



**NATIONAL EBOLA VIRUS DISEASE  
PREPAREDNESS AND RESPONSE  
PLAN  
MARCH – AUGUST 2021**

**MINISTRY OF HEALTH  
UGANDA**

<b>Table of Contents</b>	
Acknowledgement	2
<b>Background</b>	3
<b>Overview of the EVD Outbreak DRC</b>	
Current EVD Situation outbreak in Equateur Province, DRC	3
Current risk of EVD spread from DRC to Uganda	4
<b>Response to previous outbreaks</b>	5
Description of most recent EVD outbreaks in Uganda	6
<b>Risk assessment</b>	7
<b>Risk Classification</b>	8
<b>Key achievements, best practices, gaps and recommendations from EVD preparedness and COVID preparedness and response</b>	9
<b>EVD preparedness strategy for Uganda</b>	12
<b>Monitoring and Evaluation</b>	25

## Acknowledgement

The Ministry of Health of Uganda wishes to acknowledge the efforts of partners and stakeholders in the National Task Force in developing this six-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 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  
Director General Health Services,  
Ministry of Health

## **Background**

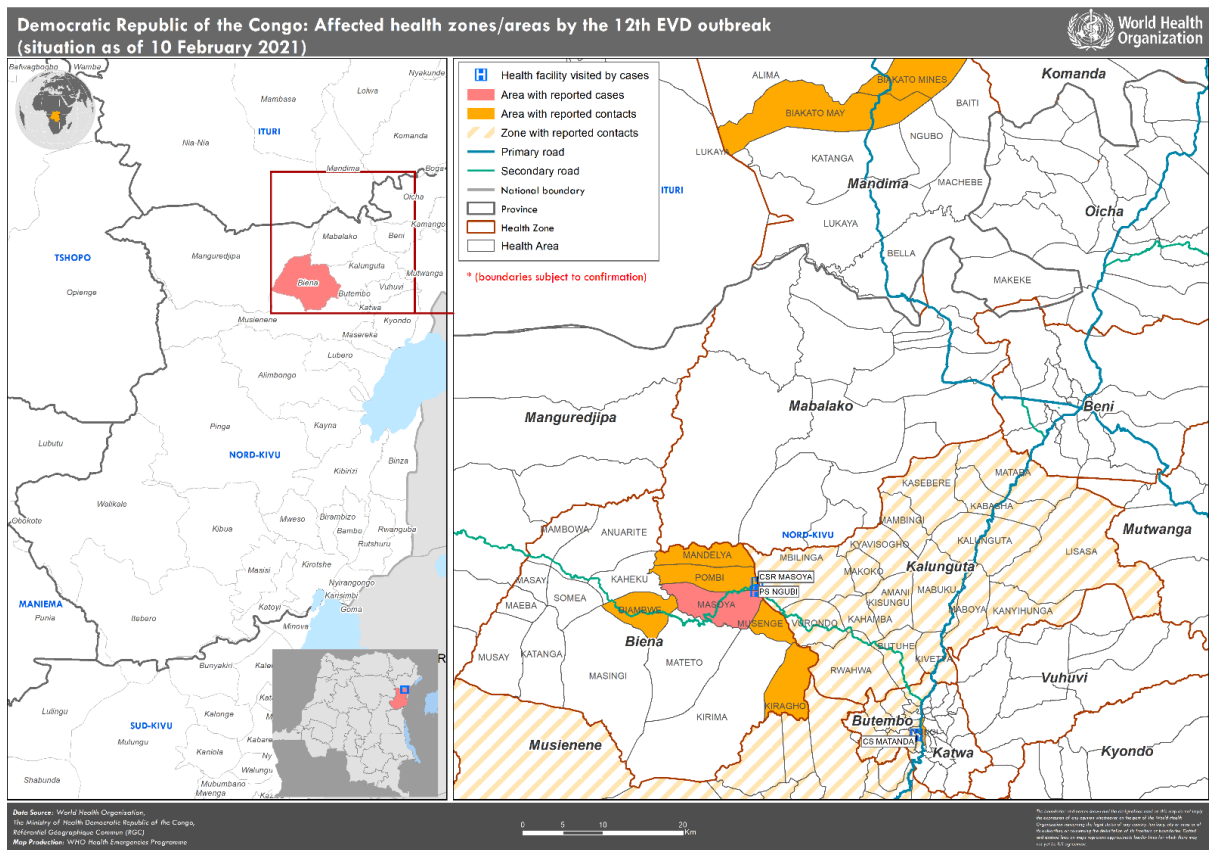
On 7 February 2021, the Ministry of Health (MOH), Democratic Republic of Congo (DRC) confirmed the 12<sup>th</sup> Ebola Virus Disease (EVD) outbreak in North Kivu Province in Eastern DRC. The current affected health zones/ province was one of the epicenters of the prolonged 11<sup>th</sup> EVD outbreak in eastern DRC. The 11<sup>th</sup> outbreak was declared over by the DRC Ministry of Health (MoH) on 25 June 2018. The 11<sup>th</sup> outbreak lasted two years and resulted in 3,481 confirmed cases, 2,299 deaths, and 1,162 survivors (Case fatality rate = 66%).

As of 22 February 2021, 8 cases have been confirmed in DRC and four have died (CFR = 50%). Confirmed cases have been reported in 3 health zones (Biena, Katwa, Musienene) of North Kivu Province. Uganda was and still remains at high risk of EVD importation from the DRC due to the proximity of its western border to North Kivu and Ituri Provinces, as well as continuous trade and travel between the 2 countries.

### **Current EVD Situation outbreak in Equateur Province, DRC**

On 7 February 2021, the Ministry of Health, DRC confirmed an EVD case in North Kivu Province in eastern DRC, marking the onset of the 12 EVD outbreak in the country. The Institute National de Recherche Biomédicale (INRB) on 2 February 2021 confirmed a positive EVD case from Butembo, North Kivu. The index case was a 42-year-old female who presented at Centre de Santé Referencial Masoya in Biena Health Zone (HZ) on 1 February with diarrhea, anorexia, chest, joint, and muscle pain, headache, difficulty breathing, bleeding gums, and vomiting blood following symptom onset on 25 January. The patient was suspected of having EVD and on 2 February 2021 was transferred to Matanda hospital, Butembo HZ, where she died on 3 February 2021.. Burial took place on 5 February 2021 in Musienene; a Safe and Dignified Burial (SDB) was not conducted.

Sequencing results from the index case sent to INRB in Kinshasa indicate the new cases are linked to some sort of virus persistence possibly sexual transmission from a patient infected during the 11<sup>th</sup> outbreak, or recrudescence of past infection. The current EVD strain (Zaire) is same as that of the previous 11<sup>th</sup> outbreak. DRC has mounted a full-scale response with Over 800 contacts have been vaccinated as part of the ring vaccination strategy despite pre-existing contextual complexities, including insecurity in the affected area.



**Figure 2. Map of DRC showing affected health zones, 10 February 2021**

### Current risk of EVD spread from DRC to Uganda

Uganda remains at risk of EVD importation from the DRC due to the continued resurgence of Ebola outbreaks in the DRC, cross-border families and communities, cross-border trade, frequent episodes of armed conflict and population displacement into Uganda, and the porosity of our borders. On 11 June 2019, Uganda reported its first confirmed case and the 6th EVD outbreak since the declaration of the 11<sup>th</sup> EVD outbreak in DRC on 1 August 2018. This was a family cluster of 3 confirmed cases, all resulting in death (CFR 100%). The 7th EVD outbreak, an imported case of a 9-year-old girl from DRC detected at Mpondwe POE on 29 August, tested positive for Ebola Zaire, died on 30 August 2019 at Bwera ETU.

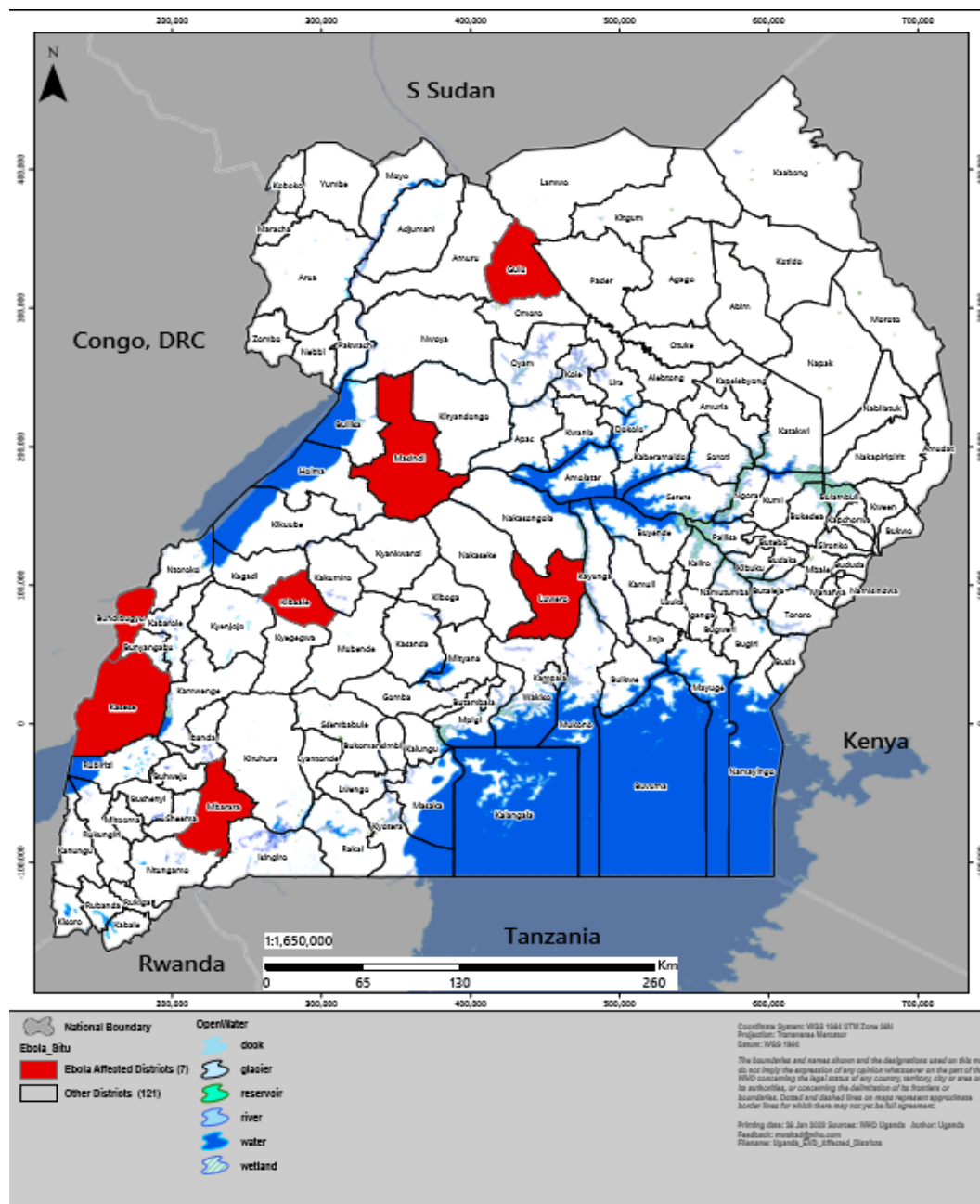
Uganda is host to 1,450,317 refugees and asylum seekers including 422,986 congolese refugees living in settlements in Hoima, Koboko, Kamwenge and Kyegegwa districts as of 31 January 2021<sup>3</sup>. Most new arrivals are hosted in Kamwenge (Rwamwanja settlement), Kyegegwa (Kyaka II settlement) and in Kikuube district (Kyangwali settlement). Most of these refugees are from North Kivu and Ituri province which is currently the epicenter of the ongoing EVD outbreak. Populations regularly move to DRC and return into Uganda frequently, including for burials of relatives. Several districts including Adjumani, Yumbe, Obongi, Koboko, Arua, Kabale, Kampala and Wakiso also receive direct travelers (mostly traders) from the DRC through both designated and undesignated POEs. Also, Uganda hosts the United Nations Regional Transport and Logistics base in Entebbe supporting the

MONUSCO operations in the DRC with an average of four to five flights per day, including some directly to Beni in North Kivu and Bunia in Ituri.

It is thus critical for Uganda, with support from WHO and other development partners, to maintain heightened preparedness, particularly in the high-risk districts the neighbouring DRC.

## Response to previous outbreaks

Since 2000, Uganda has experienced 7 Ebola Virus Disease outbreaks in Northern, Western and Central Uganda. Four of the outbreaks were caused by Ebola Sudan, 1 by Ebola Bundibugyo and 2 by Ebola Zaire. Figure 2 below shows location of previous outbreaks in Uganda.



**Figure 3. Location of previous EVD outbreaks in Uganda**

District	Gulu	Bundibugyo	Kibaale	Luwero	Luwero	Kasese	Kasese
Year	2000	2007	2012	2011	2012	2019(Jun)	2019(Aug)
Days from onset of 1st 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	1	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	3	1
Total confirmed deaths	224	37	4	1	4	3	1
Case Fatality Ratio (%)	53	25	27	100	57	100	100
Duration of the epidemic (In days)	117	101	63	NA	34		

**Table 4. Response to Previous EVD outbreaks in Uganda**

#### **Description of most recent EVD outbreaks in Uganda**

In 2019, Uganda had 2 successive EVD outbreaks, both as a result of importation of EVD from DRC. On 11 June 2019, Uganda declared the country's 6<sup>th</sup> EVD outbreak in Kasese district. A cluster of 3 close family members was confirmed positive for Ebola Zaire Virus by the Uganda Virus Research Institute (UVRI). These cases were imported from the neighbouring DRC, where a large EVD outbreak had been ongoing since 1 August 2018. The first identified case-patient, a 5-year old boy, travelled with his immediate family members to Uganda from Mabalako, in North Kivu province, eastern DRC. On 12 June 2019, the grandmother and sibling of the 5-year old boy also developed Ebola-like symptoms and tested positive for Ebola Zaire Virus infection. Unfortunately, all 3 confirmed cases died. A total of 114 contacts of the 3 patients in Uganda were followed up; 74 of the eligible contacts were vaccinated against Ebola. No other cases occurred.

On 29 August 2019, Uganda declared its 7<sup>th</sup> EVD outbreak in Kasese district. The primary case was imported from DRC. The 9-year-old girl who was identified as a possible EVD case-patient at the undesignated crossing point, isolated and admitted to an Ebola treatment unit (ETU) in Kasese, Uganda. Unfortunately, she died and her body was repatriated to DRC. Four (4) contacts were listed, vaccinated and followed and none developed EVD symptoms.

### **Risk assessment**

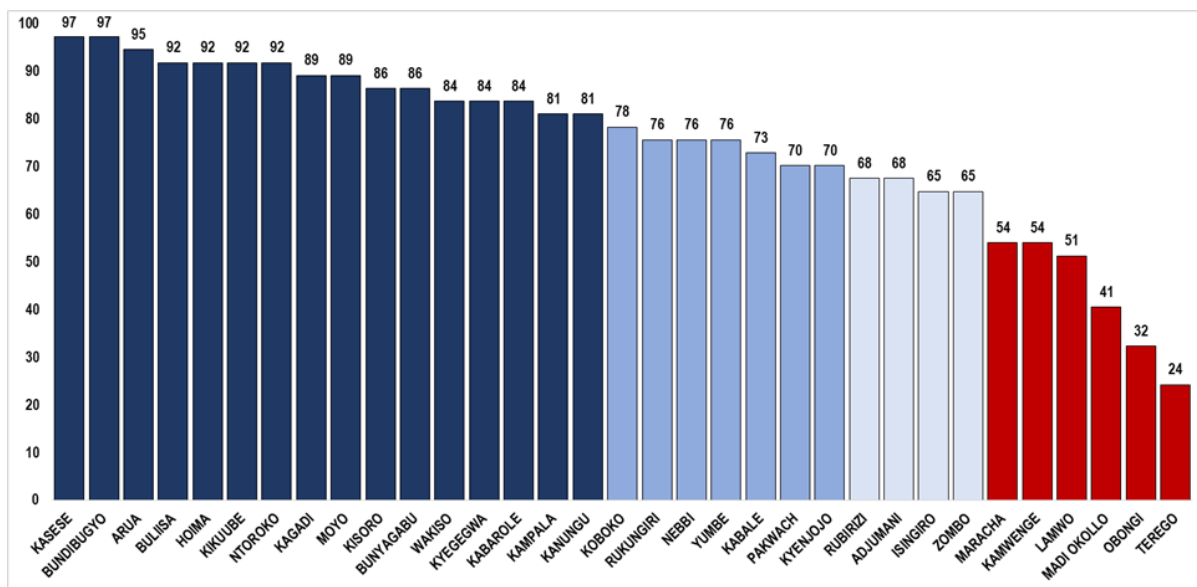
Following declaration of the 12<sup>th</sup> EVD outbreak in North Kivu on February 7<sup>th</sup>, the Uganda MoH conducted a risk assessment in the most at risk districts bordering the DRC to assess the operational readiness for Ebola outbreak response. Specific objectives of the assessment included:

1. Assessing readiness of DTF pillars to respond to potential EVD outbreak.
2. Establishing existing COVID-19 resources that can be leveraged for EVD response.
3. Recommending areas of improvement to augment operational readiness for EVD outbreak response.

Findings indicated gaps in preparedness in lack of PPEs; hand washing facilities; unready ETUs and lack of IEC materials. Immediate need for heightened active surveillance in health facilities, communities, and at points of entry; IPC supplies requiring urgent replenishment/ deployment of Ebola kits in the high risk districts, rapid refurbishment of the Ebola treatment units in Kasese, Ntoroko and Bundibugyo; deployment of vehicles to enable rapid and timely shipping of suspect samples to UVRI and evacuation of suspects; and refresher trainings and drills on management of Ebola and the need for IEC materials.

A WHO Key Performance Indicator (KPI) tool was additionally shared with the 30 high risk districts bordering the DRC to conduct a self-assessment. This was filled by the district rapid response teams and results were scored to indicate readiness as shown in the table below:





**Graph 1. District scores on the EVD key performance indicators**

Half of the 30 high-risk districts had a score of the recommended 80% readiness score or more. However, six districts (Maracha, Kamwenge, Lamwo, Madi Okollo, Obongi and Terego) scored <60. These districts had glaring gaps in capacities to coordinate and quickly respond to EVD; gaps in infection prevention and control; lack of prepositioned logistics; inadequate basic knowledge on surveillance, and gaps in basic EVD patient management. It is therefore critical to heighten preparedness activities in these areas to quickly detect any imported cases and respond in a timely manner to prevent further spread.

### Risk Classification

The detailed district categorization is as follows:

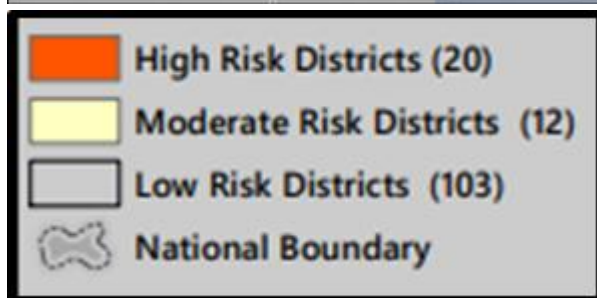
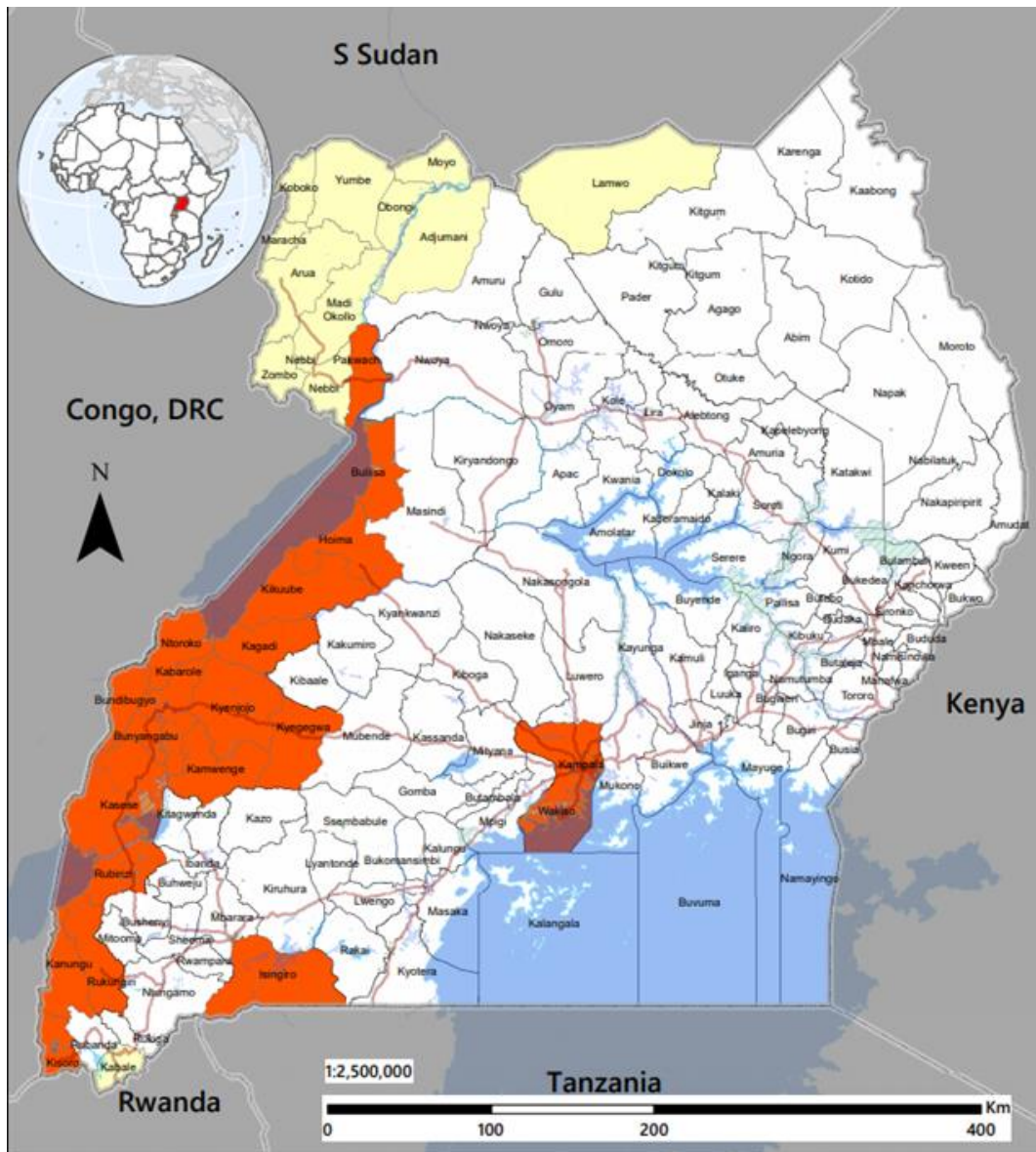
**Category one – high-risk districts:** with direct links with affected health zone of North Kivu province and refugee hosting close to affected area. (Ntoroko, Kasese, Kabarole, Bundibugyo, Bunyangabu, Kanungu, Kisoro, Rukungiri, Rubirizi, Kikuube, Kamwenge, Kyegegwa, Kyenjojo, Isingiro, Buliisa, Hoima, Kagadi, Pakwach, Kampala, Wakiso)

**Category two - moderate risk:** Districts with direct links with DRC but not with North Kivu provinces, other refugee hosting (Arua, Nebbi, Zombo, Yumbe, Moyo, Adjumani, Koboko, Lamwo)

**Category three - low risk:** The rest of the districts in the country

The incident management team will re-categorize as needed, based on new epidemiological information and risk assessments.

**Figure 2: Map showing EVD Risk categorization of Districts**



**Key achievements, best practices, gaps and recommendations from EVD preparedness and COVID preparedness and response**

Since declaration of the EVD Outbreak in DRC in August 2018, the Ministry of Health (MOH) Uganda engaged in EVD outbreak preparedness activities with support from partners. The Ministry of Health coordinated stakeholders; mobilized resources;

trained rapid response teams response teams on surveillance, case management, contact tracing, and risk communication; conducted orientation of health workers on psychosocial support; setup screening at 105 Points of Entry (PoEs) including Entebbe international airport; investigated over 470 EVD alerts; set up ETUs; setup hand washing facilities in different areas within the high-risk districts; and reached 1.6M people with EVD preventive messages.

An EVD functional simulation exercise was conducted on 11-12 April 2019 to assess capacities built, and an After Action Review (AAR) conducted on 28 - 30 to identify lessons learned. Ebola Virus Disease accountability fora were held on 29 May and 17 December 2019. During these evaluations, gaps in the preparedness and response efforts were identified. These gaps included fragmentation and duplication of efforts in response; weak framework for monitoring preparedness efforts; at-risk districts that had not received the required training; delayed reporting of alerts from the community to national level; few females reached with EVD messaging, as well as weak IPC practices at the health facility level. Recommendations from the simulation exercise and the accountability fora emphasized strengthening coordination mechanisms and IOC at health facility level.

Since Uganda is at high risk of EVD outbreaks, there is a need to sustain key interventions in surveillance, risk communication, and social mobilization, Case management/Infection Prevention and control and vaccination for EVD.

### **Integration of EVD response with COVID-19 response**

Uganda has been in a state of preparedness and response over the last 3 years, initially establishing preparedness efforts against the 10th EVD outbreak in DRC. Since January 2020, when the SARS-COV 2 outbreak was notified in China to the WHO, Uganda initiated further preparedness efforts targeted at control and mitigation of the COVID 19 outbreak. By March 2020, the country had strengthened efforts targeted to capacity at points of entry with the main aim of reducing importation of the virus. These efforts translated into staff being deployed at the points of entry to support screening and response at the POE. This has resulted in building of structured streamlined points of entry services.

Training of rapid response teams in December 2020, also strengthened the national response efforts, focusing on enhancing traditional response infrastructure for a more robust and sustained response. With provision of resources to support the efforts of the RRTs, this could prove a valuable resource to the EVD preparedness efforts and response when required.

An IPC in service facility level training was also developed targeting primary health care setting. This improves the gap in IPC, and showed considerable progress in varied IPC indicators in facilities where the programme was rolled out. The training provided a mentorship approach to capacity building and this however only covered 3 regions of the country and required sustained supportive mentorship to ensure sustained enforcement.

The COVID response efforts also strengthened the linkages with law enforcement for public health action, synergizing efforts to ensure compliance with SOPs. This strengthened collaboration provides an avenue for surge capacity.

Restrictions in COVID also led to investment in digital platforms to improve online conferencing and where applicable learning for health workers. This had varied results with increase in knowledge shown but this needs to be supported with onsite importation of skill.

## **EVD preparedness strategy for Uganda, March – August 2021**

### **General objective**

To enhance Uganda's capacity to prevent, detect early, and effectively respond to Ebola importation from DRC into Uganda amidst response to the COVID-19 pandemic

### **Specific objectives**

- Mobilize partners and resources for effective EVD preparedness and response.
- Enhance district capacity to prevent, rapidly detect and investigate all suspect EVD cases in elevated risk districts
- Raise public awareness on the threat of EVD and galvanize community support for prevention.
- Strengthen capacity for basic infection prevention and control in primary health care facilities in elevated risk districts.
- Build the capacity for the deployment of vaccination and investigational therapeutics. Sustain and integrate leadership, coordination, and resource mobilization to support EVD preparedness alongside the COVID-19 response in Uganda
- Ensure Districts have sustained capacity to rapidly detect and investigate all suspect EVD cases at facility, community, and points of entry (PoEs)
- Sustain public awareness on the threat of EVD and innovatively address fatigue and the risk of complacency towards the EVD and COVID-19 messaging.
- Ensure long term infrastructure is available for case management and IPC in high-risk districts.
- Sustain the capability for rapid mobilization and deployment of staff, and vaccines and therapeutics.

### **Strategy**

This plan will be achieved through increased ownership by the districts, strengthening coordination at all levels and integration with COVID-19 response. Enhancement of coordination and communication at the National and District levels will be achieved through promoting the active participation of all stakeholders in subcommittees.

This plan is envisioned to serve as a transition to sustainable health security for the EVD risk. To ensure sustainability, integration of activities into routine and long term planning.

### **Approach**

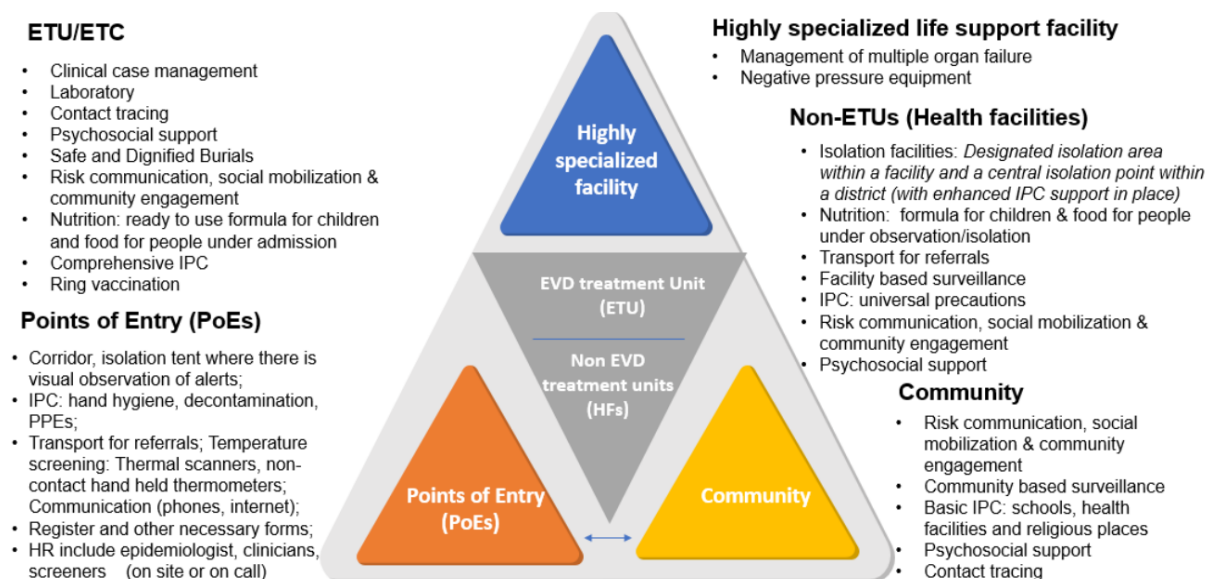
Review of the plan is guided by revised district categorization and development of scenarios aligned with these categories.

## Scenarios

There are 3 possible scenarios for cross border spread of EVD. These include;

Scenario	Definition	Actions
S1: Best case	No confirmed case, High risk of cross border spread	Cross pillar response at all levels, screening
S2: Most likely	One or more cases confirmed in a geographically limited area, for example a border district	Cross pillar response, setting up Ebola Treatment Units (ETUs), Surge teams
S3: Worst case	Multiple cases confirmed in different geographical areas <u>or an overwhelming number of cases</u> requiring escalation of response <u>or</u> cases in urban areas <u>or</u> in a refugee settlement.	Cross pillar response, setting up ETUs, Surge teams, Surge teams, Mobile labs and ETU

**Figure 3: Minimum packages for EVD integrated preparedness and response**



## EVD preparedness and response interventions

### 1. Coordination and leadership

The purpose of this pillar is to provide overall strategic guidance for implementation of EVD multi sectoral plan and mobilize resources for effective EVD preparedness and response amidst response to COVID-19 response. The pillar will ensure the participation of: the Office of the President, Office of the Prime Minister and line ministries for education; gender; labour and social development; foreign affairs; internal affairs; defence; agriculture, animal industry and fisheries; tourism, wildlife and antiquities.

**Strategy:** The EVD incident management team and the emergency operations centre will oversee coordination of EVD preparedness and response, provide secretariat services, lead resource mobilization including drafting requests and appeals to the Ministry of Finance, partners and donors, providing regular updates to the National Task Force (NTF).

### **Activities**

- Map and coordinate partners at national and district levels to ensure a robust, rapid, and effective EVD response.
- Mobilize emergency response funds from the Government of Uganda and partners to facilitate early response; propose allocation of resources; track progress in funds mobilization and utilization.
- Activate the task forces in high-risk districts and together with the national and district rapid response teams, ensure that appropriate preparedness plans are developed.
- Integrate district EVD preparedness plans within the existing COVID-19 plans
- Coordinate district and regional partners to update 4W partners matrix
- Coordinate cross border collaboration with the DRC.
- Monitor the implementation of the preparedness plan.
- Collate and disseminate updates on EVD preparedness and prevention efforts

## **2. Surveillance and laboratory**

The purpose of this pillar is to enhance capacity to prevent, rapidly detect and investigate all suspect EVD cases in high risk districts.

**Strategies:** 1) Conduct rapid risk assessment for EVD spread in the high-risk districts; 2) Sensitize district leadership, Health workers, and Village Health Teams (VHTs) on EVD surveillance; 3) Enhance PoE screening and IPC at selected ground crossing points and health facilities; 4) Support collection, packaging, and transportation of samples from suspected EVD cases to UVRI for analysis.

### **Activities**

- Deployment of central and district teams to conduct district level risk assessments
- Integrate EVD enhanced surveillance trainings with COVID-19 for health workers, VHTs, and responders
- Sensitization of immigration, revenue, and internal security officers at PoEs on risk of EVD importation from DRC
- Integrate EVD with COVID-19 supervision and monitoring of screening and IPC at PoEs in high risk districts by central and district teams
- Reorient laboratory personnel and selected health staff on appropriate EVD sample collection, packaging, handling, and transportation
- Integrate EVD with COVID-19 alert management at national and central level

- Conduct and supervise active case finding, contact tracing, and follow-up in the affected and surrounding areas.

### **Targets:**

- All notified alerts investigated within less than 24hrs
- Follow-up 100% of all contacts
- Sustain capacity at all the 47 PoEs in the high-risk districts
- Ensure that 100% of travellers are screened at formal PoEs
- Reduce epidemiological turnaround time to 12hrs

### **3. Case management (including nutrition), Infection Prevention and Control and safe and dignified burial.**

The purpose of this pillar is to provide guidance for standards of care for EVD management.

**Strategies:** 1) Capacity assessment and mapping of trained clinical teams and key partners, 2) Strengthening capacity for clinical and nutrition management of EVD, 3) Assessing and strengthening capacity for IPC in health facilities and ETUs, and psychosocial support to affected individuals and communities, 4) Establishment/refurbishment of (standby) ETUs/isolation facilities close to affected communities, 5) Prepositioning of key medical, nutrition and IPC supplies in the high-risk districts, 6) Establishing IPC measures in communities, 7) Strengthen the capacity to conduct SDBs for all suspected and confirmed EVD death

### **Activities:**

- Review, print, and disseminate standard of care tools including: case management protocols, algorithms and tools; IPC guidelines/SoPs and strategy; establishment of isolation and ETU facilities
- Improve access water supply infrastructure in health facilities
- Improve access to sanitation infrastructure in health facilities
- Capacity building and mentorship of health workers in case management, and IPC
- Capacity building of health workers in psychosocial support for EVD cases in the ETUs
- Develop a human resource plan (including deployment aspects) to implement effective EVD case management
- Procure and preposition drugs, medical supplies and equipment needed for the treatment of patients and IPC at the isolation units and selected health units
- Identification and training of safe burial teams
- Improve access to basic Water, Sanitation, and Hygiene (WASH) services in POEs, Communities, Schools, Public Places and markets.

### **Nutrition**

The main objective is to establish capacities to maintain positive feeding practices for infants and young children affected by EVD despite quarantine, disrupted



breastfeeding, trauma and stigma. Due to the continued presence and shedding of Ebola virus in breast milk, MOH will ensure continued access to ready to use infant formula (RUTF) for affected infants under 6 months and ready to use therapeutic formula for malnourished children. The support will include follow up after discharge, with integrated psychosocial support and protection.

The MOH will also ensure routine screening for malnutrition and treatment following appropriate national protocol for children affected with severe acute malnutrition. MoH will undertake procurement, quantification and last mile distribution of the required therapeutic commodities for SAM management (F-175, F-100, RUTF and ReSoMal).

**Target:** # (100%) infants (children ≤6 months) affected by EVD receive RUIF  
# of health workers in ETUs and non-ETUs oriented on nutrition in the context of EVD

# children 6-59 months of age admitted for SAM

# of health workers in ETUs and non-ETUs trained on IMAM

### **Activities**

- 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.
- Procure and manage contingency stocks of Ready-to-Use Infant Formula (RUIF) and Ready-to-Use Therapeutic Formula (RUTF)
- Train health workers in ETUs and non-ETUs on IMAM

### **WASH and IPC**

The strategy will be implemented through three tiers including: Impartation of soft skills for infection prevention and control (IPC) through WASH for health workers and district health teams; Improvement of WASH infrastructures as enablers of IPC; and provision of renewable supplies for IPC to health facilities, selected points of entry, schools and communities. Activities included:

- Provision of WASH supplies packages for health facilities (Non-ETU), Schools and Communities at high risk of EVD. Ensure a handwashing infrastructure is available, accessible, safe and functional where/when needed, prioritizing public places in EVD affected areas and high-risk areas, as well as commercial buildings, public transport stations and markets.
- Mentorship for health care workers and teachers on EVD transmission and prevention. In order to ensure that the supplies are appropriately used, UNICEF will train health workers from newly identified health facilities -one health worker per facility and teachers from each of targeted institution. This training will be carried out on site due to restrictions on classroom-based training. The District Health Officers/Assistant District Health Officers will train the health worker, visiting each location immediately after the supplies are sent. MOH and partners will support the district through cash assistance to the district meeting

transportation cost and other incidentals, while UNICEF will support provision of requisite training and Information, Education and communication materials

- Improved IPC WASH infrastructure at health facilities in high risk districts of EVD. Support improving water supply and sanitation facilities to ensure health workers and patients adhere to the IPC WASH standards. Advocate with governments and support water utilities - including through the development of policies and delivery mechanisms - to serve populations, particularly those already lacking access, ensuring a minimum water quantity to allow for hand hygiene and cleanliness in their homes.
- Coordination and Monitoring: Coordinate with the MOW, MOE, WHO, CDC UNICEF and partners, the relevant EVD response management pillars, key WASH and Health IPC stakeholders to strengthen governments' leadership and accountability, ensuring cross-sectoral coordination. Support the Ministries of Education and Health to make schools safe through the development, revision and implementation of guidelines for safe school operations in the context of EVD outbreak, including education about the prevention of EVD and active promotion of handwashing with water and soap.

#### **Targets:**

- 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 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 posters<sup>6</sup>
- 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 hygienists<sup>7</sup>
- 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 marketplaces, 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.

## **4. Risk communication, social mobilization and community engagement**

The purpose of this pillar is to provide leadership of risk communication and community engagement interventions at national and subnational levels to facilitate public health education, acceptance of all response activities and recommended behaviours, thus reducing EVD illness and minimize disruption to daily lives of local communities. This is achieved through systematic gathering of social science knowledge to inform the preparedness and response, as well as active engagement

with key stakeholders including community influencers, healthcare workers, and local communities.

Strategy: The focus is on aligning the Risk Communication and Community Engagement (RCCE) work across all subcommittees and field teams of the response through close collaboration, frequent information sharing, tracking of any rumours (social listening), and timely response to public concerns and to any form of misinformation and ensuring the active involvement of the affected population in the generation of community-led solutions. This will be facilitated by coordination of partners and stakeholders, mass media public health education, rapid social science assessments to inform activities, community engagement and social mobilization, capacity building, monitoring and evaluation.

### **Activities**

- Development of a strategy and costed national RCCE plan
- Conduct operational research to inform the plan, periodic Knowledge, Attitudes, and Practices (KAPs), social science research, assessments
- Develop and disseminate standard tools, materials, and messages
- Public health education and mobilisation using multiple mass media channels including social media.
- Building the capacity of partners, volunteers/community cadres, health workers, Teachers, and other target groups
- Mobilise key influencers and facilitate community dialogue with affected populations
- Build capacity of local communities for collective responsibility and action towards preparedness, prevention, mitigation, and post recovery.
- Monitoring and post outbreak evaluation of the effectiveness of RCCE interventions.

Targets: 70% of the affected population reached and are able to recall at least 2 preventive messages through timely dissemination of basic preventive messages and response to rumours and misinformation among the affected population.

## **5. Vaccination and operational research**

The purpose of this pillar is to facilitate ring 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 will help to stop future EVD transmission and contribute to the control of an outbreak. On November 12, 2019 WHO prequalified an Ebola Vaccine against Ebola Zaire strain. On January 11, 2021, WHO, UNICEF, International Federation of Red Cross and Red Crescent Societies (IFRC) and MSF announced establishment of a global Ebola vaccine stockpile, the stockpile will allow countries including Uganda through the International Coordinating Group (ICG) to access the Ebola Vaccine timely. The current outbreak in the DRC compassionate approach has

continued to be used. So in case an outbreak is registered in Uganda, 2 different scenarios may be explored namely continued use of compassionate approach if the cause is Ebola Zaire strain while the second scenario will be application from ICG to access the doses using the guidance documents.

Scenario 1: Use a compassionate approach if an outbreak occurs due to Ebola Zaire strain. Therefore, vaccine deployment activities will be placed under the Expanded Access framework, with informed consent and in compliance with Good Clinical Practice. If the outbreak is caused by an Ebola virus species other than Zaire, consideration should be given to the use of other candidate vaccines that target the assumed viral species if available.

Strategy: Avail and deliver the Ebola vaccine and investigational therapeutics to high risk groups as part of the control measures of EVD.

### **Activities**

- Review, amend and request for an approval through the Institutional Review Board (IRB) and Uganda National Council of Science and Technology (UNCST) to use a compassionate approach to vaccinate the at risk populations. The previously used protocol expired on 31 October 2020. There is, therefore, need to submit a new request to obtain an approval for at least 1 year.
- Development of a strategy and costed plan for EVD vaccine and investigational therapeutics deployment.
- Conduct functional assessment of cold chain systems at national Medical Stores. The vaccine requires ultra-cold chain capacity.
- Assess availability of previously used EVD vaccination or Expand vaccination teams at regional level in Ring Vaccination. Capacity building has to be conducted for both categories however the regional teams have to undertake the Good Clinical Practice (GCP) certificate and Collaborative Institutional Training Initiative (CITI) course.
- Delivery of EVD vaccines, related supplies, and equipment to the district level
- Monitoring the use of the investigational therapeutics and following up Adverse Events Following Immunization (AEFIs)
- If scenario 2 is applicable to Uganda, an application to ICG for a stockpile will be undertaken using guidance documents. It is assumed that a similar approach for yellow fever vaccine will be utilized.

## **6. Logistics**

The purpose of this pillar is to coordinate and track logistics for the EVD preparedness and response covering the following areas: procurement and supply, management of supplies/equipment, fleet management, warehousing/storage and inventory management, distribution, communications, establishment of operations hubs, reverse logistics, and security.

## **Strategies:**

- Conduct capacity and needs assessments for storage, communication, transport, and security
- Draw up an inventory of available resources
- Mapping exactly where they are and which partners and manage stockpiles as needed
- Develop and cost a national and subnational EVD logistics plan
- Standardize approaches for EVD logistics management

## **Activities**

- Evaluate storage capacities and stock management systems in place. Identify stockpile needs across all pillars and implement an efficient stockpile management system at national level and at district levels.
- Identify and ensure all transport requirements for both goods and persons, according to needs and security requirements, across all pillars.
- Prepositioning of Ebola commodities and supplies
- Assess and strengthen the existing sample transportation and hub mechanism at national and subnational levels and support the transportation to collaborating laboratories.
- Support the appropriate siting, establishment/refurbishment, day to day management and closure of standard isolation and ETUs.
- Identify and train the human resources required to ensure all logistics support activities can be implemented.
- Map out all available logistics resources including locations with capacity for warehousing.
- Identify suppliers of standard essential items for emergency response locally/internationally; assess their delivery capacity/time and explore possibilities for pre-supply agreements.
- Identify supply needs, optimize supply chains, define and implement supply SOPs to reduce delivery time and improve replenishment processes.
- Evaluate the communication network capacity and if required establish a telecommunication system to ensure all operations.
- Ensure ETUs/isolation facilities are functioning in line with IPC guidelines, with adequate isolation, waste management, water and power supply, with ensured consumables replenishment, and maintenance support.
- Define and implement all SoPs related to the logistics component (procurement, stockpile mobilization, sample transport, telecommunications, structures support and maintenance, transport resources mobilization, security management).
- Track deployment and reverse logistics

## **Targets**

## **7. Strategic Information, Research, and Innovation**

Through this pillar the Ministry of Health will leverage digital health tools to optimize the response as well as ensure that critical information is available for strategic decision making.

### **Strategies**

1. Implement digital health tools for contact tracing and alert management
2. Ensure capacity for production of information products at all level
3. Implement tool for resource management and activity tracking
4. Ensure a centralised repository of all response data

### **Activities**

- Rollout goData tool for contact tracing to all activated districts
- Implement system for integrated alert management for EVD
- Rollout sample tracking system
- Conduct training for district biostatisticians and surveillance focal persons on production of information products for the response
- Implement a budget tracking system and partner mapping dashboard for EVD
- Integrated ODK based district reporting system for EVD and COVID-19
- Integrated EVD preparedness and response data into the integrated data repository for outbreak and epidemic data
- Implement Electronic Medical Record System for Ebola treatment units

### **Targets**

- % ODK reporting rate
- % of contacts and events captured in the goData system
- % of ETU with capacity to capture data electronically

## **8. Ecological/Anthropological studies/Investigations**

Ebola Virus Disease is a zoonosis, and leads to disease with high mortalities in humans, and primates, and possibly other wildlife species. The aim of the Pillar is to guide early detection and containment of EVD outbreak in wildlife before it spills over into the domestic animal and human population. Using outcomes from ecological studies conducted, map high risk areas and animal species involved, guide the establishment and implementation of early warning systems/mechanisms for Ebola epidemics in the human population in addition to informing the mechanisms for continuous disease surveillance at the human-wildlife interface.

### **Strategies**

1. Ensure capacity to conduct ecological investigations is built within staff at both national and district level

2. Mapping of all actors/IPs involved in conducting ecological studies
3. Develop guidelines and disseminate for conducting ecological studies
4. Ensure functional Ecological committees exist at both national and district level

### **Activities**

- Train Both national and district staff to conduct ecological studies
- Constitute ecological studies committee at both national and district level
- Develop work plans and budgets for national level activities of the committee and also support districts to come up with the same

## **9. Mental Health and Psychosocial Support**

Ebola Virus Disease (EVD) may cause mental health problems because of the nature of the disease and the disruption it causes to the socio-ecology of the infected, affected, responders and their families. Targeted response interventions by health and other actors may in addition impact on EVD affected communities' mental health. Children's mental health and psychosocial well-being may be significantly affected during EVD outbreaks as well as the response interventions when friends, caregivers, family members are affected and there is a change in community service provision (such as closing of schools, community groups, etc.).

### **Strategies**

- Integrate MHPSS and child protection response into a range of EVD preparedness and response initiatives at national and sub-national levels
- Provide accessible community-based psychosocial support for Individuals, children and families in vulnerable and distressing situations.

### **Activities**

- Conduct regular national and district Task Force meetings for coordination
- Designate MHPSS focal person to participate in coordination mechanisms and ensure that the health sector at district and national levels designates a health focal person in the Coordination groups.
- Sensitisation of district task teams under the EVD response on MHPSS and Protection
- Train actors in health, education, social welfare, local government, including volunteers such as VHTs, traditional healers, para-social workers and Child Protection Committees, in MHPSS and EVD related protection concerns for children
- Train and collaborate with religious and cultural leaders in communities



- Provide mentorship to establish and maintain a functional referral pathway in affected districts to ensure access of communities to effective services
- Support supervision and establish and maintain a functional referral pathway in affected districts:
  - Mapping of partners supporting MHPSS and protection services at District, facility and community levels
  - Regular monitoring of delivery of MHPSS and protection services, including child protection service delivery
- Engage the Risk Communication Team to integrate MHPSS messages and information for preventing, raising and responding to protection concerns in the community in the communication package.
- Establish and maintain effective intra-facility, inter-facility and community referrals procedures
- Mainstream child protection concerns in every relevant SOP to ensure that a conducive physical and social environment is created for all children and other vulnerable persons
- Conduct visits to ETUs and review procedures and safety/protection related aspects of the facilities to ensure the EVD response interventions do not create additional protection concerns for children and other vulnerable persons – Develop a checklist
- Ensure support is provided to EVD infected persons, including children in ETUs, including provision of play materials for children in isolation/quarantine.
- Sensitize communities, families and children on the protection concerns in EVD outbreaks, specifically EVD related mental health and child protection concerns, including identification of signs of distress and how to access support.
- Provide community-based psychosocial support activities, including for children where appropriate, in close coordination with relevant stakeholders
- Raising awareness in communities about psychosocial distress, grief and positive coping strategies and support for each other.
- Train and support families caring for children under foster and/or kinship care arrangements
- Provide EVD affected communities with accurate and useful information about referrals and services available to cover basic needs.
- Sensitize and raise awareness around protection risks and concerns during Ebola preparedness and response phases, specifically in relation to women and children.

- Review and translate awareness-raising and sensitisation materials on EVD to ensure they do not cause psychosocial distress / put children and other vulnerable persons at increased protection risks (i.e. create isolation/abandonment, stigma).
- Work closely with education service providers to train teachers and education personnel on ways of comforting, engaging and interacting with children.
- Develop adequate alternative care strategies for children and individuals separated from their primary caregivers/families due to the EVD outbreak

## **Summary Budget**

### **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 NTF/IMT will also conduct period evaluations of the plan including: After action review; accountability forum; among others.

Report Chains and Data submission: Data collected during the implementation of this plan will be shared with the IMT which has the primary mandate for its monitoring.