ACT Alliance

CEA 261 Regional Ebola Response

Appeal

CEA 261

SECRETARIAT: 150, route de Ferney, P.O. Box 2100, 1211 Geneva 2, Switzerland
TEL.: +4122 791 6434 – FAX: +4122 791 6506 – www.actalliance.org

Table of contents

Each heading links to the corresponding section

Appeal Summary Sheet	
Appeal Code and Title	CEA 261 Regional Ebola Response
Budget (USD)	Total Requesting Members' Budget: 1,470,588 USD SMC 2%: 44,118 USD Total Budget:1,514,706 USD
Revision Schedule	1st October 2026
Locations	**DRC** Ituri, North and South Kivu. Ituri City (Mongbwalu, Bunia, Rwampara and Nyankunde Health Zones) Goma City (Karisimbi Health Zone) **Tanzania** Kagera Region: ELCT Northwestern Diocese, ELCT Karagwe Diocese, 15 Health facilities in Muleba, Bukoba TC, Bukoba DC, Misenyi, Karagwe, Kyerwa and Ngara Districts. Kigoma Region: ELCT Western Diocese and 3 Health facilities in Kigoma, Ujiji, and Kasulu districts) Mwanza Region: (ELCT ELVD Diocese and 5 Health Facilities in Mwanza CC. Nyamagana, Misungwi) Mara Region: (ELCT Mara Diocese, 5 Health Facilities in Mara - (Bunda, Rorya, and Musoma) 2 Zonal referral Hospitals – KCMC and Bugando referral Hospitals in Kilimanjaro and Mwanza.
Response Period	Start Date **01 July 2026** End Date **30 June 2027** No. of months **12**
Requesting Forum	ACT DRC Forum members: COPAD, ECC/Meru, BOAD, Christian Aid. ACT Tanzania Forum members: Evangelical Lutheran Church in Tanzania (ELCT). ☒ The two ACT Forums officially endorse the submission of this Appeal (tick box to confirm)
Requesting members	Requesting Member / Budget Christian Aid — 78,432 USD COPAD — 352,941 USD BOAD — 215,686 USD ECC/MERU — 137,255 USD ELCT — 686,274 USD
Appeal Coordinator	Name: Obed Buhendwa Email: obuhendwa@christian-aid.org
Implementing partners	N/A

Response Strategy Summary	Requesting Member	Number of Target Participants per sector (less radio sensitization, health care client numbers)	
	COPAD **Target** **> 2,096**	PPE-188 Community Engagement-208 WASH 1300	
	ECC / Meru **Target > 1,060**	Personal Protective Equipment-120 Health Workers-270 Community engagement-270 WASH -400	
	BOAD **Target > 2200**	Cash – 650. PPE-200. WASH-1300. Protection (GBV)- 50. Health Workers Training Community Engagement-	
	ELCT **Target > 1790**	Multi-stakeholder Engagement- 595 Medical supplies (including PPE) 30 Health facilities. Health Workers Training- 300	
	Christian Aid	Project Launch Workshop Passporting sessions for three partners (COPAD, ECC, BOAD. Conducting training on community accountability assessment for COPAD, ECC, and BOAD. Safeguarding training for COPAD, ECC, and BOAD. Capacity Building of partners in line with the due diligence process and monitoring.	
Outcome(s)	Targeted communities in DRC (Ituri, North Kivu, and South Kivu) and affected regions in Tanzania have improved knowledge, trust, and adoption of practical Ebola prevention and hygiene measures in a dignified and protective environment. Outcome 1: Reduced risk of Ebola morbidities and mortalities among affected communities and Frontline Health Care Workers in targeted communities in DRC and selected regions in Tanzania. Outcome 2: Increased preparedness and resilience of communities through public health interventions, community preparedness and prevention, and community engagement. Outcome 3: Religious leaders, churches and other communities of faith mobilized in managing beliefs, attitudes and social stigma, and ensuring community inclusivity and cohesion. Outcome 4: Targeted communities (vulnerable groups, individuals, households, and communities) in DRC have improved the livelihoods of the most vulnerable groups, individuals, families, and communities.		

Objectives	**Objective 1:** Strengthen health system capacity for Ebola preparedness, infection prevention and control, early detection, and effective response in high-risk regions of Tanzania by June 2027. **Objective 2:** Enhance community resilience, risk communication, and faith-based engagement for Ebola prevention, early identification, and timely referral of suspected cases in high-risk communities by June 2027. **Objective 3:** Strengthen national and regional multi-sectoral coordination, advocacy, and cross-border collaboration among faith-based and health stakeholders for effective prevention and response to Ebola and other public health emergencies by June 2027.
Target Participants	☐ Refugees ☒ IDPs ☒ host population ☒ Returnees ☒ non-displaced affected population No. of households 907,374 Based on an average of **5.3 HH** size (DRC) and **4.7 HH** (Tanzania) **Sex and Age Disaggregated Data:**

	Sex and Age								
	4-7	8-10	11-20	21-49	50-69	70-79	80-89	90+	**Total**
Male	8,911	11,383	71,113	282,142	85,839	16,828	10,113	3,432	**489,761**
Female	9,956	13,406	74,668	35,830	89,942	19,269	10,230	3,344	**256,645**
	18,867	**24,789**	**145,781**	**478,940**	**175,781**	**36,097**	**20,343**	**6,776**	**907,374**

Reporting Schedule

Type of Report	Due date
Situation report	01 October 2026 First SitRep due 01 April 2027
Interim Report (narrative and financial)	01 January 2027
Final narrative and financial report (60 days after the end date)	31 August 2027
Audit report (90 days after the ending date)	31 September 2027

Please kindly send your contributions to this ACT bank account:

US dollar
Account Number - 240-432629.60A
IBAN No: CH46 0024 0240 4326 2960A

Account Name: ACT Alliance
UBS AG
8, rue du Rhône
P.O. Box 2600
1211 Geneva 4, SWITZERLAND
Swift address: UBSWCHZH80A

Please note that as part of the revised ACT Humanitarian Mechanism, pledges/contributions are **encouraged** to be made through the consolidated budget of the requesting members, and allocations will be made based on the agreed criteria of the forum or task group. Please send an email to Humanitarian Finance (humanitarianfinance@actalliance.org) regarding contributions, **including funds sent directly to the requesting members**.

Please also inform us of any pledges or contributions, and of any contract agreements and requirements, especially from back donors. In line with Grand Bargain commitments to reduce the earmarking of humanitarian funding, if you have an earmarking request in relation to your pledge, a member of the Secretariat's Humanitarian team will contact you to discuss this request. We thank you in advance for your kind cooperation.

For further information, please contact:

Africa
Regional Representative, Elizabeth Kisiigha Zimba (Elizabeth.Zimba@actalliance.org)
Humanitarian Programme Coordinator, Caroline Njogu (Caroline.Njogu@actalliance.org)

Visit the ACT website: https://actalliance.org/

Niall O'Rourke
Head of Humanitarian Affairs
ACT Alliance Secretariat, Geneva

Context Analysis

The Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo continues to evolve rapidly, with currently no approved vaccine or specific treatment. Still, it is having sustained transmission and increasing numbers of reported cases(WHO). As of 17 June, a cumulative total of 896 confirmed cases, including 232 deaths, have been reported from the Democratic Republic of the Congo (WHO). As of 18 June, Uganda has reported 19 confirmed cases, including two deaths, as well as one probable case that has died. In Uganda, the outbreak remains epidemiologically linked to transmission originating in the Democratic Republic of Congo, with evidence of both imported infections and secondary transmission among contacts and healthcare workers. There is no vaccine for the Bundibugyo virus, and treatment consists of supportive care. Patients have experienced Ebola disease symptoms like fever, headache, vomiting, severe weakness, abdominal pain, nosebleeds, and bloody vomiting. There have been 2 previous outbreaks of Bundibugyo virus, one in Uganda (2007) and one in DRC (2012), with death rates of 32% and 55%, respectively. This outbreak is now the largest caused by the Bundibugyo virus (CDC).

Geographic Spread and Context

To date, the Ebola disease outbreak in DRC has been confirmed in Ituri, Nord-Kivu, and Sud-Kivu provinces (CDC). DRC Ministry of Health sitrep reported on the week of 10 June 2026, 41 new cases: The new cases are distributed per province as follows: Ituri provinces: Bunia (12), Mongbwalu (5), Rwampara (4), Bambu (2), Nizi (2), Lita (1), Nyakunde (1), Mangala (1), Kambala (1). North Kivu: Beni (4), Katwa (4), Butembo (1), Kyondo (1), Masereka (1), Vuhovi (1).

The outbreak is occurring in a highly vulnerable context, with insecurity, displacement, population movements, weak health capacity, and constrained access complicating investigation, surveillance, and continuity of essential services. The outbreak of the Ebola virus disease is linked to structural and cyclical problems in eastern DR Congo and to the poor health systems in DR Congo, where health facilities face enormous challenges in terms of staff qualifications and the training of healthcare workers in epidemic management, and medical facilities have poor sanitation standards.

According to the Ministry of Health's situation report, there have already been four deaths among healthcare workers who were infected while on the job (WHO).

Furthermore, low levels of education among community members and local beliefs are at the root of resistance from community members, which has even led to attacks on health care workers.

This spread of the Ebola outbreak is exacerbated by the current situation in eastern Democratic Republic of Congo, of large-scale population movements caused by armed conflicts are causing community transmission. Limited access to safe water and poor hygiene practices during forced displacement caused by armed conflicts are other factors contributing to the spread of Ebola.

Thus, this project will help address structural issues while also strengthening the capacity of healthcare workers regarding preventive measures against Ebola.

Community liaisons and religious leaders will be trained on preventive measures and will serve as channels of communication with the public to promote the adoption of preventive measures against Ebola.

In response to problems related to poor hygiene, this project will provide affected and at-risk households with hygiene kits to help combat the Ebola virus disease.

The activity packages that this project offers to people affected by and at risk of Ebola virus disease are aligned with the recommendations of the response strategy developed by the Ministry of Health of the Democratic Republic of Congo, and Tanzania specifically the alignment with the pillars of risk communication and community engagement, infection prevention and control, a multisectoral response through the distribution of cash for specific purposes, and protection/GBV through activities to combat gender-based rape and provide care for survivors.

Given the high level of community transmission resulting from strong resistance and a lack of trust among affected and at-risk populations regarding Ebola prevention messages, this project's strategy will rely on awareness-raising efforts led by local and religious leaders whom the affected and at-risk populations trust.

Given the high risk that women will be more severely affected by the Ebola virus disease, women will be among those targeted for awareness-raising efforts, and special attention will be paid to preventing all forms of rape, gender-based violence, sexual abuse, and sexual exploitation.

While Ituri province remains the epicentre of the outbreak, North Kivu and South Kivu also face a high risk of onward spread, where confirmed cases were reported, and many contacts are reportedly facing many challenges of full contact management. Contact Tracing is the Biggest Weakness in the Ebola outbreak (Reuters). The DRC Ministry of Health reported a low level of tracking contacts (less than 70%, while it expected a follow-up of contacts at 95%). This lack of follow-up on contacts is due to the insecure contexts, the physical access, and the misconceptions by communities about Ebola disease. While follow-up of cases remains low, this is attributed to the widespread nature of the Ebola outbreak, and the DRC Ministry of Health reported a very high level of community contamination of the Ebola outbreak.

While clinical response, case management, laboratory confirmation, surveillance, and contact tracing are being led by the Ministry of Health, WHO, and specialised health actors, critical gaps remain at the community level. Community resistance, rumours, misinformation, fear, and stigma are affecting acceptance of response measures. The DRC health cluster recommends intensified risk communication and community engagement, involvement of community and religious leaders, IPC-related preparedness, prepositioning of essential prevention inputs, and integration of Ebola response with WASH Multi-Sectoral assistance, protection, and psychosocial support (Relief Web)

Context Analysis for Tanzania (ELCT):

In Tanzania, the regions of Kagera, Kigoma, Mara, Mwanza, and other border districts remain highly exposed due to their proximity to outbreak-prone neighbouring countries and the high volume of cross- border interactions. Border communities, mobile populations, traders, pastoralists, fishing communities, families with cross-border links, and frontline health workers are among the groups most at risk in the event of EVD importation. Tanzania has also experienced recurrent viral haemorrhagic fever events (2023 Marburg outbreak in Kagera and 2025). The country's vulnerability to emerging and re-emerging infectious diseases exposed critical gaps in IPC readiness, emergency response capacity, trained workforce availability, and coordination systems, particularly in frontline health facilities serving border communities. WHO and regional health security assessments continue to identify Tanzania as a priority country for preparedness strengthening.

In Tanzania, the regions of Kagera, Kigoma, Mara, Mwanza, and other border districts remain highly exposed due to their proximity to outbreak-prone neighbouring countries and the high volume of cross- border interactions. Border communities, mobile populations, traders, pastoralists, fishing communities, families with cross-border links, and frontline health workers are among the groups most at risk in the event of EVD importation. Tanzania has also experienced recurrent viral haemorrhagic fever events (2023 Marburg outbreak in Kagera and 2025). The country's vulnerability to emerging and re-emerging infectious diseases exposed critical gaps in IPC readiness, emergency response capacity, trained workforce availability, and coordination systems, particularly in frontline health facilities serving border communities. WHO and regional health security assessments continue to identify Tanzania as a priority country for preparedness strengthening.

Response Strategy

Forum response strategy over the Appeal period

This project responds to the appeal launched by the Congolese government in collaboration with the WHO to help reduce community transmission of Ebola virus disease in the affected provinces, namely Ituri, North Kivu, and South Kivu in an effort to contribute to the reduction community transmission of Ebola virus disease., strengthen community engagement and trust in collaboration with local leaders, religious leaders and community liaisons and provide psychosocial support to survivors of rape and gender-based violence in provinces affected by the Ebola virus disease, while support the livelihoods of populations affecte..

To respond effectively, help build trust among populations in areas affected by MVE, and encourage them to adopt preventive measures against MVE, this project's implementation strategy will involve working with local leaders, religious leaders, and local authorities in MVE-affected communities whom those affected trust.

During epidemics, different members of the community—men, women, young people, the elderly, and people living with disabilities—are affected in different ways, particularly women, who are responsible for caring for the sick. As a result, they are at risk of contracting diseases and/or of having to abandon their livelihood activities, which makes them more vulnerable.

Therefore, during the implementation of this project, women will be targeted as the primary recipients of assistance and will be able to contribute effectively to the response.

The Government of Tanzania, through the Ministry of Health and its partners, has continued to strengthen national preparedness and response systems for epidemic-prone diseases. Investments have been made in disease surveillance, emergency coordination mechanisms, laboratory systems, rapid response teams, infection prevention and control, and community-based health interventions. Tanzania has also developed strong partnerships with Faith-Based Organizations, civil society organizations, and humanitarian actors supporting health service delivery and community engagement across the country.

These partnerships are particularly important in hard-to-reach and underserved border communities, where faith-based health facilities remain trusted providers of healthcare services. Tanzania also maintains collaborative relationships with FBO networks operating under the umbrella of the ACT Alliance in Kenya, Uganda, Rwanda, Burundi, and the Democratic Republic of Congo.

In Tanzania, the facilities are mainly distributed across the Northern, Lake, and Western Zones, including KCMC in Moshi, Nyakato Hospital and Bugando Medical Centre in Mwanza, Bunda DDH and Shirati Hospital in Mara Region, several faith-based facilities in Kagera Region, Heri Adventist Mission Hospital in Kasulu District, and Kigoma Baptist Hospital in Kigoma/Ujiji Municipality. In Uganda, the facilities include St. Mary's Hospital Kilembe in Kasese, Kitovu Hospital in Masaka, Mutolere Hospital in Kisoro, Bwindi Community Hospital in Kanungu, Kisiizi Hospital in Rukungiri, and Kuluva Hospital in Arua. In Rwanda, the identified facilities include Kibagabaga Hospital, King Faisal Hospital, Ruhengeri Hospital, Gisenyi Hospital, Rwamagana Hospital, and Nyagatare Hospital. In Burundi, the facilities include Kira Hospital, Ngozi Hospital, Gitega Regional Hospital, Bururi Hospital, and Muyinga Hospital. In Kenya, the facilities include Kijabe Hospital, Consolata Hospital Nkubu, Mater Misericordiae, Consolata Mathari, Jumuiya, AIC Litein, and Coast General Hospital.

Response during the first three months

During the first three months **in DRC,** the following activities will be conducted:

A project launching workshop will be held, followed by a knowledge, attitude, and practice (KAP) survey if possible. Purchase of a personal protective equipment (PPE) kit for project staff will be made and distributed. Contractual agreements with the local Ministry of Health will be made, followed by training healthcare staff on prevention and control measures in collaboration with the Ministry of Health.

This will be followed by training community leaders, community health workers, and health promotion staff, as well as religious leaders, on Ebola prevention, messaging, community sensitization, and measures to address

misconceptions and stigma surrounding Ebola. Awareness-raising materials like posters, flyers, and banners will be developed to support the campaign.

Hygiene kits will be purchased and distributed, and handwashing stations will be set up at markets, schools, churches, and health centres. Community meetings will be held with leaders to create more awareness.

Multi-Purpose Cash Assistance

A rapid market analysis will be conducted to identify target vulnerable households and sign contracts with finance service providers or mobile money providers. Publish lists of selected households for transparency and accountability. Identify distribution sites, conduct an analysis of the accessibility for people with disabilities, and conduct cash distribution.

Protection/Psychosocial Support.

Train communities, religious leaders, and Psycho Social Support on preventive measures against GBV. Train psychosocial assistants and religious leaders on psychosocial first aid and referral pathways.

Hygiene Promotion

A tender process to purchase hygiene kits will be conducted, including beneficiary selection and site identification. Community meetings will be held with leaders on the management of handwashing station installation in public places like schools, churches, and health centres, maintenance, and refills. Training sessions will be held on hygiene promotion with community health workers, local leaders, and religious leaders. This will be followed up by awareness campaigns on proper handwashing practices.

During the first three months **in Tanzania,** ELCT will conduct activities to strengthen Ebola preparedness and response capacity in high-risk regions, particularly Kagera, Kigoma, Mwanza, and Mara, as well as referral institutions, including Bugando and KCMC.

Training will be provided to 300 health care providers from 30 health facilities on Ebola preparedness and response. This will focus on infection prevention and control, early detection, clinical preparedness, isolation unit readiness, and timely response to suspected cases. Essential personal protective equipment and IPC supplies will also be procured and distributed, including protective gowns, gloves, face masks, eye protection goggles, boots, caps, and hand hygiene supplies.

Mentorship visits, supportive supervision, and on-site capacity building will be conducted by Trainers of Trainers from Bugando and KCMC referral hospitals. These visits will help strengthen IPC compliance, clinical preparedness, isolation unit readiness, and the implementation of the One Health approach for Ebola, Marburg, Mpox, COVID-19, and other emerging infectious diseases.

At the community level, ELCT will train religious leaders from different faith backgrounds on infection prevention and control, Ebola prevention, early identification of suspected cases, and timely referral. The first series of training sessions will take place during the first three months, with additional sessions continuing in the following quarter. Information, education, and communication materials will be provided to participating parishes, including at least 20 parishes within each participating ELCT diocese.

Water, sanitation, and hygiene facilities and equipment will also be provided to selected parishes in high-risk areas. These activities will support community-level prevention, risk communication, and acceptance of outbreak prevention measures.

ELCT will also conduct high-level advocacy and coordination meetings with key stakeholders, including representatives from the Ministry of Health, the President's Office – Regional Administration and Local Government, religious leaders, community leaders, and other relevant actors. These meetings will focus on policy dialogue, resource mobilisation, health system preparedness and response planning, community ownership, and addressing cultural practices that may contribute to disease transmission.

Primary Participants

DRC Primary Participants

The selection of intervention areas within the affected provinces—including Ituri, North Kivu, and South Kivu—is based on a cross-analysis of epidemiological data from the Ministry of Health (DPS) and humanitarian vulnerability indicators. Prioritization was based on three Levels of criteria:

Epidemiological Criterion (Epicentres): Ituri Province is prioritized as the presumed point of origin and active epicentres of the Ebola virus disease (EVD) outbreak.

Mobility and Connectivity Criteria: The targeted health zones were selected in the three affected provinces based on population movements, as these are a high-risk factor in the spread of Ebola virus disease.

Accessibility and Operational Capacity Criteria: The selected areas are those where ECC/MERU, BOAD, and COPAD GRANDS-LACS have secure access thanks to their community-based networks, ensuring a rapid response while maintaining staff safety.

The selection process will give priority to individuals at immediate risk of infection or direct impact from the crisis:

1. Epidemiological Vulnerability: Contacts of confirmed or suspected cases of MVE, survivors of the outbreak, and their immediate families.
2. Occupational and Environmental Exposure: Migrant workers in the health zones mentioned above and frontline health care workers in the targeted health care facilities.
3. Categorical Vulnerability (Protection): Internally displaced persons (IDPs) living in overcrowded sites or with unstable host families, with absolute priority given to single women who are heads of households, unaccompanied minors, and people with disabilities.
4. Promoting gender equity and the inclusion of people with disabilities: Women, older adults, and people with disabilities who are affected or at risk will be given priority, provided that awareness-raising efforts have been conducted beforehand to avoid causing harm.

ELCT Primary Participants:

The selection of project locations and participants is guided by a comprehensive risk and needs analysis based on the current epidemiological situation in the East African region, the risk of cross-border transmission of Ebola and other emerging infectious diseases, existing health system capacities, and ELCT's established presence within vulnerable communities.

Priority will be given to high-risk regions of Tanzania, particularly Kagera, Kigoma, Mwanza, and Mara, due to their proximity to international borders, high population mobility, trade routes, and previous exposure to Ebola and Marburg outbreak risks within the region. Referral institutions such as Bugando and KCMC will also be targeted because of their strategic role in managing complex infectious disease cases, providing technical expertise, and serving as centres of excellence for capacity building and mentorship.

The project will directly target approximately 940 key frontline actors selected based on their strategic roles and potential to create a multiplier effect within the health system and communities. The selection criteria include:

- **Health Professionals (300):** Frontline healthcare workers from 30 health facilities located in high-risk areas, selected based on their direct involvement in patient care, emergency response, infection prevention and control (IPC), surveillance, and ability to transfer knowledge to colleagues.
- **Faith Leaders (250):** Religious leaders from ELCT dioceses and other faith communities serving high-risk populations, selected based on their influence, community trust, regular engagement with congregations, and ability to disseminate accurate health information and address misinformation.

- **Community Health Workers (250):** CHWs operating in vulnerable communities, selected based on their active role in household outreach, community-based surveillance, early detection, referral pathways, and health promotion activities.
- **Government and Interfaith Leaders (50):** Representatives from key government institutions, local authorities, and interfaith structures selected due to their decision-making roles in coordination, policy dialogue, resource mobilization, and community acceptance of public health interventions.
- **Cross-Border Health and Faith-Based Stakeholders (at least 90):** Participants from Tanzania and neighbouring EAC countries selected based on their involvement in cross-border health initiatives, emergency preparedness, and regional information-sharing mechanisms.

The selected participants will act as agents of change within their institutions and communities, ensuring that the project's benefits extend far beyond the directly trained individuals. Through ELCT's extensive network of health facilities, congregations, and community structures, the intervention is expected to indirectly reach more than 26,500 people in Tanzania, including 12,500 individuals reached through faith leaders and congregational platforms, 9,000 patients and community members reached through 30 health facilities, and 5,000 individuals reached through Community Health Workers through awareness, surveillance, and early referral mechanisms.

This targeted and risk-informed selection approach ensures that limited resources are strategically invested in high-priority geographical areas and influential frontline actors who can sustainably strengthen community resilience, health system preparedness, and coordinated Ebola response at local, national, and regional levels.

Monitoring and evaluation

The Monitoring, Evaluation, Accountability, and Learning (MEAL) framework is designed to ensure results-based management, maximum transparency, and agile adjustment of activities in response to the volatile security and epidemiological situation in DRC and Tanzania.

DRC

Under the technical coordination of Christian Aid, the partners ECC/MERU, BOAD, and COPAD GRANDS-LACS will ensure that this project has a monitoring and evaluation plan and the necessary tools for collecting data related to the project's specific objectives, outcomes, and indicators.

Christian Aid will contribute its expertise throughout the design, implementation, and monitoring and evaluation phases to ensure compliance with the Sphere Standards and the Core Humanitarian Standards.

A participatory approach will involve the Provincial Health Divisions (DPS), health zones, community liaisons, and religious leaders to ensure the full participation of all segments of society.

To measure the achievement of objectives within a strict 3-month timeframe, data collection and analysis focus on:

Rapid baseline and endline surveys on the level of knowledge, practices, and attitudes: A rapid assessment is conducted during the first week to evaluate the level of knowledge, attitudes, and practices regarding the Ebola outbreak. We will use this data to assess the extent of progress made by our project.

Routine Monitoring and Single Database: Daily monitoring forms will be provided to field coordinators to collect the daily data needed for reporting.

Rapid Market Evaluation: Before the distribution of multi-purpose cash, this survey will be conducted to assess the functionality of the markets and determine whether to proceed with cash distributions and/or the distribution of in-kind assistance.

Post-Distribution Monitoring (PDM): This will be conducted by Christian Aid to assess beneficiary satisfaction and evaluate the cash distribution processes. The Cash Working Group's guide will be used during the PDM.

Internal situation reports (SitRep): Weekly summary reports will be shared among the three applicant members, with support from Christian Aid, to monitor the progress of project activities and make any necessary adjustments.

Joint Security Monitoring: Given the volatile circumstances, the security and health situations in the targeted provinces and health zones will be monitored daily, and necessary adjustments will be made to avoid any risks that could harm project staff and beneficiaries.

Collection of complaints and feedback from beneficiaries: In the lead-up to the project, community accountability assessment sessions will be conducted with technical support from Christian Aid to ensure that complaint-collection mechanisms tailored to local contexts are identified.

Complaints and feedback from beneficiaries will be collected daily, processed, and responded to. If necessary, adjustments will be made based on the complaints and feedback received.

Tanzania

ELCT The ACT Forum Tanzania and ELCT will implement a robust Monitoring, Evaluation, Accountability and Learning (MEAL) framework to ensure that project activities and deliverables are implemented effectively, promptly, and in compliance with humanitarian quality standards, particularly the Core Humanitarian Standard (CHS) and Sphere standards.

A detailed project implementation and monitoring plan will be developed with clear indicators, targets, timelines, responsibilities, and reporting mechanisms. Regular monitoring visits, supportive supervision, field assessments, and periodic review meetings will be conducted to track progress, identify implementation gaps, and undertake timely corrective actions.

ELCT will establish routine data collection and reporting systems through its health facilities, diocesan structures, and community networks to monitor key results, including the number of trained health workers, faith leaders, and Community Health Workers (CHWs), functionality of infection prevention and control (IPC) measures, availability of PPE supplies, and the effectiveness of community awareness and surveillance activities.

In line with CHS commitments, the project will ensure meaningful participation of affected communities in planning, implementation, monitoring, and feedback processes. Community feedback and complaint mechanisms will be strengthened through existing church and community structures to ensure transparency, accountability, responsiveness, and safeguarding of beneficiaries.
Compliance with Sphere standards will be promoted through adherence to quality benchmarks in health, WASH, infection prevention and control, and community engagement interventions. Training materials, technical approaches, and response measures will be aligned with national Ministry of Health guidelines, WHO recommendations, and internationally recognized humanitarian standards.
At the coordination level, ACT Forum Tanzania and ELCT will conduct regular project review and coordination meetings with government authorities, faith-based actors, and regional partners to assess progress, document lessons learned, and share best practices. Periodic narrative and financial reports will be prepared to ensure accountability to ACT Alliance, donors, and affected communities.
This integrated MEAL approach will ensure that the Ebola preparedness and response intervention remains timely, evidence-based, accountable, and responsive to emerging risks and community needs while contributing to a sustainable health system and community resilience.

Risk Management

In preparation for the implementation of this project, and based on our knowledge of these three provinces (Ituri, North Kivu, and South Kivu), the following risks have been identified:
Security risks: The security situation in the three provinces is extremely precarious and volatile due to the presence of numerous armed groups
Ituri (Militia CODECO, Militia zaire, Militia FPCI, among others.
North Kivu (M23 rebels, Nyatura militia, Wazalendo militia, Interahamwe, FDLR, ADF/NALU, among others.
South Kivu (M23 rebels, Militia Nyatura, Wazalendo militia, Interahamwe-FDLR, militia Twirhyaneyo,

among others).

Health risks: The epidemiological situation regarding the Ebola virus (MVE) is very alarming, with a very high rate of infection, which could worsen the situation and possibly lead to lockdowns in the affected areas.

Physical access risks in affected and/or at-risk areas due to poor road infrastructure.

Continued border closures by countries neighbouring the DR Congo, particularly in the eastern region (Rwanda, Uganda, Burundi, South Sudan, Tanzania): Given the situation regarding cross-border transmission, countries such as Rwanda and Uganda have already closed their borders with the DR Congo, and these measures are likely to be further tightened as the risk of transmission remains very high. These border closures have already made it difficult to access the affected areas and deliver humanitarian aid, and there remains a risk that these challenges will persist.

Strong resistance from populations in affected and/or at-risk areas to the Ebola virus disease: significant resistance has been documented, and incidents of attacks against healthcare workers involved in the response—including the burning of treatment centers—have been reported.

Poor financial access due to bank closures may result in cash shortages in North and South Kivu provinces.

Rape, gender-based violence, security and/or health crises may increase the risk of domestic violence, sexual abuse, and exploitation. During the 2018–2019 Ebola epidemic, numerous cases of sexual abuse and exploitation were reported in the Democratic Republic of Congo.

ELCT Risk Management:

The ACT Forum Tanzania and ELCT recognize that effective Ebola preparedness and response require continuous assessment and management of risks that may affect the timely achievement of project objectives. A dynamic risk monitoring approach will be applied throughout the implementation period, with regular reviews and updates of the risk profile as the epidemiological and operational context evolves.

Potential **negative risks** include changes in the Ebola outbreak situation, competing public health emergencies, delays in procurement and distribution of Personal Protective Equipment (PPE) and Infection Prevention and Control (IPC) supplies, limited availability of frontline health workers due to routine health service demands, misinformation and stigma within communities, and challenges related to cross-border coordination and movement of participants. These risks could affect the timeliness of activities, quality of interventions, and overall community engagement.

To minimize these risks, ELCT will maintain close coordination with the Ministry of Health, regional and district health authorities, ACT Forum Tanzania, and East African Community (EAC) partners to ensure alignment with current public health priorities. Early procurement planning, flexible implementation schedules, use of existing ELCT health and diocesan structures, strengthened risk communication, and continuous engagement of trusted faith leaders and Community Health Workers (CHWs) will be applied to maintain community trust, timely implementation, and effective surveillance and referral systems.

Additional risks include possible funding limitations or fluctuations in operational costs, which may affect the scope and sustainability of planned activities. ELCT will mitigate these through prudent financial management, regular budget monitoring, prioritization of high-impact interventions, and continued resource mobilization and partnership engagement.

The project also presents significant **positive opportunities**. ELCT's extensive network of hospitals, health facilities, dioceses, congregations, and faith leaders provides a unique platform for rapid dissemination of accurate health information and sustained community engagement. The strengthening of 940 frontline actors—including health professionals, faith leaders, CHWs, government representatives, and regional stakeholders—will create a multiplier effect that extends preparedness and response capacities to more than 26,500 community members in Tanzania and additional populations across the EAC region.

Furthermore, the enhanced collaboration between faith-based organizations, governments, health institutions, and regional actors presents an opportunity to establish long-term cross-border preparedness mechanisms, strengthen the One Health approach, improve early warning and surveillance systems, and build resilient communities and health systems capable of responding to Ebola and future emerging infectious disease threats.

The ACT Forum Tanzania and ELCT will regularly review these risks and opportunities through project monitoring and coordination mechanisms, ensuring adaptive management and timely adjustments to maintain quality, accountability, and compliance with humanitarian standards.

Safety and Security plans

For risks that have already been identified, the following strategies will be implemented:

Regarding security risks: Regular monitoring of the security situation will be conducted in collaboration with OCHA, INSO, and religious leaders to ensure that minimum security conditions are met for project staff and beneficiaries and to avoid causing harm.

Regarding health risks: The epidemiological trends of MVE will be monitored in collaboration with other stakeholders, including the WHO, the Ministry of Health, and OCHA. Project staff and other stakeholders involved in the project will be provided with personal protective equipment and will be educated on preventive measures to ensure they do not contribute to the spread of the disease. When carrying out the various project activities, preventive measures to prevent and combat the Ebola outbreak will be followed, including, among other things, wearing face masks, using hand sanitizer, and setting up handwashing stations, etc.

About access risks, it is strongly recommended that project activities be carried out during the dry season, when access is adequate.

Regarding the risks posed by border closures, advocate with the Humanitarian Access Forum/OCHA to negotiate humanitarian corridors. Consider other methods of remote project monitoring.

To address the risks posed by strong resistance, collaborate with religious and local leaders to raise awareness among communities and encourage them to embrace the messages and practices for combating the Ebola outbreak.

To mitigate the risk of cash shortages, implement alternative payment methods.

To mitigate the risks of rape and gender-based violence, sexual abuse, and sexual exploitation, field staff will receive awareness training and will sign their respective organizations' codes of conduct. COPAD will receive support from Christian Aid to develop policies to prevent sexual abuse and exploitation. In addition, beneficiaries will be made aware throughout the implementation process that assistance is provided free of charge and that they have the right to report any complaints related to sexual abuse and exploitation to the PSEA focal points. Standard messages from the PSEA/OCHA coordination team will be translated into local languages, printed, and displayed as posters.

ELCT will implement this Ebola preparedness and response project in accordance with the ACT Alliance Safety and Security Guidelines, ensuring the safety, dignity, and well-being of staff, volunteers, health professionals, faith leaders, Community Health Workers (CHWs), and the communities served.

The security risk assessment indicates that although the target areas are generally stable, frontline actors may face risks related to exposure to Ebola and other infectious diseases, inadequate IPC practices, misinformation, community resistance, stigma, and challenges associated with cross-border and remote operations. These risks will be continuously monitored throughout the project implementation.

In line with ELCT's **Duty of Care**, all frontline actors will receive appropriate training on Ebola preparedness, infection prevention and control (IPC), personal safety, safeguarding, and risk communication. ELCT will provide essential PPE and hygiene supplies, establish clear reporting and referral procedures, and ensure that staff and volunteers operate under approved safety protocols with regular supervision and communication.

The project will apply the **Do No Harm** principle by promoting culturally sensitive and inclusive community engagement, addressing misinformation and stigma, and ensuring transparent and needs-based selection of participants and resource allocation.

ELCT will utilize its established network of dioceses, congregations, hospitals, and health facilities to monitor emerging risks and maintain safe access to communities while coordinating closely with the Ministry of Health and local authorities. Additional support needs may include periodic safety and security orientation, specialized

training on infectious disease risks, strengthened emergency communication systems, and technical support from ACT Alliance security services where required.
Through these measures, ELCT will ensure that Ebola preparedness and response activities are implemented safely, responsibly, and in compliance with international humanitarian standards.

Budget

Requesting Forum/Country		DRC & TANZANIA					
Appeal Number:		CEA 261					
Appeal Title:		CEA 261 Ebola Response					
Implementing Period:		01/07/2026 to 30/06/2027					
Budget rate / FX: Local currency to 1 USD (please input exchange rate here)			0.000429				
		Appeal Total	**ELCT**	**BOAD**	**ECC-MERU**	**COPAD GL**	**CHRISTIAN AID**
			USD	USD	USD	USD	USD
Direct Costs		**1,308,566**	**603,078**	**187,844**	**124,037**	**321,117**	**72,490**
1	**Project Staff Salaries**	**261,922**	**116,722**	**27,600**	**31,200**	**44,400**	**42,000**
2	**Project Activities**	**886,360**	**421,664**	**146,390**	**78,150**	**226,116**	**14,040**
2.1	Advocacy	16,471	16,471	-	-	-	-
2.2	Education	191,861	177,821	-	-	-	14,040
2.3	Food and Nutrition	-	-	-	-	-	-
2.4	Health	227,373	227,373	-	-	-	-
2.5	Livelihood	-	-	-	-	-	-
2.6	Multipurpose Cash	226,606	-	99,500	-	127,106	-
2.7	Protection and Psychosocial	26,100	-	5,050	-	21,050	-
2.8	Shelter and Settlement	-	-	-	-	-	-
2.9	WASH	197,950	-	41,840	78,150	77,960	-
3	**Quality and Accountability**	**91,501**	**36,547**	**8,654**	**9,000**	**25,800**	**11,500**
4	**Logistics**	**46,713**	**18,063**	**3,700**	**3,600**	**17,900**	**3,450**
5	**Assets and Equipment**	**22,070**	**10,082**	**1,500**	**2,087**	**6,901**	**1,500**
Indirect Costs		**162,022**	**83,196**	**27,842**	**13,218**	**31,824**	**5,942**
Staff Salaries		96,890	60,890	16,800	8,400	10,800	-
Office Operations		65,132	22,306	11,042	4,818	21,024	5,942
Total Budget		**1,470,588**	**686,274**	**215,686**	**137,255**	**352,941**	**78,432**
ACT Secretariat management cost SMC @ 3		44,118	20,588	6,471	4,118	10,588	2,353
Total Budget + SMC		**1,514,706**	**706,862**	**222,157**	**141,373**	**363,530**	**80,784**

Code of Conduct

The Act Alliance members responsible for implementing this project (ECC/MERU, BOAD, and COPAD GRANDS-LACS), with technical support from Christian Aid, are ensuring that the project's activities align with humanitarian standards of quality and accountability.

Therefore, about the core humanitarian quality standard of accountability, Christian Aid will support community-led accountability assessments to ensure that mechanisms for collecting and reporting feedback and complaints—tailored to local contexts—are in place.

Complaints from beneficiaries will thus be collected, processed, and resolved, and as needed, this feedback and these complaints will guide any necessary adjustments to project activities.

During the implementation of this project, fundamental humanitarian quality standards—such as participation—will be central to ensuring that local religious leaders support the project's activities, thereby fostering community acceptance and helping to reduce resistance to preventive measures against Ebola.

In addition, the Sphere quality and quantity standards have guided the design of this project and will be followed throughout its implementation.

To ensure coordination, the activities of this project will be communicated at various strategic and operational coordination meetings in the field, in collaboration with provincial health divisions, central health zone offices, and other humanitarian actors on the ground, to ensure that interventions complement one another and avoid duplication to enhance efficiency.

Conflict sensitivity / do no harm

The current circumstances surrounding the Ebola virus disease are such that community members are strongly resistant to preventive measures against the disease. Within communities, there are many misconceptions about the disease, and this has led to strong resistance, including attacks on healthcare workers. This situation is the root cause of the high rate of community transmission.

To mitigate these risks and help encourage community members to adhere to preventive measures against Ebola, the strategy for implementing this project will focus on rebuilding trust, which can foster adherence to preventive measures.

Therefore, during implementation, the partners will rely on local leaders—and especially religious leaders—whom community members trust to raise awareness about Ebola prevention measures.

During implementation, the Act alliance partners responsible for carrying out the project (ECC/MERU, BOAD, and COPAD) will be supported by Christian Aid to ensure that community-led response approaches are implemented with the participation of all beneficiaries and to foster buy-in. Christian Aid has technical expertise in community-led response approaches and will make this expertise available to the partners.

ELCT will apply a conflict sensitive and **Do No Harm** approach throughout the project cycle to ensure that Ebola preparedness and response interventions do not unintentionally create stigma, exclusion, misinformation, or social tensions within communities.

The project will promote transparent and needs-based selection of target locations and participants, ensuring equitable access regardless of religion, ethnicity, gender, age, or social status. ELCT will engage government authorities, interfaith leaders, health professionals, and community structures to strengthen trust, inclusion, and community ownership of public health interventions. Through culturally appropriate risk communication, existing feedback and complaints mechanisms, and continuous monitoring of potential unintended effects, ELCT will identify and address emerging concerns promptly, ensuring that the intervention contributes to social cohesion, accountability, and long-term community resilience.

Complaints Mechanism and Feedback

To collect complaints and feedback from beneficiaries, community accountability assessments will be conducted in the communities targeted by the project to identify complaint-collection mechanisms suited to local contexts.

The mechanisms identified through participatory consultations with men, women, boys, girls, people with disabilities, and older adults will be communicated to all community members through community meetings and during project monitoring visits.

The ECC/MERU and BOAD partners used the same participatory approaches to identify community-based complaint management mechanisms, which were commended during the final evaluation of the CEA 241 project.

COPAD will receive support from Christian Aid in developing the methodology and tools needed to carry out community accountability assessments.

Communication and Visibility

The ACT Alliance members of the DRC and Tanzania forum that will implement this project—namely ECC/MERU, BOAD, COPAD GRANDS-LACS, and ELCT are committed to ensuring clear, consistent, and equal visibility for the ACT Alliance across all project sites, distributed supplies, and communication materials produced during the 12-month project period.

All visibility initiatives will strictly adhere to the ACT Alliance Branding Policy and Guidelines, using only the official style guide (colours, fonts, and logo placement).

As members of the ACT Alliance RD Congo Forum implementing the ECC/MERU project, BOAD and COPAD GRANDS-LACS will follow the co-branding guidelines: the ACT Alliance logo will always be placed in the primary position (usually at the top or on the left), flanked by the ECC/MERU, BOAD, and COPAD GRANDS-LACS logos.

During the CEA 241 appeal, the implementing partners—namely ECC/MERU and BOAD—participated in capacity-building sessions on communication and visibility; the lessons learned from this training will be applied and shared with COPAD during the implementation of this project.

Existing local communication channels—including local community radio stations—will also be utilized to publicize the project's activities, while strictly adhering to Act Alliance's communication policies.