DREF Final Report

Angola: EVD Readiness

Volunteer mobilisation key to Effective Preparedness against Ebola

Appeal: MDRAO013	Total DREF Allocation: CHF 78,002	Crisis Category: Yellow	Hazard: Epidemic
Glide Number: -	People Affected: 5,600,000 people	People Targeted: 144,000 people	People Assisted: 136,773 people
Event Onset: Slow	Operation Start Date: 10-10-2025	Operational End Date: 31-12-2025	Total Operating Timeframe: 2 months
Targeted Regions: Lunda Norte			

The major donors and partners of the IFRC-DREF include the Red Cross Societies and governments of Australia, Austria, Belgium, Britain, China, Czech, Canada, Denmark, German, Ireland, Italy, Japan, Luxembourg, Liechtenstein, Malta, Norway, Spain, Sweden, Switzerland, Thailand, and the Netherlands, as well as DG ECHO, Mondelez Foundation, and other corporate and private donors. The IFRC, on behalf of the National Society, would like to extend thanks to all for their generous contributions.

Description of the Event

Date when the trigger was met

10-06-2025

What happened, where and when?

According to the WHO, the epicenter of the outbreak in the Democratic Republic of Congo (DRC) was in the vicinity of the city of Tshikapa, capital of Kassai province, and the border with Angola (approximately 100 to 200 kilometers, depending on the nearest border crossing point). Although this area is rural and difficult to access, population movements within the province are frequent, particularly between Bulape and Tshikapa. Angola shares a 2,511-kilometre border with the DRC, featuring several active crossing points. Along the provinces bordering DRC, Angola has an estimated population of 5.6 million people who were at risk. The border is highly porous, with frequent land, sea, and air movements. Daily crossings at formal borders are estimated between 5,000 and 10,000 people, in addition to numerous informal crossings. Movements occur for trade, employment, and family visits, with travellers often using informal routes that do not require documentation. Angola also hosts about 57,000 refugees and asylum seekers, mainly from DRC, where conflict and instability continue to drive displacement.

Given that Ebola is transmitted through direct contact with infected bodily fluids or contaminated animals, this high level of population movement significantly increased the risk of cross-border transmission favoured by the large population movement. Transport across the border is mainly by commercial vehicles, motorcycles, bicycles, or on foot.

Ebola posed significant risks to various groups, including those who work across the borders. Additionally, refugees in camps and informal settings, living in close quarters were at a heightened risk of infection due to lack of space and sufficient sanitation infrastructure. Refugees often face challenges in accessing formal crossings, leading to increased reliance on informal routes. Common transportation modes include commercial vehicles, motorcycles, bicycles, and walking. However, the region faces challenges such as security concerns due to illegal activities, health risks associated with cross-border movement, and varying infrastructure quality at crossing points.

The risk of rapid escalation in case of Ebola in the country was also high due to additional challenges such as insecurity, other ongoing health threats and the overall humanitarian challenges in the at-risk areas. The case fatality rate of Ebola averages around 50% in past

outbreaks and was feared to worsen with no proper care and no preventive measures, especially in areas with weak health systems, insufficient infection prevention and control (IPC), and poor sanitation. In northern Angola, many health facilities lack essential equipment, medicines, and trained personnel. Limited infrastructure and long travel distances further hinder access to care. On the preventive part, Angola also faces low vaccination coverage, with over 700,000 under-immunized children recorded in 2021, and widespread water, sanitation, and hygiene (WASH) challenges. Open defecation, unsafe water, and poor waste management contribute to high rates of infectious diseases. These vulnerabilities increase the risk of rapid spread and severe outcomes if Ebola cases are imported. Along the provinces bordering DRC, approximately 5.6 million people were considered at potential risk, underscoring the urgent need for robust preparedness, surveillance, and response measures to prevent the spread of Ebola into Angola.

The Government of Angola had developed an Ebola contingency plan (September 2025), with this DREF operation aligned to the National Society's defined role within the government's overall preparedness and response framework.

By December 2025, the contingency plan and DREF had supported efforts to minimize the risk of Ebola entering the country, and no cases were reported in Angola by end of operation. In DRC, the outbreak was also diminishing, reducign risk of case introduction to Angola. DRC entered it's post-90 day surveillance period. During this period, the main goal is to to remain on high alert to detect, contain, and stop any new transmission chains rapidly to achieve a permanent "zero cases" status and prevent future epidemics.

Scope and Scale

Ebola is an acute, severe and extremely lethal viral disease. It is characterised by sudden onset of fever, intense weakness, muscle pain, headache, nausea and sore throat. This may be followed by vomiting, diarrhoea, kidney and liver dysfunction, and in some cases, internal and external bleeding.

Between August 10 and September 5, 2025, there were 42 cases (15 deaths) due to Ebola in the DRC. Given the land border of 4,837 km, bordering the Republic of Congo and the Democratic Republic of Congo to the north, the Democratic Republic of Congo and Zambia to the east, and Namibia to the south. Angola was considered a high-risk country due to the existence of several points of entry (land, sea and air) between the two countries.

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Source Information

Source Name	Source Link
1. Efficacy News	https://efficacynews.africa/2025/09/23/angola-steps-up-preparedness-as-ebola-outbreak-declared-in-neighbouring-drc/
2. WHO	https://www.afro.who.int/countries/angola/news/angola-strengthens-ebola-outbreak-preparedness-measures

National Society Actions

Have the National Society conducted any intervention additionally to those part of this DREF Operation?	No

IFRC Network Actions Related To The Current Event

Secretariat	IFRC CCD for Mozambique and Angola supported the Angola Red Cross NS in launching a preparedness DREF, as well as bringing in Surge technical support (Ops Manager and Public Health in Emergencies Coordinator) for Ebola preparedness. Regional IFRC Africa office also supported development of the preparedness and response plan through guidelines for Viral Hemorrhagic Fevers (including Ebola) and coordination based on the DRC Emergency Appeal that was active by the time of this DREF.

Other Actors Actions Related To The Current Event

Government has requested international assistance	No
National authorities	Developed and socialized the National Ebola Contingency Plan (2025): Focused interventions in Lunda Norte province, which borders the DRC. Deployment of a multidisciplinary team including Ministry of Health, National Institute for Health Research for assessments and planning. Training Activities: 140 officials trained in Ebola identification; Infection prevention and control; Active case finding; Disease surveillance at community and entry points; Sample collection and safe transport; Risk communication to counter misinformation Community Engagement: Over 150 traditional and religious leaders, midwives, hunters, and healers engaged. Activities aimed at building trust and aligning response with municipal outbreak action plans.
UN or other actors	WHO worked with Angola and neighbouring countries on readiness assessments and contingency planning.

Are there major coordination mechanism in place?

National multisectoral commission for emergencies was activated and led by the Ministry of Health (MoH), with participation of other Ministries and external partners. Commissions at the provincial and municipal level were also active. The commission was supported by a technical working group for Ebola preparedness and response.
In past outbreaks such as cholera The Angola Red Cross has been a strong ally of the Government for the prevention and fight against outbreaks, epidemics and pandemics in the country (notably MPOX, Cholera, Polio) and is part of the National, Provincial and municipal platforms for coordinating epidemics.

Needs (Gaps) Identified

Health

In September 2025, the Ministry of Health (MoH), with support from WHO and UNICEF, assessed the main border crossings in Lunda Norte Province to evaluate Angola's preparedness for the EVD outbreak in the DRC. The assessment confirmed a high risk of cross-border transmission and identified several urgent needs: training of health authorities and frontline workers on EVD detection, case management, infection prevention and control (IPC); risk communication and community engagement (RCCE) to counter misinformation

and increase public awareness about EVD prevention; Strengthened disease surveillance and early-warning systems, especially in high-risk border districts; Health and hygiene promotion to ensure communities remain alert and adopt safe practices.

Health system constraints remain significant. Many facilities lack essential equipment, medicines, and qualified personnel. Poor infrastructure and limited transport impede access to healthcare, as confirmed by the National Society's assessment across six provinces earlier in 2025. Communities reported long distances to health centres, transport barriers, and frequent stock-outs of medical supplies. Furthermore, Angola health system capacity is threatened by endemic or concurrent outbreaks could complicates EVD response and even preparedness as they further strain the health system. Other recurrent diseases such as typhoid, respiratory infections, diarrhoeal diseases, rabies, measles, yellow fever, malaria, and cholera also compete for limited health resources. These weaknesses increase the risk of disease spread and reduce the country's capacity to manage an EVD outbreak effectively.

On another hand, recent population health data indicated low vaccination coverage, with over 700,000 under-immunized children reported in 2021. While this is not directly linked to Ebola, it represents a potential risk factor for prevention efforts, as the same barriers contributing to low routine immunization—such as access constraints, misinformation, or community hesitancy—could also hinder Ebola vaccination uptake in the event of an outbreak. At present, no Ebola vaccination campaign has been confirmed, but it remains a potential area of intervention highlighted in the Ministry of Health's contingency plan. Should vaccination be prioritized and vaccine availability confirmed, the National Society's engagement would be essential, building on its proven role and experience in previous national vaccination campaigns.

Strengthening preparedness, surveillance capacity and alert systems, but also community awareness was therefore critical to contain potential importation and transmission of Ebola cases.

Water, Sanitation And Hygiene

Lack of access to clean water and sanitation and poor hygiene practices are the major causes of infectious diseases, contributing to malnutrition and child mortality. Lack of latrine facilities often lead to open defecation, contaminating water and contributing to an increased number of diseases such as diarrhoeal which has become the main cause of infant mortality in the country. Qualitative assessment from NS in regard to the risk and vulnerability of populations in the face of climatic and epidemiological hazards conducted earlier in 2025, found that across 6 assessed provinces, the highest mentioned issue by community focus groups was contaminated water and the increase of diseases. The focus groups reported that there was accumulation of rubbish in stagnant water points, lack of potable water or use of contaminated water sources, and lack of basic sanitation infrastructure and urban drainage systems. The needs reported by communities included cleaning, having safe water, and having hygiene items such as soap.

Community Engagement And Accountability

Need to set up two-way communication channels to share and receive critical information as well as feedback mechanisms for communities to express needs and the adequacy of response. Earlier in 2025, the NS conducted focus group assessments to understand risks and vulnerabilities in regard to climate and epidemiological hazards. It was noted that women, young people, and people with disabilities have limited engagement in decision-making at local levels, and that they were missing a defined space where to have community dialogue to discuss prevention and response to emergencies as a community. Particular emphasis and care must be taken with refugee and migrant communities at the borders, as they move, they may often be excluded from formal decision-making or not be able to benefit from services.

Operational Strategy

Overall objective of the operation

The DREF operation aimed to strengthen the readiness of the Angola Red Cross and border communities in Lunda Norte province if the Ebola Virus Disease was imported into the country from the Democratic Republic of Congo (DRC) by focusing on early detection, infection prevention and control (IPC), risk communication, and community engagement.

Under the DREF, the NS successfully increased their capacity for readiness to respond to an EVD outrbeak, including through training of volunteers, development of SOPs, and stregnthening relationships with Ministry of Health and other stakeholders. Through these readiness activities, the NS also supported the Governments contingency plan to reduce the risk of importantion of cases into Angola, through community mobilization of volunteers and community engagement activities.

Operation strategy rationale

Under the Ministry of Health (MoH) National Contingency Strategy for Ebola, the strategy was developed in a four phased approach focusing on eight provinces for a duration of six months. The four phases were preparation, alert, control, and evaluation. The NS contingency plan aligns with the MoH plan, in terms of risk analysis and priorities. This DREF focused on supporting the preparation phase starting with one province (Lunda Norte) as identified priority by the Government for two months. The strategy was designed in a way that If other provinces became focus preparedness targets and/or if cases were imported, a scale-up plan was planned to be requested. This preparedness DREF was also aligned to the IFRC guidance on preparedness activities for VHFs, including Ebola. The preparedness stage was as follows:

Preparedness phase strategy areas:

1. Early Detection and Case Referral:

Train and mobilize 100 volunteers among nurses and mobilizers for early detection of cases in their communities, in alignment with the role of NS support to the government's plan on early detection. This activity was to be coordinated cross-border with neighbouring National Societies to intensify joint surveillance efforts.

As part of this activity, it was key to finalize MoU/agreement with MoH on the role of NS in CBS and establishing a formal CBS system. This built on previous work between the NS and the MoH implemented in 2025, including a feasibility assessment for CBS and internal training on epidemic data collection and reporting at the NS.

Under this pillar, NS also aimed to improve preparedness by supporting rapid mapping of health facilities through coordination with other stakeholders and volunteers at the community level to understand health capacity and ensure that referral pathways were clear.

2. Health Promotion and Community Hygiene and Disease Prevention:

Provide health promotion and disease prevention to raise awareness of Ebola signs and symptoms, how it is transmitted, what to do in cases of symptoms for early treatment, and protection-related prevention measures. This was to be done through training of volunteers and health professionals and key community members on ways to reduce risk of transmission respecting local customs. NS also supported the MoH in the development and reproduction of graphic, audio, and video materials for social mobilization and community engagement. Additionally, due to transmission possible through infected animals, hygiene safe practices was also to be socialized. Groups targeted for this activity were further refined with the government but included at-risk populations due to the type of work and activity they partake at the border including hunters, sobas, religious leaders, sex workers, and teachers.

Improve community engagement: Intensify risk communication and community engagement efforts to promote understanding of Ebola transmission and prevention from communities, particularly in high-risk areas.

3. Preparing for scale-up (Safe & Dignified Burial and EVD Vaccination):

In coordination with the MoH, the NS continued to assess the role it could play in Safe and Dignified Burials (SDB), including supporting as needed in training personnel on SDB and developing SDB protocols. Additionally, if MoH applies for vaccine stock, NS was to support the vaccination campaign with volunteers including nurse volunteers, mobilizers, and team leaders. This was aligned with prior support the NS offers the MoH, having supported successfully with vaccination campaigns for Polio in 2024 and Cholera is 2025.

Additionally, in the process of preparing for scale-up, to guide the transition to response, the NS was to promote a people-centred approach through meaningful community participation so that their voices were heard and considered and in ways that help drive outcomes as well as foster ownership and collaboration among stakeholders and make communities increasingly resilient.

Coordination:

The NS planned to continue participating in MoH coordination meetings and defining roles and responsibilities in the preparedness and response phases of the Ebola contingency plan. They were also to continue strengthening their relationship with civil society groups working with target high-risk groups (e.g. truck drivers, sex workers, refugees, and others). The strategy also aimed to strengthen collaboration with the National Red Cross Societies of the DRC, Angola and Zambia, sharing information and best practices through the Epidemic Network to ensure a harmonized preparedness and response approach.

Human Resources & Training needs:

The operation planned to start by mobilizing 100 volunteers in Lunda Norte, in municipalities close to the borders. The focus was on preparedness in border communities, including training local volunteers and volunteer healthcare workers and establishing rapid response teams to quickly address potential outbreaks.

Volunteers and key stakeholders at community level were planned to be be trained with the technical support of health authorities and local partners on topics including IPC, case surveillance, risk communication, and health and hygiene promotion in the context of Ebola.

The 100 volunteers were to be trained in EPiC which include module on CEA and PGI. These trainings were planned to build on the previously gained capacity developed through the MPox and Cholera operations. Volunteers were to be active three times a week for a period of two months. PPE was also necessary for volunteers supporting preparedness activities in the community.

Visibility and communications needs:

All materials and supplies for implementation of preparedness activities including training materials, surveillance materials (data management), visibility, IEC, and PPE, were to be purchased in country. All purchases were to comply with the logistics and purchasing rules in use at CVA and IFRC.

Targeting Strategy

Who was targeted by this operation?

The operation targeted border communities in Lunda Norte province aimed to reach approximately 144000 people in the highest risk zones. The province was specifically targeted mainly because Angola shares a 2,511-kilometre border with the DRC, featuring several active crossing points. Along the provinces bordering DRC, Angola has an estimated population of 5.6 million people who were at risk. The border is highly porous, with frequent land, sea, and air movements. Daily crossings at formal borders are estimated between 5,000 and 10,000 people, in addition to numerous informal crossings. Due to the massive population movement between Angola and DRC, Ebola posed significant risks to various groups, including those who work across the borders. Additionally, refugees in camps and informal settings, living in close quarters were at a heightened risk of infection due to lack of space and sufficient sanitation infrastructure.

Primarily target for institutional and community readiness included:
- At National Society level: 100 volunteers from the targeted communities to facilitate integration, acceptance and RCCE
- At community level: at least 20 sex workers, six hunters, six sobas, six villagers' committee members, six Teachers and six religious leaders.

Explain the selection criteria for the targeted population

Volunteers were selected from one high risk province that border DRC where there were cases, in the municipalities that were at highest risk i.e. Lunda Norte - Chitato and Lovua. Areas selected were considered based on risk assessed under the contingency plan and National planning. The risk analysis considered where population movement with DRC was most intense.

The volunteers were a mix of nurses, mobilizers, and team leaders so that they would be able to support various preparedness activities. Additionally, specifically vulnerable groups were targeted due to their higher rate of cross-border movement which heightened their risk. These included community leaders from refugee settlements and communities, hunters/poachers, sex workers, truck drivers and others.

Total Assisted Population

Assisted Women	-	Rural	-
Assisted Girls (under 18)	-	Urban	-
Assisted Men	-	People with disabilities (estimated)	-
Assisted Boys (under 18)	-		
Total Assisted Population	136,773		
Total Targeted Population	144,000		

Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	**Yes**
Does your National Society have prevention of sexual exploitation and abuse policy?	**Yes**
Does your National Society have child protection/child safeguarding policy?	**Yes**
Does your National Society have whistleblower protection policy?	**Yes**
Does your National Society have anti-sexual harassment policy?	**Yes**

Please analyse and indicate potential risks for this operation, its root causes and mitigation actions.

Risk	Mitigation action
The area of operation is marred with potential conflict and categorised as a red zone under IFRC Security risk categorisation.	Security assessments and travel clearance was sort for IFRC staff whilst maintaining the utmost duty of care for NS staff and volunteers. Security guidelines according whilst desk top assessments were carried for the affected areas.
In the area of safety, there is the risk of exposing workers and volunteers to health hazards, especially in areas with a high risk of Ebola.	This risk was reduced through the provision of personal protective equipment, safety protocols, as well as regular health and safety training and briefings.
Risk of immediate importatation of cases and large outbreak before preparedness measures can be established	Strengthened cross-border coordination, ready for a scale-up, request more support as needed, accelerate preparedness measures.
There may be interruptions in the availability and delivery of inputs, due to logistical constraints or market prices.	To minimize this risk, local procurement was preferred, using multiple suppliers and close coordination with the logistics actors involved, ensuring the continuity of the supply chain.
There is a risk of resistance or mistrust on the part of communities towards hygiene promotion activities, due to misinformation or previous negative experiences with humanitarian actors.	This risk was mitigated through early and ongoing engagement with local leaders, community volunteers, and the use of culturally appropriate RCCE approaches that promote dialogue and trust-building.
Limited technical capacity at the level of the Angolan Red Cross national and provincial delegations on Ebola specific interventions such as SDB and biosecurity protocols.	Deployment of Public Health in Emergency Coordinator Surge to support with Ebola specific planning, SOPs and preparedness activities.

Please indicate any security and safety concerns for this operation:

Bordering areas in Lunda Norte are classified as Red Phase for IFRC staff due to heightened security conditions. For any deployment to Lunda Norte, an assessment was done and the activities followed the Security measures in place.

Has the child safeguarding risk analysis assessment been	**Yes**

completed?	

Implementation

Health

Budget: CHF 28,005
Targeted Persons: 144,000
Assisted Persons: 136,773
Targeted Male: 58,048
Targeted Female: 78,726

Indicators

Title	Target	Actual
# volunteers trianed in EPiC focusing on Ebola health and hygiene promotion	100	100
# of community members and key target stakeholders trained in Ebola health and hygiene promotion IEC and RCCE	50	93
# of people aware of the causes and preventive measures for EVD in targeted areas	144,000	136,773
# protocols for Ebola epidemic prepardness developed with NS (SDB, biosecurity, CBS)	3	3

Narrative description of achievements

On 19 and 21 December 2025, a training session was held for 90 of the 100 volunteers from the municipalities of Chitato and Lóvua in the province of Lunda Norte. This training was preceded by a Training of Trainers (ToT) held in Luanda from December 4-6, an intensive three-day capacity-building program. Both trainings were part of the Community Preparedness Project for Hemorrhagic Fevers (including Ebola Virus Disease). The ToT was aimed at 10 volunteers from the Angolan Red Cross (CVA) and 5 health sector technicians from the Lunda Norte province, from the municipalities of Chitato, Cuilo, Cambulo, and Capenda. Both training programs incorporated updated knowledge on community-based surveillance (CBS), risk communication, community engagement (CEA), infection prevention and control, rumour management, and operational preparedness, aligned with IFRC and World Health Organization guidelines.
For the municipality of Chitato, 40 volunteers were trained, of which 22 were females and 18 males, along with 4 health technicians. For the municipality of Lóvua, 50 volunteers were trained, of which 44 were males and 6 females, along with 3 health technicians. Additionally, in both municipalities, 8 hunters, 24 refugees, 18 border guard personnel, 12 personnel from the migration and foreign services, 6 religious leaders, and 25 community leaders (residents' committees and sobas) were also trained.

After the training, volunteers from the Angola Red Cross and the National Headquarter Team began awareness-raising activities door- to-door and in crowds, in markets (Mussungui, Carienga, Muanguvo, Kanunguna), churches (Catholic, Messianic, Pentecostal, World, Adventist), refugee camps, mainly at the borders between Lunda Norte and the DRC.

The limitations of the healthcare system continued to be a concern. The distances between communities and health services are enormous. Throughout the entire territorial extension, there are paths known as clandestine routes where commercial exchanges prohibited by law take place, such as fuel and minerals like diamonds. Communities reported traveling two to five hours to reach health centres, facing transportation barriers and frequent shortages of medical supplies. The Angola Red Cross volunteers in the Lóvua Municipality received support from the Local Administration, which provided a three-wheeled motorbike for the volunteers' travel to communities where there is no public transportation system. It is worth noting that the Lóvua municipality does not have a public electricity system, which further complicates the healthcare system and the work of the volunteers.

During the door-to-door awareness activities, the volunteers came across 7 suspected cases: 3 cases of malnutrition, 1 of bloody

diarrhea, 2 of malaria, and 1 of Mpox. These cases were reported to local health authorities, in accordance with the respective protocols. The Ministry of Public Health's public health teams committed to follow-up on those cases. V

Between the 16th and 20th December 2025, frontline workers at the border posts of Sandumba, Nachir, and Tchissanda were trained on EVD detection, risk communication and community engagement (RCCE) to combat misinformation and increase public awareness about EVD prevention; strengthening disease surveillance and early warning systems. More than 30 refugees within the Lóvua settlement, considered a high-risk group, were also trained in health promotion and hygiene to ensure that communities remain vigilant and adopt safe practices. It should be noted that the Lóvua settlement currently hosts 6,469 refugees from the DRC, including children, the elderly, and pregnant women.

Volunteer mobilization reached 127,680 people with necessary IEC and RCCE information, while an additional 9036 people were reached through the members of the community that where trained (religious leaders, frontline workers, refugees, etc).

Both training programs incorporated updated knowledge on community-based surveillance (CBS), risk communication, community engagement (CEA), infection prevention and control, rumor management, and operational preparedness, aligned with IFRC and World Health Organization guidelines.

The translation of IFRC 13-step Safe and Dignified Burials (SDB) framework was completed. The translation enhanced easy understanding and implementation by the local communities.

The National SOP for Ebola & Marburg safe burials was drafted and approved by CVA Secretary-General. This represents a major institutional breakthrough, as Angola is now positioned to adopt a standardized national SDB protocol aligned with global IFRC best practices.

Lessons Learnt

Screening without transport saves fewer lives: The Clinical Safety and Health (CBS) system works, but the lack of ambulances/transport and the long distances involved reduce its impact.

Deficiencies in water, sanitation, and hygiene (WASH) exacerbate epidemics: Poor water and sanitation, as well as open defecation, pollute rivers, exacerbating diarrheal diseases and malaria, and increasing vulnerability to any threat of hemorrhagic fever.

Border ecology matters: Informal crossings and the consumption of bushmeat (particularly primates in the Lóvua settlement) increase the risks of zoonotic and cross-border transmission; health messages have been adapted to these practices.

Lack of power limits care: The lack of electricity in Lóvua hinders the cold chain, nighttime care, and the mobility of volunteers.

Challenges

• Lack of means to transport patients to health units: the public health department was predisposed to make home visits to some people who were sick, however some people were not attended due to lack of means of transport, and the CVA was left with the responsibility of making home visits to these people.

Community Engagement And Accountability

Budget: CHF 5,559
Targeted Persons: 144,000
Assisted Persons: 136,773
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# community focus groups and consultations with community completed durign prepardness phase	8	8

Narrative description of achievements

There were meetings for mobilization and discussion of bidirectional communication channels for sharing critical information, as well as feedback mechanisms so that communities could express their needs and assess the impact of the CVA's work as well as the adequacy of assistance in the communities. It was observed that women, youth, and people with disabilities had limited participation in decision-making at the local level, and that they did not have a defined space to promote community dialogue and discuss issues related to emergency prevention and response as a community. Awareness actions like those provided by the volunteers of the Angolan Red Cross are not common in the province, and therefore, traditional leaders appreciated and requested that the Angolan Red Cross continue with this type of initiative.

In the Lóvua refugee camp, hunting and consumption of wild animals, especially monkeys is common according to the camp coordinator. Awareness-raising activities are not frequent. Due to the lack of means of transportation, awareness-raising actions are limited, and therefore they requested a training of trainers from the Angolan Red Cross so that they themselves can raise awareness among each other. A ToT was conducted to 10 community members who were expected to cascade the training to the wider community.

For the Soba (traditional leader) of Chitato, the actions of the Red Cross of Angola not only promoted health but have also changed the mindset of the young people in his community, who abandoned bad practices they previously engaged in due to a lack of employment, to become volunteers for the CVA and work for the good of their communities. The communities of refugees and migrants at the borders pose a significant risk of contamination as they move around; often many end up being excluded from formal decision- making and frequently avoid seeking health services because they are in an illegal situation, ultimately resorting to traditional medicine.

Contacts were established with the administrations of Chitato, Dundo, and Lóvua, as well as with the municipal health departments, which supported the training by providing the training rooms. Public health departments recognize the importance of integrating volunteers into community surveillance not only for Ebola but also for other diseases such as Cholera, Mpox, Polio, measles, malnutrition, and others.

The offices of the Migration and Foreigners Services (SME) as well as the Armed Forces showed their availability, and there was a joint effort to reach CVA personnel at the borders. CVA once again demonstrated the willingness of its volunteers and their role as state auxiliaries in the humanitarian field during the visit with the Provincial Director of Health.

Churches showed great openness, and CVA volunteers were highly welcomed with different churches. As a result, some CVA churches organized educational lecture sessions in churches to promote health. The prompt cooperation of local and community authorities invited a conclusion that CVA has strengthened its role with communities, local authorities, and partners.

Lessons Learnt

CEA is an integral part of programming: communities explicitly requested the continued presence of CVA and ToT within the refugee settlement to overcome transport barriers and sustain peer awareness.

Gendered pathways of risk: Women were reported to be often excluded from some activities yet the operation proved that they are key vectors of change through markets and household roles including bushmeat trade. Therefore, CEA must be gender intentional.

Decentralization is a pre-requisite: Border provinces with dispersed villages and weak transport require local surge capacity; central expertise alone is insufficient.

Language access promote uptake: Volunteers who were fluent in local languages (Tchokwe and Lingala) were accepted in remote and migrant/refugee communities as they could easily communicate with the targeted communities.

Preparedness must be multi-hazard: Ebola readiness must be embedded within broader surveillance for cholera, Mpox, malaria, malnutrition—reflecting syndemic realities in Lunda Norte.

Illegality and fear impede disclosure: Informal mining/fuel trade and irregular crossings lead people to hide contacts with travelers from DRC, weakening early warning and case management.

Challenges

Lack of transportation and long distances between locations: CVA had to rent three-wheeled motorcycles in Chitado and Lóvua, the Administration provided one three-wheeled motorcycle and two two-wheeled motorcycles for the volunteers' travel, and CVA only provided money for the fuel of the motorcycles.

Lack of IEC material for the population who could not read or speak Portuguese: Volunteers who speak the local languages were directed to raise awareness in the most remote areas to reach people who could not read or speak Portuguese.

Secretariat Services

Budget: CHF 30,354
Targeted Persons: 2
Assisted Persons: 2
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# surge deployed in support of operation	2	2

Narrative description of achievements

Two surge delegates were deployed to support this operation, an operations Manager, and a Public Health in Emergencies Coordinator (supported by Canadian Red Cross). The surge delegates, alongside IFRC CCD in Maputo staff, supported the NS in the planning and implementation of the activities. IFRC CCD Maputo and IFRC ARO also held regular meetings regarding the EA for EVD operation active in DRC, to ensure alignment on best practices, rapid alerts on changes in case load in DRC, and planning for sustainable impact.

Lessons Learnt

• One of the key lessons learned was the importance of early surge deployment. This enabled implementation of most activities according to the plan.

National Society Strengthening

Budget: CHF 14,084
Targeted Persons: 100
Assisted Persons: 104
Targeted Male: 75
Targeted Female: 29

Indicators

Title	Target	Actual
% of staff and volunteers working in the prepardness phase that receive the duty of care PPE and visiblity material	100	100
# monitoring visits/field visits from HQ to provinces	4	2
% of mobilised and deployed team with adequate access to personal protective equipment (PPE) in this preparedness phase	100	100
% of volunteers deployed covered by insurance	100	100

Narrative description of achievements

The 100 community volunteers who were activated to support the EVD Ebola readiness all received the duty of care PPE and visibility material. All volunteers were equipped with visibility materials bearing the logos of the CVA and the IFRC. Visibility kits included backpack, t-shirt, and hat and IPC kits (hand sanitizer, masks, and gloves). 4 NS Staff were also invovled.

Lessons Learnt

Flexible implementation modalities and stronger logistical preparedness ensure procurements are not delayed and are completed within the life of the operation.

In a bid to strengthen CVA's operational structure for epidemic preparedness, three governance instruments have been drafted and these are Volunteer Management Policy, Volunteer Standard Operating Procedure (SOP) and Deployment & coordination framework. These instruments will be formally submitted to the National Secretariat for Health (SN), providing Angola with, for the first time, a formalized volunteer surge system for epidemics.

Financial Report

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Selected Parameters			
Reporting Timeframe	2025/10-2026/3	Operation	MDRAO013
Budget Timeframe	*	Budget	APPROVED

Prepared on 05/May/2026

All figures are in Swiss Francs (CHF)

DREF Operation

FINAL FINANCIAL REPORT

MDRAO013 - Angola - Ebola Readiness

Operating Timeframe: 10 Oct 2025 to 31 Dec 2025

I. Summary

Opening Balance	**0**
Funds & Other Income	**78,002**
DREF Response Pillar	78,002
Expenditure	**-42,642**
Closing Balance	**35,360**

II. Expenditure by planned operations / enabling approaches

Description	Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items			**0**
PO02 - Livelihoods			**0**
PO03 - Multi-purpose Cash			**0**
PO04 - Health	26,296	28,005	**-1,709**
PO05 - Water, Sanitation & Hygiene			**0**
PO06 - Protection, Gender and Inclusion			**0**
PO07 - Education			**0**
PO08 - Migration			**0**
PO09 - Risk Reduction, Climate Adaptation and Recovery	33,262	3,553	**29,709**
PO10 - Community Engagement and Accountability	5,220	5,559	**-339**
PO11 - Environmental Sustainability			**0**
Planned Operations Total	**64,778**	**37,118**	**27,660**
EA01 - Coordination and Partnerships			**0**
EA02 - Secretariat Services		11,592	**-11,592**
EA03 - National Society Strengthening	13,224	-6,068	**19,292**
Enabling Approaches Total	**13,224**	**5,525**	**7,699**
Grand Total	**78,002**	**42,642**	**35,359**

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Please explain variances (if any)

On the allocation received from the DREF for the EVD readiness intervention, CHF 42,642 was spent to implement the above activities. The total variance of CHF 35,359.78 (under-expenditure) is mainly attributed to lower-than-anticipated surge costs, reduced personnel deployment, and overall cost-efficiencies in activity implementation. Furthermore, the risk significantly decreased based on the evolution of the outbreak in DR. This also resulted in slow-down and stop of some activities no more prioritised. The balance will return to the DREF pot as per IFRC procedures.

Break-down of variance per sector as follows
1) Health : The expenditure recorded under this budget line relates to surge accommodation costs that were incorrectly coded. These costs should be reallocated to AP122, resulting in an apparent overspend under AP104.
2) WASH: A variance of savings was recorded as this was a preparedness DREF. Not all volunteers initially planned were deployed, as operational needs were lower than anticipated. All planned trainings were nevertheless successfully completed. Therefore, some activities in the ground were realized as activities were implemented at a lower-than-budgeted cost, reflecting cost-efficiencies in delivery.
3) NS strenghtening : The variance is due to the National Society not fully utilizing the allocated salary budget during the reporting period. Additionally, not all administrative costs were charged. Operationally, fewer field missions were conducted, as most activities took place in Luanda and the implementation period was relatively short.
4) IFRC Secretariat cost: Significant savings were achieved under surge costs, primarily due to a shorter deployment period than originally budgeted.

Contact Information

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