TECHNICAL GUIDANCE FOR VHF READINESS DREF OPERATIONS

Version 1 - August 2025

1. Quick background

This document takes into account the health standards for viral haemorrhagic fevers (VHF), including Ebola virus disease (EVD) and Marburg Virus Disease (MVD) outbreak readiness & response. It also incorporates the learnings from previous VHF operations funded by the DREF, grants and loans from 2018-2023 as well as from the DREF operational review on VHF preparedness operations conducted between February 2024 to January 2025. The guidance below aims to **improve operational efficiency and ensure effectiveness of** readiness efforts. Ensuring that RCRC interventions fulfil their intended purpose, align with evolving risks and recommended standards, while reflecting the anticipatory aspects of epidemic readiness DREF operations.

2. Before launching a DREF operation – when an outbreak is declared in a neighbouring country

- Mapping of NS capacity from previous VHF readiness/response interventions
- Identify the main health/technical focal points for each NS and Country Cluster Delegation (CCD)
- Coordination with logistics team to identify where the kits can be prepositioned & quickly dispatched (if needed)
- Launch surge alerts for key profiles: PHiE, SDB, etc/ or identify available technical capacity

3. Guidance for NS when developing the DREF Application

3.1. DREF criteria

DREF Criteria	• **Ceiling:** Up to CHF 150,000 – this maximum only applies if the inclusion of SDB kits is approved as outlined in the table of activities below. If SDB kits are not included, the ceiling is CHF 50,000 since other preparedness activities are less costly. • **Timeframe:** Maximum 2 months, subject to alignment with the evolution of risk or the declared end of the outbreak in affected country, in accordance with DREF operational timelines. • **Key aim:** To prepare the national society to be ready in the event that a VHF case is imported into the country. The focus is on building NS readiness and capacity, not on community level or response activities.

	• **Target:** ✓ Geographical: Focused on National level capacity building, and branch level in the affected areas, based on risk analysis. ✓ Safe and dignified burial (SDB) activities should be implemented at national level as necessary, coming to agreement with MoH on NS role in SDB (if any). Once this is agreed the DREF can be modified to include SOP development and training of rapid response/training teams. ✓ Community level activities are limited in scope (Health, WASH, RCCE) to identifying potential response volunteers, reading internal rosters, training of rapid response teams, development of training material, mapping of key community influencers, and high level RCCE activities. ✓ The number of people targeted must be realistic. It should be proportionate to the capacity of the NS and the time available to implement those actions. • **Reporting:** ✓ For Operations lasting more than 6 months, a mandatory operation update is required at month # 6, in addition to the Final report. ✓ Based on lessons learned, an informal update might be requested at month #3 for any operation lasting 2 months or more, along with another update when the outbreak is declared over in the affected country. This will guided by technical health analysis.
What should trigger the development and application for an imminent DREF for epidemic readiness?	Evidence of risk in the neighbouring country. An operations call with health and operations teams is recommended to ensure alignment. Country submitting the DREF application should share a border area with the affected zone in the outbreak country.
Additional considerations and Key pointers for developing the imminent DREF Application	**Recommendations for faster review process**: Based on lessons learned, it is recommended that the NS clearly indicate the following in their DREF Application: • Their specific roles & whether this is agreed upon with MoH and active partners. • Existing protocols or policies related to the SDB/CBS/other key pillars. • Existing inter-agency/national plan and if the DREF application aligns with it. • NS which have an existing contingency plan covering the same disease will be able to compile all above information much quicker and are more likely to propose coherent and realistic intervention plans. Therefore, it is highly recommended for National Societies to link this to existing contingency plans.

	If the above exists, the supporting document/link can be shared with the DREF request. **On SDB kits:** • Based on learnings from previous VHF preparedness DREFs, minimum stocks of SDB items are to be kept in country for preparedness. • Stocks are to be held centrally in Dubai to ensure stock rotation and reduce issues with item expiry. • Once a country has agreed with MoH on their role (if any) on SDB, the ops strategy can be revised to include the procurement of SDB kits (pending approval of RO/GVA health). An initial training kit, and 1 starter kit may be procured. If an operation wants to order more, this needs to be approved by RO/GVA health and sent to Dubai for central storage.

3.2. VHF Preparedness Activities

	HR needs	Training needs	Key Activities	Logistics
Safe and Dignified Burials (SBD)	**IFRC:** • SBD surge if readiness is in new country, or NS has not worked in SDB before *(determination to be made by RO/GVA health team)* **NS:** • SDB focal point (preferably from the NS health team)	**SBD ToT** • For NS trainers – can also include MoH • 5 days (5th day focuses on training practice) **16 participants per training!** **Each training produces 2 teams.**	**Step 1** • Develop MoU or agreement with MoH outlining role of NS in SBD for VHFs **ONLY after the above is done**, OS can be updated to add the following: • Development of SDB SOPs • Identification of volunteers in high-risk areas willing and available to be part of SDB teams • Put in place plan for rapid response to SDB alerts • Depending on preparedness rating of country or zone (decided in conjunction with RO/GVA health) there are two possibilities for training: • Identification of teams for rapid training only • ToT resulting in pool of trainers and two possible rapid response teams.	**SBD kits** • Training kit = trains 2 teams • Starter kit = 1 team, first 20 burials • Initial order should not exceed 20 burials in country, or 1 starter kit, unless approved by RO/GVA health, additional orders go to Dubai for central storage and stock rotation **Planning in event of an outbreak:** • 2 vehicles per team (1 pickup, 1 hardtop) • Body bags • Chlorine • Pulverisers / sprayers

Community health activities (includes RCCE and CBS)	**IFRC:** • Health: NS with small health footprint = 1 PHiE delegate **NS:** • Community health manager (oversees RCCE and CBS) • CEA focal point	**EPiC** • Mandatory base training including CBHFA, ECV, CEA and PFA basics • 5 days for NS trainers/ supervisors • 4 days volunteers **If adding community feedback:** • 2 days for NS trainers/ supervisors • 1-day volunteers If CBS already exists in country, VHF risk can be added into system • Add on to EPiC training as only the alert code needs to be added	**Step 1** • Develop MoU or agreement with MoH outlining role of NS in RCCE or CBS for VHFs **ONLY after the above is done**, OS can be updated to add the following: • Updating of existing CBS of SDB SOPs • Identification of volunteers in high-risk areas willing and available to be part of community health teams (RCCE/CBS) teams • Put in place plan for rapid response to CBS alerts • Depending on readiness/preparedness rating of country or zone (decided in conjunction with RO/GVA health) there are two possibilities for training: • Identification of teams for rapid training only • ToT resulting in pool of trainers and two possible rapid response teams. • Develop plan for community health promotion (HH visits, FGDs, community meetings, work with traditional/religious leaders, mobile cinema and radio programmes) • Rapid mapping of health facilities • Rapid mapping of traditional healers • Put in place community feedback mechanism • If lack of information, do a KAP survey (including survey questions in the SDB guidelines and EPiC toolkit)	• IEC materials (posters, *boîte à images*[1], ECV toolkits) • Volunteer booklets (memory aids) (If CBS – include list of community-case definitions and alert codes for SMSs) • Radio slots

[1] Visual kit used in educational, humanitarian or community settings to support awareness-raising or training activities through visual materials.

			• For countries with existing CBS system → integration of EVD community case definition into ongoing activities.	

When shifting to response

	HR needs	Training needs	Key Activities	Logistics
Screening	NS: Health manager	None in preparedness	• Identification of volunteers in high-risk areas willing and available to support screening activities in event of a shift from preparedness to response • Put in place plan for rapid training and placement related to screening	• Nothing in preparedness
Contact Tracing	NS: • Health manager	None in preparedness	• Identification of volunteers in high-risk areas willing and available to support contact tracing activities in event of a shift form response to preparedness • Put in place plan for rapid training and placement related to contact tracing	• Nothing in preparedness
WASH (decontamination)	NS: • WASH focal point	None in preparedness	• Identification of volunteers in high-risk areas willing and available to support decontamination activities in event of a shift form response to preparedness • Put in place plan for rapid training and placement related to decontamination in event of an outbreak in country.	• Nothing in preparedness

Infection Prevention and Control (IPC)	NS: • IPC focal point	None in preparedness	• Identification of volunteers with clinical background to support IPC activities in RCRC health facilities. • Revision of RCRC health facility IPC protocols and training plans • Participation in IPC forums • Put in place plan for rapid training and placement related to decontamination in event of an outbreak in country.	Planning only in event of shift to response • IEC materials (posters) • IPC checklists • WASH inputs (handwashing stations, soap, waste management, latrines, sterilization,…) • PPE • Waste management plans and procedures
MHPSS	NS: MHPSS focal point	None in preparedness	• Identification of volunteers in high-risk areas willing and available to support MHPSS activities in event of a shift form response to preparedness • Put in place plan for rapid training and placement related to MHPSS in event of an outbreak in country.	None in preparedness

General HR Needs:

IFRC	NS
• 1 Health Coordinator (ideally different from response HC) • 1 Operations Manager (ideally difference from response Ops) • 1 security (if in complex setting) • 1 CEA (if community feedback is new for the NS, ideally different from response CEA)	• Health Coordinator • Operations manager • Finance • Communications • PMER • CEA

NB: Please consider :

- Mapping HR capacity in advance both for response countries and preparedness countries.
- NS to request based on identified gaps any future need for specific profiles at preparedness stage. Even if they will be needed for response. Due to the quick acceleration of the transition vs time to get adequate human resources.