THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

CORONA VIRUS DISEASE - 2019 (COVID-19)

Preparedness and Response Plan

March 2020 – June 2021

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FOREWORD

On 30 January 2020, the Emergency Committee convened by the Director General under the International Heath Regulations (2005) regarding the outbreak of the novel coronavirus declared the Corona Virus outbreak Public Health Emergency of International Concern.

As an immediate response to the epidemic the Government of Uganda (GoU) was mandated to provide policy and strategic direction for the epidemic response. Since March 2020, the GoU has implemented a series of vulnerability reduction and containment measures to curtail transmission of COVID-19. Some of the measures have included: closure of international airport starting on the 16th March 2020; closing ground crossing points for passengers with the exception of cargo drivers; closure of schools and other high congregation points; freeze of public and private transport; outlawing all mass gathering events, including for worship; overnight curfew; and a nationwide lockdown declared on 24th March 2020.

A National Task Force chaired by the Prime Minister was instituted by His Excellency, Y.K Museveni, The President of Uganda and this has enabled a Whole of Government approach to planning and responding to the COVID-19 pandemic.

The Ministry of Health has taken the central role for technical guidance in the COVID-19 response and led the development of this National Covid-19 Response Plan for the period March 2020 to June 2021. The goal of this plan is to provide a framework for coordination and control of COVID-19 by reduction of importation, transmission, morbidity and mortality in a bid to minimize the social economic disruption that might result from this outbreak. The implementation of this plan will be multi-sectoral involving Ministries, Departments & Agencies (MDAs), Partners, Non Governmental Organizations (NGOs), private sector entities and other stakeholders.

The plan emphasises the need for cross sectoral collaboration, early identification and management of cases and risk communication to alleviate public panic. I therefore call upon all key stakeholders in the COVID-19 response in Uganda to internalise the identified key interventions and activities; and implement this plan leveraging on the existing structures and available resources.

This will plan will also be utilised as the COVID-19 resource mobilization tool for this period and will be updated as the epidemic develops or resolves.

Dr. Jane Ruth Aceng

MINISTER

ACKNOWLEDGEMENT

This plan is developed in line with the guidance provided from the World Health Organisation on prevention and control of COVID-2019 outbreak. Consideration of the International Health Regulations (2005) for countries to develop core capacities to Prevent, Protect and Provide a public health response to public health threats, while ensuring safe passage.

The development and implementation of this plan has followed a highly consultative and multidisciplinary approach and therefore should be embraced and implemented by all stakeholders.

I hereby acknowledge the efforts of the staff of the Ministry of Health Planning, Financing and Policy Department under the leadership of Dr. Sarah Byakika Kyeyamwa as the Chair of the Planning and Budgeting pillar, for spearheading the development of this plan and budget. I also acknowledge all other Ministry of Health Heads of Departments who chaired the different pillars of the response and their staff for their invaluable guidance and input. Last but not least, I highly appreciate the highly participatory approach and technical input from the other Ministries, Departments and Agencies; Makerere University School of Public Health; and Health Partners——Development Partners, Civil Society Organisations and Private Sector in the development of this Coronavirus – 2019 Disease (COVID-19) preparedness and response plan and budget.

Your time and input are highly valued and will go a long way in informing the nation on how to integrate COVID-19 response activities in other sector plans.

I thank you

Dr. Henry G. Mwebesa

Director General Health Services

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ABBREVIATIONS / ACRONYMS

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 Equipments
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

1 Introduction

1.1 Context

On 31 December 2019 the World Health Organisation (WHO) was notified of a cluster of cases displaying symptoms of a "pneumonia of unknown cause" linked to the Huanan Seafood Market, Wuhan, Hubei province. On 7 January 2020, Chinese Health Commission confirmed that they had identified the new virus. The cause of the pneumonia was identified as a novel Corona Virus. As of 5 February 2020, 24,554 cases had been confirmed worldwide with over 20,000 cases under investigation.

1.2 Current Situation of Corona Virus Disease 2019 (COVID - 2019)

The virus was first detected in Wuhan city, Central China, in December 2019. It is believed to have originated from wild animals, passing to humans due to the wildlife trade and wet markets. The virus spread to other Chinese provinces in early and mid-January 2020. This was due to the increased mobility of the population during the Chinese New Year celebration. Cases were detected in other countries among international travellers from Wuhan to various countries. As of 1st of March 2020 the following countries were affected; Thailand, Japan, South Korea, Taiwan, The United States, Hong Kong and Macau, Singapore, France, Nepal, Vietnam Australia, Malaysia Canada, Cambodia, Germany, Finland, Sri Lanka and the United Arab Emirates, India, Italy and Philippines, Russia, United Kingdom, Finland, and Sweden.

1.3 History of Corona Virus Outbreaks

Coronaviruses are a group of viruses that cause diseases in mammals and birds. Corona viruses mainly circulate among animals but can evolve to infect humans. In humans, the viruses cause respiratory illnesses which are typically mild including the common cold but severe forms can be fatal. In animals may cause diarrhoea, while in chickens they cause upper respiratory disease. All corona viruses that infect humans have been shown to have human to human spread. There are no vaccines or antiviral drugs approved for prevention or treatment.

There have been two large outbreaks of Corona Virus in the last 2 decades namely; 1) Severe Acute Respiratory Syndrome (SARS) 2002- 2003 affecting over 8,000 people with 800 deaths in 29 countries and 2) Middle Eastern Respiratory Syndrome (MERS), 2012 with over 1,700 cases and 670 deaths in 27 countries.

1.4 Transmission

Person-to-person transmission - The exact mode of person-to-person spread of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) is unclear. It is thought to occur mainly via respiratory droplets, resembling the spread of influenza. With droplet transmission, virus released in the respiratory secretions when a person with infection coughs, sneezes, or talks can infect another person if it makes direct contact with the mucous membranes; infection can also occur if a person touches an infected surface and then touches his or her eyes, nose, or mouth. Droplets typically do not travel more than six feet (about two meters) and do not linger in the air.

Environmental contamination — Virus present on contaminated surfaces may be another source of infection if susceptible individuals touch these surfaces and then transfer infectious virus to mucous membranes in the mouth, eyes, or nose. The frequency and relative importance of this type of

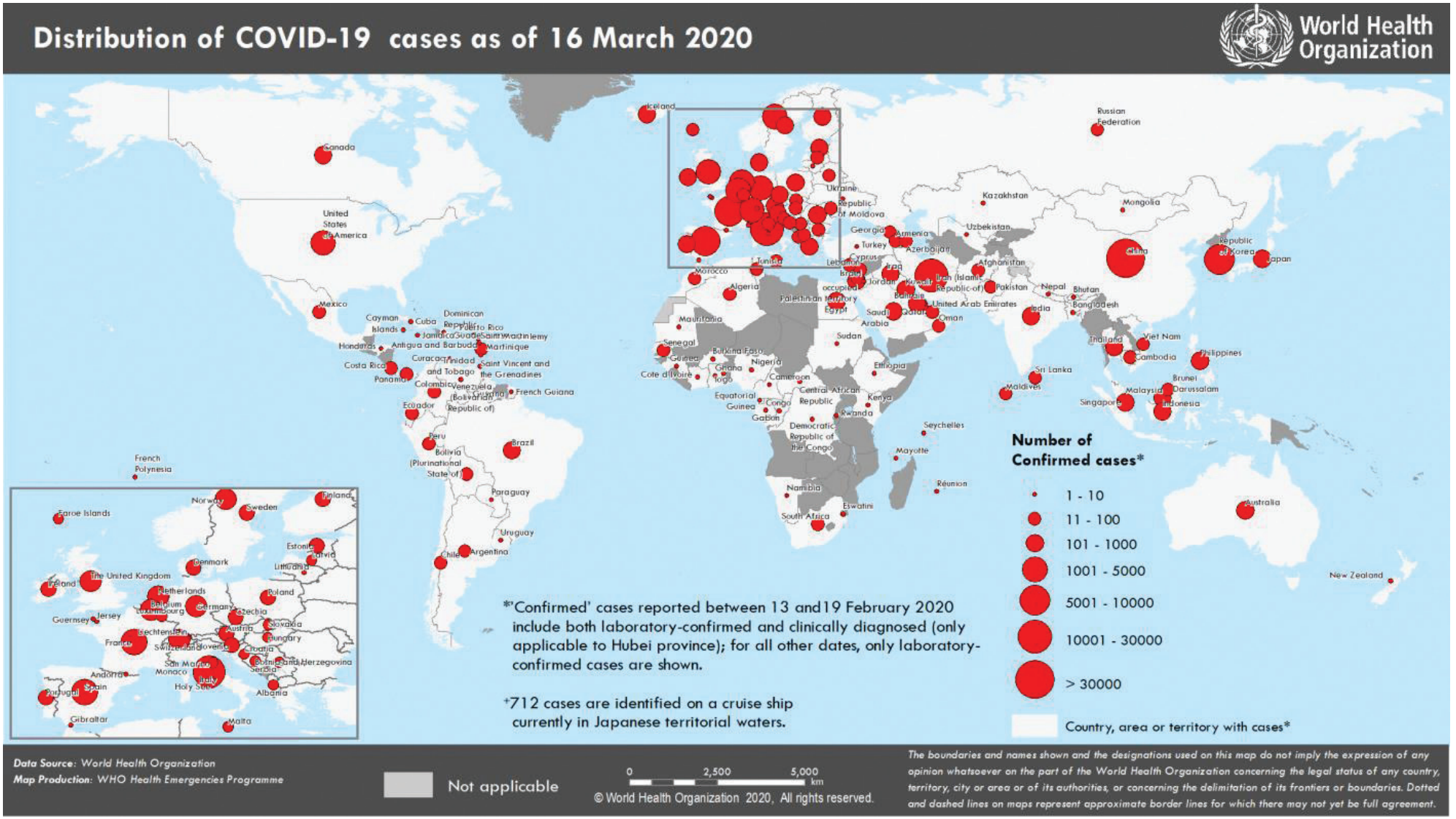
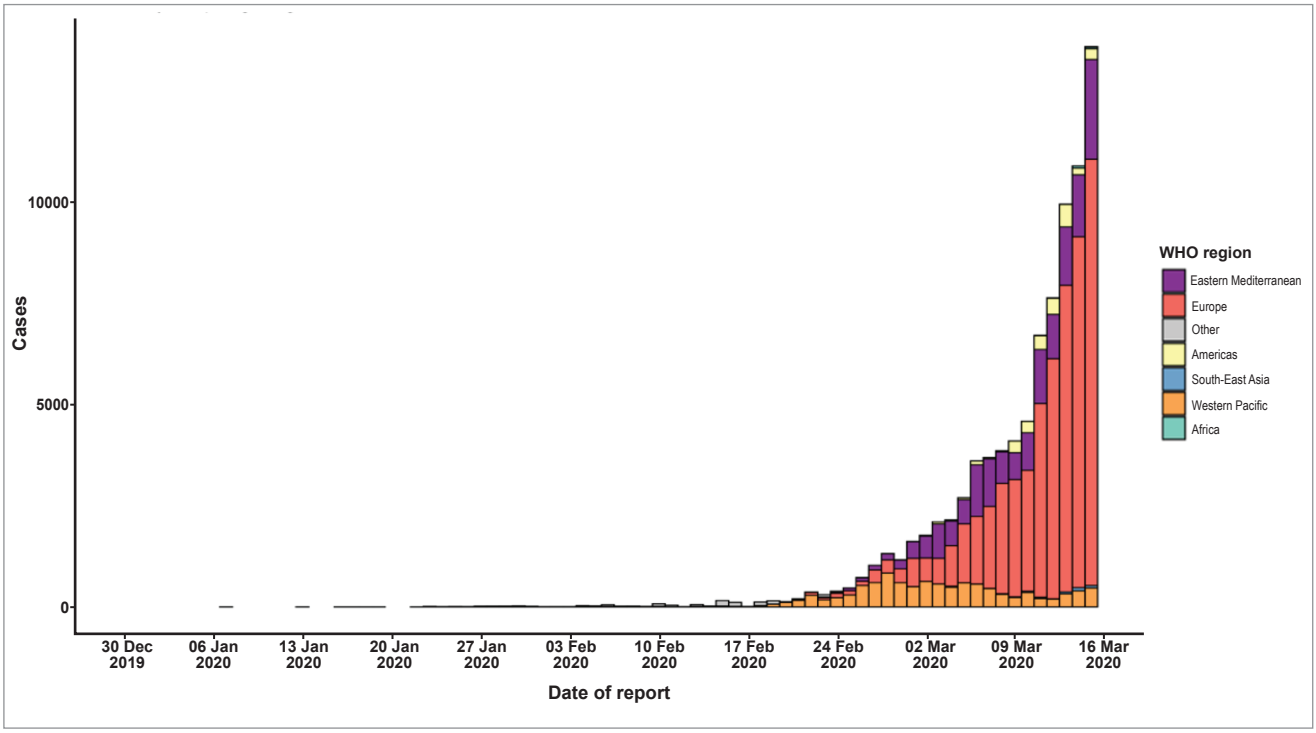


Figure 1: Countries, territories or areas with reported confirmed cases of 2019-COVID, 16th March 2020. Source: who.int

Figure 2: Epidemic curve by date of onset of COVID-19 cases identified outside China, 16th March 2020. Source: www.who.int



transmission remain unclear. It may be more likely to be a potential source of infection in settings where there is heavy viral contamination (e.g, in an infected individual's household or in health care settings).

1.5 Rationale for the plan

COVID-19 is highly spreading with over 10,000 cases reported globally and 20, 000 others under investigation in a period of only one week (26 January and 1 February 2020). This number is expected to raise due to the rapid spread of the infection and absence of available treatment. There are a substantial number of passengers who travel between Uganda and China as well as other affected countries for various reasons. This risk of importation of COVID-19 into Uganda is elevated by the increased mobility due to trade, education and travel for work globally and sustained transmission of the virus in different countries. It is pertinent that Uganda remains on high alert and invest adequately in COVID-19 preparedness and response.

As an immediate response to the epidemic the Government of Uganda (GoU) is providing strategic oversight for the response. GoU implemented a series of vulnerability reduction and containment measures to curtail transmission of COVID-19. Some of the measures have included: closure of international airport and ground crossing points for passengers; closure of schools and other high congregation points; freeze of public and private transport; outlawing all mass gathering events, including for worship; overnight curfew; and a nationwide lockdown.

The National Task Force (NTF), Incident Management Team (IMT), District Task Forces (DTFs) and their subcommittees have been activated, and various guidelines, Standard Operating Procedures (SOPs) and public awareness messages have been developed and widely disseminated. Capacity building of the health workforce and re-organization of service delivery points has been undertaken while ensuring continuity of essential services. Surveillance and laboratory services strengthening is very critical to effectively respond to the pandemic.

2 Preparedness and Response strategy

2.1 Goal

The goal of this plan is to provide a framework for coordination and control of COVID-19 by reduction of importation, transmission, morbidity and mortality in a bid to minimize the social economic disruption that might result from this pandemic. The implementation of this plan will be multi-sectoral involving Ministries, Departments & Agencies (MDAs), Development Partners, Non Governmental Organizations (NGOs), private sector entities and other stakeholders.

2.2 Specific objectives

1. To strengthen leadership, stewardship and coordination of preparedness and response efforts for COVID-19.
2. To develop country capacity for early detection; reporting; investigation; confirmation; and referral of suspected cases to designated isolation units.
3. To raise public awareness on the risk factors for transmission, prevention and control of COVID-19 and promote the infection prevention and control practices including Water Sanitation and Hygiene (WASH) to mitigate spread of COVID-19.
4. To develop capacity for case management and psychosocial support for COVID-19.
5. To strengthen the social protection mechanisms and mitigate its impact on vulnerable groups.

2.3 Approach to the development of this plan

The development of this plan has followed a highly consultative and multidisciplinary approach. The plan has been developed following review of the draft Pandemic Influenza Plan and use of the guidance from the World Health Organisation on the COVID-19. 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 Ebola Virus Disease (EVD) Preparedness and Response.

The key principles for preparedness and response to COVID-19 will encompass utilization of Information Communication Technology (ICT) innovations, community led approach and 24-hour surge capacity. The plan was conceived based on three different scenarios. In scenario 1, no case is identified in Uganda and activities are focused on preparedness. In scenario 2, a single case is identified in Uganda; response activities are initiated, and command and control structure shifted to the Office of the Prime Minister (OPM). In scenario 3, multiple cases are identified; in which case activities of scenario 2 are enhanced and business continuity plans per sector activated.

2.4 Scenarios

The following scenarios have been described basing on the risk and scale of outbreak.

Scenario	Actions
Scenario 1 (Best case scenario): *No cases reported in Uganda.*	- Continued surveillance and routine screening at Points of Entry (PoE) - Prepositioning of logistics at PoE and regional referral hospitals - Risk communication and community engagement - Infection Prevention and Control (IPC) and WASH - District categorization and preparedness focused in high risk districts
Scenario 2 (most likely scenario): *(confirmed cases in one geographical location, enhanced preparedness across the country)*	- Management of confirmed case(s) - Enhanced surveillance - Risk communication and community sensitization and engagement - IPC and WASH - Psychosocial support activities - District categorization and preparedness focused in high risk districts and response in affected areas
Scenario 3 (worst case scenario): *(confirmed in multiple locations, or overwhelming numbers of cases)*	- Cross pillar response at community level, PoE escalate to response capacities - Escalation of response activities to the NTF under OPM - Surge teams (including the Uganda People's Defence Force (UPDF) and international medical teams) - Implement community wide quarantine measures based on risk

This National COVID-19 Preparedness and Response Plan, therefore, will outline the steps and resources necessary for Uganda to respond to Scenario 3 (worst case). In doing so it will create the necessary capacities and capabilities to allow Uganda to respond to other scenarios as called for by the evolving threat(s).

In collaboration with Makerere University School Health, the parameters in Table 1 were modelled for reference in determining the quantification and priority interventions for the response.

Table 1: Projection case models from the Scientific Committee

100% Lift Up	25% Lockdown	58% Lock down
2.9% Risk Exposure	2.9% Risk Exposure	2.9% Risk Exposure
No Lock down	No restriction movements	
Social distancing 50%	Social distancing 50%	Social distancing 50%
30% Mask Adherence	30% Mask Adherence	30% Mask Adherence
50% wash Hand at least 6 times a day	50% wash Hand at least 6 times a day	50% wash Hand at least 6 times a day
Schools open	Schools open (25%)	Schools closed (25%)
Church, Mosques Open	Church, Mosques Closed	Church, Mosques Closed (33%)
Transport models operational	Transport models operational	Transport models operational
People Working	People Working	People Working

2.5 Assumptions

Due to the rate of spread and fluidity of the situation the following planning assumptions have been applied to the planning process;

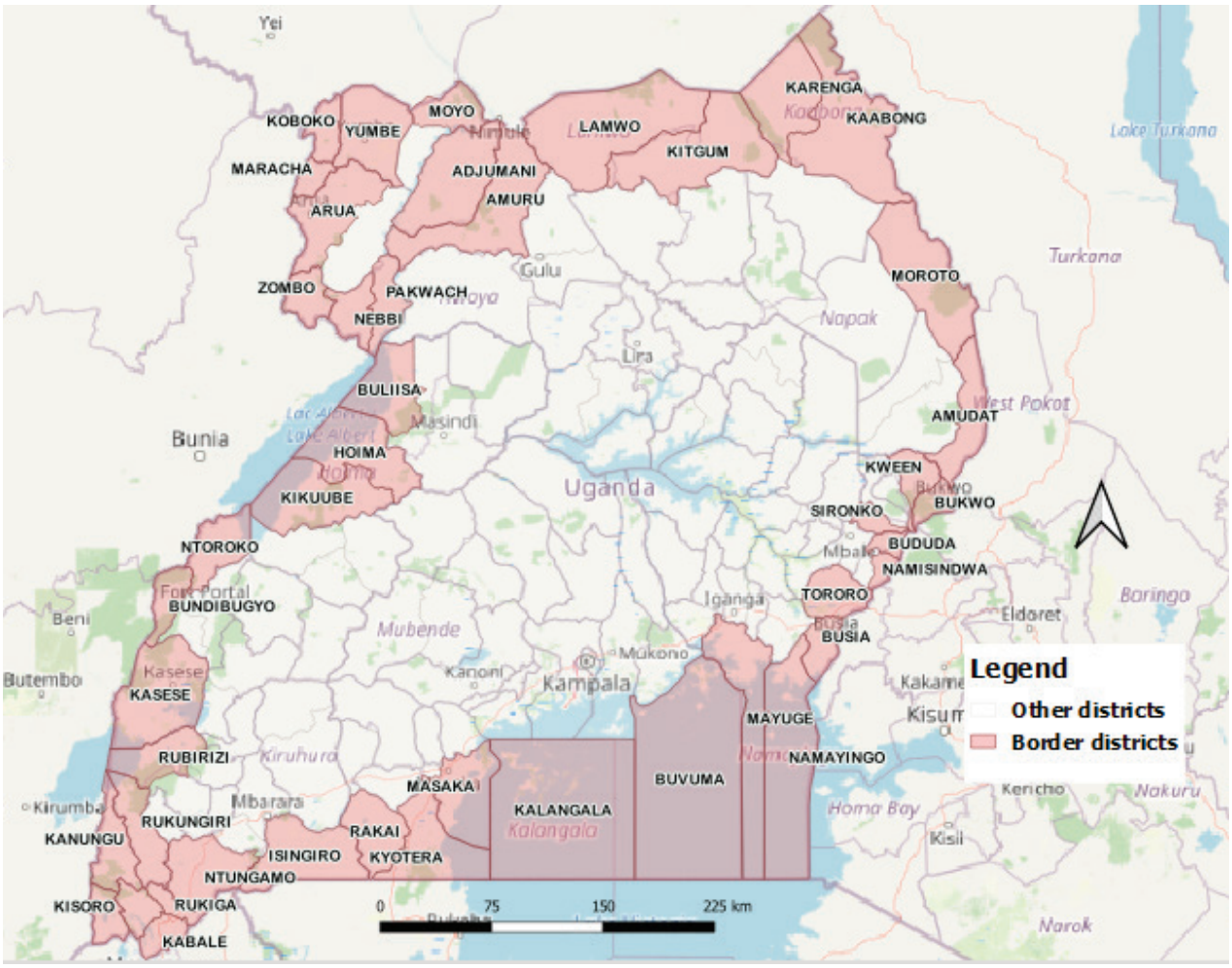
1. 2.9% (1,247,000/43,000,000) of the entire population of Uganda is at risk.
2. The typical incubation period for Corona virus is 2 days to 14 days, average 5 days.
3. With 100% lifting of control measures i.e schools open, worship places open, transport operational; 30% wearing masks; and 50% handwashing at least 6 times a day; 2.7% (33,935/1,247,000) of the at risk will be detected by 20 weeks of the first exposure (Worst case scenario).
4. Between 38% - 50% individuals infected with COVID-19 have no symptoms (from the Ugandan experience so far – 38% of the individuals hospitalized had no symptoms – Analytical report 24th April 2020), yet are able to transmit the infection.
5. Days taken for mild to recover 21, moderate 24, severe 28 (5% recover), critical 35 (12% recover) WHO.
6. All travellers will be screened.
7. All refugee new arrivals will be screened.
8. High risk travellers identified at PoE and contacts of COVID-19 cases will be quarantined immediately.
9. Outbreak related anxiety will cause increased psychogenic and stress-related illness, compounding the strain on healthcare workers, patients, suspect cases and the community.
10. Government may recommend changes example lock down, social distancing, business workplace rules, such as increased telecommunication.

2.6 Risk mapping

The whole country is at risk, however, to improve preparedness and response efforts some areas have been identified as at higher risk. Currently the country has been divided into three risk categories depending on their location. Risk assessments will however be ongoing in tandem with the evolution of the epidemic, and in-country dynamics including refugee movements.

Category	Category type/Rational	Districts
Category 1	• Districts with high volume border crossing points and Greater Kampala (Kampala, Wakiso & Mukono)	44
Category 2	• Districts along transit road for cross border cargo	54
Category 3	• Rest of the country	37

Figure 5: Map of Uganda highlighting the border districts (Category 1)



2.7 Situation Analysis

The Covid-19 pandemic threatens to overwhelm health systems globally, but especially in developing countries. With the spread in Uganda and its neighbouring countries, the question is whether Uganda health system was resilient enough to respond to the pandemic and its short, medium term and long-term effects. Concerted action needed to be undertaken at national, regional and international levels to effectively contain this pandemic, underscoring the importance of cooperation, coordination and communication.

Despite its challenges, Uganda remains a regional leader in outbreak preparedness and response. This is demonstrated through its relatively strong performance on the 2019 Global Health Security Assessment (GHSA), ranking 63 out of 195 countries,[1] and in the WHO's Joint External Evaluation (JEE)[2]. Leveraging these strengths, the country has successfully contained a series of outbreaks in the last few years, including Crimean Congo hemorrhagic fever, Marburg virus disease, Rift Valley fever, Anthrax, Meningitis, Measles, Cholera, and Ebola. At the height of the West Africa Ebola outbreak in 2014-2015, Uganda provided technical support to the most affected countries. Furthermore, between June 2019 and March 2020, the country implemented several activities to prevent the Ebola outbreak from the

1 Worldwide, the average score on the GHSA index is 40.2%. The average for the African region is 30.8% and only four countries in the region exceed the world average (South Africa, Kenya, Uganda, and Ethiopia). However, the overall score for Uganda on the GHSA is 44.3% which means that there is scope for improvement.

2 The JEE is a voluntary, collaborative, multisectoral process to assess country capacities to prevent, detect and rapidly respond to public health risks whether occurring naturally or due to deliberate or accidental events.

neighbouring Democratic Republic of the (Congo DRC) from spilling into Uganda. The experiences acquired in containing past outbreaks will undoubtedly help Uganda to manage the COVID-19 pandemic. However, responding to the COVID-19 pandemic also presents a unique set of challenges given the gaps in knowledge worldwide on the pathogeneses and epidemiological characteristics of the disease, the considerable toll on the economy (from lockdown and social distancing), and the tremendous pressure that the outbreak could place on an already fragile health system. These challenges underscore the need for additional investments in prevention, detection, and response to COVID-19 pandemic.

Global evidence on the evolution of the pandemic reveals that: (i) 80% will experience mild illness up to and including mild pneumonia; and (ii) the remaining% will experience moderate to severe illness, with about 5% percent requiring intensive care.

Currently, Uganda has less than one hospital bed per 1,000 people, and there are only 137 Intensive Care Unit (ICU) beds complete with all the necessary life support equipment in the public hospitals nationwide. Mulago National Referral Hospital (NRH) has 102 (74%) of the ICUs and the rest are located in some of the Regional Referral Hospitals (RRHs). This is woefully inadequate. Experts have estimated Uganda will require 1,000 equipped ICU beds to be able to handle the pandemic. There is therefore a short fall of 718 ICU beds to be able to manage the pandemic in addition to the general conditions.

Shortages of critical care health workers present a huge dilemma and in addition to this shifting of the few available medical staff to COVID-19 care, will exacerbate shortages in other areas. These shortages might have consequences that surpass those from Covid-19 on other essential care services during the response. There is urgent need to recruit additional critical care staff and epidemiologists to address these shortages.

Continuity of essential care is important as the lockdown measures and fear of contracting the corona virus are likely to create issues related to access to services and provision of medicines and other essential medical supplies. The most affected population groups are those suffering from chronic illnesses (HIV/AIDS, Cancer, Diabetes, Tuberculosis (TB) leading to treatment interruptions; women and children in need of child and maternal healthcare; and people in need of sexual and reproductive health services.

Lessons learned from countries like Italy, Spain, and USA also emphasize the importance of health system readiness to manage the investable caseload of the severe and critical COVID-19 patients adequately and safely.

2.8 SWOT Analysis

2.8.1 Strengths

- Strong political will at national level with the whole Government approach.
- Strong oversight function by Parliament.
- Commitment from government and partners to finance the response.
- Strong leadership and stewardship in the Ministry; existence of Public Health Emergency Operation Centre (PHEOC).
- Existing community structures for preparedness and response.
- Previous experience in the management of epidemics e.g. Ebola and disease outbreaks. Capacities have been built in surveillance, coordination, human and resource mobilisation and treatment.

- Strong laboratory capacity and networks.
- Decentralised health services that provides country wide coverage; previously activated District preparedness and response teams.

2.8.2 Weaknesses

- Un-harmonised control measures in the East African Community (EAC) region and neighbourhood and nascent Port Health.
- Weak multi-sectoral collaboration mechanisms at all levels of government.
- A Community transmission phase is likely to overwhelm the health system: Isolation; critical care; Human Resource (HR); logistics; and, capacity to respond, accommodate and feed people—including the quarantined and the general public.
- The living conditions of communities, especially congestion in urban slums, and small dwelling places in rural areas make social distancing particularly challenging.

2.8.3 Opportunities

- COVID-19 presents an opportunity to do more of research on emerging diseases.
- Upping of the HR skilling and expertise in the health sector—medical, laboratory, logistics management, and collaboration and synergy.
- Opportunity to revamp the entire health system for Universal Health Coverage.
- Improvement of the multi-sectoral collaboration within government.
- Enhancing Community involvement and participation.
- Enhancement of the use of local languages in the risk communication and social mobilization for health communication.
- Strengthening collaboration with the private sector and Civil Society.
- Strengthening collaboration and the participation of the Religious and Cultural leaders.
- Strengthening the oversight and advocacy role of Parliament.
- Strengthening collaboration and engagement of the media in the response.

2.8.4 Threats

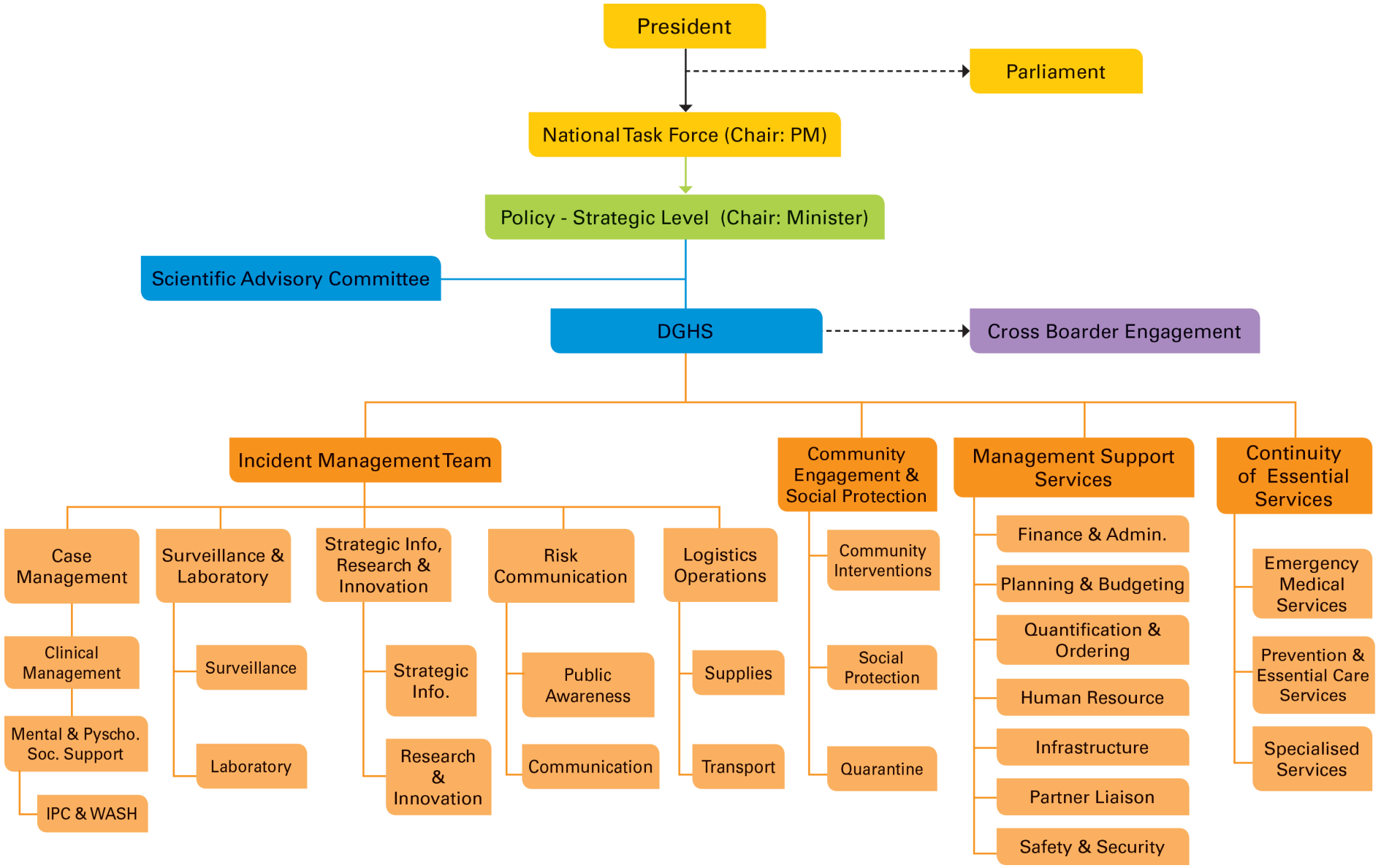
- Protracted COVID 19 outbreak may cripple the economy and limit our capacity to respond.
- Lack of social protection mechanisms is likely to trigger non adherence to containment measures.
- Misinformation by social media.
- Global and high demand leading to competition and shortage of personal protective gear and test kits.
- Climate and environmental hazards e.g floods, landslides.
- Concurrent outbreaks in the country including Crimean Congo Haemorrhagic Fever and the threat of importation of Ebola from the DRC.
- A moratorium on critical supplies from major manufacturing countries is a threat to COVID-19 response and general health service delivery
- Vaccines and treatment not available.

- Community transmission in neighbouring countries and porous borders
- Discrimination and stigma of COVID-19 cases
- Reduced donor funding.
- Strain on the health system to the detriment of continuity of essential care management of other conditions and emergencies e.g chronic conditions e.g. HIV/AIDS, Non-Communicable Diseases (NCDs), other emergencies, and Maternal and Child Health Care services including Obstetric and Neonatal Care.

2.9 Key stakeholders

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 has been elaborated in this plan and there is need for a strong Risk Communication and Social Mobilization Component; as well as Community Engagement and Social Protection.

Figure 3: COVID-19 Response Structure



3 Intervention Areas

For effective coordination and management of interventions aimed at addressing the COVID-19 pandemic, the related interventions are clustered in eitht (8) pillars. This section of the plan therefore, describes the general strategy and activities under each of the 8 pillars below for attainment of the objectives of this plan.

The COVID-19 Response pillars are;

1) Leadership, Stewardship, Coordination and Oversight;
2) Surveillance and Laboratory;
3) Case Management;
4) Strategic Information, Research & Innovation;
5) Risk Communication and Social mobilization;
6) Community Engagement and Social Protection;
7) Logistics; and
8) Continuity of Essential Services

3.1 Pillar 1: Leadership, Stewardship, Coordination and Oversight

Leadership and stewardship during epidemic response situations is very crucial to provide strategic direction as well as mobilise resources. Coordination facilitates speedy implementation; generates economies of scale; avoids fragmentation of interventions; creates synergies; and, catalyses processes. Coordinated responses, timely inter-agency assessments and information sharing reduce the burden on affected communities who may be subjected to demands for the same information from the different stakeholders.

Oversight function is necessary at all levels to ensure transparency and real time accountability. This calls for involvement of Parliament within its constitutional mandate to provide oversight and ensure a Whole of Government approach to the COVID-19 response. The Parliamentary oversight activities will be overseen by the Office of the Speaker through established parliamentary structures.

Another key leadership function that will ensure that the response goals are met is to make the resources that are required by the workers for proper performance of the tasks are available in time and in quantity as well as quality. This calls for proper forecasting, quantification and timely procurement of all inputs for the response.

Leaders and managers at all levels will be required to keep proper and effective communication with all key stakeholders in order to give guidance or receive feedback. The Corona virus situation is fast evolving and requires innovation and leveraging of digital health in the preparedness and response. There are opportunities to optimise service delivery by adopting recent developments in digital health during Uganda's preparedness and response for COVID-19. Adaptation of ICT is critical at this time to support all pillars to deliver more efficiently, ensure wider reach, quick validation of data and information while strengthening decision-making.

3.1.1 Strategies for Leadership, Stewardship, Coordination and Oversight

1) Provide strategic direction to MDAs and key stakeholders on strategic direction and policy.
2) Mainstream Government and partner support in fully operationalizing this plan.
3) Strengthen coordination and leadership for COVID-19 response at national, regional and district level.
4) Strengthen HR capacity for the COVID-19 response
5) Enhance cross border collaboration and information sharing.
6) Strengthen the supply chain management and logistics support system
7) Strengthen required health infrastructure for the response to COVID-19.
8) Strengthen the National Drug Authority's testing capacity to conduct Quality assessment of all pharmaceutical and healthcare products.
9) Digitization of the COVID-19 Response processes—including communication, coordination meetings, data management process, patient care through telemedicine and other support services.
10) Ensure transparency and accountability in resource utilization.
11) Develop a supervision, Monitoring and Evaluation (M&E) framework for the response.

3.2 Pillar 2: Surveillance and Laboratory

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.

COVID-19 surveillance activities will be conducted within the integrated disease surveillance and response framework to allow detection of other epidemic prone diseases eg. Measles, Acute Flaccid Paralysis, Ebola, and viral hemorrhagic fevers and continuity of services. Weekly and monthly Health Management Information System (HMIS) reports will continue to be submitted to Ministry of Health (MoH). The MoH will mobilize the partnerships needed for activation of all surveillance systems in the country as mentioned above.

Surveillance and screening at all the 53 PoE have been scaled up, including at Entebbe International Airport, Busia, Malaba, Elegu, and Cyanika, among others. Uganda has in-country capacity to test for COVID-19 at the Uganda Virus Research Institute (UVRI), with an existing sample transfer network and established SARS sentinel surveillance sites and Laboratories. The laboratory capacity has been scaled up and COVID-19 testing is now being done at the National Public Health Laboratory (NPHL) at Butabika, Tororo General Hospital, Mutukula PoE and Makerere University College of Health Sciences Laboratory at Mulago. There are other Laboratories in the country for example Joint Clinical Research Centre, Gulu University Hospital, Muni University in Arua whose capacity can be enhanced for the response. The MoH plans to scale up this further by establishing Port Health Facilities with laboratories for surveillance.

In the absence of treatment or vaccine, ceasing most human contact is really the only way to stop the spread of the virus. Essentially the less contact people have with each other, the less the virus

can spread. As part of containment measures, variations of quarantine will be implemented to control transmission of infection in the community setting. Quarantine measures will be instituted at varying levels dependent on risk.

These may be;

a) Home quarantine: Exposed persons are asked to quarantine themselves individually at home;

b) Institutional quarantine: Exposed persons are asked to quarantine in a monitored group setting with others;

c) Geographical quarantine: Quarantining across a defined geographical boundary e.g. village, subcounty, district, region or country

Lock-down: Given the rapid spread of the virus, social lock down is needed to bring the overall transmission down, and see whether testing followed by isolation can be effective—this is all in an attempt to 'flatten the curve' or reduce infections and spread cases out over a longer time frame to avoid overwhelming the health system.

3.2.1 Strategies for surveillance and laboratory

1) Build national and district capacity on COVID-19 surveillance and reporting (NTF, IMT, DFT, Health workers, PoE, Health workers, PoE, responders and selected VHTs).

2) Conduct rapid risk assessment for COVID-19 importation into the country.

3) Strengthen active search and alert management systems at all levels.

4) Provide office space and equipment for the MoH & EOC.

5) Build capacity of laboratory and selected health staff on appropriate COVID-19 sample collection, packaging, handling and transportation.

6) Conduct performance evaluations for new test kits, servicing of laboratory equipment, purchase of parts needed for equipment repair (UVRI).

7) Support continued operation of the National Influenza Center at UVRI and the national laboratory specimen hub transport network.

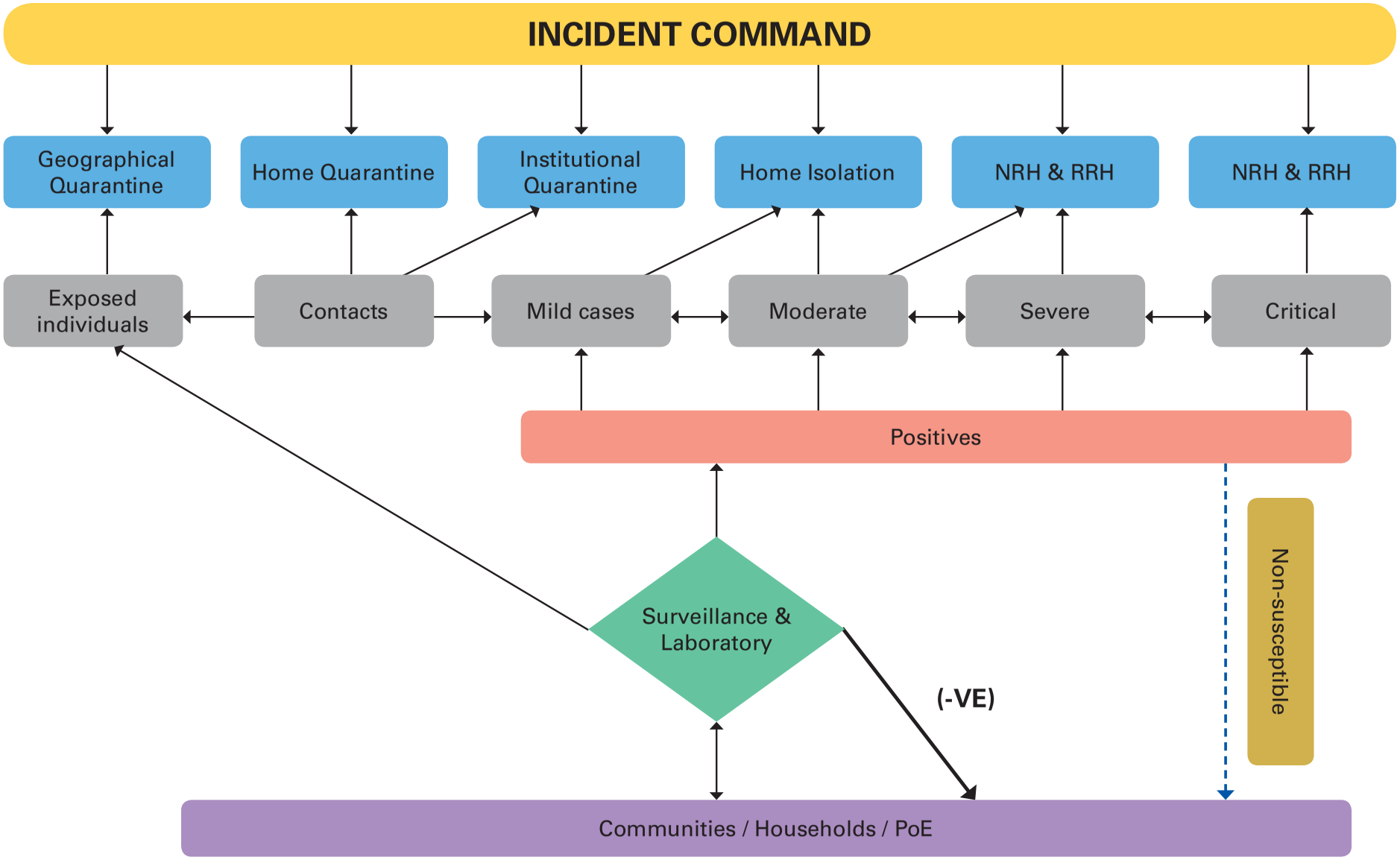
8) Support Laboratory Accreditation

9) Strengthen surveillance at PoE, on cargo in transit within Uganda and at designated transit points along trans-national trunk roads connecting ports of entry.

10) Establish Port Health Services.

All pillars under the COVID-19 Response have clear but related functions and it is important that the flow process and interlinkage between the pillars is understood. Through surveillance positive and exposed cases and their contacts will be identified and managed accordingly. Confirmed cases will be managed either at the designated referral hospitals or under home isolation depending on the severity of the diseases. Exposed individuals and contacts will be quarantined under any of the 3 categories; geographical, home or institutional as per the Quarantine guidelines.

Figure 4 demonstrates the surveillance, laboratory, quarantine and case management flow process.



3.3 Pillar 3: Case Management

In majority of COVID-19 cases, the affected individuals it is associated with mild disease (this may be in up to 80% of infected individuals) but the remaining 20% of individuals infected may have moderate to severe disease necessitating hospitalization in a designated COVID-19 facility, and 5% will have very severe and critical disease. Certain conditions put the patients at risk of severe disease and poor treatment outcomes these include; advanced age, hypertension, diabetes, cardiovascular disease, chronic respiratory diseases and immunosuppressive conditions like cancer.

Since there is no effective cure or vaccine for COVID-19, emphasis needs to be put on prevention of transmission from person to person at community level and points of congregation including Churches, mosques, schools, workplaces, etc. Focus will be on strengthening IPC including WASH in health facilities, institutions and communities. Treatment is mainly supportive. Corona virus infection may cause psychosocial stress because of the nature of the disease and may also cause social disruption to the; infected, affected, including responders and their families. Targeted response interventions by health including physical isolation may impact on COVID-19 affected communities' mental health and therefore there is need to provide quality and culturally appropriate treatment and protection interventions through planning, implementing, coordinating, and monitoring psychosocial care and protection for people who are affected by Coronavirus. All confirmed cases of COVID-19 depending on their severity, will be managed in designated isolation facilities - including homes across the country. Mildly ill or asymptomatic patients will be isolated at homes, non-traditional facilities, General Hospitals or Health Centre IVs. Moderately to severely ill patients will be hospitalized in designated COVID-19 treatment centres which have a capacity for High Dependence Units (HDU) and ICUs.

3.3.1 Strategies for Case Management

1) Enhance the country's capacity for management of COVID-19 cases.

2) Strengthen IPC and WASH in gazetted COVID-19 management facilities.

3) Strengthen the ambulance services for efficient referral of COVID-19 patients.

4) Building capacity for Mental Health and Psychosocial Support (MHSSP) for COVID-19 effects.

3.4 Pillar 4: Strategic Information, Research and Innovation (SIRI)

The novel corona virus is fast evolving and provision of strategic information will guide on what is currently happening and what interventions should be put in place to mitigate and control spread of the disease. Real time data utilization will inform decision making of the incident command. Provide the population with real time information and knowledge as the disease evolves.

There is need to understand the current situation and stimulate innovation especially now that there is global demand for commodities essential for the COVID-19 response like test kits, Personal Protective Equipments (PPEs), vaccines and therapeutic interventions. Through the Presidential Directives, a number of innovations have been initiated by Ugandan based local factories to produce commodities to support the COVID-19 interventions like locally produced surgical masks, face shields, coveralls and aprons.

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.

3.4.1 Strategies for Strategic Information, Research and Innovation

1) Establish SIRI coordination structure for COVID-19 response.
2) Map key stakeholders in the different data management functions.
3) Develop an effective data management framework for COVID-19 response.
4) Adaption of appropriate technology for data capture and dissemination.
5) Produce and disseminate information products for management decision making and policy formulation.
6) Support operational and scientific research on COVID-19.
7) Promote creativity and innovations for COVID-19 response.

3.5 Pillar 5: Risk Communication and Social Mobilization (RCSM)

The COVID-19 virus is new and, globally there is limited knowledge about this virus. There is evidence that provision of information to the general public about COVID-19 contributes to the prevention and control of the disease outbreak. The MoH therefore plans to implement RCSM interventions to raise awareness and build partnerships in preparedness and response phase of new coronavirus throughout the country. Information generation will be through the strategic information & research pillar to ensure evidence driven communication. Key messages on the status of the epidemic with respect to the status of surveillance, number of cases, prevention measures and community engagement for prevention and social protection will be given through Presidential directives and the MoH. Dissemination to reach all residents will be done by key stakeholders with and through the MoH.

3.5.1 Strategies for RCSM

1) Establish the RCSM subcommittee for COVID-19 RCSM.
2) Develop the COVID-19 Communication Strategy.
3) Support implementation of the COVID-19 Communication Strategy.
4) Develop mechanisms for monitoring effective delivery and effectiveness of the messages.

3.6 Pillar 6: Community Engagement and Social Protection

A distinct Community Engagement and Social Protection pillar is essential for targeting delivery of health services and addressing the social needs of the population—especially the most at risk and vulnerable. Beyond the immediate public health aspects of the COVID-19 pandemic, the disease will also have humanitarian and socio-economic consequences, as already seen in the global economic slow-down. Given the high degree of vulnerability for the bottom 40 percent 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 a number of measures to minimize the multi-faceted impacts of this rapidly evolving situation.

Communities are an integral platform for delivery of key basic services and essential public health functions. Community engagement—in planning, research, financing and implementation, and empowerment is critical to ensure ownership and uptake of targeted interventions. There is need to increase close to community cross sectoral, catalytic and synergistic actions, for example - environmental sanitation and hygiene, nutrition, family planning, reproduction and child health, sexual and gender-based violence, and social protection—including health financing, social security measures—among others.

Gender-Based Violence is likely to arise primarily from the breakdown of economic and social activities, restrictions on movement, and shutting down of schools. All these factors place women and girls at heightened risks of intimate partner violence and other forms of exploitation and sexual violence. In addition, life-saving care, and support to GBV survivors (i.e. clinical management of rape and mental health and psycho-social support) is limited and may be disrupted when health service providers are overburdened and preoccupied with handling COVID-19 cases. Other vulnerable groups face increased risk of exclusion during the pandemic.

The MoH in collaboration with key stakeholders will engage all communities physical and virtual—social networks. Physical communities include: households; villages; schools; places of worship; cultural and professional groups; and, work space spaces—factories, workplaces, markets, health facilities; and others, to take charge of Community based interventions. The key stakeholders will include: Government—MoGLSD, MoLG, MoE&S, MoICT&NG, MoW&E, MoT&I, MoFPED, MoIA, MoD and MAAIF; Religious and Cultural Institutions, Private Sector, Development and Implementing partners, and CSOs. They will work through existing Local Government (LG) and community structures and self-help programmes to build voluntary actions at the community level. The same community system will be supported to intensify social protection mechanisms.

3.6.1 Strategies for Community Engagement and Social Protection

1. Establish a community engagement and social protection committee for COVID-19 at National level.
2. Strengthen community engagement and social protection structures for COVID-19 in Communities.
3. Strengthen capacity for IPC and WASH at community settings underscoring schools, workplaces, institutions, public places, commercial places like shops, markets, households, shopping malls along the trunk roads, etc.
4. Develop School Program for prevention and mitigation of COVID-19 in schools.
5. Establish COVID-19 quarantine facilities.
6. Facilitate self-quarantine and continuation of essential services for COVID-19 in the community and homes.
7. Strengthen leadership, management and coordination of stakeholder response to the emerging and escalating cases of GBV, VAC, Emergency Alternative care and children in detention during and post COVID-19.
8. Provide timely prevention and response to the identified needs in GBV, VAC, Emergency Alternative Care and Children in detention during and post COVID-19.
9. Support implementation of social protection interventions for the vulnerable populations.
10. Develop mechanisms for oversight and monitoring effective delivery and effectiveness of the community interventions.

3.7 Pillar 7: Logistics Operations

Timely provision of supplies of both medical and non-medical nature is critical in the COVID-19 response. The purpose of this pillar is to ensure proper storage, distribution and tracking of both medical and non-medical logistics for the COVID-19 response.

3.7.1 Strategies for Logistics Operations

1) Establish the Logistics Operations subcommittee for COVID-19.
2) Establish an efficient logistics storage and distribution system.
3) Ensure proper storage and distribution of medical and non-medical supplies.
4) Ensure a functional and responsive fleet management system.

3.8 Pillar 8: Continuity of Essential Health Services

Uganda's health system resilience is being tested by the COVID-19 pandemic. This calls for a dual response to mitigate the impact on the Uganda population and maintain uninterrupted essential health services. This includes sustained response to outbreaks including Ebola, Yellow fever and Cholera, among others. In addition, the need to maintain responses to communicable and non-communicable conditions is important to avoid increased morbidity and mortality in the population.

Government commits to sustain the delivery of essential health services through existing networks while we continue to respond to COVID-19. Strategic actions are therefore required to harmonize and maintain essential health services within the context of COVID-19 pandemic. This will ensure the residents in Uganda continue to receive the essential care they need.

3.8.1 Strategies for Continuity of Essential Health Services

1) Strengthen coordination mechanism for essential health service continuity at the national and subnational levels.
2) Re-organize and maintain access to essential quality health services.
3) Strengthen reporting and monitoring of health service delivery.
4) Enhance capacity for delivery of essential and emergency medical services.
5) Strengthen the occupational health and safety programme in health facilities.

4 COVID-19 Response Plan Budget March 2020 to June 2021

The total budget for the multi-sectoral COVID-19 Response is UGX 2,221,990,315,936/= (USD 600,535,742/=) for the period March 2020 to June 2021. The total committed funds (UGX 766,732,429,404/=) as of June 2020 include the UGX 386,608,640,216/= (USD 104,488,822) already disbursed by the Government of Uganda to the various sectors involved in the response as well as funding from on-budget support projects, Development Partners and contributions from the private sector and individuals. Details are indicated in Tables 3 – 6.

The GoU will continue mobilizing resources to fill the current gap of USD 393,310,761 to ensure that the population is protected and those affected receive the appropriate management and social support.

Table 2: Budget Requirement, Commitments and Gap by Pillar for the Period March 2020 to July 2021

Item	Budget		Committed (USD)	Gap (USD)	% gap
	UGX	USD			
Leadership, Stewardship, Coordination and Oversight	316,290,717,031	85,483,978	24,072,355	61,411,623	72%
Human Resource	70,423,203,385	19,033,298	10,117,240	8,916,058	47%
Supply Chain Management	935,988,138,417	252,969,767	77,388,293	175,581,475	69%
Health Infrastructure	289,527,106,895	78,250,569	29,353,299	48,897,270	62%
ICT	3,881,379,296	1,049,021	971,184	77,837	7%
Surveillance and Laboratory	82,106,655,954	22,190,988	13,673,652	8,517,336	38%
Case Management	109,774,808,792	29,668,867	9,851,712	19,817,156	67%
Strategic Information, Research & Innovation	14,535,044,450	3,928,390	1,544,288	2,384,102	61%
Risk Communication and Social Mobilization	59,073,109,400	15,963,524	6,089,004	9,874,520	62%
Community Engagement and Social Protection	231,958,203,140	62,691,406	19,122,928	43,568,478	69%
Logistics and Operations	80,127,433,576	21,656,063	13,459,739	8,196,324	38%
Continuity of Essential Health Services	28,304,515,600	7,649,869	1,581,288	6,068,581	79%
Total	**2,221,990,315,936**	**600,535,742**	**207,224,981**	**393,310,761**	**65%**

Table 3: Funding Commitments by Source in USD

Item	GOU / MoH	GOU / MDAs	GOU/WB CERC	GOU / WB UCREPP	GFTAM-1	GFTAM C19RM	GAVI
Leadership, Stewardship, Coordination and Oversight		23,152,457	511,235	-	-	23,741	-
Human Resource	3,201,620	-	951,622	1,588,713		312,898	
Supply Chain Management	23,565,065	-	10,253,735	2,059,000	7,576,739	11,272,343	2,815,743
Health Infrastructure	15,191,470	-	6,227	8,675,962		4,833,052	-
ICT	216,216	-	90,433	-	-	25,000	-
Surveillance and Laboratory	1,100,378	4,795,905	396,018	2,190,821	-	83,907	-
Case Management	4,429,144	-	619,645	613,600	-	290,403	-
Strategic Information, Research & Innovation	-	-	189,189	-	-	334,161	-
Risk Communication and Social Mobilization	986,487	2,221,110	-	-	-	409,521	-
Community Engagement and Social Protection	-	16,054,054	54,804	80,000	-	343,049	-
Logistics and Operations	7,525,835	2,049,081	1,927,092	78,800	-	298,200	-
Continuity of Essential Health Services	-	-	-	-	-	591,288	-
Total	**56,216,215**	**48,272,607**	**15,000,000**	**15,286,896**	**7,576,739**	**18,817,563**	**2,815,743**

Table 4: Funding Commitments by Source in USD

Item	IsDB	USF	UNICEF	Enabel	UNITAID	KOFIH	Alibaba
Leadership, Stewardship, Coordination and Oversight	-	-	125,054	-	-	-	-
Human Resource	-	-	260,000	-	-	-	-
Supply Chain Management	13,790,000	199,486	1,742,679	-	500,485	40,000	1,038,395
Health Infrastructure	-	-	-	60,811	-	-	-
ICT	-	-	39,765	-	-	-	-
Surveillance and Laboratory	-	-	-	-	-	-	-
Case Management	-	-	761,510	-	-	936,746	
Strategic Information, Research & Innovation	-	-	10,938	-	-	-	-
Risk Communication and Social Mobilization	-	-	928,663	49,459	-	-	-
Community Engagement and Social Protection	-	-	-	-	-	-	-
Logistics and Operations	-	13,514	35,362	-	-	-	-
Continuity of Essential Health Services	-	-	-	-	-	-	-
Total	**13,790,000**	**213,000**	**3,903,971**	**110,270**	**500,485**	**976,746**	**1,038,395**

Table 5: Funding Commitments by Source in USD

Item	WHO / DFID	WHO / Irish Aid	WHO / DANIDA	WHO / Azerbaijan	USG	IOM	JICA
Leadership, Stewardship, Coordination and Oversight	-	-	9,720	-	-	20,148	-
Human Resource	224,768	127,316	203,630	-	3,233,983	12,690	-
Supply Chain Management	209,706	477,300	210,000	-	-	58,363	402,519
Health Infrastructure	-	60,000	168,000	-	-	41,561	-
ICT	-	9,770	-	-	500,000	-	-
Surveillance and Laboratory	15,785	-	-	-	5,030,017	-	-
Case Management	-	61,664	469,000	-	1,440,000		-
Strategic Information, Research & Innovation	-	-	-	-	1,010,000	-	-
Risk Communication and Social Mobilization	7,629	-	-	-	827,500	-	-
Community Engagement and Social Protection	-	-	40,000	-	2,166,030	-	-
Logistics and Operations	4,828	-	-	100,000	-	-	-
Continuity of Essential Health Services	-	-	-	-	990,000		-
Total	**462,716**	**736,050**	**1,100,350**	**100,000**	**15,197,530**	**132,762**	**402,519**

Table 6: Funding Commitments by Source in USD

Item	CHAI	UN Women	UNFPA	Private sector & Partners
Leadership, Stewardship, Coordination and Oversight	30,000	-	-	200,000
Human Resource	-	-	-	-
Supply Chain Management	480,000	-	-	696,735
Health Infrastructure	210,000	-	-	106,216
ICT	-	-	-	90,000
Surveillance and Laboratory	60,821	-	-	-
Case Management	80,000	-	-	150,000
Strategic Information, Research & Innovation	-	-	-	-
Risk Communication and Social Mobilization	3,500	-	-	655,135
Community Engagement and Social Protection	-	166,458	81,081	137,452
Logistics and Operations	-	-	-	1,427,027
Continuity of Essential Health Services	-	-	-	-
Total	**864,321**	**166,458**	**81,081**	**3,462,565**

5 Monitoring & Evaluation Logframe for the COVID-19 Response

Goal:

The goal of the COVID-19 Preparedness and Response Plan is to provide a framework for coordination and control of COVID-19.

The expected outcomes are;

- Reduction of importation of COVID-19 in Uganda
- Reduction of transmission of COVID-19 in Uganda
- Reduction of morbidity and mortality due to COVID-19 in Uganda

Key performance indicators have been identified for each pillar and progress will be reviewed during the committee meetings. The IMT will be required to compile weekly reports which will be disseminated on the MoH COVID-19 web portal.

Pillar Heads will also present weekly updated during the Strategic Level meetings.

Overall assessment of the implementation of the response plan will be the responsibility of the Director General Health Services (DGHS) supported by the Department of Planning, Financing and Policy.

Table 7: **Logframe for the COVID-19 Response Plan**

Pillar / Indicators	Targets																Data source	Risk / Assumptions
	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		
1. **Leadership, Stewardship, Coordination and Oversight**																		
1.1 NTF, IMT and national level subcommittees established	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	COVID-19 Document repository	
1.2 % districts with functional COVID-19 DTFs and subcommittees	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	PHEOC	
1.3 National response plan and budget developed.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	COVID-19 Document repository	
1.4 % resources (budget) mobilised, tracked and accounted for.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Budget performance and accountability reports	Resource mapping and tracking undertaken at all levels
1.5 % NTF meetings held	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NTF Minutes	
1.6 % Daily IMT meetings held	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	IMT Minutes	
1.7 No. of Select Committee meetings held					3	3	3	3	3								Committee Minutes	
1.8 No. of oversight visits by the Parliamentary Committees		1	1	1	2	2	2	2	2								Activity Reports	

Pillar / Indicators	Targets																Data source	Risk / Assumptions
	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		
1.9 COVID-19 Logistics plan developed and costed	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	COVID-19 Document repository	
1.10 Level of adherence to the procurement plan	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Audit reports	Procurement plan made and approved
1.11 Public health emergency eELMIS scaled up to all districts, districts nodes (9), RRHs and NRHs	NA	NA	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	eELMIS reports	
1.12 Guidelines and SOPs for management of COVID-19 supplies developed	NA	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	COVID-19 Document repository	
1.13 Procurement lead time	3 mths	3 mths	3 mths	3 mths	3 mths	3 mths	3 mths	3 mths	3 mths	3 mths	3 mths	3 mths	3 mths	3 mths	3 mths	3 mths	Stock status Reports	Supplies available on Global and local market
1.14 Stock status of PPEs and Test kits	2 mths	2 mths	2 mths	2 mths	2 mths	2 mths	2 mths	2 mths	2 mths	2 mths	2 mths	2 mths	2 mths	2 mths	2 mths	2 mths	Stock status Reports	Supplies available on Global and local market
2. **Surveillance and Laboratory**																		

Pillar / Indicators	Targets																Data source	Risk / Assumptions
	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		
2.1 # and % of alerts reported and investigated including samples collected in each district disaggregated by reporting entity	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	Surveillance Reports	
2.2 # and % of contacts followed up and samples taken with 24 hrs	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Surveillance Reports	
2.3 % of specimens collected from suspect COVID-19 cases	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Surveillance Reports	
2.4 % of COVID-19 suspected cases, reported to the EOC having laboratory confirmation within 48 hours.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Surveillance Reports	
2.5 % of travellers screened at PoE on a daily basis	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	PoE reports	
3. **Case Management**																		
3.1 % COVID-19 patients admitted in designated facilities	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Daily Situation reports	
3.2 # of staff trained in critical and acute medical care					80	80	80									150	Training Reports	Scholarships awarded

Pillar / Indicators	Targets																Data source	Risk / Assumptions
	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		
3.3 All designated health facilities (RHs) have trained teams able to manage COVID-19 cases.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Training Reports	
3.4 % of targeted referral hospitals with functional ICUs	29%	29%	29%	29%	50%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Reports	ICU Equipment is delivered in times and installed
3.5 % health workers involved in care of isolated cases get infected.	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	Reports	HWs, trained, PPEs provided and OHS program implemented
4. **Strategic Information, Research and Innovation**																		
4.1 % of PoE operating digitally using the integrated COVID-19 System.	0%	0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	POE reports	
4.2 % of activity reports submitted digitally through the budget tracker	0%	0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	POE reports	
4.3 % of weekly analytical reports shared by Monday the following week	0%	0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	IMT Reports	

Pillar / Indicators	Targets																Data source	Risk / Assumptions
	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		
4.4 # of operations researches conducted to inform implementation of the COVID-19 response.					2		2		2			2		2			IMT Reports	Funds provided for research
4.5 # of scientific researches conducted on COVID-19.					2				2			2				2	Scientific Committee reports	Funds provided for research
5. **Risk Communication and Social Mobilisation**																		
5.1 % of the entire population reached with appropriate messages on COVID-19 through mass media (Radio, TV and print communication).	50%	70%	80%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Community assessment reports	
5.2 % of calls received through call center followed up	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Call Center Reports	
5.3 % of the population reached through social media	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	Community assessment reports	Ownership of phones and bundles
5.4 % of the population 6 years & above aware about COVID-19 transmission and prevention.	20%			50%			75%			80%			90%			95%	Community assessment reports	

Pillar / Indicators	Targets																Data source	Risk / Assumptions
	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		
6. **Community Engagement & Social Protection**																		
6.1 % health facilities, institutions, public places, communities & households with access to hand hygiene facilities	NA	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Survey reports	
6.2 % of the population washing hands with soap and water at least 6 times a day	NA	50%	60%	70%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	Survey reports	
6.3 % of the hard to reach population reached through outreaches by influential community resource persons.	0%	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	100%	100%	100%	100%	VHT reports	CRP facilitated
6.4 % of quarantined people followed up & monitored by location	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Quarantine reports	Tracking system developed
7. **Logistics Operations**																		
7.1 % of scheduled committee meetings held	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Minutes	
7.2 % of deployed vehicles against request	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	IMT reports	

Pillar / Indicators	Targets																Data source	Risk / Assumptions
	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		
7.3 Timeliness of deployment of vehicles	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	IMT reports	
8. Continuity of Essential Health Services																		
8.1 Coverage targets for essential health services achieved																	HMIS	DSDM scaled up.
8.2 Availability of essential medicines	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	HMIS	
8.3 Timeliness of HMIS Reporting	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	HMIS	
8.4 Completeness of HMIS Reporting	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	HMIS	
8.5 Health worker performance in terms of duty attendance	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	iHRIS (AAA)	
8.6 Functionality of the emergency services and referral system	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	EMS reports, community feedback	

6 COVID-19 Response Implementation Plan March 2020 to June 2021

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
	Leadership, Stewardship, Coordination and Oversight																	
1.1	**Provide oversight and strategic direction to MDAs and key stakeholders on COVID-19 Response**																	
1.1.1	Activation of the NTF, IMT DTFs and sub-committees	Prime Minister, DGHS, RDCs																
1.1.2	Establish / revitalize and orient the Regional Response Teams and District Task Forces on their ToR.	IM																
1.1.3	Develop and disseminate the National COVID-19 Response Plan and Budget with all key stakeholders.	CHS PFP																
1.1.4	Develop District COVID-19 Response Plans and Budget	DHOs																
1.1.5	Support oversight function by Members of Parliament (MPs)																	
1.2	**Mainstream Government and partner support in fully operationalizing this plan.**																	
1.2.1	Partner mapping	CHS MS&HP																
1.2.2	Mobilization of resources from all partners and well-wishers to support the COVID-19 response	MoFPED/ MoH/ MoLG/ Partners																
1.2.3	Establish a budget tracking mechanism for the response.	CHS PFP																
1.2.4	Hold Partner coordination meetings at all levels	Prime Minister, IM, RDC																
1.3	**Strengthen coordination and leadership for COVID-19 response at national, regional and district level.**																	
1.3.1	Develop and disseminate ToR, Guidelines and Standard Operating Procedures (SOPs) for the COVID-19 Response.	Prime Minister, IM, DHOs																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
1.3.2	Orient national and regional teams to support the COVID-19 preparedness and response at all levels.	IM																
1.3.3	Orientation of the District Task Forces on their roles and responsibilities.	IM																
1.3.4	Hold regular coordination meetings at all levels; — NTF, National Strategic level, Incident Management Team (IMT), Subcommittees, and DTF.	PM, DGHS, IM, Pillar Heads, RDCs																
1.3.5	Ensure coordination, population safety and security at national and district level	Other MDAs																
1.4	**Enhance cross border collaboration and inform sharing.**																	
1.4.1	Implement the Joint Task Force (JTF) guidelines for the management of PoE and designated transit points along transit routes.	DGHS																
1.4.2	Hold cross border surveillance committee meetings.	EOC Manager																
1.5	**Strengthen cross border surveillance and information sharing.**																	
1.5.1	Compile and issue information products including dashboards and situation reports, press statements on COVID-19.	DGHS																
1.6	**Ensure transparency and accountability in implementation and resource utilization**																	
1.6.1	Establish a Select COVID-19 Response Committee for Parliament with clear TOR	Hon. Speaker																
1.6.2	Hold committee meetings	Chairperson of Select Committee																
1.6.3	Undertake oversight field visits (Select Committee, Health Committee, Committee on the National Economy, Committee on Tourism, Trade and Industry)	Chairperson of Select Committee																
1.6.4	Hold monthly finance committee meetings	US																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
1.6.5	Financial, procurement and monitoring assurance for COVID-19 funds.	PS																
1.6.6	Hold quarterly multi sectoral accountability forum for the National and district response	PM, RDC																
1.7	**Strengthen supervision, Monitoring and Evaluation for the response.**																	
1.7.1	Develop M&E log frame for the response	CHS PFP																
1.7.2	Generate COVID-19 response performance reports	IM																
1.7.3	Hold weekly review meetings for alignment of the work plans to the national response strategy.	IM																
1.7.4	Enhance utilization of the 4W matrix and visual monitoring using the dashboard.	PM, DG, IM																
1.7.5	Conduct support supervision visits to the Districts and PoE.	PM, IM																
1.8	**Facilitate surge staff for the COVID-19 response**																	
1.8.1	Pay hardship allowance for laboratory field sample collection officers, riders, health care providers at Center / National & RRHs/ UVRI Lab testing team	CHRM																
1.9	**Strengthen HR capacity for the COVID-19 response**																	
1.9.1	Recruit and deploy surge staff for the COVID-19 response	CHS HRM																
1.9.2	Induction and orientation of surge staff on COVID-19 interventions	CHS IES & PHE																
1.9.3	Short- and long-term training in Emergency Medicine and Critical Care	CHS HRM																
1.9.4	Train and certify 4 engineers to maintain the Biosafety Laboratory at UNLHS for package 3	CHS HRM																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
1.9.5	Procurement of uniforms	CHS Nursing																
1.10	**Strengthen the supply chain management and logistics support system**																	
1.10.1	Establish a COVID-19 SCM Committee with clear TOR	DGHS																
1.10.2	Develop and cost a national and subnational COVID-19 logistics management plan.	CHS P&NM																
1.10.3	Develop a procurement plan and procure supplies and services	AC Procurement																
1.10.4	Develop guidelines and SOPs for management of COVID-19 supplies	CHS P&NM																
1.10.2	Quantify medical and non-medical supplies as required by the various pillars.	CHS P&NM, NMS																
a)	Procure Testing kits and sample collection materials	CHS NLS																
b)	Procure PPEs and IPC materials	CHS PN&M																
c)	Procure and distribute Community masks	CHS CH																
d)	Procure and distribute hand washing facilities	CHS EH&S																
e)	Procure bio-hazard waste management commodities																	
1.11	**Strengthen capacity for quantification and procurement of medical and non-medical supplies**																	
1.11.1	Scale up eELMIS in all districts, districts nodes (9), Regional Referral and National Hospitals.	CHS P&NM																
1.11.2	Map partner support and manage stockpiles as needed	CHS P&NM																
1.11.3	Conduct supervision to promote monitoring, traceability and accountability of commodities	CHS P&NM																
1.11.4	Train the medicine management supervisors (MMS) on the new tool for Public Health emergency.	CHS P&NM																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
1.12	**Provide working space and equipment for the MOH & EOC**																	
1.12.1	Pay rent and equip EOC	PS																
1.12.2	Procure, erect and equip tent for conferencing at MoH	PS																
1.13	**Establish and improve health infrastructure at designated treatment centers, POEs, quarantine sites.**																	
1.13.1	Needs assessment of waste disposal systems in 16 RRHs	CHS HI																
1.13.2	Construct health care waste management facility (Incinerator)	CHS HI																
1.13.3	Procurement of engineering services for refurbishment and decommissioning of waste disposal systems in 15 RRHs	CHS HI																
1.13.4	Install 4 Emergency incinerators (MAK IV) and training of the waste handlers at Moroto, Mutukula, Malaba, Tororo	CHS HI																
1.13.5	Provide waste management infrastructure (incinerators) in three RRHs with limited capacity	CHS HI																
1.13.6	Procure ICU beds and ward equipment for RRHs	CHS HI																
1.13.7	Remodel and expand ICU facilities	CHS HI																
1.13.8	Establish health infrastructure for the Port Health Services at high volume PoEs.	CHS HI																
1.13.9	Procure and install oxygen plants, cylinders & accessories for Mulago NRH, Entebbe RRH, Bombo Hospital	CHS HI																
1.13.10	Equip COVID-19 treatment centres with oxygen delivery accessories	CHS HI																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
1.13.11	Strengthen the National Drug Authority's testing capacity to conduct Quality assessment of all pharmaceutical and healthcare products	ES NDA																
1.13.12	Procure Medical Equipment for health facilities	CHS HI																
1.13.13	Strengthen medical equipment maintenance	CHS HI / Hospital Directors																
1.13.14	Procurement of new standard hospital level equipment and implements for reconstitution, testing, packaging, and labelling of highly required disinfectants at Mulago Hospital and 16 RRHs to support the COVID19 response.	CHS HI																
1.4	**Strengthen the National Drug Authority's testing capacity to conduct Quality assessment of all pharmaceutical and healthcare products**																	
1.4.1	Equip NDA to conduct quality assessments of all pharmaceutical and healthcare products.																	
1.15	**Digitization of the COVID-19 Response processes**																	
1.15.1	Expand and support virtual communication facilities	Principal Systems Administrator																
1.15.2	Procure and install ICT equipment	Principal Systems Administrator																
1.15.3	Software development	Principal Systems Administrator																
	Surveillance and Laboratory																	
2.1	**Build national and district level capacity on COVID-19 surveillance and reporting (NTF, IMT, DTF, Health workers, PoE, responders and selected VHTs).**																	

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
2.1.1	Orientation of national and district level staff on COVID-19 surveillance and reporting (NTF, IMT, DTF, Health workers, PoE, responders and selected VHTs).	IM																
a)	National Training of trainers in border health for COVID-19	IM																
b)	Orient HW and Port health staff in COVID-19 surveillance using a One Health approach (300 oriented)	IM																
c)	Orientation of border health committees (including immigration, revenue, trade and internal security officers at PoEs on identification of COVID-19 affected travelers)	CHS IES & PHE																
d)	Orientation and mentoring of surveillance team involved with follow up of the high risk contacts on COVID-19 screening and laboratory sample collection, packaging, and dispatch	CHS IES & PHE																
e)	Training of Clinicians and laboratory technologists on Sentinel surveillance in Covid-19 Treatment Centers	CHS IES & PHE																
f)	Train VHTs/ Community volunteers on community based COVID-19 surveillance (4,000)	DHOs																
2.1.2	Review / Develop & disseminate guidelines and SOPs for surveillance and laboratory	CHS IES & PHE																
2.1.3	Develop, print and disseminate VHT COVID-19 training manual and community case definitions.	CHS IES & PHE																
2.1.4	Map partners and mobilize resources for implementation of COVID-19 surveillance at district and community levels.	IM, RDC																
2.1.5	Develop, prints and disseminate VHT COVID-19 training manual and community case definitions.	IM																
2.1.6	Conduct support supervision for VHTs by DHT and Health Assistants at sub-counties. (8,000 parishes, 5 days per month)	IM, DSFP																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
2.1.7	Hold quarterly meetings with VHTs at sub-county level.	DSFP																
2.1.8	Expansion of the severe acute respiratory illness (SARI) sentinel surveillance network	IM, DHO																
2.1.9	Procure thermo scanners	CHS IES & PHE																
2.2	**Conduct rapid risk assessment for COVID-19 importation into the country.**																	
2.2.1	Conduct quarterly national risk assessments at critical PoE and points of mass gatherings including work places, institutions, etc.	IM																
2.2.2	Conduct quarterly district level risk assessments.	IM, DHO																
2.2.3	After action review for the most affected districts	IM, DHO																
2.3	**Strengthen active search and alert management systems at all levels.**																	
2.3.1	Establish and support alert management system for COVID-19 in all districts	IM, CHS IES & PHE, DSFP																
2.3.2	Provide facilitation for alert management desk in each district (airtime, data, phone sets, computer systems, etc.)	CAO / DHO																
2.3.3	Deploy Go. Data tool for contact tracing and tracking of transmission chains.	IM																
2.3.4	Conduct weekly meetings to review COVID-19 surveillance performance in the districts.	RDC / DHO																
2.3.5	Conduct weekly meetings to review COVID-19 surveillance performance in the districts.	IM																
2.4	**Provide office space and equipment for the MoH & EOC.**																	
2.4.1	Pay rent and equip the EOC	PS																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
2.5	**Build capacity of laboratory and selected health staff on appropriate COVID-19 sample collection, packaging, handling and transportation.**																	
2.5.1	Training on specimen collection and packaging - National, district, laboratory staff, clinical staff and surveillance officers	CHS NPHLS																
2.6	**Performance evaluations for new test kits, servicing of laboratory equipment, purchase of parts needed for equipment repair (UVRI)**																	
2.6.1	Conduct performance evaluations for new test kits, servicing of laboratory equipment, purchase of parts needed for equipment repair	ED UVRI																
2.7	**Support continued operation of the National Influenza Center at UVRI and laboratory specimen hub transport network**																	
2.7.1	Support continued operation of the National Influenza Center at UVRI	ED UVRI																
2.7.2	Support the national laboratory specimen hub transport network	CHS NPHLS																
2.8	**Laboratory Accreditation**																	
2.8.1	Maintenance of Accreditation status for accredited labs.	CHS NPHLS																
2.8.2	Application for Accreditation (Mbale, Lacor, Arua)	CHS NPHLS																
2.8.3	Certification fees (Biosafety cabinets, critical equipment calibrations)	CHS NPHLS																
2.8.4	Sustaining the Stepwise Laboratory Improvement Process Towards Accreditation (SLIPTA) program at 12 select hospitals	CHS NPHLS																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
2.9	**Strengthen surveillance at PoE, on cargo in transit within Uganda and at designated transit points along trans-national trunk roads connecting ports of entry.**																	
2.9.1	Constitute, deploy and facilitate teams for management of PoEs and designated transit points.	CHS IES & PHE																
2.9.2	Support monitoring of cross border movements in all category 1 districts in collaboration with security agencies.	IM																
2.9.3	Facilitate cross border committee meetings to support monitoring of cross border movements in all category 1 districts in collaboration with security agencies.	CHS IES & PHE																
2.10	**Establish Port Health Services**																	
2.10.1	Define the Human Resource structure for Port Health Services	CHS IES & PHE																
2.10.2	Support creation of Port Health Services through TA, development of a Port Health Plan, electronic system for tracking cross-border population movements, equipment, training in screening operations and risk communication	DLG																
2.10.3	Develop guidelines and SOPs for Port Health Services	CHS IES & PHE																
	Case Management																	
3.1	**Enhance the country's capacity for management of COVID-19 cases.**																	
3.1.1	Assess capacity for COVID-19 management at designated COVID-19 management centers (including IPC capacity, on-site Oxygen production and supply, and logistics)	IM, CHS CS																
3.1.2	Designate facilities for management of COVID-19 confirmed cases.	CHS CS																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
3.1.3	Develop / revise, print and disseminate case management guidelines, SOPs and strategies for IPC & WASH	CHS CS																
3.1.4	Build surge capacity to support case management and IPC																	
a)	Conduct ToTs at national level in critical care.	CHS CS																
b)	Case management training in COVID-19 treatment centers	CHS CS																
c)	Orienting and protecting the HIV and TB laboratory workforce in a COVID-19 affected environment: through RHITES (all 5)	Hospital Managers																
3.1.5	Conduct simulation exercises and drills for COVID-19 management team (medical and support teams) for clinical management of COVID-19 in all referral hospitals. The teaming should enable 24hr coverage.	Hospital Directors																
3.1.6	Conduct mentorship and support supervision for case management teams	CHS CS																
3.1.7	Transfer operational funds to Regional Referral Hospitals for COVID-19 response	PS / MoFPED																
3.1.8	Supply of additional medicines and therapeutic nutrition care options for patient management at COVID 19 Treatment Centers	Hospital Directors / NMS																
3.1.9	Develop innovative approaches to case management.	Scientific Committee / Hospital Directors																
3.2	**Strengthen IPC in gazetted COVID-19 management facilities.**																	
3.2.1	Reactivate IPC and WASH Committees in Health Facilities	CHS CS / CHS EHS																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
3.2.2	Revise and disseminate the IPC and WASH Plan and SOPs to prevent hospital transmission at all health facilities.	CHS CS																
3.2.3	Conduct IPC and WASH refresher training and onsite mentorship on standard and transmission-based precautions.	Hospital Directors / DHOs																
3.2.4	Conduct surveillance for Hospital acquired infections for COVID-19 in health facilities.	Hospital Directors / DHOs																
3.2.5	Install IPC and WASH facilities in all health facilities	Hospital Directors / DHOs																
3.2.6	Activating triage at the treatment centers for IPC	Hospital Directors / DHOs																
3.2.7	Establish a nationwide network of IPC focal persons through ECHO communities of practice platform for rapid dissemination of information, updates to procedures, and supportive supervision through tele-conferencing	CHS CS																
3.2.8	Support transportation of health care and COVID19 wastes from health facilities and other collection centres	CHS EH&S																
3.2.9	Support technical assistance for immediate finalization of the national health care waste management policy, guidelines and SOPs and their related training and diffusion into the health system.																	
3.2.10	Identify residence space for health care workers in line with current COVID-19 guidelines on occupational health and safety.	Hospital directors																
3.3	**Strengthen the ambulance services for efficient referral of COVID-19 patients.**																	
3.3.1	Mobilize public and private ambulances to aid referral of patients of suspected cases from community to COVID-19 quarantine facilities and treatment centers.	CHS EMS																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
3.3.2	Orientation of Ambulance Teams on essential supplies & PPEs and regular decontamination according to SOPs.	CHS EMS																
3.3.3	Establishment of 14 Regional ambulance command centers for COVID-19 response.	CHS EMS																
3.4	**Ensure proper nutrition and welfare of patients and health care workers managing COVID-19 patients.**																	
3.4.1	Provide welfare and food assistance for patients and health care workers managing COVID-19 patients.	Hospital Managers																
3.5	**Strengthen mental health and psychosocial support services for COVID-19 effects**																	
3.5.1	Conduct training and mentorship for MHPSS to probation officers, psychiatric practitioners (clinical officers, nurses and doctors), psychologists, social workers and para-social workers with the necessary skills for Psychosocial support service provision.	ACHS NCD																
3.5.2	Orient Community Leaders on MHPSS	ACHS NCD																
3.5.3	Provision of mental health and psychosocial interventions within the affected community, including people in isolation.	ACHS NCD																
3.5.4	Management of Health Worker burnout and stress	ACHS NCD / Health Facility Managers																
3.5.5	Provision of Social Welfare Services at hospitals, treatment centres and quarantine facilities	ACHS NCD / Health Facility Managers																
	Strategic **Information**, Research & Innovation																	
4.1	**Establish SIRI coordination structure for COVID-19 response.**																	
4.1.1	Constitute SIRI Committee with terms of reference.	IM, ACHS DHI																
4.1.2	Develop SOPs for SIRI operations.	ACHS DHI																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
4.1.3	Hold daily data management meetings.	ACHS DHI																
4.2	**Map key stakeholders in the different data management functions.**	ACHS DHI																
4.2.1	Identify and map key stakeholders	ACHS DHI																
4.3	**Develop an effective data management framework for COVID-19 response.**																	
4.3.1	Review and update existing data management systems	ACHS DHI																
4.3.2	Establish data needs and sources for the COVID-19 response	ACHS DHI																
4.3.3	Develop SOPs to operationalize the data governance and confidentiality policy for COVID-19.	ACHS DHI																
4.3.4	Define data collection, reporting and dissemination processes and channels.	ACHS DHI																
4.3.5	Develop, validate, print and disseminate data management tools.	ACHS DHI																
4.4	**Adapt digital health solutions for the COVID-19 response and appropriate technology for data capture and dissemination.**																	
4.4.1	Define system requirements and needs for digital health solutions for COVID-19 response	ACHS DHI																
4.4.2	Assess appropriateness of existing ehealth applications.	ACHS DHI																
4.4.3	Develop guidelines and SoPs for implementation of digital health solutions	ACHS DHI																
4.4.4	Develop, customize and deploy digital health solutions for COVID-19 response including real time follow up of suspect cases, logistics, sample tracking and traveller screening forms at PoE and conveyance.	ACHS DHI																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
4.4.5	Conduct training/mentorship for digital health tools for the response (goData, eiDSR, call center system, PoE, Quarantine management, Activity Management, Case management, dashboards)	ACHS DHI																
4.4.6	Develop and rollout digital system for COVID-19 surveillance in schools	ACHS DHI / CHS CH																
4..4.5	Conduct training/mentorship for digital COVID-19 surveillance in schools.	ACHS DHI / CHS CH																
4.5	**Produce and disseminate information products for management decision making and policy formulation**																	
4.5.1	Develop and regularly update a data management portal for COVID-19.	ACHS DHI																
4.5.2	Conduct training/orientation for district staff on data analysis for COVID-19	ACHS DHI																
4.5.3	Use of GIS to track location and movement of high-risk persons and cases. (Collection, analyse, research,)	IM																
4.5.4	Develop information products on COVID-19 e.g daily situation, weekly, monthly reports, research findings and	ACHS DHI																
4.5.5	Disseminate information products using media (print, television, radio and social media) and other appropriate channels.	DG, IM																
4.6	**Data quality assurance and support supervision for data management and use at all levels**																	
4.6.1	Conduct DQAs and support supervision	ACHS HID																
4.7	**Support operational and scientific research for COVID-19**																	
4.7.1	Establish COVID-19 research governance framework	DGHS																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
4.7.2	Establish the scientific committee	DGHS																
4.7.3	Hold scientific committee meetings	DGHS																
4.7.4	Identify knowledge / information gaps for research on COVID-19 response.	Chair Scientific Committee																
4.7.5	Assess diagnostics, therapeutics and vaccines for compassionate use through SOPs, clinical trials, regulatory approval, market authorization and post market surveillance in the context of operational research.	Chair Scientific Committee																
4.7.6	Conduct risk assessments and KAP studies to improve the evidence-based reporting on social behaviour changes and documentation of the community-engagement processes at various levels and contexts.	CHS HP&E																
4.7.7	Conduct research on the impact of COVID-19 on the health services delivery.	DHS CS																
4.7.8	Vaccine research	UVRI																
4.7.9	Disseminate and generate an inventory of all COVID-19 research done both internationally and locally.	CHS IES&PHE																
4.8	**Promote creativity and innovations for COVID-19 response.**																	
4.8.1	Develop procedures for absorptions of innovation into the COVID response	ACHS DHI																
4.8.2	Call for innovative concepts on the management of the COVID-19 response (innovation across pillars including Art and performance)	ACHS DHI																
	Risk Communication and Social Mobilization																	
5.1	**Establish the RCSM Committee for COVID-19 RCSM.**																	

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
5.1.1	Constitute a multi-sectoral RCSM Committee with clear Terms of Reference.	CHS HP&E																
5.1.2	Hold RCSM Committee meetings	CHS HP&E																
5.2	**Develop and print the COVID-19 Communication Strategy.**																	
5.2.1	Stakeholder analysis and mapping for tailoring messages.	CHS HP&E																
5.2.2	Map communication channels and stakeholders for effective delivery of the messages.	CHS HP&E																
5.2.3	Develop and adapt messages for audiences in all communities at all levels.	CHS HP&E																
5.2.4	Print and disseminate the Communication Strategy	CHS HP&E																
5.2.5	Develop the implementation plan for the Communication Strategy.	CHS HP&E																
5.3	**Scale up of public awareness on COVID-19 through mass media, social media, IEC materials**																	
5.3.1	Develop, translate, pre-test, IEC materials in all the recognised languages in Uganda and also cater for the refugees.	CHS HP&E, DHEs																
5.3.2	Print and distribute COVID-19 IEC materials	CHS HP&E, DHEs																
5.3.3	Airing of public health messages through electronic media (TV and Radio) across the country:	MoICT & NG, CHS HP&E, DHEs																
5.3.4	Support mobile public address systems to reach rural areas with key updates including information on COVID, continuity of care and GBV	CHS HP&E, DHE																
5.3.5	Expansion of call centers capacity and activation of toll-free telephone lines for reporting suspected COVID-19 cases (0800-100-066 or 0800-203-033);	CHS HP&E																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
5.3.6	Disseminate messages on COVID-19 through social media to improve timely awareness, address public concerns, dispel rumours and misinformation, and provide platforms for dialogue and feedback	CHS HP&E, PRO																
5.3.7	Support integration of social mobilization and community engagement with community-based surveillance and psychosocial support services including refugee settlements.	CHS HP&E																
5.3.8	Orientation of key influencers on COVID-19 (politicians, elders, teachers, local council authorities, religious and cultural leaders, leaders of associations e.g. traders, boda boda, truck drivers)	CHS HP&E, DHE																
5.3.9	Facilitate radio talk-shows; recording and dissemination of audio-clips from credible and trusted sources and recording and disseminating engagements with various listeners' groups.	CHS HP&E																
5.3.10	Deploy mobile-vans and use community radio messaging and mobile megaphone messaging.	CHS HP&E																
5.3.11	Support training of VHTs and Local Council leaders and regular orientations through monthly review meetings.	CHS HP&E, DHE																
5.3.12	Support village health care meetings and support community level health improvement campaigns for improved preparedness, disease prevention and resilience.	DHE																
5.3.13	Build capacity for effective mobilisation of local NGOs, religious leaders, schools, cultural leaders and community engagement – using trusted groups, community-based influencers, VHTs and local leaders.	CHS HP&E, DHE																
5.3.15	Capacity building and surge HR support in the areas of Communication for Development and RCSM at national and district level.	CHS HP&E, DHE																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
5.4	**Develop mechanisms for monitoring effective delivery and effectiveness of the messages.**																	
5.4.1	Monitoring and evaluation of RCSM-CE activities at national and district levels	CHS HP&E, DHE																
a)	Support supervision field work, Risk assessments;																	
b)	KAP studies																	
c)	Documentation of best practices and social science research to inform programs).																	
	Community Engagement and Social Protection																	
6.1	**Establish a community engagement and social protection committee for COVID-19 at National level.**																	
6.1.1	Constitute a multi-sectoral community engagement and social protection committee with clear Terms of Reference.	CHS CH, MGLSD																
6.1.2	Hold weekly Community Engagement and social protection pillar meetings	CHS CH																
6.1.3	Hold quarterly national multi sectorial coordination meetings	CHS CH																
6.1.4	Stakeholder analysis and mapping for identification of roles and catchment	CHS CH																
6.2	**Strengthen community engagement and social protection structures for COVID-19 in Communities.**																	
6.2.1	Develop and disseminate the COVID-19 Community engagement and Social Protection strategies	CHS CH, MoLGSD																
6.2.2	Develop and disseminate Guidelines and SOPs on WASH, use of masks and social distancing	CHS CH, MoLGSD																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
6.2.4	Orient Community Health workers, VHTs, Community Resource persons in all districts on COVID-19 on community engagement and social protection strategy.																	
6.2.5	Conduct a rapid assessment of the Communities in terms of organization; health behaviour and social protection measures; and occupational health and safety in the context of COVID-19.	CHS CH, MoLGSD																
6.2.6	Support community leaders on COVID-19 preparedness and response at community levels.	CHS CH, MoLGSD																
6.2.7	Support districts to supervise community engagement and social protection implementation.	CHS CH, MoLGSD																
6.2.8	Conduct community dialogue meetings with women groups in GBV high prevalence districts	CDO, CSOs																
6.2.9	Strengthen referral for GBV victims.	CDO, CSOs																
6.3	**Develop School Program for prevention and mitigation of COVID-19 in schools**																	
6.3.1	Develop and disseminate guidelines for prevention and mitigation of COVID-19 in schools	CHS CH, MoES																
6.3.2	Provide guidance to teachers on EGR instructional processes to maintain readiness of the teaching force to re-open schools, developing distance learning resources for EGR instruction and Social Behavior Change Communication (SBCC) activities for radio broadcasts.	MoES																
6.4	**Build capacity for IPC and WASH at community settings underscoring schools, workplaces, institutions, public places, commercial places like shops, markets, households, shopping malls along the trunk road**																	

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
6.4.1	Mentorship programs for key persons in the community settings on IPC strategies to be done in phased manner. 1. Identify association leaders and build their capacity, 2. Facilitate community trained community health workers and champions	CHS CH, MoLGSD																
6.4.2	Orient Safety Officers in all workplaces on WASH, use of mask and social distancing at workplaces.	CHS CH, MoLGSD																
6.4.3	Conduct continuous modular e-learning training of Workplace Safety Committees and workers through online platforms	CHS CH, MoLGSD																
6.4.4	Facilitate Parish Chiefs to map risky areas in the communities and come up with bye laws or ordinances to enforce COVID 19 prevention measures	MoLG																
6.4.5	Facilitate Parish Chiefs to map risky areas in the communities and come up with bi laws or ordinances to enforce COVID-19 prevention measures.	MoLG																
6.4.6	Support installation of IPC and WASH facilities and social behaviour change activities in communities including schools, workplaces, institutions, public places, commercial places like shops, markets, households, shopping malls along the trunk roads, etc.	MoH, MoWE, MoLG, MoES, MoTIC, MoWT, Private Sector, etc																
6.4.7	Support CBOs to do rapid assessments to monitor the impact of COVID-19 on access to HIV, TB, Malaria, SRHR and GBV protection services in their communities, including who is being excluded from services.																	
6.4.8	Support community leaders, civil society and community groups including PLHIV and TB groups refer COVID suspects for care and reintegrate them to the community.																	

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
6.5	**Establish COVID-19 quarantine facilities**																	
6.5.1	Identify and assess areas for geographical quarantine based on number of positive cases and contact density.	CHS IES&PHE																
6.5.2	Certify institutional quarantine centers at National and district levels as per guidelines	CHS IES&PHE																
6.5.3	Develop, print and disseminate quarantine guidelines and SOPs to all national and district stakeholders.	CHS IES&PHE																
6.5.4	Set up a data management and reporting system in quarantine sites	ACHS DHI																
6.5.5	Orient all quarantine staff in IPC and WASH procedures	DHOs																
6.5.6	Provide food, beddings, and other basic personal needs to individuals in quarantine centers	US																
6.5.7	Provide masks for quarantined individuals and PPEs for staff attending to them.	PS																
6.5.8	Provide medical treatment and PSS to individuals in quarantine	IM																
6.6	**Facilitate Self-quarantine and continuation of essential services for COVID-19 in the community/homes**																	
6.6.1	Support identification and assessment of households of their suitability for home quarantine and home care for COVID-19 cases	CHS CH																
6.6.2	Orient households with persons under home quarantine and care for COVID-19 cases protocols	CHS CH																
6.7	**Strengthen leadership, management and coordination of stakeholder response to the emerging and escalating cases of GBV, VAC, Emergency Alternative care and children in detention during and post COVID-19**																	

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
6.7.1	Hold weekly national level coordination meetings on continuity of prevention and response services to GBV, VAC, Emergency Alternative care and children in detention at the national and subnational levels.	CHS CH / DCDOs / PSWO																
6.7.2	Develop a Response Plan and strategy for GBV/VAC related to COVID-19	CHS CH / DCDOs / PSWO																
6.7.3	Hold weekly committee meetings for the Sub-committee with the participation of all DCDOs/PSWOs to discuss: Case management Lessons learnt and areas for improvement	CHS CH / DCDOs / PSWO																
6.7.4	Conduct a rapid assessment of COVID 19 on GBV, VAC, Emergency Alternative care and children in detention, to inform development of an evidence based prevention and Response Plan and policy briefs on GBV/VAC, Emergency Alternative care during crises and emergencies	CHS CH																
6.7.5	Provide Technical support to the development and dissemination of SOPs on prevention of GBV/VAC/ HP including provision of Alternative Care during and after COVID-19 and orientation of key service providers (virtually).	Health and Social Workers, Security, Police, Judiciary, Community Leaders																
6.7.6	Work with MoH at national and lower level to assess referral facilities for defilement, rape, fistula survivors around the shelters to ensure they are equipped and skilled to handle survivors	MoGLSDS, ACHS RH, DHO, DCDO,																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
6.7.7	Develop standard reporting template for service providers to use in generating and reporting data on GBV, VAC, and alternative care cases (esp. those of capital offences) reported through the Media, GBV special courts and shelters, Sauti 116, Police, Health Facilities, NGOs and LCs to inform court processes.	MoGLSD, CDO																
6.7.8	Support coordinated forensic evidence on GBV and VAC cases reported through GBV special courts and shelters, Sauti 116, Police, Health Facilities, NGOs and LCs to inform court processes.	DCDOs, PSWO, SWOs Police, ODPP, DHOs, NGOs.																
6.7.9	Liaise with OPM, District Covid Task Forces and Managers of Reception / Remand Homes and GBV shelters, to provide GBV and VAC Survivors with age appropriate protection case management services, material support and other direct assistance based on needs identified	MoGLSD																
6.7.10	Conduct 3 High Level Multi-sectoral committee coordination meetings (online); one on teenage pregnancy and child marriage, one on strengthening GBV response services and GBV data generation and storage, one on dissemination of the findings of the Gender Rapid Assessment findings and recommendations	MoGLSD, MoH, MES, JLOS, all Members of the Sub-Committee																
6.8	**Provide timely prevention and response to the identified needs in GBV, VAC, Emergency Alternative Care and Children in detention during and post COVID-19.**																	
6.8.1	Conduct media engagement to disseminate messages on prevention and response to GBV, VAC, Emergency and Alternative care during and post COVID- 19, parenting, sexuality education	Chair of Sub-committee / DCDOs																
6.8.2	Coordinate the dissemination of approved IEC materials on GBV, VAC, Emergency Alternative care in COVID contexts online and through service points	Chair of Sub-committee																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
6.8.3	Orient key service providers (virtually) and disseminate the SOPs on GBV/VAC, Emergency, Alternative care prevention and response with regard to COVID 19	Health and Social Workers, Security, Police, Community Leaders																
6.8.4	Support the functionality of GBV Shelters and childcare / foster institutions in Kamuli and Namutumba (currently closed) to provide GBV/VAC response services to survivors	DCDOs of Kamuli and Namutumba and Staff of the GBV and childcare /foster institutions Shelters																
6.8.5	Equip Regional and districts health facilities provide sexual reproductive health services to survivors of defilement, rape and fistula	DHO, DCDO, Chair of the subcommittee, ACHS RH																
6.8.6	Support the collection of forensic evidence on GBV, VAC (esp. those of capital offences) reported through the Media, GBV special courts and shelters, Sauti 116, Police, Health Facilities, NGOs and LCs to inform court processes.	DCDOs, PSWO, SWOs Police, ODPP, DHOs, NGOs.																
6.8.7	Create and facilitate a team of Counselors to provide online psycho-social support to survivors of GBV, VAC, Emergency and alternative care	DCDOs, PSWO, SWOs Police, ODPP, DHOs, NGOs.																
6.8.8	Conduct support supervision to 15 GBV Shelters, Alternative care institutions and surrounding health facilities that serve as referral points for survivors and foster care families, reception and remand homes	Chair of Sub-committee / ACHS RH																
6.8.9	Provide capital, economic recovery (for IGAs) and health packages to the survivors of GBV in order to help re-establish pre-pandemic sources of income and access basic health care esp. those young and expectant mothers, breast feeding mothers, mothers who have been forced out of their “marital homes”, PLWHA and SRH and Rights related challenges	Chair of Sub-committee/Su-committee members, DHOs, NPC/ UWEP,																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
6.8.10	Provide modified nutritional support and emergency support services for OVCs identified, tailored economic strengthening, and enhanced child protection through Sustainable Outcomes for Children and Youth (SOCY) project	Sustainable Outcomes for Children and Youth (SOCY) project																
6.8.11	Provide modified nutritional support and emergency support services for OVCs identified, tailored economic strengthening, and enhanced child protection through Sustainable Outcomes for Children and Youth (SOCY) project	Sustainable Outcomes for Children and Youth (SOCY) project																
6.8.12	Support modified case management approaches, enhanced child protection measures, mental health and resilience promotion through 4Children project,	4Children project																
6.9	**Support implementation of Social Protection interventions for the vulnerable populations**																	
6.9.1	Support (food) to vulnerable people	Commissioner Disaster Preparedness																
6.9.2	Humanitarian assistance to support UNHCR's COVID-19 response for refugees and host communities in Uganda.	Commissioner Disaster Preparedness																
6.10	**Develop mechanisms for oversight and monitoring effective delivery and effectiveness of the community engagement and social protection interventions.**																	
6.10.1	Develop the monitoring and evaluation frameworks and tools for community engagement and social protection.	CHS CH, MoGLSD																
6.10.2	Monitor and document human rights abuses, provide legal advice for select human rights cases arising from COVID-19, including domestic violence and child rights, and host radio talk shows to disseminate information related to the COVID response and adherence to human rights standards	S CH, MoGLSD																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
6.10.3	Support community intervention oversight structures and mechanisms	CHS CH, MoGLSD																
	Logistics and Operations																	
7.1	**Establish the logistics operations subcommittee for COVID-19 response.**																	
7.1.1	Constitute a multi-sectoral and multidisciplinary sub-committee with clear TORs	IM																
7.1.2	Hold committee meetings	IM																
7.2	**Strengthen the inventory management system to track available resources**																	
7.2.1	Train inventory managers on inventory management, resource tracking and reporting on COVID-19 supplies.	NMS / RRHs / LGs																
7.2.3	Store, allocate and distribute medical supplies as required by the various pillars.	NMS / RRHs / LGs																
7.2.4	Store, allocate and distribute non-medical supplies (e.g. stationery, food, mattresses, office equipment, tents and furniture among others) for the COVID-19 response.	NMS / RRHs / LGs																
7.3	**Ensure a functional and responsive fleet management system.**																	
7.3.1	Assess the vehicle and drivers needs for the various pillars	PAS Transport																
7.3.2	Establish availability and functionality of the fleet	PAS Transport																
7.3.3	Mobilise vehicles, fuel, lubricants and drivers to meet the required demand	PAS Transport																
7.3.4	Deploy and fuel according to need	PAS Transport																
7.3.5	Maintain and service vehicles according to the maintenance schedule.	PAS Transport																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
	Continuity of Essential Health Services																	
8.1	**Strengthen coordination mechanism for essential health service continuity at the national and subnational levels.**																	
8.1.1	Constitute a multi-disciplinary committee on continuity of essential health services with clear Terms of Reference.	DHS CS																
8.1.2	Hold committee meetings	DHS CS																
8.2	**Reorganise and maintain access to essential quality health services.**																	
8.2.1	Functional capacity mapping of public and private health facilities	DHS CS																
8.2.2	Referral systems mapped and operationalized	DHS CS																
8.2.3	Disseminate and monitor implementation of the referral guidelines	DHS CS																
8.2.4	Develop and disseminate SOPs on integrated delivery of essential health services for improved efficiency.	DHS CS																
8.2.5	Review the patient flow mechanisms at health facility level to minimise COVID-19 spread.	Health facility managers																
8.2.6	Redistribute and task shift human resources for health to ensure uninterrupted essential services.	Health facility managers																
8.2.7	Establish outreach mechanisms as needed to ensure delivery of essential services.	Health facility managers																
8.3	**Enhance capacity for delivery of essential and emergency medical services.**																	
8.3.1	Conduct capacity building at national and district level on emergency medical services including pre-hospital care	CHS EMS																

No.	Pillars / Strategy/ Activities	Responsible Person	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
8.3.2	Provide essential supplies e.g PPEs and other IPC materials for continuity of service delivery.	DHS CS, NMS, Hospital Directors, DHOs																
8.3.3	Orientation of health care providers on continuity of essential health services in the context of COVID-19.	CHS CS, Hospital Directors, DHOs																
8.3.4	Utilise Differentiated service delivery models for management of chronic care patients.	CHS CS, Hospital Directors, DHOs																
8.3.5	Conduct support supervision, mentorship and coaching on the new approaches on service delivery in the context of COVID-19.	CHS CS, Hospital Directors, DHOs																
8.4	**Strengthen the occupational health and safety programme in health facilities**																	
8.4.1	Orient IPC committees/focal persons at all levels on COVID-19 (national, regional, district)	CHS CS, Hospital Directors, DHOs																
8.4.2	Conduct continuous modular e-learning training of IPC committees, mentors, health care workers through online platforms	Hospital Directors, DHOs																
8.4.3	Print and distribute SOPs on IPC for all health facilities.	CHS CS																
8.4.4	Provide mental health and psychosocial support services	Hospital Directors, DHOs																
8.5	**Strengthen reporting and monitoring of health service delivery.**																	
8.5.1	Conduct follow up and feedback on HMIS reporting and data quality	ACHS DHI																
8.5.2	Compile and disseminate district and health facility dashboards for key performance indicators	ACHS DHI, Programme managers, DHOs																

7 Annexes

7.1 Annex 1: Operational Case Definitions

Surveillance case definitions for COVID-19are as follows:

Suspect case

A. Any person with acute respiratory illness (temperature of 37.5ºC and above and at least one sign/symptom of respiratory illness (e.g., cough, shortness of breath), **AND** with no other cause that fully explains the clinical presentation **AND** a history of travel in the last 14 days prior to symptom onset from a country/area or territory reporting local transmission of COVID-19 disease

OR

B. Any person with any acute respiratory illness **AND** having been in contact with a confirmed or probable COVID-19 case in the last 14 days prior to onset of symptoms

OR

C. Any person with severe acute respiratory infection (temperature of 37.5ºC and above and at least one sign/symptom of respiratory illness (e.g., cough, shortness breath) **AND** requiring hospitalization **AND** with no other cause that fully explains the clinical presentation.

Probable case:

A suspect case for whom testing for COVID-19 is inconclusive.

Confirmed case:

A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

7.2 Annex 2: Indicator Definitions

Indicator Name	Definition/ Description	Frequency	Data source	Methodology	Responsibility for data collection
Leadership, Stewardship, Coordination and Oversight					
NTF, IMT and national level subcommittees functional.	Availability of minutes and updated action plans	Monthly	COVID-19 Document repository	Review of minutes and action plans	NTF/IMT Administrator
% districts with functional COVID-19 DTFs and subcommittees	Number of districts submitting district COVID-19 daily situation reports against total number of districts in the country (N=135)	Monthly	PHEOC district email communication platform	Review of district daily situation reports	EOC Information Analyst
National response plan and budget developed.	National response plan and budget is available	Annual	COVID-19 Document repository	Review of status of updating of national response plan and budget	Commissioner planning
% resources (budget) mobilised, tracked and accounted for.	Resources mobilised, tracked and accounted for against resources mobilised	Monthly	Finance budgets	Review of accountability and resource mobilisation reports	Commissioner planning
% Weekly NTF meetings held	Number of NTF meetings held against number of expected NTF meetings to be held	Quarterly	COVID-19 Document repository	Review of NTF meeting minutes	NTF Administrator
% Daily IMT meetings held	Number of daily IMT meetings conducted against expected total number of meetings to be conducted	Monthly	COVID-19 Document repository	Review of IMT meeting minutes	IMT Administrator
COVID-19 Logistics plan developed and costed	COVID-19 Logistic plan costed and available	Annual	COVID-19 Document repository	Review of status of updating of COVID-19 Logistics plan	Logistics pillar lead
Public health emergency eELMIS scaled up to all districts, districts nodes (9), Regional Referral and National Hospitals.	Districts, district nodes (9), Regional Referral and National Hospitals have access to Public health emergency eELMIS	Semi annual	Activity reports	Review of activity reports	Logistics pillar lead
Guidelines and SOPs for management of COVID-19 supplies developed	Guidelines and SOPs for management of COVID-19 supplies available	Annual	COVID-19 Document repository	SOP review	Logistics pillar lead
Proportion of medical supplies procured	Quantity of medical supplies procured against medical supplies quantified	Quarterly	Public health emergency eELMIS	Review of procurement inventory using eELMIS	Logistics pillar lead

Indicator Name	Definition/ Description	Frequency	Data source	Methodology	Responsibility for data collection
Proportion of non-medical supplies procured	Quantity of non-medical supplies procured against non-medical supplies quantified	Quarterly	Public health emergency eELMIS	Review of procurement inventory using eELMIS	Logistics pillar lead
Surveillance and Laboratory					
% of alerts reported and investigated including samples collected in each district disaggregated by reporting entity	Number of alerts investigated including samples collected against total number of alerts reported	Monthly	Uganda Supportive Supervision Data base	Extraction of district data from Uganda Supportive Supervision Data base and analysis using appropriate analytical packages	SIRI pillar lead
% of contacts followed up and samples taken	Number of contacts followed up with sample taken against total number of contacts identified	Monthly	GoData System	Extraction of data and analysis using appropriate analytical packages	SIRI pillar lead
% of specimens collected from suspect COVID-19 cases	Number of specimens collected from COVID-19 suspected cases against total number of suspected COVID-19 cases	Monthly	Laboratory Information System	Extraction of data and analysis using appropriate analytical packages	SIRI pillar lead
% of COVID-19 suspected cases, reported to the EOC having laboratory confirmation within 48 hours.	Number of COVID-19 confirmed cases reported within 48 hours against total number of confirmed cases	Monthly	Laboratory Information System	Extraction of data and analysis using appropriate analytical packages	SIRI pillar lead
Average turnaround time for results	Time of results dispatch against time of sample collection	Monthly	Laboratory Information System	Extraction of data and analysis using appropriate analytical packages	SIRI pillar lead
# of travellers screened at PoEs on a daily basis		Monthly	PoE registers, DHIS2	Extraction of data and analysis using appropriate analytical packages	SIRI pillar lead
Case Management					
% cases isolated in designated health facilities	Number of COVID-19 cases isolated in designated health facilities against total number of confirmed cases	Monthly	GoData System	Extraction of data and analysis using appropriate analytical packages	SIRI pillar lead
Number of staff trained in critical and acute medical care		Semi-Annual	Training reports	Review of training reports	Case Management Pillar lead

Indicator Name	Definition/ Description	Frequency	Data source	Methodology	Responsibility for data collection
All designated health facilities have trained teams able to manage COVID-19 cases.		Semi-Annual	Training reports	Review of training reports	Case Management Pillar lead
% of targeted referral hospitals with functional ICUs	Number of targeted referral hospitals with functional ICUs against total number of targeted referral hospitals	Semi-Annual	Assessment reports	Review of assessment reports	Case Management Pillar lead
% health workers involved in care of isolated cases get infected.	Number of health workers involved in care of isolated cases infected against total number of health workers involved in care of isolated cases	Monthly	Laboratory Information System for health care workers infected; Assessment reports for number of health care workers involved in care of isolated cases	Extraction of data and analysis using appropriate analytical packages Review of assessment reports	SIRI pillar lead
Strategic Information, Research and Innovation					
% of discharged patients followed digitally.	Number of COVID-19 patients discharged followed up digitally against total number of patients discharged	Monthly	MOH Interactive Voice Response tool	Extraction of data and analysis using appropriate analytical packages	ICT lead person
% of activity reports submitted digitally	Number of activity reports submitted digitally against activity reports done	Monthly	Budget tracker	Download and review of submitted reports	ICT lead person
% of expected weekly analytical reports disseminated	Number of weekly reports disseminated against expected weekly reports	Monthly	COVID-19 Document repository	Review of submitted weekly reports	Analytics lead person
# Number of strategic operations researches conducted to inform implementation of the national COVID-19 response plan.	Strategic operations research reports available	Quarterly	COVID-19 Document repository	Review of strategic operations reports submitted	SIRI pillar lead
# Number of scientific researches conducted to inform implementation of the national COVID-19 response plan.	Scientific research reports available	Quarterly	COVID-19 Document repository	Review of scientific reports submitted	SIRI pillar lead

Indicator Name	Definition/ Description	Frequency	Data source	Methodology	Responsibility for data collection
Risk Communication and Social Mobilisation					
% of the entire population reached with appropriate messages on COVID-19 through mass media (Radio, TV and print communication).	Number of people reached with appropriate messages on COVID-19 through mass media (Radio, TV and print communication) against total population to be reached	Semi annual	Media tracking reports KAP studies Online Polls Survey reports	Comparative assessments	MoH Health Promotion Education and Communication division with support from implementing partners
% of calls alerts received through call center that are followed up	Number of calls alerts received through call center followed up against total number of calls alerts received	Monthly	COVID-SURVEY system for call center	Trends assessments	MoH Health Promotion Education and Communication division with support from implementing partners
% of the population reached through social media (SMS texting and WhatsApp, Ureport, Facebook, Twitter and Instagram).	Number of people reached through social media (SMS texting and WhatsApp, Ureport, Facebook, Twitter and Instagram) against total target population to be reached	Monthly	Media online tracking Online analytic report Survey report	Trends assessments	MoH Health Promotion Education and Communication division with support from implementing partners
% of the community aware about COVID-19 transmission and prevention.	Number of people aware about COVID-19 transmission and prevention against total target population	Quarterly	KAP studies	Report review Trends assessments	MoH Health Promotion Education and Communication division with support from implementing partners
Community Engagement & Social Protection					
% health facilities with access to hand hygiene facilities	Number of health facilities with hand washing facilities against total number of health facilities in the country	Semi Annual	Assessment reports	COVID-19 Document repository	
% communities (households) with access to hand hygiene facilities	Number of households with access to handwashing facilities against total number of households in the country	Semi Annual	Survey reports	COVID-19 Document repository	

Indicator Name	Definition/ Description	Frequency	Data source	Methodology	Responsibility for data collection
% institutions, public places with access to hand hygiene facilities	Number of institutions, public places with access to handwashing facilities against total number of institutions, public places in the country	Semi Annual	Survey reports	COVID-19 Document repository	
% of hard to reach communities reached through outreaches by influential community resource persons	Number of hard to reached communities reached through outreaches by community resource persons against total hard to reach communities	Quarterly	District reports	Report review	MoH Health Promotion Education and Communication division with support from implementing partners
% of the hard to reach population reached through outreaches by influential community resource persons.					
% of quarantined persons followed up and monitored by location	Number of people followed up/monitored in quarantine against total number of people in quarantined	Monthly	GoData System	Extraction of data and analysis using appropriate analytical packages	SIRI pillar lead
Logistics					
Proportion of scheduled (daily) committee meetings held	Number of scheduled committee meetings held against total number of scheduled committee meetings	Monthly	COVID-19 Document repository	Review of minutes and action plans	Logistics Subcommittee Administrator
Proportion of vehicles deployed against request	Number of vehicles deployed against total number of vehicles requested for	Quarterly	Vehicle request forms	Review of vehicle requests	MOH Transport Officer
Timeliness of deployment of vehicles	Time of deployment of vehicles against time of request of vehicles	Quarterly	Vehicle request forms	Review of vehicle requests	MOH Transport Officer
Continuity of Essential Health Services					
Maternal mortality rates	Number of maternal deaths per 100,000 live births	Monthly	Maternity registers DHIS2	Extraction of data from, maternity register, DHIS2 and analysis using appropriate software packages	SIRI Lead

Indicator Name	Definition/ Description	Frequency	Data source	Methodology	Responsibility for data collection
Coverage for essential health services	Outpatient Department (OPD) trends	Monthly	OPD registers DHIS2	Extraction of data from OPD register, DHIS2 and analysis using appropriate software packages	SIRI Lead
Stock status of essential medicines	Availability of essential medicines	Monthly	Stock cards DHIS2	Extraction of data from stock cards, DHIS2 and analysis using appropriate software packages	SIRI Lead
Timeliness of HMIS Reporting	Number of facilities submitting reports against expected number of reports	Monthly	DHIS2	Extraction of data from DHIS2 and analysis using appropriate software packages	SIRI Lead
Completeness of HMIS Reporting	Number of districts submitting health facility reports against expected number of reports	Monthly	DHIS2	Extraction of data from DHIS2 and analysis using appropriate software packages	SIRI Lead
Functionality of the emergency medical services – referral system	Availability of functional ambulance at HSD level	Quarterly	District monthly reports	Review of district monthly reports	Continuity of Essential Health Services pillar lead

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