REGIONAL EMERGENCY APPEAL

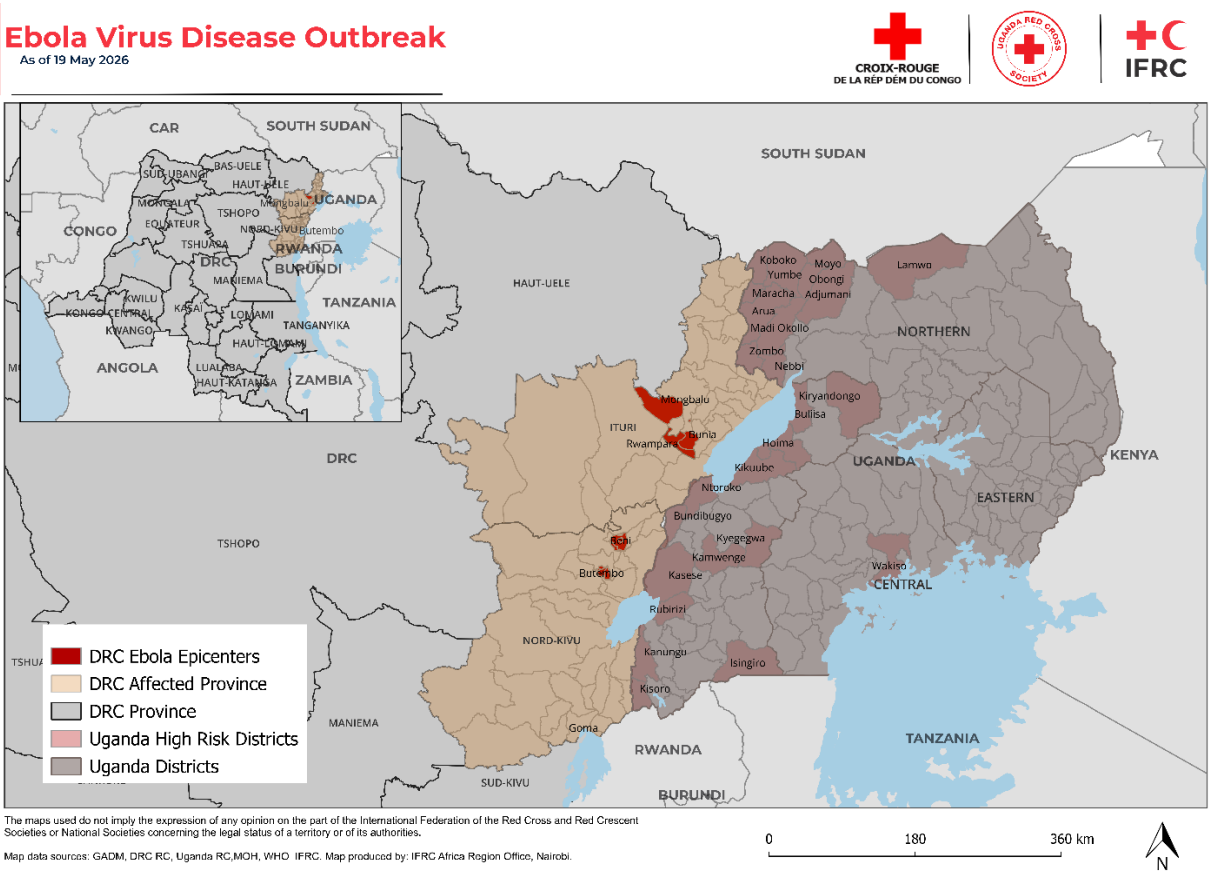
Africa Region | Ebola (BVD) Epidemic

Community sensitisation by volunteers

Appeal №: **MDRS1007**	IFRC Secretariat Funding requirements: **CHF 27.5 million**[1] Federation-wide Funding requirements: **CHF 29.5 million** [2]	
Glide №: **EP-2026-000071-COD**	People at risk: **12–18M people at high cross-border risk**	People to be assisted: **3 million people**
DREF allocation: **TBC**	Appeal launched: **20/05/2026**	Appeal ends: **31/05/2027**

[1] The secretariat ask is comprised of CHF 21M for the DRC, CHF 4.5M Uganda, CHF 2M for regional coordination for other countries to ensure resources available for readiness activities in current and potentially future Tier One countries. The funding requirement is likely to be adjusted as the situation evolves, especially if there is community transmission in Uganda or elsewhere.

[2] The Federation-wide funding requirement encompasses all financial support to be directed to the Operating National Societies in response to the emergency. It includes the Operating National Societies' domestic fundraising requests and the fundraising appeals of supporting Red Cross and Red Crescent National Societies (CHF 2 million), as well as the funding requirements of the IFRC Secretariat (CHF 27.5 million). This comprehensive approach ensures that all available resources are mobilised to address the urgent humanitarian needs of the affected communities.



SITUATION OVERVIEW

On 15 May, the Institut National de Recherche Biomédicale (INRB) Kinshasa confirmed an outbreak of the Ebola virus in Ituri Province, Democratic Republic of Congo (DRC). The virus, reported to have originated from the Mongbwalu, Bunia, and Rwampara health zones of Ituri province, has been confirmed as the Bundibugyo Virus Disease (BVD), a severe and often fatal strain.

As of 19 May, more than 500 suspected cases, including 130 suspected deaths, have been reported by the Ministry of Health. So far, 33 cases have been confirmed in the DRC. The World Health Organisation (WHO) declared the outbreak a Public Health Emergency of International Concern (PHEIC), due to the risk of further spread within the region, including across borders.

Unlike previous outbreaks caused by the Zaire strain, this Bundibugyo strain does not currently have a licensed vaccine or specific targeted treatment, making community-based measures, early detection, supportive healthcare, and prevention efforts more critical than ever.

The outbreak appears to have circulated for several weeks (with the first known case dated 24 April 2026) prior to confirmation as Ebola. The early presentation of cases with non-specific febrile symptoms, common to endemic diseases such as malaria, combined with initial laboratory testing focused on the more common Zaire strain, contributed to delays in identification. As a result, transmission occurred in both community and healthcare settings before targeted control measures were fully implemented.

Alongside multiple existing health risks in the eastern DRC, gaps in health practices may contribute to ongoing transmission of the Bundibugyo strain among communities and healthcare settings. Infection prevention and control (IPC) measures are not consistently applied, increasing the risk of transmission among health workers. The absence of an approved vaccine or specific treatment further emphasises reliance on core public health measures, including early detection, isolation, contact tracing, and supportive care, which

require sustained operational capacity and resources.

The outbreak comes just months after the DRC's sixteenth Ebola outbreak in Kasai Province, which was declared over in December 2025.

Authorities in Uganda have confirmed two BVD cases linked to cross-border movement from DRC into Kampala. The outbreak in Ituri Province in the DRC lies along the country's northeastern border with Uganda, placing it in close geographic proximity to neighbouring Ugandan districts. Key affected areas in DRC, including Mongbwalu, Rwampara, and Bunia, are located within relatively short distances of the border, in some cases approximately 100-150 km, and are linked through active cross border routes. Bunia, the provincial capital, is connected to Uganda by a major road corridor of roughly 180 km, facilitating the regular movement of people and goods, while Lake Albert also provides commonly used boat crossing route. This geographic proximity, combined with high levels of cross-border mobility for trade, mining, and service access, substantially elevates the risk of cross-border transmission into Uganda. There is a heightened risk that refugee settlements in Uganda, particularly in the West Nile region, could be affected. These areas host large refugee populations from the eastern DRC and are situated close to the border, with strong social, economic, and family ties spanning both countries. Continuous population movement, already evidenced by imported cases into Uganda, combined with active trade routes, increases the likelihood of exposure. In addition, refugee settlements often face structural constraints such as overcrowding and limited health, water, and sanitation services, which could facilitate transmission if the virus is introduced.

A key underlying driver of risk is high population mobility, especially along established transport corridors and informal border crossings. The movement of traders, transport workers, and mining communities between the eastern DRC and Uganda plays a significant role in potential disease spread, as mobility patterns are closely linked to early Ebola transmission dynamics. These cross-border linkages, reinforced by routine economic activity and service access, further elevate the likelihood of transmission and underscore the need for strengthened surveillance, community engagement, and coordinated cross-border response.

South Sudan also faces a high risk of BVD importation due to its proximity to the DRC and increased cross-border movement, compounded by very high vulnerability and insecurity, with limited readiness capacity despite some baseline measures such as Safe and Dignified Burial (SDB) protocols and trained SDB teams.

TARGETING

The BVD outbreak in the eastern Democratic Republic of the Congo (DRC) is currently concentrated in Ituri Province, and with some cases already confirmed in Goma, North Kivu. Cross-border transmission into Uganda has already been confirmed, highlighting a high-risk regional context driven by population mobility, displacement, insecurity, limited health system capacity, and mistrust in health and government systems. These factors significantly increase the likelihood of both localized transmission and regional spread across neighbouring countries.

An estimated 20–25 million people are considered at risk across the eastern DRC and high-risk areas in Uganda, with approximately 12–18 million people living in high-risk transmission zones and cross-border mobility corridors where exposure is greatest. This exposed population is concentrated in priority health zones and districts along cross-border corridors, where frequent population movement for trade, cross-border healthcare-seeking in Uganda, pilgrimage and socio-cultural events heighten transmission risk.

Within this broader exposed population, the Emergency Appeal will initially focus on approximately 30 high-priority health zones and districts across the DRC and Uganda respectively, representing key transmission hotspots, border communities, and population movement hubs. Additional areas in at-risk countries will be supported through readiness and capacity strengthening activities.

The targeting strategy prioritises populations most at risk of infection and those most likely to influence transmission dynamics. This includes communities in affected and neighbouring health zones, particularly in border areas and mobility corridors, as well as specific high-risk groups such as health workers and frontline responders, who face increased occupational exposure; caregivers and close contacts, who are directly involved in managing suspected cases; and mobile populations, including traders, miners, transport workers, refugees, and internally displaced persons, who frequently move across borders or along high-risk routes.

Particular attention will also be given to vulnerable groups with increased exposure and limited access to services, including women and young adults, who are disproportionately affected due to caregiving roles and occupational exposure, particularly in informal and high-density work settings. Women, children, and marginalised groups face additional risks linked to gender inequality, limited access to healthcare and protection services, and increased exposure to violence and stigma during outbreaks. Communities living in overcrowded displacement settings with inadequate WASH services are also prioritized due to heightened risk of rapid transmission. These groups are targeted both because of their higher likelihood of exposure and reduced access to timely information and care, and their critical role in either amplifying or interrupting transmission chains if effectively reached.

As a key pillar of the operation, the International Federation of Red Cross and Red Crescent Societies (IFRC) will work to ensure the safety, protection, and well-being of National Society staff and volunteers. Staff and volunteer safety will be prioritised through training, the provision of personal protective equipment (PPE), psychosocial support, and adherence to safety protocols, enabling sustained and safe frontline engagement in high-risk and affected areas while supporting the effective delivery of assistance to at-risk populations.

Given the constant evolving nature of the outbreak and high level of uncertainty at this phase of the epidemic, the IFRC will be constantly reassessing the risk profile of each country based on epidemiological data and other outbreak criteria. For this reason, the risk in all other countries in Africa and beyond must not be overlooked,

PLANNED OPERATIONS

The IFRC response follows an **end-to-end, community-driven approach** to the outbreak, implemented through a tiered operational model that adapts interventions to each country's epidemiological context while maintaining readiness to scale up rapidly.

Through this Emergency Appeal[3] IFRC aims to support the DRC Red Cross, Uganda Red Cross, and other key neighbouring countries in responding to, and their readiness for the BVD outbreak. The IFRC response strategy follows a community-driven approach to outbreak control, implemented through a tiered operational model that adapts interventions to each country's epidemiological context while maintaining readiness to scale up rapidly.

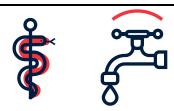
[3] It is expected that, depending on the evolution of the outbreak, the Emergency Appeal may be revised in the coming weeks or months.

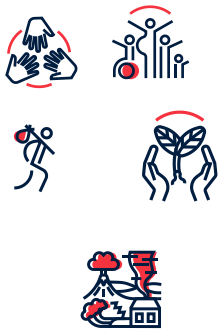
The IFRC response strategy is structured around a tiered approach, tailored to the stage of outbreak evolution in each country and guided by predefined criteria, including government priorities, national Ebola response plans, and the mandate of National Societies within their respective host countries. The overall strategy places a strong emphasis and positioning on regional cross-border coordination to co-lead and address transmission risks across countries.

- **TIER 1: At-risk countries (Direct land border with outbreak zones)**
  Focus on strengthening National Society readiness and response capacity at both national and branch levels, based on risk analysis and in alignment with government priorities. This includes clarifying National Society roles in key Viral Haemorrhagic Fever response areas such as Safe and Dignified Burials (SDB), Risk Communication and Community Engagement (RCCE), and community-based surveillance (CBS), while supporting targeted readiness for SDB activities as required. At community level, efforts will prioritise identifying of volunteers, mapping key influencers, and readiness to scale up RCCE, WASH, health, and PGI activities in the event of an outbreak, ensuring readiness for rapid response and effective community engagement in high-risk areas. The focus will also be on building the capacities of national rapid response teams to be able to respond anywhere in the country in the event of a confirmed case.

- **TIER 2 - Countries with active outbreak** (currently including the DRC and Uganda)
  In countries with active outbreaks, the response will scale up to a full public health package, including SDB, community-based surveillance, contact tracing, RCCE, and targeted IPC support to health facilities depending on identified response gaps in the response and National Society mandates. This will be complemented by WASH, Mental Health and Psychosocial Support (MHPSS), continuity of care, and hygiene promotion, alongside specialised services such as ambulance transport where relevant, supported by business continuity and risk management measures. Protection, Gender and Inclusion (PGI) and Community Engagement Accountability (CEA) through community participation, trust building exercises and Community Champions network will be mainstreamed across interventions as both components are crucial for effective Ebola response.

A special **cross-border operational modality** will also be established, combining joint coordination mechanisms, strengthened border branch capacity, harmonised protocols, and shared risk analysis to enable a coordinated and effective regional response along high-risk mobility routes.

	**Health and Care including Water, Sanitation and Hygiene (WASH)** (*Mental Health and Psychosocial Support / Community Health*) Under the Health and Care pillar, the IFRC response focuses on a set of core activities addressing prevention, detection, and response, applied across all contexts, with the level of implementation adapted to the country's tier and readiness status. • **Surveillance:** Conduct active case finding, community-based surveillance (CBS), support contact tracing, and establish screening and referral systems for early detection • **Conduct Safe and Dignified Burials (SDB**): Conduct SDBs in line with established protocols and community engagement approaches • **Infection Prevention and Control (IPC):** Strengthen IPC practices and processes in health facilities • **Community-Based Health and RCCE:** Deliver community outreach, promote protective behaviours, and establish feedback mechanisms to

	support adaptive response efforts, including points of- entry screening, integrated with RCCE at border crossing points • **Mental Health and Psychosocial Support (MHPSS):** Provide psychosocial support to affected populations and support staff and volunteer well-being • **Continuity of Essential Health Services**: Maintain access to basic health services and strengthen referral pathways for vulnerable populations • **WASH**: Promote hygiene practices, support household-level WASH, and implement WASH interventions in high-risk settings • **Patient Transport:** support for emergency patient transport and referrals where capacity allows.
	**Protecting Livelihoods and Social Cohesion** The IFRC's response places strong emphasis on community engagement through its network of volunteers and local branches, which serve as trusted actors embedded within affected communities. Under the Protecting Livelihoods and Social Cohesion pillar, the response will focus on the following: • Establish community feedback mechanisms to enable two-way communication and inform adaptive response efforts in real time • Implement stigma reduction activities to promote social cohesion, and support community acceptance • Integrate PGI approaches to safeguard vulnerable groups and ensure inclusive and safe access to services • Support early recovery actions to address socioeconomic impacts and strengthen community resilience • Strengthen CEA systems by scaling community engagement, and leveraging feedback, and community insights to ensure an adaptive and accountable response

Enabling approaches

The sectors outlined above will be supported and enhanced by the following enabling approaches:

	**National Society Strengthening** • **<u>Branch Capacity Enhancement.</u>** The IFRC will strengthen National Society capacity and readiness, with a particular focus on branches, as part of the local community health ecosystem in border areas, by investing in operational resources and digital/information management equipment, volunteer systems, pre-positioning, governance, and learning mechanisms to enable an effective and timely response to current and future outbreaks. • **<u>Duty of Care and Volunteer Protection.</u>** Ensure the health, safety and well-being of frontline responders through insurance, vaccination, adequate PPE (where relevant), medical evacuation pathways, psychosocial support, and comprehensive training and supervision aligned with duty of care

	standards. Beyond physical protection, the operation will also address the psychological and social pressures faced by volunteers. • **<u>Strengthen National Society preparedness, readiness, and response capacity</u>** at national and branch levels for Tier 1 countries; including preparing rapid response teams for nationwide deployment and clarifying roles in Viral Haemorrhagic Fever (VHF) response areas. • This Emergency Appeal includes targeted capacity strengthening measures to reinforce the effective delivery of the current response. These actions build on ongoing National Society Development (NSD) investments and align with the NSD plan and the IFRC's NSIF priorities, particularly in volunteer management, safeguarding, governance, and financial systems. They are essential to mitigating operational, safeguarding, and accountability risks, ensuring safe, timely, and scalable assistance while strengthening long-term disaster response capacity.
	**Coordination and partnerships** ***Special Operational Modality for Cross-border collaboration*** • Building on this, the IFRC will support the establishment and strengthening of cross-border coordination mechanisms while supporting engagement with local authorities, governments, intergovernmental and regional bodies to ensure a coherent, timely, and regionally coordinated response to prevent further spread. • Strengthen border branch capacity to support cross-border surveillance, information sharing, and RCCE, enabling coordinated detection and response along mobility corridors with neighbouring National Societies and authorities. • Facilitate active participation and coordination with Incident Management Support Teams, partner coordination fora, and bilaterial strategic partners at national and continental/regional levels.
	**IFRC Secretariat services** • **Technical support:** Develop and/or update relevant technical guidance and materials in the different sectors (Health, WASH, CEA, PGI, and others) and to ensure their effective dissemination among National Societies through different channels. • **Set-up Federation-wide coordination:** Set-up Federation-wide coordination, including a PMER framework and Information Management services, to support the efficient use of members resources and expertise, where all engaged and interested National Societies have visibility on existing needs and gaps. • **Surge readiness and deployment**: Prepare for and deploy experts to support National Societies' readiness and response efforts as required, including the deployment of Emergency Response Units. • **Logistics:** establish an efficient supply chain system for quality health assets, goods and services as required by National Societies and their governments, when and if the same such items cannot be procured efficiently procured in -country with the same quality standards.

	• **Humanitarian diplomacy, communication and advocacy:** In collaboration with its members, develop advocacy and communication engagement strategies targeting external partners, the diplomatic community and the media to support the work of Red Cross Red Crescent National Societies in preparing, preventing and responding to this BVD outbreak. • **Resource mobilisation:** the secretariat will engage with international donors and partners to facilitate funding and in-kind support for the implementation of the Emergency Appeal. • **Federation-wide operational support:** Facilitate an effective Federation-wide response, with support from Country Cluster Delegations and the Africa Regional Office.

The planned response reflects the current situation and is based on the information available at the time of this Emergency Appeal launch. Details of the operation will be updated through the Operational Strategy to be released in the upcoming days. The Operational Strategy will also provide further details on the Federation-wide approach which includes the response activities of all contributing Red Cross and Red Crescent National Societies, and the Federation-wide funding requirement.

After 31 May 2027, response activities related to this disaster will continue under the respective IFRC Network Country Plans for 2027. These plans provide an integrated view of ongoing emergency responses and longer-term programming tailored to the needs in the country, as well as a Federation-wide view of the country's actions. This approach aims to streamline activities under one plan, while still ensuring that the needs of those affected by the disaster are met in an accountable and transparent way. Information will be shared in due course should there be a need for an extension of the crisis-specific response beyond the above-mentioned timeframe.

RED CROSS RED CRESCENT FOOTPRINT IN COUNTRY

Anchored in their auxiliary role to governments and deep community presence, National Societies enable a response that is locally led, rapidly deployable, and regionally connected, ensuring both immediate impact and sustained preparedness across affected and at-risk countries.

The DRC RC and URCS bring strong experience and proven operational capacity in responding to VHF outbreaks, built through repeated engagement in complex public health emergencies across the region. Both National Societies have established strong, long-standing auxiliary relationships with their respective Ministries of Health, positioning them as key partners in outbreak preparedness and response. Their entrenched community presence, trained volunteer networks, and expertise in areas such as safe and dignified burials, community engagement, and risk communication allow them to play a critical role in supporting national response strategies. Leveraging this experience and coordination, the DRC RC and URCS contribute significantly to early detection, community trust-building, and the effective implementation of response measures.

National Society	Number of staff	Number of volunteers	Number of branches
TIER 2			
CROIX-ROUGE DE LA RÉP DÉM DU CONGO	122	503,311	26
UGANDA RED CROSS SOCIETY	220	44,138	51
TIER 1			
South Sudan Red Cross	200	19,500	21
CROIX - ROUGE DU BURUNDI	350	614,583	42
CROIX ROUGE RWANDAISE RWANDA RED CROSS	93	70,013	30

IFRC Network Cross-Border Coordination

Powered by local capacity and global expertise, cross-border coordination represents a core strength of National Societies in responding to outbreaks that transcend national boundaries. The IFRC response is uniquely positioned to deliver at scale through its network, combining deep community reach with global coordination, technical expertise, and surge capacity. Anchored in their auxiliary role to the public authorities and strong local presence, National Societies ensure a response that is locally led, rapidly deployable, and regionally connected. Through cross-border collaboration, neighbouring National Societies align strategies, share information and community insights, and ensure continuity of actions along mobility corridors, contributing to early detection, consistent messaging, and effective preparedness. This approach is reinforced by strong coordination with governments and partners, rapid mobilisation of volunteers and surge capacity, and sustained investment in National Society capacity, ensuring both immediate impact and longer-term resilience across affected and at-risk countries.

IFRC Membership Coordination

At the time of the launch of this Emergency Appeal, the IFRC Secretariat is actively supporting the response through its regional and country coordination structures, working closely with the DRC Red Cross and Uganda Red Cross Society, as well as with network partners. Coordination mechanisms have been activated at strategic and technical levels, including engagement with Participating National Societies (PNSs) to mobilise technical and financial support. In-country, PNS are contributing through

surge support, technical expertise, and targeted operational assistance, complementing the National Society' response efforts.

The IFRC is also supporting alignment with government priorities and strengthening the auxiliary role of National Societies within national coordination frameworks. A comprehensive overview of the Federation-wide response, including the full footprint and contributions of all National Societies, will be further detailed in the forthcoming Operational Strategy.

The IFRC Secretariat, through its Country Delegation in Kinshasa, Country Office in Kampala and its regional office in Nairobi, provides technical backstopping, surge deployments, resource mobilization of resources and Federation-wide reporting. The Secretariat also facilitates the mobilisation table and ensures coordination with external actors through the Health Cluster and UN systems.

Red Cross Red Crescent Movement Coordination

Movement Coordination Agreements (MCAs) are in place across the affected countries, providing established coordination platforms at strategic, operational and technical levels. These mechanisms will be utilised and, where necessary, reinforced to ensure coherent, efficient and well-aligned Ebola response, under the leadership of the respective Operating National Societies.

Such coordination is particularly critical in conflict-affected contexts, where access, security and operational coherence require close collaboration among Movement components. In the DRC, Movement coordination has been further reinforced through Mini-Summits held on 16 and 18 May 2026, bringing together the DRC Red Cross, IFRC and ICRC to align strategic and operational priorities, including access to vulnerable populations and the safety and security of staff and volunteers in complex environments.

External Coordination

Since the onset of the outbreak, the IFRC and National Societies have been actively coordinating at country, regional and global levels with National Societies, public authorities, and key partners, including the WHO, UNICEF, US CDC, Africa CDC and IGAD, building on existing preparedness and epidemic readiness efforts in the region. National Societies, supported by the IFRC, are engaged in government-led coordination mechanisms and interagency platforms, ensuring alignment with national response plans, contributing technical expertise, and addressing identified operational gaps. The IFRC also participates in regional and global coordination fora, supporting information sharing, joint risk analysis, and cross border preparedness and response efforts through established platforms and regional initiatives.

At the continental level, the IFRC maintains a close relationship with the African Union (AU) through its Representative Office in Addis Ababa and regularly engages with the Africa Centre for Disease Control and Prevention (AfCDC) on all health-related matters. The IFRC and AfCDC have partnered on several occasions in support of member states and National Society health responses, including during COVID-19, Mpox, and Viral Haemorrhagic Fever outbreaks, among others.

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Reference
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