EMERGENCY APPEAL

OPERATIONAL STRATEGY

Democratic Republic of the Congo (DRC), Africa | Ebola

Briefing session with volunteers in preparation for Risk Communication and Community Engagement (RCCE) activities Bulape/Kasai province. (Source: DRC Red Cross)

Appeal №: **MDRCD047**	To be assisted: **965,000 people**	Appeal launched: **15/09/2025**
Glide №: **EP-2025-000157-COD**	DREF loan allocated: **CHF 1,750,000**	Disaster Categorisation: **Red**
Operation start date: **15/09/2025**	Operation end date: **30/09/2026**	

IFRC Secretariat Funding requirement: CHF 17 million
Federation-wide funding requirement: CHF 20 million[1]

[1] The Federation-wide funding requirement encompasses all financial support to be directed to the DRC Red Cross (DRC RC) in response to the emergency. It includes the DRC RC's domestic fundraising requests and the fundraising appeals of supporting Red Cross and Red Crescent National Societies (CHF 3 million), as well as the funding requirements of the IFRC secretariat (CHF 17 million). This comprehensive approach ensures that all available resources are mobilised to address the urgent humanitarian needs of the affected communities.

TIMELINE

DRC Red Cross volunteers helping communities protect themselves from Ebola through handwashing and hygiene education in Bulape/Kasai Province. (Source: DRC Red Cross)

20 August 2025: The first known index case is a pregnant woman who arrived at Bulape General Reference Hospital with symptoms of high fever, bloody diarrhoea, haemorrhage, and extreme weakness.

4 September 2025: MoH declares the sixteenth Ebola outbreak in the Bulape health zone, Kasai Province.

5 September 2025: Movement partners in-country engage in initial discussions on the Ebola response as part of the regular monthly Movement Coordination meeting.

9 September 2025: IFRC Rapid Response Management System alerts are sent for an Operations Manager, Field Coordinator, PHiE Coordinator, and Supply Chain coordination.

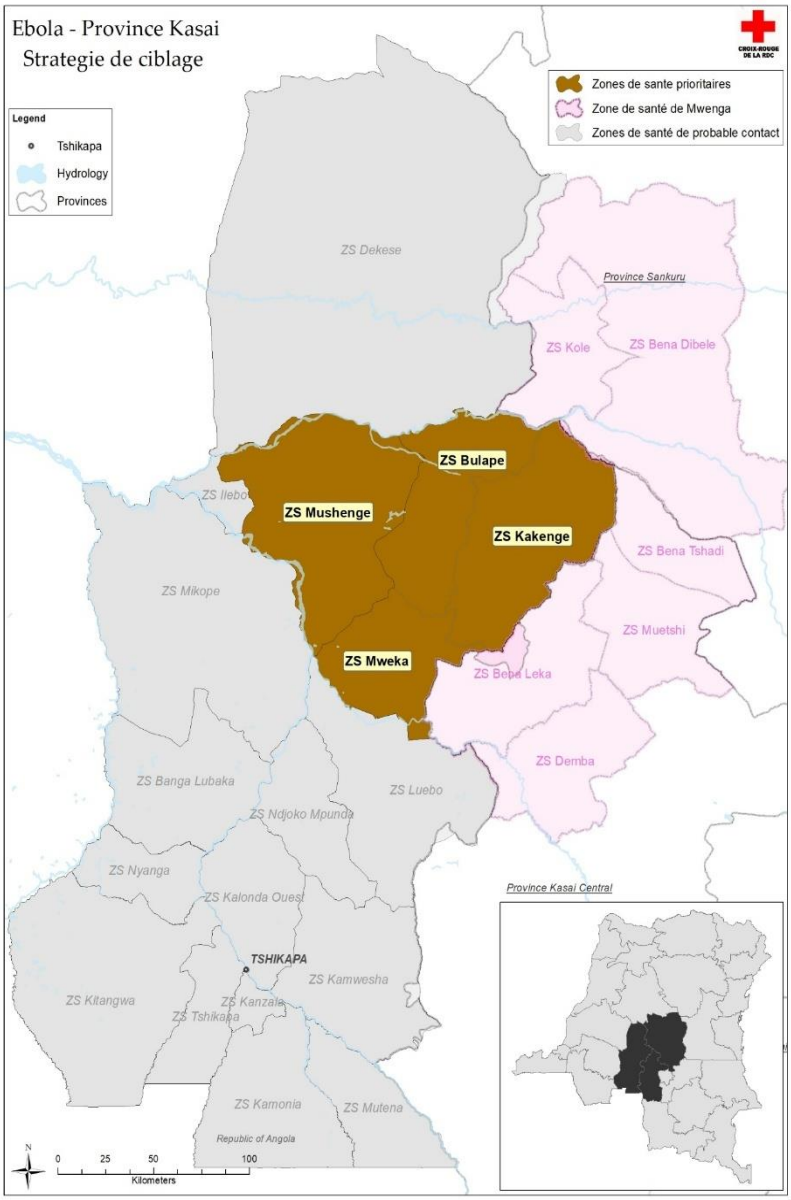
10 September 2025: The DRC RC convenes a meeting of Movement partners in-country to brief them on the situation and coordinate the initial response.

12 September 2025: The IFRC Secretary General approves the launch of an Emergency Appeal of CHF 17M and declares the sixteenth Ebola outbreak in the DRC a Red Emergency as per the IFRC Emergency Response Framework.

13 September 2025: A team of national staff from the DRC Red Cross and IFRC travel to Kasai Province and meet with the local branch of the DRC Red Cross and health authorities. Ebola vaccination begins in the Democratic Republic of Congo.

15 September 2025: The IFRC launches the Emergency Appeal and allocates CHF 1.75M from the Disaster Emergency Response Fund (DREF) to kick-off the operation.

DESCRIPTION OF THE EVENT



On 4 September 2025, the Ministry of Health officially declared an Ebola Virus Disease (EVD) outbreak in Kasai Province (Bulape, Mweka, Mushenge, and Kakenge health zones). National authorities then quickly activated the Public Health Emergency Operations Centre (COUSP), mobilising rapid response teams, strengthening epidemiological surveillance, and organising triage and isolation facilities.

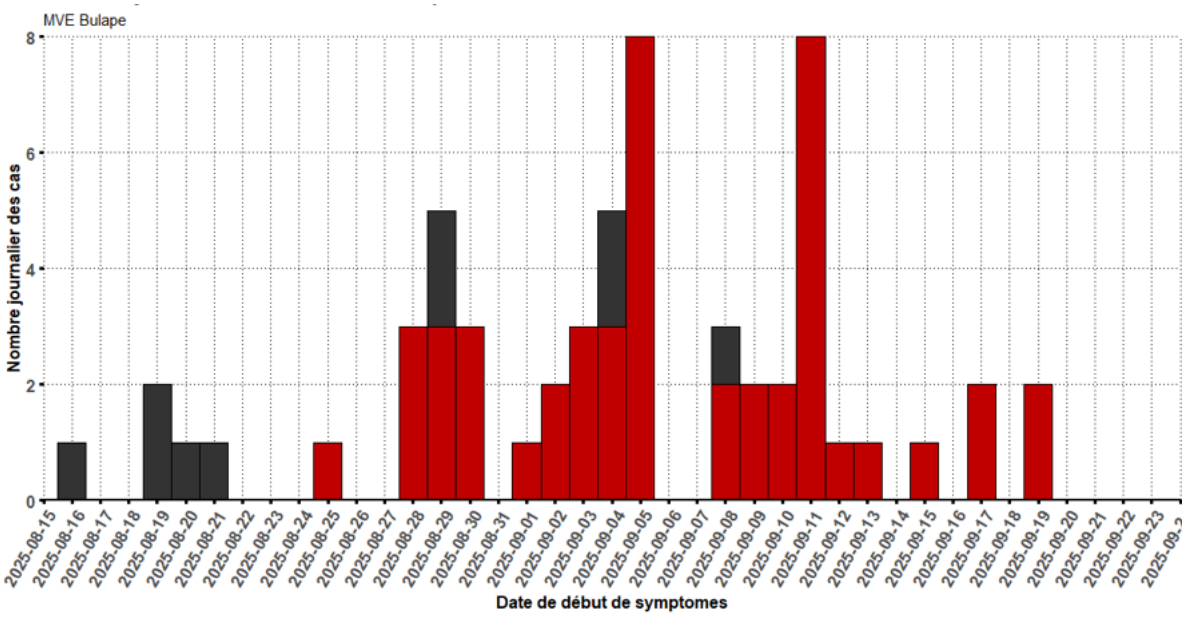
The first known index case was a pregnant woman reported on 20 August 2025 in Bulape health zone, who later died on 25 August after experiencing high fever, bloody diarrhoea, haemorrhage, and extreme weakness. The source of the outbreak has not yet been identified as of 23 September.

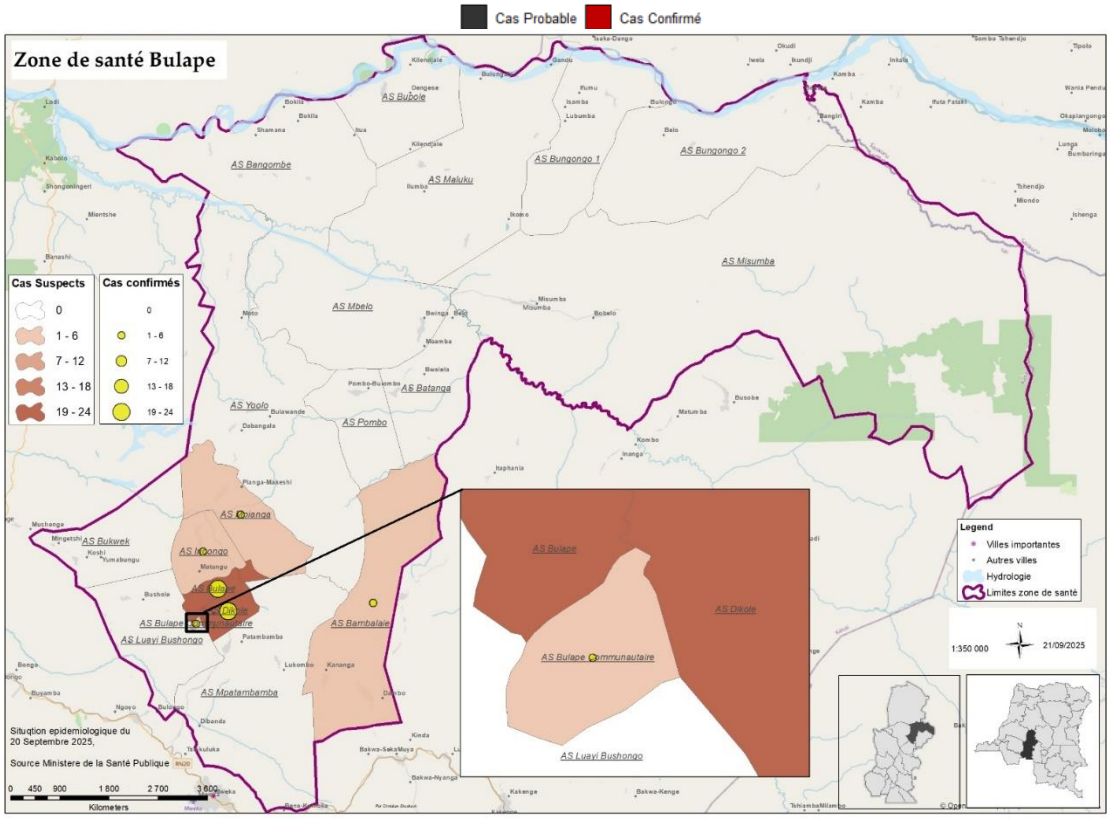
The outbreak is currently concentrated in the Bulape and Mweka health zones of Kasai Province, a region with a population of roughly 3.5 million. Kasai province has previously experienced Ebola outbreaks, including one in Luebo in 2007 and another in Mweka in 2008–2009.

The situation as of 24 September 2025 is presented below (Source: MOH):

Total number of suspected + confirmed cases	Total number of confirmed cases	Total number of deaths	Case fatality rate	Total number of Health Areas affected	Total number of contacts	Total number of contacts under follow-up (%)
59	48	41	69%	6	1,339	1,192 (89%)

Epidemic curve of the outbreak as of 24 September (Data: MOH)





Bulape Health Zone/Kasai Province – Distribution and location of suspected and confirmed cases

Severity of humanitarian conditions

Impact on accessibility, availability, quality, use, and awareness of goods and services.

As of 20 September, 43 cases have been confirmed, with 25 deaths, including four health workers. Bulape health zone is reporting the highest number of both cases and deaths. Most affected individuals are 15 years of age and older. The fatality rate stands at 58.14 per cent. The WHO currently assesses the overall public health risk posed by the current EVD outbreak as high at the national level. This outbreak is occurring in a complex epidemiological context, as the country is currently facing several other outbreaks, including mpox, cholera, and measles.

The current outbreak in Kasai has placed a massive strain on an already fragile health system. Health services in Bulape and Mweka are overwhelmed, with limited isolation capacity and severe shortages of protective equipment. The deaths of frontline health workers in the initial days of the outbreak highlighted the critical gaps in infection control, while delays in transporting samples to laboratories slowed confirmation and response efforts. The crisis has also disrupted daily life, with schools in the affected districts closed and more than 44,000 children forced out of classrooms, threatening long-term educational disruption. At the same time, economic activity is heavily constrained, as movement restrictions further hinder access to markets and essential services. In Kasai, poor road networks delay the delivery of supplies and the deployment of response teams, while traditional burial practices, community mistrust, and population movements further heighten the risk of spread. Compounding this, inadequate water, sanitation, and hygiene services continue to fuel transmission risks in both communities and health centres. The affected areas are remote rural regions with limited access to health and infrastructure. The country is simultaneously grappling with a protracted economic and political crisis, which is critically undermining resources and constraining the capacity to effectively respond to the outbreak.

Impact on physical and mental well-being

Ebola virus disease is a rare but severe and often fatal illness in humans. The virus can spread to people through direct contact with the blood, secretions, organs, or other bodily fluids of infected animals, most notably fruit bats, which are believed to be the natural reservoir. Once introduced into the human population, Ebola is transmitted from person to person through direct contact with the blood or bodily fluids of someone who is sick or has died from the disease, as well as through contaminated objects or the body of a deceased patient.

The impact of Ebola outbreaks on mental well-being in the Democratic Republic of Congo (DRC) has been significant, especially given the recurrence of these outbreaks. Previous Ebola outbreaks have led to high levels of psychological distress among affected populations, including survivors, family members, and healthcare professionals. Studies have shown that anxiety and depression are prevalent among Ebola survivors and their families. For instance, a study conducted after the 2022 Ebola outbreak in Uganda found that 55 per cent of survivors and family members experienced anxiety, while 50 per cent experienced depression. Post-traumatic stress disorder (PTSD) is also a common mental health issue following Ebola outbreaks. The same study reported that 17 per cent of participants exhibited PTSD symptoms. The trauma of witnessing severe illness and death, coupled with the fear of infection, contributes to these high distress levels. Previous Ebola responses in the DRC have also highlighted the high level of stress and burnout among volunteers, especially those engaged in safe and dignified burial (SDB) activities.

Risks and vulnerabilities

The Democratic Republic of Congo remains economically fragile, with high poverty rates, weak infrastructure, and recurrent insecurity that restricts access to affected areas and erodes trust in institutions. The health system is chronically underfunded and overstretched, leaving facilities ill-prepared to manage a crisis of this scale. The Ebola outbreak also coincides with ongoing cholera and mpox epidemics, compounding the strain on limited existing resources.

The lack of robust WASH systems and support during previous outbreaks, including Ebola, has contributed to high case fatality ratios and secondary transmission, particularly in the rural and hard-to-reach areas of Kasai. Insufficient investment in water infrastructure and restricted access to safe drinking water accelerate the spread of outbreaks. In rural communities, families spend almost an hour daily collecting water, yet access to improved sources remains limited. Risks are especially elevated among displaced and mobile populations due to unhealthy living conditions such as open defecation, overcrowding, and inadequate access to basic sanitation and hygiene

services. Additionally, the lack of robust WASH protocols, including regular handwashing, use of disinfectants and safe management of corpses and waste have contributed to high mortality among nurses and health workers during previous outbreaks.

In Kasai, more than half of the population lives below the poverty line, with 28 per cent facing to acute food insecurity and 43 per cent living in chronic food insecurity. Over 40 per cent of children under five suffer from stunting, and in Bulape alone, more than 2,000 children are currently being treated for malnutrition. The outbreak has, therefore, not only intensified health risks but also exacerbated economic and nutritional vulnerabilities, as households face reduced income, declining food production, and increasing exclusion and stigma.

Sexual and gender-based violence (SGBV) remains a major driver of protection concerns in the province contributing to killings and widespread forced displacement. In the past 12 months, 42.4 per cent of married women in Kasai reported experiencing physical violence, 38.5 per cent suffered emotional violence, and 29.6 per cent were subjected to sexual violence. Sporadic militia-led attacks continue to trigger population movements, further raising the risk of SGBV for women and girls living in temporary shelters or while in transit within the province. Past Ebola outbreaks in Kasai, notably in 2007 and 2008, as well as the current outbreak, have intensified fear, stigma against survivors, and frequent displacement. Women face increased exposure to infection and heightened risk of stigma, isolation, and sexual violence given their roles as primary caregivers and involvement in ritual burials and community health activities.

With the onset of the rainy season in Kasai and neighbouring provinces (October–December and March–May), heavy rainfall and flooding are expected to further weaken already fragile infrastructure, damage roads, and cut off communities. In the context of an Ebola response, where access is already highly constrained, these conditions may increase logistical challenges and render key routes impassable, directly affecting the timely transport of essential supplies and equipment. The movement of humanitarian staff and volunteers, including those from the DRC Red Cross, will likely face significant delays or disruptions. As communities become increasingly isolated, surveillance and contact-tracing activities may be severely hampered, while access for safe and dignified burials will also be compromised. Moreover, flooding is likely to heighten the risk of waterborne diseases and vector-borne diseases (specifically malaria) placing additional strain on health systems already under considerable pressure and making early diagnosis even more challenging.

The overall security situation in the DRC remains volatile, with ongoing armed conflict in the east diverting national attention and resources. In Kasai, violence is less acute, but the province still faces a weak state presence, poor infrastructure, and residual mistrust from past conflicts such as the Kamuina Nsapu crisis. In Bulape, local authorities have imposed confinement and movement restrictions to contain Ebola, creating operational and community tensions. Experience from previous Ebola outbreaks in Equateur and North Kivu shows that insecurity and resistance can directly disrupt treatment, vaccination, and contact tracing efforts. These risks, combined with Kasai's proximity to the Angolan border, heighten the potential for instability and cross-border spread.

CAPACITIES AND RESPONSE

1. National Society response capacity

1.1 National Society capacity and ongoing response

The DRC Red Cross (DRC RC) has been formally recognised as an auxiliary to the public authorities in the humanitarian field through the national decree of 1 March 1961. The mission of the DRC RC is to prevent disease, alleviate suffering, and improve the living conditions of the most vulnerable populations, wherever they are and without distinction of race, religion, or political affiliation, through sustainable community development programmes, relief activities, disaster preparedness and response.

The National Society counts **503,311 registered volunteers** (61 percent men and 39 per cent women) with branch committees established in all 26 provinces and 245 territorial committees nationwide. This extensive presence across the country ensures broad access and strong community acceptance throughout the territory. At the national headquarters in Kinshasa, there is an operational management structure with technical units in health, disaster risk management and emergency response, and support services. The DRC RC has a national disaster response team and branch response teams in 11 provinces.

The DRC RC is a legally mandated national responder with long-standing experience in epidemic control, public health, and emergency operations. Specifically, in EVD outbreaks, the DRC RC is recognised as lead in SDBs and

co-lead of the SDB pillar. The DRC RC's role in epidemic risk management was also recognised in both the National Response Plan to the EVD Epidemic in 2018 and the National Response Plan for the EVD Epidemic in 2014. Both plans widely acknowledge the role of the DRC RC, particularly in activities such as SDB, communication, WASH, evacuation, transportation of patients to hospitals, and epidemiological surveillance.
The National Society has extensive experience in responding to epidemics, and to EVD, having played a frontline role in the response to all previous epidemics in the country, including the large-scale crises in North Kivu, Equateur, and Ituri between 2018 and 2022. Over the years, the DRC RC has trained and deployed hundreds of volunteers in SDB, Risk Communication and Community Engagement (RCCE), Infection Prevention and Control/WASH (IPC/WASH), and Psychosocial Support (PSS), earning recognition as a trusted actor at the community level.
In the current outbreak, its role is firmly embedded in the MoH-led national Plan of Action (USD 78M), with defined responsibilities in SDBs, PSS, RCCE, and IPC/WASH. Operationally, the National Society has demonstrated strong capacities in volunteer mobilisation, community health, first aid, disaster response, contingency planning, and local risk mapping. These functions have enabled it to play a critical role in multiple health emergencies, including the current sixteenth Ebola outbreak.
DRC Red Cross interventions within the affected Health Zones (as of 23 September) are summarised below:

- A team of 16 staff from the National Society and IFRC was deployed to Bulape on 13 September to conduct assessments (including security), engage with the regional branch, conduct training, and deliver key materials for the response.
- A multisectoral mobilisation was carried out involving volunteers from the areas of Bulape, Mushenge, Kakenge, Luebo, and Tshikapa, totalling 350 volunteers, distributed as follows: a) 100 volunteers for the Bulape Health Zone; b) 100 volunteers for the Mweka Health Zone; c) 50 volunteers for Mushenge; d) 50 volunteers for the Kakenge Health Zone; e) 50 volunteers for the Tshikapa Health Zone.
- This mobilisation enabled the implementation of community awareness activities focused on health and hygiene promotion, including door-to-door visits. A total of 20,616 people were reached through door-to-door activities, while more than **25,675 people** received key messages through mass awareness campaigns in churches, schools, and markets.
- Twenty-one volunteers were trained to conduct SDBs.
- A total of 33 SDBs were carried out to date. Decontamination activities were conducted at the Bulape General Reference Hospital as well as in identified households.
- In community-based surveillance activities, volunteers recorded 144 alerts, of which 107 were investigated and 51 validated.
- More than **100 volunteers** have been deployed for house-to-house awareness in Bulape and Mweka and to support health facility decontamination and contact tracing in collaboration with the Ministry of Public Health and the WHO.
- In addition, 38 handwashing stations were installed in strategic public spaces, with a cumulative volume of 5,570 litres of water used, benefiting 11,140 people across six intervention sites (Bulape, Mweke, Mushenge, Zakenge, Tshikapa and Luebo).
- A total of 23 families also received psychosocial support, reaching 805 people, along with 18 community patients who showed symptoms consistent with case definitions and agreed to be hospitalised.

1.2 Capacity and response at the national level

The Ministry of Health (MoH), working through the National Institute of Public Health (INSP) and the Public Health Emergency Operations Centre (COUSP), is providing overall leadership for the outbreak response. This effort is supported by technical expertise from the WHO and other health partners.
Following the first alerts received from the field, an advanced team of first responders from the WHO, MoH and partner organisation was deployed to the affected health zones to rapidly strengthen key outbreak control measures including disease surveillance, treatment and infection prevention, and control in health facilities. Following the initial deployment of a national multidisciplinary rapid response team, supported by the WHO, Médecins Sans Frontières (MSF), UNICEF, and other partners, the MoH established an Incident Management Team in Bulape health zone to strengthen response operations and ensure coordination across technical sectors. To guide and monitor activities, daily coordination meetings are convened to review progress and plan next steps.

The current response is firmly anchored in the Ministry of Public Health (MoPH)-led National Plan of Action, with the DRC RC serving as an auxiliary to the public authorities. The National Society actively participates in both national and provincial health coordination mechanisms, chaired by the MoH with technical leadership from the WHO, ensuring that all Red Cross interventions are aligned with government priorities under the principle of one plan, one team, and one budget.
At the technical and operational level, the DRC RC works closely with the WHO, which leads on surveillance, case management, and vaccination, as well as with UNICEF, the co-lead on Risk Communication and Community Engagement (RCCE) and WASH. At the local level, the DRC RC is an integral part of coordination structures (COUSP).

Vaccination
As of 14 September, the WHO launched a vaccination campaign in Bulape, Mweka, and Mushenge health zones, using a ring vaccination approach targeting contacts, potential-contacts, and healthcare and frontline workers at high risk. This will be complemented by a targeted geographic approach in all hotspots where cases have been confirmed when more vaccine doses arrive. Forty-five healthcare workers have been trained to constitute teams for vaccination, while the installation of Ultra Cold Chain equipment is also ongoing in Tshikapa, Kananga, and Mweka to accommodate larger volumes of vaccine doses.
According to the Bulape COUSP sitrep of 20 September, a stock of 2,625 doses is currently available in Bulape, with an extra 2,480 expected in the coming days. As of 22 September, a total of 1,505 people have been vaccinated. This includes volunteers engaged in SDB activities, together with the entire team that travelled from Kinshasa to Bulape on 13 September to support the DRC RC branch.
It is important to note that the International Coordination Group (ICG) has approved 43,840 doses of the rVSVΔG-ZEBOV-GP (Everbo) Ebola vaccine for a reactive vaccination campaign in Kasai Province. These doses are currently en route to the DRC.

2. International capacity and response

2.1 Red Cross Red Crescent Movement capacity and response

The IFRC Country Cluster Delegation in Kinshasa supports the DRC RC with strategic and operational coordination, National Society development, and humanitarian diplomacy. It also supports accountability as a cross-cutting theme. The IFRC supports the National Society in strengthening its auxiliary role by meeting key stakeholders at the government level on a regular basis. With staff based in Goma, Kalemie, and Kinshasa, the IFRC provides support to the National Society's emergency operations and thematic programmes in the DRC, particularly in disaster preparedness, health, and protection, gender, and inclusion. This support includes planning, implementation, monitoring, and reporting, as well as participation in monitoring and evaluation.
In 2025, the operations and projects supported by the IFRC in the Democratic Republic of the Congo include the Population Movement Emergency Appeal in North and South Kivu, and the Mpox outbreak response through the Africa Region's Mpox Emergency Appeal. Additional initiatives include the DREF response to flooding in Kinshasa and Tanganyika, the Early Warning Protocol project (simplified), the Zero Famine Project in North Kivu and Tanganyika (Food Security), and the CDC MasterCard SLL (Saving Lives and Livelihoods) Project. Other ongoing initiatives also include the joint WFP–FAO–IFRC Anticipatory Action Project, titled "Disaster Preparedness: Pioneering Innovations in Flood Risk Management in the DRC", and the Maniema Immunisation Support Project supported by the CDC. The DG ECHO Pilot Programmatic Partnership (PPP) was recently concluded on 30 June 2025.
In recent years, the IFRC has supported the DRC RC through a number of Disaster Response Emergency Fund (DREF) and Emergency Appeal operations in relation to food insecurity, population movement, floods, and disease outbreaks, including Ebola virus disease, COVID-19, Mpox, plague, meningitis, measles, polio, yellow fever and cholera. The IFRC also supports the DRC RC in accessing funding from the National Society Investment Alliance, Empress Shoken Fund, IFRC Capacity Building Fund, and multilateral and governmental donors, leveraging its status as an international organisation.
The current Ebola outbreak response operation has been classified as Red as per the IFRC Emergency Response Framework. A red disaster or crisis requires the highest level of mobilisation and coordination from the IFRC Secretariat, triggering specific scale-up measures. During a Red level disaster or crisis, a "One Secretariat" approach is adopted with a move to more streamlined processes across all management levels and services. Secretariat-wide support is mobilised across all layers, requiring streamlined processes, the deployment of

essential functions, and updated standard operating procedures (SOPs). Key actions include deploying specific functions to form a priority in-country team and utilising a stand-by list for rapid deployments. Remote support mechanisms are established in Geneva and at the regional levels to ensure continuity.
The declaration of a red emergency also automatically activates the Immediate Response Protocol (IRP) to enable streamlined processes and procedures with the aim of fast-tracking more agile and responsive humanitarian operations, in line with the IFRC's commitment to the humanitarian imperative. The IRP, in particular, outlines simplified procedures for critical processes within the Secretariat, especially in the areas of Supply Chain Management, Human Resources, Finance, and other management support services.

IFRC membership
The DRC RC also benefits from the active engagement of the Belgian Red Cross, French Red Cross, Luxembourg Red Cross, Spanish Red Cross, and Swedish Red Cross, all operating under the National Society Country Plan. The National Society, with the support of Participating National Societies (PNSs), is implementing several programmes in different geographical locations and thematic areas clearly identified in its Country Plan, and which contain elements of National Society capacity building.

Name of Partner National Society	Climate	Crisis	Health	Migration	Inclusion	Engaged	Accountable	Trusted
Belgian Red Cross	✓	✓	✓		✓	✓	✓	✓
French Red Cross		✓	✓		✓	✓	✓	
Luxembourg Red Cross		✓				✓	✓	
Spanish Red Cross	✓	✓	✓		✓	✓	✓	
Swedish Red Cross	✓	✓	✓		✓	✓	✓	

The **Swedish Red Cross** supports disaster management, health, WASH, and community resilience in Kinshasa. Their contributions extend to protection, gender, and inclusion activities and strengthening the National Society's volunteer management and PMER capacities.

The **Belgian Red Cross (**French-speaking community) supports the DRC RC through activities in the province of Kwango (health areas of Barrière, Bangombe, and Pont-Wamba in the Kenge health zone), including projects on road safety, community resilience, disaster risks reduction, community health/WASH activities, and capacity building.

The **Red Cross of Flemish Belgium** supports humanitarian protection activities for displaced populations in Kwango and Kwilu provinces, as well as the National Society in first aid and blood donation.

The **French Red Cross** is supporting the DRC RC with a presence in eastern DRC, engaging in health initiatives in South Kivu and supporting protection/GBV.

The **Luxembourg Red Cross** supports the DRC RC with shelter and protection, gender, and inclusion (PGI) activities in South Kivu.

The **Spanish Red Cross** contributed to the implementation of the ECHO Pilot Programmatic Partnership and has been supporting projects in Kwilu and Tshikapa provinces since 2014, with a focus on food security, nutrition, and health/WASH initiatives.

Please refer to the section on the Federation-wide approach for further details on the IFRC membership's overall engagement and support in the current response operation.

Movement Coordination

The ICRC

Under the Movement Coordination Agreement (MCA) signed in May 2025 in the DRC and the subsequent coordination platforms established, regular meetings between the DRC RC, IFRC, and International Committee of the Red Cross (ICRC) are taking place in line with the Strengthening Movement Coordination and Cooperation (SMCC) principles and Seville Agreement 2.0.
In relation to the ongoing Ebola response, the three components of the Movement convened on 17 September to review the situation. It was agreed that, given the current epidemiological context, a collective Movement response was not required at this stage. However, the situation will be closely monitored, and the decision will be reassessed should the outbreak evolve in a way that justifies a collective Movement response.
The ICRC, with its mandate to provide protection and humanitarian assistance to victims of armed conflict and other situations of violence, as well as to promote respect for international humanitarian law (IHL), stands by the efforts of the DRC RC and the IFRC in their response to the Ebola outbreak affecting the Kasai region. Although the ICRC primarily focuses its activities in the eastern DRC, addressing humanitarian needs related to armed conflict and violence, it has also supported the DRC RC in the current Ebola crisis, providing 100 body bags for SDBs. The ICRC also participates in coordination efforts through strategic and operational meetings of the Movement, offering support and contributions where needed. In coordination with Movement partners, the ICRC remains ready to provide additional support if required, particularly in logistics, security (e.g. sharing essential information), communication (e.g. support for awareness-raising and community engagement), health, and WASH, reflecting its commitment to working alongside Movement partners to respond effectively to humanitarian crises.

2.2 International Humanitarian Stakeholder capacity and response

The MoH leads epidemic responses in coordination with the WHO and humanitarian partners. Through the DRC's National Public Health Institute (INSP) and the National Public Health Emergency Operations Centre (COUSP), the MoH is coordinating the overall response to the outbreak.
The first coordination meeting, chaired by the Minister of Health on 5 September 2025, brought together UN agencies, NGOs, and donors to validate the draft response plan and ensure alignment. The Health Cluster, led by the WHO with strong engagement from the DRC RC, plays a central role in coordinating technical support, surveillance, and response activities. The Cluster convenes regular meetings at the national and provincial levels, aligning partner interventions on management, surveillance, laboratory, IPC, WASH, SDB, vaccination, and risk communication and community engagement.

Partners engaged in the different response pillars:
Surveillance: WHO, UNICEF, MSF, FAO, US CDC, and DRC RC
Clinical care (ETC): WHO, MSF, ALIMA, IMC, and UNICEF
Infection and Prevention Control (IPC): UNICEF, WHO, and MSF. The DRC RC also plays a key role in IPC/decontamination.
Risk Communication and Community Engagement: DRC RC, UNICEF, WHO, and IOM
Logistic and operational support: WHO, WFP, UNICEF, and MONUSCO
Safe and Dignified Burials (SDBs): DRC RC, WHO, and MSF
Vaccination: WHO and UNICEF
Nutrition and food distribution: WFP
PSEA, Gender, and Protection: WHO, UNICEF, UNFPA, and all partners

OCHA and WFP convene inter-cluster coordination to ensure alignment with broader humanitarian sectors (Protection, Nutrition, Food Security, Logistics).
To reinforce the government-led response, the WHO deployed 48 national and international experts, of whom 31 are currently based in the Bulape health zone. A wide range of health partners are also engaged in supporting operations in Bulape, including the Africa CDC, International Organization for Migration (IOM), UNICEF, Médecins

Sans Frontières (MSF), the Alliance for International Medical Action (ALIMA), and the US Centers for Disease Control and Prevention. Additional contributions were received from organisations such as International Medical Corps (IMC), Family Health International 360 (FHI 360), Program for Appropriate Technology in Health (PATH), Village Reach, as well as UN agencies and the World Food Programme (WFP), UNFPA, the Gavi Alliance, and the World Bank.
Within 48 hours of the declaration, the WHO airlifted 12 tons of outbreak control materials, including personal protective equipment, patient isolation materials, water, sanitation, and hygiene supplies to support clinical care and protect frontline health workers. To fast-track the delivery of supplies and personnel, a collaboration between the WHO, WFP, and the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO) has established a temporary airbridge for an initial two weeks using a helicopter from Kananga to Bulape and Mweka.

According to WHO Sitrep of 15 September, a 40-foot container truck with essential supplies has been dispatched from nearby Tshikapa to Bulape, while an additional 600 kilogrammes of medicines, vaccines, and personal protective equipment (PPE) are en route from Kananga. An additional shipment of two tons of PPE, chlorine, and other supplies has also been scheduled.

An Ebola Treatment Centre (ETC) was rapidly established at Bulape Hospital, equipped with 18 beds, medical supplies, consumables, and 4,000 litres of water. A supply chain system has been put in place, and a new ETC with expanded capacity is under construction.

3. Gaps in the response

The response is facing several critical challenges. The region relies almost exclusively on deteriorated road networks for the movement of goods and humanitarian supplies, with no major cargo airport and frequent disruptions from flooding, landslides, and impassable routes, resulting in crucial delays in delivery times and high transport costs. The upcoming rainy season will most probably exacerbate the situation. Access from Kinshasa can take up to three days by road and certain sections are impassable for large trucks transporting goods and supplies, causing significant delays in the delivery of essential lifesaving equipment. While the established air bridge has improved the delivery of critical supplies, the frequency of flights does not currently meet the overall transport needs of the different humanitarian actors.
The main health gaps and needs identified include:

- Staffing shortages, including the absence of dedicated hygienists at the ETC.
- Delays in the delivery of essential lifesaving equipment-oxygen cylinder/concentrators, PPE, cardiac monitors.
- Shortages of essential medicines and resuscitation equipment.
- Insufficient water supply for toilets, hygiene, and patient drinking needs.
- Lack of potable water for ORS preparation and patient hydration.
- Inadequate patient meals and nutritional support.
- Gaps in the ETC workflow and patient flow requiring improvement.
- Insufficient ambulances to support referrals and outreach.
- Poor road networks hindering outreach and support to neighbouring health zones.

In addition, there is a pressing need to strengthen surveillance, management of suspected (and confirmed) cases, protection of health workers, and infection prevention and control, while implementing prevention strategies, such as vaccination. Many health facilities in the affected provinces are under-equipped and understaffed, highlighting an urgent need for more isolation units, trained health personnel, and medical supplies, including PPE. Significant gaps persist in the capacity of health facilities to isolate and treat Ebola patients due to a shortage of beds and qualified health personnel. Mental health support, which is essential for coping with the psychological impact of the epidemic, is also often lacking. Certain groups, such as children, pregnant women, and the elderly, are at higher risks and require targeted interventions. SDB teams are also under-equipped. Widespread suspicion and mistrust of the disease have been reported, with some individuals hiding or seeking care only when the disease is advanced, leading to insufficient community alerts.

WASH

In Ebola responses, WASH risk analysis identifies threats from contact with infected bodily fluids and poor hygiene practices, which facilitate transmission of the virus through hands, contaminated water, or

contaminated surfaces. In the current response, inadequate access to safe drinking water, lack of safe latrines, unhygienic water handling, and insufficient handwashing facilities have been observed. These gaps expose populations, particularly children and caregivers, to both direct and indirect contamination.
WASH activities play a crucial role in preventing and controlling EVD:

- **Access to water**: 1) Ensure that communities have access to safe, clean water to maintain hygiene practices, such as handwashing. In Kasai province, limited access to safe drinking water and adequate sanitation facilities hinders the implementation of effective hygiene practices necessary to control the spread of the virus; 2) Ensure an adequate supply of safe water for health centres, ETCs, and SDB teams to enable proper hand hygiene and infection prevention and control (IPC) practices, including the reconstitution of chlorine solutions.
- **Hygiene practices**: Promote handwashing and other hygiene practices to minimise contact with the virus.
- **Decontamination**: One of the main priorities is to implement rigorous decontamination protocols to prevent the spread of Ebola. This includes having specialised equipment and supplies to effectively decontaminate health facilities, homes, and public spaces where suspected or confirmed cases have been identified. Ensuring the availability of disinfectants, PPE, and training for personnel involved in decontamination processes is essential, alongside robust waste management systems to safely dispose of contaminated materials and protect public health and safety.

Safe and Dignified Burials (SDBs)
Several critical needs have been identified in relation to SDBs, including the provision of materials, equipment, and vehicles; adequate training for SDB teams; and enhanced protection measures for volunteers, including vaccination, insurance, and PPE. The first shipment of SDB kits and PPE arrived in Bulape on 21 September, with a second shipment expected soon from IFRC stocks in Cameroon. Additionally, all teams currently conducting SDBs have been vaccinated.
While the first Red Cross operational base is being established in Bulape, investments will be needed to ensure reliable access to water, fuel, and appropriate facilities for waste disposal (incinerators). Furthermore, there is a need to strengthen knowledge of local funeral practices and reinforce community engagement, particularly through the involvement of community and religious leaders, alongside mechanisms for continuous community feedback and rumour tracking.
SDBs are a key pillar of any Ebola response. It is therefore essential to mobilise and equip SDB teams to manage burials in a way that prevents further transmission of the virus. These burials must also be carried out in accordance with cultural customs while complying with public health guidelines and international standards.

Mental Health and Psychosocial Support (MHPSS): There is a need to provide emotional support to DRC RC volunteers and staff during their engagement in safe and dignified burials, risk communication, and IPC activities within communities. The DRC RC is delivering basic MHPSS training to its EVD operations teams in the targeted locations. For community members, Epidemic Preparedness and response in Communities (EPiC) trained volunteers will offer further psychological first aid (PFA) assistance at the community level to help mitigate stigma and discrimination faced by survivors from the Ebola Treatment Centre. It is also crucial to integrate psychosocial care and support for populations affected by stigma and the loss of relatives.

Surveillance: During an Ebola virus disease outbreak, community-based surveillance (CBS) requirements include community engagement for prevention and early case detection, training volunteers to identify and report symptoms, and actively searching for cases and contacts within the community. Effective contact tracing remains a top priority, underscoring the need to redouble efforts to achieve a 100 per cent follow-up rate to ensure that all contacts are monitored and cared for promptly to stem the spread of the virus. The MoH may also require support for contact-tracing and follow-up.

Risk Communication and Community Engagement (RCCE)
Communities must be at the heart of the response to make it more effective, timely, relevant, and ultimately, to build trust and encourage community action. In past outbreaks, DRC RC teams have encountered reluctance during SDBs. Communities are also often in a state of denial about the disease and hold preconceived ideas about Ebola and the actors involved in the response. For example, very few alerts for suspect community deaths

are reported directly by communities. In this context, it is essential to strengthen engagement around four key pillars for Ebola prevention and control: (i) early identification of suspected Ebola cases and the identification and monitoring of all contacts, relying on community understanding and cooperation to trigger alerts when suspected cases arise; (ii) vaccination of high-risk individuals; (iii) referral of persons showing potential Ebola symptoms to specialised treatment centres; and (iv) safe and dignified burials. This will require a range of approaches to work collaboratively with communities and engaging in a two-way dialogue, so they have timely information and participate in defining solutions to take preventive measures seriously, to be aware of the signs and symptoms, and promptly alert response teams in the event of suspected deaths within the community. A rapid assessment that was conducted by the RCCE pillar in Bulape also highlighted a gap in information with 35 per cent of participants not knowing how EVD is transmitted, with 45 per cent expressing distrust in responders. A few participants also referred to treatment centres as "death houses".

CEA

The right accountability mechanisms must be in place so that communities can not only voice concerns and questions, for example, through community feedback sessions, but also participate meaningfully – helping shape how strategies are changed and services adapted. This includes involving community members in the design, monitoring, implementation, and evaluation of response activities, in line with IFRC's Minimum CEA Actions standards, which require assessing, planning, implementing, monitoring, and learning with communities. Inter-agency coordination is crucial to ensure that both community feedback and social science data are systematically used across all pillars to inform decision-making.

Nutrition and Livelihoods

This Ebola outbreak is unfolding in a setting of deep structural vulnerabilities, marked by extreme poverty and widespread food insecurity. According to the 2024 Chronic Food Insecurity IPC, more than half of the population lives on less than USD 1.90 per day, with extreme poverty rates exceeding 50 per cent in Kasai Province. Acute food insecurity remains alarming, with around 33 per cent of the population in IPC Phase 3+ (Crisis), including five per cent in Phase 4 (Emergency). Chronic food insecurity is even more concerning, affecting 43 per cent of the population, including 13 per cent in Phase 4. Nutritional conditions are equally critical. More than 40 per cent of children under five suffer from stunting – well above the 30 per cent critical threshold set by the WHO. In the Bulape health zone alone, over 2,000 children are currently being treated for malnutrition, underscoring the magnitude of unmet needs and the pressure on an already fragile health system.

Despite the gravity of this situation, nutrition remains insufficiently integrated in the current Ebola response. Interventions currently focus primarily on case management, infection prevention, and community engagement, while the food and nutritional needs of patients in ETCs, survivors, and bereaved households are not systematically covered. Experiences from previous epidemics have also shown that many families are reluctant to bring patients to health facilities when food and nutritional support are not provided, further delaying treatment and increasing the risk of mortality. Providing food and nutritional support to EVD patients in ETCs will be essential, together with systematic screening and the referral of cases of severe acute malnutrition. Without increased food and nutritional support, there is a high risk of worsening acute malnutrition and the adoption of harmful coping strategies.

In addition, admission to an ETC or placement of contacts in isolation carries substantial hidden costs and may result in a significant loss of livelihoods for both the individual and their family. These factors can contribute to reluctance in seeking care or complying with inpatient treatment and isolation measures. Furthermore, SDBs often involve the destruction of personal possessions, creating additional material losses. In contexts marked by high levels of poverty, such financial and material losses can be catastrophic for the families of those affected.

Protection, Gender, and Inclusion Needs and Gaps

Epidemic outbreaks usually exacerbate pre-existing gender inequalities, which primarily affect women, children, and persons with disabilities. The first disaggregated statistics released by the MoH indicate that since the beginning of the outbreak in Kasai, children under 15 and women have been the most affected (SITREP No. 5). During the previous Ebola response in the DRC, children were particularly vulnerable due to their high risk of exposure to the disease, but also as a result of parental hospitalisation or death and family separation. This increases their risk of trauma, abuse, exploitation, and violence.

Significant gaps remain in addressing child protection needs, particularly regarding the establishment of child-friendly spaces within or near health facilities, implementing prevention measures against abuse, exploitation, and neglect, and ensuring that children's basic needs are met.

During previous outbreaks, risks of sexual exploitation, abuse, and gender-based violence (GBV) increased, particularly in relation to Ebola and access to assistance. In the current outbreak, especially in affected health zones such as Bulape, the referral system for GBV cases remains outdated, and personnel have received insufficient training on GBV and Protection from Sexual Exploitation and Abuse (PSEA). During previous outbreaks, survivors of Ebola, as well as affected families, widows, and orphans, faced increased exclusion and stigmatisation, resulting in the loss of livelihoods, heightened psychosocial distress, and the collapse of community and family support systems. Older persons and persons with disabilities, due to their vulnerabilities, also encountered numerous barriers, including lack of information, physical inaccessibility, and discrimination, in accessing Ebola prevention and response services.

Furthermore, the spread of the epidemic has been exacerbated by weak adherence to preventive measures and rumours that have reinforced stigmatisation. It is therefore crucial to integrate Protection, Gender, and Inclusion (PGI) principles into all Ebola response activities and to establish protection risk mitigation measures to reduce cases of GBV, family separation, and stigmatisation, while also addressing urgent protection needs caused by the epidemic through referrals to protection services.

OPERATIONAL CONSTRAINTS

Several operational constraints need to be taken into consideration in the planning of the overall response to the current outbreak in Kasai, including the region's limited infrastructure, concurrent public health crises, and challenges in logistics and community engagement. As highlighted in the section on gaps and needs in the current response environment, Kasai province is characterised by poor road networks that can delay the delivery of supplies and the deployment of response teams. Logistical challenges remain immense, and while the recent decision to establish an airbridge to Bulape will help ease some of the pressure on the rapid transport of goods and equipment, it is far from sufficient to enable the full-scale mobilisation required for an Ebola response in such remote areas. Additionally, power outages affecting the areas are expected to impact the use of medical equipment and communication technologies essential for surveillance and case management.

From a community engagement perspective, mistrust and resistance have already affected response efforts, with communities fearing the Ebola Treatment Centre and general suspicion towards the overall response. Initially, this fear prompted people to flee Bulape, however, many have now returned. There are also indications that some individuals delay seeking care or hide to avoid being reported.

The overall security situation in the DRC remains volatile, with ongoing armed conflict in the east diverting national attention and resources. In Kasai, violence is less severe despite the return of Congolese nationals expelled from Angola, although occasional community conflicts are reported between those who returned and those who remained in place. Since 2016–2017, parts of Kasai have faced persistent intercommunal and militia violence. Clashes, banditry, and localised armed groups continue to drive displacement and hinder access, heightening protection risks and complicating humanitarian access. In addition, according to the 2024 chronic food insecurity IPC, more than half of the population lives on less than USD 1.90 per day, with extreme poverty rates exceeding 50 per cent in Kasai province. Acute food insecurity remains alarming, with around 33 per cent of the population in IPC phase 3+ (crisis), including five per cent in phase 4 (emergency). Chronic food insecurity is even more severe, affecting 43 per cent of the population, including 13 per cent in phase 4. Nutritional conditions are equally critical, with over 40 per cent of children under five suffer from stunting, well above the 30 per cent critical threshold set by the WHO.

The province continues to face a weak state presence, poor infrastructure, and residual mistrust from past conflicts such as the Kamuina Nsapu crisis. In Bulape, local authorities have imposed confinement and movement restrictions to contain Ebola, creating operational and community tensions. Experience from previous Ebola outbreaks in Equateur and North Kivu shows that insecurity and resistance can directly disrupt treatment, vaccination, and contact tracing efforts. These risks, combined with Kasai's proximity to the Angolan border, heighten the potential for instability and cross-border spread. On 21 September, provincial authorities in Sankuru province decided to close all borders with Kasai, and all commercial exchanges between communities located in the two provinces have been halted.

FEDERATION-WIDE APPROACH

This Emergency Appeal is part of a Federation-wide approach, based on the response priorities of the DRC RC and in consultation with all Federation members contributing to the response. The approach, reflected in this Operational Strategy, will ensure linkages between all response activities (including bilateral activities and activities funded domestically) and will assist in leveraging the capacities of all members of the IFRC network in the country to maximise the collective humanitarian impact.

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

The DRC RC has formally requested this Emergency Appeal with the support of the IFRC Secretariat. Coordination within the Red Cross Red Crescent Membership is structured to ensure a coherent Federation-wide response that leverages the capacities of different actors while avoiding duplication.

The declaration of a Red level disaster/crisis is followed by an analysis to ensure that the minimum capacities are present in-country to support the operation (the Minimum in-country team). If these capacities are not present in-country, the IFRC will prioritise the deployment of specific key functions to form a minimum in-country operations team for an initial three-month period. In the current response, a list of key functions has been identified and several PNSs have confirmed their support – for example, the Swedish Red Cross is providing human resources for the Assessment Coordinator role, while discussions are taking place with the Belgium Red Cross to cover the Membership Coordinator function.

Furthermore, the Swedish Red Cross has already provided financial support. The Spanish Red Cross is mobilising additional resources and technical expertise, particularly for health and CEA components, while the French Red Cross is considering secondments and support to branch capacity enhancement. Together, these PNS contributions will be coordinated through regular meetings led by the National Society.

OPERATIONAL STRATEGY

Vision

Through this Emergency Appeal, the IFRC is supporting the DRC RC to rapidly curb Ebola transmission, prevent expansion, and reduce mortality and social harm in Kasai province. The response, aligned with MoH's action plan and WHO technical guidance, is community-centred and evidence-based. The operation will focus on Mweka, Bulape, and Mushgue, with preparedness in neighbouring health zones (Kasaï Central, Sankuru, Kwango). The strategy balances urgent lifesaving interventions with institutional strengthening (with a specific focus on the branches), trained DRC RC volunteers and staff, and enhanced readiness in both outbreak and preparedness zones. The operation will ensure that key lessons learned (such as those from the ninth and tenth outbreaks) are integrated into the planning and implementation of the current response and prevention activities.

Core Interventions:

- **Safe and Dignified Burials (SDBs):** A cornerstone of the strategy to prevent transmission while preserving cultural practices and dignity. Approaches include community engagement with leaders, training and equipping funeral teams, involving families where safe, and using reduced-risk burials (ECUMR) in insecure or hard-to-reach areas, if needed. Currently, two SDB teams are active with MoH support, with plans to expand to 10 and establish standby teams in preparedness areas.
- **WASH:** Provision of safe water, PPE, disinfectants, and hygiene kits; decontamination of homes and public spaces; installation of handwashing stations; hygiene promotion; screening at entry points; and training health workers (including traditional healers). Reintegration kits for households will combine hygiene supplies, purification kits, and psychosocial support.
- **RCCE:** Ensure that accurate, timely, and accessible information reaches communities, while also enabling their active participation in shaping the response. Activities will focus on trusted, two-way communication that builds confidence, addresses fears and misinformation, and promotes protective behaviours. This

includes tailored messaging in local languages, the use of multiple communication channels (radio, posters, social media, interpersonal dialogue), and engagement of trusted local leaders.

- **Community Engagement and Accountability (CEA):** Engage in a two-way dialogue with communities to provide risk communication and empower them to protect themselves, setting up a feedback system with rumour tracking via different community engagement strategies such as community meetings, radio, hotlines, and stakeholder engagement.
- **Community-Based Surveillance (CBS):** Volunteers support case detection and alerts. CBS systems can remain active post-outbreak to detect any resurgence. The DRC RC has CBS experience in several provinces and the systems are set up to quickly roll out surveillance if required.
- **Contact Tracing:** Support MoH teams through potential secondments to support wider contact tracing activities.
- **Mental Health and Psychosocial Support (MHPSS):** Support for patients, families, children, survivors of GBV/EAS, as well as responders. Activities include integrating PFA into volunteer training sessions, providing support to affected families, stress management for staff and volunteers, and individual or group psychosocial support.
- **Gender, Protection, and Inclusion (PGI):** Mainstreamed across all actions. Activities include rapid PGI and EAS risk analyses, child safeguarding, referral systems, disaggregated data, safe spaces for children in treatment centres, provision of dignity kits, awareness-raising on GBV and child protection, and partnerships with women's and disability rights associations.
- **National Society Capacity Strengthening:** Retraining and deployment of volunteers in SDB, CBS, RCCE, MHPSS, WASH, and coordination for both response and readiness. Investments include PPE, pre-positioned SDB supplies, contingency planning, PHIE/coordination training for provincial and HQ staff, and mapping at-risk provinces. Volunteer development also includes readiness for other concurrent threats such as cholera and Mpox.
- **Regional Preparedness:** Although the risk of regional expansion has been assessed as medium, the Government of Angola has initiated preparations for a potential cross-border infection and has called partners to support. Angola Red Cross can play a critical role in supporting the government to prepare for a potential Ebola Virus Disease (EVD) outbreak. Leveraging its nationwide volunteer network, the National Society can strengthen community-based surveillance at border areas, raise public awareness on prevention and early detection, and build trust with local populations through risk communication and community engagement. In collaboration with the Ministry of Health and WHO, Angola Red Cross can also help pre-position personal protective equipment, train frontline volunteers and health workers on infection prevention and control, and support cross-border coordination mechanisms to ensure rapid information sharing and early action. This complementary role would reinforce national preparedness systems and enhance Angola's ability to respond swiftly to any suspected importation of cases.

Targeting

1. People to be assisted

The selection of sites and targets will be guided by the evolution of the epidemic and the needs of the MoH. The currently affected health zones – Bulape, Mweka, Mushenge, and Kakenge – are being prioritised, along with health zones where contacts may potentially move, notably Banga Lubaka, Dekese, Ilebo, Kalonda West, Kamonia, Kamwesha, Kanzala, Kitangwa, Luebo, Mikope, Mutena, Mweka, Ndjoko Mpunda, Nyanga, and Tshikapa (Kasai Province). Other neighbouring areas will also be targeted with preparedness activities and response support if the outbreak spreads, including the health zones of Bena Leka, Demba, Muetshi, Bena Tshadi (Central Kasai Province), Kole, and Bena Dibele (Sankuru Province).

People affected/at risk

- Currently affected zones (as of 20 September): Bulape (epicentre); Mweka; Mushenge; and Kanzala, with validated alerts and contacts in Dekese and movement into Tshikapa. The population in immediate risk zones is approximately 680,000.
- Extended risk areas: Contacts may move into adjacent health zones in Kasai, Kasai Central, and Sankuru, with potential spread in a catchment area of approximately two million people.

People to be assisted (calculated over an initial period of 12 weeks):

- Total to be assisted: 965,000.

Direct and high-intensity support – approximately 23,200 people: This includes support to both confirmed and suspected cases, contacts, and close relatives, as well as services and support for healthcare workers in facilities and communities, together with Red Cross volunteers.

Community prevention in immediate at-risk areas – approximate population of 680,000: Coverage target of 65 per cent, reaching an estimated **442,000 people** through Risk Communication and Community Engagement (RCCE), Community-based Surveillance (CBS), Mental Health and Psychosocial Support (MHPSS), and WASH.

- **Preparedness in extended at-risk areas, covering two million people:** Coverage target of **25 per cent,** reaching approximately 500,000 people through radio campaigns, engagement with community leaders, and light-touch WASH activities.

The 965,000 figure reflects the **unique-reach target**, recognising overlap between groups but ensuring comprehensive epidemic control. It balances **direct case-related interventions** with **community-wide prevention**, consistent with MoH/DRC Centre des Opérations d'Urgence de Santé Publique (COUSP) priorities and the Emergency Appeal Operational Strategy.

Most-at-risk and vulnerable groups

The current epidemic in Kasai is exposing certain groups to disproportionately higher risks. **Healthcare workers (HCWs)** are among the most affected. At least five HCWs have already been infected, with two reported deaths. This points to severe weaknesses in IPC within health facilities and highlights the urgent need to equip and protect frontline responders. Alongside HCWs, **burial teams and first responders** face daily exposure to contaminated environments and the emotional toll of safe and dignified burials, making them a critical group for vaccination, protective equipment, and PSS.

Within the community, **women and girls** are highly vulnerable. Women, particularly those who are pregnant or lactating, carry greater exposure risks due to their caregiving roles at home and their involvement in traditional funeral practices. Pregnant women infected with Ebola also face a very high fatality rate. **Young children and elderly persons** represent two additional high-risk groups as they are more likely to develop severe forms of the disease due to weaker immune systems, while also relying on caregivers who may themselves already be infected. **People with disabilities, members of displaced households, and families living in remote rural areas** all face additional barriers to accessing timely information, health and hygiene services. They are more likely to be excluded from critical prevention messages and less able to reach treatment or isolation facilities, especially given the poor roads and long travel times in Kasai.

Stigma, fear, and mistrust further exacerbate vulnerabilities. Survivors, bereaved families, and Red Cross volunteers themselves often face rejection or discrimination, which not only undermine recovery from the outbreak but also complicate community engagement and compliance with public health measures. Without targeted protection, PSS, and inclusion measures, these groups risk being left behind in the response and may inadvertently become drivers of secondary transmission.

Women	**312,771**	Rural	**289,500**
Girls (under 18)	**178,217**	Urban	**675,500**
Men	**302,922**	People with disabilities (estimated)	**10%**
Boys (under 18)	**171,090**		
Total targeted population	**965,000**		

2. Considerations for protection, gender, and inclusion, and community engagement and accountability

This operation will support the most vulnerable during the EVD outbreak, ensuring that high-risk or exposed groups are given priority and offered continuous support (female-headed households, isolated elderly individuals, people living with disabilities, orphans and vulnerable children, Ebola survivors facing stigma,

pregnant or breastfeeding women with specific health needs, etc.). The criteria will be validated with communities through inclusive meetings and disseminated through a range of accessible channels (meetings, radios, posters). A complaints and feedback mechanism will ensure transparency, accountability and consideration of sensitive protection issues (SEA, child safeguarding).
Furthermore, staff and volunteers will maintain strict adherence to the prevention of sexual exploitation and abuse, along with other PGI considerations. Community engagement and accountability will be mainstreamed across all community activities.

PLANNED OPERATIONS

Through this Emergency Appeal, the IFRC aims to support the DRC Red Cross in its response to the EVD epidemic. The DRC RC's response strategy will focus on contributing to health, WASH, CEA, PGI, and NSD activities, both in the affected health zones and in preparedness efforts in neighbouring areas and provinces.
Given the risk of spread to other provinces, the DRC RC and IFRC will maintain regular communication with neighbouring provincial branches, sharing information and support to enable branches near the epicentre (Bulape) to carry out effective preparedness activities and scale up their response. If the epidemic is declared over before the end of the proposed timeline, the DRC RC will assist the Ministry of Health in establishing epidemic preparedness and response mechanisms in high-risk provinces that were not previously prioritised due to a perceived low epidemic profile.

INTEGRATED ASSISTANCE
HEALTH AND CARE INCLUDING WATER, SANITATION, AND HYGIENE (WASH)
(MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT/COMMUNITY HEALTH)

	Health and Care (*Mental Health and Psychosocial Support/ Community Health/Medical Services)*	Female > 18: **312,771**	Female < 18: **178,217**	**CHF: 6,356,000**
		Male > 18: **302,922**	Male < 18: **171,090**	**Total target: 965 000**
Objective:		**The spread and impact of the outbreak are reduced through community outreach in the affected health zones.**		

Priority Actions:

Activities supporting health and WASH interventions will focus on capacity building for DRC RC volunteers as well as for community health workers (relais communautaires (ReCos)), ensuring that training sessions include those supporting the response at the community level and build the capacity to extend services to neighbouring areas and provinces as well as operational and technical capacity at the HQ level.

Safe and Dignified Burials (SDBs)
Traditional funeral practices pose a high risk of transmission during EVD epidemics, as corpses carry a high risk of transmission and funerary rites are often performed by relatives who often wash and touch the body without protection. Red Cross teams will ensure that persons deceased from EVD are buried in way that prevents transmission of the infection while preserving the dignity of the deceased and the family, and that all aspects of burial and disinfection are carried out in a safe and respectful manner, taking into account local funeral rites, cultural sensitivities, and family wishes before burials. These highly trained teams, in collaboration with teams of volunteers trained in risk communication and community engagement (RCCE), help to limit the spread of infection by raising awareness among communities about safe disinfection and burial practices and processes. The DRC RC is the lead agency for SDBs under the MoH/COUSP burial commission. Two teams with supervisors have already conducted 27 SDBs in Bulape and Mweka as of 21 September. Under this appeal, the DRC RC will:

- Scale up to 10 fully operational SDB teams across affected and at-risk areas.
- Ensure that Ebola-related deaths, per MoH protocol, receive a safe and dignified burial within 24 hours of the alert.
- Provide high quality training and monitoring to all volunteers involved in SDB activities and ensure quality assurance monitoring.
- Provide burial teams with all necessary equipment (included PPE, body bags, disinfectants, etc.) as well as vehicles to maintain rapid response capacity.
- Ensure that all teams have access to an operational base with fully equipped decontamination, warehousing, and resting areas, including proper waste management and reliable access to water.
- Ensure that inaccessible areas have Community Emergency Harm Reduction Burial/Enterrements Communautaires d'urgence a Moindres Risques (CEHRBU/ECUMR) teams fully trained, equipped, and supported to conduct SDBs.
- Conduct or use an anthropological study to adapt SDB protocols to local funerary rituals, engage community and religious leaders to improve and increase acceptance of safe burial practices, coordinate closely with the CEA team to organise community activities to explain the role of SDBs in stopping the transmission of the infection and increasing their acceptance, and implement feedback mechanisms and rumour tracking.
- MHPSS and CEA are both integrated into SDB activities, offering PFA to bereaved families and to volunteers conducting the burials. Coordination with the CEA team will ensure that feedback is monitored closely and the SDB strategy is adapted accordingly.

Mental Health and Psychosocial Support

- Basic PFA is integrated into epidemic response activities delivered by volunteers at the community level.
- Targeted MHPSS support will be provided to the families of those in treatment and quarantine facilities.
- Community sessions are carried out to address stigma and stress where there are confirmed cases, including referrals to specialised care, where available.
- Provide psychosocial support to survivors of GBV/EAS.
- Strengthen psychosocial support for staff and volunteers to reduce stress, including training sessions.

Community Health

Risk Communication and Community Engagement (RCCE)

This activity will strengthen risk communication and promote behavioural change through a tailored awareness-raising strategy adapted to Kasai's context, ensuring inclusion across age, gender, disability, and language. Using culturally appropriate channels, such as radio, posters, community dialogue, caravans, and outreach campaigns, volunteers will disseminate MoH key messages on EVD prevention, including hygiene practices, early care, non-stigmatisation, SDB, IPC, vaccination, PSEA, GBV, and safe reporting/referral mechanisms. Specific activities will include:

- An awareness strategy that prioritises the dissemination of key messages defined by the Ministry of Health on EVD prevention, through accessible and culturally appropriate channels (interactive radio, posters, banners, community dialogue sessions, awareness caravans, outreach campaigns). Messages will target hygiene practices and preventive measures (handwashing, safe contact, early care).
- Update IEC and print materials to the local context (language, preferred communication mode, cultural norms). Illustrated materials will be used for people with special needs and to take into account the educational level of certain target groups. Translate IEC materials in Tshiluba and test them before wide distribution.
- Train/retrain minimal community health teams with the EPiC package, including risk communication and community engagement, namely the community feedback system, radio, communication skills development, and EAPS.
- Organise social mobilisation sessions in the community including two-way communications such as door-to-door engagement, radio interactive programmes, mobile cinema, etc.
- Produce and broadcast health education programmes on EVD in partnership with radio stations.

- Organise radio spots providing updated information or with faith/traditional leaders and other community influencers to promote accurate information.
- Mobilise traditional medicine practitioners as well as traditional, religious and community leaders on the EVD response to build trust and reduce resistance to decontamination, SDBs, and vaccinations both in response and in preparedness zones.
- Key messages on vaccine availability, eligibility, and frequently asked questions are integrated into daily RCCE activities.
- Engage with local media including community radio stations to produce interactive radio programmes.

Surveillance

- Include community level surveillance support in the outbreak response activities. Activities in support of surveillance include:
- Support to active case findings by health volunteers during regular health promotion/RCCE activities.
- Inclusion of DRC RC volunteers with MoH contact tracing teams to extend the reach of teams, as well as to promote community acceptance, as requested by the MoH.
- Expansion of the DRC RC Community-Based Surveillance (CBS) system into the response to support early detection and early action.

Nutrition and Cash for Health

Through this Emergency Appeal, consideration will be given to providing adapted food support for patients admitted to ETCs, and community-based nutrition surveillance will be strengthened in affected areas to ensure early and coordinated management of malnutrition. This could take the form of nutritional support for EVD patients admitted to ETCs, distribution of food rations to affected families, capacity building in nutrition in the context of EVD, and awareness campaigns for mothers to prevent malnutrition and support children with moderate malnutrition.

Water, Sanitation, and Hygiene

Female > 18: **220,398**	Female < 18: **125,583**	**CHF: 2,599,000**
Male > 18: **213,458**	Male < **18: 120,561**	**Total target: 680,000**

Objective: **Improve hygiene practices within the entire affected population.**

Priority Actions:

Because Ebola thrives in contexts of limited access to water and the ability to perform proper hygiene and safe caregiving, community-level and institutional WASH is a critical prevention measure. Planned activities include:

- Providing emergency and longer-term solutions to access to safe water for the branches involved and health care facilities where IPC is being supported.
- Acquiring and making available IPC equipment to Red Cross and community response personnel to reduce the risk of spreading the epidemic while enabling the community to adopt good practices ensuring proper hygiene and sanitation in the environment.
- Disinfection of households with confirmed cases, health centres that have reported cases, and affected households as requested by the MoH.
- Distributing disinfectants to households affected by EVD integrated with hygiene promotion where suspected or confirmed cases have been reported.
- Providing a reintegration kit to households affected by Ebola. This kit includes hygiene supplies, water purification kits, and sanitation equipment.

- Improving WASH conditions through the installation and monitoring of handwashing facilities and integrated hygiene promotion in public spaces.
- Screening and handwashing at all entry points to affected areas and promoting good WASH practices.
- All WASH activities will be integrated with RCCE to ensure that hygiene messages are trusted, understood, and acted upon at the household level.

PROTECTION AND PREVENTION

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

Protection, Gender, and Inclusion	Female > 18: **7,519**	Female < 18: **4,285**	**CHF: 423,000**
	Male > 18: **7,283**	Male < 18: **4,113**	**Total target: 23,200**
Objective:	**Communities identify the needs of the groups most at risk and the particularly disadvantaged and marginalised as a result of inequality, violence, discrimination, exclusion, and other forms of non-respect for human rights and respond to their specific needs according to the DAPS principles.**		

Priority Actions:

The operation will ensure that PGI principles are integrated into all Ebola response actions including promoting inclusive communication, implementing protection risk mitigation measures to reduce cases of GBV and EAS, family separation, and stigmatisation, and responding to urgent protection needs caused by the epidemic by referring people to protection services. In high-risk operations such as Ebola, where responders have close and frequent contact with affected communities, robust safeguarding and PSEA measures are essential to uphold the dignity and rights of all people. The DRC RC, supported by the IFRC, will ensure that no form of exploitation, abuse, or harassment is tolerated within the response. Core actions will include:

PGI mainstreaming:

- Conduct a rapid PGI analysis to identify barriers and threats to protection, and to inform risk mitigation (e.g. population movements, exploitation, etc.).
- Integrate the gender perspective in all training sessions and strengthen the technical capacities of staff and volunteers deployed in the response to EVD on gender and epidemics, PEAS, child protection, identification and referral of protection cases, and a survivor-centred approach to PGI.
- Strengthen the collection and breakdown of data disaggregated by sex, age, and disability.
- Support teams in other sectors to integrate PGI principles in the implementation of their activities.
- Design services to be accessible and safe, especially for women, children, and persons with disabilities.
- Strengthen collaboration with local associations (women's associations, associations defending the rights of persons with disabilities and children) to ensure that the rights of children and persons with disabilities are fully considered in EVD-related actions and protection risks.
- Promote inclusive communication.

Prevention, mitigation, and response to SGBV and child protection risks linked with EVD:

- Community sensitisation on GBV risks linked to the outbreak, stigma reduction, EAS, case reporting mechanism, violence against orphans or children survivors of Ebola, and child protection through various channels.
- Development of safe spaces (child-friendly spaces).
- Reinforce the capacities of volunteers in the management and facilitation of CFS and psychosocial support for children, including Ebola orphans (one two-day training session per health zone).

- Respond to the protection and dignity needs of affected individuals by providing dignity kits and clothing kits for children.
- Referral pathways: Work with the MoH, Protection Cluster, and specialised partners to ensure timely referrals to survivor-centred support services, including medical care, PSS, and legal aid, where possible.
- Identify, refer, and follow-up on protection cases and establish a mechanism to prevent family separation.
- Strengthen the technical capacities of staff and volunteers deployed in the response to EVD on SGBV/EAS, child protection, identification and referral of protection cases, and a survivor-centred approach to PGI.

PSEA and safeguarding

In a high-risk operation such as Ebola, where responders are in direct and frequent contact with communities, the implementation of robust safeguarding and prevention measures against sexual exploitation and abuse (SEA) is essential to protect the dignity and rights of all those affected. The DRC RC, with the support of the IFRC, will ensure that no form of exploitation, abuse, or harassment is tolerated, and that clear mechanisms for prevention, detection, and case management will be operational throughout the response.

- Conduct an EAS risk analysis and child safeguarding assessment and implement a mitigation action plan.
- **Policy enforcement:** All staff and volunteers deployed in the Ebola operation will sign and adhere to the Code of Conduct, which includes explicit commitments on safeguarding and zero tolerance for SEA.
- **Training and awareness:** Volunteers and staff will be trained on PSEA and child safeguarding ensuring a clear understanding of their responsibilities and the consequences of misconduct.
- **Reporting mechanisms**: Establish and publicise confidential and accessible reporting channels for community members, ensuring that survivors can report SEA safely, including through community feedback systems already in place for RCCE/CEA.
- **Community sensitisation**: Integrate messaging on rights, accountability, and how to report misconduct in RCCE activities, ensuring that women, girls, people with disabilities, and marginalised groups know how to safely raise concerns.
- **Monitoring and compliance:** Regular monitoring visits, audits, and after-action reviews will ensure that PSEA commitments are being upheld and that lessons are fed back into the operations.

Through these measures, the DRC RC and IFRC will safeguard communities, protect volunteers, and reinforce trust in the Red Cross Red Crescent as a safe and accountable partner in the Ebola response.

Community Engagement and Accountability	Female > 18: **312,771**	Female < 18: **178,217**	**CHF: 1,361,000**
	Male > 18: **302,922**	Male < 18: **171,090**	**Total target: 965,000**
Objective:	**People and vulnerable communities affected by the epidemic are empowered to influence the decisions that affect them and trust the IFRC network to service their best interests.**		

Priority Actions:

To ensure that the Ebola response is inclusive, transparent, and trusted by affected populations, CEA measures will be integrated across all activities. These measures will promote meaningful participation and community ownership, while supporting sustainable adherence to prevention measures, including among marginalised groups. Safe, accessible, and confidential mechanisms for dialogue, feedback, and complaints will be

established. This approach will also prevent the stigmatisation of survivors and affected families. The following actions will be prioritised:

- Initial assessment: The DRC RC will conduct a contextual analysis in Kasai to tailor the awareness-raising strategy to different groups (age, gender, disability, language).
- Marginalised groups will be included in community outreach (minorities, people with disabilities, and older adults).
- Establish feedback mechanisms adapted to the operational context (suggestion boxes, hotlines, DRC RC “numéro vert”, "Centre de Contact Communautaire” (159), focus groups) that ensure anonymous, accessible, and culturally appropriate collection of, coding of, analysis of and response to community feedback.
- In all health zones, a functional, inclusive, and confidential complaint management and feedback mechanism will be established.
- Train staff and volunteers on the community feedback and complaint mechanism.
- Ensure that staff and volunteers involved in the response have the appropriate tools to track, report, and analyse feedback and that feedback analysis is shared with the volunteers involved in RCCE/CEA activities.
- Involve communities, including marginalised groups, in the planning and delivery of services, in identifying risks and solutions, and in monitoring the programme’s impact.
- Training and inclusion of community leaders: Train community leaders and ensure their active participation in the intervention process.
- Depending on each community’s choices, additional channels for reporting complaints and providing feedback will be made available to everyone, including women, young people, people with disabilities, and marginalised groups. This mechanism can include: (i) monthly community meetings to promote direct dialogue and transparency; (ii) a hotline allowing the targeted population to anonymously report their concerns or obtain reliable information; and (iii) secure suggestion boxes installed in strategic locations (health centres, EAE, listening centres, etc.).
- In accordance with the DRC RC’s complaint management SOPs, complaints received will be handled promptly, confidentially, and impartially, with referral mechanisms to the relevant services, particularly for cases of GBV or EAS. Communities will receive regular feedback on the complaints handled, in order to build trust, improve transparency, and ensure full accountability.

Enabling approaches

National Society Strengthening	Female > 18: **440**	Female < 18: **N/A**	**CHF: 3,109,000**
	Male > 18: **660**	Male < 18: **N/A**	**Total target: 1,100**
Objective:	The National Society is prepared to effectively respond to epidemics/emerging crises, and its auxiliary role in providing humanitarian assistance is well-defined and recognised.		
Priority Actions:			

The approach to National Society strengthening under this Emergency Appeal is twofold: a) To ensure that the necessary capacities are in place to implement response and preparedness activities through reinforced National Society branches; and b) To contribute to the longer-term National Society Development Plan.
The focus will be on:
(a) Strengthening the decentralised capacities of provincial branches in Kasai, Kasai Central, and Sankuru to lead operational implementation as well as preparedness and readiness efforts.
(b) Enhancing accountability by reinforcing governance, finance, logistics and warehousing, and volunteer management systems.
(c) Building long-term preparedness by institutionalising outbreak response capacities – including SDB, WASH, and RCCE – beyond the current operation, supported by trained teams and pre-positioned stocks.

Branch capacity enhancement (with a focus on Kasai, Kasai Central, and Sankuru)
Through this Appeal, the IFRC will support branch development and preparedness through the following activities:

- Equip, train, and equip provincial branches (Kasai, Kasai Central, Sankuru) to lead operational implementation (for response and preparedness).
- Equip provincial branches with the required materials to enable the rapid mobilisation of volunteers into affected health zones.
- Ensure branch offices have access to water, power, and the internet.
- Pre-positioning of key items: Establish rapid response teams at the branch level with pre-positioned stocks of PPE, SDB kits, hygiene supplies, and community engagement tools, ensuring that branches are ready for rapid activation if required.
- Strengthen governance, finance, logistics/warehousing, and volunteer management systems at the branch level.

Digitalisation

- Upgrade digital tools and strengthen reporting, financial, procurement, and warehouse systems, including procuring additional licenses if required.
- Train branch officers in resource management for capacity building in financial and logistics management.
- Document best practices, integrate them into future preparedness plans, and share lessons learned to strengthen capitalisation and knowledge management.
- Enhance mobile data collection capacity for community feedback, rumour tracking, assessments, and operational monitoring to improve real-time decision-making and information sharing.

Volunteer and staff management

- Enhance strategies for volunteer management and retention.
- Reinforce the National Society's volunteer management system.

Enhance youth engagement in the Ebola response

- Strengthen the National Society's youth structures and promote their integration in the implementation of the Ebola operation (focus on RCCE activities).

PMER/MEAL and information management

- Support the National Society in producing analysis and evaluations that inform advocacy resource mobilisation and programming.
- Facilitate branch-level, after-action reviews and lessons learned workshops to institutionalise epidemic response knowledge and strengthen future preparedness.

Leadership and governance

- Strengthen branch leadership through training on fraud and corruption, PSEA, integrity, risk management, and decision-making processes.

Coordination and Partnerships	Female > 18: **N/A**	Female < 18: **N/A**	**CHF: 632,000**
	Male > 18: **N/A**	Male < 18: **N/A**	**Total target: N/A**
Objective:	**Technical and operational complementarity among the IFRC's membership and with the ICRC is enhanced through cooperation with external partners.**		

Priority Actions:

Membership coordination

- Mobilise a resource person specifically dedicated to operational Membership Coordination during the initial response phase of the operation (discussions are ongoing with the Belgium RC).
- Engage with IFRC Network members with a presence in the country contributing to the operation to ensure a unified response, using existing Membership Coordination platforms established at the country level under the leadership of the National Society.
- Ensure close coordination with Participating National Societies interested in supporting the operation, including those with Emergency Response Units (ERUs).
- Facilitate information sharing and joint operational and financial planning to complement efforts.
- Pursue shared leadership opportunities to use the capacities, skills, and added-value of IFRC Network members in-country, including their participation in establishing the Minimum in-Country Team (MICT).
- Continue to coordinate inputs and support information sharing and analysis between PNSs ensuring a common analysis and approach to the Ebola outbreak in Kasai.
- Test the tools of the Membership Coordination in Emergencies toolkit.

Movement cooperation

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

Engagement with external partners

- Continue strong engagement and coordination with national authorities at all levels (national, provincial, and local), as well as with the United Nations, INGOs, and other actors engaged in the response.
- Maintain strong representation with donors, external partners, and the diplomatic community in the DRC to secure ongoing support throughout the operation.
- Proactively engage with key stakeholders to build or reinforce partnerships that can mobilise resources and expertise, including outreach to the private sector and non-traditional donors for financial contributions and in-kind support.
- Ensure robust grant management and donor accountability through timely, high-quality reporting.

IFRC Secretariat Services	Female > 18: **N/A**	Female < 18: **N/A**	**CHF : 2,520,000**
	Male > 18: **N/A**	Male < 18: **N/A**	**Total target: N/A**
Objective:	**The IFRC Secretariat and National Societies leverage their unique position to influence decisions at the local, national, and international levels, ensuring the most vulnerable are prioritised.**		

Priority Actions:

The IFRC, through its Secretariat services, will ensure a robust logistics backbone to support the DRC RC in responding to the Ebola epidemic. Given the remoteness of the area and the heavy reliance on overland transport through Tshikapa, effective logistics and supply chains are critical for the success of the operation.

Surge deployments

- Recognising the current in-country capacity of the National Society, IFRC Delegation, and PNSs, mobilise complementary global and regional surge personnel, including technical specialists and support staff, to reinforce the DRC RC's capacity for the response and overall coordination. The initial mobilisation includes Rapid Response Personnel (Operations Manager, Field Coordinator, Supply Chain Coordinator, Public Health in Emergencies Coordinator, CEA, Communication, Security, PMER, and Health Staff), while the mobilisation of ERUs (PHiE: CBS, IPC modules, Logistics, IT/Telecom) is also under consideration.

The surge system will be closely coordinated through the IFRC's Global Surge Desk and Regional Office in Nairobi, ensuring that deployments are context-appropriate and embedded within DRC RC branch structures when relevant. By leveraging the global surge system and tools, the IFRC will ensure that the operation can rapidly expand if case numbers escalate, while guaranteeing quality standards and adherence to Ebola response. protocols.

Logistics, procurement, and supply chain management

- Assess, evaluate, and adjust the supply chain approach in the DRC in view of the current logistical challenges and upcoming rainy season (anticipating potential challenges).
- Support the National Society in receiving and processing items and goods for field activities.
- Ensure transport services to move goods from the IFRC's existing warehouses (Dubai and others according to needs).
- Manage customs clearances and organise transport services to ensure the timely delivery of supplies.
- Ensure constant monitoring of the operational pipeline for the mobilisation, transport, and distribution of purchased items.
- Together with the DRC RC, support warehousing operations, including the transport and storage of all procured items.
- Coordinate and cooperate with donors, suppliers, and Participating National Societies.

Communication

- Implement the communication plan developed with the support of the National Society to raise awareness among donors and the public.
- Highlight the work of the Red Cross through various media platforms (press, radio, TV, social media).
- Facilitate media interviews upon request to ensure proper coverage of the response and advocate for increased support.
- Conduct a three-day communications training to strengthen the capacity of the DRC RC in photography, videography, writing, and social media engagement.
- Make optimal use of established communications channels in the DRC, including radio, social networks, and written media to increase the visibility and impact of the intervention.

Human Resources

- Support the mobilisation and deployment of existing staff, Red Cross volunteers, and personnel from DRC RC headquarters and branches as needed for the operation.

- Mobilise existing in-country capacity from PNSs to respond to gaps and in line with the establishment of the Minimum in-Country Team.
- Deploy Rapid Response personnel from the IFRC and its Membership via regional global surge mechanisms to provide technical and operational management support to DRC RC.
- Cover some operational costs for DRC RC staff and volunteers engaged in the response, including insurance and related expenses as per the agreement reached with the National Society.

Humanitarian Diplomacy

- Strengthen dialogue with donors, embassies, and the diplomatic community to advocate for the Ebola response and address operational challenges.
- Develop humanitarian diplomacy key messages to be shared with stakeholders, donors, and decision-makers, as needed.
- Leverage partnerships with UN agencies and other key humanitarian stakeholders to promote coordinated action around potential bottlenecks or challenges faced by humanitarian actors.
- Support the National Society in engaging in humanitarian diplomacy with governments and other stakeholders to promote protection and assistance to the affected population.

Finance and Administration

- Uphold financial accountability standards, ensuring timely reconciliations and reporting to partners and donors through IFRC systems.
- Ensure and monitor compliance with IFRC financial procedures and provide continuous technical support for effective, accountable resource management.
- Ensure the required support for the operation to ensure accountability and agility, timely fund transfers, the review and validation of budgets, and technical assistance to the National Society on expense justification procedures.
- Ensure that a transparent and sound financial control mechanism is in place.

Security

- Initial deployment of the IFRC CCD Surge Office to Bulape and mobilise a surge Security Coordinator to continuously assess security management and recommend measures to improve practices and capacities.
- Ensure strict application of IFRC security plans to all personnel in all operational areas.
- Conduct and regularly update sector-specific security risk assessments.
- Monitor the evolution of the security situation in the operational areas.
- Identify and implement security risk mitigation measures to address evolving risks throughout the operation.
- Ensure all IFRC staff and encourage RC/RC staff and volunteers to complete the IFRC Stay Safe 2.0 e-learning courses.
- Provide ongoing support to the DRC RC through the IFRC Regional Security Unit, Kinshasa Delegation Security Officer, and Global Security Unit for assessments, analysis, and technical advice to build security management structure.

Information Management (IM)

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

Planning, Monitoring, Evaluation, and Reporting:

- Put in place a comprehensive Federation-wide monitoring and evaluation system to ensure consistent oversight and accountability.

- Mobilise dedicated PMER profiles as needed to facilitate comprehensive Federation-wide planning and reporting.
- Develop and maintain robust monitoring tools and data collection workflows to support internal and Federation-wide reporting.
- Oversee operational implementation, monitoring, evaluation, and reporting through the National Society's PMER Department.
- Support operational planning, implementation, monitoring, and evaluation in close collaboration with all stakeholders under the National Society's PMER Pool.
- Develop and implement an M&E plan, including an indicator tracking table (ITT) and updated reporting templates with clear reporting lines (including Fedwide).
- Carry out a satisfaction survey whenever relevant.
- Hold regular coordination meetings to ensure harmonised monitoring and consistent reporting across all partners.
- Ensure continuous PMER support to strengthen the long-term capacity of the National Society.
- Carry out a Real-Time Evaluation and a Mid-term Review to measure performance, highlight strengths, and address challenges.
- Conduct a Final Evaluation to assess overall impact and capture additional lessons learned for Ebola responses.

Staff health

- Develop and oversee the staff health and well-being plan, ensuring compliance with duty of care standards.
- Train and support staff and volunteers on stress management, PFA, and self-care.
- Organise staff health briefings, including risk communication, safe working practices, and fatigue management.
- Ensure the vaccination of staff and volunteers in line with MoH and IFRC/DRC RC protocols.
- Set up and supervise staff-focused point of entry screening and handwashing stations at offices, bases, and accommodation sites.
- Coordinate with HR, Security, and MHPSS teams to integrate staff health into operational planning.
- Track and report staff health indicators to inform decision-making and adapt support measures.

Partnership and Resource Development

- Develop partnerships at the national and international levels to mobilise resources for the operation.
- Organise field visits with donors, embassies, and partners to showcase results and impacts.
- Hold regular information-sharing meetings in close collaboration with the DRC RC.

Disaster Law

- Develop an IDRL fact sheet.
- Support the DRC RC in negotiating the formalisation of the National Society auxiliary space in this response and related emergencies.

Risk management

The IFRC is taking a proactive approach to risk management, implementing an optimal set of controls to maximise the effectiveness and efficiency of the operation. The overall risk management structure and plan (in line with the IFRC Risk Management Policy and Framework) include:

- The risk management and risk reporting procedure for the Emergency Appeal (EA)
- How to guide – risk management cycle in detail
- Roles and responsibilities in managing risk

The IFRC Delegation and operational teams are responsible for identifying, managing, monitoring, and reporting risks inherent to the operational environment. This is facilitated by the operations managers and risk champions but is a team effort, including core members of the operations team (security, logistics, finance, PMER, etc.) and key National Society counterpart(s). Risks should be captured in a country risk register, reviewed, and reported on, following an established process flow. Each month, the regional risk coordinator will review the risk register and prepare a consolidated summary to relevant IFRC stakeholders.

Along with the risks defined further in the table below, all IFRC personnel will be required to adhere to the IFRC Minimum Security Requirements throughout the operation. A Security Risk Assessment has been conducted in the operating areas and risk mitigation measures have been identified and will be implemented. All IFRC personnel must, and Red Cross and Red Crescent staff and volunteers are encouraged, to complete the IFRC Stay Safe e-learning courses. A Surge Security Coordinator is also being deployed.

Risk	Likelihood	Impact	Mitigating actions
1. Safety in the response area could present potential risks during travel, which could impede implementation (Kasai province is marked by sporadic violence and highway robberies)	High	High	• Strengthened IFRC security frameworks and protocols to ensure appropriate security analysis, monitoring the safety and security of staff and volunteers, and compliance with current security guidelines • Presence of a Security Officer in the operational areas to ensure MSR compliance • Safety contingency plans are in place with continuous security assessments • Provision of basic security training to DRC RC staff and volunteers • Monitoring of information relating to the security context, coordination with other external security stakeholders • Regular safety briefings
2. Delays or difficulties encountered in the supply of materials due to access issues and poor road conditions	High	High	• Local purchases are made when feasible and in compliance with required technical specifications and standards • Advocate for increased use of transport/helicopter/UNAHS • Diversify transportation options, establish alternative supply routes, and stockpile critical resources in key locations
3. Incidents related to community resistance	Medium	High	• Implement strong RCCE, CEA, and community-based surveillance activities, targeting specific groups with influence in communities within operational areas • Collect, process, analyse, and manage community feedback
4. Delay in the procurement process	Medium	High	• Continuous monitoring of the outbreak's evolution to anticipate needs and adapt the response accordingly
5. Spread of the outbreak, including in surrounding provinces	High	High	• Continuous monitoring of the outbreak's evolution • Flexibility in funding • Strong branch preparedness and RCCE/CEA engagement in neighbouring provinces • Rapid scale up of the response
6. The health system is overwhelmed by the increase in the number of cases	Medium	High	• Continuously invest in the key RC pillars of the response • The National Society will continue to monitor the situation and stands ready to scale up the response with the support of IFRC staff (including additional staff)
7. Safeguarding failures (inadequate prevention of sexual	High	High	• Ensure that all surged team members are screened • Strengthen safeguarding systems, ensuring that all staff and volunteers have received adequate

exploitation and abuse, or child protection measures)			briefings on the Code of Conduct, PSEA Policy, and on child safeguarding • Train all volunteers and staff on PSEA and child safeguarding • Analyse safeguarding risks and develop corresponding action plans • The Integrity Line and reporting mechanisms are clearly displayed to all staff • Conduct PSEA awareness sessions (including briefings for all volunteers and staff engaged in the response) and reinforce existing reporting mechanisms • Establish safeguarding SOPs for the operation • Establish a complaint mechanism accessible to all • Establish community awareness on sexual exploitation and abuse and reporting mechanisms • Deploy an expert technical advisor if needed
8. Risk of fraud, misappropriation of funds	Medium	High	• Building staff capacity on the DRC RC's anti-fraud policy, internal regulations, and PSEA policy
9. Financial and resource gaps (insufficient donor funding, delayed disbursements)	Medium	High	• Implement a phased funding approach and engage in continuous donor outreach
10. Risk of delayed reporting (narrative and financial) and inconsistent quality of data/information	Medium	High	• Mobilise and deploy dedicated in-country resources to support the operation (including an Operations Manager, PMER, IM, Finance, and SIMS activation) • Strengthen coordination through regular update meetings • Implement a monthly monitoring and financial reporting system with the National Society • Accelerate the validation of the MoU in the e-contract • Make staff available for data collection, data management and reporting (IM and M&E), including the creation of a single database
11. Staff and volunteer infection			• Implement staff health procedures • Ensure vaccination according to the IFRC and MoH • Provide volunteer insurance that covers infectious disease risks

Quality and accountability

The PMER team will establish a Federation-wide reporting system to track progress and ensure accountability. In addition to meeting minimum operational update requirements, the PMER team will support monthly reporting and coordinate with the operations and other technical teams to hire a consultant for a final external evaluation in accordance with the IFRC's evaluation framework. Both a mid-term review and a final evaluation will be conducted.

Working alongside National Societies, the IFRC will conduct continuous monitoring at the country level, including regular updates on the operational risk register, ensuring timely adaptation of the operation and consistent reporting on progress.
The DRC Red Cross is responsible for monitoring and evaluating the plan and will conduct weekly and monthly meetings. These will serve as a basis for strategic reorientation and replanning of activities for the following year. Periodic monitoring, supervision, and control visits to the operation's sites, regular (weekly) joint coordination meetings, and a mid-term review will ensure that the objectives initially set are achieved. Quality assurance actions will be carried out by the PMER, Programmes, and IM teams. These will essentially:

- Develop policies, procedures (SOPs), protocols, manuals, and best practices for effective monitoring and evaluation.
- Ensure that lessons learned from programmes and operations are managed and integrated into ongoing and future operations.
- Properly lead reporting and accountability to ensure that the National Society accurately reports on its achievements.
- From headquarters, work closely with PMER teams in the intervention areas to form a unified team and leverage complementary technical strengths.
- Lead the use of data to inform evidence-based decision-making.
- Oversee Federation-wide data collection systems in the country.
- Strengthen information management capacity to increase the National Society's ability to use digitised data collection, analysis, and information sharing in real time.
- Work closely with the National Society's Information Management (IM) team and the IFRC Cluster (IM/PMER).

Objective	Indicator	Target
Objective: Through this Emergency Appeal, the IFRC supports the DRC RC in rapidly curbing transmissions, preventing outbreak expansion, and reducing mortality and social harm associated with EVD in Kasai province.	# of new confirmed EVD cases (report date value)	0
Outcome 1: Health The spread and impact of the outbreak are reduced through community outreach in the affected health zones.	% increase/decrease since the last reporting period (new cases, CFR)	
Output 1.1: Safe and Dignified Burials (SDBs) The affected population is assisted with safe and dignified burials and decontamination activities.	% of deceased individuals for whom SDBs were successfully carried out	100%
	% of SDB alerts responded to through public health action within 48 hours	100%
	# of volunteers/supervisors trained/retrained in SDBs, disaggregated by sex, age, and disability	360
	# of SDB alerts received	As necessary
	% of Red Cross SDB volunteers vaccinated	100%
	% of swab samples successfully collected for deaths reported to the Red Cross	100%
Output 1.2: Mental Health and Psychosocial Support The psychosocial consequences of the outbreak are reduced through direct support to exposed and infected	% of people confirmed or suspected of having been affected by EVD receiving MHPSS support	100%
	% of personnel and volunteers reached with MHPSS support	100%

populations in Kasai province and neighbouring high-risk provinces.	# of people reached with MHPSS from the National Society	23,200
	# of supervisors and volunteers trained in psychosocial support	100
Output 1.3: Community Heath/Risk Communication and Community Engagement (RCCE) Social mobilisation, risk communication, and community engagement activities are carried out to limit the spread and impact of EVD	# of people reached with epidemic-related health promotion activities	965,000
	# of volunteers trained on EpiC, disaggregated by sex, age, and disability	1,100
	% of people surveyed who say they trust the information provided by the National Society	80%
Output 1.4: Community-based Surveillance (CBS) The government is assisted by DRC RC volunteers on surveillance and contact finding	# of CBS assessments completed	1
	# of CBS protocols/SOPs developed	1
	# of volunteers trained in CBS	1,100
	% of communities with coverage of active CBS Volunteers (1 Vol: <50HHs)	10%
	% alerts later confirmed as cases	80%
	% of community-based surveillance (CBS) alerts responded to through public health actions within 48 hours	100%
	% of CBS volunteers who are active ('zero' reporting, monthly average)	90%
	# of CBS alerts raised to the MoH	As necessary
Output 1.5: Nutrition and Cash for Health Contribution to support patients admitted to ETCs and they family with adapted food support and cash for health	# of people admitted to ETC and their family members who received food/Meal assistance from the Red Cross	1,000
Outcome 2: Water, Sanitation, and Hygiene Hygiene practices are improved within the entire affected population.	% of decontamination alerts responded to by Red Cross teams on the same day	100%
Output 2.1: The target population has access to essential water and sanitation infrastructure/services for consumption, hygiene/health.	# of hygiene kits distributed in the households of confirmed cases and contacts to avoid contamination	4,000
	# of people covered with hygiene promotion activities	680,000
	% of SDB bases that have access to clean water	100%
	# of homes, health facilities, or other locations where a confirmed or presumed case had spent time decontaminated by trained RC teams	1,000
	% of decontamination alerts successfully completed by RC teams within the same calendar day	80%
Outcome 3: Protection, Gender, and Inclusion (PGI) Protection, Gender, and Inclusion communities identify and respond to the distinct needs of the most vulnerable segments of society, especially disadvantaged and marginalised groups,	% of survivors of SGBV/SEA reporting to the National Society who are referred to appropriate medical, psychological, or other support services within 72 hours	100%

due to violence, discrimination and exclusion.		
Output 3.1: Safe Access to Services National Society programmes improve equitable access to basic services taking into account different needs based on gender and other diversity factors.	# of people (disaggregated by sex, age, and disability) reached by protection, gender, and inclusion programming	23,200
	# of (temporary) safe spaces established or operated by the National Society for the purpose of learning, psychosocial support, or recreation	6
	# of assessments and analysis carried out incorporating protection, gender, and diversity and inclusion considerations as part of emergency operations	1
Output 3.1: PSEA Emergency response operations prevent and respond to sexual and gender-based violence and all forms of violence against children	% of volunteers and staff trained on PSEA and basic SGBV awareness and survivor-centred response, including receiving and managing sensitive SGBV (including safeguarding)-related disclosures	100%
	# of National Society staff and volunteers who have signed and been briefed on the Code of Conduct	1,100
	# of gender and disability reporting mechanisms supported	1
Outcome 4: Community Engagement and Accountability People and vulnerable communities affected by the epidemic are empowered to influence the decisions that affect them and trust the IFRC network to service their best interests.	% of people surveyed who feel the National Society's services meet their most important needs and provide useful support	80%
	# of staff, volunteers and leadership trained on community engagement and accountability	1,100
	# of opportunities for community participation in managing and guiding the operation (e.g. number of community committee meetings, focus group discussions, town halls)	As necessary
	% of community members who feel their opinion is taken into account during operation planning and decision-making	80%
Output 4.1: Feedback Mechanisms Number and type of methods established to collect feedback from the community.	% of operational feedback received and responded to by the National Society	80%
	The National Society has a functioning feedback mechanism in place for the whole organisation	1
Outcome 5: National Society Strengthening National Societies are prepared to effectively respond to epidemics/emerging crises, and their auxiliary role in providing humanitarian assistance is well-defined and recognised.	The National Society is part of government-led emergency coordination platforms	Yes
	The National Society is part of the DRC RC, interagency, and international community's official emergency response coordination platforms	Yes
Output 5.1: volunteering and Branch Capacity Enhancement Improved operational scope and efficiency.	# of mobilised volunteers covered by sickness, accident, and death benefits	1,100
	The National Society has improved its preparedness, contingency, and response plans following recommendations and evidence from the operation	Yes
	# assessments carried out (initial needs assessment/anthropological study/real time evaluation/final evaluation, etc.)	4

Outcome 6: Coordination and Partnerships Technical and operational complementarity among the IFRC's membership and with the ICRC is enhanced through cooperation with external partners.	# of regular coordination mechanisms with all Movement partners	1
Output 6.1: Strategic and Operational Coordination The National Society is a member of relevant national donor platforms and forums and engages with them regularly.	# of monthly coordination meetings	12
	# of joint monitoring missions carried out (DRC RC-IFRC, PNS, ICRC)	1
	# of lessons learned workshops/mid-term reviews	2
Outcome 7: IFRC Secretariat Services Effective and coordinated disaster response is confirmed.	The resource mobilisation strategy has been completed and implemented	1
Output 7.1: Agility and Accountability The IFRC strengthens its effectiveness, credibility, and accountability.	The National Society has a risk management framework in place	1
	# of financial audits carried out	1

FUNDING REQUIREMENT

Federation-wide funding requirement*

Federation-wide funding requirements, including the National Society domestic target, IFRC Secretariat and Participating National Societies' funding requirements	IFRC Secretariat funding requirements in support of Federation-wide funding request
CHF 20 million	**CHF 17 million**

**For more information on the Federation-wide funding requirement, refer to the section: Federation-wide Approach*

Breakdown of the IFRC secretariat funding requirement

IFRC

OPERATING STRATEGY

MDRCD047 - Democratic Republic of Congo, Africa–Ebola

FUNDING REQUIREMENTS

Planned Operations	10,739,000
Livelihoods	0
Multi-purpose Cash	0
Health	6,356,000
Water, Sanitation, and Hygiene	2,599,000
Protection, Gender, and Inclusion	423,000

Community Engagement and Accountability	1,361,000
Risk Reduction, Climate Adaptation, and Recovery	0
Enabling Approaches	**6,261,000**
Coordination and Partnerships	632,000
Secretariat Services	2,520,000
National Society Strengthening	3,109,000
TOTAL FUNDING REQUIREMENTS	**17,000,000**

All amounts in Swiss francs (CHF)

Contact information

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

At the DRC Red Cross:

- **Secretary General**: Gloria Lombo; email: sgcrrdc@croixrouge-rdc.org, phone: +243856435031
- **Operational Coordination:** Dr. Benjamin Kalambayi, Health Emergency Assistant; email: kalambayi.us@croixrouge-rdc.org, phone: +243 992191313 or +243 821393427

At the IFRC:

- **IFRC Regional Office for Africa DM Coordinator:** Rui Alberto Oliveira, Regional Operations Lead; email: rui.oliveira@ifrc.org, phone: +254 780 422276
- **IFRC Country Cluster Delegation:** Ariel Kestens, Head of Country Cluster Delegation-Kinshasa; email: ariel.kestens@ifrc.org, phone: +243 853449555
- **IFRC Geneva:** Santiago Luengo, Senior Officer, Operations Coordination; email: santiago.luengo@ifrc.org, phone: +41 (0) 79 124 4052

For IFRC Resource Mobilisation and Pledges support:

- **IFRC Regional Office for Africa:** Louise Daintrey, Head of Strategic Partnerships and Resource Management; email: louise.daintrey@ifrc.org , phone: +254 110 843 978

For In-Kind Donations and Mobilisation table support:

- **Logistics Coordinator,** Allan Kilaka Masavah, Manager, Global Humanitarian Services & Supply Chain Management; email: allan.masavah@ifrc.org

For PMER (Planning, Monitoring, Evaluation, and Reporting) support:

- **IFRC** Africa Regional Office: Beatrice Okeyo, Regional Head PMER, and Quality Assurance; email: beatrice.okeyo@ifrc.org, phone: +254 721 486 953

Reference

↘

Click here for:

- Previous Appeals and updates