

DREF n° MDRUG039	Glide n° EP-2017-000157-UGA
Date of issue: 30 July 2018	Date of Disaster: 19 October 2017
Operation start date: 06 November 2017	Operation end date: 06 February 2018
DREF allocated: CHF 84,569	Budget holder/project manager IFRC: Lisa Zitman
Total number of people affected: 288,209 people (population of 3 target districts)	Number of people to be assisted: 52,971 direct beneficiaries
Host National Society presence (n° of volunteers, staff, branches): The Uganda Red Cross Society, Kapchorwa Branch, deployed a total of 230 volunteers and 2 Program Managers, to the affected Kapchorwa and Kween districts; and preparedness interventions in the neighbouring at-risk district of Bukwo.	
Red Cross Red Crescent Movement partners actively involved in the operation: Alert was shared with Netherlands Red Cross, Belgium Red Cross and German Red Cross, ICRC country offices. Kenya Red Cross had been notified of one the suspected MVD case and were actively involved in cross border monitoring.	
Other partner organizations actively involved in the operation: Ugandan Ministry of Health, World Health Organization (WHO), United Nations Children's Fund (UNICEF), Ugandan Delegation of the European Union (EU), Médecins Sans Frontières (MSF)	
Summary of major Revisions to the EPOA: NA	

Major Operational Timeline

- **19 October 2017**, Ministry of Health officially declares outbreak of Marburg Viral Disease (MVD) after Laboratory confirmation by PCR at the Uganda Viral Research Institute (UVRI).
- **20 October 2017**, Uganda Red Cross Society alerts IFRC, and launches community engagement and sensitization activities in the affected districts of Kween and Kapchorwa
- **06 November 2017**: IFRC allocates CHF 84,569 from its Disaster Response Emergency Fund (DREF n° MDRUG039) to support outbreak prevention interventions targeting 52,971 direct beneficiaries (26,394 males and 26,577 females) over the period November 6, 2017 to February 6, 2018.
- **7 December 2017**, Ministry of Health and WHO Declare Uganda Marburg Viral Disease (MVD) outbreak contained.

A. Situation analysis

Description of the disaster

On 17 October 2017, the Uganda Virus Research Institute (UVRI) confirmed through positive RT-PCR results a case of Marburg Viral Disease (MVD) from a sample obtained from Kween District in Eastern Uganda. The Ugandan Ministry of Health immediately notified the World Health Organization (WHO) and officially declared it as an outbreak on 19 October 2017, right after the laboratory diagnosis. Marburg virus disease (MVD), formerly known as Marburg hemorrhagic fever, is a severe, often fatal illness in human beings. The number of people infected rapidly increased to 6 suspected cases, and the Ministry of Health was confronted with a higher caseload, including contact tracing and an increased need for awareness activities, at that time without external support.

To mitigate the threat of Marburg Virus Disease, the International Federation of Red Cross and Red Crescent Societies (IFRC) supported the Uganda Red Cross Society (URCS) to respond to the outbreak through a Disaster Response Emergency Fund (DREF) allocation amounting to CHF 84,569. The DREF funds enabled the National Society to launch

Summary of the response

Overview of Host National Society.

Once the outbreak was confirmed, the Uganda Ministry of Health (MoH) activated the National and District Task Forces (NTF & DTF) on outbreak response. The Uganda Red Cross Society (URCS) actively participated in coordination mechanisms with Government Ministries, UN Agencies and other national and international organisations; including the World Health Organisation (WHO), United Nations Children Fund (UNICEF), Food & Agricultural Organization (FAO), Centre for Disease Control (CDC) and Medicine San Frontiers (MSF). As soon as the outbreak was confirmed, URCS immediately activated the community volunteer force in the affected districts of Kween, Kaphorwa and Bukwo; all within the operational area of Kachorwa Branch. Additionally, URCS continued to closely monitor the progress of the outbreak into neighbouring branches, including Kenya Red Cross Society's Kitale Branch which remained at high risk due to proximity. A total of 230 volunteers were deployed to facilitate social mobilization, contact tracing, and to support the referral mechanism through with Red Cross ambulance services in Kween district.



URCS volunteer engages a household member in Kween district disseminating preventive measures for Marburg Viral Disease

URCS has been involved in MVD response in all previous outbreaks, and thus garnered residual experience especially in the field of social mobilization, contact tracing, community-based surveillance and referral actions. However, in the area of Safe and Dignified Burials (SDB), URCS had limited capacity and experience to deliver professional SDB functions. It was therefore decided to request external support for this specific area through an RDRT.

Overview of Red Cross Red Crescent Movement in country

The IFRC's presence in country in the ongoing South Sudanese refugee operation facilitated necessary logistical and operational support to the MVD operation. The MVD alert and updates have been shared with all in-country Movement partners including ICRC delegation and Participating National Societies (PNSs); the Netherlands Red Cross, German Red Cross and Belgium Red Cross.

Overview of non-RCRC actors in country

The Ministry of Health (MOH) worked closely with partners, including World Health Organization, UNICEF, Médecins sans Frontiers (MSF), European Union/ECHO Uganda delegation, Uganda Red Cross, Centers for Disease Control (CDC) US, Infectious Disease Institute (IDI), WALIMU and others, to control the outbreak. The MOH and WHO deployed a team to the district to support the outbreak investigation and response, including case contact tracing. The national and district taskforces were reactivated, with daily meetings and joint field missions. National and District outbreak response plans were developed and utilized to mobilize required resources for response. Key interventions and activities implemented by URCS were part of the respective outbreak response plans, focusing on those areas that were critical and were connected to key operational areas of the Red Cross.

The MoH and WHO launched a European Union-funded mobile laboratory on 27th November 2017 that supported rapid diagnosis of all samples in the field.

Needs analysis, targeting, scenario planning and risk assessment

Needs analysis

The outbreak was the fifth MVD outbreak in Uganda. The MVD outbreaks in Uganda have created fears in the population, due to the devastating effects of the previous outbreaks.

Within the target communities, the health literacy level was low, specifically knowledge about MVD was very limited. Some of the affected communities in Kween district exhibited resistance to the MVD response, which resulted into the targeting of health workers and resistance against safe burial practices. The resistance originated from limited engagement and communication and limited access to correct information about how and why suspect cases need to be admitted to isolation wards and how these facilities were managed.

Fears and lack of information created unnecessary myths that hampered the adaptation of MVD preventive measures, including direct contacts who refused to be monitored and suspect cases that refused to be admitted to isolation wards.

The myths were countered by intensified community engagement, health promotion and risk communication campaigns through selected evidence-based social behavioural change communication (SBCC) strategies and actions, including the use of local, cultural and civic leaders like Members of Parliament (MPs) who in turn managed to convince their subjects to support the campaign and adopt preventive measures disseminated.

In the surrounding districts there was huge fear for secondary transmission of the disease, including across the border in Kenya as one of the suspect cases continued migrating into neighbouring areas to consult traditional healers, thus spreading contacts.

Targeting

The two confirmed and one suspected case lived in crowded places, and had high mobility, which generated a big risk of wide geographical spread of contacts, generating the need of extensive contact tracing to all persons with an epidemiological link to these cases. Additionally, health care workers who had handled and treated the first cases with minimal barrier nursing procedures, needed extensive contact tracing.

The communities targeted for interventions were households and individuals living within the six sub-counties of Kapraron, Mayok, Kiriki (Kween district), Western Division, Kawowo (Kapchorwa district) and Suam in Bukwo district. All contacts of suspected cases were directly targeted by the operation.

A total of 52,971 persons composed of 26,394 males and 26,577 females living in the 6 sub-counties were targeted for the health promotion campaigns, and specific households were targeted for contact tracing and follow-up. In addition, 288,209 indirect beneficiaries (144,120 males and 144,089 females) were targeted with general risk communication messaging; majorly through mass media activities. A total of 58,064 people were directly reached with community prevention and awareness activities, a slightly higher number than initially planned for, due to the decision of partners to expand the prevention activities to additional at risk districts in Kween and Bukwo.

A total number of 50 probable cases were targeted with discharge packages, and 200 people were targeted with psychosocial support interventions. Unfortunately, the 50 discharge kits could not be distributed due to delays. A total of 578 people were provided psycho social support (339 contacts + 239 volunteers).

Scenario planning

The best-case scenario was based on the assumption that there would be only one person in contact and exposed to the infection from the animal source, and thus with good contact tracing and surveillance interventions, all key contacts from this single case would be traced, closely followed up and immediately isolated for treatment before further infection could take place.

In the most likely scenario some of the contacts from the probable and confirmed cases are traced and would be isolated quickly once they became symptomatic and the outbreak would be controlled within the next two generations, with a case count below 40. The need for prevention and control on both sides of the border would be key, and ongoing successful community engagement would be critical to success.

In the worst-case scenario there would be more than one index case exposed to the animal reservoirs, combined with the population living in remote locations with great fear of seeking formal health care systems, seeking care with traditional healers, exposing many people to infections through high risk procedures. This would leave potentially hundreds of people exposed, thus allowing the disease to spread further into the communities, including outside the 3 districts with the confirmed outbreak, with contacts spread all over the country and potentially across the border.

Although some elements of the worst-case scenario were experienced, the attack rate of the disease remained low, resulting in a lower caseload than expected, with a lower-case fatality recorded.

Operation Risk Assessment

Within the National Society there was great concern among staff and/or volunteers to be incidentally infected with the virus. This risk was mitigated through proper training on SDB by WHO experts and a deployed RDRT SDB member to support the operation.

The outbreak threat continued to grow and spread, with contacts extending into the neighbouring district Bukwo and across the border into Kenya. MoH and other stakeholders agreed to expand the operational area for prevention activities to additional at-risk communities in Bukwo and Kween. Extra attention was given to the border area with Kenya, due to the mobility and trans-border crossing of one of the suspected cases. The Kenyan government and Kenya Red Cross Society were alerted and directly set up a response to closely monitor contacts in Kenya. The

operational strategy had to be reviewed to ensure the NS was properly resourced, and ready to extend the response to additional geographical areas with prevention activities.

The impassable road network within Kween district posed the risk that contacts could not be closely followed up, as access for surveillance teams to the homes of listed contacts would be challenging, as well as a timely response to community alerts. This risk was mitigated by engaging community-based volunteers with daily access to the contacts, who supported monitoring of body temperatures and other conditions and reported to surveillance officers via telephone contacts.

B. Operational strategy

Overall Operational objective: To stop the spread of Marburg in three districts in Uganda through effective communication and engagement with communities


Strong in country coordination and the extensive experience of the MoH and other partners in dealing with highly infectious diseases facilitated the development of the URCS operational strategy. URCS focused the DREF response on areas that complemented other actor's actions, focusing on areas of URCS operational strength. URCS response focused on the following areas:

- Mobilization of volunteers to support contact tracing and follow up;
- Preparedness: training of safe and dignified burials teams to ensure that in case deaths were reported, URCS could support with the management of safe and dignified burials;
- Health promotion and risk communication campaigns, through the community-based volunteer network, including: house-to-house outreaches, community meetings and media activities that helped to allay fears and quell down high temper and animosity in the public
- Mobilization of volunteers trained in PSS as needed;
- Procurement of visibility materials for the volunteers and Personal Protection equipment (PPE) as part of the safe and dignified burial kits;
- Supporting families with dispatch kits whose properties had been destroyed as a measure of Infection Prevention and Control;

The response was implemented as planned, however, due to delays in the transfer of funds and procurement processes, PPEs and dispatch kits arrived late and could not be distributed and/or used. The kits and materials have been securely stored and repositioned for rapid deployment to future outbreaks and/or similar emergency operations.

Lessons from previous viral hemorrhagic fever outbreaks have indicated the need for broad and comprehensive response including PSS, relief, RFL etc. Given the low level of attack rate and mortality of this particular MVD outbreak, the operational strategy remained focused on immediate interventions that rapidly disrupt transmission.

C. Detailed Operational Plan

 <p>Shelter People targeted: 50 discharged MVD patients, and directly affected families, Male: 66 Female: 134 Requirements (CHF) 9,591</p>			
P&B Output Code	Shelter Outcome 1: Communities in MVD affected areas restore and strengthen their safety, well-being and longer-term recovery through shelter and settlement solutions		50 affected families are supported with essential basic household items/discharge kits
P&B Output Code	Shelter Output 1.1: Short and medium-term shelter and settlement assistance is provided to 50 families affected by cases of MVD to re-build their livelihoods		50 households provided with emergency shelter and settlement assistance
	INDICATORS (Activities planned) Week / Month	TARGET	ACTUAL
AP006	Distribute essential household kits/discharge kits to 50 families whose properties have been destroyed as IPC strategy (Kit contains 1 sponge mattress of 4'*6' dimensions, 3 blankets, 2 jerry cans of 20 lit. capacity, 3 bars of 100g laundry soap, 5 cups, 5 plates, 2 mosquito nets, 2 cooking pots and 2 tarpaulins)	50 families	0 families
AP006	Procure and replenish one dispensary tent of 27 Sq m. used in the initial response	1 tent	1 tent
Narrative description of achievements			
<p>Distribute essential household kits At the start of the DREF operation, the distribution of non-food core household items remained a major gap as there was no partner who provided discharge kits. The target beneficiaries were from 6 sub-counties with documented cases or contacts at the start of the DREF operation in the three districts of Kween, Kapchorwa and Bukwo.</p> <p>Fifty kits of household Non-Food Items (NFIs) composed of a mattress, kitchen set, blankets, mosquito nets, laundry soap, cooking pots and tarpaulins were procured for distribution as discharge package to survivors of the MVD and bereaved families. Unfortunately, these kits were not distributed, because the target beneficiaries had already received the household kits from the World Health Organization (WHO). URCS could not respond promptly due to two reasons; delay in transfer of funds to the National Society and the lengthy procurement process. The procured kits have been securely stored and prepositioned for rapid deployment for future similar outbreaks.</p>			

Procure and replenish one dispensary tent

Due to heavy rains in the Sebei sub-region during this season, access by road between Kapchorwa and Kween was limited. Additionally, there were limited accommodation facilities in the newly established district of Kween. Due to these limitations, responders had to commute from Kapchorwa to Kween district on a daily basis, causing delays and limited time to access contacts and at-risk communities.

Upon request by the MoH, one tent which was previously procured and prepositioned in the central warehouse was despatched to Kween district to support the establishment of a base camp for all responders who used to commute from Kapchorwa to Kween district on daily basis. With the DREF funds the procurement of a replacement tent was ensured, to replenish the despatched tent. Additionally, URCS received two tents as a donation from UNICEF, to facilitate the establishment of a responders' base camp in proximity to the isolation facility and affected communities.

Challenges

The procured household Non-Food Items (NFIs) which were meant to be distributed as discharge packages to 50 survivors and affected/bereaved families were not distributed as the results of delayed funds transfer and procurement process such that by the time they were delivered, the same target beneficiaries had already received a similar support from the World Health Organization (WHO). The kits procured have therefore been securely stored and prepositioned for rapid deployment to future outbreaks or other similar emergency events.

Lessons Learned

To facilitate fast and timely response to such rapidly-spreading disease outbreaks, the process to transfer funds after approval of DREF allocation should be expedited such that all required supplies with longer than usual supply chains are procured in time to make sure that the target beneficiaries receive and use them.



Health

People targeted: 52,971

Male: 26,394

Female: 26,577

Requirements (CHF) 51,557

P&B Output Code	Health Outcome 2: The immediate risks to the health of affected populations are reduced	58,064 people reached with community-based epidemic prevention and control activities	
	Health Output 2.1: Community-based disease prevention and health promotion is provided to the target population		
	INDICTORS (Activities planned)	TARGET	ACTUAL
AP011	Communities identified with contacts are supported through house to house risk communication and psychosocial support	500 contacts	339 contacts
AP011	Two-way communication via mass media is delivered to the affected area and surrounding districts	52,971 persons	58,064 persons
AP011	Community engagement via key stakeholders such as traditional and religious leaders will be reinforced.	50 leaders	34 opinion leaders 16 religious leaders

AP011	Rumour monitoring is established to ensure effective communication	All intervention areas	All intervention areas
Narrative description of achievements			
<p data-bbox="94 268 2157 304">Community engagement through house to house and mass communication</p> <p data-bbox="94 304 2157 395">A significant number of volunteers were mobilized, oriented and deployed as the expansion of community prevention activities in at risk districts of Kween and Bukwo. This was agreed upon by response stakeholders as a result of the widespread mobility of the MVD contacts. The URCS' capacity to rapidly mobilize community volunteers was therefore a good solution to meet these additional needs.</p> <p data-bbox="94 427 2157 579">The National Society was able to reach 58,064 people totaling to 12,135 households with social mobilization messages through interpersonal house-to-house engagements and community meetings. A team of volunteers was responsible for a village throughout the operation, each village team had one team leader at the parish level. One of the parish team leaders was representing the team as a sub county supervisor who reported to the Branch Focal Person and eventually the Branch Manager and field Operations team lead who reported to the EPR Program manager at the head office. The team also used the same fora to carry out contact tracing, identification and referrals of suspect cases.</p> <p data-bbox="94 611 2157 715">URCS participated in the development and pre-testing of various Behavioral Change Communication (BCC) messages, which were later printed by UNICEF and disseminated to the various target audiences by the URCS volunteers. In addition, UNICEF facilitated the production and sponsorship of daily radio spot messages and talk shows, where URCS field teams participated in communicating prevention messages.</p> <p data-bbox="94 746 2157 818">On request of the Ministry of Health (MoH) and with facilitation of the World Health Organization (WHO), the URCS deployed an ambulance to Kween district to facilitate rapid response to community alerts and referral of suspect cases from the communities to the isolation centers for a period of two months.</p> <p data-bbox="94 850 2157 887">Community engagement via key stakeholders such as traditional and religious leaders</p> <p data-bbox="94 887 2157 986">Community engagement activities were integrated as part of the social mobilization interventions. Volunteers conducted community meetings with 50 leaders (clan, religious, cultural and political leaders) that helped to resolve an impasse where community members, especially in Kween District, had rejected presence of health workers in their villages as they doubted the approach of patients' isolation and general management of the deceased.</p> <p data-bbox="94 1018 2157 1054">Rumor Monitoring</p> <p data-bbox="94 1054 2157 1193">Rumor monitoring was conducted as part of the community-based surveillance system and community engagement/risk communication interventions by the volunteers. One of the suspected cases who had contact with the index case had traveled from Kween to Bukwo and eventually Kenya. This information started as a rumor and was communicated to the URCS community volunteers who then helped surveillance officers to trace the movement pattern of the case, thus able to register all contacts related to this case, up to Kenya.</p> <p data-bbox="94 1225 2157 1321">The volunteers deployed in Kween district continued to work alongside the surveillance team and shared community rumors with them until the end of the outbreak. The volunteers monitored activities in the communities where they lived and provided vital alert information to the district surveillance teams even after the outbreak was declared controlled.</p>			



Figure 1: Involvement of Red Cross Volunteers with appropriate BCC materials empowered community members with correct Marburg viral disease prevention messages that contributed to rapid control of the outbreak.

Challenges

- a) The communities in Kween, especially in Mayok Sub County where the last deceased person was buried, became violent to towards health workers because they demanded to see the body, against IPC procedures. The police had to intervene to quell the situation.
- b) Following this violent outburst, the committee for social mobilization included 15 Red Cross volunteers in Kween. However, resistance continued, especially on the content of the awareness campaign.
- c) Inadequate training of the volunteers: Volunteers were trained together with members of the district leadership; however, this training did not adequately prepare them to conduct sensitization in a violent environment. WHO and the DHO office supported the training of the volunteers financially.

Lessons Learned

Uganda Red Cross' approach of community engagement helped to build trust with communities. Strong community access enabled prevention messages to penetrate even to remote locations and facilitated acceptance which directly led to reduce the practice of hiding away suspect cases and seeking assistance of traditional healers.

P&B Output Code	Health Output 2.2: Epidemic prevention and control measures carried out.		339 people (contacts) reached by URCS with services to reduce relevant health risk factors
	Activities planned Week / Month	TARGET	ACTUAL
AP021	Volunteers are trained in Infection Prevention and Control (IPC) measures to ensure their safety	200 volunteers trained on IPC	259 volunteers trained and deployed

AP021	Three SDB groups with 6 members are trained and equipped	3 SDB Groups trained	2 groups of SDB with 6 members trained and equipped
AP021	Volunteers are trained in contact tracing and community surveillance	15 volunteers trained	30 volunteers trained and deployed as follow: Kapchorwa 15 and Bukwo district 15 following the contact listing and suspects showing signs and symptoms of Marburg in their areas.
AP021	Support surveillance outreach activities for MVD in the affected villages through daily follow-up for up to 500 contacts (as required) of probable & confirmed cases for 21 days each to monitor development of symptoms & timely isolation	500 contacts	339 contacts
AP021	Replenish URCS Personal protective gear and essential medical and sundry supplies for health workers & SDB teams by procuring /shipment of 350 PPE's (included in 3 x SDB kits and 6 x SDB kits)	350 SDB PPE kits	350 SDB PPE kits shipped from balance of the West African EVD outbreak response in Sierra Leone to Uganda

Narrative description of achievements

IPC training

A total of 27 selected volunteers received a 7-days training in Infection Prevention and Control for volunteers, which covers various pillars including; Safe and dignified burial with the Community-led Biosafety Approach, Surveillance and Contact tracing, Psychosocial Support and Psychological First Aid, Social Mobilization etc. The trained volunteers cascaded down the knowledge to an additional 232 volunteers.

SDB groups trained

The URCS team of volunteers assigned to support the burial team in Kapchorwa were trained alongside the health workers identified by the District Health Officer. The training was conducted by a team of IPC experts and psychologists from the WHO, UNICEF and MOH officials. The burial team of Kween district were also trained in a similar way. However, by the time they were trained, no new death was reported and therefore they did not participate in the actual burial. The IFRC SDB RDRT delegate arrived late but was able to review with the volunteers the key SDB skills, adding the component of bio-safety to the skills of volunteers.

Volunteers trained in contact tracing and community surveillance

The training was conducted by a team of WHO, UNICEF and MoH officials alongside the staff of Uganda Red Cross deployed together with the Branch Manager of Kapchorwa branch. The training was conducted in phases following the large number of people deployed. On 16/10/2017 the first batch of 16 volunteers were rapidly trained by WHO, UNICEF and DHOs office with support from the branch. Later on, between 26th - 30th October 2017, the need to deploy additional volunteers arose as the disease spread further in geographical scope, and the additional 223 were trained by the same team of UNICEF, WHO, DHO/MoH and officials. The trainings were conducted in cohorts in separate locations in the respective districts. The training covered a basic concept on MVD; including signs and symptoms, prevention measures and how to follow up on MVD contacts and on the outcome of the suspect cases. The training also covered information on how to approach people while limiting risk of infections, and basic PSP skills were highlighted through role plays, videos of previous outbreaks and sharing of fact sheets.

Support surveillance outreach

The volunteers supporting surveillance outreach activities for MVD had extensive knowledge on the community case definition/signs and symptoms of MVD, they were equipped with tools of suspect-case identification and reporting; including hotline telephone numbers of the MoH surveillance team to whom they would refer all suspect cases, and report on the contact follow up feedback. The activity of notification and coordination of the teams in the field protocol was agreed during the District MVD Task Force (DTF) coordination meetings. During the training, volunteers were trained in observation skills and informed about the agreed coordination protocol. It was emphasized that in case MVD sign and symptoms were noticed in a person/s during awareness raising house to house visits, the surveillance team had to be called immediately for detailed assessment and referral. Additionally, URCS volunteers were following up on rumors, through feedback from community members on rumors or any other related issues to the MVD outbreak.

Replenish PPE
A total of 350 SDB PPE kits were shipped from Sierra Leone, used for training and prepositioned for any future outbreaks.
Challenges
<p>a) Volunteer selection if it is to be done properly requires at least three days with a training of at least 2 days. In the Marburg response the deployment of volunteers was delayed for an additional 1 week and yet they were required in the social mobilization team. The delay caused complaints from the district task force.</p> <p>b) Due to the limited time available, volunteers had to start quickly, without full and adequate training before deployment, which was a challenge especially due to the hostile environment in the communities against health workers. They were not adequately prepared to implement sensitization in a violent environment.</p> <p>c) Lack of timely facilitation to support the volunteers in terms of meals and transport refund hampered the implementation speed of the operation.</p> <p>d) A lot of fear was generated on the disease as a result of inadequate information dissemination. In many cases people fled their homes whenever a family member developed similar signs and symptoms. Hostility by the communities was the biggest threat to the recovery efforts in the entire community of Kween district</p> <p>e) Shipment of the SDB PPE kits from West Africa into Uganda delayed due to import regulations to the extent that by the time the supplies arrived, the outbreak was on a downward trend with no more deaths reported. The supplies were used for volunteers' training and have been securely stored and prepositioned for rapid deployment to future outbreaks or other similar emergency events.</p> <p>f) The PPE supplies received were briefly retained by the National Drugs Authority (NDA) at the International Airport in Entebbe, Uganda as a legal requirement to facilitate inspection. This requirement was later on expedited after the intervention of Ministry of Health. In this process, the URCS experienced unexpectedly high cost of demurrage paid for the time that the supplies were under the custody of the handling company.</p>
Lessons Learned
In order to facilitate rapid delivery of supplies for response to such highly virulent diseases from outside countries, the IFRC and National Societies should engage the Government to waiver off all import regulations. This could be facilitated through integration of favorable policy frameworks towards importation of humanitarian supplies as part of International Disaster Response Law (IDRL).

P&B Output Code	Health Output 2.3: Psychosocial support provided to the target population	339 contacts & 239 RC and Community volunteers provided with psycho-social support therapy are able to overcome trauma & stigma related to MVD	
	Activities planned Week / Month	TARGET	ACTUAL
AP023	Train 20 staff and volunteers from the 3 affected districts on PSP	20	25 staff and volunteers
AP023	Provide Psycho-Social Support to affected households by the MVD	All contacts	339 contacts (all contacts)
Narrative description of achievements			
PSP Training			
25 staff and volunteers were trained in PSS by the URCS' PSS officer, as an integral part of the SDB training managed by the deployed RDRT delegate on 1st to 21st December 2017. Additional topics integrated in this training were basics on CEA in emergency and basic WASH/IPC in outbreak control.			

Provide psychosocial support

All registered contacts (339) were provided with psycho social support as well as the 239 volunteers.

Children coming from the bereaved family were stigmatized at school due to fears from community members. This fear emanates from the fact that the community views affected families in terms of witch craft allegations, additional to the fear of transmission of MVD. A team of volunteers was dispatched to the specific schools in Kwoisir parish, Kween district, to create awareness at schools and the households surrounding the schools, in order to dispel some of the stereotypes that kept the bereaved families isolated.

Challenges

- Heavy rains and difficult terrain. This caused delays in reaching out to the volunteers and heavy consumption of fuel.
- Inadequate identification and protective materials for the volunteers. Given harsh weather and difficult terrain. Only 60 gumboots and reflective jackets were procured as provide for in the budget, leaving many volunteers not covered with protective gears.
- The volunteers continued to meet pockets of resistance from the communities with up to 20% who still remained hostile and not willing to listen to them. In some of those cases the hard liners would excuse themselves and leave or they wouldn't allow a volunteer to talk to their families. This could have been contributed from the fact that many of the engaged volunteers were not identified on Red Cross uniforms as the numbers deployed became much more than initially planned. On the latter case the volunteer supervisors would alert the authorities and surveillance team to handle such households.

Lessons Learned

- Planning for provision of volunteers' protective gears and identification materials in a more comprehensive manner would have promoted more motivation and visibility of Red Cross volunteers that would have promoted community acceptance in places which exhibited resistance.
- Need for refresher RCAT training and comprehensive epidemic related in particular Marburg training for the deployed volunteers in Kween and Kapchorwa districts on social mobilization, Hygiene promotion, and Burial procedures and other relevant topics for the day to day work during Emergencies.

P&B Output Code	Health Output 2.4: Gaps in medical infrastructure of the affected population filled		3 shelter tents received (1 was procured, while 2 others were donations from UNICEF)
	Activities planned Week / Month	TARGET	ACTUAL
AP025	Procure and replenish 1 dispensary tent for support of staff & volunteer accommodation in new district of Kween	1 tent	3 tents

Narrative description of achievements

While MSF supported the establishment of isolation facilities at Kaproron Health Centre IV and Kween district with own tents and temporary shelters, the need to set up base camp for responders at Kween district was later agreed upon and thus the URCS, UNICEF, and the Uganda People's Defense Forces (UPDF) came in to support with donation of shelter tents. However, some of these tents were not utilized in the operation, thus UNICEF was able to donate 2 additional tents to URCS after the end of the operation as a means of prepositioning for rapid deployment in future outbreaks and other emergencies.

Challenges

There was limited provision of mileage costs for delivery of tents and other supplies from the central warehouse in Kampala to Kapchprwa Branch, and thus these supplies were eventually transported by the Uganda National Medical Stores (NMS).

Lessons Learned

Maintaining close partnership with the Ministry of Health, National Medical Stores and UNICEF facilitated sharing of resources facilitated URCS to deliver supplies in to field in costs effective manner, as well as receive additional supplies donated for prepositioning.

P&B Output Code	S1.1: National Society capacity building and organizational development objectives are facilitated to ensure that URCS has the necessary legal, ethical and financial foundations, systems and structures, competences and capacities to plan and perform		200 volunteers insured
	Output S1.1.1: URCS has effective and motivated volunteers who are protected		239 volunteers reached by psychosocial support
	Activities planned Week / Month	TARGET	ACTUAL
AP040	Insure 200 volunteers	200	200
AP040	Provide complete briefings on volunteers' roles and the risks they face	200	239
AP040	Provide psychosocial support to 200 volunteers	200	239
AP040	Ensure volunteers are aware of their rights and responsibilities	200	239
AP040	Ensure volunteers' safety and wellbeing	200	239
AP040	Ensure volunteers are properly trained	200	239
AP040	Ensure volunteers' incentives are paid in time and they remain well motivated	200	239
Narrative description of achievements			
<p>All volunteers mobilized were rapidly oriented by a consortium of technical expertise, including WHO, MoH, UNICEF and URCS. Information provided during the brief, rapid orientation provided basic facts about Marburg viral Disease, and suitable approaches for disease prevention, as well as risk communication and behaviour change communication strategies that volunteers could adopt. Later on, the URCS organised more detailed training for the volunteers using the Epidemic Control for Volunteers (ECV) toolkits.</p> <p>As part of technical assistance to the operation and volunteer motivation, the URCS Secretary General conducted a field monitoring & support supervisory visit of Marburg outbreak operation in Kapchorwa branch between 23rd and 25th November 2017.</p>			
Challenges			
<p>Despite the insurance cover provided to the volunteers, the conditions and activation of the insurance in case of an infection with the MVD were unclear. This resulted in some volunteers not willing to participate in this operation.</p> <p>Due to the gradual deployment of additional volunteers, unfortunately not all volunteers were insured (200 out of 239)</p>			
Lessons Learned			
<ul style="list-style-type: none"> • Due to effective training on Infection Prevention & Control (IPC), coupled with the close supervision of the deployed volunteers, none of the volunteers got infected with MVD. • IFRC needs to provide simplified guiding documents on the process of activation and conditions of the volunteers' insurance to National Societies, so that these are quickly disseminated to enable quick volunteer deployment to such highly infectious disease outbreak operations. 			
P&B Output Code	Outcome S2.1: Effective and coordinated international disaster response is ensured		1RDRT SDB (Safe and Dignified Burials) deployed
	Output S2.1.1: Effective response preparedness and NS surge capacity mechanism is maintained		1 RDRT SDB deployed
	Activities planned	TARGET	ACTUAL

	Week / Month		
AP046	Initial operational start up support implemented by IFRC for the host national society and participating national societies and other common services such as ops centre and basecamp costs	1 RDRT	1RDRT
Narrative description of achievements			
The IFRC deployed a Water and Sanitation (WASH)/Infection Prevention & Control (IPC) Regional Disaster Response Team (RDRT) member who supported the operation through trainings to volunteers in the operation.			
Challenges			
The deployment process of the RDRT was lengthy, resulting in the RDRT arriving late in the country, at a moment the outbreak was already controlled. Despite this challenge, the skills shared assisted in the post-outbreak activities that few volunteers remained to conduct.			
Lessons Learned			
Future operations should ensure that deployment of Emergency response tools; including RDRTs should be effected as soon as the appeal is approved to make optimal use of the technical skills directly offered to the operation as and when the needs are still valid.			
P&B Output Code	Outcome S3.1: The IFRC secretariat, together with National Societies uses their unique position to influence decisions at local, national and international levels that affect the most vulnerable.	# of people reached by URCS with services to reduce relevant health risk factors	
	Output S3.1.1: IFRC and NS are visible, trusted and effective advocates on humanitarian issues	1 visit of the Communication Coordinator	
	Activities planned Week / Month	TARGET	ACTUAL
AP053	Communications related to the operation are produced and disseminated	1 visit of the Communications Coordinator to document stories and social media messages	1 visit of the Communications Coordinator to document stories and social media messages
Narrative description of achievements			
The URCS Public Relations and Communications Coordinator conducted a field visit to document human interest stories and best practices that were published in the National Society website as well as posted on social media (Tweeter & face book) platforms.			
Challenges			
The sensitive nature of the outbreak made Government to limit media engagements which also limited our opportunity to facilitate the media houses to document stories that our volunteers were doing in the field. In addition, most of the field staff and volunteers lack skills of documentation of human interest stories and best practices.			
Lessons Learned			
<ul style="list-style-type: none"> In future operations, field officers and volunteers deployed could be trained on how to document human interest stories and best practices that could then be shared and published throughout the operation; There is a need for IFRC to support National society staff and field teams in the area of communication 			
P&B Output Code	Outcome S3.2: The programmatic reach of the National Societies and the IFRC is expanded.	2 operational updates submitted on time.	
	Output S3.2.1: Resource generation and related accountability models are developed and improved		
	Activities planned Week / Month	TARGET	ACTUAL

AP058	Work on reporting, accountability to communities, community engagement and accountability	2	<i>2 reports (1 operational update and final report) compiled and submitted</i>
Narrative description of achievements			
<p>Community engagement activities were integrated as part of the social mobilization interventions. Volunteers conducted community meetings with clan leaders, religious, cultural and political leaders that helped to resolve an impasse where community members, especially in Kween District had rejected presence of health workers in their villages as they doubted the approach of patients isolation and general management of the deceased.</p> <p>At National level, the URCS was involved in orienting 6 Members of Parliament (MPs) representing the three districts of Kapchorwa, Kween and Bukwo that prepared them with basic facts on MVD and approaches to engage communities. These were later engaged in community mobilization in their respective constituencies, which efforts helped to quell out the community resistance towards health workers.</p>			
Challenges			
<p>The general lack of trust that community members experienced with health workers led to situations where health workers were denied access to contacts and suspect cases, health workers being attacked physically, posing threats to health workers, including URCS staff and volunteers.</p>			
Lessons Learned			
<p>Engaging community-based volunteers who understand local cultures and opinion leaders in community mobilization program helps to unlock community resistance, some of which are deeply rooted into local cultures, customs and beliefs.</p>			

D. The Budget

Explanation of variances:

The total budget of the DREF was **CHF 84,569**, of which **CHF 61,381** was implemented (73%). The difference of **23,188 CHF** will be returned to the DREF fund.

Activity	Budget	Variance	Comment
Medical and First Aid	35,560	6,382	Caused by over budgeting of the Infection Prevention and Control (IPC) training.
Transport and vehicles	5,500	-3,628	Incorrect booking: travel costs were booked under transport and vehicles.
International Staff	8,000	3,218	Due to over budgeting of costs for the RDRT deployment
Volunteers	15,476	7,077	Due to over budgeting of the volunteer allowances
Travel	3,333	2,990	Due to incorrect coding: travel costs were booked under transport and vehicles.
Information and Public Relation	6,406	6,406	The IEC materials, megaphones and booklets were not procured, as these items were procured by other partners.

Contact information

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[Click here](#)

1. Revised Emergency Appeal budget (*if needed*) [below](#)
2. Click [here](#) to return to the title page

How we work

All IFRC assistance seeks to adhere to the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief and the Humanitarian Charter and Minimum Standards in Disaster Response (Sphere) in delivering assistance to the most vulnerable.

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.

www.ifrc.org
Saving lives, changing minds.



The IFRC's work is guided by Strategy 2020 which puts forward three strategic aims:

1. Save lives, protect livelihoods, and strengthen recovery from disaster and crises.
2. Enable healthy and safe living.
3. Promote social inclusion and a culture of non-violence and peace.

Disaster Response Financial Report

MDRUG039 - Uganda - Marburg

Timeframe: 06 Nov 17 to 06 Feb 18

Appeal Launch Date: 06 Nov 17

Final Report

Selected Parameters

Reporting Timeframe	2017/11-2018/6	Programme	MDRUG039
Budget Timeframe	2017/11-2018/2	Budget	APPROVED
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

I. Funding

	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Deferred Income
A. Budget		84,569				84,569	
B. Opening Balance							
Income							
<u>Other Income</u>							
<i>DREF Allocations</i>		84,569				84,569	
C4. Other Income		84,569				84,569	
C. Total Income = SUM(C1..C4)		84,569				84,569	
D. Total Funding = B + C		84,569				84,569	

* Funding source data based on information provided by the donor

II. Movement of Funds

	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Deferred Income
B. Opening Balance							
C. Income		84,569				84,569	
E. Expenditure		-61,381				-61,381	
F. Closing Balance = (B + C + E)		23,188				23,188	

Disaster Response Financial Report

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Selected Parameters

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Budget Timeframe	2017/11-2018/2	Budget	APPROVED
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

III. Expenditure

Account Groups	Budget	Expenditure					TOTAL	Variance
		Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability		
	A					B	A - B	
BUDGET (C)			84,569			84,569		
Relief items, Construction, Supplies								
Shelter - Relief	3,133		3,835			3,835	-702	
Medical & First Aid	35,560		29,178			29,178	6,382	
Total Relief items, Construction, Sup	38,693		33,013			33,013	5,680	
Logistics, Transport & Storage								
Transport & Vehicles Costs	5,500		9,128			9,128	-3,628	
Total Logistics, Transport & Storage	5,500		9,128			9,128	-3,628	
Personnel								
International Staff	8,000		4,782			4,782	3,218	
National Society Staff	2,000		1,506			1,506	494	
Volunteers	15,476		8,398			8,398	7,077	
Total Personnel	25,476		14,686			14,686	10,789	
General Expenditure								
Travel	3,333		343			343	2,990	
Information & Public Relations	6,406						6,406	
Financial Charges			464			464	-464	
Total General Expenditure	9,739		807			807	8,932	
Indirect Costs								
Programme & Services Support Recove	5,162		3,746			3,746	1,415	
Total Indirect Costs	5,162		3,746			3,746	1,415	
TOTAL EXPENDITURE (D)	84,569		61,381			61,381	23,188	
VARIANCE (C - D)			23,188			23,188		

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Selected Parameters

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Budget Timeframe	2017/11-2018/2	Budget	APPROVED
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

IV. Breakdown by subsector

Business Line / Sub-sector	Budget	Opening Balance	Income	Funding	Expenditure	Closing Balance	Deferred Income
BL2 - Grow RC/RC services for vulnerable people							
Disaster management	84,569		84,569	84,569	61,381	23,188	
Subtotal BL2	84,569		84,569	84,569	61,381	23,188	
GRAND TOTAL	84,569		84,569	84,569	61,381	23,188	