



THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

UGANDA NATIONAL RESPONSE PLAN

FOR EBOLA BUNDIBUGYO DISEASE OUTBREAK 2026

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Table of Contents

1.0 Introduction	4
1.1 Situation Analysis	4
1.2 Current Situation of the outbreak	5
1.3 Relation of the current epicentre and the DRC-Uganda Border.....	6
2.0 Risk mapping and categorization	6
2.2 Scenarios.....	9
2.3 The Hazard	10
2.4 Risk of Exposure	10
2.5: Conclusions	11
3.0 Purpose and objectives of the plan	12
3.1 Purpose	12
3.2 Objectives	12
3.2.1 Main objective	12
3.2.2 Specific objectives	12
4.0 The Strategy Response Priority Activities by Pillar	13
4.1 Implementation arrangements.....	13
4.2 Coordination, Leadership and One Health	13
4.3 Surveillance (Sub pillars include Contact Tracing, Case Investigation, Alert Management)	14
4.4 Laboratory.....	14
4.5 Public Health Risk Communication and Community Engagement (RCCE).....	15
4.6 Case Management	16
4.6.1 Quarantine	16
4.6.2 EVD Survivor Program.....	17
4.6.3 Infection Prevention and Control	17
4.6.4 Mental Health	17
4.6.5 Emergency Medical Services.....	18
4.7 SIRI (Strategic Actions for Information & Research)	18
4.8 Logistics.....	19
4.9 Water, Sanitation, and Hygiene (WASH)	20
4.10 Continuity of Essential Health Services (CEHS)	21
4.11 Vaccination	21

4.12 Uganda Peoples Defence Forces (UPDF) support to EVD Response.....	22
5.0 Budget.....	23
6.0 Monitoring and Evaluation (M&E) of an Ebola Virus Disease (EVD) Response	23
6.1 Purpose of M&E in EVD Response	24
6.1.1 Monitoring	24
6.1.2 Evaluation	24
6.2 Key M&E Framework for EVD Response.....	24
6.2.1 Input Indicators.....	24
6.2.2 Process Indicators	25
6.2.3 Output Indicators.....	25
6.2.4 Outcome Indicators	25
6.2.5 Impact Indicators	25
6.3 Pillar-specific Indicators.....	25
Table 1 Summary of the categorisation of districts.....	7
Table 2: Districts categorisation by region with heightened risk.....	9
Table 3 The budget below is a summary of the anticipated costs for a period of 3 months.....	23
Table 4 Monitoring and Evaluation Template for the EVD Response.....	26
Figure 1: Showing location of the DRC epicentre in relation to Uganda	6
Figure 2: Map showing risk categorization of the districts in Uganda.....	8
Figure 3 Flow monitoring points describing population mobility	11
Figure 4 Description of movement of people between DRC (epicentre) and Uganda	11



1.0 INTRODUCTION

1.1 Situation Analysis

The current outbreak in Ituri Province, Democratic Republic of the Congo, presents a serious public health concern characterized by high mortality and rapid transmission. Approximately 100 deaths have been reported over six weeks, indicating a significant case fatality rate. The epidemiological pattern shows clustered transmission within families, including a notable instance where 15 deaths occurred within a single household over two weeks. There is also strong evidence of healthcare-associated transmission, as indicated by the deaths of four healthcare workers within a short time frame. Additionally, the disease has spread across three health zones Mongbwalu, Rwampara, and Bunia suggesting expanding geographic transmission. Timeline of events in Ituri province as of 15 May 2026

The causative agent is currently identified as a non-Zaire strain of Ebola virus, with sequencing ongoing. Based on historical epidemiology in the region, the outbreak is likely caused by either Sudan virus (SUDV) or Bundibugyo virus (BDBV). This uncertainty is critical because these strains have limited or no widely licensed vaccine options, which increases reliance on non-pharmaceutical interventions such as surveillance, infection control, and community engagement.

Uganda is at immediate high risk of Ebola importation due to its direct land border with Ituri Province. The region is characterized by intense cross-border trade, mining activity, and population movement, including both formal and informal crossings. Uganda has prior experience with Ebola outbreaks, including Bundibugyo virus in 2007 and Sudan virus in 2022, which reinforces both its vulnerability and its response capacity. However, the high mobility of populations and porous borders significantly elevate the risk of cross-border transmission.

Figure 1: Location of Uganda from Ituri Province

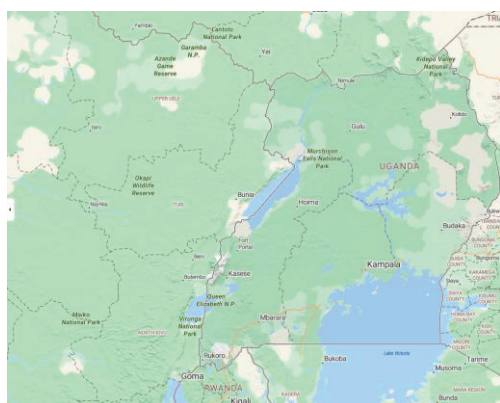
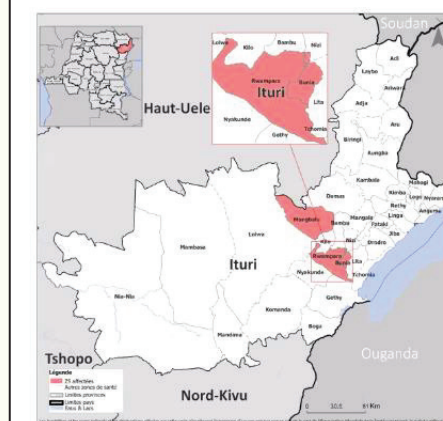


Figure 2: Distribution of cases in Ituri province



Uganda faces an imminent risk of Ebola importation due to its proximity to the outbreak, high cross-border movement, and uncertainty regarding the virus strain. Effective preparedness will depend on rapid detection systems, strong community trust, strict

infection-prevention measures, and decentralised response capacity across high-risk districts. The outbreak has been confirmed in 3 health zones Mongbwola, Rwamapara and Bunia. As of 15th May a total of 13 confirmed cases have been identified with 67 probable cases currently under investigation. The probable cases have been reported as early as 1st April 2026.

1.2 Current Situation of the outbreak

On 15th May 2026, the Ministry of Health confirmed an outbreak of Ebola Virus Disease (EVD) caused by the Bundibugyo strain in Uganda. The confirmed case was a 59-year-old male Congolese national who had been admitted to Kibuli Muslim Hospital on 11th May 2026. The patient presented with respiratory distress, recurrent episodes of fever, epigastric pain, nausea, and difficulty passing urine. While under admission, his condition progressively deteriorated, and he developed bleeding manifestations consistent with Viral Hemorrhagic Fever. He later succumbed to the illness on 14th May 2026 while receiving care in the Intensive Care Unit (ICU).

Following his death, the body was reportedly transported back to the Democratic Republic of Congo (DRC) at approximately 8:00 PM on the same day. On 15th May 2026, the Ministry of Health received notification from Public Health Authorities in the DRC regarding a suspected Ebola Virus Disease case linked to the deceased individual. Consequently, the Ministry of Health made a decision to test an earlier sample that had been obtained from the patient during clinical management. The sample was transported to the Central Emergency Surveillance and Response Support Laboratory in Wandegaya, where it was confirmed positive for Ebola Virus Disease caused by the Bundibugyo strain.

Preliminary investigations indicate that this is an imported case originating from the DRC, and as of now, Uganda has not confirmed any secondary local transmission linked to the case.

Within the first 72 hours following confirmation of the outbreak, the Ministry of Health activated national and sub-national response mechanisms and implemented several urgent public health interventions, including:

- Deployment of screening, surveillance, and Rapid Response readiness teams at official and informal points of entry, particularly along the Albertine region, major transit routes, and pilgrimage corridors.

- Activation of national and district-level EVD response structures in high-risk districts, including establishment of isolation arrangements, enhancement of Infection

- Prevention and Control (IPC) measures, deployment of a mobile laboratory at Bwera Hospital, and intensified risk communication and community engagement activities.

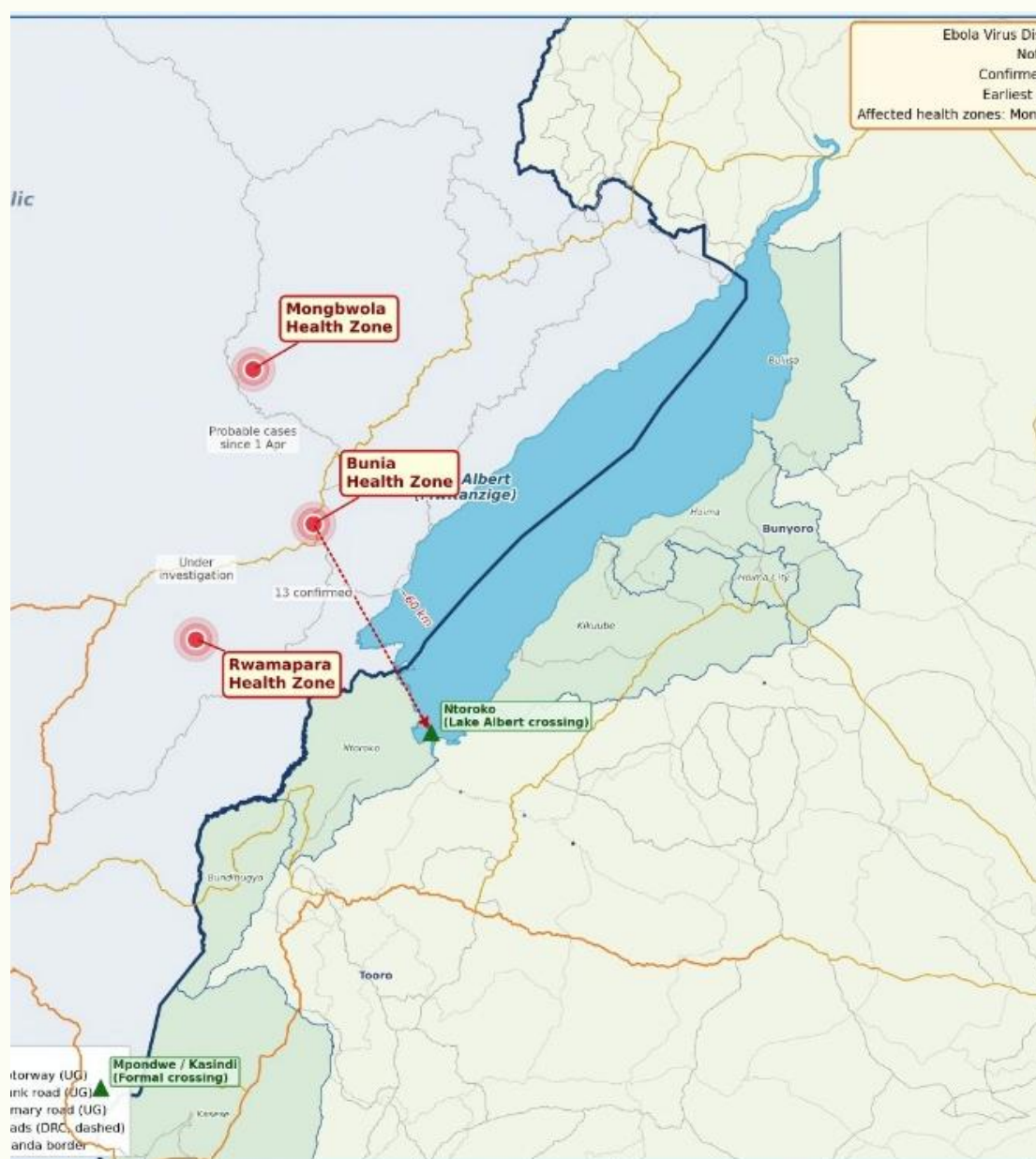
- Isolation and monitoring of one identified high-risk contact who is a close relative of the deceased case.

- Ongoing identification, listing, tracing, and quarantine of all contacts associated with the index case to prevent further transmission and ensure early detection of any secondary infections.

1.3 Relation of the current epicentre and the DRC-Uganda Border

Mongbwala in the DRC and Zombo in Uganda is relatively short, as they are located near the border, approximately 100-150 km apart in a straight line. Bunia and Rwampara within <100KM to the Mpondwe and Ntoroko borders

Figure 1: Showing location of the DRC epicentre in relation to Uganda



2.0 RISK MAPPING AND CATEGORIZATION

Following the detection of the index case, a rapid risk assessment is being conducted to support risk categorization and planning. Kampala is the capital city densely populated with high population movement in and out, thus there is risk of further spread if the outbreak is not controlled in the early stages.

Risk categorization of districts was informed by:

- Likelihood of exposure
- Potential for amplification of outbreak
- Context of response (vulnerability, acceptability of current affected population)
- Potential impact on response structure and health services

These were adopted into the following criteria to inform the risk categorization:

1. Presence of confirmed/probable cases
2. Population density and mobility
 - Complex urban setting
3. Presence of high-risk contacts
 - Family members of cases
 - Health workers that attended to the index case
 - Patients and attendants that shared hospital space with the index case
4. Neighboring the high-risk district

Table 1 Summary of the categorisation of districts

CATEGORY	DISTRICT
1 – Very high risk	Kampala (KMA), Kikuube, Ntoroko, Hoima, Hoima city, Kabarole, Fortportal City, Kasese, Bundibugyo, Arua, Zombo
2 - High risk	All districts on western DRC and Uganda border
3 – Moderate risk	The rest of the country

Table 2: Districts categorisation by region with heightened risk

WEST NILE	BUNYORO	ANKOLE	KIGEZI	RWENZORI
Moyo	Kiryandongo	Rubirizi	Rubirizi	Ntoroko
Lamwo	Buliisa	Isingiro	Kanungu	Kabarole
Adjumani	Hoima		Rukungiri	Fort Portal
Obongi	Hoima City		Kisoro	Kyegegwa
Moyo	Kikuube		Rubanda	Kamwenge
Yumbe			Kabale	Bunyangabu
Koboko				Budibugyo
Maracha				Kasese
Terego				Kitagwenda
Arua City				
Madi-Okollo				
Arua				
Zombo				
Nebbi				

2.2 Scenarios

Based on the risk categorisation criteria, 3 scenarios;

Scenario 1 (Best-case Scenario): Early ending.

- Early detection of all cases from known contacts under follow-up
- Limitation of outbreak to current very high-risk districts
- Based on the scenario, the incubation period of the disease to estimate the response would last approximately 105 days (5 incubation cycles).

Scenario 2 (Most Likely Scenario): Sustained

- Delay in detection of cases; with cases identified outside the known contact list
- Detection of cases beyond current high-risk districts, but limited to current geographical regions
- Estimate the response running for approximately 210 days (10 incubation cycles).

Scenario 3: Worst-case scenario.

- In this case, based on mobility and inadequacy of contact tracing, this worst-case scenario involves spread beyond the epicentre and high-risk districts and 3 health regions to affect new geographical locations.
- In addition, identification of a case in a neighboring country would equally warrant scenario 3.
- This would stretch resource requirements, given the specialized care required and isolation levels to avoid wider spread.
- The timeline for this response is still unclear

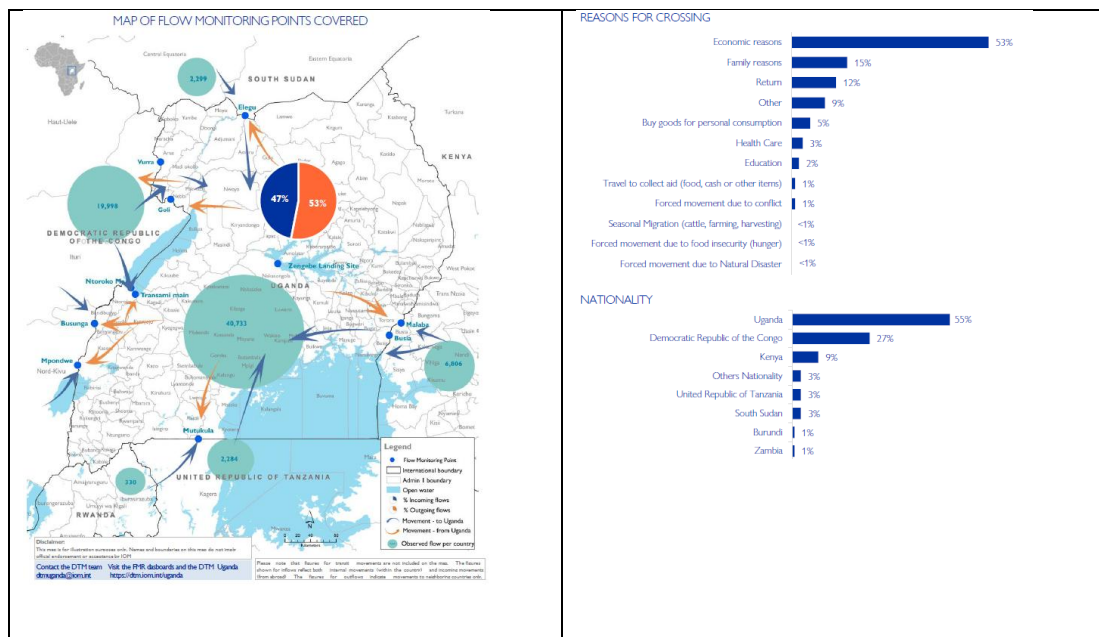
2.3 The Hazard

- The current outbreak is caused by Ebola Virus Disease – Bundibugyo Strain. BUVD is transmitted through direct close contact with body fluids. Incubation period has been recorded 2-21 days. This is a highly virulent virus with average CFR approximately 50% (Range 25 – 90%).
- The illness is characterized by acute onset fever with non-specific symptoms (abdominal pain, anorexia, fatigue, malaise, myalgia, sore throat followed by nausea vomiting, diarrhea and rash. Post illness sequelae have also been reported.
- Previous outbreak was reported in Bundibugyo District in 2007/2008, with 149 cases (37 deaths).
- No vaccine, no therapeutics.
- BUVD diagnostic panels available in country to initiate testing

2.4 Risk of Exposure

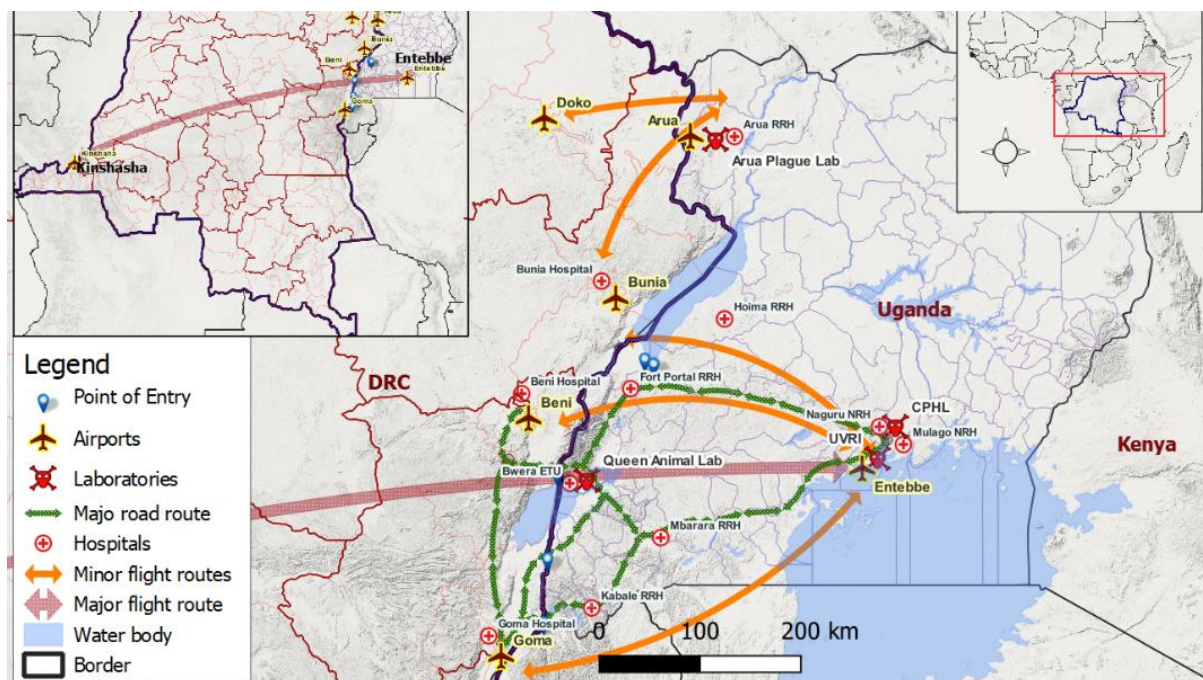
- Uganda is a host to refugees from the DRC with high mobility mapped from previous PMM exercises. There is population movement between DRC and Uganda with people moving for economic resources (dealing in gold and minerals)
- The districts bordering DRC on the west has porous borders
- With big population of Congolese seek care in Uganda health
- Estimated 6,000 pilgrims from DRC with evidence of groups already entering the country
- Flights directly twice a week from Bunia to Entebbe (ETH)
- Arua Air field also receives flights from Bunia to South Sudan

Figure 3 Flow monitoring points describing population mobility



Source: IOM

Figure 4 Description of movement of people between DRC (epicentre) and Uganda



2.5: Conclusions

- The risk categorization raised to **Very High**; based on current cases reported in the country, proximity, population mobility across Uganda DRC border and ongoing cases investigation
- DRC Epicentre is 100km to Zombo district

3.0 PURPOSE AND OBJECTIVES OF THE PLAN

3.1 Purpose

The purpose is to guide the response activities to rapidly interrupt EVD Bundibugyo transmission in Uganda to reduce morbidity and mortality to ensure minimal social and economic disruption.

3.2 Objectives

3.2.1 Main objective

To rapidly detect, contain, and interrupt Ebola Virus Disease transmission while minimizing morbidity, mortality, socio-economic disruption, and strengthening national and subnational preparedness capacities.

3.2.2 Specific objectives

1. To provide strategic leadership, operational oversight, partner harmonization, and resource coordination for an effective, timely, and accountable multi-sectoral EVD response.
2. To strengthen early detection, case investigation, alert verification, contact identification, listing, and follow-up in order to rapidly interrupt chains of transmission.
3. To ensure timely, safe, accurate, and decentralized laboratory confirmation of suspected EVD cases and support surveillance through efficient specimen management systems.
4. To provide safe, timely, high-quality clinical care, isolation, and supportive treatment for suspected, probable, and confirmed EVD cases in order to reduce mortality and prevent onward transmission.
5. To prevent healthcare-associated infections and community transmission through strengthened IPC systems, safe healthcare practices, environmental hygiene, and WASH interventions.
6. To promote public awareness, trust, behavior change, and community participation through culturally appropriate communication, rumor management, and stakeholder engagement.
7. To ensure uninterrupted procurement, storage, distribution, and accountability of essential response commodities, equipment, transport, and operational resources.
8. To implement evidence-based vaccination strategies, including ring vaccination, to protect high-risk populations and reduce outbreak spread where approved vaccines are available.
9. To ensure uninterrupted delivery, accessibility, and utilization of critical health services during the EVD response while minimizing excess morbidity and mortality from non-EVD conditions.
10. To ensure the availability of evidence and data for the response through routine data collection and operational research.

4.0 THE STRATEGY RESPONSE PRIORITY ACTIVITIES BY PILLAR

4.1 Implementation arrangements

The response will be implemented with overall leadership of the Ministry of Health. The Ministry of Health will deploy the Incident Management System (IMS), leveraging the Mpox response. The Ministry of Health will also map and coordinate partners at national and sub-national levels, including updating the 4W partners matrix to ensure a robust, rapid, and effective EVD Bundibugyo response.

This plan will be implemented through the following operational pillars:

- Surveillance (Including quarantine)
- Laboratory
- Case management (including Infection Prevention and Control safe and dignified burials, Psychosocial support)
- WASH
- Public Health Risk Communication and Community Engagement
- Logistics
- Continuity of Essential Health Services
- Vaccination

4.2 Coordination, Leadership and One Health

Strategy 1: Ensure a well-coordinated, rapid, and effective response by mapping and engaging all relevant partners at the national and sub-national levels. Establish strong leadership at both the national and district levels by activating task forces and effectively coordinating response efforts. Facilitate efficient decision-making, resource mobilization, and inter-agency collaboration for a unified response.

Interventions/Activities:

- Map and coordinate partners at national and sub-national levels, including updating the 4W partners matrix to ensure a robust, rapid, and effective EVD Bundibugyo response
- Activate task forces in high-risk districts together with the national and district rapid response teams.
- Facilitate national pillar task force meetings.
- Facilitate district task force and pillar meetings.
- Coordinate early action reviews and document to evaluate the response efforts.

Strategy 2: Strengthen surveillance and response for zoonotic diseases through a One Health approach

Interventions/Activities:

- Orient animal health workers to conduct ecological studies on Ebola reservoir species.

- Map relevant stakeholders to strengthen community-level One Health collaboration.
- Conduct sampling in animal reservoir species to monitor Ebola transmission dynamics.
- Conduct mortality surveillance in wildlife to detect unusual animal deaths and potential outbreaks.

4.3 Surveillance (Sub pillars include Contact Tracing, Case Investigation, Alert Management)

Strategy: Build a robust surveillance system that ensures early detection, investigation, and contact tracing. Implement effective active surveillance and case investigation activities to identify and report potential EVD cases swiftly. Engage local leadership and health workers in surveillance and alert management to ensure community-based monitoring.

Strategic Interventions/Activities:

- **Case Investigation**
 - Print and distribute case investigation forms, SOPs, community and health facility EVD case definitions, and other relevant guidelines.
 - Mentor health workers on mortality surveillance.
 - Mobilize and mentor sub-county and parish chiefs to conduct community death identification, notification, and reporting.
- **Contact Tracing**
- **Active Surveillance** through active case search
- **Mortality surveillance across all districts bordering DRC**
- **Quarantine**
 - Provide reasonable containment sites (Hotels) for high-risk contacts
 - Deploy and facilitate medical teams for daily medical assessments
 - Update existing quarantine guidelines to suit the context
 - Support the coordination and transfer of symptomatic contacts (suspects)
- Establish and maintain alert management desks in high-risk districts (5 per district).
- **Alert Management;** Orientation of district surveillance teams and regional PHEOCs and district staff in EVD alert management.
- Conduct POPCAB activities in high-risk districts.
- Orientation of border health teams.

4.4 Laboratory

Strategy: Ensure that laboratory capacity is strengthened to support effective sample collection, transportation, and testing. The laboratory strategy involves maintaining well-stocked and efficient labs, activating mobile testing units in high-risk districts, and ensuring timely results management for EVD testing. Capacity building for lab staff and timely sample transport are critical components.

Interventions/Activities:

- Review and update lab stock for testing and sample collection.
- Deploy standby vehicles for emergency activation of the sample transport system in high-risk districts (20 high risk districts) for the index case.
- Apportion EVD sample collection materials, PPEs, and case investigation forms.
- Conduct re-orientation on sample management for lab rapid response teams in high-risk districts.
- Activate district rapid response teams to conduct sample collection and shipping.
- Conduct risk assessment, sample remnant retrieval, and decontamination in labs that handled the index case.
- Assess the deployment of the Mobile Lab in Mbale RRH.
- EVD laboratory capacity building: physical orientation of technical and non-technical staff on sample and results management, IPC, biosafety, and biosecurity with equipment decontamination.
- Virtual reorientation of laboratory staff in 136 districts and cities.
- Operationalise the mobile laboratory.
- Conduct EVD testing, results management, and link the mobile lab into the RDS.
- Emergency sample transport and testing, including procurement of materials.
- Facilitate sample collectors and preposition sample collection materials and PPE.

4.5 Public Health Risk Communication and Community Engagement (RCCE)

Strategy: Create sustained public health awareness and social behavior change strategies to inform communities about the EVD Bundibugyo outbreak. Engage in proactive social mobilization and utilize all health promotion strategies, resources and channels to ensure that public health measures are accepted and adhered to. Building trust through effective engagements with communities and community feedback mechanisms to ensure better prevention, early detection, and case management.

Strategic Interventions/Activities:

- Public health awareness activities through use of multi-channels, and multi-discipline professionals.
- Community based social mobilization efforts through use of film vans, community audio towers, digital trucks and other community resources.
- Stakeholder engagements with a focus on health workers, religious leaders, cultural leaders, traditional leaders, the private sector, public transport actors among others.
- Build Capacity of Community Health Workers (VHTs & CHEWs); and other non-health stakeholders in prevention and control of EVD through RCCE and CBHS.
- Institute Social listening and evidence generation activities in communities
- Review, Production, Approval and distribution of health education, information, and health communication EVD materials for public use in different languages.
- Operationalization of the MoH call centre for effective community feedback, timely alerts and response.

- Deploy RCCE teams in hot spots to engage community actors like traditional healers and other actors in high-risk districts to quickly identify and link suspects into the EVD response.
- Conduct rapid Community readiness assessment for control measures that break the chain of transmission among hot spot communities
- Deploy Anthropologists to support and enforce preventive measures for contact cases and families.
- Customize and operationalize community referral protocol for unique community risky groups
- Engage community based implementers to integrate EVD interventions into already running community activities.
- Deploy RCCE teams to support the Rapid response teams in engaging communities during the rapid response.
- Deploy RCCE teams to reactivate and build capacity of local governments in high-risk communities to increase vigilance, early case identification, early reporting and linkage into the EVD Bundibugyo response.
- Activate RCCE coordination forums at different levels to ease response coordination and action at all levels.

4.6 Case Management

Strategy: Provide comprehensive case management that ensures prompt treatment and effective care for suspected, probable, and confirmed EVD patients. This includes deploying case management teams, ensuring timely IPC measures are in place, and providing survivors with necessary follow-up care and support.

Strategic interventions/Activities:

- Deploy rapid case management surge teams to support HCWs in isolation units.
- Conduct rapid orientation on IPC and case management at the district level.
- Provide case management for admitted patients.
- Provide home decontamination and discharge packages for survivors.
- Support case management teams at the district level.
- Support quarantine of all contacts
- Support EVD survivors and related sequelae

4.6.1 Quarantine

Strategic interventions/Activities

- Provide safe spaces that separate health individuals that have been exposed to a contagious disease from the population
- Closely monitor exposed individuals for symptoms of the specific condition
- Early detection and control of onward transmission to vulnerable groups and propagate early case management interventions

4.6.2 EVD Survivor Program

Strategy: Establish comprehensive survivor care programs, focusing on the physical, mental, and social needs of EVD survivors. Ensure long-term follow-up care, including medical support, psychosocial services, and community reintegration efforts.

Strategic interventions/Activities:

- Set up and functionalize coordination structures for the EVD Survivor Program.
- Hold quarterly meetings for the program, focusing on achievements, challenges, and lessons learned.
- Update, print, and disseminate standards, guidelines, and data tools.
- Train health workers on long-term follow-up survivor guidelines and conduct M&E activities.
- Monitor survivors' care and track referral pathways.
- Document survivor stories and their communities.
- Establish and operationalize survivor clinics at multiple locations.
- Provide routine biochemistry and hematology tests for survivors.
- Develop testing capabilities for regional centers.

4.6.3 Infection Prevention and Control

Strategy: Ensure robust infection prevention and control (IPC) practices are in place across healthcare settings, including the provision of necessary PPE, disinfection protocols, and staff training.

Strategic Interventions/Activities:

- Waste management at isolation and quarantine sites (e.g., Mulago, Mbale RRH).
- Deploy IPC surge teams to support RING IPC and IPC for clinical care.
- Procure assorted IPC commodities (e.g., disinfectants, PPEs).
- Print job aides materials for healthcare workers.
- Train EMS teams in IPC and safe transportation SOPs.
- Provide ambulance services for referral and suspected/probable EVD cases.

4.6.4 Mental Health

Strategy: Ensure that mental health and psychosocial support (MHPSS) services are integrated into the EVD response to provide psychological care for both patients and communities. Equip responders with the tools to handle the psychological effects of the outbreak and provide support for survivors and their families.

Strategic Interventions/Activities:

- Provide MHPSS interventions such as psychological first aid and counseling.
- Train responders in psychosocial care.
- Identify and deploy counselors at isolation, quarantine, and community levels.

- Engage in community sensitization and mobilization for prevention and treatment measures.
- Provide child care and protection services, and engage spiritual groups for support.
- Conduct home visits to survivors and their families, and facilitate family support group dialogues.
- Conduct health education talks, individual client counseling, and group sessions.
- Provision of condoms and conduct serial viral testing.
- Support research teams for Remdesivir.

4.6.5 Emergency Medical Services

- Provide ambulance services for referral of suspected/probable EVD cases from community to isolation facilities including interfacility transfers
- Set up district disinfection sites for ambulances
- Provide Patient transfer package
- Coordination and reporting logistics

4.7 SIRI (Strategic Actions for Information & Research)

This pillar aims to ensure the availability of evidence and data for the response through routine data collection and operational research. The pillar will also ensure that the Ministry of Health leverages digital health tools to optimize the response.

Strategies:

1. Deploy digital health tools for the response.
2. Ensure availability and access to high-quality data for evidence-based decision-making for the response.
3. Strengthen capacity for data analysis and visualization for the response.
4. Streamline the conduct of operational research to inform the response.

Strategic Interventions/Activities:

1. Deploy digital health tools for the response.
 - a. Reactivate and update digital outbreak response tools for the following systems; eIDSR (Case Investigation Form, Case Management, Evacuation and Point of Entry systems), RDS, Restrack, eLMIS/Logistics, goData, Knowledge Management Portal, Budget Tracker, Action Tracker, Call Center System (CRM)
 - b. Roll out digital tools for the response.
2. Ensure availability and access to high-quality data for evidence-based decision-making for the response;
 - a. Undertake data management training for the response in targeted districts.
 - b. Undertake data-related support supervision for the response.
 - c. Produce periodic high-quality information products for the response.
 - d. Compile policy briefs on key policy issues for the response.
 - e. Data entry for the case management and laboratory backlog data
 - f. Support data capture and transmission activities with the associated costs i.e. data, SMS, devices etc.
 - g. Support Ministry of Health Call Center Operations.

- h. Print paper-based tools to manage data as a backup system.
 - i. Targeted qualitative surveys.
- 3. Strengthen capacity for data analysis and visualization for the response.
 - a. Undertake capacity training on data analysis and visualisation for data analytics and visualisation teams, EoCs and high-risk districts.
 - b. Update dashboards and digital data visualisation tools.
- 4. Streamline the conduct of operational research to inform the response.
 - a. Undertake detailed qualitative studies to provide additional information to understand outbreak and response challenges.

4.8 Logistics

Strategy: The Logistics Pillar focuses on ensuring timely and efficient supply chain management to support the overall EVD response. The goal is to ensure that all necessary supplies, equipment, and transportation are available and accessible in affected areas, enabling the swift movement of field teams and effective implementation of response activities. This strategy also emphasizes the importance of resolving logistical challenges such as access issues and resource mobilization to ensure smooth operations throughout the response.

Strategic Interventions/Activities:

- **Quantification of Supplies Needed**
 - Identify and estimate the quantities of medical supplies, PPE, case investigation forms, sample collection kits, and other necessary materials for the EVD response.
 - Monitor and update supply requirements regularly to adjust to changing needs based on the evolving situation.
- **Deployment of Logistics Teams**
 - Deploy logistics teams to affected localities to conduct on-the-ground assessments of supply needs and ensure that adequate supplies are available in a timely manner.
 - Ensure that teams are equipped with tools to effectively manage and track supplies.
- **Resolution of Access Issues**
 - Identify logistical challenges related to the movement of supplies and field teams, including road access, weather conditions, and infrastructure issues.
 - Take proactive measures to expedite the movement of response teams, such as arranging for alternative transport routes or engaging local authorities for assistance.
- **Mobilization of Vehicles, Ambulances, and Fuel**
 - Mobilize a fleet of vehicles and ambulances to ensure rapid transportation of personnel, medical supplies, and samples between healthcare facilities, districts, and other relevant sites.

- Ensure that sufficient fuel and maintenance support are available to keep vehicles operational for continuous use.
- **Resource Mobilization**
 - Actively engage with national and international partners to mobilize additional resources, including funding, supplies, and personnel, to support the logistics pillar's operations.
 - Develop and implement resource mobilization strategies, including coordination with donors, private sector partners, and humanitarian organizations to secure critical supplies and support.
- **Logistical Coordination**
 - Coordinate logistics efforts with other pillars to ensure the efficient distribution of resources and avoid duplication or shortages.
 - Set up a central coordination hub for logistics operations to track the movement and availability of supplies, vehicles, and personnel.
- **Inventory Management and Tracking**
 - Establish inventory management systems for tracking the flow of supplies from central warehouses to affected districts, ensuring that critical materials are always available where needed.
 - Implement regular stock audits and ensure efficient reporting on logistics needs.
- **Logistical Support for Mobile Units**
 - Ensure that mobile units (e.g., mobile labs, emergency medical teams) are equipped with the necessary logistical support, including transport, fuel, and supplies for sustained field operations.
- **Establish Transport Networks**
 - Develop transport networks that connect all key response locations, including healthcare facilities, isolation units, and border points, to facilitate timely delivery of supplies and personnel.
- **Post-Deployment Assessment and Feedback**
 - After logistics operations have been completed, assess the effectiveness of the logistics response, including the adequacy of supply levels, transportation efficiency, and the resolution of access issues.
 - Collect feedback to improve future logistics operations and to ensure continuous improvement of supply chain management.

4.9 Water, Sanitation, and Hygiene (WASH)

Strategy: The WASH pillar aims to prevent and control the spread of Ebola Virus Disease (EVD) by ensuring access to clean water, adequate sanitation, and hygiene promotion in affected and at-risk communities. This will be achieved through risk communication, infrastructure improvements, supply distribution, capacity building, and stakeholder engagement.

Strategic Interventions/Activities

- **Risk Communication and Awareness:** Update and translate WASH awareness materials, conduct radio talk shows, and engage communities to address vulnerabilities.
- **Needs Assessment and Mapping:** Assess WASH needs in affected areas and healthcare facilities, map infrastructure gaps, and coordinate with stakeholders to prioritize interventions.
- **Capacity Building:** Train and mentor waste handlers and health workers on safe waste management and proper use of WASH facilities.
- **Provision of WASH Facilities and Supplies:** Deliver hygiene supplies, foot-operated handwashing stations, disinfectants, and other essential logistics to healthcare facilities and communities.
- **Stakeholder Coordination:** Strengthen collaboration with government agencies, NGOs, and local leaders, ensuring regular reviews to monitor progress.

4.10 Continuity of Essential Health Services (CEHS)

Strategy: Strengthen coordination and leadership to ensure uninterrupted essential health services during outbreaks

Strategic interventions/Key activities

- Establish multidisciplinary committees with clear Terms of Reference (TOR).
- Conduct regular committee meetings for oversight and decision-making.
- Map the functional capacity of public and private health facilities.
 - Conduct health facility readiness to ensure CEHS
- Disseminate and monitor adherence to CEHS guidelines.
- Redistribute and task shift health workers to maintain uninterrupted services
 - Deploy locum staff in affected facilities
- Train and orient healthcare providers on CEHS and Infection Prevention and Control (IPC).
- Support and strengthen monitoring of the data on CEHS to inform targeted response
- Provide support supervision, mentorship, and coaching on new service delivery approaches.
- Establish integrated outreach mechanisms to improve access to essential services.
- Produce and disseminate SBCC messages to enhance public awareness.
- Ensure distribution of malaria drugs in affected districts with a high malaria burden.

4.11 Vaccination

Strategy: The Vaccination Pillar focuses on the rapid deployment of vaccines to control the spread of EVD through immunization. The strategy aims to prioritize the safety, efficacy, and ethical distribution of vaccines, with a particular focus on high-risk populations. Additionally, this pillar involves a systematic approach to identify individuals

eligible for vaccination, monitor vaccination outcomes, and ensure that all logistical aspects of vaccine distribution are efficiently managed.

Strategic Interventions/Activities

1. Microplanning for conducting vaccine trials

- Work with different stakeholders to plan and discuss the availability of vaccines for the disease, and microplan procurement and vaccination

4.12 Uganda Peoples Defence Forces (UPDF) support to EVD Response

Strategy: To support the national Ebola Virus Disease (EVD) response through coordinated security, logistics, border health support, surveillance reinforcement, risk communication, emergency operations support, and intersectoral collaboration along the Uganda–DRC border and other high-risk areas in order to prevent cross-border transmission, maintain operational continuity, and enhance public health emergency response capacity

Strategic interventions/Activities

1. Border Health and Points of Entry Support
 - Support screening and monitoring at formal and informal border points
 - Assist enforcement of public health measures
 - Support cross-border surveillance coordination
 - Facilitate movement control in high-risk areas
2. Surveillance and Contact Tracing Support among UPDF communities and general population
 - Assist in locating and following high-risk contacts in hard-to-reach areas
 - Support community-based surveillance in border communities
3. Logistics and operational support in remote/insecure areas
4. Risk communication and community engagement among security communities at the border
5. Support in implementation of IPC and WASH services at border points

5.0 BUDGET

Table 3 The budget below is a summary of the anticipated costs for a period of 3 months

Pillar	Estimated total in UGX	Estimated total in USD
Coordination and leadership	9,037,240,000	2,475,956
Surveillance (Including Quarantine)	9,211,181,000	2,523,611
Laboratory	5,691,594,171	1,559,341
Public Health Risk Communication & Community Engagement	13,354,780,000	3,658,844
Case management, IPC, SDB, EMS, Mental Health	26,171,105,000	7,170,166
Quarantine	4,734,800,000	1,297,205
WASH	2,202,273,500	603,363
SIRI	472,200,500	129,370
Logistics	15,794,525,000	4,327,267
CEH	593,398,750	162,575
UPDF Support to EVD Response	2,919,128,429	799,761
Grand Total	90,182,226,350	24,707,459
USD	UGX	
1	3,650	

6.0 MONITORING AND EVALUATION (M&E) OF AN EBOLA VIRUS DISEASE (EVD) RESPONSE

Monitoring and evaluation of an EVD response is the systematic tracking of preparedness, detection, response operations, outcomes, and lessons learned to ensure rapid outbreak control, reduce mortality, interrupt transmission, and strengthen health systems. A framework will be developed to monitor response efforts against key performance indicators based on WHO standards of response as highlighted in the ERF, WHO Response KPIs and the IDSR. In addition, timeliness metrics will also be monitored with an augmented 7-1-7 metric. A set of reporting tools developed by the incident management team and disseminated to all partners of the national taskforce and its subcommittees/pillars. Process monitoring will be conducted using specific tools like the IPC assessment, EVD readiness, Risk communication checklist among others. Periodic

and ad hoc joint support supervision visits will be undertaken by the national team to specific districts.

- To ensure correctness, completeness and timeliness of monitoring data, a series of internal review mechanisms will be used, including weekly and monthly reviews at national and district levels, and support supervision.
- Evaluation: The NTF/IMT will also conduct period evaluations of the plan including After action review; accountability forum; among others.
- Report Chains and Data submission: Data collected during the implementation of this plan will be shared with the IMT which has the primary mandate for its monitoring.
- Resource mobilisation and utilization will be monitored through a 4W matrix at national and district levels and accountability

6.1 Purpose of M&E in EVD Response

6.1.1 Monitoring

Continuous, real-time tracking of:

- Case detection and confirmation
- Surveillance sensitivity
- Contact tracing performance
- Isolation and treatment
- Infection prevention and control (IPC)
- Risk communication and community engagement (RCCE)
- Logistics and supply chain
- Vaccination (if applicable)
- Safe and dignified burials (SDB)

6.1.2 Evaluation

Periodic assessment of:

- Response effectiveness
- Timeliness
- Efficiency
- Coverage
- Quality
- Impact
- Sustainability
- Preparedness improvements

6.2 Key M&E Framework for EVD Response

6.2.1 Input Indicators

Measures, resources mobilised:

- Number of trained rapid response teams
- Number of ETC beds established
- PPE stock levels
- Laboratory capacity (PCR machines, GeneXpert)

- Funding disbursed
- Number of ambulances deployed

6.2.2 Process Indicators

Tracks implementation:

- % alerts investigated within 24 hours
- % suspected cases tested within 48 hours
- % contacts listed within 24 hours
- % contacts followed daily for 21 days
- % health workers trained in IPC
- % burial teams operational

6.2.3 Output Indicators

Immediate deliverables:

- Number of confirmed cases isolated
- Number of confirmed cases admitted for treatment
- Number of confirmed cases with successful treatment and discharged
- Number of contacts traced
- Number vaccinated
- Number of communities reached
- Number of health facilities supervised
- Number of districts where IMS is activated
- Number of districts able to activate response within 7 days

6.2.4 Outcome Indicators

Measures performance:

- Case fatality rate (CFR)
- Secondary attack rate
- Reproductive number (R_t)
- Time from symptom onset to isolation
- Proportion of transmission chains interrupted
- Healthcare worker infection rates

6.2.5 Impact Indicators

Long-term goals:

- Outbreak duration
- Total cases and deaths
- Geographic spread contained
- Restoration of routine services
- Community trust and resilience

6.3 Pillar-specific Indicators

All response pillars will be responsible for designing, validating, and submitting pillar-specific monitoring and evaluation indicators aligned with the national EVD Bundibugyo 2026 response framework. Each pillar shall develop measurable input, process, output, outcome, and impact indicators relevant to its operational objectives, ensuring consistency

with Incident Management System priorities, reporting standards, and strategic response goals. Indicators will be submitted to the Coordination Pillar/M&E Unit at NPHEOC for harmonisation, quality assurance, integration into the consolidated response dashboard, and routine performance monitoring. This process will ensure standardized accountability, timely performance tracking, and data-driven decision-making across all pillars. The following template will be followed and leveraged.

Table 4 Monitoring and Evaluation Template for the EVD Response

Objective	Indicator	Baseline	Target	Data Source	Frequency	Responsible
Effective leadership	IMS activation time	>72 hrs	<24 hrs	NPHEOC records	Once	Incident Manager
Pillar accountability	% daily reports submitted	60%	100%	SitRep tracker	Daily	Pillar leads
Resource deployment	Avg deployment time	72 hours	<48 hrs	Logistics logs	Weekly	Operations lead
District functionality	% active district task forces	50%	100%	District reports	Weekly	MOH Coordination

