DREF Operation

South Sudan: BVD Outbreak Readiness

SSRC SDB training during the MVD readiness operation, Feb 2026

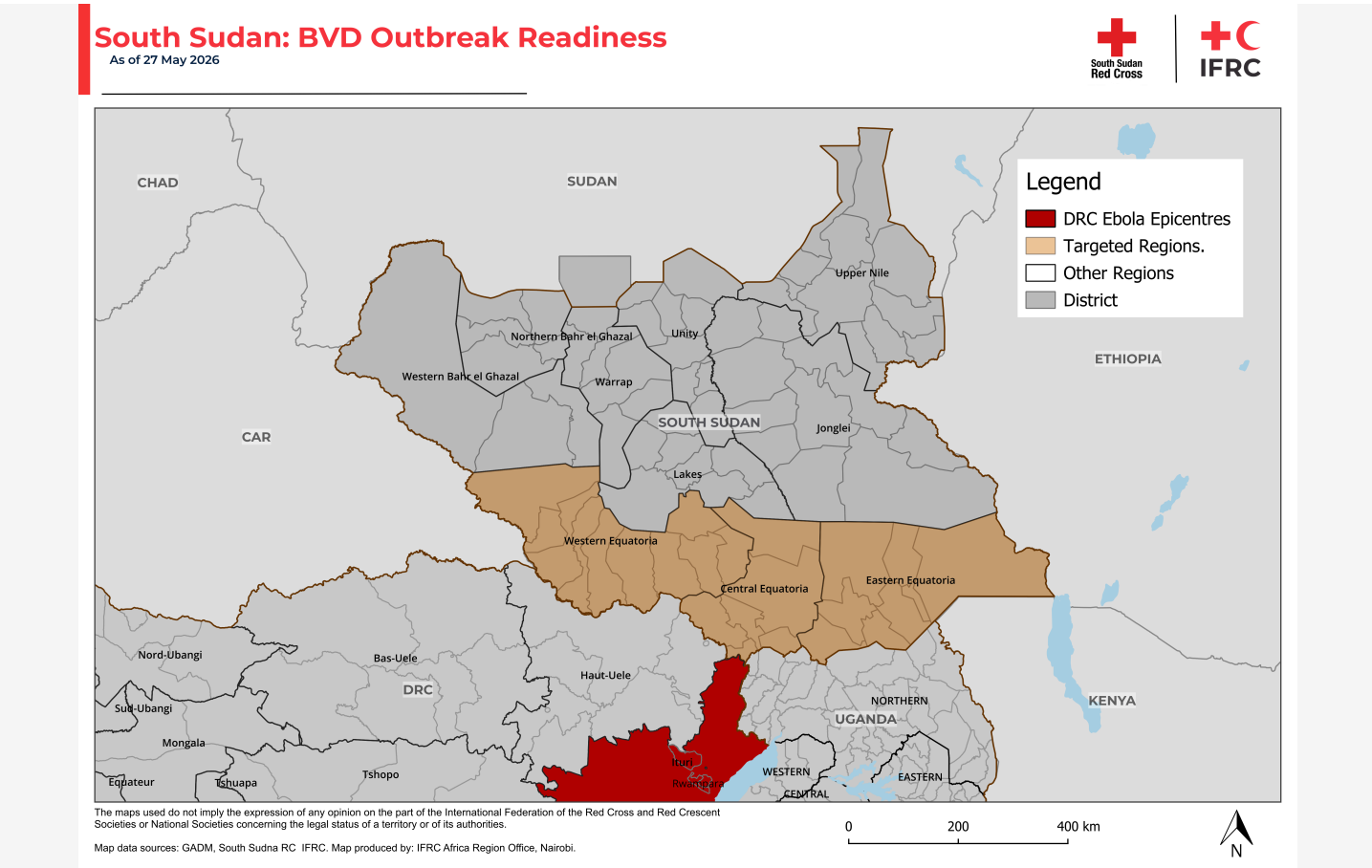
Appeal: **MDRSS019**	Hazard: **Epidemic**	Country: **South Sudan**	Type of DREF: **Response**
Crisis Category: Yellow	Event Onset: **Slow**	DREF Allocation: **CHF 48,810**	
Glide Number: **EP-2026-000071-COD**	People Affected: **500,000 people**	People Targeted: **500,000 people**	
Operation Start Date: **31-05-2026**	Operation Timeframe: **2 months**	Operation End Date: **31-07-2026**	DREF Published: **03-06-2026**

Targeted Regions: **Central Equatoria, Eastern Equatoria, Western Equatoria**

Description of the Event

Date when the trigger was met

20-05-2026



A map of South Sudan showing BVD outbreak readiness areas

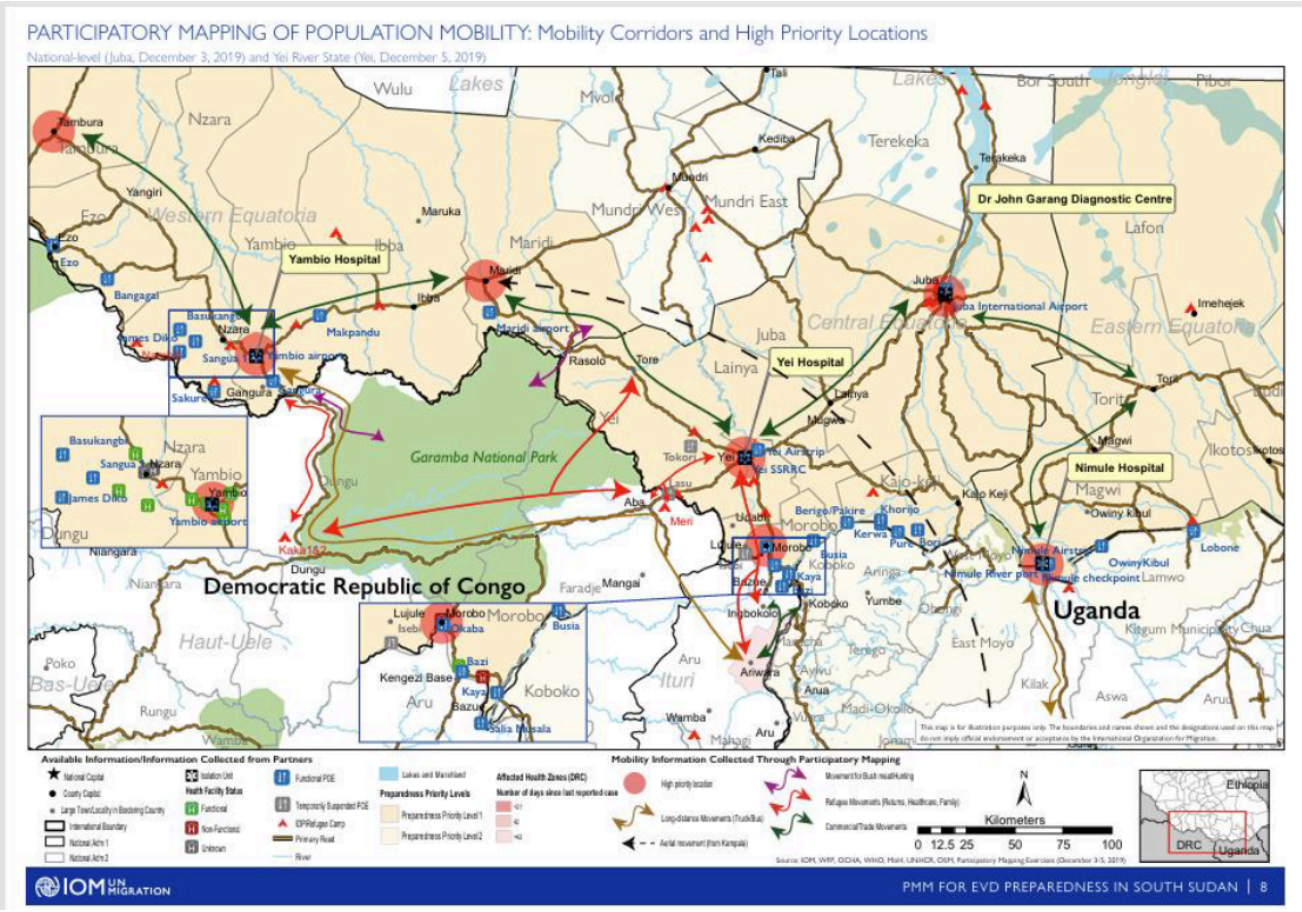
What happened, where and when?

On 15 May 2026, the Ministry of Public Health, Hygiene and Social Welfare, Democratic Republic of the Congo (DRC), and the Ministry of Health of Uganda declared an outbreak of Ebola Disease following the confirmation of Bundibugyo virus disease (BVD) in both countries. On 16 May 2026, the World Health Organization (WHO) Director-General determined that the Ebola disease caused by Bundibugyo virus in DRC and Uganda constitutes a public health emergency of international concern (PHEIC), as defined in the provisions of IHR. On 19 May 2026, the Director-General of WHO convened the first meeting of the IHR Emergency Committee, and temporary recommendations were issued to State Parties. As of 21 May, 746 suspected cases and 176 deaths among suspected cases were reported in DRC. So far 85 confirmed cases, including two in Uganda, and ten deaths, with one in Uganda, among confirmed cases were reported across both countries.

On 20 May 2026, the Ministry of Health South Sudan and WHO through the health cluster where SSRC is a member, identified the country as a high-risk country for importation of BVD due to porous borders and cross-border population movement between DRC and Uganda, and called all partners to initiate and BVD preparedness and readiness activities in the priority cross border areas across all infectious disease response pillars. This is also in line with the IFRC BVD outbreak response risk categorization that is informing response and readiness work, placing South Sudan under tier 1 countries (direct neighbors to DRC and Uganda) that are considered for preparedness and readiness actions.

Additionally, on 22 May 2026, the first meeting of the IHR emergency committee regarding the epidemic of Ebola Bundibugyo Virus Disease in the Democratic Republic of the Congo and Uganda 2026, passed temporary recommendations for States Parties with

documented detection of Bundibugyo virus (the Democratic Republic of the Congo and Uganda) and for States Parties with land borders adjoining States Parties with documented BDBV detection. Although there are no cases reported in South Sudan at present, the Health Cluster strongly encourages all humanitarian and health partners to remain on high alert, particularly in high-risk border areas and locations with population movement from neighboring DRC and Uganda. Given South Sudan's porous borders, population mobility, weak health infrastructure, limited IPC capacity, and previous public health emergency experiences, the risk of importation remains high.



A mapping of mobility corridors and high priority locations in South Sudan

Scope and Scale

Although current confirmed BVD cases remain within DRC and Uganda, South Sudan is at significant risk due to regular cross border movements for trade, markets, socio-cultural events and displacement, and the South Sudan Health Cluster Co-Chairs (the MOH and WHO) requested all partners to extend support for preparedness and readiness actions in the cross border areas with DRC and Uganda.

The eight targeted locations (Nimule, Juba, Yei, Kaya, Morobo, Maridi, Yambio and Kajokeji) has an estimated total population of 500,000 people and act as important corridors between South Sudan and her 2 neighbors, DRC and Uganda. The South Sudan cross border health facilities in these areas already operate with limited human resources, constrained WASH infrastructure, sub optimal IPC, and long distances to referral centers with laboratory capacity, all of which could delay detection of imported cases and increase the risk of onward community transmission.

With direct shared border crossing points with both Uganda and DRC, an unmitigated spillover of BVD into these locations could rapidly overwhelm local health services, fuel community fear and stigma, and disrupt livelihoods dependent on cross border trade, livestock movement and daily wage labor. Cultural practices involving close physical contact during illness and funerals, and the presence of mobile and hard to reach populations, would complicate contact tracing and safe case management if preparedness is not in place before a spillover event occurs. Given the severity of Ebola and fragile health systems in South Sudan, readiness investment in surveillance, RCCE, WASH, IPC, safe and dignified burials (SDB), and rapid response capacity is essential to avert a potentially large-scale humanitarian and public health emergency.

The South Sudan Health Cluster has recommended the following interventions to partners for support:

1. Establish a national coordination mechanism articulated with subnational levels.

2. Enhance rapidly the status of readiness to respond to BVD cases, including establishing active surveillance across health facilities, with zero reporting; enhancing community-based surveillance for clusters of unexplained deaths; establishing access to laboratories qualified to test for BVD; raising the awareness of health workers regarding BVD; training health workers on IPC precautions; establishing rapid response teams for the investigation and management of BVD patients and their contacts; establishing a mechanism for the identification and monitoring of contacts.
3. Intensify risk communication and community engagement activities, in communities residing in border areas and at points of entry, including airports and ports with direct connection with States Parties with documented BDBV detection, and provide the general public with accurate and up to date information regarding the BVD epidemic and measures to reduce the risk of exposure.
4. Exercise arrangements in place to respond to BVD through simulation exercises relating to management of BVD " alerts", including cross-border; sample referral; activation of rapid response teams and mechanisms.

Source Name	Source Link
1. World Health Organization	https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON603
2. World Health Organization	https://www.who.int/news/item/22-05-2026-first-meeting-of-the-ihr-emergency-committee-regarding-the-epidemic-of-ebola-bundibugyo-virus-disease-in-the-democratic-republic-of-the-congo-and-uganda-2026-temporary-recommendations

Previous Operations

Has a similar event affected the same area(s) in the last 3 years?	**No**
Did it affect the same population group?	**No**
Did the National Society respond?	**No**
Did the National Society request funding form DREF for that event(s)	**No**
If yes, please specify which operation	-

If you have answered yes to all questions above, justify why the use of DREF for a recurrent event, or how this event should not be considered recurrent:

-

Lessons learned:

The previous readiness operations and epidemic response have been instrumental in building SSRCS ways of working, the positioning of the NS against other actors and build some experience on epidemic context. All these improvements will be leveraged to implement this DREF.

In another hand, SSRC lessons learned from previous epidemic preparedness and response operations have help NS to define critical factors for effective prevention and readiness. Include the community engagement, a strong in-country and cross-border coordination etc. One of the most important elements in epidemic response readiness was also the need for early prepositioning of both human resources and critical equipment and supplies to ensure a seamless and swift response should an outbreak be confirmed in country- in this case BVD.

Did you complete the Child Safeguarding Risk Analysis in previous operations, what was risk level?	No

Current National Society Actions

Start date of National Society actions

15-05-2026

Health	South Sudan Red Cross has activated its volunteer network activities in the eight high-risk border locations of Nimule, Kajokeji, Kaya, Bazi (Morobo), Yei, Juba (JIA), Maridi, Yambio (Nabiapai) to support early detection and community preparedness for Bundibugyo Virus Disease. A total of 240 branch volunteers, 30 volunteers in each of the priority locations have been oriented on Ebola and given an overview on the ongoinng outbreak in DRC and Uganda. The orientation sessions focused on Ebola Virus Disease causative strains, modes of transmission, the key signs and symptoms of the disease, prevention measures and establishment of community referral pathways for suspects in the community. The sessions also integrated BVD relevant risk communication and community engagement and community-based surveillance orientation to the mobilized volunteers, who are expected to integrate these 2 interventions into ongoing community health activities. Currently, the National Ministry of Health (MOH) Rapid Response Teams and South Sudan Red Cross (SSRC) are using the existing Boma Health Workers (BHWs) and SSRC volunteers and other existing community-health platforms to map high-risk Payams, informal border crossings points along Uganda and DRC border, markets and health facilities where key community level BVD readiness and response activities will be prioritized once the DREF operation starts.
Community Engagement And Accountability	SSRC has activated its community-level feedback mechanism leveraging on presence of SSRC volunteers in all eight at-risk locations to capture community feedback on myths, fears and misconceptions reagrding EVD and to address these through targeted risk communication messaging in the affected areas through the trainined and deployed volunteers. SSRC continues to map existing health facilities for effective referral of suspected cases and strengthening reporting by community health workers and SSRC Community Based Surveillance (CBS) volunteers.
National Society Readiness	Existing capacities: SSRC has established experience in epidemic preparedness, readiness and response through previous Ebola Virus Disease and Marburg Virus Disease preparedness/readiness activities, ongoing cholera response, MPOX response and COVID-19 operations. As part of MVD readiness in February 2026, SSRC trained 4 SDB teams with participants drawn from the SSRC, the National Public Health Institute (NPHI), Ministry of Health (MOH), military hospitals, and regional health authorities. During the same readiness operation, the SSRC drafted an SDB SOP that is yet to be officially endorsed and signed by the MOH, but good enough to be a reference to guide SDB work should there be a confirmed BVD outbreak in country.

	Additionally, in the last year, SSRC has implemented Preparedness for Pandemic Response (PREPARE) activities in the areas sharing a border with Uganda with interventions geared towards strengthening the capacity of community level health workforce (RC volunteers and BHWs) in appropriate Risk Communication and Community Engagement (RCCE) messaging for infectious diseases, early detection of health threats in cross border zones and their timely reporting, as well as construction and equipping of the Nimule Sub Branch to help support closer coordination with government health team manning the Nimule/Elegu border. SSRC also has 30 trainers for Epidemic Preparedness and response in Communities (EPiC), including community-based surveillance. The National Society has 250 staff with specialties in WASH, Health, Protection and Disaster Risk Management, and over 20,000 volunteers spread across the country through 21 branches and 102 units (subbranches). Eight (8) of these are situated at the DRC-Uganda-South Sudan cross border areas with staff and volunteers. The national society has 35 health national disaster response teams enabling rapid mobilization of community-level action when adequately resourced and guided. SSRC also maintains functional coordination links with the Ministry of Health and state authorities, participates in national emergency coordination platforms, and has activated its branch network in Central Equatoria, Western Equatoria and Eastern Equatoria for the current Ebola outbreak readiness and response.
Assessment	No BVD specific rapid needs assessment has been conducted by SSRC in yet. There are currently no confirmed or suspected BVD cases in the country and the operation is framed as readiness in anticipation of a potential spillover event across the border due to high population movement occasioned by armed conflict in Eastern DRC, for trade, family and cultural ties. However, SSRC and health authorities are already using existing assessments and routine data from previous epidemic in the eight target locations to inform risk analysis, identify vulnerable groups, and prioritize high-risk Payams, health facilities, markets and border crossing points for readiness actions. SSRC is currently planning with the MOH and partners, to conduct a rapid needs assessment to gather essential information on transmission predisposition and vulnerabilities, health care service delivery status of cross border health facilities, WASH and IPC gaps, population movement patterns and community perceptions on BVD outbreak in neighboring countries. This data will be used to refine targeting and adjust the preparedness and response activities should cases be confirmed in South Sudan.
Resource Mobilization	Financial resources: The National Society is seeking a readiness DREF to cover core preparedness and early response costs, including RCCE and CBS trainings, pre-positioning of relevant PPE and SDB kits, deployment and supervision of volunteers, WASH/IPC prepositioning and NS coordination and PMER capacities. SSRC is reaching out to other in country PNSs to support other activities. Human resources, fundraising and partnerships: SSRC plans to dedicate and, where necessary, assign key staff (health/PHiE focal point, RCCE/CEA officer, WASH officer, PMER and finance/logistics staff, and county-level coordinators) to manage and supervise the BVD readiness operation. The DREF will complement bilateral partner support, while SSRC and IFRC will continue engaging partners and technical agencies (WHO, UNICEF, Africa CDC and others) to mobilize additional funding and technical support in case of transition to response.
Activation Of Contingency Plans	South Sudan Red Cross does not have EVD contingency plans and is heavily relying on the scenarios developed by the Health Cluster led by the MOH and WHO: Scenario 1 – No cases, high regional risk: If South Sudan continues to record no suspected or confirmed EVD cases but DRC and

	Uganda outbreak persists, SSRC will maintain heightened preparedness in Nimule, Juba, Marid, Yambio, Yei, Bazi, Kaya and kajokeji. Actions include continuous CBS and event-based surveillance, targeted RCCE and community dialogues, pre-positioning of PPE and SDB kits, readiness of ambulances and SDB teams, and regular coordination and information-sharing with MoH, PHEOC, WHO and partners. Scenario 2 – Imported case(s) with limited local transmission: If one or more suspected or confirmed BVD cases are detected in country, SSRC will move from readiness to response in affected areas. Steps include rapid deployment of trained volunteers and SDB teams, intensified CBS, reinforcement of IPC/WASH measures in designated health facilities, expanded RCCE and community feedback mechanism, and provision of MHPSS to affected families, health workers and volunteers. Scenario 3 – Sustained community transmission: If sustained local transmission occurs and cases spread beyond initial foci, SSRC will scale up multi-sectoral response in coordination with MoH and partners and request additional resources beyond the initial DREF. The plan foresees expanding CBS and RCCE coverage, increasing SDB and WASH/IPC capacity, strengthening surge staffing and logistics, and integrating BVD response into wider health and humanitarian operations in the affected states. In consultation with IFRC consider deploying an ERU to complement SSRC response.
National Society EOC	South Sudan Red Cross activated its Emergency Operations Centre (EOC) structure to coordinate BVD readiness and any potential response, in close alignment with the national PHEOC. EOC role and functions: When the BVD threat level is elevated, SSRC will activate its Emergency Operations Centre and assign thematic leads in (Health/PHiE, WASH, RCCE/CEA, PGI, Logistics, Finance/Administration, PMER and Security). The Emergency Operation team shall consolidate information from Nimule, Juba, Marid, Yambio, Yei, Bazi, Kaya and Kajokeji, managing tasking of volunteers and staff, and align SSRC response plan and actions with those of the Ministry of Health, Public Health Emergency Operation Centre (PHEOC), World Health Organisation (WHO) and other partners. Through the EOC, SSRC will oversee allocation and tracking of financial, material and human resources, including deployment of trained volunteers, distribution of PPE, SDB and WASH/IPC supplies, and support to ambulances and field teams. The EOC will also receive and analyse CBS alerts, situation reports and community feedback from the four counties, produce regular internal and external situation updates, and recommend adjustment of operation and escalation (or de-escalation) of activities based on the evolving risk and caseload.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC Juba Country Cluster Delegation for Uganda, Tanzania and South Sudan is based in Juba, South Sudan with technical staff providing technical support to SSRCstaff supporting the operations across the different operations (Programs, Finance, Administration, HR and Security). The cluster also facilitates coordination among movement partners and ICRC. The Cluster Public Health Delegate has been working with SSRC in monitoring the BVD outbreak situation in the region, and is supporting technically with the BVD readiness DREF application. The Finance Delegate is supporting SSRC with the DREF budgeting process, while the Head of Delegation has been instrumental in supporting internal and external coordination mechanisms in

	close coordination with the SRRC SG, ICRC country rep and country reps of PNSs in country.
Participating National Societies	There are currently seven Partner National Societies (Swedish RC, Danish RC, Netherlands RC, Swiss RC, German RC, Finnish RC, Norwegian RC) in addition to ICRC in South Sudan. They support activities in different programmatic areas of health, WASH, Protection and Disaster risk Management and security. Specific for this current outbreak readiness, the Swedish Red Cross has availed USD 50,000 and the Finnish Red Cross has contributed Euros 100,000 to support the NS to preposition.

ICRC Actions Related To The Current Event

ICRC has a delegation in the country that is working closely with the national society in health, protection, WASH, security and Disaster risk management. Under these preparedness activities, ICRC has not provided any support for the activities.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	National coordination and surveillance: The Ministry of Health has reactivated the National Public Health Emergency Operation Center (PHEOC) in Juba to coordinate preparedness and readiness, strengthen surveillance, and conduct continuous risk assessment at national and state levels. Rapid response teams have been deployed to high-risk locations bordering DRC and Uganda and along key movement corridors, including Nimule, Juba, Marid, Yambio, Yei, Bazi, Kaya and Kajokeji, to enhance event-based surveillance and early reporting. Border and community measures: Authorities have intensified screening and monitoring at formal border points with DRC and Uganda, advising health facilities and local governments in high-risk areas to be on high alert for suspected BVD cases. The Ministry of Health has issued public advisories, activated a toll-free hotline, and urged communities to promptly report symptoms consistent with viral hemorrhagic fevers for follow up. Regional and international engagement: South Sudan government has participated in regional coordination efforts convened by IGAD and Africa CDC, sharing information and aligning national preparedness and readiness measures with neighboring countries. These engagements aim to strengthen cross border early warning, laboratory readiness, infection prevention and control, and risk communication and community engagement in light of the outbreak in DRC and Uganda.
UN or other actors	WHO is working with the Ministry of Health to reinforce outbreak readiness systems, including support to rapid response teams, prepositioning of essential medical supplies, and training of health workers and community level cadres on viral haemorrhagic fever detection, case management, and IPC at different levels of the health system.

UNICEF and other humanitarian partners are using existing health, WASH and RCCE platforms to help disseminate public information on EVD, integrate key messages into ongoing community programmes, and maintain essential services in high-risk and border areas.
IGAD, through its PREPARE project, has convened high level regional coordination on the Ebola outbreak in DRC and Uganda and is working with South Sudan and other member states to strengthen cross border early warning, points-of-entry preparedness, laboratory capacity, and harmonised risk communication messaging. Africa CDC has engaged South Sudan's health authorities as part of regional efforts to support preparedness in countries neighbouring the outbreak area, including technical guidance and potential surge support for surveillance and response.

Are there major coordination mechanism in place?

Public Health Emergency Operations Center (PHEOC)
The national PHEOC in Juba serves as the central hub for coordinating preparedness and response to public health emergencies, including VHFs and other epidemics. It brings together government departments, UN agencies, NGOs and technical partners to manage incident command, analyse surveillance data, oversee logistics and resource allocation, and ensure timely risk communication in line with International Health Regulations and IDSR.

National and state task forces, IDSR and EWARS
A National Task Force (NTF) on epidemic preparedness and response, supported by technical working groups, meets regularly to guide policy, review risk, and coordinate multi-sectoral actions. At state and county levels, State Task Forces and rapid response teams work with surveillance officers to implement Integrated Disease Surveillance and Response (IDSR), including electronic EWARS reporting from health facilities, community and event-based surveillance, and cross-border monitoring for priority diseases.

SSRCS integration to borader coordination in place and RCRC coordination
SSRC is working in close coordination with the Ministry of Health and other partners at national level. SSRC is also coordinating its activities with other partners through active participation at the national steering committee meetings that bring together all partners and line ministries on weekly basis (on Thursdays) to discuss preparedness and response activities which now include VHF preparedness. SSRC also continue to coordinate its activities through the national society emergency operation center which consolidates all preparedness activities to guide decision making at management level. Other forums include the RCRC partners monthly Movement Operation Coordination (MOC) where all ongoing preparedness activities are presented. At the field level, SSRC through the branches is working closely with county health departments, state ministry of health, and other partners and this will be enhanced during the implementation of these DREF activities.

Needs (Gaps) Identified

Health

1. Insufficient Community-Based Surveillance (CBS) Capacity for Early Detection in the targeted areas
The identified high-risk border counties in South Sudan lack an adequate number of trained Community-Based Surveillance (CBS) volunteers to support early detection, alert generation, and referral of suspected BVD cases. CBS functionality at prioritized high-risk border points and community entry routes remains limited, increasing the risk of delayed detection, under-reporting, and onward transmission.

2. Limited Trained Human Resources on EPiC for BVD readiness in the targeted areas
There is a limited pool of SSRC volunteers and Community Health workers trained in the Epidemic Preparedness and Response in Communities (EPiC) module in the targeted areas. This constrains community-level preparedness and response to BVD and other Viral Hemorrhagic Fevers (VHFs), particularly in border and hard-to-reach areas, including the 8 priority locations for BVD readiness. Strengthened capacity building is required to enhance prevention, detection, and response at the community level.

3. Inadequate Risk Communication and Community Engagement (RCCE) Coverage in targeted areas
Border communities have insufficient knowledge of BVD symptoms, transmission risks, and the importance of early reporting. Existing SSRC RCCE teams are not sufficiently trained or systematically integrated into CBS structures, reducing the effectiveness of community

sensitization, rumor tracking, and timely behavior change. Targeted and intensified RCCE interventions linked to CBS are therefore required.

4. Limited Access to Safe Water and WASH Services in targeted areas
High-risk border communities face limited access to safe water and adequate WASH services, increasing vulnerability to disease transmission and undermining infection prevention and control (IPC) measures during suspected or confirmed BVD events.

Water, Sanitation And Hygiene

South Sudan continues to face significant WASH challenges, with large portions of the population lacking reliable access to safe water and adequate sanitation, particularly in rural and hard-to-reach areas where communities often rely on unsafe surface water or poorly maintained water points. Chronic shortages of soap, safe water storage containers, and functional handwashing facilities limit the adoption of basic hygiene practices, including proper hand-washing technique for disease prevention including for BVD. These gaps are further exacerbated in overcrowded IDP camps and transit sites for returnees and refugees, where WASH services are overstretched, undermining infection prevention and control and heightening vulnerability to epidemic-prone pathogens such as Ebola Virus Disease.

At both facility and community levels, chronic water shortages, poor sanitation, and weak healthcare waste management undermine effective IPC. Health facilities lack reliable water supply, storage, and backup systems needed to sustain intensive care and isolation for suspected BVD cases. Inadequate healthcare waste management, including lack of color-coded bins, sharps containers, biohazard bags, and functional incinerators, combined with training gaps among cleaners and frontline staff, increases occupational and community transmission risks.

Protection, Gender And Inclusion

Protection, Gender and Inclusion (PGI) interventions are critical to ensure that prevention, surveillance, and response efforts are safe, equitable, and accessible in remote and hard-to-reach communities. Protection actors will work with community leaders, women's groups, youth, and persons with disabilities to identify and address gender- and protection-related risks, including stigma, discrimination, fear of isolation, and barriers to accessing health services, particularly for women, girls, and mobile populations.

Community-based awareness and feedback mechanisms will be strengthened to promote dignity, informed consent, and culturally appropriate messaging, while safeguarding measures will be integrated into all preparedness activities to prevent exploitation, abuse, and neglect. In remote border areas where formal services are limited, protection teams will play a crucial role in connecting communities to available referral pathways, fostering social cohesion across borders, and ensuring that disease preparedness measures do not exacerbate existing vulnerabilities or inequalities.

Community Engagement And Accountability

Effective BVD preparedness along the South Sudan–DRC/Uganda border requires strong, trust-based community engagement to ensure early detection, acceptance of preventive measures and timely care-seeking in remote and mobile populations. Communities need clear, consistent and culturally appropriate information delivered through trusted local channels to address fears, rumors and stigma associated with viral hemorrhagic diseases. Engagement efforts should recognize cross-border movement, traditional practices related to caregiving and burial, and low access to formal services, while creating safe spaces for dialogue and feedback. Meaningful community participation is essential to build ownership, promote behavior change, and ensure preparedness measures are understood, accepted and sustained without exacerbating fear or exclusion.

Any identified gaps/limitations in the assessment

N/A

Operational Strategy

Overall objective of the operation

The main objective of this BVD outbreak readiness DREF is to strengthen preparedness and readiness at SSRC by prepositioning Safe and Dignified Burial (SDB) kits, support participation of the NS in key BVD outbreak coordination mechanisms at national and sub national level, support the NS to complement MOH's BVD risk communication messaging through radio platforms and printing of IEC materials for distribution in target cross border areas using the already existing branch capacity, support branch and HQ capacity strengthening and in the end conduct a lessons learned workshop to review the DREF implementation experience for learning and future planning.

Operation strategy rationale

For this BVD readiness operation, the South Sudan Red Cross will build up on experiences, lessons learnt and capacities created from previous Viral Hemorrhagic Fevers' preparedness and readiness work, the last one being in January to February this year following the Marburg Virus Disease outbreak in Ethiopia.

Through the MVD readiness DREF operation, SSRC was able to achieve the following capacities that the NS is leveraging on for this current outbreak:
1) Trained 4 SDB teams compromising of government and SSRC participants. One team is prepositioned in Juba, while the other 3 are prepositioned in the Eastern region of the country bordering Ethiopia. Although SSRC was able to train SDB teams, the NS was not able to procure prepositioning SDB kits due to long procurement lead time that was exceeding the operation timeframe during the 2 months of MVD readiness DREF operation.
2) Developed a draft SSRC SDB SOP in collaboration with the national MOH. SSRC is leveraging on available resources for BVD readiness through the Swedish Red Cross to convene a validation meeting of the SOP with the MOH.
3) 135 volunteers in the Eastern region of the country were trained in EPiC and CBS.

SSRC has already reactivated its disaster response mechanisms and proposes to leverage on the resources of this readiness DREF to preposition key BVD outbreak response resources in anticipation of an eventual BVD spillover event from either DRC or Uganda. This prepositioning will include:

1. Produce and disseminate BVD radio jingles and IEC materials
SSRC will leverage on the use of radio messaging for mass reach of cross border communities in the priority areas and indeed across the country with BVD messaging. This will be complemented by the distribution of printed IEC materials through the SSRC branches in affected areas to reach populations that might not have access to radio. The IEC materials will target high volume population centers such as markets, border crossing points, schools, churches among others.

2. Procurement of SDB training kits
Through previous preparedness and readiness work of SSRC in VHF outbreaks, the MOH has recognized its capacity and mandated the NS to take lead in SDB work in country. With this responsibility and mandate, SSRC will procure 4 SDB training kits for prepositioning for rapid training of 8 SDB teams in the 8-priority cross border counties in the event of a confirmed BVD outbreak in country. The affected cross border regions are hard to reach due to poor infrastructure and insecurity, thus the need to train at least 1 SDB team per location should the outbreak be confirmed in South Sudan.

Additionally, SSRC will procure 2 SDB starter kits and 2 SDB replenishment kits to preposition for conducting burials should the BVD outbreak be confirmed in country. These kits will be sufficient to support initial response, and top up request shall be made based on the evolution of the outbreak.

3. Support for coordination and partnerships
SSRC is a key member of the health cluster in South Sudan. SSRC is taking part in the national BVD outbreak coordination meetings and seeks to expand this participation into the frontline States, as well as in the 8 targeted cross border counties, while contributing to the logistical support oof setting up this sub national coordination platforms alongside other partners.

Targeting Strategy

Targeting Strategy Supporting Document

Who will be targeted through this operation?

The intervention prioritizes locations along or near the DRC and Uganda borders (Nimule, Juba, Kaya, Yei, Morobo, Bazi, Maridi, Yambio) that have been identified by the Ministry of Health as high risk for BVD due to intense cross border movement for trade, pastoralism, family and cultural ties.

These locations—already characterized by weak health and WASH services—are further strained by the presence of displaced populations and returnees due to armed conflict, increasing the likelihood of exposure and rapid transmission in the event of a viral hemorrhagic fever introduction. Targeting these areas and populations aims to reduce outbreak risk while addressing heightened health, protection, and information gaps among the most vulnerable groups.

Targeting criteria
- Locations along or near the DRC and Uganda borders identified as high risk for BVD (Nimule, Juba, Kaya, Yei, Morobo(Bazi), Maridi, Yambio).
- Areas with high levels of cross-border movement in the 8 priority cross border areas.
- Locations with weak health and WASH service coverage within these 8 target locations.
- Border and host communities with frequent contact with travelers and traders.
- IDPs, returnees, and refugees in border and transit areas living in congested settings with limited access to health care, WASH, and reliable information.

Explain the selection criteria for the targeted population

The operation target cross border communities living in cross border areas along the South Sudan-Uganda, and South Sudan-DRC borders. These frontline communities are at a higher risk of exposure to BVD spillover events from the2 neighboring countries due to high cross border population movement through formal and informal `borders. The operation targets the entire population in these areas with targeted BVD messages through radio and printed IEC materials.

Total Targeted Population

Women	**119,850**	Rural	**0.9%**
Girls (under 18)	**140,000**	Urban	**0.1%**
Men	**115,150**	People with disabilities (estimated)	**0.2%**
Boys (under 18)	**125,000**		
Total targeted population	500,000		

Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	**Yes**
Does your National Society have prevention of sexual exploitation and abuse policy?	**Yes**

Does your National Society have child protection/child safeguarding policy?	**Yes**
Does your National Society have whistleblower protection policy?	**Yes**
Does your National Society have anti-sexual harassment policy?	**Yes**

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

Risk	Mitigation action
1. Insecurity and access constraints Armed violence, intercommunal clashes and criminality can disrupt access to high-risk border counties, delay deployment of teams, and endanger staff and volunteers. This could slow implementation of CBS, RCCE and WASH/IPC activities, force suspensions or rerouting, and increase operational costs for security measures and alternative transport.	Work through local SSRC branches and volunteers from target locations who can operate safely when national staff movement is restricted, and coordinate closely with local authorities and community leaders on timing and routes. Apply strict security SOPs, use remote support (phone/online coaching, radio RCCE, pre-positioned supplies) when field access is limited, and integrate security costs (secure transport, communications) into the budget as contingency.
2. Flooding and climatic shocks Seasonal flooding regularly damages roads, airstrips and health facilities, especially in Yambio and parts of Western Equatoria, cutting off communities and humanitarian supply routes. Such disruptions could delay pre-positioning of PPE and SDB kits, limit supervision and monitoring visits, and compress timelines into shorter windows when physical access is possible.	Pre-position PPE, WASH and IPC supplies in branch warehouses and health facilities before peak rainy seasons, and use diversified transport options (boats, motorbikes, air where available) for last-mile delivery. Build flexible implementation plans with seasonal access mapping, allowing activities to be advanced or shifted between locations depending on flood conditions, with a small contingency for emergency air or river transport if critical gaps emerge.
3. Weak health system and parallel outbreaks The health system is fragile, under-funded and already strained by other epidemics (e.g., cholera) and high routine caseloads. Limited human resources, laboratory capacity and supplies mean that a EVD alert or confirmed case could overwhelm facilities, divert staff from preparedness tasks, and slow investigation and confirmation, undermining early-action objectives.	Focus Red Cross support on community-level functions (CBS, RCCE, basic MHPSS, SDB and WASH/IPC around facilities) that complement, rather than duplicate MoH services, and provide targeted training and supplies to relieve pressure on facilities. Coordinate closely with MoH, WHO and partners to align with existing outbreak responses (e.g., cholera), share RRT capacity, and activate surge technical support if concurrent outbreaks threaten to derail Marburg preparedness activities
4. Community mistrust, rumours and low risk perception High levels of misinformation and limited prior exposure to EVD can lead to denial, stigma, resistance to contact tracing and rejection of SDB, especially where authorities and aid actors are viewed with suspicion. This could reduce uptake of preventive behaviours, hinder safe isolation and burial, and force repeated engagement efforts, stretching RCCE and CEA resources and potentially extending the operation's duration.	Use a strong CEA approach with trusted local volunteers and leaders, two-way feedback channels (hotlines, help-desks, social listening) and tailored messaging that explains EVD, addresses fears around SDB, and emphasises respect for cultural practices. Regularly analyse rumours and community feedback to adapt messages and engagement methods, engaging women's, youth and religious networks to co-design solutions and build acceptance before any potential cases occur.
5. Funding shortfalls and competing crises Multiple concurrent crises (conflict spillover from Sudan, displacement, food insecurity and floods) create intense competition for limited humanitarian funding. Insufficient or delayed resources could limit the scale of preparedness activities, reduce volunteer incentives and logistics capacity, and necessitate re-prioritisation of targets, thereby constraining achievement of coverage and readiness indicators.	Phase activities so that the most critical, high-impact preparedness actions (training, CBS tools, key pre-positioning, core RCCE) are implemented early, while actively engaging donors and Movement partners for complementary funding. Include a modest, clearly justified contingency line (e.g., 5–10 per cent) for unforeseen costs linked to access constraints or scale-up, and prepare a readiness plan for rapid revision of

	targets and budget should additional resources become available or significant funding gaps arise.
Delayed implementation, program and financial reporting	The IFRC DM Delegate who is the budget holder for the operation shall provide oversight on the DREF implementation and in country monitoring with support from the regional PMER. In country CCD finance team shall provide oversight on financial reporting in line with the approved risk mitigation measures. For MVD readiness DREF, the narrative report has been shared and reviewed by the regional PMER, and currently the IFRC team is following up with SSRC on the financial report.

Please indicate any security and safety concerns for this operation:

Operations in the high-risk border counties of South Sudan face significant security and safety threats that could affect personnel, volunteers and communities.
Security concerns in target areas

The targeted locations (e.g.,Kaya, Morobo(Bazi), Yei, Yambio) are affected by In-Opposition government control areas, and criminality, leading to periodic displacement, road ambushes and attacks on civilians and aid workers. Humanitarian access snapshots report frequent incidents involving violence against staff, compounds and supplies, as well as movement restrictions, which can disrupt field missions and expose teams to elevated security risks.

Safety risks for staff, volunteers and communities
Teams operate in remote areas with poor roads, flooding, and limited communications, increasing the risk of traffic accidents, river-crossing incidents and delayed medical evacuation. Health risks include exposure to EVD or other VHFs if IPC and PPE are inadequate, plus high background burdens of malaria, malnutrition and other diseases that can affect both responders and already-vulnerable communities.
Required security protocols and measures

The operation will follow national and partner security frameworks, including context-specific security risk assessments, movement clearance procedures, curfew and route restrictions, and mandatory security briefings for all staff and volunteers. Infection-prevention protocols (training on VHF case definition, safe sample handling, PPE use, safe and dignified burials) will be strictly enforced, alongside buddy systems, communication and tracking of field teams, and contingency plans for hibernation, relocation or evacuation if the security situation deteriorates.

Has the child safeguarding risk analysis assessment been completed?	No

Planned Intervention

Health

Budget: CHF 40,552
Targeted Persons: 500,000

Indicators

Title	Target

# of SDB training kits procured	4
# of SDB starter kits procured	2
# of IEC materials produced and disseminated	250
# of BVD audio jingles produced aired on radio and other platforms	2

Priority Actions

1. Safe and Dignified Burials (SDB)
• Procure 4 SDB training kit for SDB training.
• Procure 2 SDB starter kits.
• Procure 2 SDB replenishment kits.

2. Risk Communication and Community Engagement
• Produce and disseminate BVD IEC materials
• Produce and air BVD jingles on radio• • • -

Coordination And Partnerships

Budget: CHF 4,238
Targeted Persons: -

Indicators

Title	Target
# of weekly BVD outbreak readiness and response coordination meeting attended by SSRC teams	8
# of program documentaries done	1

Priority Actions

SSRC participation in weekly BVD outbreak readiness and response coordination meetings both at national and sub national levels

Program documentation for internal and external communication

Secretariat Services

Budget: CHF 1,695
Targeted Persons: -

Indicators

Title	Target
# of financial spot checks conducted	1

Priority Actions

Conduct financial spot checks

National Society Strengthening

Budget: CHF 2,409
Targeted Persons: -

Indicators

Title	Target
# of lessons learned workshops conducted	1
# of program monthly reports submitted in time	2
# of final DREF report (narrative and finacial) submitted in time	1

Priority Actions

Conduct a lessons learned workshop
Compile and submit in time one monthly progress report for first month of implementation
Compile and submit in time final DREF report (narrative and financial)

About Support Services

How many staff and volunteers will be involved in this operation. Briefly describe their role.

An NDRT officer (BVD readiness/response focal person) will be directly engaged to oversee this DREF operation backed by the health manager and other relevant technical, finance and logistics staff at SSRC.

Does your volunteer team reflect the gender, age, and cultural diversity of the people you're helping? What gaps exist in your volunteer team's gender, age, or cultural diversity, and how are you addressing them to ensure inclusive and appropriate support?

SSRC's 17,000+ volunteers are drawn from all major ethnic, linguistic and religious groups, and volunteerism is formally open to everyone regardless of sex, tribe, clan or social status, which supports strong cultural representation in most branches. Youth are well represented through branch youth committees and a National Youth Council, and women already constitute a substantial proportion of active volunteers, especially in health, WASH and PGI activities.

Gaps and how they are being addressed:
Despite this, men still outnumber women overall, and female leadership and representation of older persons and persons with disabilities remain comparatively low in some branches, particularly in conservative or remote areas. To reduce these gaps, SSRC is:
• Setting branch-level targets to increase female, youth and disability representation in new volunteer recruitment and in community-health and RCCE teams.

• Prioritizing women and young people for team-leader roles and including PGI, SGBV and child-safeguarding content in all volunteer trainings to promote inclusive practice.
• Working with community leaders to identify trusted volunteers from under-represented Ethnic groups and vulnerable categories (e.g., people with disabilities), so that Marburg-related messaging and support are culturally appropriate and accessible to all.

Will surge personnel be deployed? If yes, please provide the role profile needed.

Yes
SRRC will need surge support in the event of a confirmed outbreak. The proposed profiles include:

1. Operations coordinator to support coordination, resource mobilization, ERP etc. Recommend standby activation.
2. Public Health in Emergencies (PHiE) coordinator to help with health technical pieces. Recommend immediate activation with possibility of combined PhiE-SDB profile in readiness phase.
3. Safe and Dignified Burials (SDB) coordinator. SDB is a major intervention for SSRC, and although SSRC has a dedicated SDB focal person, he has not been involved in a response- only preparedness and readiness, thus the need for an experienced SDB coordinator to support. Recommend standby activation

If there is procurement, will it be done by National Society or IFRC?

The proposed SDB kits procurement shall be handled by the IFRC, while SSRC will undertake the procurement of IPC supplies, radio jingles and BVD IEC materials with support by the CCD senior procurement officer.

How will this operation be monitored?

The IFRC DM Delegate who is the budget holder for the operation shall provide oversight on the DREF implementation and in country monitoring with support from the regional PMER. In country CCD finance team shall provide oversight on financial reporting in line with the approved risk mitigation measures.

Please briefly explain the National Societies communication strategy for this operation

Internal and external channels
Internally, SSRC will use email, WhatsApp/phone groups, regular coordination calls and situation reports to share updates between HQ, branches and field teams, following existing information-management and incident-management arrangements. Externally, information will flow through coordination forums (MoH PHEOC, Health and WASH clusters), partner briefings, and bilateral updates to Movement partners and donors.

Communication with communities and accountability
Risk communication and community engagement (RCCE) will rely on community meetings, local FM radio, mobile loudspeaker campaigns, religious and traditional leaders, and printed or pictorial IEC materials in local languages. SSRC will strengthen Community Engagement and Accountability (CEA) by using hotlines, suggestion boxes, face-to-face feedback during outreach, and community feedback forms, with systematic logging, analysis and response to concerns in programme adaptations and messages.

Media and public communication strategy
SSRC already uses its website and social media (e.g., X/Twitter, Facebook) and will issue timely press releases, radio interviews and social media updates on Marburg preparedness, ensuring messages are coordinated with MoH and IFRC and respect “do no harm” and data-protection principles. A brand and perception study has recommended increasing social-media presence and consistent key messages, which will inform this operation’s external communication plan.

IFRC communication support
IFRC will support SSRC through its country/cluster and regional communications teams, helping to develop key messages, human-interest stories, fact sheets and visibility materials aligned with Movement standards. IFRC communications and PMER staff will also assist with media engagement, approvals and risk-sensitive messaging, and will amplify SSRC content on IFRC global channels to support advocacy and resource mobilisation.

Budget Overview

IFRC

DREF OPERATION

MDRSS019 - South Sudan Red Cross Society
BVD Outbreak Readiness

Operating Budget

Planned Operations	**40,552**
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	40,552
Water, Sanitation & Hygiene	0
Protection, Gender and Inclusion	0
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	0
Environmental Sustainability	0
Enabling Approaches	**8,258**
Coordination and Partnerships	4,238
Secretariat Services	1,695
National Society Strengthening	2,324
TOTAL BUDGET	**48,810**

all amounts in Swiss Francs (CHF)

Internal 6/1/2026 #V2022.01

[Click here to download the budget file]

Contact Information

For further information, specifically related to this operation please contact:

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Click here for the reference