



Coronavirus Disease - 2019 (COVID-19) Preparedness and Response Plan

January – June 2020

Ministry of Health Uganda

**NATIONAL CORONA VIRUS
DISEASE - 2019
(COVID-19)**

Preparedness and Response Plan

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Acknowledgements

The Ministry of Health, Uganda wishes to acknowledge the efforts of partners and stakeholders in the National Task Force in developing this six month Coronavirus – 2019 Disease (COVID-19) preparedness and response plan.

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.

I thank you.

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Introduction

Context

On 31 December 2019 the World Health Organisation 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.

Current Situation of Corona Virus Disease (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 5 February 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.

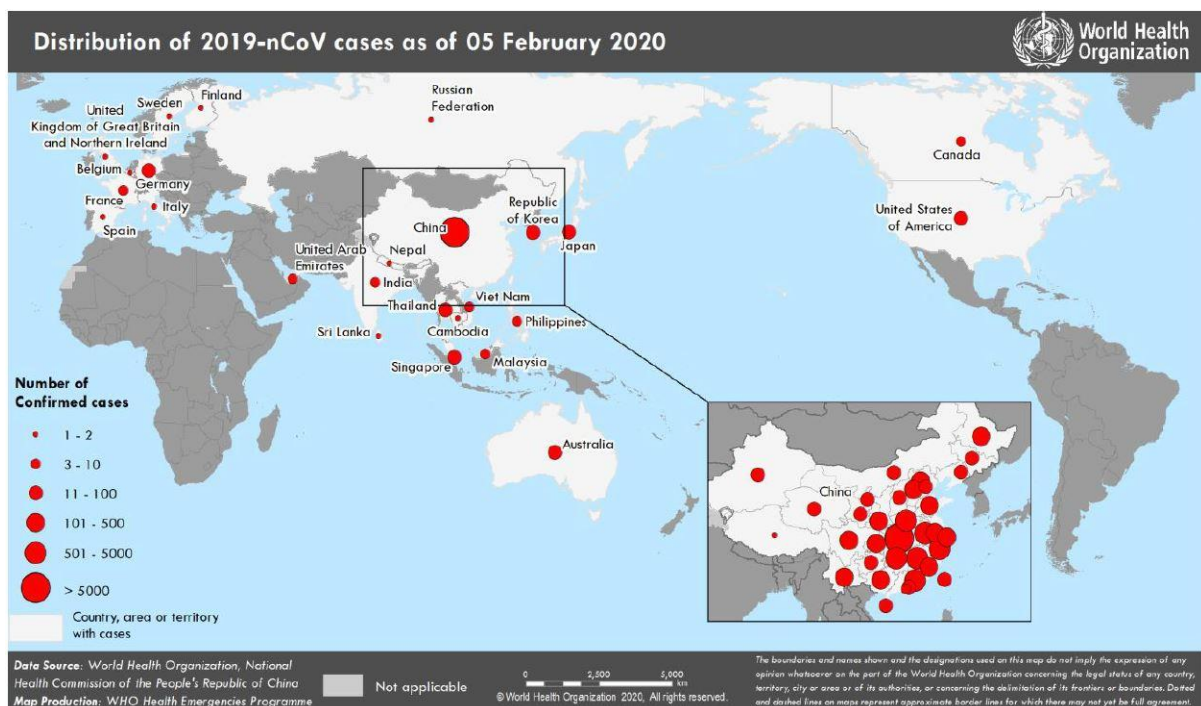


Figure 1: Countries, territories or areas with reported confirmed cases of 2019-COVID, 5th February 2020. Source: who.int

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

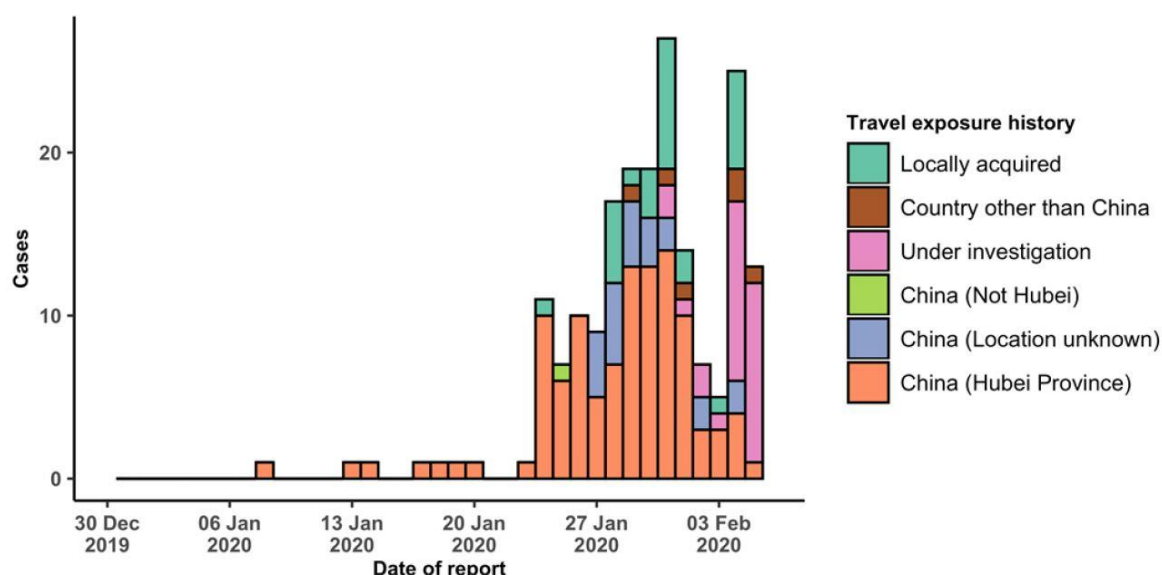


Figure 2: Epidemic curve by date of onset of COVID-19 cases identified outside China, 5th February 2020. Source: www.who.int

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 cows and pigs they 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; 1) Severe Acute Respiratory Illness (SARS) 2002- 2003 affecting over 8, 000 people with 800 deaths in 29 countries and 2) Middle Eastern Respiratory Illness (MERS), 2012 with over 1,700 cases and 670 deaths in 27 countries.

Rationale for the plan

The 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 between the two countries 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.

Due to the fluidity of the outbreak situation this plan will cover six months of the outbreak (January to June 2020).

Preparedness and Response strategy

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 as well as economic social disruption that might result from this outbreak. The implementation of this plan will be multi-sectoral involving Ministries, Departments, Agencies, Partners, private sector entities and other stakeholders.

Specific objectives

1. To facilitate coordination of preparedness and response efforts for COVID-19
2. To develop country capacity for early detection, confirmation, reporting 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
4. To develop capacity for case management and psychosocial support for COVID-19
5. To strengthen the infection prevention and control measures required to mitigate spread of COVID-19 in health facilities, institutions and at the community level.

Approach to the development of this plan

Development and implementation 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 ICT innovations, community led approach and 24 hour surge capacity.

The plan is arranged according to 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. In scenario 3, multiple cases are identified; in which case activities of scenario 2 are enhanced and business continuity plans per sector activated.

Risk mapping

The whole country is at risk including refugee settlements, however, to improve preparedness efforts some areas have been identified as higher risk;

- Kampala and Wakiso - due to connection with international airport
- Cities and towns with high congregation of high-risk travellers especially in construction projects
- Selected ground crossing points of entry with large foreign inflow
- Districts with a regional referral hospital where the isolation facilities are and sentinel sites for Severe Acute Respiratory Illness (SARI) and Influenza Like Illness (ILI)
- Refugee new arrivals from especially from DR Congo and South Sudan

Scenarios

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

Scenario	Actions
Scenario 1 (Best case scenario): <i>No cases reported in Uganda.</i>	<ul style="list-style-type: none"> - Continued surveillance and routine screening at points of entry - Prepositioning of logistics at PoEs and regional referral hospitals - Risk communication and community engagement - IPC and WASH - District categorization and preparedness focused in high risk districts
Scenario 2 (most likely scenario) <i>(confirmed cases in one geographical location, enhanced preparedness across the country)</i>	<ul style="list-style-type: none"> - Management of confirmed case(s) - Enhanced surveillance - Risk communication and community sensitization and engagement - Infection Prevention and Control and WASH - Psychosocial support activities - District categorization and preparedness focused in high risk districts and response in affected areas

Scenario	Actions
Scenario 3 (worst case scenario) <i>(confirmed in multiple locations, <u>or</u> overwhelming numbers of cases or in the refugee transit centre, reception and in settlements)</i>	<ul style="list-style-type: none"> - Cross pillar response at community level, points of entry escalate to response capacities - Escalation of response activities to the NECOC under OPM - Surge teams (including the UPDF and international medical teams)

This National COVID-19 Preparedness and Response Plan, therefore, will outline the steps and resources necessary for Uganda to respond to Scenario 1 and 2 (most likely scenario) above. 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).

Assumptions

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

- The entire population of Uganda is at risk
- The typical incubation period for Corona virus is 2 days to 14 days
- All travellers will be screened.
- High risk travellers identified at POEs will be isolated immediately
- There will be several cases under investigation at the same time.
- Outbreak related anxiety will cause increased psychogenic and stress-related illness, compounding the strain on healthcare workers, patients, suspect cases and the community.
- 20% of all infections will result in severe illness as evidenced by data from China
- Government agencies may recommend changes in business workplace rules, such as increased telecommuting

Intervention Areas

This section of the plan describes the general strategy and activities of each pillar to achieve the above objectives.

Pillar 1: Coordination and leadership

Coordination during emergencies is critical as it involves the contribution of different sectorial agencies, teams and partners towards a common goal. Coordination can generate economies of scale, avoid fragmentation of multiple and targeted programs that require collaboration at service delivery level. Coordinated responses, timely inter-agency assessments and information sharing reduce the burden on affected people who may be subjected to demands for the same information from a series of assessment teams.

Strategy

Ensure technical, operational and political support mechanisms are enhanced and supported daily to coordinate all aspects of preparedness and response.

Targets

- Provide strategic direction to districts on key interventions
- Mainstream Government and partner support in fully operationalizing this plan
- Adjust the activities in line with new information or procedure/policy depending on the scenario or phase
- Address field challenges through regular National Task Force, District Task Force and the coordination sub-committee

Activities

- Activation of National Task Force, district task force and sub-committees.
- Conduct resource mobilisation activities
- Engage relevant sectors, partners and private sectors for COVID-19 preparedness and response
- Hold advocacy meetings at national level for preparedness and response to COVID-19.
- Monitor implementation of the plan; supervision, accountability forum
- Conduct cross border coordination and collaboration
- Develop and issue information products including situational reports on COVID-19
- Conduct a simulation exercises
- Activation of National and District Rapid Response Team
- Ensure remuneration and compensation of responders
- Conduct support supervision visits
- Develop innovative approaches to effectively coordinate preparedness and response for COVID-19

Pillar 2: Case management, Infection prevention and Control

There is no definitive treatment identified for COVID-19 thus far and treatment is mainly supportive. Focus will be on infection prevention and control in health facilities, institutions and communities. All confirmed cases will be managed in designated isolation facilities across the country.

Strategy

- Support Regional Referral Hospitals to have high dependence unit (HDUs) with capability to deliver critical care
- Strengthen triage at all health facilities for acute respiratory illnesses
- Designate isolation facilities for suspect and confirmed cases

Target

- 100% cases isolated in designated health facilities
- All designated health facilities have trained teams able to manage SARI and ILI cases
- 0% health workers involved in care of isolated cases get infected.

Activities

Case Management

- Develop, print and distribute clinical management guidelines to the all health care facilities that will treat respiratory pathogens patients
- Conduct refresher trainings and drills for health care workers (medical and ambulance teams) for clinical management of Severe Acute Respiratory Illnesses (SARI) and Influenza Like Illnesses (ILI) in all high risk districts
- Equip isolation facilities at Entebbe Hospital and Naguru Hospital as High Dependence Units (HDU).
- Orientation of Health care workers in Regional Referral Hospitals, SARI sentinel sites and high volume private facilities to manage suspect and confirmed cases.
- Map public and private health facilities for COVID-19 readiness
- Map Intensive Care Unit capacity in the country
- Provide food assistance and/or specialized nutrition foods for suspects, patients and health workers
- Conduct training and mentorship for health workers
- Ensure effective and safe referral of suspects and cases.
- Develop innovative approaches to case management
- Assess diagnostics, therapeutics and vaccines for compassionate use, clinical trials, regulatory approval, market authorization and post market surveillance.

Infection Prevention and Control in health facilities and isolation facilities

- Revise and disseminate adapted IPC standard operating procedures and strategy for IPC and hospital acquired infections for COVID-19 to health facilities
- Conduct IPC refresher training and onsite mentorship on standard and transmission-based precautions
- Conduct surveillance for Hospital acquired infections for COVID-19 in health facilities.

Pillar 3: Water And Sanitation & Hygiene

This pillar aims at strengthening community infection prevention and control. Due the mode of transmission of (droplet and contact) COVID 19, emphasis needs to be put on prevention of transmission from person to person at community level and points of congregation including Churches, schools, etc.

Strategy

- Ensure access to water and sanitation in public places and community spaces most at risk
- Implement WASH at community level

Target

- 100% access to hand hygiene facilities in public places and communities at risk

Activities

- Support engagements with authorities on improvement of WASH in congregation institutions using the standardized checklist.
- Procure WASH infrastructure, supplies and commodities to strengthen hygiene practices in affected communities
- Conduct hygiene promotion and sensitization workshops on use of WASH commodities in congregational settings
- Support community engagement meetings on improvement of WASH
- Support the operationalization of WASH committees in the community.

Pillar 4: Information and Communication Technology (ICT) and Innovation

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. This pillar aims to support other pillars to

deliver more efficiently, ensure wider reach, quick validation of data and information while strengthening mechanisms for social distancing.

Strategy

- Utilizing digital tools to collect, collate, analyse and archive information including real time follow up of suspect cases, use of GIS to track location and movement of high risk persons and cases.
- Use telemedicine to provide health care and other support services.
- Implement e-meetings for coordination, communication and trainings
- Strengthen monitoring and real time reporting for logistics, sample tracking and traveller screening forms at POEs and conveyance.

Target

- 75% of the self-isolated people are monitored digitally
- 100% of activity reports are submitted digitally

Activities

- Develop and deploy e-self diagnosis and monitoring form
- Digitise traveller screening form
- Implement telemedicine
- Widen scope of implementation of e-meetings for example use of zoom
- Implement a dashboard and knowledge management portal for COVID-19
- Digitize sample management
- Digitise activity reporting

Pillar 5: Mental Health and Psychosocial Support

Corona virus infection may cause mental health problems 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. This pillar aims at providing 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.

Strategies

- Assessment of families, communities and people affected with COVID-19 for psychological distress.
- Provision of mental health and psychosocial interventions within the affected community, including people in isolation.
- Building capacity of probation officers, psychiatrists (clinical officers, nurses and doctors), psychologists, social workers and para-social workers that offer psychosocial support.

Activities

- Offer MHPSS services to individuals, families and communities affected with COVID-19 infection and the associated psychological distress.
- 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
- Provide Support supervision and monitoring of psychosocial support services in the affected communities

Pillar 6: Surveillance and laboratory

There is need for sustained surveillance to facilitate early detection, confirmation, reporting, notification, verification and response of alerts and suspect cases. This will be based on regular risk assessments and prioritization into three categories. Priority is focused on Points of Entry, Referral Hospitals, UVRI's National Influenza Centre Sentinel sites and districts with direct links to key points of entry as well as high-volume congregational points especially those hosting Foreigners.

Targets

The surveillance targets for preparedness and control of COVID-19 include;

- 100% screening of travellers at PoEs
- 80% alert verification and response system is functional
- 100% follow up of cases and monitoring of self-isolated cases
- 80% investigation of clusters of influenza like illnesses
- 100% collection of specimens from suspect COVID-19 cases

Strategies to achieve the COVID-19 surveillance targets

- Conduct Rapid risk assessment for COVID-19 importation into the country.
- Enhance Point of Entry screening for early detection of COVID-19 cases
- Enhance COVID-19 surveillance in health facilities and communities
- Intensify Monitoring of isolated high risk travellers and verification of alerts
- Enhance capacity for sample collection, transportation, testing and confirmation of COVID-19 suspect cases
- Develop innovative approaches, methods and tools to enhance surveillance activities

Activities

The priority activities of the pillar include the following:

- Conduct district level risk assessments at critical point of entry and points of congregation (Entebbe, Kampala, Wakiso, Busia, Tororo/Malaba, Katuna,

Cyanika), all districts with Regional Referral hospitals and NIC sentinel sites (Kabale, Jinja, Lira, Fort portal, Mbarara and any other emerging district at risk).

- Build district level capacity on COVID-19 surveillance (DTF, the DHT, Health workers and selected VHTs)
- Enhance community based COVID-19 surveillance through community structures
- Support collection, packaging and transportation of samples from suspected COVID-19 cases to UVRI for analysis.
- Deployment of mobile labs and field teams to quicken sample testing and confirmation.
- Orientation of health workers at district level, sentinel sites and referral hospitals on enhanced COVID-19 surveillance and reporting.
- Orientation of border officials including immigration, revenue, trade and internal security officers at PoEs on identification of COVID-19 affected travellers
- Support supervision and monitoring of screening at PoEs in areas that are likely to be affected by central and district teams.
- Build capacity of laboratory and selected health staff on appropriate COVID-19 sample collection, packaging, handling and transportation.
- Intensify screening and monitoring of alerts at designated points of entry.
- Follow-up of high risk travellers, alerts and contacts
- Active case search and verification of alerts
- Transfer of high risk travellers to isolation facilities
- Develop, print and disseminate case definition, case investigation forms, line list and SOPs
- Conduct data collection and information management at national and district level including POEs, health facilities and lab.
- Support UVRI-NIC to test for COVID-19

Pillar 7: Risk communication, Social Mobilisation and Community engagement

The general public has limited knowledge about this virus as it is new. 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 Risk Communication Social Mobilization and Community Engagements (RCSM-CE) interventions to raise awareness and build partnerships in preparedness phase of new coronavirus throughout the country.

Targets

- 70% of the entire population is reached with appropriate messages on COVID-19 through mass media

- 20% of the population is reached through social media
- 30% of the hard to reach population is reached through outreaches

Strategies

- Crisis Communication
- Health Education and stakeholder relation
- Precautionary Advocacy
- Outrage Management
- Interpersonal communication
- Innovate new approaches to enhance RSCM-CE

Activities

The risk communication activities are adapted from RSCM-CE component of national pandemic influenza plan, because of the similarities in their history on prevention and control. Activities include:

- Conduct periodic KAP assessments.
- Public awareness campaign e.g. mass media (radio, TV and newspapers) and social media
- Develop, translate, pre-test, print and disseminate IEC materials in English, Chinese, local languages and refugee languages.
- Orient the mass media personnel on the new corona virus.
- Sensitize VHTs, Religious Leaders, Cultural leaders, Political leaders, Immigration leaders, Schools, Traditional healers, Transporters, Markets, refugee humanitarian workers, Bus parks and other targeted special groups on COVID-19.
- Conduct house to house sensitization.
- Conduct technical supervision to high-risk districts.

Pillar 8: Logistics and Operations

The purpose of this pillar is to ensure that logistical needs are availed to the different sites according to need in a timely and efficient manner.

Strategy

- Operationalize Regional stores and preposition supplies
- Procure and deliver all services and supplies as required by the various subcommittee

Activities

- Conduct routine logistics needs assessment to inform forecasting and guide deployment of logistic
- Develop a comprehensive list and conduct quantification of supplies for COVID_19 to inform decision making.
- Provide warehousing and distribution services to facilities as guided
- Conduct reverse logistic to minimise wastage and enhance efficient use of resources
- Provide sample and ambulance transportation services for cases of COVID_19
- Procure and distribute clinical care supplies and equipment

Monitoring and evaluation

Indicators will be developed to assess the progress and performance of the implementation of the plan. Quarterly reviews will be conducted regularly.

Strategy

- Conduct support supervision
- Enhance utilization of the 4W matrix and visual monitoring using the dashboard

Activities

- Conduct integrated support supervision to districts
- Hold accountability fora
- Conduct data management and Reporting
- Regularly update dashboard and other information products

Summary of budgeted activities

Pillar	Total (Ushs)
Coordination and leadership	1,173,790,000
Surveillance, laboratory support & POEs	3,188,415,000
Risk communication, social mobilization and community engagement	5,006,380,000
Case management, infection prevention and control	4,872,754,286
ICT and Innovation	192,152,000
WASH	3,997,952,748
Mental health and Psychosocial support	1,091,200,000
Logistics	5,794,279,717
Total	25,316,923,751

Annexes

Annex 1: Operational Case Definitions

Surveillance case definitions for COVID-19 are as follows:

Suspect case

- A. Any person with acute respiratory illness (temperature of 37.5°C 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 37.5°C and above and at least one sign/symptom of respiratory illness (e.g., cough, shortness of 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