World Health Organization

WHO UGANDA COUNTRY OFFICE

Annual Report 2020

WORLD HEALTH ORGANIZATION CORE FUNCTIONS

- Articulating consistent, ethical, and evidence-based policy and advocacy positions.
- Managing information, assess trends and compare performance of health systems; set the agenda for, and stimulate, research and development.
- Catalyzing change through technical and policy support, in ways that stimulate action and help to build sustainable national capacity in the health sector.
- Negotiating and sustaining national and global partnerships.
- Setting, validating, monitoring, and pursuing the proper implementation of norms and standards.
- Stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health care management and service delivery.

WORLD HEALTH ORGANIZATION STRATEGIC DIRECTIONS

- Continued focus on WHO's leadership role in the provision of normative and policy guidance as well as strengthening partnerships and harmonization.
- Supporting the strengthening of health systems based on the primary health care approach.
- Putting the health of mothers and children first.
- Accelerated actions on HIV/AIDS, malaria, and tuberculosis.
- Intensifying the prevention and control of communicable and noncommunicable diseases.
- Accelerating response to the determinants of health.

WHO'S MISSION IS TO PROMOTE HEALTH, KEEP THE WORLD SAFE, AND SERVE THE VULNERABLE.

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A WHO staff member educates community members about COVID-19.

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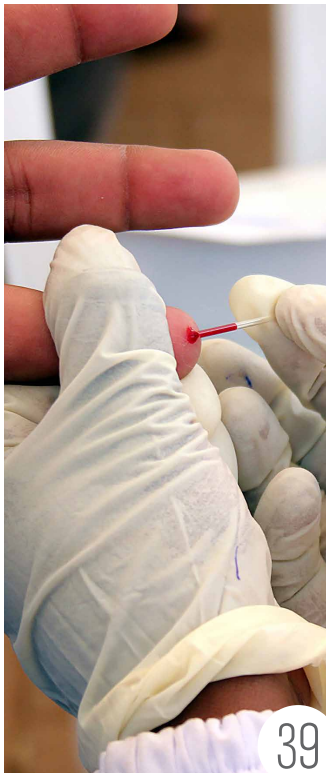

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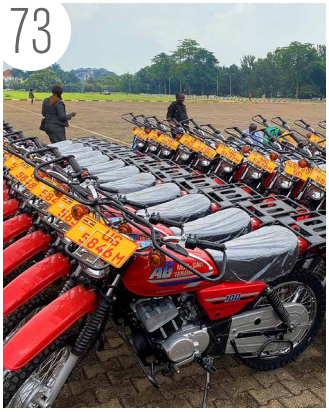

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ACRONYMS

ADPG	AIDS Development Partners Group
AfDB	African Development Bank
AFENET	African Field Epidemiology Network
AFRO	WHO Africa Regional Office
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
API	Application Programming Interface
ARCC	African Regional Certification Commission
ART	Anteretroviral Treatment
BL	Biosafety Level
CBDS	Community-Based Disease Surveillance
CCM	Country Coordination Mechanism
CEHS	Continuity of Essential Health Services
CERF	Central Emergency Response Fund
CFR	Case Fatality Rate
CHEWs	Community Health Extension Workers
CMYP	Costed Multi-Year Plan
CoD	Cause of Death
CRVS	Civil Registration and Vital Statistics
CRS	Congenital Rubella Surveillance
CSOs	Civil Society Organizations
CSU	Country Support Unit
CTU	COVID-19 Treatment Unit
DANIDA	Danish International Development Agency
DFID	Department for International Development
DPC	Disease Prevention Cluster
DRC	Democratic Republic of Congo
DTF	District Task Force
EFRIS	Electronic Fiscal Receipting and Invoicing Solutions
EMR	Electronic Medical Record
EPI	Expanded Program on Immunization
ESPEN	Expanded Special Project on Elimination of NTDs
EVD	Ebola VIrus Disease
FRH	Family and Reproductive Health
GAVI	Global Alliance for Vaccines and Immunizations
GDP	Gross Domestic Product
HBC	Home-Based Care
HC III	Health Centre III
HDU	High Dependence Unit
HMIS	Health Management Information System
HRAPs	Human Resource Action Plans
HSDP	Health Sector Development Plan
HSS	Health Systems
IAR	Inter Action Review
IATI	International Aid Transparency Initiative
ICCM	Integrated Community Case Management
ICU	Intensive Care Unit
IDP	Institutional Development Plan
IEC	Information, Education and Communication
IEHK	Interagency Emergency Health Kit
IDSR	Integrated Disease Surveillance and Response
IICS	Integrated Intelligent Computer Systems
IMCI	Integrated Management of Childhood Illnesses
IMT	Incident Management Team
IOM	International Organization for Migration
IPC	Infection Prevention and Control
IRS	Indoor Residual Spraying
IVD	Immunization Vaccine Development
JUPSA	Joint UN team on HIV/AIDS
KOICA	Korea International Cooperation Agency
LLINs	Long Lasting Insecticide Treated Nets
MAF-TB	Multisectoral Accountability Framework for TB

MCH	Maternal Child Health
MMHF	Mayanja Memorial Hospital Foundation
MNCH	Maternal Child Health
MNH QoC	Maternal New Health Quality of Care
MOV	Missed Opportunities of Vaccination
MRC	Medical Research Council
MSH	Management Sciences for Health
MTR	Midterm Review
NCDs	Non-Communicable Diseases
NHA	National Health Accounts
NIPN	National Information Platforms for Nutrition
NITAG	National Immunization Technical Advisory Group
NMCP	National Malaria Control Program
NMS	National Medical Stores
NPEC	National Polio Expert Committee
NPEV	Non Polio Enterovirus
NSP	National Strategic Plan
NTD	Neglected Tropical Diseases
NTLP	National TB and Leprosy Program
NTF	National Task Force
OCV	Oral Cholera Vaccine
ODK	Open Data Kit
PBB	Program Based Budgeting
PFM	Public Financial Management
PHRCCE	Public Health Risk Communication and Community Engagement
PoCQI	Point of Care Quality Improvement
PoEs	Points of Entry
PPEs	Personal Protective Equipment
PPH	Post-Partum Hemorrhage
PSC	Programme Support
PSEA	Prevention of Sexual Exploitation and Abuse
PSM	Procurement Supply Management
RDT	Rapid Diagnostic Tests
SARA	Service Availability and Readiness Assessment
SDG	Sustainable Development Goals
SGBV	Sexual Gender Based Vaccine/Violence
SMC	Safe Male Circumcision
SOPs	Standard Operating Procedures
SRHR	Sexual Reproductive & Human Rights
TAT	Turn Around Time
TB	Tuberculosis
UAC	Uganda AIDS Commission
UDHS	Uganda Demographic Health Survey
UHC	Universal Health Coverage
UMRESP	Uganda Malaria Reduction and Elimination Strategic Plan
UN	United Nations
UNAIDS	United Nations Programme on HIV/ AIDS
UNAS	Uganda National Academy of Sciences
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIATF	United Nations Interagency Task Force on NCDs
URA	Uganda Revenue Authority
USAID	United States Agency for International Development
UVRI	Uganda Virus Research Institute
VAC	Violence Against Children
VCD	Vector Control Division
VHTs	Village Health Teams
VPD	Vaccine Preventable Diseases
WCO	WHO Country Office
WHA	World Health Assembly
WHE	WHO Health and Emergency
WHO	World Health Organisation
WPV	Wild Poliovirus


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Risk Communication and Infection Prevention and Control Consultants educating nursing students on COVID-19.
PHOTO: WHO UGANDA

FOREWORD

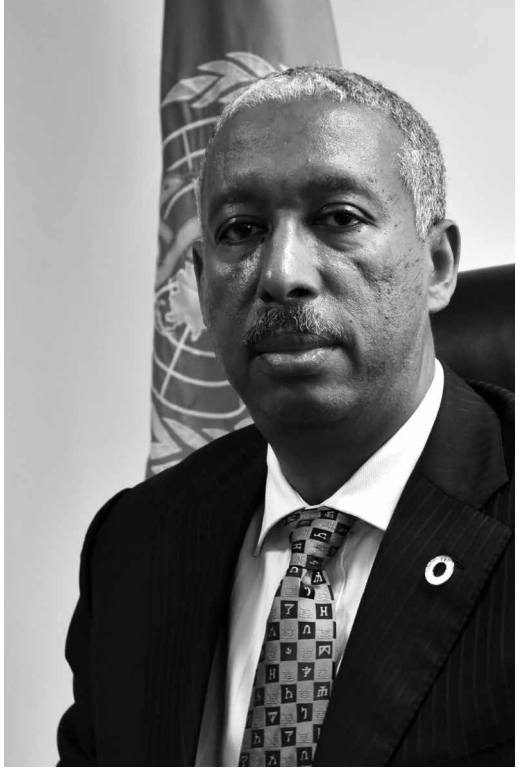
The year 2020 was the most challenging for WHO since the opening of the WHO Country Office (WCO) in Uganda. It was the COVID-19 pandemic year that brought all aspects of life to almost a complete halt. Like other public offices, the WCO was equally affected and had to close for the better part of the year.

Inevitably, the closure affected our operation and support to the country as we put more emphasis on supporting the country to control the outbreak. Working from home did not only require abrupt acquisition of new technologies but was also a new normal to our staff accustomed to physical interactions in meetings, consultations, and guidance as they deliver on their responsibilities.

Suddenly, we had to respond to a fast-spreading deadly epidemic affecting the entire country, not from a central location as we usually do, but from our homes. This was not easy, but as we indicate in this report, we managed to deliver on our technical and logistical mandate of supporting the government of Uganda to effectively respond to the pandemic.

At the same time, we continued to support other areas of wok to ensure that Ugandans do not miss out on the most critical health services despite the pandemic. In this report we highlight our achievements in our areas of work covering Health Systems Strengthening; Health Security and Emergencies; Disease Prevention and Control; immunization, vaccine development, family and reproductive health; and WHO country presence.

In 2020, socio-economic activities including public health were significantly disrupted by the COVID-19 pandemic. However, in this disruption we identified opportunity as we leant to develop coping mechanisms to the new normal including maximizing virtual capacity building, coordination, and integrated programming opportunities. We were able to



continue office work in various programs even in the absence of face-to-face interactions.

We commend our international partners who generously contributed financial resources towards our operations and though these we were able to support government on the COVID-19 response as well as other areas of public health work. This strong collaboration with partners is a game changer especially in disease outbreaks and we shall endeavor to strengthen it as we move forward.

We are also indebted to the frontline health workers including Village Health Teams (VHTs) and community members for the invaluable contribution to COVID-19 outbreak response. It is unfortunate that some of these gallant colleagues lost their lives in the line of duty but their contribution and dedication to save lives are highly recognized and appreciated. We are committed to supporting government develop community-based structures such as the Community Health Extension workers and the VHTs because they are indispensable in our work.

From COVID-19 response we have appreciated the importance of prepositioning supplies in districts that are vulnerable to disease outbreaks. This facilitates easy accesses and expeditious initiation of response to the various emergencies. The same is true for our field presence which we intensified by establishing regional hub office to support districts. From the feedback, we note our field presence provides confidence among responders and stakeholders on the organization and implementation of emergency response activities.

We report on our activities, challenges, lessons learnt and way forward for our office operational clusters. We hope that you will enjoy reading the report and give us feedback on areas we need to improve.

Dr. Yonas Tegegn Woldemariam
WHO Country Representative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HEALTH SECURITY AND EMERGENCY CLUSTER (WHE)

INTRODUCTION

The WHO Emergency program remained pivotal to public health emergencies in the country during the reporting period. Emergency response was undertaken within a delicate context of nationwide containment measures introduced by Government of Uganda to curb COVID-19 spread, and the presidential, parliamentary, and local government election preparations in the later part of the year. Several large-scale public health emergencies including COVID-19, Yellow Fever, Cholera, Measles, zoonotic disease outbreaks and the protracted crisis of refugees were responded to in the country. Below is the summary of the caseload from the emergences as of 31st December 2020.

◀ *WHO staff appealing to student to always observe COVID-19 Standard Operating Procedures.*

PHOTO: WHO UGANDA

Public Health Event	Confirmed Cases	Deaths	CFR
COVID-19 19	35,511	265	0.75
Cholera	1,269	7	0.55
Measles	46	0	0.00
Yellow Fever	8	6	75.00
Rift Valley Fever	4	2	50.00
West Nile Fever	1	0	0.00
Crimean Congo Hemorrhagic Fever	1	0	0.00

Table 1: Caseload from the emergences as of 31st December 2020.

In all the events, WHO undertook its emergencies mandate as enshrined in the Emergency Response Framework including coordination of the health sector response, ensuring that disease surveillance, early warning and response systems are in place, formulating evidence-based health sector response strategies and providing up-to-date information. The other role was to undertake a timely, independent, and rigorous Rapid Risk Assessment and Situation Analysis and promotion and monitoring of the application of technical standards and best practices.

The Main Public Health Events in 2020

The COVID-19 19 Outbreak

Uganda confirmed the 2019 Coronavirus Disease (COVID-19) outbreak on 21 March 2020. Originally, identified in Wuhan, China, the outbreak continued to transmit globally affecting over 60 million people causing more than 1.4 million deaths since its declaration as a pandemic by WHO on 11 March 2020. In Uganda, as of 31 December 2020, the cumulative cases were 35,511 including 265 deaths [Case Fatality Rate (CFR) = 0.75%]. Confirmed cases were identified from 135/136 districts in the country. Local transmission accounted for 94.4% of confirmed cases. In total there were 8 testing centers currently in Uganda. However, testing of COVID-19 was mainly conducted at the Uganda Virus Research Institute (UVRI) and the Central Public Health Laboratories. As of 02 January 2021, 757,764 samples had been tested. Overall positivity rate stood at 4.7%. However, daily positivity rate was above 5% since July 2020.

Descriptive Epidemiology of the Uganda Outbreak

Time

The COVID-19 outbreak continued to follow an exponential transmission pattern in 2020. The transmission followed a propagated pattern depicting widespread transmission foci within the communities. Prior to the lifting of the lock down and easing of several measures, the outbreak was largely contained. Figure 1 below shows the epicurve for the outbreak.

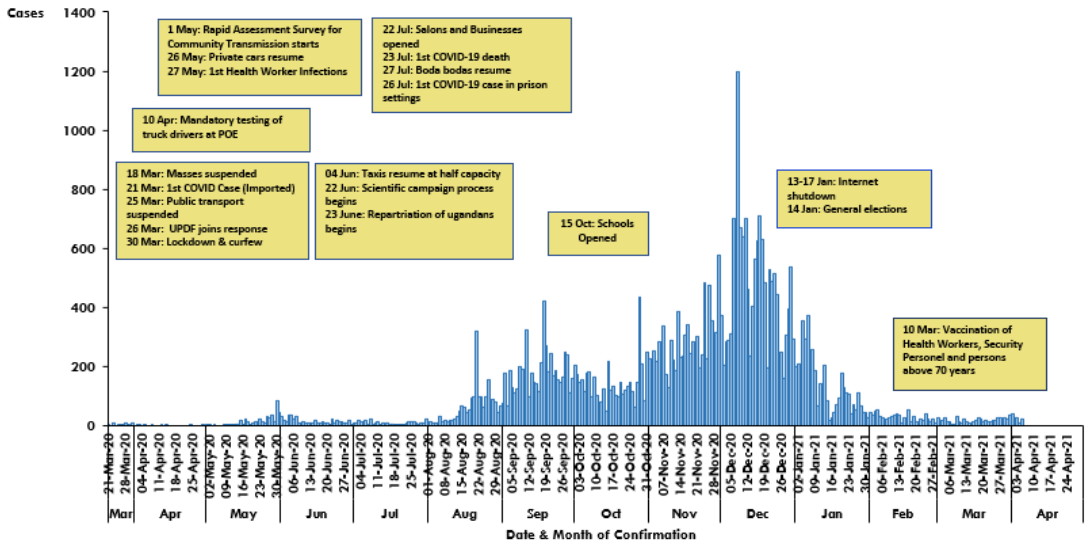


Figure 1. Epidemic curve of COVID-19 outbreak 21 March to 25 November

Initial peaks were observed in May 2020 associated with the clusters at Kasensero fishing village in Kyotera district. Intense actions neutralized the clusters and resulted in a sharp decline and later a sustained low-grade transmission until about 27 June when government opened informal business to resume operations. Since then, there was generally high transmission attributable to congregations in communities, prisons, health care facilities, factories, construction works and traditional social events such as male circumcision in the Elgon sub region. The peaks in November 2020 were associated with cluster of transmission in the schools. The country has observed a significant decline after the cessation of election activities.

Person

Most of the cases were male and among physically active groups. Overall, males were more affected than females (Figure 2). This is because in the early phase of the pandemic, almost all the cases were male truck drivers. Similarly, many cases were reported among factory workers majority of whom were males.

The age group most affected was 26 – 35 years. Reported cases were categorized as 51% alerts, 35% contacts, 5% health workers, 5% travellers, 2% truck drivers and 2% returnees.

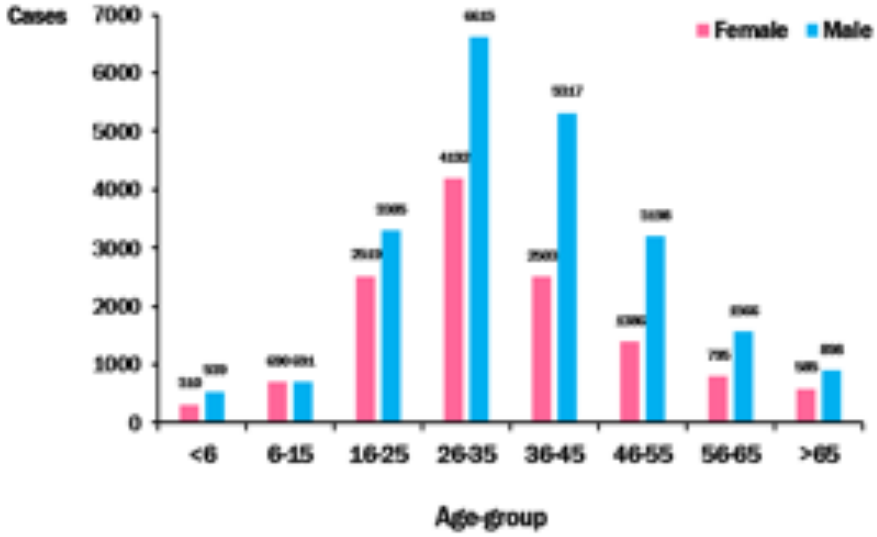


Figure 2: Distribution of cases by age group

A system for contact identification and follow up was set up in March 2020 around all the confirmed cases. As of 02 January, 2021, a total of 48,750 contacts had been identified and listed. Forty-seven thousand one hundred ninety-nine (47,199) of the total completed follow up. The patients found positive were handed over to the case management pillar and were either enrolled in CTU care for those with moderate and severe symptoms or Home-Based Care for those whose symptoms were mild or just asymptomatic. After September 2020, contact tracing was abandoned and so performance dropped well below the WHO recommended of 85% level for identified contacts. Uganda registered the first health worker infection on 27 May 2020. As of 02 January 2021, 1,800 health workers had been infected with 17 deaths. Uganda registered the highest number of health worker infections during last week of November. There was rapid increase in health worker infections which was attributed to non-adherence to IPC measures and overall increase in community transmission.

Place

There was sustained community transmission in at least 120 districts. Most of the districts were in Northern Uganda, mid central region and more recently Elgon, Rwenzori and Bukedi areas. The highest burdened districts as of end of November 2020 are shown in figure 3 below. Transmission pattern shifted from the majority being cases among truckers identified at Points of Entry to contacts of confirmed cases and alerts in the community. This only depicts local transmission.

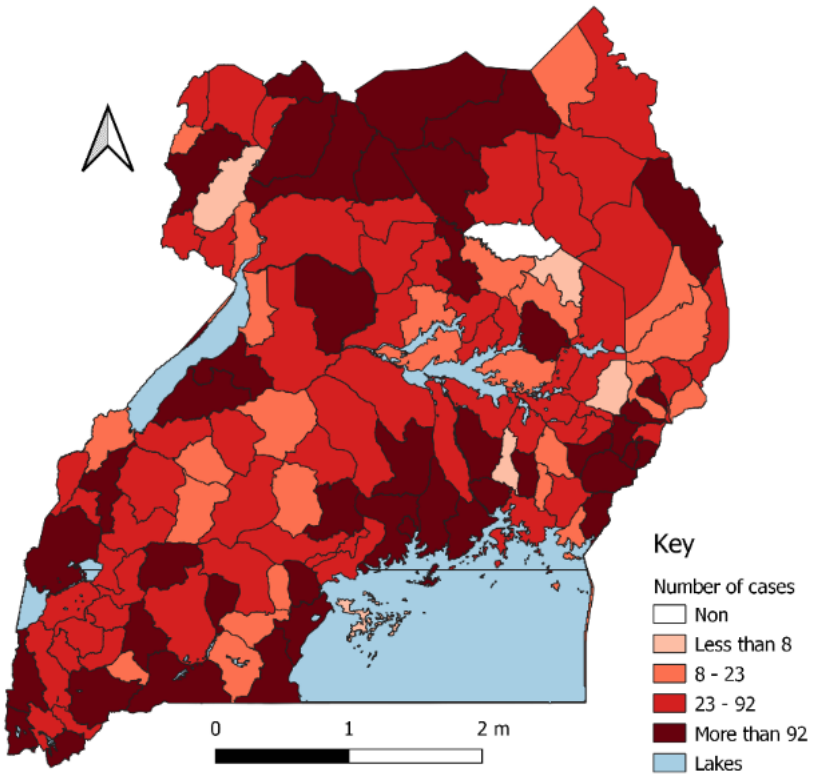


Figure 3: The highest burdened districts as of end of November 2020

Uganda protracted refugee emergency

At the end of 31 December 2020, Uganda was hosting a total of 1,446,378 refugees and asylum seekers. Uganda is the largest refugee-hosting country in Africa, and the third largest in the world, after Turkey and Pakistan. The refugees originate from South Sudan 61.4%, DRC 29.2%, Burundi 3.4%, Rwanda 1.2%, and others 1.6% (Eritrea, Sudan and Ethiopia). The refugees are hosted in 12 districts spread across the country.

Ebola Virus Disease outbreak

Uganda continued with its preparedness and readiness activities to prevent the spill over of the Ebola Virus diseases until the 10th DRC outbreak was finally declared over on the 25 June 2020. The country imported cases and contacts in 2019. On 11th June 2019, Uganda confirmed its 6th EVD outbreak from the spill over which resulted in 4 cases including 04 deaths. The 04 cases generated a total of 123 contacts, these were followed up for 21 days; with none developing symptoms. Vaccination was an essential component of the response with the strategy to immunize contacts, contact of contacts and frontline workers. Seventy-eight (78) contacts, 747 contacts of contacts and 682 front line health workers were vaccinated under the compassionate use protocol.

Overall, the following are the major achievements, challenges, and lessons under the Health Security and Emergency Cluster.

A WHO Risk Communication team member educating Boda Boda riders about COVID-19 PHOTO: WHO UGANDA

WHO Staff having his temperature measured in the field. PHOTO: WHO UGANDA

ACHIEVEMENTS

i. COVID-19 outbreak preparedness and response

Coordination

COVID-19 coordination is undertaken by the Strategic Advisory Committee advised by the Scientific Committee (strategic), Incident Management Team (operational) and District Task Forces (tactical). The IMT is responsible for the day-to-day review of COVID-19 outbreak response at national level. At the district level, coordination is in the hands of the DTF and the Rapid Response Teams. Overall, clearance of the response decisions is done at the National Task Force chaired by Office of the Prime Minister. The following were the main achievements:

- WHO was instrumental in coordination at the strategic, Incident Management Teams and in the districts. At all the levels, WHO provided technical guidance to the Ministry and actors for effective response coordination and technical quality in the response.
- A total of 15 short term staff were recruited and deployed in eight WHO strategic response support hubs including Mbale (02), Gulu (03), Arua (01), Hoima

(01), Rwenzori (02), Masaka (02), South Western region (02) and Kampala/Wakiso (02) with the funding from Irish Aid. In addition, two epidemiologists were engaged to support Kampala and Wakiso for technical backstopping to the Incident Commander and IMT in terms of ensuring that the outbreak response information are well organized and available, Sitreps and presentations are prepared for the IMT meetings. Additional twenty-five (25) short term expertise were hired and deployed to support the districts in quick emergency response using a grant from DANIDA. The staff were deployed strategically in 08 hubs.

- WHO supported the Ministry of Health to conduct the Inter Action Review (IAR). The IAR was conducted from 30 November to 5 December 2020. The IAR employed a "whole of government approach" to assess the country's COVID-19 response thus far. The assessment was conducted at National and at District Level, in eight (8) districts of Amuru, Buikwe, Kampala, Kikuube, Lira, Mukono, Pallisa, and Wakiso. The exercise unearthed the strong dividends obtained from the investments in previous preparedness activities particularly EVD and IDSR which enabled the country to uniformly kick start the response, the efficiency of approaching the response from a decentralised point of view, the innovations to involve communities and key stakeholders in the response from onset and the charismatic leadership offered by government in support of the response. The challenges highlighted included weak linkage of IMT and other coordination structures, erratic supplies of lab reagents, essential patient care commodities and Personal Protection Equipment and problems related to evacuation of severe patients. The review recommended strengthening of the decentralization of the response actions, scaling up the operationalisation of HBC, strengthen supply chain management and improvement of sample shipment arrangements. The others were limitations in contact tracing and inadequate synchronized deployments.

- WHO also supported the coordination of the UN technical team on COVID-19 and conducted regular donor and bilateral partners engagements.

Surveillance

The Surveillance pillar for COVID-19 was organised into Alert Management, Contact tracing, Case investigation, Quarantine, and laboratory and reports to the IMT. There is a central team that supports the districts. The pillar received support from several technical partners. Surveillance was supported by a network of laboratories. Epidemiological surveillance was central in the COVID-19 response. Below were the main achievements:

- WHO assigned dedicated staff at both the national and district level to support the response. Of the total staff recruited, 07 epidemiologists were dedicated to primarily support surveillance at the nationals and district level. The epidemiologists were allocated to Mbale (01), Gulu (01), Arua (01), Rwenzori (01), Masaka (01), and Kampala/Wakiso (02).
- At national and district levels, the epidemiologists conducted orientation of surveillance teams on COVID-19 case detection, setting up of the contact tracing and follow up systems and supported arranging for risk-based testing in the high transmission areas of Mbale, Amuru and Kyotera/Rakai.

- WHO supported the Ministry of Health to conduct case investigations across the country. During the reporting period, the case investigations identified and supported neutralization of at least 06 clusters of transmission in Gulu, Manafwa, Namanve industrial park in Mukono, Aswa power project in Pader district, a major Steel industry in Buikwe district and Moroto Prisons. In all the places, WHO officers worked with the districts to neutralise the clusters through effective identification and follow up of contacts, implementation of quarantine according to government guidelines and Isolation and care of the confirmed cases.
- In all the districts, alert management system was well set up and linked to the case management teams. WHO partnered with AMREF and AFENET to manage the downstream implementation of a robust alert system with the districts. All districts were enrolled and supported to report alerts identified and responded to through the Open Data Kit. Working with the district teams, reporting to national level improved from about 20% of districts in April 2020 to 69% of alert as an the end of November, 2020. In 55 districts, AFENET mobilised 478 RRTs to support alert management set up in all the districts; with alert desks and standby phones. Through this arrangement, AFENET, verified and investigated 81% (37,495/ 46,186) of all the alerts; 369 being death alerts. A total of 3,695 of the alerts had samples collected which turned out positive for COVID-19. In cosmopolitan Kampala, being the country's highest transmission centre, 99 officers were engaged to support alert management. The graph [next page] illustrates alert reporting from the AFENET program.

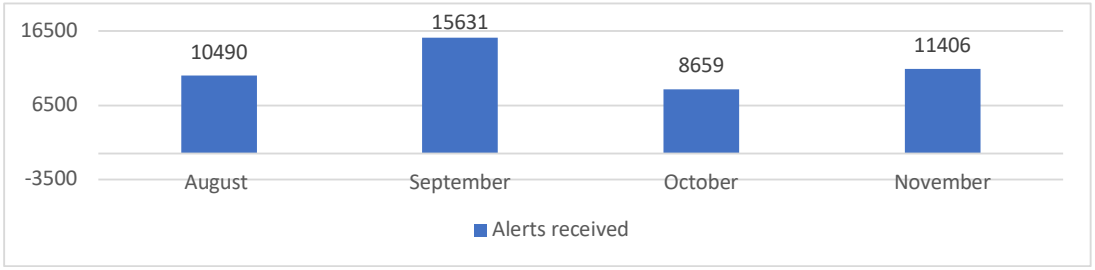


Figure 4: Alert Reporting per month

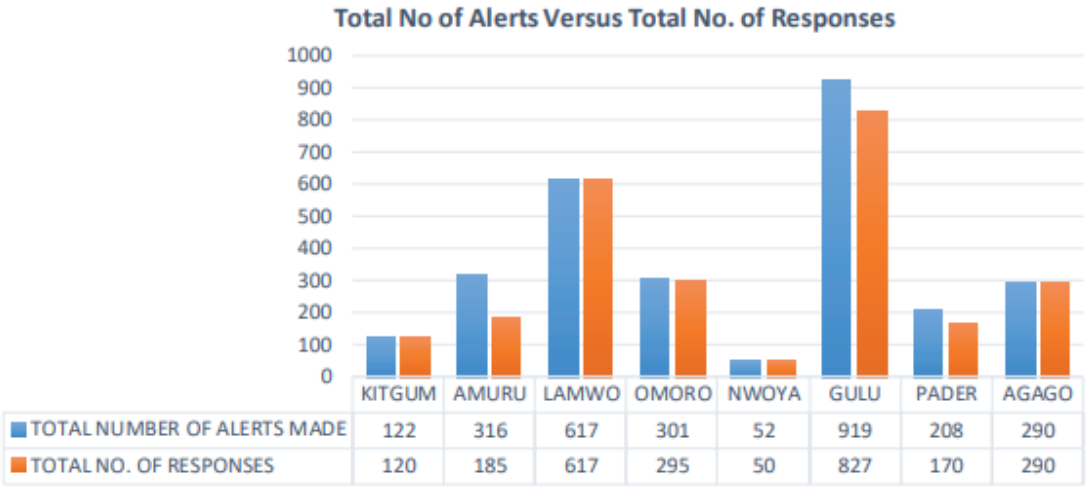


Figure 5: Alert Reporting per month

- In addition, WHO and AMREF supported the 08 districts of Acholi sub region to implement a robust alert management system with funding from DANIDA. Each district was provided with mobile phones loaded with monthly airtime. The districts received furniture comprising of three chairs and one table each and stationery to record alerts coming in from the community. Each district had a team of five Rapid Response Team members to verify and respond to alerts. This led to confirmation of 2,825 (80%) of alerts to be responded to in the Acholi sub-region. The district surveillance focal persons were facilitated with fuel to conduct further investigations and follow up of the alerts.
- Hospital based surveillance was also rolled out to some of the regions, prominent of which was Acholi (Gulu) sub region. However, this was not scaled up due to shortage of commodities, and the subsequent change in testing strategy for enrolment of persons into COVID-19 testing.

- Contact tracing which involved contact identification, listing and follow up was considered critical in the containment phase of the response. WHO worked actively with the Ministry of Health to develop through apprenticeship standby capacity that became core in supporting districts to set up contact tracing for all the exposed person. At the beginning, local responders were largely inadequate in terms of numbers and skills to be able to support the districts to deliver the scale of contact tracing required for the new emergency COVID-19. WHO supported the Ministry of Health with 15 short term hired vehicles each provided with at least 20 litres of fuel per day for a period of 3 months to support contact tracing. Contact tracers received internet data and phone credits to facilitate daily reporting and follow up in Go data system. From May to September 2020, a total of 48,750 contacts were listed and successfully followed up. This accounted for 95 – 97% of the contacts followed up in that period. However, the Ministry of Health changed over to a mitigation strategy and most entities largely abandoned contact tracing despite the successes.

- Turn Around Time (TAT) for results of lab samples was problematic from the very beginning of the response. At the border crossing points of Malaba, Busia, Elegu, Vurra, Mpondwe, Mirama hills and Mutukula among others drivers were required to wait for results of COVID-19 tests before entry into the country. The national transport system for samples was largely outstretched and there was the eminent need to support shipment of samples to the referral laboratories (Uganda Virus Research Institute and Central Public Health Laboratories) located close to the capital of the country. Upon a request from the IMT, WHO provided 12 vehicles (later reduced to six) to support transportation of samples. Six (06) Points of Entry namely Elegu, Mirama Hills, Busia, Mutukula, Malaba and Mpondwe were each supported with standby transport to move the samples to the reference laboratories. The support to the Ministry of Health with transport enabled 228,128 (50.3%) of the total 453,593 sample shipped to the testing laboratories and this arrangement went on up to 31st December 2020.

- A total of 43 points were identified by the country for intensive screening of all the travellers. WHO and IOM supported implementation of a number of interventions to strengthen the capacity of the Ministry of Health to effectively manage the PoEs. The interventions targeted Busia, Malaba, Mutukula and Elegu PoEs. Overall, 36,266 people were screened at the PoEs during the reporting period. Ninety-three frontline responders at PoEs were trained on COVID-19 information management, data capture and reporting. In addition, 07 PoEs received equipment and supplies such Personal Protective Equipment (PPEs), infrared thermometers, and hand sanitizer for the frontline responders, volunteers, facilitator and health promoters working

at the PoEs. At the same time, 12,679 IEC and promotional materials on COVID-19 were distributed to the PoEs and border communities. The COVID-19 messages were adapted to the local context and languages. As a result, 36,266 people who were screened were provided with preventive behaviour messages on COVID-19, hygiene and sanitation at Boarder points of entry thus registering a high success rate.

- In view of the supplies pipeline challenges, WHO partnered with the UK Medical Research Council (MRC) and the London School of Hygiene and Tropical Medicine to procure kits and related accessories supplies adequate to conduct 100,000 tests. The KITS were availed to the Ministry of Health testing centres following an allocation plan endorsed by the Director General of Health services.

WHO staff interacting with soldiers on COVID-19 prevention. PHOTO: WHO UGANDA

Community Engagement and Risk Communication

Risk communication is core to promoting positive behaviour practice and to reduction of risky behaviours. At risk traveller and the public were the main audience for the risk communication. Attention was paid to the sensitization of the various stakeholders with the intention to identify and dispel myths about COVID-19, build consensus on appropriate risk prevention behaviours and promote actions that reduce misconceptions and to ensure that audience supported the response efforts promoted in their communities and country. Below are the main achievements:

- Revised the National Public Health Risk Communication and Community Engagement (PHRCCE) Strategy to focus on increasing community participation.
- Trained Community Health Workers and the Local Council structures in PHRCCE and COVID-19.
- Regularly reviewed and disseminated COVID-19 messages across various media – Radio, TV, print, outdoor and social media.
- Developed SOPs for different audiences and settings.
- Conducted [online and community] assessment to establish people's Knowledge, Attitudes, Practices, and perceptions on SoPs. This informed strategy development and its Implementation.

A VHT member conducting social mobilization against COVID-19 PHOTO: MoH

- Set up and functionalized the Public Risks Communication coordination at national and district levels.
- Engaged stakeholders to support PHRCCE for COVID-19.
- Implemented practical ways to build Community trust (Shift COVID-19 message dissemination from MoH to community influencers; the Queen of Buganda, MTN Uganda a telecom company, celebrities and artists and provided daily press releases. Other interventions include Responsive social media engagement and operation of functional toll-free helplines.
- "Tonsemberera" (Keep a Distance Campaign) was successful multi-media campaign that was implemented to promote COVID-19 prevention and control measures and SoPs.
- Developed and printed assorted IEC material to support risk communication in the field. The materials are broken down as 200,000 posters, 169,000 leaflets 20 pull up banners.
- In the Acholi sub region, WHO supported broadcast of radio announcements and spots on Gulu FM, Tembo FM and Might Fire FM in Kitgum promoting COVID-19 prevention standard operation procedures. Overall, 300 radio announcements and 30 radio spots were aired in the morning and evening daily. By end of November 2020, the broadcasts were complete and approximately 5,810,000 people were reached with the messages in the sub region. This improved responsiveness of the communities in identifying alert cases and reporting them to the health staff.

Case Management

Case management was very central to the COVID-19 response in 2020. The team support patient care through a network of 18 treatment centres and six Non Tradition Isolation Facilities. These included all the regional referral hospitals (Lira, Gulu, Arua, Hoima, Fort Portal, Mubende, Kabale, Mbarara, Masaka, Naguru, Entebbe, Jinja, Mbale, Soroti and Moroto). Additional hospitals included Mulago National Referral hospital, Adjumani and Bombo General Military Hospitals. Non- traditional treatment centres were organised in Nelson Mandela National Stadium (Namboole), three Uganda Prison centres at Gulu, Jinja and Moroto, Aswa Electricity Power dam and Kyangwali refugee settlement. At the end of December, total admissions were 256 in the HDU and 160 in the ICUs. Trained health workers (non-specialists) and specialists were always available to manage moderate and severe cases to achieve desirable patient outcomes. The country has a total of 144 ICU beds with associated equipment but out of these only eight are currently functional. Below were the main achievements:

- WHO hired roving specialist's health workers (03 anaesthesiologists and 02 critical care nurses) to provide on job mentorship and technical backstopping for care at the sub-national level. The specialists covered the regional hospital ICUs where non-specialised staff were trained. The skills gained enabled the health workers to task shift and utilize available equipment in HDU and ICUs.

- WHO also supported the training of 15 health workers (doctors, nurses, paramedics and IPC specialists as well as the Police Air crew) in advanced care and medical evacuation for COVID-19 using the epi-shuttle. Participants were drawn from MoH Emergency services department, IOM, UN clinic, City ambulance, JMEDICC and the Ugandan Police Air Wing. The specialists required equipment to be able to function effectively in the care of the moderate and severely ill patients. Procurement of the WHO device kit (100 patient module) to supplement the centre for care of patients with COVID-19 was also made with a grant from Irish Aid. All supplies were handed over to the Ministry of Health.

- Eleven short term staff were recruited and deployed to enhance provision of care using a grant from Irish Aid. The funding enabled WHO to identify, engage and deploy one competent Incident Commander and nine other specialists including four case management experts, three surveillance, two Risk Communication and one Infection Prevention and Control officers. The case management specialists were deployed in Gulu, Mbale, Hoima and Kampala. The specialists also trained over 3000 health workers on the care for asymptomatic and mild cases in 75 districts that are covered by the WHO hub system.

- In addition, WHO using a grant from DANIDA engaged Makerere University Lung Institute to conduct a training of

A labaratory technician testing a laboratory light. PHOTO: WHO UGANDA

A WHO team member taking Health Centre Workers of Kalongo Hospital through procedure, like vaccine management, temperature monitoring, using fridge tags, correct recording and the use of EPI tools like the Child Register. PHOTO: WHO UGANDA

510 health workers from 26 districts on COVID-19 case management which boosted capacity in these districts to manage COVID-19.

- Availability of essential lifesaving equipment was made possible through funding from DANIDA which enabled WHO to procure 400 oxygen regulators, 1000 non-rebreather bags, 5000 nasal prongs, 65 pulse oximeters and 49 oxygen concentrators. High admission rates and demand for care characterised COVID-19. Demands for more bed space was overwhelming for the response especially towards the end of the year. Therefore, procurement of 130 beds, 100 mattresses, 300 bed sheets and 150 blankets for the Ministry of Health was timely.

- Lifesaving commodities and patient care facilities for COVID-19 response were required at national and sub-national level. Using DANIDA funding, WHO supported the Ministry of Health with essential supplies for use in the intensive care unit of Mulago National Referral Hospital and COVID-19 treatment centres. Four (4) ICU equipment, ten (10) airway breathing management devices, ten (10) airway tubing and filter devices, 31 priority ICU drugs, 12 circulation support and point of care diagnostic supplies were procured. These supplies contributed immensely to improved care of the severe and critically ill COVID-19 patients at Mulago hospital and in the country. In addition, assorted supplies for patient care and IPC were procured and distributed to all the 14 regions.

- WHO also supported the Ministry of Health to conduct Ambulance referrals working in partnership with AFENET. A total of 131 ambulances were deployed to evacuate suspect cases during alert management operations. The ambulance evacuations were distributed as follows Bududa (10), Kaabong (4), Mbale (10), Masaka (14), Rakai (7), Kalangala (2) and Wakiso (80).
- WHO and AMREF supported Kitgum, Lamwo, Nwoya, Pader, Agago and Gulu districts in the Acholi sub region to operationalise ambulance service for COVID-19. This was made possible through a funding from DANIDA and under this support AMREF working with WHO field IPC technical team oriented the local ambulance teams. A total of 28 (23 male and 05 Female) officers were equipped with knowledge and skills in handling highly infectious cases in preparation for evacuation. The ambulance teams were able to evacuate 1623 positive cases to Gulu, Namboole and Mulago hospital treatment care centers for further management. The Gulu Regional Referral Hospital (GRRH) ambulance team evacuated 21 cases from the 8 districts to GRRH and to Namboole treatment centers.
- With funding from DANIDA, WHO procured four heavy duty washing machines which were installed at Gulu, Mbale, Lira and Soroti referral hospitals to reduce the risk of nosocomial infections through handling of linen.
- COVID-19 care generated a lot of waste posing a potential risk for health facilities already challenged with waste management. WHO and Baylor College of Medicines Children's Foundation using a grant from DANIDA constructed and installed four (4) MAK IV model incinerators at Tororo Hospital and at Malaba, Mutukula and Busia PoEs and at Soroti Regional Referral hospital. At all the sites, operators were trained and equipped for the job.

ii. Consolidation of Ebola Virus Disease (EVD) readiness interventions in high-risk districts

Coordination

- WHO maintained active field operational presence in eight hubs (Mbale, Moroto, Gulu, Arua, Hoima, Rwenzori, Rukungiri, Masaka and Kampala City Council Authority) providing support to over 84 districts with funding support from AfDB. The hubs were staffed by short term consultants; one epidemiologist, Risk communicator, IPC, case management and district coordination consultants. From the field hubs, districts within the regions were actively reached whenever required, implementation of public health actions were technically supported, and districts were provided with needed commodities. The field team actively supported each of

the district response pillars to maintain a robust preparedness throughout the active and transition phases of the outbreak. All alerts were promptly enrolled, verified and resolved based on set criterial for all EVD related events. In at least 70% of the district, EVD preparedness plans were discussed and finalised and approved by the DTFs. Most of the DTFs were well mobilized and remained functional and or were readily available to convene at short notice in case of any suspected EVD events. All the technical teams had pillar members assigned, trained and were readily available to deploy at short notice in case of an EVD event. At national level, NTF continued to be supported to review the EVD situation in the high-risk districts from time to time.

The Nabagereka (Queen) of Buganda Kingdom helped to mobilize people for action against COVID-19 under tthe Tonsembelera (Don't come near me) campaign

An elderly man displays his card after receiving the Yellow Fever vaccine. PHOTO: WHO UGANDA

Infection Prevention and Control

In partnership with WALIMU and funding grant from African Development Bank (AfDB), the following achievements were made:

- Six trainers were mobilized and deployed to instruct at each of the 14-training site to deliver a tailored training curriculum *'Triage, Emergency care and management of Severe Illness in the context of COVID19 and EVD'.* A total of 420 health workers were trained in the 14 regional hospitals: Moroto, Mbale, Soroti, Gulu, Lira, Mubende, Hoima, Masaka Fort Portal Mbarara and Kabale, Arua, Jinja and Naguru.

- The high-risk districts of Kasese, Bundibugyo, Ntoroko, Bunyagabu and Kasese were provided with one comprehensive Interagency Health kit each enough to support 30,000 people for 3 months. Another five supplementary Interagency Health Kit and 20 Malaria kits were procured and distributed to the high-risk districts.
- WHO set up and operationalized triage in 14 regional hospitals as seen in the picture below from the Hoima Regional Referral Hospital triage tent. Drills in all the 14 regional referral hospitals were also undertaken.
- Three emergency deployable tents that were previously installed at Bwera and Bundibugyo hospitals and at Rwebisengo HC III were refurbished. The works involved partitioning, improving aeration, renovation of ablution facilities such as latrines and bathrooms and repair of the fencing.
- In addition, WHO and Baylor College of Medicine Children's Foundation with funding from AfDB installed two incinerators (Gulu and Moroto Regional Referral Hospitals). The incinerators were commissioned by Honourable Dr. Joyce Moriku Kaducu, Minister of State for Health).

Surveillance and alert management

- WHO and WALIMU in collaboration with the Ministry of Health supported Wakiso and Kampala districts to train 62 health workers on Community-based Disease Surveillance. Overall, 751 VHTs Kampala (341) and Wakiso (410) underwent a three-day training.
- WHO and Mayanja Memorial Hospital Foundation (MMHF) implemented a VHT follow up program in the Rwenzori areas under which 1,814 VHTs were followed through 108 meetings. A total of 156 health workers were oriented as supervisors and on the operation of the Open Data Kit in Kasese, Bundibugyo and Ntoroko districts.

COVID-19 Infection prevention and control targeted health education for clients at the antenatal clinic in Padibe HC IV, Lamwo district.
PHOTO: WHO UGANDA

iii. Cholera outbreak in Karamoja sub region

Karamoja is located north-east of Uganda and is about 512 Km from Kampala. It is largely semi-arid and inhabited by nomadic pastoralists with no permanent households or toilets. The last outbreak in the region was in 2018 in Moroto with a handful of cases. On this occasion, following vandalised solar water pumps in Moroto village, residents used a lot of pond filtered water and reportedly used water in reservoir meant for their cattle.

Cholera outbreak was confirmed on 16th May 2020, however on 28th April 2020 index suspects from Natapar Kocuc village, of Loputuk Parish, Nadunget sub-county, Moroto district, Karamoja region were admitted. The outbreak spanned 4 districts including Moroto, Napak, Nabilatuk and Kotido. The region experienced two Cholera outbreaks in four out of the nine districts in the sub region with 1614 (CFR=1.1% -18/1614).

From the outbreak investigation, use of contaminated water in ponds was the environmental source of the vibrio cholerae. Reactive OCV vaccination amidst COVID-19 helped curb the outbreak in June and August 2021.

Descriptive epidemiology of the Karamoja outbreak

Time

Two outbreaks one from 28th April to 27th October and a brief one from 28th November to 3rd December 2020 were recorded. They were propagated outbreaks with the highest peak occurring on 15th May 2020. Between 16th May and 20th June, Moroto, Nabilatuk and Napak which were more affected recorded reduced cases as indicated in the combined epicurve. By 14th November 2020, there were no cholera cases recorded in the region indicating that the outbreaks had been successfully controlled.

Place

The index case for first outbreak was a 27-year-old lady from Natapar Kwangan village, Loputuk parish, Nadunget sub-county, Moroto district. Overall, 24 cultures were positive (7 Moroto, 11 Nabilatuk, 2 Napak, 4 Kotido) tested form the Central Public Health Laboratory (CPHL).

For the second outbreak, the index case was a 31-year-old female from Nachuka village, Lotirir parish, Nadunget sub-county, Moroto District who was seen at Lotirir HCII on 28th November 2020 with Acute Watery Diarrhoea (AWD). She was treated at Loputuk HCIII as a suspected Cholera case and improved. When two of her of household contacts were referred to Loputuk CTU the next day, this cluster of cases was reported to WHO and district authorities who together with the health facility staff tested the suspects using the Cholera RDTs.

Another four people were admitted on 30th November 2020 and they tested positive on the RDT. A total of 110 contacts from three villages were identified and followed up from 2nd December 2020. Samples were taken off and tested the CPHL on 3rd December 2020 with results indicating negative (No culture growth) as the patients had taken antibiotics.

Person

Children under 5 years were predominantly affected. Overall, males were affected more than females as well as mothers aged 20 to 34 as well as grandmothers above 60 years. There were 18 deaths of which 10 occurred in Kotido and of those six were community deaths. Moroto had six deaths of which three were community deaths. Four of the 18 deaths were children under 18 years and 11 were women.

iv. Response to Floods

Through CERF rapid response allocation, WHO and its partners provided emergency lifesaving services to 160,103 individuals who were affected by floods. Overall, 49,924 patients received emergency outreach services, that is, 17,764 in Bundibugyo, 15,122 in Bududa and 17,038 in Sironko districts. The Village Health Teams (VHTs) treated 47, 681 patients using the Integrated Community Case Management (ICCM) and 62,498 individuals benefited from the Oral cholera vaccination exercise.

In addition, the project empowered 2,491 VHTs to manage ICCM (1771) and 720 for community disease surveillance. Through these VHTs, a total of 21,591 patients were assessed and referred by the VHTs. This averted undesirable outcome which could have resulted from late or none seeking of care for the children.

A total of 7000 Long Lasting Insecticide Treated Nets were distributed to expectant mothers in the facilities in the floods affected areas. This contributed to protection of the mothers and their children from Malaria. The following activities detailed in the table below were implemented in response to the floods emergency.

Table 2: Support to Flood Affected Districts

Orientation of VHTs on Community Based disease Surveillance.	All 600 VHTs were trained and supported to conduct community surveillance.
Procurement of cholera kits.	Five (05) cholera kits were procured and dispatched to affected districts.
Oral cholera vaccination exercise.	Coverage of 80% of the population was achieved.
Conduct emergency outreaches.	216 EMOs (72 in each district), serving 49,924 patients (17,764 in Bundibugyo, 15,122 in Bududa and 17,038 in Sironko).
Deployment of surge of health staff.	Staff were recruited and deployed in Rwenzori, Mbale area.
Procurement of (LLINs, IEHK, Trauma, beds).	Distribution of 05 Trauma kits, 130 Beds was done
Supervision and monitoring of activity implementation.	Supervision was done in all the districts.

v. IHR (2005) implementation

- Integrated Diseases Surveillance and Response 3rd Edition roll-out was initiated with the adoption of technical guidelines and training materials. A working group to rollout the strategy was formed with active participation of WHO. Funding was secured to for implementation to start in 2021.
- WHO supported Ministry of Health to train and facilitate 714 Rapid Response Teams across the 136 districts. They were trained by 36 National Rapid response Teams trainers as part of the sustained capacity building for public health emergency response in the districts.
- The MoH developed plans for Pandemic Influenza Preparedness and vaccine deployment. The plans will enable the country to implement the non-pharmaceutical interventions that are the lifeline of care before vaccination.

vi. Refugee Emergency

- Through CERF funded window, WHO and its partners provided critical assistance to over one million beneficiaries by averting avoidable mortality due to the various ailments in the refugee settlements. The funding enabled the training of 470 Village Health Teams on Community Based Surveillance and electronic reporting. Additional aspects addressed by the grant included alert management for all emergencies, critical gaps in IPC practice and requirements in the health facilities, building of two incinerators in Lamwo district and provision of lifesaving commodities and logistics. SARA survey was also conducted to guide responders to tailor humanitarian responses to the needs of the affected population.

CHALLENGES

- COVID-19 outbreak disrupted implementation of many WHE programs and affected timeliness of response to some of the outbreaks especially Yellow Fever, Cholera and Measles.
- Overall, commodities for emergency response were in short supply which resulted in very long lead time of up to 8 months and piecemeal deliveries.

- National and district coordination systems were overwhelmed by the requirement for protracted response. In some of the situations, new coordination structures were created but not synchronized across board.
- Existing outbreak response systems were largely abandoned during the COVID-19 response which created a system in which local responders had to work with hurriedly set up structures which were not efficient.
- There was overwhelming demand on WHO to deploy technical expertise to support sub-national response activities.
- Over reliance on other partners for warehousing created limitation on access to commodities at critical moments and temperature control challenges in some of the stores. This resulted in scattering commodities and supplies to various places which increased handling and storage costs.

LESSONS LEARNT

- Catalytic funding of selected core activities is critical in ensuring prompt initiation of emergency response.
- Strong partnerships between WHO and the local donor partners is core to the mobilization of resources for the various emergencies.
- Availability of prepositioned supplies readily accessible by the Ministry of health enables expeditious initiation of response to the various emergencies. This provides confidence among stakeholders on organization of emergency response.
- Strategically located field presence allows effective on-site support to districts on a sustained and regular basis. This improves the quality and results of emergency public health response at the sub-national level.

RECOMMENDATIONS

- WHO and partners should support the Ministry of Health to develop and implement a post COVID-19 transition intervention plan. The plan should be informed by a robust After-Action Review of the response.
- WHO should maintain selected field hub offices staffed by multi-skilled emergency staff able to quickly support sub-national public health emergency response.
- WHO should identify and hire a warehouse that is easily accessible at all times and spacious to enable efficient inventory management.
- WHO should explore innovative ways to field fleet management.
- WHO and partners should support the Ministry of Health to review the mapping of the cholera hotspot areas based on the experience and achievements of 2020.

The Burial Team burying a person who died of COVID-19 in Masaka district.

PHOTO: WHO UGANDA

2

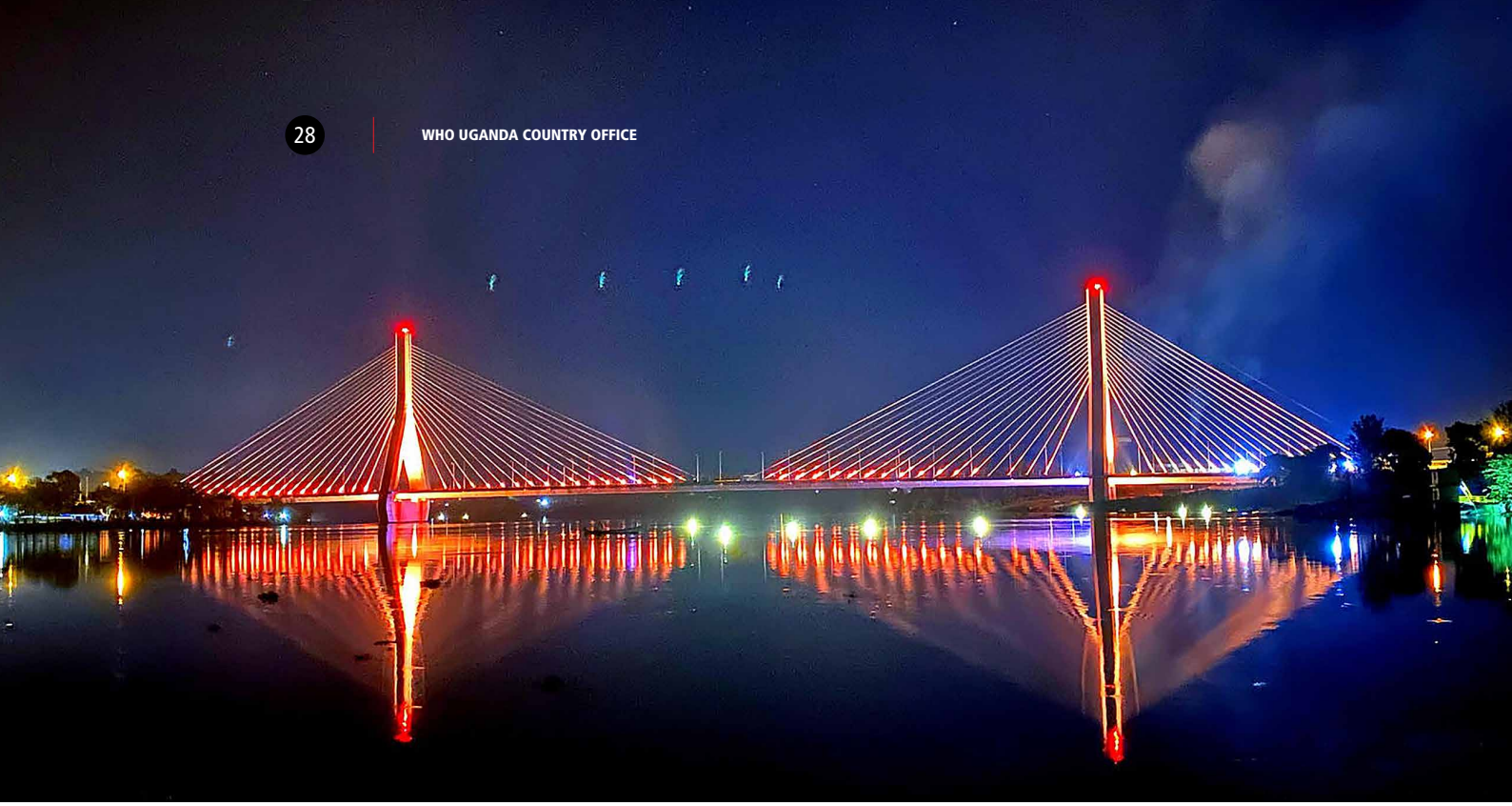
HEALTH SYSTEMS STRENGTHENING CLUSTER (HSS)

INTRODUCTION

The HSS cluster aims to support the strengthening of the health system for effective, equitable and quality health service delivery. WHO undertook to support national efforts to build a resilient health system able to deliver Universal Health Coverage (UHC) by protecting human life and producing good health outcomes. In 2020, under the Health Systems Strengthening Cluster the WHO Country Office achieved the following towards attainment of UHC.

◀ *Physical activity promotes good health and growth.*

PHOTO: WHO UGANDA



The Jinja bridge was lit in 2020 in commemoration of World Patient Safety Day. PHOTO: WHO UGANDA

ACHIEVEMENTS

i. Health Technologies and Commodities

- Strengthened the Ministry of Health leadership and governance of the Pharmaceutical Sector by undertaking the review and updating of the National Pharmaceutical Sector Strategic Plan for 2020/21 to 2024/25, which is the tool that not only provides direction to but also galvanizes partners around a common purpose.
- Improved access to medical products that were deployed for the COVID-19 response by providing technical oversight to national forecasts and quantification and also actively engaging in the logistics pillar deliberations.
- Strengthened the national medical products regulatory function by providing technical support to the development of the Institutional Development Plan and following up on its implementation. The IDP was developed following a WHO assessment of the capacity regulatory functions during the preceding year.
- Strengthened the Ministry of Health leadership and governance of the health sector by providing technical inputs to the development of the Health Sector Development Plan II for the period 2020/21 to 2024/25. This tool provides the overall strategy and direction for the health sector.
- Promoted coordination of partners through providing technical and administrative support to maintain the secretariat of the health development partners' group.

ii. Health Promotion and Public Information

- Throughout the year, WHO was at the center of COVID-19 outbreak and Health Promotion (Risk Communication) was fully repurposed as one of the major response pillars within and outside the office. In that capacity, WCO was fully represented on the National Risk Communication subcommittee of the Incident Management Team (IMT).
- Through these subcommittees the office contributed to the drafting and implementation of the Risk Communication Response Plan under which a number of activities were technically supported, funded or directly implemented. The important behaviours promoted that contributed to the significant reduction of COVID-19 cases towards the end of the year were: regular hand washing with soap and water, correct and consistent wearing of masks, physical distancing and early seeking of medical care.
- Direct community engagement was central to WHO support and for this, the office recruited and deployed ten risk communication consultants who helped districts to strategize for community engagement leading to desired results. The consultants managed to orient and involve community structures such as VHTs on COVID-19 in addition to identifying high risk individuals, communities and settings for action.
- The office actively participate in the development of Information, Education and Communication (IEC) materials that were successfully used in the COVID-19 response. These included posters, leaflets, fact-sheets, talking points, question and answer booklets, horizontal banners, pull-up banners, Standard Operating Procedures, radio spots and announcements as well as television messages.
- Aside from COVID-19 the office worked with the ministry of health to plan the piloting of the Community Health Extension Workers (CHEWs) project that will be done in four districts, i.e. Mayuge, Lira, Kyotera and Kabarole starting in 2021. This work involved preparation and finalization of plans, documents, and budgets.

A Village Health Team Member mobilizing communities against COVID-19. PHOTO: WHO UGANDA

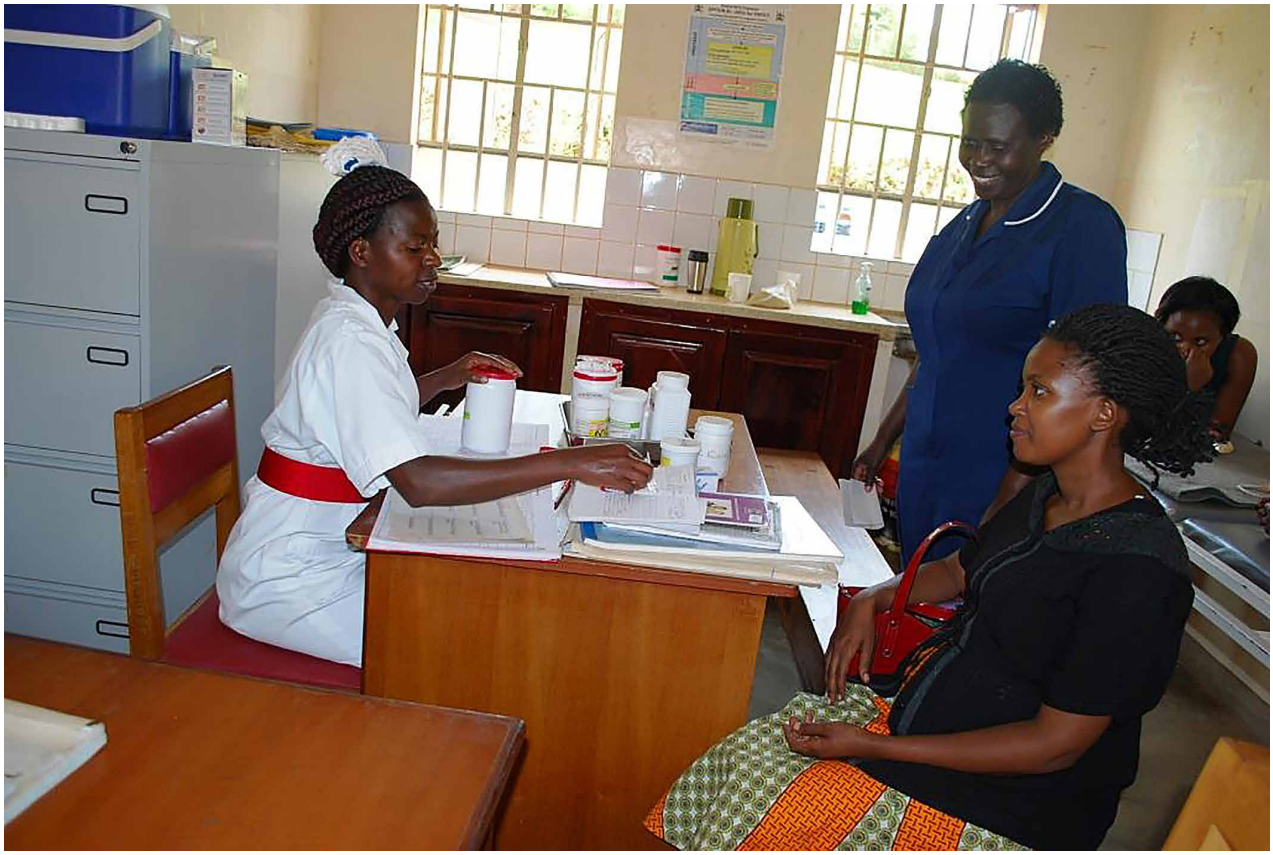
- Public information for WHO visibility was undertaken with production of bulletins, website content and consistent presence on social media. A number of short high-impact videos as well as visibility materials were produced and distributed to field teams, partners and stakeholders to enhance WHO visibility. Particular emphasis was put on highlighting WHO field contribution on COVID-19 and regular briefing of journalist to enable them report accurately on the outbreak.

A WHO risk communication team member answering questions on COVID-19 on a community FM radio station in Hoima district.
PHOTO: WHO UGANDA

iii. Analysis, Use and Access to Routine Facility Data

- Supported routine analysis of administrative facility data to inform early detection and response to epidemics, periodical monitoring of sector programme performance, including informing quarterly and annual sector performances.

- Strengthened the country capacity to improve the quality of mortality statistics in the context of COVID-19. This was done through a virtual regional training, in which key principles, terms and processes for medical certification of cause of death, ICD-11 and verbal autopsy were explained; how to use the WHO medical certificate of cause of death to assign the cause and events leading to death; use of the online ICD-11 browser and coding tool to accurately code diagnoses of diseases and of cause of death; and the use of the verbal autopsy tool to assign a cause of death.



A nurse gives out medicine to a patient at Masaka Regional Referral Hospital. PHOTO: WHO UGANDA

- Convened a country team, comprising of the Ministry of Health, the National Identification and Registration Authority and the Uganda Bureau of Statistics to conduct a rapid assessment on the status of implementation of WHO-FIC in Uganda. The rapid assessment tool highlighted the status of CRVS in the country, areas that were performing well and those that needed improvement. These included the completeness and functioning of CRVS; cause of death (CoD), reporting and generation of statistics.

iv. Monitoring Service Availability, Quality and Effectiveness

- Worked with MoH to develop a Monitoring and Evaluation Framework and Plan for the Health Sector Development Plan 2020/21 – 2024/25.
- Conducted a service availability and readiness assessment (SARA) to assess service delivery, availability (diagnostics, essential medicines, infrastructure and other resources) and readiness of health facilities to provide basic healthcare in seven refugee hosting districts in Uganda. This followed an influx of refugees that presented various challenges on service delivery in the refugee-hosting districts.

v. *Health Financing*

- WHO provided technical support to cost the 5-year Health Sector Development Plan II (HSDP II) using the One Health Tool and built capacity of MoH staff in the planning department on the use of the tool.

- As a member on the national taskforce, WHO participated in the development of the health financing transition and harmonization plan. This is critical as Uganda intensifies efforts to increase domestic resources appropriated to the health sector given the noted declining trajectory of financial support from development partners.
- Conducted the 8th cycle of the National Health Accounts (NHA) covering the FYs 2016/17, 2017/18 and 2018/19. The NHA is an essential exercise for evaluating and documenting a country's health financing landscape. The NHA allows for policy makers to track available resources in the health sector right from the source of these resources, to the financing agents, to the providers of the services (health care providers) and ultimately to the beneficiary population. This information is very central in planning and advocacy to enhance the performance of the health system.
- Developed a report on the Institutionalization of National Health Accounts in Uganda which will inform development of a guideline to institutionalize the NHA for the AFRO region.
- Provided technical support to comprehensive health sector budgeting and planning which was very helpful in advocating for an increased allocation of the national budget to the health sector especially in light of the COVID-19 pandemic.

A woman gets her blood pressure taken. PHOTO: WHO UGANDA

- With support from GAVI PEF, conducted a study to estimate the cost of introducing TB vaccine booster doses. This information is very crucial in guiding the discussion on which new vaccines should be prioritized for introduction into the country.
- Performed an assessment of the Program Based Budgeting (PBB) Public Financial Management (PFM) reform in Uganda with support from WHO/HQ. This assessment was very critical as the government of Uganda has officially transitioned from output-based budgeting to program based budgeting. The assessment will be a reference document for the health sector during this transition.
- Participated in the performance review of the EPI program in Uganda including the coordination of the development of a costed muliti-year plan (cMYP) for the immunization program. The cMYP is an essential tool to guide planning and advocacy efforts for the immunization program.
- Peer reviewed the costing and financing sections of National Deployment Vaccine Plans for seven countries in the East and Southern African Region for the COVAX facility. This was a very key exercise to ensure that countries had accurately estimated the required resources for their plans to receive and administer vaccines for COVID-19.
- Worked with other UN agencies to develop the UN Sustainable Development Cooperation Framework for 2020/21 – 2024/25 and the UNSDCF joint workplans.
- Participated in the development of the UN Socio economic impact assessment for COVID-19 report for Uganda. This socio-economic impact assessment will guide efforts to address the socio-economic challenges that resulted from the COVID-19 pandemic.

vi. eHealth

- Deployed digital health innovations such as GoData and ODK, to support of COVID-19 response. These are open source, online tools which are used on desktops and mobile devices. The tools are gradually replacing the use of paper forms and have enhanced data collection with additional capabilities such as validation, in turn improving preparedness and response.

- WHO provided technical and financial support to the integration of ICD-II coding tool/module in DHIS2. Application Programming Interface (API) were integrated in Electronic Medical Record (EMR) software (i.e. Integrated Intelligent Computer Systems, IICS) and in the health management information system software (i.e. DHIS-2) in Uganda. Within the African region, Uganda is one of the countries spearheading EMR and DHIS-2 deployment and the Ministry of Health is actively involved in ICD-11 implementation preparation.

vii. Human Resources for Health and Library Services

- Supported the Ministry of Health to write the Human Resources for Health Strategic Plan 2020-2030
- Strengthened the resource centres of three Regional Referral Hospitals with books and other reading materials under the Book Aid Project.

- Provided UN-Wellness services to staff focusing on psychosocial counselling, engagement with staff association to ease access to services during the COVID-19 pandemic and organising learning sessions for staff and families to promote social interaction during lockdown.

CHALLENGES

- The advent of the COVID-19 pandemic resulted in change of focus and prioritization of other planned activities. This affected implementation of planned activities and achievement of results.
- The pharmacovigilance program is still suffering from low reporting rates. Although there was an improvement, we continue to observe low reporting rates of adverse events resulting from use of medical products by patients, and hence hampering of detection of signals thresh holds.
- Due to fear of the risk and poor compliance to the government Standard Operating Procedures for prevention of COVID-19, physical meetings were disallowed thereby resorting to virtual engagements. This new way of working was not something majority of people were accustomed to thereby having impact on speed of implementation of activities.
- No real increases in health expenditure. There is low and stagnant share of health expenditure as a proportion of GDP.
- There are multiple arrangements for pooling of resources, with overlaps arising in financing of the services leading to inefficiencies in resource pooling and management arrangements.
- The abrupt closure of the office due to COVID-19 outbreak disrupted implementation of many health promotion activities across all programmes. While the closure was necessary it however slowed the office on programmes such as malaria, tuberculosis, HIV/AIDS and NCDs which require a lot of health promotion support to effectively deliver services.
- Health promotion continued to be underfunded leading to dependency on programmes for its interventions. Very often this approach compromises integration and synergy which health promotion can promote given its cross-cutting nature.

- Inadequate health promotion technical support affected implementation of activities especially in the Ministry of Health. This also slowed down WHO work as the available staff were either overstretched or simply not available for the required collaboration.
- The pandemic led to a general drop in the timeliness and completeness of HMIS reporting, especially in the months following the lockdown.
- The pandemic and the ensuing change in working modality have affected the implementation of the 7th Uganda Demographic Health Survey (UDHS). The UDHS is a key source of data needed to monitor and evaluate population, health, and nutrition programmes on a regular basis. By the end of 2020, the initial preparations which had started early in the year, had not resumed.

LESSONS LEARNT

- Health system strengthening activities should be cognizant of vulnerabilities and purpose to make them resilient to effects of disease outbreaks.
- Reporting of adverse events following use of medical products may not improve given the demand of multiple reporting requirements by health care workers in health facilities.
- Office work in various programs can still continue even in the absence of face-to-face meetings. This was well demonstrated with the work done on COVID-19 during the national lockdown and subsequent closure of the office. The challenge is in keeping participants effectively engaged and on building consensus.
- It is critical for WHO to support government develop health promotion structures especially the Community Health Extension workers and the Village Health Teams because they are indispensable during response to disease outbreak as demonstrated during the COVID-19 outbreak.
- Deploying WHO supported staff or consultants in the field has a lot of public health benefits because they are able to support government and districts respond to health issues in real time and are an invaluable resource to districts that have dire human resource constraints.
- Regular documenting and sharing of the contributions and best practices on WHO's community work has tremendous potential to contribute to visibility and resource mobilization efforts of the office.

WAY FORWARD

- WCO will strengthen MoH leadership and coordination role in the pharmaceutical sector, provide technical input to the development of National Drug Authority five year costed strategic plan, strengthen the national pharmacovigilance system and promote appropriate use of medical products. Support will also be provided to improve reporting of safety on medical products, governance of health products as well as promote best practices.
- In health financing, the WCO will support operationalization of the transition and harmonization plan for the health sector; development of resource mobilization strategies for disease specific and sector wide programs; institutionalization of the National Health Accounts; and assessment of the health financing strategies in Uganda using the WHO health financing matrix. Other areas of focus will be institutionalization for tracking financial risk protection indicators, conduct programmatic efficiency analysis for 5 health programs, and development of program specific investment cases.
- In health promotion and communication WCO will strive to invest in virtual working modalities and technology, support government to invest in the development of community health structures (CHEWs and VHTs) and to maintain presence in regions and districts for visibility and quick response to public health challenges. Regular documentation and sharing of WHO best field practices in print, film and photography will also be prioritized.
- Under analysis, use and access to Routine facility data, WCO will assist MoH to finalize the Health Information and Digital Health strategy; strengthen the national capacity to monitor and evaluate health sector performance; support integration of digital technologies into the health system; development of interactive data visualization tools; and train clinicians on ICD-11, verbal autopsy, classification of CoD and reporting.

Eating plenty of fruits and vegetables promotes good health. PHOTO: WHO UGANDA

3

DISEASE PREVENTION AND CONTROL (DPC) CLUSTER

INTRODUCTION

The COVID-19 pandemic greatly affected implementation of activities across all WHO Country Office (WCO) clusters. The inevitable closure of the offices, restriction on movements, meetings interactions and the nation-wide local down halted implementation and hence the expected achievement of results. Despite the COVID-19 challenges, the WCO through the DPC cluster that is comprised of the Malaria, HIV, Hepatitis, and STIs; Tuberculosis; Neglected Tropical Diseases; Non-Communicable Diseases; and Population Health and Environment programmes managed to make the following achievements.

◀ *A medical personnel draws a blood sample to test for infections.*

PHOTO: WHO UGANDA

Hon Minister of Health Dr Jane Ruth Aceng and WHO Dr Yonas Tegegn Woldemariam, at the launching ceremony of the UPFM Strategic Plan. PHOTO: WHO UGANDA

ACHIEVEMENTS

i. Policies, Strategies and Guidelines

- Supported the development, adaptation and dissemination of several plans, strategies, tools, manuals, and SOPs for disease prevention and control. These include National Strategic Plan (NSP) for TB for 2020/21-2024/25; the National Multisectoral Accountability Framework for TB (MAF-TB); the National HIV/AIDS Strategic Plan 2021/2022-2025/2026; the Tobacco control strategic plan 2021-2025; the Mental Health strategic plan 2020/2025; and the draft National Cancer Control plan 2020/2025.

- Supported the Ministry of Health (MoH) to conduct the end term evaluation of the Uganda Malaria Reduction Strategic Plan (UMRSP) 2014-2020, including a comprehensive malaria programme review whose findings were used to develop the new generation malaria reduction and elimination strategic plan (UMRESP) 2021-2025.

- Facilitated the adaptation of WHO recommendation into service tools and packages. Technical guidance was provided to MoH (AIDS Control Programme) and its partners to adapt the new ART recommendations into the revised National Consolidated Guidelines for HIV prevention and treatment which were launched and rolled-out at regional and district level.

- Contributed to the drafting of the HIV self-testing scale-up plan and training curriculum that are key guidance tools for the country scale up in both the public and private sectors.
- Provided technical guidance towards the drafting of the Tobacco Control Communication Strategy 2021-2025.
- WHO supported the MoH to develop guidelines for effective deployment of indoor residual spraying (IRS) during COVID-19 protecting over 4.9 million people.
- WHO, in collaboration with MoH/Neglected Tropical Diseases (NTD) Program and Act to End NTDs East, developed the Uganda Sustainability Plan for Neglected Tropical Diseases Control Program 2020–2025.

ii. Partnerships and Multisectoral action

- Continued to support the AIDS Development Partners Group (ADPG), Joint UN team on HIV/AIDS (JUPSA), Multisectoral HIV/AIDS Partnership forum of the UAC to steer the health sector agenda within the HIV response and facilitated the CCM as an ex-officio member.

- Provided technical support during the writing process of the Global Fund concept notes that were approved and this attracted 34 million USD to support the control of and limit effects due to COVID-19.
- Supported the formation of the "Malaria Free Uganda" cooperation led by Rotarians, and endorsed by the Office of the Prime Minister and MoH and whose main objective is to mobilize additional resources for malaria control from the private sector.
- Engaged malaria partnership and stakeholders via virtual meetings such as the malaria and COVID-19 coordination meeting, Joint High Burden High Impact (HBHI) briefings with AFRO and WHO HQ, thematic working groups resulting into proper guidance, development of tools on the observed COVID-19 SoPs and continuation of essential services in malaria including IRS, distribution of mosquito nets, treatment of cases at community and health facilities and Social Behaviour Change Communication messages.
- Worked with the United Nations Inter-Agency Task Force on NCDs (UNIATF) to write the NCD Investment Case report for Uganda as a resource mobilization tool for driving the NCD agenda in the country.
- Supported the MoH and the National Medical Stores (NMS) to quantify the insulin requirement gap following selection of Uganda by AFRO as one of the recipients of a donation from Norvatis. The insulin donation of over 10,000 doses was received by NMS.

The Minister of Health Dr Jane Ruth Aceng flagging off field survey teams for the Uganda Population Based HIV-Impact Assessment.

PHOTO: WHO UGANDA

- Supported the ***"Purple Bench Initiative",*** an NGO working on Creating awareness and advocacy for Epilepsy to write the technical report on commemoration of the World Epilepsy Day 2020.
- Facilitated the Uganda Insurers Association and Ministry of Health to organise the World Day of Remembrance of Road Accident Victims and the Uganda Cancer Society during commemoration of World Cancer Day 2020.
- WHO collaborated with NTDs partners and several NTD Disease-specific Expert Groups including Uganda Onchocerciasis Elimination Expert Group to review the progress and recommend way forward in 2020.

iii. Capacity building

- Continued to support MoH (National Malaria Control Division) through full time placement of three technical officers in three key strategic areas of partnerships and multi-sectoral collaborations, policy and strategy and malaria epidemiology. Their presence in the malaria programme contributed to the continuity of services amidst the unprecedented interruptions due to COVID-19.
- Quarterly NTD Coordination and Partnership meetings were organized by NTD/VCD and facilitated by WHO.

iv. Service Delivery

- Supported the MoH to develop guidelines for effective deployment of Indoor Residual Spraying (IRS) and Long Lasting Insecticide Treated Nets (LLINs) distribution during COVID-19. During IRS spray Phase II in May 25 – June 20 (COVID-19 Lock down period), 650,000 structures were sprayed protecting a population of over 1.8m people. Over 26 Million LLINs were distributed countrywide during waves 1- 5b of the universal coverage campaign targeting members of a household at a ratio of 1 net for every two persons reaching an administrative coverage of approximately 90%. In addition, mosquito nets were given to market venders who were sleeping at their stalls because of the lock down measures, to flooded areas of Kyotera, Kasese and other districts neighbouring Lake Kyoga.

Figure 4: Proportion of Malaria suspected cases that received a test

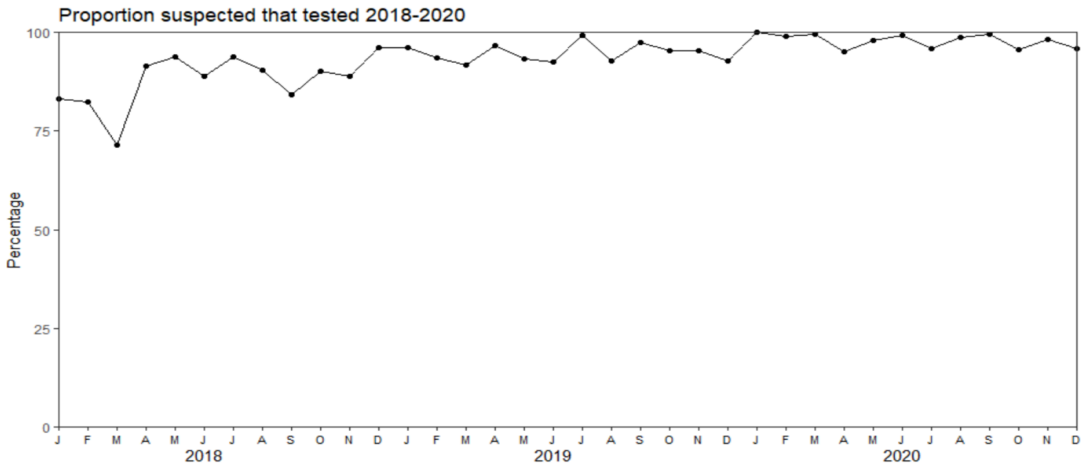
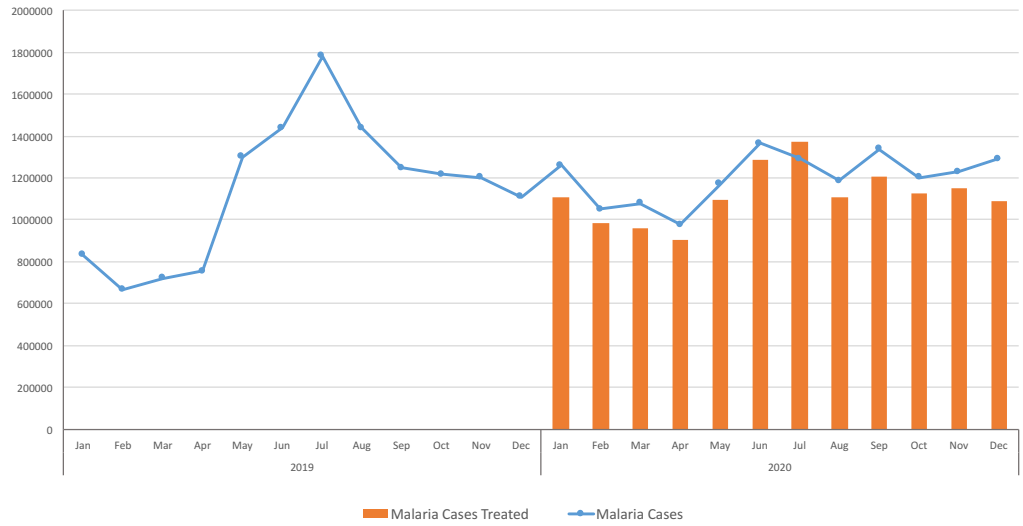
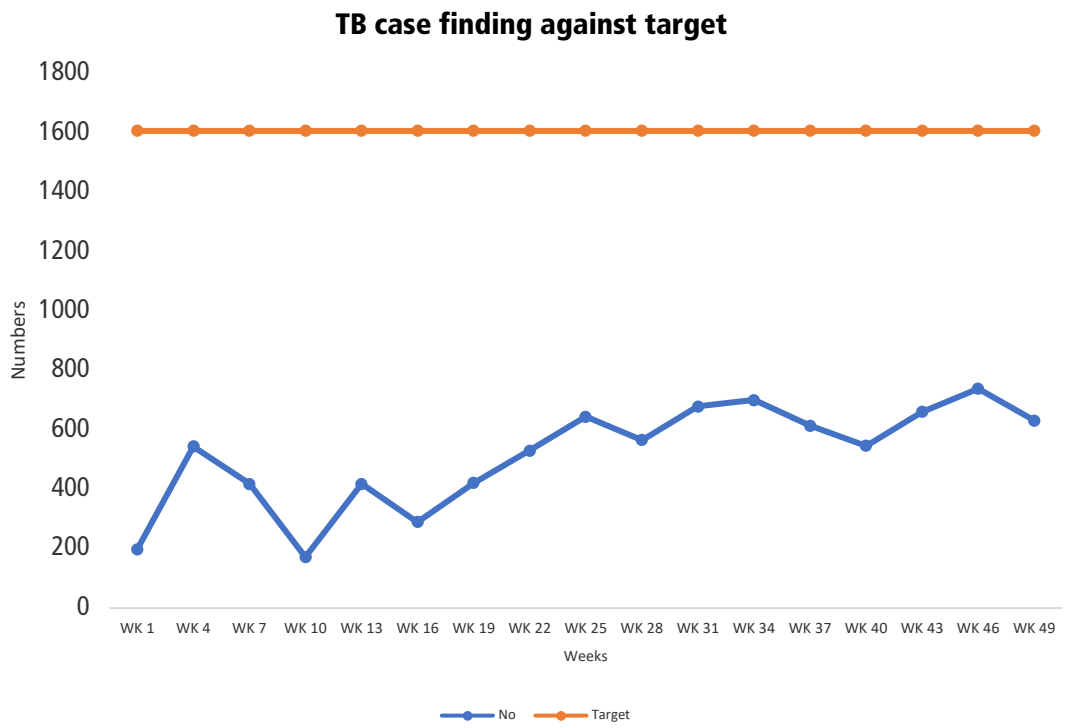


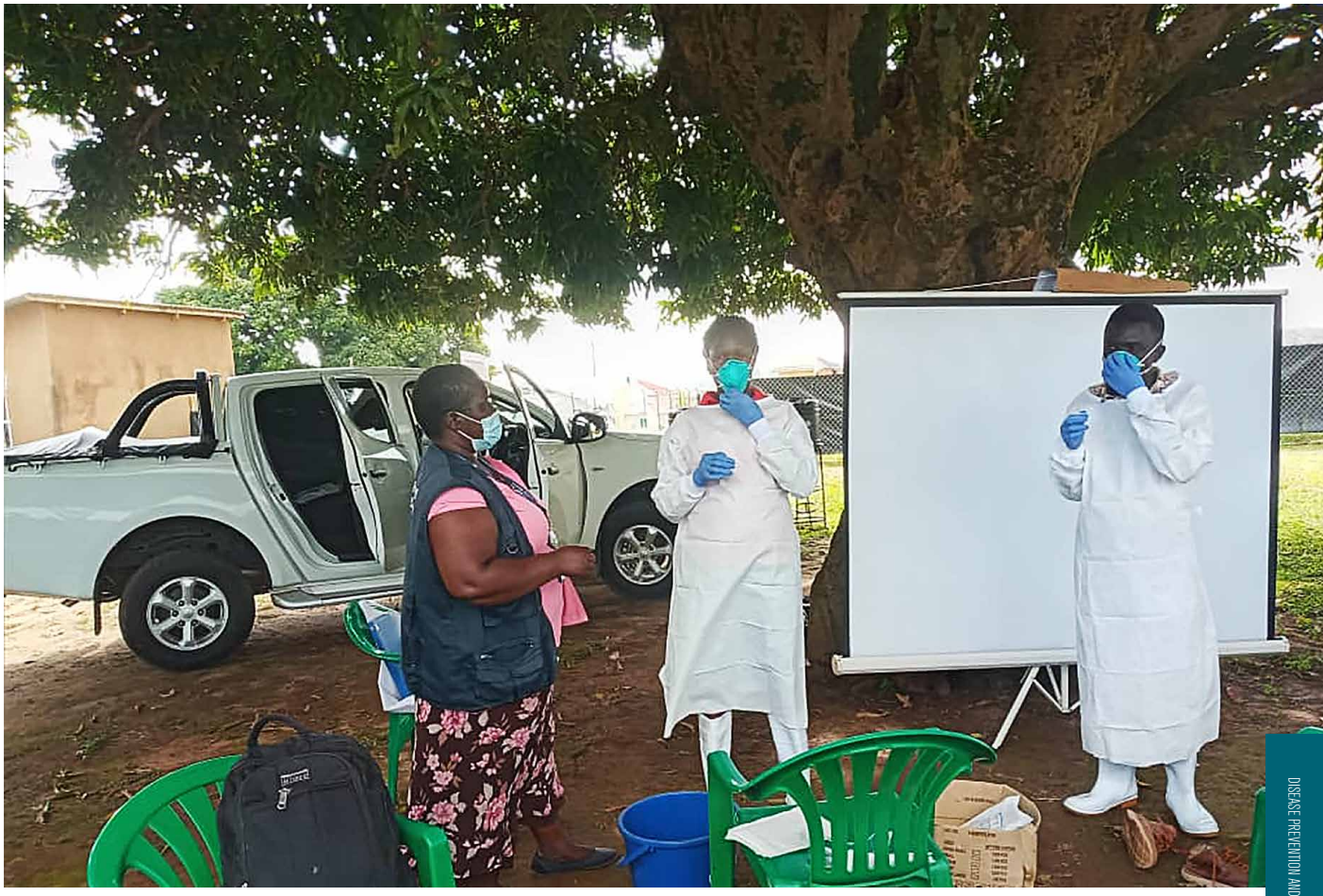
Figure 5: Percentage of confirmed malaria cases treated with Artemisinin-based Combination therapies



- Facilitated the district led programming strategy in the scale up of safe male circumcision in Karamoja Region through the Procurement of SMC supplies and commodities that included; anesthetics, syringes/needles, 2400 disposable kits and 200 re-usable kits, surgical pants, aprons, mackintosh, analgesics, gauze and cotton wool which were utilized during the SMC campaigns in two districts.
- Supported the National TB and Leprosy Program (NTLP) to orient District Health Authorities (District Health Officers and District Medical Officers) on TB and Leprosy. The District Health Authorities were targeted for the orientation because of their critical role in leadership and supervision of delivery of TB and Leprosy services. The orientation was conducted through a three-day online workshop. Topics covered included strategies for TB case finding at community and facility level, laboratory methods for TB diagnosis, monitoring and evaluation of TB and Leprosy services, and the National TB and Leprosy Strategic Plan for 2020/21-2024/25.
- Supported MoH/NTLP to develop, implement, and monitor guidelines for recovery and continuity of TB services. The implementation of the guidelines resulted in a quick recovery of the TB services in 2020. However, service delivery has remained sub-optimal as indicated in the chart below.

Figure 6: TB Case finding against target





A WHO staff teaching health workers how to wear and remove Personal Protective Equipment. PHOTO: WHO UGANDA

- Played a pivotal role towards organizing of the third virtual National TB Conference. The objectives of the TB conference were to provide an account about TB in Uganda and to launch the five-year National TB Strategic Plan for 2020-2025 and the Multisectoral Accountability Framework for TB. Over 300 delegates attended the conference via zoom online platform. The TB conference was held jointly with the 26th Health Sector Joint Review Mission.
- WHO provided advocacy support to MoH and specific technical guidance to adapt operational guidelines in the context of COVID-19 response for larval source management at vector breeding sites around markets in many Uganda urban settings.
- WHO continued to be the lead partner in procurement and supply chain management of NTD diagnostics and medicines and supplies at country level, in collaboration with Expanded Special Project on Elimination of NTDs (ESPEN), shared estimates commodity data and managed receipt on behalf of Uganda.

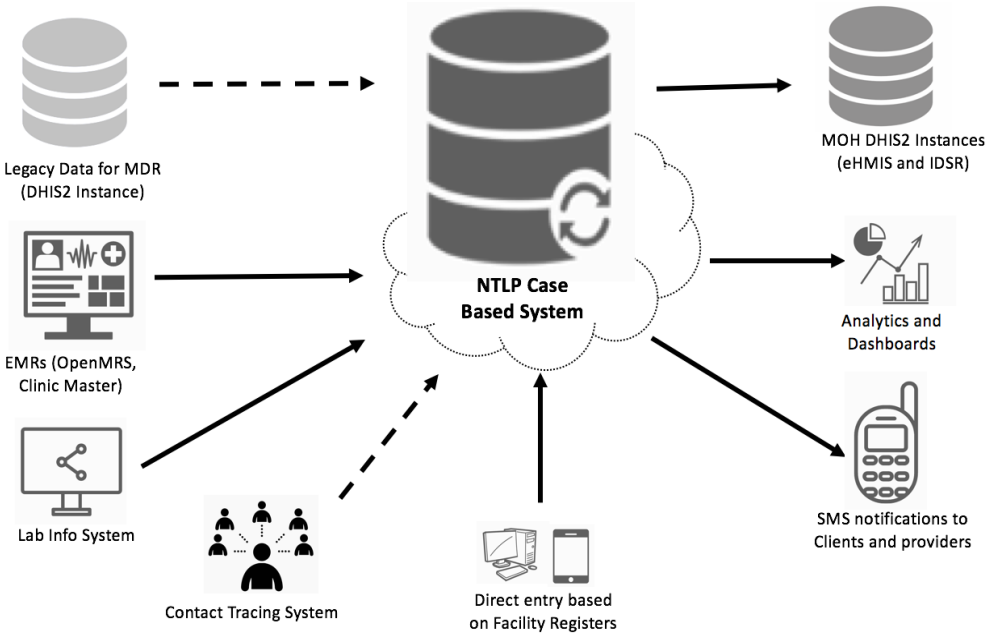
v. Data generation and strategic information

- Conducted several evaluations, reviews, and support supervisions under Strategic Priority 3 on sustaining focus on health-related SDGs in line with WHO's information function.
- Provided technical support to MoH and partners towards the finalization of the National and District level 2020 targets of core public health HIV/AIDS services for the HIV epidemic control in Uganda. The targets generated are intended to ease monitoring of service coverage including attainment of the 2020 targets at National and sub-national level with the aim of attaining sustainable HIV epidemic control.

- Facilitated the generation of the 2019 HIV epidemiological surveillance report for Uganda through technical guidance. The report provides a synthesis of the recent epidemiological data on the magnitude and dynamics of the HIV epidemic in Uganda in the recent years. It further highlights the significant gains made during the past decade towards epidemic control.
- To generate evidence to further strengthen the NMCP and strategize for effective roll-out and implementation of the malaria strategic plan, WHO supported assessments on the adequacy and appropriateness of technical assistance provided by partners to MoH and on training needs. In addition, a Technical Needs Assessment was conducted to guide capacity development efforts for the Uganda Malaria Reduction and Elimination Strategic Plan (UMRESP) implementation.
- Technical and financial support were provided to the CARAMAL Project to study the community access for pre-referral treatment of severe malaria using rectal artesunate suppositories in Apac, Kwania, Kole and Oyam districts. Evidence generated and best practices informed the use of the drug in Integrated Community Case Management (ICCM). Rectal artesunate suppositories have been included in the essential medicines list of Uganda and in the formal Procurement Supply Management (PSM) system of the MoH.
- WHO continued to support MoH to produce the weekly, monthly and quarterly malaria bulletins.
- The Open Electronic Medical Records system EMRs for tracking HIV patients in Karamoja Region was supported technically and financially enabling 17 health facilities to access EMRs. Key to note was that 53% of the health facilities had installed Uganda EMRs for data capture. However, 42% of health facilities supported had no computer to host EMRs and 72% had erratic internet access.
- The WCO provided technical input into the design of an electronic case-based surveillance of TB (eCBSS) which will be implemented at facility-level. Technical support was provided for the following:

(1) preparation of the scope of work for developing the eCBSS; (2) articulation of the TB care pathways; (3) Stakeholder engagement; and (4) WHO standards and benchmarks necessary for the eCBSS. The system is currently being rolled-out at fifty (50) health facilities.

Figure 7: Envisaged architecture of the eCBSS for TB and the Data model for TB via DHIS2



- WCO supported NTLP to develop a protocol for the 2nd DR-TB survey. The protocol was submitted to WHO/AFRO to mobilize the required funds (400,000 USD) that will, among other issues help determine estimates of drug-resistant TB in Uganda. The last DR-TB survey was conducted over 10 years ago.
- WHO led the Evaluation and mid-review of the TB emergency response that sought to: (1) Activate the national TB emergency response at the national and district level; (2) achieve >90% retention of all TB patients initiated on treatment; (3) conduct active TB case finding in the health facility and communities; (4) consolidate and disseminate risk communication materials during the response period; (5) enhance use of data for disease control at all levels, including community reporting; and (6) improve screening for rifampicin resistance for identified bacteriologically confirmed TB patients to 100%.
- In collaboration with the Ministry of Health and partners WCO coordinated data collection and validation for the Mental Health Atlas.
- During the COVID-19 outbreak, WHO coordinated data collection on Mental Health to establish the Mental Health

service gaps and needs of the affected persons that informed WHO about the needed support.

- WCO coordinated data collection for the national cervical cancer management capacity survey 2020. The findings of the survey will inform the response plan for elimination of cancer of the cervix by 2030. This is a follow-up action on the WHO Director General's call to Member States to eliminate cancer of the cervix as a public health problem by 2030.
- WHO facilitated the analysis of HMIS data comparing similar periods of 2019 and 2020 to assess the effect of COVID-19 on continuity of Essential services for NCDs.
- Figure 8 and 9 indicate a general increase in non-communicable diseases cases attended to at health facilities. However for the same period in 2020 there was a sharp decline in cases associated with COVID-19 pandemic. This presentation will be made at the CEHS pillar meeting to advocate for additional resources for non-communicable diseases service delivery.

Figure 8: Uptake of Noncommunicable diseases services from Jan to May 2019

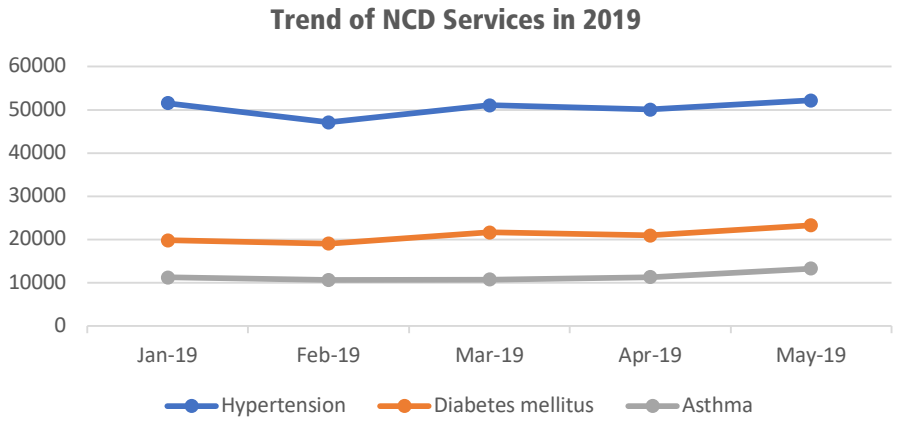
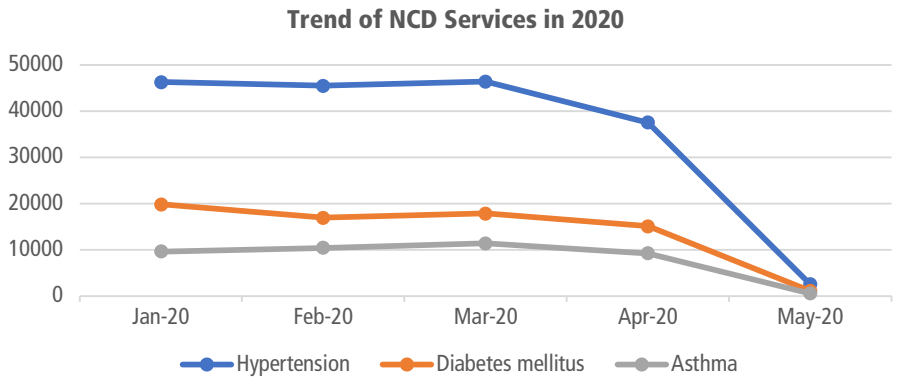
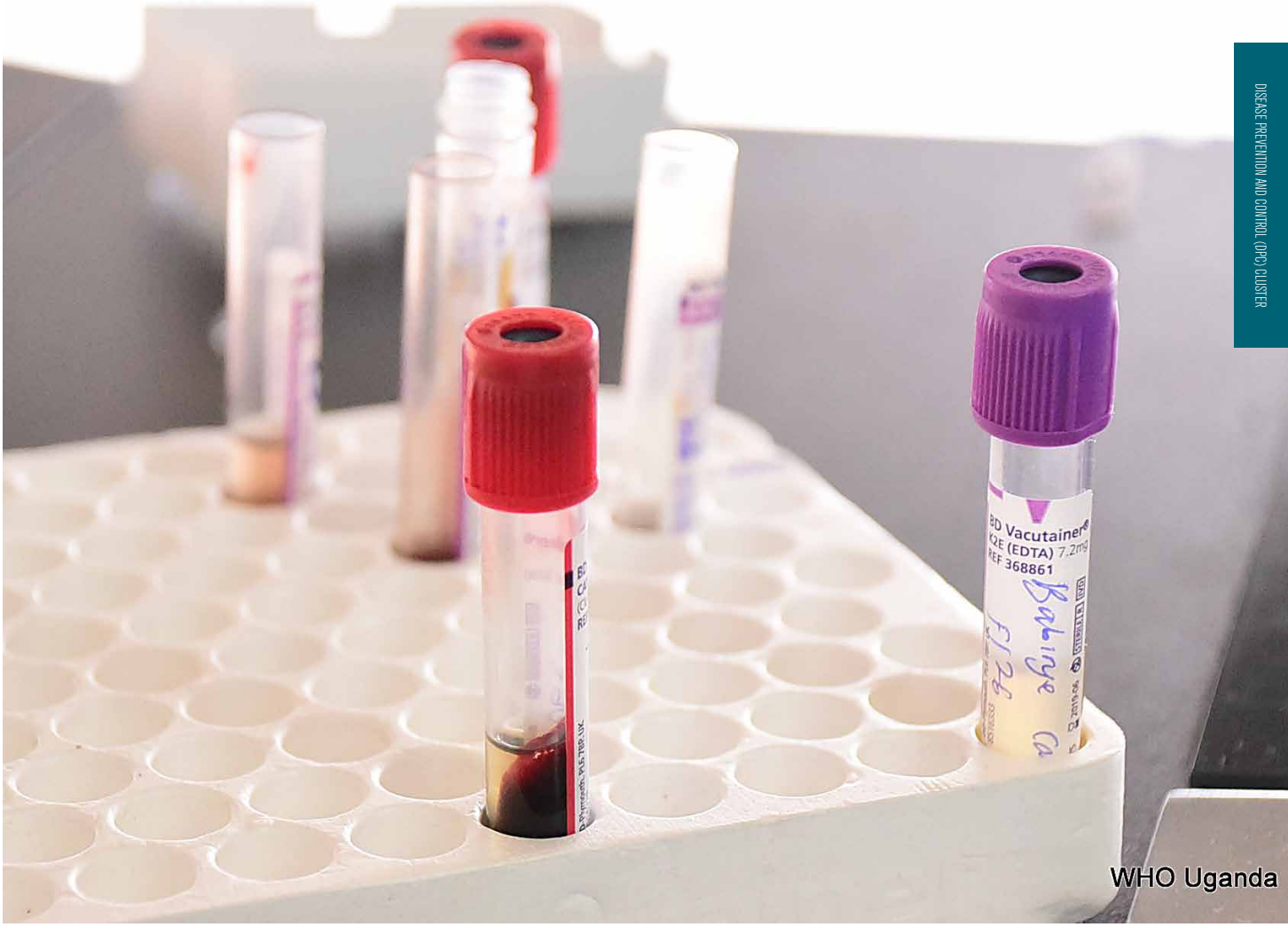


Figure 9: Uptake of Noncommunicable diseases services from Jan to May 2020



- In the context of COVID-19 response, WHO coordinated several online surveys to assess impact of COVID-19 pandemic on NTD programming that informed adaptation of generic WHO tools.
- WHO contributed national data to global WHO reports on several NTDs including Visceral Leishmaniasis (VL), Trachoma, Schistosomiasis and Guinea worm.

Blood samples ready for testing. PHOTO: WHO UGANDA



vi. Resource Mobilization

- WCO participated in the drafting of the Global Fund for TB, AIDS and Malaria Concept notes which were approved to fund the three diseases including Health Systems Strengthening.
- WHO supported MoH to advocate for increased domestic resources for malaria in addition to technical assistance to develop and disseminate guidelines on this issue. As a result, it was agreed that malaria should be mainstreamed in all ministries, departments, and agencies (MDAs) including districts. The Permanent Secretary and Secretary to the Treasury sent a circular to all sectors instructing them to mainstream malaria into their budgets.
- WCO supported MoH to develop the food procurement policy, food labelling standards and nutrition guidelines that attracted USD 75,000. Uganda is one of the three countries globally that qualified for the one -time grant from Resolve to Save Lives. WHO played a key role in drafting a proposal on management of hypertension worth USD 200,000. The proposal submitted to Resolve to Save Lives is under review.
- WHO supported MoH to write the proposal for the second NCD Steps Risk Factor Survey worth about USD 500,000 which was approved by WHO Regional Office and Headquarters.
- Technical support of the country office to Ministry of Health was critical in mobilizing USD 20,000 to strengthen implementation of WHO Package of Essential Non-communicable disease interventions (WHO-PEN) in 7 districts in central and eastern Uganda. The proposal was approved by AFRO and USD 50,000 from WHO/HQ Cervical Cancer Elimination Initiative was advanced to implement planned activities.
- WCO estimated the insulin requirement gap for Uganda in collaboration with National Medical Stores and the Ministry of Health. Based on the quantification, Uganda received 13,000 vials of insulin (protaphane, actrapid and mixtard) equivalent to 1,300,000 doses from Novartis, a Danish Pharmaceutical Company through the WHO Regional Office. Uganda also received equipment worth USD 15,282 to strengthen NCD services.
- WHO mobilized and contributed USD10,000 towards the implementation of capacity building and support supervision of Visceral Leishmaniasis (VL) in Amudat District of Uganda.

vii. COVID-19 response related activities

- The DPC Cluster members supported the office COVID-19 response through coordination of the following pillars: Field coordination; Continuity of Essential Health Services, Points of Entry, Mental Health and Psychosocial support. Various service packages and guidelines to support the response were developed and disseminated through the technical support function of the WCO.

CHALLENGES

- The national lock down and travel restrictions due to COVID-19 pandemic affected service delivery for both Communicable and Non-communicable diseases. Operations particularly those that required community engagement, trainings, mentorships and dialogues were greatly affected. However, this was quickly mitigated by supporting the continuation of essential services pillar and the development the CEHS guidelines that enabled resumption of service delivery while observing the COVID-19 SoPs.
- Access to quality care for non-communicable diseases remains an obstacle for Universal Health Coverage because of irregular access to essential medicines and basic technologies, inadequate health care workers among others.
- Lack of quality data hinders advocacy efforts for prioritizing NCDs on the national agenda. Insufficient investment in prevention and management of non-communicable diseases by the government is a huge obstacle and yet partner funding is inadequate.
- Inadequate awareness about NCD and risk factors by the population leading to late presentation with complications and high NCD mortality. With the current level of investment, the country is unlikely to achieve the global targets of reducing premature mortality by 25% by 2025 and SDG target of one-third by 2030.
- Planned Midterm Review (MTR) of the Uganda Master Plan of Action on NTDs 2017-2020 scheduled for 2020 was disrupted by COVID-19 pandemic and response interventions including lockdown.

LESSONS LEARNT

- 2020 remains a special year of COVID-19 pandemic with significant disruptions in socio-economic activities including health. However, the response to the pandemic presented a golden opportunity to develop coping mechanisms to the new normal including maximizing virtual capacity building, coordination, and integrated programming opportunities.
- High burden High impact and mass action against malaria approaches are very important initiatives where everyone's contribution in disease prevention and management, at all levels is important particularly the political level, multisector/ private sector, the community, and households.

WAY FORWARD

- Under communicable diseases, the cluster will focus on development and finalization of vital tools, guidelines, strategies and plans as well undertake programme reviews, studies, advocacy, partner dialogues and resource mobilization activities.
- For NCDs, the cluster will advocate for increased government and partner investment, dissemination of prevention and control measures, laws and regulations, generation of evidence and resource mobilization.
- WHO will continue to build on the lessons learned during the COVID-19 pandemic response season maximizing integrated programing opportunities.

Health workers in a COVID-19 testing laboratory. PHOTO: WHO UGANDA

4

IMMUNIZATION VACCINE DEVELOPMENT FAMILY AND REPRODUCTIVE HEALTH (IVD/FRH) CLUSTER

INTRODUCTION

The year 2020 marked the end of decade of vaccines which had the vision of having all individuals and communities enjoy lives free from vaccine preventable diseases. The same year was also used to develop the immunization agenda 2030 through virtual consultations with all stakeholders amidst the challenges of the Coronavirus Disease (COVID-19). Due to the COVID-19 pandemic there was disruption of routine immunization activities due to decreased demand for vaccination because of social distancing requirements and community reluctance to seek services. However, several efforts and technical guidance documents were developed to support countries resume provision of routine immunization services and supplementary immunization activities in a safe environment by protecting both the health workers and communities.

◀ *A health worker immunizing a newly born baby against polio.*

PHOTO: WHO UGANDA

In line with GPW13 targets under outcome one, the cluster addressed population-specific health needs and barriers to equity across the life course. This chapter highlights the WHO Country Office's (WCO) achievements made in 2020, a globally challenging year.

ACHIEVEMENTS

i. Maternal and New-born Health

- Supported the MoH to implement Phase two of the Maternal and Newborn Quality of Care by orienting 64 national Quality Improvement Facilitators and 40 district health teams on Point of Care Quality Improvement.
- Provided technical oversight during the development of the Ministry of Health Point of Care Quality Improvement (PoCQI) training mentorship tool and Trainer of Trainees as well as joint site mentorship in Kamuli district.
- Provided technical guidance during the establishment of the MoH Antenatal Care subcommittee that met eight times in the year to resolve issues related to finalization of the training materials for health workers on ANC and the design of the Goal Oriented ANC protocol. At the same time, WHO initiated the country processes to adapt the WHO 2016 ANC guidelines.

- Disseminated the adapted WHO 2016 guidelines through a webinar to over 65 participants in eight districts focusing on better pregnancy and birth outcomes.
- To fast-track implementation of the Maternal New Health Quality of Care (MNH QoC) the WCO organized and engaged the district health leaderships of the six MNH QoC learning districts in monthly virtual calls during which each district team presented their MNH QoC implementation progress and thereafter developed district specific action plans.
- Supported the MoH to build capacity of 55 Maternal Child Health providers from Nwoya district on the application of the Point of Care Quality Improvement (PoCQI) in their routine MNCH work in late August 2020. It was piloted during the training in Humanitarian Health in Bidi Bidi HC III in Yumbe District.

- Supported adaptation of the global MNH QoC common core indicators into the District Health Information Software 2 (DHIS2) in six districts.
- Supported the development of Community Engagement guidelines to improve MNH quality of care.
- Provided technical support to develop and print the MoH Post-Partum hemorrhage (PPH) Prevention and Control strategy.
- Supported the finalization and submission of the Strengthening Health Systems for MCH project documents to Korea International Cooperation Agency (KOICA) that provided funding for the 5-year project.
- Provided technical support to the Rotary International team to develop the WHO/Rotary proposal for a MCH project that will be implemented in Kabale, Kanungu, and Wakiso districts.
- Provided technical guidance to Makerere University School of Public Health (Mak-SPH) to develop and customize the WHO MNH QoC assessment tools, piloting the tools and training the assessors including report writing.
- Supported the writing and printing of the Maternal and Perinatal Death surveillance Report FY2018/2019 and distributed 1000 copies to eight districts.

A nurse attending to neonates at Hoima Regional Referral Hospital. PHOTO: WHO UGANDA

A young mother and her child. PHOTO: WHO UGANDA

ii. Reproductive Health

- Supported the drafting of the Mid-term review report for the ongoing implementation of the *2gether4 SRHR/HIV /GBV* project being implemented by UNICEF, UNFPA, UNAIDS and WHO.

- Supported the printing of the training materials to be used for capacity building in the eight districts. These materials included Quality Improvement in Emergency Obstetric care Leadership Manual, Family Planning Training Manual, Comprehensive Abortion Care Curriculum, Male Involvement Training Manual, Mainstreaming Gender and Rights in the Health Sector, Essential Maternal and Newborn Care Guidelines, Immunization Flip Chart, and the Postpartum Family Planning Flip Chart.

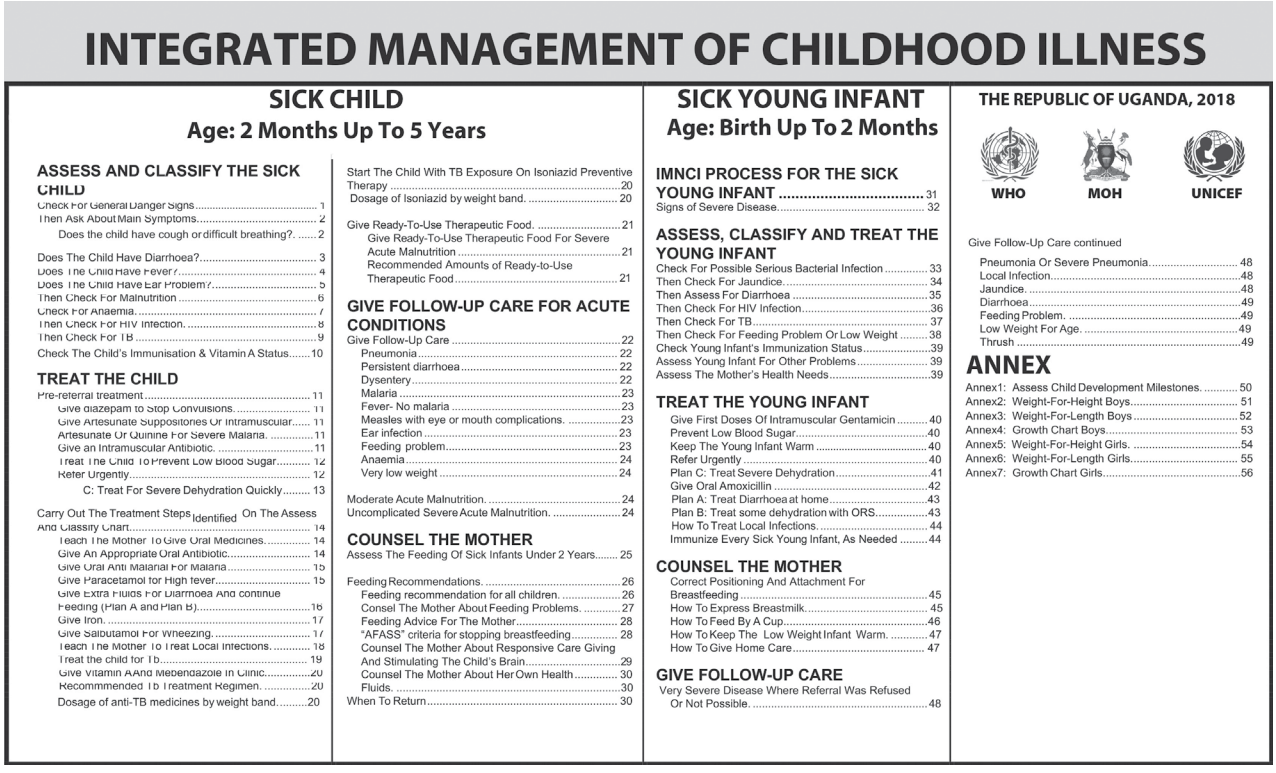
- Initiated partnership with Federal Republic of Nigeria to learn and share experiences, challenges, and good practices on using the human rights-based approach to improving quality of care in family planning. Six monthly virtual meetings were held and a road map developed to implement this initiative.

iii. Child Health

- Supported the revision of the National guidelines on the Integrated management of Childhood Illnesses to incorporate the global guidance developed by WHO regarding outpatient of newborn babies with Possible Serious Bacterial Infection (PSBI) where referral is not possible.

- Provided technical support to revise the implementation guidelines for the Integrated community case management of Diarrhoea, Pneumonia and Malaria by the Village Health Teams (VHTs). The VHT job aids were also revised to reflect the additional role that they are expected to play in PSBI implementation.
- Supported the initial technical discussions to revise the child survival strategy for Uganda. The new child health strategy has been informed by and incorporated the current proposal child health redesign that is going on at global level.

Figure 10: Integrated Management of Childhood Illnesses (IMCI) chart booklet.



INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

SICK CHILD
Age: 2 Months Up To 5 Years

ASSESS AND CLASSIFY THE SICK CHILD
Check For General Danger Signs ... 1
Then Ask About Main Symptoms ... 2
Does the child have cough or difficult breathing? ... 2
Does The Child Have Diarrhoea? ... 3
Does The Child Have Fever? ... 4
Does The Child Have Ear Problem? ... 5
Then Check For Malnutrition ... 6
Check For Anaemia ... 7
Then Check For HIV Infection ... 8
Then Check For TB ... 9
Check The Child's Immunisation & Vitamin A Status ... 10

TREAT THE CHILD
Pre-referral treatment ... 11
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Give Artesunate Suppositories Or Intramuscular ... 11
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A nurse immunises a woman at Masaka National Hospital during a medical camp. PHOTO: WHO UGANDA

iv. Adolescent Health

- Facilitated the drafting of the National Adolescent Health Strategy to be finalized by the MoH followed by developing a costed plan.
- Supported the development of the adolescent health service standards and provided technical support to Kibuli Muslim Hospital to initiate adolescent friendly services beginning with the maternal health services component.

v. Nutrition

- Supported the ministry of health to establish the National Steering Committee for the European Commission-supported Nutrition Information Project that is aimed at strengthening the use of HMIS routinely generated nutrition data in planning. The steering committee approved the project annual workplan and will meet semi-annually to steer the project over the next four years.
- Supported coordination between the core staff from National Information Platforms for Nutrition (NIPN) and the Nutrition Information System project through organization of meetings, in consultation with the MoH Nutrition Technical Working Group.

vi. Gender/GBV

- Supported Makerere University School of Public Health to review Pre-Service training curricula for Sexual Gender Based Vaccine/Violence Against Children (SGBV/VAC)/Maternal Newborn Health Quality of Care aimed at ensuring that health workers are competent in the provision of SGBV/VAC including quality Maternal Newborn Health services after pre-service training and are fit for purpose during in service.

- Participated in the UN Gender and Human Rights working group meetings while highlighting the role of WHO as well as offering the needed support.
- Participated in the quarterly Sexual Reproductive & Human Rights (SRHR) Donor working group meetings in which the Male Involvement Strategy was presented to the UN team for consultation.
- Participated in the Prevention of Sexual Exploitation and Abuse (PSEA) Coordination working group in which guidelines for use by the frontline responders and field staff were developed, printed, and disseminated to various NGOs. Government officers and UN staff will subsequently be trained on these materials.
- Facilitated the establishment of the Male Involvement working group at the Ministry of Health now chaired by the Commissioner for Health Promotion and Education.

A nurse preparing to immunise a baby in a clinic at Masaka National Hospital. PHOTO: WHO UGANDA

vii. Polio eradication

- Supported MoH (Uganda National Expanded Programme on Immunization) to implement AFP surveillance activities as a way of documenting progress from eradication to elimination of the Wild Poliovirus (WPV) transmission in the country within the Integrated Disease Surveillance and Response (IDSR) framework.
- Supported four STOP missions in fifty (50) districts where Nine hundred and fifty-three (953) health facilities of various categories were supported, and twenty-two (22) heavily populated communities visited to strengthen AFP surveillance within IDSR framework using Open Data Kit (ODK).

Figure 11: Non Polio AFP Rate as at week 52 by Districts, 2020

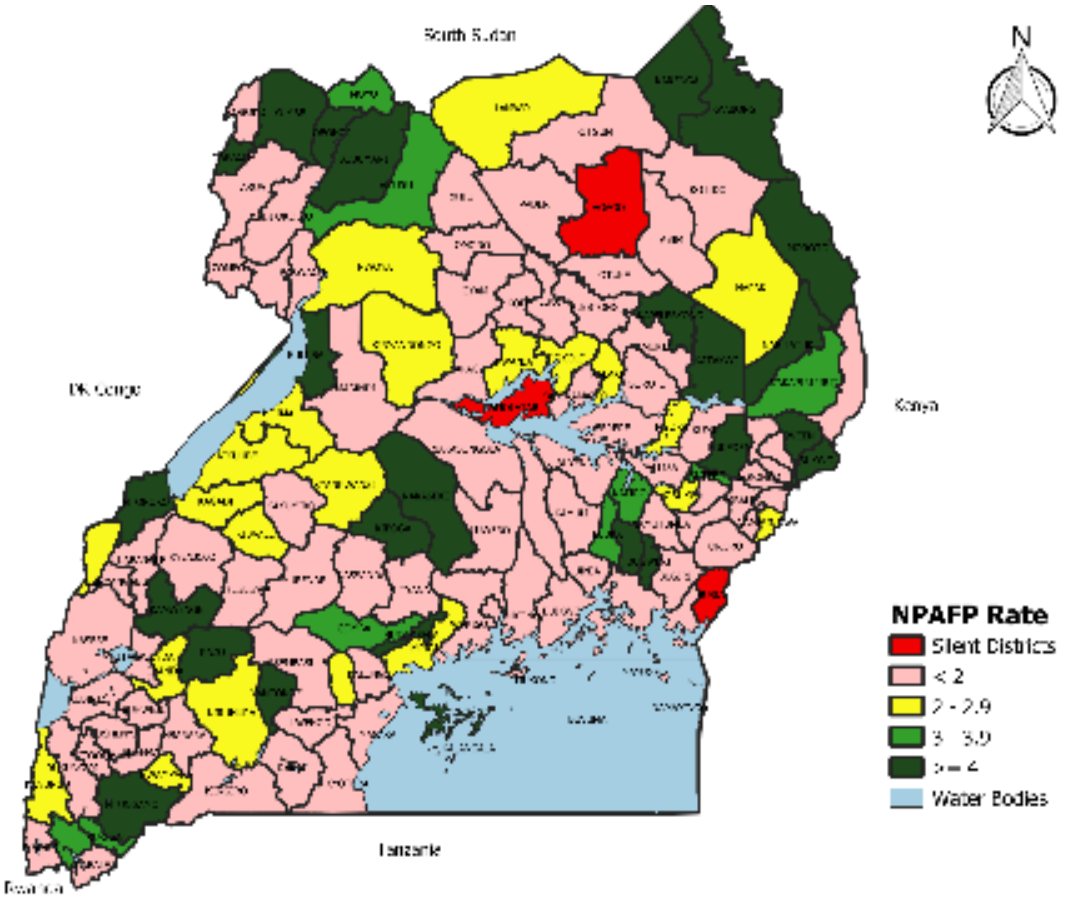
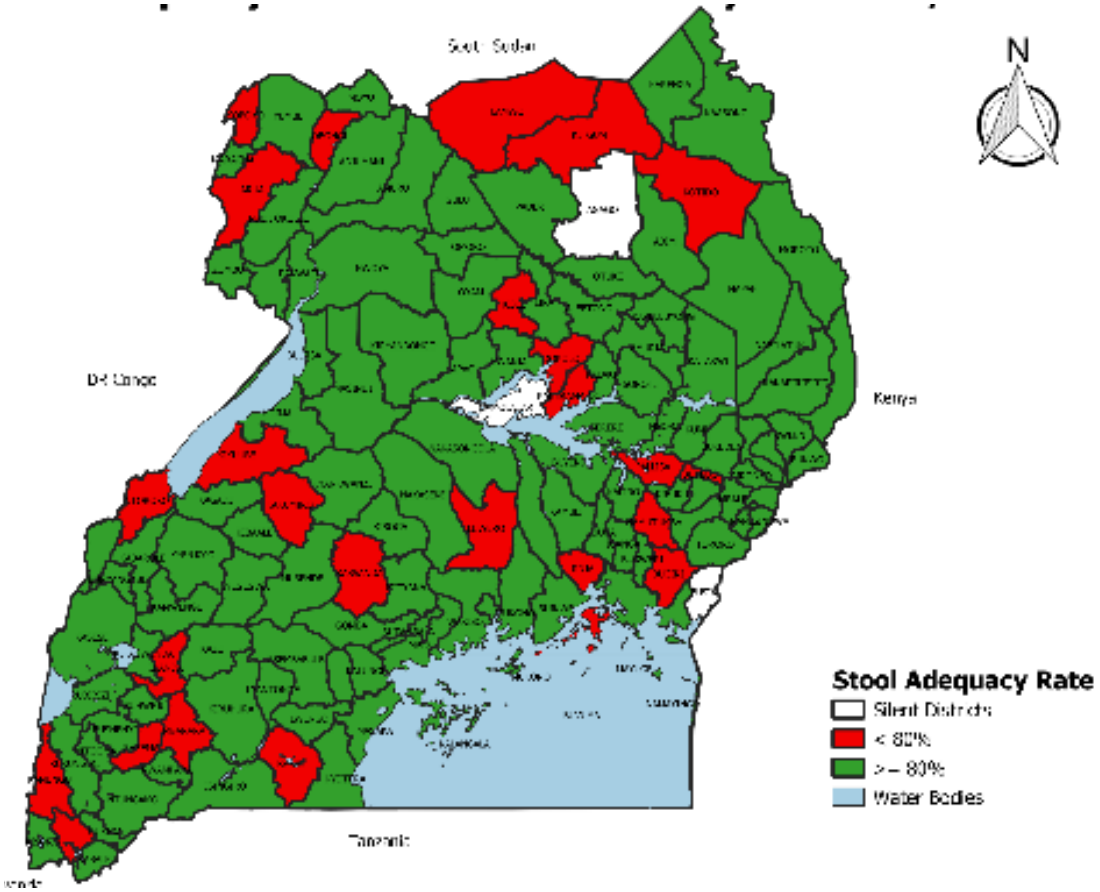


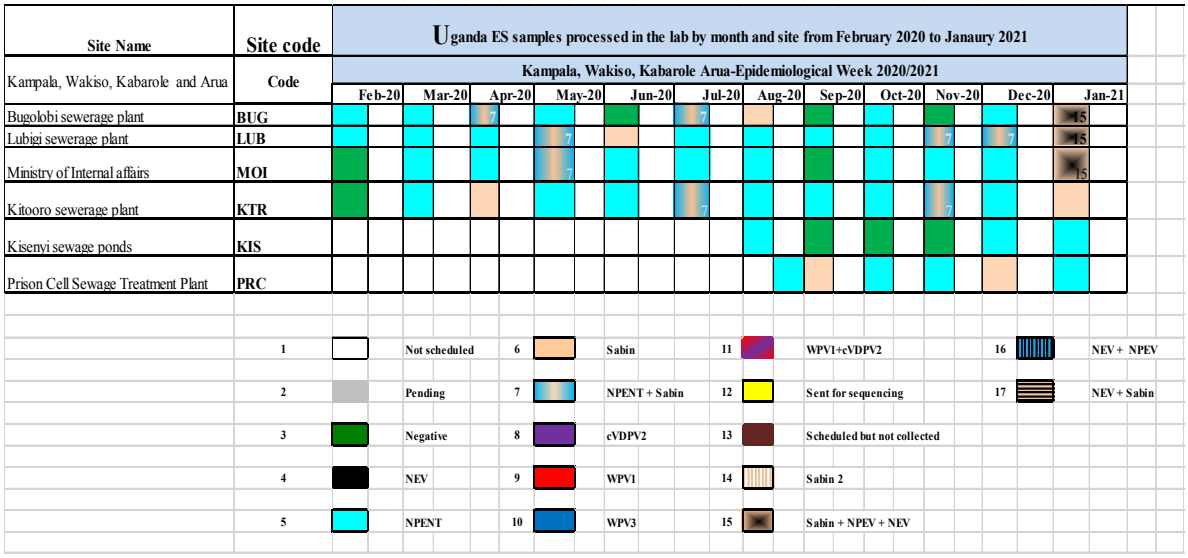
Figure 12: Stool Adequacy Rate at Week 52 by Districts, 2020



- Mentored 3,127 health workers and 5405 community members including influential leaders and 1187 VHTs on surveillance, cold chain management and routine immunization.
- Supported detection and investigation of 127 AFP cases country wide. Consequently, the national level NPAFP rate for January to December 2020 was 2.01 while stool adequacy rate was 91% - both above the required targets of 2 and 80% respectively.
- Supported the MoH to collect sewage samples from six sites in four districts an increase from the four sites in two districts the previous year. All the four (4) sites are functioning well and are collecting samples monthly. The system is sensitive as evidenced by isolation of Sabin, Non Polio Enterovirus (NPEV) and NEV.

- Supported functionality of the National Polio Committee that held 23 meetings and reviewed 2,019 annual progress report on certification drafted by the secretariat before submission to the African Regional Certification Commission (ARCC).
- Supported the review, certification, and containment of 450 AFP cases. The National Polio Expert Committee (NPEC) conducted field visits to 15 districts where 38 AFP cases were classified. In addition, The National Task Force (NTF) assessed the Biosafety Level (BL) practice in 20 laboratories in 5 districts as well as internal validation of 73 laboratories and research stations.

Figure 13: Uganda ES samples processed in the laboratory by month and site from February 2020 to January 2021



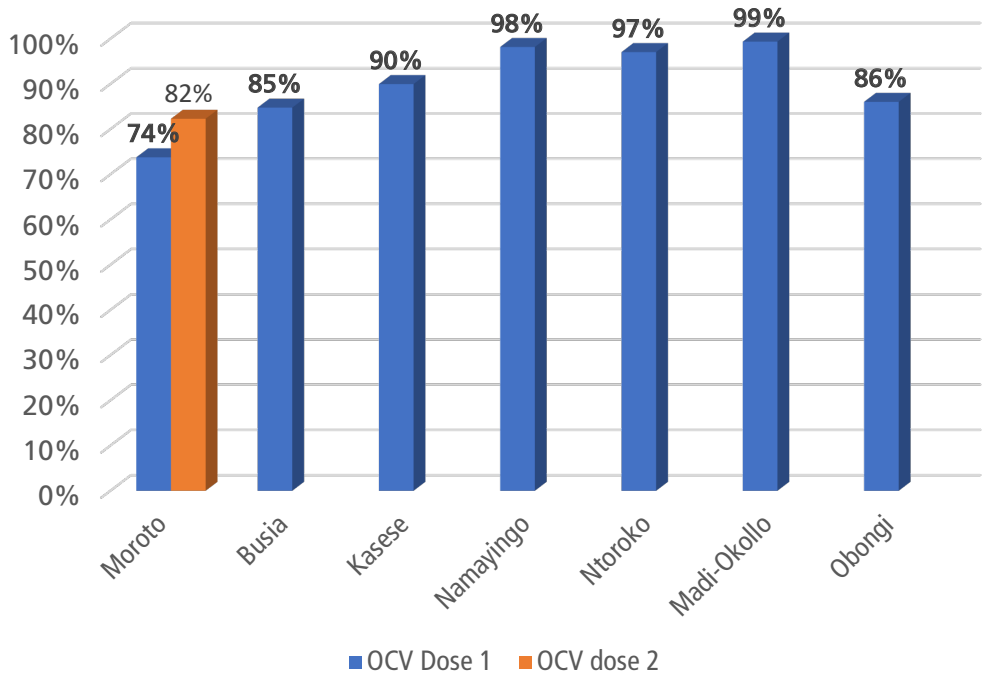
viii. Measles and rubella surveillance

- Supported MoH to implement measles surveillance activities to prevent or limit secondary transmission. Overall, 412 suspected measles cases were detected and investigated. Sixteen districts were supported to detect and investigate suspected measles outbreaks within the required 48 hours of detecting the index case.

ix. Use of new and underutilized vaccines

- Worked with MoH to implement the National Cholera strategic plan 2017/18 – 2021/22. The third phase of pre-emptive Oral Cholera Vaccine (OCV) campaign in Namayingo, Madi-Okollo, Obongi, Kasese and Ntoroko districts - a total of 41 hotspots (sub counties) were covered. A total of 950,522 persons aged above one year out of the targetted 1,073,061 received their first dose of OCV giving a coverage of 89%.
- In addition, Moroto district was supported to conduct a reactive campaign of OCV in Nadunget, Rupa, South Division, North Division and Katikekile sub counties. Of the 94,954 eligible persons 74,023 (78%) received their first dose while 65,219 (88%) received their second dose. For both campaigns COVID-19 guidelines and Standard Operating Procedures (SoPs) were strictly followed.

Figure 14: Oral Cholera Vaccination campaigns conducted in 2020



- Supported MoH to conduct a reactive yellow fever campaign in five high risk districts (Maracha, Koboko, Yumbe, Moyo, Obongi and Buliisa) among persons aged 9 months to under 60 years of age. A total of 1,773,795(109%) of the target population of 1,629,573 were offered protection against yellow fever infection.

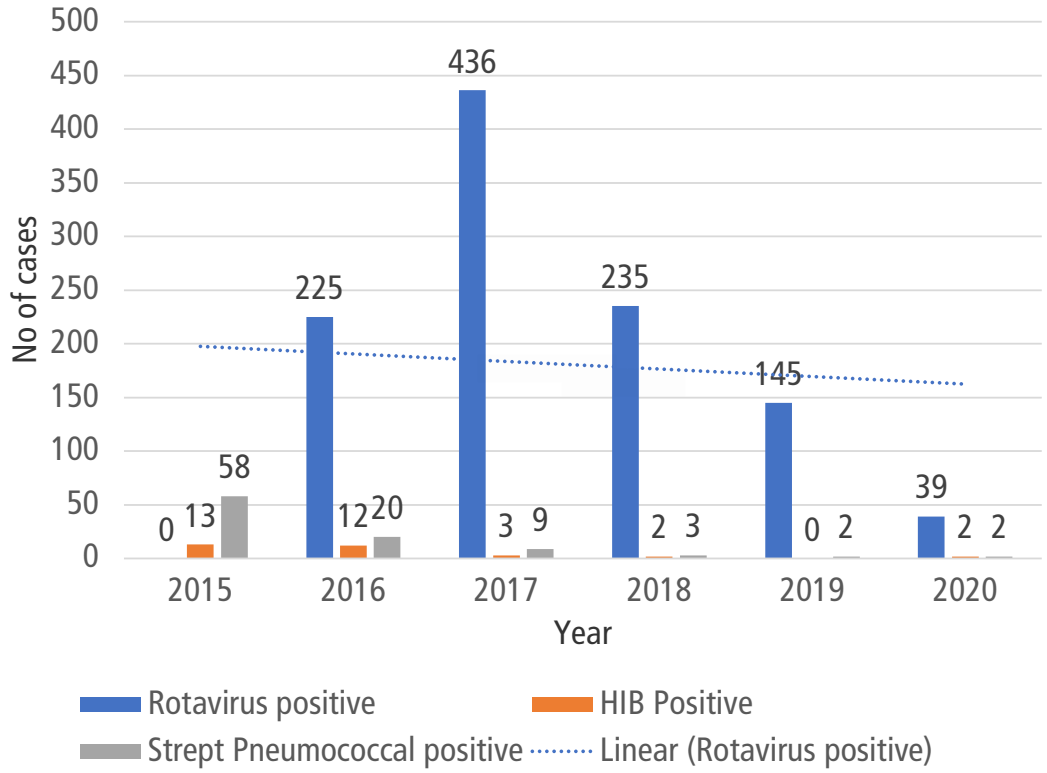
Figure 15: Yellow Fever Coverage Campaign Results 24th to 30th August 2020

Yellow Fever Campaign Results August 24th – 30th 2020							
District	**Target Age**	**Target Pop**	**No. Reached**	**Admin Coverage**	**#(and%) of sub-counties with ≥95% admin coverage**	**No. AEFI attributed to SIA**	**No. Serious AEFI**
Maracha	9m to < 60 years	193,719	212,437	110%	8/8 (100%)	7	1
Koboko	9m to < 60 years	239,940	249,103	104%	6/9 (67%)	18	3
Yumbe	9m to < 60 years	798,835	897,026	112%	13/13 (100%)	30	4
Moyo	9m to < 60 years	101,835	89,624	88%	3/7(43%)	2	1
Obongi	9m to < 60 years	162,719	194,662	120%	5/9 (565)	3	2
Buliisa	9m to < 60 years	132,525	130,943	99%	6/8 (75%)	4	0
Overall	**9m to < 60 years**	**1,629,573**	**1,773,795**	**109%**	**41/47 (87%)**	**64**	**11**

- Continued to support and coordinate three rotavirus surveillance sentinel sites i.e. Mulago National Referral Hospital, Lubaga Hospital and Naguru China Friendship Hospital. Two invasive bacterial vaccine-preventable diseases surveillance sentinel sites: Mulago National Referral Hospital and St. Mary's Hospital Lacor continued operations as well. There is a clear reduction in the number of laboratory confirmed HIB, Rotavirus and Streptococuss pneumonia cases since the introduction of Penta Valent, PCV10 and Rotavirus vaccines into routine immunization program.

- Closely collaborated with Centers for Disease Control (CDC) to conduct a cost study on the introduction of three boosters doses of DTPCV vaccine into routine immunization program. It was found that overall, after the introduction of the 3 booster doses, an estimated cost of UGX 9.7 billion ($2.6 million) and UGX 15.2 billion ($4.1 million) will be the economic cost per year for providing booster doses of DTPV at fixed health facilities and outreaches including schools.

Figure 16: Impact of Hib, Rotavirus vaccine and PCV on disease burden in under five. Source: New vaccine sentinel surveillance data, 2015 to 2020



x. *Country Ownership of Immunization Program*

- Continued to support the Uganda National Immunization Technical Advisory Group to ensure that country policy recommendations related to immunization program are provided. During the review period, a working group for COVID-19 vaccine was established. A policy brief on introduction of the second dose of IPV and an amended recommendation to introduce birth dose of hepatitis B was developed and shared with MoH.

xi. *Monitoring*

- Supported MoH to conduct an integrated Expanded Program on immunization (EPI) review that focused on assessment of the strengths and weaknesses of an immunization Programme at national, sub-national, and service-delivery levels and post validation maternal and neonatal tetanus elimination. Findings will feed into the next Multi Five Year Country Plan (cMYP).

- Supported MoH to conduct an operational research to determine the barriers to routine immunization. The findings will feed into the next cMYP.

xii. *Resource mobilization*

- Supported MoH to develop resource mobilization strategy and plan that has contributed to an increase in Government of Uganda's contribution by 100% in 2019/2020 and 2020/2021 financial years towards vaccines and operations.

xiii. *Capacity building*

- Supported MoH to conduct in service training on vaccine pharmacovigilance (Adverse Events Following Immunization surveillance) in 44 districts drawn from 2,719 health facilities where a total of 5,607 health workers' skills and knowledge on how to detect and report an AEFI were enhanced.

- Supported the MoH to implement strategies to reduce on Missed Opportunities of Vaccination (MOV), following the national MOV assessment conducted in 2019 found that MOV was at 60% in Uganda. A pool of 30 national experts on MOV was established while 1,596 health facilities drawn from 54 districts were targeted to address MOV within their catchment areas.

xiv. COVID-19 19 response related activities

- During 2020, Cluster members were repurposed to strengthen the WCO capacity to respond to the COVID-19 outbreak. They supported case management, Mental Health Psychosocial Support (MHPSS), coordination, and surveillance among other related responsibilities.

CHALLENGES

- The prolonged processes at the district level to access funds greatly affected the quality of the campaigns given that health workers were note paid immediately or as soon as possible.
- Resources were inadequate to expand the scope of work for planned activities.
- Slow progress in routine collection of RMNCAH data using online templates provided by WHO/AFRO .
- Slow progress regarding health of older person's strategic direction due to poor financial support to the Ministry of Health team.
- Inadequate prioritization and funding for gender, equality, and rights related activities
- COVID-19 restrictions on travel, meeting and other gatherings which impacted implementation of activities especially at district level.

LESSONS LEARNT

- Establishment and collaboration with stakeholders to support WHO deliver its mandate greatly enables the WCO achieve at least 80% of the planned activities.
- The MOV strategy is a major landmark in QI and EPI coverage at health facilities and in districts.
- Vaccination is an integral part of health system including service delivery and cannot be implemented as evidenced from the implantation of the MOV strategy.
- Virtual engagements eased implementation of planned capacity building efforts and are more cost-effective despite internet challenges at the sub national level.
- Prioritizing high risk pregnancies for ANC by giving mothers specific appointments enabled health workers and health facilities to reduce overcrowding and maintain physical distancing as required by the COVID-19 guidelines and SoPs.
- Tele-consultation and counselling by frontline ANC providers introduced home visits and reduced exposure of pregnant to COVID-19 Pandemic.
- Domestic violence of all types increased during COVID-19 isolation and lockdown. Children, girls, women, and people with disabilities were especially vulnerable necessitating NGOs and CSOs to work closely with the MoH to take services to communities.
- Adolescent boys and girls were more vulnerable to anxiety, stress, and health-risk behaviours, during isolation and the prolonged lockdown necessitating special programs to fill gaps in the education system. This brought on board youth serving organizations to work more closely to take services to fellow young people.

WAY FORWARD

- The cluster will work with and support MoH to implement the national immunization plan, conduct special immunization campaigns, introduction of new vaccines, and roll-out of the COVID-19 vaccine.
- More attention and focus will be put on support to maternal, neonatal, childhood and adolescent interventions throughout the country but especially in the KOICA supported districts.
- Documentation and sharing of best practices and case studies will be done for all programmes under this cluster aimed at improved service delivery, fund raising and eventually better health indicators.

A nurse attends to a mother who had just delivered a baby. PHOTO: WHO UGANDA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5

WHO COUNTRY SUPPORT CLUSTER (CSU)

INTRODUCTION

The Country Support Unit (CSU) provides operational support to Programme implementation in terms of financial management, Human Resources, Information Management and Communication (ICT), Logistics, and Compliance and Risk Management. In 2020 the CSU Cluster achieved the following results:

ACHIEVEMENTS

i. Programme Management and Support

- The country office biennial workplan 2020/21 is currently funded at USD 20,993,240 (2020 funding net of carry forwards) compared to USD 34,960,789 for the entire biennium 2018/19.

◀ *Motorcycles ready for dispatch to support community response to COVID-19.*

PHOTO: WHO UGANDA

- Out of the current funding, 25% is from Voluntary Contributions Specific (VCS), 52% for Outbreak and Crisis Response (OCR), 10% for Assessed Contributions (AC) 6% from Specialised Programs and Collaborative Arrangements (SPA), and 7% from Programme Support (PS) and Voluntary Contributions Core (VCC).

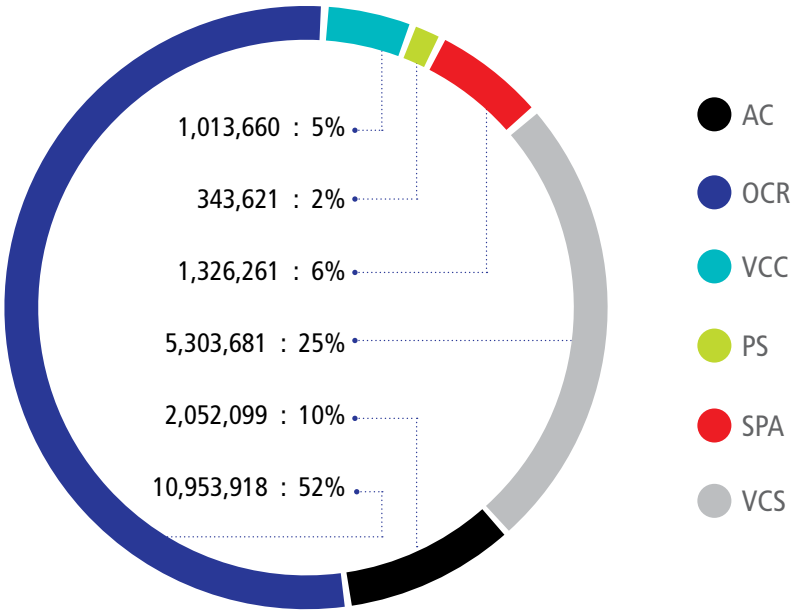


Figure 17: 2020 contributions to country office workplan by fund type

- During the year 2020, the country office mobilized financial resources locally amounting USD 8,131,519 (excluding PSC) compared to USD 13,317,562 for the biennium 2018/19. USD 6,492,462 (79.8%) of the locally mobilised funds relates to COVID-19 response which is above minimum expectation of locally mobilised funding for country offices.

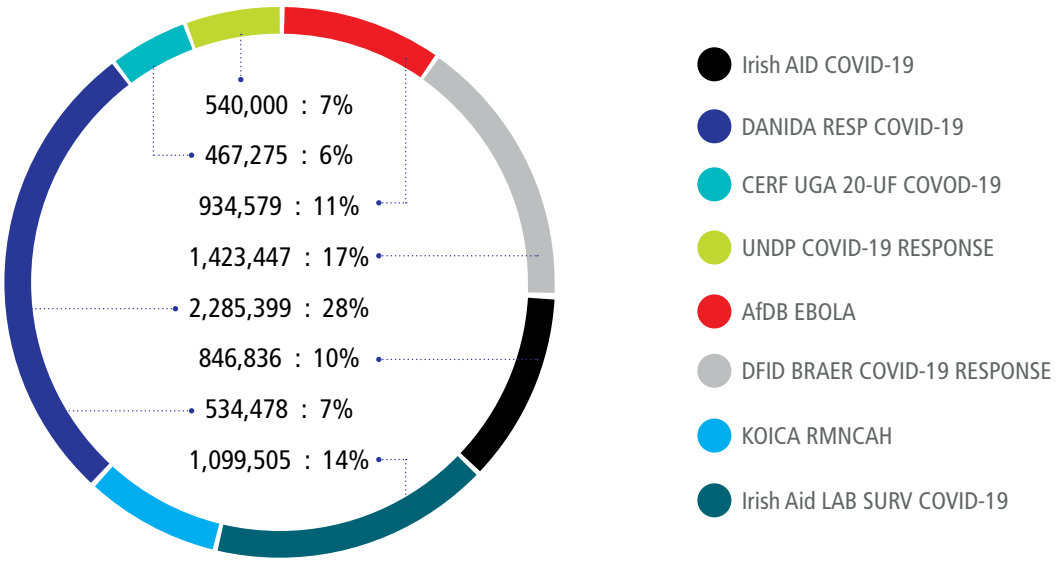


Figure 18: Donor contributions locally mobilised.

- The donor funds were used to support Government of Uganda to implement various activities. During 2020, WHO supported government activities working with implementing partners mainly for COVID-19 response, Oral Cholera vaccination and Essential services.

Table 2: 2020 funds to Implementing partners to support Government activities

COVID-19 RESPONSE	AFENET	147,404	Surveillance (Alert management)
	AMREF	57,212	Surveillance & Case management
	BAYLOR	257,186	Case management
	BAYLOR	52,345	Surveillance
	MAKERERE UNIV. LUNG INST.	118,586	Case management
	IOM	161,198	Points of Entry
	WALIMU	403,533	Case management & IPC
ESSENTIAL SERVICES	BAYLOR	183,956	IMCI in Eastern Uganda
	MakSPH	56,969	SARA Survey in Busoga region
	Malaria Consortium	60,784	Active surveillance (VPD)
	MMHF	60,626	Surveillance (CBDS)
	UNAS	10,510	Coordination (NITAG)
	UVRI	59,761	Environmental surveillance
	WALIMU	9,364	Yellow Fever launch

ii. Compliance and risk management

- In 2020 there was end of year / Biennium closure, preparations for audits with a Due Diligence Review by DFID, and external audits by WHA auditors. Overall, 67% of the external auditors recommendations were closed within 6 months by the outgoing auditors and 33% await the onboarding process of the new external auditors.
- COVID-19 pandemics and global lockdowns created new risks and scenarios in WHO's way of working. The Business Continuity Plan enabled the office to proactively respond to these scenarios. The Risk register was updated timely and the internal controls were reviewed and found to be adequate to support business operations.
- The quality of documentation to support payments was good and from the suppliers' circularization, there was a reduction in outstanding payments as at year end.
- There was an increase in staff training and personal development by more staff accessing the ilearn courses. Some courses such as working remotely helped by keeping staff productive and feeling part of the team while working from home.

iii. *Coordination*

- In addition to providing leadership and technical guidance to the Ministry and partners, WHO also made contributions to the NTF Logistics Pillar and the Supply Chain working group by deploying personnel and managing supplies for EVD preparedness and COVID-19 response.

iv. *Information Community Technology (ICT)*

- During the year 2020, WHO Uganda increased Internet Bandwidth Backed up and the speed from 10kbps to 20 Kbps with a new additional Link.
- Increasingly, WHO staff are being equipped with mobile computing (Laptops, Internet, Voice, Mobile phones and accessories) to able to work virtually.

v. *Human resource management*

- At the end of 2020, WHO Uganda had a workforce of 129 staff of which 46 are staff holding long term contracts and 83 are holders of short-term contracts hired to support EVD preparedness, COVID-19 response and other health emergencies (Special Service Agreement contracts). There are seven experts (International staff) at the WCO. Overall, 41% are female while 59% are male.

Figure 19: WCO Uganda Workforce

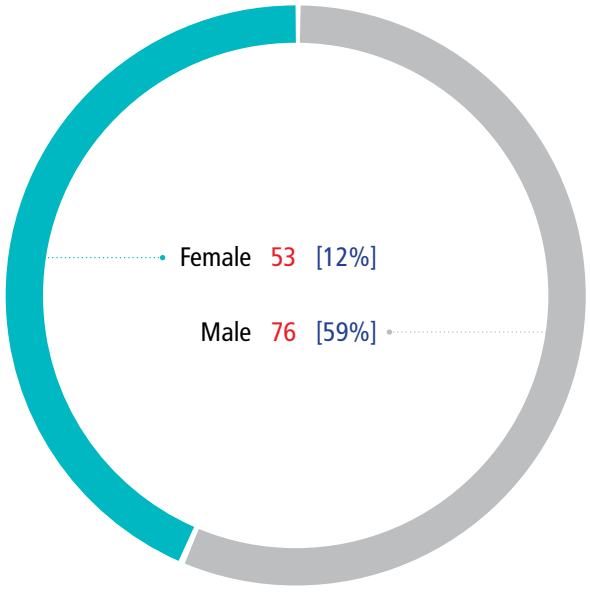
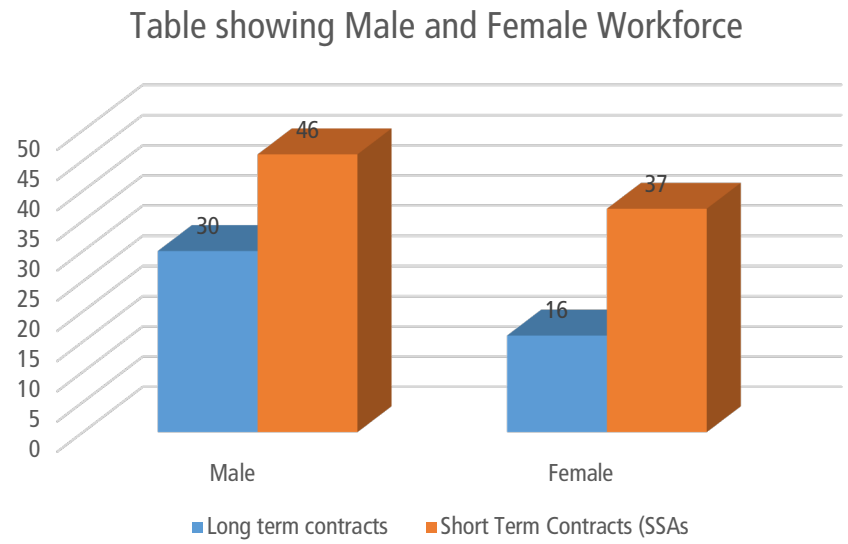


Figure 20: WCO Workforce by gender and type of contract



- The year 2020 saw establishment of objectives, mid-year and end of year performance reviews executed at 80% for all staff members within the established timeframes.
- Human Resource Action Plans (HRAPs) for recruitment, contract renewals or separation were initiated timely as per WHO policy.

vi. Staff Welfare under the UN Wellness Group

- Throughout the year, the UN Wellness Group led by WHO supported by the UN Resident Coordinator and the UN Country Team, improved engagement and well-being of UN staff and their dependents.

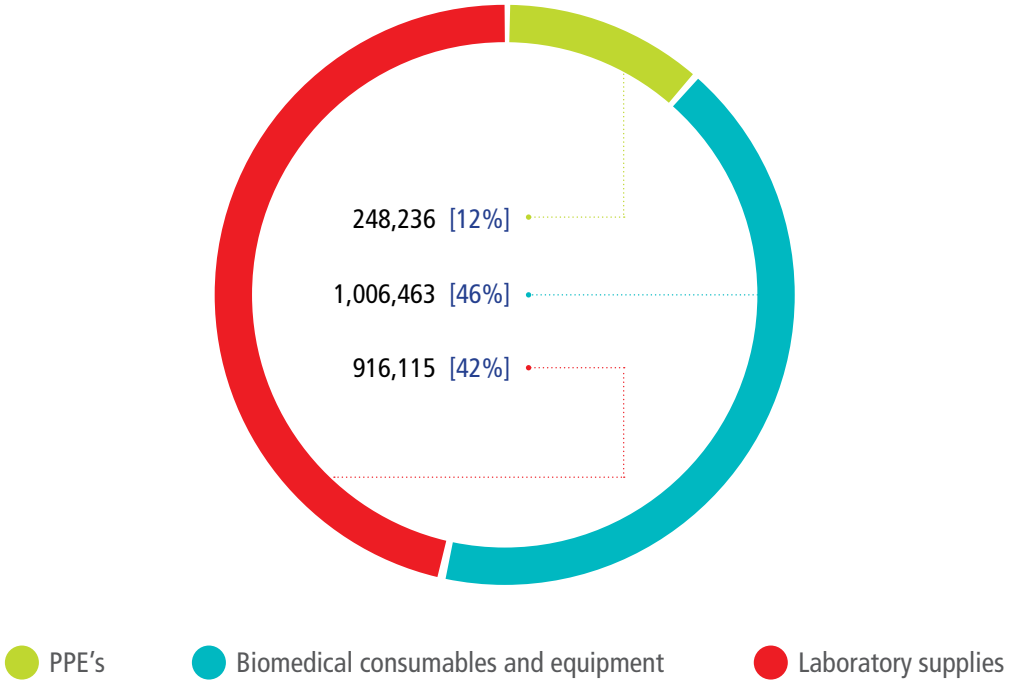
There was increased attention to staff health and wellbeing through improved services at the UN Clinic and engagement with accredited private health institutions.

vii. UN COVID-19 Supply Chain Task Force

- At the beginning of 2020, WHO used its stock of Infection Prevention and Control supplies including Personal Protective Equipment (PPEs) to support Cholera response, Ebola Virus Disease (EVD) preparedness and COVID-19 pandemic. During the year, WHO directly procured critical supplies and services locally and internationally valued at USD 1, 640,125 representing 62.8% and 37.2% respectively.

- Due to the unprecedented scale of the COVID-19 pandemic, many countries were affected by global supply shortages. Under the leadership of the UN Secretary-General and WHO Director-General, the COVID-19 Supply Chain Task Force was established in April 2020 to improve the availability of essential supplies for COVID-19.
- The Task Force, co-chaired by WHO and WFP, provided strategic direction and ensured that supply chains were driven by strategic and tactical health and medical priorities and that the most critical gaps in supplies were identified and met timely. In 2020, WCO/Uganda, through the Portal procured supplies worth USD 2,170,814, as indicated in figure 21 below.

Figure 21: WCO Procurement through the Portal



viii. Transport support to emergency response.

- During the year 2020, WHO Uganda with support from donors supported response to COVID-19 pandemic and other emergencies by providing transportation valued at USD 788,387.98 (See Table 3 below). The major expense areas were sample transportation, contact tracing and emergency coordination.

Table 3: WCO Support to COVID-19 Response Transport

S/N	Activity Name	Amount (UGX)	Amount (USD)	Percentage
1	Alert Management	208,750,000	57,035.52	7.2%
2	Contact Tracing	858,750,000	234,631.15	29.8%
3	Sample Transportation	732,000,000	200,000.00	25.4%
4	Rapid assessment Teams	105,000,000	28,688.52	3.6%
5	STOP 53 Teams	319,500,000	87,295.08	11.1%
6	Yellow Fever Campaigns	10,500,000	2,868.85	0.4%
7	OCV Campaigns	62,500,000	17,076.50	2.2%
8	Regional Hub Field Coordination	588,500,000	160,792.35	20.4%
	TOTAL	**2,885,500,000**	**788,387.98**	**100.0%**

WHO procured various logistics and supplies including motorcycles for the COVID-19 response. PHOTO: WHO UGANDA

ix. Customs Clearance

- WCO has good working relationship with partners such as Uganda Revenue Authority, Ministry of Foreign Affairs, National Drug Authority, National Bureau Of Standards, Ministry of Health and this facilitated timely clearing and delivery of emergency supplies without delay.

x. Distribution and supply management

- WHO worked with partners including National Medical Stores, World Food Programme and Uganda Virus Research Institute to ensure proper storage and distribution of supplies and temperature controlled laboratory diagnostics.

- WHO also received inkind donation from KOICA and Jack Ma of supplies worth USD 289,000 and USD 22,043 respectively. The donations were well stored and distributed with guidance from the technical units of the WCO.

- The eELMIS online took that was introduced in October 2019 by WHO and USAID/MSH enabled districts and regions to access quality data which facilitated quick management decision across all levels of the emergency supply chain thus ensuring greater commodity security, information sharing, timely ordering of supplies leading to lives saved and better health outcomes during emergency situations.

xi. Financial Management

- In September 2020, there was a training for all suppliers on the payment process requirements and the implementation of Electronic Fiscal Receipting and Invoicing Solutions (EFRIS) resulting into efficient and timely submission and processing of eTax Invoices.

- EFRIS is an initiative under the Domestic Revenue Mobilization Program whose aim is to address the tax administration challenges relating to business transactions and issuance of receipts. It is a new smart business solution used to record

business transactions and share the information with URA in real time (concurrently). Refund claims using e-receipts or e-invoices has been fast-tracked given that the information is available in the URA system.

- In view of the new iSupplier for Supplier Registration Portal and enhancements to the current AP self-service page, there was a training conducted by the Global Service Centre to enable registration of suppliers. This was aimed at having all registered suppliers view the status of their payments and update their bank details accordingly.

The Right Honorable Prime Minister of Uganda Dr Ruhakana Rugunda received immunization cold chain equipment worth USD 9 million procured with support from WHO, UNICEF and GAVI. PHOTO: WHO UGANDA

CHALLENGES

- Delays to liquidate encumbrances before the award end dates thus resulting into ex-batches or returning funds to the donors due to the slow rate of implementation of activities.
- Efforts were made to ensure that WHO staff have good ICT equipment, however some users still have old equipment which are overdue for replacement especially considering synergy being implement in WHO.
- There was national and indeed global shortage of critical medical supplies for the COVID-19 pandemic. Several suppliers were not able to complete delivery of orders in time or even deliver at all. The pandemic brought in unprecedented logistics challenges, which constrained the response.

LESSONS LEARNT

- It is important to have regular communication with suppliers and obtain Statements of Account to determine the outstanding payments and mitigate possible reputational risks.
- Critical IPC and PPEs supplies with long shelf life need to be adequately stocked at central and regional levels to cater for any eventualities.

WAY FORWARD

- Ensure that all suppliers are registered in iSupplier Registration Portal to ensure timely payment for goods and services.
- Continuous revision of work plans including aligning planned costs, adjusting award budget to ensure compliance with the International Aid Transparency Initiative (IATI) output reports.
- Continuously identify funds and replace equipment for both technical and support staff.
- The local producers that ventured in the production of PPEs such as masks, sanitizers ought to be supported to enhance quality standards and sustain production. The global travel and transportation restrictions during the Covid19 pandemic demonstrated the need for in country capacity to produce critical basic medical supplies.

SISTER FLORENCE WAISWA GOES HOME TO REST

As we went to press for this report, sad news reached the country office about the demise of our colleague Senior Nurse Florence Waiswa. She lost the fight to COVID-19 which she was in the middle of fighting as an Infection Prevention and Control (IPC) consultant based in Southwestern Uganda overseeing 6 districts.

The fact that Florence was killed by COVID-19 and right at the frontline of duty speaks volumes about her commitment to saving lives of her fellow Ugandans and humanity in general. She died doing what she loved most – preventing disease infections and saving lives.

When Ebola Virus Disease (EVD) broke out in West Africa, Florence was among the 14 health workers from Uganda who readily volunteered to go to Liberia and assist under the World Health Organization (WHO).

In Liberia, Florence and her team under the leadership of the equally indomitable Dr Anne Atai Omoruto (RIP) mounted arguably one of the best case management response to EVD on record. The setting was at the Ebola Treatment Unit (ETU) called Island Clinic in Monrovia City, which was manned exclusively by the Ugandan contingent. This ETU recorded one of the highest recovery rates of EVD patients during that outbreak! At the same time, Florence and her colleagues trained over 1,000 health workers on IPC who eventually contributed to stopping the outbreak. Such was their dedication and commitment to work that they were publicly recognized by the President of Liberia Her Excellency Ellen Johnson Sirleaf.

In Uganda, the soft-spoken Florence participated in different disease outbreak responses usually concentrating on her area of expertise – IPC. In that role, thousands of young and old health workers who interface with dangerous infectious diseases went through her experienced mentoring hands. She was a dedicated field officer who set out to achieve her purpose at all costs. Occasionally, she pushed her leave forward to achieve a given task and rarely took leave on public holidays. She had a great skill of delivering practical sessions which made trainees gain confidence to perform life-saving tasks.

"The demise of Sister Florence is not only a loss to WHO but Uganda as a whole. She served the country diligently in her capacity as an IPC expert to ensure that health workers are safeguarded from the deadly COVID-19 but unfortunately, we lost her to the same," said Dr. Yonas Tegegn Woldemariam, the WHO Representative to Uganda.

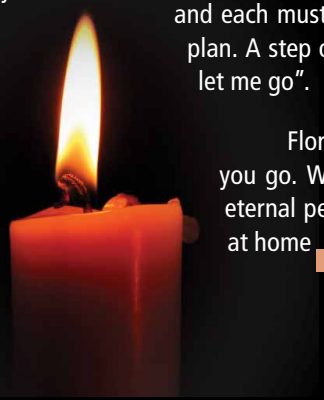
Her son Mr Anthony Wakabi echoed the same sentiments noting that "Mother was a midwife at home. Nursing the neighbourhood in Mutungo and Kitintale. Despite resistance from the family, she went to Liberia. When she came back alive, we knew she belonged to the world so we let her do what she was put on earth to do. Taking care of the sick and controlling the spread of diseases. Mother, you are a hero not only in Uganda but also Africa!"

Her colleagues in the IPC department, Sister Doreen Nabawanuka noted that "Sister Florence will be remembered as a hero to her country and to us that worked closely with her. We are more determined to fight this deadly pandemic than ever before."

Given Florence's contribution and dedication to saving lives, we take inspiration and determination to do more for humanity in the succinct words of the Victorian Poet Christina Rossetti:

"When I come to the end of the road and the sun has set for me, I want no rites in a gloom filled room. Why cry for a soul set free? Miss me a little but not for long for this is a journey we all must take and each must go alone. It is part of the master plan. A step on the road to home. Miss me, but let me go".

Florence, we miss you but must let you go. We shall continue the fight. Rest in eternal peace disease warrior until we meet at home



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