FINAL REPORT

Uganda| Ebola Virus Disease

Emergency appeal №: MDRUG047 **First launched on:** 30/09/2022	**Glide №:** **EP-2022-000315-UGA**
Final report issued on: 22/05/2025	**Timeframe covered by final report:** From 21/10/2022 to 31/12/2023
Number of people targeted: 2.7 million people	**Number of people assisted:** 2.7 million people
Funding coverage (CHF): CHF 5 million through the IFRC Emergency Appeal CHF 10 million Federation-wide	**DREF amount initially allocated:** **CHF 700.000**

Photo 1: URCS technical officers orientation of Village Task Force members in Buyengo Sub County in Jinja District on RCCE and reporting

SITUATION ANALYSIS

Description of the crisis

On 20 September 2022, the Ministry of Health (MoH) issued a statement announcing a positive case of the Ebola Virus Disease (EVD), a Sudan strain in the district of Mubende, 130 km west of Kampala with an index case being a 24-year-old man who sought care at St Johns Medical clinic in Katwe. It then spread to Kassanda, Kyegegwa, Kagadi, Bunyangabu, Wakiso, Jinja, Masaka, and Kampala districts. Outside the epicenter district (Mubende), secondary transmission took place in Kassanda, Wakiso, Kampala, Kyegegwa, and Jinja. The active phase of the response lasted for 114 days and on January 11th, 2023, the outbreak was declared over. Ministry of Health declared a 90-day recovery period with a strong focus on strengthening surveillance in communities, infection prevention and control (IPC), community engagement as well as follow-up and management of survivors. Before the outbreak was declared over, 143 confirmed cases of Ebola, with 22 probable cases, 55 deaths (CFR=39%), and 88 recoveries had been registered in this outbreak. Of the 143 confirmed cases, 85 (59%) were males while 58 (41%) were females. By age, 26 (18%) were children while 117 (82%) were adults.

This outbreak marked the 7th Ebola outbreak in the country, and the 5th attributed to the Sudan Ebola virus, which was last reported in 2012, more than a decade ago in the then Kibaale district, but present-day Kakumiro. Before this outbreak, Uganda had registered seven (7) previous Ebola outbreaks.

- In 2018, Ebola Zaire cases were imported from the DRC into Kasese District, with 4 cases and 4 deaths registered (CFR=100%).
- In 2012, two Sudan Ebola outbreaks occurred; the Kibaale district outbreak happened in July with 11 cases and 4 deaths CFR=36%) while the Luwero district outbreak happened in November with 6 cases and 3 deaths (CFR=50%).
- In 2011, the Sudan Ebola outbreak occurred in the Luwero district. This was one case and one death outbreak with no secondary transmission.
- In 2007, an outbreak occurred in Bundibugyo district (Bundibugyo Ebola outbreak) where 131 cases and 42 deaths (CFR=32%) were registered.
- In 2000, Uganda's first Ebola outbreak (Sudan Ebola outbreak) occurred in the Gulu district, where 425 cases and 224 deaths (CFR=53%) were recorded. The Gulu outbreak was and remains the largest outbreak ever registered in Uganda, which lasted for close to 6 months.

Similarly, on the 31st of July 2023, the Ministry of Health declared an outbreak of cholera in Kayunga (24 cases, 8 deaths) and Namayingo (21 cases, 0 deaths) and these were attributed to low WASH indicators in the affected sub-counties. Quite notably, the outbreak in Kayunga was anecdotally attributed to an index case that had died in Entebbe Grade B hospital and was buried in Kayunga, despite no reports of similar cases in that same area. According to MOH reports, a cholera outbreak in Kayunga and Namayingo districts started in July 2023, and the Ministry of Health sent response teams to contain the spread of the disease. Mobilized Community Health Workers conducted house-to-house campaigns on early medical seeking, contact tracing, and prevention measures, including washing hands thoroughly with soap and water, cleaning all soiled items with plenty of water, boiling drinking water, and cooking food well.

Chronology of Events:

- The first suspected case was a child of 2 years and nine months at Bugana HC III in Namayingo district, who presented with profuse watery diarrhoea, vomiting, and stomachache on July 15, 2023. 3 to 4 samples which

were collected from the suspects tested positive for vibrio cholera. By 31/07/2023, the number of cholera cases reported were; Kayunga (24 cases, 8 deaths) and Namayingo (21 cases, 0 deaths).

- 7th September 2023, Namayingo cumulatively registered twenty (20) cases (6 confirmed and 14 suspected), no deaths, and the 158 contacts listed completed the 7-day follow-up. Similarly, Kayunga cumulatively registered 58 cases, 37 confirmed and 21 suspected/probable. 923 contacts listed completed the 7-day follow-up, out of the 99 samples collected on the 7th of September 12 turned positive.

Specifically, URCS responded to the cholera outbreak by orienting and training Community Health Workers (CHW) in Community-Based Disease Surveillance training both in Kayunga and Namayingo districts. This training aimed at improving the capacity of CHWs to conduct community surveillance, recognizing, reporting, and responding to disease outbreaks in their communities.

Summary of response-EVD and Cholera outbreaks

Overview of the host National Society

The Uganda Red Cross Society (URCS) supported EVD response during both the active phase and recovery periods. In the recovery phase, health officers were deployed to the field to coordinate with the District Health Team and partners and to supervise trained community volunteers who were conducting passive surveillance. During the active phase of the response, URCS supported five pillars ;

- Coordination
- Surveillance (Community-Based Surveillance)
- Risk Communication and Community Engagement (RCCE),
- Case Management – (SDB and ambulance services)
- Water Sanitation and Hygiene (WASH)
- Mental Health (Psychosocial support) and

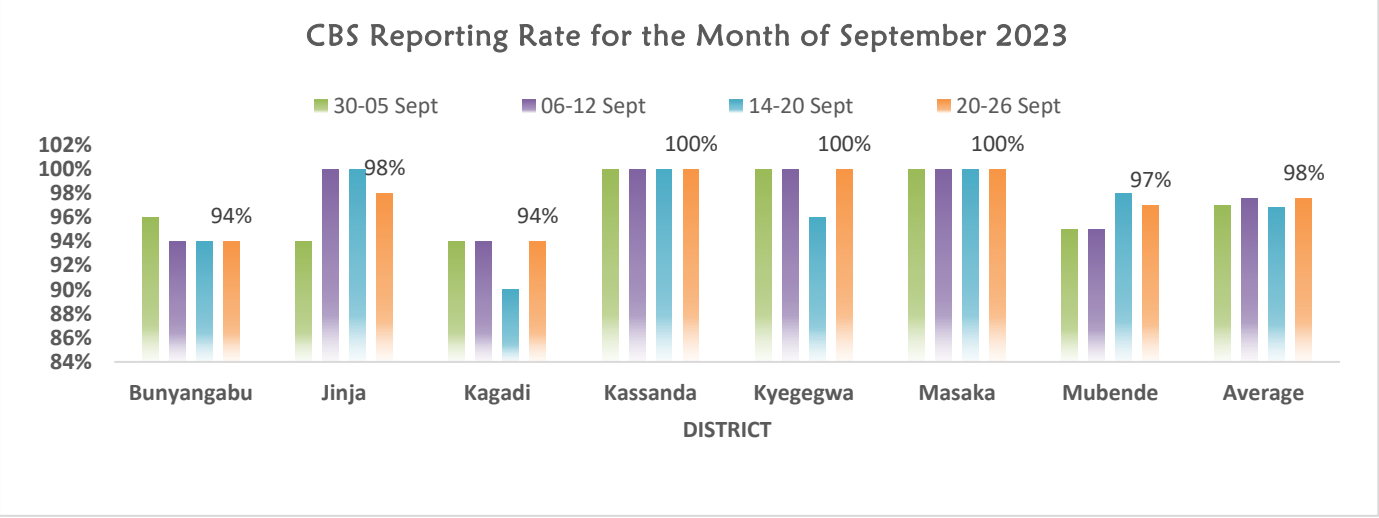
Coordination

- URCS established a field-based operations manager working hand in hand with the IFRC operations manager. The field operations manager was the team leader supported by four different supervisors: Public health, Ambulance services, Community IPC, and Monitoring and Evaluation who in turn worked through different officers under them. All the team leads attended daily briefing meetings chaired by the operations manager at 7.30 am to review progress for possible strengthening and remodeling of strategies.
- URCS participated in all task force and pillar meetings across the nine response districts: (Mubende, Kassanda, Kagadi, Kyegegwa, Bunyangabu, Kampala, Wakiso, Jinja, and Masaka) as well as at the national level.
- At the community level, URCS worked with 3,130 community volunteers across all the response districts.
- Health Officers were deployed to coordinate the District Health Team and supervise trained community volunteers while conducting passive surveillance during the recovery period.
- Monthly district-led meetings were held with the village task force members across the seven response districts and the purpose was to enhance local capacity to prevent epidemics and pandemics through strengthening surveillance, health promotion activities, and risk communication.
- URCS attended the weekly national and district task force meetings during the cholera response in Kayunga and Namayingo districts.
- At the district level, the branch managers and the field-based officers coordinated with the district and partners in responding to the cholera outbreak.

Surveillance

- 626 Village Task Force groups deployed to work in their respective communities. Each task force consisted of five members (the LC Chairman, 2 members of the village health team, a Faith/Religious leader, and a URCS representative)
- 3,950 suspected alerts were raised and directed to the MoH surveillance team with a 90% follow-up rate. The outcome of these alerts resulted in improved ambulance referral, early case detection, and contact tracing.
- During the recovery phase, 532 volunteers implemented CBS (Mubende=232, Bunyangabu=50, Kassanda=50, Kagadi=50, Kyegegwa=50, Jinja=50, and Masaka=50). Cumulatively, trained CBS volunteers sent 278 alerts. Of these, 59 percent were False alerts, 36 percent were True alerts and 5 percent were active outbreak errors.
- The overall average CBS reporting rate across all response districts stood at 98 percent with Bunyangabu and Kagadi districts having the lowest reporting rates of 94 percent, followed by Mubende district (97 percent), Jinja (98 percent), while Kassanda, Masaka, and Kyegegwa both tallying at 100 percent having the highest reporting rate. The figure below summarizes the reporting rate in all districts under intervention.
- In the cholera response, URCS trained 505 Community Health Workers (CHWs) across the high-risk villages both in Kayunga and in Namayingo on Community Based Disease Surveillance to strengthen the surveillance system. Of these, 252 were males, 53 were females and 06 were PWDs.

Figure 1: CBS reporting rate for EVD Districts as of 26th September 2023.



Source; CBS Alert Expansion Uganda data sent by community volunteers via the Kobo tool

Risk Communication and Community Engagement (RCCE)

- 626 village task forces deployed to undertake CBS in their respective communities.
- 3,130 community members of Village Task Forces deployed. These successfully conducted sessions engaging community members on Ebola myths, and community understating of the Ebola virus community case definitions, among others. This resulted in increased awareness of Ebola, its symptoms, detection and prevention measures as well as how to identify and pass communication to relevant MoH and Red Cross teams.
- 112,234 Households were reached by deployed community volunteers.
- 10,374 Communal gatherings conducted.
- 1,023,134 individuals were reached with Ebola awareness messages (521,798 males, 501,336 females)

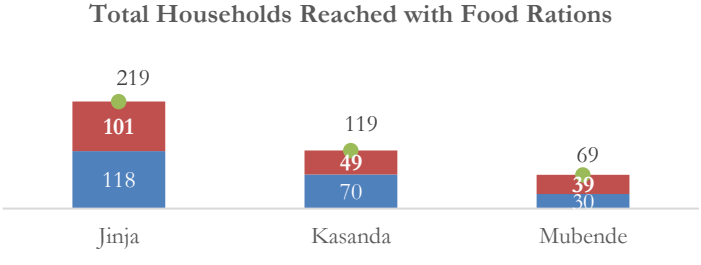
- 580 volunteers trained in EPIC (338 males, 242 females). 480 volunteers were trained during the active phase of the response while 100 were trained during the recovery period.
- 505 Community Health Workers were trained in Community Based Surveillance in both Kayunga and Namayingo districts to respond to the cholera outbreak.
- 1,426 members of the Village Task Force averagely attended bi-monthly Village Task Force meetings across all seven response districts during the EVD recovery phase (933 Males, 493 Females). This was a district-led activity where participants agreed on actions needed to conduct health promotion activities in their respective communities. Minutes on agreed actions of these meetings were hand-written by selected village task force members.

Case Management

- 6 SDB teams were deployed to support the response.
- 27 sub-county burial teams trained (13 Mubende, 10 Kassanda, 02 Jinja, and 02 Masaka) to conduct low-risk burials at the sub-county level.
- 787 burials conducted including high-risk and low-risk burials.
- 787 houses disinfected.
- Eight (8) ambulances deployed - 6 ambulances deployed in Mubende and Kassanda, Masaka and Jinja one (1) ambulance deployed in each response district to conduct evacuations.
- 914 SDB alerts received during the active phase of the response.
- 1,281 cases evacuated/transferred during the active phase of the response.

Photo 2&3: URCS volunteers during SDB training in Jinja and Masaka districts. Two teams were trained to handle both high and low risk burials.

- In Mubende 298 people averagely received hot meals daily, through collaboration with the World Food Programme (WFP). In Jinja, on average 390 people benefited from the same service at Jinja Referral Hospital.
- In Jinja district, a total of 219 Households received dry rations (118 male-headed households, 101 female-headed households)



Graph 1: Summary of Dry food distribution in Jinja, Kassanda, and Mubende response districts

while 188 from both Mubende and Kassanda benefited from the same programme under WFP (100 male-headed, 88 female-headed households)

Water Sanitation and Hygiene (WASH)

- Distributed 325 handwashing facilities in high-risk EVD districts of Mubende, Kassanda, and Jinja
- Established and gazetted a car washing area specifically for SDB vehicles at Mubende to improve sanitation
- Other WASH distributed include Chlorine where 405Kgs were distributed across EVD response districts
- Distributed 600 boxes of handwashing soap to high-risk villages of Mubende, Kassanda, and Jinja.
- Distributed more than 2,000 tippy taps and demonstrated to communities how to use them. 50 tippy taps were distributed in Jinja, particularly in the high-risk sub-county of Buyengo and public places like markets and places of worship.

Summary of response-Cholera

Summary of needs and gaps identified in Cholera

Coordination Monitoring and Resource Mobilization

- Poor resource flow for implementation of response; coordination structures were not in place, and funds for implementation of response activities were inadequate.
- Inadequate follow-up on actions/recommendations made by the task forces, especially district and sub-county task forces.
- Poor participation of the key stakeholders such as the Water Department, Local government (markets, landing sites), education department, and members of parliament.

Surveillance

- There existed low levels of suspicion amongst health workers in private and public facilities
- Existence of unclear reporting channels

Case Management

- Lack of allowances to facilitate health workers treating cholera patients.
- Glaring capacity gaps in case management and IPC
- Inadequate medicines, disinfectants, and protective wear.

Wash:

- Lack of sanitary facilities in homes and public places. Communities along River Nile and in the Lake Victoria, islands have inadequate hygiene and sanitary facilities.
- Poor quality of home and public facility inspections by the environmental health staff has contributed to low latrine coverage and use, poor hygiene in homes, and bad hygiene practices. Open defecation is rampant.
- Poor access to safe water – where water is available, it is contaminated 4. Poor hygiene practices – eating cold foods, lack of hand washing practices.

Risk Communication and Community Engagement

- Very low level of risk perception in the community as most people think they have been bewitched.
- Inadequate social mobilization activities, e.g., IEC materials, Film shows, and radio programs.
- Inadequate local level political support – village and parish levels.

Operation Risk Assessment

Kayunga is a town and a district in the Central Region of Uganda. Kayunga District enjoys a unique location as it lies in the central region of Uganda, about 74 kilometers east of Kampala, the capital and largest city of Uganda. The district has a total land area of 1,810 square kilometers. It lies between 1,000-1,200 meters above sea level. It is generally flat with no remarkable hills, and part of it is a wetland (Ssezibwa). There is Lake Kyoga in the northern part. According to the 2014 National Population and Housing Census results, Kayunga had a total of 370,210 people.
Namayingo, on the other hand, is a district in the Eastern Region of Uganda along the Equator. The district was established in 2010 after being part of Bugiri District. Namayingo district is part of the Busoga sub-region, which comprises nine other districts. Namayingo District has a total land area of 532.9 square kilometers and a population of about 232,300 people, according to a 2012 estimate. The district also borders Lake Victoria in the north and has several islands.

According to MOH reports, the cholera outbreak in Kayunga and Namayingo districts started in July 2023, and the Ministry of Health sent response teams to contain the spread of the disease. VHTs were mobilized to conduct house-to-house campaigns on early medical seeking, contact tracing, and prevention measures, including washing hands thoroughly with soap and water, cleaning all soiled items with plenty of water, boiling drinking water, and cooking food well.

The first suspected case was a child of 2 years and nine months at Bugana HC III in Namayingo district, who presented with profuse watery diarrhea, vomiting, and stomachache on July 15, 2023. 3 to 4 samples collected from the suspects tested positive for vibrio cholera. As of 31st/07/2023, the number of cholera cases reported were; Kayunga (24 cases, 8 deaths) and Namayingo (21 cases, 0 deaths).

OPERATIONAL STRATEGY

Update on the strategy

Risk Communication and Community Engagement (RCCE)

To increase the risk perception of communities about the outbreak, need to increase communication about the risk and peril that cholera poses to children and adults, as well as why communities must work together to end the outbreak. The strategy is to build local capacity for surveillance, risk communication, and community engagement. The justification is that the community members understand the contexts and the dynamics of their communities better than anybody else does, having them at the forefront of the response earns the team acceptance by the community members, and thus the community will comply with the standard operating procedures. Communities need to be sensitized about disease community case definitions to have a high-risk perception of the disease to act by reporting suspicious cases and taking steps to prevent disease spread. This necessitates using all available platforms to guarantee that messages reach communities. Use of IEC materials in the area's various languages for display in communities to guarantee people's risk perception of the disease is high while also educating them on what they should do to control the spread of the epidemic. Additionally, URCS targeted to secure more radio airtime for radio talk shows, radio spots, and jingles to ensure communities get information from different sources.

Strengthening surveillance systems.

In the cholera response, URCS's focus was to increase and strengthen surveillance in health facilities and at the community level. To ensure that most instances are captured, building a community-based monitoring system in all sub-counties other than those under attack was necessary. Furthermore, screening locations at various communal gathering points of entry, such as markets and religious places were conducted to detect persons with cholera symptoms. URCS arranged EPiC/CBS training sessions for URCS volunteers to ensure that confirmed cases are correctly reported and managed to avoid succumbing to the infection. Securing job aids for Village Health Team

members and Red Cross volunteers engaged in community engagement activities to ensure they deliver messages to communities much more effectively.

The Community Engagement Strategy

In 2020 the government of Uganda adopted the Red Cross-Community Engagement and Accountability approach to address the increased complacency to COVID-19 standard Operating Procedures, and this was operationalized as the community engagement strategy. By this, Village task forces (VTFs) were created across all the villages of Uganda each with a minimum of five members, inclusive of URCS volunteers. The concept around this structure was to strengthen Disease surveillance, risk communication, contact tracing, safe burials, health promotion, etc. URCS therefore activated these task forces in 626 villages across the nine response districts and these greatly contributed to early detection and reporting but also community compliance to EVD SOPS.

Establishment of burial teams to conduct low-risk burials.

To disrupt the widespread transmission of EVD in Mubende and Kassanda districts, the president imposed a temporary lockdown on the two districts with no mobility across. One of the directives put forward was to have all the burials conducted by a trained team. This was quite overwhelming for the three SDB teams of URCS in the two districts. The task force thought in the direction of training burial teams at sub-county levels to conduct low-risk burials. Partners contributed in various ways to have these teams trained and URCS particularly provided the trainers for this purpose. In the Mubende district, URCS was further assigned to operationalize and coordinate these teams to perform efficiently and effectively. Given the Ministry of Health's declaration of Ebola cases in Masaka and Jinja, URCS also further trained two standby SDB teams in each district to conduct both low-risk and high-risk burials.

Mentorship of the community volunteers

In collaboration with the M&E team, the health team arranged periodic mentorship of the community volunteers, especially around reporting, particularly on rumor tracking/community feedback. This was conducted across the nine response districts.

Coordination with stakeholders.

During the response, the team operated under the different national response pillars at the district level where shared responsibility was discussed and this has provided an advantage for the team, especially regarding common resources that can be shared. E.g., Vehicles, IEC materials, PPEs etc.

Daily data analysis and reporting

The M&E team conducted daily analysis of data, which was reviewed with the sole purpose of providing a basis for decision-making. For instance, we were able to tell which areas required what kind of support and acted immediately. Additionally, the M&E team continued to support other stakeholders during the response activities like dry food distribution in Jinja, Mubende, and Kassanda. Wet feeding with support from the World Food Programme (WFP) was also conducted effectively and successfully at Jinja Referral Hospital, Kaweeri ETU, and Mubende Regional Referral Hospital.

Clustering of the response team

To minimize the risk of exposure among the team members, the teams were clustered and positioned to operate at different workstations e.g., the ambulance team operated in its zone, the SDB team was allocated a small structure, and the public health/M&E /management and the rest of the team operated at their station.

Psychosocial support for the response team

Management outsourced a firm to provide psychosocial services for the teams and this was available throughout the week. In addition, there was provision for individual sessions at URCS offices in the Mubende district.

A. DETAILED OPERATIONAL REPORT

	Health & Care (*Mental Health and psychosocial support / Community Health / Medical Services).*	Female > 18: **242,227**	Female < 18: **279,863**
		Male > 18: **223,084**	Male < 18: **277,960**

Objective:	The spread and impact of the outbreak are reduced through community outreach in affected health zones.		
	Health Outcome 1: The spread and impact of the outbreak are reduced through community outreach in the affected health zones.		
Key indicators:	**Indicator**	**Actual**	**Target**
	% of CBS alerts investigated within 24 hours.	90%	100%

Community-based surveillance commenced right away from the start of the response and continued after the outbreak was declared over. However, the rate of alert reduced after the outbreak was declared over. URCS trained CBS volunteers in the affected districts who actively undertook surveillance to enhance the existing systems for early detection, reporting, responding, and monitoring of both Ebola and Cholera suspects in communities. Initially, CBS trainings were integrated into the RCCE trainings but now they were conducted independently to ensure full understanding of the expectations. During the response, URCS received alerts and worked with the Ministry of Health, the District Health Team together with other community structures to follow up on the cases reported by community volunteers.

For effective management, the alert system was centrally managed through established joint URCS and MoH centers where all calls are received through free hotlines, recorded, and referred. During the recovery phase, 16 true alerts were reported, 14 of whom were investigated and these were majorly mumps and measles across response districts of Mubende, Kassanda, Kyegegwa, Kagadi, and Bunyangabu. During the VTF bi-monthly meetings, the respected DHTs gave feedback to the village task force members of the respective districts.

To strengthen surveillance systems in Kayunga and Namayingo, 505 Community Health Workers were oriented, trained, and equipped with skills and knowledge on Community-Based Disease Surveillance so that they could quickly identify cases in their communities, collect data, and report on suspected cases. Reporting structures and channels were also established in the mentioned districts to encourage trained Community Health Workers to report and follow up on all cases reported.

Lessons Learnt

- Communities can detect and report any public health emergency if they are capacitated to do so.

- Communities can own community health programs if they are trained and given the responsibility to perform health-related tasks like health promotion and community-based disease surveillance.
- Sustainable structures right from village to district level build a strong surveillance system.

Challenges

- Delayed follow-up on true alerts sent by the District Health Team. This was commonly identified during the EVD recovery period where the district surveillance teams took longer to respond to alerts sent and verified as true alerts. This is attributed to the weak surveillance system in such districts due to logistical challenges.

	Health Output 1.1: The government is assisted by volunteers from the URCS for surveillance.		
Key indicators:	**Indicator**	**Actual**	**Target**
	# of volunteers trained in EPiC during Ebola response.	580	590
	# of volunteers trained in CBS during Ebola response.	1,110	590
	# of household visits.	112,234	12,000
	# of CBS volunteers who are active.	532	240
	# of true CBS alerts reported by trained volunteers.	2,645	NA
	# of CBS volunteers who are still active in EVD response districts.	532	240
	# of CBS volunteers who are still active in Kayunga and Namayingo.	505	350

During the active phase of the response, URCS trained 480 volunteers to support CBS from Mubende, Kassanda, Kyegegwa, Kagadi, and Bunyangabu. 100 volunteers from Masaka and Jinja were trained during the EVD recovery phase. Currently, 532 community volunteers are still conducting passive surveillance in their respective communities by sending zero alerts every week. 505 Community Health Workers were trained in Kayunga (410) and Namayingo (95) under the cholera program to conduct Community-Based Surveillance and community awareness just like was the case with the EVD team. 1,110 volunteers were trained on CBS during the Ebola response. The volunteers were able to conduct household visits both during the Ebola response and the Cholera

response. The household visits were for hygiene promotion awareness to community members and to respond to active cases through referrals.

	Health Outcome 2: The psychosocial consequences of the outbreak are reduced through direct support to the exposed and infected populations in Mubende and neighboring high-risk districts.		
Key indicators:	**Indicator**	**Actual**	**Target**
	% of people confirmed or suspected of having been affected by EVD receiving PSS support.	0	100

During the EVD response, the URCS PSS team wasn't allowed to interact with confirmed and suspected patients because of confidentiality. The MOH PSS team used to provide these services. However, URCS hired a PSS consultant firm that throughout the response, offered PSS services to all responding staff and volunteers.

It was discovered that during periods of emergencies, responding staff and volunteers undergo stressful moments, which affect their mental stability and productivity at work. Providing PSS to staff and volunteers significantly improved morale amongst team members as they felt being cared for by URCS as they do care about community people suffering from Ebola.

	Health Output 2.1: The population of the affected areas of Mubende and neighboring high-risk districts receive psychosocial support during and after the outbreak.		
Key indicators:	**Indicator**	**Actual**	**Target**
	# of personnel and volunteers reached by PSS support.	480	480
	# of community members who received PFA.	320	150

During the active phase of the response, PSS was provided to staff and volunteers on an individual and group basis. The statistics provided reflect the total number of individuals who received counseling services.

Three professional counselors were deployed to the responding teams in Mubende where they were conducting group and individual PSS sessions. All 6 SDB teams and 12 ambulance crew team members, volunteers, and staff benefited from the PSS services.

While conducting activities, deployed volunteers offered PFA to affected families.

A rest and recuperation modality was proposed for the first responders especially the SDB and ambulance teams allow recuperation.

	Health Outcome 3: Social mobilisation, risk communication, and community engagement activities are carried out to limit the spread and impact of EVD and Cholera.		
Key indicators:	**Indicator**	**Actual**	**Target**
	# of target community members reached by health messages.	1,023,134	5,188,525

URCS deployed community volunteers to conduct house-to-house risk communication to raise awareness about Ebola while targeting disease community case definitions and conducting health promotion activities. The focus was on communities with a low-risk perception of the disease, encouraging immediate action such as reporting suspicious cases and adopting preventive measures. Throughout the response, 112,234 household visits were conducted, and 10,374 communal gatherings reached across all response districts reaching out to 1,023,134 people.

	Health Output 3.1: Preparatory work is carried out to sensitize about 30% of the population of the affected areas of Mubende and neighboring high-risk districts to the social mobilization campaign of the URCS and the EVD operation.		
Key indicators:	**Indicator**	**Actual**	**Target**
	% of operation complaints and feedback received and responded to by the National Society.	36% (2062 complaints received and responded to)	80
	# of volunteers trained on community feedback.	626	50
	# of radio broadcasts.	2	24
	# of social mobilization sessions organized.	10,374 Communal gatherings	NA

- Feedback was collected by RCCE volunteers, shared via Kobo, and acted upon accordingly. Volunteers were reoriented on how to capture community feedback in a very precise way without losing its natural meaning. To effectively achieve this, all deployed volunteers were trained on community feedback during RCCE orientation, which happened in all nine (9)-response districts. These were further reoriented during the 7-day CBS training that took place in Mubende, Kassanda, Kyegegwa, Kagadi, Bunyangabu, Jinja, and Masaka. Initially, NS planned to train a maximum of 50 volunteers but due to the explosion of Ebola in Kassanda and other neighboring districts, URCS expanded its operations to the affected districts and this created a need to train more on how to capture community feedback.

- In addition to the Kobo tool, URCS set up complaint and feedback mechanisms including installing boxes in Mubende and a toll-free number anchored under the NS call center. The common feedback from the community was related to community perception in terms of rumours and misconceptions about the outbreak. A significant number of community members attached the outbreak to witchcraft and political affiliations while others had questions concerning the causes, treatment, and management of Ebola cases.
- As a way of providing feedback and listening to community members, 10,374 communal gatherings were organized across all response districts. These gatherings provided a platform for community members to talk directly to the Red Cross response technical team, and ask questions, and answers were provided instantly.
- Only two radio broadcasts were done as opposed to 24 since other RCCE activities covered a wide margin a decision was made to conduct only two radio broadcasts and cost implications were factored here as well.

	Health Outcome 4: The spread of Ebola is limited by the implementation of preparedness work and carrying out DHS under optimal cultural and safe conditions in Mubende and neighboring high-risk districts.		
Key indicators:	**Indicator**	**Actual**	**Target**
	% of deceased people for whom SDB were successfully carried out.	100	100
	% of suspected cases who are deceased were buried within 24 hours of the initial alert.	80	100

- All SDB alerts received were successfully handled.
- URCS is the lead in SDBs and has the confidence of the other response partners. The government declared all burials in the two lockdown districts of Mubende and Kassanda be conducted through SDBs, however, this puts a significant increase in the demand for SDB services. This directive saw an increase in burial alerts from an average of three a day to an average of nine alerts stretching the currently available force. Working with local authorities, MoH, and partners, URCS trained 10 burial teams in Kassanda and 19 others in Mubende to conduct less risky burials, a move that reduced the SDB workload. Given the EVD explosion in Jinja and Masaka, URCS also trained two (2) district teams in each district to conduct both high and low-risk burials. Each team in the two mentioned districts had nine (9) members in total.
- IFRC supported URCS in importing enough kits from DRC and Freetown to conduct 300 burials and additional kits were sourced internationally to increase the current stocks in the country.
- URCS received an average of nine daily SDB alerts and managed to conduct an average of three (3) safe and dignified burials translating to 33% initially. This gap was however filled by the trained burial teams at the districts and 23 burial teams at the sub-county level purposely to handle low-risk burials. This increased the response rate to suspected cases that were buried within 24 hours increased to 80% due to additional trained SDB teams.

- URCS had six (6) teams operating in Mubende and Kassanda and two (2) teams each in Jinja and Masaka. Cumulatively, the NS conducted 787 burials throughout the response.

Lessons Learnt

- There is a need to train SDB standby teams across all NS branches to handle such emergencies promptly.
- Conducting SDB requires community sensitization about its relevance to avoid community rejection.
- Need to conduct quarterly SDB drills and prepositioning of SDB kits across branches.
- The SDB team has to be composed of at least a community leader/opinion leader/cultural leader who can guide SDB teams, can easily be accepted by community members, and should lead all SDB activities.
- There is a need to incorporate cultural and religious norms within SDB activities as long as they do not compromise the safety of burial team members. Communities sometimes resist SDB stemming from total compromising religious or cultural norms.

Challenges

- Initial resistance from communities on SDB activities especially in Kassanda district and other strongly attached cultural communities.

Water, Sanitation and Hygiene

Female > 18: **242,227**	Female < 18: **279,863**
Male > 18: **223,084**	Male < 18: **277,960**

Objective:	Improve hygiene practices within the entire affected population.		
Key indicators:	**Indicator**	**Actual**	**Target**
	# Handwashing Facilities distributed.	325	NA
	# of ambulance/SDB car washing areas set.	1	1
	#other wash items distributed (Chlorine).	405Kgs	NA
	# Handwashing soap distributed.	600 boxes	NA
	# Tippy taps distributed.	2,000	NA

- Handwashing facilities, soap, and chlorine were distributed in major towns, trading centers, schools, markets, and communal gathering centers. Due to the declaration of EVD cases in Jinja, an additional 50 Handwashing facilities were distributed in high-risk areas of Buyengo particularly targeting public places including markets, areas of worship, and boda-boda stages among others.

- The MoH set aside a primary washing bay for all ambulances and SDB cars at the Ebola Treatment Units. URCS established a secondary washing to ensure the cars are safe for use for the next alert.
- IFRC supplied URCS with sufficient PPEs for the SDB teams while the MoH provided PPE kits to the URCS ambulance team.

Lessons Learned

- Communities are willing to adhere to SOPs as long as they are sensitized and demonstrated on how to use such materials.

Challenges

- Inadequacy of IPC materials given the scale of Operation.

Protection, Gender and Inclusion

Female > 18: **166,572**	Female < 18: **192,453**
Male > 18: **153,409**	Male < 18: **191,144**

Objective:	Protection, Gender and Inclusion communities identify and respond to the distinct needs of the most vulnerable segments of society, especially disadvantaged and marginalised groups, due to violence, discrimination and exclusion.		
Key indicators:	**Indicator**	**Actual**	**Target**
	# of staff and volunteers signed the Code of Conduct.	626	480
	# of people reached by Protection, Gender and Inclusion activities.	703,578	2,700,000

- Deployed community volunteers collected data through the Kobo tool designed to support teams in collecting disaggregated data by gender, age, and disability.
- During the response across all districts, URCS conducted briefing and debriefing sessions with responding teams daily and printed out guiding posters on measures to mitigate the risk of sexual and gender-based violence.
- URCS integrated gender-sensitive approaches into its response strategy to address the unique challenges faced by different genders within the community. Community members were sensitized on how to report cases of abuse and sexual harassment.

- With PGI, all 3,130 community volunteers were oriented on Protection, Gender, and Inclusion aspects and these trained to be pioneers of campaigning against sexual harassment in communities and discouraging child labor. These also emphasized the rights of children particularly those with disabilities and reporting any case of violence of their rights to the authorities. Initially, PGI was not integrated into RCCE but this was later incorporated into RCEE activities as part of communication packages to be shared with community members. Therefore a total of 703,578 people were reached with information on PGI and this was achieved during the movement of volunteers and VTF members in the communities, teaching communities on PGI while conducting routine RCCE activities. Of these, 365,861 were males while 337,717 were females. These messages were passed on clearly to all members of the community, the children and adults with the help of IEC materials. Reporting channels of any kind of violation were shared with community members during the same sessions.
- The number for PGI is less than the people reached through RCCE since PGI was just incorporated into the Kobo tool along the way during the response.

Enabling approaches

National Society Strengthening

Objective:	National Societies are prepared to effectively respond to epidemics/emerging crises, and their auxiliary role in providing humanitarian assistance is well-defined and recognised.		
Key indicators:	**Indicator**	**Actual**	**Target**
	# of supported staff dedicated to this operation.	33	33
	# of braches supported.	01	01

- The entire operation engaged 33 staff directly to support the response activities. These included; Health Officers, Monitoring and Evaluation officers, Ambulance crews, and Communication officers, among others.
- **Support to Mityana Branch:** URCS has provided support to the Mityana branch to enhance its capacity and facilitate its involvement in the response. This support included capacity building for branch volunteers, payment of office utility bills, fencing the Mubende sub-branch, and other necessary resources. Strengthening the capacity of the Mityana branch contributed to the overall effectiveness of the response efforts.

Coordination and Partnerships

Objective:	Technical and operational complementarity among IFRC membership and with the ICRC is enhanced through cooperation with external partners.		
Key indicators:	**Indicator**	**Actual**	**Target**
	# external partners	4	NA
	# of coordination meetings held with movement partners	32	48
	# of coordination meetings with partners	29	48

- URCS Collaborated with UNICEF, MOH, WHO, and WFP during the active phase of the response. Several activities were implemented effectively from these partnerships ranging from RCCE, and SDB to food distribution. For instance, WFP supported providing both hot meals and dry rations to EVD-affected families in Mubende, Kassanda, and Jinja. Using the VTF approach, affected families were easily identified and approached with assistance from URCS deployed volunteers, which enabled both entities to minimize on operational costs. Additionally, the overwhelming demand for SDB activities was minimized by training more SDB teams at the sub-county level to handle low-risk burials. In this partnership, URCS provided technical support by training these teams, and coordinating their activities while WHO and MOH financially supported the teams.
- It should be noted that among the complaints URCS volunteers captured from the community was about the suffering of Ebola patients and suspects in hospitals and ETUs due to restricted food supply from their homes. However, with the daily distribution of hot meals and dry ratios to affected families, there was increased reporting and referrals of suspected Ebola cases due to assurance of feeding both at ETU and household members left.

- URCS planned to have weekly coordination meetings with partners. However, only 29 meetings were held. This was because most of the meetings for partners were coordinated and hosted by the MoH.
- IFRC joined URCS during the weekly national task force meetings and also during the daily district task force meetings. Participating in these meetings provided an opportunity for URCS to always update both national and district task force members on how response activities are conducted, challenges faced, gaps identified, and seek any partnership and necessary support where needed. It was from these engagements that URCS was able to work closely with WHO, UNICEF, and WFP throughout the response.
- Coordination meetings with movement partners were held every week during the active phase of the response. The intention was to keep partners updated on the activities implemented, achievements, and related challenges and discuss the way forward.

Secretariat Services

Objective:	Effective and coordinated disaster response is confirmed.		
Key indicators:	**Indicator**	**Actual**	**Target**
	NS assisted with risk register development.	1	1
	NS assisted with BCP and workplace plan development.	1	1
	# of monitoring missions conducted.	1	1
	NS supported with key messages.	1	1
	NS supported with Ebola PMER framework.	1	1

- IFRC supported URCS in developing its business continuity plan, workplace plan, risk register, and Ebola PMER framework. These plans helped the NS to continue conducting other ongoing projects given a considerable number of her staff who were relocated to support the response. The workplace plan provided the safety of URCS staff and volunteers who were stationed in the field providing all necessary support to the affected communities. Additionally, the PMER framework significantly assisted the PMER team specifically in reporting, monitoring, and tracking the progress of activities implemented during the response.
- IFRC also deployed the head of operations, operations manager, finance, logistics, RCCE, Risk manager, and health delegates who provided technical support to the NS.

C. FINANCIAL REPORT

Operational Strategy

Selected Parameters			
Reporting Timeframe	2022/9-2025/03	Operation	MDRUG047

FINAL FINANCIAL REPORT

Prepared on 14 May 2025

All figures are in Swiss Francs (CHF)

MDRUG047 - Uganda - Ebola Virus Disease Outbreak

Operating Timeframe: 23 Sep 2022 to 31 Dec 2023; appeal launch date: 30 Sep 2022

I. Emergency Appeal Funding Requirements

Total Funding Requirements	**5,000,000**
Donor Response* as per 14 May 2025	**3,148,013**
Appeal Coverage	**62.96%**

II. IFRC Operating Budget Implementation

Planned Operations / Enabling Approaches	Op Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items	0	0	0
PO02 - Livelihoods	0	0	0
PO03 - Multi-purpose Cash	0	0	0
PO04 - Health	1,739,248	1,373,540	365,707
PO05 - Water, Sanitation & Hygiene	0	0	0
PO06 - Protection, Gender and Inclusion	0	0	0
PO07 - Education	0	0	0
PO08 - Migration	0	0	0
PO09 - Risk Reduction, Climate Adaptation and Recovery	277,255	858,023	-580,768
PO10 - Community Engagement and Accountability	0	0	0
PO11 - Environmental Sustainability	0	0	0
Planned Operations Total	**2,016,503**	**2,231,563**	**-215,060**
EA01 - Coordination and Partnerships	73	0	73
EA02 - Secretariat Services	1,050,689	805,749	244,940
EA03 - National Society Strengthening	0	0	0
Enabling Approaches Total	**1,050,762**	**805,749**	**245,013**
Grand Total	**3,067,265**	**3,037,312**	**29,952**

III. Operating Movement & Closing Balance per 2025/03

Opening Balance	0
Income (includes outstanding DREF Loan per IV.)	3,148,013
Expenditure	-3,037,312
Closing Balance	**110,700**
Deferred Income	0
Funds Available	110,700

IV. DREF Loan

* not included in Donor Response	Loan :	499,259	Reimbursed :	499,259	**Outstanding :**	**0**

Operational Strategy

Selected Parameters			
Reporting Timeframe	2022/9-2025/03	Operation	MDRUG047

FINAL FINANCIAL REPORT

Prepared on 14 May 2025
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MDRUG047 - Uganda - Ebola Virus Disease Outbreak

Operating Timeframe: 23 Sep 2022 to 31 Dec 2023; appeal launch date: 30 Sep 2022

V. Contributions by Donor and Other Income

Opening Balance	**0**

Income Type	Cash	InKind Goods	InKind Personnel	Other Income	TOTAL	*Deferred Income*
American Red Cross	324,914				**324,914**	
British Red Cross	112,119				**112,119**	
European Commission - DG ECHO	197,473				**197,473**	
Hong Kong Red Cross, Branch of the Red Cross Socie	23,453				**23,453**	
Italian Government Bilateral Emergency Fund	244,255				**244,255**	
Japanese Red Cross Society	33,642				**33,642**	
On Line donations	25				**25**	
Red Cross of Monaco	9,875				**9,875**	
Swedish Red Cross	134,631				**134,631**	
The Canadian Red Cross Society (from Canadian Gov	156,350				**156,350**	
The Netherlands Red Cross (from Netherlands Govern	158,400				**158,400**	
United States Government - USAID	1,752,875				**1,752,875**	
Total Contributions and Other Income	**3,148,013**	**0**	**0**	**0**	**3,148,013**	***0***
Total Income and Deferred Income					**3,148,013**	*0*

Contact information

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

At the Uganda Red Cross Society:

- Secretary-General, Robert Kwesiga; phone: +256 772 638890; email: sgurcs@redcrossug.org
- Director of Health and Social Services, Dr. Josephine Okwera; email: jokwera@redcrossug.org

At the IFRC Country Cluster Delegation:

- Mohamed BABIKER, Head of Delegation, Juba Cluster Delegation; phone: +211 91 217 9511; email: mohamed.babiker@ifrc.org
- Daniel Mutinda, Disaster Management Delegate, Juba Cluster Delegation; phone: +211 918924507; email: daniel.mutinda@ifrc.org

IFRC Africa Region Office:

- Rui Alberto Oliveira, Health, Disaster Crisis Prevention, Response and Recovery Department, Nairobi, Kenya; phone +351914758832; email: rui.oliveira@ifrc.org

IFRC in Geneva:

- Rena Igarashi, Operations Coordination, Senior Officer, DCC Unit Geneva; email: rena.igarashi@ifrc.org
- Eszter Matyeka, Senior DREF Officer, DCC Geneva Unit; email: eszter.matyeka@ifrc.org

For IFRC Resource Mobilisation and Pledges support:

- Louise Daintrey-Hall, Head of Partnership and Resource Development, phone: +254 110 843 978; email: louise.daintrey@ifrc.org

For In-Kind Donations and Mobilisation Table support:

- IFRC Africa Regional Office for Logistics Unit: RISHI Ramrakha, Head of Africa Regional Logistics Unit; phone: +254 733 888 022; email: rishi.ramrakha@ifrc.org

For Performance and Accountability support (planning, monitoring, evaluation, and reporting enquiries):

- IFRC Africa Regional Office: Beatrice Okeyo, Regional Head PMER, and Quality Assurance; email: beatrice.okeyo@ifrc.org

Reference documents

- ↘
- Click here for:
- Operations update 2
- Operations update 1
- Operations Strategy
- Emergency Appeal
- DREF Operation

How we work

All IFRC assistance seeks to adhere the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief, the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere**) in delivering assistance to the most vulnerable, to **Principles of Humanitarian Action** and **IFRC policies and procedures**. The IFRC's vision is to inspire, encourage, facilitate and promote at all times all forms of humanitarian activities by National Societies, with a view to preventing and alleviating human suffering, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

Pictorials

Capacity building of M&E team on community feedback coding during EVD in Mubende.

URCS volunteers undergoing training in EPiC and CBS at Kibalinga S/C, Mubende district.

Training of SDB team in Jinja to conduct burials

Training of SDB team in Masaka to conduct burials

URCS technical team orienting community volunteers in Mubende district during EVD recovery.

URCS technical team orienting community volunteers in Bunyangabu district during EVD recovery.

Training of CHWs in Kayunga district on CBDS

Training of CHWs in Namayingo district on CBDS