DREF Operation

South Sudan MVD Readiness

Appeal: MDRSS018	Hazard: Epidemic	Country: South Sudan	Type of DREF: Response
Crisis Category: Yellow	Event Onset: Slow	DREF Allocation: CHF 149,859	
Glide Number: -	People Affected: 131,000 people	People Targeted: 131,000 people	
Operation Start Date: 30-12-2025	Operation Timeframe: 2 months	Operation End Date: 28-02-2026	DREF Published: 10-01-2026
Targeted Regions: -			

Description of the Event

Date when the trigger was met

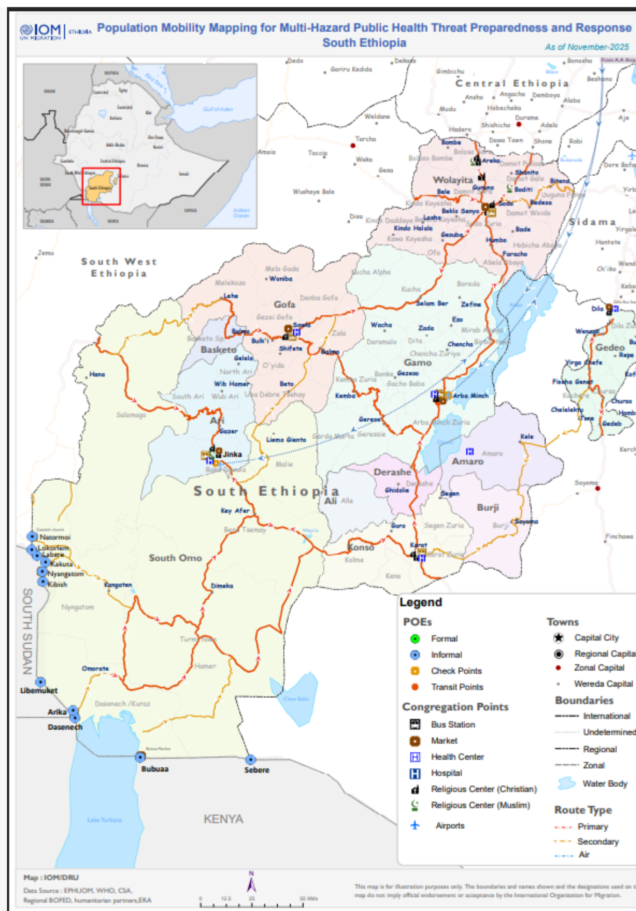
23-12-2025

What happened, where and when?

On December 23, 2025, 3 suspected Marburg Virus Disease cases (deaths) were reported in Kapoeta East County in South Sudan, involving 2 people who had a previous travel to the affected areas in Ethiopia in November 2025, and 1 suspected case believed to be due to a possible community spread to a close family contact. Field investigations into these 3 probable cases are underway and a detailed report is expected from the South Sudan National MOH Rapid Response Team. This trend with the request for support from MoH to South Sudan RC on 17 December mark a need for National Society to step in to strengthen the readiness. With the subsequent events. The SSRC engaged the national ministry of health and partners (WHO, Africa CDC, IGAD among others) at the national level to get an official letter calling for partners' support in MVD preparedness and readiness.

The Marburg Virus Disease (MVD) outbreak has been a relative risk for South Sudan since the first case in Ethiopia on 14 November 2025 in Jinka, in the South Region of Ethiopia. As of the latest update, Ethiopia has documented a cumulative total of 14 confirmed MVD cases and 9 confirmed deaths (CFR OF 64%) and 5 recoveries. There has been a further spread of cases within Ethiopia from the epicenter in Jinka, to Hawassa in Sidama Region of Ethiopia. With the events of 23 December, the risk of cross-border transmission into South Sudan has further increased, with permanent risk factors such as the sustained population movement and trade links.

The high incidence of the disease make the outbreak a significant risk for South Sudan. Marburg Virus Disease is a severe hemorrhagic fever characterized by sudden onset of high fever, headache, and malaise, followed by gastrointestinal symptoms and, in many cases, hemorrhage within one week of symptoms' onset. Case fatality rates in past outbreaks have ranged from 24% to 88%, depending on virus strain and quality of case management, and the current Ethiopian situation with a CFR of 64% is consistent with a high-severity event. Transmission occurs through direct contact with blood or other body fluids of infected people, contaminated surfaces or materials, and through unprotected contact with bodies during funerals, which makes household caregiving and traditional burials key drivers of spread in settings with limited IPC capacity.



Scope and Scale

Although current confirmed Marburg cases remain within Ethiopia, South Sudan is at significant risk due to regular cross border movements for trade, markets, grazing, social visits and displacement. Based on the outbreak location in Ethiopia (South Region) and the mapped population movement between Ethiopia and neighboring Kenya and South Sudan through informal cross border crossing points, the risk of possible spill over transmission is important for the 2 neighboring countries.

As a summary of the current trend, the outbreak was declared in Ethiopia on 14 November 2025. On 23 November 2025, the Ethiopian authorities announced that five people had died from Marburg Virus Disease in Jinka, Southern Region. As of 26 November 2025, 78 laboratory tests were conducted with 12 confirmed cases and 7 confirmed deaths. By then, more than 300 contacts had been identified and under active follow-up. As of December 22, 2025, Ethiopia had reported 14 laboratory-confirmed Marburg cases with 9 deaths. Cases reported so far have been in the Southern and Sidama Regions of Ethiopia.

As of December 23, 2025, 3 suspected Marburg Virus Disease cases (deaths) were reported in Kapoeta East County in South Sudan, involving 2 people who had a previous travel to the affected areas in Ethiopia in November 2025, and 1 suspected case believed to be due to a possible community spread to a close family contact. Field investigations into these 3 probable cases are underway and a detailed report is expected from the South Sudan National MOH Rapid Response Team.

With the outbreak declaration in Ethiopia and the trend of the outbreak, a risk mapping on potential spread into neighboring areas of South Sudan was done at country level. The four targeted counties neighboring Ethiopia affected region (Maiwut, Akobo, Pibor and Kapoeta East) host an estimated 786,000 people and act as important corridors between South Sudan, Ethiopia and, in the case of Kapoeta East, Northwest Kenya and Northeast Uganda. Health facilities in these areas already operate with limited human resources, constrained WASH infrastructure, sub optimal IPC, and long distances to referral centers, limited laboratory capacity. All these compounding factors could potentially delay detection of imported cases and increase the risk of onward community transmission as already seen with the 3 probable deaths mentioned above.

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

Source Name	Source Link
1. MOH-Republic of South Sudan	https://www.radiotamazuj.org/en/news/article/south-sudan-issues-public-alert-after-marburg-outbreak-confirmed-in-ethiopia#:~:text=The%20National%20Ministry%20of%20Health,%2C%20surveillance%2C%20and%20public%20awareness.

Previous Operations

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

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

-

Lessons learned:

Not applicable as no other VHF has recently occurred in South Sudan. SSRC will however leverage on lessons learnt in the implementation of other infectious diseases such as cholera to ensure proper coordination and timely implementation and reporting of this operation, ensure volunteer safety and to reach to all targeted populations including those living in hard-to-reach areas.

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

Current National Society Actions

Start date of National Society actions

12-04-2025

Health	South Sudan Red Cross has activated its volunteer network activities in the four high-risk border counties of Maiwut, Akobo, Pibor and Kapoeta East to support early detection and community preparedness for Marburg Virus Disease. 120 branch volunteers-30 each location trained on Marburg Virus Disease (MVD) and given an overview on the ongoing outbreak in Ethiopia. The training focused on MVD causative agent, modes of transmission, the key signs and symptoms of the disease, prevention measures and establishment of referral pathways for suspects in the community. This also include integration of initial risk communication into ongoing community health activities. SSRC is using its existing Community Based Surveillance volunteers and community-health platforms to map high-risk payams, border crossings points, markets and health facilities where community-based surveillance and RCCE will be prioritized once the DREF is approved.
Community Engagement And Accountability	SSRC has activated its community-level feedback mechanisms in all four at-risk counties to capture community feedback on myths, fears and misconceptions regarding MVD and to address these through targeted risk communication activities in the affected areas through the trained and deployed volunteers. SSRC continues to map existing health

	facilities for effective referral of suspected cases and strengthening reporting by community health workers and SSRC Volunteers.
Coordination	SSRC is working in close coordination with the Ministry of Health and other partners at national level. SSRC is also coordinating its activities with other partners through active participation at the national steering committee meetings that bring together all partners and lines ministries on weekly basis (on Thursdays) to discuss preparedness and response activities which now include VHF preparedness activities. SSRC also continue to coordinate its activities through the national society emergency operation centre which consolidates all preparedness activities to guide decision making at management level. Other forums include the RCRC partners monthly Movement Operation Coordination (MOC) where all ongoing preparedness activities are presented. At the field level, SSRC is working closely with county health departments, state ministry of health, and other partners and this will be enhanced during the implementation of this DREF activities.
National Society Readiness	Existing capacities: SSRC has established experience in epidemic preparedness and response through previous Ebola preparedness activities, current cholera response and COVID-19 operations. SSRC has 30 trainers on community-based surveillance, and risk communication and community engagement. The National Society has 250 staff with specialities in WASH, health, protection and disaster risk management. and approximately 21,000 volunteers spread across the country through 21 branches and 102 units. Four (4) of these branches are situated at the Ethiopia-South Sudan cross border areas with staff and volunteers. The national society has 35 health national disaster response teams enabling rapid mobilisation of community-level action when adequately resourced and guided. SSRC also maintains functional coordination links with the Ministry of Health and state authorities, participates in national emergency coordination platforms, and has activated its branch network in Upper Nile, Jonglei, Greater Pibor Administrative Area and Eastern Equatoria for Marburg preparedness. Preparedness strengths: At community level, SSRC can quickly deploy trained volunteers for CBS, RCCE and basic psychosocial first aid, using existing tools and methods that can be adapted to MVD outbreak response including EPiC, CBHFA, ECV, CEA and PGI modules for training volunteers. At institutional level, SSRC has systems for volunteer management, safety briefings, insurance and safeguarding/PSEA, as well as experience working with IFRC surge, PMER and logistics procedures during health emergencies. Readiness gaps the DREF will address: Despite these strengths, SSRC currently has limited MVD outbreak response specific technical capacity, insufficient SDB teams and kits, and inadequate PPE and IPC/WASH supplies pre-positioned in the four target counties. Surveillance and response coverage remains thin in remote border payams and informal crossing points, and existing feedback and communication channels require reinforcement to manage rumours, stigma and community concerns in the event of alerts or confirmed cases.
Assessment	No rapid Marburg-specific needs assessments have yet been conducted by SSRC in South Sudan. There are currently no confirmed or suspected Marburg Virus Disease cases in the country, and the operation is framed as preparedness in anticipation of a spillover across the border due to high movement people for trade and cultural ties. However, SSRC and health authorities are already using existing assessments and routine data from previous epidemic in the four target counties to inform risk analysis, identify vulnerable groups, and prioritise high-risk payams, health facilities, markets and crossing points for preparedness actions. SSRC is currently planning with Ministry of health and partners, to conduct rapid needs assessments to gather essential information on transmission context, access to health care, WASH and IPC gaps, population movement patterns and community perceptions, and this data will be used to refine targeting and adjust the preparedness and response activities should cases be confirmed in South Sudan.

Resource Mobilization	Financial resources The National Society is seeking DREF support to cover core preparedness and early response costs, including CBS, SDB and RCCE trainings, pre-positioning of IPC supplies, deployment and supervision of volunteers, ambulance readiness, WASH/IPC upgrades and NS coordination and PMER capacities. Danish Red Cross has already provided 20,000 USD to support initial preparedness activities, which is funding the training of 120 volunteers in the four target counties, their travel and field allowances, and the design and production of Marburg-specific IEC materials. SSRC is reaching out to other in country PNs to support other activities. Material resources To ensure readiness, SSRC needs to procure and pre-position adequate stocks of PPE, disinfectants, sprayers, thermometers, body bags, SDB kits, handwashing facilities, soap and chlorine for use in health facilities, ambulances and communities in the high-risk border counties. This will enhance response capacity in the border areas where no such capacity exists. Additional equipment is required for volunteers and staff, including visibility items, basic first aid and PFA materials, digital tools for CBS (phones or tablets) and supplies to support WASH/IPC improvements in selected health facilities and public places. Human resources, fundraising and partnerships SSRC plans to dedicate and, where necessary, assign key staff (health/PHiE focal point, RCCE/CEA officer, WASH officer, PMER and finance/logistics staff, and county-level coordinators) to manage and supervise the operation. The DREF will complement bilateral partner support, while SSRC and IFRC will continue engaging partners and technical agencies (WHO, UNICEF, Africa CDC and others) to mobilise additional funding and technical support in case of transition to response.
Activation Of Contingency Plans	South Sudan Red Cross does not have Marburg contingency plans however three main scenarios are linked to national PHEOC triggers and WHO guidance. Scenario 1 – No cases, high regional risk If South Sudan continues to record no suspected or confirmed Marburg cases but Ethiopia's outbreak persists, SSRC will maintain heightened preparedness in Maiwut, Akobo, Pibor and Kapoeta East. Actions include continuous CBS and event-based surveillance, targeted RCCE and community dialogues, pre-positioning of PPE and SDB kits, readiness of ambulances and SDB teams, and regular coordination and information-sharing with MoH, PHEOC, WHO and partners. Scenario 2 – Imported case(s) with limited local transmission If one or more suspected or confirmed Marburg cases are detected in any of the four counties, SSRC will move from preparedness to focused response in affected areas. Steps include rapid deployment of trained volunteers and SDB teams, intensified CBS and contact tracing support, reinforcement of IPC/WASH measures in designated health facilities, expanded RCCE and community feedback, and provision of PFA to affected families, health workers and volunteers. Scenario 3 – Sustained community transmission If sustained local transmission occurs and cases spread beyond initial foci, SSRC will scale up multi-sectoral response in coordination with MoH and partners and request additional resources beyond the initial DREF. The plan foresees expanding CBS and RCCE coverage, increasing SDB and WASH/IPC capacity, strengthening surge staffing and logistics, and integrating Marburg response into wider health and humanitarian operations in the affected states.
National Society EOC	South Sudan Red Cross activated its Emergency Operations Centre (EOC) structure to coordinate Marburg preparedness and any potential response, in close alignment with the national PHEOC. EOC role and functions When the Marburg threat level is elevated, SSRC will activate its Emergency Operations

	Centre and assign thematic leads in (Health/PHiE, WASH, RCCE/CEA, PGI, Logistics, Finance/Administration, PMER and Security). The Emergency Operation team shall consolidate information from branches in Maiwut, Akobo, Pibor and Kapoeta East, managing tasking of volunteers and staff, and align SSRC plans and actions with those of the Ministry of Health, Public health emergency operation centre (PHEOC), World Health Organisation (WHO) and other partners. Resource management and monitoring Through the EOC, SSRC will oversee allocation and tracking of financial, material and human resources, including deployment of trained volunteers, distribution of PPE, SDB and WASH/IPC supplies, and support to ambulances and field teams. The EOC will also receive and analyse CBS alerts, situation reports and community feedback from the four counties, produce regular internal and external situation updates, and recommend adjustment of operation and escalation (or de-escalation) of activities based on the evolving risk and caseload.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC country cluster for Uganda, Tanzania and South Sudan is based in Juba, South Sudan with technical staff providing technical support to SSRC staff supporting the operations across the different operations (programs, Finance, Administration, HR and Security). The cluster also facilitates coordination among movement partners and ICRC.
Participating National Societies	There are currently seven Partner National Societies (Swedish RC, Danish RC, Netherlands RC, Swiss RC, German RC, Finnish RC, Norwegian RC) in addition to ICRC in South Sudan. They support activities in different programmatic areas of health, WASH, Protection and Disaster risk Management and security. The Danish RC has already contributed financial support to this operation to an amount of 20,000 USD that enabled the kick starting of field level activities

ICRC Actions Related To The Current Event

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

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	National coordination and surveillance The Ministry of Health has reactivated the national Public Health Emergency Operation Center (PHEOC) in Juba to coordinate preparedness, strengthen surveillance, and conduct continuous risk assessment at national and state levels. Rapid response teams have been deployed to high-risk counties bordering Ethiopia and along key movement corridors, including Kapoeta East, Akobo, Pochalla and the Greater Pibor Administrative Area, to enhance event-based surveillance and early detection. Border and community measures Authorities have intensified screening and monitoring at formal border points with Ethiopia, advising health facilities and local governments in high-risk areas to be on alert for suspected MVD cases. The Ministry of Health has issued public advisories, activated a toll-free hotline, and urged communities to promptly report symptoms consistent with

	viral hemorrhagic fevers for follow up. Regional and international engagement South Sudan government has participated in regional coordination efforts convened by IGAD and Africa CDC, sharing information and aligning national preparedness measures with neighboring countries. These engagements aim to strengthen cross-border early warning, laboratory readiness, infection prevention and control, and risk communication and community engagement in light of the outbreak in Ethiopia.
UN or other actors	WHO is working with the Ministry of Health to reinforce outbreak-readiness systems, including support to rapid response teams, pre-positioning of essential medical supplies, and training of health workers and community level cadres on viral hemorrhagic fever detection, case management, and IPC at different levels of the health system. Following the suspected cases on 23rd December 2025, the WHO deployed a team to Kapoeta East County to support the local County Health Department in screening of travelers, orienting health workers on MVD, RCCE and to preposition supplies. UNICEF and other humanitarian partners are using existing health, WASH and RCCE platforms to help disseminate public information on Marburg, integrate key messages into ongoing community programmes, and maintain essential services in high-risk and border areas. IGAD, through its PREPARE project, has convened high-level regional coordination on the Marburg outbreak in Ethiopia and is working with South Sudan and other member states to strengthen cross-border early warning, points-of-entry preparedness, laboratory capacity, and harmonized risk communication. Africa CDC has engaged South Sudan's health authorities as part of regional efforts to support preparedness in countries neighboring the outbreak area, including technical guidance and potential surge support for surveillance and response.

Are there major coordination mechanism in place?

Public Health Emergency Operations Center (PHEOC)

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

National and state task forces, IDSR and EWARS

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

Needs (Gaps) Identified

Health

Insufficient Community-Based Surveillance (CBS) Capacity for Early Detection.

The identified high-risk border counties in South Sudan lack an adequate number of trained Community-Based Surveillance (CBS) volunteers to support early detection, alert generation, and referral of suspected Marburg Virus Disease (MVD) cases. CBS functionality at prioritized high-risk border points and community entry routes remains limited, increasing the risk of delayed detection, under-reporting, and onward transmission.

Limited Trained Human Resources on EPiC for Marburg Preparedness

There is a limited pool of SSRC volunteers and Community Health workers trained in the Epidemic Preparedness and Response in Communities (EPiC) module. This constrains community-level preparedness and response to MVD and other Viral Haemorrhagic Fevers (VHFs), particularly in border and hard-to-reach areas. Strengthened capacity building is required to enhance prevention, detection, and response at the community level.
Inadequate Risk Communication and Community Engagement (RCCE) Coverage

Border communities have insufficient knowledge of MVD symptoms, transmission risks, and the importance of early reporting. Existing SSRC RCCE teams are not sufficiently trained or systematically integrated into CBS structures, reducing the effectiveness of community sensitization, rumor tracking, and timely behavior change. Targeted and intensified RCCE interventions linked to CBS are therefore required.

Limited Access to Safe Water and WASH Services

High-risk border communities face limited access to safe water and adequate WASH services, increasing vulnerability to disease transmission and undermining infection prevention and control (IPC) measures during suspected or confirmed MVD events.

Key Activities

1. Epidemic Preparedness and response in Communities training
- Train 240 volunteers in EPiC in the 4 targeted cross border counties.
- Conduct door-to-door visits, community dialogues, radio programmes and market-day talks to deliver Marburg and general epidemic-prevention messages.
- Print and disseminate IEC materials (posters, and Leaflets).
- Produce and disseminate recorded audio jingles and drama information on Marburg prevention in English and Arabic languages.

2. Community-based surveillance
- Train 240 volunteers in CBS in the 4 targeted cross border counties.
- Deploy trained volunteers for community case detection and reporting of suspected MVD cases.

3. Safe and Dignified Burials
- Train 3 SDB teams (TOTs) at the national/sub national level for rapid cascade training to field level SDB teams should a case be confirmed in country.
- Procure 1 SDB training kit for the SDB TOT training.
- Work with the National Ministry of Health to develop (or review and update) and disseminate national SDB SOP.

4. Infection Prevention and Control
- Procure and preposition IPC supplies in 4 high-risk border states and referral health facilities.
- Work with the National Ministry of Health to develop (or review and update) and disseminate national IPC SOP.
- Train 60 (15 per location) healthcare workers, cleaners, porters, and waste handlers on VHF-specific IPC and waste management practices.

Water, Sanitation And Hygiene

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

At both facility and community levels, chronic water shortages, poor sanitation, and weak healthcare waste management undermine effective IPC. Health facilities lack reliable water supply, storage, and backup systems needed to sustain intensive care and isolation for suspected MVD cases. Communities—particularly mobile pastoralists, traders, and fisherfolk—depend on unsafe shared water sources, have low adoption of handwashing and safe caregiving practices, and face limited access to soap and water treatment products. Inadequate healthcare waste management, including lack of color-coded bins, sharps containers, biohazard bags, and functional incinerators, combined with training gaps among cleaners and frontline staff, increases occupational and community transmission risks.

Key Activities
- Conduct training to 80 Volunteers (20 Volunteers per location) on hygiene in emergencies
- Conduct 40 hygiene sessions (10 per location) with 30 people per session (1200 People)

Protection, Gender And Inclusion

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

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

Key activities include.
- Promote inclusion of marginalized groups, including displaced populations, pastoralists, and persons with disabilities, in preparedness planning and decision-making.
- Coordinate with health and WASH actors to ensure protection considerations are integrated into screening, isolation, hygiene promotion, and border health activities.

These two activities will be integrated into the routine volunteer activities as they undertake routine RCCE activities, and by SSRC through the various coordination forums as budgeted for in this operation.

Community Engagement And Accountability

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

Key activities
- Establish and support community dialogue, 8 sessions and feedback mechanisms (e.g. community meetings, local leaders, volunteers, hotlines) to share information, address rumors, and incorporate community concerns into preparedness planning. This activity will be integrated into daily volunteers' activities as they undertake RCCE work.

Operational Strategy

Overall objective of the operation

To strengthen Marburg virus disease (MVD) preparedness and readiness in high-risk cross border areas of South Sudan–Ethiopia by enhancing early detection, prevention, community acceptance and coordinated response capacities, while ensuring protection, dignity and inclusion of all population groups.

Operation strategy rationale

The South Sudan–Ethiopia border is characterized by high population mobility, porous crossing points, remote and hard-to-reach communities, weak health and WASH infrastructure, and limited access to timely information and services. These factors increase the risk of delayed detection and rapid cross-border transmission of Marburg virus disease. The operational strategy therefore prioritizes community-based preparedness, decentralized capacity building, and integrated multi-sectoral action (Health, WASH, PGI and CEA) to

ensure early warning, risk reduction, trust-building and inclusive implementation of preparedness measures, aligned with national and cross-border coordination mechanisms.

The priority actions will be on community health through 240 SSRC volunteers spread across the 4 priority counties. These volunteers will be equipped with knowledge and skills through EPiC training (ECV, CEA, CBHFA and PFA). The ECV package will enable volunteers to recognize and identify community members presenting with signs and symptoms of MVD for timely detection. The CEA package will enable the volunteers to appreciate how local communities are structured and be able to engage them competently for better adoption of health behaviors advocated for through RCCE activities. The CBHFA will equip the volunteers with basic skills on how to protect themselves and to guide suspected cases on actions to take to address symptoms especially those with high grade fevers as they link them to healthcare service delivery points, while PFA will give volunteers skills on how to support each other and mentally distressed community members during their routine community-based activities. RCCE interventions shall be implemented through the trained volunteers through house-to-house visits complemented by use of IEC materials and airing of MVD messages over the radio for wider coverage.

After the EPiC training the volunteers will further be trained on CBS to enable timely reporting of suspected cases for early action to avert wider MVD community spread. Further to this, the operation will support the training of 3 SDB teams (trainers of trainers) to equip them with knowledge and skill to undertake cascade training to actual SDB teams at the community level should an MVD outbreak be confirmed in South Sudan. The teams will comprise both MOH and NS participants with a mix of participants from the national and State level.

Additionally, SSRC will support the training of 60 health facility staff across the 4 counties on health facility specific IPC and waste management practices for health staff safety and to prevent hospital-community spill over events should a case be handled in any of the catchment health facilities. SSRC will further support these health facilities with IPC supplies alongside the training to facilitate proper IPC practice by healthcare workers. For infection prevention and control at the community level, SSRC will support the training of 80 Volunteers (20 volunteers per county) on hygiene in emergencies and conduct 40 hygiene sessions at the community level.

CEA and PGI prioritized activities shall be mainstreamed into the implementation of the above-mentioned costed interventions under health and WASH.

Targeting Strategy

Who will be targeted through this operation?

The intervention prioritizes counties along or near the Ethiopia border (Akobo, Kapoeta, Maiwut and Pibor) that have been identified by the Ministry of Health as high risk for Marburg due to intense cross-border movement, trade, and pastoral mobility with the outbreak epicenter (Jinka and South Omo) in Ethiopia. These locations—already characterized by weak health and WASH services—are further strained by the presence of displaced populations and returnees, increasing the likelihood of exposure and rapid transmission in the event of a viral hemorrhagic fever introduction. Targeting these areas and populations aims to reduce outbreak risk while addressing heightened health, protection, and information gaps among the most vulnerable groups.

Explain the selection criteria for the targeted population

The operation will target:
- Counties along or near the Ethiopia border identified as high risk for Marburg (Kapoeta East, Akobo, Pochalla, and the Greater Pibor Administrative Area).
- Areas with high levels of cross-border movement, trade, and pastoral mobility.
- Locations with weak health and WASH service coverage within these 4 target counties.
- Border and host communities with frequent contact with travellers and traders.
- IDPs, returnees, and refugees in border and transit areas living in congested settings with limited access to health care, WASH, and reliable information.

Total Targeted Population

Women	66,810	Rural	0.9%
Girls (under 18)	-	Urban	0.1%
Men	64,190	People with disabilities (estimated)	0.2%
Boys (under 18)	-		
Total targeted population	131,000		

Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	Yes
Does your National Society have prevention of sexual exploitation and abuse policy?	Yes
Does your National Society have child protection/child safeguarding policy?	Yes
Does your National Society have whistleblower protection policy?	Yes
Does your National Society have anti-sexual harassment policy?	Yes

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

Risk	Mitigation action
1. Insecurity and access constraints Armed violence, intercommunal clashes and criminality can disrupt access to high-risk border counties, delay deployment of teams, and endanger staff and volunteers. This could slow implementation of CBS, RCCE and WASH/IPC activities, force suspensions or rerouting, and increase operational costs for security measures and alternative transport.	Work through local SSRC branches and volunteers from target counties who can operate safely when national staff movement is restricted and coordinate closely with local authorities and community leaders on timing and routes. Apply strict security SOPs, use remote support (phone/online coaching, radio RCCE, pre-positioned supplies) when field access is limited, and integrate security costs (secure transport, communications) into the budget as contingency.
2. Flooding and climatic shocks Seasonal flooding regularly damages roads, airstrips and health facilities, especially in Jonglei, Upper Nile and parts of Eastern Equatoria, cutting off communities and humanitarian supply routes. Such disruptions could delay pre-positioning of PPE and SDB kits, limit supervision and monitoring visits, and compress timelines into shorter windows when physical access is possible.	Pre-position PPE, WASH and IPC supplies in branch warehouses and health facilities before peaking rainy seasons, and use diversified transport options (boats, motorbikes, air where available) for last-mile delivery. Build flexible implementation plans with seasonal access mapping, allowing activities to be advanced or shifted between locations depending on flood conditions, with a small contingency for emergency air or river transport if critical gaps emerge.
3. Weak health system and parallel outbreaks The health system is fragile, under-funded and already strained by other epidemics (e.g., cholera) and high routine caseloads. Limited human resources, laboratory capacity and supplies mean that a Marburg alert or confirmed case could overwhelm facilities, divert staff from preparedness tasks, and slow investigation and confirmation, undermining early-action objectives.	Focus Red Cross support on community-level functions (CBS, RCCE, basic MHPSS, SDB and WASH/IPC around facilities) that complement, rather than duplicate MoH services, and provide targeted training and supplies to relieve pressure on facilities. Coordinate closely with MoH, WHO and partners to align with existing outbreak responses (e.g., cholera), share RRT capacity,

	and activate surge technical support if concurrent outbreaks threaten to derail Marburg preparedness activities
4. Community mistrust, rumours and low risk perception High levels of misinformation and limited prior exposure to Marburg can lead to denial, stigma, resistance to contact tracing and rejection of SDB, especially where authorities and aid actors are viewed with suspicion. This could reduce uptake of preventive behaviours, hinder safe isolation and burial, and force repeated engagement efforts, stretching RCCE and CEA resources and potentially extending the operation's duration.	Use a strong CEA approach with trusted local volunteers and leaders, two-way feedback channels (hotlines, help-desks, social listening) and tailored messaging that explains Marburg, addresses fears around SDB, and emphasises respect for cultural practices. Regularly analyse rumours and community feedback to adapt messages and engagement methods, engaging women's, youth and religious networks to co-design solutions and build acceptance before any potential cases occur.
5. Funding shortfalls and competing crises Multiple concurrent crises (conflict spillover from Sudan, displacement, food insecurity and floods) create intense competition for limited humanitarian funding. Insufficient or delayed resources could limit the scale of preparedness activities, reduce volunteer incentives and logistics capacity, and necessitate re-prioritisation of targets, thereby constraining achievement of coverage and readiness indicators.	Phase activities so that the most critical, high-impact preparedness actions (training, CBS tools, key pre-positioning, core RCCE) are implemented early, while actively engaging donors and Movement partners for complementary funding. Include a modest, clearly justified contingency line (e.g., 5–10 per cent) for unforeseen costs linked to access constraints or scale-up, and prepare a readiness plan for rapid revision of targets and budget should additional resources become available or significant funding gaps arise.

Please indicate any security and safety concerns for this operation:

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

Security concerns in target areas
The targeted counties (e.g., Akobo, Pibor, Kapoeta East) are affected by intercommunal violence, cross-border raids and criminality, leading to periodic displacement, road ambushes and attacks on civilians and aid workers. Humanitarian access snapshots report frequent incidents involving violence against staff, compounds and supplies, as well as movement restrictions, which can disrupt field missions and expose teams to elevated security risks.

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

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

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

Planned Intervention

Health

Budget: CHF 131,549
Targeted Persons: 131,000

Indicators

Title	Target
# of volunteers trained on EPiC for MVD RCCE	240
# of people reached with MVD RCCE messaging	131,000
# of IEC materials produced	250
# of audio jingles produced and disseminated on radio and other platforms	2

Priority Actions

1. Epidemic Preparedness and response in Communities training
- Train 240 volunteers in EPiC in the 4 targeted cross border counties.
- Conduct door-to-door visits, community dialogues, radio programmes and market-day talks to deliver Marburg and general epidemic-prevention messages.
- Print and disseminate IEC materials (posters, and Leaflets).
- Produce and disseminate recorded audio jingles and drama information on Marburg prevention in English and Arabic languages.

2. Community-based surveillance
- Train 240 volunteers in CBS in the 4 targeted cross border counties.
- Deploy trained volunteers for community case detection and reporting of suspected MVD cases.

3. Safe and Dignified Burials
- Train 3 SDB teams (TOTs) at the national/sub national level for rapid cascade training to field level SDB teams should a case be confirmed in country.
- Procure 1 SDB training kit for the SDB TOT training.
- Work with the National Ministry of Health to develop (or review and update) and disseminate national SDB SOP.

4. Infection Prevention and Control
- Procure and preposition IPC supplies in 4 high-risk border states and referral health facilities (Personal Protective Equipment, chlorine for Disinfection & Hygiene Supplies – alcohol-based hand rubs for health facility staff, Waste & Fluid Management- biohazards bags, sharps containers, etc).
- Work with the National Ministry of Health to develop (or review and update) and disseminate national IPC SOP.

Water, Sanitation And Hygiene

Budget: CHF 8,477
Targeted Persons: 131,000

Indicators

Title	Target
# of volunteers trained on hygiene in emergencies	80
# of hygiene sessions conducted	40

Priority Actions

- Conduct training to 80 Volunteers (20 Volunteers per location) on hygiene in emergencies.
- Conduct 40 hygiene sessions (10 per location) with 30 people per session (1200 People).
- Procure IPC supplies for volunteers while at the community level (soap, hand sanitizers etc).

Protection, Gender And Inclusion

Budget: CHF 0
Targeted Persons: 131,000

Indicators

Title	Target
# of marginalized groups engaged in MVD preparedness activities	-

Priority Actions

- Promote inclusion of marginalized groups, including displaced populations, pastoralists, and persons with disabilities, in preparedness planning and decision-making.
- Coordinate with health and WASH actors to ensure protection considerations are integrated into screening, isolation, hygiene promotion, and border health activities.

Secretariat Services

Budget: CHF 7,036
Targeted Persons: 250

Indicators

Title	Target
# of monthly IFRC visits conducted	1
# of financial spot checks conducted	1

Priority Actions

- Conduct monitoring missions.
- Conduct financial spot checks.
- Conduct Lessons Learnt Workshop.

National Society Strengthening

Budget: CHF 2,797
Targeted Persons: 251

Indicators

Title	Target
# of program monthly reports submitted in time	1
# of final DREF report (narrative and finacial) submitted in time	1
# of volunteers insured	240

# of monitoring missions conducted	2
# of visibility jackets procured	120

Priority Actions

- Compile and submit in time one monthly progress report for first month of implementation.
- Compile and submit in time final DREF report (narrative and financial).
- Insure deployed volunteers.
- Conduct monitoring visits to implementing counties (by HQ).
- Procure visibility jackets for volunteers.

About Support Services

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

Approximately 5–12 SSRC staff will be directly engaged (HQ and field), including health/PHiE, WASH, RCCE/CEA, PMER, logistics, finance, security and branch coordinators.
Around 240 community-based volunteers will be specifically trained and deployed for CBS, RCCE, hygiene promotion, basic PFA and support to WASH/IPC activities in the four high-risk border counties.

Roles and responsibilities
- Community volunteers: conduct community-based surveillance and reporting, household visits, community dialogues, hygiene promotion, basic psychosocial first aid, and support distribution and follow-up of WASH/IPC supplies.
- Health and WASH staff: design and deliver trainings, supervise volunteers, support IPC and WASH, liaise with county health departments and RRTs, and ensure technical quality of interventions.
RCCE/CEA staff: lead message development, radio and community campaigns, manage feedback and rumours, and coordinate with community leaders and local media.
- PMER, logistics and finance/admin staff: oversee planning, monitoring and reporting, manage procurement and transport of supplies, track expenditures and ensure compliance with SSRC/IFRC procedures.

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

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

Gaps and how they are being addressed
Despite this, men still outnumber women overall, and female leadership and representation of older persons and persons with disabilities remain comparatively low in some branches, particularly in conservative or remote areas. To reduce these gaps, SSRC is:
-Setting branch-level targets to increase female, youth and disability representation in new volunteer recruitment and in community-health and RCCE teams.
-Prioritising women and young people for team-leader roles and including PGI, SGBV and child-safeguarding content in all volunteer trainings to promote inclusive practice.
-Working with community leaders to identify trusted volunteers from under-represented Ethnic groups and vulnerable categories (e.g., people with disabilities), so that Marburg-related messaging and support are culturally appropriate and accessible to all.

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

Routine and smaller-scale procurement (e.g., local PPE, basic cleaning materials, soap, buckets, printing of IEC materials, local transport services) will be managed by South Sudan Red Cross logistics and finance units, following SSRC and IFRC procurement rules and thresholds. For specialised or bulk items that are not reliably available or cost-effective in-country (e.g., SDB training kits, specific PPE or equipment), IFRC will lead procurement through its regional or global systems, with SSRC submitting specifications and requests and IFRC handling tendering, contracting and payment.

How will this operation be monitored?

Monitoring systems and responsibilities
SSRC will use its existing data-management and reporting tools, including branch activity-tracking forms, monthly 4Ws (who-what-where-when) reports and PMER templates aligned with the IFRC results matrix.
Branch health/WASH officers and county coordinators will compile data from volunteers while the SSRC PMER officer consolidates and analyses information at national level and prepares situation reports and DREF updates.
Community feedback and accountability mechanisms (hotlines, suggestion boxes, focus group discussions, RCCE feedback logs) will be used to monitor quality, relevance and acceptance of services.
Indicators, milestones and IFRC monitoring

Key indicators will include:
people reached with RCCE and hygiene promotion; number of CBS volunteers trained and alerts reported; quantity of PPE and WASH/IPC kits distributed; number of people receiving PFA; and proportion of community feedback issues addressed within agreed timeframes.

Milestones will follow the DREF plan of action, such as completion of initial trainings, pre-positioning of critical supplies before the rainy season, and achievement of percentage coverage targets in each county.
IFRC will conduct joint monitoring visits with SSRC to selected counties, led by the Country/Cluster Delegation PMER and technical staff, to review records, visit communities and facilities, and validate reported results; where access is constrained, remote monitoring (regular calls, online reviews of reports and photos, and spot checks) will complement in-person visits.

Please briefly explain the National Societies communication strategy for this operation

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

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

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

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

Budget Overview

DREF OPERATION

MDRSS018 - South Sudan Red Cross Society
MVD Readiness

Operating Budget

Planned Operations	140,026
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	131,549
Water, Sanitation & Hygiene	8,477
Protection, Gender and Inclusion	0
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	0
Environmental Sustainability	0
Enabling Approaches	**9,833**
Coordination and Partnerships	0
Secretariat Services	7,036
National Society Strengthening	2,797
TOTAL BUDGET	**149,859**

all amounts in Swiss Francs (CHF)

Internal 08/01/2026 #V2022.01

Click here to download the budget file

Contact Information

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

National Society contact: John Lobor, Secretary General, john.lobor@ssdredcross.org, +211 912 666 836

IFRC Appeal Manager: Mohamed Babiker, Head of Juba Cluster Delegation, mohamed.babiker@ifrc.org, +211 (0) 912179511

IFRC Project Manager: Daniel Mutinda, Delegate, Disaster Management, daniel.mutinda@ifrc.org, +25 4725599105

Click here for the reference