



DR Congo Red Cross volunteers are trained to conduct safe and dignified burials. (Photo credit: IFRC)

Appeal No: <b>MDRS1007</b>	To be assisted: <b>3 million people</b>	Appeal launched: <b>20/05/2026</b>
Glide No: <b>EP-2026-000071-COD</b>	DREF allocated: <b>DRC: CHF 2,000,000 (Loan)</b> <b>Uganda: CHF 521,073</b>	Disaster categorisation: <b>Red</b>
Operation start date: <b>20/05/2026</b>	Operation end date: <b>31/05/2027</b>	

**IFRC Secretariat Funding requirement: CHF 27.5 million**

**Federation-wide funding requirement: CHF 29.5 million<sup>1</sup>**

<sup>1</sup> The Federation-wide funding requirement encompasses all financial support to be directed to the National Society in response to the emergency. It includes the National Society domestic fundraising requests and the fundraising appeals of supporting Red Cross and Red Crescent National Societies, as well as the funding requirements of the IFRC secretariat. This comprehensive approach ensures that all available resources are mobilised to address the urgent humanitarian needs of the affected communities.

## TIMELINE



**24 April 2026:** The first currently known suspected case (a health worker) reportedly develops symptoms (fever, haemorrhage, vomiting, intense malaise) in Bunia, Ituri Province.

**5 May 2026:** The WHO receives an alert regarding an unknown illness with high mortality in Mongbwalu Health Zone (HZ), Ituri Province, including reports of four health workers who died within four days.

**15 May 2026:** The DRC's Ministry of Public Health, Hygiene, and Social Welfare officially declares the country's 17th Ebola Bundibugyo (BVD) epidemic.

**16 May 2026:** The first BVD case is confirmed in Uganda, imported from Ituri province.

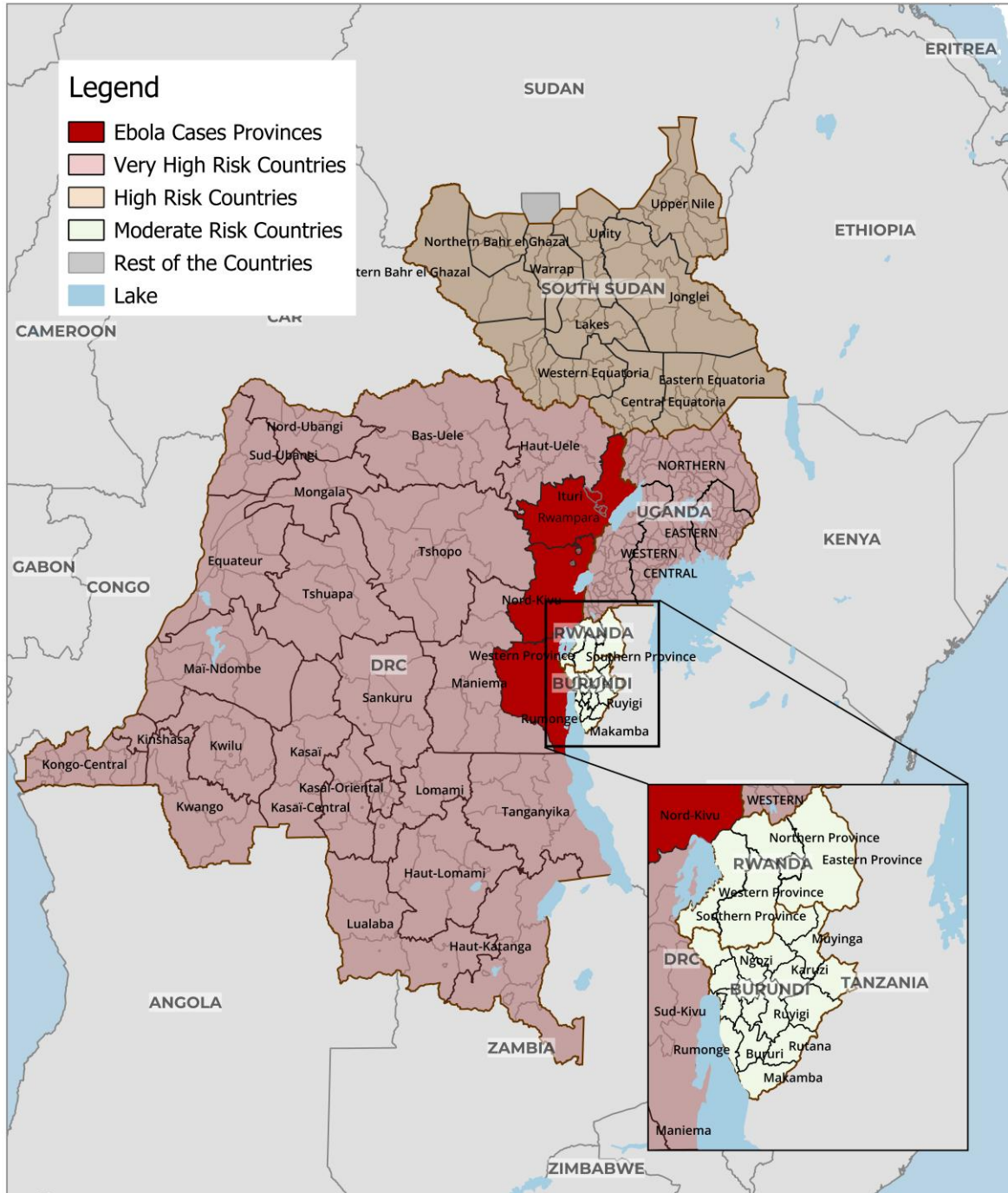
**17 May 2026:** The WHO declares the epidemic a Public Health Emergency of International Concern (PHEIC), assessing the risk as high at the national level, moderate at the regional level, and low at the global level.

**20 May 2026:** The IFRC launches a Regional Emergency Appeal of CHF 29.5 million after the IFRC Secretary General classified the 17<sup>th</sup> Ebola epidemic in the DRC and Uganda as a Red Emergency under the IFRC Emergency Response Framework.

**22 May 2026:** A IFRC cluster team arrives in Bunia, while additional surge teams have also arrived in the country to support the Ebola response operation in the DRC.

# EBOLA BVD OUTBREAK RISK COUNTRIES

As of 02 June 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: MOH, DRC RC, RW RC, SSD RC, BDI RC, UGA RC, KEN RC IFRC, UNOCHA  
Map produced by: IFRC Africa Regional, Nairobi



## DESCRIPTION OF THE EVENT

On 24 April 2026, a suspected viral haemorrhagic fever case was reported in eastern Democratic Republic of Congo (DRC). On 15 May, the Institut National de Recherche Biomédicale (INRB) in Kinshasa confirmed an outbreak of Bundibugyo Virus Disease (BVD), a strain of Ebola, in Ituri Province, DRC. The outbreak is reported to have originated in the Mongbwalu, Bunia, and Rwampara health zones of Ituri province. Uganda subsequently reported two imported cases in Kampala, highlighting the elevated risk of cross-border transmission and regional spread. On 15 May, Uganda's Ministry of Health declared a BVD outbreak after confirming a case in a 59-year-old Congolese man treated in Kampala.

On 17 May, the World Health Organisation (WHO) declared the outbreak a Public Health Emergency of International Concern (PHEIC), due to the risk of further spread within the region.<sup>2</sup> On 18 May, the Africa Centres for Disease Control (CDC) declared the outbreak a Public Health Emergency of Continental Security (PHECS). As of 2 June, the DRC had reported 116 suspected cases, 367 confirmed cases, and 72 confirmed deaths across 25 health zones in Ituri, North Kivu, and South Kivu provinces. In Uganda, 15 confirmed cases had been reported in Kampala and Wakiso, including one confirmed death.

High population mobility is a major driver of cross-border BVD transmission. The DRC and Uganda are connected through established transport corridors, extensive trade networks, particularly those linked to mining activities in Ituri, and numerous informal border crossings. These linkages, reinforced by routine economic activity and access to services, increase the risk of transmission and underscore the need for strengthened surveillance, enhanced community engagement, and a coordinated cross-border response.

At the same time, existing gaps in the DRC's health system, combined in some areas with limited awareness of preventive measures and low levels of trust in health providers and epidemic responders, have contributed to the continued spread of the virus. Unlike previous outbreaks caused by Zaire ebolavirus, Bundibugyo virus currently has no licensed vaccine or specific targeted treatment. As a result, community-based interventions, early detection, supportive care and isolation, contact tracing, safe and dignified burials, and other public health and social measures are more critical than ever.

Internationally, governments and health agencies have introduced precautionary measures to limit further spread. These include enhanced screening of travellers from affected countries, public health advisories, and the preparation of health systems to detect and manage potential imported cases. Concurrently, the WHO and partner organisations are scaling up response efforts in support of Ministries of Health in the affected areas.

On 19 May 2026, the WHO Director-General convened the first meeting of the International Health Regulations (IHR) Emergency Committee, which issued temporary recommendations to States Parties on 22 May 2026. These recommendations underscore the importance of coordinated outbreak control, enhanced cross-border collaboration, and sustained surveillance and preparedness to prevent further regional spread and ensure an effective public health response.

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<sup>2</sup> <https://www.who.int/news/item/17-05-2026-epidemic-of-ebola-disease-in-the-democratic-republic-of-the-congo-and-uganda-determined-a-public-health-emergency-of-international-concern>

# Severity of humanitarian conditions

## 1. Impact on access to and availability of essential goods and services

The BVD outbreak has created significant cross-border and logistical challenges across the DRC and neighbouring countries, particularly affecting access to essential goods and services. Mobility restrictions and disruptions at key points of entry have constrained the movement of health personnel, supplies, and affected populations.

The health system in the DRC is under severe strain, with rising demand driven by outbreak investigations and the establishment of isolation and treatment facilities. Adding to these pressures, routine service delivery has been disrupted as public mistrust grows and communities increasingly avoid healthcare facilities, reducing care-seeking for illnesses unrelated to BVD.

Persistent insecurity and armed conflict in northeast DRC and northwest Uganda further limit humanitarian access and the mobilisation of critical resources, especially in remote and border regions. Partial border closures, including at the Ishasha-Kyeshero point of entry, continue to disrupt trade flows and access to services, exacerbating existing vulnerabilities. In these contexts, affected populations are likely to adapt their service-seeking behaviours, particularly for healthcare, leading to delays in case detection and increasing both mortality and the risk of further transmission.

High population movement across porous borders, the lack of an approved vaccine or specific therapeutics for Bundibugyo virus, and resource constraints, particularly those affecting the sustainability of large-scale, geographically dispersed surveillance and response operations, continue to undermine effective epidemic containment.

## 2. Impact on physical and mental health, and psychosocial well-being

BVD's impact on overall well-being is significant, affecting both physical and mental health. No known treatment or vaccine is currently available for Bundibugyo virus disease, which has a reported case fatality rate of 25-50 per cent. The lack of a specific treatment and vaccine may also impact community trust in the response, given the availability of both interventions for other, more common, types of Ebola. In its early stages, BVD presents with non-specific febrile symptoms similar to other endemic diseases in the DRC, such as typhoid and malaria. The risks of BVD transmission are further amplified by diagnostic delays, as the disease must be confirmed by specialised tests which are only available in a few laboratories. As of 27 May, seven healthcare workers (HCWs) had contracted BVD, highlighting their risk of exposure and the potential for nosocomial transmission affecting both HCWs and patients in healthcare settings. Experiences from previous Ebola epidemics have demonstrated that viral haemorrhagic disease outbreaks are often accompanied by elevated mental health and psychosocial support (MHPSS) needs, including fear of infection, anxiety, disease fatigue, grief, stigma, social exclusion, and mistrust. These psychosocial challenges may negatively affect health-seeking behaviours, uptake of public health and social measures, and community resilience, underscoring the importance of integrating MHPSS into the outbreak response from the outset.

## 3. Risks and vulnerabilities

The DRC is currently experiencing escalating humanitarian needs, facing compounded shocks from armed violence and food insecurity which further erode its capacity to respond to and effectively manage the BVD epidemic. Although BVD is a public health crisis, its impacts are multidimensional and far-reaching. The socioeconomic consequences are severe and likely to persist, as livelihood opportunities decline and households reprioritise limited resources to meet health needs and immediate survival requirements.

Protection risks are significant and multifaceted, including stigma, social exclusion, and discrimination against affected individuals, survivors, healthcare workers, and responders, which can undermine social cohesion and discourage care-seeking. The risk of gender-based violence (GBV) may increase in the context of heightened stress, economic hardship, and disruptions to protection systems. Quarantine, isolation measures, and movement restrictions may also exacerbate child protection concerns and increase exposure to abuse and neglect.

Barriers to accessing essential services are likely to intensify, particularly for already marginalised groups, including those in remote or conflict-affected areas. Compounding these challenges, the disruption of social networks and community support systems weakens informal safety nets that are critical for coping during crises. Negative coping strategies may emerge in response to both the direct health impacts and the broader socioeconomic consequences of the epidemic.

Epidemics often heighten fear, anxiety, grief, and mistrust, particularly in relation to illness, death, isolation, and the loss of livelihoods. While some concerns are grounded in real risks, others may be amplified by misinformation and rumours. These dynamics can fuel stigma, discrimination, and harmful behaviours, while reducing engagement with health services and responders, as also outlined above. This underscores the importance of clear, accurate, and context-specific information, as well as trusted community engagement and integrated psychosocial support. Volunteers and staff should therefore be equipped with regular, updated, and fact-based information to effectively support communities and address misconceptions.

#### **4. Duty of Care**

Responders engaged in the BVD response face heightened occupational and psychosocial risks. Beyond the risk of infection and concerns about transmitting the disease to family members and communities, strict biosecurity measures including prolonged use of personal protective equipment, physical isolation, no-contact protocols, and constant vigilance can contribute to significant physical and emotional strain. Responders may also experience moral distress when public health measures conflict with the wishes or cultural practices of patients, while stigma associated with working with affected populations can further undermine well-being. These challenges are compounded by the broader social and economic consequences of the epidemic, including disrupted community networks, social tensions, and potential hostility towards health authorities, staff, and volunteers. Ensuring comprehensive duty of care measures, including psychosocial support, peer support mechanisms, adequate rest, supervision, and safeguarding protocols, is therefore critical to maintaining the health, safety, and effectiveness of responders throughout the operation.

## **CAPACITIES AND RESPONSE**

### **1. National Society response capacity**

#### **1.1 National Society capacity and ongoing response**

##### **DRC Red Cross**

The DRC Red Cross (DRC RC), officially recognised since 1961, supports public authorities in humanitarian work. Its mission is to prevent disease, reduce suffering, and improve living conditions for vulnerable populations without discrimination, through health programmes, disaster response, and community development.

The organisation has more than 503,000 volunteers and a nationwide presence across all 26 provinces, enabling strong community access and trust. It operates with a national headquarters in Kinshasa and specialised teams in health, disaster management, and emergency response, including national and provincial rapid response

teams. The DRC RC is a key national actor in epidemic response, particularly Ebola outbreaks, where it leads or co-leads critical activities such as safe and dignified burials (SDBs), risk communication and community engagement, WASH, and patient transport. It has played a frontline role in multiple Ebola epidemics (2018-2025) and is recognised for its trained volunteers and strong community-level impact.

In the current Ebola epidemic, the DRC RC is fully integrated into the national response plan, with responsibilities in SDBs, psychosocial support, risk communication and community engagement, community-based surveillance, and infection prevention and control, backed by solid operational capacity in volunteer mobilisation and emergency response.

### **Uganda Red Cross**

The Uganda Red Cross Society (URCS), as an auxiliary to the Government of Uganda, has strong experience in Ebola and public health emergency response, working closely with the Ministry of Health and partners. It maintains a wide community-based network of trained volunteers, particularly in border areas, supporting risk communication, community engagement, surveillance, and early detection.

The URCS has established capacities in infection prevention and control (IPC), SDBs, risk communication and community engagement, and community-based surveillance (CBS) systems, which can be rapidly activated. Its operations are supported by experienced staff, 51 branches nationwide, regional warehouses, and a fleet of ambulances for medical evacuations. While the URCS is a key frontline actor with strong community reach and technical expertise, additional resources are required to sustain large-scale responses, particularly in remote border areas and for volunteer protection and cross-border coordination.

### **National Societies neighbouring the DRC and Uganda**

Countries with direct land borders with areas of active transmission – including South Sudan, Rwanda and Burundi, are prioritized for enhanced readiness activities. Countries neighboring Uganda and the DRC without direct land borders with active transmission zones including Tanzania, Central African Republic, Kenya, and Zambia, BVD preparedness is approached through a regional, cross-border lens. IFRC, WHO, Africa CDC and partners prioritise these countries for enhanced preparedness due to their proximity to high risk countries and the intensity of population movement driven by trade, displacement, and social ties. Ongoing preparedness programs are being adapted to meet the changing priorities and needs in target countries.

National Societies, in close collaboration with their respective Ministries of Health, are actively strengthening community-based surveillance, screening at points of entry, and rapid response mechanisms. Recognising that volunteers play a critical role in detecting and reporting alerts in border communities, conducting risk communication and community engagement (RCCE), and promoting IPC measures, preparedness efforts are further reinforced through activities such as contingency planning, training of rapid response teams, and the pre-positioning of supplies.

Given the transboundary nature of EVD risk, strong and sustained cross-border coordination among National Societies is essential to ensure timely information sharing, harmonised protocols, and continuity of response across borders. Strengthening interoperability, joint planning, and regional and country surge capacity remains critical to mitigating the risk of cross-border transmission. Continued investment is therefore needed to support neighbouring National Societies in maintaining readiness, protecting volunteers, and scaling up operations rapidly in the event of importation, particularly in remote and resource-constrained border areas.

## 1.2 Capacity and response at the national level

### DRC

The Ministry of Health (MoH), working through the National Institute of Public Health (INSP) and the Public Health Emergency Operations Centre (COUSP), is providing overall leadership on the epidemic response. This effort is supported by technical expertise from the WHO and other health partners.

The current response is firmly anchored in the Ministry of Public Health (MoPH)-led National Plan of Action, with the DRC RC serving as an auxiliary to the public authorities. The DRC RC actively participates in both national and provincial health coordination mechanisms, chaired by the MoH with technical leadership from the WHO, ensuring that all Red Cross interventions are aligned with government priorities under the principle of one plan, one team, and one budget.

At the technical and operational levels, the DRC RC works in close collaboration with the WHO, which provides technical support to the MOH on surveillance, case management, and any potential future vaccination efforts. It also works closely with UNICEF, which co-leads the RCCE and WASH pillars of the response with the MoH. At the local level, the DRC RC is an integral part of the coordination structures established through COUSP.

### Uganda

The Government of Uganda has extensive experience in responding to Ebola outbreaks, led by the MoH through a structured national preparedness and response framework covering surveillance, case management, IPC, RCCE, and logistics. Following the May 2026 outbreak, national coordination mechanisms were activated, enabling rapid deployment of response teams, expansion of testing and isolation capacity, and intensified surveillance at both community and border levels.

The national Ebola preparedness and response is led by the MoH and guided by a comprehensive preparedness and response plan. This framework outlines coordinated actions across key pillars: surveillance and contact tracing, laboratory services, case management, IPC, RCCE, and logistics and operations. It ensures alignment between national and district-level task forces, enabling a structured, multi-sectoral response.

Risk communication and public health measures have been scaled up, alongside strengthened cross-border coordination with the DRC. While Uganda demonstrates robust response capacity, challenges remain, including high cross-border mobility, limited treatment options for the Bundibugyo strain, and resource constraints to sustain large-scale operations. Given the regional dimension of the outbreak, Uganda is prioritising cross-border coordination, particularly with the Democratic Republic of Congo. Joint efforts are underway to harmonise surveillance, screening, and referral systems to reduce the risk of cross-border transmission.

## 2. International capacity and response

### 2.1 Red Cross Red Crescent Movement capacity and response

#### IFRC membership

The IFRC has established a regional level Membership Coordination in Emergencies (MCiE) cell at the regional level to support the wider BVD response operation. The cell provides coordination support to IFRC country and regional teams, regional Participating National Society (PNS) representatives, and other network members, with the aim of establishing a coordinated regional approach for harmonising BVD-specific coordination extended to

in-country, regional, and global partners. This includes mapping stakeholder needs, interests, resources, capacities, and gaps across the region.

The IFRC supports country-level and sub-regional coordination among National Societies engaged in BVD preparedness and response, based on their respective operational plans and capacities. It provides technical and operational coordination support across key areas, including needs assessments, Federation-wide response planning, quality assurance and standards, joint communication, supply chain management, resource mobilisation, information management, as well as monitoring, evaluation, and reporting. Cross-border and bilateral coordination mechanisms between National Societies are also being strengthened to align preparedness and response efforts. In addition, information sharing, and support continuity of operations in border areas will be considered on a priority basis and as resources allow.

In the DRC, several Participating National Societies (PNSs) are supporting the response bilaterally across impacted or at-risk countries. In the DRC, in-country partners, including the French Red Cross, German Red Cross, Canadian RC, Belgian Red Cross, Swedish Red Cross, Norwegian Red Cross, Spanish Red Cross, and others are working collaboratively together to support the ONS. These partners are supporting with a range of resources and technical expertise to strengthen NS capacities in key areas such as surveillance, RCCE, IPC, WASH, SDB, and emergency response.

The IFRC also works closely with regional coordination mechanisms and supports the prepositioning of essential supplies to enable rapid response, strengthen cross-border coordination, and enhance overall preparedness and response to Ebola outbreaks in the region. Together with National Societies, the IFRC is scaling up operations across affected and at-risk countries. To support these efforts, the IFRC has launched a regional Emergency Appeal of CHF 29 million, including CHF 21m for the DRC and CHF 4.5m for Uganda.

The IFRC Country Cluster Delegation in Kinshasa supports the DRC RC through strategic and operational coordination, National Society Development (NSD), humanitarian diplomacy, and accountability as a cross-cutting priority. The IFRC continues to strengthen the National Society's auxiliary role through regular engagement with public authorities, technical ministries, Movement partners, and humanitarian coordination mechanisms at both national and provincial levels.

With an operational presence and technical support capacities in Kinshasa, Goma, Kalemie, and other field locations, the IFRC supports the DRC RC in implementing emergency operations and long-term resilience programmes, particularly in health, disaster management, community engagement and accountability (CEA), protection, gender and inclusion (PGI), safeguarding, disaster risk reduction, food security and livelihoods, and epidemic preparedness and response. This support includes operational planning, surge deployment, technical guidance, logistics, monitoring, reporting, and participation in monitoring, evaluation, accountability, and learning (MEAL) processes.

The DRC RC also benefits from strong engagement with the Belgian Red Cross, French Red Cross, Luxembourg Red Cross, Spanish Red Cross, and Swedish Red Cross, all of which operate under the National Society Country Plan. With the support of these PNSs, the National Society is implementing a range of programmes across different geographical areas and thematic sectors identified in its Country Plan, many of which include components aimed at strengthening National Society capacities.

In Uganda, the URCS is coordinating closely with IFRC and PNSs, including the German Red Cross, Netherlands Red Cross, Austrian Red Cross, and Belgian Red Cross. All PNSs have been notified and briefed on the current BVD outbreak and are closely monitoring developments. Existing membership coordination mechanisms are

being used to share information, align support, and ensure a coherent Federation-wide approach in support of URCS leadership. The IFRC has recently established a country delegation in Kampala to support the work of the URCS and, to enable immediate action, has approved a DREF allocation of CHF 521,073 to help the National Society reach up to 520,000 people through timely preparedness and response interventions in affected and high-risk districts. The operation aims to prevent and reduce morbidity, mortality, and socioeconomic disruption associated with the BVD outbreak.

## **ICRC**

The ICRC Regional Delegation covering Uganda, Rwanda, and Burundi, based in Kampala, Uganda, has a long history of supporting the URCS in close coordination with the Federation during Ebola responses and has invested in coordinated and complementary Movement-wide response to Ebola epidemics in Uganda and the DRC since 2000.

In the DRC, the roles of the three components of the Movement in the response are guided by the Seville Agreement 2.0 and the Movement Coordination Agreement in the DRC, which provide a clear framework for collaboration based on the respective mandates, expertise, and capacities of each component. Within this arrangement, the DRC RC leads and coordinates the Movement's response at the national level. The ICRC acts as a co-convenor and co-facilitator in line with the context of the crisis, while the IFRC provides complementary coordination, technical, and operational support, including mobilising international assistance to address the humanitarian needs arising from the Ebola outbreak.

Movement coordination operates at three levels: strategic, operational, and technical. The Tripartite Strategic Platform (DRC RC, ICRC, and IFRC) provides overall strategic direction and ensures alignment with Movement principles. The Operational Coordination Platform translates strategy into action through joint planning, resource mapping, and gap analysis. At the technical level, thematic platforms (health, WASH, logistics, communication) harmonise approaches, support coordination, and strengthen the quality and consistency of interventions. Overall, this structured coordination mechanism ensures a coherent, complementary, and efficient Ebola response, maximising collective impact while reinforcing the leadership and capacities of the DRC RC.

At the regional level, the IFRC and ICRC also maintain close coordination to support National Societies.

## **2.2 International Humanitarian Stakeholder capacity and response**

International humanitarian actors are playing a critical supporting role in the Ebola response, providing technical expertise, funding, operational support, and coordination under the leadership of affected governments. The response is well-established and multi-layered, involving UN agencies, international NGOs, the Red Cross Red Crescent Movement, and bilateral donors.

At the global level, the WHO is leading the technical response and coordination, having activated emergency mechanisms following the declaration of a PHEIC and supporting governments in strengthening surveillance, contact tracing, laboratory systems, case management, and cross-border preparedness. Partners are also engaged through regional coordination platforms under the regional Incident Management Support Team (IMST) led by the WHO and Africa CDC ensure coordination, optimisation of resources and alignment across countries and sectors.

In the DRC, the MoH leads epidemic response efforts in coordination with the WHO and humanitarian partners. The MoH, through the DRC's National Public Health Institute and COUSP, is coordinating the overall response to the outbreak. As of mid-May 2026, partners have rapidly mobilised and delivered significant volumes of essential equipment to support the Ebola response in eastern DRC, particularly in Ituri. Within the first days of the

epidemic declaration, the WHO deployed approximately 11.5 tons of medical supplies and equipment, including personal protective equipment (PPE), medical kits, and tents. This initial surge has been complemented by large-scale logistics operations led by the World Food Programme (WFP) and supported by the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO), which has airlifted nearly 30 tons of additional supplies into Bunia through an established air bridge, alongside vehicles and transport assets to support field operations.

Strong coordination mechanisms have been established at both the regional and country levels to support the BVD response. At the regional level, coordination is facilitated through the Incident Management Support Team (IMST) and regional Technical Working Groups (TWGs), co-led by the WHO and Africa CDC. The IFRC and National Societies actively participate in these coordination platforms to ensure alignment of community-based interventions, information sharing, resource mobilisation, and harmonised response strategies across affected and at-risk countries. At the country level, National Societies are integrated into national coordination structures, including Emergency Operations Centres (EOCs), IMSTs, and relevant technical working groups such as RCCE, surveillance, IPC, SDBs, and Points of Entry (PoE). This engagement ensures that Red Cross and Red Crescent actions are aligned with government-led efforts, strengthen auxiliary support to the public authorities, and facilitate timely information exchange and operational decision-making throughout the response. The IFRC participates in both country-level and regional-level IMSTs.

The Africa CDC plays a central regional coordination and leadership role in the Ebola response, working alongside the WHO and national governments to ensure a harmonised and cross-border approach. The Africa CDC's response focuses primarily on strengthening regional systems and ensuring alignment across countries, with key priorities including improved cross-border surveillance and early warning systems, harmonised screening and preparedness at points of entry, and enhanced real-time information sharing between countries. It also supports the strengthening of laboratory capacity, case management systems, and infection prevention and control measures, while emphasising the protection of frontline workers and vulnerable populations such as border communities and displaced groups.

## **Gaps in the response**

Rapid assessments highlight significant gaps across the Ebola response in Uganda and eastern DRC, affecting vulnerable and marginalised populations. Key challenges persist in Ebola case management, including limited emergency medical service capacity; strained health facilities; weak IPC measures; limited capacity to detect community deaths or carry out safe and dignified burials; and inadequate isolation, staffing, and laboratory capacity.

Surveillance and contact tracing remain insufficient, especially in border areas and Points of Entry, due to limited resources, insecurity, and high population mobility. RCCE and mechanisms to remain accountable to affected communities are under-resourced, with low awareness, misinformation, stigma, and mistrust undermining response efforts. Community feedback systems are weak, limiting adaptation to local needs. Both coverage and trust of SDBs require significant support, with limited community alerts, significant fear and distrust of the intervention, and significant geographic constraints due to access, distance, and the number of trained and equipped teams.

Community engagement and trust building are essential, as demonstrated by mistrust in the response and challenges with safe and dignified burials and case isolation in Ebola Treatment Centres. Widespread suspicion of both the disease and the response has been reported, with some communities said to be concealing suspected cases and deaths, and individuals seeking care only after developing advanced illness. This delays case detection, reduces the likelihood of survival, and limits opportunities to interrupt transmission.

Many health facilities in the affected provinces are under-equipped and understaffed, with significant gaps in their capacity to isolate and treat Ebola patients due to shortages of beds, qualified health personnel, and essential medical supplies, including PPE. There is an urgent need to expand treatment and isolation capacity and strengthen the health workforce to support effective case management. Significant WASH gaps persist, including limited access to safe water, inadequate handwashing facilities, and poor sanitation in communities and health settings, which increases transmission risks. Shortages of disinfectants, equipment, and trained personnel constrain effective decontamination and infection prevention, while insufficient water supply and hygiene infrastructure continue to affect health facilities, SDB teams, and high-risk areas, particularly in remote locations.

These gaps do not affect everyone equally. Drawing on lessons from previous Ebola virus disease outbreaks, women and girls often account for a disproportionate share of cases due to their roles as primary caregivers, and their involvement in health care, home-based care, and burial practices. They also tend to face greater barriers to accessing care, linked to decision-making dynamics, caregiving responsibilities, and mobility constraints. Additionally, the socioeconomic impacts of outbreaks disproportionately affect women, as they are more likely to be engaged in informal and market-based livelihoods that are disrupted by movement restrictions and declining economic activity.

Unaccompanied children and children who have lost caregivers to the disease face economic hardship, psychosocial distress, and stigmatisation. Older persons and those with disabilities are less likely to seek care early due to mobility and information barriers. Displaced populations and remote communities face additional obstacles such as distance from health facilities, limited access to information, and reduced contact with response actors. Ethnic and religious minorities face exclusion and may find epidemic response modalities less adapted to their social, cultural and religious needs. Community engagement remains the most under-resourced area of the response. Suspicion surrounding the disease and the response to it, reluctance to report symptoms, mistrust of burial protocols, and the difficulty reaching marginalised groups all reflect a trust deficit that health infrastructure alone cannot resolve. Addressing these challenges will require strong community engagement, meaningful participation, and robust feedback mechanisms that enable the response actors to understand and act on community concerns and priorities.

MHPSS needs are high but largely unmet, particularly for affected families, survivors, and frontline workers. At the same time, food insecurity and fragile livelihoods, especially in eastern DRC, are not adequately integrated into the response, affecting adherence to control measures.

Significant gaps persist in the integration of protection, gender, and inclusion across the response, with limited systematic consideration of the distinct needs, risks, and capacities of women, children, older persons, and persons with disabilities. Risks of stigma, social exclusion, and sexual and gender-based violence (SGBV) remain insufficiently addressed, while referral pathways and access to quality, timely protection services remain inconsistent and uneven across affected areas.

## **OPERATIONAL CONSTRAINTS**

Across the sub-region, Ebola response efforts face interconnected operational, social, and security challenges that increase transmission risks and complicate containment. High cross-border mobility between eastern DRC and Uganda, through informal crossings, trade routes, and family networks, continues to undermine surveillance and case detection, despite strengthened screening at official points of entry.

Cultural practices, particularly funeral rites involving direct contact with the deceased, remain a major driver of transmission. Recent spread has been linked to unsafe burial practices, highlighting the critical importance of SDBs, rapid death reporting, and strong community engagement. However, persistent mistrust, misinformation,

and stigma observed in previous epidemics continue to affect health-seeking behaviours, including a reluctance to report cases, accept isolation, or engage with response teams.

Operational constraints are compounded by insecurity in eastern DRC, where armed group activity restricts access, disrupts surveillance and response operations, and poses risks to frontline workers. Logistical challenges, including poor infrastructure, limited transport and evacuation capacity, and supply chain bottlenecks, further hinder the timely delivery of essential services and supplies across the region.

Health systems in both countries face significant capacity limitations, particularly at decentralised levels, with gaps in trained personnel, IPC measures, isolation facilities, and sustained surge capacity. In addition, the absence of an approved vaccine or specific treatment for the Bundibugyo strain places increased reliance on core public health measures.

Finally, the response is affected by resource constraints and competing humanitarian priorities, making it difficult to sustain high-intensity operations over time. These combined factors underline the need for strengthened cross-border coordination, community-centred approaches, and sustained operational support across the region.

## FEDERATION-WIDE APPROACH

The Emergency Appeal is part of a **Federation-wide approach**, based on the response priorities of the Operating National Society and in consultation with all Federation members contributing to the response. The approach will ensure linkages between all response activities (including bilateral activities and activities funded domestically) and will assist in leveraging the comparative advantages and capacities of all members of the IFRC network in the country, to maximise the collective humanitarian impact.

The Federation-wide funding requirement for this Emergency Appeal comprises all support and funding to be channelled to the Operating National Society in response to the emergency event. This includes the Operating National Society's domestic fundraising ask, the fundraising ask of supporting Red Cross and Red Crescent National Societies, and the funding ask of the IFRC secretariat.

After 31 May 2027, the response activities related to this epidemic will continue under the respective IFRC Network Country Plans. These plans provide an integrated view of ongoing emergency responses and longer-term programming tailored to the needs in the country, as well as a Federation-wide view of the country's actions. This approach aims to streamline activities under one plan, while still ensuring that the needs of those affected by the epidemic are met in an accountable and transparent way. Information will be shared in due course should there be a need for an extension of the crisis-specific response beyond the above-mentioned timeframe.

## OPERATIONAL STRATEGY

### Vision

The IFRC response follows an end-to-end, community-driven approach to curbing the outbreak, delivered through a tiered operational model that tailors interventions to each country's epidemiological context while ensuring readiness for rapid scale-up.

Through this operation, the IFRC aims to support the DRC Red Cross, URCS, and National Societies in neighbouring countries to prepared for, respond to, and maintain readiness for the BVD epidemic. The approach is anchored in community engagement as a central pillar of epidemic control, ensuring that interventions are locally led, context specific and responsive to evolving risks.

The strategy is aligned with key regional and national frameworks, including the Uganda National Response Plan for the 2026 Ebola Bundibugyo Disease epidemic (May–August 2026), and the Africa CDC and WHO Continental Preparedness and Response Plan. It also ensures coherence with national response plans in the DRC and Uganda, supporting a coordinated and harmonised regional response.

Operationally, the IFRC strategy is structured around a tiered approach, adapted to the stage of epidemic evolution in each country and guided by predefined criteria such as government priorities, national response plans, and the mandate of National Societies within their respective countries. A strong emphasis is placed on regional cross-border coordination, recognising the transboundary nature of EVD risk and positioning National Societies to collectively prevent, detect, and respond to cross-border transmission.

- **TIER 1: At-risk countries (direct land border with transmission zones)**

Focus on strengthening National Society readiness and response capacity at both national and branch levels, based on risk analysis and in alignment with government priorities. This includes clarifying National Society roles in key BVD response areas such as SDBs, RCCE, and CBS, while supporting targeted readiness for SDB activities as required. At the community level, efforts will prioritise identifying volunteers, mapping key influencers, and strengthening readiness to scale up RCCE, WASH, health, and PGI activities in the event of an outbreak, ensuring effective community engagement and rapid operational mobilisation in high-risk areas. Focus will also be placed on building the capacities of national rapid response teams to deploy anywhere in the country in response to suspected or confirmed cases.

- **TIER 2: Countries with active transmission (currently including the DRC and Uganda)**

In countries with active transmission, the response will scale up to a full public health package, including SDBs, community-based surveillance, support for MoH contact tracing, RCCE, and targeted IPC support to health facilities depending on identified response gaps in the response and National Society mandates. This will be complemented by WASH, MHPSS, continuity of care, and hygiene promotion, alongside specialised services such as ambulance transport where relevant, supported by business continuity and risk management measures. PGI, through the mainstreaming of PGI into sectors, and CEA, through community participation, trust building exercises, and the Community Champions network, will be mainstreamed across all interventions as both components are crucial to an effective Ebola response.

A special **cross-border operating modality** will also be established, combining joint coordination mechanisms, strengthened border branch capacity, harmonised protocols, and shared risk analysis to enable a coordinated and effective regional response along high-risk mobility routes.

**Duty of care** is a core pillar to the operation strategy, recognizing that the effectiveness of the response depends on the safety, health, and well-being of staff and volunteers. The IFRC and National Societies are committed to ensuring that responders are protected and supported to operate safely and effectively in high-risk epidemic contexts through appropriate systems, standards, and support mechanisms.

## Targeting

### 1. People to be assisted

The BVD epidemic in eastern DRC is currently concentrated in Ituri Province, with cases also confirmed in North Kivu and in South Kivu. Cross-border transmission into Uganda has already been confirmed, highlighting a high-risk regional context driven by population mobility, displacement, insecurity, limited health system capacity, and

mistrust in health and government systems. These factors significantly increase the likelihood of both localised transmission and regional spread across neighbouring countries.

An estimated 20-25 million people are at risk across eastern DRC and high-risk areas in Uganda, including 12-18 million people living in priority transmission zones and cross-border mobility corridors where the risk is highest. These populations are concentrated in border areas, transport corridors, urban hubs, and high-mobility settings, where frequent movement for trade, healthcare-seeking, social networks, and displacement continues to drive transmission risk.

The targeting strategy prioritises populations most at risk of infection and those most likely to influence transmission dynamics. The operation will target approximately 7.9 million people across Uganda and the DRC, including 2.9 million people in 36 high-risk districts in Uganda and five million people in the DRC. In Uganda, priority areas include districts bordering the DRC, major transport corridors, and urban centres such as Kampala, reflecting high mobility and transmission risk. In the DRC, interventions will focus on approximately 13 priority health zones across Ituri, North Kivu, and South Kivu provinces, with the highest priority given to Bunia, Mongbwalu, and Rwampara, followed by additional affected zones including Nyakunde, Nizi, Aru, Bambu, Kilo, Goma, Butembo, Katwa, and Miti-Murhesa. These priority geographies will continue to evolve as the epidemic changes.

Geographically, priority is given to border communities, transport corridors, urban centres, and areas affected by displacement and insecurity, where surveillance gaps and high population mixing increase vulnerability. In both countries, targeting reflects national risk classifications, including the presence of confirmed cases, high-risk contacts, population density, and transmission potential.

Within these areas, the operation prioritises **high-risk and vulnerable groups**, including:

- **Frontline workers** (health workers, Red Cross volunteers, burial teams), facing direct exposure risks
- **Caregivers and close contacts** involved in the care of suspected or confirmed cases
- **Mobile populations**, such as traders, miners, transport workers, and cross-border travellers
- **Refugees, internally displaced persons, and populations in remote or insecure areas**, with limited access to services

Particular attention is given to vulnerable and marginalised groups, including women, children, the elderly, and persons with disabilities, who face increased exposure, barriers to services, and heightened risks of stigma, violence, and exclusion. Women and girls are disproportionately affected due to their caregiving roles and involvement in funeral practices, while children and older persons face higher health risks and dependency. Communities living in overcrowded and underserved settings, particularly with inadequate WASH services, are also prioritised due to increased transmission risk.

The operation will further directly target households of suspected and confirmed cases, contacts, and affected communities, through integrated interventions including surveillance, RCCE, WASH, MHPSS, and SDBs to interrupt transmission chains.

As a key pillar of the strategy, the IFRC will ensure the safety and protection of National Society staff and volunteers, through training, provision of PPE, psychosocial support, and strict safety protocols, enabling sustained frontline engagement in high-risk environments. Additionally, healthcare facilities will be supported with the implementation of specialised infection prevention and control measures.

Given the rapidly evolving nature of the outbreak, targeting will remain dynamic, with continuous reassessment based on epidemiological data and operational priorities. A strong regional approach underpins the strategy,

recognising the interconnected nature of risks across borders and the need for coordinated, community-centred interventions to effectively contain the outbreak and prevent further spread within the region and beyond.

## **2. Cross-border considerations**

Powered by local capacity and global expertise, cross-border coordination represents a core strength of National Societies in responding to epidemics that transcend national boundaries. The IFRC response is uniquely positioned to deliver at scale through its network, combining deep community reach with global coordination, technical expertise, and surge capacity. Anchored in their auxiliary role to the public authorities and strong local presence, National Societies ensure a response that is locally led, rapidly deployable, and regionally connected. Through cross-border collaboration, neighbouring National Societies align strategies, share information (in alignment with existing national protocols) and community insights, jointly advocate with their respective public authorities on humanitarian access and legal facilities, and ensure continuity of actions along mobility corridors, contributing to early detection, consistent messaging, and effective preparedness. This approach is reinforced by strong coordination with governments and partners, rapid mobilisation of volunteers and surge capacity, and sustained investment in National Society capacity, ensuring both immediate impact and longer-term resilience across affected and at-risk countries.

The IFRC will support the establishment and strengthening of cross-border coordination mechanisms while enhancing engagement with local authorities, governments, and intergovernmental and regional bodies to ensure a coherent, timely, and regionally coordinated response aimed at preventing further spread. Efforts will focus on strengthening the capacity of border branches to support cross-border surveillance, information sharing, and RCCE, enabling coordinated detection and response along mobility corridors in collaboration with neighbouring National Societies and relevant authorities. In addition, the IFRC will facilitate active participation in and coordination with Incident Management Support Teams, partner coordination forums, and bilateral strategic partners at national, continental, and regional levels.

## **3. Considerations for protection, safeguarding, and community engagement and accountability**

This operation prioritises the protection and inclusion of populations most vulnerable to the BVD outbreak, ensuring that high-risk and marginalised groups are systematically identified and supported. These include female-headed households, isolated elderly persons, persons with disabilities, orphans and vulnerable children, Ebola survivors facing stigma, and pregnant and breastfeeding women with specific health needs. The intervention will ensure **safe, equitable, and dignified access to services**, addressing barriers related to gender, age, disability, and social norms. It will also promote the **meaningful participation of affected populations**, particularly women and vulnerable groups, throughout the programme cycle. All activities will be implemented in line with **protection, safeguarding, and “do no harm” principles**, including measures to prevent GBV and sexual exploitation and abuse (SEA), ensure confidentiality, and establish safe and accessible feedback mechanisms.

A strong CEA approach will underpin the response. Communities will be actively involved in the design, implementation, and monitoring of activities, with a focus on two-way communication, trust-building, and adaptation to community feedback. Community feedback mechanisms (CFMs) will be established and strengthened to ensure the safe, confidential, and accessible reporting of concerns, including sensitive protection issues such as SEA and child safeguarding. Community feedback will be systematically analysed and used to adapt programming in real time.

Recognising that women are disproportionately exposed due to their caregiving roles and presence in frontline health and community services, while also facing barriers to accessing information, services, and decision-making. The response will promote targeted messaging, engagement with women’s groups, and support for women’s participation in community decision-making structures. At the same time, the response will actively engage men and boys alongside women and girls to support behaviours that reduce protection risks.


From a broader protection and inclusion perspective, the operation aims to uphold the dignity, safety, and equal access to services for all population groups, particularly those most at risk. Measures include ensuring that information is accessible (in terms of language and format), promoting non-discriminatory access to services, and strengthening safe referral pathways for protection services. Specific attention will be given to mitigating risks linked to stigma, discrimination, quarantine, and isolation measures, as well as preventing and responding to SGBV.

All staff and volunteers will adhere to strict safeguarding (PSEAH and child safeguarding) standards and PGI principles, supported by training, supervision, and accountability mechanisms. The National Society responding to the BVD outbreak will be required to have completed a child safeguarding risk analysis and develop a plan of action based on the scoring. PGI and CEA will be fully mainstreamed across all sectors ensuring that the response is inclusive, community-driven, and responsive to the diverse needs and risks of affected populations.

## PLANNED OPERATIONS<sup>3</sup>

### HEALTH AND CARE INCLUDING WATER, SANITATION, AND HYGIENE (WASH)

#### (MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT/COMMUNITY HEALTH)

 <b>Health and Care</b> <i>(Mental Health and Psychosocial Support/Community Health/Medical Services)</i>	Female > 18: <b>715,000</b>	Female < 18: <b>585,000</b>	<b>CHF 10,481,000</b>
	Male > 18: <b>715,000</b>	Male < 18: <b>585,000</b>	<b>Total target: 2,600,000</b>
<b>Objective:</b>	<i>The spread and impact of the outbreak are reduced through community outreach in the affected health zones.</i>		
<b>Priority Actions:</b> <b>Tier two countries (active response) priority actions</b>	<ul style="list-style-type: none"> <li>• <b>Risk communication and community engagement:</b> Carry out evidence-informed risk communication and community engagement to guide health response activities and improve community uptake of and participation in epidemic response activities (e.g. adaptation of SDB protocols, improved understanding of ETCs, increased reporting of suspect cases).</li> </ul>		


<sup>3</sup> In the absence of detailed demographic data and given the nature of cross-border population movements, disaggregation by sex and age is based on standard IFRC assumptions for epidemic response operations, with an estimated 50 per cent female and 50 per cent male distribution, and approximately 45 per cent of the population under 18 years of age. Disaggregation by sex and age will be further refined through programme-level assessments.

### Tier one countries (readiness) priority actions

- **Surveillance:** Conduct active case finding and community-based surveillance (CBS), support contact tracing, and establish screening and referral systems for the early detection of suspect cases.
- **Safe and Dignified Burials (SDBs):** Conduct SDBs in line with established protocols and community engagement approaches.
- **Infection Prevention and Control (IPC):** Strengthen IPC practices and processes in health facilities, including through the provision of water and sanitation services and facilities.
- **Mental Health and Psychosocial Support (MHPSS):** Provide psychosocial support to affected populations and support staff and volunteer well-being.
- **Continuity of Essential Health Services:** Maintain access to basic health services and strengthen referral pathways for vulnerable populations.
- **Patient Transport:** Provide support for emergency patient transport and referrals where National Society mandate and capacity allow.
- **Nutrition and Cash for Health:** Considerations will be given through this Emergency Appeal to providing adapted food support for patients admitted to ETCs, while community-based nutrition surveillance will be strengthened in the affected areas to ensure early and coordinated management of malnutrition. Activities may also include the distribution of food rations to families affected by EVD, capacity building in nutrition in the context of EVD, and awareness campaigns for mothers to prevent malnutrition and support children with moderate malnutrition. (see also multi-purpose cash session)
- **Safe and Dignified Burials:** SDB Training of Trainers for the National Society and, where relevant, staff of the Ministry of Health or other implementing partners to establish a national pool of trainers and response teams. Conduct rapid SDB team training sessions in line with preparedness levels and identified response needs. Preposition SDB kits, including training kits, to support capacity building across multiple teams and starter kits to enable immediate response capacity. Ensure contingency planning for outbreak logistics by identifying and pre-arranging transport for SDB teams and prepositioning essential supplies required for rapid deployment. Carry out rapid anthropological studies and community engagement to ensure that standard SDB protocols are appropriately context adapted, including specific variations by ethnic, religious, or cultural group as needed.
- **Surveillance:** Work with the MoH to establish protocols for CBS; integrate viral haemorrhagic fever (VHF) alert systems

and case definitions into CBS structures where applicable and train volunteers in high-risk areas.

- **Risk communication and community engagement:** Establish a clear mandate with the MoH, including integration into coordination mechanisms and the development of RCCE products and plans. Implement community engagement activities through household visits, focus groups, community meetings, and engagement with traditional and religious leaders, supported by local media channels. Preposition IEC materials and job aids, strengthen feedback and accountability mechanisms, and conduct rapid mapping of health facilities and informal providers, alongside knowledge, attitudes, and practices (KAP) assessments to inform RCCE strategies.
- **Response systems and coordination:** Establish MOUs with the MoH where needed and/or clarify expectations and the National Society auxiliary mandate for epidemic response pillars. Designate key roles, including community health coordination and a CEA focal point, and establish coordination mechanisms.

	<b>Water, Sanitation, and Hygiene</b>	Female > 18:	Female < 18:	<b>CHF 3,001,000</b>
		<b>220,000</b>	<b>180,000</b>	
		Male > 18:	Male < 18:	<b>Total target:</b>
		<b>220,000</b>	<b>180,000</b>	<b>800,000</b>
<b>Objective:</b>	<i>Improve hygiene practices within the entire affected population.</i>			
<b>Priority Actions:</b>	<p><b>Scale up community and institutional WASH interventions for epidemic prevention and control</b> by supporting National Societies in strengthening hygiene measures at the community level, and points of entry, reducing the risk of transmission in high-risk settings.</p> <p><b>Strengthen hygiene and occupational health measures at points of entry and public spaces</b> by establishing and supporting handwashing stations, deploying trained personnel, and ensuring the availability of essential equipment and supplies to enable safe and systematic operations.</p> <p><b>Enhance access to safe water, sanitation, and hygiene services</b> by supporting emergency and sustainable water solutions, expanding handwashing infrastructure, and promoting improved hygiene practices at the household and community levels.</p> <p><b>Improve operational readiness and capacity for WASH response</b> by prepositioning WASH supplies (e.g. chlorine, PPE, hygiene materials), strengthening logistics systems, and supporting mobility and supervision to ensure reach in remote and high-risk areas.</p> <p><b>Strengthen disinfection and environmental hygiene interventions</b> through the safe and coordinated disinfection of households, and public spaces, in line with national protocols and in collaboration with health authorities.</p>			

**Support affected households with integrated WASH assistance** by providing hygiene kits, water treatment solutions, and reintegration packages to reduce transmission risks and support recovery.


**Integrate WASH with community engagement and risk communication efforts** to ensure that hygiene practices are understood, accepted, and sustained, and that interventions are responsive to community needs and perceptions.


**Protect frontline responders and community volunteers** by ensuring consistent access to appropriate PPE and WASH materials, and by reinforcing safe practices during community engagement and service delivery.

**Strengthen coordination with the government and partners** to align WASH interventions with national response strategies, including surveillance, IPC, and outbreak control measures.

## PROTECTING LIVELIHOODS AND SOCIAL COHESION

(PROTECTION, GENDER, AND INCLUSION (PGI), COMMUNITY ENGAGEMENT AND ACCOUNTABILITY (CEA), MIGRATION, RISK REDUCTION, CLIMATE ADAPTATION AND RECOVERY, ENVIRONMENTAL SUSTAINABILITY, EDUCATION)

 <b>Multi-purpose Cash</b>	Female > 18: <b>2,750</b>	Female < 18: <b>2,250</b>	<b>CHF 277,000</b>
	Male > 18: <b>2,750</b>	Male < 18: <b>2,250</b>	<b>Total target: 10,000</b>
<b>Objective:</b>	<i>Communities in crisis-affected areas are supported in restoring their dignity and meeting their diverse basic needs.</i>		
<b>Priority Actions:</b>	<p><b>Support for cash assistance, livelihood and early recovery will be continuously assessed in line with the evolution of the outbreak. As such, the proposed budget and targets are indicative and subject to change.</b></p> <ul style="list-style-type: none"> <li>• Conduct a CVA feasibility study.</li> <li>• Conduct a market assessment to identify gaps in markets and collaborate with local markets and vendors to ensure the availability and affordability of goods.</li> <li>• Implement an unconditional multipurpose cash (MPC) programme for emergency assistance to cover the essential needs of affected households. (e.g. For Ebola survivors &amp; families, and people affected by Ebola (BVD) outbreak)</li> <li>• Conduct monitoring activities to determine the effectiveness and impact of the assistance.</li> </ul>		

 <p><b>Protection, Gender, and Inclusion</b></p>	Female > 18: <b>N/A</b>	Female < 18: <b>N/A</b>	<b>CHF 505,000</b>
	Male > 18: <b>N/A</b>	Male < 18: <b>N/A</b>	<b>Total target: PGI target to cross-cut all sectors</b>
<p><b>Objective:</b></p>	<p><i>Communities, particularly people most at risk and disproportionately affected by Ebola and its related impacts, are supported to identify, prevent, and address protection risks, vulnerabilities, and barriers to access through inclusive, safe, and participatory approaches guided by PGI DAPS principles.</i></p>		
<p><b>Priority Actions:</b></p>	<p>The operation will ensure safeguarding and PGI principles are integrated into all Ebola response actions including promoting inclusive communication, implementing protection risk mitigation measures to reduce cases of GBV and SEA, family separation, and stigmatisation, and respond to urgent protection needs caused by the epidemic by referring people to protection services. In high-risk operations such as Ebola, where responders have close and frequent contact with affected communities, robust safeguarding and PSEA measures are essential to uphold the dignity and rights of all people. Core actions will include:</p> <ul style="list-style-type: none"> <li>• <b>Mainstream PGI across all operations and sectors</b> by supporting National Societies in conducting analysis, integrating minimum standards of PGI in emergencies, and ensuring that services are safe, accessible, and inclusive for women, older persons, children, persons with disabilities, and other at-risk groups.</li> <li>• <b>Strengthen institutional and operational capacity on PGI and safeguarding</b> by building the technical competencies of staff and volunteers on PGI, child protection, disability inclusion, SGBV, PSEAH, and survivor-centred approaches, while ensuring adherence to Codes of Conduct and safeguarding policies.</li> <li>• <b>Enhance data-driven and inclusive programming</b> by systematically collecting, analysing, and using sex-, age-, and disability-disaggregated data (SADDD) to inform and guide response design, targeting, and decision-making.</li> <li>• <b>Prevent and respond to SGBV and child protection risks</b> by integrating risk mitigation measures into all interventions, strengthening community awareness, reducing stigma, and ensuring timely identification, referral, and follow-up of protection cases, including access to health, psychosocial, and legal services. Collaborate with other protection actors and participate in in-country GBV working groups.</li> <li>• <b>Strengthen safeguarding and Prevention of Sexual Exploitation and Abuse (PSEA) systems</b> by supporting risk</li> </ul>		

assessments, establishing confidential and accessible reporting mechanisms, ensuring community awareness on rights and reporting channels, and reinforcing monitoring compliance and investigation processes. Participate in the in-country PSEA network. **Reinforce referral pathways and specialised protection services** by coordinating with the government and partners to ensure that survivors have access to comprehensive, survivor-centred support, including case management, psychosocial support, and dignity assistance.

- **Promote community engagement and inclusive communication for protection outcomes** by ensuring PGI sensitive messaging, child-friendly and accessible IEC materials, and the active engagement of community leaders and local organisations representing various vulnerable groups.
- **Strengthen partnerships with local actors and community structures** including women’s groups, child protection actors, and organisations of persons with disabilities to enhance community-based protection, prevention, and response mechanisms.



**Community Engagement and Accountability**

Female > 18: **N/A**

Female < 18: **N/A**

**CHF 2,496,000**

Male > 18: **N/A**

Male < 18: **N/A**

**Total target: CEA target crosscut all sectors**

**Objective:**

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


CEA measures and approaches will be integrated across all activities to ensure that the Ebola response is inclusive, transparent, and trusted by affected populations. These measures aim to promote meaningful participation and ownership of communities, including marginalised groups, as well as sustainable adherence to prevention measures while establishing safe, accessible, and confidential mechanisms for dialogue, feedback, and complaints. The approach will also seek to prevent the stigmatisation of survivors and affected families. The following actions will be prioritised:

- **Strengthen, scale, and harmonise existing community feedback systems across operations** by supporting National Societies in systematically collecting, aggregating, analysing and responding to feedback (e.g.

face-to-face, hotlines, preferred digital channels, community contact centres, and dialogue forums).

- **Promote inclusive and accountable community engagement approaches** by ensuring the meaningful participation of women, youth, persons with disabilities, marginalised groups, and mobile populations in programme design, implementation, and monitoring.
- **Enhance regional capacity for feedback management and analysis** by training staff, volunteers, and community leaders, and equipping them with standardised tools and systems to collect, analyse, and use feedback to inform timely and evidence-based decision-making.
- **Strengthen coordination and outreach with community structures and local actors** by engaging community leaders, influencers, health workers, and local authorities to support risk communication, service uptake, and trust-building across affected populations.
- **Support health (RCCE) to scale up risk communication and information dissemination** systems through multilingual IEC materials, toll-free lines, and targeted messaging strategies to address rumours, misinformation, protection risks, and service gaps.
- **Ensure effective accountability and referral pathways by supporting National Societies in managing complaints** in a timely, confidential, and impartial manner, with clear referral mechanisms for sensitive cases (e.g. SGBV, SEA), and regular feedback to communities to reinforce trust and transparency.
- **Leverage digital solutions and data systems for CEA** by strengthening community feedback dashboards and integrated data platforms to enable real-time monitoring, trend analysis, and adaptive programming at scale.
- **Generate and use community insights** to improve response effectiveness through tools such as KAP surveys, community consultations, and feedback analysis, ensuring that programmes are continuously adapted to evolving community needs and perceptions.

## Enabling approaches

 <b>National Society Strengthening</b>	Female > 18: <b>N/A</b>	Female < 18: <b>N/A</b>	<b>CHF 5,090,000</b>
	Male > 18: <b>N/A</b>	Male < 18: <b>N/A</b>	<b>Total target: N/A</b>
<b>Objective:</b>	<p><i>This Emergency Appeal will support the National Society in implementing pre-existing capacity strengthening efforts as outlined in the National Society Strategy or other relevant National Society plans.</i></p>		
<b>Priority Actions:</b>	<p>This Emergency Appeal incorporates targeted capacity strengthening measures to support the effective delivery of the current response. These actions build on existing National Society Development (NSD) investments and are aligned with NSD plans and IFRC National Society Investment Framework (NSIF) priorities, particularly in volunteer management, safeguarding, governance, digital transformation and financial systems. Collectively, these efforts aim to mitigate operational, safeguarding, and accountability risks, ensuring safe, timely, and scalable assistance while reinforcing long-term disaster response capacity. Identifying and complementing critical organisational processes required to manage ongoing large-scale operational activities while enhancing and protecting longer-term National Society Development remains crucial. This will require stronger integration of current capacity strengthening priorities into current operational planning and implementation processes.</p> <p><b>Duty of Care and Volunteer Protection</b></p> <p>Duty of Care is a key pillar of this response and a key priority. The operation will prioritise the health, safety, and well-being of frontline responders by ensuring access to insurance, vaccination, appropriate PPE (where relevant), medical evacuation pathways, psychosocial support, and comprehensive training and supervision aligned with duty of care standards. In addition to physical protection, particular attention will be given to addressing the psychological and social pressures faced by volunteers.</p> <ul style="list-style-type: none"> <li>Review and update National Society SOPs to include procedures that put in place systems that enable rapid scale up and scale down of volunteer engagement – systems for recruiting new and accepting spontaneous volunteers, duty of care including remunerations systems, safety and security, psychosocial and mental health needs, “contracting” issues, and the lack of inclusion in decision-making processes.</li> </ul>		

- Strengthen volunteer protection and safety mechanisms through the provision of insurance coverage, visibility measures, and enforcement of duty of care standards.
- Implement an integrated volunteer management system to support registration, skills mapping, deployment, and performance tracking, ensuring efficient and safe mobilisation.
- Promote volunteer retention and engagement through structured support systems, youth engagement initiatives, and incentives that reinforce motivation, well-being, and accountability.

### **Branch Capacity Enhancement**

The IFRC will strengthen National Society capacity and readiness, with a particular focus on branch-level structures as integral components of the community health ecosystem in border areas. This will be achieved through targeted investment in operational resources, digital and information management systems, volunteer management, pre-positioning of supplies, governance, and learning mechanisms to enable an effective, timely, and scalable response to both current and future outbreaks.

- Operationalise the “model branch” approach by standardising infrastructure, strengthening human resources, and deploying digital systems, informed by BOCA/OCA assessments and aligned with NSD standards.
- Assess and strengthen the **branch to National Society Headquarters relationship**, cooperation, and coordination right at the onset of the operation and to elevate trusted governance at all levels of operational undertakings.
- Assess the readiness and functionality of pre-designed actions, including pre-disaster agreements with the MoH, prequalified vendor/supplier networks, auxiliary role arrangements, and Humanitarian Diplomacy (HD) to support rapid decision-making, reduce operational turnaround time, and strengthen National Society capacity to lead and co-create.
- Upgrade branch-level infrastructure and logistics systems through the rehabilitation of facilities, decentralised warehousing, and optimised supply chain processes to ensure operational continuity.
- Deploy integrated digital systems at the branch level (ERP and related platforms) to strengthen financial management, HR, logistics tracking, and internal controls.
- Enhance branch connectivity and ICT capacity by providing reliable internet solutions and essential

equipment to enable real-time coordination, reporting, and decision-making.

### **Strengthen National Society preparedness, readiness, and response capacity**

- Focus on branch capacity and system strengthening through digital and logistical equipment and volunteer training to be fully part of the response and cross-border ecosystem in liaison with local authorities, including for information management.
- Continue to advocate for and formalize NS auxiliary role in epidemics (e.g. mandate for SDB, CBS, RCCS)
- Continue to advocate for and formalise the National Society's auxiliary role in epidemics (e.g. mandate for SDBs, CBS, RCCS).
- Upgrade core systems and infrastructure to enable an effective emergency response, including strengthening Emergency Operations Centres (EOCs) and ensuring that the National Society can respond rapidly and efficiently to disease outbreaks and disasters.
- Scale up logistics and supply chain capacity by prepositioning relief stocks, strengthening warehouse management systems, and ensuring end-to-end visibility and control of emergency supplies.
- Operationalise emergency coordination and early warning mechanisms by establishing and strengthening EOCs, integrating real-time information management systems, and reinforcing coordination with the government and partners.
- Implement structured preparedness and response mechanisms through the development and regular testing of multi-hazard contingency plans, deployment of Rapid Response Teams (RRTs), and systematic simulation exercises and after-action reviews.
- Build operational and leadership capacity for the emergency response through targeted training programmes (technical, coordination, and leadership), ensuring that staff and teams are prepared for rapid deployment and effective decision-making in emergencies.
- Accelerate the digital transformation across operations by rolling out integrated management systems (ERP, Business Central), strengthening system interoperability, and upgrading ICT infrastructure (including server capacity) to support secure, real-time data management.
- Strengthen performance management, accountability, and reporting systems by implementing standardised

monitoring tools and processes to support data-driven decision-making, transparency, and compliance.

- Enhance specialised response and community engagement capacities by strengthening technical areas such as SDBs and CEA/RCCE to ensure accountable, community-centred, and context-appropriate interventions.
- Strengthen data management capacity for the collection, analysis, and use of feedback.
- Build operational capacity for the emergency response through targeted training on PGI in emergencies.



## Coordination and Partnerships

Female > 18: **N/A**

Female < 18: **N/A**

**CHF 695,000**

Male > 18: **N/A**

Male < 18: **N/A**

**Total target: N/A**

### Objective:

*Effective and coordinated disaster response is confirmed.*

### Priority Actions:

#### **Special Operational Modality for Cross-Border Collaboration**

- The IFRC will support the establishment and strengthening of cross-border coordination mechanisms, while enhancing engagement with local authorities, governments, and intergovernmental and regional bodies to ensure a coherent, timely, and regionally coordinated response that limits further spread.
- Efforts will focus on strengthening the capacity of border branches to support cross-border surveillance, information sharing, and RCCE, enabling coordinated detection and response along key mobility corridors in collaboration with neighbouring National Societies and relevant authorities.
- The IFRC will, alongside National Societies, support advocacy with public authorities in respective countries to ensure the formalisation of the National Society's auxiliary role as a cross-border actor mandated to support preparedness and response in border communities, as well as contributing to national public health data and information systems.
- The IFRC will also facilitate active participation in and coordination with Incident Management Support Teams, partner coordination forums, and bilateral strategic partners at national, continental, and regional levels to ensure alignment, information flow, and operational coherence.

#### **Membership Coordination**

- Mobilise dedicated Membership Coordination in Emergencies (MCiE) capacity to support operational membership coordination during the initial phase of the regional response and strengthen cross-country collaboration.
- Utilise and reinforce existing National Society-led membership coordination mechanisms at the country level to ensure a coherent Federation-wide approach, common situational awareness, and alignment of support across the IFRC network.
- Establish regular regional membership coordination forums to facilitate information sharing, cross-border coordination, joint analysis, and alignment of operational priorities among affected National Societies, the IFRC, and Participating National Societies.
- Ensure close coordination with the PNSs interested in supporting the operation, including those who hold Emergency Response Units (ERUs).
- Facilitate information sharing and joint operational and financial planning to strengthen collective decision-making, avoid duplication, and optimise the use of network resources in support of National Society-led response efforts.
- Support the development of a common operational picture, including the mapping of stakeholder interests, capacities, resources, and gaps, to inform coordinated action and risk management.
- Pursue shared leadership/responsibility arrangements to use capacities, skills, and added-value areas of various members of the IFRC Network in-country (including their support for the establishment of the Minimum in-Country Team (MICT) for public health emergencies).
- Test the tools of the Membership Coordination in Emergencies toolkit, capturing lessons to inform future regional approaches.


#### **Movement cooperation**

- Ensure continuous engagement with Movement Partners as per the existing Movement Coordination Agreement (MCA) and regional coordination structures.
- Ensure Movement-wide alignment and complementarity of efforts to maximise the National Society's response.
- Continuously monitor the evolution of the outbreak and evaluate the need for a collection Movement Response, if needs arise.

#### **Engagement with external partners**

- Engagement with the Africa CDC and the Intergovernmental Authority on Development (IGAD).

	<ul style="list-style-type: none"> <li>• Ensure effective and principled collaboration with national authorities at all levels – national, provincial, and local – as well as with the United Nations, INGOs, and other actors engaged in the response.</li> <li>• Maintain strong representation with donors, external partners, and the diplomatic community in the DRC to secure ongoing support throughout the operation.</li> <li>• Proactively engage with key stakeholders to build or reinforce partnerships that can mobilise resources and expertise, including outreach to the private sector and non-traditional donors for financial contributions and in-kind support.</li> <li>• Ensure robust grant management and donor accountability through timely, high-quality reporting.</li> <li>• Proactively engage with other PSEA actors in the PSEA Network, and SGBV actors in the GBV working group meeting and protection working group meeting.</li> <li>• Maintain leadership of the RCCE Collective Service partnership with the WHO and UNICEF.</li> </ul>
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 <b>IFRC Secretariat Services</b>	Female > 18: <b>N/A</b>	Female < 18: <b>N/A</b>	<b>CHF 4,625,000</b>
	Male > 18: <b>N/A</b>	Male < 18: <b>N/A</b>	<b>Total target: N/A</b>

**Objective:** *The IFRC Secretariat and National Societies use their unique position to influence decisions at the local, national, and international levels that affect the most vulnerable people.*

**Priority Actions:**

**IFRC Secretariat services**  
The IFRC, through its Secretariat services, will ensure a robust logistics backbone to support National Societies in responding to the Ebola epidemic.  
In line with the duty of care pillar, the Secretariat will ensure that appropriate institutional systems are operational support are in place to protect personnel, including staff health, preparedness, deployment safeguards, and coordinated access to medical and psychosocial support services. This will enable safe, timely, and sustained deployments in complex and high-risk operating environments.

**Technical support:**

- Develop and update relevant technical guidance and materials in the different sectors (Health, WASH, CEA, PGI, and others) and to ensure their effective dissemination among National Societies through different channels.

### **Surge deployments**

- Prepare for and deploy the required surge to support National Societies in needs assessments, operational planning, coordination, and implementation of emergency response interventions. Deployments will be guided by surge guidelines and in close coordination with National Society alignment with national response structures. Emphasis will be placed on rapid response support to address critical gaps while strengthening the National Society's capacity. As required, by the operation, the Movement will coordinate the mobilisation and deployment of ERUs to support the operation.

### **Logistics, procurement, and supply chain management**

- Establish an efficient supply chain system for quality health assets, goods, and services as required by National Societies and their governments. Taking into account the technical specification of items, international procurement will be conducted from framework agreement (FWA) suppliers. This way, the IFRC will ensure the required quality, speed, and best value for money for SDB kits, body bags, and EVD vehicles.
- Establish a logistical hub in Kampala for cross-border pipeline to Bunia (tentative), in close coordination with Uganda RC and the DRC RC.
- This will be an air-heavy operation, given the poor road infrastructure and the landlocked nature of the DRC.
- The utilisation of pro-bono flights by IFRC standing partners will ensure good value for money across supply corridors.
- The main supply corridor will be constantly assessed for effectiveness, accountability, and practicality.
- Positioning surge and IFRC personnel across four nodes – Nairobi, Entebbe, Kinshasa, and Ituri (Bunia) will ensure adequate coverage of all potential supply corridors to Ituri province.
- The Regional Logistics Unit in Nairobi and Sourcing Unit in Budapest will serve as the main procurement entities for the operation.
- The global hub in Dubai will serve as the main route for the mobilisation of pre-positioned stocks and vehicles.
- The African hub in Las Palmas may serve as an alternative supply route in later phases.

### **Risk Management**

- The IFRC will provide risk management advice to support the National Society in strengthening key processes and

controls, adapting operational modalities, and updating mitigation measures through the Capacity Review and Risk Assessment under the Working with Project Partners modalities.

- The risk management approach for this operation is guided by a moderate–high risk appetite, reflecting both the life-saving imperative of the Ebola response and the highly volatile epidemiological and humanitarian context in eastern DRC and the wider region. In this context, the IFRC is prepared to accept elevated operational and implementation risks, including those related to access constraints, security volatility, and rapid surge deployment, in order to ensure timely and effective delivery of critical interventions. This approach builds on the long-standing positioning of the DRC Red Cross and IFRC as trusted, community-based partners to public authorities, enabling access and impact in complex environments.
- At the same time, the IFRC maintains a low tolerance for fiduciary, compliance, safeguarding (PSEA/PGI), and reputational risks. These remain strictly non-negotiable, with full adherence to IFRC financial controls, procurement standards, and integrity frameworks. Risk mitigation measures will therefore prioritize strengthened oversight, clear segregation of duties, and systematic monitoring, complemented by regular spot checks and reinforced coordination with partners to ensure accountability and transparency at all levels of implementation.
- Given the rapidly evolving nature of the outbreak and the operational constraints on the ground including insecurity, population movement, and fragile health systems risk management will be dynamic and adaptive, with continuous reassessment of risk exposure based on epidemiological trends, operational access, and data reliability. This includes the possibility of applying exceptional modalities to operating procedures where necessary to avoid bottlenecks in the delivery of lifesaving assistance, while ensuring that any deviations are time-bound, documented, and supported by additional mitigation measures.
- To balance speed and control, the operation will adopt a dual approach: enabling operational flexibility to accelerate response delivery, while maintaining strict controls on integrity risks and accountability. Clear escalation mechanisms will be in place to ensure that any risk exceeding agreed thresholds is promptly addressed

at the appropriate level of authority, including adjustment of operating modalities, scale-down, or temporary suspension where required to uphold the duty of care and the “do no harm” principle.

- Ultimately, the effectiveness of the risk management framework will depend on maintaining a careful balance between operational agility and robust control, ensuring that risks are actively managed within acceptable thresholds while safeguarding the integrity, security, and accountability of the response to affected populations, authorities, and partners.

#### **Information Management (IM)**

- Activate Surge Information Management Support (SIMS), with the objective of mobilising remote support to: a) create detailed maps of targeted areas (for access purposes, EVD cases, and updates on the outbreak’s evolution); b) develop key products and infographics that will help in profiling the operation; c) produce regular briefings on the evolution of the situation and any contextual or political considerations that could influence the course of the operation; and d) support for ongoing data collection at the country level for analytical purposes.
- Coordinate with the response team to strengthen IM processes, with a focus on standardising data collection, management, and analysis across all pillars.
- Support field operations with mapping and visualisation products to guide decision-making.
- Provide detailed analysis and interpretation of data on key themes, including for RCCE purposes.

#### **Humanitarian Diplomacy (HD)**

- Develop HD key messages in line with HDiE guidelines on IFRC humanitarian diplomacy priorities for responding to the escalating Ebola (BVD) outbreak in eastern DRC (Ituri), which is now spreading to neighbouring countries, including Uganda. These messages will focus on mobilising coordinated advocacy, communication, and external engagement to support Red Cross and Red Crescent National Societies in preparedness, prevention, and response.
- **Key asks to public authorities:** authorities and partners are urged to restore humanitarian access and logistics, remove administrative and physical barriers, protect aid workers, and avoid restrictive measures such as border closures.
- Calls for the immediate scale-up of essential supplies, strong community engagement to counter misinformation, and coordinated cross-border action are

critical. The IFRC also calls for rapid, flexible funding and sustained investment in preparedness and health systems to enable an effective response.

- In collaboration with its members, develop advocacy and communication engagement strategies targeting external partners, the diplomatic community, and the media to support the work of Red Cross Red Crescent National Societies in preparing, preventing, and responding to this BVD outbreak.

### **Disaster Law**

- Develop analysis and fact sheets for countries affected during the response to provide clarity on legal and regulatory frameworks, parameters for humanitarian access, existing legal facilities, and proposed advocacy plans to address legal barriers, including those related to cross-border coordination and collaboration.
- Support the development of official advocacy strategies and communications for National Societies in their engagement with public authorities on access, legal facilities, and the formalisation of the National Society's auxiliary role.
- Support the development of cross-border collaboration framework agreements for joint National Society action across borders, as well as with public authorities and regional partners.
- Support National Societies in negotiating the formalisation of their auxiliary role in this response and related emergencies.

### **Communications**

#### *Media and Public Visibility*

- Develop and implement a communications and visibility plan to support public awareness, media engagement, and donor outreach throughout the operation.
- Develop and disseminate press releases, media advisories, key messages, and spokesperson materials.
- Facilitate media engagement opportunities, interviews, and briefings to increase visibility of the response and humanitarian needs.
- Monitor and analyse media coverage to identify opportunities and emerging reputational risks.

#### *Humanitarian Storytelling*

- Produce human-interest stories, volunteer profiles, field features, photo essays, and video content showcasing the contribution and impact of National Societies and Red Cross Red Crescent volunteers in affected communities.

- Document cross-border preparedness and response efforts to demonstrate regional cooperation and solidarity.

#### *Digital Communications*

- Develop social media content packages, digital campaigns and multimedia assets for IFRC and National Society channels.
- Amplify key operational updates, humanitarian diplomacy messages, and response achievements through digital platforms.

#### *Humanitarian Diplomacy and Advocacy Communications*

- Develop key messages, advocacy materials, communication briefs and visibility products to support engagement with governments, public authorities, regional institutions, diplomatic missions, donors, and partners.
- Support communication and visibility around humanitarian access, cross-border coordination, legal preparedness, and the auxiliary role of National Societies in epidemic preparedness and response.
- Develop communication products based on Disaster Law analysis and advocacy priorities to highlight legal and policy barriers affecting response operations and promote enabling frameworks for humanitarian action.
- Support the visibility of cross-border collaboration initiatives, regional coordination mechanisms, and agreements that facilitate preparedness and response efforts across affected and at-risk countries.

#### *Resource Mobilisation and Donor Visibility*

- Produce operational snapshots, factsheets, donor visibility materials, impact stories, and multimedia products demonstrating response progress, funding needs, and humanitarian impact.
- Support communication activities linked to donor engagement, high-level visits, and partner events.

#### *Communications Capacity Strengthening*

- Strengthen the communications capacity of National Societies through training, mentoring, and technical support in photography, videography, storytelling, media engagement, social media management, and content production.
- Support National Societies in developing high-quality communication products and ensure they maintain visibility throughout the operation.

### **Monitoring and Evaluation**

- Ensure **evidence-based impact measurement** across the operation, including via mid-term and end-term evaluations.
- Develop and launch the Federation-wide Planning, Monitoring, Evaluation, and Reporting (PMER) framework of the operation.
- Provide PMER support enabling Federation-wide planning, development, and maintenance of monitoring tools and workflows, supported both internally and Federation-wide, as well as donor reporting, which contribute to longer-term capacity building of the National Society.
- Periodically review implementation progress in collaboration with key thematic leads and recommend corrective action, where necessary.

### **Security**

- Area-specific security risk assessments will be conducted for any operational area prior to the deployment of any IFRC personnel; risk mitigation measures will be identified and implemented accordingly.
- The Kinshasa Country Cluster Delegation and the Regional Security Unit will use existing internal staff capacity by deploying Country Security Officers to the response locations. The Country Security Officers will take the lead in ensuring the implementation of IFRC security plans (MRS) and coordination with the ICRC under the L3 security support agreement applicable in eastern DRC.
- In Uganda and South Sudan, the Juba Country Cluster will utilise existing internal security capacity by deploying the Security Delegate to conduct a dynamic security assessment in western Uganda and other areas of potential concern.
- The IFRC Regional Security Unit and Global Security Unit will provide active support by conducting security analyses and reviewing security plans (MSRs), enabling the team to implement risk mitigation measures in line with the latest developments, monitor the security environment, provide technical advice, ensure compliance with IFRC policies, and ensure that any internal or external security-related incidents or emergencies are immediately and appropriately managed and reported to the security unit and the Regional Director.
- All IFRC personnel must complete, and RCRC staff and volunteers are encouraged to complete, the IFRC Stay Safe e-learning courses, i.e. Stay Safe 2.0 Global edition Levels

1-3. Insurance coverage for volunteers involved in the operation should also be ensured.

#### **Staff Health**

- Develop and oversee the staff health and well-being plan, ensuring compliance with duty of care standards.
- Train and support staff and volunteers on stress management, PFA, and self-care.
- Organise staff health briefings, including risk communication, safe working practices, and fatigue management.
- Set up and supervise staff-focused point of entry screening and handwashing stations at offices, bases, and accommodation sites.
- Coordinate with HR, Security, and MHPSS teams to integrate staff health into operational planning.
- Track and report staff health indicators to inform decision-making and adapt support measures.
- Deploy a staff health advisor to establish appropriate mechanisms and enhance capacity.

#### **Resource Mobilisation**

- The IFRC Secretariat will support the DRC RC, the URCS, and neighbouring National Societies in strengthening strategic partnerships at the national, regional, and international levels to mobilise resources for the operation.
- This will include facilitating donor and partner engagement through the organisation of field visits for Participating National Societies, embassies, and other key stakeholders to highlight operational achievements, needs, and impacts.
- The Secretariat will work closely with National Societies to ensure regular information sharing, coordination, and partner briefings, promoting coherence, visibility, and sustained support for the response.

## **Risk management**

<b>Risk</b>	<b>Likelihood</b>	<b>Impact</b>	<b>Mitigating actions</b>
Infection of employees or volunteers	Medium	High	<ul style="list-style-type: none"> <li>• Provision of PPE and appropriate training according to the risk level of activity</li> <li>• Training and provision of standard SDB kits to SDB teams for safe burial procedures, avoiding improvisation without adequate materials and protection</li> <li>• Provision of regular PSS support to all response teams</li> </ul>

			<ul style="list-style-type: none"> <li>• Activation of the Red Family Funds in case of deaths of National Society personnel</li> </ul>
Incidents related to community mistrust, including violence	High	High	<ul style="list-style-type: none"> <li>• Strong RCCE, CEA targeting specific groups with community influence</li> <li>• Collection, processing, analysis, and management of community feedback</li> <li>• Track and ensure the application of recommended response changes to improve community acceptance</li> <li>• Conduct security assessments in operational areas and adapt security measures jointly with the ICRC</li> <li>• Establish security incident reporting systems</li> </ul>
Safeguarding risks			<ul style="list-style-type: none"> <li>• Mitigate risks through training and sensitisation of staff and volunteers on safeguarding, and ensure that all sign the Code of Conduct</li> <li>• Ensure that safeguarding systems are properly set up at the National Society level, including reporting channels</li> <li>• Reinforce and motivate timely and anonymous reporting of safeguarding breaches</li> </ul>
Spread of the epidemic, including in surrounding provinces	High	High	<ul style="list-style-type: none"> <li>• Continuously monitor the evolution of the outbreak.</li> <li>• Ensure flexible funding</li> <li>• Strengthen branch preparedness for outbreak response in neighbouring provinces</li> <li>• Scale up the response</li> </ul>
Risk of fraud, misappropriation of funds	Medium	High	<ul style="list-style-type: none"> <li>• Strengthening of the control environment in sectoral risk areas, including through re-arranged operating modalities.</li> <li>• Strengthen staff capacity on the National Society anti-fraud policy, internal regulations, the RCRC's PSEA policy, and child safeguarding policy</li> <li>• Regular spot-checks on the ground for compliance and quality verification.</li> </ul>

## Quality and accountability

The PMER team will establish a Federation-wide reporting system to highlight progress and accountability, including the provision of operational updates. The PMER, operations, and other technical teams will collaborate on a final external evaluation in accordance with the IFRC's evaluation framework.

Working alongside National Societies, the IFRC will conduct continuous monitoring at the country level, including regular updates on the operational risk register, ensuring timely adaptation of the operation and regular reporting on progress in the implementation of the activities.

**Key indicators are outlined below, with the framework to be further expanded as operational activities evolve across the response and are contextualised at the country level.**

Objectives	Indicators
<p><b>Objective:</b> Through this Emergency Appeal, the IFRC supports National Societies in the DRC, Uganda, and neighbouring countries to curb transmission, prevent cross-border spread, and reduce mortality and social impacts associated with Bundibugyo Virus Disease (BVD).</p>	
<p><b>Outcome 1: Health</b> The spread and impact of the outbreak are reduced through community outreach in the affected health zones</p>	<p><i>Due to the multi-actor nature of the response and evolving surveillance and reporting systems, attribution of a single outcome-level indicator is not appropriate. Progress will be assessed through a combination of output-specific indicators reflecting RCRC contributions</i></p>
<p><b>Output 1.1: Community-based surveillance (CBS)</b> Governments are assisted by Red Cross volunteers for surveillance and contact finding</p>	<p>% of suspected cases identified through RCRC active case finding support</p> <hr/> <p># of screening points supported by National Society interventions</p>
<p><b>Output 1.2: Safe and Dignified Burials</b> Affected populations are assisted with safe and dignified burials and decontamination activities</p>	<p>% of SDB alerts responded to through public health measures within 48 hours</p>
<p><b>Output 1.3: Infection prevention and control</b> Targeted health facilities are being strengthened and are implementing infection prevention and control measures according to public health standards</p>	<p># of health facilities supported with infection prevention and control interventions</p>
<p><b>Output 1.4: Community Health/Risk Communication and Community Engagement (RCCE)</b> Social mobilisation, risk communication and community engagement activities are carried out to limit the spread and impact of BVD</p>	<p># of people reached with epidemic-related health promotion activities</p> <hr/> <p>% of people surveyed who say they trust the health information provided by the National Society</p>
<p><b>Output 1.5: Mental Health and Psychosocial Support</b> The psychosocial consequences of the outbreak are mitigated through direct support to exposed and infected populations</p>	<p>% of staff and volunteers supporting the response who receive psychosocial support</p> <hr/> <p># of affected people who receive psychosocial support through RCRC support</p>
<p><b>Outcome 2: Water, Sanitation, and Hygiene</b></p>	<p>% of people (and households) who can identify, without prompting, key times for handwashing (including after defecating or cleaning after toilet use, before eating or preparing food, and after blowing their nose, coughing, or sneezing)</p>

Improve safe water availability and hygiene practices	% of people (and households) assisted by the Red Cross (with water sources) that have access to sufficient safe water which meets Sphere and WHO standards in terms of quantity and quality in the preparedness period
<b>Output 2.1: WASH</b> The target population has access to essential water and sanitation infrastructure/services for consumption, hygiene/health	# of households covered reached with hygiene promotion activities
	# of handwashing stations established and functional at points of entry/public spaces
	# of people accessing safe water through supported interventions
	# of households disinfected according to protocols
<b>Outcome 3: Multi-purpose cash</b> Cash is used as the means to support the basic needs of BVD supported families in an accountable and efficient manner	% of Ebola affected households who report being able to meet the basic needs of their households, according to their priorities (minimum expenditure basket)
<b>Output 3.1: Cash assistance</b> Targeted family members and survivors of BVD have the resources to recover their basic needs.	# of cash assessments carried out
	# of people (and households) who received cash assistance according to the selection criteria
<b>Outcome 4: Protection, Gender, and Inclusion (PGI)</b> Protection, Gender, and Inclusion communities identify and respond to the distinct needs of the most vulnerable segments of society, especially disadvantaged and marginalised groups, due to violence, discrimination, and exclusion.	% of operational sectors in this appeal with an integrated PGI approach, enabling communities to become more peaceful, safe, and inclusive by addressing the needs and rights of the most vulnerable # of rapid PGI assessments or analyses conducted including PSEA and safeguarding # of at-risk individuals reached through inclusive services
<b>Output 4.1: Strengthened institutional and operational capacity on PGI and safeguarding</b>	# of staff and volunteers trained on PGI, safeguarding, PSEA, child protection, and SGBV, and reporting mechanisms
	% of staff and volunteers signing and adhering to the Code of Conduct
	# of safeguarding focal points trained and deployed
<b>Output 4.2: Enhance data driven and inclusive programming (SADDD)</b>	# of reports that are sex, age, and disability disaggregated (SADDD), whether periodical, assessments, studies, or evaluations
	# of confidential reporting mechanisms established and functional
	# of operational sites displaying safeguarding and reporting information
<b>Output 4.3: Reinforce referral pathways and specialised services</b>	# of functional SGBV referral pathways established or strengthened
	% of referred SGBV cases receiving services
<b>Output 4.4: Promote community engagement and inclusive communication</b>	# of PGI-sensitive community engagement sessions conducted
	# of accessible IEC materials developed and distributed
	% of IEC materials adapted for disability inclusion and literacy needs

	# of community leaders engaged in protection-focused activities
<b>Output 4.5: Strengthen local partnerships with local actors</b>	# of partnerships established with women's group, OPDs, and child protection actors
	# of joint protection initiatives implemented
	# of community-based protection committees supported
	# of coordination meetings conducted with local protection actors
<b>Outcome 5: Community Engagement and Accountability</b> People and vulnerable communities affected by the epidemic are empowered to influence the decisions that affect them and trust the IFRC network to service their best interests	% of respondents who feel that the National Society's support and services meet their most important needs and provide useful support
	% of community members who feel their opinions are taken into account in operational planning and decision-making
<b>Output 5.1: Feedback mechanisms</b> Effective methods established to collect feedback from the community	# of employees, volunteers, and leaders trained in community engagement and accountability
	# of opportunities provided to the community to participate in the management and direction of activities (e.g. number of community committee meetings, focus group discussions, public meetings)
	% of operational feedback received and addressed by the National Society
	The National Society has established a functional feedback mechanism for the entire organisation
<b>Outcome 6: National Society Strengthening</b> National Societies are prepared to effectively respond to epidemics and emerging crises, and their auxiliary role in providing humanitarian assistance is well-defined and recognised	The National Society is part of government-led emergency coordination platforms
	The National Society is part of the official emergency response coordination platforms of the DRC Red Cross, the interagency community, and the international community
<b>Output 6.1: Volunteer and Branch Capacity Enhancement</b> Improved operational scope and efficiency	# of volunteers mobilised covered by insurance covering illness, accident, and death
	The National Society has improved its preparedness, emergency, and response plans following recommendations and evidence from the operation
	# of assessments carried out (initial needs assessment, anthropological study, real-time assessment, final assessment, etc.)
<b>Outcome 7: Coordination and Partnerships</b> Technical and operational complementarity among the IFRC's membership and with the ICRC is enhanced through cooperation with external partners	# of regular coordination mechanisms with all Movement partners
	# of monthly coordination meetings

<b>Output 7.1: Strategic and Operational Coordination</b> The National Society is a member of relevant national donor platforms and forums and engages with them regularly	# joint monitoring missions carried out (National Society, IFRC, PNSs, ICRC)
	# of lessons learned workshops and mid-term reviews coordinated with Movement partners
<b>Outcome 8: IFRC Secretariat Services</b> Effective and coordinated disaster response is confirmed	The resource mobilisation strategy has been completed and implemented
<b>Output 8.1: Agility and Accountability</b>	The National Society has established a risk management framework
	# financial audits carried out

# FUNDING REQUIREMENT

## Federation-wide funding requirement\*

Federation-wide funding requirements, including the National Society domestic target, IFRC Secretariat, and Participating National Societies' funding requirements	IFRC Secretariat funding requirements in support of the Federation-wide funding request
CHF 29,500,000	CHF 27,500,000

## Breakdown of the IFRC secretariat funding requirement

*\*For more information on Federation-Wide funding requirement, refer to section: Federation-wide approach*



## OPERATING STRATEGY

### MDRS1007 – Regional Appeal – Ebola (BVD) Epidemic

#### FUNDING REQUIREMENTS

Planned Operations	17,090,000
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	607,000
Health	10,481,000
Water, Sanitation, and Hygiene	3,001,000
Protection, Gender, and Inclusion	505,000
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0

Community Engagement and Accountability	2,496,000
Environmental Sustainability	0

<b>Enabling Approaches</b>	<b>10,410,000</b>
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Coordination and Partnerships	695,000
Secretariat Services	4,625,000
National Society Strengthening	5,090,000

<b>TOTAL FUNDING REQUIREMENTS</b>	<b>27,500,000</b>
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*all amounts in Swiss francs (CHF)*

## Contact information

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

### At the DRC Red Cross

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- **Operational coordination:** Dr. Benjamin Kalambayi, Health Emergency Assistant, email: [kalambayi.us@croixrouge-rdc.org](mailto:kalambayi.us@croixrouge-rdc.org)

### At the Uganda Red Cross

- **Secretary General:** Robert Kwesiga, email: [sgurcs@redcrossug.org](mailto:sgurcs@redcrossug.org)
- **Operational coordination:** Dr. Josephine Okwera, Director of Health and Social Services, phone: +256 (414) 258 701/2

### At the IFRC:

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  - Gabriela Arenas, Regional Coordinator Operations; email: [gabriela.arenas@ifrc.org](mailto:gabriela.arenas@ifrc.org)
  - Irene Kiiza, Health and Care Manager; email: [irene.kiiza@ifrc.org](mailto:irene.kiiza@ifrc.org)
- **IFRC Country Delegation (or Country Cluster Delegation):**
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- **For In-Kind donations and Mobilisation table support:**
  - Regional Logistics Services: Nikola Jovanovic, Coordinator Partnerships and Innovation (Supply Chain Management); email: [nikola.jovanovic@ifrc.org](mailto:nikola.jovanovic@ifrc.org)
  - Logistics Coordinator for mobilisation and In-kind donations, Carren Ouma Oyayo; email: [carren.oyayo@ifrc.org](mailto:carren.oyayo@ifrc.org)
- **For PMER (Planning, Monitoring, Evaluation, and Reporting) support:**
  - IFRC Africa Regional Office: Beatrice Okeyo, Regional Head PMER, and Quality Assurance; email: [beatrice.okeyo@ifrc.org](mailto:beatrice.okeyo@ifrc.org)

### Reference



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