



THE REPUBLIC OF UGANDA

NATIONAL CORONA VIRUS DISEASE – 2019
(COVID-19)

RESURGENCE PLAN

June 2021 – June 2022

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(COVID-19)

Resurgence Plan

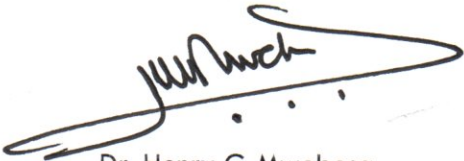
June 2021 – June 2022

Acknowledgement

The Ministry of Health, Uganda wishes to acknowledge the efforts Ministries, Departments and Agencies in responding to the COVID 19 pandemic since March 2020 when Uganda first identified a case. The Ministry also acknowledges the commitment of partners and stakeholders in the National Task Force in contribution to success in the response.

This resurgence plan has been developed through a consultative process and builds on lessons learnt in implementation of the response efforts through the COVID 19 Preparedness and Response Plan March 2020 – June 2021. The plan provides a basis for response to the COVID 19 pandemic with a goal of integrating response activities into on-going health system strengthening efforts. It also takes into account the changes in epidemiology of the pandemic inclusive of emergence of variants of SARS-COV2.

I thank you

A handwritten signature in black ink, appearing to read 'H. Mwebesa', written over a horizontal line.

Dr. Henry G Mwebesa

Director General Health Services

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Abbreviations

COVID	Corona Virus Diseases
CSOs	Civil Society Organizations
DGHS	Director General Health Services
DRC	Democratic Republic of Congo
DTF	District Task Force
EAC	East African Community
EVD	Ebola Virus Disease
GBV	Gender-Based Violence
GHSA	Global Health Security Assessment
GoU	Government of Uganda
HDU	High Dependence Units
HMIS	Health Management Information System
HR	Human Resource
ICT	Information Communication Technology
ICU	Intensive Care Unit
IMT	Incident Management Team
IPC	Infection Prevention and Control
JEE	Joint External Evaluation
LG	Local Government
M&E	Monitoring and Evaluation
MAAIF	Ministry of Agriculture Animal Industry and Fisheries
MDA	Ministries, Departments & Agencies
MERS	Middle Eastern Respiratory Syndrome
MHSSP	Mental Health and Psychosocial Support
MoD	Ministry of Defense
MoE&S	Ministry of Education and Sports
MoFPED	Ministry of Finance Planning & Economic Development
MoGLSD	Ministry of Gender Labour and Social Development
MoH	Ministry of Health
MoIA	Ministry of Internal Affairs
MoICT & NG	Ministry of Information Communication Technology and National Guidance

MoLG	Ministry of Local Government
MoT&I	Ministry of Trade and Industry
MoW&E	Ministry of Water and Environment
NCDs	Non Communicable Diseases
NGO	Non Governmental Organization
NPHL	National Public Health Laboratory
NRH	National Referral Hospital
NTF	National Task Force
OPM	Office of the Prime Minister
PHEOC	Public Health Emergency Operation Centre
PoE	Points of Entry
PPEs	Personal Protective Equipment
RCSM	Risk Communication and Social Mobilization
SARS	Severe Acute Respiratory Syndrome
SOP	Standard Operating Procedures
TB	Tuberculosis
UPDF	Uganda People's Defence Force
UVRI	Uganda Virus Research Institute
WASH	Water Sanitation and Hygiene
WHO	World Health Organization

Introduction

The Coronavirus disease (COVID-19) outbreak was declared a Public Health Emergency of International Concern on 30th January 2020 and a pandemic on 11th March 2020. Over a year into the response, COVID-19 continues to overwhelm health systems globally, with evidence showing that it is most likely to extend beyond 2021. Globally, the cumulative number of cases has surpassed the 100 million mark, with 141,754,944 million cases and 3,025,835 million deaths confirmed as of 21st April 2021.

The outbreak has been characterised by several waves with many affected countries experiencing upsurge in the cases from time to time. As of 21st April 2021, all regions reported an increase in the number of cases, with the largest increases in the South-East Asia, Western Pacific, and African Regions, all of which have been on an upward trajectory in recent weeks. The European Region and the Region of the Americas continue to account for approximately 80% of all new and cumulative cases and deaths. In the Africa Region, over 15 countries have reported a surge in the number of cases of COVID-19. In the Eastern Africa region, an exponential upsurge has been recorded in Kenya, Ethiopia, Madagascar, Mauritius and Rwanda over the last 28 days preceding 7th April 2021. Ethiopia alone accounted for 24% of new cases in the last 4 weeks. Below is a graph showing the trend in cases in Africa.

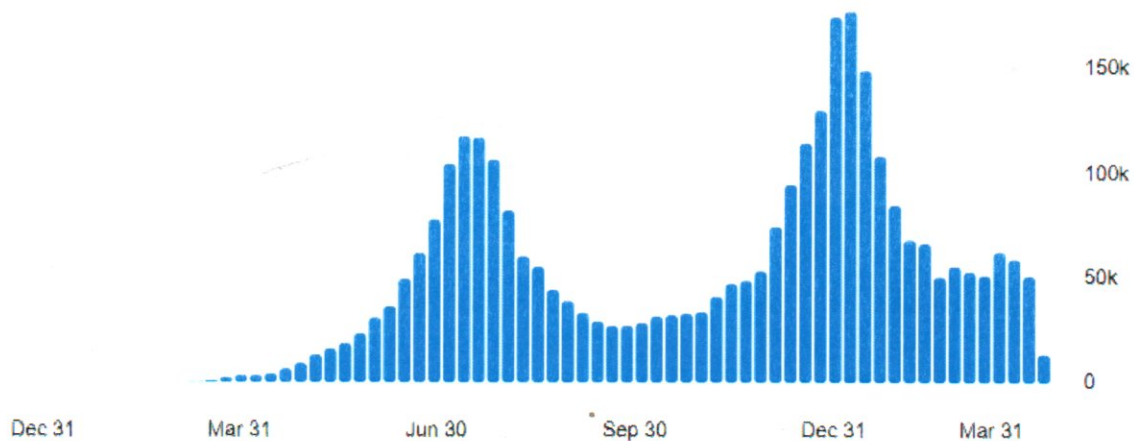


Figure 1: Trend of COVID 19 confirmed cases in the African Region

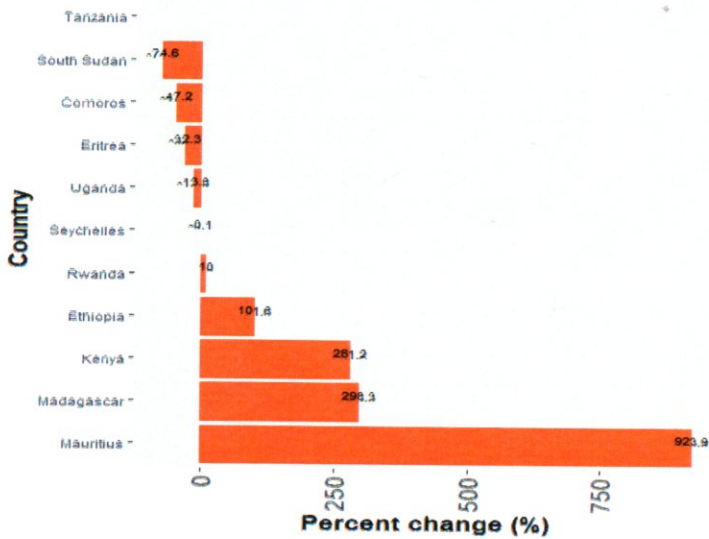


Figure 2: Graph showing percentage increase in COVID-19 cases in Eastern Africa

Resurgence

Resurgence is defined as an increase in disease incidence after a period of lower transmission; and can also be referred to as a 'second wave'. In most of the countries, resurgence has been associated with the following factors:

- Poor adherence to non-pharmaceutical public health measure (social distancing, use of masks and hand hygiene)
- Opening up of economies (workplaces, schools, travel, etc)
- Emergence of SARS-COV2 variants of concern

The most well document variants in the Africa region are 20H/501Y.V2 (first detected in South Africa) and 20I/501Y.V1 (first detected in the UK). Below is the map showing the global distribution variants of concern.

Countries, territories and areas reporting SARS-CoV-2 501Y.V2 as of 30 March 2021



Countries, territories and areas reporting SARS-CoV-2 VOC 20212/01 as of 30 March 2021



Figure 3: Maps showing global distribution variants of concern

This resurgence plan is developed in line with the World Health Organization’s April 2020 COVID-19 Strategy Update. It’s intended to provide a framework for robust response to acute and gradual but sustained rise in the number of cases, mitigate the risk associated with COVID-19 resurgence and to strengthen sustainable structures for emergency response in the country.

This document is therefore intended to be used as a practical guide for response to a potential COVID-19 resurgence in Uganda. It was largely informed by gaps identified by the Intra-Action Review (IAR) and in implementation of the current (March 2020 – June 2021) national COVID-19 preparedness and response plan while considering key issues observed in other countries.

Background and overview of the public health response in Uganda

Uganda confirmed the COVID-19 outbreak on 21st March 2020. Originally identified in Wuhan, China, the outbreak continued to transmit globally affecting over 100 million people. In Uganda, at the time of writing this document, the cumulative cases stood at 41,422 including 339 deaths [Case Fatality Rate (CFR) = 0.81%] with confirmed cases identified from 135/136 districts in the country.

Situation analysis

Descriptive epidemiology of the Uganda outbreak

The COVID 19 outbreak has evolved over time; initially dominated by imported cases then progressing to sustained community transmission. As seen in figure 4 below, we only registered 3,038 confirmed cases over a 6-month period (March to August 2020), while it progressively took 4 months (September to December 2020) to register 22,021 cases (88% of the national case count at the time).

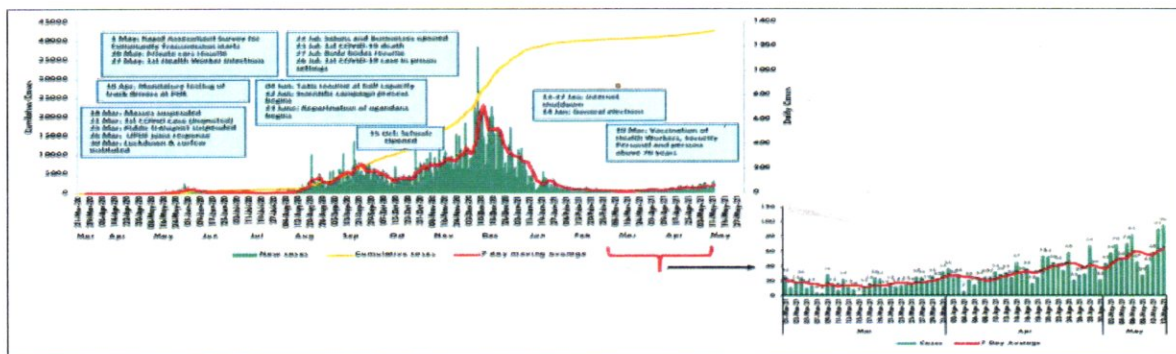


Figure 4: Epicurve of the COVID-19 outbreak

Initial peaks observed in May 2020 were associated with the clusters in border districts such as Rakai, Kyotera, Tororo and Amuru and majorly the transnational truck drivers. Intense actions neutralized the clusters and resulted in a sharp decline. In June 2020, the GOU opened various sectors of the economy, followed closely by the elections process. Between August and mid-December 2020, there was a generally high transmission rate attributable to involvement of

congregation communities; prisons, health care facilities, factories, construction works and traditional social events such as those in the Elgon area.

The decline in cases between end of December and January was drastic and since then, Uganda has observed a significant decline in the number of incident cases reported. However, as seen in figures 5 and 6 below, April has seen a much faster epidemic growth rate than March; by mid-March, the cumulative number of cases reported within the month were at 284, yet by the same date within April, the cumulative cases had almost doubled (525), which if sustained, could easily potentiate into the 2nd wave of the outbreak.

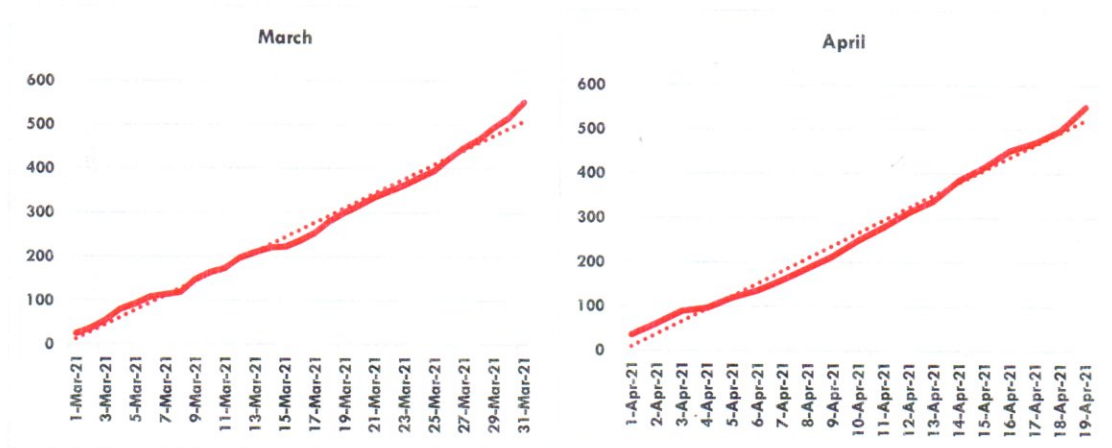


Figure 5: Cumulative distribution of cases in March

Figure 6: Cumulative distribution of cases in April

Currently, upsurges remain localized to the districts of Gulu, Arua, Kitgum, Wakiso and Kampala but could quickly spread to other districts and regions. The Greater Kampala Metropolitan Area (Kampala, Wakiso and Mukono) accounts for the greater bulk of the confirmed cases (57%), with Kampala district single-handedly contributing 48% to the national case count. The current outbreak scenario is that of the propagated transmission pattern depicting widespread transmission foci within the communities. Figure 7 below depicts the cumulative burden of COVID-19 by region.

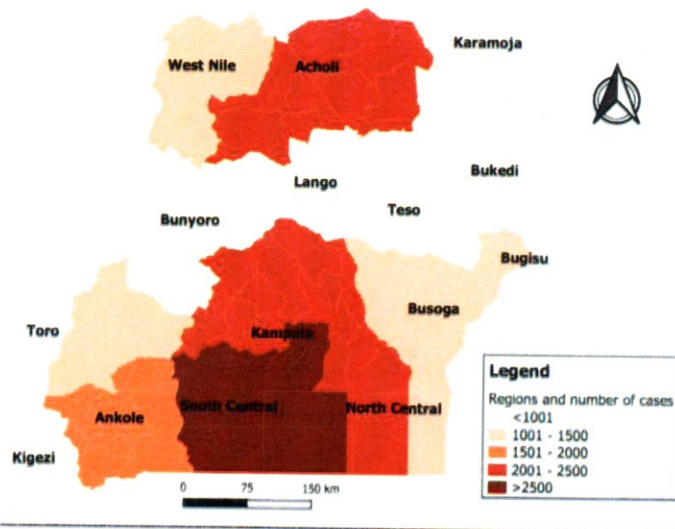


Figure 7: Map showing cumulative burden of COVID-19 by region

Regarding gender, the initial months of the outbreak saw males (80%) overwhelmingly more affected than females (20%). However, currently there's a 60% - 40% (male-female) distribution with the most affected age group being 26 – 35 years for both genders. Reported cases are categorized as 51% alerts, 35% contacts, 5% health workers, 5% travellers, 2% truck drivers and 2% returnees.

Uganda continues to implement COVID-19 pandemic response measures under the technical leadership of the Ministry of Health and the overall oversight of the Office of the Prime Minister. Health sector interventions have targeted coordination, surveillance, case management, risk communication and Strategic Information, Research and Innovation. In addition to this, the Ministry of health conducted an Intra Action Review of the COVID-19 response, for the period of 21st March 2020 – 30th September 2020 and a population-based, age and gender-stratified sero-survey to establish the prevalence of SARS-COV-2 in Uganda.

Alongside these interventions, Uganda rolled out the COVID-19 vaccination on 10th March 2021 in a phased manner. The initial phase targeting selected high-risk groups such as the health workers in public and private facilities, security personnel (UPDF, UPF and Prisons), teachers, persons above 50 years, and persons below 50 years with comorbidities. As of 21st April 2021, over up to 245,939 persons have been vaccinated, 29% of whom are security personnel and 13% health workers. Uptake of the vaccine has been slow with only 15% of the targeted population receiving the first dose of the vaccine, a finding which partly forms the basis of justification for this resurgence plan.

Main achievements from the response.

Leadership, stewardship, coordination and oversight;

COVID 19 coordination is undertaken by the Strategic Advisory Committee advices by the scientific Committee (strategic), Incident Management Team (operational) and District (tactical). The IMT is responsible for the day to day review of COVID 19 outbreak response. Overall clearance of the response decisions is done at the National Task Force chaired by Office of the

Prime Minister. Table I below provides the achievements, gaps and recommendations so far from the COVID 19 response

Table 1: Achievements Gaps and Recommendations

Key achievements/best practices	Gaps/Challenges
<ul style="list-style-type: none"> ✓ Activation of the IMS coordination structures at national and district. National level coordination structures were activated including all the technical pillars, Incident Management Team, Strategic Management Committee and the COVID-19 National Task Force. At subnational level, coordination platforms were activated at regional and District Task Force in each district ✓ A National and Preparedness and Response plan was developed with participation of the partners. The plan had a total budget of USD 600.5 million and initially 35% of funding from government but only USD 75.26 million was realised. Additional funding was provided by partners amounting to USD 77.5 million. ✓ A national dashboard for monitoring progress in the COVID 19 response was launched. The Dashboard is updated regularly ✓ Additional partner coordination forum – the partner platform was initiated but was later integrated into the public health emergency NTF that discusses all public health emergencies in the country ✓ Inter Action Review was conducted to review the response on 'what went well and what did not go so well'. ✓ Technical and political monitoring of the response was conducted by the MoH ✓ Development of Standard Operating procedures and guidelines. 	<ul style="list-style-type: none"> ✓ Centralised support to districts created ownership challenges and slowed use of traditional outbreak response mechanisms previously developed by the ministry. ✓ Most of the district level activities were underfunded which created lapses in response implementation ✓ IMT which takes most of the operational decisions on implementing outbreak response activities had limited funding to support operational decision. ✓ Technical teams from the operational partners have been largely overstretched in the response ✓ There is very limited linkage between the central response structures and the districts ✓ Limited funding to handle resurgence in the districts
Recommendations: <ul style="list-style-type: none"> ✓ IMT should be allocated funding to effectively finance operational and tactical level interventions ✓ The strategic committee should decentralize decision making powers for financing operational activities to the IMT or NTF ✓ Greater participation of funding and operational partners to IMT should encouraged. ✓ There is need to strengthen the DTFs by adequate resourcing district response since they have better capacity, are more organised and have a better mandate to organise health services. ✓ There is need for a surge plan to enable support to high burden districts with funding to support the plane 	

Surveillance and laboratory

Surveillance pillar is organised into Alert Management, Contact tracing, Case investigation, Quarantine and laboratory operating under guidance of Pillar lead and is supported by several technical partners. The pillar reports to IMT. There is a central team that supports the districts. Surveillance is supported by a network of laboratories at central and regional levels .Table 2 below are the major achievements, Challenges and recommendations of the pillar in response to COVID 19.

Table 2: Laboratory and Surveillance Achievements

Key achievements/best practices	Gaps/Challenges
<ul style="list-style-type: none"> ✓ Activation of the pillar and mobilization of all core partners involved in surveillance and laboratory intervention was done. This included AFENET, IDI, Resolve, CDC and WHO ✓ Tailoring of case definition for community and health facility suspected cases, probable and confirmed cases was done. The guidance supported the districts and health facilities increased index of suspicion in the identification of suspected COVID 19 alerts ✓ Alert management system was initially set up with presence of at least 05 rapid responders per district supported with an ambulance. The rapid responders received rumours, verified and investigated events as reported. ✓ Conducted training of regional and district teams on core surveillance functions related to COVID 19 and the key performance requirements ✓ Developed and disseminated SOPs and various technical guidelines to guide surveillance for COVID 19 at district and regional level ✓ Conducted investigation of cases during phase 2 and 3 to inform response and have continued to investigate all cases of health workers infections ✓ Organised a system for contact tracing and ensure that all listed contacts were followed up daily during phase 2 and 3 of the outbreak. However, funding for this reduced significantly ✓ Conducted various trainings both virtual and face to face trainings. ✓ Conducted several emergency surge deployments in response to upsurge and to undertake risk-based testing. ✓ Procured and supplied assorted supplies for lab investigations ✓ Set up a total of 21 laboratories for COVID 19 testing. 	<ul style="list-style-type: none"> ✓ Reporting remains a challenge in some of the districts. ✓ Reduction of Response staff in various areas of operation in the wake of escalating number of COVID 19 cases ✓ Contact Tracing System remains suboptimal ✓ Reduced Sample transportation vehicles, resulting in increased TAT ✓ Delay in receiving Test Kits and other laboratory supplies from Global supply Chain ✓ Delayed Payment of Allowances ✓ Current data show that more cases are being identified from contacts (~35%) and yet only a small fraction of contacts is being traced

Recommendations:

- ✓ There is need to strengthen the District Rapid Response Teams for transition into sustained response to the COVID 19 outbreak
- ✓ There is need to consider mobilization and instruction of a dedicated technical team in each district to conduct contact identification
- ✓ Mobilize and facilitate the Rapid Response Teams to provide sustained oversight of response in the districts
- ✓ Expand community surveillance; orient and engage VHTs in contact tracing around each confirmed case
- ✓ There is need to strengthen IDSR to support a systematic surveillance approach
- ✓ Data management needs to be strengthened for the various aspects of the response
- ✓ Support surge teams to high burdened districts for the management of upsurges and resurgence

Case management

Case management has been very central to the COVID 19 response. The team has a well organised and have support care through a network case management pillar organised a total of 18 treatment centres and 06 Non tradition Isolation facilities. These include all the regional referral hospitals (Lira, Gulu, Arua, Hoima, Fort Portal, Mubende, Kabale, Mbarara, Masaka, Naguru, Entebbe, Jinja, Mbale, Soroti and Moroto). Additional hospitals include Mulago National Referral hospital, Adjumani and Bombo general Hospitals was also set into a treatment centre. Non- traditional treatment centres were also organised in Namboole, 03 prison centres (Gulu, Jinja & Moroto), Aswa power dam and Kyangwali.

Table 3: Case Management Achievements and Challenges

Key achievements/best practices	Gaps/Challenges
<ul style="list-style-type: none"> ✓ The cumulative of 42,676 cases have been handled with a total of 41,971 recovered as of 09 May 2021. A total of 347 patients died. ✓ Organised a total of 18 treatment centres and 06 Non tradition Isolation facilities. These include all the regional referral hospitals (Lira, Gulu, Arua, Hoima, Fort Portal, Mubende, Kabale, Mbarara, Masaka, Naguru, Entebbe, Jinja, Mbale, Soroti and Moroto). Additional hospitals include Mulago National Referral hospital, Adjumani and Bombo general Hospitals was also set into a treatment centre. Non- traditional treatment centres were also organised in Namboole, 03 prison centres (Gulu, Jinja & Moroto), Aswa power dam and Kyangwali ✓ Essential trainings have been conducted in basic case management, Advanced Care of COVID 19 patients. Additional trainings included triage management in all the 14 regional hospitals for a total of 1600 health staff. ✓ Mobilized a total of 5 ambulances for emergency long distance evacuations. A total of 131 patients have so far been evacuated to treatment facilities over the period in the districts of Bududa (10), Kaabong (4), Mbale (10), Masaka (14), Rakai (7), Kalangala (2) and Wakiso (80). ✓ A total of 144 ICU beds were set up. However not all the beds are functional because of staffing issues and connectivity to oxygen ✓ Procured and provided assorted supplies for case management including PPEs, medical supplies, Ventilators, Oxygen supply equipment, patient beds and mattresses. ✓ Developed and disseminated clinical guidelines on Home based Isolation and Care and Hospital clinical management 	<ul style="list-style-type: none"> ✓ Inadequate qualified Human resource to facilitate operation of the Intensive Care Units in Regional Referral Hospitals including Mulago (Main referral) ✓ Patient evacuation delays has been wide spread; some fatal ✓ Overwhelming community resistance: denial of results, uncooperative contacts and non-compliance with directives and guidelines ✓ Provision of Psycho social services in HBC and CTUs has been suboptimal ✓ Challenges of providing meals to patients in Isolations ✓ Bed capacity is also inadequate especially for functional critical care beds ✓ PPE and other Medical supplies shortages ✓ High Oxygen demand by COVID 19 patients outstripping the capacity currently in place. ✓ Rapid changing situation of clinical care
Recommendations: <ul style="list-style-type: none"> ✓ There is need to provide adequate oxygen supplies facilities; oxygen concentrators, PSA facilities for additional hospitals and delivery accessories ✓ In view of the inadequate number of specialists intensivists and critical care nurses to man the ICUs and HDUs across the country, there is need develop urgently a tailored made short capacity building course to be used to quickly skill up non-ICU nurses and clinician to develop basic competence to support functionalization of ICUs and HDU. An initial target of 400 health workers has been set; ✓ Personnel protective equipment should be provided to districts to support safe care by health staff in high-risk service points and activities ✓ Innovative mechanisms to address the issue of meals for the patients the hospitals otherwise isolation of even severe cases will never be complete ✓ There is need to streamline the implementation of the home-Based Care (HBC) for COVID-19 through capacity and empowering of community structures such as the VHT system and the formation of Village COVID-19 Committees to take charge of HBC implementation. 	

Risk Communication and social mobilization

Risk communication is core to promoting positive behaviour practice and to reduction of risky behaviours. At risk traveller and the general public were the main audience for the risk communication. Attention was paid to the Sensitization of the various stakeholders with the intention to identify and dispel myths about COVID, build consensus on appropriate risk prevention

behaviours and promote actions that reduce misconceptions and to ensure that audience supported the response efforts are promoted in their communities and country. Table 4 below outlines some of the achievements

Table 4: Risk Communication Achievements and Gaps

Key achievements/best practices	Gaps/Challenges
<ul style="list-style-type: none"> ✓ Revised the National Public Health Risk Communication and Community Engagement (PHRCCE) strategy to focus on increasing community participation. ✓ Trained our Community Health Workers and the Local Council structures in PHRCCE and COVID-19. ✓ Regularly reviewed and disseminated COVID-19 messages across various media – Radio, TV, Print, Outdoor and social media. ✓ Developed SOPs for different audiences and settings. ✓ Conducted [online & community] assessment to establish people's Knowledge, Attitudes, Practices, & perceptions on SOPs. This informed strategy development & its Implementation ✓ Set up and functionalized the Public Risks Communication coordination ✓ Engaged Stakeholders to supporting PHRCCE COVID-19 ✓ Implemented Practical ways to build Community trust (Shift COVID-19 message dissemination from MoH to community influencers; the Queen of Buganda, MTN Uganda a telecom company, Celebrities and Artists and Provided daily press releases. Other interventions include Responsive social media engagement and Functional toll-free helplines ✓ "Tonsemerera" (Keep a Distance Campaign). This was successful multi-media campaign that was implemented to promote ✓ Developed and printed assorted IEC material to support risk communication in the field. ✓ Over 400 radio talk shows have been conducted on COVID 19 in 310 radio stations across the country ✓ Over 200 radio spots have been aired out in the various radio stations ✓ Two (2) national KAP surveys were conducted; 7 regions specific KAPs conducted ✓ Over 25,000 community leaders have been engaged at national and subnational level. This is broken down as, 10,000 religious' leaders, 10,000 political leaders, 5,000 cultural leaders and others. ✓ Over 20 Risk Communication/community engagement SoPs produced ✓ Dialogue meetings have been organised with various groups including boda bodas, taxi operators, teachers, manufactures, traders, commercial sex workers, truck drivers, fishermen, students, uniformed forces, immigration officers, hoteliers, etc, etc. ✓ Engagement of religious and cultural leaders has been undertaken at national and subnational level. 	<ul style="list-style-type: none"> ✓ There is a shift from public's risk perception / appreciation of severity of the disease - To the effects [Socio-Economic] of COVID-19 Response interventions such as national and business-related lock-down ✓ Limited funding for effective decentralized implementation of developed strategies [district and sub county level Community Engagement activities]. ✓ Evolving nature of COVID-19 and regular changes in preventive scenarios. Too many adhoc requests and high expectations but with limited funding, and costly inputs. ✓ Growing levels of fake news from social media platforms
<p>Recommendations:</p> <ul style="list-style-type: none"> ✓ There is need to organize community engagement teams in each district to mount a dedicated response to each cluster and to provide strategic directions to local response. ✓ Messages need to be translated into the local dialects to ease comprehension. ✓ Regular Media briefs & Engagements to address misinformation. ✓ Investment in Social Media, the minority on social media influences the majority on mainstream media. 	

Community engagement and social protection

The community engagement and social protection pillar was created as multi-sectoral entity to concentrate efforts by the various actors aspiring to empower communities against COVID 19. The pillar is a joint arrangement between the Ministry of Health and the various inter-ministerial representatives mobilized under the National Task Force for COVID 19. Table 5 below summarises the achievement of this pillar so far.

Table 5: Community Engagement and Social protection Achievements

Key achievements/best practices	Gaps/Challenges

<ul style="list-style-type: none"> ✓ Revised the National Public Health Risk Communication and Community Engagement (PHRCCE) Community engagement strategy finalized and launched by the Prime Minister in Kampala and the Minister of Health in Lira district. ✓ They have so far mobilized UGX 700m for initial activities; a comprehensive budget of UGX 15.5bn has also been developed. ✓ Consensus has been built among the various stakeholders. There is clarity now that this multi-sectoral committee is now responsible for the government community-based interventions. The sub-committees in MoH and other ministries that are doing similar work are now subservient to this committee. This is the official position of the government of Uganda. ✓ The national CES committee has been joined by development partners such as WHO, UNICEF, USAID, CDC and others. They gave indications of willingness to support the work on the committee ✓ The representative of Ministry of Local Government clarified that the district Chief Administrative Officers are the main accounting officer for this intervention in close collaboration with DHOs. ✓ The Ministry of Health is still responsible for producing technical guidelines and tools to be used by the committee. The pending one are guidelines for VHTs on Home-based care. ✓ The consensus on the work of VHTs as articulated in various MoH documents will be highlighted by the successes or achievements of this national committee. It's therefore critical that all partners and implementer work towards the success of the committee as it implements the strategy. 	<ul style="list-style-type: none"> ✓ There is slow pace of response of rollout to districts ✓ Not all the required guidelines are yet available. ✓ Funding has been announced but the modalities for utilization at the district level remain a challenge ✓ Too many stakeholders at national level making coordination and consensus building a major challenge.
Recommendations <ul style="list-style-type: none"> ✓ There is urgent need to provide funding for this pillar especially for community focuses activities by the VHTs ✓ The pillar should be supported with office and administrative supports such as personnel, office space and logistics for facilitate coordination of stakeholders and daily management ✓ Tools, guidelines and other resource materials for the VHTs should be revised, aligned to the work of the VHTs, translated into appropriate local languages, printed and distributed urgently throughout the country. 	

Logistics

Emergency logistics is a vital part of every readiness effort. During preparedness and response donation of various assortment of commodities is often received which required careful coordination and management. The logistics pillar has very instrument in the coordination and supply chain and inventory management of procured commodities for the response. In the response Government of Uganda and partners provided substantial support to ensure that commodities were available to mount an effective response. Table 6 outlines the main achievements:

Table 6: Logistics achievements and gaps

Key achievements/best practices	Gaps/Challenges
<ul style="list-style-type: none"> ✓ In consultation with the other pillars, prepared a quantification of the logistical needs for the COVID-19 response. ✓ Maintained a weekly update of the COVID-19 logistics quantification to keep it responsive to the needs of the users and to the evolvement of the pandemic. ✓ Initiated procurements for test kits and sample collection materials, PPEs and IPC materials, community masks, hand washing facilities, biohazard waste management commodities. ✓ Tracking of commodities in procurement pipeline to ensure a judicious use of the available resources for sustainability of the response. ✓ Developed SOPs for logistics operations, such as Ordering for supplies, use of PPEs ✓ All districts trained and COVID-19 treatment units (CTUs) in utilizing the eELMIS in ordering ✓ All COVID-19 treatment units equipped with computers and internet connectivity for utilization of eELMIS for ordering and accountability of COVID-19 supplies ✓ Conducted supervision in various treatment units to ensure rational use of supplies ✓ Receipt, processing and fulfilment of orders for commodities from all response units i.e., COVID-19 treatment units, surveillance sites, testing sites and all districts. ✓ Streamlined commodity warehousing and distribution of supplies from government and partners to rationalize the response to user requests. This involved positioning of all medical supplies at NMS, all non-medical supplies at partner warehouses (WFP and WHO) and WASH supplies at UNICEF ✓ Supported procurement of COVID-19 supplies by MoH, partners and other funders through providing quantification of needs and budgetary reconciliation, technical specifications, evaluation of bids. ✓ Coordination of logistics partners for the response to promote streamlined commodity flow to the different users. ✓ Monitoring of appropriate use of commodities by response sites and districts as well as at the national level to promote accountability. ✓ Provision of guidance to other pillars on appropriate use of available resources 	<ul style="list-style-type: none"> ✓ Inadequate funding for procurement of COVID-19 supplies to meet the requirements ✓ Insufficient global supplies of test kits, PPEs and other IPC supplies that affected the uninterrupted supply ✓ Late payments of allowances for personnel involved in the response e.g. pillar members have not been paid allowances since July 2020 ✓ Irrational use of PPEs by final users e.g. using PPEs for non-recommended purposes ✓ Low production capacity of some locally produced supplies such as masks which delayed distribution ✓ Lack of funds to conduct last-mile distribution (from district towards the final recipients) ✓ Poor quality some of the masks delivered by manufacturers ✓ Suboptimal use of a central information system like eELMIS by partners which limits visibility into the stock status or distribution activities of partners ✓ Inadequate funding to support routine supervision of user units to promote rational use and accountability of commodities ✓ Unreliable internet connectivity in some districts which affected use of the eLMIS
Recommendations <ul style="list-style-type: none"> ✓ Prioritize rational use of COVID -19 supplies by frontline health care workers especially PPEs and other IPC items ✓ Mobilize more funding for procurement and timely distribution of COVID-19 supplies for the response. ✓ Procurement of buffer stock ✓ Combining procurement needs with the other agencies. ✓ Provision of monthly procurement plans from all pillars. ✓ Developing shorter procurement processes for emergency supplies. 	

Vaccination

Issue: Government received 964,000 doses of COVID-19 vaccine on 5th March 2021 and started vaccination of health workers, teachers and security forces on the 10th of March 2021. The priority groups have since been expanded to include older persons 50 years of age and persons with underlying health conditions aged 18-50 years. However, uptake of the vaccination by the prioritized persons to take the initial doses has been slow at (253,000) 30% as of 22nd April 2021. At that time vaccination service points were in only five centres in each district and the target population was supposed to seek a service to any of the five sites. However, it was noted that there was a slow uptake

The vaccination was designed to be a campaign

Cause: The slow uptake has been attributed to;

- i) Delayed logistics at the districts and vaccination centers
- ii) Poor sensitization and mobilization of health workers
- iii) Resultant lack of understanding of the risk of infection for health workers and prioritization of health workers.
- iv) Lack of funding to districts for facilitating vaccination exercise
- v) Hesitancy among some health workers
- vi) Lack of viable micro plans
- vii) Poor dissemination, adoption and adaptation of additional guidance by districts
- viii) Few vaccination points per district limited access
- ix) Virtual training affected quality of training
- x) Difficulty in planning for vaccination activity with unlimited duration and un managed outputs

To reverse the gaps districts will be supported to support vaccination teams to move into communities and vaccinate target populations mobilized by LCs and VHTs. Mobilization of target groups with what determines the speed and coverage of vaccination while health workers control quality of the campaign.

Justification for a Resurgence strategy

Uganda is sandwiched by neighboring countries that are experiencing exponential rise in the incidence of COVID-19. Being a landlocked country, and also transit route to many countries, the risk of importation of even the new variants is very high from these highly burdened territories. The communities have shown significant laxities in adhering to the COVID-19 public health measures characterized by nearly no use of masks in crowded public places and very limited social distancing. Vaccination of high-risk groups offers an opportunity and is currently targeting

highly vulnerable populations but is being dampened by low uptake and misconceptions. However, even if the uptake was optimum, the vaccine availability challenges still leave a large population unprotected from COVID-19. In addition, the emergence of new COVID-19 variants of great concern in the East African region. In neighbouring Kenya, for example, the new variants have been linked to the ongoing wave of new infections that the country is experiencing. Similarly, the Y.501.V2 variant in South Africa has contributed to resurgence in the country and in the neighbouring Botswana, Zimbabwe, Namibia, Swaziland, Lesotho and Eswatini. With the resumption of travel across borders, the risk of importation of these variants into Uganda is high and thus calls for institution of preparedness strategies to mitigate this risk. What is almost certain is that the COVID-19 pandemic will be protract throughout 2021 in Uganda and there is a high likelihood of the second and subsequent surges in addition to coping with ongoing and newly emerging public health events and crises.

Prioritization and triggering of the resurgence interventions

Effective response to resurgence requires prompt identification and management of upsurges through a robust surveillance and patient care systems. For the purpose of prioritization resurgence interventions will be designed around trigger levels based on a carefully selected criteria addressing control, **alert and action thresholds** requirements.

Alert threshold will be a range defined as an increase 10% to 20% of the average incidence of COVID-19 cases (using a 7-day moving average) over 7 days, within a defined geographic area (e.g., sub-county, district, regions). Alert threshold constitutes a signal of very serious risk of possible resurgence, and which should be encountered by implementing high impact interventions with the aim of avoiding the resurgence in line with the differentiated surveillance strategy as developed earlier in response. The health systems ability to cope with a resurgence must be assessed and capacity should be strengthened as required.

The following indicators or scenarios will also constitute an alert:

- The occurrence of one or more case in high-risk populations – that is cases in prisons, schools, healthcare workers.
- The occurrence of ongoing transmission in closed occupational settings (occupations where employees share a closed space for several hours at a time like factories).
- Positivity rate rising above 20% in a geographic area
- 60% of reported cases from the past 14 days occurred in the last 5 days
- Slow resurgence: Daily new cases has surpassed 15% of the first surges peak.

The table below illustrates the interpretation of progression from an alert threshold

Table 7: Interpretation of progression from an alert threshold

Alert If an alert has been activated in a district, or region	i. For 7 days, the alert response will remain activated. ii. If during the 7 days, the resurgence threshold is crossed – Resurgence is immediately activated. iii. If during the 7 days, there has consistently been less than 10% increase over 7 days, – the geographic area can move into under control. iv. If during the 7 days there has consistently been less than 20% increase over 7 days, – the geographic area can move into alert. v. If during the 7 days since the first alert was activated there are increases over 7 days between 10% to 20% then the geographic area will remain in alert and the cycle restarts.
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Action threshold: (Resurgence)

A COVID-19 resurgence is defined as approximately greater than a **20% increase** of the average incidence of COVID-19 cases (using a 7-day moving average) over 7 days, within a defined geographic area (e.g., district). Resurgence connotes rapid response through prompt identification of health system capacity gaps, adequate human resources and capacity enhancements that are identified and implemented immediately based on the best available evidence. Progression of the outbreak should then be continuously monitored, analysed and reported to inform which interventions should be implemented. Teams may be deployed into the geographic area where resurgence has occurred as surge, must provide daily feedback to the districts, regions and national on the progress and success of the localised interventions.

The table below outlines the main indicators for detection of progression to action threshold.

Table 8: Main indicators for detection of progression to action threshold

	Indicator	Description (use moving average)	Additional criteria for resurgence
1	Testing rate	COVID-19 testing ratio	The test to case ratio must be greater than 5 tests for every 1 positive case
2	New cases per day	New COVID-19 cases per 100,000 population	Increase by 10 % alert Increase by 20% response

3	Percentage positivity rate (note within which population groups)	Percentage of positive tests of all tests conducted	Positivity rate increased to >5% at national level and/or in specific population groups
4	Active cases	Active COVID-19 cases per 100,000 population	Increase by 10 % alert Increase by 20% response
5	COVID-19 hospital admissions	COVID-19 hospital admissions	Increase by 10 % alert Increase by 20% response
6	COVID-19 mortality	COVID-19 deaths per 100,000 population	Increase by 10 % alert Increase by 20% response
7	All-cause mortality	All-cause mortality per 100,000 population	Increase by 10 % alert Increase by 20% response

Interpretation: If a Resurgence has been activated in district:

- i. For 7 days Resurgence will remain activated.
- ii. If during the 7 days, there has consistently been less than 20% increase over 7 days or decreases over x days – the geographic area can move into alert.
- iii. If during the 7 days since the Resurgence was activated there are increases over 7 days that are over 20% then remain in Resurgence (cycle restarts).

Response strategy

Main Objective

The main objective of the resurgence plan is to mitigate transmission of COVID-19 to a level that minimizes the public health and socio-economic impact of a prolonged response and promote decisive control of the outbreak in Uganda

Specific Objectives for 2021

1. Strengthen coordination activities aimed at mitigating resurgence of COVID 19
2. Strengthen early detection to upsurge in the new and severe cases of COVID-19
3. Strength pillar response to shocks created by the resurgence in the alert and action phases
4. Reenergise district level outbreak response systems for sustained protracted local response to the crisis.

Approach to development of the plan

Development and implementation of this plan has followed a highly consultative and multidisciplinary approach. The plan has been developed following review of the COVID 19 preparedness and response plan March 2020- June 2021. It also builds on gaps identified in the Inter-Action Review conducted between September and November 2020. The plan emphasises the need for cross sectoral

collaboration, early identification and management of cases and risk communication to alleviate public panic. The implementation of this plan will leverage on the existing structures developed during the implementation of the first

Interventions Areas

Leadership, Coordination, Stewardship and Oversight

The Uganda COVID-19 preparedness and response Plan was established under the Leadership of His Excellency the president of Uganda, following an outbreak of COVID-19 in Wuhan in China. The existing Coordination mechanisms shall be utilized to respond to any possible Resurgence in the country. The response to COVID-19 will be through a whole-government approach with involvement of all key stakeholders including; Cabinet, Parliament, MDAs, Development Partners, Religious Leaders, Cultural Leaders, Civil Society Organizations (CSOs), Private Sector entities, Communities and individuals. A coordination structure was elaborated under the main COVID-19 Preparedness and Response Plan. The operational unit in response to COVID-19 Resurgence shall be the district supported by the national structures. This requires strengthening of the District Taskforces as well as the District Health Teams to provide health leadership to the DTF.

The Incident Management Team shall continue to operate as technical arm of the COVID-19 Response with the appointment of Pillar Leads delegated with the necessary authority to facilitate decision making. Budget allocation to the IMT shall enable operations of the system in response to the time sensitive activities to be undertaken by the IMT.

Technical subject matter shall be referred to the Strategic Committee chaired by the Minister of Health following input from all the Pillars and recommendations. This requires clear procedures for introducing the subject matter to the Strategic Committee. Feedback Mechanisms from the Strategic Committee are critical to facilitate implementation of the recommendations.

The district as a unit of functionality shall be supported to functionalize the District Taskforce which shall be responsible for implementation of the resurgence activities as well as continued implementation of activities outlined in the CORONA VIRUS DISEASE – 2019 (COVID-19) Preparedness and Response Plan. Districts shall develop appropriate plans which shall be coordinated through the DTFs. The main objective of the intervention area in the resurgence plan is to:

- Consolidate information and build structure for the COVID-19 response at both national and district level
- Provide technical and strategic guidance for the successful implementation of COVID-19 response mechanisms considering Resurgence

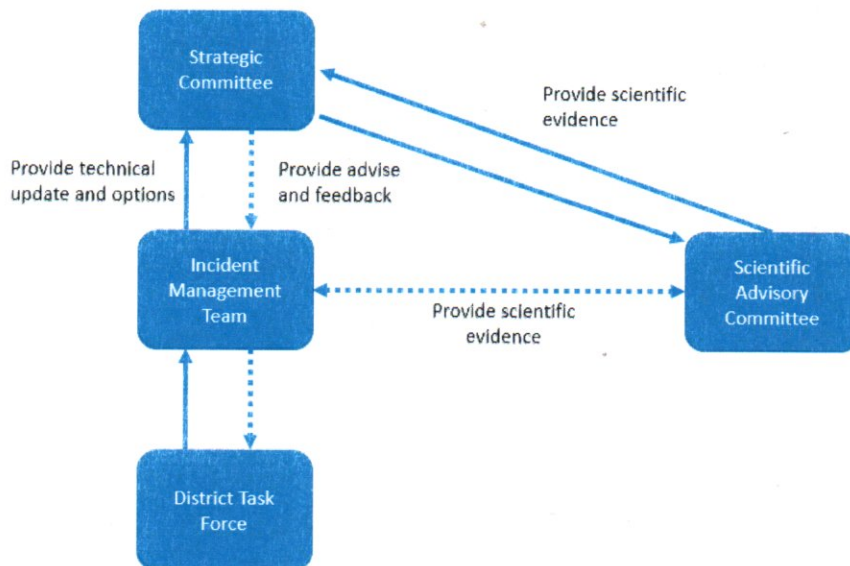


Figure 8: Structure of the COVID-19 response

The main action items for the alert and response phases within this intervention area are described below:

National level interventions:

- Provide strategic direction to MDAs, districts and key stakeholders on strategic direction and policy.
- Support coordination and leadership for COVID-19 response at national level.
 - Provide operational support (HR, equipment and running costs) for the Incident Management Team.
 - Support regular supervision visits and onsite mentorships to RRH and high burdened districts.
- Build capacity of key actors to participate in the COVID-19 response.
 - Conduct multi sectoral coordination meetings including participants from congregate facilities at national and district level
 - Advocacy meetings with parliamentarians and other key stakeholders on resurgence interventions
- Review and recommend geographical areas that require restrictions due to high COVID-19 transmission
- Support the national and regional PHEOCs to coordinate response activities
- Enhance cross border collaboration and information sharing.
- Conduct supervision, Monitoring and Evaluation (M&E) for the COVID-19 response.
 - Conduct Intra Action and After-Action Reviews at national and district level
 - Develop an automated action tracker application system and operationalize decision monitoring systems

- Facilitate accountability forums in resource mobilization and utilization.
- Support the National Drug Authority's testing capacity to conduct Quality assessment of all pharmaceutical and healthcare products.

Regional level interventions:

- Support coordination and leadership for COVID-19 response at national level.
 - Support regular supervision visits and onsite mentorships to districts.
- Support the regional PHEOCs to coordinate response activities

District level interventions:

- Support coordination and leadership for COVID-19 response at district level.
 - Provide operational support (HR, equipment and running costs) for the DTFs
 - Support DTF coordination of district response activities
 - Support regular supervision visits and onsite mentorships to Health Facilities.
- Build capacity of key actors to participate in the COVID-19 response.
 - Conduct multi sectoral coordination meetings including participants from congregate facilities at district level
 - Conduct orientation of the private sector to participate in the COVID-19 response.
- Conduct supervision, Monitoring and Evaluation (M&E) for the COVID-19 response.
 - Conduct Intra Action and After-Action Reviews at district level

Leadership and coordination are key to success of the plan. The coordination arm will focus on resource mobilization, monitoring of response efforts and strengthening district capacity to respond. We believe this investment at district level will reduce overall cost and as observed in the first wave, will not overstretch the human resource at the center.

Surveillance

There is need for sustained surveillance to facilitate early detection, reporting, verification, investigation, confirmation, and response to alerts and suspected cases. The following enhanced surveillance strategic areas will be focused on: Alert management and active case search, laboratory-based surveillance, community-based disease surveillance, health facility-based surveillance, quarantine, point of entry surveillance and contact tracing. This will be based on regular risk assessments and prioritization of districts.

Throughout the initial phase of the response gaps in surveillance of variants of concern have been highlighted with surveillance data delinked from the laboratory outputs. More still there has been

minimal follow up of cases under Home Based Care. This strategy aims to address these, and more gaps identified. The unit of observation will be maintained at district level to detect and contain resurgence early.

Activities

National level interventions:

1. Support integrated sentinel surveillance system establishment
2. Build core capacities for responding to PHEIC at points of entry.
 - a. Supervision of POEs
 - b. Screening travellers at points of entry
 - c. Follow up of cases from countries reporting variants of concern
 - d. Streamline port health services within the IESPHE department for sustainable enforcement of port health requirements
 - e. Provide health infrastructure at POEs for the response to COVID-19.
3. Support the functionality of Integrated Epidemiology Surveillance and Public Health Emergencies department in responding to PHE
4. Monitor variants of concern through sampling PCR positive cases for genomic sequencing
5. Rollout 3rd edition IDSR across the country in the context of COVID 19
6. Strengthen surveillance and management of Adverse Events Following Immunization (AEFIs)
7. Conduct COVID-19 surveys at population level to inform policies and interventions.
8. Build capacity for active all-cause mortality surveillance
9. Build capacity for surveillance at mass gatherings and congregate settings.

Regional level interventions:

- Enhance capacity of the districts to effectively respond to COVID-19 emergencies
 - Deployment of surge staff to support district level investigations
 - Support mapping of cases within the regions.
 - Provide technical support to districts through regional PHEOCs
- Establish regional call centres to support a regional alert management system and daily reporting at the regional level
 - Procure toll free system that links national level call centre and the Regional Surveillance Officers
 - Assign and deploy alert desk surveillance officers
 - Train and facilitate regional and DSFPs on the regional alert system based on the eIDSR platform in all health regions
 - Provide essential equipment (vehicles, tablets, internet data, power bank and airtime) to facilitate alert management activities

District level interventions:

- Strengthen timely detection and response to COVID-19 emergencies
 - Investigate alerts and suspected cases, especially new clusters and newly affected areas
 - Conduct contact tracing for high-risk contacts through use of Go Data tool. (including contacts of cases identified with variants of concern), health workers and where possible for all probable and confirmed cases especially in newly affected areas
 - Conduct active case finding, focusing on the most affected areas guided by data
 - Emergency deployment of Rapid Response Team to high burden areas
 - Support alert management and daily reporting from all health facilities and districts
 - Monitor self-quarantined contacts and mild cases in home based care to detect new cases and refer deteriorating cases
- Strengthen school-based surveillance (SBS)
- Strengthen Community and Facility-Based Disease Surveillance (CBDS)
- Strengthen Mortality surveillance (MS)

Laboratory

The laboratory pillar will support the surveillance pillar interventions by bringing testing even closer to the population through rollout of point of care testing using the rapid diagnostic tests. Surveillance for the variants is key in the second wave of the outbreak. This will ensure early identification of cases that are linked to new variants and implementing enhanced public health measures.

Activities

1. Expand testing capacity across all sectors by providing access to RDTs and PCR testing at national and subnational levels inclusive of the 53 points of entry for border health
2. Expand capacity for COVID 19 genomic surveillance and laboratory sequencing to yield evolutionary trends and monitoring of mutational rates for rational decision making
3. Support Quality Assurance and control across testing labs for RDTs and PCR methods
4. Strengthen supply chain management of laboratory commodities i.e. lab consumables, reagents, PPEs
5. Coordination and support supervision
6. Engage laboratory partners in the regions to rollout M&E framework for COVID 19
7. Support routine M&E processes required to inform timely response interventions
8. Optimise the national sample transportation network to support outbreak response and emergency sample transportation

Case management

Case management intervention area will focus on, health facility readiness, continue to expand bed capacity, improve oxygen provision and the number of high-dependency care beds, case management and emergency medical services are considered. The facility readiness and case management intervention area are key to ensure the availability of sufficient capacity for health service delivery. Isolation of suspected and confirmed cases is key to reducing the transmission of the virus both in the community and in the facility.

The objective of the intervention area is to:

- Ensure sufficient supply of key resources in facilities
- Ensure that that case management guidelines are available and adhered to
- Strengthen the implementation of the Infection prevention and control guidelines and advice
- Ensure availability of adequate and appropriate isolation facilities at Regional Referral Hospitals level
- Ensure efficient Emergency Medical Services response at National and Regional level
- Strengthen our engagement with the private sector to ensure care is available through all available resources

Case management

National level interventions:

- Strengthen emergency medical services for COVID-19
 - Procure ambulances for type B and C
 - Establishing Call and Dispatch centres for ambulance teams
 - Provision of operational costs for ambulances.
- Expand the human resource capacity for both specialist and non-specialists to manage severe and critical COVID 19 cases.
 - Recruit and train additional critical cadres of health workers along the continuum of care
- Updating Health workers on the revised COVID-19 case management guidelines, job aids and protocols
- Improving availability of Oxygen for COVID-19 management in the country
- Strengthen implementation of Hospital Based Care at the COVID 19 treatment centres
 - Strengthening and functionalize ICUs around the country
 - Maintain the private/public agreement as a back-up for bed provision to allow for patient transfer to Private facilities
 - Establish ICU/High Care accurate bed occupancy monitoring system and activate expansion when necessary
 - Accommodation for health workers on duty in 17 facilities (850 Health Workers).

- Hardship allowance for 850 Health workers at RRH level, and 650 in General hospitals including psychosocial support 2 people per facility
- Feeding of 1,000 persons health workers and patients daily
- Laundry services for 7 facilities
- Strengthen monitoring of commodities
 - Audit of clinical consumables and restock consumables
 - Audit and Maintain adequate quantity of medical supplies and Personal Protective Equipment at the Regional Referral facilities at all time
- Regular assessment of oxygen demand with improvement of reticulation and supply at district and regional hospitals
- Strengthening capacity for operational research in COVID-19

Regional level interventions:

- Strengthen emergency medical services for COVID-19
 - Conduct prehospital management & transfer of severe & critical COVID-19 patients
- Strengthening and functionalize Isolation and Care Units in the Regional Referral Hospitals and other selected health facilities
 - Support supervision of COVID-19 treatment and isolation centers.
 - Strengthen implementation of Hospital Based Care
 - Strengthening and functionalize ICUs around the country
- Updating Health workers on the revised COVID-19 case management guidelines, job aids and protocols

District level interventions:

- Strengthen implementation of Hospital Based Care for COVID 19 in selected health facilities
- Support supervision of COVID-19 treatment and isolation centers.
- Conduct integrated outreaches to move services closer the population, reduce crowding at health facilities and expand access to continuity of essential public health services in the context of covid-19.

Infection prevention and control

IPC is the main intervention for minimizing amplification of infection in the health facilities as well as prevention of health workforce infection. Its practice is dependent on availability of facilities/supplies, motivation for health workers and application of proper skills. The approach to IPC skills enhancement for the health staff involve Identification and training of mentors, conducting of on job mentorship of health staff in the facilities, reinforcing compliance structures and involvement of communities in IPC in the context of HBC. IPC committees that follows up adherence on a day to day basis. The interventions are outlined below:

National level interventions:

- Capacity Building of Health workers using the IPC multi modal package
 - Train health care workers in IPC multi modal package, IPC assessments, IPC adherence monitoring, and health care worker IPC toolkit
 - Printing and dissemination IPC guidelines.
 - Develop a system for monitoring and reporting on IPC compliance.
- Support triage, screening and establishment of isolation areas at health facilities
 - Construct 5 rooms structures with sanitary facilities in each RRH (14 Permanent 5 roomed structures with in-built sanitation facilities ambulance Ramp)
 - Provide equipment and furniture for the triage, screening and holding areas. (*permanent hand-washing facility one each, Furniture for the 5 facilities-one desks for each and 3 benches each; Signage's, 2 examination beds for each facility*)
 - Recruit and deploy health workers to man triage at RRH (2 paramedics per facility)
- Support health care worker protection at work place.
 - Develop and disseminate policy for health care worker protection at the work place at national, regional and district level.
 - Conduct risk exposure assessments for health care workers.

Regional level interventions:

- Conduct IPC assessments and IPC adherence monitoring
 - Conduct IPC mentorship and adherence assessments in health facilities
 - Conduct regional review meetings

District level interventions

- Support IPC coordination activities
 - Activate IPC committees
- Support WASH activities.
- Support community IPC interventions
 - Orient CSOs on ring IPC
 - Review ring IPC guidelines for community use.
- Conduct IPC assessments and IPC adherence monitoring
 - Conduct IPC mentorship and adherence assessments in health facilities
 - Conduct regional review meetings

Logistics

The pandemic has exposed significant weaknesses in many health commodity supply networks and requires sourcing and distribution strategies that can mitigate supply distributions. The logistics

pillar shall therefore seek innovative sourcing strategies to ensure the items listed for the response have resilient supply networks and shall remain operational as the pandemic progresses

The Logistics pillar shall support all the other response pillars, with the timely provision of critical response supplies that shall facilitate testing, treatment and protection of Health workers and others involved in the response. The pillar shall develop acquisition and distribution strategies that shall ensure the availability of critical of medical and non-medical response supplies throughout the response.

Activities

1. Quantification of medical and non-medical response supplies
2. Development of supply plans to ensure the availability of response supplies.
3. Monitoring of Procurement of response supplies
4. Receiving, reviewing and approval of orders from users (Districts, Health Facilities and Points and Entry).
5. Coordination and monitoring distribution of commodities.
6. Ensure Covid-19 Data visibility and use across the supply chain through the development and implementation of the Health facility module on the eELMIS
7. Provide technical support supervision towards data quality improvement and PSM.

Assumptions

The planning for this resurgence plan is based on the first wave response and these have informed the basis for the new assumption in logistics planning i.e. it is anticipated that country shall get no more than 30,000 cases in 6 consecutive months.

Distribution Strategy

Supplies for the covid-19 response shall distributed from 3 main warehouses (NMS, UNICEF, WFP) the issuance of these supplies shall be against requests from the user units and approved by the DG of the Ministry of Health. In response to the 2nd wave of the pandemic, laboratory supplies i.e Antigen RDTs shall be supplied by NMS on a bi-monthly basis.

All PPEs for user units shall be incorporated into the routine medicines supply chain and provided to user units at least once every 2 months while large units shall receive supplied every month.

Risk communication

Risk communication activities will be scaled up in all the 146 districts of the country and implementation of activities will be led by the district health teams assisted by implementing partners and community influencers to achieve the desired change in attitudes and behaviors through interpersonal communication with various groups of affected populations in their immediate contexts. The national level will concentrate of developing generic messages, IEC

materials, SoPs, implementation guidelines, capacity building in addition to resource mobilization. It is envisaged that successful implementation of the plan will lead to increased community awareness about COVID-19 and the need for vaccination through wide use of the mass media. Messages, IEC material and all risk communication intervention will be guided by evidence generated through social listening, research, and other social science methods. In addition, continuous community mobilization and engagement will be driven by trained Village Health teams, community influencers and other community-based structures, to reinforce prevention and compliance through supervised enforcement of the COVID-19 prevention measures. Specific activities to be implemented include:

Activities

National level interventions:

- Develop, translate, and print IEC materials
- Procure mass media campaign airtime for the responders.
- Develop and disseminate weekly messages through social and mass media platforms
- Conduct Rapid assessments; KAP studies; Online Polls; Support Supervision and documentation
- Strengthen community-based radio (megaphone) systems to achieve effective communication and efficient use of existing communication channels and resources (Supplies, Recorded messages & logistics).
- Develop/procure a feedback mechanism for monitoring community on COVID-19 control messaging and service utilisation
- Support mass and social media monitoring

District level interventions:

- Strengthen partnerships with key Influencers and their respective institutions
- Facilitate district and sub-county level RCCE meetings; microplanning, scheduling of radio talk-shows and outreaches to most at risk communities.
- Facilitate engagement of key district responders with the media houses
- Support Radio talk shows at district level.
- Conduct sub-county mobilization drive
- Support interpersonal communication and community dialogue meetings with affected communities (using existing community structures to achieve community collective responsibility and action).
- District-based support supervision and monthly review meetings (logistics and allowances).

Community Engagement

Given the high degree of vulnerability for the bottom 40% of the population, particularly in rural areas and refugee-host communities, the COVID-19 pandemic is bound to disrupt essential health and social services and exacerbate gender-based violence (GBV). The GoU needs to take several measures to minimize the multi-faceted impacts of this rapidly evolving situation. Community engagement, in planning, research, financing and implementation, and empowerment is critical to ensure ownership and uptake of targeted interventions.

Activities

National level interventions:

- Train and support faith based medical bureaus (Uganda Protestant Medical Bureau, Catholic Medical Bureau and Uganda Muslim Medical Bureau) Compliance Officers and enforcement of SOPs
- Strengthen coordination of the actors involved in community engagement
- Stimulate and enforce COVID-19 preventive measures and other community health related interventions.
 - a. Recommend enforcement of COVID-19 preventive measures
 - b. Support the technical inter-sectoral committee COVID-19 coordination meetings
 - c. Conduct MOH technical support supervision on community engagement activities

District level interventions:

- Stimulate and enforce COVID-19 preventive measures and other community health related interventions.
 - a. Facilitate enforcement of COVID-19 preventive measures
- Support functionality of the Village COVID 19 Task Forces (VCTFs)
 - a. Orientation of VCTFs on their roles and responsibilities
- Enhance capacity of districts to manage cases under home based care
 - a. Orient districts on HBC
 - b. Facilitate districts to monitor implementation of HBC within their districts.
 - c. Conduct district CSO coordination meetings for community engagement COVID-19 interventions
 - d. Training District Health Teams on reporting on HBC through mTrac
- Build the capacity of CSOs in HBC patient follow-up, reporting and supervision of VHTs
 - a. Conduct orientation of CSOs on HBC
 - b. Develop guidelines and train COVID Compliance Officers in MDAs at national level.
 - c. Provide tools and guidelines for reporting

- Build capacity of Biostatisticians, HC III Health Assistants and VHTs on community timely reporting including death notification and data management

Strategic Information, Research and Innovation

Real time data utilization has informed decision making of the incident command. Provide the population with real time information and knowledge as the disease evolves.

Conducting research is critical to understand the novel Corona virus and the social economic aspects the virus poses on the population of Uganda. There is currently no known cure for COVID-19 and thus the need to explore research and innovations in prevention, diagnosis and treatment including traditional medicine. There is also need for innovative approaches to managing the COVID-19 response.

Implementation of the data management and analytics will ride on the existing frameworks in the health sector and the key stakeholders for managing the epidemics. Due to the evolving nature of the COVID-19 pandemic, use and adaptation of technology will support timely and appropriate response as well as sharing and use information.

Activities

1. Implement Standards-based Interoperable Systems Linked to All Response Pillars for surveillance, specimen transportation, laboratory testing, Case management, Vaccination as well self-service system for the general public
2. Strengthen mechanisms for the production of Relevant Information Products, including the implementation of a centralized repository of response data
3. Strengthen mechanism for Data Governance including the development of relevant guidelines and SoPs
4. Strengthen ICT infrastructure for the response including the last mile connection to the national backbone infrastructure for internet
5. Link the vaccination system to the EAC Pass system
6. Develop and implement framework for identification and adaptation of innovations into the response
7. Develop a framework for identification of key operation challenges in the response, coordinate the undertaking of operational research for the response and facilitate the adaptation of research findings into the response

Vaccination:

Uganda launched the COVID-19 vaccination program on March 10, 2021 using AstraZeneca Vaccine from Serum Institute of India. Since then daily monitoring focusing on the uptake of the vaccine was done by the national and sub national level. Several gaps were identified that were contributing to the slow uptake of the vaccine and hence mitigation strategic measures were

developed and shared with districts. Government received 964,000 doses of COVID -19 vaccine on 5th March 2021 and started vaccination of health workers, teachers and security forces on the 10th of March 2021. The priority groups have since been expanded to include older persons 50years of age and persons with underlying health conditions aged 18-50 years. However, uptake of the vaccination by the prioritized persons to take the initial doses has been slow at (253,000) 30% as of 22nd April 2021. At that time vaccination service points were in only five centres in each district and the target population was supposed to seek a service to any of the five sites. However, it was noted that there was a slow uptake. The COVID-19 vaccination approach will be expanded beyond static vaccination to waves of vaccination outreach campaigns. The waves of vaccination outreach campaigns will be activated to consume consignments of COVID-19 vaccines in the shortest time possible to achieve coverage and protect from risk of expiry. This relies on good mobilization of target population and a supported health team.

National level interventions

Activities;

- Define target populations and vaccination approaches
 - Expand vaccination service points up to all health centre IIIs in addition to hospitals and health centre IVs
 - Build capacity of health teams to expand vaccination service points
 - Outreaches should be implemented in addition to static sites
 - Reduce the number of vaccination team members from six to three members
 - Districts to review and amend the micro plan developed in January/February 2021
 - Expand supervision teams at district level beyond the 3 members to include 4 persons or more
- storage and distribution of supplies:
 - Vaccine and Logistics management – Distribution and daily accountability
 - Security arrangements if required

District level interventions

- Advocacy for COVID-19 vaccination
 - Engage district leaders to provide the required leadership and manage partnerships
 - Sensitize RDC, DHO and ADHO to understand the broader context of Covid 19 pandemic and the vaccination intervention
 - Activate weekly district Task Forces and ensure a vaccination pillar is established

- Use locally generated data to drive implementation by having updated daily summaries and individual data.
 - Regional partner engagements
 - Intensify and facilitate sensitization and mobilization of priority groups at district level.
 - Sensitize; health workers, teachers, the elderly and those with underlying health conditions; and later persons 18-50 years of age.
 - Sensitize communities to appreciate the phased and prioritized approach to Covid 19 vaccination for compliance
 - Orient and Engage LCs and VHTs to mobilize communities; use 10 mobilizers per vaccination team
- Monitor implementation of vaccination
 - District task force meeting to discuss the vaccination wave, review performance midterm and at the end.
 - Training of expanded vaccination teams
 - Support supervision by a lean team some of whom should get information at review only
 - Daily review meeting
 - Data management; data entrants and internet data
 - Communications through mass media

Continuity of Essential Health Services

CEHS Pillar is one of eight pillars in the covid-19 pandemic national response Current Terms of Reference among other things, the pillar will: a) Strengthen coordination mechanism for essential health service continuity at the national and sub-national levels including the community. This is key especially making data use in the CEHS pillar in the district task force and support remedial actions to ensure essential services continuity; b) Re-organize and maintain access to essential quality health services; c) strengthen reporting and monitoring of health service delivery; d) enhance capacity for delivery of essential and emergency medical services; and e) Strengthen the occupational health and safety program in health facilities, review and updating the CEHS guidelines and related tools.

Activities

The plan is hinged on the core tool kit intervention areas including;

1. High level engagement on CEHS with various stakeholders at national and district levels
2. Maintain access to essential commodities through NMS

3. Enhance facility readiness for provision of uninterrupted quality health services delivery (Clinical Services and various programs - malaria, RMNCH, EPI, TB, HIV/AIDS, MHPSS, Non-communicable diseases, etc. supported by partners and stakeholders at all levels of the Health System)
4. Strengthen reporting and monitoring of health service delivery. Tracking performance and evaluating results with the use of standardized indicators adapted to the local context.
5. Human resources – availability, quality capacity and motivation
6. Strengthen the occupational health and safety programme in health facilities in order to promote access of patients to care, their safety and security must be assured by the Health System.

Implementation modalities

The Ministry of Health will lead implementation of this Resurgence Plan. Activities at the district level will be coordinated through the District Task Forces. Though general activities have been identified for implementation throughout the timeframe of the plan, quarterly work-plan will be developed and approved through the IMT and strategic committee for planning and implementation purpose. Inclusive participation and involvement of key stakeholders in the implementation is critical realization of the Resurgence plan and also in maximizing the gains already garnered towards achieving full control of the COVID 19 outbreak. The National Task Force chaired by the President and co-chaired by the Office of the Prime Minister will be responsible for overall oversight and intersection mobilization of members from other sectors to participate in the implementation of the health portion of the response. The robustness of the current COVID 19 response coordination mechanisms will be maintained to allow for ultimate participation and involvement of all key stakeholders. Members will participate in the strategic, operational or tactical role at districts or national level depending on the individual expertise, position and interests. At the national level, implementation of the plan will be under the advisory oversight of the Strategic Management Committee advised by the scientific Committee (strategic) but the responsibility for day-to-day execution rests with the Incident Management Team (operational) and the Districts (tactical). The IMT will be responsible for the day-to-day implementation reviews of COVID 19 outbreak response at the national level. Synergy and complementarity will be enhanced by upgrading and stepping up the management of the 4W matrix and dashboard in the COVID 19 portal.

Budget

Pillar	Estimated total in UGX	Estimated total in USD
Coordination	12,050,615,000	3,301,538
Surveillance	59,351,555,000	16,704,631
Laboratory	84,980,169,800	22,967,613
Case management	93,803,704,350	25,701,015
Risk communication	68,192,074,850	19,037,751
Community engagement	6,544,069,136	1,783,125
SIRI	70,338,280,000	19,010,345
Logistics	808,393,297,732	218,484,674
Continuity of Essential Services	114,194,158,000	31,200,590
Vaccination	2,628,000,000	710,268
Grand Total	1,320,475,923,868	358,901,550

COVID-19 Monitoring and Evaluation Framework

Introduction

For this COVID-19 response, Monitoring and evaluation (M&E) will be important in assessment of the level of attainment of intended results.

The M&E function will be conducted by a dedicated team of staff as part of the coordination pillar of the IMT in close collaboration with the SIRI pillar.

Evaluation

It is important to conduct systematic and objective assessment of this COVID-19 response including its design, implementation, and results to determine its relevance and fulfilment of objectives, efficiency, effectiveness, and impact. The review process will also be used to document lessons learnt and best practices as well provide critical information required for any modification of strategy.

The following reviews will be conducted for the COVID -19 response:

- Inter-action reviews of the response every six months
- Comprehensive annual reviews of the response

The IMT will also conduct a comprehensive evaluation of the response at the end of the response

Result Monitoring

The IMT will monitor result as per the indicators articulated in the Log frame below and the M&E plan matrix in annex 1. Indicator will be monitored and updated as per the stated frequency of reporting. A periodic report will be compiled and discussed in quarterly performance review meeting.

Process Monitoring

Process monitoring is critical in ensuring that activities are translated into outputs and outputs to outcomes. Process monitoring will be conducted directly by the response pillars and all response pillars will be expected to submit monthly process monitoring report to the M&E secretariat who will present these to the IMT. The process monitoring will include;

- Readiness assessment as per the MoH tool adapted from the WHO readiness assessment tool
- Specific Monitoring Checklist developed for monitoring and supervision all service delivery points
- Training pre-post test tools

All process monitoring tools will be developed and presented to the IMT for approval

Survey, assessment and operational research

As part of evidence generation for the response; surveys, assessment and operational research will be conducted. These surveys and assessment will be both qualitative and quantitative and evidence from these will be incorporated into the evaluations and review processes above. These will be conducted by the M&E secretariat of the IMT and the SIRI pillar.

Activity Monitoring

Activity Reporting is important to ensure reporting and accountability. All pillars will be required to submit an activity reports for all activities implemented as part of this response. The activity report will be based on the activity report template (Annex 2). All activities reports will be submitted to the Pillar heads and a copy to the M&E Secretariat with participant lists, targeted districts and sites, facilitator lists, pictorial evidence and item distribution lists as applicable.

Log frame for COVID-19 Resurgence

Result level Result (Similar to Objective) Indicator Means of Verification Assumption

Impact	COVID -19 mortality and morbidity reduced	Indicator	Means of Verification	Assumption
Outcome 1	COVID-19 cases and clusters identified and classified and data/information available to facilitate response	- Prevalence of COVID -19 - Number of new COVID -19 cases - COVID -19 Deaths per population - COVID-19 reproducibility number - COVID-19 Test positivity rate - % of alerts investigated with 48 hours of notification	Sero-survey SITREP	
Output 1.1	Mechanism for alert/contact investigation and follow-up implemented	% of alerts investigated % of contacts investigated	SITREP	
Output 1.2	A first and efficient COVID-19 testing system implemented and functional across the country	% of sample results returned within 24 hours of sample collection	SITREP	
Output 1.3	Availability and access to COVID-19 response data ensured for all response pillars	% of response pillars with response data in the repository % of district submitting daily summary reports on time	Quarterly SIRI response data status report	
Outcome 2:	Enabling environment for the COVID-19 response strengthened	- response funding rate, overall and by pillar and by district - response activity implementation rate, by pillar, by district	Quarterly response status report	
Output 2.1	The IMT has a functional coordination mechanism for the response	% of pillars having more than 90% of schedule pillar meetings % of issues in action tracker resolved by the scheduled date % of districts/institutions with a functional coordination mechanism	Quarterly response status report	
Output 2.2	COVID-19 activities implemented in line with the approved work plan	- % of unplanned activities implemented by pillar and district	Quarterly response status report	
Outcome 3	access to COVID-19 curative services strengthened	- COVID-19 case fatality rate - Average length of stay for severe COVID-19 cases in treatment unit	CTU reports	
Output 3.1	capacity for management of cases	- Bed capacity of COVID-19 treatment centres against target - % of COVID-19 treatment centres with Oxygen stock out rate above acceptable levels	CTU stock report	
Output 3.2	All COVID-19 confirmed cases are enrolled into an approved management and treatment programme	- % COVID-19 confirmed cases enrolled into a treatment programme	SITREP	
Output 3.3	Contraction of COVID-19 by health workers and other response staff in the line of duty prevented	- % of health worker who contracted COVID-19	SITREP	
Outcome 4	COVID-19 prevention through vaccination implemented	- COVID-19 second Vaccination coverage	KAP Survey	
Output 4.1	Implementation of COVID-19 Vaccination implemented for all vulnerable groups	- # of targeted groups registered for vaccination against target - % of registered target category receiving first dose COVID-19 vaccine by district and target category - % of registered target category receiving first dose COVID-19 vaccine by district and target category	Programmatic report	
Outcome 5	COVID-19 prevention and control measures taken by the general population	- % of general population taking COVID-19 prevention and control measurements according to MoH SoPs - % of general population believing conspiracy theories on COVID-19	KAP Survey	

Output 5.1	Knowledge of COVID-19 effects and control measures among the general population provided and sustained	- % of the general population with knowledge of the COVID-19 prevention measures - % of general population with knowledge of COVID-19 signs and symptoms - % of population with Vaccination hesitancy Stock out rate by commodity type	KAP survey
Outcome 6	COVID-19 commodities availability at all points of service ensured		Stock status report
Output 6.1			
Outcome 7	Disruption to the Provision of essential health services due to the COVID-19 pandemic minimised	OPD attendance per 1000 population	HMIS report
Output 7.1	Coordination meetings for the continuity of essential services with minutes and an updated action tracker held at national and district levels	% of districts sharing action points for follow-up % of agreed action points resolved as per the agreed timeline	Meeting Minutes
Output 7.2	Access to essential commodities during the C-19 pandemic maintained	% of essential commodities delivered to districts according to schedule	NMS
	Health worker are able to continue providing health services during the C-19 pandemic response	Health worker attendance rate	iHRIS
	Strengthen reporting and monitoring of health service delivery	% of HMIS reports submitted on time % of RRH submitting maternal audit report forms on time	HMIS