

**Ebola Response Plan (Sudan Virus Disease) in Uganda**

**October 2022 – March 2023**

***Version: 18 October 2022***

**Research assistant drawing blood for tests during the baseline malariometric survey**

**@Malaria Consortium/Anthony Nuwa/August 2018**



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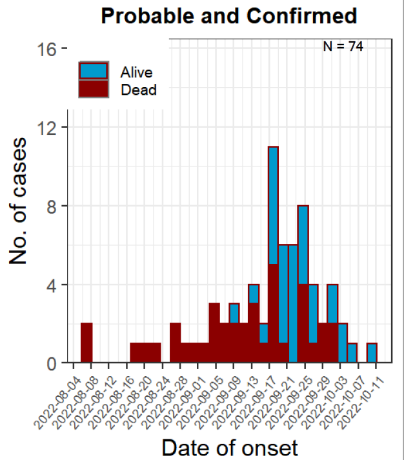
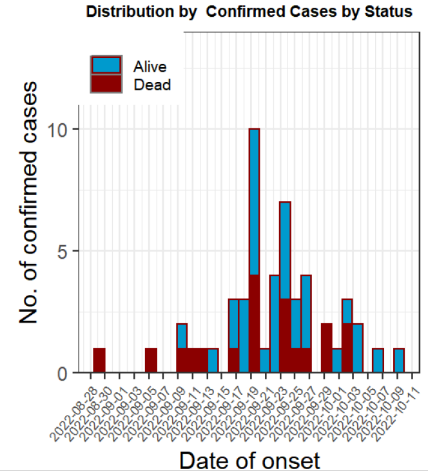
# Introduction

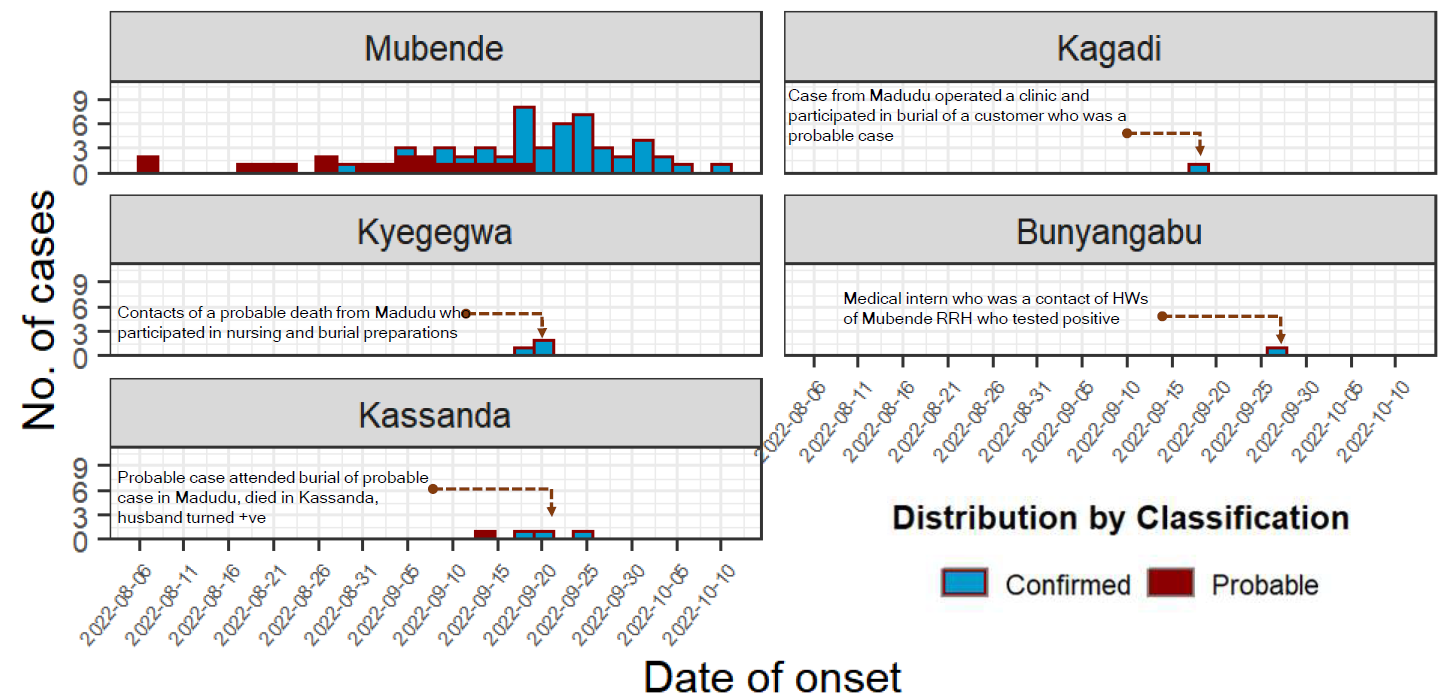
This plan describes the *Sudan Ebola virus* disease (SVD) response strategy for the UNICEF Uganda Country Office. It is aligned to the Uganda National SVD Response Plan and covers a six-month period from October 2022 to March 2023.

# Epidemiological situation and context

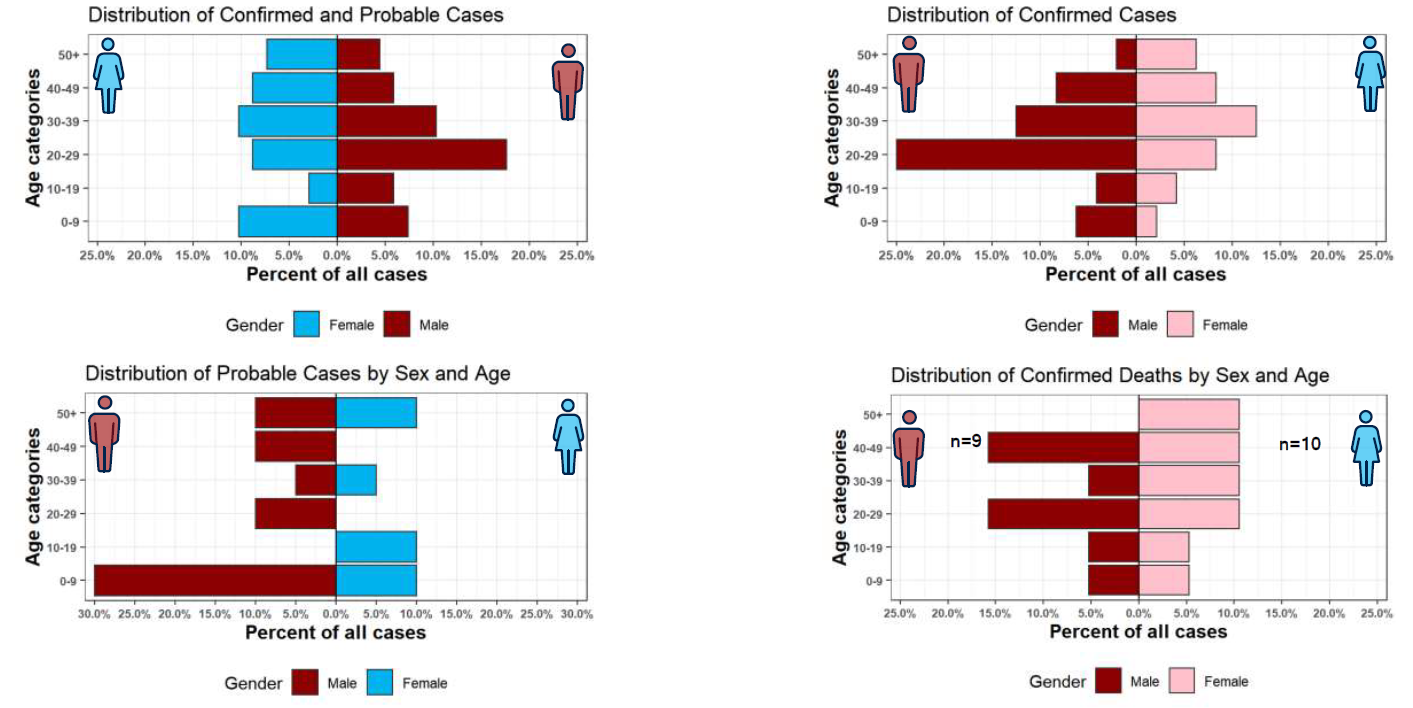
The Uganda Ministry of Health (MoH) declared its 7th Ebola disease outbreak on 20 September 2022, following a positive test result for Ebola Sudan strain of a 24-year-old male from Madudu sub-county in Mubende district on 19 September 2022. On 11 September he developed symptoms including high-grade fever, convulsions, blood-stained vomit and diarrhea, chest pain, and bleeding from the eyes among others. He visited a private clinic and was treated for malaria but got worse and self-referred to another clinic and was later referred to Mubende Regional Referral Hospital on 15 September. His condition deteriorated on treatment, and he died on 19 September. The ongoing outbreak is a local emergence from a reservoir in Mubende, where there is an ongoing ecological study to determine the source. As of 10 October 2022, five districts were affected namely: Mubende (epicenter), Kyegegwa (refugee hosting), Kassanda, Kagadi and Bunyangabu reporting a cumulative of 48 confirmed cases with 17 confirmed deaths (CFR 35%), and 20 probable cases[[1]](#footnote-2). Women and girls account for 58% (25) of all cases. Children account for over 35% of all reported cases. The mean age is 27 (range 1 - 60 years)[[2]](#footnote-3).

**Figure 1. Distribution of cases as of 14 October 2022**





**Figure 2. Characteristics of cases as of 14 October 2022 (age and sex)**



There appear to be more deaths among females aged 40-60 years, and more deaths among males Under 40 years.

# Previous outbreaks of Ebola in Uganda

Uganda has reported seven other Ebola outbreaks (2 due to importation from DRC) is the eighth, and the fourth outbreak caused by the SVD in Uganda, the first having occurred in 2000-2001 affecting Gulu, Masindi and Mbarara with a cumulative 445 cases including 224 deaths.

**Figure 3. Summary of Previous Ebola outbreaks in Uganda 2000-2022**

|  |  |
| --- | --- |
| **Year/causative agent** | **Numbers/Locations affected by outbreak** |
| 2019, Zaire e*bola virus* | Kasese (2 outbreaks both imported from N.Kivu, occurred in June - 2 cases-deaths; August – 1 case, no local transmission from either outbreak) |
| 2012, *Sudan ebola virus* | Kibaale district (11 cases with 4 deaths, CFR 36%) - June |
| 2012-2013, *Sudan ebola virus* | Luwero, Jinja, and Nakasongola districts (7 cases, 4 deaths, CFR 57%) - November |
| 2011, *Sudan ebola virus* | Luwero, 1 case-death (CFR 100%) |
| 2007-2008, *Bundibugyo ebolavirus* | Bundibugyo. 149 cases with 37 deaths (CFR 25%) – novel strain of *ebola virus* |
| 2000-2001, *Sudan ebolavirus* | Gulu, with spread to Masindi and Mbarara (425 cases with 224 deaths CFR 53%) |

# Risk Assessment

Ebola virus disease is a severe, often fatal illness that infects humans, nonhuman primates (monkeys, gorillas and chimpanzees), for which the fruit bat is a reservoir. The virus is introduced into the human population through close contact with the blood, secretions, organs or other bodily fluids of infected animals. It then spreads through human-to-human contact via direct contact (through broken skin or mucous membranes) with either blood or body fluids of a person who is sick/has died from Ebola or objects that have been contaminated with infected body fluids (like blood, feces, vomit). The incubation period ranges from 2 to 21 days and the virus can only spread until infected persons develop symptoms, and they remain infectious as long as their blood contains the virus. Besides Sudan ebola virus, four other species of Ebolavirus exist, namely: *Zaire ebolavirus*, *Reston ebolavirus*, *Tai Forest ebolavirus*, and *Bundibugyo ebolavirus*. The Case fatality ratio of the Ebola disease (EVD and SVD) has varied from 25% to 90% in past outbreaks.

Following the declaration of the outbreak in Mubende district, the WHO conducted a rapid risk assessment (RRA) and categorized the event as a Grade 2 emergency with a high risk of national spread, moderate risk of regional spread, and low risk of global spread. The grading was due to: (i) the lack of an authorized vaccine or therapeutics for the Sudan virus disease; (ii) the likelihood that the outbreak was detected over 3 weeks (at least 1 incubation period) after it started, with the possibility that secondary cases are already starting (iii) patients visited various health facilities and traditional healers with suboptimal/no infection prevention and control and were not buried safely (iv) Uganda is responding to multiple crises and a rapid expansion of the outbreak could overwhelm the health system. Additionally, the affected area has a highly mobile population due to the gold mine – and Mubende is on a major trunk road that connects eastern DRC, Rwanda, Tanzania, and South Sudan with Kampala. It is anticipated that the RRA will be updated as soon as the situation changes, especially if Kampala or border districts start reporting cases.

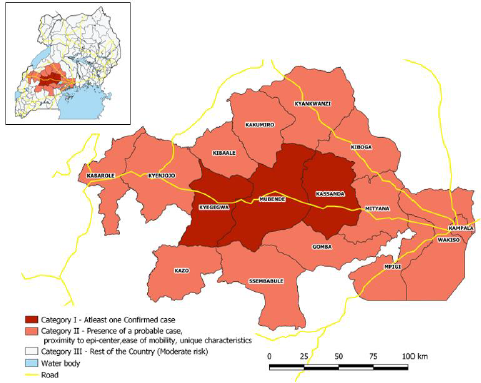
## Risk mapping

The index case is yet to be identified; however, the first confirmed case was detected in Mubende district, which informed the rapid risk assessment for planning. Intense population movement is documented within Mubende and other districts and is approximately 2 hours from Kampala and other regional towns. Classification of risk was informed by:

* Presence of confirmed cases (Epicenter)
* Proximity to the epicenter
* Detection of probable cases
* Unique characteristics of districts; Refugee hosting districts; population density; Presence of mines and forests
* Complex urban settings
* High mobility road networks/highways

**Uganda SVD risk classification, September 2022**

|  |  |
| --- | --- |
| **Category** | **District** |
| Very high risk | Mubende, Kyegegwa, Kassanda |
| High risk | Kakumiro, Mityana, Mpigi, Kampala, Kiboga, Kibaale, Kyankwanzi, Gomba, Sembabule, Kazo, Wakiso, Kyenjojo, Kabarole, Kamwenge, Fort Portal City, Mukono |
| Moderate risk | Rest of the country |

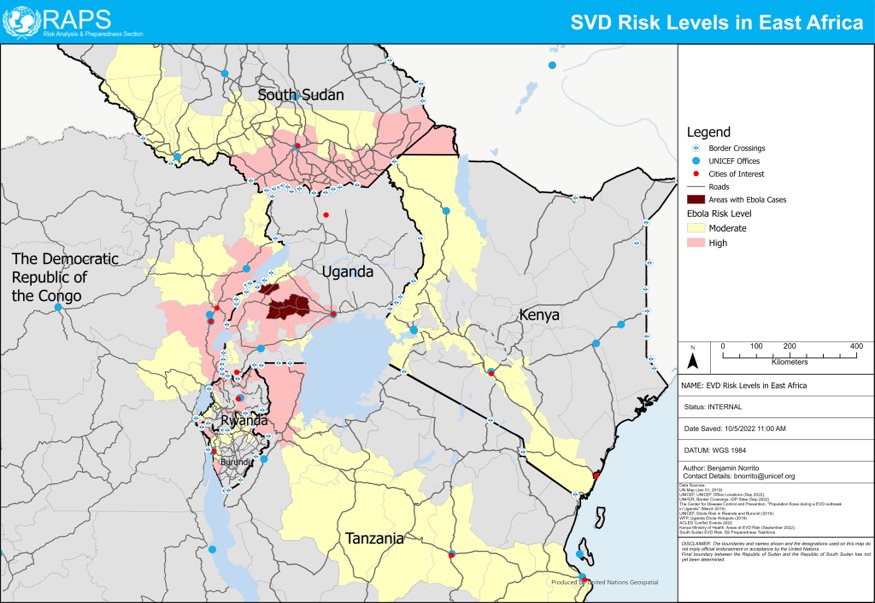


**Figure 4. Uganda SVD risk classification map (MOH)**

The risk of the local spread of SVD outbreak in Uganda remains high. Findings from the anthropological study conducted in May 2019 indicated that livelihoods will take priority over any recommended preventive measures, and in some communities, which share family and borders with affected districts, there is pre-existing institutional mistrust, with episodes of violence against responders and linkages of the outbreak to a plan by the government to evict communities from the mining areas and prohibition from fishing.

## Risk of SVD transmission to the rest of east Africa/great lakes

Intense cross border population movement is recorded daily in the region, for cross border family unions and socio-economic activities. Uganda, the DRC, Rwanda and South Sudan are landlocked hence thousands of vehicles transporting goods and passengers move across borders through Kenya and Tanzania to and from the coastal ports and across cities. The updated population movement data is still being compiled. The map below shows the assessed risk levels for the spread of this outbreak across the region.



**Figure 5: Internal regional risk map**

## Other events of public health concern

On August 22, 2022, the Ministry of Health of the Democratic Republic of the Congo (DRC) announced an outbreak of *Zaire Ebola virus* in North Kivu Province. Sequencing results from the INRB lab in Goma showed a link between this case and the 2018-2020 EVD outbreak in the same region, suggesting a relapse of EVD, or infection by a survivor experiencing a relapse or who had a persistent EVD infection. As was the case in 2019, Uganda remains at risk of importation of this outbreak and is considered a priority 1 country for the risk of importation of Ebola zaire cases from North Kivu Province, DRC, to border districts with which there is intense population mobility due to trade, family and conflict.

Uganda had reported 169,396 COVID-19 cases with 3,628 deaths (case fatality rate 2.14%) by 10 October 2022. The country continues to report cases, albeit at a much lower level than during the previous wave, with a continued decoupling of the trend of cases and deaths. Over 28 per cent of Uganda’s population had completed the primary vaccination series of COVID-19 vaccination by 10 October 2022 – however, a significant proportion of high -priority groups such as older persons and people with comorbidities have not completed their primary schedule. Coverage of boosters remains low. Should another wave (or new variant) emerge, these groups will be at particular risk.

There are other ongoing events with public health impact including: severe food insecurity in Karamoja Region (North Eastern Uganda); [Crimean Congo Haemorrhagic Fever outbreak in Amuru](https://veoci.com/api/v2/p/files/9gjopnebu1oqp2hq/content) district; [Malaria upsurges](https://veoci.com/api/v2/p/files/0k0hloodl8zierll/content) in >42 districts; Anthrax outbreaks in [Ibanda](https://veoci.com/api/v2/p/files/uiyogokcvulxoji7/content) and [Bududa](https://veoci.com/api/v2/p/files/dbukl5aappyozvlw/content) and Mudslides in [Mbale](https://veoci.com/api/v2/p/files/fmyv4rmxr1xqumqz/content) and [Kasese](https://veoci.com/api/v2/p/files/vevf31qydrzuxn7f/content) districts.

As of October 2022, Uganda is host to over 1.5 million refugees and asylum seekers, including 60% from South Sudan and 30% from DRC – they have frequent cross -border movement with their home countries ([UNHCR, 2022](https://data.unhcr.org/en/country/uga)).In August 2022, Uganda received over 89,000 new arrivals from South Sudan and DRC. The 15 existing reception and transit facilities receiving new arrivals across the country have the maximum capacity to host 20, 760 new arrivals for a short stay and are therefore overcrowded and risk for disease outbreaks and protection concerns.

# Lessons learned and good practices

In the EVD preparedness and response in August 2018 – December 2019, UNICEF’s response was aligned within the Government of Uganda National EVD preparedness and Response Plan. The UNICEF- supported interventions were based on the organisation’s comparative advantage, agreed division of labor with other UN agencies and focus on the strengthening national and district capacities in high-risk districts to effectively coordinate, plan, implement, and monitor EVD activities with focus on RCSM, IPC through WASH in non-ETUs, schools and public places, nutrition and psycho-social support, including child protection.

UNICEF’s responses focused on pillars of comparative advantage including Coordination, RCCE, WASH, and the case management sub-pillar of MHPSS. UNICEF conducted a multi-country stocktake of the EVD responses. MoH conducted an After-Action Review (AAR) which also gathered challenges and lessons learnt to inform action. During the initial COVID-19 response, MoH also conducted an Inter-Action Review (I-AR) for the same purpose. The list of Lessons learned is not exhaustive but highlights the most relevant to the UNICEF response across the stocktake and action reviews.

* **Strong government ownership and leadership** at national and sub-national levels is key to a functional coordination, effective programming, efficient resource allocation and sustainability of investments. As demonstrated by various PHE responses, districts with stronger leadership and ownership were able to achieve better results.
* A functional **UN coordination forum and the agreed division of labor in EVD context** helped the roles and responsibilities of partners and facilitated communication and coordination with the Government and donors.
* **District coordination and use of existing structures** (district health promotion officers, IPC teams, VHTs, probational officers, para-social workers) facilitated efficient resource use, coverage, and sustainability.
* **Value of evidence informed EVD response**: The Anthropological and two KAP studies provided important insights that informed the strategy, implementation approaches, and key messages (e.g., better targeting of groups, refined messaging) and contributed to enhancing the broader response.
* **Harmonization of information, education and communication materials including translation into local languages:** The government, including MoH, was fully involved in the development, approval, and dissemination of IEC materials. Local languages were reviewed within the beneficiary districts. All partners reproducing any products had to use only authorized versions which unified messaging via IEC materials across all districts.
* **Lack of a National Mental Health and Psychosocial Support** (MHPSS) strategy resulted in weak coordination of support**.** Once rectified,Close collaboration between social welfare and health actors, resulted in joint training on child protection and MHPSS for district staff and this facilitated a more holistic response in ETUs.
* **Lack of sustainable water supply and limited sanitation facilities at health facilities, institutions, and public spaces** (e.g., border points) limited the use of hand-washing facilities. A shift in programmatic emphasis to strengthening WASH facilities, including water supply, in health centers is recommended.
* The **solar-powered on-site chlorine generators** offer a low-cost, environmentally friendly option for chlorination of water and disinfection of linen and floors. However, the equipment is not being systematically used in all the health facilities. The use of chlorine generators is disincentivized by ongoing distribution of chlorine by various partners.
* Bring together multiple data actors to support the MoH on **integrated outbreak analytics (IOA)** which brings together different data sources (methods/actors including programmes, surveillance, HIS, community sourced data, events, social and gendered data) in order to better understand and explain outbreak dynamics and the impacts of the outbreak and response on communities. IOA has been used to adapt outbreak response for more accountable and effective EVD interventions.

# National response plan and scenarios

The aim of the response plan is to guide UNICEF Uganda’s multi-sectoral response activities to contribute to the interruption of Ebola transmission in Uganda and curb/prevent its spread within the country and to other neighboring countries. The response is implemented across 9 strategic pillars coordinated by the incident management team of the Public Health Emergency Operations Center (PHEOC). Pillars include Coordination and leadership, Surveillance, Laboratory, Case management (including infection prevention and control, safe and dignified burial, and psychosocial support), WASH, Risk communication and social mobilization, Community engagement, Logistics, and Vaccination.

The National Task Force (NTF) coordinates all activities in collaboration with multiple sectors and partners in high-risk districts. UNICEF supports the NTF at the national level and district level through the District Taskforce, and District Health Management Teams (DHMT and DTFs) at the subnational level, directly and through partners.

The response plan builds on lessons learned from the COVID-19 pandemic and previous EVD preparedness and response and deploys the essential packages of activities across the districts according to risk.

The national preparedness and response plan is based on the three scenarios related to the EVD outbreak:

**Scenario 1**

Early detection of all suspected and confirmed cases, isolation, and follow-up of all contacts; outbreak is limited to the current geographical locations. Based on this scenario, the response would end in 5 EVD incubation cycles (105 days).

**Scenario 2 (Current scenario)**

Delayed detection of cases with the outbreak spreading beyond the epicenter to other districts. The response would run for 6 – 9 months.

**Scenario 2 (worst case scenario)**

As a result of high population mobility, inadequate contact tracing and response interventions, multiple cases confirmed in different geographical regions, an overwhelming number of cases are reported at the same time, requiring escalation of response beyond the existing capacity. The timeline for response is undefined.

# UNICEF EVD preparedness and response in August 2018 – December 2019

Positioned within the Government of Uganda National EVD preparedness and Response Plan and the UNICEF-supported interventions were based on UNICEF’s comparative advantage, agreed division of labor with other UN agencies and focus on the strengthening national and district capacities in high-risk districts to effectively coordinate, plan, implement, and monitor EVD activities with focus on RCSM, IPC through WASH in non-ETUs, schools and public places, nutrition and psycho-social support, GBV including child protection.

# UNICEF EVD preparedness and response strategy 2022

The UNICEF response plan covers the period from September 2022 to February 2023. The plan assumes scenario 2 of the EVD National Response Plan where there is transmission in multiple foci requiring coordinated response in multiple locations.

The plan builds on the MOH-led Government of Uganda National Country Response Plan and considers the need for timely action on a no-regrets basis, based on established multi-sectoral inter-agency partnerships, collaboration with the national and local governments, and unhindered access, and where possible depending on securing the sustained presence by partners.

The UNICEF response is aligned with the Ebola WHO global Strategic Response Plan (SRP), and the UNICEF Ebola Humanitarian Action for Children appeal. UNICEF is initially targeting 20 high-risk districts with response activities from September 2022 to February 2023, aligned with the pillars of the Uganda National Response Plan, and informed by lessons learned from past EVD responses. The focus will be revised in line with the outbreak evolution. UNICEF’s Response to public health emergencies (PHE) is anchored in UNICEF's Core Commitment for Children (CCCs), more specifically, to the CCCs in PHE[[3]](#footnote-4).

In the immediate stage, UNICEF has prioritized intense response under health/Coordination and leadership, Risk communication, community engagement, and social behaviour change (RCSM/RCCE/SBC), Case management through WASH IPC in non-Ebola Treatment Units (non-ETUs), nutrition, and mental health and psychosocial support (MHPSS), prevention, mitigating and responding to gender-based violence (GBV) including Protection from Sexual Exploitation and Abuse (PSEA); and WASH in communities, public places, and schools for the next three months; and in the longer term for the next 3-6 months.

The following actions under each priority objective for both response and preparedness actions are not exhaustive and will be complemented by the activities provided in the UNICEF EVD program guidance.

# UNICEF Uganda objectives

**General Objective**

To contribute to the government of Uganda’s efforts to reduce Ebola-related morbidity and mortality and interrupt transmission in the country

**Specific objectives**

1. Strengthen multi-sectoral national and sub-national coordination by participating in the national and district taskforces, UN Coordination, and the Steering Committee and other forums.
2. Increase public awareness of the threat of Ebola and galvanize community action for prevention, timely reporting and early treatment seeking.
3. Strengthen capacity for infection prevention and control including through WASH in the outbreak-affected and high-risk districts with a focus on non-ETU health facilities and communities.
4. Support EVD case management ensuring that there is appropriate management including feeding for Infant and young children, psychosocial support, and child protection in outbreak-affected and high-risk districts.
5. Prevent and address the indirect impact of the outbreak and minimize the negative human and socio -economic impacts)
6. Use Integrated Outbreak Analytics to better understand outbreak dynamics, inform response adaptation to be more accountable and effective based on evidence.In delivering, UNICEF will ensure that GBV and PSEA risk mitigation will be mainstreamed throughout its response.

**EVD Response strategy**

The response to the EVD outbreak is led by the Minister of Health at the national level, and by district-designated response leads in affected and high-risk districts. An Incident Management System (IMS) was activated to oversee the response implemented through 9 operational pillars (Coordination, Surveillance, Laboratory, Case management (including Infection Prevention and Control safe and dignified burials, Psychosocial support), WASH, Risk communication and social mobilization, Community engagement, Logistics, Vaccination), with support of partners. UNICEF support to the response will focus on coordination, SBC, WASH, Case Management, in addition to ensuring continuity of essential health and social services and mitigating the indirect impact of the outbreak on children. GBV risk mitigation will be cross cutting.

# UNICEF Response areas and activities

## Response area 1: Coordination, Leadership, and partnership

**1.1 Internal and external coordination and partnership**

**Internal coordination**

The UNICEF Uganda Representative and senior management team oversee the office’s preparedness and response to disease outbreaks including Ebola. This is linked to national outbreak risk analysis; an escalation triggers the activation of the country office crisis management unit with the involvement of all sections.

* UCO management oversees all response including public health emergencies under the leadership of the Representative, with the advice of a delegated/designated Ebola Coordinator together with technical support from regional and global levels.
* Oversight during L2 emergencies is provided by the Eastern and Southern Africa Regional Director, and during L3 emergencies, by a Global Emergency Coordinator (GEC), designated by the UNICEF Global Director, Emergency Operations (EMOPS), with support from the Associate director, Public Health Emergencies (PD Health).
* Section heads and staff lead technical level work in line with the national response pillars and priorities and in line with UNICEF mandate and focus in public health emergencies.
* Additional surge capacity (international and national) will be deployed as needed to ensure that UCO provides the required level of support to Government and delivers against its mandate in the response.
* UNICEF will deploy field coordinators to the three clusters of hubs (1 each) and district coordinators (1 each) to outbreak affected districts, under leadership of the Ebola coordinator. They will actively engage with and support the government leadership and partners and advise on the response. They will support planning and monitoring of progress, ensuring that feedback on areas of the response requiring improvement is provided to government and response teams and addressed.
  + UNICEF will actively engage with the government and partners to track progress in the implementation of the response activities, ensuring appropriate representation in various fora including national accountability fora. Hubs will expand in line with outbreak dynamics. UNICEF will deploy technical response staff to support RCCE, case management, MHPSS/CP, IPC/WASH pillar activities, with the flexibility to reprogram activities or redeploy staff to other districts in line with the outbreak evolution.
  + Support will include direct contributions to MOH National and Sub-national resources, in-kind support, and overall technical support, working within existing structures to foster the integration of EVD activities into regular programs. These will be supported by districts and partner’s regular programming partnerships.

UCO operationalizes its support to MOH and other sector Ministries supporting Ebola preparedness and response by developing and supporting partnerships with government and implementing partners including resource mobilization; supporting human resource surge capacity through internal mechanisms and standby partners; providing essential medicines and supplies through UNICEF Supply Division; strengthening infrastructure to support designated interventions i.e. IPC at selected health facilities and schools; and building capacity through training, development, and distribution of evidence-based standards and tools and supporting the use of innovative technologies to improve preparedness and response efforts.

**External coordination**

External coordination is overseen by the UNICEF Representative, with the Ebola coordination. Partnerships will be managed in line with country office mechanisms, adapted to the Ebola coordination mechanism. UCO Ebola response plan is aligned to the national Ebola response plan. It will be implemented by the Government of Uganda (Ministry of Health) leadership in partnership with other UN agencies including WHO, UNHCR, IOM, WFP, and other partners US-CDC, Africa CDC, Uganda Red Cross Society (URCS), USAID, Infectious Disease Institute (IDI), JHPIEGO, AVSI Foundation, Lutheran World Federation (LWF), and Baylor Uganda among others[[4]](#footnote-5). In addition, UNICEF will provide support at the national and sub-national levels to improve coordination and leadership, case management, and integration of community-based surveillance in community engagement and household activities by VHTs.

**Activities**

UNICEF will support the National and Subnational taskforces to coordinate all response activities initially focusing on two hubs for response and support for preparedness in high-risk areas:

1. **Mubende** **Hub**- covering Mubende and Kassanda, the current epicenter**,** and expanding to priority 2 districts for preparedness. Focus will be informed by the Ebola evolving epidemiology and associated risk of spread.
2. A second hub covering **Kyegegwa, Bunyangabu, and Kagadi** districts
3. **Greater Kampala Hub**, which includes Kampala, Wakiso and Mukono districts
4. **Preparedness in high-risk districts** in line with the updated risk analysis

**1.1 Integrated Outbreak Analytics - in support of the Strategic Information, Research and Innovation (SIRI) Pillar**

Based on best practice developed, evaluated, and modeled during recent outbreaks of Ebola and other diseases, UNICEF will lead and support a multi-actor, agency and disciplinary IOA Cell that will guide the response using transdisciplinary data

1. IOA will develop data collection and analytics plans based on evidence gaps and key questions required to support the outbreak response (e.g., explaining outbreak trends, understanding impacts of outbreaks on communities and community health and to support outbreak response pillars to improve the quality and appropriateness of the response activities)
2. IOA will use program data from affected areas through pillars/sub-pillars, including Surveillance, IPC-WASH, RCCE, Vaccination, Care and Support, Nutrition and Health information systems (DHIS-2) data and community sourced data (social sciences from qualitative or surveys with community, health workers).

The evidence and analysis will be used for co-development of actions with the pillars, communities and implementing partners for follow-up over time. IOA is organized together with key partners (WHO, CDC-Atlanta, MSF-Epicentre among others) and works under the SIRI pillar to support pillars in the quality of data collected, in analysis and use. IOA

## Response area 2: Risk communication, social mobilization and community engagement.

Throughout the response, UNICEF will support the increase, and sustain interventions for increasing awareness of the risks of SVD and foster community-centered, evidence-driven approaches to support prevention behaviors including behaviours as well as supporting early detection, and early treatment seeking.

UNICEF aims to support MoH/districts to increase and sustain public awareness of EVD risks, transmission modes, prevention, reporting, and referral mechanisms. Support amplification of existing or develop new messages and engage communities to own the response by adopting appropriate behavior . This will be donedo this through trusted SVD-specific risk communication, community engagement, and social mobilization, mainly through mass media, engagement of key influencers, community groups, women and youth groups, health workers, faith-based leaders, and community volunteers (VHTs) to build their capacity to understand risks of EVD transmission and how they can make decisions to better protect themselves, their families and their communities through raising alerts, promoting behavior change through participatory interventions, early treatment seeking with feedback mechanisms including GBV/PSEA[[5]](#footnote-6)

In terms of feedback, in collaboration with the other partners involved in the RCCE, UNICEF will ensure the collection and analysis of feedback data. After the joint analysis, results will be used to generate recommendations for action to the different pillars, or the reorientation of their interventions to take into account the concerns of the communities. A mechanism for implementing the recommendations will be put in place for better follow-up with the pillars and coordination.

**Activities:**

* 1. **Mass media messaging:** UNICEF Social and Behavior Change (SBC) section will support nationwide risk awareness through the mass media and intensified mass-media and interpersonal messaging in outbreak affected and 20 most at-risk districts e.g., Mubende, Kyegegwa, Kassanda, Kagadi, Bunyangabu, Kampala, Wakiso and surrounding area to ensure timely and effective execution of RCCE activities. In each district, RCCE will aim at ensuring that people are reached with evidence/based gender and age-sensitive, socially, culturally, and linguistically appropriate messages on Ebola disease prevention through multiple channels including radio, TV, and interpersonal communication, to ensure that they know where to get related services, participate in communal protection, continue to use and access other key health services including maternal and child health, routine immunization, among others.
  2. **Mobilisation of key influencers**: In each of the supported districts local actors and influencers with institutions (formal and informal) will be oriented during interactive sessions and empowered supported with visualized messages and materials (banners, posters, job aides, and booklets with frequently asked questions) to raise awareness, promote healthy practices and collect community feedback on ongoing response. These will include health workers, traditional healers, Train those who are or will be engaged in RCCE, such as community-based groups, local women’s groups, community mobilisers, and volunteers, on GBV and PSEA core concepts and guiding principles, safe and ethical consultation, and GBV referral pathways. These will include health workers, religious and cultural leaders, owners of schools, learning centers, and teachers, uniformed personnel (e.g. Police, customs/immigration at POEs, prisons staff and security personnel, owners of pharmacies, owners of hotels and shopping arcades, leaders of taxi drivers, and motorcyclists (boda-boda riders). UNICEF through the partnership focal person will establish/reactivate coalitions with the Uganda Private Sector Foundation and KACITA (Kampala Traders’ Association), which coordinate key employers and business entities.
  3. **Community engagement:** District local governments from sub-counties, parish, and village levels will be facilitated to actively engage in community-dialogue meetings, mobilize local action in active contact-tracing and infection community prevention, and ensure that they capture and address rumors and misinformation, get feedback, and are provided with timely updates on the EVD response. UNICEF will guide the community engagement process through the deployment of social and behavior change consultants to work with the district teams and build the capacity of civil society groups and ensure the participation of the affected and most vulnerable groups including migrant communities, effective support out-reaches to schools, and out-of-school adolescents. Develop a strategy for mapping out and engaging with traditional herbalists and spiritual healers. The community engagement process will include special efforts, to identify/map and reach out to leaders of faith-based groups, and other community-based organizations (CBOs) since these are the major influencers and the first persons to be contacted in many set-ups/communities. In each district UNICEF will support the reactivation of monthly meetings between district health teams and the village health workers (VHTs) and Local council leaders (LC1s), support the door-to-door visits, and regular community engagement meetings by the VHTs and other community-based mobilizers.
  4. **Social data:** UNICEF will ensure that RCCE activities are data-driven through support to the government through adapted data collection which may include community feedback, social listening, adapted anthropological studies. UNICEF will build on research undertaken during previous outbreaks and will update findings based on the communities in affected districts and consider how the COVID-19 response has affected community trust and engagement in public health response. Data collection activities will be targeted based on the epidemiological situation and organized together with Integrated Outbreak Analytics (IOA) and the SIRI pillar to ensure that they are the most adapted and appropriate for use. Findings will be shared and reviewed by partners with recommendations made for how to better engage communities.
  5. **Systems strengthening:** UNICEF support will include strengthening SBC capacity in the decentralized health structures and local governance systems, starting from the village task force (village health committees) and the creation of risk-communication and community engagement subcommittees at sub-county and district levels, in each of the supported districts – this will be done in partnership with other actors like Uganda Red Cross Society of the most **ideal** partner in a respective region.
  6. **Vaccination:** If and when a vaccine becomes available,UNICEF will support the government with microplanning, RCCE, and logistics for conducting vaccination campaigns as per recommended EVD vaccination strategies. The evidence generation task force under the RCCE subcommittee will document and channel community feedback.
  7. **Media training at national and regional levels**

On behalf of the Ministries’ Health Promotion, Education, and Communication Department and the Public Relations Unit, UNICEF will facilitate media orientation in Kampala (2 x 50 pax) and in selected regions (8 x 30 pax).

**Objectives of the media orientation:**

* To ensure accurate and effective reporting about EVD outbreaks by media
* To ensure responsible and ethical reporting by journalist factoring in patients’ privacy during the outbreak
* To take stock of the current rumors and fears from the public and curb fake news and misinformation during EVD outbreak
* Equip journalists with basic information on EVD to enable accurate reporting

## Response area 4: Surveillance and contact tracing

The ongoing Ebola outbreak has had a devastating impact on children and women. Children account for 30% of all reported cases and have exhibited a high death rate over 76%, almost doubling the overall observed case fatality rate for all confirmed and probable deaths. They also account for almost 50% of deaths among probable cases.

UNICEF and partners will support contact tracing and management of children affected by Ebola, in isolation, ETUs, and survivors through documentation and provision of access to child friendly services, mental health and psychosocial support, child protection and continuity of learning among others. Additionally, UNICEF is supporting the data collection and analysis for action including with Go data and IOA through provision of technical support.

## Response area 5: Water, Sanitation, and Hygiene Promotion (WASH)

UNICEF with the support of the RCCE and IPC pillars will contribute to reducing the risks of transmission of EVD and other hospital-acquired infections to health workers, caregivers, patients, and the community by strengthening their ability to practice IPC through orientation on recommended procedures and practices, the provision of essential supplies and equipment (soap, chlorine, portable hand washing stations, improvement of WASH infrastructure at non-Ebola Treatment health facilities, schools, and in communities. Response will be at health care facilities (formal/informal) and schools and community.

**5.1 Support for infection prevention and control in Ebola affected communities**

* To be populated

**5.2 Provision of essential WASH supplies and equipment**

* Working with government and partners through implementation pillars, organize supply planning for prioritized activities. UNICEF will procure and distribute critical hygiene and prevention items (including soap, hand-sanitizer, portable handwashing stations, disinfectant, and personal protection equipment) for use in schools, and selected public places, and replenishing in Communities at high-risk of Ebola disease.
* UNICEF will procure and distribute critical hygiene and prevention items (including soap, hand-sanitizer, portable hand washing stations, disinfectant, and personal protection equipment) for use in health facilities (including targeting health facilities in new high-risk areas, and replenishing supplies in Health facilities that were provided with WASH supplies),
* Support periodic review and update of a minimum package of WASH activities based on context-specific risk analysis for different settings (i.e., healthcare facilities, households, schools, other public spaces, and vulnerable settings such as refugee settlements and urban slums).
* Ensure a handwashing infrastructure is available, accessible, safe, and functional where/when needed, prioritizing public Ebola-affected, and high-risk areas, as well as commercial buildings, public transport stations, and markets.

## Response area 6: Case Management

UNICEF will enhance capacity for appropriate and child friendly EVD case management including appropriate Infant and young child feeding, psychosocial support (PSS), and child protection (CP) in Ebola treatment Units/Isolation facilities and affected communities.

UNICEF will strengthen government capacities at the national, district, and sub-county levels and para-social workers to identify, report child protection concerns, and to provide basic community-based psychosocial support services. The EVD-related services will be integrated with routine programs and community-based structures. These include Probation and Social Welfare Officers, and community-based para-social workers.

**Activities**

* 1. **Nutrition**

UNICEF will enhance the health workers and communities’ capacities to maintain positive feeding practices for infants, young children and mothers affected by EVD despite quarantine, disrupted breastfeeding, trauma and stigma. Mothers will continue to breastfeed until highly suspected or confirmed positive for Ebola, for the interruption to begin. UNICEF will ensure continued access to ready-to-use infant formula (RUIF) for affected infants under 6 months and ready-to-use therapeutic feeds (RUTF) for malnourished children 6-59 months, by strategically prepositioning stocks ready to ship. The support will include follow-up after discharge, with integrated psychosocial support and protection. Equipment for monitoring the nutrition status of children will be provided to targeted health facilities. Mothers who have recovered and want to continue breastfeeding will be supported to have two consecutive laboratory tests on their breast milk, done 24 hours apart.

**Building the capacity of the district, health facility, and community managers and service providers in IYCF and nutrition in the context of Ebola**

* Working with the MOH to orient the district health teams (DHTs) and EVD Response teams on appropriate IYCF and nutrition for infants and young children affected by EVD to ensure continuity of nutrition services.
* Support the DHTs and Nutritionists/Nutrition focal persons update and orient health workers and community health workers on IYCF practices and behavior for infants and young children affected by EVD
* Integrate key nutrition and IYCF messages into the mainstream SBC package for supporting caregivers through updating the communication materials and supporting the translation, printing, and distribution to the districts, health facilities, and communities
* Printing and dissemination of Nutrition SOPs, IMAM guidelines, and job aids for health workers

**Support access and availability of essential nutrition supplies and commodities for EVD response**

* Procure and pre-position RUTF, F75, F100, and ReSoMal to the Regional Referral Hospitals, and other facilities providing therapeutic care for acutely malnourished children affected by Ebola
* Support MoH and DHTs to conduct supportive supervision, coaching, and mentorship of the health workers in EVD Response facilities on appropriate management, documentation, and reporting of RUIF, RUTF, and therapeutic milk.
  1. **MHPSS and child protection**

**Support MHPSS services for EVD-affected individuals and families, including children in ETUs and communities and survivors**

* Train district core MHPSS teams (health, social welfare, community development) on MHPSS service provision, including for children.
* Train community structures focusing on para-social workers, and VHTs on the provision of basic PSS and psychosocial first aid (PFA) in affected communities.
* Support the provision of MHPSS services at the facility, and at the community level through trained structures, including for discharged patients.
* Support the deployment of psychologists, and psychiatrists to EVD treatment and isolation units to provide MHPSS to admitted patients, and their families
* Support provision of MHPSS services to health workers deployed in the EVD response, including through individual, and group-based support.
* Support innovations for tele-counseling services for patients under isolation, and treatment, and their families.
* Develop and disseminate targeted messages on MHPSS in communities, schools, and with healthcare workers
* Support the government led initiative for the establishment of the survivor's program
* Advocate to ensure support systems (e.g., psychosocial support, regular debriefing, and regular paid time off) are in place for all frontline workers. Consider the special needs of female frontline workers as their workloads at home are likely increased.

**Support protection services, including interim care and foster care for EVD-affected children**

* Recruit/deploy health workers at to ETUs/isolation facilities to ensure the provision of adapted integrated paediatric care (including nutritional support, MHPSS, CP) ensuring that care is child friendly in ETUs, isolation facilities and once recovered, children are fully supported to reintegrate in their communities.
* Support health actors to ensure that the design and set up of isolation and treatment units are child-friendly, including through the provision of play materials
* Monitor treatment units and isolation facilities (including through safety audits) to ensure that they are gender-sensitive and safe for women, girls, and other groups at risk of GBV.
* Provide case management services to women and children who are at risk or experiencing violence, children and women at risk, and those experiencing neglect related to EVD including survivors.
* Support provision of interim and foster care and support to children requiring temporary alternative care and establish linkages between health and social welfare actors to ensure reporting and referrals of children when needed.
* Train Probation and Social Welfare Officers, Community Development Officers, and para-social workers on the impact of EVD on children’s protection, on the provision of case management and care, and basic support to affected children
* Train district staff and community structures on prevention and social behavior change interventions for children, caregivers, and communities.
* Provide mobile community-based psychosocial support to children and families.

Advocate ensuring support systems (e.g., psychosocial support, regular debriefing) are in place for all frontline workers. Consider the special needs of female frontline workers.

## Response area 7: Prevent and address the indirect impact of the outbreak

Prevent and address the indirect impact of the outbreak and minimize the negative human and socio-economic consequences, including continuity of essential health services. UNICEF will continuously, systematically assess and monitor the secondary effects of the outbreak and its containment measures on the population, with a focus on the most vulnerable, including the impact on education, protection, health system, social support, food and nutrition systems, poverty, and other key areas as defined in Uganda.

**Activities**

**7.1 Support the safe continuity of essential health services to women, children, and vulnerable communities**

UNICEF will support the MOH and partners to ensure the continuity of primary health care services during the outbreak response, including nutritional services and appropriate breastfeeding, pre and postnatal care, HIV, and immunization. This will be achieved by ensuring the availability of necessary supplies and the creation of extra space (decongestion) to support routine services in targeted health facilities and communities.

* UNICEF will support the procurement and distribution of essential medical including for personal protection of health workers, orientation on IPC and replenishment to ensure all health workers are protected and continue to provide services to the population beyond the 20 at-risk districts, within the context of EVD/SVD response and its impact.
* Nutrition therapeutic supplies and the management of children with severe acute malnutrition, with a focus on refugee hosting districts, food-insecure areas (e.g., Karamoja region), and Regional Referral Hospitals.
* Support the continuity/scale up, and access to, GBV case management services, as an entry point for women and girls, and linkages to other essential services.
* Advocate with the government at national and sub-national levels as required to ensure that protection services continue to be considered critical and that assistance is provided to children and families and support the government in the development and dissemination of key guidance documents related to child protection and EVD.
* Support community-based structures to provide basic psychosocial support to children and families through mobile and home-based approaches.
* Procure and distribute high-performance tents to affected districts/ health facilities to provide adequate space for the continuity of health services. UNICEF will also provide targeted support for recommended and appropriate PPEs and generators for ETUs and infrared thermometers for schools. Effort will be made to ensure that procured PPE for a range of cadres is suitable, accessible, and culturally acceptable for all frontline workers regardless of gender etc.

**7.2 Support households directly affected by EVD including survivors and chronically poor households to meet their basic needs**

The Government of Uganda is responding to multiple public health, humanitarian, and climatic emergencies, and hosts over 1.5 million refugees. The socio systems are already overstretched, further complicated by the ongoing outbreak a high-risk of escalation and spillover to multiple regions, and even to other countries. It will be important to support chronically poor households to meet their basic needs (food and non-food) to prevent them from falling into deeper poverty; support households affected by EVD including survivors.

In collaboration with other stakeholders, under the leadership of the government, UNICEF will support the delivery of social protection interventions in support of the poor, vulnerable, and marginalized communities in the EVD outbreak districts. Additionally, UNICEF will support children/ school going children, and households directly affected by EVD (cases, isolated, contacts) to counter the effects of stigma. The following are the key interventions planned:

* Monitoring the socio-economic impact of EVD in identified districts
* Provide multi-purpose unconditional cash transfers to support communities meet their basic needs
* Provide complimentary services to cash transfer recipients e.g., protection, nutrition information, SRHR services

**7.3 Continuity of Learning**

UNICEF in collaboration with WHO will support the Ministries of Education and Health to develop and implement guidelines for safe school operations during this Ebola outbreak e.g., integrated school-based surveillance for EVD, COVID-19, reporting, and referral, promotion of hand and respiratory hygiene, sanitation, screening and referral of suspected cases, as appropriate), and education about Ebola prevention. UNICEF will also support school-based MHPSS and access to protection services.

* Provision of home learning materials to families to support home study in short term in case of school closures in 4 high-risk districts (contingent on actual school closure.)
* Support the Ministry of Education and Sports (MOES) and District Education Offices (DHO) in high-risk districts to effectively monitor and supervise implementation of Ebola SOPs by schools in high-risk districts.
* Support the activation and orientation of school health task force on IPC measures to strengthen awareness raising on IPC for teachers and learners in schools.
* Supply of posters and IEC materials to 2,000 schools to reinforce awareness raising and infection and prevention measures (supplied by SBC).
* Procure and distribute temperature guns and accessories to schools in high-risk districts for temperature screening and monitoring of teachers, learners and visitors to schools. (Supplied by CSD)
* Transmission reduction strategies such as chlorinating surfaces, use of soap or hand sanitizer for hand hygiene.
* Support identification and referral of learners and teachers affected by Ebola to mental health and psychosocial support (MHPSS in collaboration with Child protection team).

## Response area 8: Logistics and Operational Support

Logistics is a cross-cutting component of all response pillars and sub-pillars. The UCO logistics team will support timely placement, and access to designated supplies, and related services. In conjunction with programs. UCO will also provide technical and surge support to district logistics teams as needed, to strengthen supply chain management, avoid stockouts and reduce waste.

**Activities**

* Support the national system, by working with the national coordination structures both at the planning and implementation levels.
* UNICEF is a member of the Logistics Subcommittee of the National Taskforce for Health Emergencies and will channel its support to the logistics response through that mechanism. This includes providing technical assistance to the core functions of the Committee (in the form of direct inputs to its strategy and approach, but also by offering additional human capacity required by the MoH) and ensuring that UNICEF supply contributions are quantified, procured, stored, distributed and monitored through existing Government systems, or in any case, through UNICEF means that supplement those Government systems. The principle of Government-led response also implies that UNICEF will work with and through the National Medical Stores as the central entity mandated by Government to manage the supply chain in the health sector and adopt the Emergency Logistics Management Information System as the platform to ensure that all supply assistance is visible to the central level.
* Focus UNICEF supply contribution in areas where UNICEF has a comparative advantage and a good understanding of the market.
* UNICEF will leverage existing coordinating structures for COVID-19 and EVD (NTF and IMT) and channel its contributions through the logistic subcommittee under the NCC, where UNICEF is actively engaged and represented. This support, both in terms of supply contributions as well as technical assistance, will follow the same principles (comparative advantage and country-led) as outlined above

**Vaccination:** If/when a vaccine is approved for use,UNICEF will support the government with microplanning, RCCE, and logistics for conducting vaccination campaigns as per recommended EVD vaccination strategies and on the invitation of the vaccine pillar. Community feedback will be gathered by the interagency evidence generation task force.

**Gender Based Violence (GBV), and Prevention of Sexual Exploitation and Abuse (PSEA)**

Gender Based Violence (GBV), including risk of Sexual Exploitation and Abuse (SEA) are heightened during emergencies. The impact of public health emergencies (PHEs) is not gender neutral. Instead, PHEs and GBV mutually reinforce each other. Women and girls, especially in humanitarian settings, are disproportionately impacted as crises exacerbate gender inequality, violence, and community transmission. Women and girls play critical roles in controlling and preventing infectious diseases at home, in the communities and as frontline workers. Sexual exploitation and abuse (SEA) is a form of GBV that constitutes an abuse of power by aid workers against the affected population. As such, mitigating GBV risks in programmes is a key component of UNICEF’s organizational commitments on PSEA.

**Activities**

* Conduct safety audits in facilities supported by UNICEF and partners to identify and address observable GBV risks and assess specific vulnerabilities of women, girls, boys, and men to the identified risks.
* Support access to GBV risk mitigation, prevention and case management services.
* Conduct periodic safety audits in facilities and service delivery points to identify and address observable GBV risks and assess specific vulnerabilities of women, girls, boys, and men to the identified risks.

# Actions taken to date

Since the declaration of the EVD outbreak on 20 August, UNICEF has reprogramed funds, send funds and in-kind support and deployed staff at national level and to the affected districts. The embedded table is not exhaustive buts summarizes preliminary response within seven days of declaration, as of 27 August.

|  |  |
| --- | --- |
| **IPC** | IPC Supplies (various) dispatched: US$ 12,198 for:  2,567 patients x 4 months and 25 district health facilities x 3months |
| **WASH** | US$ 24,366  10 mobile toilets (capacity of 20+ people each/ total 375 people) dispatched (5 delivered to Mubende RRH; 10 to be delivered to Madudu sub county on 27 Sept)  7 Water tanks x 10,000 l for water trucking; ETA Mubende today |
| **Contact Tracing** | US$ 50,000  Rented vehicles (15),Go Data mapping (GOARN) and support to Strategic Information |
| **RCCE** | US$ 20,000 sent to Mubende and Kyegegwa district authorities for grassroot RCCE  35,400 IEC materials worth US$ 85,691 delivered |
| **Staff deployed to Epicentre** | 1 WASH specialist to support IPC; 1 RCCE/SBC specialist to support risk communication for behavior change and coordination. Additional rotating staff. |
| **Total US$** | **$ 192,256 provided** |

## Inter-Agency Coordination, Government Engagement and Partnerships

Uganda does not have a cluster coordination system. As such, the overall coordination of all emergency and humanitarian responses is led by the government, with a well-established incident management system up to the Office of the Prime Minister, with the support of WHO. However, the UN Resident/Humanitarian Coordinator leads the UN agencies and non-government partner coordination/response efforts in the country under the technical guidance of WHO. UNICEF is the lead for the RCCE and WASH pillars within the technical working group. UNICEF’s senior management team is part of the UNCT.

In line with ESARO guidance on country office response to health emergencies, oversight of the response is managed by UCO senior management. Technical oversight and coordination of the EVD preparedness and response is led by the UCO CSD section. Should there be an escalation to scenario 3, leadership will be transferred to UCO senior management under the guidance of the Representative.

## Monitoring/Third party monitoring and Evaluation

The ongoing adaptation of UNICEF’s programs relies on monitoring and evaluation data, including real-time data and evidence, to ensure organizational learning and continuous improvement. Additionally, UNICEF continuously works with the government to strengthen national statistical systems and the evidence generation taskforce under the RCCE subcommittee will document and channel community feedback and ensure that data are available to facilitate decision-making. In the wake of the EVD outbreak, this endeavor becomes even more crucial, and UNICEF aims to provide financial and technical support (deployment of Go data surge) to conduct further analysis of national surveys and data to support more effective planning and programming.

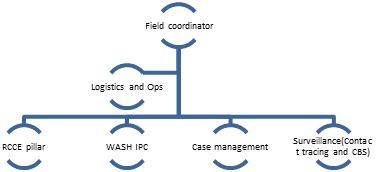
Accountability to Affected Populations (AAP) is an essential part of the response to the outbreak and is a central part of ongoing efforts to strengthen Risk Communication and Community Engagement (RCCE) in the current EVD response. It is critical that affected populations: receive relevant and timely communication; participate in indecisions that affect their lives and have access to trusted feedback mechanisms. The evidence generation task force under the RCCE subcommittee will document and channel community feedback.

UNICEF Uganda is committed to ensuring that at-risk populations receive the most relevant information they can act on, and in the most appropriate format, is a priority and, for the purpose of this response plan, will be guided by people’s expressed information needs and should include information such as services available, how to mitigate the impact of EVD on livelihoods, how to address the disruption of personal and family routines. Decisions around prevention, containment, and response to EVD may cause confusion or resentment and have adverse effects on the population. It is therefore important that affected populations not only understand the rationale behind those decisions but are engaged and participate in those decisions, especially at the local level. Participation leads to a level of ownership amongst the affected population which will help to increase the success and quality of interventions and ensure their sustainability.

For this purpose, UNICEF Uganda partnership agreements include provisions for establishing/ strengthening processes for and monitoring engagement with and participation of affected populations in response decisions and local actions in tandem with EVD response protocols. A cornerstone of being accountable to affected populations is ensuring that community complaints and feedback are heard and acted upon so that responses are effective, relevant, and do no harm. Complaints and feedback mechanisms are powerful tools to track perceptions, rumours, misinformation, and information gaps, as well as overall satisfaction from the response.

## Human Resources

Majority of UNICEF Uganda programme personnel are engaged in one way or the other to support the planning, implementation, monitoring and reporting on EVD. This includes support to all aspects of the response including the continuity of essential social services. UCO will maintain a surge tracking system for the Ebola outbreak response, that brings together UCO deployments and recruitments and external surge.



**Dummy district response structure**

A district-based coordination structure is being established to work hand-in-hand with the designated government incident management systems and WHO, and to ensure adequate coverage across all pillars of commitment and comparative advantage. This will feed into the country office internal coordination mechanism, with regular internal coordination meetings.

**Security and access**

All districts of Uganda are accessible, with good security levels. Access can be occasionally interrupted by floods, and armed conflict among herders. The affected districts are not affected by these events

**Staff wellbeing and duty of care**

Before the declaration of the first EVD case, The UNICEF Uganda Country Office applied ongoing specific measures to ensure staff safety. These measures include:

* Disinfection of surfaces and objects.
* Installation of automated hand disinfectant dispensers in all common areas and inside sections.
* Change of office biometric access from fingerprint to cards.
* Compulsory temperature screening and hand sanitizing at the main entrance before obtaining access to the compound.
* Hand-sized sanitizers were issued to staff on an on-going basis.
* Hand sanitizers and masks were placed in all official UNICEF vehicles.
* Procurement order of additional sanitizers and masks was placed.

The office has a separate duty of care document. To minimize the risk of infection, in 2020 UCO activated the Business Continuity Plan which is aligned to the UN BCP. Several logistical arrangements were put in place to ensure staff are able to deliver on programme and operational goals. The measures initially instituted remained in place with additional interventions applied to facilitate safety and most are applicable for EVD. The country office SOPs to respond to a suspected case among staff are being finalized.

# Budget/Funding requirements

**To be pasted**

# ANNEXES

## 

## Annex 1: Activity breakdown including targets and key indicators

**Annex 2: Detailed results and performance framework**

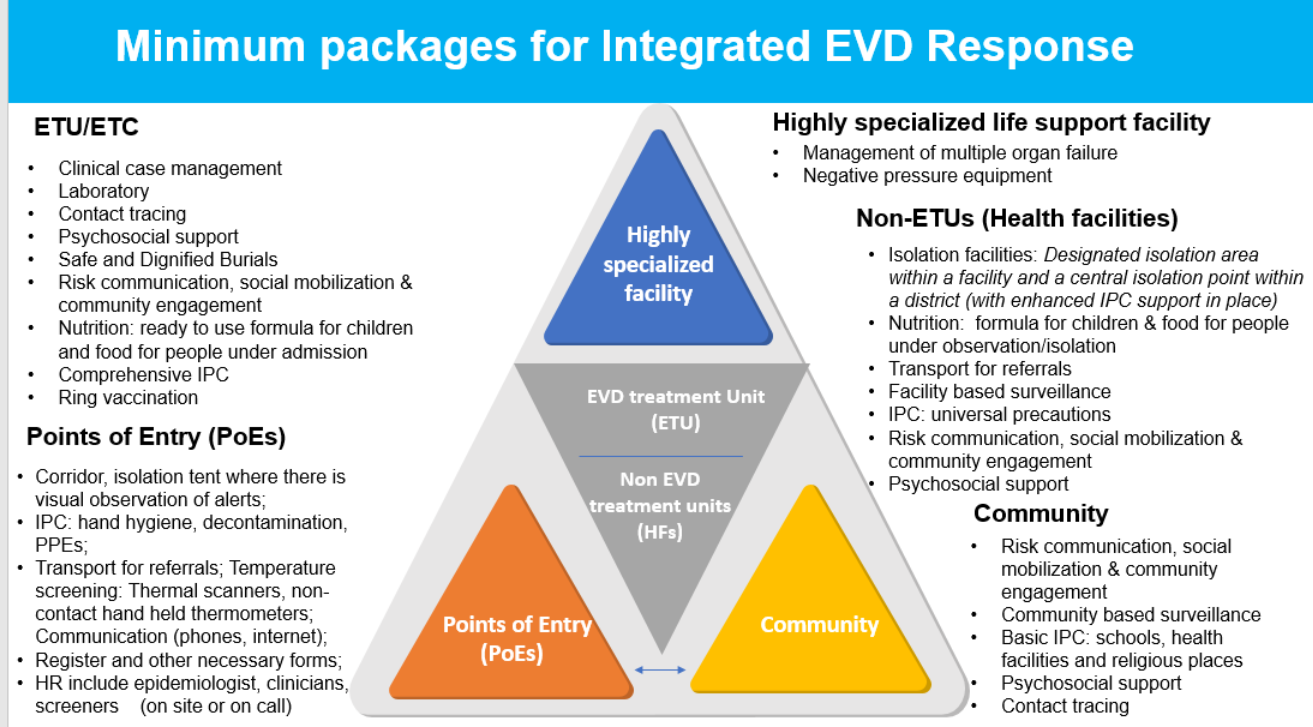
UNICEF will employ innovative and result-based management approaches to track program implementation, drive performance improvement and manage program risk for maximum impact.

| **Intervention pillar** | **Intervention strategy** | **Indicator** | **Baseline** | **Target** | **Frequency of reports** | **Assumptions** |
| --- | --- | --- | --- | --- | --- | --- |
| **Result area 1: National and sub-national capacity strengthened for improved coordination and leadership for EVD prevention and control** | | | | | | |
| Coordination and leadership | Strengthen the capacities of National and District Task Forces to coordinate and conduct oversight activities for the districts and counties | % of districts with functional DTFs (meetings at least twice a week, following up action points, updated 4W matrix, and submitting district sitreps) | 10% | 100% | Monthly |  |
| Source of data: DTF minutes, and subcommittee shared documents | |
| # of MOH joint supervision and on-the-job mentorship visits | 0 | 6 | Monthly |
| Source of data: NTF and subcommittee shared documents | |
| # of districts with updated microplans for EVD response | 0 | 20 | Monthly |
| Source of data: NTF and subcommittee shared documents | |
| **Result Area 2: Enhanced community awareness and knowledge on EVD prevention and control** | | | | | |  |
| Risk Communication and Social Mobilization | Reach vulnerable people with tailored risk messaging through community engagement and interpersonal communication approaches | # of people reached through accurate, cultural, and gender-appropriate messaging on EVD prevention and access to services | 0 | 6,528,690 | Monthly |  |
| Source of data: IPSOS analysis | |
| # of key influencers (teachers, local leaders, traditional leaders, religious leaders, local council leaders) engaged on EVD prevention | 0 | 65,287 | Monthly |
| Source of data: District reports | |
| # of people sharing their concerns and asking questions through established feedback mechanisms | 0 | 2,611,476 | Weekly |
| Source of data: DHO reports | |
| # of people who participate in engagement actions (community dialogues) conducted to raise awareness for EVD prevention and control | 0 | 1,958,607 | Weekly |
| Source of data: District reports | |
|  |  |  | Source of data: DHO and UCO reports | |  |  |
|  |  |  | Source of data: Monitoring Reports | |  |  |
| **Result Area 3: Strengthened infection prevention and control through WASH at health facilities and in communities** | | | | | |  |
| Infection prevention & control at health facilities | Provision of institutions (health facilities and schools) with critical WASH supplies | # of health facilities reached with essential WASH supplies (including 700 HFs+3 RRHs) | 0 | 703 | Monthly |  |
| Source of data: DHO UCO reports | |
| # of ETUs reached with essential WASH supplies, and upgraded water systems using solar | 0 | 20 | Monthly |
| Source of data: DHO reports | |
| # of schools reached with essential WASH supplies (including chlorine, soap, handwashing facilities, WASH IEC) | 0 | 1000 | Monthly |
| Source of data: District reports | |
|  | Enhanced district capacity to prevent transmission of EVD in institutions and communities | # of health care staff trained on infection prevention and control related to WASH in areas affected or at risk of EVD (disaggregated by facility and community, includes VHTs) |  | 1406 | Monthly |  |
|  | Source of data: District reports | |  |  |
| Case management | Provision of essential supplies and equipment | # of ETUs supplied with portable generators (with fuel) as the emergency power source | 0 | 5 | Monthly |  |
| Source of data: District reports | |  |  |
| # of health facilities supported with tents for decongestion and continuity of services including immunization | 0 | 30 | Monthly |  |
| Source of data: District reports | |  |  |
| **Result area 4: Infant and young child feeding (IYCF) practices promoted and protected for children affected by EVD** | | | | | |  |
| Infant and Young Child Feeding | Orient health workers in EVD high-risk districts on IYCF | # of health workers trained on IYCF and nutrition in EVD in affected districts | 0 | 800 | Monthly |  |
| Source of data: DHO reports | |
| Procurement and pre-position of RUTF for management of SAM | # of Cartons of RUTF procured and distributed in EVD response areas (to cover 100 children) | 0 | 3000 | Monthly |
| Source of data: DHO reports | |
| Management and care for severely malnourished children 6-59 months affected by EVD | # of children 6-59 months with severe wasting admitted for treatment | 0 | 1780 | Monthly |
| Source of data: HMIS/DHIS2 | |
| Procurement and preposition of RUIF to support infants affected by EVD | # of packs of RUIF procured and prepositioned to EVD response areas (to cover 50 children) | 0 | 900 | Monthly |
| Source of data: DHO reports | |
| **Result area 5: EVD affected children, individuals and families provided with psychosocial support, protection and child care support** | | | | | |  |
| Mental health and psychosocial support | EVD affected communities including children and their families are provided with mental health and psychosocial support services at facility and community levels | # of children, adolescents and caregivers accessing community-based mental health and psychosocial support | 0 | 15000 | Monthly | Communities accept and welcome the provision of community-based psychosocial support as part of the EVD response  Families in affected communities are willing to provide alternative care for temporarily separated children |
| Source of data: partner reports (DLGs and CSOs) | |
|  |  | # of psychologists, psychiatrists, health workers and community structures trained and deployed to EVD treatment and isolation units and communities to provide MHPSS | 0 | 1156 | Monthly |  |
|  |  | Source of data: partner reports (DLGs and CSOs) | |  |
| Child protection including care | Children affected are provided with critical child protection prevention and response services, including alternative care | # of girls and boys who have experienced violence reached by health, social work, or justice/law enforcement services | 0 | 1875 | Monthly |  |
| Source of data: partner reports (DLGs and CSOs) | |
| # of unaccompanied and separated children provided with alternative care and/or reunified | 0 | 625 | Monthly |
| Source of data: partner reports (DLGs and CSOs) | |
| **Result area 6: Education** | | | | | |  |
| Education | Enhance school-based surveillance | # of schools/learning institutions provided with infrared thermometers and accessories for screening | 0 | 1000 | Monthly |  |
|  | # of teachers and non-teaching staff oriented on SVD prevention, early treatment seeking and notification | 0 | 13,200 |  |  |
|  |  | Source of data: DEO reports | |  |  |
|  | # Number of learners receiving home learning materials | 0 | 12,500 |  |  |
|  | Source of data: DEO reports | |  |
| Support activation of school level Ebola task Force | # of Schools in high risk sub-counties with functioning school Ebola task force | 0 | 750 |  |  |
| Source of data: DEO reports | |  |  |
| Support MoES/DEOs to monitor schools in high -risk districts/sub-counties | # of schools with at least one supervisory visit from MOES/DEO | 0 | 375 | Monthly |  |
| Source of data: DEO reports | |  |
| **Result area 7: Social policy** | | | | | |  |
| Social policy | Monitoring socio-economic impact of EVD | # of socio-economic impacts reports produced | 0 | 2 | Bi-Monthly |  |
| Source of data: UBOS, U-Report, Surveys | |
| Provide multipurpose unconditional Cash Transfers to poor and vulnerable community members | # of households reached with cash transfers | 0 | 1500 | Bi-Monthly |
| Source of data: programme reports | |
| **Results area 8: GBV/PSEA** | | | | | |  |
| Gender based violence/Prevention of sexual abuse | Monitor GBV risks and assess specific vulnerabilities of women, girls, boys, and men to the identified risks. | # of children and adults who have access to a UNICEF supported SEA reporting channel. | 0 | 12,645 | Monthly |  |
| Source of data: | |  |
| **#** of women, girls, and boys accessing GBV risk mitigation, prevention, or response interventions. | 0 | 8,430 | Monthly |  |
| Source of data: | |  |
| **Results area X: Continuity of essential health services** | | | | | |  |
| Continuity of essential health services | Health facilities provided with essential medical supplies | # of health facilities provided with targeted supplies (medical and PPEs) | 0 | 120 | Quarterly |  |
| Source of data: DHO, District Pharmacy, eLMIS Reports | |  |
|  |  |  |  |
| Source of data: DHO, District Pharmacy, eLMIS Reports | |  |

## Annex 3: UN agencies division of labor

|  |  |  |  |
| --- | --- | --- | --- |
| **Technical areas** | **Sub themes** | **Lead UN agency** | **UN agency participants** |
| **Risk Communication** | Risk communication | UNICEF | UNICEF, UNFPA, UNDP, WHO, OHCR |
|  | Community engagement | UNICEF | UNICEF, UNFPA, UNDP, WHO |
|  | Public communication | UNICEF | UNICEF, UNFPA, UNDP, WHO |
|  | Community surveillance | WHO | WHO, UNICEF, UNFPA |
| **IPC WASH** | ETU | WHO | UNHCR, UNICEF, UNFPA, WHO |
|  | Outside ETU | UNICEF | UNHCR, UNICEF, UNFPA, WHO |
|  | WASH interventions in the schools | UNICEF | UNHCR, UNICEF, UNFPA |
|  | WASH at Health facilities | UNICEF | UNHCR, UNICEF, WHO, UNFPA |
|  | WASH in the communities | UNICEF | UNHCR, UNICEF, WHO |
| **Surveillance and POEs** | Water supply | IOM | UNHCR, IOM, UNDP, UNICEF |
| Sanitary facilities | IOM | UNHCR, IOM, UNDP, UNICEF, |
| Hygiene promotion | IOM | UNHCR, IOM, UNDP, UNICEF, |
| IPC supplies at the PoEs | WHO | UNHCR, IOM, UNFPA, WHO, |
| Management of screeners | IOM | UNHCR, WFP, IOM, WHO, UNDP |
| Information management | IOM | IOM, UNHCR, WHO, UNDP |
| Risk communication at point of entry | IOM | UNICEF, IOM, OHCR, UNHCR, UNDP |
| **Refugees** | Surveillance | UNHCR | WHO, UNHCR, UNFPA |
| Case management | WHO | WHO, UNHCR, UNFPA, UNICEF |
| Risk communication/CE | UNHCR | UNHCR, UNICEF, WHO, OHCR, UNDP, UNFPA |
| PoEs | UNHCR | UNHCR, IOM, WFP |
| IPC/WASH | UNHCR | UNICEF, UNHCR, WHO, UNFPA |
| Logistics | UNHCR | UNHCR, UNFPA, WFP |
| **Logistics** | Supplies management/ quantification | WHO | UNICEF, WHO, UNHCR, WFP, UNFPA |
| Storage | WFP | UNICEF, WHO, UNHCR, WFP |
| Transportation/distribution incl. last mile | WFP | UNICEF, UNHCR, WHO, WFP |
| Operations support - customs/clearance | WHO | UNHCR, WHO, UNICEF, UNFPA |
| Communications/IT support | WFP | UNDSS, WFP |
| **Psychosocial support** | Child protection | UNICEF | UNHCR, UNICEF, OHCHR |
| Mental health/PSS first aid | WHO | WHO, UNHCR, UNICEF |
| Referral pathway for PSS | OHCR | WHO, OHCHR, UNHCR, UNICEF, IOM |
| Gender based violence | UNFPA | UNFPA, UN Women, UNICEF, UNHCR, UNDP, WHO, IOM |
| Discrimination and stigma | OHCR | UNHCR, UNICEF, OHCR, UNDP |
| Survivor management | UNDP | UNHCR, UNFPA, WFP, UNDP, WHO, UNICEF |

## Annex 4: MoH Minimum response packages



1. Community deaths meeting the case definition that were buried before confirmation. These were reported before 20 September 2022. [↑](#footnote-ref-2)
2. *MOH Sitrep #7 16 September 2022* [↑](#footnote-ref-3)
3. [CCC | PUBLIC HEALTH EMERGENCIES (PHE) | Humanitarian UNICEF](https://www.corecommitments.unicef.org/ccc-2-5-1) [↑](#footnote-ref-4)
4. Annex 4: UN Division of labor [↑](#footnote-ref-5)
5. MOH/UNICEF Knowledge, Attitudes. Perceptions and Behavior study in 17 EVD high risk districts, November 2019 [↑](#footnote-ref-6)