the post-epidemic period of heightened surveillance	417 carried out (98,3%)	424 of alerts
Narrative description of achievements <ul style="list-style-type: none"> During the period of heightened surveillance after the declared end of the epidemic, DRC Red Cross SDB teams in Beni were transformed and equipped to provide post-mortem surveillance by administering rapid diagnostic tests (RDT) to deceased suspect cases. Red Cross worked in 10 health areas with a total of 70 volunteers including 8 team chiefs and 2 supervisors. DRC RC teams worked in partnership with MoH, IMAPP and FHI 360 to deliver post-mortem surveillance activities. Overall, 424 alerts deceased suspect cases were received by Red Cross team based post-mortem surveillance during the post-epidemic period of heightened surveillance. Red Cross teams carried out 417 of the RDTs (98,3%) of which 55% were from deaths in health facilities and 45% in the community. 		
Challenges <ul style="list-style-type: none"> Post-mortem surveillance activities were stopped earlier. Then there were the 12th and 13th Ebola outbreaks in the Beni area. It might be important to carry out post-mortem surveillance over a longer period of time in order to contribute to the prevention of Ebola epidemics. 		
Lessons learned/ Key drivers/enablers of success. <ul style="list-style-type: none"> Ebola Rapid diagnostic tests (RDT) were adequate to support testing of community deaths and especially in insecure settings. The use of RDT was important to shorten the result turnaround time and to support decision-making on whether or not a SDB was required. This has contributed to reduce tensions between community and response teams to boost their commitment to EVD activities. Post-mortem (Ebola RDT) testing can effectively complement outbreak response efforts both during epidemics and enhanced surveillance. However, community trust and well-trained local staff are key to success. Good collaboration and coordination between stakeholders/consortium (MoH, IMAPP, FHI360, Red Cross, etc) contributed to the success of post-mortem surveillance activities within 90 days of the end of the epidemic 		
Health Outcome 4: The psychosocial wellbeing of impacted communities and volunteers is improved		
Indicators	Actual	Target
# of participations in psychosocial support activities during the Ebola operation in the Democratic Republic of Congo	91,451	90,000
Health Output 4.1: Psychosocial support provided to the volunteers and staff		
Indicators	Actual	Target
# of DRC RC bases involved in the EVD response supported by psychosocial support activities.	7	3
# of activities implemented by trained and supervised PSS volunteers to reduce the psychosocial impact of the EVD epidemic.	11,155	10,000
# of trained volunteers implementing PSS services to preserve or restore the psychosocial well-being of volunteers involved in the EVD response.	50	42
# of health structures providing specialised psychological care for DRC RC volunteers requiring acute support.	1	7

Narrative description of achievements

- PSS teams reached staff and volunteers with 91,451 participations through 11,155 PSS activities.
- Activities implemented were PFA, individual and group PSS sessions, psycho education sessions and awareness raising sessions. There was also the provision of PSS activities to DRC RC staff and volunteers.
- A workshop was conducted with all Focal points/supervisors to ensure smooth phase out from PSS activities of the 10th epidemic. The Workshop was attended by 7 Focal points and supervisors and the aim was to bolster technical and managerial skills. With an end objective to identify capacities after 2 years of PSS programming to allow for identification of persons who have the capacity to manage and support future PSS interventions.
- Two assessment visits were conducted to Bunia to inform future programming targeting IDPs in the area. The assessments highlighted the lack of sufficient services to the IDP camp population additionally exacerbated by the lack of coordination amongst service providers to better serve the community in question. This informed the structuring of the foreseen PSS intervention in said camp, namely the need to strengthen community interventions and resources hence empowering the camp community to be better aware how to access services and how to provide support at community level etc. Also, the need to work on strengthening the capacity of other field service providers on issues pertaining to PSS (namely identification and referral). Finally advocate to make available higher level mental health PSS (MHPSS) and protection services for the camp community.

Challenges

- Weak capacity of some service providers in the field on PSS issues (in particular, the understanding of the process of identification and referral of cases by volunteers).

Lessons learned/ Key drivers/enablers of success.

- Review and improvement of data collection and reporting tools enhanced accurate collection of data used to report on the indicators.
Timely and successful closure of PSS activities regarding the 10th epidemic ensured that needs were covered, and the staffing left would ensure proper closure of the active cases.

Health Outcome 5: Contribute towards preventing the spread of Ebola in South Kivu, Tshopo, Maniema and Haut Uélé provinces through social mobilization, risk communication and community-based surveillance activities**Health Output 5.1: Conduct Ebola preparedness activities in South Kivu, Tshopo and Haut Uélé provinces through social mobilization, risk communication and community-based surveillance activities**

Indicators	Actual	Target
# of volunteers per health zone receiving basic integrated training on CEA, IPC, SDB, CBS and PSS	24	30
# of master trainers actives and transferring knowledge to volunteers in targeted provinces	551	523

Health Output 5.2: Contribute towards preventing the spread of Ebola in South Kivu, Tshopo, Maniema and Haut Uélé provinces through social mobilization, risk communication and community-based surveillance activities

Indicators	Actual	Target
# of people reached targeted communities with risk communication and community engagement activities to identify and reduce health risks of Ebola in DRC	553,106	1,000,000
# of information functional kiosks set up	9	11
# of handwashing stations set up	30	30
# ofapid Response Teams trained and equipped	78	72

Narrative description of achievements

- Preparedness activities were implemented in 4 provinces (South Kivu, Maniema, Haut Uele and Tshopo) in 13 health zones. A total of 551 volunteers were trained and 78 rapid response teams set up, of which 22 were activated. CEA awareness-raising activities were also conducted these provinces. In total, DRC Red Cross volunteers reached 553,106 people by EVD and COVID-19 prevention messages. A total of nine information kiosks are established in Bukavu, Minova, Kisangani, Bafwasende and visited more than 21,000 people.

- As part of the Ebola and COVID-19 response, the South Kivu Red Cross branch, in collaboration with the Bukavu town hall, forged a partnership for nearly 100 volunteers from the Kadutu commune were mobilized to encourage the community to practice environmental hygiene, especially in the context of COVID-19. Thus, a large-scale sanitation action was organized in Bukavu on 6 June 2020 with the participation of almost 100 RC volunteers. In addition, a total of 30 handwashing stations were installed in certain public places in Bukavu (including 10 kits in Katudu and 10 kits in Ibanda).
- In order to reduce the reticence surrounding rumours linked to epidemics and the acceptance of RC volunteers in the community concerning the meetings, the South Kivu CEA teams organized six community dialogue meetings in Bukavu and Minova with the participation of 79 leaders, administrative authorities and pressure groups. These were 3 meetings in Bagira with 26 participants, 1 Kadutu meeting with 20 participants, 1 meeting in Ibanda with 15 participants and Minova 1 meeting with 18 participants.


Challenges

- As a challenge, CEA teams in Kinsangani and Bukavu have been attacked by communities due to rumours about COVID-19. Addressing these issues, community dialogue meetings were held in Bunaku and Kisangani, with the participation of influencers and influential key leaders.
- Due to the lack of contracts with local radio stations, radio broadcasting activities could not be implemented as planned.

Lessons learned/ Key drivers/enablers of success.

- Dissemination of EVD and COVID-19 prevention messages through information kiosks was an innovative activity which increased the visibility of DRC RC in Bukavu, Kisangani, Minova and Bafwasende.

Achievements for the 11th epidemic (Equateur)

	<h3 style="color: red;">Health</h3> <p>People reached: 456,491. Male: 205,421 Female: 251,070</p>	
<p>Health Outcome 1: The immediate risks to the health of affected populations are addressed through scaled up community engagement and early detection approaches</p>		
<p>Output 1.1: RCCE activities are conducted to limit the spread and impact of EVD, COVID 19 and other health risks</p>		
<p>Indicators</p>	<p>Actual</p>	<p>Target</p>
<p># Red Cross branches provided with support in addressing the Ebola epidemic</p>	<p>2</p>	<p>2</p>
<p># of people reached in affected communities that are supported by the operation to effectively detect and respond to the EVD epidemic in DRC</p>	<p>426,778</p>	<p>600,000</p>
<p>Health Output 1.2: Community feedback mechanisms are in place and feed into programming</p>		
<p>Indicators</p>	<p>Actual</p>	<p>Target</p>
<p># of people reached in affected communities with RCCE activities to identify and reduce health risks of Ebola in Democratic Republic of Congo</p>	<p>228,121</p>	<p>600,000</p>
<p># of data points collected and analysed from comments shared by the community during CEA activities and systematically added to the Red Cross Community Feedback Database</p>	<p>114,442</p>	<p>300,000</p>
<p>% of community feedback received by DRC RC volunteers as comments of appreciations or encouragements to the Red Cross and the response in general</p>	<p>20%</p>	<p>20%</p>
<p>Narrative description of achievements</p>		

- In total 426,778 of people reached in affected communities that were supported by the operation to effectively detect and respond to the EVD epidemic in DRC.
- 528 CEA volunteers reached 228,121 people (58% under 18 years and 55% women) with door-to-door sensitization.
- 114,442 community feedback data points were collected from community members, analysed, and used to inform decision-making across pillars.
- Communities were engaged in various activities through women's groups, traditional healers, pharmacists, motor taxi associations, local health workers and CACs (Cellules d'Animations Communautaires). From community feedback collected and analysed, community-based activities including households visits, community dialogue, mass sensitization, educational talks and focus groups discussions, the engagement sessions provided information based on community needs and issues which have driven essential service provision in the affected community and promoted healthy and safe social practices and community ownership of their own health. Communities were mobilized and empowered to prevent and stop the spread of Ebola and COVID-19 through provision of relevant, clear, and tailored information and meaningful dialogue to reduce resistance and increase community acceptance, address stigmas for Ebola survivors, rumours or cultural misperceptions based on the feedback received. Incorporating CEA into all pillars and emergency programming at the NS level continues. CEA teams also conducted activities to strength capacity of the NS staff and volunteers to communicate and engage with the communities in improving awareness and understanding of the importance of accountability and transparency during community engagement activities.
- More than 40 interactive radio programs anchored by the volunteers were conducted across Equateur province and rebroadcasted to raise the profile of the DRC RC and improve engagement with the communities. The radio programs were interactive allowing two-way communication, the CEA volunteers could listen, answer, and address the community's questions about Ebola and COVID-19. Radio programs were well received in the communities, with increasing number of phone calls and SMS messages from the community members every week. Feedback collected during the radio programs helped plan the radio show based on information needed in the community.
- The hotline also served as a rapid notification system of suspected Ebola or COVID-19 cases, car accidents and flooding in the communities. The CEA team used feedback from the hotline as formative evaluation data, drawing from community needs to adapt messages, improve quality of services, improve outreach and social mobilization awareness of disease prevention, and improve community-based surveillance for Ebola and COVID-19. CEA teams also worked in collaboration with other pillars such as RRT, SDB, IPC and PSS to improve quality of services in the community.
- The CEA teams shared weekly community feedback collected during community mobilization with Internews for use to produce the weekly "*Tulivyo Sikia*" bulletin, which is shared widely with IFRC, and DRC Red Cross and other stakeholders and partners present in the communities after analysis and recommendation. This also helps to increase the coverage of the people and institutions reached with regularly analysed community feedback. The volunteers were briefed daily with answers from the bulletin to respond to community feedback. After the declaration of end of the 11th Ebola epidemic, the CEA teams continued community mobilization activities to increase community-based surveillance awareness and build community capacity to prevent and prepare for disease epidemics.
- The CEA team used feedback from the hotline as formative evaluation data, drawing from community needs to adapt messages, improve quality of services, improve outreach and social mobilization awareness of disease prevention, and improve community-based surveillance for Ebola and COVID-19. From community feedback collected and analysed, community-based activities including households visits, educational talks and focus groups discussions, the engagement sessions provided information based on community needs and issues which have driven essential service provision in the affected community and promoted healthy and safe social practices and community ownership of their own health. IFRC CEA team conducted evaluation of the volunteers' level of knowledge on disease with epidemic potential such as cholera and measles to ensure a better capacity building before deactivation. After the evaluation, the IFRC CEA team organized multiple refresher training for the 167 volunteers from four different health zones on different topics including community-based surveillance, malaria, cholera, measles, Ebola, and Covid-19. The IFRC CEA team in collaboration with the National Society provincial office started the process of scaling down of CEA volunteers at the end of January and with full deactivation on February 28, 2021.

Challenges:

- There was difficulty in collecting feedback forms from remote areas with limited accessibility by road network and no telephone services or internet. This often to delays in receipt of data and hence analysis and sharing of findings.
- Lack of phone network coverage and no access to radio station to use for sensitisation in some areas meant that some of the targeted population could not be reached.
- Unwillingness of some of Ebola survivors to participate on the radio talks for the sensitization on Ebola. The volunteers conducted activities with Ebola survivors to help them understand why their participation is important in the response, especially in the radio show as this would help reduce stigma towards them.
- Some community members did not understand the importance of the RRT team in their communities and hence were not cooperative. CEA team organized multiple RCCE activities regarding the importance of the RRT team with community leaders, health care workers and youth and women's associations.
- The full deactivation of CEA volunteers had impacted the mobilization for COVID-19 and other diseases of epidemic potential in the community.

Lessons learned/ Key drivers/enablers of success.

- The importance of collecting community feedback in the response to and control of EVD/COVID-19 was the key to the response and community participation. Integrating and involving community leaders in activities was an important way to ensure the success of activities and the ownership of response by the community. Hearing from their own people had more impact and engagement. The RCCE approach allowed communities to express themselves and change their attitudes, but also it allowed stakeholders to orient their actions to meet the community's expectations and needs. The importance of teamwork and collaboration between the NS and other partners in the Ebola response was also a plus.
- In term of multi-sectoral response, did having a hotline that allowed people to report not just on EVD but also on things that were more important to them (e.g. flooding) have any positive impact on acceptance

Health Outcome 2: Infection risks to the health of the affected population are reduced through improved infection prevention and control measures

Indicators	Actual	Target
# of local health facilities supported to effectively detect and respond to infectious disease epidemics -during the Ebola operation in the Democratic Republic of Congo	9	15 ²
# of people screened in local health facilities supported to effectively detect and respond to infectious disease epidemics	456,491	500,000

Health Output 2.1: Targeted health facilities (including traditional healers) are better protected to through improved IPC services

Indicators	Actual	Target
% of Red Cross supported health facilities having obtained an IPC score greater than or equal to 80% to reduce the risk of nosocomial transmission	25%	70%
% of Red Cross supported health facilities having an IPC package in line with MoH standards and protocols to improve IPC practices and protocols and reduce the risk of nosocomial transmission of EVD	100%	100%
# of triage and pre-triage zones and isolation centres constructed	4	15
# of health services providers, traditional healers and volunteers trained on IPC	287	80
# of WASH infrastructure renovated in the FOSA	2	5

Narrative description of achievements

- 11 institutions (including 9 health facilities, Provincial DRC RC office and central Mbandaka Prison) were supported to improve IPC standards. The target of 15 has been set earlier on in the operation and only after assessments were completed that it was seen that with the resources available, 11 institutions could be supported to improve IPC standards.
- 456,491 people were screened, less than the expected 500,000 people following deactivation plans that led to the progressive reduction of the work of volunteers with the gradual handover of the screening activity to the

² The target of 15 included 13 are health facilities (the other 2 are Mbandaka prison and the local red cross office).

staff of the health facilities. This shows that the disengagement of volunteers had an impact on this activity and that during the epidemics, volunteers must be mobilized because medical staff often do not prioritize this screening activity as they should.

- It is presumed that the risk of nosocomial transmission is highest in unsupported health facilities, small health posts and the premises of traditional healers. Following this assumption, the IFRC and the FRC decided to conduct assessments in health facilities with difficult access and poor support. During the explorations, Red Cross Health Posts and the prison, it has been found that because the precarious humanitarian situation, these places could easily be hot spots not only for Ebola transmission, but also other diseases such as cholera. The low IPC score at the time of the assessments indicated the IPC level of the FOSA at the point of selection and improved over time as more improved IPC measures were implemented.
- The actions taken to reach the objectives are supporting the screening and rapid isolation of suspected cases with trained and competent health providers and DRC RC volunteers but also with the acknowledgment that traditional healers play a vital role in community health and can be great asset in the fight against Ebola and other infectious diseases. For this reason, it was decided to train and implement SOP amongst traditional healers to improve IPC practices. In total of 287 health services providers, traditional healers and volunteers have been trained on IPC
- Other actions taken were the building of triage areas, provision of IPC supplies and equipment, strengthening the utilisation of standard operating procedures through training and formative supervision and, where necessary, rehabilitating water and sanitation infrastructure to ensure that supported facilities attain an IPC score of at least 80% on the response-wide IPC scorecard. In Equateur, support have been giving to strengthen IPC in accordance with Ministry of Health's SOPs while maintaining minimum package of IPC interventions (triage, decontamination, awareness against other diseases, etc.). Support have also been giving to Mbandaka Prison.
- The level of the health facilities in Equateur was much lower in IPC in terms of infrastructure and knowledge. French Red Cross teams on considering the amount of the needs and the very low level of IPC standards in the health facilities supported, noted that it was almost impossible to obtain a score card of 80% for most of the facilities supported in view of the timeframe and funding available therefore efforts were made to try and achieve a 25% score. In total, 50% of health structures had increased their score to 25%.
- Construction of triage and pre-triage zones was suspended because of the interest shown by the Provincial Health Division wishing to take over the triage construction despite the approval of selected contractors by the IPC Commission. Therefore, out of 9 FOSA enrolled, 4 benefited from a semi-durable system (HGR Wangata, CS Maman Balako, CS Jules Chevalier and CS Wangata) and 4 others from a temporary system (parasol, table, etc.)
- 287 people - 75 hygienists, 30 traditional healers, 134 medical staff and 48 volunteers were trained on IPC. The target was largely exceeded considering the training needs expressed by the health facilities and the number of staff assigned to these facilities, which was underestimated at the beginning of the project as the facilities had not yet been identified. The staffing needs had also increased following the epidemic and some health facilities recruited new staff during the project, most of whom were not trained on IPC measures at all. In addition to the people trained, 8 out of 9 health facilities' IPC committees were also trained.

Challenges

Several challenges, most of them linked to coordination, community resistance and difficult access to the facilities were experienced:

- Poor communication issues characterized by cut-off telephone and internet networks resulted in delays in responding to requests or in transmitting reports.
- The lack of IPC materials (including digital thermometers, masks and gloves) and their unavailability at the local level, delayed the supply of the necessary equipment and materials to the triages.
- The lack of coordination between humanitarian actors in the field impacted the implementation of activities. For some of the health facilities supported, in particular Wangata (CS and HGR), the work provided for in the construction plans of the waste disposal areas were ultimately not executed (another partner took care of it). This showed the need to strengthen coordination mechanisms early on to avoid potential duplication of activities.
- The coordination challenges experienced at the beginning of the response was due to limited numbers of partners. The issue was addressed by looking for support from multiple actors present in the region and ad-

vocating together to the MoH. Also, joint supervision missions were organised to include IFRC, DRC RC and MoH to check on implementation progress.

- Community resistance resulted in 3,986 refusals by patients to be screened at the triage. Community resistances were also manifested in a latent distrust in health care facilities that prevented people from seeking health care. To address this, there was improved collaboration between CEA and IPC teams, sharing feedback and creating messages to tackle the reasons behind the community resistance.
- Access difficulty due to geographic and economic barriers. The majority of people who live in remote areas or along the river do not have any way to reach the health facilities. Some areas are reachable only by motorbike or by boat and most of the inhabitants do not have access to these modes of transportation nor money to pay for transportation. Also, the fees for health care are beyond the means of some patients and hence some people avoid the health centres, preferring the traditional healers. This was addressed by handling the challenge from IFRC perspective and not trying to address the structural challenge such as infrastructure. IFRC worked on finding the right transport means (to facilitate the movement of the supervisors) and paying credit units to the supervisors and team leaders, in order to facilitate the communication between them field and the office.
- As far as IFRC and DRC RC capacities, the difficult access translated to remote management, due to distance and the challenging environment. Due to these constraints the decision was made to reduce from the original 15 health facilities targeted to nine in order to provide quality support. This factor, distance and remote management, made data collection a challenge that affected timely reporting and data analysis.

Lessons learned/ Key drivers/enablers of success.

- The presence of a strong and adapted IPC delegate team was one of the keys to be successful in this activity.
- Collaboration with other pillars e.g., addressing with the CEA team's community resistance, traditional beliefs and educating the population to seek health care from the health facilities and to agree to the screening was another fundamental key driver to the success.
- As the collaboration with the CEA team was fundamental to address to the community resistance, the collaboration with the IM department was valuable for the feedback and data analysis.
- Finally, one of the key drivers of success was good relations with the heads of health centres.

Health Outcome 3: Transmission of EVD and other diseases of epidemic potential is reduced

Health Output 3.1: Red Cross SDB teams are set up and conduct safe and dignified burials in areas where the epidemic is sustained to limit the spread of EVD

Indicators	Actual	Target
# of households benefiting from a safe and dignified burial in Ebola-affected areas of the Democratic Republic of Congo	465	NA
% of SDB alerts responded to by SDB teams	82%	100%
% of successful completion of safe and dignified burials in the EVD operation	56%	>80%
# of SDB teams trained and equipped	17	20
# of cases of EVD infection among SDB personnel	0	0

Health Output 3.2. Red Cross Rapid Deployment Teams (RDT) are set up and conduct SDB, CEA and PSS activities in areas newly affected by the epidemic, to limit the spread of EVD and other diseases of epidemic potential

Indicators	Actual	Target
# of RDT trained and equipped	2	2
# of RDT deployments completed	3	3

Health Output 3.3: Red Cross Rapid Response Teams (RRT) are set up and conduct patient transfer activities in areas affected by the epidemic, to allow safe access to health care services (suspect cases, confirmed cases and others)

Indicators	Actual	Target
# of RRT trained and equipped	7	6
% of active multisectoral RRT out of the total trained	100%	50%
% of patient transport requests that resulted in RRT transportation	60%	100%
# of cases of infection among RRT personnel related to their activities	0	0

Narrative description of achievements

- Creation/re-activation of SDB teams was the first response in the 11th Ebola epidemic to contain the spread of Ebola virus disease. Establishing these teams followed the trend of the epidemic and as a result, there were 17 SDB teams in 11 health zones with a total of 316 volunteers. The SDB teams, during their activities, received 1,197 alerts and they responded to 978 (81.7%) of them. Community resistance against the activities and the expectation of the families to receive financial/in-kind support from the RC was the main reason for non-response to 18% of the alerts.
- Later, to give an appropriate response to the geographic spread of the 11th Ebola epidemic, a flexible response strategy was adopted. Instead of training SDB, CEA and IPC volunteers where they were not already trained, 2 RRT were created. This set-up permitted a quick and flexible response to the epidemic and reduced logistical challenges.
- The Rapid Deployment Teams (RDT) are multidisciplinary teams, formed by 6 volunteers, trained (SDB and CEA) to be deployed within 24-48 hours maximum following receipt of an alert in a new operational area. They were deployed three times during this epidemic, once to the border with the Republic of Congo, once in the health zone of Lilanga Mapoko and the last time in Makanza for the last case of the epidemic. All three times, the teams were ready to conduct SDB and CEA activities with the affected communities. With the declaration of the end of the epidemic, SDB and RDT teams were put in "hibernation", ready to be reactivated in case of another alert.
- For the 90-day surveillance period, the strategy was modified, and 7 Rapid Response Teams were created. 3 teams covered the 2 health zones - Mbandaka and Wangata. 2 teams were created to cover the Health Zone of Bikoro and another 2 to cover the health zone of Ingende. Health zones were selected based on accessibility, population density and risk profile according to 11th EVD epidemic data. The multidisciplinary teams of 6 local volunteers were trained on first aid, patient transport, CEA, PSS and SDB. Each team operated only during the day, due to security and logistic reasons. During this period, the RRT responded to a total of 49 alerts, 42 for EVD, 4 for COVID-19 and 3 general alerts. The distribution of the alerts is the following: 32 in Bikoro, 13 in Mbandaka and 4 in the HZ of Wangata. With this approach it was possible to transport patients suspected to have EVD and other diseases safely, to improve the capacity to refer patients and it was designed to be sustainable and guarantee a successful handover to the NS after the gradual withdrawal of the IFRC until the complete handover at the end of June 2021. In order to ensure high-quality SDB operations, decontamination sites (an operational base in Mbandaka and a base at Nkalamba) were constructed.
- To strengthen the capacities of the 7 RRTs, there were simulation exercises conducted on proper patient transfer in Bikoro and Mbandaka. Each team had a refresher session to ensure protocols were followed and any unclear issues clarified specially to ensure biosafety of the team and prevent potential transmission of infection to the RRTs. Formative supervision was carried out for RRTs in Bikoro and Mbandaka.
- There was the development of protocol for the use of ambulances and tricycles used by the RRT for the transfer of patients and other RRT activities. The RRTs responded to alerts associated with occurrence of Monkeypox where 7 cases were recorded in Bikoro with 2 deaths reported. There was partial deactivation of the RRT in February 2021 with a lean team left to respond to alerts and Full deactivation in the end of April 2021.

Challenges

The challenges are a mix of cultural, logistics and organizational issues.

- Cultural because the SDB, RDT and RRT had been confronted a lot of community resistance due to rumours, traditional beliefs and low education levels. The refusal of SDB was justified with several arguments like that Ebola does not exist; refusal to accept that the person has died of Ebola; fear of stigma; expectation that the volunteers will push to do the SDB and offer money to the bereaved family. Also, there was the belief that the Red Cross was distributing coffins for the burials and once the family saw that there was no coffin, they refused the SDB. This resistance was overcome thanks to an integrated work of CEA, IM and SDB, promptly analysing feedback from the community and adapting the messages given to the community on the existence of the disease, symptoms and how to prevent the spread.
- The logistical problems were linked to characteristics of the environment of the Equateur province, difficult to reach remote areas, sometimes reachable only by boat or by motorbike. Sometimes it happened that if eventually the SDB team was able to reach the locality, the family had already buried the dead. Moreover, the telephone network was poor leading to late reception of alerts. The access challenges also presented a problem of taking swabs to the laboratory. Some samples arrived really late, in this way compromising the result of the

test. Difficulties accessing the remote areas was addressed by providing the team with the right transport. A donation of motorbike and tricycles was done to the NS. Two canoes were bought, one is for the health zone of Ingende and the other for the health zone of Bikoro and the IFRC is looking how to provide the Provincial Committee with a boat for Mbandaka. In the same way the problem of lack of network was addressed by installing a VHF radio system that relies on repeaters installed in the offices of the local committees of the various health areas or in the health centres and health posts to facilitate timely communication.

- Organisational problems arose because some alerts got stuck somewhere in the communication chain as well as having different actors doing the same activity, lack of coordination, and in this way contributing to the idea of Ebola as a business. These challenges were addressed by improving coordination and dialogue with other actors involved in the response in addition to participating in all the relevant coordination meetings with other actors as the WHO and MoH.
- During the rainy season, there was difficulty to access some of the areas especially responding to alerts which hindered the transfer of patients to the appropriate health facilities for care.
- There was weakness in the strict application of the protocols in the field. Through formative supervision, it was possible to make corrective measures and ensure adherence to the protocols.

Lessons learned/ Key drivers/enablers of success.

- The presence of focal points for each pillar, which with the support of the Delegates (Field Co and Health Co.) were able to follow the activities locally and to guide the transition from SDB/RDT to RRTs
- Clear data and feedback analysis shared with the teams.
- Joint work between pillars created synergies needed for successful implementation of planned activities.
- The extensive network of frontline RC volunteers in the DRC has been important in contributing to the SDB.

Health Outcome 4: The psychosocial wellbeing of impacted communities and volunteers is improved

Indicators	Actual	Target
# of participations in psychosocial support activities during the Ebola operation in Democratic Republic of Congo	2,992	5,000
Health Output 4.1: Psychosocial support provided to the target population		
Indicators	Actual	Target
# of DRC RC bases involved in the EVD response supported by psychosocial support activities	2	2
# of activities implemented by trained and supervised PSS volunteers to reduce the psychosocial impact of the EVD epidemic	1,182	2,000
# of trained volunteers implementing PSS services to preserve or restore the psychosocial well-being of volunteers involved in the EVD response	56	21
# of health structures providing specialised psychological care for DRC RC volunteers requiring acute support	0	1

Narrative description of achievements

- PSS teams implemented 2,992 activities that benefited both RC staff and volunteers.
- Three 1-day workshops benefitting 56 volunteers took place. The aim of the workshops was to better clarify interventions and coordination with other pillars. This workshop was supported by IFRC and facilitated by French Red Cross (FRC) PSS delegate.
- Training of the 3 RRT in the area on the PFA module developed for RRT teams by the Swedish Red Cross.
- 2 group PSS sessions were done with the local indigenous people to discuss issues that they faced in their community and help them identify solutions to them.

Challenges

- A long time was taken before the identification of a suitable focal point to support implementation of activities. The Federation supported the recruitment of a new focal point to add value to programme implementation.
- Recruitment process for a long-term PSS delegate (FRC) in Equateur took longer than anticipated.

Lessons learned/ Key drivers/enablers of success

- Consideration of the PSS pillar at the beginning of an Ebola operation is essential for early care by volunteers

Achievements for the 12th epidemic (North Kivu: Butembo - Biena)

Risk Communication and Community Engagement and Accountability

- With the resurgence of the EVD on February 7th, 2021, CEA volunteers were reactivated in Butembo, Katwa and Musienene to increase community mobilization and awareness raising on EVD prevention and the acceptance of vaccination and SDB in the community. The volunteers in Biena were not activated due to lack of funding, however they have been conducting mass mobilization activities in a small scale in their community to increase awareness of EVD prevention and the importance of the SDB. The IFRC CEA team conducted multiple refresher training to capacitate the volunteers in RCCE technique and strategies including how to integrate messages of other diseases of potential epidemics such as COVID-19 into the activities. A total of 180 CEA volunteers benefited from the refresher training in seven health zones including Butembo, Biena, Musienene, Katwa (Health zones with cases) and Kalunguta, Mabalako and Beni (high risk zones). 14 new volunteers were trained on RCCE during EVD epidemic in Biena health zone.
- RCCE activities were conducted in four health zones with cases using different approaches to facilitate community feedback analysis, community-based activities, specifically house visits, community dialogues, educational talks, community meetings and focus group discussions. In total, **15,010 people (58% female)** were reached during community mobilization activities and 751 feedback collected and analysed to adapt CEA messages based on community needs. The RCCE activities were complemented by interactive radio programming and intensified different group engagements including local opinion leaders, community leaders, local health workers, traditional healers, community animation cells (CAC), motor taxi associations, women's groups, and youth associations. This has strengthened community participation, ownership, and enhanced community access e.g. in Biena health zone, the epicentre of the resurgence of the EVD, strengthening community involvement through local leaders and other opinion leaders, some of whom were previously associated with community resistance against vaccination was important. Now these leaders were involved in the awareness raising activities of the Red Cross, including participation in the radio programs to help mobilize their own community and support the work of Ebola response. RCCE activities were adapted based on community feedback received during door-to-door and mass mobilization activities. The volunteers were capacitated to return to communities with appropriate responses and solutions after analysing community feedback.
- In the resurgence of EVD, the CEA strategy was adapted to the context, characteristics and lessons learned from the 10th and 11th epidemics based on community participation in the response. CEA teams also worked in collaboration with other pillars such as RRT, SDB, vaccination and PSS to improve quality of services and acceptance in the community especially the SDB and vaccination.
- There was the deactivation of CEA volunteers in Butembo, Katwa and Musienene April 30th. The deactivation of CEA volunteers at the end of April had impact the 90 days post EVD for community mobilization and community-based surveillance. IFRC CEA team was not able to continue providing minimal technical support and assistance to the DRC RC CEA team as needed. There were transfer of all CEA activities to the National Society.

Challenges

- Inability to activate volunteers in Biena for the door-to-door activities due to lack of funding.
- The distance between villages, remoteness, lack of accessible road and telephone services in Biena health zone made it difficult for volunteers to reach out to everyone.
- Insecurity situations in Butembo and Katwa health zones prevented CEA volunteers to conduct activities.
- It was difficult to mobilise additional funds to support the DRC Red Cross to respond to the epidemic and allow for continued presence and preparedness throughout the period of enhanced surveillance (until at least 30 September 2021). Funds were needed to support an adequate operational facility, including DRC Red Cross staff (SDB, rapid response teams, community engagement/accountability, community

surveillance, information management, logistics, finance, HR and security) and logistics (vehicles, warehouses, supplies for infection prevention and control and burial stocks).

Lessons learned/ Key drivers/enablers of success.

- Acceptance of the DRC RC in the community, capacity building of the CEA volunteers and the integration of the CEA in the SDB and other pillars created synergy and smooth implementation of activities specially in Biena health zone.
- The use of the hotline by community members to report alerts (deaths of family members, suspected Ebola cases and other communities' issues) showed community participation and engagement in community-based surveillance and prevention of diseases.
- Good collaboration with other partners such as the Ministry of Health.

Infection Prevention and Control (IPC)

- IPC assessments took place in Biena, Katwa and Butembo together with the Ministry of Health. 10 health facilities were assessed with the revival of hygiene committees in the health facilities being done. In addition to this, there was supply of chlorine to the FOSA in the affected areas.

Refresher training for volunteers on IPC were done in Butembo and Katwa. There was also rehabilitation of the Butembo base to ensure IPC standards were maintained. Technical support was also given to FOSA managers on the proper management of inputs within their health facilities in Butembo, Katwa, Biena and Musienene.

Challenges

- Suspension of training because of insecurity
- Inconsistent practice/application of high IPC standards – as there were no cases for about 3 weeks following the resurgence, it was noted that the health staff tended to forget to practice good ways to protect themselves.

Rapid Response Teams (RRT)

- A total of 531 alerts were responded by the RRT of which 256 patient transfers were accomplished. There were six decontaminations done. Of the alerts received, 42% were related to Ebola, 29% involved provision of first aid services, 5% for Covid-19, and 24% for other diseases.
- Overall, 224 (36%) of the 617 SDB alerts were completed successfully by Red Cross teams. The Civil Protection carried out 393, or 64% of the SDB. These were present in two more Health Zones than the DRC RC teams (5). The Civil Protection also had 14 teams per day while the DRC RC had 4 per day.
- Challenges experienced by the RRTs were inadequate supply of swabs and spreading of false rumours about the Ebola treatment centre (ETC) causing a transfer failure to Masoya.

Psychosocial Support (PSS)

Meetings took place with traditional leaders in Biena and Musienene to assess psychosocial support needs in communities.

A challenge experienced was the difficulty to get volunteers previously trained in PSS. Some had been identified to be trained but this was not possible due to inadequate funding and insecurity situation.



Protection, Gender and Inclusion

People reached: 75,649.

Male: 51,006

Female: 24,643

PGI Outcome 1: Communities become more peaceful, safe and inclusive through meeting the needs and rights of the most vulnerable.

PGI Output 1.1: Programmes and operations ensure safe and equitable provision of basic services, considering different needs based on gender and other diversity factors.

Indicators	Actual	Target
Proportion of female volunteers engaged in the operation.	33%	>30%
# of focal points and supervisors trained on PSEA.	46	94

Narrative description of achievements

- The IFRC continued to work systematically to increase awareness and identify and reduce risks of sexual exploitation and abuse (SEA) in all its operations and in the community where it serves. To achieve this, IFRC has implemented a hotline to help survivors and the communities to report any situations of abuse. The hotline is a confidential independent line available to the community members including IFRC and DRC RC staff wishing to report misconduct. A total of **75,649 calls** were received during the operation where majority of the issues were resolved at the hotline (47 22 22) level and sensitive feedback was referred to IFRC and the NS for further action. No SEA feedback was received concerning IFRC during this period. Congo Call Centre managed the hotline and informed callers that their information would be shared only after their consent was received and then with only the IFRC and DRC RC hotline focal points for assistance requested or issue reported. The hotline interaction was kept confidential and sensitive complaints were immediately brought to the attention of IFRC focal point as needed. The IFRC used feedback from the hotline as formative evaluation data, drawing from the communities' needs to adapt messages, improve quality of services, improve outreach and social mobilization awareness of the PSEA.
- Eleven (11) workshops were carried out for staff and volunteers on code of conduct and PSEA where a total of 320 people were sensitized in Mbandaka, Bikoro, Butembo, Mangina, Beni, Bukavu and Goma. Discussions at the local level included brainstorming concrete action points to better integrate gender mainstreaming and provide all volunteers agency and power to report safely as well as actions to reduce power disparities and lessen the motivation and opportunity for abuse before it happens.
- Violation of the code of conduct or acts of SEA is a risk that poses serious threats to the organization and can affect its reputation, so to avoid their manifestation it was important to use effective means for their prevention, talking about how to mitigate these risks. An efficient way to mitigate these risks was to do sensitisation through continuous refresher/training sessions, focus groups, spontaneous discussions, briefings and online trainings like those on the learning platform. This has been useful in increasing awareness on PSEA so that it ceases to be a taboo subject, that it is understood and that the consciences of the IFRC staff, DRC RC staff and volunteers are awakened for everyone to make a commitment to fight against the risk of sexual exploitation and abuse (SEA).

Feedback categories

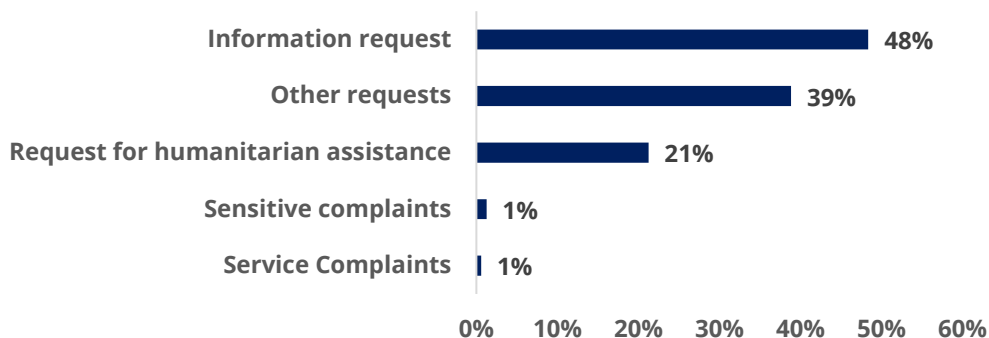


Figure 11: Categories of feedback calls received.

Challenges

- No popularisation of Code of conduct and other related policies. Soft and hard copies of the code of conduct and related policies were shared for better distribution.

- Language barrier as the code of conduct was available only in French, Swahili Spanish and English. Discussion on the translation of the code of conduct in local languages was carried out and waiting for the implementation.
- The culture and behaviour of the community in the field and provincial towns is varied therefore it is important to adopt this code of conduct to some basic reality of the field due to different culture, behaviour. For example, the staff mentioned that in the rural areas, they are often given gifts, mostly foodstuffs like bananas, chicken and the community feel offended if not accepted. They feel slighted hence the need for adaptation. The advice given was that if gifts are accepted then this is declared on return to the office and shared as appropriate with colleagues.
- NS staff was afraid to report any violation of code of conduct as it may affect their work if the person accused knows that they have reported him/her. During the training sessions, staff were encouraged to report via the safe call/green line as it is anonymous and ensuring them that all information is handled in strict confidence. There is protection of the whistle-blowers.
- Fear that people of the hotline do not know the sensitivity of the matter that the staff would need to report. Ensured that Congo Call centre is briefed and trained about sensitive feedback and how they should handle it.
- Fewer women called the Hotline compared to men. The IFRC worked on its social mobilization strategy targeting women's groups to use the Hotline 47 22 22 for reporting PSEA matters.

Lessons learned/ Key drivers/enablers of success.

- The use of the hotline by community members to report alerts and cases of abuse demonstrated community participation and involvement in community surveillance and disease prevention.

ENABLING ACTIONS

Strengthen National Society

S1.1: National Society capacity building and organizational development objectives are facilitated to ensure that National Societies have the necessary legal, ethical and financial foundations, systems and structures, competencies and capacities to plan and perform

S1.1.1 National Societies have effective and motivated volunteers who are protected

Indicators	Actual	Target
# of volunteers engaged with DRC National Society.	3,223	1,000

S.1.1.2 NS have assessed their capacity at HQ and branch level and identified areas for organizational improvement.

Indicators	Actual	Target
# of office space and operational bases rehabilitated	4	2
# of NS staff trained in financial management, security management and data collection	25	20

S.1.1.4 NS capacity to support community-based disaster epidemic response and preparedness is strengthened

Indicators	Actual	Target
# DRC RC Epidemic Preparedness plan and SOPs at the provincial level	2	3
# of DRC RC staff and volunteer trained in warehouse management and compliance	59	48
# of DRC RC staff and volunteers trained in logistics and supply chain management	33	36
Effective and coordinated international disaster response is ensured		
S.2.2 The complementarity and strengths of the Movement are enhanced		
S.2.2.1 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)	1	1 per week
S.2.2.2 Shared services in areas such as IT, logistics and information management are provided.		
# of warehouses rehabilitated/constructed	4	5
Ensure a Strong IFRC that is accountable		
S.4.1 The IFRC enhances its effectiveness, credibility and accountability		
S.4.1.2 IFRC staff shows good level of engagement and performance		
Indicators	Actual	Target
End of operation evaluation completed	1	1
S.4.1.3 Financial resources are safeguarded; quality financial and administrative support is provided contributing to efficient operations and ensuring effective		
Indicators	Actual	Target
# of audits of financial statements conducted in compliance with international financial reporting standards	2	2
S.4.1.4 Staff security is prioritised in all IFRC activities		
Indicators	Actual	Target
% of IFRC staff and volunteers participating in security briefings	100%	100%
Narrative description of achievements		
<ul style="list-style-type: none"> IFRC provided accident insurance coverage for DRC RC volunteers who were involved in response and preparedness activities. In total, 3,223 volunteers were trained and took part in the activities. IFRC trained 26 NS staff in financial management, security management and data collection. Concerning finance, the objective of this training was to provide management staff with the tools and information necessary to ensure a better quality of the supporting documents submitted to donors in addition to strengthening the fight against fraud and corruption in the humanitarian sector. A two-hour webinar session was organized each week with DRC RC HQ finance and logistics staff on IFRC working advance and procurement procedures as well as reporting, compliance, fraud, and corruption. Concerning data collection, there has been volunteers cascade trainings. Proper mobile phone-based data collection trainings took place during the operation. Some data used for the operations have been exported from Kobo, and it was keyed in by DRC RC volunteers with the technical support of the Information Managers (IDRTs) of the operation. The Planning, Monitoring, Evaluation and Reporting (PMER) and Information Management (IM) teams contributed to collect valuable and quality data that have been used in due course to report to donors. A mobile phone-based data collection system has been put in place, and DRC Red Cross are currently being trained on how to collect data using mobile phones. ICRC has supported the DRC RC by providing materials, supporting the deployment of NS volunteers, and maintaining excellent daily coordination and information sharing. There were implementation of logistics staff plans to include the logistics positions for warehousing, fleet, procurement and supply chain management services in 8 bases located in North and South Kivu, Ituri and Equator provinces. EVD operation were supported by 20 logistics staff and 63 drivers. In total, 33 DRC RC staff and volunteers were trained in logistics and supply chain management. Specialized trainings and on job trainings were also conducted for Federation logistics staff. 		

- To boost the transportation capacity of the NS, 5 vehicles were donated to DRC RC, one each for Goma, Mbandaka and Bunia while in Equateur, 2 canoe (pirogues) ambulances and 2 tricycle motorbikes were donated for the transfer of patients.
- IFRC supported the DRC RC through the rehabilitation of 2 warehouses in Beni and Bukavu, construction of 2 warehouses in Goma and Bunia. Due to lack of funding, the construction of the warehouse in Butembo did not take place although architectural drawings for the structure were available for implementation.
- At the time of writing this report, the end of operation evaluation was ongoing.

National Societies Development (NSD)

- A Branch Organisation Capacity Assessment (BOCA) exercise was carried out in December 2020 for North Kivu and South Kivu branches. The aim of this was identify areas to strengthen organisational capacities at both headquarters and branch level of the DRC RC in the two provinces to better respond to disasters of all kinds that hit the region. Through the exercise, the teams fostered a broad consensus on the major organisational problems and the relevant responses to be made to them in the long term. A total of 27 participants from the two (02) provinces attended the session.
- The DRC Red Cross, with the financial and technical support of other components of the Red Cross and Red Crescent movement, has been seriously involved in the Response to EVD epidemics. These operations were a Response to the priority challenges faced by the DRC RC in terms of NS capacity, infrastructure, fleet, and storage, capacity of the vast network of volunteers in the target bases and sub-bases, availability of permanent managers from headquarters, ready to give the best of themselves.
- The 10th EVD epidemic was a Response to the priority challenges faced by the DRC RC, including fleet, infrastructure, storage, and NS capacity.
- At the end of operation, a distribution plan of EVD stocks in Goma and field bases completed. The stock was split into 2 parts (contingency for IFRC and NS stock to be donated to DRC RC). All the donation completed and documentation available with logistics team.

Challenges

- It was not possible to collect medical supplies from Red Zones in the closed hubs and bring them to Beni occasioned by insecurity in these regions. IFRC staff liaised with ICRC to advise on security situation and with support from local volunteers this task was accomplished – stock was retrieved and brought to Beni.
- There was delayed approval of warehouse rehabilitation and construction in Beni and Mbandaka. The team negotiated for the 3 months rental contract extension period to secure supplies and allow completion of the NS storage facilities.

Lessons learned/ Key drivers/enablers of success.

- Strengthening the capacity of the NS in human resources, materials and equipment is a factor in the success of the operation and this should be sustainable.
- Good internal coordination between members of the movement is essential for the success of international operations such as the Ebola Response. The reinforcement of this component is useful for the positioning of the movement and for the good extreme coordination.
- Security constraints, geographical accessibility and resistance/reluctance have been well addressed through the ECUMR strategy in localities that have reported positive EVD cases; This has contributed positively to Community-based surveillance. Communities were constantly appealing to ECUMR even after the EVD Response. This ECUMR strategy had promoted the reunification of communities supporting tribal-ethnic conflicts or based on economic and political manipulations. It has opened the door to the joining of the Red Cross of a large number of volunteers but also communities in areas of intervention at risk.

South Sudan



Health

Health Outcome 1: The immediate risks to the health of affected populations are reduced

Health Output 1.3: Community-based disease prevention and health promotion is provided to the target population

Indicators	Actual	Target
# of awareness sessions carried out	200	192
# Number of people sensitised on EVD	455,000	360,800
# of community leaders sensitized	300	300
# of radio shows on EVD conducted	18	180
# of households reached through door-to-door sessions	28,000	28,000
# of SSRC/IFRC staff trained on safety and security	15	15

Health Output 1.4: Epidemic prevention and control measures carried out.

Indicators	Actual	Target
# of SSRC Staff and NDRT trained as TOT (Training of trainers)	16	15
# of additional volunteers trained on SDB (additional 12 teams, 8 volunteers / team to trained and setup)	97	96
# of SDB refresher training, drills and simulations carried out	60	75
# of drills carried out by 5 SDB teams	60	90
# of bicycles procured and deployed to the 4 target areas (40 procured but only 10 has been deployed)	40	50
# of new locations with materials and equipment for disinfection	5	3
# of vehicles deployed	8	7
# of vehicles prearranged for SDB	4	3
# of SDB bases established and ready for operation (Bases identified, but yet to be ready in Yambio and Maridi. SDB materials prepositioned)	3	5
# of NTF, TWG and MTF Coordination meeting held	17	36
# of people reached on Key Messages on EVD	455,776	160,000
# of Supervisors trained on CBS	20	20

Health Output 1.5: Psychosocial support provided to the target population

Indicators	Actual	Target
# of volunteers trained in psychosocial support	190	180

Narrative description of achievements

Through the DREF and funding through the EVD One International Appeal, the following key results have been achieved:

- In total, SSRC trained 510 volunteers on RCSMCE, SDB, PSS and SSRC reached over 455,776 people in awareness sessions.
- Mobilized and trained 400 volunteers in four high-risk locations in Yei, Maridi, Nimule and Yambio. The volunteers were trained on EVD Risk Communication, Social Mobilization and Community Engagement knowledge - RCSMCE, prevention/protection and behavioural change to carry out social mobilization and community engagement.
- 150 volunteers were trained on safe and dignified burials - SDB. Established and fully equipped 6 SDB teams in all four high-risk areas including Juba Capital, as part of the mobile and rapid response SDB teams ready to be deployed in the event of an EVD epidemic.
- 190 of the same volunteers, trained on RCSMCE, were trained on psychosocial support PSS.

- 11 full and 11 starter SDB kits, as well as 400 body bags, procured and prepositioned: one in each of the four high-risk locations (Maridi, Nimule, Yambio and Yei). Each kit is enough to carry out 20 safe and dignified burials. The remaining kits and body bags are positioned in Juba for use by the mobile and rapid response team if need arises and or to replenish the prepositioned SDB kits in the four high-risk locations.
- SSRC issued its first Community Based Surveillance (CBS) Protocol
- 20 key staff and volunteers received training of trainers/supervisors on Community Based Surveillance (CBS) for selected priority diseases and public health events (viral haemorrhagic fevers, acute watery diarrhoea, measles, polio and cluster human and animal deaths/illnesses). These were act as CBS activity implementation for supervisors and assist with 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 a long- and short-term CBS intervention.

Challenges

- EVD activities have been interrupted by the advent of COVID-19 crisis, however RCCE activities have been maintained.

Lessons learned/ Key drivers/enablers of success.

- SSRC established functional EVD Movement Taskforce (MTF), which drew participants from its technical departments (WASH, Protection, Health, DM and Support Services), in-country PNs, IFRC and ICRC. Externally, SSRC and IFRC were active participants in the National Task Force (NTF), members of the Social Mobilization and Risk Communication technical working group (TWG), and co-lead of the Safe and Dignified Burial TWG as well as Case Management and WASH-TWG. SSRC also coordinated with various partners at operational level.

Outcome S1.1: National Society capacity building and organizational development objectives are facilitated to ensure that National Societies have the necessary legal, ethical and financial foundations, systems and structures, competencies and capacities to plan and perform

Indicators	Actual	Target
# of volunteers insured	400	360
Output S1.1.7: NS capacity to support community-based disaster risk reduction, response and preparedness is strengthened		
Indicators	Actual	Target
# of staff recruited/contracted and actively supporting EVD preparedness operation at HQ and branch levels	14	14
SSRC EVD Contingency plan developed and used	1	1
EVD PMER tools and system fully functional and supporting the operation	1	1
# of local review/assessment of the EVD Preparedness operation	1	2
# of supportive supervision/monitoring visits provided by SSRC HQ relevant sectorial heads for the EVD preparedness operation	6	12
# of EVD related reports produced and shared with relevant stakeholders (weekly, monthly & Quarterly)	18	24

Narrative description of achievements

The SSRC was the lead agency for SDB and through the end of EVD. The SSRC with support of IFRC trained 157 volunteers on SDB who were deployed to respond to EVD alert. SSRC responded to eleven (11) EVD alerts and conducted SDB to seven (7) of the alerts across the country.

From September 2020, SSRC focused on the following preparedness readiness activities:

- Refresher training TOT on CBS and reporting for supervisors and team leads using best practices learned during EVD activities.
- Lessons learnt review meeting.

There was an outbreak of suspected/unidentified haemorrhagic fever in South Sudan in September 2020 and the SSRC was able to mobilise SDB teams and prepared to move equipment before the test results came back negative for Ebola. This highlights that preparedness activities have increased technical and organisational capacity to respond quickly.

Other achievements include:

- Increased capacity on RCCE following implementation of appropriate EVD messaging enabled SSRC to quickly respond to EVD+ messaging incorporating COVID-19 prevention messages.
- Increased capacity of SDB teams in the 4 high risk locations
- Increased capacity on implementation of PSS during epidemics in the 4 high risk location
- Identification of the burials sites that can be used for another pandemic.
- Ownership documentation for burial sites in Nimule and Juba
- SSRC was prepared to respond to EVD or EVD suspected cases.
Processes and expertise built during EVD preparedness contributed greatly to the continuing response to COVID-19.


Challenges

- Lack of additional funding in 2020 did not allow completion of CBS activities (other than the supervisors trainings) as initially planned.

Lessons Learned/Key drivers/enablers of success.

- The first phase of the EVD preparedness in South Sudan was fully funded allowing a smooth implementation of the project and in some area achieved more than what was planned, for example number of people reached through RCCE. Furthermore, the SSRC took this project as an opportunity to strengthen their RCCE capacity and knowledge on SDB which was new to the NS when the project started.
- Conduct SDB and critical hygiene promotion practices trainings for community leaders, religious leaders on rational use of PPE, IPC WASH is important for a EVD preparedness.

Uganda

	Health	
Health Outcome 1: The immediate risks to the health of affected populations are reduced		
Health Output 1.3: Community-based disease prevention and health promotion is provided to the target population		
Indicators	Actual	Target
# of people reached by NS with services to reduce relevant health risk factors	10,868,958	7,068,060
# of volunteers conducting risk communication, social mobilization activities in 7 districts for 3 months	480	360
# of CEA mechanisms established	2	2
# of HH reached with EVD messages on prevention, identification, and referral through risk communication activities (188.724 HH//month x 3 months)	374,057	566,171
# of people reached with EVD messages on prevention, identification, and referral through risk communication activities (1,321,066 people/month x 3 months)	1,629,657	3,000,000
# of community/group meetings held on EVD prevention, identification, and referral (2,620 community groups/months x 3 months)	14,647	5,000
# of people taking part in community/group meetings held on EVD prevention, identification and referral (142.221 people/month x 6 months)	1,067,178	853,326
# of people reached with EVD prevention messages through mobile cinema sessions (150 people/sessions x 105 sessions); 4,400 people reached with EVD prevention messages through drama sessions, target: (100 people/session x 44 sessions).	16,075	42,000
# of mobile cinema sessions conducted	133	210
# of volunteers trained on surveillance and contact tracing	505	420

Health Output 1.4: Epidemic prevention and control measures carried out.		
Indicators	Actual	Target
# of SDB trainings from health partners supported by URCS facilitators	29	13
# of volunteers conducting screening activities at 28 PoE for 3 months	334	334
# of people screened at PoE crossing the border for trade, family, religious, health and education reasons in 3 months (946.662 people/month);	10,393,083	7,200,000
# of SDB drills conducted by 3 SDB teams,	18	30
# of SDB simulations conducted by 3 SDB teams	8	15
# of joint MoH and URCS quality control missions on SDB simulations conducted	20	5
Health Output 1.5: Psychosocial support provided to the target population		
Indicators	Actual	Target
# of volunteers providing PSS in 7 districts for 3 months	527	30
# of discharge kits procured	10	50
Outcome S1.1: National Society capacity building and organizational development objectives are facilitated to ensure that National Societies have the necessary legal, ethical and financial foundations, systems and structures, competences and capacities to plan and perform		
Output S1.1.4: National Societies have effective and motivated volunteers who are protected		
Indicators	Actual	Target
# of National Society contingency and preparedness plan adopted, including SDB SOPs	1	1
# of volunteers insured	358 (85,2%)	420
# of people who have received PSS	47,029	586
Output S1.1.6: National Societies have the necessary corporate infrastructure and systems in place		
Indicators	Actual	Target
# of monitoring missions conducted by IFRC staff	5	5
Outcome S2.1: Effective and coordinated international disaster response is ensured		
Output S2.1.1: Effective response preparedness and NS surge capacity mechanism is maintained		
Indicators	Actual	Target
# of NDRTs deployed	2	3
Output S2.1.4: Supply chain and fleet services meet recognized quality and accountability standards		
Indicators	Actual	Target
# of emergency procurement procedures reviewed	1	1
# of motor-vehicles deployed to the field to support the operation	6	4
# of URCS logistic support staff fully dedicated to the operation	2	1
Output S1.1.7: URCS capacity to support community-based disaster risk reduction, response and preparedness is strengthened		
Indicators	Actual	Target
# Reviews done on URCS epidemic contingency/preparedness	4	2
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 in-country coordination meetings	3	3
# of Lessons learnt workshops conducted	2	1
Narrative description of achievements		
URCS implemented the following activities with funding and technical support from the IFRC:		
<ul style="list-style-type: none"> • 42 volunteers were trained to implement Safe and Dignified Burials in Kanungu, Kasese and Bundibugyo, • Procurement of essential equipment for EVD response including PPEs and SDB kits 		

- 480 volunteers conducted sensitization activities at the community level. These volunteers provided facts on Ebola to allay fears and anxiety, raised in the occasion of suspected cases, identify individuals with psychosocial needs, provide psychological first aid, and make appropriate referrals if required.
- An operational meeting was organized between URCS and DRC RC, to strengthen cross border collaboration through sharing information and lessons learned.
- URCS supported screening at the points of entry in the districts of Kisoro, Kanungu, Kasese, Bundibugyo and Ntororko. Screening of travellers was planned at the major and minor points of entry in the project period at the project sites. This was a daily activity running regularly and it was conducted by URCS volunteers who were facilitated per day worked. Overall, 10,393,083 people were screened during operation. The volunteers were supervised by technical health officers based at the project sites managed by the technical team based at URCS headquarters and the activity was implemented in coordination with the ministry of health, the district local government, UN agencies and other stakeholders.


Challenges

- The **COVID-19** pandemic led to provision of adequate trainings to volunteers in infection prevention and control for COVID-19. The volunteers were also equipped with adequate infection prevention and control equipment.
- Insurgency in the neighbouring DRC causing many displacements.
- Occurrence of floods which destroyed households and food supply causing displacements of many people in Ntoroko, Bundibugyo and Kasese. URCS mobilised and provided non-food items to the flood affected households.

Lessons Learned/Key drivers/enablers of success.

- Government strategy in line with project objectives enabled support from stakeholders in implementation. The government of Uganda rolled out the community engagement and accountability strategy as a move to prevent and control the spread of COVID-19. This strategy was to be implemented by URCS in partnership with the government of Uganda and other implementing partners. This strategy was adopted from the community engagement and accountability strategy of the Red Cross.
- URCS has a strong partnership and collaboration with; the partner national societies, IFRC, the government of Uganda, UN agencies and other implementing partners and thus will find it easy to mobilise should there be a reoccurrence of a similar event.
- The performance of URCS in the EVD preparedness and response program has been highly commendable and thus a partner of choice. The community-based surveillance system has been strengthened through the training of 420 volunteers in CBS, these volunteers work closely with the district surveillance team to be able to detect and report alerts.

Burundi

	Health	
Health Outcome 1: The immediate risks to the health of affected populations are reduced		
Health Output 1.3: Community-based disease prevention and health promotion is provided to the target population		
Indicators	Actual	Target
# of people sensitized on EVD	2,234,231	834,588

# of households reached through door-to-door sessions	37,498	10,000
# of community leaders trained on EVD	819	120
# of cultural shows disseminating EVD messages	4	30
# of roadshows disseminating EVD messages	202	202
# of awareness sessions carried out in schools	119	84
# of volunteers refreshed on CEA	117	117
# of volunteers trained on CEA	120	120
# of radio shows and interactive shows on EVD conducted	480	24
# of EVD KAP surveys conducted for Baseline and End line	2	2
# of targeted communities who have good knowledge of EVD after volunteer's sensitization	29.4%	50%
# of people who have adopted safe and preventive practices for EVD following after volunteer's sensitization	95%	90%

Health Output 1.4: Epidemic prevention and control measures carried out.

Indicators	Actual	Target
# of drills carried out by 6 SDB teams	67	50
# of people trained in SDB (volunteers and local CHWs)	228	120
# of communal teams for SDB established and trained	20	10
# of volunteers trained in Infection Prevention and Control (IPC)	80	60
# of SDB refresher trainings carried out	7	12
# of SDB vehicles procured	2	2
# of bicycles procured	60	60
# of handwashing stations procured and pre-positioned at Branch level	300	200

Health Output 1.5: Psychosocial support provided to the target population

Indicators	Actual	Target
# of staff and volunteers trained in PSS	122	120
# of PSS sessions provided	1	N/A
# of BRCS Psychosocial support Plan of action elaboration workshop conducted	1	1

Narrative description of achievements

- The BRCS mobilised staff and volunteers who were trained in various thematic areas, including:
 - 120 people were trained on risk communication, social mobilisation, and community engagement (RCCE) who are helping in promoting messages and behaviour change in their own communities.
 - 122 staff and volunteers were trained in PSS, and cascaded the training to their communities.
 - 228 people were trained in SDB (volunteers and local CHWs).
 - In addition, SDB drills were continuously conducted leading cumulatively to 67 SDB drills.
- 40 SDB kits were procured and used to train the volunteers in SDB (8 used in simulations)
- PSS achievements were the capacity building of existing branches, which was carried out in 3 steps: Training of national trainers leading to 14 staffs trained at the national level. This was followed by a training of provincial trainers leading to 38 staff and volunteers trained. And finally, it was followed by cascade trainings at the commune level, leading to 122 volunteers trained in the PSS in the targeted municipalities. In addition, BRCS has developed a Mental Health and Psychosocial Support (MHPSS) action plan to integrate and deliver community-based PSS activities across the country.
- Key messages were developed to be used on fliers for distribution as well as in radio spots. These key messages are broadcasted each day on national radio and television before the news in the national language, French, Swahili and English, and BRCS conducted its own 1-hour radio shows on EVD. By the end of the operation, 2,234,231 people had been reached with EVD messaging. The over achievement of RCCE target is due to the fact that during the implementation period, the country having been affected by the COVID-19 epidemic obliged the NS to strengthen RCCE activities at community level including COVID-19 preventive messaging. After the epidemic of COVID-19 in Burundi on March 31, the Government declared recommendations to all humanitarian actors to include essential information for awareness-raising, prevention and actions regarding

COVID-19 virus in all their activities. As a result, Burundi Red Cross (BRCS) integrated COVID-19 awareness messages into EVD messaging activities and intensified its community actions

- The number of volunteers deployed, and the frequency of activities were consistently increased resulting in more people reached. Also, the timeline of the project was initially of six months, but RCCE activities were implemented for eight months.

Challenges

- The implementation of the operation followed the initial plan; however, it should be noted that changes were made due to some unforeseen situations. These included the COVID-19 pandemic, the sudden death of the President and the presidential elections that led to suspension and delay in project implementation resulting to electoral campaign regulations and national mourning period of former President. To overcome that, the teams strengthened training for safer access to the BRCS staff and volunteers in the branches, to integrate this training at the beginning of the project to ensure that volunteers have a good knowledge, attitudes and practices for their safety management. These situations disrupted the normal course and necessitated adjustments in terms of activities and deadlines to achieve the objectives.
- There was government authorities' disinterest in the EVD activities and cancellation of some activities planned in the project, at the onset of the COVID pandemic. To overcome that we adapted and integrated COVID-19 preventive messages into all EVD activities especially RCCE.
- Integration of COVID-19 preventive messages into EVD sensitization resulting in a lower-than-expected knowledge of targeted communities. Despite the strong awareness carried out at community level on EVD by BRCS volunteers, the proportion of target people with good knowledge and especially that of acceptable knowledge was still not satisfactory regarding the expected objectives (29.4% at the final evaluation CAP vs 50% expected). This finding could be explained by the confusion created by the massive awareness-raising on COVID-19 at the same time as EVD, and also because of the integration of awareness messages concerning COVID-19 simultaneously during the awareness on EVD as recommended by the Ministry of Public Health and the National Ebola and COVID-19 Task Force.

Lessons Learned/Key drivers/enablers of success.

- Continuous assessment and review of implementation context enables timely decision making to limit potential delays in project implementation.
- Good acceptance/perception of BRCS at community level: this allowed the implementation of activities and access to places where no other humanitarian actors could go during the immediate pre- and post-election periods.

Outcome S1.1: National Society capacity building and organizational development objectives are facilitated to ensure that National Societies have the necessary legal, ethical and financial foundations, systems and structures, competencies and capacities to plan and perform

Output S1.1.4: National Societies have effective and motivated volunteers who are protected

Indicators	Actual	Target
# of volunteers insured	298 (93,1%)	320
# of security trained staff and volunteers	20	20

Output S1.1.7: NS capacity to support community-based epidemic risk reduction, response and preparedness is strengthened

Indicators	Actual	Target
# reviews done on NS epidemic contingency/preparedness	1	1

Outcome S2.1: Effective and coordinated international disaster response is ensured

Output S2.1.1: Effective response preparedness and NS surge capacity mechanism is maintained

Indicators	Actual	Target
# of missions conducted by IFRC staff	4	6

Narrative description of achievements

- EVD funds enabled the BRCS to strengthen its presence and visibility at the strategic level and to demonstrate that it remains one of the priority actors in the management of disasters and emergency situations in Burundi. The smooth implementation of activities also improved the perception of the BRCS by communities and government authorities. Finally, this made it possible to maintain and develop the achievements of the BRCS in terms of human resources, logistics, technical skills, and other areas which the project has helped to strengthen and for which without these funds it would not have been possible.
- Through this operation, the BRCS was able to strongly strengthen its logistical and technical capacities, particularly in the early detection of cases, the management of infectious remains, the RCCE as well as PSS and PFA. All these achievements are now capitalized in the response to the COVID-19 epidemic and support to health authorities in other public health emergencies in the country. The implementation branches are now equipped with rapid response teams comprising volunteers trained in RCCE, IPC, and monitoring/follow-up of contacts able to provide a rapid response in the event of an alert and support the teams of the Ministry of health. The achievements of the Ebola project have made it possible to strengthen the response capacities to public health emergencies and strengthen the community and institutional preparedness of the Burundi Red Cross.
- Local purchases could be made as part of the implementation. However, due to the global strong demand and subsequent shortages of SDB Kits it did not allow for purchases as planned, however, from the stocks predisposed in the DREF Ebola 2019, BRS were able to constitute for each of the targeted Branches, full SDB kits and pre-position them in each branch for the implementation of activities, and so that the branches formed may be able to respond of EVD cases in the country.


Challenges

- Closure of Burundian borders following COVID-19 epidemic: This situation resulted in a fluctuation of local prices in the market, which delayed the procurement processes, as well as some shortages (locally and abroad as well like for SDB kits and materials). The procurements have been concluded by BRCS through regular market assessments to identify price fluctuations and adapting the purchasing strategy.

Lessons Learned/Key drivers/enablers of success.

- Shift in government priorities necessitates the review of community messaging e.g. the inclusion of COVID-19 messages alongside the EVD messaging enabled continuation of activities and surpassing of targets.
- The EVD assets were transferred to the BRCS in accordance with the IFRC policies and procedures in force and as soon as possible given the constraints linked to the global situation of COVID-19 which therefore allowed the smooth implementation of activities.
- Good integration of BRCS at strategic coordination level, in particular within the Task Force and technical sub-committees: This allowed BRCS to actively participate in the adaptation and orientation of public health actions thanks to its rich experience in the implementation of community interventions. This made easy to adapt activities to the current epidemic context and adapt them to the recommendations of the National Task Force and the sub-committees respecting the strict measures compliance which have been put in place to prevent the spread of the virus.

Rwanda

	Health		
Health Outcome 1: The immediate risks to the health of affected populations are reduced			
Health Output 1.3: Community-based disease prevention and health promotion is provided to the target population			
Indicators	Actual	Target	

# of people reached with community-based epidemic prevention and control activities	4,514,113	5,000,000
# of mobile cinema sessions conducted	305	290
# of volunteers refreshed on CEA (10 volunteers in each of the 15 districts)	150	150
# of teams that receive CEA branch level training	30	15
Health Output 4.3: National Society volunteers support safe and dignified burials to limit the spread of disease		
Indicators	Actual	Target
# of trained frontline SDB teams that are ready to deploy	8	2
# of trained reserve SDB teams that are ready to deploy	15	15
# of simulation exercises conducted (attended)	6	N/A
Health Output 4.4: Transmission is limited through early identification and referral of suspected cases using community-based surveillance, active case finding, and/or contact tracing		
Indicators	Actual	Target
# of volunteer teams trained in contact tracing	11	15
Health Outcome 7: National Society has increased capacity to manage and respond to health risks		
Health Output 7.1: The National Society and its volunteers are able to provide better, more appropriate, and higher quality emergency health services		
Indicators	Actual	Target
# of branches with trained rapid response teams for health emergencies	11	15
Health Output 6.1: Psychosocial support provided to the target population as well as to RCRC volunteers and staff		
Indicators	Actual	Target
# of volunteers trained in psychosocial support	320	75
Outcome S1.1: National Society capacity building and organizational development objectives are facilitated to ensure that National Societies have the necessary legal, ethical and financial foundations, systems and structures, competencies and capacities to plan and perform		
Output S1.1.7: NS capacity to support community-based disaster risk reduction, response and preparedness is strengthened		
Indicators	Actual	Target
# of NS contingency and preparedness plans updated	1	1
# of RCCE orientation sessions conducted	31	30
Outcome S2.1: Effective and coordinated international disaster response is ensured		
Indicators	Actual	Target
# of districts with trained rapid response teams for health emergencies	11	15
Output S2.1.1: Effective response preparedness and NS surge capacity mechanism is maintained		
Indicators	Actual	Target
# of trained frontline SDB teams that are ready to deploy	2	2
# of trained reserve SDB teams that are ready to deploy	11	15
Outcome S3.1: The IFRC secretariat, together with National Societies uses their unique position to influence decisions at local, national and international levels that affect the most vulnerable.		
Output S3.1.2: IFRC produces high-quality research and evaluation that informs advocacy, resource mobilization and programming.		
Indicators	Actual	Target
# of evaluation and lessons learned reviews conducted	1	2
Narrative description of achievements		
Out of the targeted 5 million people to be reached with epidemic prevention and control activities, RRCS reached 4,514,113 people. The target was not achieved because the NS only received part of the funds and therefore ended up cancelling other planned activities. More so, there was a 36% increase in number of mobile cinemas conducted attributed to demand with no additional costs. The number of volunteers targeted for PSS training was increased due		

to the need of PSS as a new program which needs to be reinforced. Teams trained on CEA increased by 50% after the trained 15 teams each trained another team making 30 teams at the branch with very minimal costs covered by the branches.

The majority of the planned activities were completed as shown below:

- PSS Training for 320 volunteers from 5 districts (Nyanza, Bugesera, Gasabo, Nyarugenge and Kicukiro)
- Refresher training for 8 SDB frontline teams composed by 10 members/each.
- Refresher training for PSS 30 trainers on PFA (Psychological First Aid) and Basic PSS Training for 150 NDRT.
- Revised work plan finalised in December 2019, in alignment with One International Appeal as well as national plans and strategies.
- Procurement and distribution of 2,396 posters and flyers with EVD messages in 15 districts
- Community mobilization using mobile cinema - conducted 305 mobile cinema sessions on EVD in 13 districts (Rusizi, Nyamasheke, Karongi, Rutsiro, Rubavu, Nyabihu, Mu-sanze, Burera, Gicumbi and Nyagatare, Nyarugenge, Kicukiro and Gasabo)
- Conducted 803 community awareness sessions in community meetings, schools, markets in 13 districts (Rusizi, Nyamasheke, Karongi, Rutsiro, Rubavu, Nyabihu, Musanze, Burera, Gicumbi and Nyagatare, Nyarugenge, Kicukiro and Gasabo and 325 Sensitization in schools in 13 districts
- Coordination meetings were attended during the reporting period, thereby ensuring the National Society continues to effectively engage in relevant coordination structures at various levels. Procurement and pre-positioning of one SDB starter kit and 15 training kits. RRCS headquarter staff involved in the project include PSS coordinator, Preparedness and DRR coordinator, Communication and CEA/RCCE coordinator and Financial Accountant.

Challenges

- Lack of funds to continue epidemic prevention and control activities as planned.

Lessons Learned/Key drivers/enablers of success.

- Investment in EVD preparedness enhanced the National society capacity to respond to the current COVID-19 pandemic. Early preparedness and capacity building in management of potential epidemics bore fruit in tackling the information dissemination and handling of the community during the COVID-19 pandemic.
- Constant monitoring of the funding situation is important to limit/reduce implementation delay. This enabled quick mobilisation of alternative funds to continue carrying out EVD operations. The agility of the teams made possible the adaptation of work plans and acceleration of implementation that utilized the remaining days effectively leading to the mentioned accomplishments while cancelling those of low priority to effectively use the existing funds.
- Through this Appeal, RRCS has carried out different trainings which have increased the skills of RRCS disaster response and health teams in epidemic response. These teams will help the National society in quick deployment for any health emergency preparedness and response activities in future. SDB teams formed through EVD funds supported the burial of EVD suspected cases, decontamination and IPC activities during the EVD preparedness. The preparedness activities done for EVD, provided the experience and the capacity for the preparedness and response to COVID-19. The risk communication activities done, and approaches used with the Ebola preparedness activities provided good experience which has been used during the COVID-19 and will continue to be used for other health emergency preparedness and response. PSS training and activities have been integrated into emergency activities through the EVD funds.

Find further details here: [RoC EVD preparedness DREF Operation Final Report](#) and [CAR EVD preparedness DREF Operation Final Report](#)

D. FINANCIAL REPORT

The funding requirement for this Emergency Appeal is 56 million CHF as indicated in the [Emergency Appeal Revision 7](#) budget. Donor cash response reached CHF46,634,067 or 83.2%. In addition, the IFRC DREF has granted CHF783,832 to this operation and in-Kind donations gives a total income of CHF47,439,415 or 84.7% against the funding requirement. The total expenditure was CHF48,437,409, surpassing the income by CHF781,826. For more financial information, a financial report is enclosed.

Emergency Appeal

FINAL FINANCIAL REPORT

Selected Parameters			
Reporting Timeframe	2018-2023/11	Operation	MDRCD026
Budget Timeframe	2018-2021	Budget	APPROVED

Prepared on 15 Jan 2024

All figures are in Swiss Francs (CHF)

MDRCD026 - DR Congo - Ebola Virus Disease Outbreak

Operating Timeframe: 12 May 2018 to 30 Sep 2021; appeal launch date: 21 May 2018

I. Emergency Appeal Funding Requirements

Thematic Area Code	Requirements CHF
AOF1 - Disaster risk reduction	0
AOF2 - Shelter	0
AOF3 - Livelihoods and basic needs	0
AOF4 - Health	37,000,000
AOF5 - Water, sanitation and hygiene	0
AOF6 - Protection, Gender & Inclusion	0
AOF7 - Migration	0
SFI1 - Strengthen National Societies	2,000,000
SFI2 - Effective international disaster management	13,500,000
SFI3 - Influence others as leading strategic partners	0
SFI4 - Ensure a strong IFRC	3,500,000
Total Funding Requirements	56,000,000
Donor Response* as per 15 Jan 2024	46,634,769
Appeal Coverage	83.28%

II. IFRC Operating Budget Implementation

Thematic Area Code	Budget	Expenditure	Variance
AOF1 - Disaster risk reduction	2,571	1,464	1,108
AOF2 - Shelter	8,428	8,329	99
AOF3 - Livelihoods and basic needs	2,275	9,548	-7,273
AOF4 - Health	27,141,761	27,409,610	-267,849
AOF5 - Water, sanitation and hygiene	137,104	233,652	-96,548
AOF6 - Protection, Gender & Inclusion	650	880	-229
AOF7 - Migration	0	0	0
SFI1 - Strengthen National Societies	2,030,892	1,996,086	34,806
SFI2 - Effective international disaster management	18,790,686	18,553,661	237,025
SFI3 - Influence others as leading strategic partners	115,861	139,993	-24,132
SFI4 - Ensure a strong IFRC	122,544	84,186	38,358
Grand Total	48,352,772	48,437,409	-84,637

III. Operating Movement & Closing Balance per 2023/11

Opening Balance	0
Income (includes outstanding DREF Loan per IV.)	47,655,583
Expenditure	-48,437,409
Closing Balance	-781,826
Deferred Income	785
Funds Available	-781,041

IV. DREF Loan

* not included in Donor Response	Loan :	1,502,168	Reimbursed :	502,168	Outstanding :	1,000,000
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Emergency Appeal

FINAL FINANCIAL REPORT

Selected Parameters			
Reporting Timeframe	2018-2023/11	Operation	MDRCD026
Budget Timeframe	2018-2021	Budget	APPROVED

Prepared on 15 Jan 2024

All figures are in Swiss Francs (CHF)

MDRCD026 - DR Congo - Ebola Virus Disease Outbreak

Operating Timeframe: 12 May 2018 to 30 Sep 2021; appeal launch date: 21 May 2018

V. Contributions by Donor and Other Income

Opening Balance							0
Income Type	Cash	InKind Goods	InKind Personnel	Other Income	TOTAL	Deferred Income	
American Red Cross	404,024				404,024		
Australian Red Cross			0		0		
Australian Red Cross (from Australian Government*)	672,300				672,300		
Austrian Red Cross (from Austrian Government*)	109,482				109,482		
Belgian Government - Flanders	170,709				170,709		
British Red Cross	1,280,948				1,280,948		
British Red Cross (from British Government*)	10,027,978				10,027,978		
CDC Centers for Disease Control and Prevention	3,447,989				3,447,989		
Danish Red Cross	400,000				400,000		
Danish Red Cross (from Danish Government*)	2,167,182				2,167,182		
DREF Response Pillar				1,000,000	1,000,000		
European Commission - DG ECHO	3,492,165				3,492,165		
Finnish Red Cross	110,810		29,877		140,687		
Finnish Red Cross (from Finnish Government*)	612,237				612,237		
Hong Kong Red Cross, Branch of the Red Cross Socie	50,512				50,512		
Icelandic Red Cross	425,000				425,000		
Icelandic Red Cross (from Icelandic Government*)	225,000				225,000		
Italian Government Bilateral Emergency Fund	562,395				562,395		
Italian Red Cross	108,203				108,203		
Japanese Red Cross Society	89,554				89,554		
Kenya Red Cross Society			18,083		18,083		
Kuwait Red Crescent Society	297,923				297,923		
London School of Hygiene & Tropical Medicine	82,191				82,191		
Norwegian Red Cross	596,742				596,742		
Norwegian Red Cross (from Norwegian Government*)	159,515				159,515		
On Line donations	239				239		
Other	-186,671				-186,671		
Paul G Allen Family Foundation	957,956				957,956		
Red Cross of Monaco	17,401				17,401		
Sales				-8,311	-8,311		
Spanish Government	109,035				109,035		
Sundry Income				3,739	3,739		
Swedish Red Cross	493,485				493,485		
Swiss Government	1,000,000				1,000,000		
Swiss Red Cross	227,000				227,000		
The Canadian Red Cross Society	3,107	10,018			13,125		
The Canadian Red Cross Society (from Canadian Gov	3,004,506				3,004,506		
The Netherlands Red Cross	269,166				269,166		
The Netherlands Red Cross (from Netherlands Govern	1,210,007				1,210,007		
Turkish Red Crescent Society	60,000				60,000		
United States Government - USAID	9,483,440				9,483,440	785	
United States - Private Donors	1,897				1,897		
Western Union Foundation	9,484				9,484		
WHO - World Health Organization	4,744,735				4,744,735		
Write off & provisions				-295,467	-295,467		
Total Contributions and Other Income	46,897,644	10,018	47,960	699,960	47,655,583	785	
Total Income and Deferred Income					47,655,583	785	

Reference documents

Click here for: [Previous Appeals and updates](#)

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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 (NGOs) 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.

E 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.



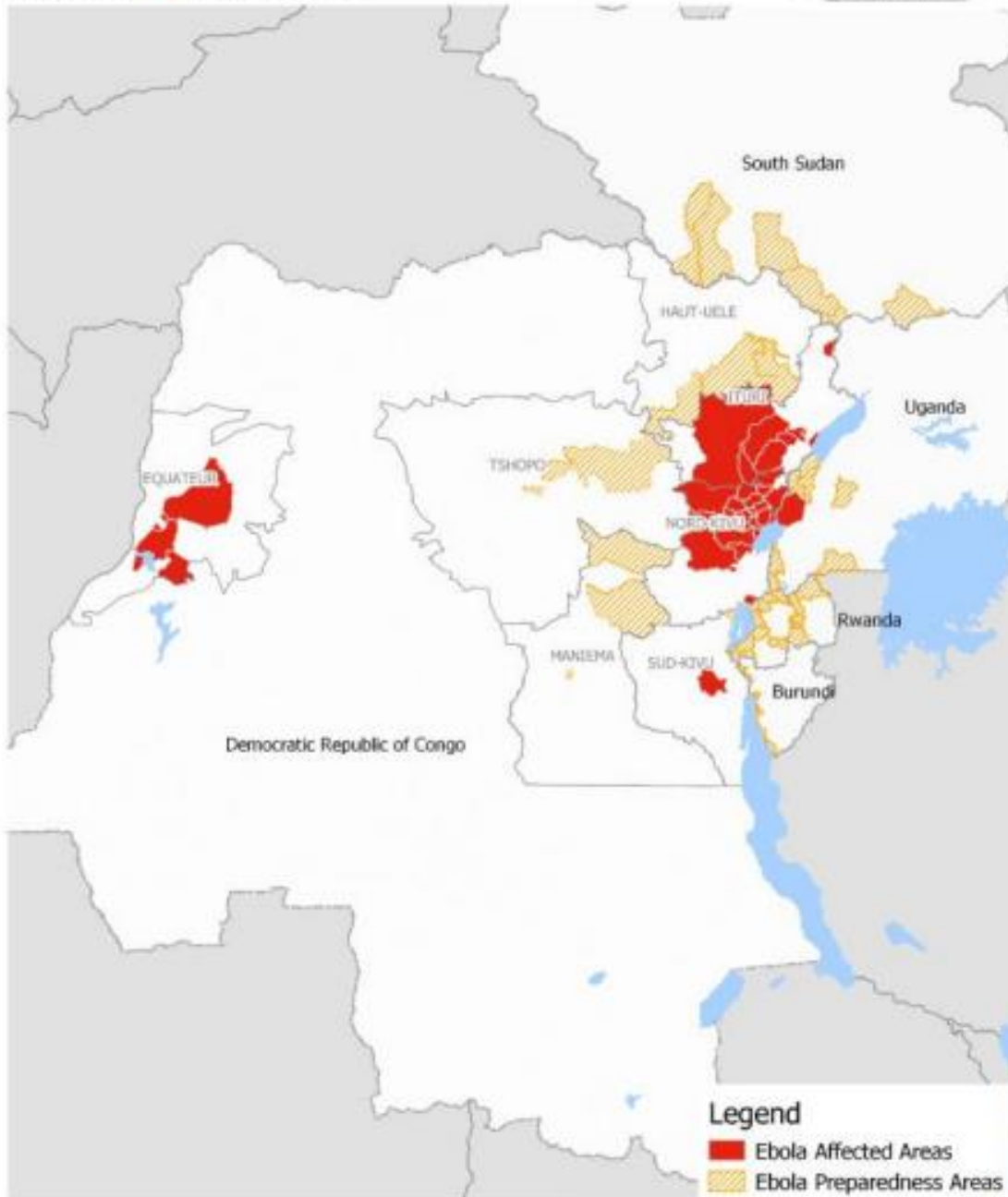
Promote social inclusion
and a culture of
non-violence and **peace**.

Regional preparedness and coordination

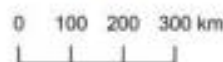


Ebola Virus Disease Response and Containment Operations Update

16 June 2020 ● EP-2018-000129-COD



The maps used do not imply the expression of any opinion on the part of the International Federation of the Red Cross and Red Crescent Societies or National Societies concerning the legal status of a territory or of its authorities.
Map data sources: OCHA, Natural Earth, MSF, IFRC.

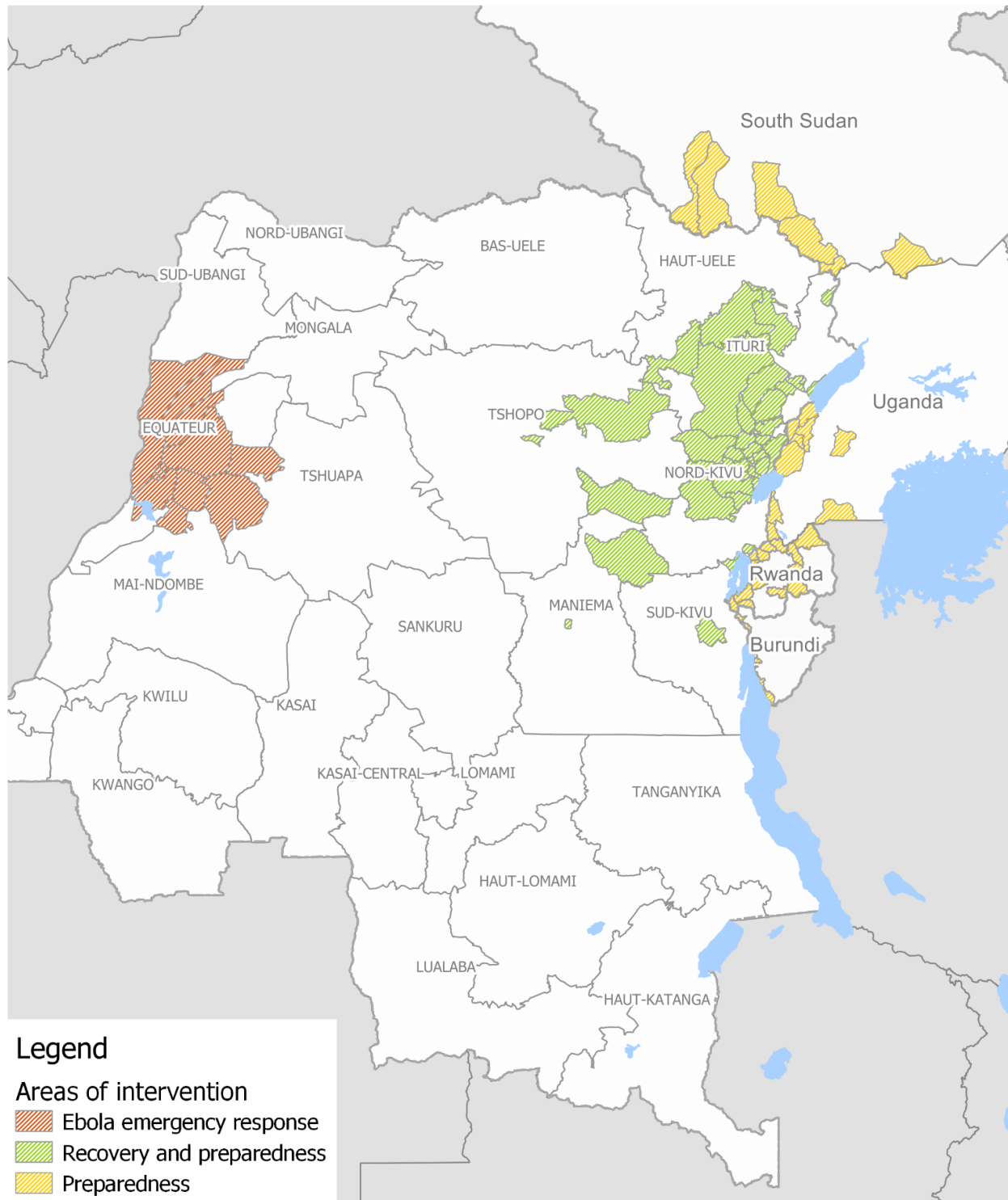




CROIX-ROUGE
DE LA RDC

Ebola Virus Disease Response and Recovery Revised Emergency Appeal 6

29 September 2020 ● EP-2020-000151-COD



Legend

Areas of intervention

- Ebola emergency response
- Recovery and preparedness
- Preparedness

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Map data sources: OCHA, Natural Earth, MSF, IFRC.

