Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

Uganda Mission Report
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ACKNOWLEDGEMENTS

The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (IOAC) is very grateful to the Republic of Uganda for hosting the visit and providing excellent support. The IOAC also wishes to express its appreciation to the WHO Country Office in Uganda, the Regional Office for Africa, and Headquarters for offering their time and sharing their insights in a transparent manner.
MISSION OBJECTIVES AND ACTIVITIES CARRIED OUT

In light of the Ebola outbreak in North Kivu province, Democratic Republic of the Congo (DRC), and the large-scale movement of people across the border, the Independent Oversight Advisory Committee (IOAC) for the WHO Health Emergencies Programme (WHE) judged it appropriate to conduct a field visit to the neighbouring country of Uganda. The objective of the mission was to review the effectiveness of WHO’s overall Ebola response and WHO’s work to support country preparedness and core capacity building for the International Health Regulations (IHR).

The Chair of the IOAC met with WHO senior management and the Ebola Incident Management Team at Headquarters prior to the field visit, which took place from 15 to 19 October 2018. During the visit, the IOAC team had meetings with the Ministry of Health, the WHO Representative to Uganda and his team in the WHO Country Office, and key partners including CDC, DFID, MSF, the Red Cross, UNICEF, UNHCR and WFP. The IOAC visited the Uganda Virus Research Institute (UVRI) before travelling to four high-risk districts bordering the DRC, namely Bundibugyo, Kabarole, Kasese and Ntoroko. During the district visits, the IOAC met with the local district administration team, medical officers, health-care workers, volunteers and partners on the ground. The IOAC observed the various entry screening points and visited Ebola treatment units (ETUs) in different districts.

BACKGROUND

Immediately after the announcement of the end of the DRC’s ninth recorded Ebola outbreak in Equateur province on 1 August 2018, the Ministry of Health declared a new outbreak of Ebola in North Kivu province. Cases were also subsequently found in Ituri province. By 15 October 2018, a total of 216 cases of Ebola (181 confirmed and 35 probable cases), including 139 deaths, had been reported in seven health zones in North Kivu province, and three health zones in Ituri province. Of the 139 deaths, 104 were among confirmed cases. A total of 20 health-care workers had been affected as of 15 October 2018.1

North Kivu and Ituri are among the most populated provinces in the country and both share borders with Uganda. The north-eastern area of the DRC has been affected by insecurity and a humanitarian crisis due to protracted armed conflict over decades. The current Ebola outbreak is the country’s largest ever and the situation remains dangerous and unpredictable. There is a potential risk of transmission at national and regional levels given the 1 million internally displaced people in the DRC and the continuous movement of refugees to neighbouring countries, including Uganda, Burundi and Tanzania.

Given the context and the challenges around the outbreak in the DRC, the first International Health Regulations (IHR) Emergency Committee on the Ebola virus disease outbreak in the Democratic Republic of the Congo, was convened on 17 October 2018.

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1 SITREP: [http://apps.who.int/iris/bitstream/handle/10665/275458/SITREP_EVD_DRC_20181017-eng.pdf?ua=1](http://apps.who.int/iris/bitstream/handle/10665/275458/SITREP_EVD_DRC_20181017-eng.pdf?ua=1)
Nine neighbouring countries have been advised that they are at high risk of spread and have been supported with equipment and personnel. Particular emphasis has been placed on Uganda, Rwanda, Burundi, and South Sudan in terms of preparedness activities.2

Geographical distribution of confirmed and probable Ebola virus disease cases in North Kivu and Ituri provinces, Democratic Republic of the Congo, 15 October 2018 (n=216)
Source: http://apps.who.int/iris/bitstream/handle/10665/275458/SITREP_EVD_DRC_20181017-eng.pdf?ua=1

FINDINGS AND OBSERVATIONS

WHO’s response to the Ebola outbreak in the DRC

The IOAC noted strong commitment and leadership by WHO’s senior management including the Director-General, Regional Director for Africa and Deputy Director-General of emergency response and preparedness. The IOAC observed an immediate escalation of response activities

by the Ministry of Health, WHO and partners, following the declaration of the outbreak of Ebola. The Ministry of Health and WHO immediately deployed rapid response teams to the affected health zones to initiate response activities using a no-regrets approach. The IOAC acknowledged that an excellent Incident Management System (IMS) model has been established and is managed well by all levels of the Organization. Staff noted that there is good and transparent communication through the IMS at different levels.

The IOAC noted that WHO is working on response, research and preparedness with a wide range of multisectoral and multidisciplinary regional and global partners and stakeholders, including in neighbouring countries. Collaboration with the partners on the ground as well as in Headquarters (46 organizations participating in the response as of October 2018) seemed to be very good, particularly the relationship with WFP, MONUSCO and UNDSS.

The response to the Ebola outbreak in the DRC is being seriously impeded by the increasing insecurity in Beni and surrounding areas, reducing the effectiveness of contact tracing, early identification of cases, and ring vaccination, which raises serious concerns about the containment of the outbreak. With the current security situation in North Kivu, the risk of the regional spread of Ebola is very high. Security is a critical part of the Ebola response, enabling WHO to carry out daily operations at the epicentre of the outbreak. The IOAC recognizes that WHO is operating in one of the most hazardous and complex contexts.

**WHO’s support for Ebola preparedness in Uganda**

In May 2018, WHO conducted a formal rapid risk assessment which determined that the public risk was high at the regional level following the notification of an Ebola case in Equateur province.

On the basis of this rapid risk assessment, the WHO Regional Office for Africa identified nine countries neighbouring the DRC with the aim of supporting them with preparedness and readiness activities: Angola, Burundi, Central African Republic, Republic of Congo, Rwanda, South Sudan, Tanzania, Uganda and Zambia. A strategic regional plan has been developed in collaboration with these nine countries.³

Uganda has a long and porous border with the DRC. There are cross-border markets in several border districts in Uganda and DRC that involve up to twenty thousand people per day crossing into and out of DRC and Uganda for trade purposes in the markets, a couple of times a week. The epicentres of the ongoing Ebola outbreak in DRC – Beni and Tchomia – are located about 100 km and 20 km from the respective borders of Uganda.

³ Regional plan for EVD preparedness and readiness
Uganda has demonstrated the capacity to respond to emergencies and has previous experience in managing recurring disease outbreaks such as Crimean-Congo haemorrhagic fever, Ebola and Marburg virus disease. Uganda started implementing response measures in August 2018 upon notification of the case from North Kivu. This response has been led by the Ministry of Health in support of WHO. The National Task Force is replicated from local to national level including key partners, and information flows between the levels.

The IOAC noted that Uganda developed its first Ebola preparedness plan during the West African Ebola outbreak in 2014 and revised it following the Ebola outbreaks in the DRC, most recently in May 2017 and in May 2018. The IOAC noted that WHO is supporting the government to implement Ebola readiness activities together with other partners.

[Map of Uganda showing the high risk districts]

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The IOAC was very impressed by the country’s political support, Ministry of Health leadership, technical capacities built on previous outbreaks, and local districts’ commitment and engagement through well established mechanisms (the National Task Force, District Task Forces, Emergency Operation Centre, budget allocation for Ebola, regular meetings, standard operating procedures [SOPs], and protocols widely shared down to the district level).

The IOAC was told that the Joint External Evaluation (JEE) conducted in 2017\(^5\) helped the country identify gaps and that the process was very useful in preparing for an Ebola outbreak and improving readiness. However the JEE recommendations were not yet fully implemented at the time of the mission. There are concerns with regard to the country’s long borders and the large-scale movement of people (about 20 000 people per day travel twice a week for the market at Mpondwe and 2000 per day in Bundibugyo). The IOAC observed that there is close contact between families spread across the border of DRC and Uganda. The IOAC also noted that Uganda has been open and generous in hosting refugees, and allowing them free movement.

Given the sociocultural context and in light of the deteriorating security situation in Beni, Ebola has become a serious threat to Uganda. WHO should support active engagement among the neighbouring countries and further cross-border coordination for preparedness activities and screening, particularly in Tchomia-Ntoroko and other districts on the border.

Intense efforts have already been made in terms of Ebola preparedness and a high number of health-care workers and auxiliary staff/volunteers have been mobilized in all districts. There is a standard framework, IMS and protocols to be followed. While the National Task Force and the District Task Forces are aligned, and communicating on a weekly basis, coordination and resource sharing among the neighbouring districts at the time of the mission, seemed lacking, and there may be a need for more granular reporting.

All five high-risk districts have ETUs and are conducting point-of-entry (POE) screening activities on the borders. Screening is taking place at POEs on a massive scale, but better screening structure and quality control, and dissemination of community awareness/educational material at POEs would be desirable.

The IOAC reiterates the importance of community-based surveillance and recommends further investment in community engagement and intensified training of health-care workers in surveillance, case management, infection prevention control and clinical management.

There is some variability in terms of capacity and quality among the different districts and further efforts are required for training, technical support and mentorship. The IOAC noted that there is potential to share resources and expertise among the districts. Gaps in risk communication, community engagement and community mobilization still exist.

The IOAC was briefed that protocols for Ebola vaccination and treatment were under review by the national authorities. After the IOAC’s mission, on 7 November 2018, the Ministry of Health, with support from WHO, started vaccination of frontline health-care workers in the five high-risk districts bordering the DRC.

The IOAC recognized that Uganda has developed strong laboratory capacity: the UVRI and the Joint Mobile Emerging Disease Intervention Clinical Capability (JMEDICC) programme are exemplary. However, there are concerns about financial sustainability and surge capacity.

**Operational and technical partnerships in Uganda**

In Uganda, WHO is seen as a credible partner of the Government and recognized as the coordinating agency for Ebola preparedness and response. Regular meetings of the National Task Force are chaired by the Director-General of Health or the WHO Representative.

The key partners seem to appreciate WHO’s leadership as a technical agency for Ebola that provides timely epidemiological information on the ongoing Ebola outbreak. However, they urged that WHO should better support the Ministry of Health regarding the pending decision around vaccine protocol approval, and lead the activities of various partners in a more coordinated way. Further coordination and collaboration with partners would be required at the field level to enhance Ebola awareness, community-based surveillance, community engagement, and training of community health workers and safe and dignified burial teams. Partners also noted that a high turnover of focal persons in partner agencies was a challenge to coordination.

Donors appreciated the “one plan, one budget” approach (referring to a joint strategic response plan for Ebola in the DRC) led by WHO. The IOAC was briefed by the WHO Secretariat that there was an extremely positive donor response to the joint strategic response plan for the Ebola outbreak in Equateur province, which exceeded the initial total funding request of US$44 million. However, the donor response to the preparedness plans for the DRC and neighbouring countries has been slow. The IOAC emphasizes the importance of preparedness and readiness.

**WHE implementation at country level**

Both WHO staff at country level and partners whom IOAC interviewed during the visit noted the successful implementation of WHO’s reform of its work in emergencies and outbreaks and its positive impact on the current Ebola outbreak. Partners recognized WHO’s “no regrets” approach in the Ebola response in the DRC and in assisting with preparedness in Uganda. An IMS has been set up in Uganda as part of preparedness and readiness efforts and WHO Country Office staff have been reorganised as per a new IMS organogram. The Ministry of Health noted that the deployment of five Ugandan experts with a Special Services Agreement (SSA) to the high-risk districts has been extremely helpful.

WHO Country Office staff showed appreciation towards the Regional Office and Headquarters, remarking that they are very supportive and consultative in emergencies. Staff noted that there

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was good support and three-level collaboration during the last Marburg outbreak and Ebola preparedness activities. Three-level teleconferences on the Ebola response are considered useful and are highly appreciated by Country Office staff.

The IOAC noted that there is high awareness of emergency SOPs and Delegations of Authority in the Country Office but that staff are experiencing difficulty in implementing them. Multiple layers of staff involved in the process have different levels of understanding and confidence. WHO is encouraged to make further efforts to familiarize all levels of staff involved in emergency business processes with SOPs for timely and full implementation.

The WHO Country Office in Uganda has been classified as a WHE priority 3 location, but recruitment of the planned positions is pending due to a funding gap. The IOAC noted that additional challenges include lack of a talent pool, disagreement on suitable candidates between the three Organizational levels, and the speed of recruitment processes in non-emergency contexts. The IOAC noted that WHE priority country classification and the Country Business Model should be regarded as a benchmark and that HR planning should be adapted to country-specific needs.

CONCLUSION

The IOAC acknowledged that WHO continues to respond to the Ebola outbreak in DRC by working side-by-side with the Ministry of Health and partners on the ground. However, the response has been severely hampered by security challenges, further increasing the risk that the virus may spread to neighbouring provinces and countries.

Uganda is well advanced in making the WHE Programme a reality in the way that it works closely with the Regional Office and Headquarters. It is a country that is experienced at dealing with major outbreaks, including Ebola, and has internal and regional capacity to manage them successfully. The strong National Task Force mechanism, with District Task Forces communicating regularly, is an established method of working with all partners and has enabled the Government to work with WHO to strengthen its preparedness plans over several years.

Although Uganda is doing all the right things in terms of preparedness, it now needs to accelerate its implementation in communities, ensuring that cases can be swiftly identified through surveillance mechanisms and community engagement, as a matter of urgency.

Findings from the Uganda field visits emphasized the importance of IHR core capacities and long-term investment in preparedness and readiness. Given the ongoing Ebola outbreak, WHO’s work in support of the neighbouring countries’ Ebola preparedness should be given priority.