UNITED NATIONS
UGANDA

Ebola Response Plan UN Uganda

September 2022 - March 2023

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Table of Content

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Cover Photo: ETU, Mubende

I. Overview

1. Introduction: Uganda's Ministry of Health (MoH) declared the 8th outbreak of Ebola Virus Disease (EVD) caused by the Sudan Virus strain (SVD) on 20 September 2022. With 64 confirmed cases, three of whom travelled to the capital Kampala, and 25 confirmed deaths[1] as of 19 October 2022, the situation on the ground is rapidly evolving. In addition, 20 other probable cases have been reported. The case fatality rate (CFR) has remained at 39%, among the confirmed cases since the first death of a 25-year-old on 19 September in Mubende district, the epicentre of the outbreak, located near a highly mobile population and close to the Kyaka and Rwamwanja refugee settlements in Kyegegwa districts, home to over 200,000 Congolese refugees. These factors escalate the urgency of contact tracing. On 15th October, the Government of Uganda imposed movement restriction into and out of two highly affected districts, Mubende and Kassanda. The situation is evolving quickly and threatens to impact beyond public health on the wider economy, as well as cross-border implications.

64

Confirmed EVD Cases

> $ 106.5

Required for effective response to support government containment efforts

21

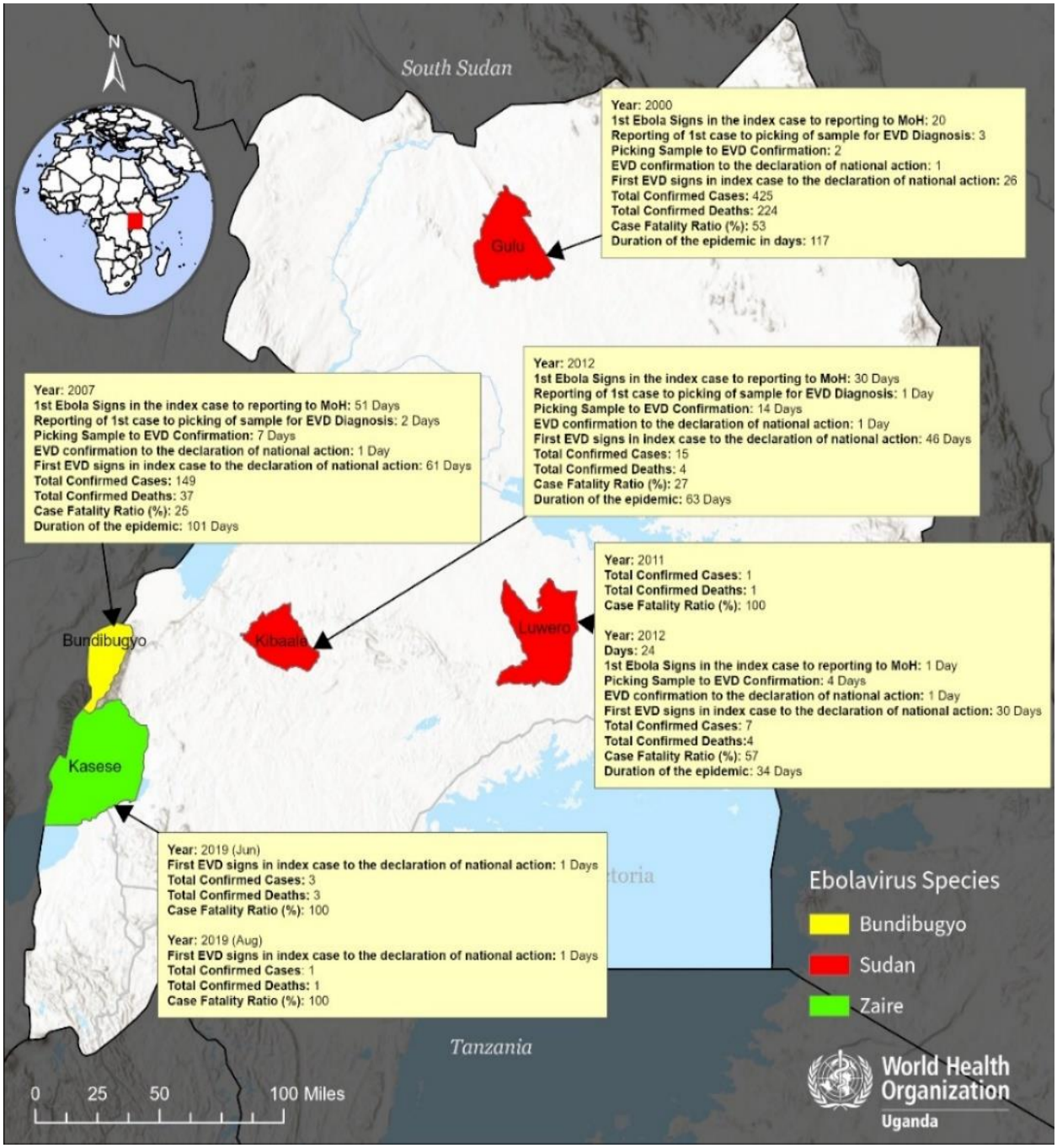
High-risk Districts, including 5 affected

2. Epidemiological Situation: According to the WHO Risk Assessment and Grading in September, the EVD outbreak is high at national-Grade 02. Of the total reported cases, women and girls account for an estimated 51 %; children account for over 20%; and the mean age is 27 (range 1-60 years)[2]. At least five districts have registered a total of 64 confirmed cases and 20 probable cases, with cumulative contacts 2007 listed (WHO data). Contact follow up rate is 93%. Of the total confirmed are 09 children and 04 of them have died; 19 children are affected in total[3]. The CFR among the confirmed cases is 39.1% and among all cases (confirmed and probable) is 54%[4]. The CFR among confirmed cases for children is 44 %; and it increases to 74 %[5] if included both confirmed and probable cases of children. Four health workers of the total confirmed, have died too. Of all cases, 25 people have recovered. At present, there is no vaccine or approved therapeutic treatment for the Sudan strain of the EVD. The EVD outbreak is unfolding against the backdrop of Uganda's multiple public health emergencies, including a Grade 3 nutrition crisis in Karamoja region, the still present COVID-19 pandemic, the impact of recent floods and mudslides, Rift Valley Fever, Yellow Fever, Malaria and a recent Measles outbreak in the refugee settlement. A recent Ebola alert received also from Amuru district (bordering South Sudan) on September 29, 2022, which later was confirmed as Crimean Congo Hemorrhagic Fever (CCHF), a Viral Hemorrhagic Fever. The CCHF cumulative cases were three, with one confirmed and two probable cases.

[1] MoH/WHO Sitrep# 29, 19 October 2022
[2] MOH Sitrep #7 16 September 2022
[3] National Task Force EVD Update 19, Oct', 2022
[4] WHO and National Task Force EVD Update 19, Oct', 2022
[5] National Task Force EVD Update, 19, 0ct, 2022

3. Previous EVD Outbreaks: The EVD is a serious, often fatal disease in humans. The virus is transmitted to humans from wild animals and spreads amongst populations through human-to-human transmission. The average CFR is more than 50% without supportive care. During previous EVD outbreaks, estimated CFR ranged from 41% to 100%. Uganda has experienced seven EVD outbreaks previously since 2000, in the North, West and Central regions. Four of the outbreaks were caused by Sudan strain, one due to Bundibugyo Strain and two due to Zaire strain. While the four EVD outbreaks (Sudan strain) were reported in 2000, 2011 and two in 2012; the last two outbreaks (EVD Zaire) occurred in 2019 in Kasese district following the importation of cases from the Democratic Republic of Congo (DRC).

Figure1. Previous Outbreaks



4. Risk Mapping and Categorization: Following the detection of the index case, the MoH with support from WHO and partners, conducted a rapid risk assessment to support risk categorization and planning. Mubende is a district with high population movement, thus there is risk of further spread, if the outbreak is not controlled in the early stages. Mubende is approximately 2 hours from Kampala and other regional towns.

The following criteria informed the risk categorization:

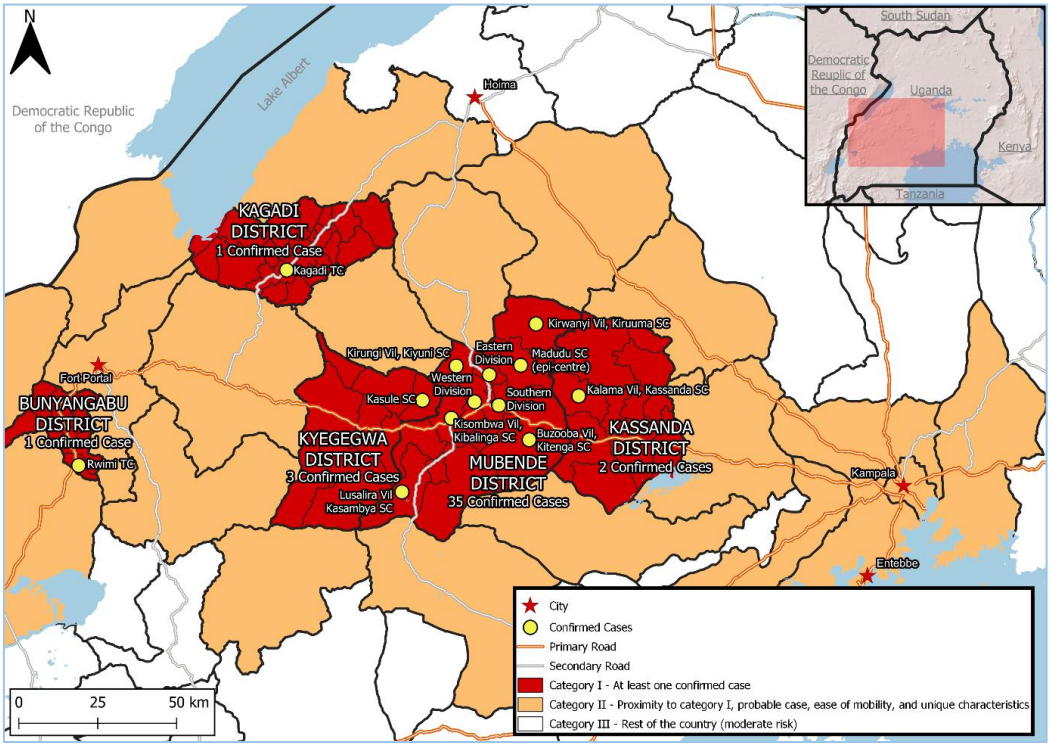
- Presence of confirmed cases (epicenter)
- Proximity to the epicenter
- Presence of probable cases
- Unique characteristics of the districts (refugee hosting districts; population density; presence of mines and forests)
- Complex urban settings, including presence of overcrowded prisons[6]
- High mobility road networks/highways

Table 1: Risk Categories/Districts

Category	Districts
Very High Risk	Mubende, Kyegegwa, Kassanda including Kyaka II refugee settlement, Kagadi and Bunyangabu
High Risk	Kakumiro, Mityana, Mpigi, Kampala, Kiboga, Kibaale, Kyankwanzi, Gomba, Sembabule, Kazo, Wakiso, Kyenjojo, Kabarole, Kamwenge, Fort Portal City, Mukono, including refugee in Kampala and those in the settlement of Rwamwanja, Kyangwali, Nakivale and DR Congo refugee transit centres.
Moderate Risk	Rest of the country

5. Risk Analysis: Since the declaration of the Uganda home grown 8th EVD outbreak, WHO Rapid Assessment team 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. There are currently 5 districts affected, and all cases outside of Mubende district have shown linkage to the Mubende. 19 other districts, including the capital Kampala have been categorized as high-risk districts.

Figure 3. Five districts affected by the EVD at present (as of 10 Sep 2022).



[6] The affected districts have 11 prisons with a total population of 3,461 prisoners (UNODC).

6. Uganda is still a priority 1 country for importation of cases from the DRC. The risk of the spread of the local EVD outbreak in Uganda remains high. Findings from an anthropological study conducted in May 2019 indicated that livelihoods 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.

7. In 2019 the second knowledge, awareness, practices, and behaviors (KAPB) conducted in 17 EVD high-risk districts found that the EVD risk perception was low, with only 30% of respondents afraid of being infected. Risk perception was only 9% in the Central region, which includes Kampala and Wakiso; 27% in Western and Southwestern regions respectively; and 24% in West Nile region – all the districts were identified at high risk of EVD importation from the DRC at the time. The findings may have changed to much lower levels. This 2019 Assessment is being refreshed as part of this plan.
Due to high population mobility, including to and from detention facilities, cross border trade, refugee influxes and repatriation and travel movements and ongoing population displacement due to conflict, along with superimposing humanitarian crises, the risk of spread of the EVD virus to neighboring countries (DRC, Burundi, Rwanda, South Sudan) remains high, with a need to sustain preparedness, surveillance, and response efforts across the region.

8. National Response Plan for EVD (Sep-Dec 2022): Since the first EVD outbreak in 2000, Uganda has built its capacity through strengthening preparedness, including by expansion of laboratory capacity for VHF (Viral Hemorrhagic Fever) detection. The country has a cadre of health responders trained to manage the situation including rapid response team. In addition, Uganda's Ministry of Health has developed a National Response Plan for Sudan Ebolavirus (Sep- Dec 2022), which builds on lessons learnt from previous outbreaks and deploys the basic minimum packages of activities across the districts according to risk. The national EVD response plan is based on the three scenarios and outlines minimum response packages that builds on past lessons on need to maintain continuity of essential health services.

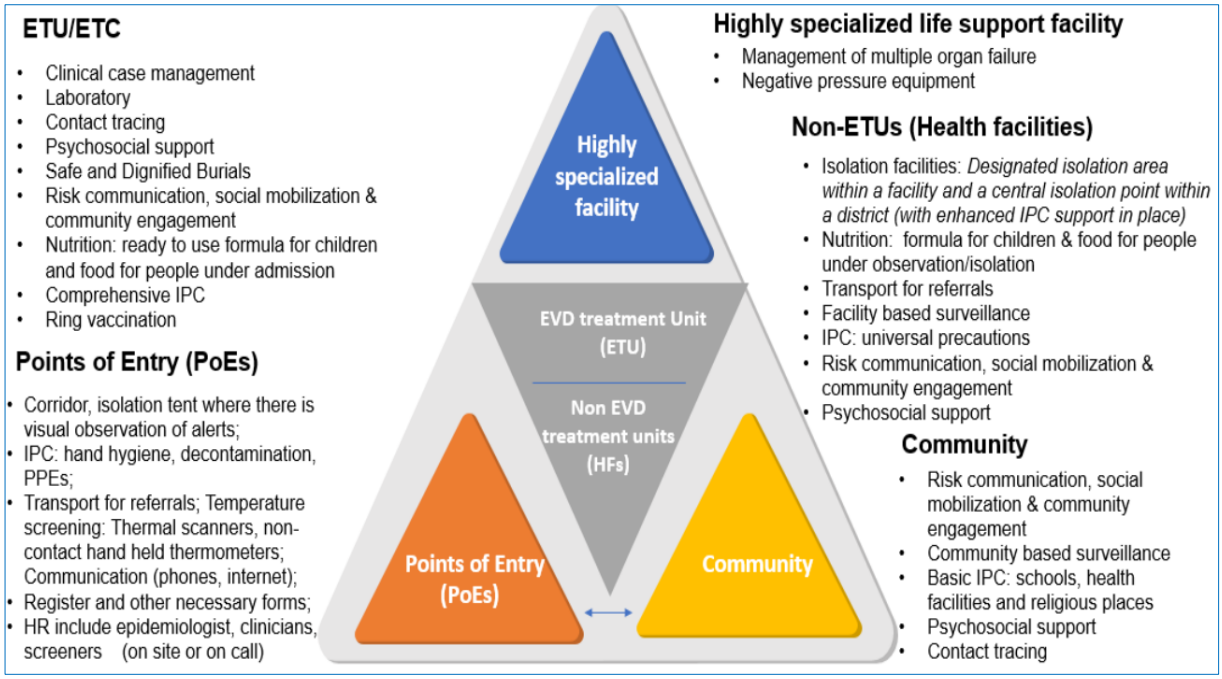
Based on the risk categorization criteria, 3 potential scenarios:

Scenario1 – Best Case Scenario: Early Ending	Scenario 2 – Most Likely Scenario: Sustained	Scenario 3: Worst Case Scenario.
- Early detection of all cases (suspect and confirmed), isolation all the cases and follow-up all the contacts to trace all transmission. - Limited to the current geographical location, with no spread beyond the currently affected districts (or health regions). - Based on scenario, incubation period of the disease the estimate of response would last approximately 105 days (5 incubation cycles).	- Delay in detection of cases with spread of outbreak beyond the current 5 districts reporting cases, to high-risk districts but containment within these 21 districts (3 health regions) currently affected by the outbreak. - Given the vast mobility of this community across the high-risk districts for cultural, and trade reasons this provides most likely scenario. - Cases arising from a refugee settlement - Estimate the response running from 6 to 8 months.	- In this case, based on mobility and inadequacy of contact tracing this worst-case scenario involves spread beyond the epicenter and high-risk districts and 3 health regions to affect new geographical foci or a complex urban setting and/or refugee settlements. - In addition, identification of a case in a neighboring country would equally warrant scenario 3. - This would stretch human resource requirements given the specialized care required and isolation levels to avoid wider spread.

9. Immediate Response: National and local authorities, UN (WHO, WFP, IOM, UNHCR and UNICEF) and partners have moved quickly to respond to the outbreak. Rapid response teams from the national level have been deployed to carry out case investigation, support capacity building for local contact tracing, put in place case management and other control measures.

10. The country has also made deliberate steps to contain the outbreak, including, a) the activation of the national task force for outbreak response; b) the official declaration of the outbreak by the MoH as a public health emergency; c) the deployment of a multidisciplinary field team; and d) the inventory of available logistics and supplies kits. The response covers nine strategic pillars coordinated by the incident management team of the Public Health Emergency Centre (PHEC). The pillars include – coordination and leadership, surveillance, laboratory, case management, including infection prevention and control (IPC), safe and dignified burial and psychosocial support, WASH (water sanitation and hygiene), risk communication and social mobilization, community engagement, logistics and vaccination. A National Task Force (NTF) coordinates all activities in collaboration with multiple sectors and partners in targeted high-risk districts.

Figure 4: Illustration of minimum response packages[7]



[7] National EVD Response Plan (Sep-Dec, 2022).

WHO released US$ 500,000 from its Contingency Fund for Emergencies (CFE) to immediately scale up its response. Immediately, a WHO team was deployed to Mubende district and mobile technical staff were mobilised from the operational hubs in Hoima and Rwenzori to support the response. WHO has also supported additional surge deployment across all response pillars. WHO continues to provide operational and technical support for the EVD response in Kampala, Mubende and any other affected areas.

UNICEF too has so far invested US$ 584,000 by repurposing available resources in addition to initial 500,000 allocation by its HQ, and responded to critical needs in three districts, Mubende, the epicentre of the outbreak, Kyegegwa, Kassanda districts by providing IPC/ WASH supplies, engaging in broad risk communication through 23 radio and three TV stations in the country, IEC materials worth US$85,691 delivered to affected districts, 10 vehicles have been provided to MoH to support RCCE activities and supporting the surveillance effort in streamlining data management. 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.

WFP has deployed critical logistical assets and Mobile Storage Units (MSUs) to serve the sanitation and storage requirements of the Government in the affected districts of Mubende, Kyegegwa, Kassanda, Kagadi, and Bunyangabu districts, in close coordination with the Ministry of Health, WHO, and partners. WFP is also providing logistics support services for transport and storage to Ministry of Health to enable the transport, set-up, and installation of Mobile Storage Units (MSUs), Ebola Treatment Units (ETUs), and ICT (information communication technology) equipment, and it is on standby to provide airlift services to WHO. The agency is also providing the Government with food assistance to support in surveillance and case management, in response to the Government's request to support delivery of meals to Ebola patients, health workers and contacts undergoing isolation in ETUs, and it is working towards in support of this request. WFP is also leveraging food assistance as a platform for building community trust and sharing sensitization messages to support treatment and recovery, reintegration and rehabilitation of cured patients and disease containment strategies.

IOM has provided Mubende district with assorted PPEs, IPCs and tents that were procured by repurposing the agency's own resources totaling US$ 40,000. IOM's support aims to strengthen capacity to better prevent, detect, and respond to the EVD cases at Points of Entries (PoE) and points of convergence in Mubende, with a human mobility perspective. IOM has also conducted population mobility mapping in the epicenter Mubende, detailing the connectivity routes and convergence points including in the four other affected districts. A risk assessment for the Entebbe airport has been conducted, and these assessment and mobility mapping will facilitate: a) identification of mobility patterns that have public health related impacts both within and/or outside the districts; b) identification of PoE and vulnerable places where mobile populations gather and are at risk of contracting or transmitting the disease; and c) identification of priority sites with limited capacities to prepare and respond to public health emergencies. IOM has prioritized strengthening surveillance and preparedness, including transboundary communications, to address the imminent threat of cross-border transmission.

UNHCR has supported refugee hosting districts by activating task forces across the refugee settlements. Provisions of support was made available to activate task forces for surveillance and risk communications activities, isolation and transportation of suspects to the Ebola treatment centers, sample transportation and WASH/infection prevention and control for institution and communities. In addition, medical tents to support establishment of the Ebola treatment center and standby ambulance to support referrals to the ETU have been made available for the refugee hosting districts.

Meanwhile, other agencies, including UNDP, UNFPA, UNWOMEN, UNAIDS have contributed to the UN joint response planning, particularly with a focus on risk communications and community engagement as well as research for effective IPC, procurement, and logistics, and on maintaining other essential services, including the SRHR, GBV, HIV prevention and treatment, and protection, crucial for holistic response.

Mechanisms on protection from sexual exploitation and abuse (PSEA) has been activated, with the preparation and implementation of a 'PSEA Checklist in the Ebola Response' by a UN inter-agency group. The Checklist articulates priority actions for prevention of SEA, establishment of Safe and Accessible Reporting Channels, promoting a Speak Up Culture, and enabling for Support and Protection.

II. UN EVD Response Plan for 2022 Sudan strain outbreak

Drawing from the Government of Uganda National EVD Response Plan, the UN Country Team (UNCT) in Uganda proposes to address multi-sector needs with focus on IPC through Health and WASH interventions; Logistics - critical infrastructure, procedures and operational support mechanisms, risk communication and community engagement (RCCE); along with provisions of food and nutrition as well as mental health and psycho-social care/support services, including protection. The goal is to contribute to measures to rapidly contain transmission and reduce morbidity and mortality related to EVD (Sudan strain). The plan covers a period of six months (Sep 2022- March 2023) and will be implemented in 21 high risk districts in alignment with the National EVD Response Plan pillars. The UNCT response is also aligned with the Ebola WHO global Strategic Response Plan (SRP) as well as other UN Agencies' specific Ebola Humanitarian Action and instruments.

This comprehensive six-month response plan requires over US$ 106.5 million to address the following objectives:

11. Specific Objectives

Infection Prevention and Control (IPC):

- Strengthen the capacity of National and District Health System for infection prevention and control (IPC) by enhancing the national laboratory response, rapidly detecting, investigating, and following up of cases and contacts, as well as through provision of WASH services in the outbreak-affected and high-risk districts with a focus on non-ETU health facilities including those in the refugee settlements.
- Reduce the risk of EVD transmission in the community and nosocomial transmission in health facilities, including by supporting and strengthening the strategic and operational coordination, enhancing leadership and partnership at national and district levels; and through the integration of research in the outbreak response to evaluate candidate vaccines and therapeutics.
- Strengthen surveillance and information management capacity to ensure optimal implementation of epidemiological surveillance activities for quality data and analysis, including at the Point of Entry and point of pontrol for early identification, reporting, investigation and follow up.

Case Management Capacity:

- Support provision of clinical supportive and psychosocial care of patients, convalescents and staff involved in the management of the outbreak.
- Support enhancement of capacity for appropriate EVD case management including appropriate patient feeding, infant and young child feeding, psychosocial support, and protection services in outbreak-affected and high-risk districts.

Risk Communication and Community Engagement (RCCE):

- Support public awareness, including at point of entry, of the threat of EVD and continue to galvanize sustained population, in support for prevention, and early treatment seeking for preventing the spread of EVD in other districts and refugee settlements.
- Strengthen community engagement and risk communication for EVD preparedness and response aimed at: a) promoting good individual and collective practices; and b) ensuring continued access and utilization of health services, including SRHR (sexual and reproductive health rights), GBV (gender-based violence) and HIV/TB prevention and treatment.

Maintain continuity of essential services:

- Ensure maintenance of essential health services in affected areas by strengthening the capacity of health facilities and service providers for sustaining provisions of services, including the SRHR, HIV prevention and treatment, GBV and PSEA (protection from sexual exploitation and abuse).
- Prevent and address the secondary impact of the outbreak and minimize the human consequences by providing and strengthening critical infrastructure, procedures, and operational support mechanisms.

12. Response Strategy: This EVD Response Plan is based on the major pillars identified in the National EVD Response Plan, and priority UN interventions in Thematic Areas are articulated below. The implementation of this plan will be carried out by UN Agencies in support to the national response efforts, and in close collaboration and coordination with the MoH and partners. The UN seeks to contribute to multi-sectoral national and sub-national coordination and will work with partners in the implementation of this UN response plan in accordance with the Incident Management System of Uganda. The response plan also seeks to deploy effective EVD response through gender responsive approaches at community, national and regional levels. The single purpose is to contain the outbreak and address its impact on public health and associated social-economic life of affected people.

Table2. Thematic Areas/Sectors for UN Response and Agencies:

Areas for UN Response Theme/Sectors	Major Operational Pillars of the National EVD Response Plan
Health Infection Prevention and Control (IPC) Case Management Emergency SRHR, GBV, Protection from Sexual Exploitation and Abuse (PSEA) Surveillance, Strategic Information, Research and Innovation **WHO, IOM, UNFPA, UNHCR, UNICEF, UNDP**	Coordination Surveillance Laboratory Case Management Infection Prevention and Control (IPC) Strategic Information, Research and Innovation
RCCE: Risk Communication and Community Engagement, including Research PSEA, PRSEAH **UNICEF, UNDP, UNHCR, UNWOMEN, IOM, WHO, UNFPA, UNAIDS, UNODC**	Risk communications and social mobilisation, Community Engagement
Logistics, Critical infrastructure, operational support and supplies **WFP, UNICEF, WHO, UNHCR, UNDP**	Case Management Surveillance IPC Supplies
Food & Nutrition **UNICEF, WFP, UNHCR**	Case Management IPC
Protection: Child Protection, GBV, PSEA Mental Health and Psychosocial Support **UNICEF, UNHCR, UNWOMEN, UNFPA**	Case Management Risk Communications and Social Mobilisation Community engagement IPC Mental Health and Psychosocial Support
Water, Sanitation and Hygiene (WASH) **UNICEF, UNHCR**	Case Management, IPC
Education **UNICEF, WHO, UNHCR**	RCCE, IPC/WASH in school

13. UN Response Plan Thematic Areas [Refer to Annex 2 for Activities detail]

Health Response: Activities under the Health sector will focus on **Infection Prevention and Control (IPC),** effective **Case Management**, and strengthening **Surveillance**, including active case finding, contact tracing and investigation of cases as rapid detection and isolation of new cases is the key to preventing onward transmission of the virus. Providing guidance for standards of care for EVD management and prevention of transmission in healthcare settings, in specific places such as prisons/detention centers and in the communities will be prioritized. **Strengthening laboratory and diagnostic capabilities, integration of research in response and maintenance of essential services, including Sexual and Reproductive Health (SRH), HIV/TB prevention and treatment and Gender Based Violence (GBV)**, will be prioritized. IPC activities, with particular focus on maternal health, orientations for health workers and Village Health Teams (VHTs), strengthened referral services for pregnant mothers and neonates will form support towards ensuring continued access to SRH services. Given the risk of sexual transmission of the disease for up to 6-months post-recovery, condoms will be made available in affected communities, including female sex workers as part of the IPC. **Psychosocial Care** for patients and family members is integrated in the response at the earliest to prevent stigmatization and better recovery. In addition, mechanisms for prevention and response to sexual exploitation, abuse, and harassment (PRSEAH) and essential services to survivors will be prioritized.

Key infrastructure, procedures, technical and operational support mechanisms will be maintained and supported for ensuring effective coordination of all aspects of the EVD response. Leadership for the coordination will be enhanced by ensuring technical support and deployment of surge advisers/staff. **IPC measures** will be reinforced **at Point of Entry (PoE) and Point of Control (PoC),** nearby health facilities and strategic points of social gathering along mobility corridors. Implementation of the PoE data application for the data/information management at PoE/PoC will be supported, including by training local management teams on PoE/PoC management across high-risk districts, including in government detention facilities (prisons). Conducting analysis of the population movement in connection with the EVD outbreak, epidemiological surveillance across border will be reinforced.

Systematic assessment and monitoring of the secondary effects of the outbreak and its containment measures on the population, with a focus on the most vulnerable, including the impact on food and nutrition systems, social support and health system, gender-based-violence, poverty, and key other areas, will be continued. Support will be provided to the Ministry of Health to ensure **continuity of primary health care services** during the outbreak response, including nutritional services and appropriate breastfeeding, family planning, prenatal and postnatal care, safe deliveries, HIV prevention, testing and treatment, immunization, and clinical management of Rape, as well as the SRHR and the GBV. This will be achieved by ensuring the availability of necessary supplies, including high performance tents and creation of extra space (decongestion) to support routine services in targeted health facilities and communities. **Procurement and distribution** of nutrition therapeutic supplies and management of children with severe acute malnutrition (SAM), including in refugee hosting districts and food insecure areas and referral hospitals is another area of priority. This plan covers services to affected refugee population and affected districts that host refugees.

Investment will be made to **strengthen coordination at refugee settlement and districts**, intensify surveillance and laboratory capacities and facilitate case management by setting up isolation facilities and referral capacities, and to ensure continuity of health services with a specific focus on the refugee and host population. The Ministry of Health will be supported to **roll out the trial vaccine**, to **strengthen WASH** and IPC, provide psychosocial support and risk communication, specially targeting refugee population and refugee hosting areas. The pre-existing need for psychosocial care for refugees will be prioritized and integrated in the response at the earliest to prevent stigmatization and better recovery. The Ebola package will be delivered for non-ETU health facilities in the settlement and Points of Entry that are used by refugees.

Risk Communications and Community Engagement (RCCE): Past outbreak experience has shown that affected communities hold the key to preventing the transmission of the EVD. Hence, creating high public awareness of the EVD risks transmission modes, prevention, reporting, and referral mechanisms will be prioritised. Support will be delivered to amplify existing and/or to develop new messages, as well as to engage the population for behaviour change. This will be done through trusted EVD-specific risk communication and social mobilization, mainly through mass media, and by orientation/capacity building of key influencers, community groups, women and youth groups, health workers, faith-based and traditional leaders and VHTs for awareness raising and promoting healthy practices, including contact tracing.

Package of risk communication will also be delivered to the refugee and surrounding host population. In addition, scaling up community engagement; mobilization and awareness raising on PSEA and integrating GBV in RCCE for community-based groups, local women's groups, community mobilisers and volunteers; and mechanisms for safe and ethical consultation – community-based reporting and complaint mechanisms – on GBV and PSEA as guiding principles; and GBV referral pathways will be priority RCCE interventions. Ministries of Education, Health will be assisted to develop and implement guidelines for safe school operations during this Ebola outbreak e.g., integrated school-based surveillance for EVD, reporting, and referral, promotion of hand and respiratory hygiene, sanitation, screening, and referral of suspected cases, as appropriate), and education about Ebola prevention. In addition, with the support of communities of PLHIV (people living with HIV) and women led organizations, in the affected and at-risk districts, integration of HIV related messages will be incorporated with Ebola sensitization messages in communities by trusted community members, using evidence-based communication forum.

The UN will also work with Ministry of Internal Affairs on risk communications in order to prevent the outbreak in prison setting, given there are 11 prisons with a total population of 3,461 prisoners in affected districts. Support will be delivered for enabling provisions of mental health and psychosocial services (including school-based services) and for ensuring access to protection services, including the GBV and SRHR services. Specific activities will focus on working with the Ministry of Health to circulate and orient on the continuity of SRH services, including training to social workers on the provision of psycho-social support to pregnant or new mothers, and on supporting female headed families to reduce the impact, including social-economic aspect of the EVD outbreak. Health structures and local governance systems will be supported for strengthening social and behavior change (SBC) capacity, including on data collection and analysis.

Logistics, Operational Support and Supplies: Supply chain and programmatic support, including critical logistical assets have been deployed to Mubende district, and critical infrastructure and logistics support, including in the refugee settlements and selected refugee hosting districts, will be prioritized. The UN humanitarian air service will be available for airlift services. A few UN agencies, with their specific comparative advantage on procurement services, stand ready to support the national system on procurement and distribution of supplies. The UN will also continue providing planning, programme and operational support to the Government's response efforts.

Food and Nutrition: The Government of Uganda has requested food assistance to Ebola patients, health workers and contacts undergoing isolation in ETUs. Wet feeding programmes will be undertaken in isolation centres, in accordance with hygiene protocols. Hot meals will be prepared and served three times a day to address the food and nutrition needs of EVD patients, contacts, families of contacts, caretakers, and survivors for 6 months. To ensure that the programme can upscale immediately, existing stocks from other UN operations have been leveraged, ready to be reallocated to its cooperating partners for meal preparation. On the nutrition side, capacities will be enhanced to maintain positive feeding practices for infants and young children affected by EVD despite quarantine, disrupted breastfeeding, trauma and stigma. Due to the continued presence and shedding of the Ebola virus in breast milk, 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 will be ensured, 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.

Protection: Capacity of the government entities at the national, district, and sub-county levels as well as of para-social workers, will be strengthened 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. **Protection services, including the GBV and PSEA** will be ensured through maintenance and strengthening of essential services across high-risk districts. Community based structures will be supported to provide basic psychosocial support to children and families through mobile and home-based approaches**.** Protection of refugees will be continued ensuring that xenophobia is prevented and the **protection space for refugees** in Uganda is preserved even in the situation of the outbreak in the settlements.

WASH: Reducing risks of transmission of EVD and other hospital-acquired infections to health workers, caregivers, patients, school going children and the community, including those in prisons will be continued, by strengthening adherence to IPC and, through the improvement of **WASH infrastructure** at non-Ebola Treatment health facilities. Measures will be deployed to strengthen adherence to principles and practices of infection prevention and control to reduce transmission of Ebola virus and other infectious organisms to health workers, care givers, patients, prison wardens and the community. In addition, WASH/IPC package, including 450g of soap per refugee per month, will be delivered in the refugee settlement and selected host district facility.

14. Funds Required/Timeline: This plan is prepared for six months [September 2022 - March 2023] considering the most likely Scenario 2, covering the 5 EVD affected districts and the 16 high-risk districts**. The total funds required to ensure comprehensive quality response for minimum of six months is US$ 106.5 million**. So far, $ 13.4 million has been secured through the UN Agencies' own resources (HQ and re-purposing) as well as from donors, including USAID, FCDO/UK, Norway and Novo Nordisk foundation. Other $ 5.7 million more has been pledged by UN Central Emergency Response Fund (CERF), ECHO, Denmark, AfDB, FCDO/UK and Irish Aid. This makes the funding **gap at present at 81 %** in total.

The summary of the required funds by UN Agencies is below. The detail on areas and corresponding breakdown is presented in Annex 1.

Agencies	Funds Required	Funds Available	Funds in Pipeline / Pledges	Gap %
IOM	$ 1,911,157	$ 40,000	$ 0	98 %
UNAIDS	$ 71,658	$ 0	$ 0	100%
UNDP	$ 500,000	$ 0	$ 0	100 %
UNFPA	$ 753,300	$ 0	$ 0	100 %
UNHCR	$ 14,896,000	$ 0	$ 0	100 %
UNICEF	$ 18,350,000	$ 2,584,000	$ 1,050,000	80 %
UNWOMEN	$ 312,000	$ 0	$ 0	100 %
WFP	$ 6,233,012	$ 1,000,000	$ 250,000	80 %
WHO[8]	$ 63,549,876	$ 9,838,690	$ 5,712,810	76 %
Total	**$ 106,577,003**	**$ 13,462,690**	**$ 7,012,810**	

[8] Activities related to research and innovation is included and fully funded.

15. Addressing PRSEAH: The current Ebola outbreak in Uganda poses a unique situation for mainstreaming of the Preventing and Responding to Sexual Exploitation, Abuse and Harassment (PRSEAH) in Public Health Emergency operations and in non-humanitarian setting. The UN is prepared to take the leadership role to engage with, and coordinate efforts of other partners for ensuring Joint PSEAH (Preventing Sexual Exploitation, Abuse and Harassment) actions are mainstreamed into the response operations. Support will be delivered for the coordination of all PRSEAH activities in the emergency while working closely with the other UN agencies. Structures that will support the implementation of PRSEAH activities have been established with Focal Points identified, trained, and deployed. The collaboration between the MoH, WHO and RC's office will remain pivotal in undertaking key prioritized activities, including regular/mandatory training and briefings and ensuring staff with right skills-set deployed for EVD response operations. As per the core recommendation from the WHO management response plan (following SEA incidents in the DRC Ebola response), role of women leaders will be enhanced for strengthened accountability. This will include appointing female staff to senior positions in field operations and continuation of ongoing/regular engagement with local women's groups and women's networks.

16. Enhancing capacity of implementing partners on PRSEAH and establishing/strengthening accountability mechanism for partners will be prioritized. Community-based complaint mechanism on SEA will be ensured by establishment of safe and accessible and child-sensitive SEA reporting mechanism. Some key activities include: a) scaling up community engagement, mobilization and awareness raising on PSEA including on the UN Zero tolerance on SEA for humanitarian workers, and the right to access humanitarian aid services free of charge; b) training aid workers (Government, UN and CSO partners, VHTs and other volunteers and community structures involved in the response) on PSEA; and inclusion of PSEA reporting toll free lines; Sauti 116 and FRRM 0800323232 in all awareness materials in the EVD response. An UN inter-agency team has developed a PSEA Checklist in the Ebola Response, which will be strictly adhered to by all UN agencies and its partners.

17. Monitoring and Evaluation The ongoing adjustment of UN programme-operations rely on Monitoring and Evaluation data, including real-time data and evidence, to ensure organizational learning and continuous improvement. It will be crucial to ensure that all partners involved in response have accurate information in order to direct response efforts where they will be most effective. Thus, the health information management and reporting system, will ensure that all partners are provided with regular updates on the latest information on epidemiological situation and the health status of the population. WHO, together with partners, will continue to provide daily epidemiological updates, complemented by weekly comprehensive situation reports and periodic reporting of response indicators.

It will also support the production of ad hoc information products as needed by response partners, donors and others. In addition, UN Agencies will continue to support strengthening national statistical systems 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. UNHCR will also use the already established interagency Feedback Referral and Response Mechanism (FRRM) platform to ensure accountability to the affected persons.

Accountability to Affected Populations (AAP) is another essential part of the response to an outbreak and is central part of the ongoing efforts to strengthen RCCE in the current EVD response. It is critical that affected populations: receive relevant and timely communication; participate indecisions that affect their lives; and have access to trusted feedback mechanisms. UN Uganda is committed to ensuring that at risk populations receive the most relevant information they can act on, and in the most appropriate format. For this purpose, UN Agencies' 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. Hence, complaints and feedback mechanisms will be established to track perceptions, rumors, misinformation and information gaps.

On the other hand, accountability is considered as a responsibility being entrusted on funds allocated to improve health globally. WHO and UN Agencies follow a result based managerial framework that calls for delegated responsibility, authority, and accountability at all levels of the organization. This means that decisions on the use of financial and other resources are taken by managers at all levels in all locations. Integrity is a key element of UN accountability framework which is supported by a sound internal control framework that facilitates the transparent implementation of this UN EVD response plan.

Annex 1: Required Funds for the UN Response Plan to EVD

AGENCY	PILLAR/Thematic Areas	Required Funding / USD (6 months)
IOM	Staff Costs	
	Office Costs	
	Population mobility analysis at PoE/PoC is strengthened	
	Epidemiological surveillance data at PoE|PoC are strengthened	
	Capacity building of Frontline workers at PoE and PoC on epidemiological surveillance.	
	Contact tracing, alert detection, notification, investigation, and validation at POE and POC are strengthened	
	Operational support to PoEs and POCs	
	Support Community based surveillance in at PoCs and PoEs	
	Cross-border coordination with neighbouring countries is reinforced	
	Infection, Prevention and Control measures are reinforced at PoE/PoC, and along the mobility corridors	
	RCCE	
	Renumerations & Grants Counterparts	
	IOM Overhead 7%	
	TOTAL	1,911,157
UNAIDS	Tailored risk communication materials to communities of traditional healers and cultural leaders	24,555
	Conduct a mapping on the impact of HIV service provision to PLHIV and key population in the 5 districts plus Kampala	8,286
	Conduct sensitization meeting with the PLHIV and sex workers on Ebola response.	7,480
	Support the hotline started during the COVID-19 to integrate EVD	9,750
	Personnel costs*	15,095
	Programme support costs	6,497
	TOTAL	71658
UNDP	Procure and support distribution Infection, Prevention and Control (IPC) supplies for ETUs, Isolation Centers and communities	300,000
	Support risk communication, social mobilization, and community engagement	100,000
	Support specialized Human Resource (HR) to the Treatment Units in the affected districts	100,000
	TOTAL	500,000
UNFPA	Risk communication, social mobilization, and community engagement	90,000
	Continuity of essential SRHR services	663,300
	TOTAL	753,300
UNHCR	Health	5,200,000
	Community Support	2,196,000
	WASH and Infection Prevention and Control	7,500,000

	TOTAL	14,896,000
UNICEF	Coordination, case management, continuity of essential services and Social Protection	4,500,000
	RCCE, Communication and advocacy	3,600,000
	IPC/WASH	6,000,000
	MHPSS, Child protection, GBV and PSEA	2,600,000
	Education	750,000
	Operational Cost	900,000
	TOTAL	18,350,000
UNWomen	RCCE	97,000
	Community based surveillance and referral for expert care	40,000
	Psychosocial support to affected members in affected districts	90,000
	Implementation of `IPC Procedures and practices	45,000
	Reduced financial stress and resilience for women headed affected households	20,000
	Engendering response by national partners	20,000
	TOTAL	312,000
WFP	Food assistance requirements	3,583,101
	Logistics response (augmentation of infrastructure, purchase/installation of MSUs, ICT equipment	2,649,911
	TOTAL	6,233,012
WHO	Strengthening the multi-sectoral coordination	3,000,000
	Surveillance, active case finding, contact tracing and investigation of cases	3,250,000
	Strengthening laboratory and diagnostic capabilities	1,880,587
	Case management	10,955,566
	Infection prevention and control and WASH in health facilities and communities	1,488,683
	Risk communication and social mobilization	1,400,000
	Community engagement	1,000,000
	Point of Entry	304,000
	Psychosocial care	1,690,356
	Research in response	12,000,000
	Operations and programme support	2,000,000
	Health Supplies	20,845,647
	Transport	936,542
	Continuity of Essential Services	1,398,494
	Communication, External Relations and Visibility	1,000,000
	PRSEAH (Training, Feedback, Hotline)	400,000
	TOTAL	63,549,875
	GRAND TOTAL	106,577,003

Annex 2: Planned Activities in Thematic Areas/Sectors

HEALTH & NUTRITION	
Agencies	Areas of Work/Activities
UNDP	
	1. *Procure and support distribution infection, prevention and control supplies for ETUs, Isolation Centers and communities* 2. *Support specialized human resources to the treatment units in the affected districts*
UNFPA	
Continuity of essential SRHR services	1. Train/refresher train health workers on the Minimum Initial Services Package (MISP) for SRH services 2. Procure PPE and appropriate IPC materials such as soap and alcohol-based sanitizers for use at points of care for pregnant women, and women in labor 3. Facilitate values clarifications and attitude transformations (VCAT) sessions on EVD for health workers 4. Print the MoH adapted guidelines for continuity of SRHR service delivery in lieu of EVD 5. Orient health workers and VHTs on the MoH adapted guidelines for continuity of integrated SRHR, HIV and GBV response service delivery in lieu of EVD. Target is 2000 VHTs and 270 HWs. 6. As needed, hire ambulances (and meet their operational costs (fuel and maintenance) that are dedicated for referrals of EVD exposed or affected pregnant girls and women, as well as sexual assault victims in the 4 targeted districts, for a six-month period 7. Procure and distribute clean baby/mama kits to all pregnant women, whilst concurrently strongly recommending skilled birth attendance at a health facility 8. Train/refresher train midwives and doctors at BeMONC and CeMONC health facilities on how to manage pregnant women who are suspected or confirmed with EVD 9. Train para social workers on provision of psychosocial support and counseling to pregnant women and girls 10. Ensure the availability and distribution of condoms among affected communities, with a particular focus on individualss who have recovered, complemented with relevant information regarding proper and consistent use and information on preventing the spread of Ebola.
UNHCR	
Support to improved coordination	1. Daily Settlement Task force on a daily basis on Ebola 2. Facilitation of 13 District Health Team to provide onsite mentorship
Intensified surveillance and laboratory	1. VHT Community surveillance (2777) paid extraduty allowance 2. Refresher Trainings of VHTs, on Ebola and community based disease surveillance for each of the VHT 3. Roll out of the community surveillance health information system 4. Strengthen the functionality of 500 villages health task forces 5. Training of school administratons and teachers for 200 schools in Ebola and school surveillance 6. Training of 1,000 health workers and community health workers (VHTs) in Ebola and contact tracing 7. Training of Health managers in IDSR 8. Facilitation of district rapid response teams for alerts and suspects 9. Procurement motorcycles to support community surveillance 10. Setup screening 30 tent/shelters at entrances of high volume health facilities 11. Establish screening at 25 high risk communal points (tents/shelters at Food distribution points, Refugee verification centres, transit, Activity reception centres and key points of entry for refugees) 12. Facilitation and Allowances for 13 surveillance teams (health workers) of 4 13. Facilitation for district health workers for Point of Entry screening
Case management including continuity of health services in the settlements	1. Setup permanent isolation spaces at High volume health facilities 2. Procure 5 ambulances and 10 logistics support Safe dignified burrials, nutrition and psychosocial and provision of solidarity packages 3. Recruit 30 surge health teams to support isolation facilities 4. Procure medical tents to support isolation facilities and preposition drugs, medical supplies and equipment needed 5. Refresher trainings for health workers in Case Management in 13 settlements

Infection prevention and control measure for institutions and communities including WASH	1. Procurement of 450 g of Soap per person per month for 6 months 2. Procure an assortment of PPEs and hand washing facilities 3. Increase WASH coverage to average 18lpd 4.Fencing of 20 health facilities 5. Build 7 mortuaries at 7 health facilities 6. Procure 10 incinerators for waste management 7. Equipping of the Kiryandongo Warehouse 8. Solar lighting at 30 health facilities with no reliable power source
Risk communication and community mobilization including psychosocial support	1. Printing of IEC Ebola materials 2. Procurement of Megaphones for VHTs 3. Procure VHT kits to facilitate house to house risk communication by the VHTs 4. Institute village task forces per village to increase risk communication, case finding at the community 5. Printing VHT handbooks, CBDs handbook, Health education handbooks for each of the VHTs 6. Community sensitization meetings through mounted speakers on bike and cars 7. Establish Self help groups, group therapy and self help plus in each of the the community 8. Training the community health workers in case identification, refferal and counselling
UNICEF	
Support the safe continuity of essential services, ensuring sustained access to adequate health care for women, children, and vulnerable communities	1. UNICEF will support the procurement and distribution of nutrition therapeutic supplies and the management of children with severe acute malnutrition, with focus on refugee hosting districts, food insecure areas (e.g., Karamoja region) and Regional Referral Hospitals. 2. 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 government in the development and dissemination of key guidance documents related to child protection and EVD. 3. Support community-based structures to provide basic psychosocial support to children and families through mobile and home-based approaches. 4. Procure and distribute high performance tents to affected districts/ health facilities to provide adequate space for continuity of health services. UNICEF will also provide targeted support for PPEs and generators for ETUs and temperature guns for schools.
UNWomen	
Implementation of infection, prevention, and control (IPC) Procedures and practices	1. *Support procurement and distribution of PPEs to exposed communities and affected households* 2. *Community mobilisation and awareness raising on strict adherence to IPC procedures* 3. Conduct targeted orientation on PSEA for frontline female health workers and community volunteers
WHO	
Strengthening the coordination, leadership and accountability	1. Deploy WHO technical experts in EVD management and coordination at the national and subnational levels. 2. Support National Task Force and District Task Force in the affected districts to coordinate the response and engage communities. 3. Support MoH to enhance partner coordination, resource mobilization and accountability for resources based on implementation of the response plan. 4. Conduct support supervision and monitoring of response efforts at district levels, including joint monitoring missions. 5. Build capacity of partners involved in the response on Prevention and Response to Sexual Exploitation, Abuse and Harassment (PRSEAH). 6. Support the development of the national response plan and its revisions. 7. Deploy technical experts to support the EVD Response at the national and subnational levels. 8. Support the coordination of cross border collaboration activities/meetings.
Surveillance, active case finding, contact tracing and investigation of cases	1. Support the deployment of Rapid Response Teams in affected districts through covering allowances, transport, and related costs. 2. Support deployment of teams at sub-national level to rapidly support alert management, case investigation, and contact tracing. 3. Build capacity of Village Health Teams to enhance contact tracing and event-based surveillance in affected communities. 4. Support active case search in health facility. 5. Print and distribute tools and technical guidelines to support surveillance activities. 6. Support on collating and disseminating information products to the national task force and other relevant stakeholders.

	7. Support cross boarder surveillance activities.
Strengthening laboratory and diagnostic capabilities	1. Orient district laboratory teams on safe sample collection, packaging, transportation, and laboratory testing. 2. Support sample transportation to referral laboratories for testing. 3. Support quality assurance and quality control mechanism for laboratory testing for both static and mobile labs. 4. Contribute to the procurement and distribution of laboratory logistics. 5. Support genomic surveillance at national level
Case management	1. Establish, perationalize, and maintain ETUs to effectively manage EVD cases. 2. Deploy technical experts to support in provision of care to cases. 3. Conduct training for health workers and auxiliary staff on care of patients in an ETU setting. 4. Support ambulance services to facilitate referral of suspect cases from community and non-ETU health facilities. 5. Safe and Dignified Burials 6. Build the capacity of Burial Teams on the process of Safe and Dignified Burial including the donning and doffing, decontamination in line with IPC standards. 7. Support Burial Teams to conduct safe and dignified burials with necessary logistics and supplies. 8. Provide logistical capacity for disinfection and decontamination of vehicles, and homes of confirmed cases in affected communities as per national guidance.
Continuity of Essential Services	1. Provide guidance on maintenance of essential health services through response to p public health emergencies. 2. Conduct monitoring of health services performance in non- ETU care. 3. Engage partners and key stakeholders to promote access to essential services during public health emergencies. 4. Conduct readiness assessments of health facilitate to inform resilient health system.
UNAIDS	
Continuation of HIV/TB services	1. Mapping of HIV prevention, testing and treatment services in the 5 districts and beyond to ensure continutiy of services 2. Conduct a senstization meeting with PLHIV and female sex workers to ensure prevention sexual transmission of Ebola, STD and HIV 3. Ensure the provision of prevention services for sex workers
EDUCATION	
UNICEF	
RCCE	1. 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.) 2. 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. 3. 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. 4. Supply of posters and IEC materials to 2,000 schools to reinforce awareness raising and infection and prevention measures (supplied by SBC). 5. 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. 6. Transmission reduction strategies such as chlorinating surfaces, use of soap or hand sanitizer for hand hygiene. 7. Support identification and referral of learners and teachers affected by Ebola to mental health and psychosocial support
FOOD & NUTRITION	
UNICEF	
Building the capacity of district, health facility and community managers and service providers in IYCF and nutrition in the context of Ebola	1. 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. 2. Support the DHTs and Nutritionists/Nutrition focal persons update and orient health workers and community health workers on IYCF practices and behaviour for infants and young children affected by EVD 3. 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 4. 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	1. 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 2. Support MoH and DHTs 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.
WFP	
Food Security & Nutrition	1. Procure Food and nutrition assistance to support 25,000 EVD affected individuals
LOGISTICS	
UNICEF	
	1. Focus UNICEF supply contribution in areas where UNICEF has a comparative advantage and a good understanding of the market. 2. 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 3. Support the national system, by working with the national coordination structures both at the planning and implementation levels. 4. Provide technical assistance to the core functions of the Logistics Subcommittee of the National Taskforce for Health Emergencies (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.
WFP	
	1. Provide transport, storage and logistics asset to support to MOH to augment government and partners' logistic capacity
WHO	
Operational and programme support	1. Provide logistics and supply chain management at national and sub-national levels. 2. Procure, preposition, and distribute lifesaving medical supplies. 3. Deploy a team of experts to support logistics management in epicentre and high-risk districts.
Risk Communication, Social Mobilization and Community Engagement (RCCE)	
IOM	
Population mobility analysis at POE/POC is strengthened.	1. Conduct a rapid assessment of population mobility in EVD hotspots and update existing maps from previous PMM, confirming known axes and identifying new population mobility patterns. 2. Conduct at least one population mobility mapping per district, including a micro-mapping health area, a PMM of Mubende District and neighboring districts 3. Disseminate results of the assessment of population mobility to the surveillance commission and the overall response structure to inform decision making on the emergency EVD outbreak response.
Epidemiological surveillance data at POE/POC are strengthened through timely data collection, transmission, and analysis and reporting.	1. Activate online data collection tool POE Data for the management of epidemiological surveillance information at the POE/POC to be shared daily with the commission. 2. Deploy tablets at POE/POC for collection and transmission of surveillance data. 3. Procure internet airtime for electronic transmission of surveillance data from POE/POC.
Frontline workers at POE/POC have increased capacity on epidemiological surveillance.	*1. Train frontline workers on epidemiological surveillance at the XX POE/POC including the organization of practical sessions and simulations.* *2. Organize a training on POE/POC management for local health authorities from the XX priority health zones* *3. Supervise and provide technical support to frontline workers. Where close supervision is not possible, implementation of the remote supervision guidelines developed by IOM.*

Contact tracing, alert detection, notification, investigation, and validation at POE/POC are operational.	*1. Train the investigators at 12 POE/POC on the secondary screening of alerts.* *2. Promote the use of POE/POC as first point of care and implement self-reporting. Sensitization of POE/POC surrounding communities and travelers to promote "self-reporting" of any suspected EVD cases at POE/POC to seek for health information and orientation to appropriate health center.* *3. Provide telephone units to POE/POC focal person and to the health center's nurse in charge (IT) to facilitate communication in the event of an alert with the IT for investigation. The provided internet units will also support the prompt transfer of contact lists.* *4. Facilitate referral of validated alert cases for further investigation and management to nearby health facilities.*
POE/HSPs are supported operationally.	1. Provide equipment and supplies to 23 priority POE/POC identified for according to standard list of supplies approved by the MOH. 2. Establish 12 HSPs at strategic points.
Community-based surveillance is maintained around POE/POC.	*1. Community event-based surveillance is reinforced around POE/POC.*
Cross-border coordination with neighboring countries is reinforced.	1. *Support the organisation of a cross-border meeting with Uganda's neighbouring countries.* 2. Support the development of a mechanism to exchange data, alert information, RCCE messages with Ugandan border authorities
Community perceptions are assessed to develop tailored positive-prevention messaging.	1. Organization of focus groups with stakeholders to identify the reasons for refusal of screening and other public health interventions at the POE/POC. 2. Organization of meetings with local community leaders, people of influence in the communities, local associations, and frequent users of the POE to collect feedbacks on the service provided and establish ownership by the community.
RCCE at POE/POC and surrounding communities is strengthened, ensuring active participation of local communities, and prisons to reinforce trust and collaboration.	1. *Refresh training for frontline workers to enable them to engage with travelers and address cases of resistance to screening and other relative community concerns. PSEA module is also introduced in all trainings conducted to engage with the community*. 2. Organization of groups of discussion with traditional leaders and people of influence in the community to ensure their buy-in and collaboration in disseminating RCCE messages and developing culturally sensitive and adapted messages. 3. Dissemination of culturally sensitive and adapted risk communication messages at POE and along mobility corridors. 4. Provision of equipment and information, education, and communication material (posters, leaflets) developed in collaboration with the key authorities. 5. Organization of public campaigning (with precautions regarding the barrier measures), radio messages, community theatre and other social gathering activities to engage with high-risk groups such as frequent travelers, traders, transport agencies, taxi and moto-taxi associations, to raise their awareness of health risks and adherence to screening protocols. 6. Organize community dialogues with mobile populations and local communities living around POE/POC. 7. Set-up multi-disciplinary POC platforms composed of different services working at the POE/POC and community members.
UNDP	
	1. *Support risk communication, social mobilization, and community engagement*
UNFPA	
	1. *Reproduce and disseminate MoH approved IEC materials on EVD and translated into local languages (posters, banners, leaflets, job aids flip charts, and fact sheets for schools and prisons)* *2. Facilitate public health education and mobilization of communities to create awareness about EVD response services as well as availability and access to other essential services, using multiple mass media channels including (social media, radio messages, call-ins and talkshows, Whatsapp messages)* *3. Enhance the capacity of relevant stakeholders and key influencers at district and sub county level including sub county and parish level leaders, health workers, Village Health Teams (VHTs), para social workers, head teachers, religious & cultural leaders ; other community structures (Male Action Groups, SASA! Activists, peer educators) to disseminate key messages on risk perception and prevention against EVD at community level* *4. Conduct operational research as well as post outbreak evaluation to gauge the effectiveness of the RCCE strategy and interventions* *5. Create community feedback mechanism to inform response planning (through community radios, radio-talkshows, call ins)*
UNHCR	
Risk communication and community mobilization including psychosocial support	1. Printing of IEC Ebola materials 2. Procurement of Megaphones for VHTs 3. Procure VHT kits to facilitate house to house risk communication by the VHTs 4. Institute village task forces per village to increase risk communication, case finding at the community

	5. Printing VHT handbooks, CBDs handbook, Health education handbooks for each of the VHTs 6. Community sensitization meetings through mounted speakers on bike and cars 7. Establish Self help groups, group therapy and self help plus in each of the the community 8. Training the community health workers in case identification, refferal and counselling
UNICEF	
	1. *Mass media messaging*: UNICEF Social and Behavior Change (SBC) section will offer nationwide risk awareness and public health education through the mass media and intensified mass-media and interpersonal messaging in the 21 most at-risk districts e.g., Mubende, Kyegegwa, Kassanda, Kagadi, Bunyangabu and surrounding districts to ensure timely and effective execution of Risk Communication and Community Engagement (RCCE) activities; through a program of cooperation agreement (PCA) with Uganda Red Cross Society (URCS), for a period of three months. In each district, RCCE will aim at ensuring that people are reached with gender- and age-sensitive, socially, culturally, and linguistically appropriate messages on Ebola disease prevention through multiple channels (radio, TV, interpersonal communication), to ensure that they know where to get related services, participate in communal protection, continue to use and access other appropriate health services like COVID-19 vaccination, 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 and promote healthy practices. These will include health workers, religious and cultural leaders, owners of schools and learning centers, owners of pharmacies, owners of hotels, leaders of taxi drivers, and motorcyclists (boda-boda riders). 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 communal protection, 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, and interact with traditional herbalists and spiritual healers. 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 dialogue meetings by the VHTs and other community-based mobilizers. 4. *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 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. Vaccination : UNICEF will support the government with microplanning, RCCE, and logistics including the last mile for conducting targeted, ring, or mass vaccination campaigns, if such are undertaken by MoH/WHO. 5. Social sciences research: Support the government to continue the collection and analysis of social and behavioral sciences data (including KAP / rapid anthropological studies, qualitative and mixed methodology studies) Conduct off-line and online social listening related to Ebola, including on social norms, on local care-seeking patterns, burials practices, and myths, beliefs and misinformation. Target specific at-risk/ vulnerable populations as well as targeting interventions in health facilities, schools, cultural, and religious institutions. Develop behavioral indicators as necessary and identify data collection plans to inform the RCCE/SBC response. Vaccination : UNICEF will support the government with microplanning, RCCE, and logistics including the last mile for conducting targeted, ring, or mass vaccination campaigns, if such are undertaken by MoH/WHO.
UNWomen	
Risk communication and community engagement in beneficiary districts	1. Support development and dissemination of gender aware messages 2. *Provide relevant sensitisation and advocacy material in local languages* 3. Conduct Ebola risk awareness sessions targeting women leaders, AGYW including those at risk of other communicable and non-communicable diseases. 4. Facilitate EVD planning sessions for information dissemination through women networks, community leaders and rural women structures as channels for information flow on Ebola at the community level 5. Facilitate convening for district EVD taskforces in beneficiary districts 6. *Facilitate community radio dialogues focusing on facts, society norms, and harmful practices that promote Ebola virus transmission*

	7. Attend and provide technical guidance to national and local authorities, civil society groups, prioson authorities, the media, MoH and UNCT to ensure successful
Community based surveillance and referral for expert care	1. Contribute to facilitation and field allowances for IP volunteer teams and grassroots women leaders 2. Provide PPE to community volunteers and women leaders active in the surveillance procedures
UNAIDS	
Risk communications and Community engagement	1. Organize a meeting with 60 traditional healers to sensitize them about Ebola 2. Translate communication Materials into local languages 3. Pre testing of the translated fact sheets 4. Re priniting of the translated materials 5. Procurment of IPC materials and thermometer for traditional healers when engaging with communities 6. Procurement of mega phones and batteries 7. Facilitation of selected tradional healer advocates 8. Support the hotline service for Ebola integrated with GBV and HIV
WHO	
Risk communication, social mobilization, and community engagement	*1. Train health educators, health assistants and VHTs on Sudan ebolavirus risks, preventive, and control measures.* *2. Engage, sensitize, and equip VHTs with educational material on EVD to conduct community sensitization in affected districts.* *3. Update, redesign, print and disseminate Information, Education and Communication (IEC) materials.* *4. Develop key messages on prevention, detection, and control and facilitate dissemination through mass media and social media.* 5. Support the activation of Sub- County, Parish and Village Task Forces for increased vigilance and community awareness, early case identification and reporting.
Point of Entry	*1. Support high level coordination meetings between the neighbouring countries of the EAC* *2. Support cross border surveillance*
Integrating Research in the response	1. Appoint a national research coordinator and establish a research coordination platform within the outbreak response committee 2. Update diagnostics guidelines, and conduct testing of key candidate diagnostics 3. Evaluate and update the WHO guidelines and tools for clinical management 4. Carry out operational research on risk factors 5. Conduct randomized clinical trials of key candidate therapeutics and vaccines
WASH	
IOM	
Hand washing practices at POE/POC are reinforced.	1. *Provision of hygiene kits at POE/POC to promote hand washing practice.*
UNHCR	
Infection prevention and control measure for institutions and communities including WASH	1. Procurement of 450 g of Soap per person per month for 6 months 2. Procure an assortment of PPEs and hand washing facilities 3. Increase WASH coverage to average 18lpd 4. Fencing of 20 health facilities 5. Build 7 mortuaries at 7 health facilities 6. Procure 10 incinerators for waste management 7. Equipping of the Kiryandongo Warehouse 8. Solar lighting at 30 health facilities with no reliable power source
UNICEF	
Infection prevention and control	1. Working with government and partners, organize supply planning for UNICEF-prioritized activities. UNICEF Procure and distribute critical hygiene and prevention items (including soap, hand-sanitizer, masks (as appropriate per latest guidelines), drinking water dispensers, disinfectant, and personal protection equipment) for use in schools, health facilities (includes targeting health facilities in new risk areas, and also replenishing supplies in Health facilities that were provided with WASH supplies), and Communities at high-risk of Ebola disease.

	2. Support periodic review and update of a minimum package of WASH activities based on context-specific risk analysis for different settings (i.e., health care facilities, households, schools, other public spaces, and vulnerable settings such as refugee settlements and urban slums). 3. 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.
WHO	
Infection prevention and control and WASH in health facilities and communities	1. Build capacity of health workers on IPC in ETU and non-ETU settings. 2. Improve IPC and access to WASH facilities in affected communities as per national guidance.
PROTECTION	
UNICEF	
Mental Health and Psychosocial Support (MHPSS)	1. *Build capacity of district and community systems to provide Mental Health and Psychosocial Support (MHPSS) services for EVD affected individuals and families, including children in ETUs and communities* 2. *Train district core MHPSS teams (health, social welfare, community development) on MHPSS service provision, including for children.* 3. *Train health workers at Regional Referral Hospitals, district and sub-county levels on the provision of MHPSS to patients in treatment, and isolation for EVD, affected communities including contacts and family members of admitted patients including children.* 4. Train community structures focusing on para-social workers, and VHTs on the provision of basic PSS and psychosocial first aid (PFA) in affected communities. 5. *Support the provision of MHPSS services at the facility, and at the community level through trained structures, including for discharged patients.* 6. Support the deployment of psychologists, and psychiatrists to EVD treatment and isolation units to provide MHPSS to admitted patients. Support provision of MHPSS services to health workers deployed in the EVD response, including through individual, and group-based support. 7. Support innovations for tele-counseling services for patients under isolation, and treatment 8. Develop and disseminate targeted messages on MHPSS in communities, and schools, and with health care workers.
	1. Support health actors to ensure that the designs and set up of isolation and treatment units are child-friendly, including through the provision of play materials# 2. Provide case management services to child victims of violence, children at risk, and those experiencing neglect related to EVD including survivors. 3. 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. 4. 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 5. Train district staff and community structures on prevention and social behaviour change interventions for children, caregivers, and communities. 6. Provide mobile community-based psychosocial support to children and families. 7. Establish safe and accessible child-sensitive SEA reporting mechanisms. 8. Scale up community engagement ; mobilization and awareness raising on PSEA 9. *Train aid workers (Government, UN and CSO partners, VHTs and other volunteers and community structures involved in the response) on PSEA.* 10. Include PSEA reporting toll free lines in all awareness materials in the EVD response. *11.* Build capacity of district and community systems to provide Mental Health and Psychosocial Support (MHPSS) services for EVD affected individuals and families, including children in ETUs and communities: training of district core MHPSS teams, health workers at Regional Referral Hospitals, community structures focusing on para-social workers, and VHTs on MHPSS service provision; Support the deployment of psychologists, and psychiatrists to EVD treatment and isolation units to provide MHPSS to admitted patients; Support provision of MHPSS services to health workers deployed in the EVD response 12. Ensure protection of children from violence and provide adequate protection services, including interim care and foster care for EVD affected children
UNWomen	
Reduced financial stress and resilience for women headed affected households	1. Facilitate women leaders to access secure health certified markets/trading areas, through engaging dialogue among MoH, etc 2. Link women h/h to UN and NGOs to access emergency food, incl. food supplements and seeds 3. Strengthen capacity of market women and women farmers for savings and loans 4. Strengthen capacities for business coping strategies focusing on women H/H

Psychosocial support to affected members in affected districts	1. *Provide first level psychosocial support and referral for expert care to affected women and girls in target districts* 2. *Provide ongoing counselling and counselling support for recovering patients that are reintegrating with family and communities*
The leadership of MoGLSD and other key other key stakeholders to engender the response	1. Support the Ministry of Gender to articulate gender perspective of Ebola crisis among key government departments including Health, Internal Affairs, Planning, Finance and Parliament 2. Support the Ministry to have an effective monitoring and reporting systems on Ebola crisis in communities 3. Strengthen capacities of MoGLSD to facilitate dialogue among community' leaders to minimize the risk exposure of populations, in particular women 4. Strengthen capacity of UN staff trained on Gender in the Ebola response and PSEA
WHO	
Psychosocial care	1. *Train providers and community leaders on essential psychosocial care* 2. Equip teams with appropriate trainings, tools and support 3. *Provide food / nutrition and non-food support to affected individuals and families* 4. Establish a psychosocial action plan to combat stigma and other consequences 5. *Assist in the care and social reintegration of survivors and orphans*