The UN Uganda Multi-Partner Trust Fund

Programme Document Template

Window	Emergency Window
Title	Improving Availability and Utilization of Life Saving Health Services in the context of COVID-19 response in Uganda.
MPTF Office Project Number (if applicable)	
Description	UN Emergency Appeal for Response to COVID-19 and its Impacts
Universal Markers	Gender Marker: *(bold the selected; pls select one only)* a) Have gender equality and/or the empowerment of women and girls as the primary or principal objective. b) **Make a significant contribution to gender equality and/or the empowerment of women and girls.** c) Make a limited contribution or no contribution to gender equality and/or the empowerment of women and girls.
Participating UN Organizations (PUNOs)	WHO
Implementing Partners	Ministry of Health Selected District Local Governments Save the Children, CUAMM
Programme and Project Cost	From UN Uganda MPTF: US$ $140,571.41 Other sources: US$0 Total Budget: USD $140,571.41
Programme Duration	**Estimated Start Date:** 3 May 2021 **Duration (months):** 12 months **Estimated end date:** 2 May 2022
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Executive Summary

The executive summary contains a comprehensive summary of all sections focusing on the significance and relevance of the joint programme, its contribution to national priorities and international commitments, the results expected to be achieved, intended beneficiaries, donors and implementing partners

COVID-19 and cholera are priority public health events in Uganda which have been included in the UN Emergency Appeal. COVID-19 is also reflected in Uganda March 2020 – June 2021 Response Plan. Since March 2020, cases have been increasing and the country is in phase 4 with wide community transmission[1]. As of 20 February 2021, 40,102 cases have been confirmed, of which, 1,941 are health workers infected.[2] A total of 331 deaths have been confirmed.

Cholera is of public health significance in Uganda. In an outbreak from April to June 2020 in Moroto District of Karamoja, 452 cases were reported with two deaths. The outbreak then crossed into Kotido District on June 24. The Ministry of Health (MoH) continues to track cholera cases as a priority public health event with five suspected cases being reported in a second outbreak in Karamoja as of 1 Nov 2020. The Cholera Strategic Plan indicates inadequate implementation of the Public Health Act, poor water and sanitation infrastructure, weak coordination for cholera prevention and control actions. For both public health events, the response actions are designed through the following pillars: Coordination and leadership; Risk communication and community engagement; Logistics and supplies; Epidemiology, surveillance and laboratory; and Water, sanitation and hygiene.

WHO will use funding from MPTF to provide support in case management interventions which shall include standard training in cholera and COVID 19 case management, capacity to rapidly detect, confirm and investigate all suspected cases will be enhanced in the target districts

Situation Analysis

On 31 December 2019, China notified the World Health Organization (WHO) of clusters of pneumonia of unknown origin in Wuhan City in Hubei Province. On 7 January 2020, health authorities confirmed that the cases were caused by a novel coronavirus later named 2019-nCoV-SARS. In general, coronaviruses cause 5-10 per cent of community-acquired upper respiratory tract infection (common colds) in adults, occurring sporadically or in outbreaks of variable size worldwide; HCoV-229E, HCoV-NL63, HCoV-HKU1, HCoV-OC43 are endemic globally. Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) are examples of coronaviruses that can cause severe respiratory disease and death.

On 21 January 2020, WHO confirmed human-to-human transmission of the virus. On 30 January 2020, following the advice of the emergency IHR (2005) committee on COVID-19 the Director-General of WHO declared the COVID-19 outbreak a public health emergency of international concern (PHEIC) under the International Health Regulations (IHR, 2005). On 11 March 2020, WHO pronounced the COVID-19 to be a pandemic.
Since its discovery, the geographic distribution of COVID-19 continued to evolve, reaching over 213 countries, areas and territories globally by end of June. As of 30 June 2020, WHO reported nearly 10 million confirmed COVID-19 cases, including close to 500,000 deaths. The latest epidemiology can be found on https://covid19.who.int/.

Uganda reported its first case on 21 March 2020. The first COVID-19 case was a Ugandan man who was returning from Dubai. Since then, cases have increased reaching a cumulative of 33,695 confirmed COVID-19 cases, including 1,984 cases among children [0-19 yrs] and 1,853 cases among health workers. Since the start of the epidemic, Uganda has reported 301 COVID-19 deaths. Most of the confirmed COVID-19 cases in Uganda continue to be male (66 per cent) and 96 per cent local transmission.

Uganda, like many countries continues to experience shortages of laboratory testing supplies and PPE. The

[1] https://www.health.go.ug/cause/update-on-covid-19-response-in-uganda-3/
[2] Ministry of Health COVID-19 Situation Report – #363

testing turnaround time is also challenging, leading to the government granting accreditation to private laboratories to conduct testing for COVID-19. Limited funding and the closure of the fiscal year in July affected district capacity to mount effective COVID-19 response activities, including the implementation of enhanced surveillance and community-based activities in hot-spot districts.

Uganda shares vast borders with multiple countries including Kenya, Rwanda, South Sudan (SS), the Democratic Republic of Congo (DRC), and Tanzania. SS and DRC are chronic complex emergencies, with large numbers of refugees and asylum seekers hosted in Uganda. Additionally, DRC has had EVD and plague outbreaks, both bubonic and pneumonic plague which are seasonal. Besides these, Uganda has had active outbreaks of Yellow Fever for which vaccination was interrupted by the COVID-19 mitigation measures, sporadic measles and cholera outbreaks, and other public health emergencies including flooding and landslides. Uganda has also experienced cholera outbreaks in Moroto, Nabilatuk and Napak Districts in the Karamoja sub region. There is also a high risk of cholera in hotspot districts such as Kasese and Arua – mainly due to seasonal flooding. To promptly address the outbreak and prevent the resurgence of cholera in other districts, it is vital to intensify risk communication in line with newly launched community engagement strategy, strengthen surveillance, improve the readiness and case management capacities at the district level.

Beyond COVID-19 response, cholera is endemic and considered a public health priority in Uganda as reflected in the MoH strategic plan for its prevention and control. The country reports an average of 1,850 cholera cases and 45 deaths annually. Poor sanitation costs Uganda approximately US$107 million annually, while one prolonged cholera outbreak lasting for over a year costs approximately US$1.7 million, in addition to affecting other revenue sectors like tourism and trade. The MoH strategic plan indicates inadequate execution of provisions in the Public Health Act for cholera prevention and control leading to poor water and sanitation situation in the country.

WHO is working through UN coordination, the Incident Management Team (IMT) and the public health emergency operations center of MoH (PHEOC) to increase attention to ongoing and emerging public health emergencies which includes, COVID 19 and Cholera as well supporting the pillar on continuity of essential health services.

Uganda has widespread community transmission of COVID-19. A sharp rise in COVID-19 cases was witnessed in the period between 6-19 Nov 2020 where Uganda recorded 3,053 COVID-19 confirmed cases in 91 districts in Uganda. Figures 1 and 2 show districts with local transmission as of 21 Nov 2020.

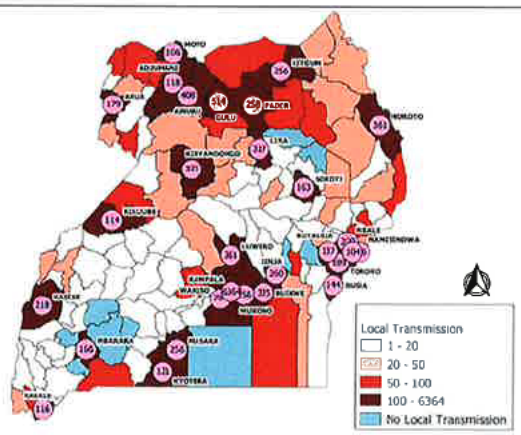

Figure 1: Uganda map with districts with local transmission as of November 21, 2020 (n=15,736 cases.

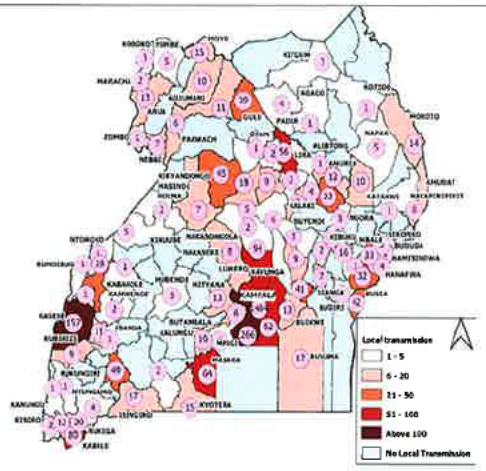

Figure 2: Uganda map with districts reporting confirmed cases between Nov 6 and Nov 19, 2020 (n=3,053 cases; 91 districts.

The funding from UN Multi Partner Trust Fund (MPTF) will be timely to support coordination, leadership as well as reporting of emergencies in selected districts. It is anticipated that with support to coordination, linkage with central level will be enhanced. The prioritization exercise conducted by the UN Health Thematic Working Group, realised the need to strengthen community-based surveillance, an aspect which is important in rapid detection confirmation and investigation of epidemic prone diseases. The situation will facilitate integration of COVID 19

monitoring with other conditions. WHO will also focus on areas of Case management for cholera and COVID 19.

Table 1: Priorities for cholera and COVID-10 response, control and prevention by MOH pillar and Agencies				
Pillars as per MOH	**Priority areas identified**	**Geographic scope/ district**	**Lead Agency**	**Implementing Partner**
Coordination, leadership. Monitoring and reporting	Support the functionality of district coordination structures [have plans, and document meetings, improve link with national coordination structure]	*Adjumani* *Amuru* *Arua* *Gulu* *Karamoja Districts* *Kasese* *Madi-Okollo*	WHO	*CUAMM – Karamoja* *IRC – West Nile* *SCU – Kasese, N Uganda*
Epidemiology, surveillance and laboratory	*Support community-based surveillance at hotspot districts/ POEs and cholera affected districts*	*Adjumani* *Amuru* *Arua* *Gulu* *Karamoja Districts* *Kasese* *Madi-Okollo*	WHO/IOM	
Case management including infection prevention and control	*Support package for expanding isolation centre*	*Kampala* *Wakiso*	WHO	*CRS* *IRC for protection mainstreaming*
	Procurement and prepositioning of cholera supplies in districts such as cholera kits		WHO	

Table 2: Budget estimates by objective and agency				
Objective	**Amounts for each agency in US$**			
	WHO	**IOM**	**SCU**	**CUAMM**
Objective 1: To strengthen outbreak response coordination, leadership, monitoring, reporting mechanisms and supplies in selected districts	7,230		*No funding allocated	*No funding allocated
Objective 2: Strengthen case management interventions and entail a full package of response including standard training in cholera and COVID-19 case management	61,384		*No funding allocated	*No funding allocated
Objective 3: To strengthen district capacity to rapidly detect, confirm and investigate all suspected cases in affected and high-risk districts including Elegu point of entry and adjacent communities	71,957	21,212	*No funding allocated	*No funding allocated
Total	**140,571**	**21,212**		

**Funding to the Ips reflected in UNICEF Prodoc but does not cover the WHO proposed activities. Reflecting the funding under this section will be duplication. WHO will not be able to support these partners under sections highlighted*

Beneficiaries

WHO, CUAMM and Save the Children action with funds from MPTF will benefit 446,643 people as indicated in Table 3.

Table 3: Population of beneficiaries in 7 selected districts 893,286 people

District	Female (100%)	Male (100%)	Overall Total (100%)	Female (30%)	Male (30%)	Overall Total Target Pop (30%)	Category
Kasese	403,200	390,000	793,200	120,960	117,000	237,960	1
Kaabong	66,930	58,780	125,710	20,079	17,634	37,713	2
Moroto	61,700	56,800	118,500	18,510	17,040	35,550	2
Karenga	34,800	33,700	68,500	10,440	10,110	20,550	2
Amudat	66,800	68,100	134,900	20,040	20,430	40,470	2
Nabilatuk	46,800	42,900	89,700	14,040	12,870	26,910	2
Napak	86,100	72,200	158,300	25,830	21,660	47,490	2
Total	**766,330**	**722,480**	**1,488,810**	**229,899**	**216,744**	**446,643**	

The WHO Uganda Country Office COVID-19 pandemic preparedness and response plan is aligned to the National Uganda COVID-19 preparedness and Response Plan 2020/21 as well as the WHO African Regional Office strategy.

WHO has also jointly developed a costed plan for United Nations Emergency Appeal for the Impact of Covid-19, that addresses issues beyond COVID-19. The Appeal plan also covers continuity of essential health services including other emerging public health emergencies. WHO chairs the UN Technical working group and co-chairs the Health thematic group which led to the development of multi-partner trust fund established by the UN Resident Coordinator's Office. Joint proposal submissions with implementing partners have been made to support COVID-19, other public health emergencies and components of essential service continuity.

WHO transitioned from EVD to COVID-19 response playing critical role with the technical pillars under the Public Health Emergency Operations Centre and the Incident management Teams. WHO was instrumental in the setting up of the Incident Management structure which is the tactical arm of the response and also contributes to the Strategic management Committee. WHO contributed immensely to the procurement of Medical and laboratory supplies for both COVID 19 and cholera including the Personal Protective Equipment (PPE) including Infection Prevention and Control (IPC) supplies.

WHO has presence in 8 Regional Hubs; Hoima, Arua, Rwenzori, Gulu, South Western, Lira and Mbale where the technical teams provide support to a total of 84 districts. Presence in the Hubs enabled the WHO staff to support setting up and operationalisation of the Incident Management Teams under the coordination of the District Taskforces. The Field Coordinators supported chairing of the IMT whilst the other technical officers (Epidemiologists, Risk Communication, Case Management, Infection Prevention and Control Consultants) were Co-Chairs of the technical pillars. WHO has also supported the procurement of laboratory testing supplies for COVID-19 and plays a major role in the decentralization and essential service continuity technical working groups among other activities.

WHO main objective for COVID-19 Preparedness and Response is to strengthen national capacity to prevent and reduce morbidity and mortality associated with COVID-19 through the following main areas.

A. Strengthen outbreak response coordination, leadership, monitoring, reporting mechanisms, and supplies in selected districts for COVID-19 and Cholera

Part A: Coordination, leadership, monitoring and reporting by WHO

- *Conduct rapid functionality assessments of district COVID-19 and Cholera readiness response status and provide technical assistance to DTFs for revised action plans to address identified capacity gaps*
- *Support district taskforces to cascade orientation of Terms of Reference, Guidelines and Standard Operating Procedures to Health Sub-Districts and lower local governments.*
- *Support online DTF coordination meetings on COVID-19 and Cholera response with participation of regional teams*

The District Taskforces have been operating sub-optimally in several districts during the COVID-19 pandemic. Reports have been that these have not been supported in terms of expertise and financially. The districts have

been involved in several coordination activities dating back to Ebola Virus Disease and beyond of which the gains experienced could be used to improve coordination structures. Supporting coordination will facilitate development of plans as well as to document activities within the districts and enhance preparedness and response activities. In terms of cholera control, the following districts will be supported Karamoja districts; Moroto, Nabilatuk and Napak.
The COVID-19 outbreak has had hotspot districts emerging which will be supported, these will include Adjumani, Amuru, Arua, Gulu, Karamoja districts (3), Kasese, Madi-Okollo and Kasese will be given an orientation
WHO and selected IP will maintain district presence where the field teams will be supported to functionalise the District Taskforce. The field staff will support development of COVID-19 plans, convening of meetings, mapping of partners and providing strategic direction. The field staff will also participate in the orientation of taskforce members on COVID-19. All the district staff will develop individual plans which will be discussed and approved by the Incident Manager or his deputy. Performance evaluation will be conducted halfway through the conduct and at the end of contract.

B. *Strengthen case management interventions and entail a full package of response including standard training on COVID-19 on for homecare and cholera case management*

- *Strengthen case management interventions including standard training in cholera and COVID-19 case management*
- *Strengthen national human resource capacity in acute diarrhoea treatment centres, and communities.*
- *Train Health workers in early cholera detection and management including Infection prevention and control.*

In order to establish adequate capacities to provide access for prompt and effective treatment of cholera and COVID-19 patients. It is important in the case of Cholera to provide quick access to the life-saving Oral Rehydration Salts (ORS) therapy. In both situations, case management materials should be stocked and pre-positioned in high risk areas. Other interventions should include adequate training of health workers, improving health infrastructure, *services and medical technologies, providing clear treatment guidelines, and ensuring prompt patient referral.*

Summary Activities

- *Training of Health workers in case management and Infection prevention and control*
- *Printing of case management protocols, guidelines, job aids and posters*

C. *Strengthen district capacity to rapidly detect, confirm and investigate all suspected cases in affected and high-risk districts including Elegu point of entry and Adjumani Refugee Settlement.*

WHO and implementing partners will focus on:

- *Procurement and distribution of cholera personal protection equipment and materials, medical supplies (cholera kits, Intra-Venous fluids, ORS, giving sets, chlorine, drugs, etc), fuel to support transport logistics, disinfectants and detergents for use at Cholera Treatment Centers.*
- *Support functionality of real-time district COVID-19 surveillance and reporting systems at POE including screening and collection of truck drivers at POEs.*

Surveillance data is used to guide other thematic groups of the National Cholera Taskforce and Incident Management system in the case of COVID-19 response. Rapid detection and confirmation of a case of cholera or COVID-19 is necessary and requires that health workers are trained, provided with necessary logistics and supplies to facilitate the process. The Central Public Health Laboratory as the national Public health laboratory has capacity to confirm cholera and other enteric bacterial infections within 48-72 hours. It is necessary therefore to provide the required media to support transportation of samples from districts to National level.

COVID-19 surveillance activities will be conducted within the integrated disease surveillance and response framework to allow detection of other epidemic prone diseases. MOH in collaboration with WHO and partners will mobilize the partnerships needed for activation of all surveillance systems in the country; Community based

surveillance, surveillance at POE, Facility based surveillance, laboratory-based surveillance and sentinel surveillance systems. MOH will engage all communities in all districts to take charge of Community based surveillance through Village Heath Team (VHT).

Summary activities

- *Conduct and supervise active case finding, contact tracing and follow-up in the affected and surrounding areas.*
- *Orient VHTs to conduct active case finding, contact tracing and follow-up.*
- *Support timely collection and referral of specimens from the field to the national reference laboratory*
- *Training in community Based surveillance*
- *Provide transport for sample collection and transportation*

Support implementation of Infection Prevention and Control measures: **Results Framework**

Outcome 1: Outbreak response, coordination, leadership, monitoring and reporting mechanism functional in selected districts strengthened					
		Baseline	**Target**	**Means of verification**	**Responsible Org**
Outcome Indicator	Proportion of districts with functional coordination mechanism	22%	25%	HMIS/DHIS2	MoH, DLG
Output 1	Districts enabled to coordinate, provide leadership, monitor and report outbreaks				
Output Indicator 1.1	*Number of districts with established and functional District Taskforces*	0	7	DTF Minutes	Save the Children Fund Uganda (SCU) CUAMM and WHO
Output Indicator 1.2	*Number of districts' teams oriented and applying the Incident management system including pillar approach*	0	7	ODK Meeting minutes	WHO CUAMM
Outcome 2: Improved Capacity of health institutions to provide case management interventions for cholera and COVID-19 patient					
Outcome Indicator	Proportion of health facilities providing patient care according to set protocols	40%	50%	Standard protocols Patient outcomes	WHO
Output 2	Health facilities enabled to provide case management interventions to patients suffering from cholera or COVID 19 through training and use of standard protocols				
Output indicator 2.1	*Number of health workers trained in case management and infection prevention and control*	40%	50%	Training reports ODK	WHO
Output indicator 2.2	*No of health facilities basic set of diagnostic equipment and monitoring for use at the isolation centre*	1	7	Delivery Reports	WHO
Outcome 3: Districts Capacity to detect, confirm and conduct investigation of suspected cases improved					

Outcome Indicator	Proportion of districts timely detecting reporting and investigating suspected cases	30	50%		
Output 3	**Suspected outbreaks rapidly detected, confirmed and investigated**				
Output indicator 3.1	*Number of VHTs from High risk districts with capacity to conduct active case finding, contact tracing and follow up*	0	40%	ODK report s	
Output indicator 3.2	*Number of facilities timely collecting specimen and submitting to national reference laboratory*	15%	40%	Laboratory and surveillance reports	
Output indicator 3.3	*Number of VHTs trained in Community Based Surveillance*	0	40%	Training reports	

SDG Targets and Indicators

Please consult Annex: SDG List

Please select no more than three Goals and five SDG targets relevant to your programme.

(selections may be bolded)

Sustainable Development Goals (SDGs) [select max 3 goals]			
☐	SDG 1 (No poverty)	☐	SDG 9 (Industry, Innovation and Infrastructure)
☐	SDG 2 (Zero hunger)	☐	SDG 10 (Reduced Inequalities)
☒	**SDG 3 (Good health & well-being)**	☐	SDG 11 (Sustainable Cities & Communities)
☐	SDG 4 (Quality education)	☐	SDG 12 (Responsible Consumption & Production)
☐	SDG 5 (Gender equality)	☐	SDG 13 (Climate action)
☒	**SDG 6 (Clean water and sanitation)**	☐	SDG 14 (Life below water)
☐	SDG 7 (Sustainable energy)	☐	SDG 15 (Life on land)
☐	SDG 8 (Decent work & Economic Growth)	☐	SDG 16 (Peace, justice & strong institutions)
☐	SDG 17 (Partnerships for the Goals)		

Relevant SDG Targets and Indicators
[Depending on the selected SDG please indicate the relevant target and indicators.]

Target	**Indicator # and Description**	**Estimated % Budget allocated**
3.3 & 3d	**SDG Target 3.3** By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases SDG Target 3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	**100%**

Risk

What risks and challenges will complicate this solution, and how they will be managed and overcome? Please enter no more than 3.

Event	Categories Financial Operational Organizational Political (regulatory and/or strategic)	Level 3 – Very High 2 – Medium High 1 - Low	Likelihood 6 – Expected 5 – Highly Likely 4 – Likely 3 – Moderate 2 – Low Likelihood 1- Not Likely 0 – Not Applicable	Impact 5 – Extreme 4 – Major 3 – Moderate 2 – Minor 1 – Insignificant	Mitigating Measures (List the specific mitigation measures)
Risk1 Description	For health: current political campaign may accelerate spread of COVID-19	Medium	Likely	Major	Sustain sensitization of communities
Risk 2 Description	For health: Operational	Disruption of global supply of PPE	Moderate	Major	Continue procurement and distribution of PPE supplies

Budget by UNDG Categories – Health

Budget Lines	WHO	Total
		USD
HEALTH		
1. Staff and other personnel	**0**	**0**
2. Supplies, Commodities, Materials	**4,320.00**	**4,320.00**
3. Equipment, Vehicles, and Furniture, incl. Depreciation	**25,000.00**	**25,000.00**
4. Contractual services	**39,787.41**	**39,787.41**
5. Travel	**55,292.07**	**55,292.07**
6. Transfers and Grants to Counterparts	**0**	**0**
7. General Operating and other Direct Costs	**6,975.67**	**6,975.67**
Sub Total Programme Costs	131,375.15	131,375.15
8. Indirect Support Costs * 7%	9,196.26	9,196.26
Total	**140,571.41**	**140,571.41**

** The budget does not reflect the costing form SCU and CUAMM as these were already captured under UNICEF. In terms of implementation it means WHO will not disburse funds to these organisations as the funding for items reflected were not funded or reflected in the approved budget*

Signatures

For: WHO **Name:** **Dr. Yonas Tegegn Woldemariam** **Title:** **WHO Representative, Uganda** **Date:** **3 May 2021**	[redacted] 03 May 2021