



Ministry of Health Uganda

National Ebola Virus Disease (EVD) Response Plan

12 June – 12 September 2019

Ministry of Health Uganda

**National Ebola Virus Disease (EVD)
Response Plan**

June – Sept 2019

Date: 8 July 2019

Acknowledgements

The Ministry of Health of Uganda wishes to acknowledge the efforts of partners and stakeholders in the National Task Force in developing this three-month National Ebola Virus Disease (EVD) response plan.

This plan is developed in line with the guidance provided in the International Health Regulations (2005) for countries to develop core capacities to Prevent, Protect and Provide a public health response to public health threats, including EVD. This plan brings together inputs from Kasese, high risk districts and the national level and is therefore a blueprint for all partners, donors and stakeholders to engage and contribute to timely detection, response and immediate containment of the EVD outbreak in Uganda.

I thank you.

Dr. Henry G Mwebesa
Ag. Director General,
Ministry of Health

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Introduction

Context

An Ebola virus disease (EVD) outbreak was notified to the World Health Organization (WHO) by the Ministry of Health of the Democratic Republic of the Congo (DRC) on 1 August 2018 in Mabalako health zone, Beni territory in North Kivu Province, after four blood specimens tested positive for *ebola zaire virus* by GeneXpert automated-polymerase chain reaction (PCR). After sequencing, this outbreak was confirmed to be separate from the 9th outbreak that had just ended in Orientale Province in Western DRC, making this the 10th EVD outbreak in DRC. From August 2018 to 10 June 2019, a total of 2,062 cases (1,968 confirmed) with 1,390 deaths (1,296 confirmed) and 96 probable cases had been reported in North Kivu and Ituri Provinces of DRC.

Following the declaration of the 10th Ebola Outbreak in North Kivu and subsequent spread to Ituri province of DRC (*both provinces border Uganda*), WHO conducted a risk assessment and rated the risk of spread as high at national and regional levels and identified Uganda, Rwanda, South Sudan and Burundi as priority 1 for scaling up EVD readiness; and Tanzania, Zambia, Angola and Central African Republic as priority 2. Uganda developed an Ebola Contingency Plan and has implemented heightened EVD preparedness activities to enhance operational readiness to handle any imported cases of Ebola over the last 10 months with a focus on 31 very high and high-risk districts across the western part of Uganda. The plan was revised to cover June to December 2019 and resources to support its implementation are being mobilized.

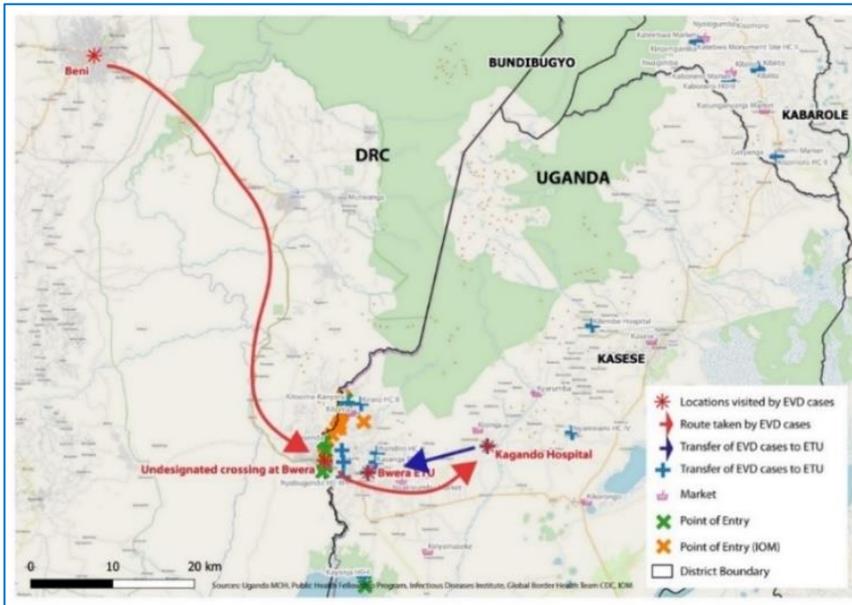
With the enhanced preparedness activities, Uganda has been on high alert for any imported Ebola cases from DRC. In this regard screening of travellers at several designated points of entry is ongoing, and health facility and community-based disease surveillance active and has identified and investigated over 600 alerts since August 2018.

Current Situation of the EVD outbreak of June 2019

On 11 June 2019, a confirmed case of Ebola Virus Disease was reported by the Uganda Ministry of Health to the World Health Organization. The index case was a 5-year old boy who travelled to Uganda from Mabalako (Territory of Beni) DRC where he and his relatives had participated in a burial of a relative (grandfather) suspected to have died of EVD. Six of the 12 symptomatic members escaped from Kashindi Hospital Isolation Facility where they were awaiting transport to Beni ETU, having been detected by the National Border Health Program at Kasindi health checkpoint ([ProMED/MoH DRC 12 June 2019](#)). They entered the country through the informal point of entry at Mpondwe market, see figure 1 showing their movements. The ill boy presented to Kagando hospital, Kasese district, for medical care on 10 June 2019, where the attending health worker suspected Ebola as the possible cause of illness and had him transferred to Bwera Ebola Treatment Centre (ETC) in Kasese where a sample was taken and referred to the laboratory at Uganda Virus Research Institute (UVRI) at Entebbe for testing.

The UVRI Viral Haemorrhagic Fever (VHF) laboratory confirmed Ebola in the specimen by RT-PCR on 11 June 2019. Subsequently, two of the family members that had travelled with the boy from DRC also developed Ebola-like symptoms and tested positive for *Ebola Zaire virus* by PCR. The first case as well as the 2nd case (grandmother to the first case) subsequently died at Bwera ETC. The 3rd case (sibling to the first case) was repatriated to DRC but died on arrival in DRC. As of 24 June, there were 3 confirmed cases of Ebola from the same family, all of whom had died (Case fatality rate of 100%). A total of 106 contacts of the 3 cases had been listed and were under follow up by 14 June 2019. The district and other high-risk districts continue to identify and investigate several Ebola alerts.

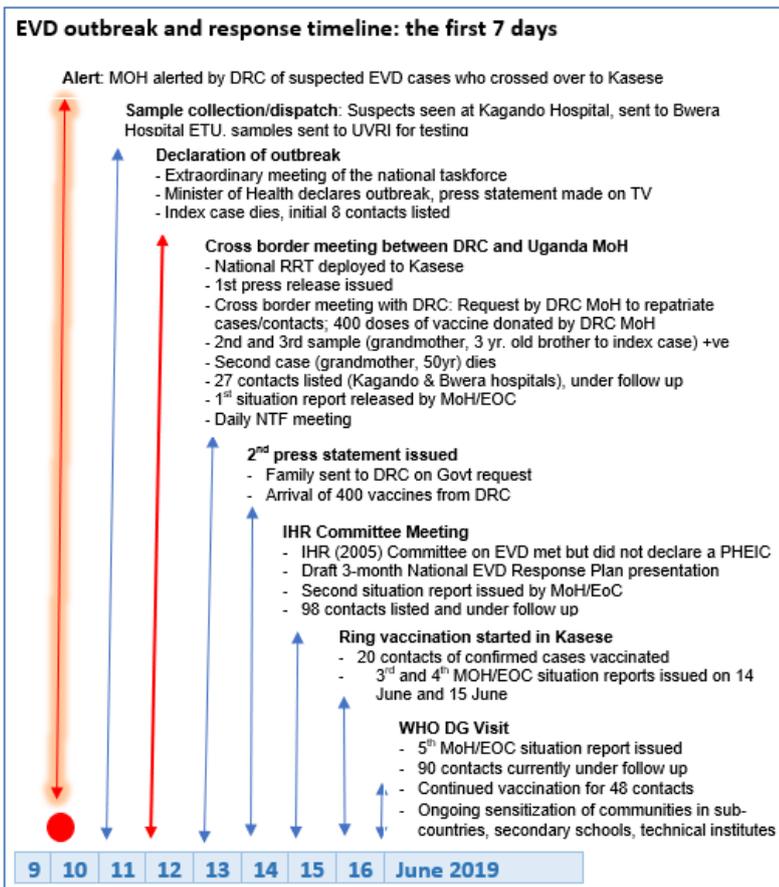
Figure 1: Movement of the cases from DRC into Uganda



Following outbreak confirmation, the Ministry of Health and partners transitioned to response mode (scenario 2 of the contingency plan) and are supporting the response to Ebola outbreak in Kasese. The response is building on and making use of capacity built at national and district levels during preparedness (*scenario 1 of the national EVD contingency plan*). The surveillance system was able to detect timely the first

confirmed case at Kagando hospital and the subsequent cases, also making use of cross border surveillance links previously established with DRC MoH, which notified MoH Uganda about the contacts on the night of 10 June. The case management team received, investigated, and managed the cases at Bwera Ebola Treatment Centre. Find in figure 2 below a timeline of key EVD response events as of 16 June 2019.

Figure 2: Timeline of key events: the first 7 days of response (10-16 June 2019)



As of 22 June, no additional cases had been reported, although contacts were under 21 days mandatory follow up. However, Kasese and other districts neighbouring DRC remain at risk of importation of EVD. Kasese is in southwest Uganda, around 296 kilometres from Kampala via Fort Portal. It shares a direct border with provinces in DRC which have been experiencing an outbreak since 1 August 2018. The district is at risk of EVD importation given the porous border with DRC, continued cross border trade and travel and cross border displacement resulting from insecurity/conflict. The WHO Director General convened a meeting of the [IHR Emergency Committee on EVD on 14 June](#) to make recommendations on the Ebola outbreak in DRC, after international spread from DRC into Uganda. While the committee was

concerned about reinfection in areas where the outbreak had ended and exportation into Uganda,

it did not find it unexpected, given limited funding and insecurity hampering response in DRC, and continued risk for neighbouring countries. The committee did not recommend that the Director General declare it a public health event of international concern, but issued advice including further enhancing preparedness in neighbouring countries and improved funding to facilitate readiness to respond to possible EVD importation.

Operational context

Uganda shares a 2,698km border with DRC directly through 17 districts, with over 120 formal and informal points of entry, including 38 in Kasese district, which people use for trade and other purposes. Informal border crossings, including smuggling routes and refugee entry points enable people to cross undetected (*often by foot or by boat*) and beyond the reach of surveillance. Shared language and ethnicity promotes social ties such as marriage and trade, with a high level of cross border interactions, and refugee to/from movement from DRC which are an additional risk. Social science reviews conducted in late 2018 found that there is mistrust of leadership including public health workers, in Bundibugyo and Kasese districts. Additionally, high levels of mistrust were expressed by fishing communities, who are very mobile and often cross into DRC. Kasese district has low literacy levels, which impacts on health seeking behaviour and behaviour change. Research has shown that traditional healers are often the first point of contact for health issues, especially in remote areas. Furthermore, burial rites, including transportation of the dead via boda boda for burial at home (Kasese and other districts), interaction with the body in preparation for burial (washing, touching, sharing of effects) put people at risk of EVD (Anthrologica, 2019; Mafigiri, 2019; URCS, 2018).

Risk of Spread

The combination of a highly mobile population, influx of refugees (*over 21,000 since January 2019*) as well as refugee return movements to DRC, possibility of primary transmission from infected vectors, inadequate infection prevention and control measures and traditional practices that can amplify transmission means there is a continued risk of EVD spreading within Uganda. In the districts bordering DRC, the risk is largely linked to movement of high risk contacts for reasons related to trade, displacement as well as those fleeing isolation. Road transport routes link these districts with the rest of Uganda and indeed the rest of East Africa (*Kenya, Rwanda, Burundi, South Sudan*). Any delays in the availability of resources for the response and preparedness will elevate the risk of spread outside the currently affected district.

Women, traditional community leaders and youth play a critical role in the transmission and control of EVD. Evidence from the current outbreak in DRC has shown that women are disproportionately affected by EVD (>42 per cent of confirmed cases) due to their role as caregivers within the family and community and/or health workers. In Uganda, the multiplicity of women's roles in society makes them pivotal agents of change on the road to containment of the EVD outbreak. Instituting women within the leadership of awareness raising, planning, monitoring and the implementation of the National Campaigns at national and district level will enhance both the journey to zero cases and ensuring the country remains at zero.

Preparedness and response to previous outbreaks

Historical context

Uganda has previously experienced EVD outbreaks in Northern, Western and Central Uganda. Since Uganda's first recorded EVD outbreak in 2000, it has experienced five outbreaks, four caused by *Ebola virus Sudan* and one by *Ebola virus Bundibugyo*. The current outbreak is caused by *Ebola virus Zaire*. Figure 3 shows location of previous outbreaks in Uganda and table 1 provides a summary of key EVD response indicators.

Figure 3: Location of previous EVD outbreaks in Uganda

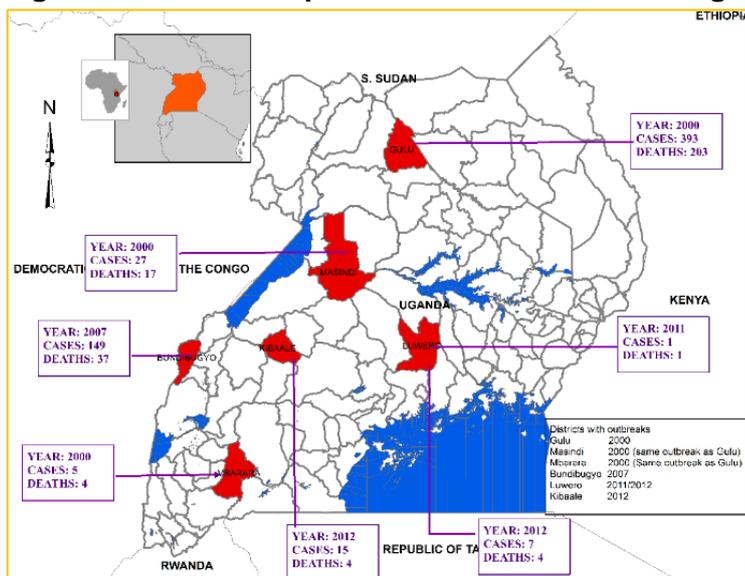


Table 1: EVD preparedness and response to the previous EVD outbreaks in Uganda

EVD indicator (Outbreak response/ Timeliness/ Effectiveness)	Gulu, 2000	Bundibugyo, 2007	Kibaale, 2012	Luwero, 2011	Luwero, 2012
Days from onset of first Ebola signs in the index case to reporting to MoH	20	51	30	NA	24
Days from reporting of first case to picking of sample for EVD diagnosis	3	2	1	NA	1
Days from picking of sample to EVD confirmation	2	7	14	NA	4
Days from EVD confirmation to declaration of national action	1	1	1	NA	1
Days from onset of first EVD signs in index case to declaration of national action	26	61	46	NA	30
Total confirmed cases	425	149	15	1	7
Total confirmed deaths	224	37	4	1	4
Case Fatality Ratio (%)	53	25	27	100	57
Duration of the epidemic (In days)	117	101	63	NA	34

EVD preparedness August 2018 to date

Since August 2018 to date, the Uganda Ministry of Health has engaged in EVD outbreak preparedness activities with support from partners. The activities have covered the following pillars: (i) coordination and leadership; (ii) surveillance, laboratory, and points of entry; (iii) case management, infection prevention and control, safe and dignified burials, mental health and psychosocial support; (iv) risk communication and social mobilization; (v) vaccination and investigational therapeutics (vi) logistics. Through these pillars the Ministry of Health was able to: mobilize resources for preparedness and coordinate stakeholders; train teams on surveillance, case management, contact tracing; conduct orientation of health and parasocial workers on EVD psychosocial support; establish screening at 47 formal points of entry including Entebbe international airport; investigate over 600 alerts; setup nine stand by Ebola Treatment Units (ETUs); setup infection prevention and control and hygiene measures at targeted health facilities, schools and communities within the high risk districts; put in place risk communication and social mobilization in affected districts and at national level and reached all Ugandans with EVD prevention messages.

However, an EVD functional simulation exercise conducted from 11-12 April 2019 to assess readiness capacities as well as the EVD accountability forum conducted on 29 May 2019 found that there were still glaring gaps in preparedness. Among key findings, there were some gaps in the coordination resulting in duplication of partner efforts in some pillars; weak framework for monitoring preparedness efforts; some districts did not receive the required training; delayed

reporting of alerts from the community to national level; inadequate isolation facilities, as well as weak infection prevention and control including in districts where trainings were conducted. Recommendations from the simulation exercise and the accountability forum as well as those from the NTF point towards further efforts to strengthen EVD readiness of the country. In the following section key achievements, gaps and recommendations for EVD preparedness from August 2018 to March 2019 are presented.

Key achievements, best practices, gaps and recommendations from EVD preparedness

Coordination and Leadership

Key achievements/ Best practices	Government and partners quickly mobilized resources (USD 18.7 million as at the end of April 2019) for EVD preparedness
	EVD operational readiness assessments were conducted in 12 districts and activated the district task forces
	An EVD dashboard was developed to enable information sharing by all partners and key stakeholders. It is considered a barometer for transparency and accountability.
	Stakeholder mapping using the 4W matrix contributed to improving coordination of partner efforts and reducing duplication of contributions
	Two EVD accountability fora were held by the Minister of Health. The events facilitated information sharing on resource use and outputs, contributing to broader accountability for EVD preparedness
	Disseminated daily updates of EVD preparedness efforts
Gaps/challenges	Incremental and phased implementation of the EVD plan led to varied levels of preparedness across districts
	Inadequate monitoring of the implementation of the EVD plan
	Bureaucratic financing mechanism hampered timely disbursement of funds from government to district levels, delaying implementation of some activities
Recommendations	Devise efficient, robust payment mechanisms for responders at National and field levels
	Strengthen monitoring and support supervision of EVD activities by national teams using standard key performance indicators
	Implement a full preparedness package for each of the high-risk districts
	Continue to enhance cross border collaboration with DRC

Surveillance, Laboratory Support and Points of Entry

Key achievements/ Best practices	Training on surveillance & contact tracing: 716 health workers in EVD surveillance, and 719 contact tracers in 26 districts
	Training in EVD diagnostics (RDTs and GeneXpert): Conducted for 19 Laboratory technicians from Central Public Health Laboratories, Uganda Virus Research Institute, and National TB Reference Laboratory
	Training in community disease-based surveillance(CBDS): for 7,575 VHTs in 6 districts
	PoEs: EVD screening operationalized at 47 Points of Entry; 7,073,104 individuals screened up to May 2019
	Alerts: 702 alerts were reported and investigated by 12 June 2019. Laboratory results turnaround time reduced from 48hrs in August 2018 to 21.7hrs in May 2019
Gaps/ Challenges	Critical training gaps: for health workers in surveillance and contact tracing not conducted in 4 districts including Wakiso District; and CBDS for VHTs in 18 districts
	Surveillance and risk communication for mobile communities from EVD affected areas in DRC living in greater Kampala was not effectively addressed
	Delay in receiving alerts from communities
	Inadequate infection prevention and control at many points of entry
Recommendations	Complete training of health workers in surveillance and contact tracing 4 districts; and VHTs on CBDS in 18 districts
	Engage all key stakeholders: Community, Immigration, Security and Law Enforcement agencies, Transporters, Traders and Media in EVD prevention and control
	Conduct drills on contact tracing in the 24 high risk districts
	Provide funds to districts to conduct active case search at both community and health facility level

Case management Infection prevention and control and safe and dignified burial

Key achievements/ Best practices	Training/mentorship: 526 health workers trained in EVD case management; 9,806 health workers mentored in 562 health facilities in 11 districts; and 18 safe and dignified burial teams constituted and trained; 389 front line health workers oriented in infant and young child feeding in the context of ebola, ready to use infant formula & therapeutic formula (768 RUIF/954 RUTF) prepositioned for rapid deployment.
	Stand by ETUs: 6 functional ETUs (<i>Bwera Hospital in Kasese, Bundibugyo Hospital in Bundibugyo District, JMEDICC facility in Kabarole District, Rwebisengo HCIII in Ntoroko District, Kasonga HCIV in Kikuube District, Entebbe Hospital in Wakiso District</i>); 2 under construction (<i>Naguru, KCCA and Kihhi in Kanungu District</i>); 3 isolation units in Arua, Mbarara, and Gulu.
	Distribution of infection prevention supplies: 5,512 hand washing facilities distributed to 535 health facilities, 962 schools, and 60 PoEs in 17 districts; 4245 cartons of bar soap, 1201 cartons of liquid soap, 1452 cartons of aqua tabs, 1782 pH meters, 1782 chlorine pool testers to 535 health facilities and 962 schools in 17 districts; 512 buckets (45kg) of chlorine distributed to 535 health facilities in 17 districts.
	50 tanks of 2,000-litre capacity distributed to 50 selected health facilities, 50 solar powered chlorine generators distributed to district hospitals/HCIVs in 14 districts
	Gaps/challenges
	Weak adherence to infection prevention and control protocols (IPC) in districts, partially attributed to inadequate infrastructure/ facilities coupled with stock out of IPC supplies at many health facilities and PoEs.
	Training in case management was not conducted in 13 districts (<i>Buliisa, Isingiro, Kabale, Kagadi, Kamwenge, Kyenjojo, Kyegegwa, Nebbi, Pakwach, Rubirizi, Rukungiri, Wakiso, Zombo</i>) targeting 40 health workers per district
	Training of health workers in IPC was not conducted in 8 high risk districts (<i>Kyegegwa, Kyenjojo, Isingiro, Kagadi, Kamwenge, Kikuube, Hoima, Buliisa</i>)
	Lack of national capacity for advanced care of complicated EVD cases
Recommendations	Complete training of district teams in case management in 13 districts
	Train and equip at least one team in advanced EVD case management
	Train health workers from 8 districts in IPC; mentor and supervise health workers trained in all high-risk districts
	Conduct drills and mentorship on case management
	Preposition IPC supplies and streamline into the national supply system
	Construct permanent structures (<i>ETUs, PoEs and isolation units</i>) at strategic points

Mental Health and Psychosocial Support

Key achievements/ Best practices	<ul style="list-style-type: none"> Trained 404 health workers (counsellors, psychiatric nurses, clinical officers) in 13 districts (Bundibugyo, Bunyangabo, Isingiro, Kabarole, Kagadi, Kanungu, Kasese, Kikuube, Kisoro, Ntoroko, Rubirizi, Isingiro and Kabale) Oriented 1,390 para-social workers and VHTs in Bundibugyo, Bunyangabu, Kabarole, Kasese, Kanungu, Kisoro, Ntoroko, and Rukungiri districts.
	Developed a sensitization manual for para-social workers on child protection in disease outbreaks and training materials for health workers and parasocial workers on EVD psychosocial support
Gaps/challenges	Limited funding to finance psychosocial support
	17 districts not covered with psychosocial support training
	No supervision of trained health workers was conducted in the period
	No designated focal persons responsible for MHPSS at district taskforces
Recommendations	Complete training: of health workers in 11 districts, para-social workers and VHTs in 15 districts
	Designate focal persons for MHPSS at district levels
	Map partners involved in MHPSS interventions per district
	Conduct support supervision, mentorship and simulation exercises in district that have completed training

Risk communication, social mobilization and community engagement

Key achievements/ Best practices	25 press releases have been issued by Ministry of health since August 2018 to inform the public on status of EVD preparedness and to dispel misinformation and rumors
	2,395,466 people were reached with EVD prevention messages in 24 high risk districts through 344,054 household visits, 14,160 community dialogue meetings, 7,610 VHTs, 4,817 local council leaders, 816 religious leaders, and 3,474 teachers.

	IEC materials (724,193 posters, 883,627 flyers, 108 banners, 18,000 job aids in 17 languages) distributed; 24, 673 radio spots and 394 talk shows broadcast on 21 stations in 30 districts, reaching 5,617,220 people. 98,502 people on U-Report received key EVD messages, sent questions and received feedback.
	EVD awareness was 89% and the proportion of individuals who knew two ways of preventing EVD was 82%.
	First KAP survey conducted in December 2018, and a follow up has been completed; social science review on EVD; and an anthropological study conducted in May 2019.
Gaps/challenges	Funding for community engagement in the high-risk districts was insufficient. Inadequate funding to support media engagement in the high-risk districts
Recommendations	Conduct support supervision and quality assurance of EVD interventions at the district level. Provide regular mentorship to district pillar leads and taskforces Use findings of the surveys to inform the communication strategy

Vaccination and operational research

Key achievements/ Best practices	Uganda successfully requested and obtained 5,537 doses of EVD vaccines, 3,000 additional doses were approved Uganda pioneered vaccination of 4,420 health workers in 13 high risk districts (Buliisa, Bundibugyo, Bunyangabo, Hoima, Kabarole, Kagadi, Kanungu Kasese Kikuube Kisoro, Ntoroko, Rubirizi, Rukungiri) in a preparedness context Safety follow up visits on day 3, 14 and 21 for 2,398 (90%); 2,132 (80%) and 1,588 (60%) Finalized the Protocol for EVD vaccination of health workers Trained 13 national vaccination teams each with 14 members for EVD vaccination Procured cold chain equipment for vaccination storage at central store NMS) and for transportation to the field
Gaps/challenges	Health workers in Kampala, Wakiso, Pakwach, Nebbi, Zombo, Arua, Kyegegwa, Kamwenge, and Isingiro have not been vaccinated
Recommendations	Conduct vaccination of health workers in the remaining high-risk districts

Logistics

Key achievements/ Best practices	Availed storage capacity of 20,000m ² for partner EVD items 30 VHF kits received from partners 16 ambulances, 2 pickups, 80 motorcycles and 2500 bicycles for VHTs procured Thermo-scanners procured and installed at Entebbe Airport (2) and Mpondwe border post (1) to enhance surveillance 5 high risk districts provided with chlorine generation machines Provided transport for IPC items to 344 HCs in November 2018, January and May 2019 Constructed Mpondwe screening and isolation unit Installed 29 tents in high risk districts Database has been established for tracking EVD supplies
Gaps/challenges	Inadequate monitoring of use of supplies at the district level
Recommendations	Construct 5 regional warehouses Additional ambulances Update supply plan to inform procurement of EVD supplies Roll out the emergency electronic logistics management information system

EVD preparedness in high risk districts neighbouring DRC, initiated in August 2018, was successful, as evidenced by district leadership and timely detection, isolation and management of the first case imported from DRC. The plan moved from scenario 1 (preparedness) to scenario 2 (response to a cluster of cases). The rest of the document deals with response arrangements.

EVD response strategy for Uganda

Goal

To contribute to the reduction of EVD related morbidity and mortality in the affected area and prevent transmission to new areas in the country.

Specific objectives

The specific objectives are to:

- **Objective 1:** Mobilize partners and resources for effective EVD response and enhanced preparedness in outbreak affected and high-risk districts.
- **Objective 2:** Enhance district capacity to rapidly detect and investigate all suspect EVD cases in outbreak affected and high-risk districts.
- **Objective 3:** Raise public awareness on the threat of EVD and galvanize community support for prevention and early treatment seeking in outbreak affected and high-risk districts.
- **Objective 4:** Enhance capacity for appropriate EVD case management, safe and dignified burials and psychosocial support in outbreak and high-risk districts.
- **Objective 5:** Strengthen capacity for infection prevention and control in outbreak and high-risk districts.
- **Objective 6:** Rapidly conduct EVD vaccination and deploy investigational therapeutics in the affected area.

Approach

This plan was developed following the declaration of an EVD outbreak on 11 June 2019; it builds on preparedness and prevention work implemented from August 2018 to date in identified high risk districts. The plan focuses on response in Kasese district (*referred to as category 1*) and enhanced preparedness in 10 category one¹ and 13 category two districts². It includes the review of district categorization; development of scenarios aligned to the categories and a minimum package for integrated/holistic EVD preparedness and response interventions³.

Scenarios

This plan builds on the national EVD contingency plan, which is based on three scenarios, listed below. Of note, Uganda has moved from scenario 1 (preparedness) to scenario 2. An escalation to scenario 3 is possible if multiple cases are confirmed in various locations. Interventions are guided by scenarios.

Table 2: Scenario and actions

Scenario	Action
Scenario 1: <i>Preparedness - no confirmed case. This was implemented in Uganda from August 2018 to May 2019.</i>	Cross pillar preparedness through pillars, implemented from August 2018 to May 2019
Scenario 2 (<i>confirmed case, enhanced preparedness in high risk districts</i>)	<ul style="list-style-type: none">• Cross pillar response at community, points of entry, non-ETUs (health facilities), with refurbishment of ETUs as needed• Surge teams (<i>national RRT, MSF, others</i>)• In the event of mass refugee influx to outbreak and high-risk districts, thermoscanners will be deployed at

¹ Rubirizi, Kamwenge, Kabarole, Bunyangabu, Bundibugyo, Ntoroko, Kanungu, Kisoro, and based on movement and trade, Kampala and Wakiso

² Kabale, Rukungiri, Kikuube, Kyegegwa, Kyenjojo, Isingiro, Buliisa, Hoima, Kagadi, Pakwach, Zombo, Arua, and Nebbi

³ From community, health facility (non-ETUs), ETUs and specialized care facilities (proposed for those suffering multiorgan failure)

Scenario	Action
	<p>the border points when the arrival rate reaches at least 1000/day</p> <ul style="list-style-type: none"> • District categorization and preparedness focused in high risk districts
<p>Scenario 3 (<i>confirmed in multiple locations, <u>or</u> urban areas <u>or</u> refugee settlement, <u>or</u> overwhelming numbers of cases</i>)</p>	<ul style="list-style-type: none"> • Cross pillar response at community, points of entry, non-ETUs (health facilities), with establishment of new /refurbishment of existing ETUs as needed • Surge teams (<i>national RRT, MSF, UPDF medical team, international medical teams</i>) • Mobile labs and ETU • District categorization and preparedness focused in high risk districts

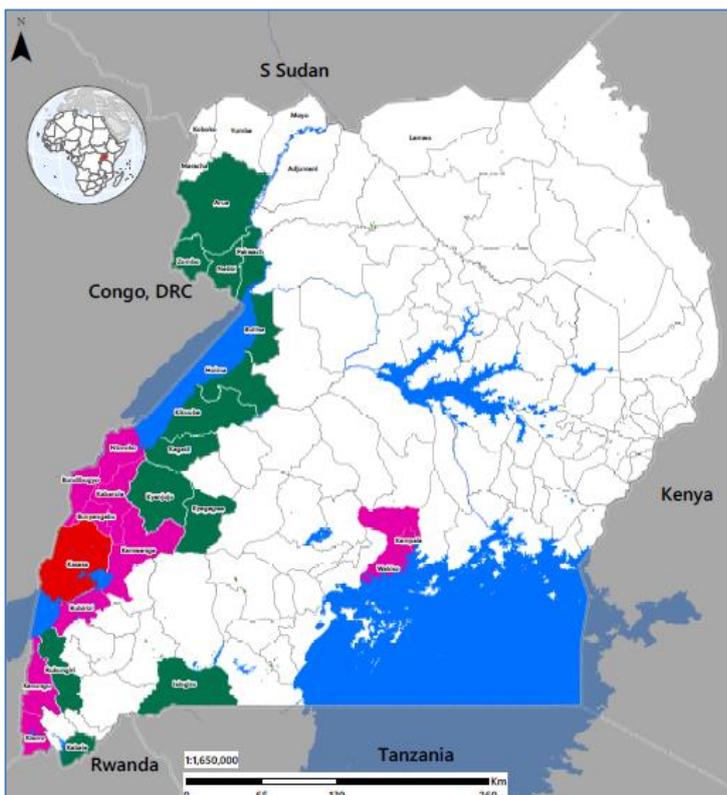
Risk Classification

Three district categories are described below based on risk level. The risk levels are based on proximity to DRC and/or the affected district (Kasese) as well as on movement from the DRC or Kasese (See table 3 and figure 4).

Table 3: District categorization

Category	Districts	Rationale
Category 1	<i>Kasese district</i>	Affected district
Category 2 (10 districts)	<i>Rubirizi, Kamwenge, Kabarole, Bunyangabu, Bundibugyo, Ntoroko, Kanungu, Kisoro, and based on movement and trade, Kampala and Wakiso</i>	<i>Districts bordering Kasese and/or with direct routes to/from DRC</i>
Category 3 (13 districts)	<i>Kabale, Rukungiri, Kikuube, Kyegegwa, Kyenjojo, Isingiro, Buliisa, Hoima, Kagadi, Pakwach, Zombo, Arua, and Nebbi</i>	<i>Districts requiring enhanced preparedness due to population movement, refugee hosting, not necessarily bordering Kasese</i>

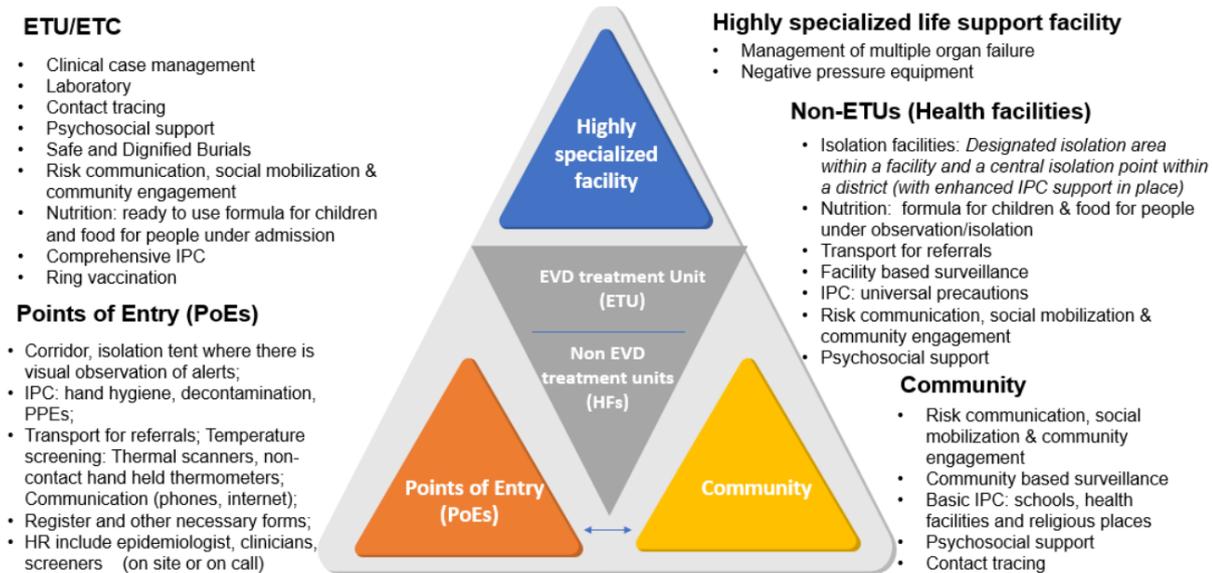
Figure 4: District risk classification



Interventions by objective

The response will be implemented with overall leadership of the Ministry of Health and districts, with the support of partners. EVD response and enhanced preparedness activities are being implemented through the following pillars: (i) coordination and leadership (ii) surveillance, laboratory support and point of entry screening; (iii) case management including infection prevention and control, safe and dignified burials; (iv) risk communication, social mobilization and community engagement; (v) logistics and (vi) vaccination and investigational therapeutics (vii) Psychosocial support. These will be implemented through the packages summarized in figure 5 below.

Figure 5: Minimum packages for EVD integrated preparedness and response



Objective 1: Mobilize partners and resources for effective EVD response and enhanced preparedness in high risk districts.

Coordination and Leadership

Gains made during preparedness: The Ministry of Health had mobilized \$18.7 million as at the end of April 2019 to implement EVD readiness activities. The National Taskforce for Epidemics was activated and held bi/weekly coordination meetings, and sub-committees operationalized as outlined in the Standard Operating Procedures for responding to Ebola/Marburg Virus Disease outbreaks in Uganda. The Director General designated an Incident Manager and set up the Incident Management System to support coordination of preparedness activities. National rapid response teams were deployed to conduct EVD readiness assessments using the WHO preparedness checklist in 12 Districts and set up systems for EVD preparedness aligned with the national plan. Cross border meetings and surveillance with DRC and other neighbouring countries under the auspices of the East African Community Surveillance Network; meetings were held in Entebbe, Goma, Kigali and Kasese. Twenty-four districts, including refugee hosting districts received support to develop preparedness plans. Eighteen districts received funding to operationalize EVD coordination. Other support to overall EVD preparedness in Uganda included the: Preparedness Support Team Mission (Aug 2018), Joint Monitoring Mission (Nov 2018), WHO’s Independent Advisory Team visit (Nov 2018) and the full scale EVD simulation exercise conducted in April 2019. Two EVD accountability fora were held in December 2018 and May 2019. Coordination structures are well established at the national level and in the districts including Kasese; however, they operate at varying capacities. However, partner plans were not well aligned with the national EVD national plan and there was suboptimal monitoring of the plan. The preparedness coordination mechanisms immediately transitioned to response mechanisms upon confirmation of Ebola cases in Uganda.

Strategy: Appropriate procedures, technical and operational support mechanisms enhanced and supported daily to coordinate all aspects of the response in outbreak affected areas and heightened preparedness in category 2 and 3 districts. Effort will be made to integrate and coordinate approaches between the preparedness, response and recovery phases and laying the foundation for resilience building.

General targets

- Attack rate for EVD outbreak

- Case fatality rate below < 50%

Activities

- Coordinate meetings of the national/district taskforce, subcommittees and provide regular progress reports on preparedness and response tasks.
- Partner coordination and resource mobilization for the response including funding for district response plans to enable community led interventions.
- Provide timely and up to date information on the evolution of the crisis and needs through the publication and dissemination of daily reports.
- Rapidly deploy the technical expertise required to respond to the outbreak.
- Strengthen the outbreak preparedness and response coordination structure (DHT and others) in the affected district.
- Assess and update relevant preparedness, response and recovery plans at central and local levels, ensuring full stakeholder engagement throughout the process.
- Ensure continuous and in-depth analysis of the evolution of the outbreak.
- Coordinate with security agencies to ensure safety of responders.
- Establish emergency medical evacuation procedures for field teams and activate as needed.
- Support cross-border coordination with DRC and other neighbouring countries.
- Facilitate regular support supervision and mentorship at the district level.
- Monitor and evaluate the response using performance key indicators and after-action review, once the outbreak is officially declared over.

Objective 2: Enhance district capacity to rapidly detect and investigate all suspect EVD cases in elevated risk districts.

Surveillance and laboratory support

Gains made during preparedness: Efforts over the past 10 months have ensured that rapid response teams are trained, health workers and village health teams are oriented on the EVD case definition and contact tracing and selected health workers and laboratory staff trained to safely collect, transport specimens for laboratory confirmation. Capacity for screening, isolation and referral has been built at official points of entry and refugee transit and reception centres. The priority for the pillar will be to: strengthen surveillance for case detection, information management and case investigation, including for suspects tracked through points of entry; enhance contact tracing capacity and follow-up in the affected and surrounding districts and improve sample transportation for rapid and safe specimen collection and transport from peripheral areas to UVRI laboratory in Kampala.

Strategy: Rapid detection, immediate notification and investigation of suspected cases is key in stopping the current outbreak.

Targets:

- All notified alerts investigated within <24hrs
- Follow-up 100% of all contacts
- Sustain all the 47 points of entry in the high risk districts
- Ensure that 100% of travelers are screened at formal PoEs
- Reduce epidemiological turnaround time to 12 hours

Activities

- Create an alert desk and daily reporting from health facilities to district and MoH levels.
- Deploy Rapid Response Teams to rapidly investigate alerts and conduct initial response in affected areas as needed.

- Train and mentor of health workers (including private practitioners) to rapidly detect and contain EVD.
- Conduct and supervise active case finding, contact tracing and follow-up in the affected and surrounding areas.
- Orient VHTs to conduct active case finding, contact tracing and follow-up.
- Support timely collection and referral of specimens from the field to the national reference laboratory.
- Establish mobile field laboratory(ies) as needed in the affected districts
- Ensure the availability of reagents, consumables and equipment for EVD diagnosis and differential diagnosis of other pathogens.
- Data management, analysis and reporting.

Points of entry:

Points of entry (PoEs) are important nodes in disease detection and sensitization of travellers crossing borders. Given the ongoing population movement from EVD affected areas in DRC and the high risk of importation, it is important to improve IHR public health core capacities at POEs and refugee collection centres, especially for screening of EVD.

Gains during Preparedness: During the EVD preparedness phase since August 2018, screening services were established at several high volume formal and informal points of entry in all high-risk districts bordering DRC. The PoEs were equipped with temperature monitoring equipment including a thermoscanner at the busiest Mpondwe PoE, tents, furniture, IPC equipment and supplies, and the health workers and volunteers manning the PoEs were trained. The PoEs are linked to isolation facilities and ambulance services to transport any alert cases from the PoEs to the isolation facilities for investigation. Over 3 million people have been screened as they went through the PoEs since August 2018; and over 100 alerts were detected and investigated. Fortunately, all tested negative for Ebola.

The Ministry of Health is prioritising the establishment of permanent structures at the PoEs for longer term preparedness activities at high volume crossing points. This response plan is prioritizing the following activities for EVD response and prevention at 105 formal and informal PoEs including 38 in Kasese district alone.

Targets: Ensure that 100% of travelers are screened at formal PoEs.

All alerts detected at POEs are investigated within 24 hours

Activities

- Intensify appropriate screening and management of alerts/suspects at POE and congregation points, and if necessary, establish screening at informal crossing points.
- Referral of alerts/suspects from PoEs to designated isolation facilities.
- Training of immigration, Customs and internal security officers at PoEs on EVD responses and procedures for entry and exit screening.
- Mentor and supervise of screeners at the 105 PoEs in Kasese.
- Pay screeners at 105 PoEs.
- Provide security at 105 PoEs to ensure the safety of screeners.
- Pay PoE overheads as needed - for example electricity, water bills.
- Provide forms/tools and job aids
- Manage data, analysis and reporting
- Provide IPC supplies
- Ensure adequate WASH services including safe water, clean toilets, handwashing with soap and water and management of waste water from PoEs.
- Conduct risk communication and social mobilization activities at PoEs.

Objective 3: Enhance capacity for appropriate EVD case management, safe and dignified burials and psychosocial support in outbreak and high-risk districts.

Case management

All EVD patients should access quality care to improve survival, symptom relief and palliative care, with every effort made to reduce the risk of transmission to health workers and the community. Experimental therapeutics available on compassionate basis, are on trial in DRC and have in recent months provided hope for better survival of patients enrolled at ETCs.

Gains made in Preparedness: In Uganda over the past 10 months, nine ETUs were established in high risk districts to enhance readiness to respond to EVD importation. Over 500 health workers country wide have received EVD case management training, at the same time, those who have previously been engaged in EVD case management have been mobilized by MoH. The affected district, Kasese, already had a trained case management team and one stand by treatment centre at Bwera Hospital which received and managed the Ebola cases. The case management team been through several drills as they managed alert and suspected cases in the ETU. MSF/Epi Center had already applied and have now received ethical approval for MEURI through the National Council for Science and Technology and approval of an importation permit and will deploy these therapeutics should there be additional confirmed cases. JMMEDIC also applied for ethical approval and is pending approval. The focus will be to enhance the capacity to identify and appropriately manage EVD cases.

EVD and malaria have similarities in clinical presentation (especially fever and vomiting) and Ebola may mimic severe malaria presenting with haemorrhage. Malaria and Ebola comorbidities are common in areas of malaria steady transmission such as Kasese. The case management teams were thus trained on how to safely conduct malaria RDTs on alert and suspected cases of Ebola to rule out malaria. Prevention of malaria will reduce the burden on the health system while reducing the risk of health workers contracting EVD from contact with infected body fluids. Other tests for common parasitic infections such as schistosomiasis, leishmaniasis and filariasis may be considered on a case by case basis and cases managed to improve survival.

However, not all the case management team members in the high-risk districts have been trained on management of malaria in Ebola cases as nutrition, especially for children. Furthermore, the existing ETUs can provide basic care; some of the ETUs are being supported with necessary equipment and expertise to provide advanced care.

Strategy: Appropriate triage, isolation and management of suspected/confirmed cases.

Target:

- Train 1224 health workers in patient management including Malaria and nutrition
- Operationalize advanced care in at least one ETU
- Reduce case fatality rate below 50%.
- Zero health workers contract EVD.
- Presumptive malaria treatment for 100% of EVD suspects, probable and confirmed cases.

Activities

- Establish isolation and ETU facilities.
- Procure and distribute EVD kits, medical supplies including medicines for malaria management.
- Provide clinical care to suspected, probable and confirmed cases, including nutritional assessment, identification and management of co-morbidities.

- Conduct refresher training for health workers in patient management/clinical care including, on the collection of sex and age disaggregated data and advanced care using MEURI protocol.
- Conduct drills and exercises to sharpen skills and competency of health workers in EVD management.
- Train health workers on nutrition in the context of EVD including Infant and Young Child Feeding, nutritional care for EVD patients, management of acute malnutrition in the context of EVD.
- Provide food assistance and/or specialized nutrition foods for suspects, cases/patients and health workers (including RUIF for Under 6 months, RUTF for cases with SAM).
- Provide child/mother friendly EVD patient care, ensuring that safe mother and baby friendly areas are established/designated in isolation for children separated or orphaned at ETU/community⁴.
- Deploy investigational therapeutics and relevant diagnostics for patient monitoring.
- Provision of lighting, security and risk allowance.
- Provide discharge package for discharged patients for re-integration/ compensation of destroyed items including psychosocial support and health education for EVD survivors⁵.
- Provide adequate and safe ambulance services to facilitate referral of suspected cases from community to isolation facility.
- Post discharge assessment, appropriate management and follow up of survivors (length of monitoring to be discussed).
- Conduct support supervision visits by the MoH officials.

Safe and dignified burials

During the response phase, safe and dignified burials should be accorded for all suspect EVD deaths in accordance to their religious and cultural beliefs.

Gains from Preparedness: At least one burial team trained in 14 of the 31 high-risk districts. Necessary equipment was provided to the districts for safe and dignified burials.

Target: Safe burials conducted for 100% of deceased suspected and confirmed cases

Activities

- Train additional safe and dignified teams in districts where the response is ongoing
- Conduct drills to enhance skills and competency of burial team.
- Decontaminate the homes of affected families.
- Provide a solidarity package to affected communities

Mental Health and Psychosocial Support

EVD may cause mental health problems concerns because of the nature of the disease and the disruption it causes to the infected, affected, responders and their families. Targeted response interventions by health including physical isolation may impact on EVD affected communities' mental health. Community assets, for example the National Forum for People Living with HIV Networks in Uganda, may have a role to play in contributing to EVD prevention including early treatment seeking and adherence, safe sex, and addressing stigma and discrimination in EVD affected communities.

Gains from Preparedness: 11 high risk districts were supported to establish and train psychosocial support teams to provide the required psychosocial support to patients, health workers, and communities. Some of the team members had already been involved in providing psychosocial support to alert and suspected cases admitted to ETUs during the preparedness phase

⁴ This will require training of health workers, partitioning of isolation, sanitary, beddings and supplies, food assistance.

⁵ Discharge package includes: Beddings, 2 full sets of clothes, dignity kits, cookery set, jerrycan, male condoms, food items

Strategy

EVD public health activities must be complemented by social and mental health interventions which address important issues that have repercussions on mental health.

Target: # (%) of EVD affected people (those in isolation, their families and communities) who received psychosocial support including at community level.

Activities

- Sensitization of communities, families and children on EVD related psychosocial distress and mental health concerns.
- Provision of mental health and psychosocial interventions within the ETU, including for people in isolation.
- Provision of psychosocial care for health workers engaged in EVD response, ensuring that they are assessed, briefed and debriefed following deployment.
- Provision of psychological first aid (PFA) and community counselling, including through existing networks to reduce stigma towards affected survivors, families and communities.
- Building capacity of health workers, social workers, community cadres and other relevant groups to deliver appropriate psychosocial support.
- Conduct bereavement counselling for families and negotiate safe burial.
- Provision of individual child protection services and livelihoods support including child friendly PSS to EVD affected children and their families, including orphaned children in need of care psychosocial care.

Objective 4: Strengthen capacity for infection prevention and control in outbreak and high-risk districts

Strategy: To curb transmission of EVD to health workers, caregivers, patients and the community by strengthening adherence to infection prevention and control protocols. Additionally, to increase access to safe water and sanitation in health facilities, points of Entries, Schools, Public Places and markets.

Gains from preparedness: 22 out of the 30 targeted districts by for enhanced preparedness were supported to train district IPC mentoring teams. Assessment of IPC practices in the health facilities in these districts was conducted and many gaps identified. In about 10 of the districts, the IPC mentoring team has been supported to conduct mentoring visits to all health facilities, mentoring health workers to improve IPC practices. IPC supplies that were a big gap in most health facilities were provided to all health facilities in the 5 very high-risk districts, including hand washing facilities to ensure adequate supplies for appropriate IPC implementation. However, the health worker behaviour change is relatively slow and more mentoring is still required.

Target:

- All health centres maintain an IPC score above 80%.
- 100% institutions (schools, health facilities, public places) have handwashing stations utilized.

Infection Prevention and Control in ETUs

- Provision of additional IPC supplies for health care workers & support staff
- IPC training and information provision for health care workers & support staff
- Mentorship, drills and exercises to enhance skills and competencies in IPC
- Chlorine preparation and handling, strict cleaning and disinfection protocols
- Removal and safe disposal of fluid spills and cleaning of various areas of the ETU
- Safe laundry management

- Management of waste in the ETU (disaggregation, disposal)
- Provision of solidarity kits
- Disinfection of patient homes
- IEC materials and job aids on IPC

WASH for EVD response

WASH in ETUs

- Provision of hand washing stations with soap and water
- Provision of clean and safe water
- Establishment of chlorinated water distribution system with different concentrations as needed
- Provision of sanitation equipped with chlorinated handwashing points and soap
- Establishment and decommissioning of ETU waste disposal systems (waste pits, incinerators, soak away pits).

WASH in non-ETUs (health facilities)

- Establishment/refurbishment of isolation facilities, areas within facilities and central isolation point for high risk districts as needed
- Procurement and distribution of PPE supplies for clinicians and laboratory staff
- Management of hazardous and normal waste
- Formalization and functionalization of IPC committees.
- Mentorship (including conducting drills and exercises) to enhance IPC skills and competencies of health workers
- EVD prevention communication: production and dissemination of IPC related job aids, booklet and/or posters⁶
- Construction and rehabilitation of water and sanitation infrastructure
- Provision of hand washing stations with soap and water
- Procurement and distribution of soap, chlorine and alcohol hand rub
- Provision of supplies for hygienists⁷
- Delivery of supplies to the end user

WASH in EVD affected communities

- Provision of WASH services (renovation of infrastructure etc).
- Hygiene promotion and sensitization on use of WASH commodities (chlorine tablets, soap etc.)
- Provision of an IPC kit and education for homes of patients/contacts.

WASH in institutions (schools, public places, refugee transit centres, refugee reception centres, refugee food distribution points)

- Provision of safe water, clean toilets, handwashing facilities with soap and water, hygiene promotion in school, communal places and refugee distribution points.
- Hygiene promotion and sensitization on use of WASH commodities.
- Engagement with local authorities on improvement of WASH in market places, inspection of food vending places, markets and other public places using a standardized checklist.
- Water and sanitation needs assessment in selected institutions (health facilities, schools, and public places and food distribution points).
- Decongest the new refugee arrival collection, transit, reception centres to minimize risk of transmission in the event of an outbreak.

⁶ Cover: chlorine solution preparation, HWWs, excreta risks, Ebola risks, cleaning procedures, spills, PPE guidance

⁷ Includes: chlorine powder, alcohol hand rub, buckets, disposable and heavy-duty gloves, reusable and disposable aprons, waste bins (color coded) and biohazard bags.

Objective 5: Raise public awareness on the threat of EVD and galvanize community support for prevention and early treatment seeking.

Risk communication, social mobilization and community engagement:

Strategy: To promote adoption of protective behaviours for EVD prevention and control at individual and community level.

Gains made in preparedness: Over 344,000 households reached. 7610 VHTs trained on EVD prevention, reporting and control, with key messages for community in 22 districts. 4,817 Local Council, 816 religious leaders and 3474 teachers oriented on EVD prevention and control in 22 districts. Distributed translated IEC materials to 30 high risk districts and aired radio talk shows in 22 districts

Target:

- # of people (leaders, school children, communities) reached with key EVD prevention messages
- Number (%) of people who recall 3 ways to prevent EVD

National level activities

Public awareness through mass media

- Development of key messages and production of IEC materials: Coordinate the development, adaptation, pretesting, translation and production of EVD materials. It covers:
 - Printing of EVD IEC materials in various formats and languages
 - Distribution of EVD IEC materials to specific districts
- Media promotion and broadcasts via radio (production, translation and dissemination). This covers radio airtime for spots and jingles and radio talk shows.
 - Radio airtime for talk shows and facilitation of key panelists
 - Radio airtime for spots and jingles
- Media promotion and broadcasts via Television:
 - TV airtime for talk shows and facilitation of key panelists
 - TV airtime for spots/adverts
 - Deployment of MoH film vans for community sensitization and message dissemination to key established spots of activity e.g. entry points, markets along the border, refugee camps etc.
- Media promotion and broadcasts via newspapers
- Social Media: information development and dissemination, rumors management, tracking and feedback.
- Other media: Information dissemination by SMS, MTRAC and U-Report
- Engagement with key media houses to promote responsive and responsible media reporting.
- Anthropological and KAP studies to inform risk communication

Coordination

- Coordination of national level actors
- Conduct rapid assessment focusing on EVD behavioral issues, risk perception, existing communication channels and other studies: conduct rapid assessments, social evidence reviews and documentation of trends.
- Conduct supportive supervision and mentorship in districts.
- Deploy surge staff to outbreak affected and high- risk districts.

Key risk communication and social mobilization activities at District Level

Public awareness through mass media

- Media promotion and broadcasts via radio (production, translation and dissemination)

- Radio airtime for talk shows and facilitation of key panelists (at least three talk shows in a week)
- Radio airtime for spots and jingles
- Distribute IEC materials to different PoEs formal and informal, ETUs and non-ETUs, Schools and key points of convergence
- Other media: Information dissemination by SMS, MTRAC and U-Report

Community engagement

- Reorient religious leaders, cultural leaders, traditional healers and private practitioners on EVD (Safe burials, avoidance of stigmatization etc), conduct focus group discussion at district and sub-county levels to ensure broader participation and capturing of contextual issues (at least a session in each sub-county and to be reinforced with community dialogue meetings)
- Conduct school outreaches using school administrators (DHE, ADHEs, School Inspectors, CDO, ACDO - a team of 5, to reach education institutions (ECD, Primary, secondary, BTVET, etc.).
- Orientation of municipal leaders, leaders of traders, hoteliers, transporters and key public-sector groups on EVD (hold one meeting per sub county, at least one session per sub-county) to avoid rumors, address misconceptions put safety measures, identify and broaden change agents/champions.

Interpersonal communication

- Orientation of facility-based health workers on improving interpersonal communication - at least a session at each referral hospital or Health centre 3) – complemented with distribution of relevant IEC materials: posters, fact-sheets, EVD job aide cards and Flip charts.
- Training of EVD Volunteers (frontline health mobilisers like Health Assistants and VHTs)
- Conduct house-to-house visits and community-dialogue sessions in various communities.

Coordination

- Coordination of district level actors.
- Conduct planning at district and Sub county levels (once a month)
- Supportive supervision of district and sub county team to conduct - assessments, supervise trained volunteers (one visit per month); conduct quarterly planning and review meetings at sub-county level.
- Rumors monitoring and feedback.
- Capacity building and mentorship of District teams, implementing partners in C4D in emergencies – execution of risk communication, community mobilisation and active community engagement and information management and quality reporting. (Deployment of additional staff or support national level facilitators from MoH or RCSM sub-committee to conduct monthly or quarterly visits).

Objective 6: Rapidly conduct EVD vaccination and deploy investigational therapeutics in the affected area.

Vaccination and investigational therapeutics

This pillar aims to facilitate EVD vaccination among high risk groups and to deploy investigational therapeutics as part of the EVD control measures. Coupled with the other prevention and control measures, an effective vaccine, deployed to populations that have been known to fuel transmission, will contribute to the rapid control of an EVD outbreak. Although the Ebola vaccine has not yet been prequalified by WHO or completed the WHO Emergency Use Assessment and Listing (EUAL) procedure, the SAGE recommendation of April 2017 recommended its deployment

under the Expanded Access framework, with informed consent and in compliance with Good Clinical Practice. New SAGE recommendations were released in May 2019 and there is need to update the vaccination protocol and fast track its approval in line with them⁸.

Strategy: Rapid deployment of the Ebola vaccine to high risk groups and use of investigational therapeutics at ETUs/ETCs to contribute to improved survival of EVD patients.

Target: 100% of eligible persons vaccinated

Activities

- Conduct training in EVD vaccination
- Deliver and deploy EVD vaccines, related supplies and equipment
- Import and deploy investigational therapeutics
- Conduct training for clinicians in the use of investigational therapeutics.
- Monitoring the use of the investigational therapeutics and following up AEFIs.
- Establish a clinical committee to monitor the enrolment and use of investigational therapeutics.

Cross cutting support

Logistics

The goal of the logistics pillar is to provide timely and adequate logistical support for the EVD response. This will cover capacity needs in in the affected and high-risk districts, inventory and stock management, development of harmonized EVD logistics/supply plan, standardizing approaches for EVD logistics management, capacity building and deployment.

Target: 0% stock outs of IPC supplies in outbreak affected district(s)

Activities

Central level

- Assess logistical needs and develop a harmonized supply plan.
- Procurement of supplies to support the response.
- Coordinate and track partner logistics support to the EVD response.
- Allocate and authorize logistics support from partners to the EVD response districts and facilities.
- Coordinate last mile distribution of supplies and transportation.
- Conduct support supervision to epicenter and the other high-risk districts.
- Fleet management

Kasese district

- Conduct rapid assessment of logistics needs/gaps and develop a district supply plan.
- Orient logistics staff in logistics and supply chain management (LSCM) and electronic emergency logistics management information system (EELMIS).
- Equip district with EELMIS hardware.
- Conduct assessment of the logistics capacity in the district and health facilities.
- Improve storage capacity in the district and health facilities where necessary, through the provision of pallets, shelves, shelter and store management tools.
- Monitor use and provide accountability of supplies in the district.
- Fleet management

High-risk districts

- Train personnel in pre-positioning centers in the high-risk districts in LSCM and EELMIS.

⁸ including to administer paracetamol to all vaccinees

- Equip the logistics hubs with EELMIS equipment
- Fleet management

Summary Budget

To implement the activities in the plan, a total of 64.6 billion Uganda shillings (USD 17 million) will be required. Table 1 below gives a summary budget for implementation of the activities under each pillar.

Pillar	National	Category 1 (Kasese)	Category 2 (10 districts)	Category 3 (13 districts)	Total (Ushs)	Total (USD)
Coordination and leadership	762,018,000	78,588,000	121,080,000	90,502,000	1,052,188,000	280,583
Surveillance, laboratory support & POEs	701,250,000	3,144,231,900	1,860,547,000	1,301,822,500	7,007,851,400	1,868,760
Risk communication, social mobilization and community engagement	1,376,782,000	1,242,404,000	11,092,124,000	685,737,000	14,397,047,000	3,839,213
Case management, infection prevention and control, SDBs	1,285,822,000	9,229,128,752	3,710,902,000	3,791,359,000	18,017,211,752	4,804,590
WASH	190,000,000	1,419,479,000	7,609,240,000	7,872,602,000	17,091,321,000	4,557,686
EVD vaccination & investigational therapeutics	0	1,744,810,234	0	0	1,744,810,234	465,283
Mental health and Psychosocial support	98,500,000	500,430,000	332,493,000	285,216,000	1,216,639,000	324,437
Logistics	936,500,000	1,372,053,000	820,530,000	961,689,000	4,090,772,000	1,090,873
Total	5,350,872,000	18,731,124,886	25,546,916,000	14,988,927,500	64,617,840,386	17,231,424

Monitoring and Evaluation

A framework will be developed to monitor key performance results information and disseminate it for management decision-making, reporting, and use by the stakeholders all levels. 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 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.

Annex 1: Summary Budget

Coordination

Activities	National	Category 1 (Kasese)	Category 2 (10 districts)	Category 3 (13 districts)	Total (Ushs)	Total (USD)
Coordinate meetings of the district taskforce, subcommittees	50,000,000	50,000,000	10,000,000	8,750,000	118,750,000	31,667
Communication	7,500,000	10,000,000	5,000,000	5,000,000	27,500,000	7,333
EVD dashboard hosting/running costs	6,750,000				6,750,000	1,800
Advocacy: breakfast/donor meetings	90,000,000				90,000,000	24,000
Deploying the NRRT	45,000,000				45,000,000	12,000
Daily reports/info pdts	112,420,000				112,420,000	29,979
Monitoring & Supervision	1,200,000	1,200,000	12,000,000	15,600,000	30,000,000	8,000
Monitoring: High level missions, Minister, DG, Directors, Commissioners Diplomatic corps	112,476,000	14,112,000	94,080,000	61,152,000	281,820,000	75,152
Coordinate with security agencies to ensure safety of responders	13,356,000				13,356,000	3,562
Cross border meetings		3,276,000			3,276,000	874
After Action Review	143,316,000				143,316,000	38,218
	180,000,000	78,588,000	121,080,000	90,502,000	1,052,188,000	280,583

Surveillance, laboratory support and points of entry

Activities	National	Category 1 (Kasese)	Category 2 (10 districts)	Category 3 (13 districts)	Total (Ushs)	Total (USD)
Investigation by DRRT		204,624,000	48,720,000	63,336,000	316,680,000	84,448
Training on surveillance & contact tracing		14,062,500	140,625,000	182,812,500	337,500,000	90,000
Establishment of alert desk + airtime + allowance		3,700,000	300,000	300,000	4,300,000	1,147
Procurement of mobile phones + SIM		20,000,000	5,000,000	6,500,000	31,500,000	8,400
Data management and analysis		4,073,400			4,073,400	1,086
Active case search		226,800,000	75,600,000	98,280,000	400,680,000	106,848
Contact tracing		243,000,000			810,000,000	216,000
Orientation of VHTs in contact tracing and active case search		407,550,000	150,000,000	390,000,000	947,550,000	252,680
Supervisors for contact tracers		324,000,000			324,000,000	86,400
Specimen transportation		40,500,000	67,500,000	40,950,000	148,950,000	39,720
Procure motorcycles for surveillance	438,750,000				438,750,000	117,000
Establish mobile laboratory in Kasese		6,105,000			6,105,000	1,628
Adapt protocols for mobile laboratory testing		5,190,000			5,190,000	1,384
Technical support supervision for surveillance and laboratory		18,816,000	31,360,000	37,632,000	87,808,000	23,415
Training of sample handlers and use of the chain of custody		32,667,000			32,667,000	8,711

Activities	National	Category 1 (Kasese)	Category 2 (10 districts)	Category 3 (13 districts)	Total (Ushs)	Total (USD)
Training of personnel at POEs		7,854,000	6,462,000	6,462,000	20,778,000	5,541
Deployment of screeners at POEs		405,000,000	693,000,000	202,500,000	1,300,500,000	346,800
Payment of water and Electricity bills		314,640,000	331,200,000	207,000,000	852,840,000	227,424
Printing of tools and job aids		1,000,000	20,000,000	2,500,000	23,500,000	6,267
Provide security at POEs		205,200,000	207,900,000	40,500,000	453,600,000	120,960
Provide of IPC supplies (Aquatabs /Chlorine / handwashing stations/ jerricans/gloves /sprayers/ boots/ raincoats etc)		13,950,000	35,805,000	6,975,000	56,730,000	15,128
Referral of alerts from POEs to ETUs		2,400,000	2,345,000	1,725,000	6,470,000	1,725
Procurement of Infrared and batteries		14,700,000	37,730,000	7,350,000	59,780,000	15,941
Thermal scanners at high volume POEs	262,500,000				262,500,000	70,000
Risk communication at POEs (IECs, posters, PA systems, development of messages and Flat screens)		30,000,000	7,000,000	7,000,000	44,000,000	11,733
	701,250,000	1,906,039,900	1,860,547,000	1,301,822,500	5,769,659,400	1,538,576

Risk communication, social mobilization and community engagement

Activities	National	Category 1 (Kasese)	Category 2 (10 districts)	Category 3 (13 districts)	Total (Ushs)	Total (USD)
Media promotion and special broadcasts via newspapers inserts	9,000,000	0	0	0	9,000,000	2,400
Orientation of Media teams by MoH - to promote responsive and responsible media reporting.	45,000,000				45,000,000	12,000
Design, translate & Production TV messages	10,800,000	3,400,000	34,000,000	44,200,000	92,400,000	24,640
Printing of EVD IEC materials in various formats and languages	150,000,000				150,000,000	40,000
Distribution of EVD IEC materials to specific districts	120,000,000				120,000,000	32,000
Radio spots and jingles	7,200,000				7,200,000	1,920
Radio talk shows and facilitation to key panelists	67,500,000	67,500,000	270,000,000	351,000,000	756,000,000	201,600
Airtime for Radio talk shows	2,400,000				2,400,000	640
Media monitoring	60,000,000	64,800,000	108,000,000	140,400,000	373,200,000	99,520
Media promotion and broadcasts via Television - TV talkshows	8,500,000				8,500,000	2,267
Media promotion and broadcasts via Television - TV Adverts	48,000,000				48,000,000	12,800
Social Media: information development and dissemination, rumours management, tracking and feedback - support to MoH Call Centre	21,000,000				21,000,000	5,600
Other media: Information dissemination by SMS, MTRAC and U-Report	36,000,000	450,000	450,000		36,900,000	9,840
Deployment of MoH film vans for community sensitization at concentration points e.g. entry	6,000,000				6,000,000	1,600

Activities	National	Category 1 (Kasese)	Category 2 (10 districts)	Category 3 (13 districts)	Total (Ushs)	Total (USD)
points, markets along the border, refugee camps etc.						
Mobilization of uniformed forces (UPDF, Prisons, Police)	28,182,000				28,182,000	7,515
Conduct rapid assessment, social evidence reviews and documentation of trends.	0	10,800,000	108,000,000	140,400,000	259,200,000	69,120
Planning, coordination and quarterly reviews of subcommittee activities	0	600,000	6,000,000		6,600,000	1,760
Media engagement		21,600,000	600,000	600,000	22,800,000	6,080
Support National RSCM subcommittee and MoH HPE & C to conduct supportive supervision and mentorship in districts.	6,000,000	6,000,000	3,000,000	3,000,000	18,000,000	4,800
Orientation of facility-based health workers on improving interpersonal communication	0	12,274,000	12,274,000	6,137,000	30,685,000	8,183
Training of EVD Volunteers (frontline health mobilisers like Health Assistants and VHTs)		27,000,000	270,000,000		297,000,000	79,200
Conduct house-to-house visits and community-dialogue sessions in various communities.		46,980,000	469,800,000		516,780,000	137,808
Conduct community meetings (with herbalists and traditional healers; boda-bodas; fishing communities - youths and local traders; drug sellers and owners of private medical facilities; women, market vendors and youth groups)		864,000,000	8,640,000,000		9,504,000,000	2,534,400
Reorient religious leaders and cultural leaders on EVD (Safe burials, avoidance of stigmatization etc) - meetings to be held at district and sub-county levels to ensure broader participation and capturing of contextual issues		36,000,000	360,000,000		396,000,000	105,600
Conduct school outreaches using school administrators (DHE, ADHEs, School Inspectors, CDO, ACDO)		27,000,000	270,000,000		297,000,000	79,200
Orientation of municipal leaders, leaders of traders, hoteliers, transporters and key public-sector groups on EVD		27,000,000	270,000,000		297,000,000	79,200
Deploy surge staff to districts at outbreak affected and high- risk districts	751,200,000				751,200,000	200,320
Sub-total	1,376,782,000	1,242,404,000	11,092,124,000	685,737,000	14,397,047,000	3,839,213

Patient management

Activities	National	Category 1 (Kasese)	Category 2 (10 districts)	Category 3 (13 districts)	Total (Ushs)	Total (USD)
ETU running costs		897,000,000	500,000,000	650,000,000	2,047,000,000	545,867
Procurement of kits and medical supplies	333,000,000				333,000,000	88,800
Procurement of anti malarials and diagnostics - kits	750,000,000				750,000,000	200,000
Procurement of solar lighting	25,000,000				25,000,000	6,667
Procurement of ready to use infant formula and Ready to Use Therapeutic Food (RUTF)	30,000,000				30,000,000	8,000
Training of health workers on IYCF in the context of EVD		36,236,000	362,360,000	471,068,000	869,664,000	231,910
Refresher trainings for health workers in patient management/ clinical care - including malaria and Nutrition		72,321,000	723,210,000	940,173,000	1,735,704,000	462,854
Drills of health workers on EVD management		72,321,000			72,321,000	19,286
Provide a solidarity package for all discharge patients		75,000,000			75,000,000	20,000
Ambulance services for referral of suspect cases		441,000,000			441,000,000	117,600
Create child/ mother friendly space in the ETU		15,000,000			15,000,000	4,000
Provide security services at the ETU		39,600,000	33,000,000	42,900,000	115,500,000	30,800
Procure beddings - bed sheets, blanket, patient gowns	49,500,000				49,500,000	13,200
Orientation of VHTs on Malaria presumptive treatment	0	126,715,000			126,715,000	33,791
Monitoring & Supervision	36,822,000				36,822,000	9,819
Provision of IPC kits for health facilities and support staff in ETU	0	940,959,752			940,959,752	250,923
IPC training, drills and information provision for health care workers and support in ETU		30,966,000	216,762,000	92,898,000	340,626,000	90,834
Mentorships exercises for IPC including functionalizing IPC committees		56,250,000	281,250,000		337,500,000	90,000
Disinfection of patients' homes		48,480,000			48,480,000	12,928
Establish/refurbish isolation facilities, areas within facilities and central isolation point for high risk districts	61,500,000				61,500,000	16,400
Safe and dignified burials		6,377,280,000	1,594,320,000	1,594,320,000	9,565,920,000	2,550,912
Sub-total	1,285,822,000	9,229,128,752	3,710,902,000	3,791,359,000	18,017,211,752	4,804,590

WASH in EVD Response

Activity	National	Category 1 (Kasese)	Category 2 (10 districts)	Category 3 (13 districts)	Total (Ushs)	Total (USD)
Management of waste in the ETU (incinerators)		140,000,000	980,000,000	840,000,000	1,960,000,000	522,667
Produce and disseminate IPC related job aids, booklet and/or posters	70,000,000				70,000,000	18,667
Construction and rehabilitation of water and sanitation infrastructure	0	800,000,000	4,000,000,000	5,200,000,000	10,000,000,000	2,666,667
Establishment of chlorinated water distribution system within ETU and provision of Hand washing stations		15,000,000	75,000,000		90,000,000	24,000
Sanitation facilities equipped with chlorinated handwashing points and soap		450,000	4,500,000		4,950,000	1,320
Establishment and decommissioning of ETU waste disposal systems (waste pits, soak away pits, management of sludge)		9,000,000	27,000,000	31,500,000	67,500,000	18,000
Water supply in targeted health facilities (including construction or rehabilitation of water infrastructure, Improve onsite water treatment capacity)		45,000,000	225,000,000	292,500,000	562,500,000	150,000
Sanitation (including construction and rehabilitation of sanitation infrastructure)		93,750,000	937,500,000	937,500,000	1,968,750,000	525,000
Provision/repairing/replacing of hand washing stations with soap and water in 24 selected Health facilities.		18,000,000	900,000,000		918,000,000	244,800
Procurement of water tanks to improve on water collection	120,000,000				120,000,000	32,000
Provision of hand washing stations with soap and water	0	26,250,000	112,500,000	146,250,000	285,000,000	76,000
Provision of supplies for hygienists including dedicated bucket, mops, and gumboots	0	11,250,000	90,000,000	90,000,000	191,250,000	51,000
Waste mgt - HCFs/Non ETUs		3,750,000	37,500,000	48,750,000	90,000,000	24,000
Construction / rehabilitation of sanitation facilities in schools & Public places		234,375,000			234,375,000	62,500
Hygiene promotion and sensitization on use of WASH commodities (chlorine tablets, soap etc)		18,750,000	187,500,000	243,750,000	450,000,000	120,000
Inspection of food vending places, markets and other public places using a standardized checklist.		1,204,000	5,740,000	7,252,000	14,196,000	3,786
Needs assessment of water and sanitation in selected institutions (health facilities, schools, and public places)		2,700,000	27,000,000	35,100,000	64,800,000	17,280
Sub-total	190,000,000	1,419,479,000	7,609,240,000	7,872,602,000	17,091,321,000	4,557,686

Mental Health and psychosocial support

Activities	National	Category 1 (Kasese)	Category 2(10 districts)	Category 3(13 districts)	Total (Ushs)	Total (USD)
Training of health workers, social workers, community cadres and other relevant groups to deliver appropriate psychosocial support	0		177,540,000	177,540,000	355,080,000	94,688
Conduct drill in the high risk districts		72,321,000	72,321,000		144,642,000	38,571
Mentorship of health workers, social workers, community cadres	0	72,321,000	7,500,000	7,500,000	87,321,000	23,286
Conduct support supervision in high risk districts	0	37,566,000	75,132,000	100,176,000	212,874,000	56,766
Develop SOPs, tools and guides for reintegration of affected individuals, paying special attention to children	32,500,000	0	0	0	32,500,000	8,667
Conduct psychosocial support to patients, contacts, family and community members	0	318,222,000	0	0	318,222,000	84,859
Provision of individual child protection services including child friendly PSS to EVD affected children and their families, including orphaned children in need of care	66,000,000				66,000,000	17,600
	98,500,000	500,430,000	332,493,000	285,216,000	1,216,639,000	324,437

EVD Vaccination & Investigational therapeutics

Activities	National	Category 1 (Kasese)	Category 2 (10 districts)	Category 3 (13 districts)	Total (USD)
Development of the micro plan	26,629,000			26,629,000	7,101
Re-orientation of teams in ring vaccination	42,796,000			42,796,000	11,412
Deployment of vaccination teams	743,100,000			743,100,000	198,160
Vaccine logistics in the field	100,000,000			100,000,000	26,667
Transportation of teams and Vaccines	713,700,000			713,700,000	190,320
Operational cost	6,300,000			6,300,000	1,680
National coordination and planning	42,828,117			42,828,117	11,421
Training and deployment of the therapeutics	26,629,000			26,629,000	7,101
	1,744,810,234	0	0	1,744,810,234	465,283

Logistics

Activities	National	Category 1 (Kasese)	Category 2 (10 districts)	Category 3(13 districts)	Total (Ushs)	Total (USD)
Development of Supply plan - meeting	6,250,000				6,250,000	1,667
Conduct rapid assessments of logistics needs		2,549,000	25,490,000	33,137,000	61,176,000	16,314
Procurement of vehicles	618,750,000	0			618,750,000	165,000
Car rentals for transportation of teams, supplies	0	1,215,000,000			1,215,000,000	324,000
Telecommunication and airtime/internet	176,500,000	0	0	0	176,500,000	47,067
Computers	105,000,000	0	0	0	105,000,000	28,000
Printers	30,000,000				30,000,000	8,000
Storage costs - pallets, shelves etc		40,000,000			40,000,000	10,667
Last mile delivery		70,000,000	350,000,000	350,000,000	770,000,000	205,333
Orient on emergency logistics management		24,504,000	245,040,000	318,552,000	588,096,000	156,826
Minor repairs for warehouses		20,000,000	200,000,000	260,000,000	480,000,000	128,000
Sub-total	936,500,000	1,372,053,000	820,530,000	961,689,000	4,090,772,000	1,090,873

Annex 2: Points of entry and concentration

Name	Type PoE/POC	Type of Ground PoE Assessed	District	Screening Point Active
Bundinamandi	PoE	Informal	BUNDIBUGYO	1
Busoru II	PoE	Informal	BUNDIBUGYO	1
Busunga	PoE	Formal	BUNDIBUGYO	1
Butogo II	PoE	Informal	BUNDIBUGYO	1
Butogo Main	PoE	Informal	BUNDIBUGYO	1
Kasiri	PoE	Informal	BUNDIBUGYO	1
Kazaroho	PoE	Informal	BUNDIBUGYO	1
Kaiso Landing Site	PoE	Informal	HOIMA	1
Kabukanga	PoE	Informal	KAGADI	0
Ndaiga	PoE	Informal	KAGADI	0
Bukoto/Mushunga	PoE	Informal	KANUNGU	1
Butogota/Kyeshero	PoE	Formal	KANUNGU	1
Ishasha 1	PoE	Informal	KANUNGU	1
Ishasha 2	PoE	Formal	KANUNGU	1
Kabingo	PoE	Informal	KANUNGU	1
Kashenyi	PoE	Informal	KANUNGU	1
Kyabuyorwa Lower	PoE	Informal	KANUNGU	1
Kyabuyorwa Lower2	PoE	Informal	KANUNGU	1
Kyabuyorwa Upper	PoE	Informal	KANUNGU	1
Mukasite(Omukasite)	PoE	Informal	KANUNGU	1
Mukatesani (Rurama)	PoE	Informal	KANUNGU	1
Munyaga lower/2	PoE	Informal	KANUNGU	1
Munyaga upper/1	PoE	Informal	KANUNGU	1
Mwanjari	PoE	Informal	KANUNGU	1
Nyakirehe	PoE	Informal	KANUNGU	1
Omukatesani (Runyinya)	PoE	Informal	KANUNGU	1
Omukigano	PoE	Informal	KANUNGU	1
Rwamagali	PoE	Informal	KANUNGU	1
Burambi	PoE	Informal	KANUNGU	1
Omukigano – Posiano	PoE	Informal	KANUNGU	1
Bingasi	PoE	Informal	KASESE	0
Kamugomba	PoE	Informal	KASESE	0
Kanyatsi	PoE	Informal	KASESE	0
Katwe Landing Site	PoE	Informal	KASESE	1
Kayanzi	PoE	Informal	KASESE	1
Kisabu	PoE	Informal	KASESE	0
Kisangi	PoE	Informal	KASESE	0
Kisolholho	PoE	Informal	KASESE	1
Kithoma	PoE	Informal	KASESE	1
Kyabayenze	PoE	Informal	KASESE	0
Mirami	PoE	Informal	KASESE	1
Mpondwe Main (Mpondwe)	PoE	Formal	KASESE	1
Mpondwe market (Madepo)	PoE		KASESE	
Bonamayi	PoC		KASESE	
Mwanamolho	PoC		KASESE	
Kyasenda	PoC		KASESE	
Masango	PoC		KASESE	
Mbathathania	PoC		KASESE	
Byakatonda Kamasasa	PoC		KASESE	
Kisanga/Kisangi	PoC		KASESE	
Kiraru	PoC		KASESE	
Malaba	PoC		KASESE	
Kyasesa	PoC		KASESE	
Kayanja main	PoC		KASESE	
Kayanja Health center point	PoC		KASESE	
Isango	PoC		KASESE	
Katwe Main/ Katwe Landing Site	PoC		KASESE	
Mweya main gate	PoC		KASESE	
Kyakitale	PoC		KASESE	
FAO	PoC		KASESE	
Kasese Airfield	PoC		KASESE	
Lhubiriha Link Bus terminal	PoC		KASESE	
Pokopoka Bwera Bus terminal	PoC		KASESE	

Name	Type PoE/POC	Type of Ground PoE Assessed	District	Screening Point Active
Kango Bwera Link bus stage	PoC		KASESE	
Kasese Link terminal	PoC		KASESE	
Kasese Taxi Park	PoC		KASESE	
Kampala Hoppers Bus terminal	PoC		KASESE	
Kyabayenze	PoC		KASESE	
Kiapapere	PoE	Informal	KIKUUBE	0
Nsonga	PoE	Formal	KIKUUBE	1
Bugeyo	PoE	Informal	KISORO	0
Bunagana	PoE	Formal	KISORO	1
Bunyangaro	PoE	Informal	KISORO	0
Busanza/Mupaka	PoE	Informal	KISORO	1
Busigi	PoE	Informal	KISORO	1
Cyanika/Kyanika	PoE	Formal	KISORO	1
Gahenerezo	PoE	Informal	KISORO	0
Gatwe	PoE	Informal	KISORO	0
Ghetto	PoE	Informal	KISORO	0
Kabingo/chahafi	PoE	Informal	KISORO	0
Kanombe	PoE	Informal	KISORO	1
Kasoko		Informal	KISORO	0
Kibaya	PoE	Informal	KISORO	1
Kulanya		Informal	KISORO	0
Masoro		Informal	KISORO	0
Muko	PoE	Informal	KISORO	1
Muremure		Informal	KISORO	0
Nteko	PoE	Informal	KISORO	1
Nyamigenda		Informal	KISORO	0
Nyamikumbu		Informal	KISORO	0
Rugabano	PoE	Informal	KISORO	1
Goli BCP	PoE	Formal	NEBBI	1
Buguma	PoE	Informal	NTOROKO	1
Fridge	PoE	Informal	NTOROKO	1
Haibale North	PoE	Informal	NTOROKO	1
Haibale south	PoE	Informal	NTOROKO	1
Kabimbiri	PoE	Informal	NTOROKO	1
Kamuga	PoE	Informal	NTOROKO	1
Kanara	PoE	Informal	NTOROKO	1
Kanara Main	PoE	Formal	NTOROKO	1
Katanga	PoE	Informal	NTOROKO	1
Katolingo	PoE	Informal	NTOROKO	1
Kayanja I	PoE	Informal	NTOROKO	1
Kyanzi II	PoE	Informal	NTOROKO	1
Kigungu	PoE	Informal	NTOROKO	1
Kyapa	PoE	Informal	NTOROKO	1
Mulango	PoE	Informal	NTOROKO	1
Ntoroko Main	PoE	Formal	NTOROKO	1
Rwangara	PoE	Formal	NTOROKO	1
Rwentuhe	PoE	Informal	NTOROKO	1
Kashaka	PoC	Informal	RUBIRIZI	1
Katunguru	PoC	Informal	RUBIRIZI	1
Kazinga	PoC	Informal	RUBIRIZI	1
Kisenyi	PoC	Informal	RUBIRIZI	1
Rwenshama	PoC	Informal	RUKUNGIRI	1
Arua-Airport	PoE	Formal	Arua	
Vurra	PoE	Formal	Arua	
Lia	PoE	Formal	Arua	
Odrachaku	PoE	Informal	Arua	
Wanseko	PoE	Informal	Buliisa	
Butiaba	PoE	Formal	Buliisa	
Walikuba	PoE	Informal	Buliisa	
Bugoigo	PoE	Formal	Buliisa	
Kalolo	PoE	Informal	Buliisa	
Katala	PoE	Informal	Buliisa	
Kabolwa	PoE	Informal	Buliisa	
Nyamukuta	PoE	Informal	Buliisa	
Para	PoE	Informal	Buliisa	
Katebwa	PoE	Informal	Bunyangabo	
Kibate	PoE	Informal	Bunyangabo	
Mitami	PoE	Informal	Bunyangabo	

Name	Type PoE/POC	Type of Ground PoE Assessed	District	Screening Point Active
Rwagimba HC	PoE	Formal	Bunyangabo	
ERUSI	PoE	Informal	NEBBI	
PARAMBO	PoE	Informal	NEBBI	
Dei	PoE	Informal	Pakwach	
Panyimur	PoE	Formal	Pakwach	
Entebbe international airport	PoE	Formal	Wakiso	
ALISI	PoE	Informal	Zombo	
Ambere/Paidha	PoE	Formal	Zombo	
LENDU FOREST	PoE	Informal	Zombo	
PADER (Padea?)	PoE	Formal	Zombo	

Annex 3: Malaria case management in Ebola situations

Background

Rationale for controlling malaria in Ebola outbreaks

Ebola and malaria have similarities in their clinical presentation especially fever and vomiting. Ebola may mimic severe malaria presenting with haemorrhage and thus health workers may wrongly diagnose either disease resulting in increased mortality. In addition, it is not uncommon to find malaria and Ebola comorbidities especially in areas of malaria steady transmission such as Kasese. Prevention of malaria will result in less fever cases going to health facilities and thus reduce the burden on the health system. In addition, clients may fear going to health facilities which have been reported to have Ebola cases.

Health workers are at a very high risk of contracting Ebola because of coming into contact with body fluids containing the virus. It is therefore important that observation of universal infection prevention and control procedures are observed. Besides, health workers should be provided with adequate PPEs. This program will go a long way to restore confidence for the health care system among the communities. The National Malaria Control Division (NMCD) contributes to the efforts of the NTF and has a mandate to managing malaria in the country through policy, quality assurance and providing guidance to health teams.

Objectives of the intervention

- To minimize fever cases reporting to the health facility or VHT thus reducing on the need for assessment for Ebola among malaria cases
- To increase health worker capacity to manage malaria Ebola comorbidities
- To reinforce infection prevention and control in malaria management
- To increase protection against malaria

Proposed interventions and approaches

1. Malaria mass drug administration which is recommended by WHO (GMP 2015) and has already been used in Sierra Leone during the Ebola outbreak. *"Use of time-limited MDA to reduce malaria morbidity and mortality may be considered in complex emergencies, during exceptional circumstances when the health system is overwhelmed and unable to serve the affected communities"*
2. Presumptive malaria treatment for all Ebola suspects, probable and confirmed cases.
3. Malaria prophylaxis of front line health workers using DP.
4. Increasing health worker protection using Personal Protection Equipment and improving infection prevention and control.
5. Provision of LLINs to the Ebola suspects, probable and confirmed cases, health workers and the community of origin.
6. Integrating malaria messages in the Ebola Social Behaviour Change Communication messages.
7. Strengthening malaria surveillance in the affected areas.

The proposed service delivery approach for MDA and LLINs is the door to door designed in such a way that it doesn't promote transmission. The recommended medicine for MDA is dihydroartemisinin-piperaquine given orally over a period of three days. A team comprising of health workers, the VHT and local leader will move from house hold to house hold educating the community about malaria and Ebola, the purpose of providing MDA, promoting net use culture. All households and persons given DP will be registered at the time when the medicine/LLIN is given. The first dose of DP will be provided as a DOT and the VHTs will be expected to follow up subsequent doses. LLIN will be given as per sleeping space. NMCD will through the NMS provide adequate doses of antimalarials to the health facilities serving the affected communities.

In case management, all fever suspects will be screened using the Ebola screening tool and those fitting the Ebola suspect or probable case criteria will be immediately isolated, provided an ACT i.e. AL for uncomplicated malaria and the Ebola surveillance team alert. At the ETU, the team will be encouraged to use part of the sample collected to conduct an mRDT to rule out malaria coinfection. Other tests for common parasitic infections such as schistosomiasis, leishmaniasis and filariasis should be considered on a case by case basis. The health facilities will be provided a buffer of 25% above their usual ACT supply to cater for presumptive treatment. Health workers will be provided with PPEs and additional IPC supplies such as gloves, JIK, masks, googles and aprons.

At community level, VHTs providing iCCM in the area with an Ebola suspect, probable or confirmed case will have to be stopped from conducting mRDTs. They will provide presumptive treatment for fever cases using AL and alert the surveillance team to take action. The SBCC team will integrate malaria messages into the Ebola messages reinforcing malaria prevention, early treatment seeking and compliance with malaria treatment. Surveillance for malaria will be escalated from weekly to daily reports using the 033b tool and the mTrac channel.

Log frame of interventions

Intervention	Rationale	Recommendation	Target	Activities	Budget	Assumptions
MDA	Reduce burden of fevers	<ul style="list-style-type: none"> • Use dihydroartemisinin-piperaquine • Door to door distribution by VHTs and health workers • Supplies through the NMS supply chain to district and health facilities • Health workers (private, public and VHTs) take medicines to community • First dose given as DOT, VHT follows up subsequent doses • Initiate MDA within 48 hours of confirming an Ebola case 	<ul style="list-style-type: none"> • Village, 5Km radius from household of confirmed Ebola case • All community members including women and children < 5kg 	<ul style="list-style-type: none"> • Orientation of 2 health workers, 2 VHTs and LC1 for each village • SBC activity • Door to door registration and community drug distribution • Monitoring by DHO and NMCD • Reporting • Pharmacovigilance • Supply chain management – ordering, distribution and storage 	USD 200,000	<ul style="list-style-type: none"> • DP available to the public health facilities • VHT available and willing to work • Availability of IPC supplies including PPEs
Malaria case management	Minimize missed opportunities for malaria case management	<ul style="list-style-type: none"> • Adhere to the national malaria case management guidelines (T3) • Follow the national Ebola screening procedures and case definition • If Ebola suspect or probable case, give ACTs presumptively • Observe Infection Prevention and Control procedures • Do mRDT in isolation unit • In the community – VHT should assess using the Ebola community tool, if alert case inform surveillance team • VHTs should adhere to iCCM guidelines unless it is an alert case 	<ul style="list-style-type: none"> • Frontline Health workers • Frontline VHTs 	<ul style="list-style-type: none"> • Training in IPC for health workers and VHTs • Provision of IPC supplies – gloves, Jik, buckets, masks, aprons etc • Training of private health sector staff in Kasese and Kampala targeting higher facilities • SBCC for malaria • Daily surveillance reports • Weekly monitoring by DHT and NMCD • Provision of job aids and PPEs • Provision of 25% buffer stock of ACTs, 	150,000	<ul style="list-style-type: none"> • Funds available to support activities • Availability of IPC supplies • Integration of malaria into the ebola trainings

Intervention	Rationale	Recommendation	Target	Activities	Budget	Assumptions
				mRDTs and LLINs		
Malaria prevention	Minimize new malaria cases among the risk population, health workers, Ebola suspects and cases	<ul style="list-style-type: none"> Prophylaxis is recommended for the vulnerable groups – sicklers, non-immune travelers etc. Prophylaxis not recommended to residents of high malaria transmission areas – give MDA as recommended above All health workers, ebola suspects, probable and confirmed cases should be given a LLIN. LLINs of ebola cases be disposed off with the rest of the linen. LLINs be distributed with MDA medicine door to door by health workers and VHTs in the village with Ebola suspect and confirmed cases. 	<ul style="list-style-type: none"> Health workers Ebola suspects, probable and confirmed cases Household members in the village of suspect, probable or confirmed case 	<ul style="list-style-type: none"> Orientation of health workers, VHTs and LC1 for each village SBC activity Door to door registration and LLIN distribution Monitoring by DHO and NMCD Reporting Supply chain management – ordering, distribution and storage 	200,000	Availability of LLINs
SBCC	To raise awareness on malaria	<ul style="list-style-type: none"> Intensify SBCC messages focusing on prevention, early treatment seeking, compliance with T3 policy, adherence to treatment, IPTp etc 	<ul style="list-style-type: none"> Private health sector Community members Leaders 	<ul style="list-style-type: none"> Radio talk shows Community dialogues Home visits 	Cost in the main budget 300,000	
Surveillance	To obtain real time malaria data	<ul style="list-style-type: none"> Daily surveillance report using 033B Pharmacovigilance 	<ul style="list-style-type: none"> Public and private health facilities 	<ul style="list-style-type: none"> Data collection, analysis DQA 	200,000	