



# OPERATION UPDATE 6 MONTH

## Democratic Republic of the Congo (DRC) | Ebola

<b>Emergency appeal №: MDRCD047</b> <b>Emergency appeal launched: 15/09/2025</b> <b>Operational Strategy published: 30/09/2025</b>	<b>Glide №: EP-2025-000157-COD</b>
<b>Operation update 6month</b> <b>Date of issue: 18/05/2026</b>	<b>Timeframe covered by this update:</b> From 15/09/2025 to 15/03/2026
<b>Operation timeframe: 12 months</b> (15/09/2025 - 30/09/2026) <b>New timeframe after extension: 15/09/2025 - 30/03/2027</b>	<b>Number of people being assisted: 965,000 people</b>
<b>Funding requirements (CHF):</b> CHF 17 million through the IFRC Secretariat Emergency Appeal, as part of the CHF 20 million Federation-wide EA	<b>DREF amount initially allocated:</b> CHF 1,750,000

The Emergency Appeal with a secretariat funding ask of **CHF 17,000,000**, is currently standing at **22% funded**, based on confirmed contribution and potential support under discussion. While the 16th Ebola outbreak has been declared over, preparedness and surveillance activities remain ongoing in previously affected areas. Following the declaration of a 17th outbreak in Ituri Province, the IFRC is reviewing the most suitable tool to support both the new response to new outbreak and continue the preparedness efforts under this EA.

## A. SITUATION ANALYSIS

### Description of the crisis

The 16<sup>th</sup> outbreak of Ebola virus Disease (EVD) in the Democratic Republic of Congo (DRC) was declared on September 4, 2025, by the Minister of Public Health, Hygiene and Prevention, following its emergence in Kasai Province. Since then, the outbreak has resulted in 64 total cases (53 confirmed, 11 probable) and 45 deaths<sup>Error! Bookmark not defined.</sup>. The epicenters were concentrated in the Bulape and Dikolo health areas, which together account for approximately 78% of all reported cases.

On December 1, 2025, the Government officially declared the outbreak over, marking the completion of the 42-days countdown from the discharge of the last confirmed case from the Ebola Treatment Centre (ETC) on October 19, 2025. Coordination of health activities would be handed over to provincial health structures from the Government's public health emergency operations center. A 90-day plan to strengthen post-epidemic surveillance in Kasai Province and Surrounding Areas has been enforced for the period of heightened surveillance.

Vaccination efforts during the outbreak reached 47,577 individuals. Following the declaration of end of the epidemic, the vaccination campaign in the affected area has concluded and is no longer mandatory.

The 16<sup>th</sup> EVD outbreak remained geographically confined to Kasai Province, primarily within the Bulape Health Zone. Six health areas were affected: Bulape, Bulape Communautaire, Igongo, Mpianga, Bambalaie, and Dikolo. However, due to significant population movement between Bulape and neighboring zones, the risk of virus spread had been considered high throughout the outbreak. As a result, continuous surveillance across a wider geographic area and sustained preparedness measures remains essential to mitigate risks.

Since the [start of the outbreak](#), staff and volunteers of the Democratic Republic of Congo Red Cross (DRC Red Cross) have worked tirelessly to save lives, supported by the [emergency appeal](#) launched by the International Federation of Red Cross and Red Crescent Societies (IFRC) on September 15, 2025.

During the immediate post-outbreak period, the DRC Red Cross remains a critical actor in sustaining community engagement, monitoring for potential flare-ups, supporting survivors, and maintaining preparedness structures. To ensure continuity, the National Society has developed an immediate plan aligned with the Government's priorities for the transition period of 90-day, from December 2025 to February 2026, heightened surveillance period per Ebola response protocol. According, the Operation Strategy along with the emergency appeal has been revised to reflect this shift in the 90-day period and beyond, focusing on strengthening community-level readiness, reinforcing surveillance, improving water, sanitation and hygiene (WASH) and infection prevention and control (IPC) standards, ensuring trusted communication, and providing survivor support. The preparedness and the readiness for a new outbreak have also been integrated as a priority for the transition plan 90+ days, as long-term resilience period.

### **17<sup>th</sup> EVD outbreak (May 2026)**

As of 15<sup>th</sup> May 2026, the Ministry of Health and the Africa Centre for Disease Control (Africa CDC) reported the 17<sup>th</sup> outbreak with about 246 suspected cases and over 80 deaths, with laboratory testing confirming 13 Ebola-positive cases linked to the Bundibugyo strain of the virus. The outbreak is centred in Ituri province in Eastern DRC mainly the Mongwalu, Bunia and Rwampara Health zones, with hundreds of suspected cases already before the outbreak was announced. Humanitarian and health partners are particularly concerned about the high level of cross-border population movement, insecurity caused by armed groups, weak health infrastructure, and challenges in surveillance and contact tracing. The situation is further complicated by the absence of a licensed vaccine specifically for the Bundibugyo strain, unlike previous outbreaks caused by the Zaire strain. Regional coordination efforts involving the DRC Ministry of Health, WHO, Africa CDC, IFRC, Uganda, and other partners are ongoing to strengthen surveillance, contact tracing, logistics, safe burials, community engagement, and rapid response readiness across the region.

Uganda has already confirmed one imported fatal Ebola case connected to the DRC outbreak. The case involved a 59-year-old Congolese male who was admitted to Kibuli Muslim Hospital in Kampala on 11 May 2026 with severe symptoms and later died in intensive care. Laboratory testing at the Uganda Virus Research Institute confirmed the sample as Ebola Bundibugyo virus disease. The Ministry emphasized that this was an imported case from the Democratic Republic of Congo linked to the ongoing outbreak in Ituri Province, and stated clearly that no local transmission had been confirmed in Uganda at the time of the announcement. Uganda's Ministry of Health and partners including the Uganda Red Cross Society have activated preparedness and surveillance measures, especially in Kiryandongo, one of the border districts. Uganda Red Cross Society has held coordination meetings with its operational teams at the affected district and have deployed CBS-trained volunteers to monitor and report potential alerts.

Uganda has substantial prior experience responding to Ebola outbreaks in the past, including the major 2022–2023 Sudan virus outbreak that caused 77 deaths. Africa CDC, WHO, Uganda, DRC, South Sudan, and humanitarian partners are currently coordinating a regional response due to fears of wider spread across the Great Lakes region.

## Summary of response

### Overview of the host National Society and ongoing response to the 16<sup>th</sup> Outbreak

Over the first six months of the Ebola response in Kasai Province, the IFRC and the DRC Red Cross focused on rapidly containing the outbreak while supporting communities across **six health areas in Bulape** and **two in Mweka**. The operation relied on the strong mobilization of **874 volunteers**, whose presence on the ground enabled early detection of suspected cases, timely referrals, and continuous engagement with affected populations.

Community-based surveillance played a central role in the Ebola response, with **6,276 alerts** (4900 were investigated, and 2,843 validated) reported to the Ministry of Health through a network of trained volunteers, community health workers, and animal health workers. Of these alerts, 4,900 were investigated and 2,843 were validated, strengthening early warning capacities and sustaining vigilance in areas at risk of further transmission.



*Volunteers training in Bulape*



*Safe and Dignified Burials (SDB) in Luebo*

In parallel, extensive risk communication and community engagement (RCCE) activities were implemented through door-to-door visits, mass sensitization sessions, and **240 radio broadcasts**. In the absence of precise radio audience measurement data, a standard estimation rate of 50% of the total targeted **beneficiaries (960,000 people)** was applied, in line with common humanitarian RCCE practices. This estimated reach was incorporated into the figures for door-to-door and mass sensitization activities, resulting in a total of **1,185,813 people** reaching through community engagement interventions. These efforts contributed to improved community understanding of Ebola, reduced misinformation, and strengthened trust affected communities, and response actors. Safe and Dignified Burials remained a critical component of the response. Trained teams conducted **209 SDBs**. During the epidemic and throughout the transition phase until the end of February, activities continued. In parallel, training activities were maintained, particularly through regular refresher sessions and practical case exercises. Work on the repositioning of kits was also carried out.

WASH interventions complemented these efforts, with **158,189 people** reached through hygiene promotion and access to handwashing facilities. More than **89.235 litres** of water were used for handwashing, and all households linked to Ebola-related deaths were fully decontaminated. In parallel, assessments have identified significant gaps in infection prevention and control across five health facilities, guiding the next phase of support for reinforcement of these facilities.

Psychosocial support was integrated throughout the response, with **33,528 people** receiving emotional and psychological assistance during **1,180 sessions**, including survivors, bereaved families, and frontline volunteers.

Protection, gender, and inclusion considerations were embedded across activities to ensure equitable access to services. Since the launch of the Emergency Appeal, the operation has prioritized Protection, Gender and Inclusion (PGI) through capacity strengthening and community engagement. All volunteers (**874**) were trained on minimum PGI standards, GBV, PSEA, child protection and safeguarding, referral mechanisms, and the survivor-centred approach, with an additional 296 (104 female and 192 males) volunteers receiving dedicated PSEA while 44 (27 males and 17 females) received dedicated PGI training. PGI activities were further reinforced through awareness-raising sessions and focus group discussions addressing key protection concerns, reaching over 6,200 community members.

Some highlights of results in figure (as of March 15th, 2026):

- **740,083 people** through health and care related activities.
- **158,189 people** through water, sanitation & hygiene promotion interventions.
- 6,276 community alerts raised by the teams involved in the CBS (case findings) activities.
- 1,180 sessions of MHPSS and reaching **33,528 persons**.
- 209 Safe & Dignified Burial performed.
- 12,466 community feedback collected, 240 live radio shows broadcasted, and 159 focus group discussions conducted.

To support these activities, international assistance was mobilized through rapid response mechanisms and Emergency Response Units (ERUs). A Public Health ERU, equipped with Infection Prevention and Control (IPC) and Community-Based Surveillance (CBS) modules, was deployed in Bulape until the end of February to reinforce operations. The ERU team consisted of four specialists with expertise in IPC clinical practices, IPC logistics, community-based surveillance, and epidemiology.

In addition, several operational profiles were deployed for periods ranging from one to three months to further strengthen the response, including an operations manager, a Public Health in Emergencies Coordinator, a supply chain coordinator, an assessment coordinator, a communications coordinator, a finance officer, a field coordinator, an administrative assistant, and a CEA coordinator.

### **Action in response to the 17<sup>th</sup> Outbreak in Ituri**

The DRC Red Cross is actively engaged in the response to the newly declared EVD outbreak in Ituri Province, building on its existing operational presence under this ongoing Emergency Appeal (MDRDC047). With support from the IFRC and partners, the National Society has initiated immediate response actions, including strengthening surveillance, community-based early detection, SDB, risk communication and community engagement (RCCE) activities in affected areas. The DRC Red Cross is working closely with national and provincial health authorities, ensuring alignment with government-led response structures while supporting coordination at field level.

At the same time, the National Society is scaling up operational readiness and working in close alignment with the government and other key partners. This includes mobilizing trained volunteers, reinforcing infection prevention and control (IPC) measures, SDB, RCCE and supporting activities as required. Efforts are also being coordinated with the Uganda Red Cross to strengthen cross-border preparedness and information sharing. Through a planned scale up, the DRC Red Cross, supported by IFRC, will expand its response capacity in Ituri and affected areas while maintaining preparedness and recovery activities in areas previously affected by the 16th outbreak, ensuring a comprehensive and adaptable approach to the current crisis.

In order to strengthen support to the response and the DRC RC, Membership and Movement coordination mechanisms have been activated at all levels. The DRC Red Cross, IFRC, and ICRC convened an initial mini-summit on 16 May to reinforce coordination across the Movement, ensure clear roles and responsibilities, and align operational priorities in line with the Seville 2.0. This engagement marks an important step in strengthening

collective action, enhancing information sharing, and ensuring a coherent and well-coordinated response in support of national authorities.

## Needs analysis

In response to the 16<sup>th</sup> outbreak, DRC RC teams conducted a multisectoral needs assessment in October 2025, which informed decisions on priority geographic areas, sectoral interventions, and risk management. These priorities continue to guide the ongoing operation, with a focus on the extensive needs in community engagement particularly in feedback management, rumor tracking, and trust-building, community-based surveillance, water and sanitation, and infection prevention and control measures.

Addressing the needs of hard-to-reach areas are of key concern during this 90-day period, to reducing the risk of delayed epidemic detection and response. Persistent gaps in access to essential health and hygiene items, basic water supply, and related services require continuous attention to prevent further vulnerabilities.

Government-led preparedness efforts are underway in Bulape Health Zone in Kasai Province and have been extended to neighboring provinces and border areas. These activities will continue even after the transition phase of 90 days plan of Ebola outbreak. The prioritize health zones across three provinces: Kasai, Kasai Central, and Sankuru. Building on the initial needs assessments, additional sector-specific analyses were undertaken to fine-tune activity design and ensure that interventions deliver significant impact aligned with the needs of the population and the operational context. For instance, in the WASH/IPC sector, an in-depth evaluation was conducted to refine construction needs for the health facilities previously identified. A gender, protection, and inclusion assessment was also further developed to guarantee the inclusion of the most vulnerable groups.

The new outbreak in Ituri is generating urgent humanitarian and public health needs, driven by ongoing transmission, high population mobility, and fragile health systems. Priority needs include strengthened surveillance and contact tracing, strengthening of IPC in health facilities, reinforcing of safe and dignified burial protocols, and expanded risk communication and community engagement to address rumours and improve community acceptance. In parallel, there is a critical need for increased operational capacity, including trained personnel, medical supplies, and logistical support, as well as sustained funding to ensure an effective response while maintaining preparedness and recovery in previously affected areas. Additional WASH gaps also require urgent attention, including access to safe water, improved hygiene and disinfection facilities, and proper waste management, alongside strengthened community hygiene practices and safe burials to help reduce transmission.

## Operational risk assessment

The risk of disease re-emergence persists both within the affected area and beyond, underscoring the need for continued vigilance. The DRC Red Cross has been pursuing its efforts with a continuity of the 90-day plan developed by the Ministry of Health by designing a new strategy aimed at enhancing resilience through improved preparedness and readiness, supported by strong surveillance systems to ensure the rapid detection of any Ebola resurgence and health system reinforcement to improve the local capacity.

Operational challenges persist due to poor infrastructure, roads especially, particularly during the wet season. Movement of people and essential materials is heavily constrained by long, hazardous roads, which significantly impacts activities that rely on effective communication with communities and timely delivery of essential supplies.



These constraints affect efforts to rebuild health structures and sustain operations, making logistical planning and resource allocation crucial for success.

*Picture of road and infrastructure challenges on the field*

The lack of local supplier is also an issue that created delay in the implementation of activities especially for constructions and kits distribution

Moreover, the response in Ituri faces significant operational risks linked to insecurity, population movements, and community dynamics. Ongoing armed group activity and intercommunal tensions continue to restrict access to affected areas, pose threats to staff and volunteers, and disrupt response activities. High population mobility particularly towards mining areas and across borders with Uganda and South Sudan further increases the risk of disease spread and complicates surveillance and contact tracing efforts. In addition, community mistrust and widespread rumours, including beliefs in non-medical causes of the disease, risk limiting acceptance of response measures such as safe burials, isolation, and reporting of suspected cases. Weak health infrastructure, limited infection prevention and control capacity, and logistical constraints also pose challenges to scaling up the response rapidly. Together, these factors create a complex operating environment requiring strong coordination, sustained community engagement, and flexible response approaches.

## B. OPERATIONAL STRATEGY

### Update on the strategy



*PCI/WASH Activity at the Bulape Base*

The operational strategy in response to the **16<sup>th</sup> outbreak** is being revised to reflect the natural evolution of the response in the area, and it will focus on preparedness and recovery in the area of Bulape, with the DRC Red Cross continuing to lead the operation as it has from the outset. Among the scenarios initially projected by Africa CDC, the situation following the last outbreak has followed Scenario 1, the most limited trajectory, with fewer than 100 cases and transmission remaining contained within Bulape Health Zone. While early projections considered that a more significant spread (Scenario 2 or even Scenario 3) might materialize, the outbreak remained localized, with no

exponential growth or cross-border transmission. This adjustment ensures that the Appeal remains realistic, needs-based and proportionate to the epidemiological context, while allowing the DRC Red Cross to sustain essential preparedness and community-level activities.


Since March, the approach has been placing even greater emphasis on national implementation, as international surge support gradually wended down. This reinforced the National Society's longstanding leadership by ensuring that remaining activities particularly preparedness, community-based surveillance and health promotion are fully carried out through its own structures and volunteer network. Strong attention will continue to be placed around Protection, Gender and Inclusion (PGI) to ensure that services remain safe, dignified and accessible for women, survivors, persons with disabilities and other at-risk groups during the transition in Bulape. PGI principles will continue to guide all engagement, referrals and psychosocial support.

In addition, through this Operational update, the IFRC and relevant National Societies seek to extend this Emergency Appeal for an additional 6 months until 30th March 2027. This extension will provide the National Society and IFRC adequate time to effectively complete the implementation of the ongoing preparedness activities (especially construction activities to contribute to the National Society Development), while also maintaining an adequate level of readiness and operational support throughout the end of 2026. Overall, this revised approach will ensure a responsible, nationally anchored closure of the Ebola operation, leaving behind empowered communities, strengthened protection mechanisms and an even more capable National Society ready to manage future health risks.

## C. DETAILED OPERATIONAL REPORT

### STRATEGIC SECTORS OF INTERVENTION

*\*The following section reports on the actions from DRC RC up to March 2026 in response for the 16<sup>th</sup> outbreak in Bulape.*

	<b>Health &amp; Care</b> <i>(Mental Health and psychosocial support / Community Health / Medical Services)</i>	Female > 18: <b>229,866</b>	Female < 18: <b>187,609</b>
		Male > 18: <b>171,872</b>	Male < 18: <b>150,736</b>
<b>Objective:</b>	<i>The spread and impact of the outbreak are reduced through community outreach in the affected health zones.</i>		
<b>Output 1.1 Safe &amp; Dignified burial (SDB)</b>	<b>Key indicators</b>	<b>Actual</b>	<b>Target</b>
	<i># of SDB alerts received</i>	209	As necessary
	<i>% of SDB alerts responded to through public health measures within 48 hours</i>	100%	100%
	<i>% of deceased for which SDB was successfully carried out when alert is received</i>	100%	100%
	<i>% of samples collected using swabs for deaths reported to the Red Cross</i>	100%	100%

<i>% of decontamination alerts completed by Red Cross teams within the same calendar day of SDB</i>	100%	80%
<i># of volunteers/supervisors trained/re-trained in SDBs, disaggregated by gender, age and disability*</i>	256	360
<i>% of Red Cross SDB volunteers vaccinated with EVD vaccine</i>	100% (response area) 80% (preparedness area)	100%

### Achievements:

To date, a total of **256 volunteers (198 men and 58 women) have been trained** in Safe and Dignified Burial (SDB) practices across the health zones. Since the start of the operation, **209 safe and dignified burials** have been successfully conducted. In parallel, **173 specimen swabs<sup>1</sup>** were collected and transferred to the INRB for laboratory confirmation. To support these activities, **55 SDB kits were supplied** and distributed to the volunteers involved.

15 DRC Red Cross SDB teams are fully operational and on standby: 8 in Bulape, 2 in Mweka, 3 in Tshikapa, 1 in Mushenge, and 1 in Luebo. All teams operate strictly in accordance with Ministry of Health-validated Standard Operating Procedures (SOPs) and in close coordination with existing surveillance structures.

To strengthen the capacity of the national society at the branch level, 10 training sessions, including practical simulation exercises, were organized between September 2025 and March 2026 across 10 health zones.

In the coming period further training sessions are planned to increase readiness capacities for Safe and Dignified Burial teams in the areas around Bulape, first through a national training of trainer (TOT) to have a pool of volunteers and staff able to train others and, then a training at the branch level in order to have a pool of volunteer ready to deploy in the province (and beyond as needed).

<b>Output 1.2</b>	<b>Key indicators</b>	<b>Actual</b>	<b>Target</b>
<b>Mental Health &amp; Psychosocial Support (MHPSS)</b>	<i>% of people confirmed or suspected to have been affected by EVD receiving MHPSS services</i>	100%	100%
	<i># of people who receive mental health &amp; psychosocial services provided by National Society</i>	33,528	23,200
	<i># of supervisors and volunteers trained in psychosocial support</i>	44	100
	<i>% of staff and volunteers supported by MHPSS services or relevant activities</i>	100%	100%

### Achievements:

As part of the Ebola response operation in the Kasai region, psychosocial support (PSS) remains at the core of the intervention led by Red Cross volunteers. Through their continued engagement, a total of **1,180 psychosocial support**

<sup>1</sup> Early in the response (until mid-November), systematic swabbing was not consistently conducted for deaths occurring in health facilities (e.g. hospitals or treatment centres), although safe and dignified burial procedures were implemented

**sessions** were conducted by trained PSS volunteers providing essential emotional and psychological assistance to affected individuals, **reaching 33,528 people (14,502 men and 19,026 women)** in the Bulape Health Zone and surrounding areas. This human-centered approach is a key pillar of our integrated response, ensuring that mental well-being and community coping capacities are prioritized alongside health interventions, helping strengthen community resilience and reduce fear, stress, and stigma associated with the disease.



*Picture of a PSS group session*

Through three trainings in Bulape, Mweka and Mushenge, a team of **44 volunteers (27 male and 17 female) has been trained** and continues to operate across affected health areas, providing Psychological First Aid (PFA) and emotional support to families of Ebola patients, discharged survivors, bereaved households, and communities impacted by fear and stigma.

In the upcoming period, several training activities are planned to strengthen readiness for MHPSS support in future outbreaks. These will include Training of Trainers sessions aimed at enhancing the National Society's capacity to deliver Mental Health and Psychosocial Support (MHPSS) training and to have a qualified pool of volunteers ready to intervene in a wider geographical area in case of a new epidemic .

<b>Output 1.3: Risk Communication and Community Engagement (RCCE)</b>	<b>Key indicators</b>	<b>Actual</b>	<b>Target</b>
	<i># of people reached by epidemic-related health promotion activities</i>	740,083	965,000
	<i># of volunteers trained on EpiC with RCCE component, disaggregated by sex, age, and disability*</i>	642	1,100
	<i>% of people surveyed who say they trust the information provided by the National Society</i>	TBD	80%
	<i># of community (health area or city) EVD awareness raising sessions held</i>	21	21

**Achievements:**

A total of **642 volunteers** (408 men and 234 women) were trained across communities in Epidemic Preparedness and response in Communities (EPIC). This training equipped volunteers with the essential knowledge and skills required to effectively disseminate key awareness and prevention messages to affected populations while promoting protective behaviour change.

Through this trained volunteer network, at least 174 mass awareness sessions were conducted, reaching 373,741 people (85,929 men, 115,762 women, 74,775 boys, and 97,275 girls). In addition, 54,673 door-to-door visits were carried out, reaching a further 332,172 people (71,033 men, 94,844 women, 75,961 boys, and 90,334 girls). **In total, 740,083 people were reached.**



*Door to door visit to ensure hygiene promotion*

To further expand the reach of community sensitization efforts, **240 radio broadcasts (12 broadcasts a week from mid-October 2025)** conveying key prevention messages were aired through **five local radio stations.**



*Radio broadcast done by the DRC Red Cross*

	Key indicators	Actual	Target
<b>Output 1.4 Community based surveillance: (CBS)</b>	<i># of CBS assessments conducted</i>	1	1
	<i># of CBS protocols/SOPs developed</i>	1	1
	<i># of volunteers trained in active case finding</i>	632	1,100
	<i># of volunteers trained in CBS</i>	232	1,100

% of communities covered by CBS (1 Volunteer: <50HHs) in Red Cross responding geographical areas	10%	100%
% of alerts subsequently confirmed as cases	45,2%	NA
% of alerts from community-based surveillance (CBS) for which public health measures were taken within 48 hours	100%	100%
% of active CBS volunteers (monthly average)	100%	90%
# of CBS alerts reported to the Ministry of Health	<b>6,276</b>	As necessary

### Achievements:

The Red Cross ERU team identified **42 villages** across eight health areas for Community-Based Surveillance (CBS) implementation. Through 4 training sessions, a total of **232 community stakeholders (183 men and 49 women)** including Red Cross volunteers, community health workers, animal health workers, team leads, and supervisors were trained and mobilized. The 2-day training consisted of two main modules: the first, *Welcome to the Red Cross Movement*, introduced participants to the Red Cross Movement and its principles, as well as introduction to CEA and RCCE. The second module, focusing on *community-based surveillance*, covered essential topics (1) Introduction to CBS; (2) Priority diseases, identification; (3) How to report an alert (template and informal alert reporting channels); (4) CBS tools (NYSS too) and training for team leaders and IT staff; (5) Introduction to SGBV and MHPSS; (6) Explanation of the volunteer handbook; and (7) simulation exercises before deployment to the field.



*EpiC and SBC training implemented in Mweka*

In addition, during EpiC training, a total of **632 volunteers** were trained on active case finding, strengthening community-based surveillance capacities.

As a result of these efforts, **6,276 alerts** were reported and **4,900 investigated<sup>2</sup>**, and only **2,843** from the reported alerts were retained by MoH as meeting the community case definition<sup>3</sup>. Overall, **54,673 households**, representing **328,038 individuals**, were reached through community-based surveillance activities.

<sup>2</sup> **Investigated Alerts:** True alerts for which an investigation/follow-up has been conducted (community visit, verification at the health facility level, or verification by the investigation/supervision team, IT) to clarify the event and decide on actions to take.

<sup>3</sup> **Confirmed Alerts:** Investigated alerts whose conclusion established that it is a confirmed event based on the results of verification/investigation, requiring documentation and/or a response action

Output 1.5 Nutrition and Cash for Health	Key Indicator	Actual	Target
	<i># of people admitted to the ETC and their family members who received food/meal assistance from the Red Cross</i>	0	1000

**Achievements:**

As the outbreak came to an end and earlier initially anticipated (Scenario 2), the revised response for Bulape will no longer include this activity.

Output 1.6 Infection prevention and Control	Key Indicator	Actual	Target
	<i>% of supported health facilities with functional IPC &amp; WASH systems</i>	Ongoing	Ongoing
	<i># of health practitioners trained with infection prevention and control</i>	34	100

**Achievements:**

A joint needs assessment conducted by the Ministry of Health, the DRC Red Cross, and the Red Cross ERU team (IPC module) preliminarily identified five health facilities with critical gaps in infection prevention and control (IPC), posing a heightened risk of infection. Key issues include inadequate sterilization, poor waste management, limited water access and utilization, and lack of gender-sensitive sanitation facilities all flagged as priority elements in the Government's resilience plan.

During the reporting period, **34 healthcare workers (26 men and 8 women) were trained in Infection Prevention and Control (IPC)** across four health facilities: CSR MBelo, CS Pombo, CS Bwkwek, and PS CRRDC Bambalaie. Both theoretical and practical training sessions were conducted to ensure participants acquired essential competencies in IPC, including hand hygiene, standard precautions, proper donning and doffing of Personal Protective Equipment (PPE), equipment disinfection, and biomedical waste management.

In addition, supplementary training sessions focusing on disinfection were delivered, building on the previously conducted SDB trainings to further reinforce practical skills and standardize practices.

Complementary to capacity building, significant efforts were undertaken to strengthen IPC and WASH infrastructure in the same four health facilities. Technical specifications (terms of reference) were developed and published to guide the selection of a qualified service provider for the planned works. Close coordination was maintained with ICAP and IMC to ensure a harmonized approach, particularly with regard to the standardization and similarity of construction works across facilities.

In the upcoming period, the planned construction works will be completed, and additional training sessions will be conducted for healthcare staff to further strengthen local capacities and ensure the sustainability of IPC practices.



## Water, Sanitation and Hygiene promotion

Female > 18: 43,559

Female < 18: 39,712

Male > 18: 42,045

Male < 18: 33,273

### Objective:

*Improve hygiene practices within the entire affected population.*

### Output 2.1 Water, sanitation & hygiene promotion

Indicator	Actual	Target
<i># of hygiene kits distributed in the households of response area</i>	47	250 (revised)
<i># of people covered with hygiene promotion activities</i>	158,589	680,000
<i># of homes, health facilities, or other locations where a confirmed or presumed case had spent time decontaminated by trained RC teams</i>	167	1,000

### Achievement:

The **47 handwashing facilities** previously installed across eight communes remain fully operational. In total, **90,220 liters of water** were used, enabling **158,589 people** (42,045 men, 43,559 women, 33,273 boys, and 39,712 girls) to practice proper hand hygiene.

In addition, as part of the Safe and Dignified Burial (SDB) activities, all households of suspected cases were decontaminated. A total of **167 decontamination operations** were successfully carried out, contributing to infection prevention and community safety.



*Decontamination operation implemented*

In the upcoming period, the handwashing facilities will remain fully operational. In parallel with handwashing activities, hygiene promotion sessions will continue to be conducted to reinforce good hygiene practices within the communities

The indicator related to the distribution of kits was revised during the reporting period. Due to limited funding under the Emergency Appeal, prioritization of activities was required. With the operational change in Bulape, there will be

a focus on the distribution of 250 hygiene kits targeting selected households within the response zones, rather than the initially planned 4,000 kits for families of deceased individuals and contacts. This adjustment reflects the shift towards targeted support aligned with available resources and the evolving operational context.



## Protection, Gender and Inclusion

Female > 18: 3,480	Female < 18: 0
Male > 18: 2,793	Male < 18: 0
Male: 452	Female: 480

People with disabilities

**Objective:** *Communities identify and respond to the distinct needs of the most vulnerable segments of society, especially disadvantaged and marginalized groups due to violence, discrimination and exclusion, and other forms of non-respect for human rights and respond to their specific needs according to the DAPS principles.*

	Key indicator	Actual	Target
<b>Output 3.1 Safe Access to Services</b>	<i># of people (disaggregated by sex, age, and disability) reached by protection, gender, and inclusion programming</i>	6,273	23,200
	<i># of (temporary) safe spaces established or operated by the National Society for the purpose of learning, psychosocial support, or recreation</i>	N/A	N/A (revised)
	<i># of assessments and analysis carried out incorporating protection, gender, and diversity and inclusion considerations as part of emergency operations</i>	1	1
<b>Output 3.2 Protection from sexual exploitation and abuse</b>	<i>% of volunteers and staff trained on PSEA and basic SGBV awareness and survivor-centred response, including receiving and managing sensitive SGBV (including safeguarding)-related disclosures</i>	79.4%	100%
	<i>% of survivors of SGBV/SEA reporting to the National Society who are referred to appropriate medical, psychological, or other support services within 72 hours</i>	100%	100%
	<i># of National Society staff and volunteers who have signed and been briefed on the Code of Conduct</i>	874	1,100
	<i># of gender and disability reporting mechanisms supported</i>	1	1

### Achievements:

Since the launch of the Emergency Appeal, **874 volunteers have been trained** over three days on the minimum PGI standards, gender-based violence (GBV), the DRC Red Cross Code of Conduct, Prevention of Sexual Exploitation and

Abuse (PSEA), child protection and child safeguarding, the survivor-centered approach, referral mechanisms, and Community Engagement and Accountability (CEA).

In addition, **296 volunteers (192 men and 104 women)** received specific training on PSEA, reinforcing compliance with safeguarding and accountability standards.

Complementary to these capacity-building efforts, multiple awareness-raising sessions and focus group discussions have been conducted since the start of the operation to raise awareness and identify key protection concerns. Topics addressed included early and forced marriage, child labour, sexual violence, women’s rights, and physical and psychological violence. These activities targeted a diverse range of groups, including community leaders, young women, and persons with disabilities, among others. In total, **6,273 people were reached through these activities (3,480 women and 2,793 men).**

Procurement of dignity kits is currently underway and will enable distribution to targeted populations. In addition, further training sessions are planned, particularly on safeguarding, including trainings targeting law enforcement actors, to strengthen protection mechanisms and referral pathways.

To facilitate the reporting of complaints, 01 feedback mechanism has been set up in Bulapé. This mechanism includes: the PGI focal point, 09 CBCM set up by the PSEAH coordination of the Ebola response, and the 159 hotlines of the CRCR movement. These CBCMs are representative of the vulnerable groups in the community. Radio broadcasts and community awareness (door-to-door, group and mass) have been conducted in various places (church, schools, market) to inform the population of the existence of these mechanisms and encourage their use, with a particular focus on women and people with disabilities. During the sensitization 8368 females including 480 females were reached.

Through these awareness-raising, rumors about cases of sexual violence and SEA have been reported: volunteers collected about 2100 feedback related to GBV incidents, including 170 related to sexual violence. However, only 02 girls survivors of rape within 72 hours were identified and referred to the medical service. Many challenges remain for the reporting of cases due to cultural barriers, stigma, and ignorance. Following the community-based SEA risk analysis carried out, community awareness-raising continues to be strengthened.

The indicator related to the establishment of safe space areas was removed following the revision of the operational strategy. It was determined that the creation of dedicated safe spaces is primarily critical during the acute phase of an outbreak. As this activity could not be implemented at an earlier stage, often due to limited infrastructure or the lack of appropriate and available spaces, it was decided to continue the planned activities without setting up dedicated safe space areas. Instead, emphasis was placed on ensuring confidentiality and privacy during individual sessions conducted within existing structures and operational settings.



## Community Engagement and Accountability

### Objective:

*People and vulnerable communities affected by the epidemic are empowered to influence the decisions that affect them and trust the IFRC network to service their best interests.*

### Key indicators

### Actual

### Target

<b>Output 4.1 Feedback mechanism</b>	<i># of staff, volunteers and leadership trained on community engagement and accountability</i>	874	1,100
	<i># of opportunities for community participation in managing and guiding the operation (e.g. number of community committee meetings, focus group discussions, town halls)</i>	159	As required
	<i># of feedback received from community</i>	23 770	As required
	<i>% of operational feedback received and addressed by the National Society</i>	100%	80%
	<i>The National Society has established a functional feedback mechanism for the entire organization.</i>	1	1

### Achievements:

Based on findings from multiple assessments conducted during the initial phase of the response, the operational strategy was adjusted to better reflect community needs and expectations. A total of 874 volunteers were trained and deployed to implement Risk Communication and Community Engagement (RCCE) and Community



*Data collect activities for the Community Trust Index (CTI)*

Engagement and Accountability (CEA) activities across eight response health zones: Bulape, Mweka, Mushenge, Kakenge, Luebo, Kalonda Ouest, Kanzala, and Tshikapa.

Community participation in managing and guiding the operation was systematically integrated through 159 structured engagement opportunities, contributing directly to decision-making, activity adaptation, and accountability to affected populations. These opportunities included:

- Community committee and dialogue meetings with local leaders, traditional authorities, and health committees at health-area and village levels.
- Focus group discussions (FGDs) with diverse population groups, including women, youth, religious leaders, traditional healers, and persons with disabilities.
- Community feedback and consultation sessions, including door-to-door discussions and facilitated group dialogues.

Specifically, six (6) focus group discussions involving 125 participants were conducted in Bulape, Mweka, Mushenge, Luebo, Kakenge, and Tshikapa, providing qualitative insights into community perceptions, concerns, and expectations. These FGDs were complemented by additional small-group discussions, community committee meetings, and dialogue sessions conducted regularly by trained volunteers across the eight health zones, bringing the cumulative total to 159 participation opportunities during the reporting period.

To further strengthen community-informed programming, a Community Trust Index (CTI) assessment was conducted in Bulape and Mweka. Forty-five volunteers were trained on CTI data collection procedures and conducted interviews with 1,500 community members. This quantitative exercise was complemented by 13 additional focus group discussions (seven in Mweka and six in Bulape), deepening community input into the design and adjustment of RCCE and CEA approaches. While data cleaning and analysis are ongoing, preliminary findings are already informing operational reflections and future engagement planning.

Throughout the reporting period, 23,770 community feedback entries were collected across the health areas of Mweka, Kalonda Ouest, Kanzala, Tshikapa, Bulape, Luebo, and Kakenge through multiple feedback channels. One hundred percent (100%) of operational feedback received was reviewed and addressed by the DRC Red Cross, exceeding the target of 80 percent and demonstrating strong accountability and responsiveness.

In parallel, the DRC Red Cross successfully established and operationalized one (1) functional feedback mechanism covering the entire organization, fully achieving this indicator. This included standardized tools for feedback collection, analysis, and response, as well as capacity-building initiatives, such as the March 2026 training of COUSP and DRC Red Cross teams on the Community Data Analysis and Management Tool and the monitoring of feedback received through the toll-free hotline 158.

Specific efforts were also undertaken to improve inclusion and accessibility for marginalized groups, including persons with disabilities, older persons, and minority communities, while reinforcing the engagement of community leaders in awareness raising and community mobilization activities.

## Enabling approaches



### National Society Strengthening

Objective:	<i>The National Society is prepared to effectively respond to epidemics/emerging crises, and its auxiliary role in providing humanitarian assistance is well-defined and recognised.</i>		
Output 5.1 Volunteering And Capacity Building	Key indicator	Actual	Target
	<i># of mobilized volunteers covered by sickness, accident, and death benefits</i>	874	1,100
	<i>The National Society has improved its preparedness, contingency, and response plans following recommendations and evidence from the operation</i>	Yes	Yes
	<i># of assessment carried out (initial needs assessment/anthropological study/real time evaluation/final evaluation, etc.)</i>	1	3

### Achievements:

All mobilized volunteers involved in the response were covered under the IFRC global accident insurance scheme throughout the reporting period, ensuring adequate protection and duty of care during the implementation of activities.

A participatory workshop was organized a few days prior to the official declaration of the end of the outbreak, bringing together 30 participants, including 15 staff from the DRC Red Cross, 10 from IFRC, and five representatives from Partner National Societies. The workshop provided a structured space for joint reflection, learning, and the consolidation of good practices related to community engagement and accountability implemented during the response.

As part of the revised operational strategy, support is planned to strengthen National Society infrastructure through the rehabilitation or construction of operational facilities and a warehouse in Tshikapa, Mweka, and Bulape, as well as at the national level. These investments are intended to enhance the National Society's operational capacity and preparedness for future public health emergencies.

In the coming period, the operation will also support the introduction of digital tools for the National Society to strengthen coordination, reporting, and data management. In parallel, leadership training will be organized at the Bulape branch level, and support will be provided for the strengthening of a National Disaster Response Team (NDRT), contributing to improved readiness and sustainability of response capacities.



## Coordination and Partnerships

**Objective:** *Technical and operational complementarity among the IFRC's membership and with the ICRC is enhanced through cooperation with external partners.*

	<b>Key indicator</b>	<b>Actual</b>	<b>Target</b>
<b>Output 6.1 Strategic and operational coordination</b>	<i># of regular coordination mechanisms with all Movement partners</i>	1	1
	<i># of monthly coordination meetings</i>	6	16
	<i># of joint monitoring missions carried out (DRC Red Cross-IFRC, PNS, ICRC)</i>	1	1
	<i># of lessons learned workshops/mid-term reviews coordinated with Movement partners</i>	2	2

### Achievements:

During the reporting period, one (1) regular Movement coordination mechanism was formally established and maintained, meeting the target of one. This mechanism brought together the IFRC, the DRC Red Cross, and in-country IFRC network members and served as the primary platform for strategic alignment, information sharing, and joint decision-making throughout the operation. In-country Movement coordination was led by the DRC Red Cross, with technical and operational support from the IFRC.

Under this coordination mechanism, the DRC Red Cross hosted six (6) monthly Movement coordination meetings, against a target of 16 for the full operation period. These meetings were conducted during the active months of the response and ensured continued operational alignment among Movement partners during a context characterized by rapid shifts in operational priorities. While the annual target was not fully achieved due to the shorter-than-planned active coordination period, the six meetings held were regular, inclusive, and effective in supporting collective planning and implementation.

In parallel, the mobilization of Red Cross and Red Crescent Movement partners in the Democratic Republic of Congo continued in a coordinated manner through this established mechanism. Partner National Societies including the French Red Cross, Belgian Red Cross, Spanish Red Cross, and Swedish Red Cross aligned their bilateral and multilateral support with the agreed operational strategy under the leadership of the DRC Red Cross. During the initial phase of the response, Swedish Red Cross and Belgian Red Cross deployed technical staff to provide direct operational support. Several Partner National Societies also increased their financial engagement through direct contributions or by covering deployment costs. In addition, the deployment of one Public Health Emergency Response Unit (ERU) was jointly led by the Norwegian Red Cross, and French Red Cross.

As planned, two (2) lessons learned workshops/mid-term review sessions were coordinated with Movement partners, fully achieving the target. These learning activities aimed to capture operational lessons, identify challenges encountered during implementation, and inform adjustments for ongoing and future responses.

One of the workshops, conducted as part of the National Society Strengthening component, brought together 30 participants, including 15 staff and volunteers from the DRC Red Cross, 10 representatives from the IFRC, and five participants from Partner National Societies. The discussions highlighted several key findings:

- **Strong Movement coordination and complementarity** were identified as a major strength of the response, particularly the clear leadership role of the DRC Red Cross and the effective technical backstopping provided by the IFRC and Partner National Societies.
- **Early deployment of technical expertise**, including surge staff and ERU support, significantly enhanced response quality, particularly in public health preparedness and field-level coordination.
- **Information flow between national and field levels** was generally effective, though participants noted the need to further streamline reporting and feedback mechanisms to reduce duplication and improve timeliness during peak operational periods.
- **Volunteer engagement and community acceptance** were assessed as key enablers of the response, while challenges related to volunteer workload and psychosocial support were identified as areas for further attention.
- **Preparedness and transition planning**, including alignment with national Ebola response structures, were highlighted as essential lessons for future outbreak responses.

The second learning session reinforced these findings and further emphasized the importance of early planning for transition and handover, stronger integration of National Society development objectives within emergency operations, and continued investment in preparedness capacities at branch level.

Overall, the lessons learned workshops facilitated a shared understanding among Movement partners of operational strengths, gaps, and priorities, and their outcomes are being used to inform internal planning, coordination approaches, and future Ebola and epidemic preparedness responses.

Operational coordination at field level further complemented these achievements through regular weekly EVD coordination meetings involving all engaged branches. In addition, the DRC Red Cross and IFRC actively participated in multiple national and provincial coordination platforms. Both institutions played a key role in the development and implementation of the national Ebola transition plan, working closely with partners under the leadership of the Public Health Emergency Operations Center (COUSP).

The IFRC and DRC Red Cross participated in the Ebola After-Action Review held in Tshikapa from 25 to 28 February 2026, organized by the Ministry of Health in collaboration with partners. In addition, a technical workshop on qualitative community feedback data management was organized jointly with the US Centers for Disease Control and Prevention (CDC) for 30 members of the RCCE pillar, including representatives from COUSP, the DRC Red Cross, IFRC, and other partners.

Following the transition phase, a revised coordination and operational set-up has been in place since early March. All international SURGE deployments have been concluded, except for one IFRC Operations Manager remaining in-country to support coordination and transition efforts. The DRC Red Cross has resumed leadership over ongoing activities, which are now primarily focused on preparedness and readiness. To support continued coordination and transparency, weekly meetings have been established to present implemented activities and monitor progress and are open to all Partner National Societies operating in the country.

Engagement with external partners remained strong throughout the operation. At the national level, the DRC Red Cross and IFRC actively participated in coordination meetings at the Public Health Emergency Operations Center (COUSP) prior to the official declaration of the end of the Ebola outbreak. Following the declaration, close coordination continued with the Ministry of Health and local authorities to support transition planning and ensure sustained preparedness and readiness efforts.



## Secretariat Services

<b>Objective:</b>		<i>Effective and coordinated disaster responses are confirmed.</i>	
	<b>Key indicator</b>	<b>Actual</b>	<b>Target</b>
<b>Agility and Accountability</b>	<i>The resource mobilization strategy has been completed and implemented</i>	1	1
	<i>The National Society has a risk management framework in place</i>	1	1
	<i># of financial audits carried out</i>	0	1
<b>Achievements:</b>			

**Surge mobilization:** During the reporting period of immediate response, the IFRC surge system has been closed, while works has been gradually handed over to the IFRC cluster team and the DRC Red Cross. Up till March 2026 21 surges profiles were deployed of whom all have completed their mission. The deployment included the following profiles: Regional Operations Coordinator, Operation Manager, Field Coordinator, Staff Health Coordinator, Epidemiologist, Public Health in Emergencies Coordinator, WASH Coordinator, CEA Coordinator, PMER Coordinator, Security Coordinator, Communication Coordinator, Membership Coordinator, Assessment Coordinator and logistic coordinator.

In addition, a Public Health Emergency Response Unit -CBS/IPC module (Norwegian Red Cross, French Red Cross,) has been deployed until the end of February. The team included ERU Team leader & CBS, ERU CBS Epidemiologist and ERU IPC Clinical profiles.

**PMER and IM:** The IFRC Country Cluster delegation team and the PMER continue to support the DRC Red Cross and the technical operation team in planning, monitoring and reporting. Especially to align and cross validate plans, data, and indicators to the National Society both at the headquarters level and in the field. So far, 6 situation updates, 4 snapshots, and 3 operation updates have been posted. Along with some pledge-based reporting.

**Security:** Regular meetings between security colleagues in IFRC and DRC Red Cross are in place

#### **Logistics & ICT:**

The logistics team continued to work in close coordination with the National Society to ensure timely procurement of goods and the maintenance of adequate stock levels throughout the reporting period. Local procurement activities were managed by the Kinshasa-based logistics team, enabling flexibility and responsiveness to operational needs.

Five motorcycles were delivered to the National Society to support field mobility, while a pickup truck was deployed to facilitate water transport operations. In addition, Starlink internet connectivity was installed at the Bulape base camp and is fully functional, significantly improving communications and coordination capacities.

Further logistical assets are currently in the procurement pipeline, including 25 additional motorcycles and three new vehicles to strengthen field and supervisory capacities. Two additional vehicles have already been purchased and handed over to the National Society. To reinforce energy autonomy at operational sites, three generators have been procured and delivered.

To support continued implementation and coordination of activities, five computers and 15 mobile phones are planned to be provided to the National Society. In parallel, hygiene kits are currently under procurement following the selection of a supplier and will contribute to the continuation of response and preparedness activities.

#### **Communication et visibility**

Below are links to published articles and social media

- [Ebola in DRC: A race against time to save lives](#)
- [Powerful testimony from Bulape](#)
- [Strengthening community care in Bulape](#)
- [From Yaoundé to Bulape, solidarity in motion](#)
- [Open arms to the vaccine](#)
- [Community surveillance training in Bulape](#)

- [Without communities' voices, there can be no effective response. Focus group with women, children, and people with disabilities](#)
- [Volunteers help communities restore dignity through PSS programmes during post-outbreak phase](#)
- [As Ebola in DRC declared over, IFRC calls for investment in community-based surveillance](#)
- [The Infection Prevention and Control teams of the IFRC and the Red Cross of the DRC continue to carry out essential work in Bulape](#)
- [Specialized teams in safe and dignified burials \(EDS\)](#)
- [The DK Danish Red Cross \(@danskrodekors\) conducted a field visit to Bulape and Mweka.](#)
- [Volunteers launched the first Trust Index Survey in Bulape & Mweka](#)

**Welcome services & administration:**

Support is in place for surge visa & in-country arrangement, movement to & from Kinshasa to Bulape was mainly via the UNHAS platform and restricted by their availability. Accommodation quarters in the field is also being reviewed.

## D. FUNDING

As of March 15, 2026, the funding coverage of the Federation-Wide contribution to support the operation is CHF 4,411,793.26.

<b>Funding Coverage</b>	<b>Funding Requirement (CHF)</b>	<b>Amount Raised* (CHF)</b>	<b>Funding Gap (CHF)</b>	<b>Coverage</b>
IFRC Secretariat	17,000,000	4,283,450	12,716,550	25.20
Bilateral	3,000,000	128,343.00	2,871,657	4.28
Federation-wide contribution (IFRC Secretariat & bilateral)	20,000,000	4,411,793.26	15,588,206	22.06

*\* The amount raised reflects both soft and hard pledges, including in-kind contributions. ERU in-kind support will be recorded once the value is confirmed*

## Contact information

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

### At the DRC Red Cross

- **Secretary General:** Gloria Lombo, email: [sgcrrdc@croixrouge-rdc.org](mailto:sgcrrdc@croixrouge-rdc.org), phone: +243 856435031
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### At the IFRC

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### For In-Kind Donations and Mobilization table support:

- **IFRC Africa Regional Office for Logistics Unit:** Nikola Jovanovic, Acting Head, Regional Supply Chain Unit, Africa, Email : [nikola.jovanovic@ifrc.org](mailto:nikola.jovanovic@ifrc.org) phone: +41 76 200 12 96

### For PMER (Planning, Monitoring, Evaluation, and Reporting) support:

- **IFRC Africa Regional Office:** Beatrice Okeyo, Regional Head PMER, and Quality Assurance; phone: +254 721 486 953, email: [beatrice.okeyo@ifrc.org](mailto:beatrice.okeyo@ifrc.org)

### Reference documents



Click here for:

- Previous Appeals and updates : [MDRCD047ea.pdf](#)
- Operation strategy: [MDRCD047 OS.pdf](#)
- Operation update report 1: [MDRCD047eu1.pdf](#)
- Operation update report 2: [MDRCD047eu2.pdf](#)
- Operation update report 3 : [MDRCD047eu3.pdf](#)

## How we work

All IFRC assistance seeks to adhere the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief, the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere)** in delivering assistance to the most vulnerable, to **Principles of Humanitarian Action** and **IFRC policies and procedures**. The IFRC's vision is to inspire, encourage, facilitate and promote always 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.