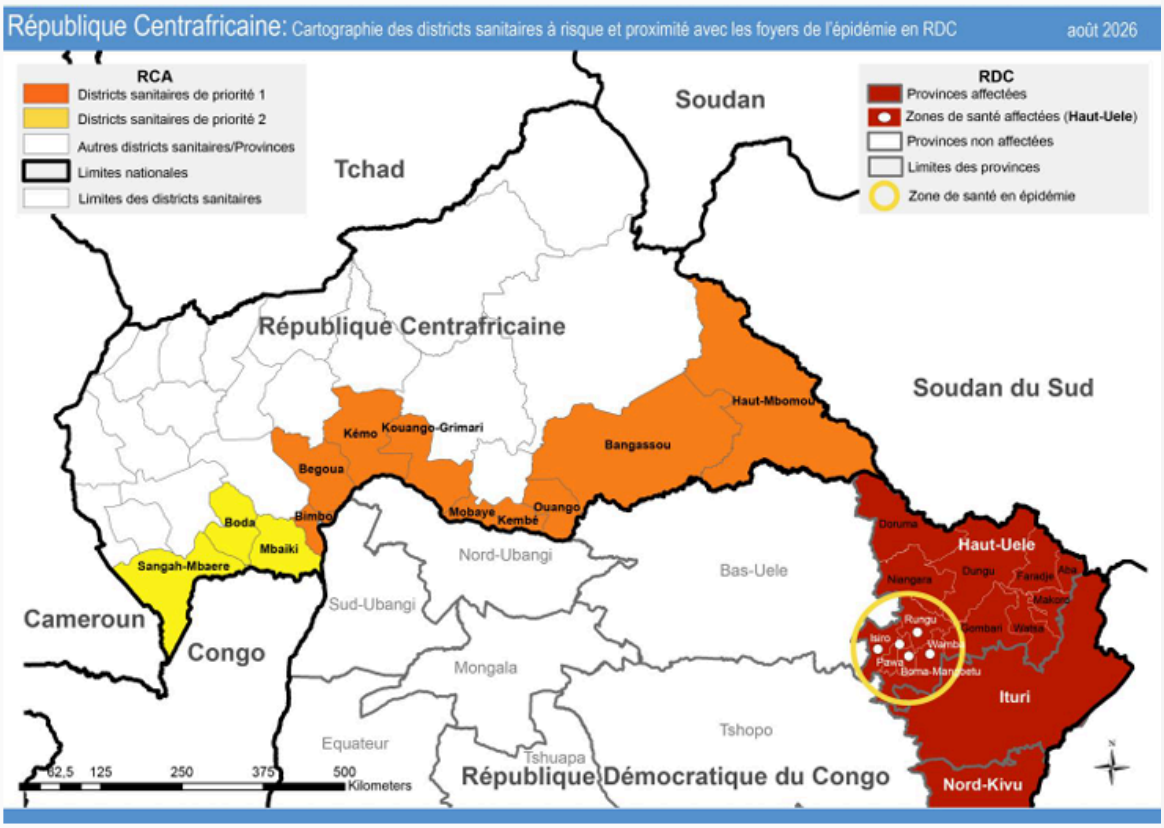
DREF Operational Update

Central African Republic BVD Readiness

Medias briefing

Appeal: **MDRCF034**	Total DREF Allocation: **CHF 149,994**	Crisis Category: **Yellow**	Hazard: **Epidemic**
Glide Number: **-**	People Affected: **2,534,064 people**	People Targeted: **69,030 people**	
Event Onset: **Sudden**	Operation Start Date: **17-06-2026**	New Operational End Date: **31-10-2026**	Total Operating Timeframe: **4 months**
Reporting Timeframe Start Date: **17-06-2026**		Reporting Timeframe End Date: **30-11-2026**	
Additional Allocation Requested: **-**		Targeted Regions: **Bangui, Basse-Kotto, Haut-Mbomou, Kémo, Lobaye, Mbomou, Ombella M'Poko**	

Description of the Event



CARTOGRAPHIE DES ZONES PRIORITAIRES MVE RCA

Date of event

17-05-2026

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 public health emergency. This declaration was rapidly echoed by the World Health Organization (WHO) and the Africa Centres for Disease Control and Prevention (Africa CDC).

At that time, the outbreak was mainly affecting three provinces in the DRC, namely Ituri, North Kivu, and South Kivu. As of 18 June 2026, a total of 33 health zones had reported confirmed cases, distributed as follows:
21 out of 36 health zones (58.3%) in Ituri;
11 out of 34 health zones (32.4%) in North Kivu;
1 health zone in South Kivu.
These figures confirmed that Ituri Province remained the epicentre of the outbreak.
According to WHO data available on 18 June 2026, the DRC had recorded 896 confirmed EVD cases, including 208 deaths and 78 recoveries. Cross-border transmission had also been reported in Uganda, with 19 confirmed cases, including two deaths and seven recoveries.

Although the Central African Republic (CAR) had not reported any confirmed EVD cases at that time, the country remained at high risk of disease importation due to its proximity to affected areas of the DRC. This outbreak, the seventeenth recorded in the DRC and the second associated with the Bundibugyo strain, had progressively expanded towards provinces located near the CAR border, notably Haut-Uélé. Available epidemiological information indicated a high likelihood of ongoing undetected transmission in this province, which, although it

does not share a direct border with CAR, represents an important population movement corridor towards the border provinces of Bas-Uélé and South Ubangi, thereby increasing the risk of regional spread. Furthermore, several public health alerts had been reported in areas close to the CAR border, including:

The report of a death associated with a suspected viral haemorrhagic fever in Libenge Health Zone, South Ubangi Province, which hosts Central African refugees.

A report dated 18 June 2026 from the Chief Medical Officer of Yakoma Health Zone in the DRC regarding a suspected EVD case in a locality bordering Ouango-Gambo Health District in CAR. A sample was collected and sent to the National Institute for Biomedical Research (INRB) in Kinshasa for testing, while the situation was closely monitored.
In this context, although no province directly bordering CAR had been affected at that stage, the combination of proximity to areas of probable transmission, intense cross-border population movements, repeated epidemiological alerts, and limited preparedness capacities fully justified the activation of a DREF preparedness operation. The operation aimed to anticipate and reduce the risk of EVD introduction and spread in CAR through proactive preparedness, community-based surveillance, and community engagement activities. A risk map illustrating the relationship between the affected provinces in the DRC and vulnerable areas in CAR was attached to support this analysis.

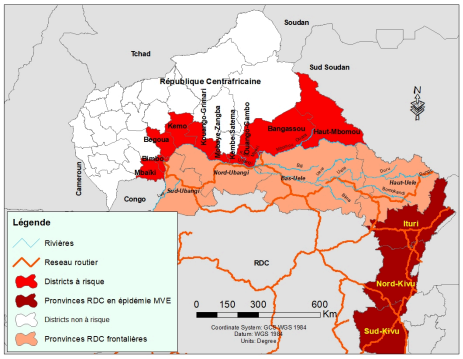
Since the launch of the preparedness operation, seventeen suspected EVD cases have been reported and investigated in CAR. All laboratory results returned negative for Ebola Virus Disease.

However, the epidemiological situation has evolved in a concerning manner over the past two months, with the outbreak progressively spreading to provinces that share a direct border with CAR. In August 2026, Bas-Uélé Province, which borders CAR, reported its first confirmed EVD case in Buta Health Zone, becoming the sixth affected province in the DRC. The confirmed case was linked to travel from Haut-Uélé Province, highlighting the persistent risk associated with population movements between affected areas and border districts in CAR.

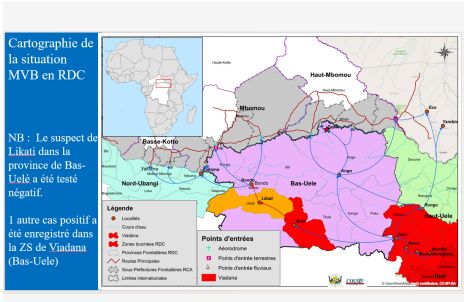
As of 19 August 2026, the epidemiological situation in the DRC reported 103 new confirmed cases and 35 new deaths. The cumulative number of cases had reached 5,208 confirmed cases, compared with 896 cases on 18 June 2026, while cumulative deaths had risen to 2,476, compared with 208 deaths recorded on 18 June 2026. In addition, 84 per cent of identified contacts were under follow-up. On the same date, another confirmed EVD case was reported in Viadana Health Zone, Bas-Uélé Province, in close proximity to the Haut-Mbomou, Mbomou, and Basse-Kotto health districts of the Central African Republic.

The progression of the outbreak is particularly alarming. While three provinces and 33 health zones were affected as of 18 June 2026, the situation by 19 August 2026 had expanded to six provinces and 55 affected health zones. The number of affected provinces therefore doubled within two months, while the number of affected health zones increased by nearly 67 per cent. This continued geographical expansion has brought the outbreak significantly closer to the CAR border and has substantially increased the risk of virus introduction into the country.

In response to this evolving situation, national authorities strengthened preparedness measures. A crisis coordination meeting was convened, and, on 22 August 2026, the Minister of Health led a field mission to Mbomou Prefecture accompanied by a multidisciplinary team. The mission aimed to assess the evolving situation, reinforce preparedness activities, and strengthen coordination mechanisms in areas considered at highest risk of cross-border transmission.
Given the rapid evolution of the outbreak in neighbouring DRC provinces, the recent confirmation of cases in areas bordering CAR, the doubling of affected provinces within only two months, and the continued high volume of cross-border population movements, sustained and strengthened preparedness efforts remain essential to reduce the risk of EVD introduction into the Central African Republic and to ensure the readiness of health authorities, communities, and Central African Red Cross response structures.



Mapping of risk areas



The highest-risk areas in CAR, share borders with affected areas in Bas-Uélé

image showing a practical exercise of wearing PPE during SDB training

image showing CRCA volunteers in CREC activities

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.
No new quantitative preparedness assessment has been conducted since the start of the operation. However, a preparedness checklist covering the different EVD response pillars was completed in August 2026. The results highlighted significant progress in several priority areas, particularly in coordination, community engagement, and the preparedness of Safe and Dignified Burial (SDB) teams. Nevertheless, gaps remain in a number of areas, including the availability of equipment, the full operationalization of response teams, the completion of simulation exercises, and the strengthening of specific technical capacities. These findings confirm the need to continue preparedness activities in order to achieve an adequate level of readiness in the face of the ongoing risk of Ebola Virus Disease (EVD) introduction into the Central African Republic.
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
The risk of EVD introduction into CAR is further heightened by the intensity of cross-border trade and population movements. The Buta-Bondo area, where EVD cases have been reported, is an important commercial corridor frequently used by traders from the Bangassou and Ouango-Gambo districts in CAR. These regular movements of people between affected areas in the DRC and CAR border communities increase the risk of virus importation and underscore the need to sustain and strengthen preparedness measures, community-based surveillance, and risk communication activities at priority points of entry.
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.
No change regarding priority areas and vulnerabilities
As part of this Operational Update, the target population has been revised to take into account the three-month extension of Risk Communication and Community Engagement (RCCE) activities and community feedback collection, as well as the increase in the number of volunteers to be trained for Safe and Dignified Burial (SDB) activities.

For RCCE activities, the operation will continue to mobilize 76 community volunteers (community mobilizers) deployed around the 19 identified priority points of entry (PoEs). In addition, 19 supervisors will be deployed, with one supervisor assigned to each point of entry.

For SDB activities, the target has been significantly increased from 20 to 198 volunteers in order to establish two SDB teams in each targeted locality. Each team is composed of nine members and two drivers, making a total of eleven personnel per team. Across the nine targeted localities, this represents a total of 198 SDB volunteers.

Summary of Changes

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

Please explain the summary of changes and justification:

This Operational Update seeks approval for a two-month extension of the implementation timeframe.

The extension is necessary to address implementation delays resulting from the late transfer of DREF funds and procurement lead times for Safe and Dignified Burial (SDB) kits, which are still pending delivery. It is also justified by the continued high risk of cross-border transmission of Ebola Virus Disease (EVD) from the Democratic Republic of the Congo (DRC) to the Central African Republic (CAR), requiring sustained preparedness activities in high-risk areas.

Although five SDB teams have been identified (two trainer teams based in Bangui and three local teams in Obo, Zemio, and Mboki), they are not yet fully operational. A limited quantity of SDB equipment has been received; however, as of the reporting date, these supplies remain stored at the Ministry of Health and have not yet been deployed to the three targeted localities due to logistical constraints.

As a result, the teams currently lack the minimum equipment required for operational deployment. In addition, simulation exercises and practical drills, which are essential to validating team readiness and functionality, still need to be completed. The extension period will therefore allow for the deployment of equipment, the completion of simulation exercises, and the full operationalization of the SDB teams in the targeted high-risk districts.

Despite these delays, significant progress has been achieved. Under the Safe and Dignified Burials (SDB) and Risk Communication and Community Engagement (RCCE) pillars, the CRCA has finalized its Standard Operating Procedures (SOPs) for SDB, which are currently awaiting formal validation. In addition, four SDB teams have been trained and equipped with operational plans for implementation in three high-risk localities in Haut-Mbomou (Obo, Zemio, and Mboki). Furthermore, 36 volunteers have been trained in RCCE and Social and Behaviour Change (SBC) across these three localities. In the coming days, they will conduct household awareness-raising activities around nine priority points of entry, jointly identified with the Ministry of Health and Population (MoHP), while also collecting community feedback to help strengthen preparedness and response interventions.

For the remaining priority localities, namely Bimbo, Mobaye-Zangba, Mongoumba, Bangassou-Rafaï, and Ouango-Gambo, the deployment of trainers is scheduled for the week of 24 August 2026. This deployment will support the rollout of volunteer training and community-based Social and Behaviour Change (SBC) activities in the targeted communities.

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 is supporting the preparedness process through a contribution of EUR 120,000. In this context, the National Society developed a concept note, which was subsequently submitted to the Ministry of Public Health (MoPH). The proposed intervention focuses on four key pillars: Epidemiological Surveillance and Disease Detection (EDS), Community Engagement and Risk Communication (CERC), Infection Prevention and Control (IPC), and Coordination.

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.
The ICRC supported the CRCA by providing 20 body bags to enhance preparedness and ensure safe and dignified dead body management if needed during the Ebola response. The ICRC also provides logistical support by deploying teams to areas that are difficult to access and which UNHAS is unable to reach.

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 Surveillance and Laboratory Acquisition of a mobile laboratory with support from the World Health Organization (WHO) and the Institut Pasteur de Dakar (IPD). The laboratory was installed in Obo, in the Haut-Mbomou Health District, located along the border with the Democratic Republic of the Congo (DRC) and South Sudan. Laboratory personnel have been

	trained, and the facility is fully operational for the diagnosis of any Viral Hemorrhagic Fever (VHF) cases that may occur in the area. Investigation of 17 suspected cases, all of which tested negative for Ebola Virus Disease (EVD). Operationalization of all 40 official points of entry (PoEs) along the border with the DRC (40/40). Risk Communication and Community Engagement (RCCE) Weekly radio and media programmes led by Ministry of Health experts focusing on the prevention of and response to Bundibugyo Ebola Virus Disease. Dissemination of EVD prevention messages through radio spots and information, education, and communication (IEC) materials, including posters. Case Management / Infection Prevention and Control (IPC) Ongoing efforts to establish an Ebola Treatment Centre (ETC) in Obo, as well as triage and isolation units in high-risk areas, including Mboki, Zemio, and Bambouti. Pre-positioning of Personal Protective Equipment (PPE) in health facilities across the south-eastern part of the country. A second crisis committee meeting since the beginning of Ebola preparations was chaired by the President of the Republic on Monday, August 17, 2026, with the health ministers of the five countries bordering the DRC and at high risk (Uganda, South Sudan, DRC, Congo, and CAR) in attendance. During this session, a draft agreement for cross-border collaboration and coordination was presented and approved. The next step will be the signing.
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 On 14 August 2026, Africa CDC announced an allocation of USD 1.5 million to support Ebola preparedness activities in the Central African Republic. From 14 to 17 August 2026, the World Health Organization (WHO) convened a high-level regional meeting bringing together Africa CDC, CEMAC, and representatives from five countries affected by or at risk of the ongoing Ebola outbreak. The meeting aimed to strengthen cross-border collaboration and coordination through the development and endorsement of a regional cooperation framework. A joint field visit was also conducted in the tri-border area between the Democratic Republic of the Congo, the Central African Republic, and the Republic of the Congo to assess preparedness measures and cross-border surveillance systems. The IFRC Regional Director for Africa was invited to the meeting and was represented by the IFRC Bangui Cluster Delegation.

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.
No major changes have been reported in the coordination structure. Coordination mechanisms continue to function effectively at the national level and have been further strengthened at the decentralized level through enhanced engagement of district authorities, technical partners, and local response actors in high-risk areas.

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
For this update, we'll be looking at reviewing the need for the number of EDS teams per location to 2 and making sure the training happens, whereas in the DREF currently under revision, it was only planned to train the trainers to train 2 potential EDS teams.

Operational Strategy

Overall objective of the operation

The IFRC DREF operation objective will remain to support the Government of the Central African Republic in maintaining and strengthening Ebola Virus Disease (EVD) preparedness in priority high-risk districts by enhancing community engagement and surveillance, operationalizing Safe and Dignified Burial teams, reinforcing coordination mechanisms, and improving readiness to detect and respond rapidly to a potential cross-border introduction of EVD from the Democratic Republic of Congo. Until October 2026, the IFRC-DREF allocation will be implemented in alignment with that contribution.

Operation strategy rationale

This DREF operation followed the national contingency plan and was implemented under Activation Level 0: Enhanced Standby / Preparedness, in a context where no confirmed Ebola Virus Disease (EVD) cases had been reported in the Central African Republic (CAR), but where the risk of importation from the Democratic Republic of the Congo (DRC) continued to increase due to the geographical expansion of the outbreak towards CAR border areas. This preventive scenario remains the one implemented with now an even higher importance considering the evolving context.

NS will therefore continue with the 4 main priorities:(1) strengthening Risk Communication and Community Engagement (RCCE), (2) strengthening Safe and Dignified Burial (SDB) capacity, and (3) supporting coordination and preparedness in high-risk districts (4)

Ensuring NS community-centred approach is designed and ready to address key weaknesses in Protection, Gender and Inclusion (PGI) integration, and coordination challenges at local level.

During the implementation period, important progress was achieved. The CRCA finalized and updated its SDB Standard Operating Procedures (SOPs), established five SDB teams, including two national trainer teams based in Bangui and three local teams in Obo, Zemio and Mboki, and trained 25 trainers who now form the core surge capacity for SDB preparedness. Community engagement activities also progressed, with 40 national staff members trained on Ebola preparedness and response, 36 volunteers trained on RCCE and Social and Behaviour Change (SBC), awareness sessions conducted for media professionals, civil society representatives, market leaders and transport associations, and advocacy meetings held with local authorities and community leaders in high-risk localities. Two Ebola prevention radio spots were produced and disseminated through local radio stations, while community feedback mechanisms were established in the first intervention areas. In addition, CRCA volunteers contributed to community-based surveillance activities, supporting the reporting and referral of alerts through established mechanisms.

On the RCCE/CEA strategies, beyond NS readiness with training of the potential response teams, the operation planned to disseminate harmonized prevention messages through community outreach, media engagement, local leaders, and awareness activities around 19 priority points of entry (PoEs) and surrounding communities. In parallel, volunteers were expected to collect community feedback and contribute to early warning and alert systems.

The operation also integrated Protection, Gender and Inclusion (PGI) considerations by incorporating PGI modules into SDB and RCCE trainings, identifying branch-level PGI focal points, and establishing reporting mechanisms. However, several planned activities could not be completed within the original timeframe due to delayed fund transfers, prolonged procurement and transportation lead times for SDB equipment, logistical constraints affecting access to targeted locations, and the delayed delivery of Personal Protective Equipment (PPE) and SDB kits required for training, simulations and deployment. As a result, many SDB teams remain only partially operational, simulation exercises have not yet been conducted, and several RCCE, PGI and branch-level preparedness activities remain pending.

The extension period will therefore focus on completing the remaining preparedness activities and strengthening operational readiness in the highest-risk areas. Priority actions will include the validation and deployment of SDB SOPs, receipt and pre-positioning of PPE and SDB kits, training and operationalization of SDB teams in the remaining high-risk localities, establishment of operational bases, completion of simulation exercises and drills, and development of costed operational plans for all teams. RCCE activities will be expanded to the remaining priority localities through volunteer deployment around points of entry and border communities, with continued awareness campaigns, community feedback collection, radio programming, advocacy meetings, and engagement with community leaders and high-risk professional groups.

The extension will also allow completion of delayed PGI activities, including refresher training for PGI focal points, mapping of vulnerable and hard-to-reach groups, deployment of PGI materials and referral pathways, and strengthening of safeguarding, child protection, GBV and accountability mechanisms. Operational coordination will continue to be reinforced through support to local coordination structures, supervision missions, monitoring activities and collaboration with the Ministry of Health, WHO and other partners. Collectively, these activities remain aligned with the original preparedness objective of reducing the risk of EVD introduction and ensuring that communities, volunteers, local authorities and CRCA response structures possess the capacities required to respond rapidly and effectively to a potential Ebola alert or outbreak in the Central African Republic.

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.

A change has been made to the methodology used to calculate the target population. In the original DREF currently under revision, the methodology outlined below was used during the initial planning phase to calculate the target population for Risk Communication and

Community Engagement (RCCE) activities.
Methods of calculating this population - The operation covers 9 priority health districts, comprising a total of 19 strategic entry points.
It should be noted that the operation does not cover all nine priority health districts identified under the preparedness plan. Instead, it focuses on high-risk localities bordering the Democratic Republic of the Congo (DRC) and key points of entry considered most vulnerable to Ebola Virus Disease (EVD) importation. For example, in Haut-Mbomou Health District, activities are being implemented in the localities of Obo, Zemio, and Mboki. To date, the operation has covered these three localities within a single health district. The rollout of activities in the remaining priority localities located in Bimbo, Mobaye-Zangba, Mongoumba, Bangassou-Rafaï, and Ouango-Gambo health districts is planned during the extension period.

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 3 months. 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.
As part of this Operational Update, the target population has been revised to reflect the three-month extension of Risk Communication and Community Engagement (RCCE) and community feedback activities, as well as the need to strengthen operational capacity for Safe and Dignified Burial (SDB) interventions.
For this Operational Update, the following methodology was used to calculate the target population, with revised assumptions compared to those applied in the original DREF.
This revision is based on several strategic adjustments. First, the number of volunteers to be trained for SDB activities has been increased to ensure the availability of sufficient operational teams in high-risk localities. This increase will strengthen deployment capacity and geographical coverage in the event of an alert or outbreak.
In addition, the implementation approach for RCCE activities has been adapted. While the initial plan envisaged each volunteer reaching 25 households per day individually, activities will now be conducted in pairs. Each pair of volunteers will cover 25 households per day while simultaneously conducting awareness-raising activities and collecting community feedback. This approach is intended to improve the quality of community interactions, strengthen feedback collection mechanisms, and enhance volunteer safety during field activities.
No changes have been made to the specific groups targeted by the operation. The population groups identified during the initial approval of the operation remain unchanged. However, in line with the risk-based targeting approach, activities for these vulnerable groups will be implemented only in the priority localities and points of entry located along the border with the Democratic Republic of the Congo (DRC), rather than across the entire health districts concerned. This approach enables available resources to be focused on the areas at highest risk of Ebola Virus Disease (EVD) introduction and transmission.
1. Specific vulnerable groups.
Mobile/cross-border populations (traders, fishermen, transporters) that are difficult to reach and highly mobile, favouring the spread.
2. 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.
3. 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
4. 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 9x4= 36.
5. 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.

no changed according to the selection criteria for the targeted population.

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.
Delay in the transfer of funds to CRCA affected the timely implementation of planned activities.	Anticipate fund transfers to enable the early start of activities, where possible prior to the completion of the MoU signing process.

	Prioritize local fund transfers to reduce administrative delays and accelerate implementation. Promote pre-financing mechanisms by IFRC and CRCA for critical preparedness activities when operationally feasible.
Lengthy international procurement lead times affected the timely availability of essential supplies.	Future operations should anticipate procurement processes earlier and, where possible, prioritize local or regional sourcing mechanisms to ensure timely delivery of critical equipment.
Delays in the transportation of SDB equipment to hard-to-reach locations: Logistical constraints related to the air transport of nationally and internationally procured SDB equipment may delay its deployment to targeted border localities, thereby affecting the operational readiness of SDB teams and the implementation of planned simulation exercises.	Adequate budget provisions will be made for cargo transportation and, where necessary, special flights to ensure the timely delivery of SDB equipment to targeted localities. Coordination will also be strengthened with the International Committee of the Red Cross (ICRC), which operates regular flights to the intervention areas, to facilitate the transport of equipment and personnel.

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.

No significant changes in the security situation were reported during the reporting period.

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

Planned Intervention

Health

Budget: CHF 64,075
Targeted Persons: 228,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
Number of localities have kit SDB	1	0

Number of EDS teams pre-identified	9	5
Number of localities with an EDS operational plan	9	1
Number of community, religious leaders, media and relays trained and committed.	225	100
• Number of priority PoEs with volunteers spreading awareness messages	19	0
- Disaggregated number of registered individuals (male, female, female, and male) at ports of entry	35,000	0
SOP mis a jour et valide	1	1
Number of local branches that received training on ECV and PSSBC	19	0

Progress Towards Outcome

Progress on SDB

Rapid mapping of health facilities with morgues is ongoing in the nine high-risk health districts, together with the identification of stretcher bearers and individuals who could support dead body management activities. The Memorandum of Understanding defining the role of the National Society in Safe and Dignified Dead Body Management during Viral Haemorrhagic Fever outbreaks was already established through an official Ministry of Health directive designating the Central African Red Cross (CRCA) as the lead organization for Dead Body Management. The Safe and Dignified Burial (SDB) Standard Operating Procedures (SOPs) were updated and finalized and are currently awaiting formal endorsement. Twenty-five trainers were trained and five SDB teams have been identified and are available for deployment, including two trainer teams in Bangui and three district-level teams in Obo, Zemio and Mboki.

Progress on procurement and PPE

Procurement of Personal Protective Equipment (PPE) has been partially completed, although internationally procured items are still pending delivery. Contact lists for morgue attendants and stretcher bearers from the two existing morgues were also established.
The internationally procured PPE and SDB equipment are still pending delivery, with shipment arrangements underway. As a result, key preparedness activities such as equipping teams, completing training in remaining locations, and conducting simulation exercises have been delayed. The receipt of PPE, training kits and SDB starter kits is expected by September 2026, with the objective of fully operationalizing the SDB teams and completing the remaining preparedness activities by the end of September 2026/ mid october.

Progress on the RCCE/CREC

Under the Community Engagement and Risk Communication component, the capacities of 40 CRCA staff members at national level were strengthened on Ebola Virus Disease prevention and response, while branch-level training remains pending. The production of Information, Education and Communication (IEC) materials is ongoing. Two radio spots containing key EVD prevention messages in French and Sango were produced and distributed to four radio stations, resulting in 24 broadcasts in Bangui and Obo. Interactive radio programmes on Ebola prevention and preparedness have also started. In addition, awareness and briefing sessions were conducted for media professionals, market leaders, motorcycle taxi representatives and civil society organizations, while advocacy meetings were organized with community leaders and local authorities in Obo, Zemio and Mboki to strengthen community engagement and preparedness.

Challenges Encountered

Implementation of the operation was affected by delays in the procurement and delivery of Personal Protective Equipment (PPE) and Safe and Dignified Burial (SDB) kits, logistical constraints linked to transporting equipment to hard-to-reach areas accessible primarily by air, and limited availability of transport and operational bases in some targeted localities. In addition, RCCE activities faced challenges in reaching all community radio stations operating in high-risk areas, while the lack of communication and documentation equipment

limited outreach, visibility, documentation of activities and community feedback collection. These constraints delayed the full operationalization of SDB teams and the rollout of awareness activities in all planned locations.

Remaining Activities

During the extension period, priority actions will focus on the validation and dissemination of the finalized SDB Standard Operating Procedures (SOPs), completion of the SDB team registry, identification and establishment of operational bases, finalization of operational plans, receipt and deployment of PPE and SDB kits, completion of pending volunteer trainings, and the organization of refresher trainings and simulation exercises to ensure full operational readiness.

Under RCCE, efforts will focus on completing the production and distribution of IEC materials, continuing radio broadcasts and interactive programmes, conducting the remaining advocacy meetings and media briefings, deploying trained facilitators in the remaining targeted areas, and strengthening community feedback and awareness activities in high-risk localities and points of entry.

Protection, Gender And Inclusion

Budget: CHF 10,318
Targeted Persons: 2,500
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
- Number of focal points/CSAs trained/recycled on ERP	27	3
- Number of reporting mechanisms in place	1	1
- Number of reported ERP incidents	0	0
- Number of ERP materials developed and pre-positioned (posters, flyers, code of conduct, etc.)	1,900	0
Number of localities with developed and pre-positioned ERP awareness materials and tools	19	0

Progress Towards Outcome

During the implementation period of this DREF operation, Protection, Gender and Inclusion (PGI) considerations were integrated across preparedness activities. PGI modules were developed and incorporated into the Safe and Dignified Burial (SDB) Standard Operating Procedures (SOPs). They were also included in training sessions conducted for Central African Red Cross-national staff and volunteers involved in both Safe and Dignified Burial (SDB) and Risk Communication and Community Engagement (RCCE) activities.

Three PGI focal points from the local branches within the three high-risk localities have been identified and will receive refresher training on the integration of Protection, Gender and Inclusion (PGI) in the context of Ebola Virus Disease (EVD) preparedness and response.

A rapid assessment to map vulnerable populations and communities' preferred communication channels, together with the training of volunteers on Risk Communication and Community Engagement (RCCE), Protection, Gender and Inclusion (PGI), Social and Behaviour Change (SBC), and Infection Prevention and Control (IPC), is scheduled to commence during the week of 24 August, in line with the deployment plan for trainers in the targeted areas.

The remaining activities under this component include:

Refresher training for the six PGI focal points in the targeted high-risk localities.
Completion of the mapping of vulnerable and hard-to-reach groups, including the identification of communication channels adapted to their specific needs.
Deployment of trained volunteers to conduct community outreach activities while ensuring the integration of Protection, Gender and Inclusion (PGI) considerations.
Integration of PGI findings and recommendations into Risk Communication and Community Engagement (RCCE), Social and Behaviour Change (SBC), and community feedback activities.

Strengthening referral pathways and community-based mechanisms for the identification and support of vulnerable groups.

Ensuring that awareness-raising messages and communication materials are accessible and adapted to the needs of women, children, older persons, persons with disabilities, and other vulnerable populations.

Monitoring the effectiveness of PGI interventions and documenting lessons learned to inform future preparedness and response activities.

Particular attention will also be given to the deployment of PGI and communication materials to the localities of Obo, Zemio, and Mboki, where volunteers and focal points have already received training but are still awaiting the necessary materials and tools to effectively implement the planned activities. The distribution of these materials will be prioritized to ensure the full operationalization of PGI interventions and the effective dissemination of information on complaint and feedback mechanisms in these high-risk localities.

Community Engagement And Accountability

Budget: CHF 26,620
Targeted Persons: 228,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
Number of volunteers and CHWs and supervisors trained and deployed around ports of entry and in surrounding communities	92	0
Number of priority localities with at least 1 functional mechanism for feedback, rumour management and community feedback.	19	0
Percentage of feedback collected and processed in communities	100	0

Progress Towards Outcome

Community feedback mechanisms were established and operationalized in the priority areas of Obo, Zemio and Mboki (Haut-Mbomou Health District). CRCA volunteers have initiated feedback collection through door-to-door activities and the Ministry of Health's 1212 hotline.

The first community feedback report is expected during the week of 31 August 2026.
Reporting tools: Daily point of entry data collection forms and Ministry of Health summary reporting forms are used for surveillance and reporting.

Alert reporting pathway: Community volunteers collect surveillance and SBC data at points of entry and during household visits. Information is submitted daily to the District Surveillance Officer, who forwards it to the Ministry of Health and shares it with the Ebola Technical Working Group.

Surveillance results: To date, 5,144 alerts have been reported, 764 verified, and 119 investigated/referred, contributing to strengthened

community-based surveillance and early warning capacities.

Volunteer teams are organized into groups of four, with two volunteers deployed at points of entry and two assigned to community feedback collection activities. Community-Based Surveillance (CBS) alerts are captured through daily reports from points of entry, door-to-door visits, the national toll-free hotline (1212), and direct reporting by community members.

These reports are submitted to District Surveillance Officers, who compile and analyse the information before forwarding it to the Public Health Emergency Operations Centre (PHEOC/COUSP). Since the declaration of the Ebola outbreak, the PHEOC has convened daily coordination meetings to review surveillance data, monitor trends, and guide preparedness and response actions.

Changes to existing activities

All activities will continue to be implemented in the 9 health districts, with expanded coverage to 19 localities. Consequently, all existing activities will be carried out across the 19 targeted localities. For expansion of the readiness, NS is exploring further support beyond the DREF.

Coordination And Partnerships

Budget: CHF 5,329
Targeted Persons: 500
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
Number of coordination meetings held	20	4
Number of individuals receiving communication credits was increased to ensure effective coordination, communication, and reporting across all coordination pillars throughout the six-month operation.	36	0
number of update meetings organised	4	0

Progress Towards Outcome

Four (4) coordination meetings were organized at CRCA headquarters and in the three targeted localities of the Haut-Mbomou Health District (Obo, Zemio, and Mboki), facilitating information sharing, activity planning, and coordination among stakeholders involved in EVD preparedness.

Coordination mechanisms at branch and community levels have been established and are functioning in the three localities currently covered by the operation. Preparatory work for the establishment of coordination structures in the remaining targeted localities has been initiated and will be completed during the deployment mission planned for the week of 24 August 2026. Coordination and information sharing with the Ministry of Health and Population (MoHP), WHO, and other partners have continued throughout the implementation period.

Changes

No major changes are proposed under this component. However, additional support will be provided to strengthen coordination mechanisms at branch and local levels during the extension period.
The number of supervision and coordination missions will be increased to support the expansion of activities to additional high-risk localities.

Challenges Encountered

Delays in the deployment of coordination structures in the remaining targeted localities due to the phased implementation approach.

No direct support has yet been provided to the Ministry of Health and Population (MoHP) for the organization and functioning of coordination meetings and technical sub-committees.

Establish and operationalize coordination structures in the remaining targeted localities during the deployment mission scheduled for the week of 24 August 2026.

Support the organization of coordination meetings and technical sub-committee meetings led by the Ministry of Health and Population (MoHP), starting in September 2026 and continuing throughout the extension period.

Strengthen information sharing and coordination between CRCA, MoHP, WHO, and other partners involved in EVD preparedness activities.

Revised Activities

1. Meeting quantities were doubled to account for the extension period, with four meetings per month over five months, for a total of 20 meetings in central level. A total of 20 meetings will be held at the central level and 360 meetings at the decentralized level to support coordination and implementation throughout the extended operational period.

2. Communication credits are provided for the five coordination pillars and PGI for six months, resulting in a total of 36 allocations throughout the operation.

New activities

1. All decentralized coordination activities will be implemented in 18 localities instead of 9 districts. This expansion of geographical coverage is intended to strengthen preparedness, coordination, supervision, and response capacities at the local level, particularly in hard-to-reach and high-risk areas. The increase from 9 districts to 19 localities will consequently require additional operational and coordination

2. Monthly narrative and financial update reports will be prepared and shared to ensure regular monitoring of activities, accountability, timely decision-making, and effective communication with stakeholders regarding program progress and financial performance.

Secretariat Services

Budget: CHF 13,323
Targeted Persons: 25
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
Number of lessons learned workshop held	1	0
Number of IFRC monitoring missions	1	0
Number of surge deployed	1	1

Progress Towards Outcome

A surge support delegate was deployed for 10 days and provided technical support to the operation. During the mission, the surge supported the training of volunteers on Event-Based Surveillance (EBS/EDS), contributed to the revision and updating of the Standard

Operating Procedures (SOPs), and provided guidance on preparedness activities. Following the deployment, the surge will continue to provide remote technical support to the National Society to ensure the effective implementation of planned activities and ongoing technical follow-up.

No formal surge support requirements have been identified by CRCA to date. Existing preparedness activities are currently being implemented using available CRCA capacities, with support from IFRC and partners. Any future surge needs will be assessed and addressed based on operational requirements and available funding.

On 16 August 2026, IFRC participated in a joint assessment of surveillance and screening systems at points of entry in Mongoumba, alongside the Ministers of Health of South Sudan, Uganda, the Democratic Republic of Congo, the Republic of Congo, and the Central African Republic. The mission was conducted within the framework of cross-border coordination and collaboration efforts to strengthen regional preparedness and response to the ongoing Ebola outbreak.

The IFRC monitoring mission is planned for the week of 24 August 2026 to assess progress and support the implementation of Ebola preparedness activities in the target areas.

No changes are proposed to the planned activities under this component. All activities remain relevant and will continue during the extension period with stronger and closer monitoring and coordination.

Challenges Encountered
- Limited dedicated personnel available to support the implementation and follow-up of the operation.
Remote surge support has proven insufficient to effectively address operational and technical needs in real time.
- A Need for in-country surge support to strengthen coordination, monitoring, reporting, and technical guidance throughout the extension period.
- Persistent insecurity in the operational areas prevented the surge personnel from conducting field visits to supervise and mentor the recently trained facilitators. As a result, opportunities for direct monitoring, technical support, and quality assurance of implemented activities were limited.

Mitigation measures:
- To address this challenge, a remote monitoring mechanism was established through regular coordination meetings, phone calls, and systematic review of activity reports. The Central African Red Cross also benefited from the technical support and close field follow-up provided by the World Health Organization (WHO) and the Ministry of Health and Population (MoHP), which helped ensure continued supervision and implementation of activities in the targeted areas.
- For a surge support, the IFRC BVD coordination team and health team are analysing the possibility of support.

National Society Strengthening

Budget: CHF 30,329
Targeted Persons: 190
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
Number of vehicles and ambulances undergoing maintenance	6	0

Progress Towards Outcome

Under the National Society Development component, several interventions have been successfully implemented during the reporting period, while others are currently ongoing in line with the operational plan.

The Head of Health Department, a Finance Assistant, a PGI Focal Point, a Communication Assistant and an SDB Focal Point were designated to support the implementation of the operation. While this core team ensured the coordination of key preparedness activities, the increasing scope of interventions and the geographical expansion of activities highlighted the need for additional

operational support capacity.

Maintenance and repair work on four vehicles and two ambulances are currently underway to support operational deployment and field supervision activities.

Office supplies for the nine targeted branches have been procured, with part of the supplies already delivered to the field. These materials support the day-to-day management and coordination of preparedness activities.

The functioning of the response coordination team was ensured through support for key staff positions, including the Finance Assistant, the EDS Focal Point, the PGI Officer, and the Communication Assistant.
and also, PSP focal point whose need had not been identified during the initial planning phase

Communication between field teams, local branches, and headquarters was maintained throughout the implementation period, facilitating the monitoring and coordination of preparedness activities.

Office supplies and essential operational resources were provided, enabling the smooth implementation of planned activities. Fuel was provided to support staff and volunteer movements, as well as supervision missions, thereby facilitating the effective implementation of activities in the targeted areas.

In the extension, all the planned activities remain relevant and will continue during the extension period to ensure the achievement of the Ebola Virus Disease (EVD) preparedness objectives.

Challenges: The main challenge identified under this component is the limited capacity of the Health Department team to independently manage and report on the DREF operation through the IFRC GO platform. This has highlighted the need for additional capacity strengthening to enable staff to effectively plan, monitor, report on activities, and update operational information directly in GO.

Mitigation measure: Capacity strengthening sessions will be organized for the Health Department team on DREF management, including practical training on the IFRC GO platform, to enhance their ability to independently manage operational updates, monitoring, reporting, and data entry requirements.

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.
-1 Assistant PMER
-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
- 293 volunteers in total, including: 198 volunteers (2 EDS teams par district soit 18 equipes x 11 membres) 95 (76 volunteers and 19 supervisors) volunteers deployed in 19 entry points covering 9 priority districts.
A change has been made to this component to reflect the additional human resources required to effectively support the implementation, monitoring, and reporting of the operation during the extension period.

The revised budget includes support for a Psychosocial Support (PSS) Focal Point, whose role is essential to ensure the integration and implementation of psychosocial support activities within the EVD preparedness operation.

In addition, the budget revision includes the deployment of a Surge support staff member to provide technical and operational support, strengthen field supervision, mentoring, and coordination activities, and build the capacity of the National Society team.

An PMER Assistant has also been included to strengthen monitoring, data collection and analysis, indicator tracking, information management, and the timely production of operational reports. This additional capacity is necessary given the expansion of activities, the increased number of targeted localities, and the reporting requirements associated with the extension period.

These adjustments will help ensure the effective implementation, monitoring, coordination, and reporting of the operation while strengthening the overall preparedness capacity of the Central African Red Cross.

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? Please provide the role profile needed.

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
No changement in this section; the needs of surge of this operation is important

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.

no change about this section.

Delays in the procurement process affected the timely acquisition and delivery of critical supplies and equipment required for the implementation of preparedness activities. The lead times associated with procurement procedures, supplier availability, and transportation arrangements contributed to delays in the operationalization of some planned activities, particularly those related to SDB preparedness.

Mitigation measure

Procurement planning will be strengthened through earlier initiation of purchase requests, closer follow-up with suppliers, and the exploration of sub-regional procurement options to reduce lead times and ensure the timely availability of essential supplies and equipment.

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.
For the follow-up part, if the operation needs to continue, there is a need for a PMER assistant who can help with monitoring and producing reports on time.

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.
no change for this section

Contact Information

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

National Society contact:
MANDAZIMBALLAH Leandre, Chef de departement sante CRCA, lmandazimballah@gmail.com, 00236 72 83 15 73

IFRC Appeal Manager: Adinoyi Adeiza, Head of Delegation, adinoyi.adeiza@ifrc.org

IFRC Project Manager: Christel GAUNEFET, Focal Point CBH, christel.GAUNEFET@ifrc.org

IFRC focal point for the emergency: Regis KOHOWA PATAKI, Senior officer CEA PGI IFRC, regis.kowoho@ifrc.org, 00236 74 39 34 81

Media Contact: DOUMTA Bienvenu, Chef de departement communication, doumyb@yahoo.fr, 00236 72025579

National Societies' Integrity Focal Point:
KOYENGUE Jocelyne, Point Focal Protection Genre et Inclusion, jocelynekoyenga.nzenga@gmail.com, 00236 72 19 28 81

National Society Hotline: 00236 72 10 17 11

Click here for the reference