



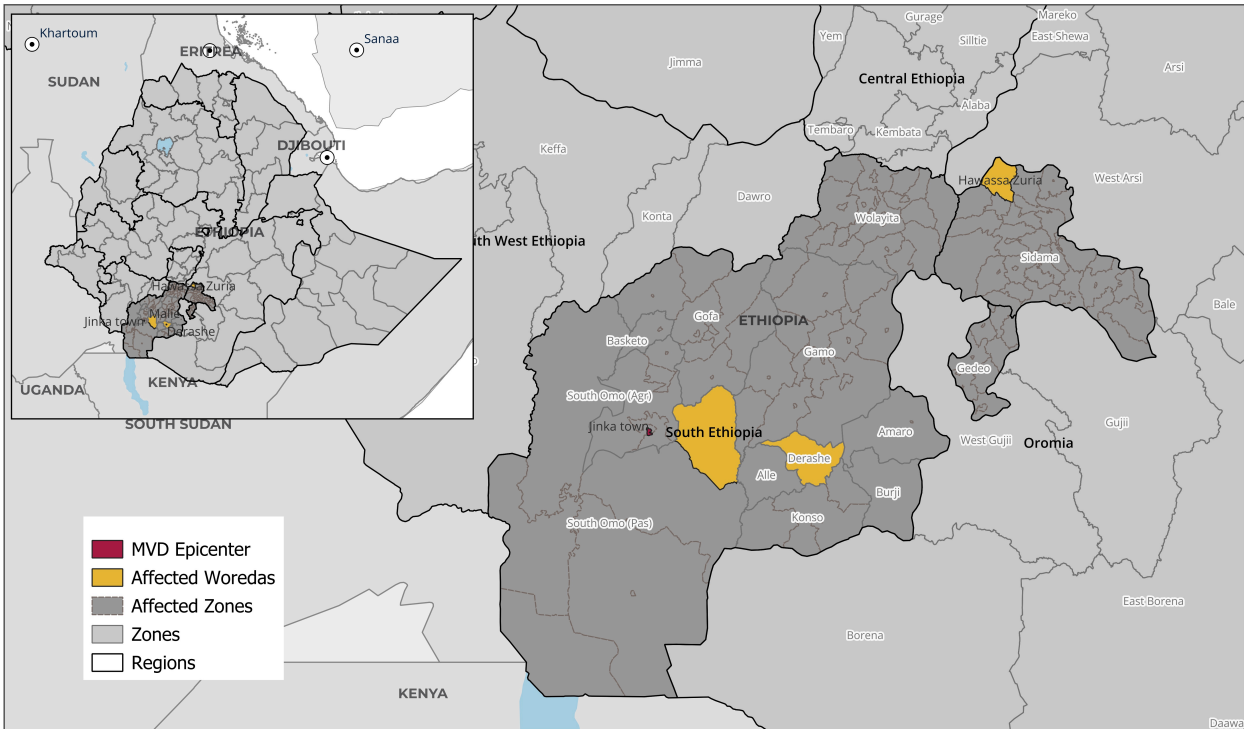
SDB VOLUNTEER TRAINING HELD AT SIDAMA BRANCH

Appeal: <b>MDRET039</b>	Total DREF Allocation: <b>CHF 478,670</b>	Crisis Category: <b>Orange</b>	Hazard: <b>Epidemic</b>
Glide Number: -	People Affected: <b>573,000 people</b>	People Targeted: <b>573,000 people</b>	
Event Onset: <b>Slow</b>	Operation Start Date: <b>19-11-2025</b>	New Operational End Date: <b>31-05-2026</b>	Total Operating Timeframe: <b>6 months</b>
Reporting Timeframe Start Date: <b>19-11-2025</b>		Reporting Timeframe End Date: <b>28-02-2026</b>	
Additional Allocation Requested: <b>0</b>		Targeted Regions: <b>SNNP, Sidama</b>	

# Description of the Event

## Ethiopia : Marburg Outbreak

As of February 2026



The maps used do not imply the expression of any opinion on the part of the International Federation of the Red Cross and Red Crescent Societies or National Societies concerning the legal status of a territory or of its authorities.  
Map data sources: GADM, Ethiopia RC, IFRC. Map produced by: IFRC Africa Region Office, Nairobi.

Affected Zones in Ethiopia where MVD cases were detected

## Date when the trigger was met

12-11-2025

## What happened, where and when?

On 26 January 2026, the Federal Ministry of Health (FMoH) declared Ethiopia “Marburg free,” marking the end of the Marburg virus disease (MVD) outbreak after two consecutive incubation cycles (42 days) without any detected case or death. While the outbreak has officially ended, the outbreak has proved to be a significant public health risk, and recovery and preparedness efforts remain critical to prevent resurgence. In this context, the Ethiopian Red Cross Society (ERCS), in coordination with government and partners, is actively planning post-outbreak recovery activities. Once finalized, the recovery plan will be integrated into a revised operational strategy and published on GO alongside the next Operations Update.

The MVD outbreak was initially declared on 14 November 2025 by the FMoH, in collaboration with the Ethiopian Public Health Institute (EPHI), following confirmation of cases in the South Region of Ethiopia. As of early January, a total of 3,745 laboratory tests had been conducted, confirming fourteen cases, including nine deaths and five recoveries. Given the high fatality rate and rapid transmissibility of the Marburg virus, an immediate and coordinated public health response was initiated.

In response, the ERCS, with support from IFRC through the Disaster Relief Emergency Fund (DREF), implemented a comprehensive preparedness and response operation aligned with national Public Health Emergency Management (PHEM) policies and the Incident Management System (IMS). Since November, ERCS has supported early detection, isolation and contact tracing, strengthened infection prevention and control (IPC) in health facilities, ensured the safety of health workers, mobilized rapid response teams (RRTs), and delivered effective risk communication and community engagement, with a focus on South Ethiopia and Sidama regions.





KAP Survey Data Collection Training, Oromia, Sidama Region, 23 January 2026



RCCE Volunteer Orientation, Ari Zone, South Ethiopia Region, 6 January 2026



RCCE FIELD MONITORING



KEY MESSAGE OWNED AND DEMONSTRATED BY CHILDREN DURING SCHOOL AWARENESS

## Scope and Scale

The Marburg virus disease (MVD) outbreak reported in Jinka town of the South Ethiopia Region was Ethiopia's first outbreak of Viral Hemorrhagic Fever (VHF). As of the end of the outbreak, a total of 14 cases and 9 deaths have been reported. Genetic analysis by the Ethiopian Public Health Institute revealed that the virus is of the same strain as the ones that have been reported in previous outbreaks in other countries in East Africa.

Marburg disease is a severe and often fatal illness caused by the Marburg virus. The disease is often characterized by high fever, severe headache, muscle aches and fatigue. Many patients develop severe bleeding within a week of onset. The disease is rapidly transmitted through direct contact with bodily fluids of infected individuals or contaminated materials. The disease can lead to significant disruption to local health systems. A potential outbreak could lead to increased morbidity and mortality, fear and stigma within communities, and interruption of essential services due to movement restrictions or fear of healthcare settings. With the declaration of the outbreak's end on 26 January 2026, the risk profile shifted from active transmission to:

- Risk of resurgence through cross-regional mobility and continued interaction with the animal reservoir
- Persistence of misinformation and stigma, particularly for survivors and their families
- Institutional fatigue following rapid mobilization
- Reduced sense of urgency potentially weakening preparedness systems

The populations most at risk during the outbreak remain the same in relation to the residual risks identified. The populations most likely to experience impacts include those residing near major cross-border traffic areas such as Jinka Town and surrounding rural kebeles within the South Omo Zone. Limited access to health infrastructure, sanitation and clean water compound frequent population movement for trade and pastoral activities, all of which increase exposure and complicate containment efforts.

### 1) Geographic and Social Vulnerability:

The epi center, South Omo Zone, Ari zone, Gamo zone, Wolayta of South Ethiopia and Sidama region where there reported cases remain to be at risk for continuous monitoring. The population's mobility across regional and cross-border routes (e.g., with Kenya and South



Sudan) also increases the risk of wider spread. Cultural practices such as close family care for the sick and traditional burial rituals further heighten transmission risks if not managed with community engagement and safe practices.

2) Additional vulnerabilities for specific groups include:

- Health workers who are at elevated risk due to direct exposure and inadequate infection prevention and control (IPC) measures.
- Children and the elderly, who have weaker immune systems and limited resilience to infection and dehydration.
- Pregnant and lactating women, due to heightened physiological vulnerability and barriers to care-seeking.
- People with disabilities often face mobility and communication challenges during health emergencies.
- Internally Displaced Persons (IDPs) and refugees in and around the South Omo area, who live in crowded conditions with poor access to health services.

## Source Information

Source Name	Source Link
1. Ministry of Health- Ethiopia	<a href="https://www.dawan.africa/news/ethiopia-warns-of-hemorrhagic-fever-outbreak">https://www.dawan.africa/news/ethiopia-warns-of-hemorrhagic-fever-outbreak</a>
2. Afro WHO	<a href="https://www.afro.who.int/news/ethiopia-suspected-viral-haemorrhagic-fever-outbreak">https://www.afro.who.int/news/ethiopia-suspected-viral-haemorrhagic-fever-outbreak</a>
3. African CDC	<a href="https://africacdc.org/tag/haemorrhagic-fever/">https://africacdc.org/tag/haemorrhagic-fever/</a>

## Summary of Changes

Are you changing the timeframe of the operation	No
Are you changing the operational strategy	Yes
Are you changing the target population of the operation	No
Are you changing the geographical location	No
Are you making changes to the budget	Yes
Are you requesting an additional allocation?	No



**Please explain the summary of changes and justification:**

This operation update is to inform about the progress of the Marburg Virus Disease (MVD) outbreak response operation that has been implemented since 19 November 2025 but also provide details on the shift required in the intervention priorities following the declaration of the end of the outbreak back in 26.01.2026.

The DREF was approved on 19 November 2025 as an Orange-level crisis, with a budget of CHF 478,670, targeting 573,000 people over a six-month period ending on 31 May 2026. With DREF support, ERCS developed a comprehensive response plan structured around four pillars that fed into MoH priorities pillars: Surveillance and Early Warning; Case Management and Infection Prevention and Control (IPC); Risk Communication and Community Engagement (RCCE); and Protection, Gender and Inclusion (PGI). ERCS actively participated in coordination mechanisms through the Regional Emergency Operations Centre (EOC) and national-level partner coordination forums. Following the rise in active cases in Southern Ethiopia (epicentre) and Sidama regions, ERCS interventions contributed to the collective efforts to contain the outbreak, working alongside the Government and key stakeholders including the Ethiopian Public Health Institute (EPHI), the Ministry of Health (MoH), WHO, and other partners. This coordinated response ensured the activation of all relevant pillars within a harmonised and multi-stakeholder framework.

Following the official declaration of the end of the emergency on 29 January 2026, the Ethiopian Red Cross Society (ERCS) is requesting a strategy adjustment and budget revision to realign the operation with evolving priorities. The proposed revision shifts the focus away from acute emergency response toward post-outbreak recovery, in line with current national priorities. This adjustment aligns with the 90-day post-emergency plan jointly developed by the Ministry of Health (MoH), the Ethiopian Public Health Institute (EPHI), WHO, and partners, aimed at ensuring continuity of Marburg Virus Disease (MVD) post-operation activities. The revised approach prioritises strengthening surveillance systems, reinforcing community-based interventions, and supporting MVD survivors and affected families, including follow-up and mental health and psychosocial support (MHPSS).

The revised planned interventions are summarized as follows:

- Target in current phase: corridors areas from the epicenter (Jinka) to Hawassa town. But also, ERCS branches.
- Activities maintained for current phase:
  - Provide EPIc training for health care workers from cross-border areas (formal and informal) on VHF and epidemic-prone diseases surveillance, IPC, travel screening, isolation, and referral for 5 days
  - Systematic review training for MVD evidence generation related to PoE for HCWs and ERCS staff for 5 days
  - Facilitate training on basic PHEM protocols and assign PHEM officers at all health centers and hospitals to ensure preparation for future outbreaks.
  - Continue to enhance the branches capacities on risk communication to insist on positive behaviors and risk-taking habits, with revised key messages to community through different channels. NS will ensure the items purchased under this DREF remains an asset valuable for future risk/outbreaks. Other community level messages are stopped considering the relevance at this stage.
  - Ensure survivor follow up and provide MHPSS. The planned approach is to ensure continuous risk awareness that remains limited and ensure stigma elimination and psychological healing to the affected. Target is group based for survivors, and community based for social integration.
  - All related IPC and WASH supplies, procurement and sanitation at community level are stopped as this is not as relevant on this phase.

The updated strategy clarifies that all revised activities remain directly linked to the MVD context, with emphasis on post-outbreak recovery, preparedness, and resilience building. Consequently, some activities originally planned under the emergency response phase will be adapted or discontinued, as they are no longer aligned with the current needs and operational phase.

## IFRC Network Actions Related To The Current Event

<b>Secretariat</b>	The International Federation of Red Cross and Red Crescent Societies (IFRC) maintains a permanent presence in Ethiopia, providing strategic, technical, and operational support to the Ethiopian Red Cross Society (ERCS) on Coordination, Technical and Strategic Support through deployed surge team comprising of Operation manager, Public health, SDB, Staff health, CEA, and cluster existing capacity on DRM, PMER, Finance, Logistic and security, Administrative support.
<b>Participating National Societies</b>	Participating National Societies (PNSs) maintain ongoing partnerships and support programs with the Ethiopian Red Cross Society (ERCS) in various sectors, primarily focus on longer-term health system strengthening, disaster risk reduction, and community resilience initiatives across different regions of the country. For this specific emergency, the Norwegian RC, Netherlands RC and Danish RC directly supported NS with 10000 USD each, whereby, the British Red Cross through Foreign Commonwealth



and Development Office (FCDO) have contributed funds to strengthen Risk Communication and Community Engagement and Prepositioned stocks.

The Canadian Red Cross has provided an in-kind donation of 3 sets of SDB kits, and 2 surge deployment, PHIE and operation manager. The German RC and Japanese RC also contributed to the surge deployment, PHIE and staff health respectively.

## ICRC Actions Related To The Current Event

ICRC has presence in the country and continue to support NS on security scanning on regular Movement, strengthening Cooperation and coordination.

## Other Actors Actions Related To The Current Event

<b>Government has requested international assistance</b>	Yes
<b>National authorities</b>	The Ethiopian Public Health Institute and Ministry of Health, continue leading and coordinating with partners in transitioning toward post recovery. Efforts are centered on consolidating surveillance gains, preventing resurgence, and reinforcing health systems for early detection and rapid response to future outbreaks. A joint coordination platform between MoH and EPHI remains active to ensure sustained information sharing, laboratory oversight, and evidence-based decision-making in the recovery phase.
<b>UN or other actors</b>	WHO, UNICEF, IOM, ACDC, INGO and local NGO fully participated in the response through the established coordination co-chaired by WHO and MOH. WHO Afro, UNICEF and ACDC deployed technical teams to support the regions in response.

### Are there major coordination mechanism in place?

The Ethiopian Public Health Institute (EPHI), under the Ministry of Health (MoH), leads preparedness and response coordination through the existing Incident Management System (IMS) at regional levels. Technical working groups will support Regional Emergency Operation Centers (EOCs) in improving preparedness to quickly initiate surveillance, case investigation, laboratory testing, and risk communication in the event of future outbreaks.

National coordination is guided by the Public Health Emergency Operations Center (PHEOC) chaired by EPHI, with participation from MoH, WHO, UNICEF, and key partners. At the regional level, the Regional Health Bureau (RHB) leads coordination through PHEM units in collaboration with local authorities and community health workers.

### Role of ERCS:

The Ethiopian Red Cross Society (ERCS) participates in coordination platforms at regional levels, supporting community engagement, risk communication, contact tracing, and surveillance through its volunteer network. While not in a lead role, ERCS is a vital operational partner in community-based response activities.



# Needs (Gaps) Identified



## Health

With the Marburg Virus Disease outbreak now contained, the focus has shifted from immediate response to strengthening preparedness and community resilience. Rather than emphasizing urgent material needs, priority is placed on sustaining and enhancing key public health functions led by the EPHI and supported by the Ethiopian Red Cross Society.

Core areas of focus include strengthening Community-Based Surveillance (CBS) systems for early detection and reporting of potential cases, as well as scaling up Risk Communication and Community Engagement (RCCE) to promote preventive behaviors, address misinformation, and maintain community trust. In addition, continued efforts in community awareness, volunteer capacity building, and integration of MHPSS support into routine outreach activities remain essential.

These interventions aim to ensure sustained vigilance, reinforce community-level preparedness, and enable rapid detection and response to any future public health threats.

Health Facility field assessments conducted identified significant preparedness gaps across health facility, border, and community levels. Although screening, reporting, and outreach activities were observed to be operational, infrastructural limitations, insufficient training of health workers, and inadequate supplies will compromise effectiveness in addressing future outbreaks.

Mental Health and Psychosocial Support (MHPSS) is a critical component of the MVD response, as outbreaks are associated with high levels of fear, stigma, grief, and psychological distress among affected individuals, families, and frontline responders. Evidence from previous outbreaks, including WHO, IFRC, and UNICEF reports, highlights persistent gaps in access to structured MHPSS services, limited integration of psychosocial support into frontline health responses, and insufficient community-level capacity. Assessments from similar epidemics also show increased stigma toward survivors and health workers, low utilisation of mental health services, and weak referral pathways for severe cases. Frontline healthcare workers, ERCS staff, and volunteers are particularly vulnerable, facing fear, burnout, and social exclusion. These gaps underscore the need to strengthen community-based MHPSS, improve awareness, and ensure accessible, coordinated support, including sustained follow-up. Strengthened MHPSS is essential to address grief and trauma, emotional distress among survivors and affected families, anxiety related to post-exposure prophylaxis, and the wellbeing of responders. To this end, Community Health Workers and Red Cross volunteers' capacity on MHPSS training is essential, especially for survivor's care and post-outbreak MHPSS continuity. Training must be targeted to identify early signs of distress, provide Psychological First Aid (PFA), and refer complex cases to specialised services.

At the same time, the National Society's capacity and technical knowledge on Marburg remain limited and require continued strengthening. This operation will therefore prioritize building community-based health service capacity and supporting health facilities to respond to possible outbreaks.



## Water, Sanitation And Hygiene

Continuous WASH assessments were conducted in Sidama and Jinka to identify WASH related gaps at the household level. This information was incorporated into the operation to inform the intervention in terms of hygiene promotion and identify gaps in infrastructure. The findings show both encouraging practices and important gaps that may affect community health.

In Jinka, assessments indicated 100% gap in proper handwashing infrastructure while in Sidama region 28% of households handwashing with running water. This is a critical concern because handwashing with soap and water is one of the most effective measures for preventing communicable diseases such as diarrheal diseases, cholera, respiratory infections, and hemorrhagic fever. The absence of such facilities suggests a need for stronger community education and promotion of simple handwashing stations (such as tippy taps) In two regions it indicated that most of latrines were functional and in use, which reflects relatively good sanitation. However, in Sidama 15% and Jinka 10% respectively Were observed to be practicing open defecation, which remains a significant public health risk.

In the two regions, findings show that they maintain clean household environments, 78% Sidama and Jinka 68%. This indicates a positive level of awareness regarding environmental hygiene and waste management though more effort needs to address the remaining percentage to help reduce prevalence of malaria in Jinka district.

Most households practiced proper handling and storage, which is a strong indicator of good food hygiene practices. Proper food storage helps prevent contamination by pests, dust, and microorganisms that can cause foodborne illnesses. However, continued education is important to ensure that all households adopt and maintain safe food handling practices.

Overall, the WASH findings indicate strong performance in environmental cleanliness and food storage practices, suggesting that many households are aware of basic hygiene principles. However, critical gaps remain in handwashing facilities, mosquito net coverage, and



the elimination of open defecation. Addressing these gaps through community health education, sanitation promotion, and improved access to WASH facilities will help reduce the risk of communicable diseases and improve community health outcomes.



## Protection, Gender And Inclusion

Currently, the response has been completed and mostly focusing on recovery and preparedness for future pandemics and epidemics. Through this DREF ERCS will integrate protection, gender and inclusion interventions to ensure specific needs of the special groups are addressed. Symptoms exhibited by the disease are bound to bring stigma and discrimination amongst affected community members, which requires parallel action. The right to information will be reinforced for different groups to ensure no one is left behind.



## Community Engagement And Accountability

Misinformation and limited community knowledge remain at significant risks that must be addressed from the outset. Lessons learned from previous responses highlight the importance of a robust feedback management system and active engagement at both community and institutional levels, leveraging local leaders, stakeholders, and other actors. Data collection and management will serve as a key pillar for awareness-raising efforts collaboration with the Regional Health Bureau (RHB), key messages will be translated and disseminated through multiple media channels to maximize reach and prompt actionable responses from both individuals and institutions. The recently finalized KAP survey will inform you of the dissemination of key findings, providing critical evidence to guide RCCE strategies and decision-making.

Through funding from the British Red Cross and FCDO, a concurrent project has been undertaken to improve RCCE mechanisms and gathering Community Based Feedback. While this project does not contribute to the operation, it has leaned heavily on the lessons learned from the MVD response, and the outputs, including a shared Community Based Feedback dashboard shared with EPHI and Collective Service partners will integrate into recovery programming once completed.

## Any identified gaps/limitations in the assessment

The areas identified as at-risk for MVD re-emergence are additionally impacted by high rates of other vector-borne illnesses (such as malaria) as well as malnutrition. Malaria in particular presents many of the same symptoms as MVD, creating challenges in surveillance and detection. Areas with insufficient access to testing may experience additional pressures on health services, while malnutrition may lead to higher morbidity in suspected cases.

As the Government scales back Emergency Operation Centers post-outbreak, coordination gaps may emerge. Developing alternative mechanisms for information sharing, such as common reporting dashboards, will be critical in maintaining a common operating picture for recovery.

# Operational Strategy

## Overall objective of the operation

The IFRC-DREF operation has modified its objectives from preventing and controlling the Marburg Outbreak in Ethiopia to focus on post recovery, systems strengthening, and preparedness for future outbreaks of VHF.

Following the shift of situation since January 2026, ERCS is replanning the intervention within unspent allocation to align with Ministry of health recovery plan in Sidama and Southern Ethiopia region to be implemented until the end of the DREF on 31.05.2026.

## Operation strategy rationale

This revised strategy is revised based on standard post recovery approaches for viral hemorrhagic disease, as well as alignment to the priorities identified by the Ethiopian MoH and EPHI. The ERCS Operations Team, supported by IFRC Surge, continues to strengthen the capacity of the local branches and coordinate actions through the national Incident Management System. The Marburg outbreak post recovery action will follow a community-centered approach, focusing on the following main areas: health prevention, MHPSS, RCCS



Pillar 1: Health Prevention – strengthening facility level response , post recovery and prevention capacity.

- The Ethiopian Red Cross Society, in coordination with the Ministry of Health and the Ethiopian Public Health Institute, will implement a targeted prevention strategy to strengthen health facility and community preparedness, addressing gaps identified during the MVD response.
- Points of Entry (PoE) surveillance capacity through EPiC will be strengthened in high-risk and cross-border areas to enhance early detection and reduce transmission risks.
- Continue the awareness raising that is targeting essentially representative and community structure, ensuring continuity of the messages within the communities.

Pillar 2: Community Level Prevention and Mental Health Support

- ERCS will reinforce community-based surveillance and RCCE capacity to support early case detection, timely reporting, and sustained behavior change
- Together, these actions will strengthen resilience for effective prevention, early detection, and rapid response to future public health threats. Specifically:
  - Mental Health and Psychosocial Support (MHPSS) – addressing psychological needs and promoting resilience through group- based PSS and HH visits.
  - This integrated approach ensures a well-coordinated, evidence-based response anchored in the community while reinforcing institutional readiness at all levels.
  - Complete/extend the training for health workers from cross borders on VHF and epidemic prone disease surveillance
  - Capacity building planned in coordination with EPHI on evidence generation for MVD and other Epidemic including lesson learned from outbreak on surveillance and data management - it's a request by the EPHI, included in the revised plan.

### 1) Health strategy details

SDB ToT trainings have been completed and procured SDB kits provided by the Canadian Red Cross has ensured that sufficient capacity is in place in the event of a future outbreak. These SDB and other response focused activities such as Safe and Dignified Burials (SDB) and Ambulance support that started during response/emergency are no longer necessary and were stopped following the end of outbreak. In this response, the ERCS was recognized in the response phase of the operation for its ability to mobilize at the community level to deliver effective door-to-door surveillance and risk communication during response phase and even previous outbreaks. ERCS put in place Event-Based Surveillance to Rumor Tracking, Strengthen Linkage to Health Facilities by encouraging early care-seeking behavior. Also increased awareness on VHF diseases as well as messages to address fear, misinformation, and stigma.

During the recovery and preparedness phase, the activity will be more targeted, community-led, and preventive to sustain community-based surveillance, shift from “emergency mode” to stronger capacity for routine alert detection, Identify and report unusual illnesses or deaths early, follow-Up on Survivors that will help reduce stigma and reintegration challenges and refer complex cases to health facilities for management. Awareness integrated messages will solely focus on the dissemination of the end of the outbreak to help communities understand that MVD is declared over to maintain trust in the health system continue to address community stigma and misinformation for MVD.

### 2) RCCE intervention shift details

Risk Communication and Community Engagement (RCCE) has focused on delivering clear, well-translated case definitions and prevention messages through multiple channels to promote community understanding and adoption of protective behaviours. Messages were co-developed with relevant stakeholders, translated by ERCS, and disseminated via radio and TV broadcasts, community dialogues, printed materials, and door-to-door sensitisation in high-risk areas.

In current phase

- NS will ensure the items purchased under this DREF remains an assets valuable for future risk/outbreaks. Other community level messages are stopped considering the relevance at this stage. Risk communication will be sustained only for messages on the end of the outbreak. Particular attention will be given to non-Amharic speakers and populations with lower literacy levels, as identified through lessons learned.
- As part of the EPIC training to expand to more branches volunteers and health workers will ensure the branches capacities on prevention and risk communication are enhanced for future purpose. Giving them skills to address similar situation. ERCS continue to leverage its auxiliary role to strengthen community-level surveillance, risk communication, and volunteer mobilisation throughout the recovery period, with continued engagement of community representatives, religious, and local leaders to foster trust and adherence to public health measures.
- In collaboration with EPHI, ERCS conducted two Knowledge, Attitudes and Practices (KAP) surveys followed by rapid qualitative assessments. The Sidama KAP survey findings have been disseminated to government and partners, while the South Ethiopia report is pending final publication. Results from both surveys will be used to tailor RCCE futur messaging to population groups with lower awareness of MVD symptoms and prevention measures.
- Community feedback and rumour-tracking systems reports once consolidated will be used to identify misinformation, address stigma—particularly toward survivors—and adapt messaging in real time. A national toll-free information line will remain operational to support two-way communication.

### 3) WASH intervention changes details

WASH initially prioritised the IPC, spraying and promotions. In the current phase, ERCS will prioritise support expand the assessments to ten more facilities (to a total of 20). This is the readiness assessments to identify gaps in IPC materials, triage systems, and isolation capacity to health facilities in coordination with MoH and EPHI.

For the spraying, materials procurment and provision to health facilities or at households level, all not committed procurement by the



time of the outbreak end are stopped. Assessment findings will inform priorities in case of resurgence of outbreak. All community-level activities will be strictly restrained to RCCE interventions, enabling targeted disinfection in areas with suspected cases. All spraying, IPC and WASH activities will stop. Include the awareness raising for hygiene and WASH prevention. These activities do not align with current phase and may create more confusion for the WASH/IPC considerations for MVD risks.

#### 4) PROTECTION, GENDER AND INCLUSION

Under PSEA and GBV prevention, mitigation, and response, the priority will be to provide clear community information on referral pathways, prevention, and safe feedback mechanisms. ERCS will continue emphasizing personal safety (Stay Safe), and the code of conduct during project implementation, Relevant safeguarding briefings will be maintained. Led by the PGI focal point, trained teams will conduct a post recovery GBV and stigma to inform key messaging. Update referral pathways for VHF survivors. Integrated with CEA/ feedback reporting channels, and key safeguarding messages, hotlines, and other reporting channels will continue to be shared. ERCS will investigate any PSEA allegations in line with its policies.

#### 5) Coordination

Coordination for post recovery will continue to be reinforced through the Emergency Operations Center (EOC), the central hub for information sharing, situational monitoring, and strategic decisions. To support timely data management and evidence-based action, the NS will have developed a host of digital tools for reporting, feedback collection, and information dissemination, ensuring real-time updates flow efficiently between field teams, branches, NS leadership, and stakeholders.

The Ethiopian Red Cross Society has been recognized by the Ethiopian Public Health Institute as a highly effective operational partner, particularly in Risk Communication and Community Engagement (RCCE), community-based surveillance, Infection Prevention and Control (IPC), and logistical support. Its extensive volunteer network, strong community presence, and auxiliary role to public authorities have enabled timely outreach, improved risk awareness, and strengthened last-mile service delivery during the response phase.

Engagement with MoH and EPHI will continue throughout the recovery phase, with a strategic shift toward reinforcing ERCS's role in preparedness and resilience building. This includes structured participation in coordination platforms, joint planning, and expanded involvement in cross-border surveillance initiatives. Priority will be given to strengthening community-based early warning systems, enhancing volunteer capacity on epidemic preparedness and response, and supporting the institutionalization of RCCE and EPIC capacity of health workers and NS.

Furthermore, ERCS will contribute to support health facilities and scaling up interventions in high-risk areas. This sustained engagement will ensure that communities remain vigilant, systems are better prepared, and response mechanisms can be rapidly activated to mitigate the impact of future public health emergencies.

#### 6) Support in place

##### 6.1. National society operational support strengthening

Surge specialists with prior experience in VHF outbreaks have been deployed in Public Health in Emergency (PHiE) and Safe and Dignified Burials (SDB) roles to support the National Society in strengthening response and planning for recovery. In addition to Staff Health and Operations Surge, these roles have supported implementation of training to recruited branch-level staff and volunteers to increase capacity in surveillance, IPC, SDB and PPE use.

Volunteers involved in project have been covered with the standard ERCS insurance coverage. Due to attrition, new volunteers will continue to be insured, and refresher training may be provided based on need based on national society standard insurance is covered for volunteers whenever accidents or medical conditions happen. We also Provide project cycle management training to the staff on MVD innervation targeted areas.

##### 6.2. Secretariat services

The IFRC is providing ongoing support for NS and sub-regional coordination efforts, donor engagement, and compliance with response standards.

In the response phase, IFRC activated emergency tools and surge mechanisms to strengthen technical capacity. Post-outbreak, the IFRC Cluster Team is supporting the ERCS in developing a recovery plan and exit/transition strategy that ensures alignment to existing programs, such as the PREPARE project.

## Targeting Strategy

### Who will be targeted through this operation?

The operation targeted both community and health system actors in the Sidama and South Ethiopia region, multiple zones, and woredas at high risk of epidemic-prone diseases and/or where MVD cases have been reported with a focus on populations at highest risk of exposure and transmission.

Primary Target Groups during response phase:



The response prioritized affected and at-risk communities in Jinka and surrounding areas, including populations along the Jinka–Hawassa corridor, to support early detection, prevention, and stigma reduction. Frontline health workers and facilities were supported with IPC training, PPE, and preparedness for safe case management. Community health and ERCS volunteers assisted with surveillance, contact tracing, and risk communication. Capacities of RRTs and PHEM officers were strengthened for effective outbreak detection and coordination. Special focus was given to vulnerable and hard-to-reach groups, including mobile populations, refugees, and schoolchildren. Targeting followed a risk-based approach using locally embedded volunteers, tailored communication, and coordination with authorities and partners to ensure comprehensive coverage.

Primary focus for recovery/post emergency.

After MVD was declared over, the focus shifted to recovery and preparedness.

- Target in current phase remains corridors areas from the epicenter (Jinka) to Hawassa town.
- Priority targeted groups are health workers and PHEM structures to maintain surveillance, IPC, and outbreak readiness, especially in cross-border areas. Survivors and affected families were supported through follow-up, MHPSS, stigma reduction, and safe practices to enable recovery and reintegration. Communities in previously affected areas remained a focus for continued risk communication and awareness for positive behaviors for survivors and community stigma management. HCWs and ERCS staff were also targeted for learning and evidence generation to strengthen future preparedness.

## Explain the selection criteria for the targeted population

The operation will continue to target specific groups through a risk-based and vulnerability-focused approach. In the post-outbreak phase, additional emphasis will be placed on healthcare workers, PHEM officers, and health facilities along main transportation corridors to increase preparedness for future outbreaks. As indicated in initial plan, the criteria for the targeting have combined three key criteria during the response phase and this remains relevant for the current phase:

- Risk exposure, particularly in previously affected areas and transport corridors. For current phase, risk exposure analysis includes for potential resurgence, based on experience of this outbreak. This explains the priority to the populations in immediate proximity to the animal reservoir and in main transportation corridors are more likely to contract and spread the infection.
- Functional role, prioritizing actors essential to preparedness and rapid response. These criteria define the target of Health workers and surveillance actors as critical for containment; their protection and capacity directly influence outbreak control effectiveness.
- Vulnerability, ensuring equitable access to information, services, and protection for mobile and marginalized groups.

The ERCS and IFRC will continue to ensure that all activities are aligned with the Ethiopian Ministry of Health and the Ethiopian Public Health Institute to increase capacity in RCCE, Surveillance, MHPSS, and emergency response.

## Total Targeted Population

Women	292,230	Rural	20%
Girls (under 18)	-	Urban	80%
Men	280,770	People with disabilities (estimated)	10%
Boys (under 18)	-		
Total targeted population	573,000		

## 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?	No
Does your National Society have whistleblower protection policy?	Yes
Does your National Society have anti-sexual harassment policy?	No

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

Risk	Mitigation action
Compounding effects of other natural disasters (floods, landslides) increasing transmission risk.	<p>Closely monitor and plan for additional flood/landslide responses through existing DREF.</p> <p>Develop contingency plans to reprioritize health/WASH activities in newly affected areas with high MVD risk as defined in existing targeting strategy.</p>
Safeguarding risk.	<ul style="list-style-type: none"> <li>- Provide compulsory safeguarding and PSEA training for all staff, volunteers, contractors, and implementing partners.</li> <li>- Establish multiple confidential reporting channels</li> <li>- Community Awareness and Feedback Loops</li> <li>- Communicate a clear zero-tolerance stance on any safeguarding violation.</li> </ul>
Misinformation and stigma could potentially lead to resistance and denial which could be a security risk for our staff and volunteers.	<ul style="list-style-type: none"> <li>- Strengthen community engagement and awareness.</li> <li>- Use trained local volunteers who understand local dynamics and languages to reduce tensions and build trust.</li> <li>- Monitor rumors and misinformation in real time and update in regular reports.</li> <li>- Ensure staff safety protocols</li> </ul>
MVD Re-emergence in same or new regions.	<p>Mitigation by training the staff and volunteers in other areas and branches on MVD prevention and control.</p> <ul style="list-style-type: none"> <li>• Conduct branch MVD preparedness to the neighboring branches and take all the precautions.</li> <li>• Continuous Sharing updates with staff guidance from the in-country coordination.</li> <li>• Expand RCCE tools for use with other languages and contexts.</li> </ul>
Limited knowledge to manage Marburg which may lead Infection of ERCS employees, Health care workers, or volunteers.	<ul style="list-style-type: none"> <li>• Linkages to government ETUs to support ERCS employees, HCW or volunteers should they fall sick.</li> <li>• Provision of PPE (personal protective equipment)</li> <li>• Training and provision of standard SDB kits to SDB teams for safe burial procedures, avoiding improvisation without adequate material and protection.</li> <li>• Provision of regular PSS support to all response teams.</li> <li>• Sharing updated guidance through memos from the secretary general's office to all staff and volunteers.</li> </ul>
Long procurement process for urgent supplied.	<p>Use of available emergency procurement procedures.</p> <p>Utilize available international supply through IFRC and other PNS in the country</p>
Security Situation Prevents access to affected areas.	<p>Continue to engage local volunteers in conflict fragile settings.</p> <p>Continuously monitor security situation through Cluster Senior Security Officer</p>



Develop contingency plans for activities if access cannot be achieved.

**Please indicate any security and safety concerns for this operation:**

According to the IFRC security risk classification, South Omo Zone is currently categorized under the Orange (high overall Risk) security phase. Contributing factors include:

- Harsh climate and environment, increasing operational challenges.
- Climate-related stressors drought, irregular rainfall, and resource scarcity—affecting pastoralist mobility and potentially triggering tension.
- Cross-border and inter-communal dynamics, including occasional pastoralist conflicts over grazing land and water.
- Public health vulnerabilities, where limited access to healthcare and weak surveillance systems may hinder early detection and response to outbreaks
- Misinformation and stigma could potentially lead to resistance and denial which could be a security risk for our staff and volunteers.

Has the child safeguarding risk analysis assessment been completed?

**No**

## Planned Intervention



**Budget:** CHF 159,047  
**Targeted Persons:** 573,000  
**Targeted Male:** -  
**Targeted Female:** -

### Indicators

Title	Target	Actual
No. of volunteers trained in CBS and RCCE	200	208
No. of volunteers deployed to conduct risk communication and CBS	200	180
Percentage of CBS alerts investigated (>80%)	80	100
No. of people reached with risk communication messages through HH visits	286,500	188,149
No of people reached to with risk communication messages through group gatherings or community meetings	343,800	299,599
No. of SDB starter kits procured	2	4
No of SDB training kits procured and delivered	1	4



No of SDB replenishment kits procured	1	4
No. of SDBs conducted	30	0
Percentage of SDB alerts responded to	90	0
Percentage of ambulance evacuations done by the EMS team	5	0
Cumulative number of vehicles/ambulances disinfected	5	0
No. of SDB and EMS personnel supported in deployment	42	4
No. of volunteers supported with DATA and airtime	116	116
No of people screened at high traffic areas such as schools, churches, hospital gates etc.	300,000	295,597
No of volunteers trained on MHPSS	30	0
# of groups reached with CB PSS	-	0
# of community reached with PSS through HH visits	1,000	0
# of HCW trained on Basic PHEM	50	0
# of RRT attended refresher training	50	0
# of OH actors trained on EPIC	50	0
# oh Port Health staff trained on management of VHF	50	0

## Progress Towards Outcome

Community-Based Surveillance (CBS) and Risk Communication and Community Engagement (RCCE) remain critical components of the response during the recovery phase, continuing to support early case detection and prevention messaging. These efforts are being aligned with the Ministry of Health (MoH) to incorporate additional communicable diseases such as malaria. Coordination with key stakeholders, including MoH and the Ethiopian Public Health Institute (EPHI), is ongoing to reassess priorities, including patient referral needs and overall preparedness. Psychosocial support services are also being strengthened to provide comprehensive care to survivors, affected families, and frontline health workers, while planned Safe and Dignified Burial (SDB) Training of Trainers will focus on simulation exercises to enhance readiness.

In terms of capacity building, a total of 30 healthcare workers and Rapid Response Team members (20 male and 10 female) were trained on case detection, referral, IPC, and PPE use, achieving 60% of the target. An additional group of 16 participants (15 male and 1 female) also received similar training. However, implementation gaps were noted, particularly in Sidama Region, where no training was conducted despite a planned target of 20 participants, resulting in 0% achievement. Similarly, IPC and PPE training overall reached only 60%, with no progress in Sidama. These gaps highlight disparities in regional implementation and the need for targeted follow-up to ensure equitable capacity development.

RCCE interventions focused on enhancing community awareness, trust, and behavior change through engagement and dialogue. Although the planned broadcasting of three radio and TV spots was not implemented (0%) due to the declaration of the MVD outbreak being over and shifting priorities, community-level engagement remained active. A lesson-learned workshop conducted with EPHI included 13 participants from South Ethiopia and 3 from Sidama. Additionally, 15 community dialogue sessions were held, reaching 180



participants (140 male and 40 female), including teachers, religious leaders, students, and administrators. While these efforts contributed to improved community engagement, the low implementation of media activities and gender imbalance in participation remain key areas for improvement moving forward.

Priority activities based in community needs in MVD affected target regions

- Deliver structured Mental Health and Psychosocial Support (MHPSS) services to affected families, isolated individuals, and responders Families of deceased, Individuals who were isolated, Frontline responders - give out soap for hand washing
- Group-Based Psycho-education & Support Sessions -For survivors, caregivers., and health workers on coping, grief, safety, reintegration, fear reduction (refreshment)
- Training of 30 volunteers on MHPSS for respective communities to support in community-based PSS, through community groups, family visit, and for frontline workers
- Conduct EPiC training for One Health Actors (human, animal, and environmental health sectors) from affected and high-risk woredas at regional level
- Systematic review training for MVD evidence generation related to PoE for HCWs and ERCS staff for 5 days
- Focus messages for survivors, affected families, and contacts of MVD cases on post-recovery precautions. Addressing follow-up feedback, stigma management etc.



## Water, Sanitation And Hygiene

**Budget:** CHF 102,556  
**Targeted Persons:** 573,000  
**Targeted Male:** -  
**Targeted Female:** -

### Indicators

Title	Target	Actual
# of HF supported with IPC/PPE materials	10	12
# of HF supported with IPC/PPE materials	10	12
# of volunteers equipped with PPE	232	208
# of Hand Washing facilities procured and distributed to public sites	150	11
# of HH identified with suspect case or contacts, received HW bucket and soap	5,000	0
# of volunteers deployed to support IPC at community level	40	48
# of spray pump procured and distributed	50	0
# of CHW refreshed with IPC/WASH training	60	0

### Progress Towards Outcome

#### 1) Achievements

Support to health facilities with IPC/PPE materials exceeded the target (120%), indicating strong supply distribution capacity. Deployment of volunteers also surpassed the target (120%), demonstrating good community mobilization efforts. Volunteer PPE distribution reached 90% of the target, showing progress but still requiring completion. Procurement and distribution of handwashing facilities is at 7% achievement though the ERCS is in the final stage of procurement for wash basins and soap. Planning for distributions is ongoing and is expected to take place in the coming weeks.



Health facility support: 12 health facilities (10 in Southern Ethiopia, 2 in Sidama) were equipped with essential medical supplies. ITN procurement is nearly complete and distribution is underway.

PPE distribution: 300 staff and volunteers involved in the MVD response received PPE based on needs.

Community engagement: 208 volunteers carried out WASH/IPC activities, reaching 1,239 people across 410 households through hygiene promotion and assessments.

Public handwashing facilities: 11 handwashing units have been installed, with remaining installations expected within three weeks. Planned spray pump procurement was canceled due to successful containment of the outbreak

2) Priority Activity for current phase

ERCS is planning to Train 60 IPC/WASH focal person on IPC (proper utilization of PPE, from the health facility in the affected regions).



## Protection, Gender And Inclusion

**Budget:** CHF 1,772

**Targeted Persons:** 286,500

**Targeted Male:** -

**Targeted Female:** -

### Indicators

Title	Target	Actual
# of volunteers oriented on SGBV prevention, response and mitigation	232	208
# of awareness sessions targeting on children	20	0
# of inclusive IEC materials developed and distributed.	2,000	0
# of referral pathways identified and activated	6	0

### Progress Towards Outcome

1) Achievements

Integration of PGI will continue as inclusiveness of IEC materials has been identified as a key challenge in lessons learned. IEC materials will be adapted to provide better access for low literacy levels and messages will be translated into local languages.

Risk groups identified (women caregivers, elderly, people with disabilities, displaced populations) Cultural considerations (burial practices, caregiving norms).

Data was Disaggregated by Sex (male/female) Age groups Disability status keeping in consideration the percentage women vs men reached with health messaging. Inclusive risk communication and community engagement (RCCE) ensuring material are in local language.

All trainings conducted and planned will continue to integrate PGI elements as well as information on SEA reporting.

2) Priority activity for current phase

Awareness creation for survivors, affected families, and contacts of MVD cases on post-recovery precautions. Messages will be limited to these groups and focus on safeguarding, feedback reporting systems, addressing feedback, stigma management and MHPSS referrals.



## Community Engagement And Accountability

**Budget:** CHF 26,083



Targeted Persons: 573,000  
 Targeted Male: -  
 Targeted Female: -

## Indicators

Title	Target	Actual
# engagement meetings conducted community influencers and community members	30	19
# feedback channels established	4	3
% of feedback collected and addressed	80	100
# of lesson learned session conducted	1	1
# of KAP survey conducted	2	2
# Number of staff and volunteers trained on implementing CEA minimum standards	200	208

## Progress Towards Outcome

### 1) Achievements

Community engagement meetings achieved 63% of the target, suggesting slower-than-planned outreach to community influencers and members. ERC is planning to continue with Awareness creation for survivors, affected families, and contacts of MVD cases on post-recovery MVD prevention precautions (safe sex, medical follow-up, etc.) activities.

The KAP Surveys conducted in Sidama and South Ethiopia Regions is in the translation phase, with publication expected before the end of April. Training of staff and volunteers surpassed the target, strengthening capacity for effective CEA implementation. Planned lesson sessions and KAP surveys were fully completed, supporting program learning and evidence-based planning. Establishment of feedback channels reached 75%, indicating good progress but requiring completion to ensure accessibility for all communities. All collected feedback has been addressed (100%), exceeding the target and demonstrating strong accountability to communities.

### 2) Ongoing

- Lessons learned workshops, along with systems strengthening activities for RCCE and community feedback mechanisms is ongoing and will be further enhanced with an external grant from the FCDO.
- Community risk communication will be limited to safeguarding, feedback reporting systems, addressing feedback, stigma management and survivors' key messages.



## Coordination And Partnerships

Budget: CHF 0  
 Targeted Persons: 0  
 Targeted Male: -  
 Targeted Female: -

## Indicators

Title	Target	Actual
# of national level coordination meetings attended	12	12



# regional level meetings attended	24	24
# of joint supportive supervision conducted	2	2

## Progress Towards Outcome

### 1) Achievements

Coordination and supportive supervision activities have been fully implemented as planned. All targets were achieved, demonstrating strong engagement with coordination platforms and effective program oversight.

Full participation in both national and regional coordination meetings ensured alignment with stakeholders and partners.

All planned joint supportive supervision visits were successfully conducted, contributing to quality assurance and program monitoring.

Strong coordination and collaboration with partners at all levels Effective planning and adherence to scheduled activities good program oversight through supervision mechanisms

ERCS will Continue commitment to coordination and supervision will be essential to sustain overall program success

-Regular cross-border coordination meetings established, with representatives from Ethiopia, Kenya, and South Sudan.

-Multi-sectoral collaboration with MOH, community stakeholders, and INGOs ongoing at the zone, region, and national levels.

### 2) Priorities maintained

- Strong coordination and collaboration with partners at all levels Effective planning and adherence. Include at national and regional levels led by EPHI and the Regional Health Bureau (RHB).



## Secretariat Services

**Budget:** CHF 110,855

**Targeted Persons:** 250

**Targeted Male:** -

**Targeted Female:** -

## Indicators

Title	Target	Actual
#. of monitoring missions conducted	4	4
# of financial spot checks conducted	1	1
# of Lessons Learnt Conducted	1	1
# of surge capacity deployed to support field activities	3	4

## Progress Towards Outcome

### 1) Achievements

IFRC Surge Role now in place and supporting the National Society with Operations, Public Health, SDB, and Staff Health. IPC Officer role stood down due to changing operational needs lack of suitable candidates.

All planned monitoring missions and financial spot checks were completed, ensuring strong program oversight and compliance.

The lessons learned session was successfully conducted, contributing to continuous improvement and knowledge sharing.

Surge capacity deployment exceeded the target (133%), demonstrating the program's ability to respond flexibly to emerging field needs.

### 2) Priorities in current phase

- Planning for recovery was conducted in conjunction with EPHI and MOH. NS has been engaged with Government on planning after the



end of the outbreak to define priorities for this phase.

- Cross Border Learning Event was conducted Ethiopia in conjunction with the PREPARE program Lesson learned documented and the outcome of the same to be shared in due course.



## National Society Strengthening

**Budget:** CHF 87,356

**Targeted Persons:** 247

**Targeted Male:** -

**Targeted Female:** -

### Indicators

Title	Target	Actual
# NS staff engaged in the operation (Fully /Partially)	15	19
# of volunteers deployed to support operation	232	208
# of volunteers insured	232	208
# branches supported in capacity strengthening	2	2
% of contribution to digitize the NS data collection and documentation	50	0
# of monitoring visits conducted at HQ and branch level	8	4
# Operational decisions or changes made based on community feedback	5	1

### Progress Towards Outcome

#### 1) Achievements

Engagement of National Society (NS) staff exceeded the target (127%), ensuring strong human resource capacity. Capacity strengthening support to branches was fully achieved, contributing to institutional development.

Volunteer deployment and insurance coverage reached 90% of targets, indicating good progress but requiring completion.

Monitoring visits are at 50% and is still in progress.

Use of community feedback in decision-making is low (20%) however RCCE and CBS activity is in progress that will improve the indicator by the end of the project.

In the achievements, some limitations noticed. for instance,

- No progress has been made in digitizing data collection and documentation systems, reason being delay in procurement process to actualize the activity.
- Weak integration of community feedback into operational decision-making.

#### 2) Priorities in current phase

- To provide project cycle management training to the staff on MVD intervention targeted areas.



# About Support Services

## How many staff and volunteers will be involved in this operation. Briefly describe their role.

A total of 5 technical officers, 3 support staff, 2 drivers, 5 professional volunteers, and 200 volunteers will be involved. The technical staff will include the operations manager, Field coordinator, Supervisor for RCCE/CBS supervisor, MHPSS coordinator, and EMS coordinator. These will take lead in ensuring that activities under the different pillars are executed accordingly under overall leadership of the operations manager.

The support staff will include the logistics officer and finance officer who will support in ensuring procurement and financial processes are expedited.

The NDRTs will include 3 NDRT health officers, 1 PMER NDRT focal person, 1 volunteer management focal person, 1 Communications focal person, 5 EMTs, 5 ambulance drivers and 4 drivers for usual vehicles.

300 volunteers shall be deployed to support routine RCCE and CBS activities while 20 shall be deployed to support screening at selected public places.

## Does your volunteer team reflect the gender, age, and cultural diversity of the people you're helping? What gaps exist in your volunteer team's gender, age, or cultural diversity, and how are you addressing them to ensure inclusive and appropriate support?

- The ERCS is capturing sex disaggregated data for volunteers and beneficiaries in activities.

## Will surge personnel be deployed? Please provide the role profile needed.

This operation brings in peer support from neighboring countries with experience to set up MVD response while the surge team are sought. IFRC will support with Deployment of surge capacity to support with.

### 1. Project coordination (PHiE):

- Coordination with MOH, WHO, ACDC at the ICP and pillars.
- Community based surveillance interventions (Engagement with community structures and enhance the RCCE interventions, through HH visits, FGDs, community meetings, Contact tracing).
- Link with stakeholders and other implementing partners and health facilities.
- CBS: rapid assessment and system design.
- Regular mentoring, quality assurance and supervision by supervisors.
- Put in place community feedback mechanism and review process.
- Conduct KAP survey to inform communication strategy.

### 2. IPC Coordinator; Ambulance Management - EMS (Stood Down)

### 3. Safe and Dignified Burials (SBD):

- ToT trainings at regional and HQ levels.
- Providing technical advice for SOP development and alignment with National policies and standards.
- Simulations and rapid deployment/activation capacity in preparedness zones.
- Regular mentoring, quality assurance and supervision by supervisors – this includes IPC for SDB and swabbing
- Regular data tracking and analysis, including daily data sharing with epidemiological management team (MOH, WHO and/or others).
- Simulations in recovery period.

### 4. Staff Health:

- Rapid assessment of duty of care for staff and volunteers.
- Support with SOP development and implementation of best practices.
- Coordination with internal support services (MHPSS, HR, Health) to provide supports to personnel.



## 5. Operations:

- Coordination with internal and external stakeholders for implementation.
- Movement coordination with IFRC, Kenya Red Cross, South Sudan Red Cross, Ethiopia Red Cross, relevant PNS.
- Planning support for NS.
- MEAL support; implementation of lessons learned.
- Team management and operational leadership.

## If there is procurement, will it be done by National Society or IFRC?

Most required materials can be procured in-country and are either completed or in progress. Only items (visibility materials) that cannot be procured locally or are more cost effective to source out of country will be procured by the IFRC through regional procurement.

All procurements by the national society shall be conducted according to the existing procurement policy. Procurement that exceeds stated thresholds shall be initiated from ERCS and shared with IFRC for review. Distribution and utilization of procured items shall be done according to national society accountability and finance policies.

The procurement of SDB kits has been revised due to a change in operational needs. The Canadian Red Cross has provided a donation of SDB kits that will be sufficient to cover training and readiness needs at this time.

## How will this operation be monitored?

The intervention and operations will be monitored regularly using the existing IFRC and ERCS PMER system. The system will incorporate field level visit, regular reporting and communication with branch offices and coordination meeting, data collection and analysis. The progress of the implementation tracked on weekly and monthly bases by the assigned focal point from both ERCS and IFRC. The IFRC team will visit the area as needed with ERCS and other actors. Monthly indicator tracking tool will be filled to track the status.

## Please briefly explain the National Societies communication strategy for this operation

The Ethiopian Red Cross Society (ERCS) utilizes a coordinated internal and external communication approach to ensure timely, transparent, and evidence-based information sharing during the Marburg response. The ERCS Emergency Operations Center (EOC) at HQ will continue to monitor the situation, consolidate field updates, and support rapid decision-making.

### Internal Communication

The EOC/ MOH will collect surveillance and operational reports from the Region Branch and share consolidated updates with ERCS leadership and field teams. Communication is maintained through email, WhatsApp/Telegram channels, and virtual coordination meetings through the Task force, which will guide operational adjustments and resource deployment.

### External Communication

ERCS continues to provide regular intervention updates to MoH, EPHI, the Regional Health Bureau, local authorities, and partners through situation updates, briefing notes, and email communication. Public information will be shared through ERCS social media platforms and, when necessary, press releases aligned with MoH/EPHI messaging.

### Communication With Affected Communities

Volunteers will continue to deliver RCCE messages approved by EPHI through community dialogues, door-to-door sensitization, and distribute IEC materials. Local radio and feedback mechanisms (volunteers, hotlines, rumor tracking) will support two-way communication and address misinformation.

### Media Strategy

ERCS will issue press releases and conduct media engagements as needed, following safety, confidentiality, and “do no harm” principles.

### IFRC Support

IFRC has provided technical communication support, including help with SitReps, key messages, press releases, and visibility products, and is ensuring alignment with Movement communication and coordination standards.



# Budget Overview



## DREF OPERATION

### MDRET039 - Ethiopian Red Cross Society Ethiopia Marburg Outbreak

#### Operating Budget

<b>Planned Operations</b>	<b>274,515</b>
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	144,484
Water, Sanitation & Hygiene	99,830
Protection, Gender and Inclusion	1,772
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	28,429
Environmental Sustainability	0
<b>Enabling Approaches</b>	<b>204,155</b>
Coordination and Partnerships	0
Secretariat Services	110,855
National Society Strengthening	93,300
<b>TOTAL BUDGET</b>	<b>478,670</b>

*all amounts in Swiss Francs (CHF)*



# Contact Information

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

**National Society contact:** Abera Lulessa, Secretary general, [ercs.sg@redcrosseth.org](mailto:ercs.sg@redcrosseth.org)

**IFRC Appeal Manager:**

Dr. Asha Mohammed, Head of Delegation , Ethiopia and Djibouti CCD, [asha.mohammed@ifrc.org](mailto:asha.mohammed@ifrc.org), Head of Delegation , Ethiopia and Djibouti CCD

**IFRC Project Manager:** Sahal abdi, IFRC- Program and Operation Coordinator, [sahal.abdi@ifrc.org](mailto:sahal.abdi@ifrc.org), +251 911207163

**IFRC focal point for the emergency:** Robi Wambura, DRM-Delegate, [robiwambura@gmail.com](mailto:robiwambura@gmail.com), +251 953909988

**Media Contact:** SAHAL HASSAN ABDI, Coordinator, Programs and Operations, [sahal.abdi@ifrc.org](mailto:sahal.abdi@ifrc.org)

**National Societies' Integrity Focal Point:** Kassahun Tegegne, [kassahun.tegegne@redcrosseth.org](mailto:kassahun.tegegne@redcrosseth.org), 0911207163

[Click here for the reference](#)

