DREF Final Report

Uganda_Anthrax outbreak

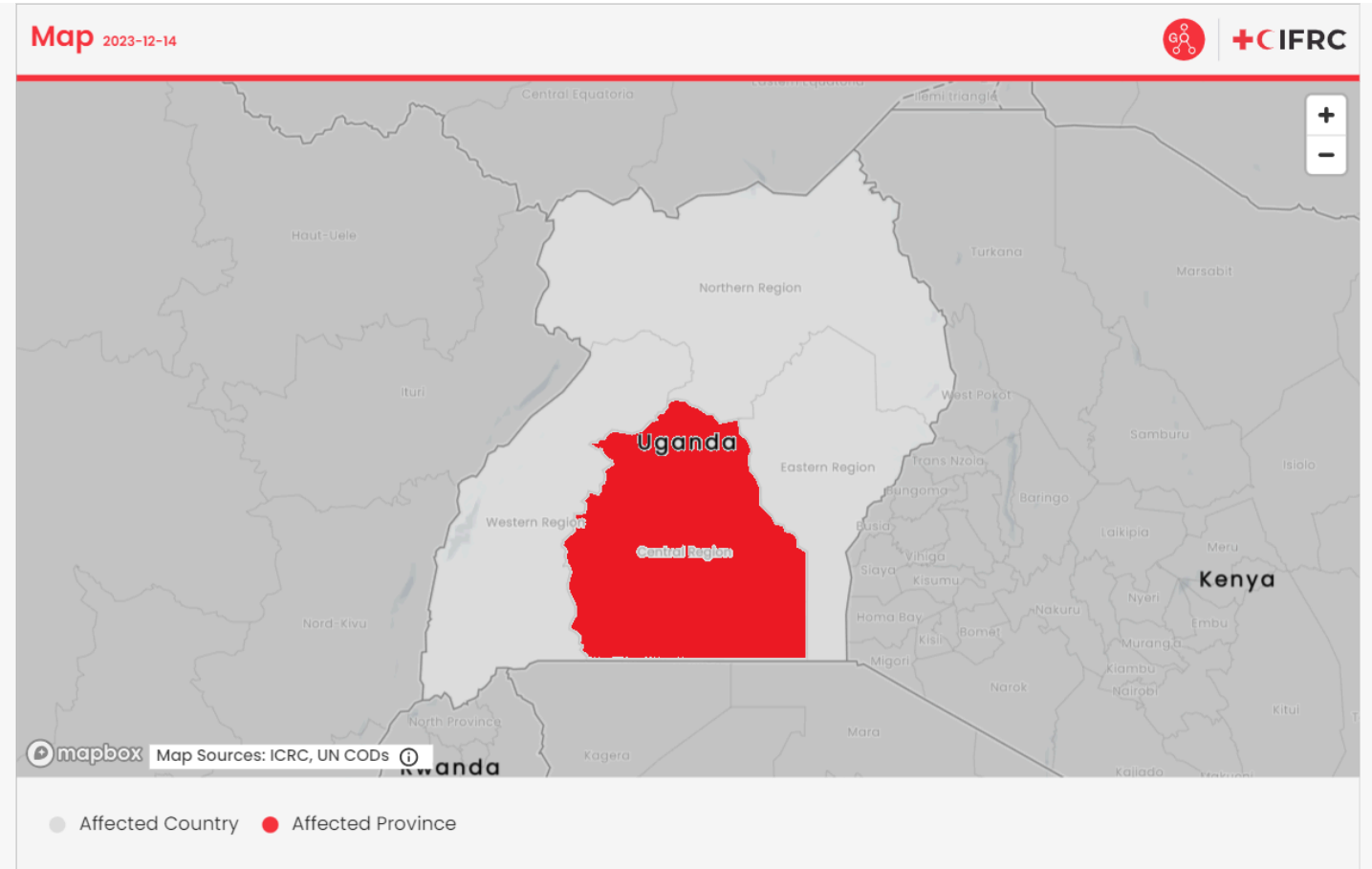
URCS volunteer doing risk communication at mass gathering in Ninzi Ward, Kyotera

Appeal: **MDRUG049**	Total DREF Allocation: **CHF 129,613**	Hazard: **Epidemic**	Crisis Category: **Yellow**
Glide Number: **-**	People at Risk: **69,340 people**	People Targeted: **69,340 people**	People Assisted: **71,822 people**
Event Onset: **Slow**	Operation Start Date: **12-12-2023**	Operational End Date: **31-03-2024**	Total Operating Timeframe: **3 months**

Targeted Regions: **Central Region**

The major donors and partners of the IFRC-DREF include the Red Cross Societies and governments of Australia, Austria, Belgium, Britain, China, Czech, Canada, Denmark, Germany, Ireland, Italy, Japan, Luxembourg, Liechtenstein, Malta, Norway, Spain, Sweden, Switzerland, Thailand, and the Netherlands, as well as DG ECHO, Mondelez Foundation, and other corporate and private donors. The IFRC, on behalf of the National Society, would like to extend thanks to all for their generous contributions.

Description of the Event



@Red is the region where affected Kyotera district is located

Date when the trigger was met

29-11-2023

What happened, where and when?

The 2023 Anthrax outbreak was officially declared on November 29th, 2023, in Kabira sub-county, later spreading to Nabigasa, Lwankoni, and Kyotera T/C in Kyotera district. According to the Kyotera District surveillance team, the outbreak likely started in June 2023 on a farm in Kyamayembe village, Bwamijja Parish, Kabira Sub-County, following the consumption of meat from a dead cow. Initial investigations yielded negative results for anthrax bacteria.

Evolution of the situation:

- June 2023: Initial signs of anthrax surfaced after consumption of contaminated meat, leading to rashes, swelling, and skin lesions among victims.
- July 2023: The consumption of meat of dead animals persisted, resulting into three (3) more individuals displaying signs of the disease.
- 17th October 2023: Kyotera district surveillance team collaborated with the Uganda Virus Research Institute (UVRI) to conduct a field investigation in Kabira sub-county where suspected cases were reported. More samples were collected from several suspects, which tested negative for Anthrax. However, similar unknown disease incidences continued to happen in the same locations, which prompted for further investigations.
- 29th November 2023: Ministry of Health's national task force officially declared the outbreak after investigations revealed positive anthrax cases. The Government of Uganda through the Ministry of Health (MoH), Ministry of Agriculture, Animal Industries and Fisheries (MAAIF) mounted response actions aimed at controlling spread of the disease among animals, stop human exposure and minimizing environmental contamination. All these aimed at not only controlling the outbreak among humans and animals but also prevent future anthrax incidences.
- Cumulatively by 30th March 2024, Kyotera district had registered 20 confirmed human anthrax cases, with 07 probable and 58-suspected cases. In animals, the outbreak registered 02 laboratory confirmed case, 14 sudden animal deaths with 84 probable cases.

- The outbreak was reported to have fully end in July 2024. With 102 suspected cases, 7 confirmed. The outbreak peak in March and the DREF resources were instrumental on ensuring NS could support awareness, risk communication, case identification at community level. It also supports the mind and behavior change which was essential to the stop the transmission in the targeted district of Kyotera.

URCS technical staff training volunteers in EPiC and CBS

Engagement with local leaders and farmers in Nabigasa S/C

Scope and Scale

Anthrax is a severe zoonotic disease caused by Bacillus anthracis, a gram-positive spore forming bacteria that can survive in the environment for a long period of time and has a potential of being used as a bioweapon. The diseases unleashed a public health crisis in Kyotera district. This bacterium predominantly affects herbivores such as cattle, sheep, and goats, with humans at risk through contact with infected animals or their products. The outbreak was declared in Kabira sub-county with spillovers in Nabigasa. Lwankoni and Kyotera Town Council thus affecting close to 70,000 people.

• The District Task Force(DTF) was activated to coordinate the response with support from the central government. The team comprised of the one health technical working personnel at district level, representatives from local leadership, Ministry of Health and Ministry of Agriculture, animal industry and fisheries (MAAIF), and partners. The DFT updated the national task force on a weekly basis. The DTF was chaired by RDC and DHO/DVO being secretary of the force. The Ministry of Health with logistical support from Red Cross built capacity of the district team in incident management to enhance response coordination at the district level through a series of orientations. At the sub-county level, sub-county task forces were also oriented and activated across the affected sub-counties to combat the spread of the virus.

Summary of response

The Government of Uganda through the Ministry of Health (MoH), the Ministry of Agriculture, Animal Industries and Fisheries (MAAIF) mounted response actions aimed at controlling the spread of the disease among animals, stop human exposure, and minimizing environmental contamination. All these aimed at not only controlling the current outbreak among humans and animals but also prevent future anthrax incidence. In order to control the spread of the virus, the District Task Force enacted restrictions on movement of cattle and cattle products from and within the district. Meat and milk consumption were banned. The fear of exposure led community members to abandon their livelihood activities, particularly affecting farmers whose primary income sources include milk, beef, and livestock trading and this largely affected both household incomes and food security.

Additionally, human anthrax outbreak created fear and anxiety, disrupting daily life and social interactions. Kyotera district has numerous tribes with various cultural backgrounds and practices which initially contributed to spread of the virus. Traditional practices, such as consuming raw meat or blood from infected animals, contribute to the spread of anthrax since some societies consider the practice of littering milk as a taboo.

Beyond immediate health concerns, addressing socio-economic, food security and awareness challenges was imperative. Community members in affected catchment areas had limited knowledge on causes, transmission, management of dead animals and prevention of virus and this posed a great challenge controlling in the spread of the virus and avoid environmental contamination.

Upon declaration of the outbreak, Uganda Red Cross Society (URCS) with support from IFRC DREF joined the Government of Uganda through MOH, MAAIF and other partners to support the response through different pillars created by District Task Force to handle the response. A team of seven (07) NDRTs were deployed and stationed in the district until the outbreak was declared over.

Source Information

Source Name	Source Link
1. MDRUG049_ DREF plan of action november 2023	https://www.ifrc.org/fr/appeals?date_from=&date_to=&search_terms=&search_terms=&appeal_code=MDRUG049&search_terms=&text=
2. Uganda National Institute of Public Health (UNIPH)	https://uniph.go.ug/anthrax-outbreak-associated-with-sleeping-on-the-hides-of-cattle-that-died-suddenly-in-amudat-district-uganda-dec-2023-jun-2024/

National Society Actions

Have the National Society conducted any intervention additionally to those part of this DREF Operation?	No

IFRC Network Actions Related To The Current Event

Secretariat	URCS works closely with the IFRC Juba cluster delegation which covers, Uganda, South Sudan, and Tanzania. The cluster supported URCS in the development of the Anthrax response plan, indicator tracking table and Monitoring and Evaluation Plan. The team was supported by the DM coordinator, Finance Delegate, PMER officer and CP3 Delegate who offered technical support throughout the intervention.
Participating National Societies	Partner National Societies (PNS) present in the country include the Netherlands Red Cross, Belgium Red Cross Flanders, Austrian Red Cross, and the German Red Cross, who are directly providing technical and financial assistance to URCS' humanitarian and development projects targeting beneficiaries in the various parts of the country. However, there was no support from the PNSs in country in regard to the DREF. The NS kept the coordination platform active with information shared.

ICRC Actions Related To The Current Event

ICRC has a small delegation in the country focusing on restoring family links within the refugee camps to the west and southwest of the country. ICRC received briefs from the national society throughout the implementation period.

Other Actors Actions Related To The Current Event

Government has requested international assistance	No
National authorities	The Government of Uganda through the Ministry of Health (MoH), the Ministry of Agriculture, Animal Industries and Fisheries (MAAIF) mounted response actions aimed at controlling the spread of the disease among animals, stopping human exposure, and minimizing environmental contamination. All these aimed at not only controlling the current outbreak among humans and animals but also preventing future anthrax incidence. In order to control the spread of the virus, the District Task Force enacted restrictions on movement of cattle and cattle products from and within the district. Meat and milk consumption were banned.

UN or other actors	The World Health Organization worked in partnership with the Ministry of Health to coordinate the response by providing strategic functions including technical and logistical support to the response.

Are there major coordination mechanism in place?

The Ministry of Health activated a national task force that provided strategic leadership to the response and oversaw the respective pillars at the national level under the leadership of an incident commander while the district task force coordinated all the pillars at their level.

The national society is a member of the task force both national and district level and attended all the task force meetings organized by the governments.

Needs (Gaps) Identified

Health

Kyotera district has a very weak surveillance mechanism which explains why the investigation was delayed. The alerts were traced back to June 2023 while the outbreak was confirmed 5 months later in November 2023.
The following needs were identified under health

- Need for a robust local capacity for surveillance.
- Sensitize the community on dangers and the measures to take to prevent the spread of the disease.
- Poor health seeking behaviour including late presentations of cases to health facilities leading to a high case fatality rate and seeking care from traditional healers and religious leaders.
- Animals management, vaccinations and behavior changes within groups involved and commonly managing animals. Environmental observations indicated the presence of scattered bones and abandoned animal skins, suggesting widespread animal deaths and the potential persistence of anthrax spores in the soil. [SOURCE]

The risk of infection was higher among individuals who stay on animal hides (OR = 11, 95% CI: 2.6–47) and those involved in slaughtering animals (OR = 5.3, 95% CI: 1.8–15). A dose-response effect was observed, with increasing odds of infection among individuals who engaged in multiple exposure activities. Those who slaughtered, skinned, and carried carcasses had the highest odds (OR = 19, 95% CI: 2.6–136), followed by individuals who slaughtered and carried carcasses (OR = 13, 95% CI: 2.2–78) and those who slaughtered and skinned animals (OR = 8.1, 95% CI: 2.1–31). This trend was considered in the intervention priorities.

The outbreak lasted for seven months, with a peak in March 2024. The overall attack rate (AR) was 167 cases per 100,000 people, with males (AR = 201/100,000) more affected than females (AR = 132/100,000). [SOURCE]

Further details and health context under the initial plan in the IFRC appeal website. Link above.

Protection, Gender And Inclusion

The anthrax outbreak is strongly linked to livelihood more so in households that lose livestock to anthrax, livestock business linked operators including road side meat vendors, dairy operators, butcher men among others who derive income the livestock value chain. The frustration due to disruption in household livelihood could easily translate in undesired tendencies like domestic violence unleashed to people with disabilities, women, children and other vulnerable groups in the community. Therefore, it was prudent to have psychosocial support messages and actions incorporated into response activities.

Whereas people with disabilities e.g. deaf, blind, dumb among others may contribute small portion of the general target population, they are equally affected by the anthrax outbreak therefore have equal rights to access to health information. Therefore, volunteers were trained on how to pass on health information to such people in the community during the response.

Community Engagement And Accountability

Under CEA, it was established that there was need to accommodate change from the communities' established customs or practices especially those that encourage unhealthy traits like taking raw meat and blood to better healthy practices, this was to be achieved by

engaging various stakeholders at all levels using volunteers who are skilled in Risk Communication and Community Engagement.

Whereas majority of the feedback was appreciating the efforts by the RC response teams, some sections of the community were registering complaints on limited access to vaccination services; how their livelihoods are being affected by the anthrax control measures like a ban on consumption and slaughter of livestock; Other feedbacks were in form of rumors on the possible cause of the illness, where some sections of the community attributed the strange illness to witchcraft, cannibalism, political stunt to impose more poverty in the areas and other sections of the community were not in agreement with the existence if the disease in the district. All community feedback were discussed with other response actors and addressed through feedback specific messages that were jointly developed by all response actors. Dissemination of feedback through different channels including radio talk shows, communal gatherings, household visits among others.

Further details and CEA context under the initial plan in the IFRC appeal website. Link above.

Operational Strategy

Overall objective of the operation

The objective of this DREF response was to enable Uganda Red Cross Society to support the Uganda Government and partners to prevent and reduce morbidity and mortality resulting from the Anthrax outbreak in Kyotera district and for a period of three months. The operation involved sensitizing the community on the preventive measures for anthrax and other communicable diseases and to strengthen health promotion at household level in the respective communities.

Operation strategy rationale

The strategy was to build local capacity for surveillance, risk communication and community engagement based on the fact that the community members understand the contexts and the dynamics of their communities better than anybody else, having them at the fore front of the response earned the team acceptance by the community members and thus the community was willing to comply to the standard operating procedures. Financially, it was cheaper to use local resources and besides they could integrate the response activities into their other community activities including livelihood, strategically, this is sustainable and also feeds into the Ugandan Ministry of Health's plans to skill community health workers across the country in community-based surveillance. The response team conducted risk communication and community engagement on Anthrax in Kyotera and neighboring high-risk districts. The activities that were carried out by the response team included, but are not limited to, the following:

Justification for Local Capacity Building:

Community Understanding and Acceptance: Local community members possess an intrinsic understanding of the contexts and dynamics within their communities. By placing them at the forefront of the response, the team gains acceptance and trust from the community. This, in turn, enhances compliance with standard operating procedures, fostering a collaborative and effective response.

Financial Efficiency: Utilizing local resources is financially efficient. By tapping into existing community capacities, the response activities can be integrated into ongoing community initiatives, including livelihood projects. This strategic alignment not only ensures cost-effectiveness but also contributes to long-term sustainability.

Strategic Sustainability: The approach aligns with the Ugandan Ministry of Health's plan to skill community health workers across the country in community-based surveillance. This not only supports national health strategies but also ensures the sustainability of the response by creating a network of skilled individuals within the community.

The response team undertook a range of activities to address the Anthrax outbreak:
Gap Identification: Identified government and other partners' support and planned interventions, pinpointing gaps to be filled by URCS in the response. This ensured a targeted and complementary approach.
Coordination and Field Visits: Actively participated in coordination meetings at all levels, ensured alignment with broader response efforts. Field visits were conducted to monitor and ensure the quality of interventions in regards to planned intervention activities.
Emergency Intervention: Intervened in emergency cases related to outbreaks, pandemics, and disasters. This rapid response capability was crucial in mitigating the immediate impact of health crises.
URCS's health promotion activities, including risk communication and community engagement, specifically targeting the affected district and neighbouring high-risk areas. Key activities included:

- Community-Based Surveillance (CBS): Training volunteers on CBS to support early detection through active case finding and contact tracing. This enhanced the community's capacity to detect new cases promptly.

- Awareness Sessions: Conducting awareness sessions in communities with dietary habits that include meat. Sensitizing families on prevention measures ensures a well-informed and proactive community.
- Sensitization for Animal Traders and Butchers: Engaging animal traders in markets and farm areas, emphasizing the importance of animal vaccination and Anthrax prevention. One-on-one discussions with butchers aim to ensure their active involvement and reduce any potential misinterpretation in public awareness.

In essence, the response strategy aligns with principles of community engagement, financial efficiency, and long-term sustainability. By empowering local communities and individuals, URCS aims not only to address the immediate Anthrax outbreak but also to build resilience and capacity for future health challenges.
The pillars supported include;

- Coordination
- Risk Communication and Community Engagement (RCCE)
- Surveillance
- Animal health

Coordination:

- URCS participated in National Task Force (represented by the Director of Health and HQ-based technical officers) and District Task Force (represented by URCS field-based officers) meetings. At district level, meetings were held every week on Tuesday and Thursday to discuss the progress made, challenges faced and updates from all implementing partners. It was through these engagements that URCS used the opportunity to present its operational strategy that was endorsed by DTF members. DTF members allocated URCS with 100 high-risk villages to operate in supporting the response. The villages were selected from four highly affected sub-counties of Kabira, Kasasa, Nabigasa and Kasaali and two (2) town councils of Kyotera and Kalisizo.
- Participated in partner coordination meetings with MoH, MAAIF, WHO, UNICEF, IDI, and USAID-SBA among others to strengthen coordination, share resources and avoid duplication of activities. Majority of these meetings used to happen virtually on a daily basis where partners could share their daily progress on certain activities/pillars supported.
- At community level, URCS collaborated with 300 community resource personnel at the village level who supported house-to-house risk communication as well as at mass gatherings. Each village comprised of 3 members of the task force (Chairperson, VHT, URCS volunteer).

Risk Communication and Community Engagement (RCCE)

- URCS activated 100 Village Task Forces from 100 high risk catchment areas of Kabira, Nabigasa, Kasasa, Kyotera T/C, Kasaali, and Kalisizo T/C to conduct Risk Communication at community level using door-to-door approach. Each task force included three (3) members (LC Chairperson, VHT, URCS volunteer) giving a total of 300 community volunteers who supported the response. These were oriented and trained in Anthrax Community Case definitions specifically on Anthrax signs and symptoms, causes, transmission, prevention and management of Anthrax cases both in animals and in humans. Initially communities had a low risk perception about the virus and the approach resulted into increased community awareness about Anthrax and improved medical seeking behaviours (hospital referrals) particularly Anthrax victims.
- 8,933 households reached by deployed community volunteers and 754 mass gatherings reached with Anthrax awareness. The volunteers used health messaging on Anthrax using the MOH-approved Information, Education and Communication (IEC) materials.
- 55,845 people reached out through using household visit approach while 15,977 reached out through mass gatherings. Of these, 36,776 are males (65.8%) and 19,069 are females (34.2%). From mass gatherings, 7,984 were males (49.9%) while 7,993 were females (50.1%).
- Eleven (11) community mass drives were conducted in Nabigasa sub-county and Kyotera T/C reaching out to more than 10,068 people.
- Cumulatively, 71,822 people were reached through intensified RCCE activities using household visits, mass gatherings, and mass community drives.
- Furthermore, URCS developed jingles and these were broadcasted on CBS FM, which is a leading local radio station listened by communities in the district. These can be accessed through link below. https://1drv.ms/f/s!ArOAzjEUaJ3Ls3sSk8n6ldty609K?e=OQktlv
- Conducted one radio talk show on 93.0 Ekisweeko FM with Kyotera DSFP and sensitized people on Anthrax.
- More than 3500 IEC materials were distributed to communities that are at high-risk of Anthrax. MoH provided the IEC materials for both animals and humans to aid deployed URCS volunteers while conducting risk communication.
- 10 engagement meetings conducted with local farmers and meat value-chain actors in Kyotera T/C, Kasaali, Kalisizo T/C, Nabigasa, Lwankoni, and Mitukula T/C with support from DTF and local leadership. These were oriented on their roles in stopping the spread of Anthrax in the district. More than 900 participants attended during these engagements. Leadership of the mentioned sub-counties were requested to continue enforcing animal slaughter laws and movements in order to stop anthrax by enforcing the requirements for cattle traders to have licenses issued by MAAIF.
- Engaged 92 traditional healers (Males 64, Females 28) in Kabira S/C. A big section of community members affected by Anthrax was seeking medical support from traditional healers especially from Kabira and Nabigasa S/Cs while attaching the disease to witchcraft. This engagement was identified as an effective mechanism of breaking the chain of community beliefs about Anthrax to enhance better medical seeking behaviors through increased referrals from traditional healers.
- Supported the district to conduct lessons learnt workshop where lessons were drawn from the response for improvement in the

current response actions and subsequent responses both at the district and national level.

Surveillance (Community Based Surveillance)

- 300 community volunteers were deployed to conduct surveillance from their respective communities. CBS was incorporated into RCCE during orientation and activation of village task forces.
- 100 URCS deployed volunteers underwent through CBS and EPiC training for seven days (Males 61, Females 39) to effectively conduct Community Based Surveillance and behavioural change.
- Deployed community volunteers sent 10 alerts and some turned out to be positive. Before CBS and EPiC training, deployed volunteers used to send alerts via WhatsApp and text messages. Currently, alerts are being sent through Kobo tool for easy management and follow up on cases identified. URCS field team received alerts from deployed community volunteers and worked with District Task Force/District health team together with other community structures to follow up the cases. This was the case in Kabira S/C where most of the alerts come from.

Animal Health
- The district received 10,000 dozes from MAAIF to assist in vaccination of animals. The DTF target was to vaccinate 70,000 animals in order to combat the spread of Anthrax in the district.
- Cumulatively, 23,455 animals were vaccinated across the district during the response. Of these, URCS supported vaccination of 8,750 animals through mobilization of local farmers using deployed volunteers, mobile drives, cinemas community radio announcements encouraging private public partnerships community sensitization for this service delivery. The same avenues were used to create anthrax awareness among the population.
- Furthermore, Red cross logistically supported district veterinary technician to conduct mass animal vaccinations and also subsidise on costs in the public private partnership to ensure good livestock vaccination coverage.
- Deployed volunteers continued to sensitize communities on carcass disposal by digging a recommended 3-4-meter-deep and gazetting places where suspected dead animals were buried.

Targeting Strategy

Who was targeted by this operation?

The operation strategically targeted a diverse range of stakeholders to ensure a comprehensive and effective response to the Anthrax outbreak. The primary audience included:

1. Community Members in Affected Sub-Counties: Directly affected by the Anthrax outbreak, community members in the affected sub-counties were the priority target. The goal was to provide them with essential information on preventive measures, early detection, and proper health practices.

2. URCS Volunteers: URCS volunteers play a crucial role as frontline responders and community connectors. By targeting them, the operation aimed at equipping volunteers with the necessary skills and knowledge to effectively engage with and support the community during the Anthrax response.

3. Community Health Workers (Animal and Human Sectors): Community health workers, spanning both health and human sectors, are vital for the success of health promotion and surveillance efforts. The operation targeted this group to enhance their capabilities in early detection, risk communication, and community engagement.

4. District Health Team: Engaging the district health team is essential for coordinated and synchronized efforts. By targeting this group, the operation aimed at strengthening collaboration between the Uganda Red Cross Society and local health authorities, ensuring a unified response.

5. Farmer Groups: Farmer groups, particularly those involved in livestock management, were a critical audience. The operation intentionally targeted these groups to disseminate information on Anthrax prevention, safe livestock practices, management of suspected dead animals, and the importance of vaccinations.

6. Traditional Healers: Recognizing the community's reliance on traditional healing practices, the operation targeted traditional healers. This engagement sought to foster collaboration, ensuring that traditional healers are aligned with modern health strategies and supporting the community in health promotion.

7. Meat Value Chain Stakeholders: Stakeholders in the meat value chain, including butchers and traders, were essential for ensuring safe practices in handling and selling meat products. Targeting this group enhanced awareness and promoted adherence to proper hygiene and safety meat standards.

By strategically targeting these diverse groups, the Anthrax response operation aimed at creating a network of informed, empowered, and collaborative stakeholders to effectively address the health challenges posed by the outbreak.

Explain the selection criteria for the targeted population

The selection of the targeted population for the Anthrax response operation was guided by both a strategic assessment conducted by the Ministry of Health and proximity-based considerations. The criteria for selecting specific groups included:

1. Ministry of Health Assessment: The Ministry of Health conducted a comprehensive assessment to map out the affected areas. This assessment, which included factors such as reported cases, prevalence, and geographical distribution, served as a foundational basis for selecting the targeted population.
2. Proximity to Incident Areas: Community structures and groups were selected based on their proximity to the areas directly affected by the Anthrax outbreak. This proximity-based approach ensured that the response was concentrated where the impact was most significant, optimizing the use of resources and interventions.
3. Community Structures' Role in Solutions: Community structures, including traditional healers, farmer groups, community health systems, and volunteers, were highly targeted because of their integral role in facilitating positive behaviour change in communities. Recognizing these groups as key influencers and agents of change, the selection criteria prioritized their involvement to enhance the effectiveness of the response.
4. Proactive Solutions from Community Structures: The selection of community structures was driven by their potential to be part of the solutions to the Anthrax problem. By engaging traditional healers, farmers, community health systems, and volunteers, the response operation aimed to harness local knowledge, expertise, and influence to address the challenges posed by the outbreak.

In summary, the selection criteria for the targeted population was grounded in a combination of strategic assessment by the Ministry of Health and the recognition of the reactiveness role of community structures can play in finding solutions to the Anthrax outbreak.

As events unfolded during the response, several operational assessments were continuously done together with other key response actors including local government authorities, central government, local leaderships and partners. It's through these interactions that response team realised need to increase our target population given the perceived increase in the number of people at risk evidenced by incidence of anthrax cases in areas that were earlier perceived as no risk areas. It was therefore prudent to make fine adjustments in specific field response actions to accommodate a wider reach within the available resources. this is the reason why 71,822 people were reached against the target of 69,000.

Total Assisted Population

Assisted Women	-	Rural	**80%**
Assisted Girls (under 18)	-	Urban	**20%**
Assisted Men	-	People with disabilities (estimated)	**0.1%**
Assisted Boys (under 18)	-		
Total Population Assisted	**71,822**		
Total Targeted Population	69,340		

Risk and Security Considerations (including "management")

Please analyse and indicate potential risks for this operation, its root causes and mitigation actions.

Risk	Mitigation action
The volunteers contracting the disease.	Sufficient training and personal protective equipment was provided to the volunteers, together with supervision and onsite mentorship.

	The risk did not materialize.
Harm to the responders	The community engagement team was locally selected, so they understood the contexts of the community. The response team was sensitive to feedback and responded to as soon as possible. The risk did not materialize.

Please indicate any security and safety concerns for this operation:

Kyotera which lies under Masaka region has had a long spell of insecurity. Volunteers were briefed on safe and security before deployment while briefings and debriefs were undertaken every day. Volunteers were grouped into teams with continuous supervision of a team leader.

Has the child safeguarding risk analysis assessment been completed?	**No**

Implementation

Health

Budget: CHF 56,583
Targeted Persons: 69,340
Assisted Persons: 71,822
Targeted Male: 35,192
Targeted Female: 36,630

Indicators

Title	Target	Actual
No of URCS volunteers trained in Epic and CBS.	100	100
No of people reached with risk communication messages.	69,340	71,822
No of mobile drives and community cinemas conducted.	5	11
Number of animals mobilised for vaccination.	3,000	8,750
% of alerts investigated by authorities within 24hrs	80	91
Number of alerts raised via CBS system later confirmed as cases	0	3
No. of traditional healers, religious and local leaders reached	500	521
No. of engagement meetings with cattle farmers	10	10

Narrative description of achievements

• URCS completed training of URCS deployed volunteers in Epidemic Preparedness and Community-Based Surveillance (EPiC and CBS). Just like in previous responses, URCS volunteers worked alongside community health workers to detect and report suspicious cases of Anthrax and other diseases promptly. Kyotera district had a very weak surveillance system without reporting structures, which was

attributed to delayed response thus contaminating the environment. Building a community-based monitoring system enhanced surveillance, enabled early detection and strategic allocation of resources in terms of awareness creation.

Deployed URCS volunteers and community health workers conducted mass sensitization on Anthrax using house to house approach and mass community gatherings. Community members had a very low risk perception about the bacteria and therefore the need to raise their knowledge and perception was paramount. Deployed volunteers worked alongside existing community structures to sensitize communities on Anthrax while targeting community case definitions. Additionally, deployed volunteers used Information, Education and Communication materials, which were provided and approved by MoH and MAAIF as visual aids to further strengthen their message delivered to community members. Additionally, community volunteers collected rumours regarding anthrax outbreak as part of risk communication strategy. Communities initially had strong attachment of animal and human death to traditional beliefs, and this had jeopardized control measures through referral system. Throughout the response, 8,922 household were visited and were oriented about anthrax while deployed volunteers conducted 754 mass gatherings.

Other health promotion activities such as emphasizing handwashing at household level, support in proper carcass disposal and encouraging vaccination of livestock are still on going as part of risk communication package to enhance behavioral change to enable households practice better and safe health actions.

During the response, the district secured 10,000 dozes from MAAIF for anthrax vaccination as the best preventive method for further outbreaks. The district's target was to vaccinate 70,000 cattle and only managed to achieve 33.5% (23,455) of the target. However, through mobilization and coordination using deployed community volunteers, URCS supported the District Task Force to vaccinate 8,750 across the high-risk catchment areas using public-private partnership.

In abide to bring all stakeholders on board, URCS organized engagement meetings with various community groups/sections among which include; Local leaders, religious leaders, traditional healers, and local/cattle farmers in order to increases their awareness about anthrax and be champions in spreading the message to their social groups especially followers. Initially, Kyotera District was highly contaminated with traditional beliefs as the causes and solutions to anthrax outbreak and thus many victims were identified seeking medical solutions from shrines especially in Kabira and Nabigasa sub-counties. Their engagement created a strong communication bond between District Task Force and Community influencers and thus increased hospital referrals through increased case reporting and surveillance. Engagement with cattle farmers created a smooth platform for animal vaccination. Other risk communication activities included radio talk shows, mass risk communication mobiles and mobile cinemas and use of banners portraying anthrax message particularly on cause, transmission, prevention and management of anthrax victims both in humans and in animals.

Through community feedback gathered during formal and informal coordination meetings with various stakeholders in regards to the response unfolding events, the team modified earlier planned approaches in addition to adopting new ones which increased the response team output within the available resources. For example, initially the team had planned to mobilize farmers for animal vaccination through community based volunteers, animal health authorities and other key stakeholders. During implementation the team realized that the above strategy would mobilize the initially targeted animals but the would have minimal impact relative to the district target of 70000 livestock amidst limited resources at hand. The team adjusted the approach to include using mobile community radios to directly mobilize farmers, using model farmers to encourage fellow farmers to embrace livestock vaccination even through public private partnerships.

Community-based surveillance commenced right away from the start of the response and this was the benchmark for success of the response. During needs assessment, URCS discovered that the district task force had no structures on the ground to support effective community disease surveillance. To cover the deficit, URCS trained and oriented community volunteers on how to conduct surveillance, particularly in highly affected catchment areas. At the start of the operation, community based surveillance was integrated into RCCE trainings to enable deployed volunteers to report all suspected anthrax cases from their communities.

URCS worked with the District Surveillance Focal Person, District Veterinary Officer and other DHT members to make sure that all alerts sent by volunteers receive maximum attention deserved. Before URCS's volunteer deployment, Kyotera District Task Force had received a total of 83 alerts and by end of the response, 96 alerts were sent from both affected and non-affected communities. Of these, deployed volunteers sent 11 alerts that were confirmed as true alerts and only 10 (91%) were investigated by the authorities. Of these, 3 alerts turned out to be positive for Anthrax and URCS volunteer reported the last Human Anthrax case from Kabira sub-county. The high investigation rate is attributed commendable coordination between the authorities and the RC response team. In some case, the field team used the available field level resources to logistically support the investigation teams to timely conduct investigations more so in human alerts.

Lessons Learnt

- Communities can detect and report any public health emergency if they are capacitated to do so.
- A well-established community reporting structure is crucial for effective community-based surveillance. As long as community volunteers know how and where to report alerts, communities can easily overcome escalation of epidemics.

• Communities can own community health programs if they are well oriented and given the responsibility to perform health-related tasks like health promotion and community-based disease surveillance.
• Engaging various community influencers is relevant and applicable in fighting against epidemics and pandemics. These have different platforms and different audiences and once they are brought on board, they can influence a number of community members towards better health seeking behaviors and assist in surveillance.
• Working with community leaders and volunteers ease risk communication since majority of rural people believe in physical interaction more especially with people whom they are familiar with. Therefore orienting and working with VHTs and Local leaders enhanced risk communication and increased peoples' risk perception about the bacteria.
• House-to-house and use of mass gatherings approaches enable trained volunteers to provide timely feedback to household members especially on questions regarding the subject matter.
• Application of One Health was manifested during the response since it combined human health, animal health, environment and wildlife departments. All these stakeholders were part of District Task Force to respond to the outbreak effectively.

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Challenges

• Delayed response to investigate true alerts sent somehow reduced volunteers' motivation to report suspected Anthrax cases, especially for animals. The district task force did not investigate many suspected animals that experienced sudden death on time.
• Limited feedback given to the community after taking animal samples. Due to lack of logistics, a number of communities where animal alerts were picked did not receive feedback from the district authorities and this somehow jeopardized community-based surveillance due to lack of feedback on reported cases.
• Initial beliefs that the outbreak was spiritual made risk communication efforts hard at the early stages of the response.
• Difficulties in carcass management since majority of community members could not safely manage carcass for both confirmed and suspected animal cases. The communities rarely made the recommended 7ft depth pit for disposing off carcass and leaving spores exposed on soils.
• Inadequate IEC materials provided by MoH and MAAIF. Deployed community volunteers lacked adequacy of IEC materials, as visual aids during risk communication and those which were provided, were not translated into local dialect for easy understanding.
• Deployed volunteers faced some objections while conducting RCCE due to uplifting of quarantine on animal slaughter and movement during festive season. The District Task Force uplifted a ban for two weeks during Christmas festive season and this created misconceptions amongst beneficiaries asking as to why the district authority had to lift the ban at a time when meat is highly demanded.
• Lack of gazette animal slaughter places across the district to enable authorities enforce slaughter rules and meat consumption standards. Failure to enforce public health regulations created gaps for consumption of un-certified/unsafe meat products.
• Limited vaccines supplied by MAAIF limited vaccination of 70,000 cattle as per the task force target.

Community Engagement And Accountability

Budget: CHF 27,557
Targeted Persons: 55,472
Assisted Persons: 71,822
Targeted Male: 35,192
Targeted Female: 36,630

Indicators

Title	Target	Actual
No. of dialogue meetings with DTF	8	8
% of feedback and complaints collected and responded to	80	81
Number of functional hotline numbers monitored and manned	1	1
% of community members who agree they have adequate information about Anthrax outbreak and how to protect themselves	80	100

Narrative description of achievements

URCS deployed community volunteers collected feedback and complaints using designed kobo tool. These were submitted on a daily basis and thus thematically analyzed. Most of the feedback/complaints were concerned with anthrax outbreak and the district's intention of lifting quarantine on animal slaughter and movement during Christmas season. URCS volunteers were always re-oriented on how to respond to some of the complaints raised and a significant number of them were responded to right away by URCS volunteers.

Additionally, URCS technical officers also responded to all the complaints and feedback during community engagement meetings with local farmers, traditional healers, local leaders, meat value chain actors and among other mass gatherings. The vast majority of complaints were responded to through the communication channels they were received, however there some complaints that were not addressed as the sources were un accessible through the channels they reported through such channels included direct calls from poor connectivity parts of the district.
No hotline was established as a result of inability to meet all the length bureaucratic processes to acquire an effective and community user friendly hotline. Therefore, all feedback was collected through conversional methods.

URCS strategy aimed at effectively facilitating community members to understand the anthrax disease; community case definitions for anthrax in both animals and humans, prevention and control measures to encourage effective
The URCS field teams attended all the 8 district level coordination meetings in addition to over 10 partner coordination meetings. Through the DTF response strategies including messaging, livestock restrictions like quarantines, ban of animal products consumption were discussed resolved and implemented through different stakeholders.

These meeting contributed to effective and timely response upon declaration of the outbreak as it is through the platforms that resources were mobilized, realigned and effectively utilized by the responders depending on the current and urgent needs. URCS also logistically supported the incident management training for the district taskforce by the MOH and MAAIF for effective response coordination.

Furthermore, a joint lessons learnt workshop was organized by the district with logistical support from URCS and IFRC. The workshop had excellent participation from all stakeholders of the district taskforce, NTF representatives from MOH and MAAIF, IFRC cluster representative and URCS senior management members.

Majority of the feedback was appreciating the efforts by the RC response teams, some sections of the community were registering complaints on limited access to vaccination services; how their livelihoods are being affected by the anthrax control measures like a ban on consumption and slaughter of livestock; Other feedbacks were in form of rumors on the possible cause of the illness, where some sections of the community attributed the strange illness to witchcraft, cannibalism, political stunt to impose more poverty in the areas and other sections of the community were not in agreement with the existence if the disease in the district. All community feedback were discussed with other response actors and addressed through feedback specific messages that were jointly developed by all response actors. Dissemination of feedback through different channels including radio talk shows, communal gatherings, household visits among others.

Lessons Learnt

- Its import to identify local foci of origin or rumors and misconceptions for effective de-mystification of rumors in communities.
- Effective health messaging should be through various channels emphasizing the interactive sessions for quick feedback to the community.
- There is need to engage policy makers to reduce on bureaucratic processes during emergency operations whenever certain services are required.

Challenges

• The delayed response undermined the response actions at the start of the response as a result of myths and misconceptions about the illness within the community.
• Some traditional healers were not cooperative at the start of the response.
• IECs materials where not in the local languages hence required interpretation by literate individual all the time.

Secretariat Services

Budget: CHF 8,083
Targeted Persons: 107
Assisted Persons: 107

Targeted Male: 50
Targeted Female: 57

Indicators

Title	Target	Actual
Number of monitoring missions conducted	3	3

Narrative description of achievements

IFRC ensured a proper monitoring with URCS. The joint monitoring approach facilitated the technical support and the implementation.
• The IFRC delegation ensured regular calls were organized and in-country mission to provide the adequate and timely support and facilitate joint missions.
• A total of 2 missions were conducted to the field by the URCS senior management team and 1 mission was conducted jointly with IFRC. It's through these missions that monitoring of the response activities was conducted.
• Learnings were documented for this intervention.

Lessons Learnt

• N/A

Challenges

• N/A

National Society Strengthening

Budget: CHF 37,390
Targeted Persons: 107
Assisted Persons: 107
Targeted Male: 50
Targeted Female: 57

Indicators

Title	Target	Actual
Number of volunteers insured	100	0
Number of NDRTs mobilised and deployed	7	7
Number of branch manager supported	1	1
NUmber of visibility jackets procured	100	100

Narrative description of achievements

• URCS deployed 7 health NDRTs with leadership of one of the CP3 program officer at field level, under direct supervision of the manager for EPPR under the health directorate. The NDRTs included 3 health officers, 1 communications officer, 1 volunteer management officer, 1 monitoring and evaluation and 2 drivers for logistical support in terms of fleet. In addition, support of the Rakai Branch Manager.

The team coordinated implementation of response activities through 100 volunteers and other 200 Village task force members. The

volunteers were equipped with personal protective equipment inters of branded gumboots and masks and Red cross branded reflectors. Insurance of volunteers was not realized because of the short response time, as it was not enough to engage a service provider.

Lessons Learnt

• Deployment of readily available technically competent/ capacitated human resource influences early effective and successful response to outbreaks.

Challenges

• Procurement of insurance policies for volunteers proved futile due to time constraints.

Financial Report

Selected Parameters			
Reporting Timeframe	2023/12-2024/11	Operation	MDRUG049
Budget Timeframe	2024-2024	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

Prepared on 06/Aug/2025

All figures are in Swiss Francs (CHF)

MDRUG049 - Uganda - Anthrax Epidemic

Operating Timeframe: 12 Dec 2023 to 31 Mar 2024

I. Summary

Opening Balance	**0**
Funds & Other Income	**129,613**
DREF Response Pillar	129,613
Expenditure	**-125,653**
Closing Balance	**3,960**

II. Expenditure by area of focus / strategies for implementation

Description	Budget	Expenditure	Variance
AOF1 - Disaster risk reduction		247	**-247**
AOF2 - Shelter			**0**
AOF3 - Livelihoods and basic needs			**0**
AOF4 - Health	115,243	120,625	**-5,382**
AOF5 - Water, sanitation and hygiene			**0**
AOF6 - Protection, Gender & Inclusion			**0**
AOF7 - Migration			**0**
Area of focus Total	**115,243**	**120,872**	**-5,629**
SFI1 - Strenghten National Societies	6,280	595	**5,684**
SFI2 - Effective international disaster management			**0**
SFI3 - Influence others as leading strategic partners			**0**
SFI4 - Ensure a strong IFRC	8,090	4,185	**3,904**
Strategy for implementation Total	**14,370**	**4,781**	**9,589**
Grand Total	**129,613**	**125,653**	**3,960**

Click here for the complete financial report

Please explain variances (if any)

IFRC-DREF allocation to this intervention was CHF 129,613 through the Response Pillar. Expenses were in total CHF 125,653. Closing Balance of CHF 3,960 will return to the DREF pot following the publication of this report.

• The variance Under Area of Focus 4 1 is attributable to costs previously budgeted under strengthening NS and Disaster Risk Reduction which were booked under Health since the operation was health related.
• The variance under Strategy for Implementation (SFI) 4, previously budgeted for IFRC costs is attributable to the underspent because part of IFRC costs were charged to other ongoing operations in Uganda.

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Click here for reference