

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

**Jan-July 2023**

***Version: 8th March 2023***

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

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



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# Introduction

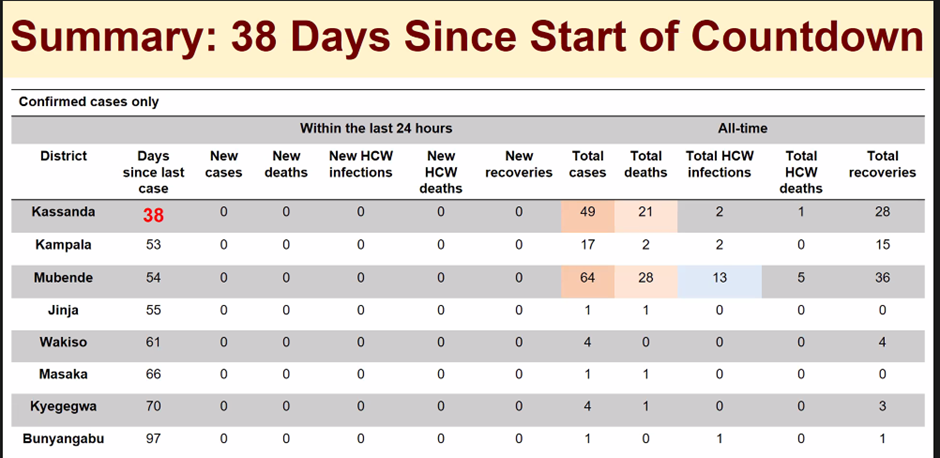
This plan describes the post *Sudan Ebola virus* disease (SVD) response strategy for the UNICEF Uganda Country Office. It is aligned to the Uganda National post SVD Response Plan and covers a six-month period 180 days (5months) from February to June 2023.

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 if 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.

# Epidemiological situation and context

The Uganda Ministry of Health (MoH) declared the 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 had developed symptoms including high-grade fever, convulsions, blood-stained vomit and diarrhea, chest pain, and bleeding from the eyes among others. He had visited a private clinic and was treated for malaria but got worse and self-referred to another private clinic and was later referred to Mubende Regional Referral Hospital (a public health facility) on 15th September 2022. His condition deteriorated while on treatment, and he died on 19th September 2022. This outbreak was of a local emergence from a reservoir in Mubende. where ecological studies were carried out to determine the source. By 11th January 2023, when the outbreak was declared over, the original source of the Sudan virus for EVD had not been confirmed, despite GoU conducting ecological studies conducted.

The month of November 2022 saw an increase in EVD cases that spread to other four new districts including Kampala, Wakiso, Masaka and Jinja bringing the number of affected districts to nine and 27 sub counties. Positively, the countdown commenced in December 2022, as there were no new EVD cases. By end of the outbreak on January 11th there were 142 confirmed EVD cases, cumulatively; 55 cumulative EVD deaths and 87 recoveries. Children were more affected with children under 15 years, children under 5 years, and children under 1 year represent **20%**, **7%** and **1%** of total cases respectively. The Case Fatality Rate (CFR) was 39% of all cases. There were 37 EVD cases among children, out of whom 23 died. The CFR among children was at 60% which was higher than the CFR in the general population. And yet there had been 11 probable /suspected cases of EVD among children, though all 11 died, before the 20th of September declaration of the EVD outbreak. Please see Figure 1.



*Figure 1: Countdown to 38 days without new EVD cases nationally, by 5th Jan before declaration of end of the outbreak (11th Jan 2023)*

The figure lists all districts that had an EVD confirmed case, Mubende, Kassanda, Kampala, Mubende, Jinja, Wakiso, Masaka, Kyegegwa and Bunyangabu. It presents days since the last case per district. MoH and partners have additionally planned to support a survivor’s program, for 18 months post outbreak, to sustain, care and support, and knowledge management.

Figure 2. Epidemic Curve of confirmed and probable cases (as of 11 January 2023)

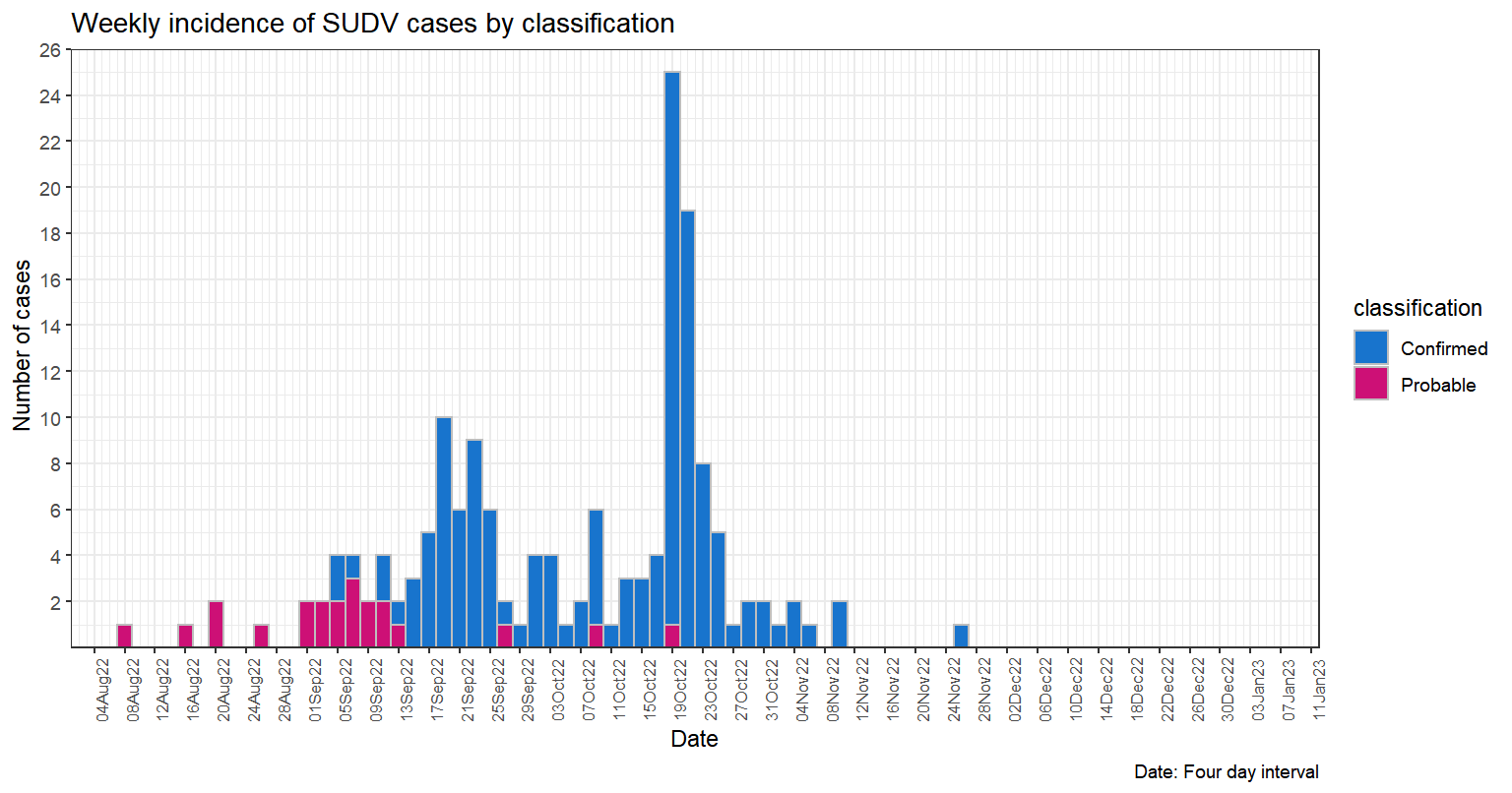
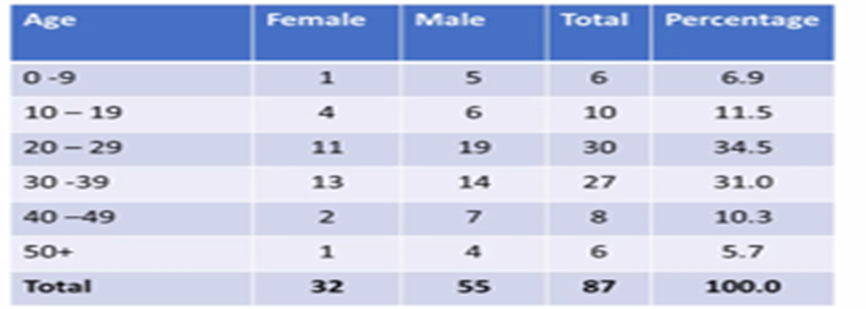


Figure 3: Age/gender specific categorization of survivors for EVD



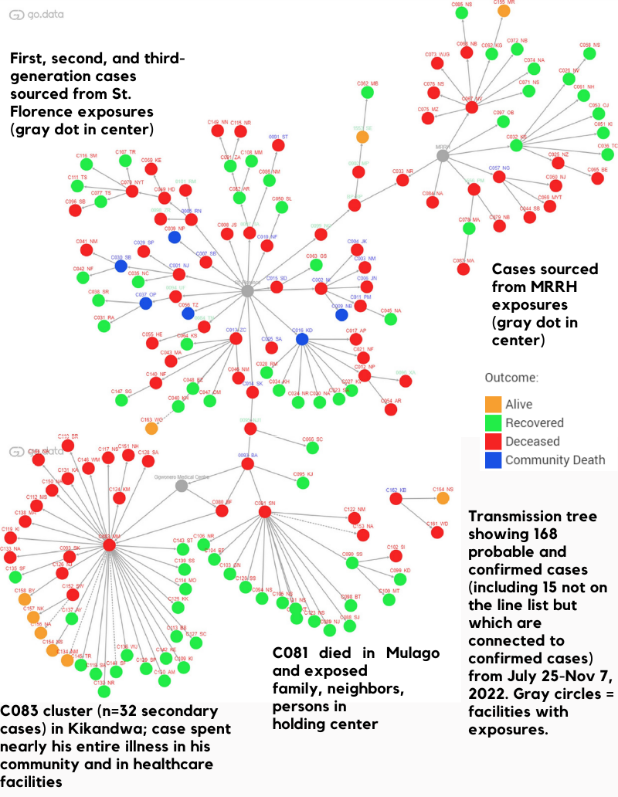
*Figure 3: Age and gender distribution of survivors*

Figure 2 above shows that there are 16 surviving children, with the gender distribution presented in the table below. Among the Adolescents, 10-19 years, there are 10 survivors, out of whom 6 are male. These adolescents and other adult males shall be followed up for the prevention of the sexual transmission of EVD. The MoH and its partners will ensure that needed support for survivors is provided across the districts. By the 29th of Nov, it was 69 days and the country registered complete breakage in transmission of the virus.

# Transmission dynamics

Around **136 (96%)** of all confirmed cases have a known epidemiological link and **135 (95%)** of all confirmed cases were known contacts. Household and nosocomial/ health care associated transmission have been the biggest drivers of transmission to-date, representing **52%** and **27%** of all exposure events respectively.

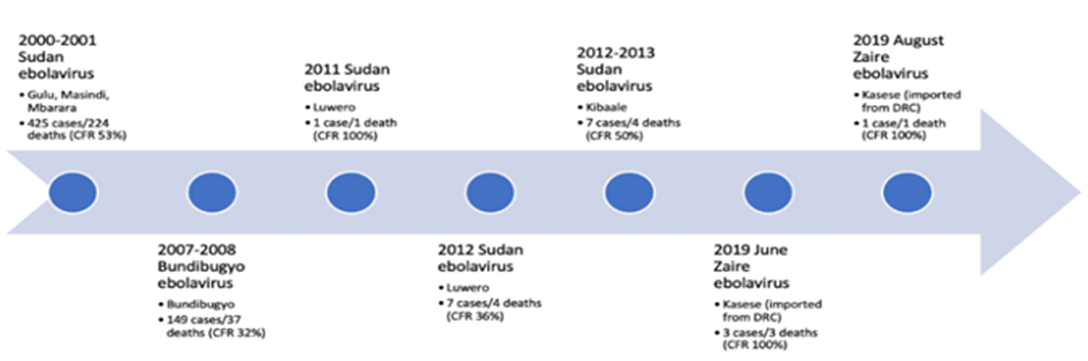
The following figure shows details on relationships created in the Go. Data platform. Most cases with data on exposure history were linked to other cases via the household setting.



**Figure 4 Chain of transmission**

# Previous outbreaks of Ebola in Uganda

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



**Figure 4 Timeline of Previous Ebola outbreaks in Uganda 2000-2022**

Diagram

Description automatically generated

Figure 5: Location of previous EVD outbreaks in Uganda

# Risk Assessment

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

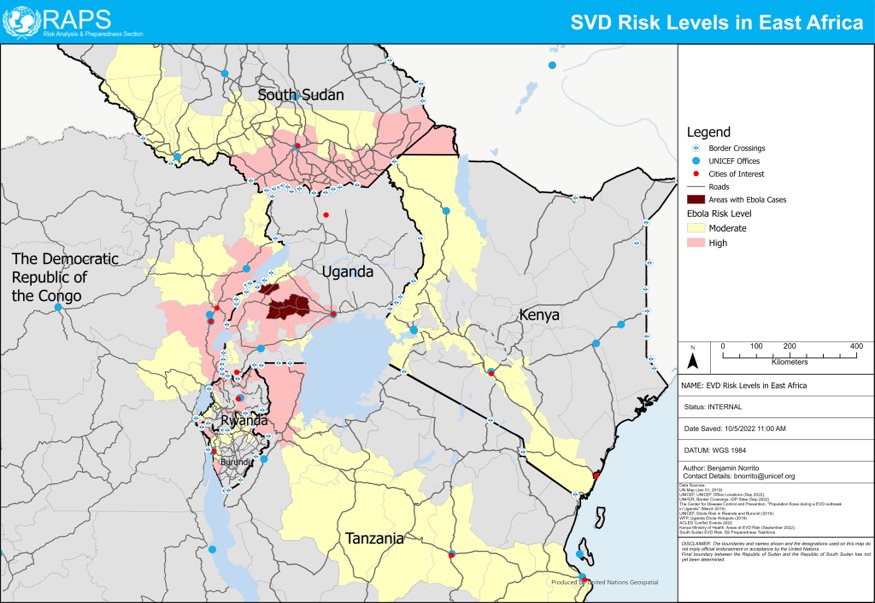
Following the confirmation of the Ebola virus disease outbreak in Mubende in sept 2022, the following districts were classed as very high risk, high risk and moderate risk and eventually other districts like Jinja and Masaka reported cases even though they were outside the categorization.

|  |  |
| --- | --- |
| **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 |

The risk of the local spread of SVD outbreak in Uganda remained 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 was 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.

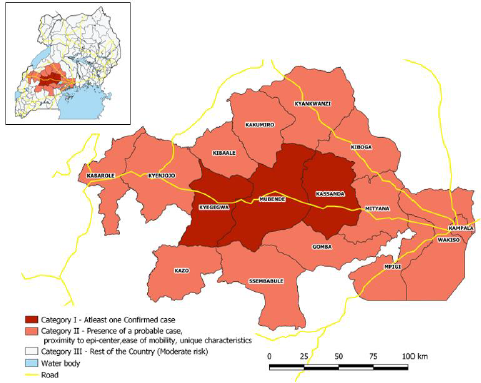
# Risk of SVD transmission to the rest of east Africa/great lakes

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 7: 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.

**Figure 6. Uganda SVD risk classification map (MOH)**

Uganda had reported cumulatively 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 Hemorrhagic 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 organization’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 stock take 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 stock take and action reviews.

* **Strong government ownership and leadership** at national and sub-national levels is key to 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 and avoided duplication of activities.
* **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 and in the community. Following the outbreak, there is an increased understanding and recognition of the role and need of fully integrating MHPSS in EVD responses at all levels.
* **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) 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 was 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 was implemented across 9 strategic pillars coordinated by the incident management team of the Public Health Emergency Operations Center (PHEOC). Pillars included 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) coordinated all activities in collaboration with multiple sectors and partners in high-risk districts. UNICEF supported 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 built on lessons learned from the COVID-19 pandemic and previous EVD preparedness and response and deployed the essential packages of activities across the districts according to risk.

The national preparedness and response plan was 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 be 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 was 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 covered the period from Sept 2022 to Dec 2022. The plan assumed scenario 2 of the EVD National Response Plan where there is transmission in multiple foci requiring coordinated response in multiple locations.

The plan built on the MOH-led Government of Uganda National Country Response Plan and considered 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 was aligned with the Ebola WHO global Strategic Response Plan (SRP), and the UNICEF Ebola Humanitarian Action for Children appeal. UNICEF initially targeted 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 was to 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[[1]](#footnote-2).

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 first 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 though not exhaustive, were 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 ensured that GBV and PSEA risk mitigation were mainstreamed throughout its response.

# EVD Response strategy

The response to the EVD outbreak was 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 focused 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 was cross cutting.

# UNICEF Ebola Response activities during and post outbreak

The MoH declared end to the EVD outbreak on the 11th of Jan 2023 and stated its priorities for the 180-day period, after the declaration of the end to the EVD outbreak.

1. Support to research -vaccine, diagnostics, therapeutics, social anthropology
2. Support sustainable IPC work in both public and private health facilities
3. Support capacity building of staffs taking advantage of existing infrastructure
4. Comprehensive support to survivors -social economic, stigma, etc
5. Establish multidisciplinary team of responders ready to deploy when emergencies occur in the country- WHO and Africa -CDC are already working on the surge capacity for responders
6. Support the recovery programme following the MoH plan which is under design (180 recovery plan)
7. Support the community-based approach program (all relevant community actions in view of emergency response.

In line with MoH priorities, and with the comparative advantage of UNICEF in some areas and building from UNICEF inputs during the outbreak, UNICEF will prioritize some actions across pillars as described below.

# 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 was linked to national outbreak risk analysis; an escalation triggered 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 on 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 deployed field coordinators to the five clusters of hubs (1 each) and district coordinators (1 each) to outbreak affected districts, under leadership of the Ebola coordinator. They actively engaged with and supported the government leadership and partners and advised on the response. They supported planning and monitoring of progress, ensuring that feedback on areas of the response requiring improvement was provided to government and response teams and addressed.
  + UNICEF actively engaged 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 expanded in line with outbreak dynamics. UNICEF deployed technical response staff to support RCCE, case management, MHPSS/CP, IPC/WASH pillar activities, with the flexibility to reprogram activities or redeployed staff to other districts in line with the outbreak evolution.
  + Support provided included 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 was supported by districts and partner’s regular programming partnerships.

UCO operationalized 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.

**Post Ebola**, UNICEF will maintain an internal coordination and information sharing system through the EMT system and keep monitoring the situation through the zonal office technical health specialists and emergency officers.

**External coordination**

External coordination was overseen by the UNICEF Representative, with the Ebola coordination. Partnerships were 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 was 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[[2]](#footnote-3). In addition, UNICEF provided 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.

**Post Ebola**, UNICEF remains an active member of all national level coordination structures including strategic committee, NTF, IMT and others. At sub-national level, UNICEF will still maintain close coordination through the DDMCs, and any technical review meetings organized by the district technical departments.

UNICEF will also support the MoH to establish EoCs in Jinja and Mubende sub-regions to provide oversight function to emergency response including capacity building support to other EoCs

**Activities**

UNICEF supported 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 was 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
5. Additionally, Masaka and Jinja hubs were also established following the 2 districts registering Ebola cases.

## 1.2 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 l led and supported a multi-actor, agency and disciplinary IOA Cell that guided the response using transdisciplinary data

1. IOA developed 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 used 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 were 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

During this phase of post Ebola-180 days recovery response plan, UNICEF working with MoH-division of health information (DHI) will expand the IOA and integrate the Go-data app into the DHIS2. UNICEF will further provide technical support to the MOH team during the recovery response period of 180days.

# Response area 2: Risk communication, social mobilization and community engagement (RCSM-CE).

Throughout the response, UNICEF supported interventions for increasing awareness of the risks of SVD and promote preventive and preparedness behaviours and practices like early detection, and early treatment seeking. UNICEF supported the affected districts to apply community-centred, evidence-driven approaches to improve community-level vigilance in prevention and preparedness against disease outbreaks.

**Activities**

**2.1 Mass media messaging:** UNICEF Social and Behavior Change (SBC) section supported nationwide risk awareness through the mass media and intensified mass-media and interpersonal messaging in the nine outbreak-affected districts (Mubende, Kassanda, Kagadi, Kyegegwa, Bunyangabu, Kampala, Wakiso, Masaka and Jinja); and the surrounding most at-risk districts. The RCSM-CE pillar aimed at nationwide reach and coverage, to ensure 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.

**2.2 Mobilization of key influencers**: In each of the supported districts local actors and influencers with institutions (formal and informal) were 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.

**2.3 Improving Interpersonal communication skills (IPC**) capacity for integrated messaging among the non-medical community-based mobilizers influencers, leaders, and volunteers from other entities like religious, faith-based groups and cultural leaders, head teachers, 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).

**2.4 Refinement and production of communication tools** - UNICEF facilitated the development and distribution of packages/job-aides with integrated messages and information and education communication IEC materials in various formats which included other cross-cutting messages on mental health, GBV and PSEA core concepts and guiding principles, safe and ethical consultation, and GBV referral pathways.

**2.5 Community-level advocacy** through engagement with stakeholders with institutions and civil society groups to improve community-led enforcement of desired behaviours and practices in their domains of influence. UNICEF established and planned to reactivate coalitions with the Uganda Private Sector Foundation and KACITA (Kampala Traders’ Association), which coordinate key employers and business entities.

**2.6 Coordination of community engagement and community feedback interventions:** District local governments from sub-counties, parish, and village levels were 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 supported the functionality or reactivate inter-departmental SBC-RCCE subcommittees at district and sub-county levels and monthly meetings, to improve strategic planning for integrated messaging, mobilization, and community engagement by aligning EVD to other routine services; improve /build SBC-CE capacity at district and sub-district levels to ensure effective use/application, reporting and accountability on RCSM\_CE interventions. The community engagement process included special efforts for joint/ integrated support and linking public health interventions and workers (VHTs) to the village and parish level structures of local governance (e.g., Village taskforce and parish development committees); and regular mapping and interaction with faith-based groups, traditional herbalists, spiritual healers and other community-based organizations (CBOs) since these are the major influencers and the first persons to be contacted in many set-ups/communities and during disease outbreaks.

**2.7 Social data:** UNICEF ensured 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 built on research undertaken during previous outbreaks and updated 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 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 were shared and reviewed by partners with recommendations made for how to better engage communities.

**2.8 Systems strengthening:** UNICEF support included 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 was done in partnership with other actors like Uganda Red Cross Society of the most **ideal** partner in a respective region.

**2.9 Vaccination:** UNICEF planned to 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 continued to document and channel community feedback.

1. **Media training at national and regional levels**

On behalf of the Ministries’ Health Promotion, Education, and Communication Department and the Public Relations Unit, UNICEF facilitated 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 of the public and curb fake news and misinformation during the EVD outbreak
* Equip journalists with basic information on EVD to enable accurate reporting

## Post Ebola outbreak, UNICEF under the SBCC RCCE pillar will focus on.

The main post-EVD activities for RCSM-CE include:

1. Sustaining Ebola awareness and positive behaviour change by re-packaging and disseminating messages focusing on survivors, public health awareness for EVD and other public health emergencies, and continuation of essential health services, using a mix of interpersonal, mass media, and social media channels of communication.
2. Supporting the reintegration of survivors into schools and communities with dignity and targeted engagements for control of the possible secondary transmission.
3. Improving the capacity of community-level leaders and influencers to effectively deliver messages on EVD, address fears and respond to emerging misinformation, disinformation, rumours, and concerns on EVD and other public health emergencies in a timely manner.
4. Supportingregular sensitization and engagement of different groups of affected populations e.g., children and adolescents in and out of school, women and youth groups, traditional healers, health workers, faith-based leaders, and community volunteers (VHTs) to build their capacity to understand the 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/PSEA5
5. Facilitating systems for collecting community feedback through online social listening and media monitoring, setting up a hotline, U-Report online polls, and monthly community dialogue meetings.
6. Scaling up community-based listening and community feedback mechanisms by identifying community-level influencers, stakeholders, and EVD/RCCE champions who can help inform related community discourses on EVD and other disease outbreaks.
7. Building SBC-CE capacity at district and sub-district levels to reactivate inter-departmental SBC-RCCE subcommittees to improve strategic planning for integrated messaging, mobilization, and community engagement by aligning EVD to other routine services.
8. Improving interpersonal skills and confidence of facility-based and community-based health workers on EVD and other disease outbreaks through job mentorship, provision of communication tools, and IEC materials.
9. Enhance community-level advocacy through engagement with non-health stakeholders and influencers with institutions to support and participate in EVD preparedness, prevention, and the enforcement of desired behaviours and practices in their domains of influence.
10. UNICEF will promote the use of social data through regular collection and analysis of feedback data. After the joint analysis, results will be used to generate recommendations for action to the different pillars at the national and district levels. A mechanism for implementing the recommendations will be put in place for better follow-up with the pillars and the coordination structures at different levels.

# Response area 3: Surveillance and contact tracing

The Ebola outbreak just like the past outbreaks, has had a devastating impact on children and women. Children account for 26% of all reported cases and have exhibited a high death rate of 60%, almost doubling the overall observed case fatality rate for all confirmed deaths. They also account for almost 50% of deaths among probable cases.

UNICEF and partners supported 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. UNICEF also supported the response by providing thermometers for school temperature monitoring

UNICEF will continue to work with the MoH on Go-Data app and IOA to integrate into DHIS2 while providing technical support during the 180 days recovery response plan.

UNICEF will support Capacity building for community-based surveillance (CBDS/EBS) and mortality surveillance with focus on the 29 UNICEF supported districts and or at high risk of VHFs.

# Response area 4: Water, Sanitation, and Hygiene Promotion (WASH)

UNICEF with the support of the RCCE and IPC pillars contributed 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. Post outbreak activities will be at health care facilities (public and private), schools and community.

## 4.1 Support for infection prevention and control in Ebola affected communities

* Support for IPC sustainability
* UNICEF will provide support to 16 RRHs to ensure that they have functional IPC/WASH committees at hospitals, availability of supplies, tools, and mentorship to other health workers within the same hospital across departments. This is intended to build capacity of the RRH as centers of excellence from where support can be obtained for lower-level health facilities.

**Support for infection prevention and control in schools**

UNICEF will continue to engage with the School Health Team (MOH) and support the School Based Disease Surveillance to build capacity of district education and health teams in monitoring and reporting disease outbreak in schools.

UNICEF will:

* Support collaboration between the local government stakeholders (DHO, DEO, DIS) to develop and strengthen IPC practices in schools
* support mentorships of district education staff, schoolteachers and support staff on IPC practices that are applicable in schools
* Engage with stakeholders to provide psychosocial support to learners and teachers in schools affected by EVD
* Facilitate DEOs/DIS to monitor implementation of IPC measures in schools

## 4.2 Provision of essential WASH supplies and equipment

* Working with government and partners through implementation pillars, organize supply planning for prioritized activities. UNICEF procured and distributed 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 procured and distributed 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),
* Supported 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).
* Ensured 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.

## In the post EVD recovery response plan, UNICEF will focus.

Support MoH to strengthen IPC WASH and to clearly define the roles and responsibilities of stakeholders in the implementation of IPC Strategy.

## Provide critical WASH supplies for safe re opening of schools and improve IPC standards in health care facilities. In total UNICE planned to reach 330 schools and 336 HCFs in the EVD hot spot districts

## UNICEF will continue to support MoH to conduct monitoring IPC WASH in schools and health facilities in at risk districts of EVD.

## Strengthen the management structures for operation and maintenance of the water supply systems in Kassanda and Mubende districts

# Response area 5: Case Management

UNICEF enhanced 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 strengthened 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 were integrated with routine programs and community-based structures. These include Probation and Social Welfare Officers, and community-based para-social workers.

**Activities**

## 5.2 Nutrition

UNICEF enhanced 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 continued to breastfeed until highly suspected or confirmed positive for Ebola, for the interruption to begin. UNICEF support included follow-up after discharge, with integrated psychosocial support and protection. Equipment for monitoring the nutrition status of children was provided to targeted health facilities. Mothers who recovered and wanted to continue breastfeeding were 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 focused on.**

* Support 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 continuity of nutrition services to children/Infants attending survivors’ clinics at established ETUs/Isolation units.
* Build the capacity of community-based resource persons to screen and refer children discharged from ETUs/Isolation Units from community- health facility for e.g., Para social workers, CDOs, parish chiefs and health assistants including village EVD task force members.
* Support community based follow up of the children discharged from ETUs/Isolation Units in the Ebola affected districts.
* Continue to support Infants 0-6 months affected with Ebola with RUIF until they reach 6-11 months and are ready to be discharged.
* 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.
* Support the districts affected by EVD to develop comprehensive nutrition emergency response plans for 2023/2024.
* Integrate nutrition package into the child friendly SVD response action plans developed with support from the child protection team in the Ebola affected districts.

**Support evidence generation and development of Knowledge Management products on nutrition in context of EVD. Focused on:**

* Support documentation of the best practices, challenges and lessons learned in the implementation of nutrition response actions in context of EVD in Ebola affected districts.
* Support national and regional EVD nutrition response review meetings to share experiences and lessons learned with relevant stakeholders.

## 5.2 MHPSS and child protection

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

Specific response activities during the EVD outbreak:

* Train district core MHPSS teams (health, social welfare, community development) on MHPSS, child protection in public health emergencies, GBV/PSEA service provision, including for children.
* Train community structures including community development officers, para-social workers, and VHTs on the provision of basic PSS and psychosocial first aid (PFA) to affected individuals, families, and communities.
* Support the provision of MHPSS services including selfcare and social care initiatives at the facility, and at the community level through trained structures for admitted and discharged patients respectively.
* Support the deployment of psychologists, and psychiatrists to EVD treatment, isolation units, communities to provide MHPSS to admitted patients, and their families
* Support provision of MHPSS services to health and social (frontline) workers deployed in the EVD response, including through individual, and group-based support.
* Support innovations for tele-counseling services for patients, survivors under isolation, treatment, in communities and their families.
* Develop and disseminate targeted messages (including child friendly) on MHPSS, child protection, GBV/PSEA in communities, schools, and with healthcare and social workers
* Support the government led initiative for the establishment and roll out 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 efforts to ensure functionality of the MHPSS sub – pillar at District level to foster coordination and dialogue on the well-being and protection of children, families, and communities through a functional referral system.
* Support community based follow up of children and families by social workers and psycho – social teams to provide
* Support government in provision of alternative care to children from households of survivors, suspects, and patients through training of social workers and health teams.

Specific recovery phase activities after the declaration of the end of the EVD outbreak:

* Train district core MHPSS teams (health, social welfare, community development) on MHPSS, child protection in public health emergencies and other emergencies, GBV/PSEA service provision, including for children.
* Train community structures including community development officers, para-social workers, and VHTs on the provision of basic PSS and psychosocial first aid (PFA) to affected individuals, families, and communities.
* Train social welfare workforce and national and sub – national to understand how public emergencies affect children, their families, and communities, how people cope with the emotional effects and how they can support a natural recovery process.
* Support the provision of MHPSS services including self-care and social care initiatives at the facility, and community level through trained social welfare and health teams for patients, survivors, contacts, their families, and communities. admitted and discharged patients respectively.
* Develop and disseminate targeted messages (including child friendly) on MHPSS, child protection, GBV/PSEA in communities, schools, and with healthcare and social workers
* Support the provision of MHPSS services to survivors in the government established survivor's program

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

Specific response activities during the EVD outbreak focused on:

* Recruit/deploy health and social workers to ETUs/isolation facilities to ensure the provision of adapted integrated pediatric care (including nutritional support, MHPSS, CP including GBV/SEA) 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 and that children have access to 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/SEA.
* Provide child protection case management services including for GBV against children for children at risk and those who have experienced violence, including neglect in the EVD context. 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 behaviour 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.
* Advocate to the District Local Government to continue understanding and documenting the child protection and MHPSS needs in the EVD affected districts
* Conduct dialogues with the EVD affected communities to participate and own the protection of children and ensure reporting/ on MHPSS needs to relevant service providers and individuals

Specific recovery phase activities after the declaration of the end of the EVD outbreak:

* Provide child protection and GBV case management services to women and children who are at risk or experiencing violence, 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 behaviour 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 6: 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 and social 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**

## 6.1 Support the safe continuity of essential health services to women, children, and vulnerable communities

UNICEF supported 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 was be achieved by ensuring the availability of necessary supplies and the creation of extra space-tents (decongestion) to support routine services in targeted health facilities and communities, development of guidelines and their dissemination to lower-level facilities lower le.

* UNICEF supported 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.
* Supported 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.
* Advocated 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.
* Supported community-based structures to provide basic psychosocial support to children and families through mobile and home-based approaches.
* Procured and distributed high-performance tents to affected districts/ health facilities to provide adequate space for the continuity of health services. UNICEF also provided targeted support for recommended and appropriate PPEs and generators for ETUs and infrared thermometers for schools. Effort was 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.

In the post EVD outbreak, UNICEF will only focus on monitoring through the zonal offices to ensure that service continuity is maintained, and all CEHS activities are completed in all supported districts.

Support MoH to update the national guidelines for ensuring EHS continuity in the context of emergencies

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

The Government of Uganda continues to respond 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 recent outbreak of a high-risk of escalation and spillover to multiple regions, and even to other countries. It was 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 planned to support the delivery of social protection interventions in support of the poor, vulnerable, and marginalized communities in the EVD outbreak districts. Additionally, UNICEF supported children/ school going children, and households directly affected by EVD (cases, isolated, contacts) to counter the effects of stigma. The following were 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

UNICEF will maintain these activities in the post EVD outbreak and the recovery phase of 180 days since the declaration of end of outbreak.

## 6.3 Continuity of Learning

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

* Support Coordination between the School Heath Team (MOH), Ministry of Education and Sports and other stakeholders in aligning national level planning with local government systems
* Continue to provide technical support to the School Health Team (MOH) and Ministry of Education and Sports in development/review of guidelines and tools for school level monitoring and reporting on Disease surveillance in schools and learning institutions
* Provision of home learning materials to affected children to support home study in short term for children who are in isolation or in case of school closures. 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 training of school health task force on IPC measures to strengthen preparedness and awareness raising on IPC for teachers and learners in schools.
* 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.
* 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 services for better care and protection.

# Response area 7: Logistics and Operational Support

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

**Activities focused on included:**

* 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 leveraged 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, followed the same principles (comparative advantage and country-led) as outlined above

**Vaccination:** If/when a vaccine is approved for use,UNICEF planned to 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. As part of the EVD response including recovery phase, GBV and PSEA measures will be integrated across all the different pillars with support from the child protection section.

**Activities**

* Conducted 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.
* Supported 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
* Train frontline workers across all sections on PSEA and on the GBV Pocket Guide to be able to safely handle disclosures of GBV/SEA cases and to link survivors with available service providers/specialists.
* Integrate messages on available GBV services and how to access them in different community engagement and mobilization activities.

# Actions taken to date

Since the declaration of the EVD outbreak on 20 Sept 2022, UNICEF reprogramed funds, sent funds and in-kind support and deployed staff at national level and to the affected districts.

## 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 have been an escalation to scenario 3, leadership would have been 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 if required.

A district-based coordination structure established will continue 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.

**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 developed 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 can 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

**List of Prioritized activities in the UCO Post Ebola recovery response plan Jan-May 2023 (with available funds)**

|  |  |  |
| --- | --- | --- |
| **Pillar** | **Estimated Budget (UGX)** | **Estimated Budget -USD** |
| **Coordination, Leadership, and partnership** | 184,000,000 | 49,932 |
| **RCCE**  **HSS- Community engagement** | 800,000,000  184,000,000 | 217,096  50,000 |
| **Surveillance and contact tracing** | 0 | 0 |
| **Water, Sanitation, and Hygiene Promotion (WASH)/IPC** | 3,316,500,000 | 900,000 |
| **Case Management-Nutrition** | 676,000,000 | 183,446 |
| **Case Management -MHPSS** | 497,470,000 | 134,998 |
| **CEHS/Education** | 101,000,000 | 27,408 |
| **Social Protection** | 0 | 0 |
| **CEHS** | 99,000,000 | 27,000 |
| **GBV/PSEA** | 368,500,000 | 100,000 |
| **SIRI-IOA** | 368,500,000 | 100,000 |
| **Total** | 5,795,270,000 | 1,570,000 |

**Total amount-Ugx-5,795,270,000 (USD-1,570,000 at exchange rate of 3,685 per dollar)**

**\*\*-These funds are with LWF and URCS for on-going activities**

# ANNEXES

# Annex 1: Activity breakdown including targets and key indicators

# Annex 2: Detailed results and performance framework

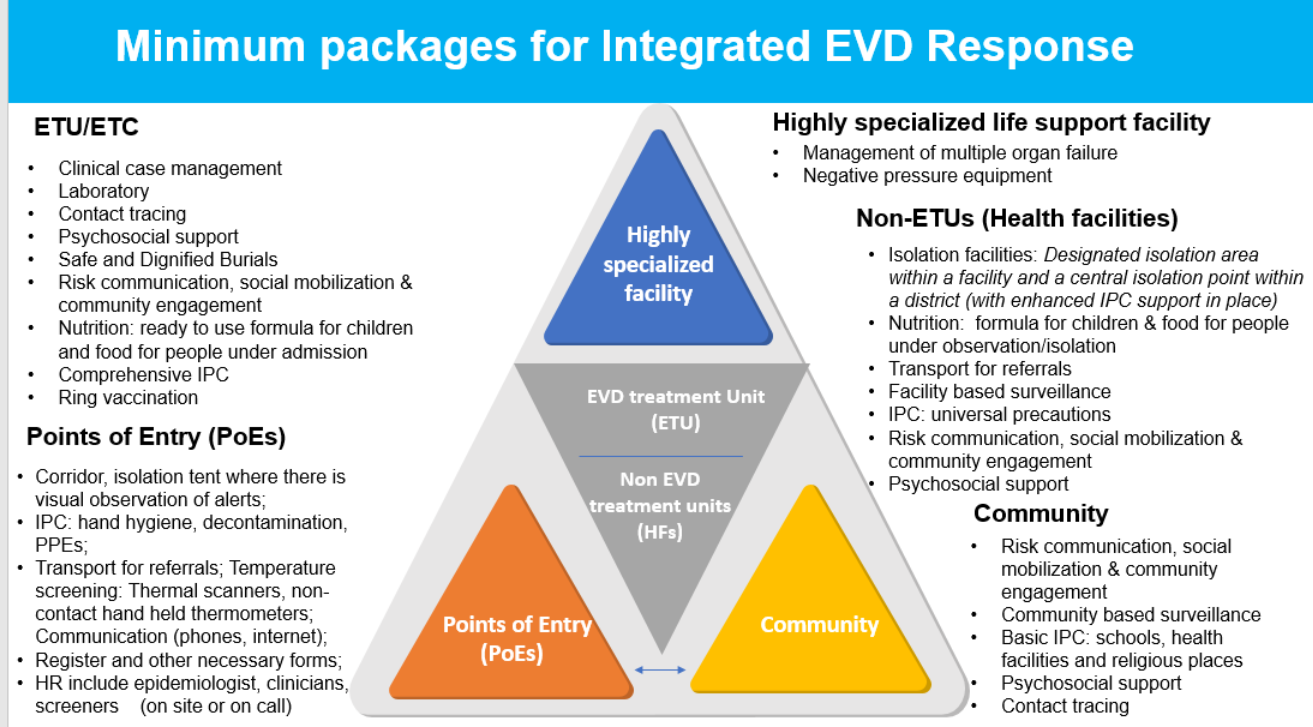
**Annex A: Summary of programme results**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **UNICEF and implementing partners' response** | | |
| **Indicator disaggregation by SVD pillars** | | **2022 target** | **2023 results** | **Progress** |
| **Case management- Infection Prevention and Control (IPC/WASH)** | |  |  |  |
| # of health care staff trained on infection prevention and control/ WASH in areas affected and at high risk of SVD (disaggregated by facility and community, includes VHTs) | | 1,406 | 4,233 | 301%% |
| # of health facilities reached with essential WASH supplies in SVD-affected and high-risk areas (including 700 health facilities, three regional referral hospitals & 20 ETUs) | | 350 | 212 | 61%% |
| # of health facilities/ETUs in SVD affected areas reached with upgraded WASH services (water supply & sanitation facilities) | | 10 | 8 | 80%% |
| # of schools in areas affected and at high risk of SVD reached with essential WASH supplies (including chlorine, soap, handwashing facilities, WASH information, education and communication materials) | | 350 | 183 | 52%% |
| **Case management – MHPSS** | |  |  |  |
| # of psychologists, psychiatrists, health workers, and community structures trained and deployed to SVD treatment and isolation units and communities to provide MHPSS | | 1,156 | 570 | 49%% |
| **Case management – Nutrition** | |  |  |  |
| # of packs of Ready-to-Use Infant Formula provided to ETUs (to cover 120 children) | | 73,125 | 28,218 | 39%% |
| # of health workers trained on IYCF and nutrition in SVD in affected districts | | 800 | 845 | 106%% |
| **Case management – Health** | |  |  |  |
| # of ETUs supported by UNICEF | | 5 | 5 | 100%% |
| **Continuity of Essential services – MHPSS/Child Protection** | |  |  |  |
| # of unaccompanied and separated children due to SVD (in isolation, ETUs and community) provided with alternative care and/or reunified | | 625 | 40 | 6%% |
| # of children, adolescents, and caregivers in affected districts accessing community-based mental health and psychosocial support. | | 15,000 | 32,457 | 216%% |
| # of girls, women and boys who have experienced violence in SVD-affected communities reached by health, social work, or justice/law enforcement services | | 1,875 | 258 | 14%% |
| **Continuity of Essential services – Health** | |  |  |  |
| # of health facilities supported with tents for decongestion and community services, including immunization | | 6 | 6 | 100%% |
| # of health facilities provided with targeted supplies (medical and personal protective equipment) | | 120 | 1 | 1%% |
| **Continuity of Essential services – Education** | |  |  |  |
| # of schools/learning institutions provided with infrared thermometers and accessories for screening | | 12,600 | 3,345 | 27%% |
| # of schools in high-risk sub-counties with functioning school Ebola task force | | 750 | 283 | 38%% |
| # of schools supported with at least one supervisory visit from Ministry of Education and Sports/ District Education Officer | | 375 | 191 | 51%% |
| # of teachers and non-teaching staff oriented on SVD prevention, early treatment seeking and notification | | 13,200 | 3,029 | 23%% |
| **Continuity of essential services – Social Protection** | |  |  |  |
| # of socioeconomic SVD impact monitoring reports produced | | 2 | 0 | 0% |
| # SVD affected households reached with cash transfers | | 5,000 | 0 |  |
| **Risk communication and social mobilization/ Community Engagement** | |  |  | 0% |
| # of people reached through accurate, cultural, and gender-appropriate messaging on SVD prevention, early treatment and access to services | | 6,528,690 | 6,215,797 | 0%  95%% |
| # of key influencers (teachers, local leaders, traditional leaders, religious leaders, local council leaders) engaged on SVD prevention | | 65,287 | 61,585 | 14%% |
| # of people who participate in engagement actions (community dialogues) conducted to raise awareness for SVD prevention and control | | 1,958,607 | 1,292,547 | 66%% |
| # of people sharing their concerns and asking questions through established feedback mechanisms (online and offline) | | 2,611,476 | 1,876,971 | 14%% |
| **Coordination and Leadership** | |  |  |  |
| % of districts with UNICEF supported pillars with plans | | 100% | 100% | 100%% |
| **GBV/PSEA** | |  |  |  |
| # Children and adults who have access to a UNICEF-supported SEA reporting channel. | | 12,645 | 23,714 | 188%% |
| # Women, girls and boys accessing GBV risk mitigation, prevention, or response interventions | | 8,430 | 929 | 11%% |

# 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. [CCC | PUBLIC HEALTH EMERGENCIES (PHE) | Humanitarian UNICEF](https://www.corecommitments.unicef.org/ccc-2-5-1) [↑](#footnote-ref-2)
2. Annex 4: UN Division of labor [↑](#footnote-ref-3)