THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

GUIDELINES FOR CONTINUITY OF ESSENTIAL HEALTH SERVICES IN THE CONTEXT OF PUBLIC HEALTH EMERGENCIES

November 2023

Developed with assistance from

World Health Organization Uganda

FOREWORD

The COVID-19 pandemic caused an unprecedented health and socio-economic crisis, which overwhelmed health systems by increasing demand for healthcare resources across the world. Evidence from COVID-19 and other epidemics showed that morbidity and mortality due to other diseases outnumbered those due to the epidemics themselves because of inadequate provision, access to, and utilization of healthcare services. Thus, countries had to make difficult decisions to balance the demands of responding directly to the epidemics while simultaneously engaging in strategic planning, response actions, and adaptations for maintaining essential health service delivery.

The Government of Uganda (GoU) instituted several measures as part of a health emergency response plan to control the COVID-19 pandemic. The Uganda National Security Council set up a multisectoral National Task Force (NTF), which is led by the President, coordinated by the Office of the Prime Minister, and has representatives from several ministries and sectors, including the private sector. To mitigate the impact of the pandemic and its control measures on the provision, access, and utilization of essential health services, the Ministry of Health (MoH) adopted the WHO operational guidance for maintaining the provision of essential health services in the face of COVID-19. This included developing national guidelines and establishing coordination committees to ensure the continuity of essential health services at all levels.

As the country recovered from the COVID-19 pandemic in 2021, an outbreak of Ebola virus disease (EVD) was confirmed in 2022 in Mubende district. The EVD outbreak later spread to seven other districts. To mitigate further spread, a lockdown in the affected districts was imposed, which further disrupted essential health and other social services in the affected districts. Beyond COVID-19 and EVD, Uganda has experienced a number of other epidemics in the past, including Marburg, yellow fever, cholera, and avian influenza, among others. This increase in public health emergencies in the recent past justifies the need to update the national guidelines for the continuity of essential health services. The update is also in tandem with the World Health Organization's recommendation for countries to revise their guidelines to adapt to changing emergencies.

The overall purpose of these guidelines is to contribute towards building a resilient health system in Uganda by sustaining CEHS while ensuring appropriate responses to public health emergencies. Specifically, the guidelines provide key health system building blocks requirements that need to be addressed and programmatic guidance for decision-makers at the national and sub-national levels on adapting and setting priorities to ensure the provision, access, and utilization of essential health services during a public health emergency.

I am grateful to all the individuals and institutions that provided technical guidance in developing these guidelines.

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ACKNOWLEDGEMENT

Public health emergencies such as infectious disease outbreaks, natural disasters, and humanitarian crises affect essential health services due to disruptions in the provision, access, and utilization of services. These threaten to undermine and derail the gains the country has made in improving the health and social-economic status of the population. In the recent past, our health system has been confronted by several public health emergencies, including the COVID-19 pandemic, Ebola virus disease, Marburg, yellow fever, cholera, and floods.

To ensure that the country adequately responds to public health emergencies while maintaining essential health services, the Ministry of Health has developed this guidance on the continuity of essential health services in the context of public health emergencies.

Special recognition is made of the efforts of all the individuals who provided technical input in the development of the guidelines. The Ministry of Health also wishes to acknowledge the technical and financial support of the World Health Organization in Uganda. We also acknowledge the technical support of the Makerere University School of Public Health and the various departments of the Ministry of Health, Implementing Partners, the Private Sector, and District Local Governments.

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ARDS	Acute Respiratory Distress Syndrome
ART	Antiretroviral Therapy

CHW	Community Health Worker
COVID-19	Coronavirus Disease
CEHS	Continuity of Essential Health Services
DHO	District Health Officer
DTF	District Task Force
EVD	Ebora Virus Disease
FP	Family Planning
HCW	Health Care Worker
HSDP	Health Sector Development Plan
HF	Health Facility
iCCM	Integrated Community Case Management
ICF	Intensified Case Finding
IP	Implementing Partner
ICU	Intensive Care Unit
IMT	Incident Management Team (IMT)
IPC	Infection Prevention and Control
LLINs	Long lasting Insecticide Treated Net
MNCH	Maternal Newborn and Child Health
MoH	Ministry of Health
NCD	Non-Communicable Diseases
NTF	National Task Force
PHE	Public Health Emergency
PPE	Personal Protective Equipment
RCSM	Risk Communication and Social Mobilization
RRH	Regional Referral Hospital
RUTF	Ready-to-use therapeutic food
SRHR	Sexual Reproductive Health and Rights
TB	Tuberculosis
ToR	Terms of Reference
UNEPI	Uganda National Expanded Program for Immunization
VHT	Village Health Teams

1.0 OVERVIEW

1.1 Background and rationale

Public health emergencies (PHEs) affect continuity of essential health services (EHS) due to disruptions in provision, access, and utilization of the services. These PHE can be caused by disease outbreaks, climate disasters, or conflict leading to displacement of populations [1]. The COVID-19 pandemic exposed the fragility of health services globally. In multiple settings, provision, access to and utilization of essential health services were compromised with the most vulnerable facing greatest impact; many routine and elective services were suspended, and the existing delivery approaches were adapted, based on the risk-benefit analysis. In addition, the uncertainty associated with job losses, food insecurity, and social care service discontinuations disrupted family and community relationships, hampered opportunities for children, adolescents and young adults, and negatively affected people's mental health and violence in communities. Similarly, the Ebola outbreak in West Africa posed significant challenges to the health system with the most vulnerable, such as women and children, suffering the most.

The Government of Uganda applied several policies and measures as part of its health emergency response plan to control the COVID-19 outbreak. The measures included a national lock down that was implemented in other countries to contain the spread of the disease. This lockdown negatively impacted on access and utilization of health services by communities as most health service providers were closed due to various reasons, including lack of transport for human and material resources needed for service delivery. To mitigate the impact of the pandemic and its control measures on provision, access and utilization of EHS, the Ministry of Health (MoH) adopted the WHO operational guidance for maintaining provision of EHS in the context of COVID-19 [2]. When the country emerged from the worst of the COVID-19 pandemic between 2020 and 2021, an outbreak of the Ebola Virus Disease (EVD) was confirmed in 2022 in Mubende district. The EVD outbreak later spread to 7 other districts including Kassanda, Kyegegwa, Kagadi, Bunyangabu, Kampala, Wakiso and Jinja. To mitigate further spread, a lock down in some of the affected districts was imposed, further threatening to disrupt routine EHS provision. Beyond the COVID-19 pandemic and EVD, Uganda has faced several epidemics in the past 10 years that have posed a challenge to continuity of essential health services (CEHS). Examples of these outbreaks are typhoid outbreaks, cholera outbreaks and viral hemorrhagic fevers [3] [4] [5] [6] [7].

The national response to COVID-19 and EVD restored the emergency response structures at all levels of the health care system. Several committees/pillars by Government and partners were established to ensure coordinated response to the outbreaks while maintaining essential health services. Although the national response to COVID-19 and EVD was commended, the health system response to pandemics and epidemics is compromised by inherent weaknesses such as

[1] World Health Organization. (2018). *Primary health care and health emergencies* (No. WHO/HIS/SDS/2018.51). World Health Organization.
[2] World Health Organization. (2020). COVID-19: operational guidance for maintaining essential health services during an outbreak: interim guidance, 25 March 2020. World Health Organization. https://iris.who.int/handle/10665/331561. License: CC BY-NC-SA 3.0 IGO
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scarcity of resources, poor infrastructure, and high burden of other health conditions such as HIV/AIDS, tuberculosis, malaria, and malnutrition, among others. These challenges support the invaluable need for aggressive containment and preventive measures which may overshadow delivery of other health services to maintain health in the general population.

Due to the frequent public health emergencies (PHE) in Uganda over recent years, there is need to develop comprehensive guidelines to support system resilience for uninterrupted service delivery during any PHE. These guidelines promote a rights-based approach to health care and therefore Universal Health Coverage. Implementing these guidelines will lead to improved health system resilience at national and sub-national levels.

1.2 Purpose of the guidelines

These guidelines contribute towards building a resilient health system for ensuring continued provision, access, and utilization of essential health services while ensuring appropriate response to public health emergencies in Uganda.

The specific objectives of the guidelines are to:

a. Provide key health system building blocks domain requirements that need to be addressed to ensure provision, access, and utilization of EHS during a PHE.
b. Provide programmatic guidance for decision-makers and planners at national and sub-national levels on adapting, setting priorities for and implementing EHS in the context of PHE while monitoring the implementation and impact.

1.3 Target audience

These guidelines are primarily intended for use by national and sub-national policymakers and planners. These include but are not limited to the following:

- The National PHE response structure that includes the: President, Parliament, National Task Force, Director General of Health Services, Incident Management Team, and Continuity of Essential Services Pillar, among others
- Health Sector Development Partners and Implementing Partners
- Private health sector leadership
- International and bilateral agencies and organizations that provide financial and technical support to health programs in Uganda.
- National Program managers include managers for tuberculosis, malaria, HIV, Non-communicable diseases control programs, laboratory services, among others.
- Regional Referral Hospital (RRH) managers, District Health Teams (DHT) and health facility management teams
- Community-based organizations

1.4 Guiding principles

The following principles informed the development of these guidelines and should guide their implementation:

- The implementation of the guidelines should contribute to CEHS in the context of a PHE based on people-centered and integrated health service delivery principles.

- The guidelines are based on strategies that have been employed to ensure CEHS during epidemics or pandemics in different settings.
- The recommendations within these guidelines should be implemented with a view to strengthening the broader national health system, especially delivery of Primary Health Care and protection from financial hardship (Universal Health Coverage).
- Implementation of the recommendations in these guidelines should be informed by regional and district local context, including the PHE faced, resilience of the region/district, availability of resources, organization, and capacity of the health system in the region, and anticipated cost-effectiveness of the interventions.
- Implementation of the guidelines needs to be accompanied by efforts to promote an enabling environment, protection of the right to health care and protection from financial hardship; universal health coverage needs to be fast tracked.
- Implementation of the guidelines should promote greater involvement of the service users of the different EHS.

Development of these guidelines was based on the following:

- The World Health Organization (WHO) recommendation to revise country guidelines to adapt to the changing pandemic conditions, including development of emergency response plans and operational guidelines.
- An increase in public health emergencies in recent past justifies the need to update the CEHS guidelines to support health system resilience for ensuring CEHS.
- National and international evidence on CEHS during public health emergencies in various settings, particularly in Sub-Sahara Africa.

1.5 Methods for developing the guidelines.

The guidelines were developed through a sequential multi-method phased highly consultative and participatory process, involving relevant stakeholders at national and sub-national levels (Figure 1).

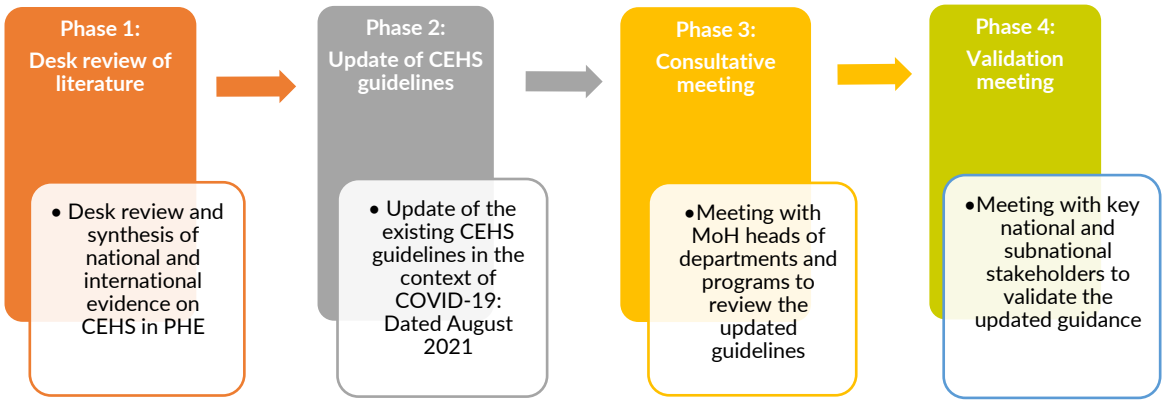

Figure 1. Development phases of the Guidelines on CEHS in PHE

The development process involved:

a. Evidence synthesis of relevant national and international evidence on health service continuity in the context of PHEs. This involved conducted a scoping literature review to

identify strategies for ensuring CEHs during PHEs from different countries/contexts with specific focus on Sub-Sahara Africa: Published and grey literature was reviewed.

b. Update of the existing guidelines on continuity of essential health services in the context of COVID-19 pandemic dated August 2021[8].
c. Consultative meeting with various heads of departments/programs in the Ministry of Health, including the CEHS pillar members and other relevant pillars/NTF sub committees and stakeholders.
d. Meeting with key stakeholders at national and sub national levels to review and validate the updated guidelines.
e. Expert review of the guidelines by national and international experts in health systems strengthening and emergency preparedness and response.

1.6 Organization of the guidelines

This guidance (CEHS in the context of PHE) is structured according to the World Health Organization (WHO) health system framework of 6 building blocks: (i) leadership and governance; (ii) health financing; (iii) supply chain management; (iv) human resources for health; (v) health information systems; and (vi) health service delivery (Figure 2) in chapters 3 to 8. Guidance is provided in line with the respective health system building block sub-domains.

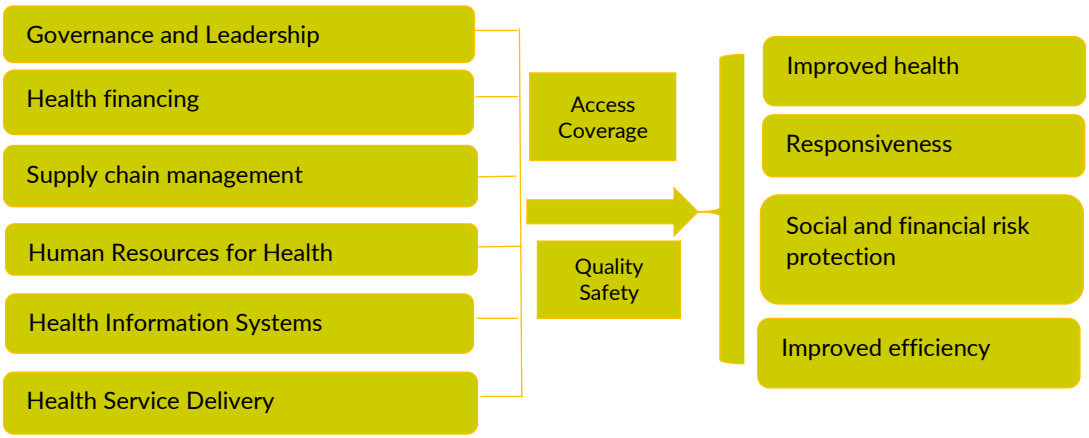

Figure 2. The WHO health systems framework

Chapter 2 presents the essential services based on the Uganda National Essential Health Care Package.

Chapters 3 to 8 provide guidance based on the health system building blocks: Governance and leadership; health financing; supply chain management; human resources for health; health information systems; and health service delivery.

Chapter 9 provides a plan for dissemination and update of the guidelines.

[8] Ministry of Health Uganda, Guidance on Continuity of Essential Health Services in the context of COVID-19 pandemic. August 2021

2.0 THE UGANDA NATIONAL ESSENTIAL HEALTH CARE PACKAGE

The Ministry of Health selected high priority essential services based on the Uganda National Essential Health Care Package (UNEHCP)[9] - summarized in Table 1 below. Two new clusters have been introduced to cover surgical and anesthesia care as well as emergency, critical and high dependency care. Emergency medicine is a specialty concerned with the care and treatment of acutely ill or injured patients who need immediate medical attention. The package also includes PHC defined as "Universally available and affordable preventive, basic curative services and rehabilitative care that the majority of the population needs." Primary Health Care (PHC) is "an overall approach which encompasses the three aspects of: multisectoral policy and action to address the broader determinants of health; empowering individuals, families and communities; and meeting people's essential health needs throughout their lives,." PHC services form the minimum set of services that should be provided to all citizens equitably to address the highest burden of disease among the majority of the population. The selection of these high priority essential services was guided by the Health Sector Development Plan and epidemiological profile of causes of morbidity and mortality in the country.

For each of the package of services, the respective MoH divisions/department/programs shall develop standard operating procedures in alignment with PHE as they occur; for each PHE and dependent on the mitigation strategies in place, the pillar will ensure that priorities are set and this informs the SOPs and algorithms to be developed by the various programs. In addition, MoH will periodically review these packages and updates them in response to the evolving PHE situations.

Table 1: Components of the UNEHCP.

Cluster	High priority essential services for consideration
Cluster 1: Health promotion, disease prevention and community health initiatives	1. Health promotion and education 2. Environmental health and sanitation 3. Emerging environmental health problems 4. Immunization 5. Prevention and control of communicable diseases 6. Prevention and control of NCDs 7. Nutrition services 8. Epidemic and disaster preparedness and response 9. Occupational health and safety
Cluster 2: Management and control of communicable diseases	1. Management of STIs/ HIV/AIDS 2. Management of tuberculosis 3. Management of malaria 4. Management of the neglected tropical diseases (Leprosy, Guinea Worm, Sleeping 5. Management of zoonotic diseases 6. Management of common mycoses and viral infections 7. Management of infections of the ear, skin, nervous, respiratory, digestive, musculoskeletal, and genitourinary systems 8. Sickness, Onchocerciasis, Schistosomiasis, Trachoma, Lymphatic Filariasis, Tungiasis)

[9] Ministry of Health: Uganda National Essential Health Care Package: 2022

Cluster	High priority essential services for consideration
Cluster 3: Management and control of NCDs	1. Management of endocrine and metabolic diseases 2. Management of cardiovascular diseases (Hypertensive diseases and other cardiovascular diseases) 3. Management of disabilities and rehabilitative health 4. Management and palliative care for benign and malignant neoplasms 5. Management of mental and behavioral disorders 6. Management of neurodevelopmental disorders 7. Management of Anemia 8. Management of nutritional disorders 9. Management of non-infectious diseases and disorders of the ear, skin, respiratory, nervous, digestive, musculoskeletal, and genitourinary system
Cluster 4: Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) services	1. Routine antenatal care services 2. Management of hemorrhage 3. Management of maternal disorders related to pregnancy. 4. Maternal care related to the fetus, amniotic cavity, or delivery problems. 5. Delivery care services 6. Emergency obstetric care services 7. Postnatal care 8. Family Planning services 9. Management of the newborn and infections of the newborn 10. Promotion of breastfeeding and complementary feeding 11. Management of common childhood Illnesses 12. Management of gender-based violence
Cluster 5: Surgical and anesthesia care	1. General surgery 2. Pediatric surgery 3. Ear nose and throat surgical procedures 4. Ocular surgery 5. Neurosurgery 6. Oral and maxillofacial surgery 7. Thoracic and cardiovascular surgery 8. Orthopedic and trauma surgery 9. Genitourosurgery 10. Anesthesia 11. Plastic and reconstructive surgery
Cluster 6: Emergency, high dependency, and critical care	1. Management of cardiovascular related emergencies 2. Management of respiratory emergencies 3. Management of severe acute exacerbations of diseases of the gastrointestinal tract 4. Management of emergency complications of diabetes mellitus 5. Management of emergency disorders of the genito-urinary system 6. Management of emergency acute alcohol use disorders 7. Management of emergency drug use disorders 8. Management of acute convulsive seizures and epilepsy 9. Management of severe thermal and chemical injuries (burns)

Cluster	High priority essential services for consideration
	10. Management of envenomation injuries, poisoning, toxic and environmental exposure and injuries 11. Management of severe infections 12. Management of premature births 13. Management of severe mechanical injury 14. Evacuation and referral services 15. Critical care

Box 1: Key recommendations

1. For each PHE, a prioritization of essential health services to be delivered will be done with a view to ensuring the population has adequate access as needed.
2. Following the prioritization, the levels of delivery (National, region, district, Individual, Community, School, health facility (by level), workplace etc.) will be agreed upon with a view to reduce the risk of the beneficiaries from being affected.
3. Based on the peculiarities of the PHE, program areas will develop standard operating procedures (SOPs) and algorithms for guiding continuity of the respective essential health services. These will be revised based on the emergency and setting.

3.0 GOVERNANCE AND LEADERSHIP

Leadership and governance ensure that strategic policy frameworks and guidelines are in place, plans and budgets are developed, and that key stakeholder engagement, and accountability for results exist. In all PHEs, Leadership and Governance are to be championed by the His Excellency the President, and supported by the Office of the Prime Minister, the Ministry of Health at the National level, and the District Taskforce at subnational level. At National level, the leadership and governance function are to be played by the National Taskforce under the Office of Prime Minister and the Strategic Committee at the Ministry of Health. While at the sub-national level, this role is to be played by the District Taskforce, sub-county taskforce, and village taskforces. Leadership and Governance at all these levels have been subdivided into four domains: (i) Key policies and guidelines; (ii) Governance and leadership function; (iii) Stakeholder coordination and (iv) Private sector engagement.

3.1 Key policies and guidelines

This guidance is aligned to the following policy documents.

1. The Public Health Act 2022
2. National Health Policy (review)
3. National Action Plan for Health Security (review)
4. National Development plan 3 (review)
5. The COVID-19 resurgence plan 2021-2022 (review)
6. Continuity of Essential Health Services in the context of COVID-19 pandemic (review)
7. The National Policy for Disaster Preparedness and Management (review)

3.2 Governance and leadership functions

Public Health Emergency (PHE) governance in Uganda has a National Task Force (NTF) which is led by the President. The NTF is coordinated by the Office of the Prime Minister and has representatives from the Ministry of Health, Finance, Internal Affairs, Defense, Works and Transport, Trade and Industry, Information, Communication and Technology, local and city leaders, and the private sector. The NTF oversees and provides strategic direction to the Incident Management Team, which comprises of the Continuity of Essential Health Services (CEHS) as one of the pillars (Figure 3). However, the current governance function emphasizes the control and management of the PHE, with less emphasis on the CEHS during PHEs. Therefore, there is need to strengthen the health governance even when there is no outbreak. This can be done through ensuring that the National Rapid

Response committees have CEHS agenda included and prioritized. The need to strengthen political commitment, leadership, and stakeholder engagement to ensure availability of capacity to implement CEHS interventions during PHE is critical.

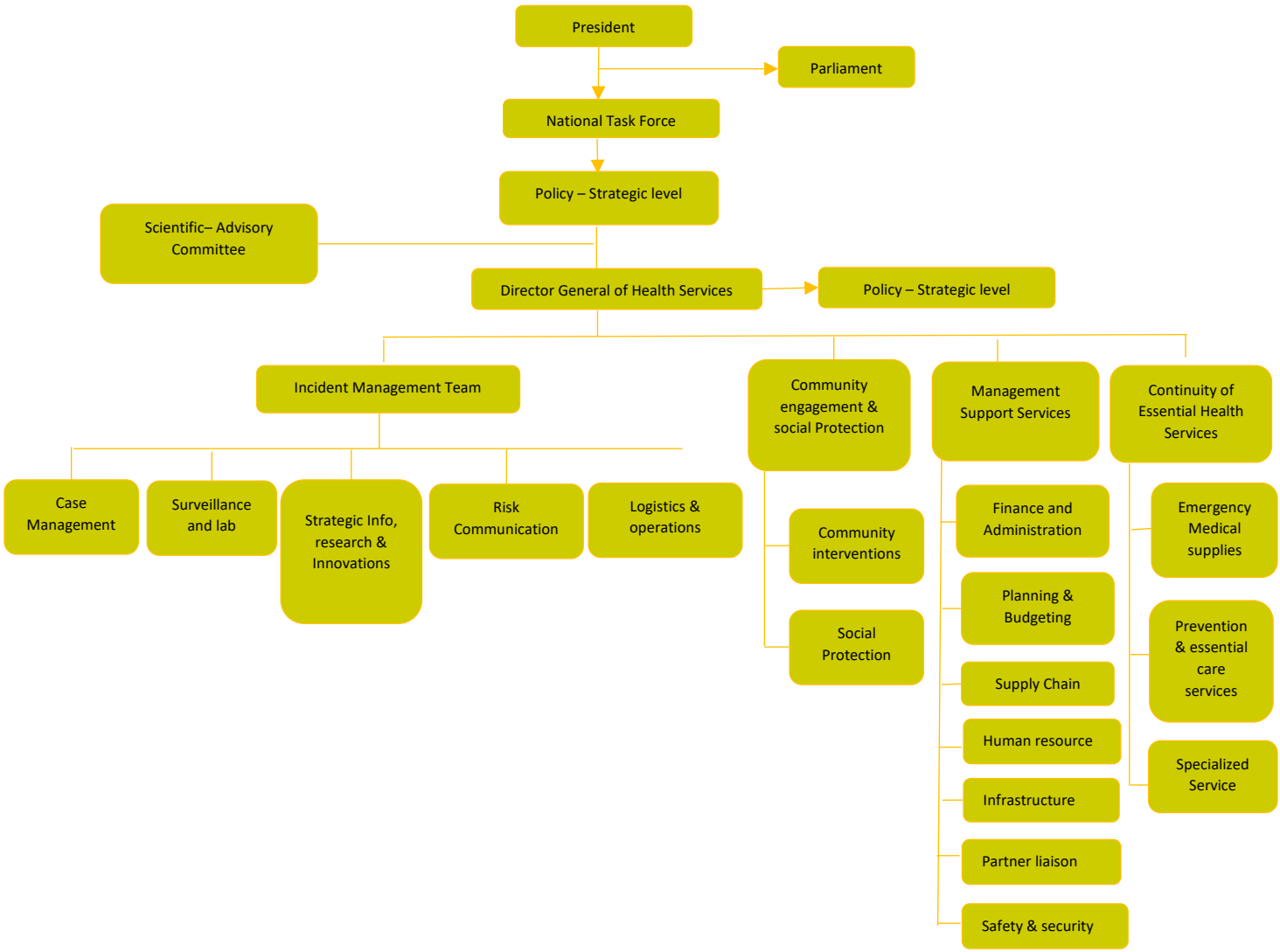

Figure 2. National Task Force for Public Health Emergencies

At National level, the CEHS committee is led by the Director Health Services-Curative and is comprised of the various technical programmes/departments in the Ministry of Health (MoH), Health Sector Development Partners (HSDP) and Implementing Partners (IPs) among others. This committee works in close coordination with the Incident Management Team (IMT)

At sub national level, District Task Force sub-committees on essential health services ensure decentralization of the response efforts. The key responsibilities of the National and subnational level committees include (i) identifying and prioritizing essential health services, (ii) monitor delivery of the services, and (iii) guide optimization of service delivery.

The Terms of Reference (ToR) for governance and coordination structures for CEHS in the context of PHE are summarized in Table 2 below.

Table 2. Terms of Reference for Governance and Coordination Structures for CEHS

Governance and Coordination Structures	
1. CEHS Pillar	
Composition	**Chair:** Director Health Services-Curative **Secretariat:** Continuity of essential health services liaison officer **Members:** • Representatives from all departments and programs in the Ministry of Health including but not limited to: - Maternal and Reproductive Health - Immunization Programme (UNEPI) - Malaria Control Programme - AIDS Control Program - Surveillance department - TB Control Programme - Nutrition - Community health - Laboratory and diagnostic services - Pharmacy including NMS. - Health Information - Mental health - Emergency Medical Services - Clinical services - Blood bank - Non-communicable diseases - Health Service Commission - Planning department - Human resource department • Representatives from Regional Referral Hospitals (RRHs) • Representatives from District Health Offices (DHOs) • Representatives from Health Sector Development Partners (HSDP) • Representatives from Implementing Partners at National and regional level. • Representatives from the private sector (PNFP and PFP) • Representatives from security agencies • Representative from Civil Society Organizations

Governance and Coordination Structures	
Scope of work	The CEHS pillar shall work with the MoH technical programmes/departments, the Incident Management Structures, and others to undertake the following: 1. Establish triggers and thresholds that activate a phased re-allocation of routine comprehensive service capacity towards essential health services. 2. Assess and monitor ongoing delivery of essential health services to identify gaps and the potential need to dynamically remap referral pathways. 3. Support the MoH to identify and prioritize essential health services through: • Generating a list of essential services. • Identifying routine and elective services that can be delayed and disseminate guidance. • Creating a roadmap for a progressive phased reduction of services 4. Guide optimization of service delivery settings and platforms during the PHE • Conduct a functional mapping of health facilities including those in public and private for isolation of cases. • Redirect chronic disease management to focus on maintaining supply chains for medications and supplies with a reduction in provider encounters. • Establish outreach mechanisms as needed to ensure the delivery of essential services. 5. Guide the establishment of effective patient flow (screening, triage, and targeted referrals) at all levels. • Support the sub-committee to disseminate information to prepare the public and guard safe care-seeking behavior. • Establish screening services for all patients visiting all health facilities. • Establish mechanisms for isolation of patients in all care-seeking sites. • Establish clear criteria and protocols for targeted referral and counter-referral pathways. • Establish a waiver awarding system for priority groups under CEHS when lockdown measures are instituted. 6. Develop guidance on re-distribution of health workforce including re-assignment and task sharing. • Map health worker requirements • Maximize occupational health and staff safety measures in all categories. • Create a roadmap for phased implementation of the strategies for timely scale-up. • Initiate training mechanisms including for triage, clinical management and essential infection prevention and control. 7. Identify mechanisms to maintain availability of essential medicines including vaccines, equipment, and supplies. • Map essential services list to resource requirements • Map public and private medicines suppliers • Create a platform for reporting inventory, stock-outs, and conditions for re-distribution of supplies at national and sub-national levels. 8. Liaise with health stakeholders to keep them informed of strategic, programmatic, and operational adjustments. 9. Undertake resource mobilization and support for the implementation of essential services

Governance and Coordination Structures	
Outcomes	✓ Advocacy for sustained and uninterrupted essential health service delivery and utilization ✓ Development and dissemination of guidelines and protocols for uninterrupted essential health services ✓ Framework for national and sub-national engagement and coordination of sustaining uninterrupted essential health services delivery established. ✓ Indicators for closely monitoring essential health services delivery developed. ✓ Strengthened collaboration with other sub-committees and pillars to adapt to the existing standards for continuity of essential health services
Meetings	The CEHS pillar shall hold bi-weekly meetings during an active PHE and quarterly meetings when there is no active PHE
2. Regional Support Teams	
Composition	**Chair:** Director, Regional Referral Hospital **Members:** • Regional coordinators (Including EMS, Epidemiologist, Biostatisticians, Laboratory, Supply chain) • Regional health development partners (HDPs) • Regional Implementing Partners (IPs) • Regional focal persons • Civil Society Organizations • Private sector • Security agencies
Scope of work	• To ensure that the sub-national Task Force Sub-committee on CEHS is fully operational and linked to the CEHS pillar. • To ensure that the regional and District response systems are fully operational and linked to Incident Management Team (IMT) The specific roles and responsibilities of the Regional Support Teams include the following:
	Response:
	1. Analyze and provide regular feedback on the CEHS activities at sub-national level. 2. Support the sub-national Rapid Response Teams hold regular meetings. 3. Follow-up with the sub-national teams to ensure that the CEHS activities priority issues are raised by districts in the regions they support for urgent action. 4. Provide regular update to the national CEHS pillar and support to relay and follow-up the decisions in sub-national level
	Continuity of essential health services:

Governance and Coordination Structures	
	1. Lead the development of regional plans for continuity of health services. This should be done in close collaboration with the DHT within the region. 2. Monitor the implementation of the regional plans for continuity of health services. 3. Technical supervision of the sub-national Task Force sub-committees on continuity of essential health services: o Support the districts to identify, prioritize and implement continuity essential health services delivery during PHE. o Advise sub-national levels on strategies for maintaining essential medicines, supplies and equipment during PHE. 4. Monitor ongoing delivery of essential health services to identify gaps and advise on how to address the gaps during response to PHE. 5. Mobilize the regional HDPs, IPs, CSOs, and other stakeholders to support implementation of essential health services during PHE. 6. Coordinate regional performance reviews to identify gaps in continuity of essential health services delivery and develop joint plans for addressing the gaps. 7. Provide regular updates on CEHS delivery and utilization at sub-national levels to the CEHS pillar. 8. Link the districts to the CEHS pillar and vice versa.
Outcomes	✓ Established regional framework for engagement and coordination of response and essential health services delivery continuity during PHE. ✓ Effective response and uninterrupted EHS delivery and utilization during PHEs ✓ Strengthened collaboration between regional HDPs, IPs, CSOs, sub-national Health Teams and other stakeholders for adapting existing standards while maintaining essential health services delivery. ✓ Strengthened focus on mitigating the direct and indirect impacts of the PHE on the CEHS
Meetings	The regional support teams should hold weekly meetings during the PHE. Meeting minutes should be shared with the IMT and National CEHS pillar.
3. District/City Task Force sub-committee on CEHS	
Composition	**Chair:** District Health Officer (DHO)/ City Mayor **Secretariat** Assistant DHO in-charge of Maternal and Child Health/ City Medical Officer Members: • All DHT members/ City Health Services team • HR officer or CAO's representative • All health sub-district and facility in-charges • All health development and implementing partners. • Civil Society Organizations • Private sector

Governance and Coordination Structures	
Scope of work	The District/City Task Force sub-committee on CEHS will undertake the following during PHE: 1. Establish triggers and thresholds that activate reallocation of routine service capacity towards essential health services. 2. Assess and monitor ongoing delivery of essential health services to identify gaps and the potential need to dynamically remap referral pathways. 3. Identify relevant essential services and support the district to identify and prioritize essential health services; (Prevention for communicable diseases particularly vaccine-preventable, reproductive, maternal and child health services, medicines and essential supplies, medications and supplies for the ongoing management of chronic diseases, continuity of critical inpatient services, emergency health conditions and common acute presentations and auxiliary services-basic diagnostic imaging, laboratory services and blood bank services) • Generate a list of essential services (as per MoH guidance) • Identify routine and elective services that can be delayed and disseminate guidance (as per MoH guidance) • Create a roadmap for a progressive phased reduction of services (as per MoH guidance) 4. Guide optimization of service delivery settings and platforms • Conduct a functional mapping of health facilities including those in public, private and military systems including for isolation of cases. • Redirect chronic disease management to focus on maintaining supply chains for medications and supplies with a reduction in provider encounters. • Establish outreach mechanisms as needed to ensure the delivery of essential services. 5. Guide the establishment of effective patient flow (screening, triage, and targeted referrals) at all levels. • Support the sub-committee to disseminate information to prepare the public and guard safe care-seeking behavior. • Establish screening of all patients at all health facilities • Establish mechanisms for isolation of patients in all care-seeking sites. • Establish clear criteria and protocols for targeted referral and counter-referral pathways. 6. Develop guidance on re-distribution of health workforce capacity including through re-assignment and task sharing. • Map health worker requirements • Maximize occupational health and staff safety measures in all categories. • Initiate rapid training mechanisms including for triage and IPC. 7. Identify mechanisms to maintain the availability of essential mediation, equipment, and supplies. • Map essential services list to resource requirements • Map public and private medicines suppliers • Create a platform for reporting inventory and stock-outs and conditions for re-distribution of supplies at the district level. 8. Liaise and identify resource needs and support from the: health development partners, IPs, CSOs, private sector and other stakeholders in consultation with the CAO.

Governance and Coordination Structures	
Outcomes	✓ Advocacy for sustained and uninterrupted essential health service delivery and utilization in the district strengthened. ✓ Guidelines and protocols on continuity essential health services disseminated. ✓ Established sub-national framework for engagement and coordination around sustaining uninterrupted essential health services delivery. ✓ Development, implementation and monitoring common essential health services delivery indicators. ✓ Strengthened collaboration with other sub-committees of the district task force (DTF) to adapt existing standards for continuity of essential health services. ✓ Strengthened focus on mitigating the impact of PHE on the District Health Care System
Meetings	The DTF/ City TF sub-committee on CEHS will hold weekly meetings during the PHE. Meeting minutes to be shared and approved with the DTF and then shared with National CEHS. CO
4. Subcounty Task Force	
Composition	**Chair:** Subcounty chief **Secretariat: In-charge HC III** **Members** • In-charges of HC IIs • Parish chiefs • LCIII chairpersons • CSOs • CBOs • School representatives • Private sector representatives
Scope of work	1. Assess and monitor ongoing delivery of essential health services in the sub county. 2. Ensure timely ordering of medicines/products for essential health services. 3. Provide updates on new developments pertaining continuity of essential services in relation to the pandemic and SOPs. 4. Guide the establishment of effective patient referral flow to the health facilities from the village/community. Establish clear criteria and protocol for targeted referral from the community. 5. Ensure timely submission of continuity of essential health services data to the health facilities. 6. Ensure that patients on chronic care continue their medication and where necessary be supported to attend clinical reviews during PHEs. 7. Guide mobilization of the community for essential services, while adhering to the SOPS to PHE. Streamline outreach mechanisms as needed. 8. Support risk communication for PHE in the community, as per the MoH guidelines.
Outcomes	✓ Advocacy for sustained and uninterrupted essential health service delivery and utilization in the community ✓ Coordinated delivery of essential health services at subcounty level ✓ Information on continuity of essential health services delivery and utilization is disseminated. ✓ Continued provision of essential health services at subcounty level. ✓ Strengthened coordination between the subcounty and health facility levels of service delivery
Meetings	The Subcounty Task Force should hold monthly meetings. Minutes of these meetings to be shared with the health facility task force.
4. Community (Parish/Village) Task Force	

Governance and Coordination Structures	
Composition	**Chair: Parish chief** **Secretariat:** VHT coordinator **Members** • VHTs • LLC1 and II chairpersons • CSOs • CBOs • Private sector
Scope of work	1. Assess and monitor ongoing delivery of essential health services, delivered by VHTs in the community, to identify gaps and potentially correct these. 2. Ensure timely ordering of medicines/products for essential health services. 3. Provide VHTs with updates on new developments pertaining to continuity of essential services in relation to the pandemic and SOPs. 4. Guide the establishment of effective patient referral flow to the health facilities from the village/community. Establish clear criteria and protocol for targeted referral from the community. 5. Ensure timely submission of continuity of essential health services data to the health facilities. 6. Ensure that patients on chronic care continue their medication and where necessary be supported to attend clinical reviews during PHEs. 7. Guide mobilization of the community for essential services, while adhering to the SOPS to PHE. Streamline outreach mechanisms as needed. 8. Support risk communication for PHE in the community, as per the MoH guidelines.
Outcomes	✓ Advocacy for sustained and uninterrupted essential health service delivery and utilization in the community ✓ Coordinated delivery of essential health services at community level ✓ Information on continuity of essential health services delivery and utilization is disseminated. ✓ Continued provision of essential health services at the community level. ✓ Strengthened coordination between the community and health facility levels of service delivery
Meetings	The Parish/village Task Force sub-committee should hold weekly meetings. Minutes of these meetings to be shared with the health facility task force.

3.3 Stakeholder coordination

Due to the complex nature of PHEs that can be caused by different risks, threats and hazards, the health sector alone cannot effectively respond to emergencies. Thus, a multisectoral approach that leverages and coordinates resources from multiple sectors is required[10]. Face-to-face coordination of key stakeholders is critical for ensuring smooth provision of logistics and reduce the mistrust amongst the actors[11]. The CEHS pillar, under the leadership of the Director General of Health Services, shall organize regular meetings with key stakeholders inclusive of private sector, CSOs, IPs, DPs, patient organizations for information sharing and resource mobilization both before, during, and after PHEs. The frequency of these meetings will be decided upon by the different coordination levels and guided by the CEHS pillar.

[10] https://www.who.int/activities/strengthening-multisectoral-engagement-for-health security#:
[11] http://d-scholarship.pitt.edu/38061/

3.4 Private sector engagement

The private sector includes all organizations and individuals that are neither owned nor directly controlled by government and are involved in the provision of health-related goods and services. These consist of formal and informal healthcare providers ranging from drug shops to specialized hospitals, comprising for-profit and not-for-profit entities, both domestic and foreign. These need to be engaged in ensuring the continuity of essential health services and thus, their representation on all relevant committees is to be implemented. Representatives of the private sector need to take part in the CEHS pillar committees at all levels.

4.0 HEALTH FINANCING

Financing for CEHS shall be prioritized as part of the PHE response plan and its implementation budget. During PHE, there is need to protect the funds for EHS and mobilize for more funds to ensure EHS are provided. Protection of existing funds is key; these should not be swept off to contain the PHE. The CEHS pillar shall mobilize additional resources from stakeholders to implement the CEHS budgeted interventions highlighted in PHE preparedness and response plan.

During PHE, the household income to support out of pocket contribution among patients mainly those on chronic condition may reduce thus affecting their access to essential health care services. Therefore, government and stakeholders should work together to provide additional resources to affected groups to mitigate the resultant burden due to limited availability of essential health services.

Resource mobilization, as described at all CEHS sub-pillar TORs, shall follow key aspects for raising or pooling finances for CEHS in public health emergencies[12][13]. The following will be considered for implementation:

1. Establish and sustain dedicated budgets for national planning and activities for maintaining essential health services delivery. If, in the face of a PHE, funds for EHS are utilized for the response, these should be replaced as soon us funds for the PHE are availed.
2. Conduct regulatory review to address health services fees waiver requirements; and align resources to rapidly address deficits.
3. Establish a system through front-loading budgets and pre-funding public and private providers, contracting and reimbursement mechanisms, equity funds or voucher systems.
4. Increase funding for human resources for health, including the community health workers and their capacity building/enhancement activities.
5. Negotiate with agencies to provide funding to health for EHS through their social cash transfers.
6. Make access to EHS by the entire population, independent of migration status.
7. Continually make adjustments in allocation of funds in the face of a PHE while taking into consideration the populations displaced and facilities that were forced to close. Work with The Office of the Prime Minister and Ministry of Disaster and Emergency Preparedness to include EHS in the emergency vote some money from that dedicated budget can be allocated to CEHS to boost its budget.

[12] https://www.who.int/publications/m/item/covid-19-strategic-preparedness-and-response-plan-operational-planning-guideline

[13] World Health Organization. (2018). *Primary health care and health emergencies* (No. WHO/HIS/SDS/2018.51). World Health Organization.

5.0 SUPPLY CHAIN MANAGEMENT

A well-functioning supply chain management system ensures equitable access to essential medicines and health supplies. This should facilitate timely distribution of routine medicines, vaccines, laboratory supplies and technologies of assured quality, safety, efficacy and ensure their cost-effective use. The supply chain domain is divided into four sub domains: (i) Essential medicines and health supplies; (ii) Basic equipment and technologies; (iii) Laboratory logistics and supplies and (iv) Vaccines and related immunization supplies.

During PHE, the distribution of routine essential medicines and health supplies should not be interrupted by the distribution of emergency response supplies to allow for CEHS.

5.1 Access to essential medicines and health supplies

Ensuring access, affordability, and equity to essential medicines and other health products is critical to resilient health systems. PHEs have shown how quickly failing to safeguard these principles reverses progress towards universal access to health and UHC. Therefore, the coordination and distribution of essential medicines and supplies are paramount, especially during health emergencies. The following actions should be considered:

1) Maintain the mapped essential services list to resource requirements; ensure this information is at hand and ready for a PHE situation.
2) Map major public and private distribution Centres in the area and assess supply chain constraints[14]. Ensure this information is at hand and ready for a PHE situation.
3) Maintain the medicines and supplies for continuity of health care services separate from the emergency response supplies.
4) Ensure that the routine distribution cycles are not disrupted by the distribution activities for the response. Establish distribution mechanisms for the response.
5) Establish mechanisms and alternative service delivery models to ensure CEHS medicines and supplies[15] for example, Differentiated Service Delivery Models- community drug refills, Telemedicine, ICCM:
    - To ensure availability of essential medicines to patients during the response period, the supply chain should ensure continuity of treatment for chronic diseases such as HIV, TB, and NCDs (high blood pressure, diabetes mellitus and mental health).
6) **T**o ensure access to essential medicines and health supplies for CEHS, the following general guidance is provided for facilities:
    - Adherence to the National Medical Stores (NMS)/Joint Medical Stores (JMS) ordering and delivery schedules
    - All facilities should adhere to essential medicines and health supplies management principles as outlined in the medicines management manual.
    - Order supplies in a timely manner
    - Monitor stock by carrying out bi-monthly stock taking exercises.
    - Focus on the unique issues to be considered for each subdomain of the Health System building blocks.

[14] https://www.who.int/publications/m/item/covid-19-strategic-preparedness-and-response-plan-operational-planning-guideline

[15] https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-022-07996-

5.2 Vaccines

1. The distribution of vaccines and other consumables should continue as scheduled by cycles.
2. Stockpiling of essential vaccines and prepositioning the stockpiles strategically in areas prone to emergencies or hard to reach, public-private partnerships should be leveraged on to reduce financial and logistical burdens of vaccines procurement and supply.
3. Streamline regulatory processes to ensure rapid vaccine availability.
4. Allocate government funding for vaccine distribution in emergency situations.
5. Implement public awareness campaigns to inform communities about the importance of vaccination and the safety of emergency use listing vaccines.
6. Address vaccine hesitancy and misinformation
7. Develop efficient transportation and logistics systems to ensure vaccines can reach affected areas rapidly.
8. Rapidly respond to vaccine safety reports

5.3 Access to basic equipment, technology, laboratory, and diagnostic services

1. Maintain availability of equipment and supplies for diagnostics and monitor stocks.
2. The maintenance and servicing of laboratory equipment should continue during the public health emergency.
3. Redistribution of basic equipment and laboratory supplies should continue as necessary and in accordance with the re-distribution guidelines. It should not compromise CEHS.
4. Integrate use testing/diagnostic equipment and supplies for more efficiency. For example, use of the Gene-expert machine for testing multiple conditions including the pathogen of concern, as necessary.

6.0 HUMAN RESOURCES FOR HEALTH

The level of functionality of health systems, as well as its resilience (ability to effectively prepare for, withstand the stress of and respond to public health events), is dependent on health workers. To ensure resilience, health workers should be of adequate number, competent (qualified and

skilled), motivated, empowered and equitably distributed at all levels of care and geographies (rural and urban)[16].

The Global Strategy on Human Resources for Health (HRH) Workforce 2030 emphasizes that health systems can only function well when they have a health workforce with sufficient numbers, and equitably distributed health staff that is skilled, competent, responsive, motivated and productive[17]. The HRH domain has been divided into 4 sub domains: (i) health workforce planning; (ii) Health workforce management (iii) Health workforce safety and protection and (iv) Health workforce education and training.

Preparing the health workforce for future health emergencies and CEHS requires a paradigm shift. Uganda adopts a multidimensional approach that should be mainstreamed by the government and other stakeholders rather than being ad hoc. This entails inclusion of Health workforce policy makers and planners for public health emergencies, conducting workload analysis, and health workforce estimations, guaranteeing the safety of health workers, provision of incentives and improving the knowledge and skills of health workers, in alignment with the subdomains, the following shall be done:

6.1 Health workforce planning

1. Utilize Emergencies' surge calculators to inform planning and ensure availability of the right numbers and cadres[18].
2. Implement a systematic "life cycle" approach to having the workforce that ensures services continuity and respond to the emergency [19].
3. Create and implement a roadmap for phased implementation and timely scale-up of a workforce hiring, re-deployment and redistribution strategy.
4. Strengthen health workforce units to supervise, monitor and evaluate the impact of public health emergencies and work conditions on health workers and implement needed strategies.
5. Advocate for emergency recruitment during PHE. Work with Ministry of Public Service for approvals to do so.

6.2 Health workforce management.

1. Re-distribute health workforce by skill set, including re-assignment within and between facilities and task sharing/shifting by ensuring appropriate working hours and enforced rest periods.
2. Ensure timely payment of relevant remunerations, salaries, or allowances.
3. Health workers in high-risk categories such as those pregnant and over 50 years of age and those with underlying conditions need to be reassigned to tasks that reduce risk of exposure to the contagion.
4. Explore and employ mechanisms to identify additional health workforce capacity to increase health worker availability include the following:
    a. Request part-time staff to expand working hours and the full-time staff to work overtime.
    b. Reassign staff from non-affected areas/facilities/districts/regions.

[16] Preparing the health workforce for future public health emergencies in Africa | BMJ Global Health
[17] Global Strategy on Human Resources for Health Workforce 2030: Geneva, WHO 2016
[18] Preparing the health workforce for future public health emergencies in Africa | BMJ Global Health
[19] https://fmch.bmj.com/content/10/2/e001449

5. Utilize registration and certification records to identify additional qualified health workers, including licensed retirees and trainees for appropriate roles.
6. Identify high-impact clinical interventions for which rapid training would facilitate safe task sharing and consider expansion of scopes of practice where possible.
7. Utilize web-based platforms to provide key training (e.g., on the management of time-sensitive conditions and common undifferentiated presentations in frontline care), clinical decision support and direct clinical services where appropriate.
8. Increase community- and home-based service support with support from Community health Workers (such as Village Health Teams)
9. Engage and increase the capacity of community leaders and Community Health Workers to assist patients who are treated at home and may need support services such as the delivery of food, medication and other goods as well supporting the referral system and follow-up from communities to higher service delivery centers.
10. At operation level, facility managers need to adjust duty roster in accordance with emergency for safety of health worker. The workload needs to be reasonable to ensure staff safety.
11. Equip and prepare CHWs to be able to maintain speed and coverage of community-delivered care[20].

6.3 Health workforce safety and protection

1. Provide guidance, training and supplies to limit health worker exposures to contagion; providing physical security and psychosocial support; treatment, monitoring for illness, stress, and burnout.
2. In case of restricted movements, make transport arrangements for health workers.
3. Offer accommodation arrangements for critical staff, as relevant.
4. Ensure health worker protection and safety during emergencies by providing adequate and appropriate PPE, Training, and IPC[21]
5.
6. For health workers who get infected in line of duty, provide for them special facilities for their treatment.
7. Develop a communication plan for health workers on what is expected of them regarding CEHS during PHEs and, the facility re-arrangements to be done.

6.4 Health workforce education and training

1. Include training of all health workers and health managers on epidemic and pandemic preparedness in the training curricula
2. Train health workers on emergency preparedness and alternative service delivery models[22]
3. Provide staff with increased screening and testing for early detection and treatment[23].
4. Ensure decent working conditions, including implementing occupational health and staff safety measures including psychological support for all health workers and caretakers.
5. Initiate rapid training mechanisms and provide job aids for key capacities, including for screening, triage, clinical management, supply chain management, use of digital tools, and essential IPC measures for existing and newly recruited health workers.

[20] https://bmjopen.bmj.com/content/12/5/e052407
[21] https://pubmed.ncbi.nlm.nih.gov/32414379/
[22] https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-022-07996-
[23] https://pubmed.ncbi.nlm.nih.gov/34246501/

6. Include training on epidemic preparedness and response in the curricula of all cadres of health workers and health managers.

The health workforce investments need to be made across the following areas:

- **Technical workforce**: These comprise all persons with formal pre-service training in the health professions. These include the medical workforce, the nursing and midwifery workforce and the paramedical workforce.
- **Management workforce**: These comprise all persons who carry out management/ leadership functions. These include managers at the national or sub-national levels (MoH headquarter teams and District Health Management Teams (DHMT) and the facility and outreach level managers.
- **Administrative and support workforce**: The comprise all persons providing administrative support functions that are not usually particular to the health sector or require a health professions background. They include accountants, logisticians, clerical, and secretarial staff´.
- **Ancillary, including community health workforce**: These comprise all persons recruited for individual, family and community engagement and mobilization activities.

7.0 HEALTH INFORMATION SYSTEMS

Health information systems (HIS) have four key functions: (i) data generation, (ii) collation, (iii) analysis and synthesis, and (iv) communication and use. This is essential for health-related decision-making. The HIS domain is divided into 3 subdomains: (i) Generation of quality data, analysis, synthesis and use; (ii) Information dissemination and (iii) Research and Innovation

7.1 Generation of quality data, analysis, synthesis, and use

This involves data collection and reporting on essential health service delivery and utilization. Data sources will include national HMIS, program reports and any evaluation results. Key indicators will be used to track essential health services delivery and utilization at various levels; national, regional, district, health facility and community levels. A list of indicators based on relevance, alignment with the national health management information system (HMIS) and the feasibility of data collection and use are prioritized. These indicators are summarized in Table 3 below. Individual programs may, however, add to these indicators on a case-by-case basis as deemed necessary by the program.

Table 3. List of proposed indicators for monitoring CEHS

Area	Indicator
General	• Total number of outpatient attendances or primary care visits • Number of health workers infected, disaggregated by occupational group, including health or care workers in nursing homes and long-term care facilities
MCH	• Number of pregnant women with at least one ANC visit
	• Number of health facility births (disaggregated normal/assisted deliveries including caesarian section)
	• Number of perinatal, neonatal, and maternal deaths
	• Number or percentage of low birth weight (<2500 g) among newborns
	• Number of children younger than 1 year receiving their first dose of DPT, third dose of diphtheria–tetanus–pertussis (DPT3) or their first and second dose of measles Rubella vaccine
	• Number/proportion of HIV exposed infants (HEI) receiving ARVs at birth
	• Number/proportion of HIV positive pregnant & lactating women receiving ARVs for PMTCT
Nutrition	• Number of term infants who were put to the breast within 1 hour after birth (Breastfeeding, early introduction)
	• Number of children 0-59 months diagnosed with severe wasting and bilateral pitting oedema (SAM) • Number of children 0-59 months of age identified with moderate wasting (MAM)
	• Number of children 0–59 months of age who received an age-appropriate dose of **vitamin A** in each semester
Malaria	• Percentage of confirmed malaria cases treated with artemisinin-based combination therapies (ACT)
HIV	• Percentage of adults living with HIV currently receiving antiretroviral therapy who are affected by treatment disruptions
TB	• Percentage of bacteriologically confirmed TB cases that started and completed treatment (disaggregated by sex and age)
SGBV	• Number of cases of violence against women and girls (physical, sexual, other), by type of perpetrator, recorded at the health facility level (SGBV)

FP	• Number of women and girls receiving (a) oral and (b) injectable contraceptives– (FP users)
	• Number HIV +ve women/mothers who receive a method of FP (FP users in high-risk population
NCDs	• Number of patients attending OPD with one underlying NCD condition (disaggregated by type e.g., hypertension, diabetes, Asthma/Chronic Obstructive Airway Diseases, obesity, CVDs, Cancer, Mental illness, etc.)
EMHS	• Essential medicines or supplies for which there is less than 2 months' inventory without confirmation of on-time replenishment or with or without confirmation of replenishment (Logistics/PSM)
Laboratory and diagnostics	• Percentage of essential laboratory and imaging services maintained during the PHE. • Availability of laboratory and imaging supplies during the public health emergency

An indicator matrix for monitoring continuity of essential health services which details data disaggregation, data sources, analysis and frequency is attached in Annex A.

In addition to the above indicators, the top 10 causes of morbidity and mortality will be tracked monthly. Granular analysis of HMIS data at national and district level will be performed and the information periodically shared with key stakeholders. Table 4 below shows the leading top 10 causes of mortality, according to the Annual Health Sector Performance Report (AHSPR) for FY 2020/21[24]

Table 4. Top 10 causes of mortality (AHSPR 2020/21)

No	Top 10 causes of morbidity
1.	Malaria
2.	Pneumonia
3.	Other neonatal conditions
4.	Anaemia
5.	Asthma
6.	Premature babies
7.	Septicaemia
8.	Tuberculosis
9.	Hypertension
10.	Diabetes Mellitus

WHO recommendations[25] that the country adopts:

- Assess and monitor utilization of essential health services and barriers, including financial, gender-based, geographical, and cultural barriers to utilization and identify solutions in close collaboration with communities.
- Strengthen the integrated community-based reporting with facility-based health information systems to maintain a comprehensive approach to monitoring service delivery and utilization.
- Create a dedicated platform for monitoring inventory and stockouts of essential medications, equipment, and supplies, and for the coordination of re-distribution of supplies.

[24] Ministry of Health: Annual Health Sector Performance Report (AHSPR) for FY 2020/21
[25] https://www.who.int/publications/m/item/covid-19-strategic-preparedness-and-response-plan-operational-planning-guideline

7.2 Generation of quality data, analysis, synthesis, and use

Data from the various sources will be aggregated and analyzed periodically to generate reports. Granular analysis of data by region, district and facility levels will be performed to identify areas with drops in essential health service delivery and utilization. This information will be disseminated on a monthly basis to key stakeholders to stimulate action. An interactive dashboard showing coverage maps and line graphs will be developed to facilitate visualization of essential health services data for prompt action. In line with the WHO guidance[26]:

- Disseminate information to prepare the public for changes in service delivery platforms (including outreach and community-based health care), and to guide safe care-seeking behavior.
- Use multiple communication approaches, including social media channels, to build public confidence and encourage continued utilization of essential services during the outbreak.
- Identify information sources trusted by the public – such as primary care clinics, pharmacies, community health workers and leaders, and peer networks – and ensure these sources are kept up to date about changes in essential service delivery and about available resources, such as hotlines.

7.3 Research and innovation

- Embed implementation research in delivery of EHS in PHE contexts in order to provide acceptable and feasible solutions[27] [28]
- Conduct rapid health facility assessments to monitor the evolving capacity to provide essential health services; assess disruptions, mitigation approaches, capacity for screening and triage, workforce capacity and the availability of essential equipment, medicines, and supplies (including PPE)[29]
- Conduct a coverage and equity assessment of the vaccination services, set targets, prioritize interventions, and monitor outcome (reduction in inequalities) as well as process indicators (implementation of pro-equity strategies)"[30]
- Document adaptive responses (such as teleconsultation, integrated primary care, remapping of referral pathways) and incorporate capacity gains from the response into PHC strategies to improve system resilience and integration of health security planning within national health strategic plans.
- Identify the most effective shifts in service delivery, including use of digital platforms, to reduce transmission risks and enhance continuity of care.
- Develop secure digital platforms for clinical decision making and patient care to support health workers. Include self-care-oriented platforms.
- Identify and document local adaptations and innovations to maintain essential health services in hard to reach, low capacity and humanitarian settings.
- Co-design with communities' strategies for meaningful community engagement, building trust, and ownership of innovations to ensure CEHS.
- Monitor and disseminate information on disruption of EHS to inform national and sub-national decisions.

[26] https://www.who.int/publications/m/item/covid-19-strategic-preparedness-and-response-plan-operational-planning-guideline
[27] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9476489/
[28] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7999346/
[29] https://www.who.int/publications/m/item/covid-19-strategic-preparedness-and-response-plan-operational-planning-guideline
[30] https://pubmed.ncbi.nlm.nih.gov/36159029/

8.0 HEALTH SERVICE DELIVERY

In the context of a PHE, ensuring availability of health services that meet a minimum quality standard and securing access to them are key functions of a health system. From the WHO recommendations, Uganda will: (i) **Generate a country-specific list of essential services, ensuring the particular needs of marginalized populations are addressed**; (ii) identify routine and elective services that can be delayed or relocated to non-affected areas, and create a roadmap for progressive phased reduction and re-introduction of services; (iii) **Identify the most effective service delivery platforms during acute phases of crises** and (iv) Conduct functional mapping of health facilities for acute, chronic and long-term care, including those in public and private health systems[31]. Decision-makers need to maintain flexibility in starting, stopping, restarting adaptations for EHS continuity.

Service delivery is divided into 3 subdomains: (i) prevention; prevent exposure to the contagion and disruption of the EHS; (ii) responsiveness and (iii) recovery.

8.1 Prevention

Measures that should be taken at all health care facilities to deliver essential health services effectively should include the following:

a. Health facility staff

- Provide information and training on occupational safety and health, including infection prevention and control (IPC) measures like use and disposal of personal protective equipment (PPE).
- Re-activate/strengthen IPC focal point (s) and IPC committee and ensure its functionality at health facilities.
- Ensure availability of key documents at all levels of care such as IPC SOPs, communication materials (e.g., visual alerts for screening, hand hygiene poster, poster on the use of PPEs, poster on chlorine preparation, etc.).
- Develop contingency plan for equipment, supplies and commodities shortages including IPC materials in collaboration with national and sub-national public health authorities.
- Advise health care workers to check for any signs of illness with the contagion before reporting to work each day and notify their supervisor if they become ill.
- Limiting entry of healthcare workers suspected to be infected with the contagion, monitor their movement, and return to work.
- Orient health workers on diagnosis, triage, clinical management, and referral pathways for cases.
- Provide continuous mentorship through virtual web-based mechanisms. If this is not possible, use physical meetings that strictly adhere to control measures in place.
- Provide, support, or refer health workers for testing, psychosocial support, and counselling resources, as necessary.
- Monitor health care workers and patient's compliance with standard precautions and provide mechanisms for improvement as relevant.
- Modify supportive supervision approach in the event that movement is restricted. Alternative communications can be used between community members, CHWs and supervisors in health facilities. This includes using video conferencing, mobile phones, WhatsApp, SMS etc.

[31] https://www.who.int/publications/m/item/covid-19-strategic-preparedness-and-response-plan-operational-planning-guideline

- Ensure continued community-based support and access to medications and supplies for chronic conditions through the release of stocks for multiple months.
- Monitor supplies for CHWs at the community level: Request and preposition stock of essential supplies and medicines for 2-3 months to minimize the capacity constraints. Consider the need for community buffer stock if utilization of services is anticipated to increase.
- Prepare and support task-shifting to VHTs for services that can be delivered at the community level.
- Have mechanism to pay salaries and other allowances on time. This is for both CHWs and the temporary workers.

b. Community health workers

- Orient/train the community health workers on safety including IPC measures and provide PPEs.
- Orient/Train on the provision of essential health services amidst the public health emergency
- IEC materials such as posters, job aids and flyers on personal protection, hygiene and the emergency of concern should be placed in strategic places.

c. Public/community

- Disseminate the information to prepare the public for any changes in the platforms for delivery of EHS e.g., through outreaches, digital platforms, and repurposed facilities.
- Define essential services which should continue at a minimum, consider antenatal, postnatal, and essential newborn care, sexual and reproductive health services, promotive and preventive services-including immunization[32], and treatment of common childhood conditions (malaria, pneumonia, diarrhea, and malnutrition). Communicate this to the communities.
- Use traditional (e.g., radio) and social media platforms to communicate to the public information on any adjustments to critical service delivery modality to guide health care-seeking behaviors.
- Map out and target the most vulnerable populations that are unable to access and utilize EHS e.g., people with disabilities, the elderly, and refugees.
- Identify, and co-design with communities, safe alternatives for accessing care: This could include telehealth consultations, identification of danger signs, and referrals system.
- Avoid community-level service delivery approaches that entail large gatherings of people.
- Establish and strengthen outreach programs and capacity of CHWs to ensure delivery of EHS.

d. Patients at the facility

For any public health emergency, continuity of triage and screening are particularly important for effective service delivery and identification of suspects infected with the pathogen of concern. The primary aims of triaging and screening are to identify suspected cases as early as possible and isolate/separate them from others to reduce the risk of transmission.

- Adjust hospital admission and discharge protocols to limit the duration of inpatient stays as appropriate and safe.
- Limit -face-to-face encounters by integrating services across disease programs, increasing self-care/management, and using digital platforms as much as possible.
- Consider organizing re-purposed facilities in order to decongest the facilities and limit exposure to the contagion.

[32] Guiding principles for immunization activities during the COVID-19 pandemic

- Modify the screening procedure at the health care facility depending on the emergency prior to any service delivery point.
- Screen all patients, visitors and staff coming to the facility.
- Modify and implement appropriate IPC measures and practices in accordance with public health emergencies.
- Assign a health worker to manage the screening area: These staff should be trained in triage procedures, case definition and IPC.
- Provide appropriate IPC equipment, supplies and commodities at triage.
    - Ensure routine application of standard precautions in relation to ALL patients/caregivers. Assume every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare settings. Create conditions and enforce the implementation of: Hand hygiene; Respiratory hygiene (etiquette); PPE according to the risk; Safe injection practices, sharps management and injury prevention; Safe handling, cleaning, disinfection and sterilization of patient care equipment and soiled linen; Environmental cleaning; and Waste management.
- The case definitions and standardized triage algorithms should be displayed at the triage station.
- IEC materials such as posters, job aids and flyers on personal protection, hygiene, and the emergency of concern should be placed in the triage area and in strategic places around the health facility.
- Assign staff to educate patients and visitors about the early recognition of symptoms, basic precautions to be used and what to do in case of symptoms of emergency of concern.
- Limiting the number of attendants/companions.
- Where possible, explore alternatives to face-to-face triage and visits such as digital technologies, teleconsultation, and virtual platforms to reduce unnecessary healthcare visits and prevent transmission of infections.

e. Suspected or confirmed cases.

Suspected cases should be isolated for the period necessary to confirm their status. The following actions should be taken:

- Health care facilities should identify and establish isolation room (s) for suspected cases.
- Health facilities can repurpose rooms in the emergency department or outpatient department.
- Health facilities without isolation rooms should look for ways of establishing isolation spaces and beds in the vicinity of health facilities through re-purposing of ancillary buildings, schools, churches, other spaces or setting up temporary structures/tents for isolation and management of mild and moderate cases.
- Care for all suspected and confirmed cases should take place in the designated treatment area, according to disease severity and acute care needs.
- All health facilities should be made aware of the dedicated transfer ambulances for suspected or confirmed cases.
- Ensure that IPC measures are always respected during patient referrals.

f. Referral

Local authorities should establish transportation systems to allow access to health services. This includes:

- Allocate ambulances to support referral for essential health services: Avoid deployment of all ambulances to deal with PHE.

- Streamline the referral pathway for essential services in alignment with the adjusted made to cater for PHE.
- Setting up a list of transportation providers outside health facilities to ensure adequate coverage of the entire population in the community.
- Widely communicate to the public the process and contacts of relevant officials/providers for transportation of patients

8.2 Responsiveness

In the event of a PHE, there is need to modify the health service delivery approaches to ensure continuity of essential services. This could be achieved through:

- Identify routine and elective services that can be delayed or relocated to non-affected areas and create a roadmap for progressive phased reduction and re-introduction of services[33]
- Ensure integrated services and CEHS strategies are adapted into routine care[34]
- Differentiated service delivery including multi-month dispensing of drugs, virtual educational care, telehealth consultations and language-sensitive information, responsive to the needs of patients to alleviate the burden on the healthcare system[35]
- Use of mobile teams to provide essential services during crisis[36]
- Prioritize treatment (non-urgent care and/or elective surgeries cancelled or postponed[37]
- Establish triggers/thresholds for phased reallocation of capacity from routine comprehensive services towards essential services, and for the re-expansion and transformation of services as the pandemic evolves.
- Establish outreach mechanisms and strengthen community-based health care, including increased availability of medicines at pharmacies, as needed to ensure delivery of essential services.

Immediate actions to re-organize and maintain access to essential health services.

Measures that should be taken at all health care facilities to deliver essential health services effectively:

1) Orient all health facility personnel and disseminate information on critical services and service continuity in the context of the particular PHE to the public to guide healthcare-seeking behaviors.
2) Ensure triage and screening of all patients on arrival to facilitate the early recognition of cases of suspected contagion using its standard case definition.
3) Establish mechanisms for isolation/separation of patients with suspected or confirmed contagion and for referral of cases according to disease severity and acute care needs.
4) Enhance infection prevention and control and apply stringent standard precautions at all times to ensure safe delivery and continuation of essential health services and protect health workers.
5) Establish mechanisms to maintain the availability of essential medications, equipment, and supplies. (Systems for community delivery of medicines for stable patients on chronic care programmes to reduce defaulters and congestion at health facilities - this applies to patients that usually need regular medicine refills – TB, HIV, Epileptic, Hypertensive, Diabetes, children with SAM, etc.)
6) Rapidly re-distribute health workforce capacity, including by re-assignment and task sharing.
7) Ensure continuity of care through optimizing community health platforms (e.g., outreaches and community-based programmes such as ICCM) and linkages to primary health facilities.

[33] https://www.who.int/publications/m/item/covid-19-strategic-preparedness-and-response-plan-operational-planning-guideline
[34] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9716818/
[35] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9389928/
[36] https://pubmed.ncbi.nlm.nih.gov/36158930/
[37] https://pubmed.ncbi.nlm.nih.gov/34246501/

8) Mobilize and work with NGOs and the district CDO to establish necessary prevention and management services for SGBV/GBV
9) Mobilize and work with youth-serving organizations and Family Planning service providers both private and public to scale up availability of adolescent-friendly services and Family planning services at all levels including pharmacies and trained drug shops.

DHTs should map all available ambulances (govt, private, NGO) in the district and assign catchment health facilities for each of the ambulances. Establish/update the CHWs/VHT database for the entire district.

The sections below detail the specific activities for each measure listed above.

a. Orient all health facility personnel and disseminate information to the public on critical services and service continuity in the context of the PHE to prepare and guide healthcare-seeking behaviors.

All health care facilities should orient their health care staff on the following:
- Provide information, instruction and training on occupational safety and health, including refresher training on infection prevention and control (IPC); and use, putting on, taking off and disposal of personal protective equipment (PPE). Orient health workers on diagnosis, triage, clinical management, and referral pathways for infected persons.
- Disseminate optimized guidance on the continuation of essential services.
- Explore virtual web-based rapid training mechanisms, mentorship, and supportive supervision opportunities to orient health workers. If this is not possible, use physical meetings that strictly adhere to social distancing measures in place (e.g., not more than 5 people in a room, at least 1m between people, etc.).
- Work with other service providers so as to increase coverage and reach out to vulnerable populations without congesting health facilities.
- Continue to promote social/physical distancing.
- Increase health education programs in liaison with opinion leaders and community leaders of all categories as well as media houses.

In addition, all health care facilities will:
- Provide a blame-free environment for workers to report on incidents, such as exposures to blood or bodily fluids from the respiratory system or to cases of violence, and to adopt measures for immediate follow-up, including support to victims.
- Honor the right to compensation, rehabilitation, and curative services if infected with the contagion following exposure in the workplace. This would be considered occupational exposure and resulting illness would be considered an occupational disease.
- Provide, support, or refer their health personnel for psychosocial support and counselling resources as found necessary.

Use traditional (e.g., radio) and social media platforms to **communicate to the public information on any adjustments to critical service delivery modality** in the context of the PHE to guide health care-seeking behaviors.

b. Ensure triage and screening of all patients on arrival to facilitate the early recognition of cases of suspected contagion using its standard case definition.

During infectious disease outbreaks, triage and screening are particularly important to separate patients likely to be infected with the pathogen of concern. Screening is the process in which a healthcare worker (HCW) rapidly and systematically assesses all patients at first point of access based on the standard case definition for early recognition of possible pathogen and immediate isolation of patients with suspected disease in an area separate from other patients. The primary aims of screening are to:

- Identify suspected cases as early as possible.
- Isolate/separate patients with suspected cases from other patients, HCWs and visitors to reduce the risk of transmission and avoid nosocomial infections.
- Allow for prompt notification of public health authorities and testing for the pathogen.

Set up a screening area for all patients, visitors and staff coming to the health facility.

- Install a screening station at the health care facility entrance, prior to any waiting area to screen patients for the pathogen. An existing structure with a roof using locally available materials, plastic sheeting, tent or shed under a tree can be used. Ensure that all patients, visitors, and staff coming to the health facility go through the screening area.
- In the screening area, install water handwashing stations with soap or make readily available alcohol-based hand rub at the triage area for the use of healthcare workers, patients, and visitors. Add a physical barrier (e.g., table, 1 m spatial distance) between the patient and the health worker.
- Assign dedicated trained health workers (e.g., nurses) for physical evaluation of patients presenting with respiratory symptoms at triage. These staff should be trained in triage procedures, pathogen case definition, and appropriate personal protective equipment (PPE) use. Also, train personnel working in the reception of patients on how to perform hand hygiene, maintain appropriate distance, and on how to advise patients properly on the use of facemask (if aerosol pathogen), hand hygiene, and separation from other patients.
- Provide personal protective equipment (PPE), i.e., gloves and medical mask, and other screening equipment for health care workers (HCW) at the triage station, based on specifications for the pathogen.
- Increase hand washing facilities in both the compound, entry points to the health facilities and inside the health facilities with special attention to maternity services.
- Ensure HCW wears appropriate personal protective equipment, stands at least 1 meter away from patients and visitors during screening. Ensure HCW cleans hands with soap and water before putting it on and after taking off PPE. A bin with lid should be available at triage where patients can discard used paper tissues.
- The pathogen case definition and a standardized triage algorithm/questionnaire should be displayed at the triage station. HCWs should be encouraged to have a high level of clinical suspicion of the pathogen.
- Post information, like posters, job aids and flyers on protection, signs and symptoms and prevention means, at the triage area and in strategic places around the health facility. Assign staff to educate patients and families about the early recognition of symptoms, basic precautions to be used and what to do in case of symptoms.

Set up a "respiratory waiting area" for Aerosol contagion.

- Healthcare facilities without enough single isolation rooms or those located in areas with high community transmission should designate a separate, well-ventilated area where patients at high risk for infection with the contagion can wait. This area should have benches, stalls or chairs separated by at least one meter distance.
- Post clear signs informing patients of the location of "respiratory waiting areas." Train the screening staff to direct patients immediately to these areas after registration.
- Install water handwashing stations with soap or make readily available alcohol-based hand rub at the "respiratory waiting area."
- Develop a process to reduce the amount of time patients are in the "respiratory waiting area," which may include:
    - Allocation of additional staff to triage patients at high risk for contagion.
    - Setting up a notification system that allows patients to wait outside of the facility (if medically appropriate) in a place where social distance can be maintained and be notified by phone or other remote methods when it is their turn to be evaluated.

c. Establish mechanisms for isolation/separation of patients with suspected or confirmed contagion/pathogen and for referral of cases according to disease severity and acute care needs.

Following the screening and triage, patients suspected of the contagion should be isolated for the period necessary to evaluate/confirm their status and be taken care of. To ensure this:

- Health care facilities should identify and establish a single isolation room(s) for pathogen suspected cases. HCFs can repurpose rooms in the emergency department or outpatient department.
- Healthcare facilities without enough single isolation rooms should look for ways of establishing isolation spaces and beds in the vicinity of health facilities through re-purposing of ancillary buildings, schools, churches, other spaces or setting up temporary structures/tents for isolation and management of mild and moderate cases of pathogen.

Care for all suspected and confirmed contagion patients should take place in the designated treatment area, according to disease severity and acute care needs.

- All health care facilities should be made aware of the designated health facilities for the management of patients with contagion established within their jurisdiction (district or municipality) and the referral pathways according to the disease severity and acute care needs.
- MoH, RRHs and DHOs should communicate the details of contagion designated facilities to all command and dispatch Centres for appropriate destination triage.
- All health care facilities should be made aware of the dedicated transfer vehicles and ambulances for all suspected or confirmed infected persons.
- Ensure that IPC measures are always respected during patient retrieval and transport and that vehicles are disinfected properly.
- Establish communication channels between healthcare facilities and public health authorities who can facilitate linkages with laboratory testing and epidemiology/contact tracing. Have the list and telephone numbers of focal points (e.g., surveillance, lab, transport) readily available at the health facility level.
- HCFs should also distribute contact information to communities.

Referral of non-contagion cases from communities and inter-facility referrals

Local authorities will work to establish transportation systems to allow patients to access health services and support referrals. Among others, this will include:

- Clarifying the management of ambulances and sharing the contact details with all health facilities
- Setting up a list of transportations providers outside health facilities ensuring adequate coverage of the entire population in the district/municipality.
- Referral systems should support transportation for maternal (ANC, delivery), newborn and child, acute conditions (e.g., malaria, accidents), etc. in line with the list of essential services.
- Widely communicate to the public the process and contacts of relevant officials/providers for transportation of patients.

d. Enhance infection prevention and control, and always apply stringent standard precautions to ensure safe delivery and continuation of essential health services and protect health workers.

The goal of IPC activities in the PHE response is to support the maintenance of essential healthcare services by preventing healthcare-associated transmission of contagion among healthcare workers and patients.

Core facility IPC activities regardless of epidemiologic scenario involve the following:

1) (Re)activate IPC focal point(s) and IPC committee and ensure its functionality.
2) Ensure availability of key documents at all levels of care such as IPC SOPs, communication materials (e.g., visual alerts for screening, hand hygiene poster, poster on the use of PPEs, poster on chlorine preparation, etc.).
3) Ensure routine application of standard precautions in relation to ALL patients. Assume every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare

settings. Create conditions and enforce the implementation of: Hand hygiene; Respiratory hygiene (etiquette); PPE according to the risk; Safe injection practices, sharps management and injury prevention; Safe handling, cleaning, disinfection and sterilization of patient care equipment and soiled linen; Environmental cleaning; and Waste management.

4) Develop plans to carry out actions that prevent the spread of acute respiratory infections (ARI), within the facility and in the community, including:
    - Triage at initial healthcare facility encounter.
    - Identification of out- and in-patients with suspected contagion of concern.
    - Advise HCWs to check for any signs of illness before reporting to work each day and notify their supervisor if they become ill. Limiting entry of healthcare workers with suspected contagion, monitor their movement and return to work.
    - Limiting entry of visitors.
    - Where possible, explore alternatives to face-to-face triage and visits. The following options can reduce unnecessary healthcare visits and prevent transmission of respiratory contagions in the facility:
        - Instruct patients to use available telephone lines, on-line self-assessment tools, or call and speak to a clinic and available hot-line staff (at national and district level) if they become ill with symptoms linked to the contagion.
        - Where possible, identify staff to conduct telephonic and telehealth interactions with patients. Develop/implement protocols so that staff can triage and assess patients quickly via telephone.
        - Determine algorithms to identify which patients can be managed by telephone and advised to stay home, and which patients will need to be sent for emergency care or come to your facility.
5) Develop and implement SOPs for environmental cleaning procedures, particularly for the triage and isolation areas where suspected or confirmed contagion patients will be placed.
6) Develop staffing plans to adequately staff isolation areas and consider whether to cohort staff is feasible.
7) Provide adequate IPC and PPE supplies (masks, gloves, goggles, gowns, hand sanitizer, soap and water, cleaning supplies) in sufficient quantity to healthcare or other staff caring for suspected or confirmed contagion patients, such that workers do not incur expenses for occupational safety and health requirements.

Follow infection control processes for managing visitor access, including essential support persons for women in labour (e.g., spouse, partner) and provide PPE as appropriate for the protection of women and babies and visitors.

1. Consider the impact of theatre Infection Control Procedures on theatre availability and account for when operating on confirmed or suspected contagion infected patients.
2. Develop contingency plans for PPE shortages and other IPC consumable (e.g., alcohol-based hand rub) shortages in collaboration with national and sub-national public health authorities.
3. Develop communication plans to ensure adequate internal and external communication regarding the contagion.
4. Educate HCW, patients, and visitors on the contagion signs, symptoms, and required IPC protocols.
5. Establish communication channels between healthcare facilities and public health authorities who can facilitate linkages with laboratory testing and epidemiology/contact tracing.
6. Monitor health care workers and patient's compliance with standard precautions and provide mechanisms for improvement as relevant. Establish mechanisms to maintain the availability of essential medications, equipment, and supplies.

e. Establish mechanisms to maintain availability of essential medications, equipment, and supplies.

The supply chain to ensure continuity of established treatment regimens for key chronic diseases (HIV, tuberculosis, high blood pressure, diabetes, mental health) are to be strengthened to limit acute

exacerbations, reduce the need for provider encounters, and minimize unscheduled attendance at emergency departments.

- Review the quantification of essential medicines and supplies at health facilities to ensure optimized care for chronic (e.g., tuberculosis, HIV, diabetes, hypertension) and acute (e.g., acute malnutrition) – as per updated guidelines in the context of the PHE.
- Check and regularly monitor the vaccine stocks.
- Report low stocks and stock outs via mTRAC.
- Place orders in line with the updated quantification
- Monitor stocks and take proactive actions to avoid stock-outs, including through redistribution of stocks within the jurisdiction.

f. Rapidly re-distribute health workforce capacity, including by re-assignment and task sharing.

Many health facilities in Uganda already face existing health workforce challenges. Any PHE may further limit the availability of health workers to deliver essential services during the outbreak, including through re-assignment of staff to treat increasing numbers of patients with the contagion, and loss of staff who may be quarantined, infected, or required to care for infected friends and family. The combination of increased workload and reduced number of health workers is expected to pose a severe strain on the capacity to maintain essential services. These predictable challenges should be managed through a combination of strategies.

Critical support measures include:
- ensuring appropriate working hours and enforced rest periods.
- providing guidance, training and supplies to limit health worker exposures.
- providing physical security and psychosocial support.
- monitoring for illness, stress, and burnout; and
- ensuring timely payment of salaries.

Health workers in high-risk categories for complications from the contagion, including HCWs who are pregnant, are over 60 years or have an underlying condition, may need to be reassigned to tasks that reduce risk of exposure.
Offering accommodation arrangements to reduce staff travel time and protect health workers' families from exposure may be appropriate.
Mechanisms to identify additional health workforce capacity include:
- Request part-time staff to expand hours and full-time staff to work overtime.
- Re-assign staff from non-affected areas (ensuring alignment of clinical indemnity arrangements where relevant).
- Utilize registration and certification records to identify additional qualified workers, including licensed retirees and trainees for appropriate supervised roles.
- Mobilize non-governmental, military, Red Cross, and private sector health workforce capacity, including through temporary deployment to the public sector where relevant.
- Identify high-impact clinical interventions for which rapid training would facilitate safe task sharing and consider expansion of scopes of practice where possible.
- Utilize web-based platforms to provide key training (e.g., on the management of time-sensitive conditions and common undifferentiated presentations in frontline care), clinical decision support and direct clinical services where appropriate.
- Increase community- and home-based service support with support from community-based volunteers (such as Village Health Teams, Red Cross Volunteers).
- Engage and increase the capacity of local community leaders and VHTs to assist patients who are treated at home and may need support services such as the delivery of food, medication, and other goods.

g. Ensure continuity of care through optimizing community health platforms and linkages to static points of care, including primary health facilities.

- **Define core and essential services which should continue (in consultation and with support to and from national authorities):** at a minimum consider antenatal, postnatal, and essential newborn care, sexual and reproductive health services, promotive and preventive services-including immunization[38], iCCM (or community IMNCI) for malaria, pneumonia and diarrhea (including referral for severe cases), Vitamin A supplementation, deworming (where the context applies), and screening, and referral for acute malnutrition and treatment for uncomplicated wasting.
- **Define roles for CHWs and supervisors in the provision of core service delivery:** including potential adaptations, deviations or modifications to their existing role and treatment and referral protocols.
- **Identify, and co-design with communities, safe alternatives for requesting and accessing care:** This could include telehealth consultations to obtain client history, identification of danger signs, and provide referrals.
- **Modify modality of supportive supervision:** in the event that movement is suspended as part of contagion control response, alternative communications will be needed between community members, CHWs and supervisors in health facilities. This can include using mobile phones, SMS, WhatsApp, etc.
- **Revise and update guidelines and SOP for safe client interaction:** As part of the national and primary healthcare social communication, reinforce IPC including handwashing with soap immediately before and after each visit and maintaining a safe interpersonal distance of 1meter. In situations where sufficient supplies of appropriate and effective PPE cannot be made available to avoid contamination between patients, consider a CHW-supervised 'No Touch' policy, especially in communities with high contagion transmission[39];[40]. Consider task sharing and shifting of responsibilities between caregiver and CHW when diagnosing and caring for a sick child (e.g., caregiver administered MUAC, RDT, rectal artesunate with CHW supervision) and modification of case management protocols as appropriate.[41]
- **Develop community guidelines for IPC inclusive of CHWs and community platforms:** Guidelines should be informed by national policy and the local health system context, transmission phases and availability of resources for IPC.
- **Avoid community-level service delivery approaches that entail large gatherings of people:** Manage queues to ensure a safe interpersonal distance of 2 meters. If needed, temporarily suspend mass vaccination campaigns to reduce community transmission. Monitor and re-evaluate at regular intervals the necessity for the delay of mass vaccination and child health days campaigns and maintain contact tracing of children who have missed vaccinations to ensure they receive needed services post-COVID (i.e., mop-up campaigns).
- **Encourage and facilitate referrals for primary healthcare** (antenatal, delivery, postnatal, EPI/ immunizations, Vitamin A, deworming, screening, and referral for cases of acute malnutrition and other SRH services, cases of severe disease). Continuity of primary healthcare is essential but facility-based utilization may decline because of fear, stigma, mistrust, misinformation, or other restrictions on access. CHWs and other community platforms should encourage continued care-seeking of essential services and facilitate referrals to primary healthcare facilities.
- Support review of policies to **ensure continued community-based support and access to medications and supplies for chronic conditions (HIV, TB) through the release of stocks for multiple months.**

[38] Guiding principles for immunization activities during the COVID-19 pandemic

[39] The introduction of the Low and No-Touch Policies should be guided by local transmission patterns and attack rates. In areas with low or no transmission which could include rural and remote, hard to reach areas, 'No Touch' policy may not be necessary. If and when transmission patterns evolve and cases emerge, consider adopting 'No Touch' with clear guidance and training for CHWs.

[40] No Touch Guidelines for CHWs providing iCCM during Ebola are currently under revision and the guidance will be updated to address risks and mitigate transmission of COVID19 to CHWs providing care for sick children

Reduction of provider encounters at primary health care facilities will ease the burden at the facility level, simultaneously easing access issues when travel restrictions are enforced.

- **Quantification and pre-positioning of sufficient supplies**: immediately assess available supplies at the community level for CHWs to continue offering essential services. Request and preposition stock of essential supplies and medicines for 2-3 months to minimize the capacity constraints and not to overburden health facilities and to limit travel and contact between communities. Consider the need for community buffer stock if utilization of CHWs services is anticipated to increase or treatment protocols are modified for presumptive treatment. It is advised to ensure that CHWs providing curative services have sufficient stock of supplies to diagnose and treat malaria, pneumonia, and diarrhea for at least two months.
- **Prepare and support task-shifting to Village Health Teams for services that can be delivered at the community level.**

8.3 EHS Recovery Plan

- Implement a recovery plan for services to catch up with the EHS for example organizing outreach services, catch-up visits for example vaccination of children, HIV, TB, chronic conditions, ANC[42] and emergency preparedness.

9.0 DISSEMINATION AND UPDATE OF THE GUIDELINES

The Ministry of Health CEHS pillar will work closely with the line Ministries, other PHE pillars, program managers and health/implementing partners to ensure the guidelines are disseminated at national and sub-national levels. Dissemination will be through various channels such as: meetings, print publications, power point presentations, and MoH e-portal/website.

The guidelines will be updated in full, or part based on changes in evidence, country experience and the PHE landscape. The CEHS pillar will trigger the review process and bring on board all key stakeholders. As needed, technical updates will be provided on specific domains and program areas. The maximum interval for review shall not exceed five years.

[42] https://pubmed.ncbi.nlm.nih.gov/36180374/

ANNEX A

Table 5. Indicator matrix for monitoring continuity of essential health services during public health emergencies

No	Indicator Name	Disaggregation	Data source	Means of Verification	Frequency	Responsible	Collaborating partners
1	Total No. of outpatient attendances or primary care visits	By type of HF and PPP	HMIS	Field monitoring / supervision	Weekly Monthly	Biostatician	DHMT partners
2	No. of health workers infected by COVID-19	Occupational group, HF type	DTF Situation Report	Field monitoring / Supervision	Weekly Monthly	DHO/DTF Chair	DTF Partners
3	No. of pregnant women with at least one ANC visit	1st ANC in first trimester, 4th ANC visits	HMIS	Field monitoring / supervision	Monthly	Biostatistician	MCH Partners ADHO-MCH
4	No. of health facility births	Normal deliveries & caesarian section	HMIS	Field monitoring / supervision	Monthly	Biostatistician	MCH Partners ADHO-MCH
5	Number of perinatal, neonatal, and maternal deaths	Perinatal deaths and Maternal deaths	HMIS	Field monitoring / supervision	Weekly Monthly	Biostatistician	DHMT partners ADHO-MCH
6	No. or percentage of low birth weight (<2500 g) among newborns	Gestational age and gender,	HMIS	Field monitoring / supervision	Monthly	Biostatistician	DHMT partners
7	No. of children < 1 year receiving their third dose of (DPT3) or their first dose of measles vaccine		HMIS	Field monitoring / supervision	Monthly	Biostatistician	DHMT partners EPI focal person
8	No. or percentage of HIV exposed infants (HEI) receiving ARVs at birth		HMIS	Field monitoring / supervision	Monthly	Biostatistician	DHMT partners
9	No. or percentage of HIV positive pregnant & lactating women receiving ARVs for PMTCT	By pregnancy or lactating status	HMIS	Field monitoring / supervision	Monthly	Biostatistician	DHMT partners
10	No. of children 0-59 months diagnosed with severe wasting and bilateral pitting oedema (SAM)	By severity	HMIS	Field monitoring / supervision	Monthly	Biostatistician	DHMT partners
11	No. of children 0–59 months of age who received an age-appropriate dose of vitamin A in each semester	By age	HMIS	Field monitoring / supervision	Monthly	Biostatistician	DHMT partners

No	Indicator Name	Disaggregation	Data source	Means of Verification	Frequency	Responsible	Collaborating partners
12	No. of children 0-59 months of age identified with moderate wasting (MAM)	By age	HMIS	Field monitoring / supervision	Monthly	Biostatistician	DHMT partners
12	Percentage of confirmed malaria cases treated with artemisinin-based combination therapies	By age group (U5, A5)	HMIS	Field monitoring / supervision	Monthly	Biostatistician	DHMT partners
13	Percentage of adults living with HIV currently receiving antiretroviral therapy who are affected by treatment disruptions	By age and gender	HF Report	Field monitoring / supervision	Monthly	Biostatistician HIV clinic in-charge	DHMT partners
14	Percentage of bacteriologically confirmed TB cases that achieve treatment completion/cure (disaggregated by sex and age)	By age and gender	HMIS	Field monitoring / supervision	Monthly	Biostatistician TB focal person	DHMT partners
15	No. of cases of violence against women and girls (physical, sexual, other)	By type, perpetrators, age of victims	HMIS	Field monitoring / supervision	Monthly	Biostatistician MCH/SGBV in Charge	DHMT partners
16	No. of term infants who were put to the breast within 1 hour after birth (Breastfeeding, early introduction)	By time (within 1 and after 1 hour)	HMIS	Field monitoring / supervision	Monthly	Biostatistician MCH/NUT in Charge	DHMT partners
17	No. of women and girls receiving (a) oral and (b) injectable contraceptives– (FP users)	By FP contraceptive type	HMIS	Field monitoring / supervision	Monthly	Biostatistician MCH/FP in Charge	DHMT partners
18	No. HIV +ve women/mothers who receive a method of FP (FP users in high-risk population)	By childbearing status and FP contraceptive type	HMIS	Field monitoring / supervision	Monthly	Biostatistician MCH/FP in Charge	DHMT partners
19	No. of patients attending OPD with one underlying NCD condition (disaggregated by type e.g..)	By NCD type (hypertension, diabetes, Asthma/Chronic Obstructive Airway Diseases, obesity, CVDs, Cancer, Mental illness, etc.), age and gender,	HF Report	Field monitoring / supervision	Weekly Monthly	District Biostatistician (DHMT) & Surveillance/NCD in Charge	DHMT partners
20	Essential medicines or supplies for which there is less than 2 months' inventory without confirmation of on-time replenishment or with or without confirmation of replenishment (Logistics/PSM)	By type of medicine / supplies, duration, …	HF Report	Field monitoring / supervision	Weekly Monthly	Biostatistician PSM in Charge	DHMT partners

No	Indicator Name	Disaggregation	Data source	Means of Verification	Frequency	Responsible	Collaborating partners
21	Percent of essential laboratory and imaging services maintained during the PHE	By type of services supplies, duration, …	HF Reports	Field monitoring / supervision	Weekly Monthly	Biostatistician	DHMT, partners
22	Availability of laboratory and imaging supplies during the PHE	By type of supplies, duration, …	HF Reports	Field monitoring / supervision	Weekly Monthly	Biostatistician	DHMT, partners