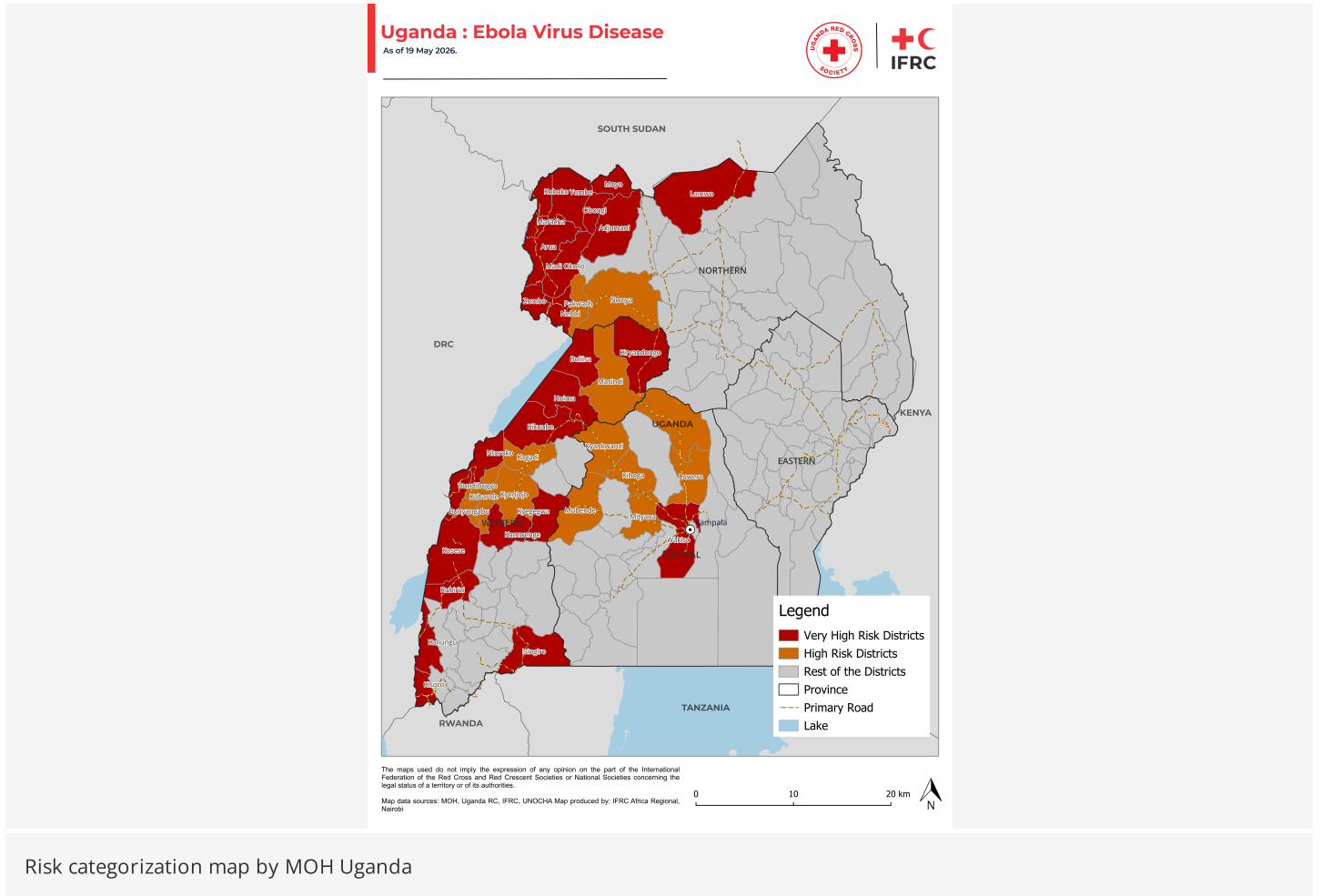




Adam, a URCS volunteer conducting a community session on Ebola

| | | | |
|--|--|---|---|
| Appeal: MDRUG058 | Total DREF Allocation: CHF 750,000 | Crisis Category: Orange | Hazard: Epidemic |
| Glide Number: EP-2026-000071-COD | People Affected: 4,200,000 people | People Targeted: 650,000 people | |
| Event Onset: Sudden | Operation Start Date: 23-05-2026 | New Operational End Date: 30-11-2026 | Total Operating Timeframe: 6 months |
| Reporting Timeframe Start Date: 15-05-2026 | | Reporting Timeframe End Date: 02-06-2026 | |
| Additional Allocation Requested: 228,927 | | Targeted Regions: Central Region, Northern Region, Western Region | |

Description of the Event



Date of event

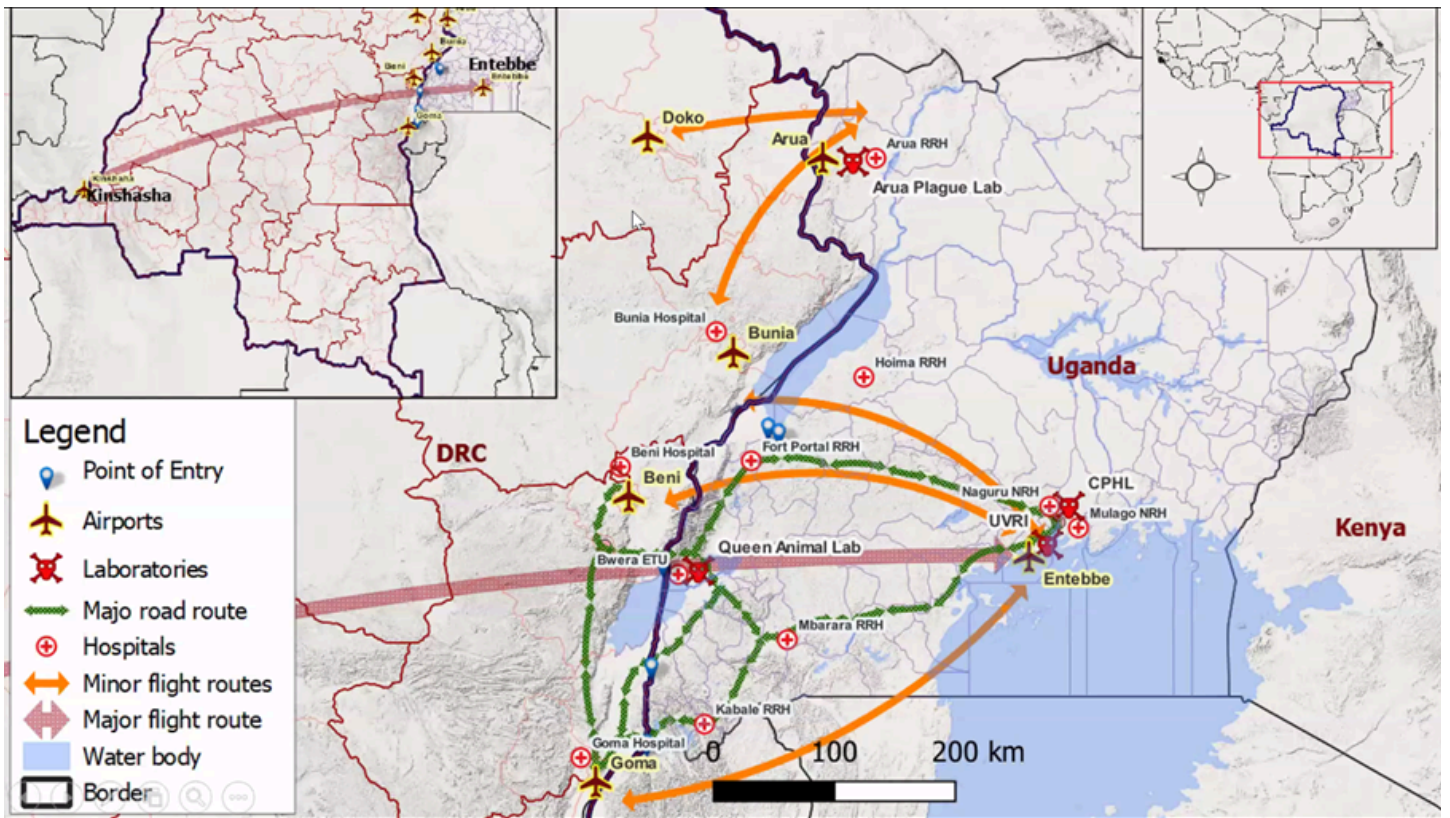
15-05-2026

What happened, where and when?

An outbreak of Bundibugyo Ebola Virus Disease (BUVD) was declared by the Uganda Ministry of Health on 15 May 2026. The outbreak is located in Uganda, primarily linked to Kampala (Kibuli Hospital) and involving cases connected to cross-border transmission with the Democratic Republic of Congo (DRC). The index case was a 59-year-old male from DRC who sought medical care in Kampala and died on the same day; his case is epidemiologically linked to an ongoing outbreak in DRC. As of 2 June 2026 (reporting date), a total of eleven confirmed cases, one probable case and one confirmed death have been identified, with no new cases reported in the previous 24 hours.

The evolving cross-border outbreak dynamics between DRC and Uganda led to the launch of the IFRC Regional Emergency Appeal (MDRS1007). This DREF operation contributes to the implementation of that regional response in Uganda.





Uganda/DRC population movement mapping by Uganda MOH

Scope and Scale

As of 2 June 2026, Uganda continues to respond to an outbreak of Bundibugyo Ebola Virus Disease (BUVD) first declared on 15 May 2026. The outbreak is epidemiologically linked to ongoing transmission in the Democratic Republic of Congo (DRC), with the index case identified as a 59-year-old DRC national who sought care in Kampala and died on the same day.

As of 2 June 2026 (reporting date), a total of eleven confirmed cases, one probable case and one confirmed death have been identified, with no new cases reported in the previous 24 hours. Six cases are Ugandans and five cases DRC nationals. Surveillance and contact tracing efforts remain extensive. A total of 580 cumulative contacts have been identified, with 518 currently under active follow-up. However, the overall follow-up rate in the last 24 hours was 59%.

Response coordination continues at the highest levels, with national task force meetings chaired by senior government leadership and regular incident management meetings ensuring alignment across all response pillars. Engagements with private healthcare providers and public communications are ongoing to strengthen surveillance, infection prevention, and control measures. Temporary movement restrictions have been implemented along the Uganda–DRC border to limit cross-border transmission, with enforcement support from security forces.

Surveillance activities report steady alert generation and response, with seven alerts investigated and one evacuation conducted in the past 24 hours. Point-of-entry screening remains robust, with over 5,855 travelers screened and no alerts detected among them. Community-based surveillance and sensitization efforts continue to expand, including home visits, referrals, and awareness campaigns.

Laboratory capacity remains functional with a cumulative total of 327 tests conducted across multiple laboratories in 55 Districts. Ongoing training and preparedness activities are strengthening laboratory response capacity, including proper use of personal protective equipment and outbreak response planning.

Case management services are active, with 21 suspect cases currently admitted at the Mulago Ebola Isolation Unit and a cumulative total of 50 admissions. Emergency medical services facilitated the evacuation of one contact and one suspected case. Infection prevention and control measures continue to be reinforced across healthcare facilities, with assessments and staff orientation ongoing.

Efforts to maintain continuity of essential health services are underway, particularly in the Kampala Metropolitan Area, where healthcare facility readiness is being assessed and supported. Mental health and psychosocial support services have assisted discharged patients and continue to provide support to those still admitted.



Logistics and supply chain operations are ongoing, with distribution of medical supplies to points of entry and high-risk districts. Resource mobilization efforts are active, supported by coordination among partners and updates to operational planning tools.

Risk communication and community engagement activities remain a priority, with widespread dissemination of prevention messaging through radio, film vans, and community outreach. Training of community health workers and local leaders is enhancing community-level awareness and early detection capacity.

Source Information

| Source Name | Source Link |
|-------------------------------|---|
| 1. MDRS1007 Regional EA | https://go.ifrc.org/emergencies/7937/reports |
| 2. MDRUG058 DREF initial plan | https://go-api.ifrc.org/api/DownloadFile/95031/MDRUG058do |

Summary of Changes

| | |
|---|-----|
| Are you changing the timeframe of the operation | No |
| Are you changing the operational strategy | No |
| Are you changing the target population of the operation | Yes |
| Are you changing the geographical location | No |
| Are you making changes to the budget | Yes |
| Are you requesting an additional allocation? | Yes |



Please explain the summary of changes and justification:

The update inform stakeholder on the scale-up of the IFRC-DREF allocation provided to Uganda as part of the Regional Emergency appeal MDRS1007 launched for the IFRC federation wide response to BVD outbreak now declared a PHIEC.

In response to the evolving outbreak situation, the DREF contribution to the EA is scaled up to ensure increase of the target population from 520,000 to 650,000 people, alongside a budget revision from CHF 521,073 to CHF 750,000 with an additional allocation to serve to expand NS interventions to the current scope of the outbreak.

While the overall operational strategy and geographic coverage remain unchanged, implementation has been intensified within existing high-risk districts, particularly in urban and cross-border areas. The scale-up prioritizes expanded surveillance and point-of-entry screening, strengthened risk communication and community engagement, and increased capacity for case management, emergency medical services, safe and dignified burials, and WASH/IPC interventions. These changes are driven by the shift from a single imported case to multiple confirmed cases with ongoing transmission and greater operational demands.

NS has already delivered noticeable contribution to ongoing efforts at country level. 3 weeks in the response, URCS thanks to the DREF allocation has deployed volunteers to support surveillance, RCCE, SDB, and EMS, alongside screening operations at multiple points of entry reaching over 10,000 people. Initial community sensitization activities have been launched, with strengthened coordination and active participation in national and district-level response mechanisms.

This scale-up reinforces IFRC- DREF 's support to ensure URCS can rapidly initiate and expand priority interventions in Uganda, in alignment with the IFRC Regional Emergency Appeal (MDRS1007). It enables early implementation of key response actions while contributing to the Federation-wide strategy for outbreak control and strengthening the National Society's contribution to regional containment efforts.

IFRC Network Actions Related To The Current Event

| | |
|---|---|
| Secretariat | <p>Currently, within the IFRC office in Kampala, the team consists of an Acting Head of Office, Finance Delegate, Public Health in Emergencies (PHiE) Delegate, Logistics Delegate, PMER Officer, Finance Officer, and Protocol Officer. In addition, regional support is provided through out posted positions, including a Regional WASH Coordinator and a Regional Community Health Coordinator. On 26 May, the staff health team conducted a briefing for the entire IFRC Juba Cluster team, and a similar session is scheduled for Uganda Red Cross Society (URCS) staff on Friday, 29 May.</p> <p>All DREF-supported actions are implemented within the Federation-wide approach of the Emergency Appeal, ensuring complementarity with regional operations in DRC and other at-risk countries, and alignment with the 'one plan, one team, one budget' principle. Other ongoing support to Uganda RC under the emergency appeal can be further provided within the EA documentation. See SOURCE.</p> |
| Participating National Societies | <p>URCS hosts national societies including Germany Red Cross, Netherlands Red Cross, Austrian Red Cross and Belgian Red Cross. PNS have been notified and briefed about the outbreak and following the events closely. Regular coordination meetings will be conducted to update partners and seek for support. At the point of this application, German Red Cross has expressed willingness to support the response operation.</p> |



ICRC Actions Related To The Current Event

ICRC Regional Delegation covering Uganda, Rwanda, Burundi, based in Uganda, Kampala has history of supporting the URCS in close coordination with the Federation in Ebola responses since year 2000 and investing in coordinated and complementary Movement response to Ebola outbreaks in Uganda and DRC. In the last outbreak in 2022, ICRC supported the URCS and the IFRC with provision of two vehicles for SDB (Safe and Dignified Burials), provision of SDB kits and Risk Communication and Community Engagement in the refugee settlements. In this response, as part of the Movement coordination mechanisms, led by the URCS, URCS reaches out to the ICRC and the Movement partners to mobilize and support the URCS Ebola response to the people in need.

Other Actors Actions Related To The Current Event

| | |
|--|---|
| Government has requested international assistance | Yes |
| National authorities | <p>The ministry of health activated the incident management team and dispatched rapid response teams at formal and informal points of entry along the Uganda-DRC border, especially along major transit routes and pilgrimage corridors. So far, a close relative of the index case has been isolated, and all line listed contacts are set to be quarantined.</p> <p>Authorities have activated strong containment measures, including:</p> <ul style="list-style-type: none">- Contact tracing and monitoring of identified contacts- Isolation and treatment of confirmed cases- Enhanced surveillance and screening, especially at borders- Public health messaging (hygiene, early reporting) [mediacentre.go.ug]- At least 100+ contacts were identified early and placed under monitoring/quarantine <p>The Ugandan government has temporarily suspended public transport to the Democratic Republic of Congo and restricted mass gatherings in border areas to limit the spread of Ebola. Passenger buses, ferries, and direct flights will be suspended for four weeks, while cargo trucks and food shipments will continue operating.</p> <p>Following this declaration, Africa CDC, working closely with WHO and partners, activated a joint Incident Management Support Team (IMST) to coordinate the response using a unified approach (one plan, one team, one budget, one monitoring framework). At the operational level, Africa CDC has been supporting countries including Uganda by deploying technical experts (epidemiology, laboratory, IPC, logistics and risk communication), strengthening surveillance and laboratory testing, and enhancing contact tracing and infection prevention measures, particularly in high-risk and border areas.</p> <p>Africa CDC has also taken a leading role in regional coordination, convening high-level ministerial meetings (including in Kampala on 22-23 May 2026) to align Uganda, DRC, South Sudan and partners around cross-border preparedness, harmonised measures, and continuity of essential services. In addition, the organisation has supported resource mobilisation at continental level, including helping drive a broader African response plan (estimated at over US\$300 million) and mobilising initial funding and supplies, such as diagnostics, therapeutics and IPC materials routed through its regional coordinating centres.</p> |



UN or other actors

At the regional and global level, WHO has played a central role in technical leadership and coordination, including declaring the outbreak a Public Health Emergency of International Concern on 17 May 2026 and supporting cross-border coordination among Uganda, DRC, and neighbouring countries.

The United Nations has mounted a coordinated, system-wide response to support the Government of Uganda in containing the BUVD outbreak. Under the leadership of the UN Resident Coordinator, UN agencies (including WHO, UNICEF, WFP, UNHCR, IOM and others) have activated a joint response, mobilising financial, technical and operational support. So far, the UN Country Team has repurposed several million US dollars (around US\$3.1–3.5 million) for immediate response activities and, on 27 May 2026, launched a US\$15.8 million emergency appeal to scale up interventions over a three-month period.

Are there major coordination mechanism in place?

The response is coordinated by the Ministry of Health National Task Force through the Public Health Emergency Operations Center using the incident management system that comprises of the national task force, response pillars and sub pillars system. The pillars for this response so far include Coordination, Surveillance, Risk Communication and Public Health Awareness, Logistics, Case Management, Community Engagement, Laboratory, Strategic Information, Research, WASH/IPC and Innovation.

Through its activities, URCS directly contributes to case management pillar through SDB and EMS services, Risk Communication and Community Engagement, Surveillance, Psychosocial support, WASH and Coordination. URCS will be involved in sector and pillar meetings to not only align the response activities with ministry action plan but also provide updates and feedback on actions being undertaken by the movement.

Needs (Gaps) Identified



Preliminary engagement with the Ministry of Health and frontline Red Cross teams has highlighted gaps across key response pillars, including risk communication and community engagement (RCCE), community-based surveillance, case management, infection prevention and control (IPC), safe and dignified burials, psychosocial support, and WASH.

Health facilities in high-risk border districts require strengthened capacity for screening, triage, isolation, case management, laboratory sample transport, and IPC infrastructure. At the community level, gaps in awareness and persistent misinformation, particularly in cross-border areas, refugee-hosting districts, and informal urban settlements, risk undermining early detection, reporting, and adherence to prevention measures. Safe burial capacity, psychosocial services, and surveillance systems also remain limited, as illustrated by the unsafe repatriation of the index case.

Operational and resource constraints continue to challenge the response. Stocks of essential supplies, including PPE, disinfectants, body bags, and hygiene materials, are limited, while funding gaps hinder rapid deployment of trained personnel, volunteer engagement, and repositioning of supplies in high-risk areas.

High cross-border population movement, insecurity in eastern DRC, and poor infrastructure in hard-to-reach locations complicate screening, contact tracing, and timely response. These challenges are further exacerbated by overcrowded settlements, mobile mining populations, and limited healthcare workforce and isolation capacity in some districts.

Coordination challenges are also anticipated, particularly in ensuring effective cross-border surveillance, data sharing, and alignment among multiple actors. The evolving nature of the outbreak requires stronger coordination between national and sub national authorities, partners, and communities to prevent duplication and gaps. Weak communication and information-sharing mechanisms in some border areas may delay timely reporting and hinder a fully synchronized response.

Specific gaps:

Case management including EMS, IPC, SDB and community WASH.

- Need for additional support in EMS in terms of capacity building of providers, additional equipment and human resources.



- Logistics for ambulance transfers including repairs, service and fuel.
- Airtime and data for EMS teams.
- Need for continuity of essential services.
- Need to setup and/or operationalize ambulance and SDB bases with functional decontamination infrastructure
- Activation and deployment of trained SDB teams to support safe and dignified burials.
- Training of additional SDB teams for West Nile (Northwest).

Risk communication and community engagement.

- Inadequate IEC materials.
- Low awareness and risk perception among the general population especially border communities.
- Limited resources to support deployment of surge officers.
- Limited Knowledge on EVD in the general population.
- Activation of cross border village health taskforces to reinforce RCCE messaging

Surveillance

- The biggest gap has highlighted in surveillance and points of entry especially in the Western part of the country.
- The pillar highlighted need to conduct screening and hand washing at entrances of public places like hospitals, markets among others.
- Many PoEs along Lake Victoria such as Port Bell, Kiyindi, Kasenyi do not have remunerated staff. Others such as Katosi, Namanve and Kyetume are not manned which poses a risk of the outbreak going beyond Uganda borders.
- Activation of cross border village health taskforces to reinforce community-based surveillance



Water, Sanitation And Hygiene

Gaps exist in Water, Sanitation and Hygiene (WASH) capacity to effectively support the BVD outbreak response, particularly in high-risk border districts and vulnerable communities. Health facilities require urgent strengthening of infection prevention and control (IPC) infrastructure, including adequate water supply, functional handwashing stations, sanitation facilities, and waste management systems to safely handle infectious materials. Limited availability of hygiene supplies—such as chlorine, disinfectants, soap, and personal protective equipment—poses a risk to both healthcare workers and patients.

At the community level, there are critical gaps in access to safe water and hygiene facilities, especially in hard-to-reach cross-border areas, refugee-hosting settlements, and informal urban settings. These conditions restrict the ability of communities to practice effective hand hygiene and environmental cleaning, increasing the risk of transmission. In addition, inadequate community awareness and behaviour change related to hygiene practices further undermines prevention efforts.

There is also a need to strengthen WASH support for safe and dignified burials, including availability of disinfection materials, trained teams, and systems to safely manage contaminated environments. Current limitations in these areas increase the likelihood of unsafe practices during handling of bodies.

Key priority needs include scaling up supply and distribution of essential WASH materials; strengthening water and sanitation infrastructure in healthcare facilities and communities; supporting hygiene promotion and community engagement; and deploying trained personnel to ensure proper IPC and environmental health measures. Without these improvements, WASH gaps will continue to pose a major risk to effective outbreak containment.



Protection, Gender And Inclusion

In previous responses, we identified several gaps related to Protection, Gender, and Inclusion (PGI). One significant gap was the lack of clear understanding regarding gender roles and relations prior to public health emergencies. We did not fully assess how these roles and relations impacted our response efforts. Additionally, we did not adequately identify the varying needs, capacities, and coping strategies of women, men, boys, girls, and individuals with disabilities.

The available data both primary data from URCS and secondary data from other studies did not sufficiently account for factors such as disability, ethnicity, HIV status, and other priority areas in the context of the outbreak. This gap highlights the need for conducting a comprehensive gender and inclusion analysis at the start of every response. Without this, the diversity of needs and experiences within affected communities can be overlooked, which may result in less effective interventions.

Beyond infection risk, protection concerns are significant. Ebola outbreaks are associated with increased gender-based violence, including domestic and sexual violence, driven by stress, economic disruption, and weakened protection systems. These risks are often



underreported and insufficiently addressed in response efforts. Furthermore, as National Society, URCS recognized that individuals in Ugandan communities' and especially at border areas experience crises differently due to intersecting factors such as power, age, disability, and other forms of vulnerability. Unfortunately, in some areas of our operations, these differences were not adequately considered, which limited the effectiveness of our responses.

Stigma is another major issue, as survivors and health workers frequently face rejection and discrimination, limiting their ability to reintegrate socially and economically. In addition, already vulnerable groups—such as older persons and people with disabilities—face barriers to accessing information and services, indicating gaps in inclusive outreach. Overall, the analysis shows that Ebola both exposes and amplifies existing inequalities. Women face higher exposure, men face behavioral risks linked to delayed care, and vulnerable groups are often excluded. Protection risks such as GBV, stigma, and lack of access to services are central and must be addressed alongside the health response.

Considering learnings from previous outbreaks, the COVID-19 pandemic, in particular, highlighted the critical need to address gender-based violence (GBV) in emergencies. It exacerbated existing vulnerabilities, with many communities experiencing a significant rise in GBV cases. It became evident that recognizing and addressing GBV must be a collaborative effort, involving everyone in the community. We must ensure that interventions to reduce GBV are designed together, incorporating the experiences and needs of all community members.



Community Engagement And Accountability

Learning from previous outbreaks and the current outbreak trends, EVD outbreaks are associated with rumors, misinformation, denial, stigmatization and low risk perception among specific groups like health workers and the general public. These are mainly driven by gaps in knowledge among the community members coupled with lack of effective approaches to address the same in communities. Misinformation, stigmatization among others undermines public health actions aimed at preventing and controlling the outbreaks.

Strengthening community feedback mechanisms to collect community concerns and respond to them on a timely manner

Any identified gaps/limitations in the assessment

The Uganda Red Cross BVD outbreak response plan of action of CHF 5 million remains largely underfunded limiting the reach of the NS to all vulnerable communities across the very high-risk districts as per the MOH categorization. So far, the plan is only funded through this BVD Response DREF.

Operational Strategy

Overall objective of the operation

The objective of this operation is to support the Government of Uganda to prevent and reduce morbidity, mortality, and socio-economic impacts associated with the Bundibugyo Ebola Virus Disease (BVD) outbreak through the scale-up of timely, coordinated, and evidence-based preparedness and response interventions targeted for key BVD pillars. In alignment with Government priorities and risk analysis, URCS is scaling-up community-based surveillance, risk communication, infection prevention and control, safe burials, psychosocial support, and referral systems to enable early detection, rapid response, and community-level prevention activities across targeted high-risk districts; expanding community outreach from 520,000 to 650,000 people in the high risk areas of Kampala Metropolitan Area, Kasese, Bundibugyo, Ntoroko, Zombo, Hoima, Nebbi, Fort Portal and Arua

Note that this DREF operation constitutes a part of the Uganda country-level implementation of the IFRC Regional Emergency Appeal (MDRS1007), operationalizing its Tier 2 response approach for countries with active transmission and contributing directly to the Federation-wide objective of reducing Ebola transmission, mortality, and socio-economic impact.

Operation strategy rationale

This Operations Update revised strategy reflects the current outbreak dynamics and aligns with the latest trends and cases reported in the Ministry of Health situation reports. In line with the evolving epidemiological situation with all 11 confirmed cases coming from



Kampala suggestive of community spread especially in Kampala and its metropolitan area, the operation will expand to, adopting a risk-based, flexible and decentralized approach that prioritizes high-transmission areas, cross border districts, urban centers, informal dwellings and other vulnerable settings.

The operational strategy is directly aligned with and contributes to the Emergency Appeal's tiered regional approach, translating its priority interventions into targeted country-level action directly supporting Government of Uganda and complementing ongoing national efforts to contain the Bundibugyo Virus Disease (BVD) outbreak and prevent further transmission in affected and high-risk districts. The intervention is informed by lessons learned from previous Ebola and public health emergency responses in Uganda, including Ebola preparedness (2018), Sudan Ebola outbreaks (2022 and 2025), COVID-19, Mpox, and Marburg preparedness. The strategy is aligned with Government response pillars as follows:

Coordination and Community Engagement (RCCE/CEA):

The operation will strengthen risk communication, community engagement, and accountability mechanisms to address misinformation, fear, stigma, and low risk perception. Community dialogue sessions, mass awareness campaigns, and feedback mechanisms will be prioritized to build trust, promote early reporting, and improve adherence to preventive measures. Particular focus will be given to high-risk groups, including border communities, urban informal settlements, transport operators, market vendors, schools, and mobile populations.

Surveillance (Community-Based Surveillance and Contact Tracing Support):

URCS will support early detection through community-based surveillance by leveraging trained volunteers to identify, report, and refer suspected cases to district surveillance teams. This will strengthen early warning systems and rapid response capacity, particularly given concerns that some contacts linked to confirmed cases may not yet have been identified.

Points of Entry (PoE) Screening:

The operation will strengthen screening and early detection at official and informal border crossing points, airports, and high-traffic transit hubs. URCS volunteers will support temperature screening, handwashing, risk communication, and identification of suspected cases at points of entry, in close coordination with Ministry of Health teams. Given the high cross-border mobility between Uganda and the DRC, this intervention is critical to reducing the risk of importation and onward transmission, as well as strengthening cross-border surveillance and referral systems.

Case Management:

The operation will support safe patient identification and referral systems. URCS will work closely with the Ministry of Health to facilitate early detection and referral of suspected cases and support preparedness through trainings, simulations, and coordination with Ebola Treatment Units (ETUs).

Safe and Dignified Burials (SDB):

The operation will strengthen safe burial practices to prevent transmission associated with handling of the deceased. URCS will deploy and support trained SDB teams, conduct refresher trainings and simulation exercises, and ensure availability of required materials in line with national protocols. URCS has 2 starter kits and 1 replenishment in country. The available in country kits have been used to activate 2 teams below the current SDB gap in the country. Therefore, Additional 4 training, 4 starter and 4 replenishment kits will be procured in the operation. These will be used to facilitate activation of additional SDB teams, and additional trainings as the old, expired kits items are not sufficient to conduct trainings as they have been utilized to conduct pre-deployment drills and simulation for the 15 standby SDB teams.

Emergency Medical Services (EMS):

URCS will support emergency transport and referral systems through ambulance services and coordination with district health authorities. This includes safe evacuation of suspected cases, timely referral to treatment facilities, and support to rapid response teams.

Infection Prevention and Control (IPC) and WASH:

The operation will address transmission risks through improved hygiene and IPC measures. This includes provision of handwashing facilities, chlorine, soap, and hygiene promotion in communities, health-related settings, and high-traffic locations such as markets and points of entry.

Mental Health and Psychosocial Support (MHPSS) and Protection, Gender and Inclusion (PGI):

The operation will integrate psychosocial support and protection measures across all interventions to address the social impact of the outbreak. It will ensure inclusive programming for vulnerable groups, including women, children, persons with disabilities, refugees, and frontline workers, while promoting safeguarding, stigma reduction, child protection, and gender-sensitive approaches.

Logistics and Operational Support:

The operation will address supply and logistical gaps, including procurement and prepositioning of PPE, disinfection materials, and essential response equipment in high-risk districts to enable timely and effective interventions.



Across all pillars, URCS will leverage its extensive volunteer network to implement community-level interventions, including screening at points of entry, house-to-house sensitization, and public awareness campaigns. The strategy takes into account contextual challenges such as high cross-border movement with DRC, urban transmission risks in Kampala Metropolitan Area, limited health system capacity, and logistical challenges in hard-to-reach areas.

The operation will be implemented over six months, with priority life-saving interventions frontloaded in the first two months—aligned with the minimum period required for two incubation cycles in the absence of new confirmed cases.

Coordination will be ensured through the national incident management system, with close collaboration between the Ministry of Health, IFRC, Movement partners, district task forces, and other stakeholders to ensure harmonized implementation, avoid duplication, and maximize operational efficiency.

Targeting Strategy

Who will be targeted through this operation?

The operation will target populations in affected and high-risk districts with priority focus on communities and groups at increased risk of exposure, transmission, and severe socioeconomic impacts resulting from the Bundibugyo Virus Disease (BVD) outbreak. Initial target areas will include Kampala Metropolitan Area and selected high-risk border districts including Kasese, Bundibugyo, Ntoroko, Zombo, Hoima, Nebbi, Fort Portal and Arua due to their shared porous border with DRC characterized by high population movement, transport connectivity and trade, and cultural linkage to communities in Eastern DRC.

The operation will specifically target front line healthcare workers, caregivers, community volunteers, transport operators, market vendors, boda-boda riders, taxi and bus park operators, school communities, informal traders, and populations living in densely populated urban settlements. These groups are prioritized because they experience frequent person-to-person interactions and are therefore at higher risk of exposure and onward transmission. Healthcare workers and caregivers remain particularly vulnerable due to direct contact with suspected or confirmed cases, while transport and market related populations facilitate movement and mixing of large numbers of people within and across districts.

The operation will also prioritize households and communities linked to confirmed or suspected cases, especially in areas with identified surveillance gaps, high risk behaviors, or limited access to timely health information and preventive services. Community engagement and surveillance interventions will focus on locations with high public interaction including markets, transport hubs, schools, health facilities, places of worship, and points of entry.

Special consideration will be given to vulnerable and marginalized populations whose risks are heightened by socio-economic, physical, or protection-related factors. These include refugees, asylum seekers, migrants, cross-border traders, internally displaced persons (IDPs), older persons, persons with disabilities, pregnant and lactating women, children, child-headed households, and people living in informal settlements or hard-to-reach communities. Many of these groups face barriers in accessing healthcare, public health messaging, referral systems, and social protection services, increasing their vulnerability during disease outbreaks.

The overall approach will be community-based and inclusive, leveraging on Uganda Red Cross Society's extensive branch and volunteer network, community structures, village task forces, and existing partnerships with local leaders and district authorities. Volunteers trained in Community-Based Surveillance (CBS), Epidemic Preparedness and Response (EPI-C), Risk Communication and Community Engagement (RCCE), and Safe and Dignified Burials (SDB) will support identification and engagement of vulnerable populations within communities.

To ensure inclusion of vulnerable groups and timely collection of community feedback to inform decision making, the operation will adopt Protection, Gender and Inclusion (PGI) and Community Engagement and Accountability (CEA) approaches throughout the implementation. IEC materials will be adapted into accessible and inclusive formats for people with hearing and visual impairments, while child-friendly and gender-sensitive messaging will be integrated into awareness activities. Community feedback mechanisms and toll-free reporting channels will be strengthened to ensure vulnerable populations can safely report concerns, rumors, protection issues, and service gaps.

Engagement with refugee-hosting districts, border communities, and highly mobile populations will be coordinated closely with district authorities, humanitarian partners, and community leaders to ensure targeted risk communication, surveillance, and referral support. The operation will further ensure that women, youth, persons with disabilities, and marginalized groups are represented in community dialogue sessions and feedback structures to strengthen participation, trust, and accountability.



Explain the selection criteria for the targeted population

Healthcare workers and caregivers: Healthcare workers, caregivers, ambulance teams, and Safe and Dignified Burial (SDB) teams are prioritized because they face the highest direct risk of exposure through contact with suspected or confirmed Bundibugyo Virus Disease (BVD) patients, contaminated materials, and bodily fluids. Previous Ebola outbreaks in Uganda demonstrated high infection and mortality rates among health workers due to delayed detection, inadequate infection prevention and control (IPC), and limited protective equipment. The operation will target both public and private healthcare providers, including lower-level clinics and drug shops, as these are often the first points of care for symptomatic individuals. Strengthening awareness, surveillance, IPC practices, and referral systems among these groups is essential to interrupt transmission and protect the health system workforce.

High mobility and urban populations: The operation will target populations living and working in high-density urban and peri-urban settings including Kampala Metropolitan Area, Fort portal, Arua, and other high-risk western border districts due to the increased risk of rapid transmission associated with overcrowding, intense social interaction, and high population movement. Particular focus will be placed on transport operators, boda-boda riders, market vendors, traders, and individuals working in transport hubs, markets, and public gathering spaces because they interact daily with large numbers of people and may contribute to the spread of infection across communities and districts. POE Screening, handwashing facilities, community sensitization, and risk communication activities will therefore prioritize these high contact environments.

Border and cross border communities: Communities living near the Uganda-DRC border and along major transport corridors are being targeted because of frequent cross-border movement linked to trade, migration, mining activities, family ties, and refugee flows. The ongoing outbreak in eastern DRC increases the risk of importation and cross border transmission into Uganda, especially through formal and informal points of entry. The operation will therefore prioritize border populations, mobile communities, and individuals involved in cross border trade and transportation for surveillance, community engagement, and preventive interventions to strengthen early detection and reduce transmission risks. Whereas Entebbe airport and Arua airstrip are listed among high-risk infrastructure of possible transmission of the outbreak, Currently, the government through the ministry of health and other partners have intensified the portal health activities at these airports. Therefore, at the moment, the operations will focus on other selected very high-risk points of entry with limited resources.

Vulnerable and marginalized groups: The operation will intentionally target vulnerable populations including refugees, asylum seekers, internally displaced persons (IDPs), persons with disabilities, older persons, pregnant and lactating women, children, and people living in informal settlements or hard to reach areas. These groups are often disproportionately affected during outbreaks due to limited access to healthcare, public health information, sanitation facilities, and protection services. Refugees and migrants may face language barriers, stigma, overcrowded living conditions, and mobility-related challenges, while persons with disabilities and older persons may have difficulties accessing information, referral systems, and healthcare services. Child friendly, gender-sensitive, and accessible communication approaches will be used to ensure inclusion and equitable access to services and information.

Community structures and at-risk households: The operation will also target households linked to confirmed or suspected cases, community influencers, religious leaders, teachers, village task forces, and local leaders because of their critical role in influencing community behavior, addressing rumors and misinformation, and supporting acceptance of public health interventions. Communities with identified surveillance gaps, low risk perception, or previous resistance to outbreak response activities will receive intensified engagement to strengthen trust, reporting of alerts, adoption of preventive behaviors, and community participation in outbreak control efforts.

This targeting approach is consistent with the Emergency Appeal's prioritization of high-risk populations in cross-border corridors, urban hubs, and high-mobility settings.



Total Targeted Population

| | | | |
|---------------------------|---------|--------------------------------------|-----|
| Women | 164,000 | Rural | 60% |
| Girls (under 18) | 164,000 | Urban | 40% |
| Men | 161,000 | People with disabilities (estimated) | 1% |
| Boys (under 18) | 161,000 | | |
| Total targeted population | 650,000 | | |

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 |
|---|---|
| Delayed DREF reporting by the NS | <ul style="list-style-type: none"> - The NS is required to provide monthly progress narrative and financial reports under the new IFRC/URCS operating modalities including for this DREF operation thus addressing any delayed reporting. - IFRC Juba country cluster PMER officer will work closely with the NS EVD response PMER focal person to ensure timely reporting of this DREF operation. |
| Infection of URCS employees or volunteers | <ul style="list-style-type: none"> • Linkages to government ETUs to support URCS employees or volunteers should they fall sick. • Provision of PPE (personal protective equipment) • Training and provision of standard SDB kits to URCS SDB teams for safe burial procedures, avoiding improvisation without adequate material and protection. • Provision of regular PSS support to all response teams. |



| | |
|--|---|
| | <ul style="list-style-type: none"> • Sharing updated guidance through memos from the secretary general's office to all staff and volunteers. |
| Expansion of the affected area outside the Kampala district and beyond the neighboring districts. | <ul style="list-style-type: none"> • Mitigation by training the staff and volunteers in other areas and branches on EVD prevention and control. • Refresher trainings for the URCS SDB teams in high-risk districts as listed by MoH. • Sharing updated staff guidance from the SG's office. |
| Safeguarding risks | <ul style="list-style-type: none"> - Mitigation by training/sensitizing staff and volunteers in on safeguarding and ensure all sign the code of conduct - Reinforce and motivate timely and anonymous reporting of safeguarding breaches |
| <p>Please indicate any security and safety concerns for this operation:</p> <p>The ongoing conflict in DRC may expand to border areas with Uganda, with spillover of asylum seekers into neighboring districts of Arua, Hoima, Nebbi, Bundibugyo, Kasese, Ntoroko and Kisoro. This poses a challenge if Ebola cases would spread to those areas.</p> <p>Road traffic accidents are a serious safety concern especially to volunteers since the outbreak is in an urban area with heavy traffic and many motorcyclists. Volunteers deployed in borders of DRC will also receive the stay safe training</p> | |
| Has the child safeguarding risk analysis assessment been completed? | Yes |

Planned Intervention



Budget: CHF 504,708
Targeted Persons: 650,000
Targeted Male: 322,000
Targeted Female: 328,000

Indicators

| Title | Target | Actual |
|---|---------|--------|
| # people reached with health/hygiene promotion/RCCE services | 650,000 | 3,949 |
| % of targeted community reached with health messages | 80 | 0 |
| % of target population who can recall 3 or more EVD protective measures | 80 | 0 |
| # of community EVD awareness raising sessions held | 5,400 | 0 |
| # of volunteers trained in and providing health/ hygiene promotion in | 350 | 0 |



| | | |
|--|-----|-----|
| their communities (Epic and CBS) | | |
| % of deaths to which safe and dignified burials were successfully carried out | 100 | 0 |
| # of new volunteers trained on SDB | 48 | 0 |
| % of districts 'at high risk' that are covered by RC SDB teams | 80 | 8 |
| % of deceased suspect and confirmed cases that are buried within 24 hours of initial alert | 100 | 100 |
| # of trained SDB teams activated or drilled | 8 | 2 |
| % of CBS 'true' alerts (match CCD) | 80 | 0 |
| % of CBS volunteers who are active ('zero' reporting, monthly average) | 80 | 0 |
| # of MHPSS peer support initiatives | 50 | 2 |
| # of calls and alerts handled by the EMS team within 24H | 80 | 11 |
| # of people that received assistance with ambulance service | 200 | 11 |
| # of staff and volunteers trained in MHPSS | 40 | 0 |
| # of BVD outbreak response task force meetings (national and district) attended | 56 | 4 |
| # of BVD outbreak response pillar meetings attended | 108 | 12 |

Progress Towards Outcome

Surveillance (including PoE Screening)

- URCS is supporting surveillance through extensive screening at multiple points of entry (PoEs) across high-risk districts including Hoima, Kasese, Kisoro, Bundibugyo, Ntoroko, and Kikuube.
- Across 6 Districts there are 26 screening points with a total of 82 screeners deployed at formal border crossings, transport hubs, and community entry points.
- To date, 10,359 people have been screened (6,469 male and 3,890 female), contributing to early detection and prevention of cross-border transmission.

Case Management and Emergency Medical Services (EMS)

- URCS is strengthening referral and emergency response through 8 ambulances deployed across Kampala Metropolitan Area (3), Fort Portal, Kasese, Kisoro, Arua, and Nebbi.
- Operational updates show that 11 evacuations have been conducted, involving suspected cases and contacts, and response teams have been drilled to ensure readiness.

Safe and Dignified Burials (SDB)

- A total of 102 trained SDB volunteers is mobilised across six high-risk districts including Bundibugyo, Ntoroko, Kasese, Kisoro, Kabale, KMA, and Arua to safely manage burials and reduce transmission risks.



- 3 teams have been taken through pre-deployment drills.
- Recent updates show 7 alerts received, with 5 responses conducted in Kampala (2 ETU and 2 Community) and Kasese (1 health facility). All SDB alerts that were cleared for SDB (2) were accorded SDB. For 3/5 responses, the suspected bodies were collected from the community, taken to the mortuary and handed over to the families when they tested negative for EVD.

Risk Communication and Community Engagement (RCCE) / Community-Based Surveillance

- URCS has mobilized 350 community volunteers and health workers across six districts to support community awareness, early detection, and rumor management. Activities include house-to-house sensitization, outreach, and community dialogue sessions, particularly targeting high-risk and border communities. So deployed volunteers have conducted house to house sensitization.

Coordination (national and sub national task force, and pillar meetings)

- URCS participated in coordination meetings including 4 district task force meetings in Kikube, Ntoroko, Kasese and Bundibugyo, and 1 coordination meeting with the Rwenzori Regional Public Health Emergency Operation Centre to further appreciate the current needs and also shared URCS support to the region, as well as coordination meetings with URCS branch management within the branches.
- URCS participated in 12 pillar and sub pillar meetings including Surveillance, RCCE, SDB, EMS and Case Management pillars where URCS shared the complementary support it is offering to MOH's BVD outbreak response interventions.
- URCS took part in the MOH led joint assessments with district teams and partners aimed at establishing the existing response gaps and areas of support.
- URCS updated the national and regional 4W matrix for the Rwenzori region.



Water, Sanitation And Hygiene

Budget: CHF 80,935

Targeted Persons: 650,000

Targeted Male: 322,000

Targeted Female: 328,000

Indicators

| Title | Target | Actual |
|---|--------|--------|
| # of PoE screening sites supported by URCS | 18 | 11 |
| # of people screened at PoE | 51,500 | 10,359 |
| # of volunteers deployed to support WASH and screening activities | 82 | 82 |
| # of 45 kg Chlorine buckets procured | 10 | 0 |
| # of hand washing facilities procured | 150 | 5 |

Progress Towards Outcome

- From the URCS pre-positioned emergency stock, distributed 40 infrared thermometers, 5 collapsible high density plastic tables & 10 chairs, 10 1L bottled sanitizers, 88 face shields were also distributed.
- Installed 5 handwashing stations in 5 POEs in Kasese
- 26 POEs supported by URCS volunteers prior to closure to the Uganda-DRC boarder for non essential travels. Currenty 11 screening sights are active including entrances to public spaces





Protection, Gender And Inclusion

Budget: CHF 13,414

Targeted Persons: 650,000

Targeted Male: 322,000

Targeted Female: 328,000

Indicators

| Title | Target | Actual |
|--|--------|--------|
| % of staff and volunteers who feel supported to do their work. | 100 | 0 |
| % of PSEA related allegations reported and investigated | 100 | 0 |
| # of awareness sessions conducted within the mentioned topics | 10 | 0 |
| # of rapid gender analyses conducted | 10 | 0 |
| % of URCS staff and volunteers who required PSS supported | 100 | 0 |
| # of dissemination sessions for child protection policy | 10 | 0 |
| # of volunteers who signed the volunteer code of conduct | 350 | 0 |

Progress Towards Outcome

- Activated volunteers and staff are being orientated on URCS safeguarding policies (PSEA)



Community Engagement And Accountability

Budget: CHF 35,177

Targeted Persons: 650,000

Targeted Male: 322,000

Targeted Female: 328,000

Indicators

| Title | Target | Actual |
|--|--------|--------|
| % of complaints and feedback received and responded to by the NS | 80 | 0 |
| # of targeted community rapid perception surveys conducted | 1 | 0 |
| # of private health workers engaged | 175 | 0 |



| | | |
|---|--------|---|
| # of IEC materials printed and distributed | 10,000 | 0 |
| # CFM systems and community participation settings types operationalized (e.g., committee meetings, focus groups, town halls) in place | 3 | 0 |
| % of people surveyed who report receiving useful and actionable information – to measure effectiveness of meetings with community influencers and community members | 80 | 0 |
| % of community members, including marginalized and at-risk groups, who know how to provide feedback. | 80 | 0 |
| % of community members, including marginalized and at-risk groups, who feel the support provided addresses their most important needs and concerns. | 80 | 0 |
| % of operational decisions or changes made based on community feedback. | 20 | 0 |

Progress Towards Outcome

- URCS is strengthening the community feedback mechanism system.
- URCS is engaging with community influencers and community members.
- URCS is strengthening the community feedback mechanism system. They have updated their feedback collection kobo tools to reflect the BVD response. They are also contextualizing the BVD FAQ document to reflect feedback that has been collected online from partners and through the URCS DEH.



Coordination And Partnerships

Budget: CHF 0

Targeted Persons: 450

Targeted Male: 225

Targeted Female: 225

Indicators

| Title | Target | Actual |
|--|--------|--------|
| # of movement partners meetings held | 8 | 3 |
| # of key stakeholders' meetings (donors, private sector actors, social media influencers etc.) held or participated in | 10 | 4 |

Progress Towards Outcome

- URCS have organized three virtual Movement Coordination meetings to date.
- URCS has held meetings with FCDO and the Japanese Embassy in Uganda to present the NS BVD outbreak response plan of action and



resource mobilize.

- URCS has also taken part in the high level regional technical working group and ministerial meeting organized by Africa CDC in Uganda



Secretariat Services

Budget: CHF 43,917

Targeted Persons: 100

Targeted Male: 50

Targeted Female: 50

Indicators

| Title | Target | Actual |
|---|--------|--------|
| # of financial spot checks conducted | 2 | 0 |
| # of monitoring visits conducted | 4 | 0 |
| # of lessons learnt workshops conducted | 1 | 0 |
| Set up IFRC logs hub | 1 | 0 |

Progress Towards Outcome

- Mobilized Finance and Logistics support - including logistics from Nairobi Regional Office.
- Participated in technical and ministerial coordination level Africa CDC meetings of 22-23 May.
- Participating in IMST meetings - national and regional level.
- SDB kits have been requested through IFRC Regional Office
- Mobilisation Table being prepared for the Appeal.
- Procurement tracker set up for the current DREF – URCS preparing Concept Notes.
- Set up IFRC logs hub



National Society Strengthening

Budget: CHF 71,849

Targeted Persons: 500

Targeted Male: 250

Targeted Female: 250

Indicators

| Title | Target | Actual |
|---------------------------------------|--------|--------|
| # of Branch level EOCs functionalised | 2 | 0 |
| # of warehouses supported | 4 | 0 |



Progress Towards Outcome

- URCS EOC is mobilised to track and share information.
- URCS branches have all been mobilized in high-risk Districts
- URCS is strengthening the community feedback mechanism system. They have updated their feedback collection kobo tools to reflect the BVD response. They are also contextualizing the BVD FAQ document to reflect feedback that has been collected online from partners and through the URCS DEH

About Support Services

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

A total of 7 technical staff, 2 support staff, 3 drivers, 5 NDRTs and 410 volunteers (350 RCCE/CBS AND 60 POE volunteers) will be involved. The operation will leverage on the already existing resources and capacity within the NS.

The technical staff will include the Manger for Epidemic and Pandemic Preparedness and Response, Operations manager, Public health supervisor (SDB, RCCE AND CBS) Ambulance service supervisor, Boarder health supervisor (Screening at POE and Community WASH) and communications officer. These will take lead in ensuring that activities under the different pillars are executed accordingly under overall leadership of the director Health and the National society response task force led by the Secretary General.

The support staff will include the fleet officer who will support in ensuring procurement and financial processes are expedited. The NDRTs will include 2 NDRT health officers, 1 SDB NDRT, 1 PMER NDRT focal person, 1 volunteer management focal person, 1 EMT, 1 ambulance drivers. At the moment, URCS will use already existing national capacity, and additional human resource shall be requested when the need arises.

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?

Yes. URCS volunteer teams largely reflect the gender, age, and cultural diversity of the targeted communities because volunteers are recruited from local areas, enabling culturally appropriate and community centered engagement. The network includes women, men, and youth from different social and cultural backgrounds, strengthening trust, communication, and outreach. However, gaps remain in female participation in high-risk roles such as Safe and Dignified Burials (SDB) and EMS, as well as inclusion of persons with disabilities and specialized language capacities. To address these gaps, URCS will promote gender balanced recruitment, inclusive programming, safeguarding training, accessible communication materials, and deployment of volunteers with relevant local language and cultural skills.

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

All procurements for this operation will be handled by the IFRC with support from the Uganda RC in adherence to the signed URCS/IFRC operating modalities.

How will this operation be monitored?

Monitoring will be done through the URCS operations department. Monitoring tools like periodic reports, internal meetings, activity reports shall be shared to the respective stakeholders including the IFRC. The IFRC together with the NS PMER team will develop reporting tools and also set desired timelines for response actions. Further monitoring of the operation will be by the IFRC cluster through monitoring visits. All response operations will be monitored by the NS senior management under stewardship of the Director Operations.



Please briefly explain the National Societies communication strategy for this operation

A communications NDRT shall be nominated by the directorate of communications, resource mobilization and partnerships. Key highlights, events and success stories during the operation will regularly be shared on different platforms including local media, social media, NS website among other platforms.



Budget Overview



DREF OPERATION

MDRUG058 - UGANDA RED CROSS SOCIETY BEVD Outbreak (2026)

Operating Budget

| Planned Operations | 634,234 |
|---|----------------|
| Shelter and Basic Household Items | 0 |
| Livelihoods | 0 |
| Multi-purpose Cash | 0 |
| Health | 504,708 |
| Water, Sanitation & Hygiene | 80,935 |
| Protection, Gender and Inclusion | 13,414 |
| Education | 0 |
| Migration | 0 |
| Risk Reduction, Climate Adaptation and Recovery | 0 |
| Community Engagement and Accountability | 35,177 |
| Environmental Sustainability | 0 |
| Enabling Approaches | 115,766 |
| Coordination and Partnerships | 0 |
| Secretariat Services | 43,917 |
| National Society Strengthening | 71,849 |
| TOTAL BUDGET | 750,000 |

all amounts in Swiss Francs (CHF)



Contact Information

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

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[Click here for the reference](#)

