Dynamique des Jeunes Leaders pour la Paix et le Respect des Droits Humains
DYJEPREDHU asbl
Dynamics of Young Leaders for Peace and Respect for Humains Rights
CHANGEMENT | TRANSFORMATION | IMPACT

Strengthening Ebola prevention mechanisms in DRC

May 2026

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PROJECT TECHNICAL PROPOSALS

I. Project Summary

1. Title of the project: Strengthening Ebola prevention mechanisms in DRC

2. Contact details:

• Name of the organization: Dynamic of Young Leaders for Peace and Respect for Human Rights, "DYJEPREDHU asbl" in acronym

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3. Organization Mission Statement

"Our mission is to **strengthen global health security and foster community resilience** by transforming fragile healthcare ecosystems into proactive, sustainable shields against infectious diseases. Through data-driven epidemiological surveillance, structural clinical upgrades, and trusted grassroots partnerships, we empower local populations to intercept lethal pathogens at their origin, ensuring equitable health safety, preserving human dignity, and protecting regional economic stability."

Why this statement works:

- **Action-Oriented**: It uses strong verbs (*strengthen, transform, empower, intercept*).
- **Broad yet Specific**: It establishes a global vision while clearly highlighting the exact mechanism used in your Ebola project (surveillance, infrastructure, community trust).
- **Donor-Friendly**: It incorporates high-value terminology (*health security, resilience, sustainability, equitable*) favored by international funding agencies.

Project Beneficiaries

The project strategically targets both immediate frontline actors and the broader vulnerable population across the high-risk intervention zones. Beneficiaries are divided into direct and indirect categories:

1. Direct Beneficiaries (Estimated: 5,500 individuals)

Direct beneficiaries are individuals who interact face-to-face with project activities, receive technical materials, or participate directly in capacity-building training.

- **Healthcare Professionals (approx. 250 individuals):** Doctors, nurses, midwives, and laboratory technicians working in the 10 targeted frontline clinics who will receive certified IPC/triage training and a continuous supply of medical-grade PPE.
- **Community Health Volunteers / Workers (approx. 150 individuals):** Grassroots health mobilizers who will be trained and equipped with mobile smartphones and data plans to run the real-time digital early warning surveillance network.
- **Local and Traditional Leaders (approx. 100 individuals):** Religious figures, tribal chiefs, and traditional healers who will participate in co-designing the Risk Communication and Community Engagement (RCCE) campaigns.
- **Border Control and Transit Agents (approx. 50 individuals):** Officials stationed at high-mobility Points of Entry (PoE) who will be trained and equipped with infrared thermometers to conduct safe cross-border screenings.
- **Clinic Patients and Visitors (approx. 4,950 individuals):** Community members visiting the 10 targeted health facilities who will directly utilize the newly installed, heavy-duty WASH stations and safe isolation areas.

2. Indirect Beneficiaries (Estimated: 85,000 individuals)

Indirect beneficiaries are individuals who do not participate in training sessions but are protected from viral threats as a direct result of the project's interventions.

- **The Local Population (approx. 60,000 individuals):** Residents living within the catchment areas of the upgraded clinics who benefit from reduced institutional transmission risks, reliable local health centers, and localized radio safety broadcasts.
- **Mobile and Cross-Border Traders (approx. 25,000 individuals):** Merchants, truck drivers, and travelers moving through the secured transit corridors and points of entry, whose livelihoods are protected from sudden border closures or localized quarantine lockdowns.

Total cost of the project: US $ 150,000

- **Bank account: Dynamique des Jeunes Leaders pour la Paix et le Respect des Droits Humains, DYJEPREDHU asbl**

Goma Agency -DRC

No. 1272-28000-23526760001-87

Following code: TRMSCD3L

Context and Justification of the Project

Project Context and Rationale

1. The Global and Regional Context

Ebola Virus Disease (EVD) remains one of the most lethal zoonotic pathogens threatening global health security, causing severe hemorrhagic fever with mortality rates reaching up to 90%. Historically confined to isolated rural pockets, recent epidemiological trends demonstrate that EVD outbreaks now move faster and hit harder due to increased regional mobility, rapid urbanization, and dense cross-border trade corridors [1, 2, 3]. In highly vulnerable regions—such as West Africa and the Great Lakes region—the constant threat of viral spillover from wildlife reservoirs to human populations creates a permanent state of public health insecurity.

2. Institutional and Systemic Vulnerabilities

Despite decades of international intervention, local healthcare systems remain structurally weak and structurally unequipped to manage the threat proactively. Frontline healthcare facilities in high-risk zones face severe deficits in basic Infection Prevention and Control (IPC) infrastructure, including a chronic lack of personal protective equipment (PPE) and clean water (WASH systems). Consequently, rural clinics frequently become amplification points where the virus spreads to medical workers and patients. Furthermore, traditional surveillance systems are slow and centralized, routinely delaying the detection of index cases for weeks, which allows the virus to expand across porous borders undetected.

3. Socio-Cultural Barriers and Misinformation

The persistence of Ebola outbreaks is deeply tied to socio-cultural dynamics. Standard emergency mandates often ignore local customs, fueling community mistrust, rumors, and active resistance against public health teams. Dangerous practices, such as traditional unsafe burial rituals and the concealment of symptomatic relatives, continue to drive secret transmission chains. Without an established baseline of community trust and adapted risk communication before a crisis hits, medical interventions face severe local opposition.

4. Project Justification: Shifting from Reactive to Proactive

The justification for this project lies in the urgent need to break the costly cycle of reactive crisis management. Waiting for an outbreak to explode before mobilizing international humanitarian aid results in catastrophic loss of life, severe economic regressions, and billions of dollars in emergency expenditures. This project is justified because it builds a sustainable, permanent shield before the next outbreak occurs. By fortifying clinic IPC systems, deploying real-time digital surveillance, and empowering local leaders, the project secures high-risk zones, protects the healthcare workforce, and stops Ebola at its source.

The solution is achieved through three integrated intervention pillars:

1. Hardening Clinical Defense Systems (IPC & WASH)

To stop healthcare facilities from becoming amplification points for the virus, the project structurally upgrades rural clinics.

- **Infrastructure Deployment**: We install reliable, heavy-duty Water, Sanitation, and Hygiene (WASH) stations to ensure constant access to clean water.
- **Supply Chain Security**: The project establishes a continuous, reliable supply of Personal Protective Equipment (PPE) and medical-grade disinfectants.

- **Rigorous Training**: Healthcare workers receive intensive training on strict decontamination protocols and universal triage procedures, ensuring every potential case is isolated safely before entering general wards.

2. Digitizing and Decentralizing Early Warning Networks

To eliminate response delays, the project replaces slow, centralized reporting with a real-time, community-led surveillance network.

- **Mobile Alerts**: Community health workers are equipped with mobile-based SMS and app tools to immediately flag unusual health events or clusters of symptoms.

- **Rapid Isolation Protocols**: By training local networks to detect index cases instantly, the time between initial symptom onset, testing, and patient isolation drops from weeks to hours, effectively neutralizing the virus before it spreads.

- **Border Surveillance**: The project sets up active screening points at high-mobility border crossings to monitor transit corridors and stop cross-border transmission.

3. Transforming Community Trust and Engagement

To eliminate community resistance and misinformation, the project integrates local socio-cultural realities into its safety communication strategy.

- **Local Leadership Integration**: We partner directly with trusted community leaders, traditional healers, and religious figures to co-design health messages.
- **Behavioral Change**: Educational campaigns focus on actionable, respectful alternatives to high-risk behaviors, such as modified safe and dignified burial practices and safe wildlife handling.

- **Trust Building**: By making the community active partners in the prevention process rather than passive recipients of emergency orders, we build long-term trust in the healthcare system.

  By combining strong clinic defenses, rapid digital detection, and deep community cooperation, this project replaces a fragile, reactive system with a permanent, resilient shield capable of neutralizing Ebola threats at the source.

Project Objectives

General Objective

To **strengthen Ebola prevention mechanisms** in high-risk zones in order to eliminate localized transmission chains, protect healthcare personnel, and transition from reactive emergency response to a sustainable, proactive system of regional health security.

Specific Objectives

To achieve this general goal, the project will fulfill the following four specific objectives:

- **Objective 1: Upgrade Clinical Infection Prevention and Control (IPC)**
  To equip 100% of frontline healthcare facilities in target areas with standard Water, Sanitation, and Hygiene (WASH) infrastructure and secure a continuous supply of Personal Protective Equipment (PPE) within the first 6 months.

- **Objective 2: Decentralize Early Warning and Surveillance Systems**
  To deploy a real-time, mobile-based epidemiological reporting system and train local community health volunteers to detect, isolate, and report potential index cases within 48 hours of symptom onset.

- **Objective 3: Build Local Institutional Capacity**
  To provide intensive, certified protocol training to medical staff, border control agents, and local rapid-response teams on standardized containment and triage procedures.

- **Objective 4: Enhance Community Trust and Behavioral Change**
  To partner with traditional, religious, and community leaders to co-design culturally adapted Risk Communication and Community Engagement (RCCE) campaigns, effectively eliminating unsafe burial practices and medical mistrust.

Project Mission

Our mission is to **safeguard high-risk communities from Ebola Virus Disease** by replacing fragile, reactive crisis management with sustainable, proactive prevention mechanisms. Through the integration of resilient clinic infrastructure, real-time digital surveillance, and trusted community partnerships, we protect frontline healthcare workforces and neutralize viral transmission chains at their origin to secure long-term health stability.

Project Values

To achieve this mission, our project team and operations are strictly guided by five core values:

- **Proactivity**
  We actively build defense barriers before outbreaks occur, prioritizing permanent preparedness over emergency damage control.

- **Community-Centricity** We believe local populations are not passive targets of aid, but active, respected leaders and essential guardians of their own public health safety.

- **Structural Safety** We enforce the highest standards of Infection Prevention and Control (IPC) to guarantee that frontline healthcare clinics remain places of healing, not contamination.

- **Inclusivity and Respect** We respect local traditions and cultural heritage, co-designing safety protocols with community leaders to build trust without alienating populations.

- **Scientific Integrity and Innovation** We deploy proven, data-driven epidemiological methods and modern digital tools to maximize response speeds and optimize resource distribution.

Project Activity Timeline (12-Month Cycle)

Phase & Activity	Q1	Q2	Q3	Q4	Key Deliverable / Output
Phase 1: Setup & Assessment					
1.1 Conduct baseline IPC assessment in target clinics	**X**				Comprehensive vulnerability report
1.2 Stakeholder engagement & community leader mapping	**X**				Memorandum of Understanding (MoU) signed
1.3 Procurement of WASH infrastructure & PPE supplies	**X**				Materials secured in regional warehouses
Phase 2: Infrastructure & Logistics					
2.1 Install WASH infrastructure in frontline clinics		**X**			Operational clean water stations
2.2 Distribute PPE and medical-grade disinfectants		**X**	**X**		Stocks delivered to targeted facilities
2.3 Set up border health screening checkpoints		**X**			Active transit monitoring stations
Phase 3: Capacity Building & Tech					
3.1 Train healthcare staff on IPC & triage protocols		**X**	**X**		Certified frontline medical workers
3.2 Deploy mobile surveillance tools to community workers			**X**		Active real-time digital alert network

3.3 Co-design and launch RCCE behavior change campaigns			**X**	**X**	Culturally adapted safety messages broadcasted
Phase 4: Monitoring & Closure					
4.1 Conduct quarterly field monitoring & system audits		**X**	**X**	**X**	Mid-term progress & compliance reports
4.2 Final project evaluation and impact analysis				**X**	Final evaluation report & project handover

Key Milestone Summary

- **Month 3 (End of Q1):** Baseline assessments completed and all clinical materials procured.
- **Month 6 (End of Q2):** Frontline clinics upgraded with functional water stations and basic staff training.
- **Month 9 (End of Q3):** Mobile digital surveillance network active across all community zones.
- **Month 12 (End of Q4):** Final project evaluation completed and infrastructure handed over to local health authorities.

Project Budget Summary

Category / Line Item	Unit Cost (USD)	Quantity / Duration	Total Cost (USD)	% of Budget
1. Clinical Infrastructure & WASH Supplies			**$48,000**	**32%**
1.1 Heavy-duty WASH Stations (Water tanks, piping)	$2,000	10 facilities	$20,000	
1.2 Personal Protective Equipment (PPE) kits	$50	300 kits	$15,000	
1.3 Medical disinfectants & decontamination supplies	$1,000	12 months	$12,000	
1.4 Infrared thermometers & isolation triage tents	$200	5 sets	$1,000	
2. Capacity Building & Training			**$34,500**	**23%**
2.1 IPC protocol training workshops for clinic staff	$1,500	8 sessions	$12,000	
2.2 Community health worker surveillance training	$1,000	10 sessions	$10,000	
2.3 Training manuals, printing, and certifications	$5	500 copies	$2,500	

2.4 Border agent screening protocol training	$2,000	5 sessions	$10,000	
3. Technology & Community Engagement (RCCE)			**$25,500**	**17%**
3.1 Mobile smartphones for community surveillance	$100	80 units	$8,000	
3.2 Mobile data plans & server hosting fees	$250	12 months	$3,000	
3.3 Radio broadcasting for safety campaigns	$500	15 months/slots	$7,500	
3.4 Culturally adapted flyers, posters, and banners	$2	3,500 units	$7,000	
4. Personnel & Local Operations			**$31,200**	**21%**
4.1 Project Manager (Part-time / Local rate)	$1,200	12 months	$14,400	
4.2 Epidemiologist / Technical Officer	$1,000	12 months	$12,000	
4.3 Field travel, fuel, and vehicle maintenance	$400	12 months	$4,800	
5. Monitoring, Evaluation & Contingency			**$10,800**	**7%**
5.1 Field audits, mid-term & final evaluations	$2,500	2 audits	$5,000	

5.2 Contingency fund (Emergency price fluctuations)	Fixed	Lump sum	$5,800	
TOTAL PROJECT BUDGET			**$150,000**	**100%**

Budget Justification Notes

- **Clinical Prioritization (32%):** The largest portion of funds is allocated to buying material goods (WASH infrastructure and PPE) to directly resolve the lack of medical tool defense barriers in target zones.
- **Sustainability (23%):** Training costs ensure that local health workers retain permanent technical skills long after the 12-month project timeline ends.
- **Low Overhead (21%):** Administrative and personnel costs are kept minimal by using local experts and sharing transportation resources, maximizing the money spent directly in fields and clinics.

Done in Goma, May 25, 2026

For DYJEPREDHU asbl

Christian AHADI BEN MASONGA
EXECUTIF DIRECTOR, HUMAIN RIGHTS ACTIVISTI