DREF Operation

Central African Republic BVD Readiness

Local Branch Volunteers

Appeal: MDRCF034	Hazard: Epidemic	Country: Central African Republic	Type of DREF: Response
Crisis Category: Yellow	Event Onset: Sudden	DREF Allocation: CHF 149,994	
Glide Number: -	People Affected: 2,534,064 people	People Targeted: 69,030 people	
Operation Start Date: 17-06-2026	Operation Timeframe: 2 months	Operation End Date: 31-08-2026	DREF Published: 26-06-2026

Targeted Regions: Bangui, Basse-Kotto, Haut-Mbomou, Kémo, Lobaye, Mbomou, Ombella M'Poko

Date of event

17-05-2026

CAR : Ebola Preparedness
As of 23 June 2026.

MAPPING OF THE MVE CAR PRIORITY AREAS

What happened, where and when?

Between 15 and 18 May 2026, the Democratic Republic of the Congo (DRC) declared an outbreak of Ebola virus disease (EVD) caused by the Bundibugyo strain as a major health emergency, quickly followed by Uganda, WHO and Africa CDC.

The epidemic mainly affects three provinces of the DRC, namely Ituri, North Kivu and South Kivu. As of June 18, 2026, a total of 33 health zones has reported confirmed cases, including:

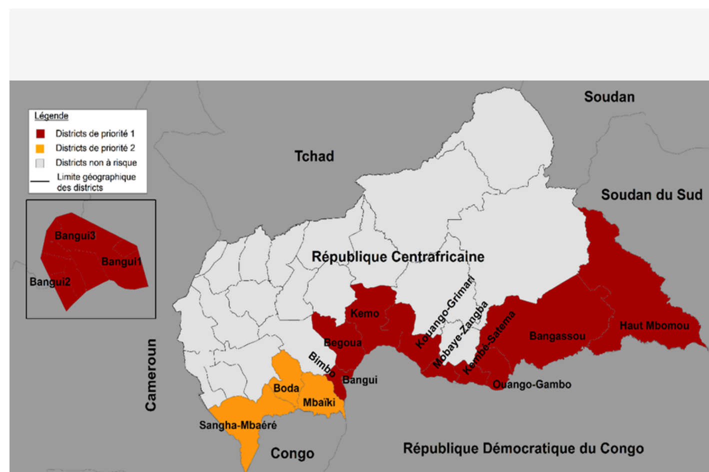
• 21 out of 36 areas (55.5%) in Ituri,
• 11 out of 34 (29%) in North Kivu, and
• 1 in 34 (3%) in South Kivu, thus, confirming that Ituri is the most affected province.

According to WHO data as of June 18, 2026, the DRC has recorded 896 confirmed cases, including 208 deaths and 78 recoveries. A cross-border extension has also been reported in Uganda, with 19 confirmed cases, including 2 deaths and 7 recoveries.

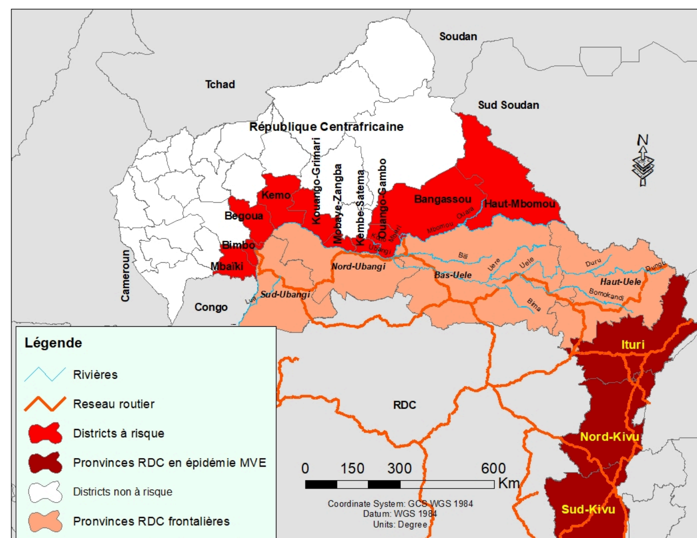
Although the Central African Republic (CAR) has not yet recorded any confirmed cases of Ebola virus disease (EVD), it is at high risk of introduction due to its proximity to affected areas in the Democratic Republic of Congo (DRC). This epidemic, which is the 17th in the DRC and the second linked to the Bundibugyo strain, is spreading to border provinces, including Haut-Uélé. The latest health information indicates a high likelihood of undetected active transmission in Haut-Uele province, which shares a direct land border with CAR.

In addition, suspected cases have already been reported, including:
- Report of a death following a viral hemorrhagic fever in the health zone of Libengue, province of south ubangui (Central African refugee camp in the DRC).
- Report dated June 18, 2026, D of a suspected EVD case by the Chief District Medical Officer of the Yakoma health zone in the DRC

bordering the Ouango Gambo Health District in CAR; Sample taken to the INRB in Kinshassa and the situation is monitored.
Thus, even in the absence of a direct border with Ituri, the combination of proximity to areas of probable transmission (Haut-Uélé), significant cross-border movements, early signals (suspected cases), and limited preparedness capacities fully justifies the establishment of a preparedness DREF whose objective is to anticipate and reduce the risk of introduction and spread, in accordance with the principles of proactive emergency management. The map of risk areas, in connection with the affected provinces in the DRC, is attached to support this analysis.



Priority areas of the epidemic in CAR



Mapping of risk areas

Scope and Scale

The introduction of Ebola virus disease (Bundibugyo strain) into the Central African Republic (CAR) would represent a major public health emergency, likely to affect several regions of the country, particularly border areas and high-density urban centres.

Given porous borders, high cross-border mobility and a limited level of preparedness (42%), a possible outbreak could spread rapidly and have serious and multidimensional consequences.

Potential impacts
Health:
o rapid increase in mortality;
o Overcrowding of health facilities and disruption of essential services.

Socio-economic:
o disruption of livelihoods;
o Impact on commercial activities, particularly cross-border activities.

Psychosocial:
o fear, stigma and social tensions;
o Impact on survivors, families and health workers.

Essential services:
o disruption of health, education and social protection systems;
o aggravation of vulnerabilities (food insecurity, living conditions).

Key vulnerabilities
• High population mobility and active cross-border corridors
• Limited access to health services in rural and border areas
• Precarious living conditions (water, hygiene, overcrowding)
• Cultural practices at risk (funeral rites, home care)
• Insecurity and constraints on humanitarian access

The CAR has a national emergency management framework, an integrated surveillance system, a reference laboratory. However, these

capabilities remain unevenly deployed, with gaps in infection prevention and control, case management, entry points and logistics and risk communication.

The most exposed populations are:
• Communities in the south-eastern districts;
• populations living along the Oubangui River;
• Residents of Bangui and its surroundings (high density and mobility).

The high-risk places are.
• Weekly markets with the DRC
• Entry points
• Border IDP sites
• Health facilities

Vulnerable groups are:
• Health and community workers
• Women (care of the sick and funeral practices)
• Internally displaced persons and refugees
• Carriers and travellers
• Hunters and traditional healers

The main factors that can amplify transmission are:
• High cross-border mobility
• Overcrowding (urban areas and camps)
• Weak health system capacity
• Detection and response delay
• Limited access to water and sanitation
• Insecurity
• Lack of available vaccination

Geographic prioritization is based on:
• Proximity to high-risk borders;
• Mobility and trade corridors;
• The presence of entry points (PoE);

The Priority Districts are classified into 2
Priority 1:
Haut-Mbomou, Ouango-Gambo, Bangassou, Kémo, Bangui, Kembé-Satema, Mobaye-Zangba, Kouango, Grimari, Bégoua, Bimbo

Priority 2:
Sangha-Mbaéré, Boda, Mbaïki
the experience of the last DREF EBOLA Preparation of the CRCA in 2018, where the epidemic had affected the province of Equateur in the DRC which shares a border of about 1,300 km with the CAR along the Oubangui River. There were also 2 priority areas
Priority Area 1 which is the current Priority Area 2 and Priority Area 2 is the current Priority Area 1.
The CRCA had worked exclusively in Priority Area 1 and covered an estimated total population of 1,585,167 people (approximately 317,033 households) through community-based surveillance and outreach activities.

A total of 432,000 people (approximately 86,400 households) were directly reached through the activities carried out by 180 volunteers, organized into 90 teams, with an average capacity of 40 households covered per team per day.

Previous Operations

Has a similar event affected the same area(s) in the last 3 years?	**Yes**
Did it affect the same population group?	**Yes**
Did the National Society respond?	**Yes**

Did the National Society request funding form DREF for that event(s)	**Yes**
If yes, please specify which operation	MDRCF024 FROM 05 06 2018

If you have answered yes to all questions above, justify why the use of DREF for a recurrent event, or how this event should not be considered recurrent:

This event is not recurrent, there are two outbreaks of Ebola virus disease; the 2018 one was of Zaire strain and affected the province of Equateur with as red priority area the areas currently in orange in the current epidemic of the Bundibugyo virus strain, with a location in the province of Ituri initially, before extension to North Kivu and South Kivu so different strain and different area.

Lessons learned:

Lessons learned from previous operations, including the response to Mpox, have been proactively integrated to limit constraints and improve the effectiveness of this intervention:
• Strengthening coordination from the start: Active participation in COUSP meetings with the PSF and partners is ensured from the outset to ensure strategic alignment, prevent institutional bottlenecks and avoid duplication.
• Joint planning of activities: Interventions are defined in line with the national priorities defined in CAR's national EVD preparedness and response plan and by integrating the community health workers of the MSP, in order to ensure acceptance and complementarity of the actions.
• Prepositioning of key resources: Safe burial kits, protection and trained teams are mobilized in advance to avoid operational delays.
• Improvement of financial mechanisms: Measures are put in place to accelerate the availability of funds to the CRCA (standardization of transfers, anticipation of DREF deadlines, coordination with regional and country levels).
• Integrated community-centred approach: Community engagement activities are systematically integrated to build buy-in and reduce resistance.

At the level of the NS, measures are taken to anticipate in the procurement procedures and in the rapid management of financing and the submission of coherent and timely reports.

Did you complete the Child Safeguarding Risk Analysis in previous operations, what was risk level?	**Yes**
What was the risk level for Child Safeguarding Risk Analysis?:	**Child Protection Risk can be classified as Moderate.**

Current National Society Actions

Start date of National Society actions

24-05-2026

Community Engagement And Accountability	The CRCA, an auxiliary of the public authorities in the humanitarian field, has a solid operational network with 112 staff members and about 20,000 volunteers, structured through 92 local committees covering the entire territory, including remote areas. It enjoys strong community acceptance and maintains close collaboration with the authorities, including the Ministry of Health (MOH) at all levels (national, district and community). The CRCA has a proven track record in managing health emergencies, including outbreaks (cholera, COVID-19, EVD 2018; Mpox 2024), and plays an active role in the current preparation. Since the beginning of the epidemic, the CRCA has already:

	1. Identify an EDS focal point, 2. Actively participate in the development and validation process of the national preparedness and response plan. 3. Took part in the coordination meetings of the COUSP and the validation of key messages; 4. Took part in the capacity building session for trainers organized by the MSP (Head of the Health Department, EDS focal point covering in particular: CREC, infection prevention and control (IPC), psychosocial care, surveillance at points of entry, dressing/undressing and case management. 5. Ensure the training of the volunteers of the CRCA of Bangui by the MSP The HR situation shows. 1. The head of the health department. 2. the EDS focal point, the CRCA. 3. The head of the communication department and the dissemination focal points in the local branches. 4. A CEA focal point and 1 PGI focal point at the head office. 5. The Disaster Manager also provides support. Logistically, the CRCA has 4 vehicles acquired as part of the Mpox emergency call, all of which are in poor condition and require curative maintenance. In accordance with the PUOC Memorandum No. 071 signed on June 12, 2026, implementing an incident management system (see attached memorandum); the CRCA is the Lead of the Dignified and Safe Burial (EDS) preparation pillar and a member of the CREC pillar.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC is present in CAR through its delegation in Bangui and supports the CRCA at the technical, strategic and operational levels, ensuring alignment with the PSF and the coordination of the Movement. It provides support through its key services: PMER (Planning and Reporting), Finance (Management and Disbursement), Administration/HR, Security, Logistics and Development of the NS, as well as technical reinforcements to ensure a fast and effective response.
Participating National Societies	Two participating National Societies are present in CAR: The French Red Cross (CRF) supports the Infection Prevention and Control (IPC) pillar, in particular through the provision of hydroalcoholic gel and personal protective equipment (PPE). The Netherlands Red Cross (CRNL) intends to support the preparation, and a coordination meeting is planned to avoid duplication

ICRC Actions Related To The Current Event

The ICRC delegation is located in the city of Bangui with sub-offices in the interior of the country.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	The Central African authorities quickly activated the national response system by declaring the risk of Ebola importation and setting up an Incident Management System. Coordination has been strengthened through regular meetings at the COUSP and the appointment of an Incident Manager. Priority actions have been undertaken, including strengthening surveillance at points of entry, assessing management capacities, mobilizing the national laboratory and validating key messages, and awareness-raising measures through posters; radio broadcasts; training of trainers and cascade training of staff and community health workers. A 12-month national preparedness and response plan budgeted at $20 million structured in 12 pillars has been developed and validated, accompanied by resource mobilization and continuous monitoring of the situation. designation of CRCA as lead of the EDS component and member of the CREC team
UN or other actors	United Nations agencies (World Health Organization, United Nations Children's Fund, UNICEF, International Organization for Migration; World Food Programme); The INGOs (ALIMA, MSF) support the national authorities in the 6 pillars according to their expertise. MINUSCA/UNHAS is supporting the transport of teams, samples and equipment to the field

Are there major coordination mechanism in place?

1. National level,
a. Public Health Emergency Operations Centre (COUSP) in which the IFRC and CRCA participate.
Piloting: Ministry of Public Health (MSP).
Role: Strategic and operational coordination, holding crisis meetings, monitoring the situation
Involvement of the NS (CRCA): Active participation in meetings).
b. Working groups by pillars (CREC, PCI/EDS, Surveillance, etc.)
Involvement of the NS (CRCA): Active participation in the meetings of the working group, support for the implementation of activities (CREC, EDS).
c. The Red Cross Movement's Health and Epidemic and Disaster Management Working Group will reactivate its meetings in order to closely monitor the evolution of the epidemiological situation.

2. At the decentralized level
Coordination meetings will be organized as needed at each level in order to take stock of the follow-up of the warning indicators and the operations underway in each sensitive area.
During these meetings, the managers will be asked to:
- Assess the status of the implementation of interventions and manage operational risks;
- Make proposals/suggestions for improvement for the rest of the interventions;
- Reorganize operations based on the evolution of the situation and the means available.

Needs (Gaps) Identified

Any identified gaps/limitations in the assessment

The assessment of CAR's level of preparedness to deal with Ebola virus disease, carried out in 2023 and revised in 2025, shows an overall level of preparedness of 42%. Deficiencies persist in critical areas such as infection prevention and control, case management, entry points (40 formal entry points and 136 informal entry points to be monitored), risk communication, logistics and continuity of health services. The activities of CREC by the CRCA volunteers and the EDS activities for which he is the lead have started due to a lack of resources.

The needs are:
1. For the Dignified and Safe Burial pillar:
The CRCA has a solid basis for intervening in the framework of EDS: volunteers trained in EDS (last training in 2024 as part of the Mpox emergency appeal), recognition and community acceptance.
The unmet needs for EDS are:
-lack of EDS SOPs and training modules not updated
-Lack of training/retraining of volunteers on EDS.
- Absence of personal protective equipment and dignified and safe burial kits for training, simulation exercises and for prepositioning,
-Lack of logistical means: ambulance and pick-up
-Low capacity for rapid deployment in affected areas, some of which are landlocked with deterioration of road infrastructure and insecurity
The unmet needs for the Surveillance component are:
Like DHS, the CRCA has trained volunteers with experience in community-based surveillance of cases of diseases under surveillance and notification
Monitoring needs include:
-Capacity building of volunteers in case detection, early warning,
- Community outreach to encourage early reporting and reduce stigma
- Logistical support (transport, communication) for the coverage of hard-to-reach areas

Logistically
As part of EVD preparedness, the Central African Red Cross (CARC) must have adequate logistical means to ensure a rapid, safe and effective response.
- Vehicles for rapid deployment of teams
- Motorcycles to access isolated areas
- Fuel available at all times
- Mobile phones/tablets for feedback collection
- Communications credits (call/internet)
- Communication radios in areas without a network

Coordination difficulties:
The hardest to reach populations in CAR include remote communities (indigenous pygmies, Fulani, insecure areas, IDPs, mobile/cross-border populations). Their limited access to services, mobility and security constraints complicate their coverage in EVD preparedness and response, and their needs may not be sufficiently addressed.
Certain constraints limit the actions of the CRCA, it is necessary to
Key needs
1. Human capacity building
• Training/retraining of volunteers by:
• Ebola community surveillance
• Infection prevention and control (IPC)
• Risk Communication and Community Engagement (RCCE)
• EDS
2. Equipment and materials
• Personal protective equipment (PPE)
• EDS Kits
• Handwashing devices
• Awareness-raising materials
3. Logistics and mobility
• Means of transport
• Fuel and maintenance

• Means of communication
4. Coordination and Oversight
• Strengthening coordination mechanisms
• Supervision of field activities
• Monitoring and reporting
5. Community Involvement
• Raising awareness
• Combating disinformation

[Assessment Report]

Operational Strategy

Overall objective of the operation

The IFRC DREF operation aims to strengthen the preparedness capacities of the CRCA at the national level and priority districts in order to support the government in dealing with a possible importation of a case of Ebola virus disease strain Bundibugyo.

Operation strategy rationale

According to the contingency plan, the activation level is 0: Enhanced Standby / Preparedness. The operational strategy adopted by the Central African Red Cross is based on a preventive and community-based approach, adapted to a context of high risk of importation of the Ebola virus disease (EVD), with no confirmed cases to date in the country.

It builds on the key gaps identified, including low levels of information and risk perception within communities, risk of rumours, stigmatisation and rejection of interventions, inadequate community and point-of-entry monitoring mechanisms, limited capacity for safe and dignified burials (DHS), as well as coordination challenges at the local level.

In view of these needs, the operation focuses on three priorities:

1. Strengthening risk communication and community engagement (CRREC) to improve understanding of the disease, promote the adoption of preventive behaviours and reduce rumours at the 19 entry points and households in the neighbourhoods/villages around the entry points.

2. Capacity building in EDS to prevent transmission during funeral practices, identified as high-risk.

3. Support for coordination in at-risk districts.

The choice to prioritize risk communication and community engagement (CRREC) is justified by the fact that community buy-in is a determining factor in the prevention and control of epidemics.
In a context marked by the circulation of rumours and misperceptions, the dissemination of harmonised messages through appropriate channels (media, local awareness-raising) will improve understanding of risks, promote preventive behaviour and strengthen confidence in interventions.

The deployment of trained volunteers around the ports of entry and in the surrounding communities responds to the need to target the area's most at risk of importation, due to the mobility of the populations. This approach makes it possible both to strengthen prevention measures (hygiene, awareness), but also to ensure a feedback and feedback mechanism, which is essential for early detection.

In addition, capacity building in safe and dignified burials (DSB) is justified by the critical role of funeral practices in the transmission of EVD. The establishment of trained teams and the prepositioning of kits will allow a rapid and appropriate response, thus reducing the risk of spread in the event of death.

Support for operational coordination and capacity building of community health workers is part of a logic of alignment with the Ministry of Public Health and existing mechanisms, in order to avoid duplication, optimize resources and guarantee a coherent and effective response.

Finally, the involvement of community leaders, professional groups and key stakeholders aims to strengthen the social acceptability of interventions and to ensure a broad dissemination of messages to hard-to-reach populations. The objective of the ERP component is the preparation of volunteers/CHWs in ERP, GBV, child protection and safe, equitable, dignified and accessible mechanisms for all populations while taking into account inequalities and vulnerabilities related to gender, age; disability and social context
The following activities will be implemented:

Taken together, this strategy allows for a targeted response to the priority needs identified in the preparedness phase, combining prevention, community engagement, capacity building and coordination, in order to reduce the risk of introduction and limit the potential impact of EVD in CAR.

Targeting Strategy

Who will be targeted through this operation?

In general, targeting is based on:
-The level of exposure to the risk of importation (ports of entry, border areas)
- Social and structural vulnerability (isolated populations, marginalized groups)
-The role in transmission or prevention (leaders, community actors, funeral practices).
This approach maximizes the impact of interventions by focusing efforts on the populations most at risk, while ensuring a wider dissemination of prevention messages.1. Directly targeted groups
-Port of Entry populations (travellers, carriers, traders, border staff)
targeted because of their direct exposure to cross-border flows from affected or at-risk countries
-Communities living around targeted ports of entry as they are in regular contact with travellers and therefore at increased risk of exposure.

Methods of calculating this population - The operation covers 9 priority health districts, comprising a total of 19 strategic entry points. At each entry point, it will be deployed:
• 4 pairs of volunteers (8 volunteers);
• 1 supervisor ensures coordination;

The teams work 7 days a week for 30 days. A total of 95 volunteers will be mobilized for CREC activities at the ports of entry. Based on national passenger flow data (COUSP meeting of 19 June 2026), each entry point registers an average of 80 people per week. Taking into account the operational capacity of the teams, the intervention targets an average of 12 people per day and per port of entry. Thus, the total number of people directly targeted is estimated at: 12 people x 19 ports of entry x 30 days = 45,600 people. These beneficiaries mainly include:
• Travellers;
• transporters (canoeists, motorcycle taxis, drivers);
• Traders and mobile populations.
The operation also targets households around entry points;

Here it will be a question of deploying 2 pairs of volunteers in each district/village around the entry points for CREC activities and feedback collection, i.e. 76 volunteers/ASC
Each ASC pair will do 3 outings per week for 4 weeks, i.e. a total of 12 outings.
Each pair visits 25 households per day, i.e. 50 households per day and per village
50 households x 3 days per week, i.e. 150 households per week per entry point and for 1 month this will be 150 X 4 = 600 households per month.
For 19 villages and neighborhoods around the entry points, we multiply by 600 equal to 11400 households.

How was the target population calculated?
The size of households in CAR is 6 so we target a total of 11400 Households x 6 people or 68400 Directly targeted people
45600+68400=114,400 people targeted by the CREC.
19 supervisors will supervise and coordinate the work of the CHWs at a rate of 1 per entry point covering the volunteers of the entry point and households.
2. Specific vulnerable groups.
Mobile/cross-border populations (traders, fishermen, transporters) that are difficult to reach and highly mobile, favouring the spread.
3. Groups with a key role in influencing social behaviours and norms.
Community, religious and political leaders and media professionals at a rate of 25 per RO base, i.e. 25X9 = 225 Community Leaders.
4. Group at risk of social exposure

Traditional healers, motorcycle taxis, canoeists, drivers at a rate of 25 per RO base, i.e. 25X9 = 225 Community Leaders
5. Actors related to funeral rites (stretcher-bearers, mortars) - 4 per regional hospital (4), district hospitals (9) and central hospitals. (5) i.e. a total of 18x4= 72.
6. Red Cross volunteers and CRCA staff. 40 at the national headquarters and 10 per local branches, i.e. a total of 130 volunteers and national staff.

Explain the selection criteria for the targeted population

1. Health workers, community health workers, traditional healers who consult the sick and are at risk of being in contact with the cases.
2. Hunters for the handling of dead animals.
3. Embalmers who handle bodies.
4. Taxis, motorcycles, canoeists who transport the population from one city to another.
5. Traders who participate in weekly markets where the populations of the 2 neighboring cities mix.

Total Targeted Population

Women	**35,205**	Rural	-
Girls (under 18)	-	Urban	-
Men	**33,825**	People with disabilities (estimated)	-
Boys (under 18)	-		
Total targeted population	69,030		

Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	**Yes**
Does your National Society have prevention of sexual exploitation and abuse policy?	**Yes**
Does your National Society have child protection/child safeguarding policy?	**Yes**
Does your National Society have whistleblower protection policy?	**Yes**
Does your National Society have anti-sexual harassment policy?	**Yes**
Please analyse and indicate potential risks for this operation, its root causes and mitigation actions.	
Risk	Mitigation action

Insecurity linked to armed and inter-community conflicts in some localities leading to Difficulty in accessing at-risk districts, delayed deployment, interruption of activities.	Training of staff and volunteers on safer access and security rules in situations, training on IHL, raising awareness among stakeholders on the mandates of the RED CROSS and RED CRENT Movement.
Deterioration of road infrastructure due to a lack of road maintenance leads to inaccessibility in geographical areas.	Use of other means of transport (UNHAS flight) and communication (flight, thuraya etc).
Reluctance of volunteers to implement certain activities, including Safe and Dignified Burials (DSS), due to lack of awareness and fear of the Ebola virus disease.	Train volunteers on EDS protocols, including hands-on demonstrations. Ensure a good understanding of personal protective measures. Offer psychosocial support to reduce fear and stress for volunteers and communities.
Rumors, beliefs and misinformation (very common with Ebola). Lack of acceptance of interventions (vaccination, isolation).	Organize participatory exchange sessions to answer questions and correct rumours and false beliefs Involve traditional and religious leaders to facilitate acceptance. Establish a community monitoring system to quickly identify and address false information Adapt messages according to the rumors detected Setting up spaces for dialogue to voice concerns
Protection risks, including gender-based violence.	- Train teams on ERP, GBV, child protection concepts and safe referral mechanisms. - Designate ERP focal points for monitoring and secure referencing. - Establish confidential mechanisms for the identification and referral of survivors. - Raise awareness in communities against GBV and violence
Poor coordination among partners leading to duplication of efforts and inefficient use of resources.	Establish or strengthen regular central and decentralized coordination meetings (weekly/monthly). Setting up an information-sharing system.
Reluctance or low acceptance of Red Cross interventions by the Government, which may lead to operational constraints or limited access to areas of intervention.	1. Maintain a regular dialogue with government authorities at all levels 2. Organize briefing and accountability meetings on the activities carried out. 3. Alignment with national priorities. 4. Actively participate in government coordination frameworks (clusters, technical committees). 5. Involvement of the authorities in the activities: Involve government officials in planning and implementation. Invite authorities to field missions and key activities 6. Respecting national administrative procedures.

Please indicate any security and safety concerns for this operation:

- Some areas of intervention in the CAR present security risks related to insecurity (Haut Mbomou, Kembe Satéma, Bangassou and Mobaye) all these areas are classified red according to the IFRC security.

- Potential exposure to Ebola virus disease in the event of introduction for volunteers involved in community activities or EDS.

The following measures will be taken:
- Compliance with the Movement's security procedures (IFRC/ICRC) and close coordination with security actors;
- Carrying out regular security analyses and adapting activities according to the context;
- Limiting travel to high-risk areas and using local volunteers to reduce exposure;
- Training of volunteers on infection prevention (IPC) measures and provision of protective equipment;
- Strengthening community dialogue to improve acceptance and prevent incidents;
- Establishment of secure means of communication (VHF radios, telephones) and evacuation plans in case of emergency.

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

Planned Intervention

Health

Budget: CHF 63,276
Targeted Persons: 35,000

Indicators

Title	Target
Percentage of districts with Personal Protective Equipment (PPE) and Dead Body Management Materials (Training Kit and Starter Kit) including Body Bags, Chlorine and Sprayer Purchased and Stocked	100
Number of EDS teams pre-identified and formed	9
% of districts with an EDS operational plan	100
Number of community, religious leaders, media and relays trained and committed.	225
• Number of priority PoEs with volunteers spreading awareness messages	19
- Disaggregated number of registered individuals (male, female, female, and male) at ports of entry	35,000

Priority Actions

-Carry out rapid mapping of health facilities with morgues in high-risk health districts and identify mortar and stretcher bearers.
- Develop a Memorandum of Understanding or Agreement with the Ministry of Health outlining the role of the NS in DHS for VHFs. Already done cf note attached.
- Update the EDS operational strategy.

• Development of standard operating procedures (SOPs) for EDSs.
• Identification of volunteers in the 9 high-risk districts willing and available to be part of the EDS teams.
• Implementation of a rapid response plan in the event of an EDS alert.
• Training of trainers leading to the constitution of a pool of trainers and potentially two EDS rapid response teams (2 teams of 8 volunteers on EDS including ERP, PEAS and stress management.
- Acquisition of Personal Protective Equipment (PPE)
-Purchase of 1 GDM Training Kit to train 2 teams and 1 GDM Starter Kit including Body bags, chlorine and sprayer
-Development of a plan for EDS vehicles in case of epidemic (1 pick up and 1 hard top and fuel)
As part of the CREC component; The following activities will be carried out:
-Strengthen the capacities of CRCA staff at the national level (40 staff) and members of the 9 local branches (90 or 10 people per local branch) of high-risk districts on EVD prevention and response
• Rapid mapping of traditional healers
• Support for the production of communication materials and supports (A2 and A3 self-adhesive posters, image boxes and leaflets, large A0 posters)
• Broadcast 3 of the key message spots and organize interactive programs per week on community radios on EVD prevention
• Organize the briefing of media professionals, market managers, associations, the Red Cross, religious networks, traditional healers and other community networks/structures (Piroguiers and motorcycle taxis)

Protection, Gender And Inclusion

Budget: CHF 10,318
Targeted Persons: 27

Indicators

Title	Target
- Number of focal points/CSAs trained/recycled on ERP	9
- Number of reporting mechanisms in place	1
- Number of reported ERP incidents	0
- Number of ERP materials developed and pre-positioned (posters, flyers, code of conduct, etc.)	19
Number of districts with developed and pre-positioned ERP awareness materials and tools	9

Priority Actions

• Integrate the ERP and backup training modules into all the training courses of the components of the DREF (CEA; EDS).
• Map at-risk and hard-to-reach groups as well as communication channels tailored to their needs.
• Develop and pre-position data collection tools and awareness-raising materials (ERP, PSEA).
• Plan the purchase of ERP/PSEA materials (posters, flyers, CEA integrated collection sheets, PSEA guide) as part of EVD preparedness in the event of epidemics.
• Identify and retrain the ERP Focal Points of the local branches of the 9 high-risk districts in the context of EVD.
• Setting up the channels for reporting PSEA.

Community Engagement And Accountability

Budget: CHF 27,419
Targeted Persons: 69,030

Indicators

Title	Target
Number of volunteers and CHWs and supervisors trained and deployed around ports of entry and in surrounding communities	95
Number of priority districts with at least 1 functional mechanism for feedback, rumour management and community feedback.	9
Percentage of feedback collected and processed in communities	100

Priority Actions

ACE activities will be carried out within the framework of Operation DREF to gain community buy-in and reduce risk behaviours through appropriate communication, continuous dialogue and active management of community feedback to the most vulnerable populations of households around entry points.
- Organize a rapid survey to understand the needs, preferred communication channels, capacities and context in the risk areas.
- Organize EPiC training for staff and volunteers, including modules on risk communication, community engagement and accountability.
- Identify and train for 05 days 76 potential volunteers/CHWs in the local branches of the 9 high-risk health districts on general knowledge of ACE. management of the feedback mechanism; Community-Based Monitoring, Principles of IMP and Safeguarding.
- Identify influential people within the community.
- Support the organization of educational talks by volunteers with influential people in at-risk communities (2 per health district).
- Organize 9 advocacy meetings with community leaders and political-administrative authorities at the DS level
- Set up a community feedback mechanism (purchase of 16 phones, multiplication of tools), collection of feedback and feedback and deploy 4 pairs of volunteers in charge of the feedback mechanism in the households of the area around the entry point (3 outings per week for 4 weeks) in order to listen and respond to concerns, questions, perceptions and suggestions from the communities.
- Support to the organization of community feedback coordination and analysis meetings and develop FAQs for volunteers based on community feedback trends and translate them into local languages (in collaboration with the health team).

Coordination And Partnerships

Budget: CHF 5,329
Targeted Persons: 200

Indicators

Title	Target
Number of coordination meetings held	12

Priority Actions

• Support to the organization of coordination meetings and sub-units at the MSP.
• Organize coordination meetings of the operation at the headquarters and the 9 DS.
• Communication appropriations for coordination.

Secretariat Services

Budget: CHF 13,323
Targeted Persons: 1

Indicators

Title	Target
Number of lessons learned workshop held	1
Number of IFRC monitoring missions	2
Number of surge deployed	1

Priority Actions

• IFRC Bangui follow-up.
• Reporting & Translation (Final Report).
• Lessons Learned Workshop and Report Writing.
• Surge PHiE and EDS Specialist.

National Society Strengthening

Budget: CHF 30,329
Targeted Persons: 90

Indicators

Title	Target
Number of local branches trained on BOCA	9
Number of vehicles and ambulances undergoing maintenance	6

Priority Actions

• Contribution to the salary of Finance Assistant, EDS Focal Point; ERP, communication assistant.
• Communication of the teams over the 2 months.
• Office supplies and other office expenses - activities.
• Operation of the operational PC CRCA (internet, electricity) at the level of the headquarters and the 9 local branches.
• Maintenance of the 4 vehicles and 2 ambulances.
• Vehicles Fuel.

About Support Services

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

The operation will mobilize technical resources (IFRC/CRCA), support resources, decentralized supervisors and volunteers,
1. Technical and coordination resources
IFRC:
-1 PHIE Surge for technical and strategic support.
- Health and Care Coordinator and Health Representative.

- Senior officer ERP and CEA.

CRCA (national level):
-Head of the Health Department (National Coordinator + IPC Focal Point)
-1 MHPSS Focal Point.
-1 EDS Focal Point.
-1 CEA/ERP Focal Point.
-1 Communication Assistant.

2. Management and Support Resources
-1 Finance Assistant.
-2 Drivers.
-2 vehicles dedicated to EDS activities.

3. Decentralized Operational Resources
- 9 district dissemination focal points (including 1 for Bangui) for field supervision.
- Disaster Managers at the local branch level.

4. Volunteers
- 108 volunteers in total, including: 16 volunteers (2 EDS teams) 92 (76 volunteers and 16 supervisors) volunteers deployed in 19 entry points covering 9 priority districts.

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

The composition of the CRCA/ASC volunteer team will reflect, to the extent possible, the diversity of the targeted communities in terms of gender, age and socio-cultural background. However, some gaps persist such as an under-representation of women in some teams in technical activities such as DHSs and a limited representation of certain groups (e.g. people living with a disability).

To remedy this, measures will be implemented to ensure an inclusive and appropriate response:
- Promotion of gender parity during the deployment of volunteers;
- Raising awareness of the teams on the principles of inclusion, protection and gender;
- Collaboration with community leaders to facilitate access to often marginalized groups.

Will surge personnel be deployed? If yes, please provide the role profile needed.

Yes
The NS will play the role of lead for the EDS component and therefore it needs support Surge PHIE and an EDS specialist
Backup personnel must have:
University degree (Bachelor's/Master's) in:
Public Health
Epidemiology
Medicine or Biomedical Sciences
Statistics or health informatics
Specific training in:
Epidemiological surveillance
Health emergency management
Infection Prevention and Control (IPC)
Monitoring and evaluation in humanitarian contexts
Dead Body Management

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

All purchases will be made by the CRCA and these purchases will involve local suppliers except for EDS equipment and materials which will be purchased by the IFRC in Yaoundé. Simplified tendering procedures will be initiated in accordance with the DREF rules, with an optimised deadline to ensure rapid implementation

How will this operation be monitored?

The operation will be monitored through Planning, Monitoring, Evaluation and Reporting (PMER) mechanisms, building on the existing systems of the CRCA with the support of the IFRC.
1. Tracking systems
Use of harmonized data collection sheets for awareness-raising, CREC and DHS activities.
Regular reporting tools (SitRep, weekly/monthly reports).
Community feedback mechanism to capture perceptions and adjust interventions.
2. Progress Monitoring and Accountability
Main responsibility: CRCA (field teams, supervisors, PMER).
Support: IFRC (data quality, analysis, consolidated reporting).
Regular monitoring by field supervisors and coordination at national level.
3. Key Performance Indicators
Number of operational EDS teams.
Number of feedback collected and processed.
Geographical coverage of activities.
4. Monitoring by the IFRC
Regular follow-up visits by the IFRC will be organised, depending on the security context.
These visits will assess the quality of implementation, verify data and make recommendations.
Remote monitoring (online meetings, review of reports) will complement the field missions.

Please briefly explain the National Societies communication strategy for this operation

1. Internal communication
Internal communication will be based on:
Regular coordination meetings (national and district level) and information sharing through periodic reports (SitRep, activity reports).
The use of operational means of communication (telephone, WhatsApp, VHF radios) for real-time monitoring of activities.
A clear feedback circuit between volunteers, supervisors and national coordination.
2. External communication
The CRCA will ensure proactive communication through: information sharing during coordination meetings (COUSP, working groups).
3. Communication with the community through the establishment of a community feedback mechanism to collect perceptions, concerns and rumours
Engaging community and religious leaders to build acceptance.
The IFRC will support the strategy and visibility of the operation.

Budget Overview

DREF OPERATION

MDRCF034 - Central African Republic
BVD Readiness

Operating Budget

Planned Operations	101 013
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	63 276
Water, Sanitation & Hygiene	0
Protection, Gender and Inclusion	10 318
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	27 419
Environmental Sustainability	0
Enabling Approaches	**48 981**
Coordination and Partnerships	5 329
Secretariat Services	13 323
National Society Strengthening	30 329
TOTAL BUDGET	**149 994**

all amounts in Swiss Francs (CHF)

Internal 23/06/2026 #V2022.01

Click here to download the budget file

Contact Information

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Click here for the reference