MINISTRY OF HEALTH

Guidance on Continuity of Essential Health Services during the COVID-19 outbreak

April 2020

Acknowledgment

Uganda has a robust health sector development plan that seeks to, among other goals "accelerate movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life" The health of the population is central to the socio-economic development of country. Unfortunately, the COVID-19 pandemic significantly threatens to undermine and derail the gains the country has achieved in improving the health and social-economic development of Uganda.

Uganda health system resilience is being tested by this pandemic and to ensure that the country responds adequately and mitigates the impact of the pandemic, the Ministry of Health (MOH) developed these guidelines to address the increased demand on the health system generated by COVID-19 pandemic on delivery of essential health service while maintaining uninterrupted quality essential health service delivery.

The Ministry of Health would like to express its sincere appreciation to all the health sector development partners including the civil society, the private sector, non-government organisations and the UN system in Uganda.

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Acronyms

ARDS	Acute Respiratory Distress Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretrovirals
CHW	Community Health Worker
COVID-19	Coronavirus disease
DHO	District Health Office
DHMT	District Health Management Team
HCW	Health Care Worker
HF	Health Facility
iCCM	Integrated Community Case Management
ICF	Intensified Case Finding
ICU	Intensive Care Unit
IPC	Infection Prevention and Control
LLINs	Long lasting Insecticide Treated Net
MNCH.	Maternal Newborn and Child Health
PCR	Polymerase Chain Reaction
PEEP	Positive End Expiratory Pressure
PPE	Personal Protective Equipment
RCSM	Risk Communication and Social Mobilisation
RRH	Regional Referral Hospital
RUTF	Ready-to-use therapeutic food
TB	Tuberculosis
UNEPI	Uganda National Expanded Program for Immunization
VHT’s	Village Health Teams

Introduction and overview

The unprecedented COVID-19 pandemic has rapidly spread across the world. As demonstrated by the experience of countries at the forefront of the outbreak (China, Iran, Italy, Spain, USA etc.), COVID-19 can quickly overwhelm any health system due to increased demand for services and disrupt the delivery of essential health services at both facility and community levels, placing many children, mothers and population at large at risk of dying from existing preventable and/or treatable conditions.

As of 15 April 2020, 45 out of 47 Member States of the WHO African Region have reported COVID-19 cases[1]. The experience with Ebola Virus Disease (EVD) outbreak in 2014 saw more people dying from malaria than from the outbreak hence the need not to have a repeat the same experience with COVID-19. WHO Regional Director for Africa, Dr Matshidiso Moeti urged all countries to not lose focus on their gains made in health as they adapt to tackle this new threat[2].

Already, Uganda is endemic to globally known fatal diseases and conditions such as malaria, respiratory diseases, MCNH conditions, HIV/AIDs, Tuberculosis, non-communicable diseases, just to mention a few. The early symptoms of COVID-19, including fever, myalgia, and fatigue might be confused with malaria and other febrile infections. This can lead to challenges in early clinical diagnosis and management. The country has just conducted a very successful Measles/Rubella vaccination campaign. Uganda cannot afford to lose that gain hence the need for continued routine immunizations of high risk populations.

Therefore, while responding to the demands generated by the COVID-19 pandemic, the Ministry of Health of Uganda developed this guidance for health managers at national and district level, as well as frontline health service providers in public, private and community level on how to continue or discontinue the implementation of selected key essential service during the COVID 19 outbreak.

Main **objectives** of the guidelines are to:

1. Strengthen governance and coordination mechanisms for essential health service continuity at the national and sub-national level.
2. Define high priority essential health services.
3. Provide guidance on a set of targeted immediate actions at health facility level to re-organize and maintain access to essential quality health services.
4. Monitor continuity of essential health services and provided support to sustain quality essential health services.

The sections below describe adjustments in service delivery organization and actions associated with each of the above objectives. The Annexes to this document contain programme specific guidance for essential service continuity. The guidance, including Annexes, will be periodically updated to adjust to the evolving situation.

1. Governance and coordination mechanisms for essential service continuity

At national level, the MoH **nominated a focal point (MoH Director Clinical Services) and a coordination mechanism** to ensure the continuity of essential health services as there is a risk that

[1] https://www.afro.who.int/publications/situation-reports-covid-19-outbreak-sitrep-07-15-april-2020
[2] https://www.afro.who.int/news/who-urges-countries-not-let-covid-19-eclipse-other-health-issues

attention would be diverted towards preparedness and response mechanisms which may result in negligence of other routine essential health services.

The MoH service continuity focal point and related committee will be working in close coordination with the MoH Incident Management system for COVID-19 for effective linkage with other pillars.

Similarly, the DHOs should constitute a committed at the district level that will ensure continuity of critical health services within the district covid-19 response mechanism as defined by this guideline.

The Terms of Reference on Governance and Coordination Arrangements for Essential Service Continuity in the context of COVID-19 is attached as Annex 1.

In addition, Local Governments (District/Municipality) will establish a service continuity committee to work with the respective District COVID-19 Task Forces and operationalize service continuity in their jurisdictions Annex 2.

2. High priority essential services

The selection of priorities has been guided by the Health Sector Development Plan and epidemiological profile of diseases in the country based on their potentials, if their services are discontinued, to overwhelm the health system and negatively impact on (hinder) effective response to COVID-19 pandemic. The Ministry has prioritized the following services under the Primary Health Care Package as shown in the table below

Table 1: Prioritized Health Services

Primary Health Care package	Prioritized Package of Services
1: Health Promotion, Environmental Health, Disease Prevention and Community Health Initiatives, including epidemic and disaster preparedness and response	1. Integrated outreaches 2. Vector Control Initiatives (IRS, LLIN distribution, Larviciding, etc) 3. Community health initiatives implemented through VHTs e.g. Integrated Community Case Management (ICCM), pregnancy mapping, Community Based Disease Surveillance (CBDS), VHT Trainings and community referral pathways/initiatives 4. Community sensitization meetings as defined under the different scenarios 5. Prevention, detection and prompt response to health emergencies and other diseases of public health importance including EVD, VHFs, diarrheal and vaccine preventable diseases 6. Auxiliary services, such as basic diagnostic imaging, laboratory services, and blood bank services.
2: Prevention, Management and Control of Communicable Diseases	1. Malaria prevention, diagnosis and treatment services 2. Prevention, care and treatment of Respiratory Illnesses 3. HIV/AIDS prevention, diagnostics and treatment services. 4. Tuberculosis prevention, diagnostic and treatment services 5. Vaccine Preventable Diseases 6. Referral system Management
	1. Management of non-communicable diseases, including;

3: Prevention, Management and Control of Non-Communicable Diseases	a) mental health conditions b) hypertension c) diabetes d) CVDs e) COPDs including Asthma f) Cancers g) Sickle Cell Disease 2. Oral Health 3. Palliative Care 4. Nutrition services including; a) IYCF b) SAM and MAM treatment 5. Disabilities including orthopedic services
4: Maternal, Child and Adolescent Health	1. Services for Maternal, Newborn Child and reproductive Health including; a) care during pregnancy (ANC), b) Basic and Comprehensive Emergency Obstetric Care c) Newborn Care d) postnatal care services. e) Immunization services. 2. Management of childhood illnesses 3. Adolescent Responsive/Friendly Services 4. Prevention and management of Sexual and Gender Based Violence (SGBV)

For each of the above services (package of services), the MoH has developed the following, optimized guidance for response in the context of COVID-19. The list of available of guidance is provided below with detailed recommendations included in the annexes:

- Annex 3. Guidance on care during pregnancy, delivery and postnatal care in the context of COVID-19
- Annex 4. Guidance on continuation of immunization services during the COVID-19 outbreak
- Annex 5. Guidance for a revised implementation of Integrated Community Case Management of Childhood Illnesses (ICCM) during the COVID-19 outbreak
- Annex 6. Guidance on continuity of nutrition services in the context of COVID-19
- Annex 7. Guidance for the Integrated Management of Acute Malnutrition in the context of COVID-19
- Annex 8. Guidance on Malaria prevention, diagnostic and treatment activities in the context of COVID-19
- Annex 9. Guidance on HIV prevention, diagnostic and treatment activities in the context of COVID-19
- Annex 10. Guidance on Tuberculosis prevention, diagnostic and treatment activities in the context of COVID-19
- Annex 11. Guidance for Sexual and Reproductive Health and Rights: Access to Modern Contraceptives in the context of COVID-19
- Annex 12. Guidelines On Providing Mental Health And Psychosocial During Covid-19 Pandemic Response
- Annex 13. Provision of Sexual Reproductive Health, HIV and gender based Violence services in the context of COVID-19
- Annex 14. Interim Guidelines For continuity of care and wellbeing of adolescent and young people during Covid-19 Outbreak

- Annex 15. District response and readiness checklist-COVID-19

Table 2: Programme Criticality Matrix

COVID-19 Epidemiological Profile at District Level	Interventions To Continue	Interventions to Discontinue
No COVID-19 cases	• Routine and outreach immunization services • All malaria prevention and control activities including vector control including supervised mass LLIN distribution • TB/HIV Care and treatment • Community sensitization meetings • ANC, health facility delivery and PNC • Family Planning services • Nutrition services (OTCs and ITCs) • Adolescent friendly services • SGBV prevention and management services • All health facility departments (OPD, IPD, Maternity, ART/TB, surgical procedures and specialized clinics)	• Mass vaccination campaigns including child health days • Mass nutrition screening
One or more cases, imported or locally acquired (sporadic cases)	• Continue with routine immunization services at fixed posts • Malaria prevention and control activities including vector control • TB/HIV Care and treatment including differentiated service delivery models • ANC, health facility delivery and PNC • All health facility departments (OPD, IPD, Maternity, ART/TB, surgical procedures and specialized clinics)	• Mass vaccination campaigns including child health days • Outreach activities • Community sensitization meetings • Mass nutrition screening
Clusters of cases in time, geographic location, or common exposure (clusters of cases)	• Continue with routine immunization services at fixed posts • Malaria prevention and control activities including vector control. Mass drug administration in COVID-19 affected areas and other unaffected areas but with high malaria incidence • TB/HIV Care and treatment including differentiated service delivery models • ANC, health facility delivery and PNC • Family Planning services • Adolescent friendly services • SGBV prevention and management services	• Mass vaccination campaigns including child health days • iCCM • Mass LLIN distribution • Outreach activities • Community sensitization meetings • Mass nutrition screening

	• All health facility departments (OPD, IPD, Maternity, ART/TB, surgical procedures and specialized clinics)	
Larger outbreaks of local transmission (community transmission)	• Continue with routine and outreach immunization services as well as catch-up campaigns • Malaria prevention and control activities including vector control. Mass drug administration in COVID-19 affected areas and other unaffected areas but with high malaria incidence • TB/HIV Care and treatment including differentiated service delivery models • ANC, health facility delivery and PNC • Family Planning services • Adolescent friendly services • SGBV prevention and management services • All health facility departments (OPD, IPD, Maternity, ART/TB, surgical procedures and specialized clinics)	• iCCM • Community sensitization meetings • Mass nutrition screening • Mass LLIN distribution

The MoH will periodically review this guidance and develop new ones to respond to the evolving situation.

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

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

a. Orient all health facility personnel and disseminate information on critical services and service continuity in the context of COVID-19 to the public 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 COVID-19 using the COVID-19 standard case definition.
c. Establish mechanisms for isolation/separation of patients with suspected or confirmed COVID-19 and for referral of cases according to disease severity and acute care needs
d. 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.
e. Establish mechanisms to maintain 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)
f. Rapidly re-distribute health workforce capacity, including by re-assignment and task sharing.
g. 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.
h. Mobilize and work with NGOs and the district CDO to establish necessary prevention and management services for SGBV/GBV

i. 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 to map all available ambulances (govt, private, NGO) in the district and assign catchment health facilities for each of the ambulance
Establish/Update the VHT database for the entire district

Section below details 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 COVID-19 to prepare and guide health care-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 COVID-19 patients.
- Disseminate optimized guidance on 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 COVID-19 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 COVID-19 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 COVID-19 using the COVID-19 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 COVID-19 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 COVID-19

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 COVID-19. 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 patients and the health worker.
- Assign dedicated trained health worker (e.g. nurses) for physical evaluation of patients presenting with respiratory symptoms at triage. These staff should be trained on triage procedures, COVID-19 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 advice patients properly on the use of facemask, 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. (see list of equipment below)
- 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 on and after taking off PPE. A bin with lid should be available at triage where patients can discard used paper tissues.
- The COVID-19 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 COVID-19 given the global pandemic.
- Post information, like posters, job aids and flyers on respiratory hygiene, cough etiquette and social distancing, 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.

Table 3: Ministry of Health COVID-19 case definitions

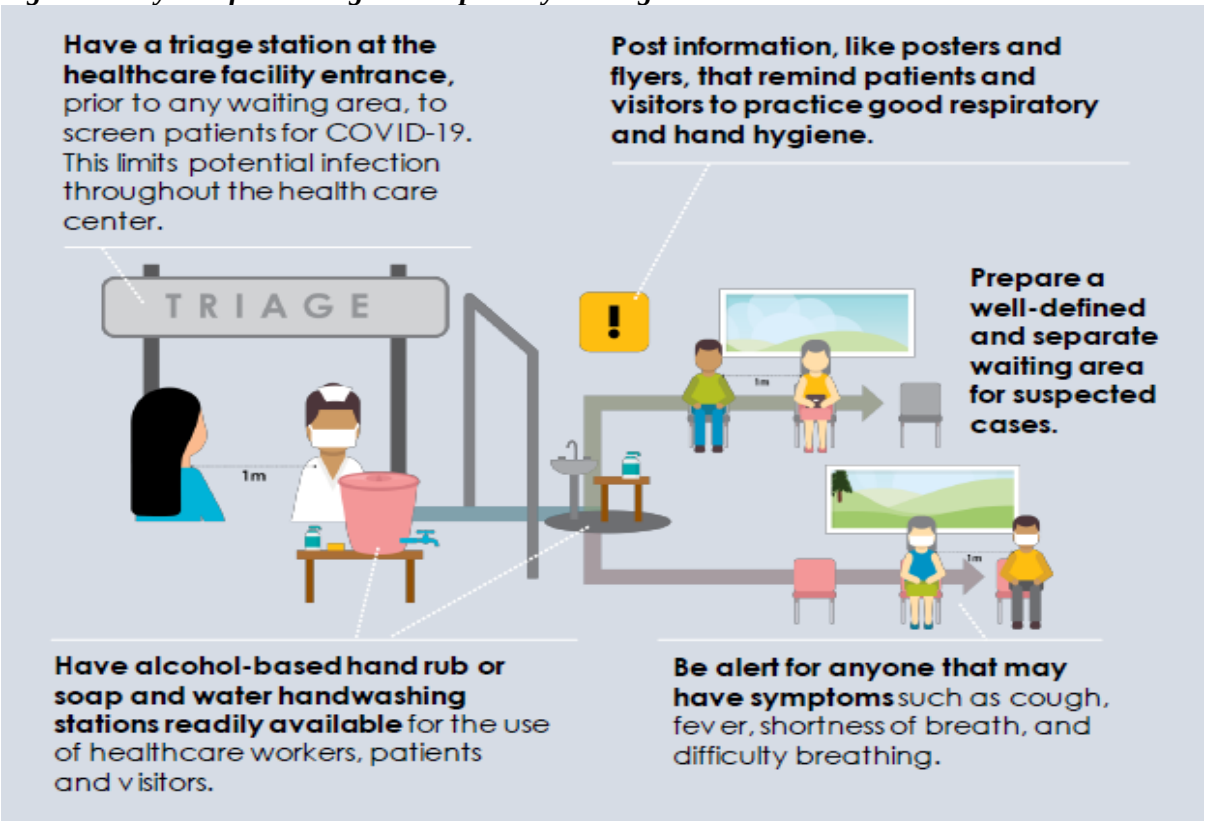
Suspect case (sporadic or cluster transmission pattern)	A. Any person with acute respiratory illness (temperature greater than 37.5ºC and at least one sign/symptom of respiratory illness such as cough, shortness of breath) AND no other cause that fully explains the clinical presentation AND history of travel in last 14 days before onset to area reporting local transmission of COVID-1. **OR** B. Any person with acute respiratory illness (temperature greater than 37.5ºC and at least one sign/symptom of respiratory illness such as cough, shortness of breath) AND no other cause that fully explains the clinical presentation AND requiring hospitalization

	OR C. Any person with acute respiratory illness (temperature greater than 37.5ºC and at least one sign/symptom of respiratory illness such as cough, shortness of breath) AND contact with a confirmed or probable COVID-19 case in last 14 days before symptoms
Suspect case (community transmission pattern)	Any person or groups of persons with flu-like symptoms such as fever, running nose, sneezing, cough, sore throat and difficulty in breathing.
Probable case	A. A suspect case for whom testing for COVID-19 is inconclusive **OR** B. A suspect case for whom testing could not be performed for any reason.
Confirmed case	A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.
Contact	Any person who experienced any one of the following exposures during the 2 days before and the 14 days after the onset of symptoms of a probable or confirmed case: 1. Face-to-face contact with a probable or confirmed case within 2 meter and for more than 15 minutes; 2. Direct physical contact with a probable or confirmed case; 3. Direct care for a patient with probable or confirmed COVID-19 disease without using proper personal protective equipment Note: for confirmed asymptomatic cases, the period of contact is measured as the 2 days before through the 14 days after the date on which the sample was taken which led to confirmation.
WHO. Global surveillance for COVID-19 caused by human infection with COVID-19 virus. Interim guidance. 20 March 2020	

Set up a "respiratory waiting area" for suspected COVID-19 patients

- 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 COVID-19 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 COVID-19
    - Setting up a notification system that allows patients to wait outside of the facility (if medically appropriate) in a place that social distance can be maintained and be notified by phone or other remote methods when it is their turn to be evaluated.

Figure 1: Layout of screening and respiratory waiting area



Equipment and supplies at screening area

- Infrared thermometer
- Personal protective equipment (gloves & medical mask)
- Handwashing station with soap and water or alcohol-based hand rub (ABHR). If these are not available, 0.05% chlorine solution can be used ***(see Annex 10 how to prepare 0.05% and 0.5% chlorine solution)***
- Screening logbook ***(see Annex 11 for variables of screening logbook)***
- Pen or pencil
- Posters and IEC materials (standard case definition, screening flow chart, signs and symptoms, how to protect yourself, what to do in case of symptoms)
- Table and two plastic chairs placed at least at 1-2m distance b/w chairs, adhering to 'social distance'
- Rubbish bin and biohazard bags (bin liners)
- Dual cordon (orange fence), tape or another barrier material (ropes) to reinforce patient and staff flow.
- Safe drinking water for staff and patients (e.g. bucket with tap)

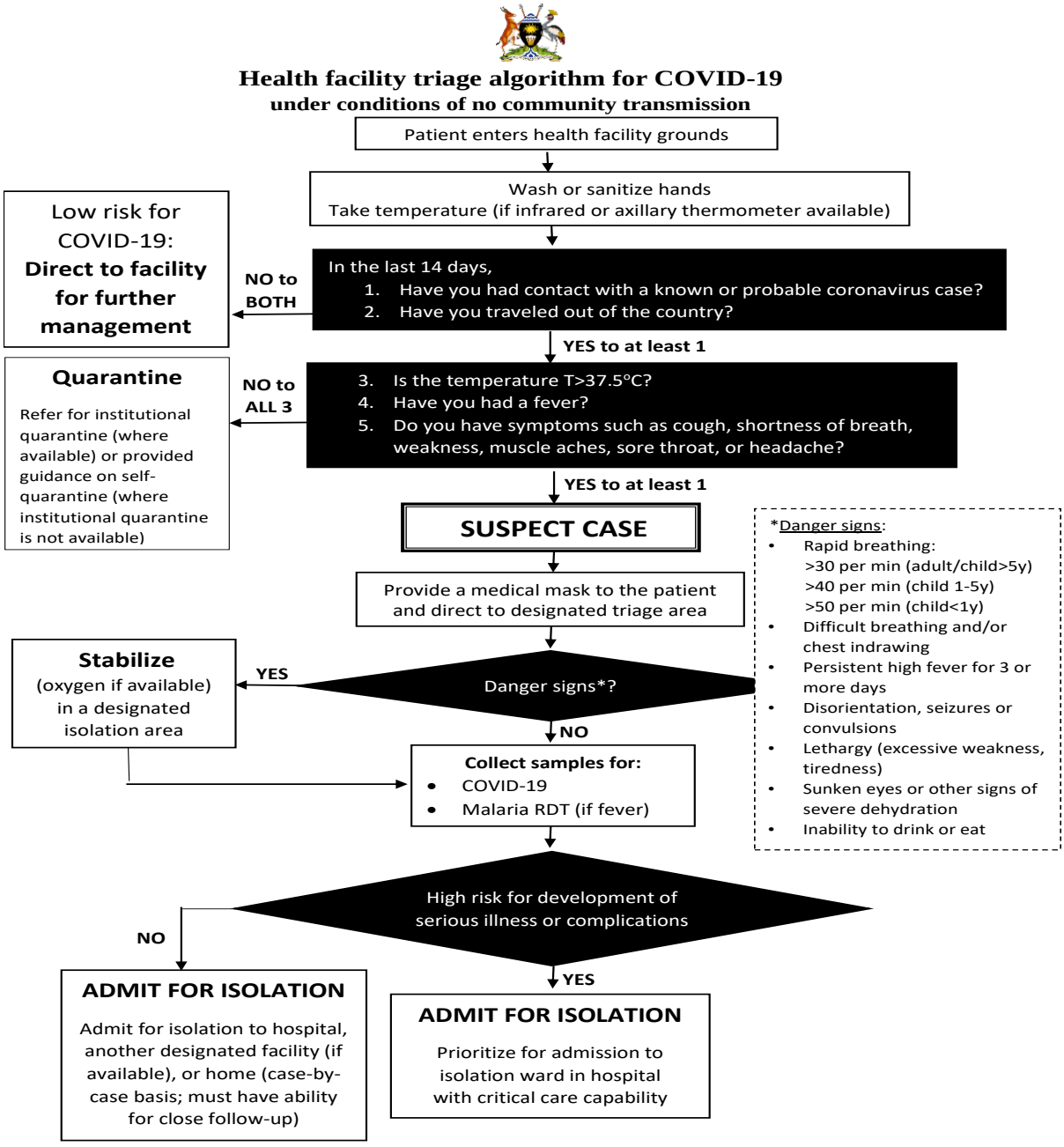
Screening Process

The following screening process should be followed at the triage area. Steps at screening applies for all patients, clients, visitors and staff entering the health facility.

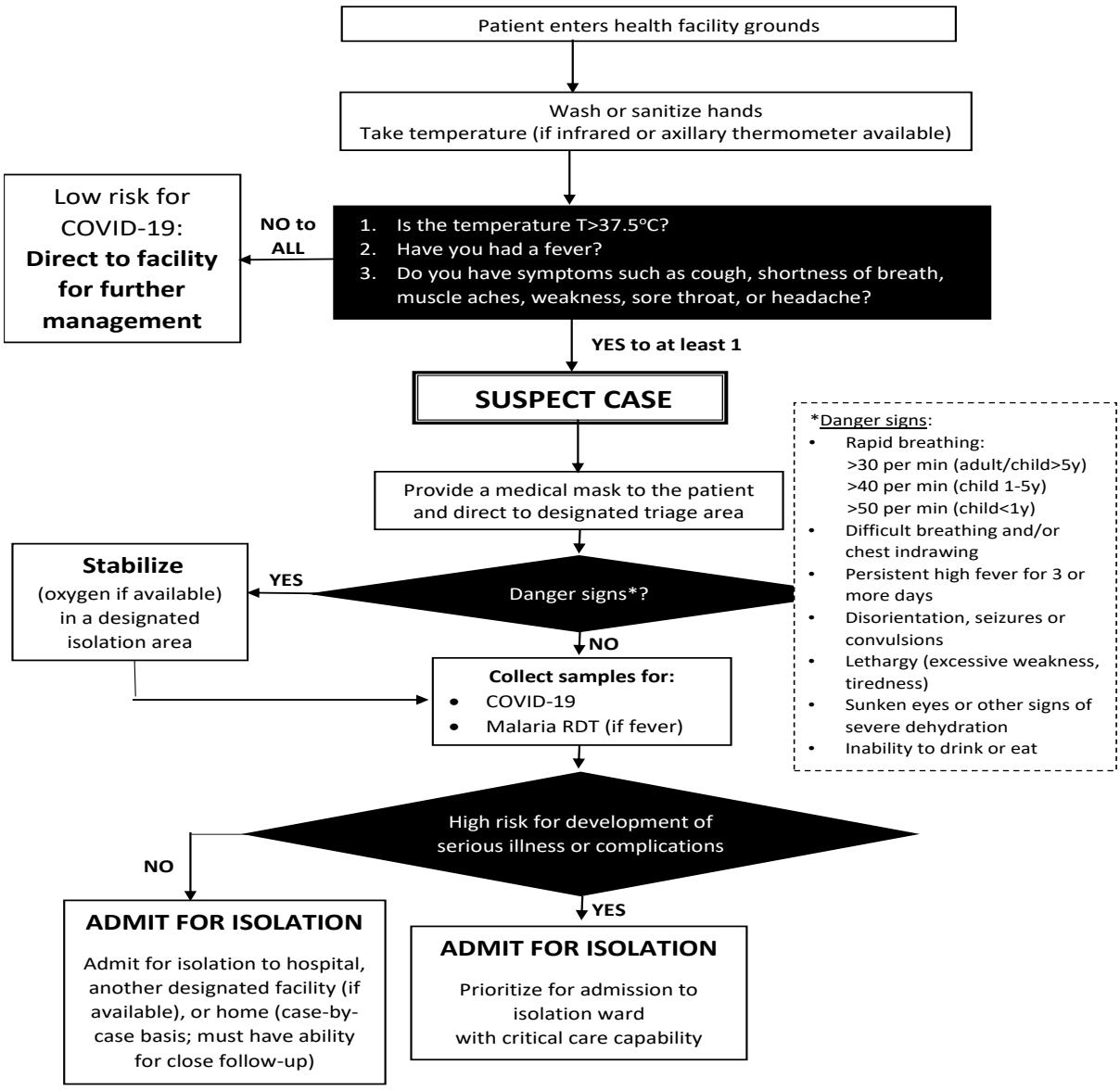
Table 4: COVID-19 screening process and steps

Screening process – steps
Instruct all patients and visitors to wash their hands with soap and water (whenever they arrive at HF and while leaving HF)
Stand at least 1-2 meters away from the person being screened and keep the isolation barrier between the patient and the HCW
Assess patients for symptoms of COVID-19 based on the standard case definition for COVID-19 by interviewing and observing**.** Physical examination should not be conducted. The following signs, symptoms and history should be assessed: ▪ Signs or symptoms of illness suggesting respiratory infection should be evaluated, including o Fever > 37.5c or the patient mentioning feeling feverish. Take temperature using infrared thermometer and record those with 37.5c or above. If there is no Infrared thermometer, ask the patient for fever or history of fever **(See Annex 12 on how to take temperature with infrared thermometer)** o Cough o Breathing difficulties ▪ A history of possible exposure to the COVID-19 virus should be evaluated, including o travel to a country/location with ongoing transmission of the COVID-19 virus in the last 14 days prior to the onset of symptoms o Having been in contact or cared for someone who shows signs and symptoms of fever, cough and shortness of breath (probable or confirmed COVID-19 case)
Determine if the person being screened is a suspected COVID-19 case or not, using screening decision tree/algorithm ***(See figure 2 for screening algorithm)***
Record in the logbook the person's name, phone number and other information only for those patients suspected to have COVID-19. Tally all patients and visitors screened. ***(See Annex 11 on logbook information)***
Provide a medical mask to all suspected cases meeting the standard definition and direct them immediately to a separate waiting area (an isolation room if available). Keep at least 1m distance between suspected patients and other patients while directing the patient to the separate waiting area. Communicate with patients with respect and empathy and reassure them. Under the conditions of sustained community transmission, consider COVID-19 as a possible etiology of all patients with acute respiratory infection. Allow in the health facility post triage point all patients not meeting the standard definition.
Notify to the public health authority.

Figure 2: Screening algorithm in the context of (1) no or limited community transmission and (2) widespread community transmission



Health facility triage algorithm for COVID19 under conditions of community transmission



Additional considerations for triage during periods of community transmission

- Ask the general public to call ahead of time if they are seeking care for respiratory symptoms (e.g. cough, fever, shortness of breath)
- Begin or reinforce existing alternatives to face-to-face triage and visits such as telemedicine.
- Designate an area near the facility (e.g., an ancillary building or temporary structure) or identify a location in the area to be a "respiratory virus isolation/assessment facility" where patients with fever or respiratory symptoms can seek evaluation and care.
- Ensure separate/dedicated entry for patients coming for critical outpatient visits (e.g. infant vaccination or antenatal care visits for high-risk pregnancy/adolescent pregnancies) to not place them at risk of COVID-19
- Expand hours of operation, if possible, to limit crowding at triage during peak hours.
- Prepare and support task-shifting to Village Health Teams for services that can be delivered at the community level.

- Identify more NGOs and youth serving organizations and orient them on COVID-19 updates so that they can also be assigned roles to increase coverage for some selected services.

c. Establish mechanisms for isolation/separation of patients with suspected or confirmed COVID-19 and for referral of cases according to disease severity and acute care needs

Following the screening and triage, patients suspected for COVID-19 should be isolated for the time period necessary to evaluate/confirm their status and be taken care of. To ensure this:

- Health care facilities should identify and establish single isolation room(s) for COVID-19 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 COVID-19.

Care for all suspected and confirmed COVID-19 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 management of patients with COVID established within their jurisdiction (district or municipality) and the referral pathways according the disease severity and acute care needs.
- MoH, RRHs and DHOs should communicate the details of COVID-19 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 COVID-19.
- 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 health facility level.
- HCFs should also distribute contact information to communities.

Referral of non-COVID-19 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 public the process and contacts of relevant officials/providers for transportation of patients

d. 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

The goal of IPC activities in the COVID-19 response is to support the maintenance of essential healthcare services by preventing healthcare-associated transmission of SARS-CoV-2 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 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), such as COVID-19 within the facility and in the community, including:
    - Triage at initial healthcare facility encounter.
    - Identification of out- and in-patients with suspected COVID-19.
    - 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 COVID-19, 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 viruses in your 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 such as fever, cough, or shortness of breath.
        - 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 COVID-19 patients will be placed
6. Develop staffing plans to adequately staff isolation areas and consider whether cohorting 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 COVID-19 patients, such that workers do not incur expenses for occupational safety and health requirements
8. 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 protection of women and babies and visitors
9. Consider impact of theatre Infection Control Procedures on theatre availability and account for when operating on confirmed or suspected COVID-19 infected patients.
10. 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
11. Develop communication plans to ensure adequate internal and external communication regarding COVID-19

12. Educate HCW, patients, and visitors on COVID-19 signs, symptoms, and required IPC protocols
13. Establish communication channels between healthcare facilities and public health authorities who can facilitate linkages with laboratory testing and epidemiology/contact tracing.
14. Monitor health care workers and patient's compliance with standard precautions and provide mechanisms for improvement as relevant. Refer to health facility assessment checklist – Annex 15

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) will 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 in COVID-19
- 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. COVID-19 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 COVID-19, 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 offset 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 of COVID-19, including HCWs who are pregnant, is over 60 years or have 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 trainings (e.g., on 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 capacity of local community leaders and VHTs to assist patients who are treated at home and may need support services such as 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 minimum consider antenatal, postnatal, and essential newborn care, sexual and reproductive health services, promotive and preventive services-including immunization[3], iCCM (or community IMNCI) for malaria, pneumonia and diarrhea (including referral for severe cases), Vitamin A supplementation, deworming (where context applies),and screening, and referral for acute malnutrition and treatment for uncomplicated wasting.
- **Define roles for CHWs and supervisors in 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 COVID-19 lockdown 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

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

Touch' policy especially in communities with high COVID-19 transmission[4];[5]. 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.[6]

- **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. It is currently recommended to temporarily suspend mass vaccination campaigns due to the increased risk of promoting community circulation. 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 release of stocks for multiple months.** 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 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 overburdening 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 diarrhoea for at least two months.
- **Prepare and support task-shifting to Village Health Teams for services that can be delivered at the community level.**

[4] 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.

[5] 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

4. Monitor continuity of essential health services and provided necessary support to sustain quality essential health services.

To facilitate planning and decision making for essential health service delivery, data from routine and other sources will be collected at community, health facilities, institutions for decision making at all levels on the impact of COVID-19. This will provide insight of key actions to improve access to essential health services

Table 5: Essential health service utilisation indicators

Indicators	**Data source**
Utilization of Family Planning services	HMIS
Antenatal care (ANC) attendance	
Deliveries at health facilities	
Post-natal care (PNC) attendance	
Perinatal deaths	
Maternal deaths	
Utilization of immunization services	
Utilization of nutrition services	
Utilization of HIV/AIDS services	
OPD attendance rates	
Utilization of GBV services	
Utilization of mental health services	
Availability of supplies, medicines and laboratory reagents	

In addition, morbidity and mortality from the 10 top cause (as per HSDP and AHSPR-2018/19) will be tracked on a weekly basis at national and district level

Leading causes of morbidity	**Leading causes of death**
Malaria	Malaria
Presumptive TB	Macerated Still births
Typhoid Fever	Fresh Still Birth
Dysentery	Neonatal 0-7 days
TB - New and Relapse	Maternal death
Animal bites	Buruli ulcer
SARI	AEFI deaths
Diarrhoea <5	Measles
Hepatitis B	Other VHF - Deaths
Measles	Typhoid Fever

S/No.	HCS level	Monitoring and supervision role	information /data required	Responsible for data management?	Resources required
1	Village and community (HC I, LC I)				
2	School (post lockdown, when schools resume)				
3	Private HFs (For- and Not-for-profit)				
4	Parish (Ward, HC II, LCII)				
5	Sub-County (HCIII, LCIII, Members of Uganda Parliament)				
6	County (HC IV, LC IV / Mayor)				
7	District (HC IV)				
8	Regional (Regional Referral Hospitals)				
9	National (incl. Big Hospitals _ Public and Private)				

Actions to be taken

1. Health facilities should immediately notify and report any increase in morbidity or mortality outside the normal channel to the DHO and district surveillance focal person.
2. The DHO and district surveillance focal person should investigate and close all alerts of changes reported on morbidity and mortality.
3. Health facilities should notify and report any stock-outs of the essential medicine and health supplies to the DHO and district medicines management supervisor (MMS)

Annexes

Annex 1. Terms of Reference on Governance and Coordination Arrangements for Continuity of Essential Health Services in the context of COVID-19 in Uganda

Introduction

Uganda has a robust health sector development plan that seeks to, among other goals "accelerate movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life".

The Uganda health system is currently being confronted with rapidly increasing demand generated by the COVID-19 outbreak. When health systems are overwhelmed, both direct mortality from the COVID-19 outbreak and indirect mortality from vaccine preventable and treatable conditions may increase dramatically.

Maintaining the Ugandan population trust in the capacity of the health system to safely meet essential needs and to control infection risk in health facilities is key to ensuring appropriate care-seeking behaviour and adherence to public health advise.

At the moment, the COVID-19 case load is limited, and the health system has capacity to maintain routine service delivery in addition to managing COVID-19 cases however when caseloads increase including among the health workers, the health system needs to be augmented to maintain quality uninterrupted essential health services.

Purpose

To outline the roles of the focal point and coordination committee for continuity of essential health services in the context of COVID-19.

Scope of work

In collaboration with the Ministry of Health technical programmes/departments and the COVID-19 Incident Management Structures, the Essential Service Continuity Focal Point and Coordination Committee will:

1. Establish triggers and thresholds that activate a phased reallocation of routine comprehensive service capacity towards essential health services
2. Assess and monitor ongoing delivery of essential health services to identify gaps and potential need to dynamically remap referral pathways
3. Identify relevant essential services and support the MoH to identify and prioritize essential health services; (Prevention for communicable diseases particularly vaccine preventable diseases, 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 that require time sensitive interventions and auxiliary services-basic diagnostic imaging, laboratory services and blood bank services)
    - Generate list of essential services
    - Identify routine and elective services that can be delayed and disseminate guidance
    - Create a roadmap for progressive phased reduction of services
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 COVID-19 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 delivery of essential services

5. Guide the establishment effective patient flow (screening, triage and targeted referrals) at all levels
    - Support the RCSM sub-committee to disseminate information to prepare the public and guard safe care-seeking behaviour
    - 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 (based on COVID-19 transmission scenarios)
    - Maximize occupational health and staff safety measures in all categories
    - Create a roadmap for phased implementation of the strategies for timely scale-up
    - Initiate rapid training mechanisms including for triage, clinical management and essential infection prevention and control
7. Identify mechanisms to maintain availability of essential mediations, 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 national and district level.
8. Liaise with health development partners to keep them informed of strategic, programmatic and operational adjustments and mobilise support to the implementation of essential services.

Intended Outcomes

1. Advocacy for sustained uninterrupted essential health service delivery
2. Development and dissemination of guidelines and protocols for uninterrupted essential health services
3. Establish framework for national and district engagement and coordination around sustaining uninterrupted essential health services delivery
4. Development, implementation and monitoring common essential health services delivery indicators
5. Strengthened collaboration with other sub-committees and pillars to adapt existing standards for continuity of essential health services
6. Strengthened focus on mitigating impact of COVID-19 on the Uganda Health Care System
7. Fostered new multi-sectoral and multi-stakeholder alliances and collaborations to promote uninterrupted essential health services in Uganda during the COVID-19 outbreak

Membership

Chair: Director Clinical Services

Secretariat:

Continuity of essential health services liaison officer (with HDP)

Administrative support staff

Members:

1. All Program Managers from the Ministry of Health
    - Maternal and Reproductive Health
    - Immunization Programme (UNEPI)
    - Malaria Control Programme
    - AIDS Control Program
    - TB Control Programme

- Nutrition
- Community health
- Pharmacy
- Health Information
- Mental health
- Non-communicable diseases

2. Representation from Regional Referral Hospitals
3. Representation from District Health offices
4. Representation from health development partners
5. Representation from MoH implementing partners including those based at regional level

Meetings

The coordination committee will hold at least two meetings a week:

- Every Monday (9-11am) – internal committee meeting
- Every Friday (9-10am) – meeting with HDPs

Annex 2. Terms of Reference: District Task Force sub-committee on Continuity of Essential Health Services in the context of COVID-19

Introduction
Uganda's robust health sector development plan seeks to "accelerate movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life" Unfortunately, the COVID-19 pandemic significantly threatens to undermine and derail the gains the country has achieved in improving the health and social-economic development of Uganda.

To ensure that districts respond adequately and mitigates the impact of the COVID-19 pandemic, the Ministry of Health (MOH) developed guidelines on continuity of essential health services. To support the operationalization of these guidelines, the MoH established a sub-committee on continuity of essential health services and is providing guidance to support the establishment of similar coordination structures at district level.

Purpose
Outline the roles and responsibilities of the District Task Force sub-committee on continuity of essential health service.

Scope of work
The District Task Force sub-committee on continuity of essential health service will:

4. Establish triggers and thresholds that activate a phased reallocation of routine comprehensive service capacity towards essential health services
5. Assess and monitor ongoing delivery of essential health services to identify gaps and potential need to dynamically remap referral pathways
6. 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 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 progressive phased reduction of services (as per MoH guidance)
7. 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 COVID-19 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 delivery of essential services
8. Guide the establishment effective patient flow (screening, triage and targeted referrals) at all levels
    - Support the RCSM sub-committee to disseminate information to prepare the public and guard safe care-seeking behaviour
    - 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
9. Develop guidance on re-distribution of health workforce capacity including through re-assignment and task sharing

- Map health worker requirements (based on COVID-19 transmission scenarios)
- Maximize occupational health and staff safety measures in all categories
- Initiate rapid training mechanisms including for triage and IPC

10. Identify mechanisms to maintain availability of essential mediations, 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.
11. Liaise with the district health development partners and mobilize support for the implementation of essential health services.

Intended Outcomes

1. Advocacy for sustained uninterrupted essential health service delivery in the district
2. Dissemination of guidelines and protocols for uninterrupted essential health services
3. Established district framework for engagement and coordination around sustaining uninterrupted essential health services delivery
4. Development, implementation and monitoring common essential health services delivery indicators
5. Strengthened collaboration with other sub-committees of the district task force (DTF) to adapt existing standards for continuity of essential health services
6. Strengthened focus on mitigating impact of COVID-19 on the District Health Care System

Membership

Chair: District Health Officer

Secretariat:

1. Assistant DHO MNH

Members:

1. All DHT members
2. All health sub-district and facility in-charges
3. All district health development partners
4. Civil Society Organisations

Meetings

The sub-committee will hold at least two meetings a week. Minutes of these meetings will be shared with the district COVID-19 task force.

Annex 3. Guidance on care during pregnancy, delivery and postnatal care in the context of COVID-19

Background

Sexual and Reproductive health (SRH), safe pregnancy, childbirth and postnatal care services are regarded as essential health services during pandemics, and should therefore be planned for along with other essential services to be provided during this COVID-19 pandemic

There's need to ensure that access to SRH services including contraceptive services is maintained, with special attention to women among vulnerable populations such as adolescents, persons living with disabilities, persons living with HIV, and people in humanitarian settings.

Currently, there is no evidence that pregnant women present with different signs or symptoms or are at higher risk of severe illness. There is currently no known difference between the clinical manifestations of COVID-19 pregnant and non-pregnant women or adults of reproductive age.

There is limited data on effects of the COVID-19 virus among pregnant, breastfeeding feeding women and infants. The Ministry of Health will continue to provide additional guidance to health facilities on the management of pregnant, breastfeeding women and infants

So far, there is no evidence of mother to child transmission of COVID-19. Some cases of premature rupture of membranes, foetal distress and preterm birth have been reported.

The COVID-19 pandemic has raised specific concerns regarding the management of pregnant, breast feeding women and infants. These guidelines have been developed to address concerns and guide health workers on how to deliver essential RMNCAH services during this period. This includes routine care for pregnant women, including those with Suspected, Probable or Confirmed COVID-19 along the entire continuum of care for mothers and new-borns during Antenatal care, Delivery and Postnatal periods

Care of pregnant women including adolescents during antenatal care period in the covid-19 pandemic

Key messages:

- Health workers should continue to provide antenatal care as a routine package but should practice appropriate Infection Prevention and Control (IPC) measures for COVID-19, including hand washing and personal protective equipment (Refer to Figure 1)
- Ensure Social distancing at Antenatal (ANC) clinics of 4 metres and use of face masks, among other IPC measures by all pregnant women while in the ANC clinic, and in the community to prevent them from transmitting the virus SARS-CoV2. Overcrowding MUST be avoided at the ANC clinics- 4 metre social distancing.

Figure 1: Universal Precautions for Prevention and Control of COVID-19

- Hand washing with water and soap following the WHO recommended technique and use of an alcohol-based hand rub; for at least 20 seconds.
- Use alcohol-based hand sanitizers- 60% alcohol and above- to disinfect reusable dedicated equipment such as thermometers between patients or 0.5% Sodium hypochlorite for disinfection of frequently touched surfaces
- Avoid touching your eyes, nose, and mouth
- Practicing respiratory hygiene by coughing or sneezing into a bent elbow or tissue and then immediately disposing off the tissue
- Wearing personal protective equipment (PPE) such as; a medical mask, gloves, eye protection (goggles or face shields) etc and performing hand hygiene after disposing off the mask.
- Personal protective equipment should be changed between use and for each different patient. Health care workers should wear a medical mask in the triage area and when entering a room where patients with suspected or confirmed COVID-19 are admitted
- Maintaining social distance (a minimum of 1 meter) from persons with respiratory symptoms
- Waste produced during the care of patients with suspected or confirmed COVID-19 infection should be disposed of as infectious waste.

- Pregnant women should pay particular attention to avoiding contact with people who are known to have COVID-19 or those who show possible symptoms.
- Pregnant women attending ANC, including those in the communities should receive information on the signs and symptoms, the spread, prevention and control of COIVD-19, including knowledge on the asymptomatic carriers.
- While in the community, if a pregnant woman develops symptoms suggestive of COVID-19 and fits the criteria for case definition for suspect or probable case for COVID-19, she should contact the health care professional attending to her at the health facility to postpone the routine ANC visits. The health worker will contact surveillance teams to continue checking on the suspected, probable pregnant woman to ensure they comply with the self-quarantine measures.
- At the health facility, if a pregnant woman is a suspected, probable case and fits the criteria for case definition of COVID-19, the health worker shall inform the laboratory staff who shall initiate testing for COVID-19. If the patient is negative but has been exposed, she should start self-quarantine for 14 days. She should contact the health workers at the health facility to postpone routine visits and the health worker should ensure that the health surveillance team conducts follow up checks until the self-quarantine period is over.
- Women should be advised to attend routine antenatal care unless they meet current self-quarantine guidance for individuals and households of individuals with fever or respiratory symptoms such as cough or shortness of breath
- Every mother, whether she has symptoms or not, should be considered a Suspected case of COVID-19, until proved otherwise, especially with the on-going pre-symptomatic transmission
- Actively screen all clients attending ANC to identify any suspected symptoms of COVID-19 using the MOH guideline
- If a pregnant woman is infected with COVID-19, she is still most likely to have no symptoms or may present with mild illness from which she can recover.
- If the pregnant woman develops more severe symptoms or her recovery is delayed, this may be a sign that she is developing a more significant chest infection that requires enhanced care. The woman should contact a health worker for medical further information and advice.
- Health facilities should conduct targeted integrated ANC/EPI outreaches to extend services, especially in hard to reach communities with large numbers of pregnant women
- Screen mothers for Intimate Partner Violence (IPV) according to the existing guidelines. There is increased risk of IPV during emergence situations such as the current COVID-19 pandemic
- Health workers should provide psycho-social counselling and support to suspected, probable or confirmed pregnant women with COVID-19. Pregnant women have fears of contracting COVID-19, including transmission of the disease to their un-born babies
- Sensitize women on the risk and mitigation of stigma and discrimination that may be associated with COVID-19.

Care of pregnant women including adolescents during labour and delivery period in the covid-19 pandemic

Maternity departments with direct entry for patients and the public should have in place a system for identification of potential cases as soon as possible to prevent potential transmission to other patients and staff. This should be at the first point of contact to ensure early recognition and infection control. This should be done before a patient sits in the maternity waiting area.

Key messages

- If a pregnant woman is a confirmed COVID-19 case in Labour, the health worker should refer her to the isolation unit for management. The mother will continue receiving obstetric care while in the isolation unit
- If a pregnant woman presents with an obstetric emergency and being suspected or confirmed to have COVID-19, maternity staff MUST first follow IPC guidance. This includes

transferring the woman to an isolation room and wearing appropriate PPE such as face masks, eye shields, Eprons, among others. Once IPC measures are in place, the obstetric emergency should be dealt with as a top priority.

- During the delivery process, the health workers should continue observing the IPC guidelines.
- Do not delay emergency obstetric and newborn care (EMONC) service delivery in order to test for COVID-19.
- Continue providing care for a woman with COVID-19, until a negative test result is obtained.
- All reusable maternity equipment should be decontaminated after use in line with the IPC guidelines
- Encourage pregnant women to deliver from health facilities for their safety and that of their newborn.
- Health workers should actively screen the pregnant women to identify suspected symptoms of COVID-19 using MOH guidance
- Health workers should conduct health education on signs and symptoms of COVID-1 and the precautions in prevention for all women who present in Labour
- Once settled in an isolation room, a full maternal and fetal assessment should be conducted to include: Assessment of the severity of COVID-19 symptoms and should follow a multi-disciplinary team approach including an infectious diseases or medical specialist, Maternal observations including temperature, respiratory rate and oxygen saturations; Confirmation of onset of Labour, as per standard care and electronic fetal monitoring.
- If labour is confirmed, then care in labour should continue in the same isolation room, ensuring privacy, respect and dignity for the mother
- Management of mothers in labour should continue as per standard practice like use of partographs to monitor all mothers in active labour, while observing IPC measures such as use of PPE, hand washing with water and soap
- Where women with suspected or confirmed symptoms of COVID-19, or confirmed COVID-19 have scheduled appointments for pre-operative care and elective caesarean birth, an individual assessment should be made to determine whether it is safe to delay the appointment to minimize the risk of infectious transmission to other women, healthcare workers and, post-Nataly, to her infant.
- If a pregnant woman is diagnosed with COVID-19, without respiratory distress and requires delivery by cesarean section, the health worker should administer spinal anesthesia.
- If the pregnant woman is diagnosed with COVID-19, and is critically ill, with features of respiratory distress, and requires ventilation, the mother should be delivered by Caesarean section under General Anesthesia with ventilation.

Care of pregnant women including adolescents during the postnatal period in the covid-19 pandemic

Key Messages

- Health workers should encourage women to breastfeed and take necessary precautions to limit viral spread to the baby. Hand washing before touching the baby, breast pump or bottles; avoiding coughing or sneezing on the baby while feeding at the breast; considering wearing a face mask while breastfeeding, if available; following recommendations for pump cleaning after each use.
- All postnatal women with or recovering from COVID-19 should be provided with psychosocial counselling and information related to the potential risk of adverse pregnancy outcomes.
- Routine immunisation services delivery will continue but with strict observance of the COVID-19 infection prevention and control measures such as social distancing to avoid overcrowding at the vaccination sites.
- Health workers should provide information and services for family planning with emphasis on postpartum family planning using the Medical Eligibility Criteria (MEC) wheel
- Provision of modern short- and long-acting contraceptives, information, counseling and services (including emergency contraception) is lifesaving and should be available and accessible during the COVID-19 pandemic response.

- Women on short-term contraceptives methods, especially the oral contraceptives should be given commodities to cover at least a 3-months'period. This will minimize the frequent visits to the health facility for refills. Client should be fully counseled on the side effects and how these can be managed, when to switch and when to return to the health facilities. Client should be linked to the respective community resource persons for any immediate support in case of refill or support.
- Health facilities that are already providing contraceptive community-based distribution of oral contraceptives, DMPA SC including self-injection, ensure that the village health teams (VHTs) that are actively involved are well-oriented on the COVID-19 signs and symptoms, preventive measures and what to do in case of identification of a suspect or probable case
- Ensure adequate stock management at both health facility and community and monitor stock levels of RMNCAH commodities.
- Infants born to mothers with suspected, probable, or confirmed COVID-19 should be fed according to standard infant feeding guidelines, while applying necessary precautions for IPC.
- Breastfeeding counseling, basic psychosocial support, and practical feeding support should be provided to all pregnant women and mothers with infants and young children, whether they or their infants and young children have suspected or confirmed COVID-19.
- Breastfeeding women should not be separated from their newborns, as there is no evidence to show that respiratory viruses can be transmitted through breast milk. The mother can continue breastfeeding, as long as the necessary IPC precautions are applied:
- Symptomatic mothers well enough to breastfeed should wear a mask when near a child (including during feeding), wash hands before and after contact with the child (including feeding), and clean/disinfect contaminated surfaces, avoid touching the baby's eyes, mouth or nose.
- If a mother is too ill to breastfeed, she should be encouraged to express milk that can be given to the child via a clean cup and/or spoon – while wearing a mask, washing hands before and after contact with the child, and cleaning/disinfecting contaminated surfaces.
- All recently pregnant women with COVID-19 or who have recovered from COVID-19 should be provided with information and counseling on safe infant feeding and appropriate IPC measures to prevent COVID-19 virus transmission.
- **Note**: Health Workers should continue to monitor the other pregnant mothers during labour and postnatal period

Handling referrals for pregnant women, newborns and children during the covid-19 pandemic

Key recommendations

- Health facilities should liaise with the district health officer to ensure that transport means are available for referral of clients to higher level facilities for further management
- The health workers should engage community structures such as boda boda cyclists to arrange for transport of pregnant, post-partum mothers, newborns and children from communities to health facilities, especially in the event of emergencies.
- Health workers to map out Boda boda riders within the facility catchment area and link them up to pregnant women during antenatal care sessions. The list of boda boda riders in the catchment area should be pinned up at the maternity unit so that they can easily be accessed by the pregnant women.
- The health worker should support the boda boda rider to secure emergency travel permits, with the support of the DHO's office

Introduction

- Few cases have been reported of infants confirmed with COVID-19;
- Those that have been reported experienced mild illness.
- No vertical transmission of COVID-19 (during pregnancy, delivery or breastfeeding) has been documented.

- Amniotic fluid from six mothers positive for COVID-19 and cord blood and throat swabs from their neonates who were delivered by caesarean section all tested negative for the COVID-19 virus.
- Breastmilk samples from the mothers after the first lactation were also all negative for the COVID-19 virus
- Breastfeeding protects against morbidity and death in the post-neonatal period and throughout infancy and childhood.
- The protective effect is particularly strong against infectious diseases that are prevented through both direct transfer of antibodies and other anti-infective factors and long-lasting transfer of immunological competence and memory.

Therefore, during COVID-19, standard infant feeding guidelines should be followed with appropriate precautions for IPC as stated in the recommendations below.

Annex 4. Guidance on continuation of immunization services during the COVID-19 outbreak

Background

Owing to the current circumstances imposed by the COVID-19 pandemic, MOH-UNEPI recognizes that there is risk of disruption to routine immunization activities due to both COVID-19 related burden on the health system and decreased demand for vaccination because of social distancing requirements or community reluctance. However it is important to note that any disruption of immunization services, even for a brief period, will result in increased numbers of susceptible individuals and raise the likelihood of outbreak-prone vaccine preventable diseases (VPDs) such as Measles, Pneumonia, Diarrhea and Polio. Such VPD outbreaks may result in increased morbidity and mortality predominantly in infants and other vulnerable groups.

The high potential for VPD outbreaks makes it imperative for the entire country to maintain continuity of immunization services under safe conditions for both the health workers and the population. Therefore, all districts are requested to ensure the following information reaches all health facility in-charges during this period:

1. Minimize exposure to COVID-19

- Follow the existing guidelines on COVID-19 infection prevention measures during immunization sessions.
- Static site immunization services and VPD surveillance should be executed while maintaining social distancing measures and appropriate infection control precautions, equipped with the necessary supplies for those precautions.
- Based on the current understanding of the transmission modes of the COVID-19 virus and the recommended prevention measures of social distancing, it is advised to temporarily suspend the conduct of planned mass vaccination campaigns due to the increased risk of promoting community circulation. This advice applies to the following planned vaccination campaigns that have been postponed to a later date that will be communicated as soon as possible:
    a. The April Integrated Child Health Days campaign
    b. The Yellow Fever reactive vaccination campaign that was to be held in April in the districts of: Buliisa, Moyo, Obongi, Maracha, Koboko and Yumbe.
    c. Vaccines that are usually given to children in the school setting: HPV, Tetanus Toxoid are temporarily suspended since the children are not at school

2. Administrative controls

- Enforce daily immunization at all static sites; this will reduce the weekly turnup we have been observing.
- Ensure children don't miss their due antigens as we need to ensure that our children's immunity is insured in anticipation of any severe infection including the corona virus infection. For this reason, at this critical time, urge the population to take all children who have not completed the immunization schedule to catch up.
- Mothers and their children are free to access medical services by boarding the available vehicles prepositioned by the districts and KCCA or use of personal vehicles after obtaining clearance
- Mothers going for immunization services should carry the child's immunization card clearly showing the date of the next visit.
- At static and outreach sites, immunize clients as they turn up in groups not exceeding FIVE (**5)** mother/child pairs at a time.
- Assess and triage immunization clients, their caregivers for acute respiratory symptoms and risk factors for COVID-19 first to minimize chances of exposure .

- Avoid crowding in waiting rooms: maintain a distance of at least 1 meter equivalent to 3 feet apart from others and dedicate separate specific rooms for sick visits, away from the well visits and immunization.
- Enrich the routine education package with messages on prevention of the Corona virus disease. Inform caregivers attending the immunization sessions on COVID-19 measures, including use of hand hygiene, respiratory hygiene and importance of social distancing.
- Consider outreaches whenever feasible to equitably improve access to immunization, while minimizing risk of infection.
- Enumerate cohorts of children who may have missed their vaccine doses and develop an action plan for catch-up vaccination.
- Enhance VPD weekly surveillance and collect blood and stool samples from suspected patients for complete investigation of case-based surveillance for measles and Acute Flaccid Paralysis cases respectively.
- Alert all health facilities through M-trac on proper case management and line listing

3. Environmental controls

- Conduct vaccination preferably in dedicated immunization clinics or in a separate room in the healthcare facility. At all times ensure social distancing.
- Allocate well ventilated areas and ensure feasibility of social distancing for caretakers and children waiting for immunization.

4. Standard precautions

- Ensure procedures on hand hygiene, use of personal protective equipment, preventing needle-stick or sharps injury, waste management, cleaning and disinfection of equipment and environment are followed in line with the guidelines of the Ministry of Health and adapted according to the COVID-19 situation.
- At all immunization sessions, health facilities should provide for hand washing facilities (soap and water) or hand sanitizer when available.
- Healthcare professionals and workers should receive all appropriate vaccines and should be up-to-date with recommended vaccines i.e., Hepatitis B.

5. Adverse Events Following Immunization (AEFIs)

Districts should anticipate increased risk of coincidental AEFIs due to ongoing SARS-CoV-2 transmission coinciding with vaccination. All vaccinated children/adults should be kept under observation after vaccine(s) have been administered for at least 15 minutes. District Surveillance focal persons should ensure that for all identified AEFIs, health workers should immediately fill in an AEFI reporting form for all identified AEFIs and for serious/severe AEFIs a detailed AEFI investigation should be conducted by the district technical team. All filled in AEFIs forms should be sent to UNEPI immediately.

Annex 5. Guidance for a revised implementation of Integrated Community Case Management of Childhood Illnesses (ICCM) during the COVID-19 outbreak

The COVID 19 outbreak has created numerous challenges for the continuation of primary healthcare across affected countries, including significant decline in the utilization of health facilities due to the fears of community members of COVID 19 being transmitted by the health facilities.
Malaria, pneumonia, diarrhea, TB, HIV and malnutrition continue to be the primary killers of children under five in affected countries, As trusted members of the community who have the ability to provide lifesaving treatments for children, Community Health Workers (CHWs) have an important role to play in increasing access to prompt treatments for malaria, pneumonia, and diarrhea for children in rural hard to reach areas, in contact tracing and referral of suspected COVID-19 cases, and providing key messages to communities and families regarding COVID-19.

CHWs/VHTs are encouraged to follow the ICCM guidelines to assess to possibility of malaria, pneumonia, diarrhea or exposure to TB, HIV and malnutrition.

Temporary suspension of classroom trainings, routine home visits, VHT quarterly review meetings community outreaches and dialogues that require mass gatherings.

Malaria

Test and treat for Malaria at the community will continue in respect with the COVID guidelines.

If VHT finds a fever that tests positive for malaria, VHT should treat malaria and patient isolates at home until symptoms abate. If fever does not resolve from ACT, VHT should instruct patient to go to the facility within 3 days after management for malaria or pneumonia (and/or sample collection hub) as Covid-19 suspect.

NO touch iCCM will be instituted if the threshold of COVID cases goes beyond the required as per NTF guidelines, CHWs will then therefore classify suspected malaria cases only on a history of fever, and provide appropriate antimalarial treatment with artemisinin combination therapy (ACTs), i.e. “presumptive” treatment of malaria. Suspect malaria cases will be treated empirically with full dose ACTs and clinical response to ACT expected within 48hrs. No response to ACT treatment (absence of fever clearance within 48hrs) virtually excludes malaria as a cause of fever and strengthens the likelihood of other febrile illnesses, including COVID 19. Therefore, active follow-up of fever cases will be required, and if symptoms have not resolved by 48 hours then referral to the nearest health facility for further investigation will be required.
The VHT will take contacts of clients for follow up and easy identification in case of an identified suspect.

For pneumonia (children with a history of cough and/or difficult breathing), CHWs should continue to classify suspected pneumonia cases based on fast breathing using the known age-specific cut off points with use of respiratory rate timers. (The child’s caregiver should be asked to lift clothing as necessary to allow observation of the chest while avoiding touching of the sick child) and provide appropriate antibiotic treatment.

For diarrhea, CHWs should continue to provide oral rehydration therapy (ORS) and zinc to all children with history of frequent stools, defined as three or more loose stools in the past 24 hours. Any danger signs observed (as per existing IMCI/iCCM protocol) should continue to warrant referral to the closest health facility for further assessment and management.

For a child with a danger sign, The CHW should continue to use appropriate measures such as gloves to insert rectal Artesunate or ask the care giver to insert the RAS for a child with fever and a danger sign and refer the child to the health facility for further assessment.

In addition to the above management for malaria, pneumonia and diarrhea (iCCM), the following is also advised for CHWs during the COVID 19 outbreak:

i. CHWs should be provided with key messages on COVID 19 and malaria to help them support sensitization at community level as frontline messengers. The "COVID 19 Guidance Package: Advice for Individuals and Families" document produced by WHO and the MOH COVID/Malaria package has the necessary information that CHWs can use. This should be translated in messages which can enable transfer of knowledge to the communities
ii. CHWs play a key role in surveillance and they alert the closest health facility of suspected cases and probable deaths in their communities
iii. CHWs should also be provided with key messages for their own protection when interacting with patients–e.g. hand washing with soap and maintaining social distancing. They should be trained on infection control measures and provided with the necessary protective equipment, including gloves and use of face masks when made available.
iv. The guidance that we have at hand regarding use of PPE at community level points to promote preventive and mitigation measures should be emphasized, namely:

- Performing hand hygiene frequently
- Avoiding touching nose, eyes and mouth
- Practicing respiratory hygiene
- Maintaining social distance from persons with respiratory symptoms
- Wearing a medical mask if one has respiratory symptoms and performing hand hygiene after disposing of the mask

v. VHTs are advised to see the children where possible outside rather than inside the house and encourage hand washing with soap before patient is seen, use of gloves and masks once provided or any cloth mask improvised.
vi. Health facilities will continue to support VHTs with necessary medicines and supplies in a safe way in respect to social distancing.
vii. Health facilities should use channel of VHT parish coordinators to enable dissemination of health messages to fellow VHTs on COVID 19 prevention within the communities and replenishment of medicines and supplies and preventive gears.

Provision of essential medicines and equipment needed for VHTs to deliver services–Acts, Malaria RDTs, Amoxicillin dispersible tablets , ORS and Zinc, respiratory rate timers, gloves, soap and necessary 'job aids' (e.g. COVID-19 and Malaria messages for families/communities) will be provided through the health facility through use of parish coordinators

Coordinators should be given stock cards to ensure traceability of medicines taken to the community.

PPE will be provided to the CHWs/VHTs and they will be trained on how to use the PPE as well their safe disposal.

Targeted support supervision and mentorship will be conducted virtually on e-platforms or by phone calls to enhance quality of care.

Annex 6. Guidance on continuity of nutrition services in the context of COVID-19

Key facts: infant and young child nutrition and COVID-19

1. COVID-19 virus has not been detected in **breastmilk**.
2. COVID-19 is **NOT** transmitted through pregnancy, delivery or breastfeeding)
3. For all infants and young children, breast milk provides a strong immune system to fight against infectious diseases, including COVID-19.
4. During COVID-19, **standard infant feeding guidelines** should be followed with appropriate precautions for **infection prevention and control**.

Recommendation 1: Negative, suspected, probable, or confirmed COVID-19 infected mother and or child 0-23 months of age

- Initiate Breastfeeding within 1 hour of birth.
- Breastfeed Exclusively for 6 months
- Introduce adequate, nutritious, safe and age appropriate complementary foods at 6 months
- Continuing breastfeeding up to 1 year and beyond.
- Provide breastfeeding counselling to the mother and psychosocial support

Recommendation 2: Negative , suspected, probable, or confirmed COVID-19 infected mother and or child -*other required actions*

- Encourage mother to practice frequent breastfeeding to increase fluid intake.
- Encourage the child to eat frequently safe and adequate complementary foods for children aged 6-23 months.
- Mothers and infants should be enabled to practice skin-to-skin contact, kangaroo mother care and to remain together and to practice rooming-in throughout the day and night, especially immediately after birth during establishment of breastfeeding, whether they or their infants have suspected, probable, or confirmed COVID-19
- Parents and caregivers who may need to be separated from their children, and children who may need to be separated from their primary caregivers, should have access to appropriately trained health or non-health workers for mental health and psychosocial support.
- Provide psychosocial support to both the mother and infant at all times

Recommendation 3a: Suspected, probable, or confirmed COVID-19 infected mother unable to continuing direct breastfeeding

- Support mother to express breastmilk and feed child with breastmilk if she is able to do so.
- the milk can be given to the infant using a cup with a wide mouth, or a cup and spoon
- using a bottle is not advised as it requires sterilization prior to each use and makes it more difficult for the baby to return to the mother's breast when she becomes well again
- expressed breast milk in a closed container or covered with a cloth or plate at room for up to eight hours
- if stored in a sterile container, expressed breastmilk can be kept for 24 hours at 18 to 20 degrees centigrade C in a shady place, for about 72 hours in a refrigerator and for about four months in a freezer (at -18 to -20 degrees centigrade)
- start replacement feeding with RUIF if the infant is less than 6 months of age and mother is unwell to express breastmilk
- provide psychosocial support to both the mother and infant.

Recommendation 3b: Complementary feeding recommendations for infants and young children 6-23 months of age

- Encourage mother to continue breastfeeding on demand
- Provide, and ultra-heat treated (UHT) milk and complementary feeding if the infants 6-23 months of age.
- Young children need to consume a variety of foods to meet their nutrient needs and expose them to various tastes and textures.
- A diverse diet includes meals consisting of foods from a variety of food groups each day: (1) breastmilk; (2) grains, roots and tubers; (3) legumes, nuts and seeds; (4) dairy (milk, yoghurt, cheese); (5) flesh foods (meat, fish, poultry, and liver or organ meats); (6) eggs; (7) vitamin A-rich fruits and vegetables (carrots, mangoes, dark green leafy vegetables, pumpkins, orange sweet potato); and (8) other fruits and vegetables.
- Do NOT provide drinks or foods with low nutritional value, such as sugar-sweetened beverages, candy, chips and other foods high in sugar, salt and trans fats.
- Provide psychosocial support to both the mother and infant.

Recommendation 4: Infection prevention and control (IPC) for infant and young child feeding during COVID-19

- Always wear a medical mask when feeding or near a child if mother/caregiver has respiratory symptoms.
- Wash with soap and water before and after contact with the child.
- Routinely clean with soap clothes for both mother and child
- Routinely clean with soap surfaces and other areas of contact for both mother/caregiver and child
- Maintain physical distancing with other people and avoid touching yes, nose and mouth

Annex 7. Guidance for the Integrated Management of Acute Malnutrition in the context of COVID-19

Introduction

Acute malnutrition levels are anticipated to rise due to the preparedness and response measures put in place by governments during the COVID-19 global pandemic. For instance, response measures such as quarantine and social distancing limit access to both food and health care services. The poor and other vulnerable social categories of the population are the most affected. They have fewer resources to cope with the loss of jobs and incomes, the rise of food prices and the instability of food availability results into low ability to adapt to this crisis.

Uganda is grappling with the high burden of acute malnutrition in many areas; this makes it challenging to deal with the adverse impacts of COVID-19. For instance, acutely malnourished pregnant and lactating women(PLWs) and mothers or caregivers of children with acute malnutrition are finding it difficult to attend the weekly follow up visits because of the current COVID-19 response measures. Similarly, PLWs and mothers/caregivers are finding it difficult to access health care services where they can easily screen and identify malnourished children and PLWs. To prevent acute malnutrition, supplementary feeding programme (SFP) services, inpatient and outpatient therapeutic services need to be adjusted to minimize the risk of spread of COVID-19. This standard operating procedure is based on the MoH guidelines for integrated management of acute malnutrition, WHO guidance on Infection prevention and control during health care and WHO guidance on water, sanitation and waste management in COVID-19 era.

Rationale

This standard operating procedure is intended to guide frontline workers on how they can continue to provide optimal services to all children 6-59 months of age with severe acute malnutrition, and PLWs that may be identified with acute malnutrition under COVID 19 interventions.

What this SOP covers

- Community identification and referral
- Triage at OPD
- Nutrition status assessment
- Admission
- Access to nutrition therapeutic commodities at SFP (supplementary feeding program), and OTC (outpatient therapeutic care)
- Frequency of ready-to-use-therapeutic-food/ready-to-use-supplementary-food/corn-soy-blend++ (RUTF/RUSF/CSB++) refill
- Amount of RUTF/RUSF/CSB++ to give at each visit
- Number of caregivers at the OTC site
- Monitoring of SAM patients in OTC
- Reporting in the health management information system (HMIS/DHIS2)

Table 1: Recommended actions on the management of children 6-59 months of age with acute malnutrition in the frame of COVID-19

Procedure	Usual action	Recommended action during COVID -19
OUTPATIENT SERVICES		
Community identification and referral	• Self-referral when children are sick or present with signs of acute malnutrition • Referral by the VHT upon assessment • Referral by a health worker from a lower-level health facility	• Continue self-referrals • Continue assessment and referral by VHTs and should be done only when are equipped with PPEs and follow respiratory, personal and environmental hygiene specified for COVD-19. • Provide coloured MUAC tapes to all mothers/caretakers to routinely asses their children's nutrition status at their homes (they should refer any child in yellow or red to health facility). • Contact health worker if MUAC is in red or yellow to discuss how client meets nutrition services.
Triage at OPD	• All clients coming through the OPD (U5, 5-18 years, PLWs, adults) • IPC procedures, including handwashing, are not prioritised or practised at all. • No crowd control strategies are employed • Social distance is not put into consideration	• Use the MOH COVID-19 guidelines to screen and isolate all patients with suspected COVID-19 at first point of contact with health care system such as the outpatient department/clinic. Triage the patients using standardized IMAM guidelines. • Maintain social distancing recommended by the MoH • Assess and/or refer any clients/patients with signs and symptoms of COVID -19 • Where available use infra-red thermometers to take the temperature of every person before entering the service area • Place posters and flyers prominently in each area to remind patients and visitors to practice good respiratory and hand hygiene • Set up and observe the usage of handwashing facilities at the entry and exit of the triage to be used by every person • Provide hand sanitizers to all health workers working at the triage • Follow the MOH standard precautions for IPC during COVID-19
Nutrition status assessment	• Weight, height and MUAC measurements are usually taken without disinfecting equipment. • Sharing of weighing pants	• Allow in a client (mother child pair at a time**)** • Unless critically required, use only MUAC measurement for screening. • Disinfect the weighing scales and MUAC tapes after each measurement[7] • Assessment for bilateral pitting oedema (use gloves where needed e.g. if open wounds or other skin conditions are present otherwise sanitise hands after every measurement

[7] Health facilities that have inadequate supply of MUAC tapes should wash the MUAC tape with soap and water or disinfect using alcohol-based sanitizer (>60% alcohol) after every measurement.

	(for hanging scales) • Assessment of bilateral pitting Oedema • Taking of weight and height measurements • Crowding at the screening area	• Health worker to disinfect hands (either with a 0.05% bleach solution or>60% alcohol hand rub) for every client handled • Handwashing for everyone in the screening area
Enrolment and or Admission for treatment	Use of any of the following: • MUAC<12.5cm in children 6-59 months and <23cm in PLWs for MAM (Yellow MUAC) • MUAC<11.5cmin children 6-59 months and <21cm in PLWs for SAM (Red MUAC) • Weight for height Z-score cut-off • Bilateral pitting oedema	Use any of the following (excluding weight for height) • MUAC<12.5cm in children 6-59 months and <23cm in PLWs for MAM (Yellow MUAC) • MUAC<11.5cmin children 6-59 months and <21cm in PLWs for SAM (Red MUAC) • Bilateral pitting oedema
Provision of nutrition commodities to outpatients (SFP or OTC)	• Provided at designated health facilities or community based SFP outposts and integrated outreach sites • Crowding at service points. • IPC procedures are not prioritised • Nutrition counselling and guidance on the use of treatment products	• Where possible extend RUTF distribution to health Centre II's. • Support all health Centre II's in the documentation of the numbers and amounts of RUTF taken • Services to be provided at designated health facilities or CBSFP outposts. • Develop and disseminate cluster-based distribution schedules of SFP • Clearly designate entry and exit points at all service points • Set-up and observe handwashing facilities at entry and exit points • Health workers to follow IPC procedures throughout the time of service provision • Designate a records person to ensure record-keeping • Use IEC materials and empower VHTs to support client counselling and guide product usage. • HIV+ children on RUTF should be aligned with their ARVs prescription pick up at the same time from the facility

<table>
<tr><td></td><td></td><td colspan="3">For HIV+ children on RUTF receiving ARVs through community delivery (CCLADs and CDDPs), the facility should deliver their RUTF together with ARVs to the nearest designated community point for clients who are not able to come to the facility.
Children with SAM on RUTF- a mechanism for follow up on progress including making calls and providing support and counselling is advised in the face of the prevailing travel restrictions
Children assed as not making desired improvement or having feeding difficulties should be supported to come into the facility for detailed assessment and further treatment.
Provide client education with emphasis on implications of ration sharing and misuse of treatment products
Health workers to follow IPC procedures throughout the time of service provision
Provide psychosocial support to both the caretaker and older children</td></tr>
<tr><td>Frequency of refill for nutrition commodities RUTF/RUSF/CSB++</td><td colspan="2">Weekly rations for RUTF
Bi-weekly rations for RUSF/CSB++</td><td colspan="3">Give monthly rations to SAM children 6-59 months who can visit the health facility
Bi-weekly rations of RUTF for clients that (1) need more close observation, e.g. returning defaulters, returning relapses, (2) clients close to the health facility etc.
Bi-weekly rations if the facility has low stocks of RUTF to do monthly
Provide monthly rations of RUSF or CSB++ to children 6-59 months and PLWs with MAM
Emphasise client education on implications of ration sharing and misuse of treatment products</td></tr>
<tr><td rowspan="9">Amounts of RUTF</td><td>Weight. of child</td><td>Sachets/wk</td><td>Weight. of child</td><td>Sachets/2wks</td><td>Sachets/month</td></tr>
<tr><td>3.0–3.4</td><td>8</td><td>3.0–3.4</td><td>16</td><td>24</td></tr>
<tr><td>3.5–4.9</td><td>10</td><td>3.5–4.9</td><td>20</td><td>40</td></tr>
<tr><td>5.0–6.9</td><td>15</td><td>5.0–6.9</td><td>30</td><td>60</td></tr>
<tr><td>7.0–9.9</td><td>20</td><td>7.0–9.9</td><td>40</td><td>80</td></tr>
<tr><td>10.0–14.9</td><td>30</td><td>10.0–14.9</td><td>60</td><td>120</td></tr>
<tr><td>15.0–19.9</td><td>35</td><td>15.0–19.9</td><td>70</td><td>140</td></tr>
<tr><td>20.0–29.9</td><td>40</td><td>20.0–29.9</td><td>80</td><td>160</td></tr>
<tr><td>≥ 30.0</td><td>50</td><td>≥ 30.0</td><td>100</td><td>200</td></tr>
<tr><td>Amount of CSB++</td><td colspan="2">200grams per person per day</td><td colspan="3">200grams per person per day</td></tr>
</table>

Amount of RUSF	• 100grams per person per day	• 100grams per person per day
Number of caregivers at the OTC site	• Not indicated	• Opt to hold the OTC in an open space when caregivers are in a large number. Social distancing of clients should be maintained as a matter of priority • Maintain social distancing recommended by the MoH
Monitoring of SAM patients in OTC	• Weekly monitoring	• Use VHTs who have the necessary PPE and capacity to follow recommended personal, respiratory and environmental hygiene practices if possible • Conduct a monthly review of all children at the nearest health facility
Reporting in the HMIS/DHIS2	• Daily reports in the INR • Monthly summary report or the DHIS2	• Facilities that provide routine MAM/SAM services should continue reporting • Monthly aggregates of data elements
INPATIENT SERVICES		
Location and spacing of beds	• No guidance	• Suspected COVID-19 children who also have SAM should be isolated from other SAM children • Increase physical space to at least two (2) metres between beds in stabilisation centres or nutrition corners
Family member visits	• No guidance	• Limit family member visits to the primary caregiver only. • The family member should wear protective equipment each time they are in contact with the child • The family member should not be allowed to mix freely with other patients and community members
Kitchen facilities and safety of human resource	• No guidance	• IPC in view of COVID 19

Annex 8. Guidance on Malaria prevention, diagnostic and treatment activities in the context of COVID-19

Malaria remains the leading cause of morbidity and mortality in Uganda and negatively impacts the health and productivity of the population.13.4 million cases of Malaria were confirmed in 2019 alone of which 4000 Ugandans died.

Malaria and COVID 19 have some similarities. The early symptoms of COVID-19, including fever, myalgia, and fatigue might be confused with malaria and other febrile infections. This can lead to challenges in early clinical diagnosis and management. There is need to consider the preventive measures against not only the COVID 19 but also likely impact on existing malaria control efforts.

Main Objective: **To prevent malaria infection and ensure access to care and treatment for all people at risk as well as preventing Corona virus (COVID-19) transmission**.

- All patients including pregnant women that present with a fever should be screened at the facility entry, appropriately triaged and comprehensively assessed (through history taking, physical exam and laboratory investigation) and treated based on findings, recommended WHO/MOH guidelines ensure malaria treatment is done according to the COVID guidelines like hand washing with soap, use of gloves, facial masks, social distancing (at least 1m between patient and health worker)Maintain the 3 Ts (Test, Treat and Track) both at health facilities and community level
- Preferably use RDT for malaria testing for outpatient because it takes a shorter time and reduces congestion in health facilities, but for isolation centers, microscopy is preferred
- * **For every COVID suspect, first rule out Malaria since the two diseases have similar symptomatology (fever, malaise)**Health facilities will continue to support VHTs with necessary medicines and supplies in a safe way in respect to social distancing
- Redistribution of commodities will continue to take place in respect with COVID guidelines. For severe Malaria at community, Rectal Artesunate should be inserted with gloves as usual, and referred immediately to Health facility.
- Malaria in Pregnancy control interventions (IPTp, ITN for prevention plus diagnosis and treatment) are key in reducing Maternal, newborn, infant mortality and morbidity and should continuously be provided to all targeted persons in respect to COVID-19 guidelines.
- Private sector alongside public sector is critical in ensuring delivery of malaria case management in the COVID-19 era Drug shops, pharmacies and clinics are encouraged to screen all cases reporting with fever for testing, reporting and management.
- iCCM has a vital role to play in decongesting facilities during the pandemic, facilities and VHTs continue to work hand in hand "remotely" in keeping OPDs safe and running smoothly.
- Temporary suspension of activities that require mass gatherings (that require more than 10 people), however mentorships and support supervision will continue to be done virtually through E-platforms or over phone to ensure quality of care.

Long Lasting Insecticide treated Nets (LLINs)
Scale up continuous distribution through existing mechanisms like ANC and EPI plus special groups like market vendors.
Utilize community based structures to deliver mosquito nets to households without gatherings

IRS
Modified IRS will be conducted in the previously targeted high burden districts in the Northern and Eastern regions in the country
The IRS guidelines have been modified with enhanced infection prevention control (IPC) measures and Personal protective Equipment (PPE), social distancing as per the COVID guidelines.

Other preventive measures like Larviciding in targeted areas, cutting bushes around the homes, closing windows and doors early, using mosquito repellants and clearing stagnant water should be continued.

Annex 9. Guidance on HIV prevention, diagnostic and treatment activities in the context of COVID-19

This guidance will continue to be updated as new guidance on COVID-19 evolves globally. The Ministry of Health emphasizes the importance of maintaining critical HIV prevention, care and treatment services during COVID-19 to reduce vulnerability of PLHIV to COVID-19, ensure continuity of ART therapy and accelerated decongestion of health facilities to minimize transmission of COVID-19.

A. General Considerations

District Teams (Supported by the Regional Implementing Partner)

- The district will maintain its role in leading the implementation of all comprehensive HIV services.
- The regional Implementation Partners will work with the districts to ensure that critical HIV services are not interrupted during the Covid-19 response period. They will provide the necessary technical and financial support.
- District health officers and ART clinic in charges will ensure that skeletal staff is available at facilities to: attend to the clients seeking HIV and TB services in the ART clinics; record details of clients served; quantify ARVs and other drug supplies; and place emergency orders.
- The districts with support from the IP should adopt the use of telephones, and internet platforms to communicate to facilities and other stakeholders, including conduct trainings and mentorships.
- The districts with support from the IP will work with the existing Networks of People living with HIV to ensure the uninterrupted supply of ART to all recipients of care.

Networks of PLHIV and Civil Society

- The PLHIV networks at national level will continue working with MoH, through the national taskforce, to coordinate the national HIV response to ensure safety of clients and uninterrupted supply of ARVs.
- The PLHIV networks at the district level will work with districts, through district taskforce, to monitor coordination and provide timely feedback on the quality of services during the response.
- The Peer support staff at HIV service points (such as YAPs, Linkage facilitators, peer/mentor mother) should have their services at the facility suspended until the COVID 19 pandemic is under control. The PLHIV peers may work from home using phones to follow-up clients: remind them of appointments, drug pickups and linkage to nearest community ART services points.

Health Facilities

- The facilities will display toll free and other telephone numbers for COVID-19 response teams in visible places so that Clients can save them in their phones or write them down.
- All ART, TB and other HIV related clinics should have functional safe thermometers.
- All clients who come to the clinic must have their temperature taken.
- Use telephone calls, SMS, social media platforms to communication to clients and other stakeholders on services availability, follow up, adherence support and clinic attendance among others.
- Health Providers will use the appropriate Personal Protective Equipment (PPE) for all staff. If a Client is suspected to have COVID-19, a gown and goggles should be used in addition to gloves and medical face mask (where feasible). Face mask and gloves are most important PPE.

- ART Providers and Clients should practice frequent hand hygiene, including before and after patient care, when coming into contact with secretions, before eating and after using the toilet.
- Maintain infection prevention standards in the ART clinic by sanitizing all surfaces e.g. with hypochlorite per MOH guidelines.
- Inform MOH, relevant authorities of any suspected COVID-19 case among the ART patients. Documenting the clinical course of COVID-19 in PLHIV is important to inform optimal care.
- Monitor the number of HIV and TB service providers that are tasked to work on COVID-19.

- Ensure continuous antiretroviral therapy (ART) provision to current recipients of care based on the available stocks of ARVs at the site in order to maintain virologic suppression.
- Health facilities should accurately document the contact details of the clients who come to seek health services for easier follow up in case of Covid-19 exposure.
- Conduct on a regular basis on going activities of Information, education and communication (IEC) for the recipients of care to learn about the signs and symptoms of CoviD-19 using the hand out messages, telephone calls/SMS, social media platforms and mass media.

Triage

- Facilities must take temperature measurements for all PLHIV clients on arrival at the clinic.
- Patients presenting with fever, cough, flu like/ respiratory symptoms) should be isolated immediately and infection prevention and control observed.
- Screen for TB using the ICF guide at all entry points

Community activities

- The general community health services including HIV testing, HIV Prevention services and TB activities are temporarily stopped as per the Presidential directive on community gatherings.

Supply Chain Considerations

- Facilities with inadequate stocks, should place emergency orders for ARVS. However, all facilities must ensure that sufficient stocks of drugs regimens are available during this time. Districts and partners should support inter facility and inter-district commodity transfers, where applicable.

B. HIV prevention services

For HIV prevention, most services are community based and require mobilization using community gatherings, and or interaction with several community members. This poses a risk of exposure and transmission of the virus to the community and services providers who are mostly lay persons. Its therefore recommended that all community activities including mobilization, outreaches, meetings and workshops are temporarily put on hold.

HIV testing services

- During this interim period, all community activities including HTS outreaches are suspended.
- Facility-based HTS should continue in: Testing in ANC, labor/maternity, Early infant diagnosis (EID), in patient department for diagnostic testing, people with TB, STIs, and malnutrition, Assisted Partner Notification, and index client testing.
- Use of self-testing outside of the clinic setting should be encouraged.

Safe male circumcision

- The community camps including community mobilization are suspended. The SMC services shall be offered as a routine service in facility on appointment to avoid crowding.
- The health workers offering SMC must ensure that waiting time for clients is reduced and at any one time, not more than ten (10) clients should be waiting for the service.
- The Post-operative follow-up for clients already circumcised should continue using telephone calls and clinic visit for clients with adverse events

Community activities in Drop-in Centers (DICs), AGYW and KP/PP social interactions safe spaces

- AGYW safe spaces are temporally closed as per the presidential directive.
- The facility should focus on, line listing clients.
- The AGYW should continue accessing the non-curriculum-based services at the health facilities.
- At DICs walk in services will be provided but no more than 10 individuals should be served at any one time.
- Social gathering at DIC must stop in line with the Presidential directive on social distancing
- KPs, AGYWs and services providers are encouraged to use social media platforms for communication.

Continuity of PrEP services

- Facilities should evaluate the stock medicines available at their sites
- Where stocks allow, individuals already on PrEP, should be given a 3-month drug supply.
- When possible, follow up and adherence support of clients on PrEP should be done using telephone, SMS, social media platforms.

C. HIV treatment services including PMTCT services

These guidelines are aimed at reducing crowding of clients at ART delivery points as well as ensuring continued access to ART during the COVID-19 pandemic. ART delivery is majorly facility based which may potentially increase risk of the spread of the virus within the facility, therefore, focus should be placed on decongesting the facilities.

Multi-month dispensing (MMD)

- Multi-month dispensing (MMD) of three months is recommended for all clients regardless of age. This however should be based on availability of adequate ARV stock across the different drug regimens at the facility.
- The Facility should systematically call all clients with scheduled clinic visit in the next month for their ART refills and viral load testing if due.
- The facility should deliver ARVs to the nearest community point for clients who are not able to come to the facility. This can be through quick establishment of CDDPs.

One-month dispensing

The following categories of clients should be maintained on monthly appointments and refills at the facility however IPC measures should be adhered to.

- Visiting clients i.e. clients not registered at the ART facility
- Clients on 2nd or 3rd ART line regimen
- Virally non-suppressed clients
- The very sick e.g. clients co-infected with TB and are in intensive phase of TB treatment

Community drug distribution

- Clients receiving their care and refills through Community Drug Distribution Points (CDDPs) and Community Client Led ART Delivery (CCLADs) should continue receiving their care and refills through the same approaches.
- Infection Prevention and Control (IPC) measures should be emphasized at all times.

- Facilities should support clients to form CCLADs as a measure of decongesting the facility-based ART service delivery points.

Facility Based Groups

- Facilities should suspend all Facility Based Groups (FBGs) such as the Family support groups, Adolescent groups, teen clubs etc. until further notice.
- Members of such groups should be given multi-month refills if they qualify or else monthly appointments and refills with proper scheduling to avoid congestion at the ART service delivery points.

Access to ART services for unregistered clients

- It is MoH/ACP guidance that clients far from their usual ART facilities can visit any nearby facility for their ARV refills during the COVID 19 lockdown.
- Such clients will be considered "Visitors".
- "Visitors" will be provided with one-month drug supply

a. Documentation

- Open a counter book for temporary recording of clients as there is inadequate stock of HMIS tools at the health facilities.
- Unique ID: Document the client No and Health facility name. For example, If the parent facility is Kangulumira HCIV, ART No 22 the patient unique ID will be 22/ Kangulumira.
- Record the client demographic data, history, clinical assessment results (Weight, TB status, Nutrition status, ART refill, CTX refill for those eligible, INH initiation/refill etc.)
- For those without their ART exercise books, then the health worker should contact the parent health facility using the directory to find out the patients' details (History) and record them appropriately.
- Record all this information in the temporary register and clients' book as a reference point for the parent facility to document / update clients' records in the HIV/ART care card and ART registers when they go back for ART services after the Covid-19 pandemic.
- Dispense drugs for 3 months to ensure accelerated decongestion of health facilities to minimize transmission of COVID-19 and protect PLHIV

b. Reporting

- Using the health facility directory; the health worker should contact the parent health facility of the client to ensure records reconciliation.
- If the client has gone back to the parent facility, then he/she will be reported on by the parent health facility.
- If the client has not gone back to parent facility for ART services, then he/she will be reported on by this temporary health facility.

c. Tracking

- Attach all clients to a peer educator/ expert client.
- Follow up clients with a phone call after the duration of dispensation to find out whether they have gone back to the parent health facility.
- Using the health facility directory; the health worker should contact the parent health facility of the client to update them about their client.

TB/HIV Services

The majority of clients in the HIV and TB clinic present with cough and other symptoms that may simulate the presenting signs and symptoms of COVID-19. This presents a challenge of screening for COVID-19. Clients who have COVID-19 maybe mis-diagnosed.

- With PPE in place, the usual recommended screening for TB should continue and in addition take off recommended samples for COVID-19 testing from suspects (see MOH leaflet for samples to be taken).
- ART refills and anti-TB/TPT refills should be aligned for all PLHIV co-infected with TB or on TB preventive treatment.
- Not all cough is COVID-19, TB screening should be conducted but IPC measures should be adhered to.
- Ensure that all presumptive cases receive TB diagnostic test, Initiate TB treatment for positive ones.
- Coughing patients should be advised to practice home based self-isolation and referral of "suspects" should continue while being investigated for both diseases while waiting for result.
- Meanwhile if TB is confirmed, TB treatment should not be delayed while waiting for the corona test result, having two comorbidities can worsen the client's outcome.
- Supportive treatment should continue for those who are negative for TB and negative for COVID-19 as outlined in the Uganda guidelines for management of upper or lower respiratory disease.
- TPT (IPT) drugs should be provided for 6 months and patients monitored through phone calls

a) TB treatment

- Ensure alignment to Anti-TB medicines to ART refills
- Drugs may be dispensed to patients at any nearby TB diagnostic and treatment facility

b) MDR-TB

- Inpatients should stay on the ward for their DOT
- For patients under care at follow up facilities, health workers shall deliver medicine/treatment support at follow up facilities
- Treatment support should be identified to observe DOT at home and report any issues to the health worker promptly.
- A supply of MDR-TB drugs of up to 2months should be offered to the patient and treatment supporter where it is available
- Patients will access monthly reviews as soon as the situation allows
- Patients who require hospital admission and close monitoring should be admitted and managed accordingly per national guidelines

PLHIV with Co-morbidities

- Those with conditions such as diabetes mellitus should ensure good glycemic control by taking their medications well to avoid severe COVID-19. Similarly, the hypertensives should ensure blood pressure control and have enough drug refills during this uncertain period.
- NCD medicine refills should be aligned with their ART refills

Pregnant WLHIV

- Currently, there is limited information about pregnancy and maternal outcomes in individuals who have COVID-19. Immunologic and physiologic changes during pregnancy generally increase a pregnant individual's susceptibility to viral respiratory infections, possibly including COVID-19.
- For all Pregnant and breast-feeding women living with HIV, routine care should be followed as per recommendation in the consolidated HIV prevention and care and treatment guidelines.
- Its recommended that the ART refills should be aligned to scheduled ANC visits.

Children with HIV

- From the limited available data, children appear less likely to become severely ill with COVID-19 infection than older adults. However, there may be subpopulations of children at increased risk of more severe COVID-19 illness; in studies of infection with non-COVID-19 coronaviruses in children, younger age, underlying pulmonary pathology, and immunocompromising conditions were associated with more severe outcomes.
- Infants and children with HIV should be up to date on all immunizations, including influenza and pneumococcal vaccines.

Annex 10. Guidance on Tuberculosis prevention, diagnostic and treatment activities in the context of COVID-19

Background

This guidance will continue to be updated as new guidance on COVID-19 evolves globally. The Ministry of Health emphasizes the importance of maintaining critical TB prevention, care and treatment services during COVID-19 to reduce vulnerability of TB infected people to COVID-19, ensure continuity of TB treatment, prevention, screening and diagnosis services whereas ensuring prevention measures to minimize transmission of COVID-19.

People ill with COVID-19 and tuberculosis (TB) show similar symptoms such as cough, fever and difficulty breathing. Both diseases attack primarily the lungs and both biological agents transmit mainly via close contact. People ill with both TB and COVID-19 may have poorer treatment outcomes, especially if TB treatment is interrupted or delayed. These outcomes may even be worse for patients with TB-HIV co-infection.

It is therefore important to provide sustainability of essential TB services during the COVID-19 pandemic and leverage services across both diseases including health worker protection from both diseases, ensuring availability of the recommended commodities and supplies to manage both diseases, and protecting people seeking TB care during the pandemic.

A. General Considerations

Regional level

- The regional Implementation Partners and Regional TB Leprosy focal persons will work with the districts to ensure that critical TB/HIV services are not interrupted during the Covid-19 response period. They will provide the necessary technical and financial support.
- Plan and disseminate guidance on COVID prevention, TB and other services in the context of COVID

District Health Teams

- The district will maintain its role in leading the implementation of all comprehensive TB/HIV services.
- Maintain a line list of all TB patients in care and ensure continuity of treatment
- Updates at the district TASK force on the status of TB patients in the district should be provided.
- District health officers supported by the District TB Leprosy Supervisors and health facility in charges will ensure that skeletal staff is available at facilities to attend to the clients seeking TB services ; record details of clients served, those who miss appointment and plan to get them refills as soon as possible
- The districts with support from the IP should adopt the use of telephones, and internet platforms to communicate to facilities and other stakeholders, including conduct trainings and mentorships and dissemination of the guidelines.

Health Facilities

- The facilities will display toll free and other telephone numbers for COVID-19 response teams in visible places so that Clients can save them in their phones or write them down.
- All, TB clinics should have functional safe thermometers. Some partners have provided the infrared thermometers for all the TB wards.
- All clients who come to the clinic must have their temperature taken.

- Use telephone calls, SMS, social media platforms for communication to clients and other stakeholders on services availability, follow up, adherence support and clinic attendance among others.
- Health Providers will use the appropriate Personal Protective Equipment (PPE) for all staff. If a Client is suspected to have COVID-19, appropriate PPE should be used
-
- Conduct on a regular basis on going activities of Information, education and communication (IEC) for the recipients of care to learn about the signs and symptoms of CoviD-19 using the handout messages, telephone calls/SMS, social media platforms and mass media.

With PPE in place, the usual recommended screening for TB should continue.

- Not all cough is COVID-19, TB screening should be conducted but IPC measures should be adhered to.
- Ensure that all presumptive cases receive TB diagnostic test, Initiate TB treatment for positive ones.
- Coughing patients should be advised to practice home based self-isolation (provide amask) and referral of "suspects" should continue while being investigated for both diseases while waiting for result.
- Meanwhile if TB is confirmed, TB treatment should not be delayed while waiting for the corona test result, having two comorbidities can worsen the client's outcome more especially now that there is no treatment for COVID.
- Supportive treatment should continue for those who are negative for TB and negative for COVID-19 as outlined in the Uganda guidelines for management of upper or lower respiratory disease.

(i) Infection prevention including TB

- In accordance with COVID guidance to continue service delivery, all facilities should establish triage at entrance of health facilities.
- Designate isolation spaces in and outside the health facilities for suspected COVID cases
- HCWs should offer individualized health education about Corona Virus Disease (COVID-19) and TB to patients presenting at all health facility
- Refer to the national COVID-19 guidelines for prevention of COVID-19 (regular hand washing with soap and water or sanitizer, cough/sneeze etiquette, distancing etc.)
- In addition, implementation of TB infection control practices should continue as per the national TB guidelines

(ii) TB screening and TB diagnosis

- TB screening using the ICF guide should continue at all the facility entry points including the ART clinics.
- For people with respiratory symptoms, who do not meet the case definition for COVID-19, conduct evaluation for TB in order to increase chances of reaching undiagnosed TB in the community and minimise risk to HCWs
- All patients with a positive TB symptom screen should be linked to the laboratory for TB testing as per the national TB guidelines
- Sample collection should be done in an open space and health worker should not stand near patients during collection.
- Health workers should maintain a distance of 4 meters within the laboratory and while giving instructions to patients.
- Where available and functional use a Biosafety Cabinet II to do microscopy and Xpert.

- Where there is no Biosafety Cabinet II, use N95 respirator if available. If N95 respirator is not available, use any available mask.
- Strictly follow TB laboratory practices that minimize aerosol formation
- Disinfect and dispose off sputum containers correctly
- Maintain good ventilation in the laboratory
- Do not allow patients to enter the laboratory

NB.

- Sputum from a confirmed COVID-19 patient must be tested in a BSL-2 laboratory (with a functional Biosafety Cabinet II,N95 respirator, gown etc) or BSL-3 laboratory
- Please maintain a functional hub system for referral of TB samples for GeneXpert testing

(iii) TB treatment and follow up

- The district TB focal person through the DHO should provide an update to the District Task Force about the TB situation in the district highlighting key aspects on Treatment services and how patients are accessing services.
- Refills of TB medicines should be planned and aligned to available resources within the district covering all TB patients at the various treatment units.
- All patients diagnosed with TB should be started on TB treatment as per the national TB guidelines and educated/counseling prior to dispensing of medicines
- Admitted patients with TB should be stabilized before discharge in order to improve outcomes
- TB medicine refills and TPT refills should be aligned for all PLHIV co-infected with TB or on TB preventive treatment
- Ensure alignment to HIV DSDM models for patients with TB/HIV co-infection
- ART refills and anti-TB/TPT refills should be aligned for all PLHIV co-infected with TB or on TB preventive treatment.

(a) ***TB treatment: Treatment for tuberculosis must be started immediately for all newly diagnosed patients***

- Treatment for TB may be dispensed at any nearest TB treatment unit but records must be harmonized with the initiation site after lockdown.
- **Newly Diagnosed TB patients:** Dispense TB medicines for 2 months for newly diagnosed patients (2RHZE)
- **Patients on Initial Regimen (HRZE):** Dispense amount of TB medicines to complete the remaining period of the intensive phase for TB patients who are already in care.
- **Patients on continuation phase:** Dispense up to 2 months of drug refill for patients in the continuation phase

(b) ***Follow - up***

- Lines list all patients who interrupt treatment and follow them up through SMS or phone calls to arrange on how refills will be done. Arrange transport or use VHTs to reach all patients who fail to pick medicines.
- Follow up sputum tests should be conducted at the time of refills whenever possible

(c) ***MDR-TB***

- In-patients should stay on the ward for their DOT

- Patients who require admission and close monitoring should be admitted and managed accordingly per national guidelines
- For patients under care at follow up facilities, health workers at the treatment initiation facilities shall deliver medicine/treatment support at follow up facilities
- A treatment supporter should be identified to observe DOT at home and report any issues to the health worker promptly.
- A supply of MDR-TB drugs of up to 2 months should be offered to the patient and treatment supporter (when available)
- Patients will access monthly reviews as soon as situation allows. Where it is not possible, patients who are due for clinical review should be contacted by phone in order to ascertain:-
    (i) whether they are accessing medicines,
    (ii) status of DOT and adherence
    (iii) general well-being.
- For patients who need additional medical support, the MDR TB treatment initiation facility should contact the DHO for transport facilitation to the initiation facility for further management.

Frequently asked questions in the context of COVID

Purpose: To provide responses to frequently asked questions and guidance to health workers regarding TB management in the context of COVID – 19

Target group: Health Workers

	Question	Response
	What are the similarities between TB and COVID 19	Both COVID-19 and TB cause respiratory symptoms – cough and shortness of breath. Both cause fever and weakness. One of the biggest differences is the speed of onset. TB symptoms are of a gradual onset, often over a period of weeks or longer, unlike COVID-19, where symptoms can occur within a few days
	Who is presumed of having Tuberculosis	Any person with cough of 2 or more weeks and/or fever of 2 or more weeks and/or noticeable weight loss and/or contact with TB patient or a child who is not growing well. *<u>Note:</u> The individual presenting with any of the above symptoms should be assessed further by a health worker and have sputum examined in the laboratory*
	What are the available options for patients to access TB treatment or preventive therapy during this period of travel restrictions?	The TB patients can collect their TB treatment or preventive therapy refills from the facility where the treatment was initiated or from a TB diagnostic and treatment health facility nearer to the patient's home Community deliveries (including home deliveries or deliveries to the nearest pick up point) by a community health worker or health facility staff or DTLS or peer *<u>Note:</u> The Health worker will line list all clients due for refills and contact them in advance to coordinate the mode of delivery in collaboration with the community service provider, other health facility teams and DTLS as appropriate. The Health worker will also ensure that all patient refills are duly documented in the treatment register*

	Can patients on TB treatment receive multi-month supply?	Yes, given the current travel restrictions, patients on TB treatment can receive multi-month supply as follows:- Assess the stock at hand to ensure to ensure that it is adequate for the active patients and or multi-month refills Dispense TB medicines for: 2 months for newly diagnosed patients remaining period of the intensive phase for TB patients who are already in care. up to 2 months for patients in the continuation phase TB treatment refills and ART refills should be aligned for all PLHIV on TB treatment.
	Can patients on TB preventive therapy receive multi-month supply?	Yes, given the current travel restrictions, patients on TB preventive therapy can receive multi-month supply as follows:- Assess the stock at hand to ensure to ensure that it is adequate for the active patients and or multi-month refills 2 months refills for TB preventive therapy should be offered for under five contacts TPT refills and ART refills should be aligned for all PLHIV on TB preventive treatment.
	How does the health facility ensure adequate stock of TB medicines and supplies?	Conduct weekly facility level stock taking to inform re-distribution or pulling of stock as appropriate and ensure reporting RASS. Follow NMS schedule to order for communities
	How will the patients with TB/HIV co-infection be managed during this period?	TB treatment refills and ART refills should be aligned for all PLHIV on TB treatment. Regular follow – up phone calls for TB/HIV co-infected patients especially during the first 2 months of treatment.
	Who supports/provides transport for health workers to deliver medicines and enablers for MDR-TB patients?	The District Task Force and Implementing Partners will work together with the MDR-TB treatment hospitals to support/provide the required transportation for health workers to deliver MDR-TB medicines to patients Patients should be able to receive their enablers even during this COVID-19 lockdown When enablers are available, they should be delivered together with the MDR-TB medicines
	How will the patient monthly clinical reviews be conducted during this period when patients cannot access MDR-TB treatment initiation hospitals?	Patients will be followed up through phone calls during clinic days, if patient very sick; provide transport through the district task force for their admission for standard care
	How will newly diagnosed MDR TB patients access treatment?	Health workers should contact the district COVID task force (including the DHO) to support the transportation of the patient to the nearest DR TB initiation site.
	How are health workers protected from TB and COVID?	Follow the MOH guidance on prevention of COVID and TB Ensure proper use of available personal protective equipment (such as masks, gloves); hand washing; and hand sanitizers. Triage of persons accessing the health facility for risk of COVID - 19 and TB could help minimize risk to health workers and result in rapid identification Establish triage area (desk or tent) away from the waiting area in OPD

	How will protection be ensured for treatment supporters who help deliver medicines to TB patients?	Follow national guidance on prevention of COVID 19 Ensure social distancing, hand washing/use of sanitizers, masks (when available)
	How will treatment monitoring be supported during this period?	Technology aided monitoring including phone calls to patients to remind them of their daily doses Video Observed therapy where available including patient consent Self- Administered Therapy DOT by a family member treatment supporter Formation of dedicated chronic care teams or strengthen them during this period to ensure continuity of care for all patients with chronic illnesses. Sputum monitoring should done at the recommended time for both sensitive and DR-TB patients whenever possible (such as at the time of medicine refills at the health facility level or within the community)
	What will happen to community activities like contact tracing during COVID lock down	Self-reporting by contacts with symptoms of TB at the facility Use of community health workers staying in the same community as the TB patients could be used to identify symptomatic contacts and referral of samples to health facility where possible. Other community TB screening activities should wait until after the lockdown

Annex 11. Guidance for Sexual and Reproductive Health and Rights: Access to Modern Contraceptives in the context of COVID-19

Background

- Many women in Uganda would like to limit or delay getting pregnant, but do not have access to consistent use of modern contraceptive methods. Out of 100 married women or those in union, 28 of them want to prevent pregnancy but are not using modern contraception, while 58% of the total demand for family planning is being met.
- Outbreaks including COVID-19 can heighten vulnerabilities of different population groups, including women and girls, and the most marginalized. As we have seen with past pandemics, social and economic upheaval can also negatively impact SRH services and access to care. Our already burdened health system needs to be prepared to see a rise in unintended pregnancies, demand for post abortion care services, and requests for contraception.
- In addition to impacting access to health care for contraceptive counseling, method procurement and provision, the pandemic is also disrupting the supply chain for contraception, especially the last mile delivery to the community delivery points.
- Modern contraceptive commodities and supplies, including menstrual health and hygiene items, are central to adolescents and women's health, empowerment, and the exercise of sexual and reproductive health and rights.
- Disruptions in the availability and distribution of contraceptives, essential maternal health medicines may have life-threatening consequences and reverse recent gains in universal access to sexual and reproductive health and rights.
- There is continued need to maintain access to quality, rights-based contraceptive care in the context of the COVID-19 pandemic through ensuring a secure and reliable supply of reproductive health commodities, including contraception. Innovations around last mile distribution, and contraceptive counselling and method access are required to ensure equitable access to sexual and reproductive health services to girls and women in their communities.
- The national stock status for contraceptives is still healthy for a range of methods at both Joint Medical Stores (JMS) and National Medical Stores (NMS).
- Much as there could be health facility stock out of contraceptive methods during this period, the central warehouses are still delivering their mandate of providing health commodities to all health facilities countrywide.

Core Message

People will continue to have SRH needs during the COVID-19 pandemic. As such, provision of modern short- and long-acting contraceptives, information, counselling and services (including emergency contraception) is lifesaving and should be available and accessible as part of the COVID-19 pandemic response.

Advice to health workers while providing contraceptive services

Adoption of Integrated COVID- 19 messaging and observation of universal precautions:

- Observe universal precautions of COVID-19 prevention while providing family planning services
- The protection of health workers must be prioritized as they provide sexual and reproductive health and rights services including contraception. This is critical and lifesaving and all health

workers and other community resource persons must ensure adoption of precautions for prevention and screening for COVID-I9 as per the MOH guidelines.

- Triage all women that visit the health facility for signs and symptoms of COVID-19 based on the MOH guidelines. Actively screen all the clients to identify any with suspected symptoms of COVID-19 (Signs and symptoms of Covid-19 disease: Fever, cough, sore throat and shortness of breath).
- Conduct health education on signs and symptoms of COVID-19 and the prevention measures. Sensitize women on the risk and mitigation of stigma and discrimination that may be associated with COVID-19.
- At the health facility, if a woman is a suspected, probable case and fits the criteria for case definition of COVID-19, the health worker should inform the laboratory staff who shall initiate testing for COVID-19. She should be referred to the isolation unit for further management as per MOH guidelines. If the client is negative but has been exposed, she should start self-quarantine for 14 days. She should postpone her routine visits to the health facility and the health worker should ensure that the health surveillance team conducts follow up checks until after the self-quarantine period is over.
- Address any stigma, myths and misconceptions, and discrimination of people that present with COVID-19 like symptoms, and health care providers working in facilities with COVID-19 cases.
- For health facilities that are already providing contraceptive community-based distribution of oral contraceptives, DMPA SC including self-injection, ensure that the village health teams (VHTs) that are actively involved are well-oriented on the COVOID-19 signs and symptoms, preventive measures and what to do when identifying a probable case or suspect.
- Provide medical supplies for prevention and infection control, for community health workers according to MOH guidelines as part of COVID-19 preparedness and response.

Provision of family planning services

Family planning provision is an essential service and will continue to be provided during this period.

- Ensure that access to sexual and reproductive health information and services including contraceptive services is maintained, with special attention to women among vulnerable populations such as persons living with disabilities, persons living with HIV, and people in humanitarian settings.
- Creatively avail and ensure access to contraceptive information, counselling and services by the adolescents and youth using various platforms including social media, adolescent peer educators, VHTs and static clinics and facilities.
- Ensure provision and access to emergency contraception targeting vulnerable groups and general population at both static clinics and in the community. Need to avail platforms and contact details to ensure that women, adolescents and couples that may want to speak with healthcare practitioner before taking emergency contraception can do so.
- Where possible family planning services should be integrated with other essential services such as antenatal, delivery, postnatal and HIV services.
- Women on short-term contraceptives methods, especially the oral contraceptives should be given commodities to cover at least a 3-months'period. Women who are self-injecting with DMPA-SC can be given three units of DMPA-SC injectables to take home. This will minimize the frequent visits to the health facility for refills. Clients should be fully counselled on the side effects and how these can be managed, when to switch and when to return to the

health facilities. Client should be linked to the respective community resource persons for any immediate support in case of refill or support.

- Maintain the different service delivery models including community-based distribution, outreaches to health facilities, static clinics etc. Outreaches should be conducted with modifications to incorporate the COVID-19 preventive measures. Do not plan for massive community mobilization and drive. The health facility leadership and implementing partners have to engage with district leadership and the district COVID19 response team to agree on the implementation modalities of the planned outreaches and community service delivery activities.
- Inform the population (community level) on the availability of family planning services and how these can be accessed during the COVID-19 pandemic period.
- Review the data management tools to identify beneficiaries that may be due for contraceptive refills/revisits, and those on long-term methods nearing expiry. Actively reach out to them through phone calls or by VHTs reminding them about continued availability and accessibility of family planning services.
- Continue to innovate to access to family planning services. Promote community distribution of DMPA SC, including self-injection, community-based distribution using VHTs, trusted 'boda boda' or bicycle rider and distribution along food distribution exercises.

Supply chain to ensure availability of method mix:

- Ensure adequate stock management at both health facility and community and monitor stock levels of contraceptives using the Logistic Management Information system (LMIS). May need to consider higher levels of stocks to ensure continued availability of an adequate contraceptive method mix and dispensing 3-monthly refills for oral contraceptives and 3 DMPA-SC units for the women who are self-injecting.
- Prepare and submit commodity orders based on the ordering and reporting schedules of NMS and JMS. However, in case of stock out or shortage, contact the District Medicine Management supervisor or Assistant DHO for possible redistribution within the district.
- Mobilise and redistribute commodities that are overstocked in the facilities and district stores to ensure constant availability of these commodities at all service delivery points.

Data management for family planning at both facility and community

- Ensure that all the relevant data management tools for family planning service provision including stock management are available to capture both facility and community data.
- Ensure proper documentation in the relevant health management information systems tools.
- In addition, data quality reviews should be undertaken at district and regional level to detect and respond to RH/FP data gaps in a timely manner and make these data more useful for planning and monitoring FP service delivery.

Annex 12. Guidelines On Providing Mental Health And Psychosocial During Covid-19 Pandemic Response

Uganda registered her first case of COVID-19 on March 21st, 2020; and since then the cases of COVID-19 have continued to slowly increase. The government has put in place strict measures to contain the COVID-19 outbreak at the population level. However, the unprecedented measures undertaken to break the chain of transmission are causing public panic and unrest and generating psychological stress in the population.

Adequate provision of psychological support and access to services contributes to a sense of normalcy, foster the healing process and enhances resilience of the affected populations. This therefore means that the population should be supported to manage the stress, to prevent the negative psychological outcomes including anxiety, depression, panic attacks, and sleep disturbances.

The mental health professionals have put down some guidance and messages for the different sub-populations to support their mental and psychosocial well-being during this COVID-19 outbreak.

HEALTH CARE WORKERS

1. Feeling pressured is a likely experience during management of epidemics and is not a reflection that you cannot do your job or that you are weak. Some optimum level of stress is necessary to maintain vigilance and for maximum functioning.
2. Understand the sources of stress during this time including risk of contracting the disease and contaminating others and the strict bio security measures to be taken; conflicting personal and professional demands and stigma.
3. Prepare yourself through training or widely reading about the basic specific details about COVID-19 and the available Uganda MoH protocols and guidelines for screening, PPE, quarantine, isolation and case management.
4. Manage your mental health and psychosocial wellbeing during this time as well as your physical health.
5. Be honest with yourself and sure you are ready to be a responder. This is important because it helps you reduce on the fear and anxiety.
6. Take care of yourself. Use helpful coping strategies such as ensuring sufficient rest and respite during work or between shifts, eat sufficient and healthy food, and engage in physical activity.
7. Avoid using tobacco, alcohol or other drugs as a coping strategy. In the long term, these can worsen your mental and physical wellbeing. Use appropriate and helpful strategies that have worked for you in the past to manage times of stress.
8. Staying connected with your loved ones, with family and friends through digital methods and explain to them if possible about COVID -19 so as to reduce on the stigma.
9. Turn to your colleagues, your manager or other trusted persons for social support but be mindful that your colleagues may also turn to you for help in case they are having problems.
10. Use understandable ways to share messages with people with intellectual, cognitive and psychosocial disabilities.
11. Know how to provide support to people who are affected with COVID-19 and know how to link them with available resources.
12. At the end of the pandemic, follow up with a mental health professional if you experience problems with; sleeping, eating and getting integrated back into your family, community and workplace.

HEALTH FACILITY MANAGERS OR TEAM LEADERS

1. Keeping all staff protected from chronic stress and poor mental health during this response means that they will have a better capacity to fulfill their roles. Be sure to keep in mind that the current situation will not go away overnight and you should focus on longer term occupational capacity rather than repeated short-term crisis responses.

2. Ensure good quality communication and accurate information updates are provided to all staff. Use different forms of communication other than written information.
3. Rotate workers from higher-stress to lower-stress functions. Partner inexperienced workers with their more experienced colleagues.
4. Create and facilitate the buddy system which helps to provide support, reduce stress and reinforce safety procedures.
5. Ensure there is time for colleagues to provide social support to each other.
6. Ensure that outreach personnel enter the community in pairs.
7. Initiate, encourage and monitor work breaks.
8. Implement flexible schedules for workers who are directly impacted or have a family member impacted by a stressful event.
9. Facilitate access to, and ensure that both workers and managers are aware of where they can access mental health and psychosocial support services.
10. Orient responders, including nurses, ambulance drivers, volunteers, case identifiers, teachers and community leaders and workers in quarantine sites, on how to provide basic emotional and practical support to affected people using psychological first aid
11. Manage urgent mental health and neurological complaints (e.g. delirium, psychosis, severe anxiety or depression) within emergency or general health care facilities.
12. Deploy appropriate trained and qualified staff and ensure that general health care staff can provide basic mental health and psychosocial support.
13. Ensure availability of essential, basic psychotropic medications at all levels of health care. People living with long-term mental health conditions or epileptic seizures will need uninterrupted access to their medication, and sudden discontinuation should be avoided.

CARE PROVIDERS FOR CHILDREN

1. As a Care provider for children, learn to manage your anxiety and tolerate uncertainties by being mindful of the present. This will help you stay grounded and calm in the present and not the past or the future.
2. Help children find positive ways to express feelings such as fear and sadness. Every child has their own way to express emotions including: seeking reassurance, tantrums and meltdowns, trouble sleeping and complaints of headaches and stomachaches. Sometimes engaging in a creative activity, such as playing, and drawing can facilitate this process. Children feel relieved if they can express and communicate their feelings in a safe and supportive environment.
3. Keep children close to their parents and family, if considered safe for the child, and avoid separating children and their caregivers as much as possible.
4. If a child needs to be separated from their primary caregiver, ensure that appropriate alternative care is provided and that a social worker, or equivalent, will regularly follow up on the child.
5. During periods of separation, regular contact with parents and caregivers is maintained, such as twice-daily scheduled phone or video calls or other age-appropriate communication (e.g., social media depending on the age of the child).
6. Maintain familiar routines in daily life as much as possible, or create new routines, especially if children must stay at home.
7. Engage children into age appropriate activities, including activities for their learning. Encourage children to play and socialize with others, or within the family when advised to restrict social contact.
8. Avoid giving too much reassurance because this is not sustainable and it makes anxiety worse when caregivers are not able to provide reassurance. Instead reinforce and remind them of the precautions they are taking to stay safe e.g frequent hand washing and physical distancing. Support them to stay in the moment by practicing mindfulness
9. Discuss COVID-19 with children using honest and age- appropriate ways. Address their concerns, to ease anxiety. Children will observe adults' behaviors and emotions for cues on how to manage their own emotions during difficult times.

OLDER ADULTS, AND PEOPLE WITH UNDERLYING HEALTH CONDITIONS

1. Older adults, especially in isolation and those with cognitive decline/dementia may become more anxious, angry, stressed, agitated, and withdrawn during the outbreak/while in quarantine.
2. Health professionals and care takers should provide practical and emotional support through sharing simple facts about what is going on and giving clear information about how to reduce risk of infection that older people with/without memory disturbances can understand.
3. Instructions need to be communicated in a clear, concise, respectful and patient ways. Repeat the information whenever necessary.
4. Engage their family and other support networks in providing information and helping them practice prevention measures (e.g. handwashing etc.)
5. If you have an underlying health condition, make sure to have access to any medications that you are currently using. Activate your social contacts to provide you with assistance, if needed.
6. Be prepared and know in advance where and how to get practical help if needed, like calling a friend/ family member, having access to near-by food stores and requesting medical care. Make sure you have up to 2 weeks of all your regular medicines that you may require.
7. Learn simple daily physical exercises to perform at home, in quarantine or isolation to maintain mobility and reduce boredom.
8. Keep regular routines and schedules as much as possible or help create new ones in a new environment, including regular exercising, cleaning, daily chores, singing, reading, maintaining the compound etc. Keep regular contact with loved ones (e.g. via phone or other accesses).

PEOPLE IN ISOLATION

1. Stay connected with family and friends and maintain your social networks via e-mail, social media, video conference, telephone, etc
2. Keep your personal daily routines or where possible create new routines.
3. During times of stress, pay attention to your own needs and feelings.
4. Engage in healthy activities that you enjoy and find relaxing.
5. Exercise regularly in appropriate ways that suit your age and situation
6. Keep regular sleep routines and eat healthy food.
7. Keep things in perspective it may not be possible to be provided with everything as you want it.
8. Seek information updates and practical guidance from trusted health professionals and WHO website and avoid listening to or following rumors that make you feel uncomfortable.

Annex 13. Provision of Sexual Reproductive Health, HIV and gender based Violence services in the context of COVID-19

Background

Emergencies always bring women and girls as critical actors in the response as well as victims in need of care and protection. Women represent 70 percent of the health and social sector workforce globally. In Uganda, women constitute the majority in the health sector workforce. Lessons from previous epidemics suggest that women health staff face increased risks of abuse, intimidation, and harassment. At the frontline of Covid-19 treatment, not only involves dedicated health-care professionals, but they are also supporting staff such as cleaners, laundry, catering, of which the majority of these are women, and as such these frontline workers experience significant high virus exposure.

With 90 countries in lockdown and nearly four billion people sheltering at home from the COVID-19 pandemic, domestic violence has become an epidemic within an epidemic. During this COVID-19 period, women, girls, children, older people, people with disabilities, people living with HIV&AIDS, the marginalized and the displaced have experienced disproportionate impact and pay the highest price. Mortality and morbidity incidences have increased during the COVID-19 crisis in Uganda to about 76 deaths per week because of Malaria and maternal mortality. In times of crisis such as an outbreak particular population groups experience disproportionate impacts. Women and girls at greater risk of intimate partner violence and other forms of domestic violence due to increased tensions in the household. In context of the lockdown some adolescents and young people are subjected to violence including defilement and rape by family members affecting both boys and girls. Data emerging from the GBV Shelters, Uganda Police, Uganda Child Help Line (UCHL), CSOs and the media indicate an increase in GBV incidences against women and children. For example, 1,211 cases have been reported through GBV shelters, 256 cases have been reported through the UCHL between 3rd and 9th of March 2020, and 200 child protection cases from 20 districts have been reported through the Catholic Relief Services (CRS) among others in the same period despite the low levels of reporting country wide.

The COVID-19 lockdown has deprived many Ugandans of their livelihoods resulting in lack of basic needs including food, clothing and access to essential services which has driven some especially women and girl child heads of families and sex workers to be sexually exploited to access food. During the lockdown, many Ugandans (men and women) are not able to fend for their families, which is bringing family tensions and domestic violence.

Similarly, individuals experiencing violence are not able to access services in the health facilities and other service points for reasons such as restricted movements, lack of public transport and fear of overcrowding that can lead to COVID-19 transmission.

It is important to note that the Presidential directives prioritized essential medical services and security. However, this has on the other hand constrained the delivery of other equally important services such as GBV/VAC prevention, response and referral as well as access to Sexual and reproductive health (SRH) services. In addition, there is a manifest absence of the social sector in the playing field of COVID-19 response right from national to subnational levels hence worsening the desired timely and appropriate response to GBV.

Government guidelines on COVID-19 present an opportunity for strengthening GBV prevention, risk mitigation and response as well as access to SRHR services and information. Thus, protection of women and girls should further be a priority as the epidemic compound existing gender inequalities and increase the risks of gender-based violence and sexual abuse. It is paramount to keep essential GBV prevention and response workers such as CDOs, probation and welfare officers, CSOs,

counsellors and the whole referral system chain in place and fully equipped to carry out community surveillance, support reporting and management of cases and access to related services.

Therefore, the intention of the SOPs is to provide guidance for different key service providers to integrate GBV in the delivery of COVID-19 response services.

1. GUIDANCE TO LEADERSHIP AT DISTRICT AND COMMUNITY LEVELS (RDC AND SECURITY AGENCIES, DHO, DISTRICT TASK FORCE LOCAL COUNCILORS, AND PARISH CHIEFS ETC)

- Integrate GBV prevention and response in COVID-19 response services.
- Monitor response and manage GBV cases in local Governments to ensure effective & efficient services delivery to men and women, boys and girls and children.
- Ensure documentation and reporting of GBV cases through the National GBV Database (NGBVD).
- Enlist GBV coordination mechanism among the essential services during the COVID-19 period within the district.
- Mobilize communities to prevent and respond to GBV through the existing local government structures.
- Monitor the implementation of different GBV prevention and response interventions including the GBV shelters and advisory centers.
- Sensitize communities on issues related to prevention and response to GBV
- Establish a mechanism to ensure timely response of Local Council Courts to cases of GBV
- Implement existing Bye-laws for elimination of GBV
- Ensure clear measures should be in place to prevent and mitigate harassment, abuse and all forms of GBV towards female frontline workers.
- Mitigate the effects of stress for all health care workers (male and female), as well as develop strategies to counter potential stigmatization and discrimination
- Create community awareness on the existing GBV referral pathway using various channels of communication.
- Link the survivors/victims to food distribution services.
- Discuss the crisis of domestic violence with community leaders, elders, politicians, sports heroes, celebrities, or other influential people, and ask them to make statements speaking out against abuse at home.
- Broadcast these messages through radio, television and social media platforms.
- Start hashtags and online campaigns that promote positive messages about women and girls and vulnerable groups. Message can also teach families how to be safe from coronavirus, declare that abuse is never acceptable, and that encourage community members to de-escalate and speak out against violence.

2. GUIDANCE TO HEALTHCARE WORKERS

- Screen the client for GBV related issues
- Clients screened and identified as GBV survivors must be provided with the recommended services available in the facility (Refer to the Ministry of Health GBV clinical management guidelines).
- For victims of sexual violence, Post Exposure Prophylaxis (PEP) and other related services
- Assess the need for support services such as counseling or legal help and assist the survivors to access them.
- Appropriately refer GBV survivors as per the referral pathway for psychosocial support, legal assistance, social protection and clinical case management that might not be available in the facility.

- In management of GBV cases, clearly document, collect, and preserve any forensic evidence for use in subsequent court trials should the need arise.
- In the humanitarian setting, provision of the Minimum Initial Service Package (MISP) should be adhered to.
- Mitigate the effects of stress for all health care workers (male and female), as well as develop strategies to counter potential stigmatization and discrimination
- Key communities and service providers must be informed and updated on the existing referral pathways through the available awareness channels

3. GUIDANCE ON PROVISION OF FORENSIC (MEDICO-LEGAL) SERVICES

- Collect, analyze, store and document findings from the forensic-related investigations
- If a focal person is not in attendance, in that facility, then other person equipped with skills to collect samples according to the level of facility and type of GBV case, will collect and submit the samples to the relevant forensic authorities for further investigation.
- Serve as an expert/factual witness in court, if summoned by a magistrate or judge

4. GUIDANCE ON PROVISION OF PSYCHOSOCIAL SUPPORT AND LEGAL SUPPORT

- Assess the need for support services such as counseling or legal help and assist the survivors to access them
- Health worker should provide and/or refer clients for emotional support and psychosocial care for survivors/victims and if needed for the perpetrator
- Create rapport with GBV survivors and treat them respectfully and in a culturally appropriate manner
- For any GBV victim/survivor identified/ handled, immediately report to the L.C officials, Local Police Station or Parish Chief promptly for further support
- Health workers should assess and liaise with other service providers (CDOs, Probation officers, police and CSOs) to ensure that the victims/survivors receive all the care and support they need from other service providers.
- Treat all information collected in the course of providing psychosocial support with utmost confidentiality.
- In case of Children GBV survivors/victims, provide age appropriate support
- Appropriate psychosocial support services should be provided to people with disability, female sex workers, other vulnerable groups including minority groups
- Health workers should popularize the Toll-free lines provided by the MOH and MGLSD including the SAUTI helpline 116.
- Offer community education/sensitization on GBV prevention and response

5. GUIDANCE TO POLICE OFFICERS AND LEGAL SERVICE PROVIDERS

- Introduce yourself to the victim/survivor and explain your role in the matter.
- The officer receiving the victim and or report should endeavor as much details as possible and complete PF3 and refer the Victim/survivor to the health facility
- Escort the victim/survivor for medical examination
- Develop rapport with the victim/ survivor to build her/his trust/ confidence
- Interview the victim/survivor in privacy or in camera.
- Limit the number of times you interview the victim/survivor, to avoid secondary trauma – the less the number of interviews the better
- Keep the victim/survivor and the guardian (in case of children) informed of the progress of the investigations/case

- Inform the victim/survivor about the different actors in the court and their roles.
- Inform the victim of the court procedures that are likely to follow.
- Take the victim/survivor for a court visit prior to the hearing date, especially if it is a child.
- Inform the victim/survivor of his/her role in the case in order for court to reach a just decision.
- Apply to court for use of available victim friendly procedures/facilities
- Put the victim/survivor, especially a child, at ease by asking small talk on a subject of interest before going to the substance of his/her testimony.
- Respect morality and cultural feelings of the victim/survivor.
- Protect the victim/survivor from embarrassing or unfair questions in cross-examination, through court.
- Know what questions and language to use with the victim /survivor and if a child, take into account the age and the child developmental needs e.g. use of anatomically detailed dolls or pictures for demonstration.

6. GUIDANCE TO DCDOs/CDOs/PROBATION OFFICERS

- Joint advocacy and dissemination of IEC materials on GBV.
- Support community GBV surveillance
- Map and update the district referral pathway and existing services within the district
- Coordinate other players and actors on GBV prevention and response
- Link GBV survivors/victims to services (medical, legal, psycho-social support, protection, food etc)
- Liaise with the health workers to ensure that survivors/victims access relevant services in addition to health
- Actively listen to the victim/ survivor and offer counselling.
- Respond to immediate physical and psychosocial needs of the victim/ survivor and link them to services.
- Ensure that probation and social welfare officers are equipped with logistical support and made available to represent the child victim/survivor in court.
- Confidentially collect, document and analyze data on quality of services.
- Link with the district COVID-19 task force and offer support

7. GUIDANCE TO CSOs/NGOs/FBOs

- Map and update the district referral pathway and GBV existing services within the area of operation
- Coordinate with GBV thematic groups and CDOs in areas where there are mutual advantages for delivery of essential services
- Offer protection services to victims of GBV
- Creating awareness among communities on elimination of GBV at all levels.
- Document and share experiences and reports with the CDOs
- Offer support to the District Task force whenever called upon
- Key communities and service providers must be informed and updated on the existing referral pathways through the available awareness channels

8. BUILD MEN'S ALLIES WITHIN FAMILIES AND THE COMMUNITY AND PUBLICIZE THEIR POSITIVE VIEWS

- Encourage men, boys and other allies who condemn domestic violence to speak up and share their stories in ways that dismantle harmful stereotypes on gender roles and behaviors.

- Testimonies might include vignettes about men and boys taking up their fair share of household chores and sharing responsibility for other domestic tasks with women and girls in their families, especially during COVID-19 lock downs.
- Men should also describe their role as fathers or caregivers who utilize peaceful alternatives to physical violence and promote gender-equality among their children.
- Men as social agents of change - identify, engage and work with role model men and boys (RMMB) on the premise that not all men are opposed to women empowerment and gender equality but rather, there are men who do support or are willing to support gender equality. These RMMB include: (i) already gender sensitive men practicing positive masculinity and (ii) men who have been violent or in unstable/vulnerable households but willing to change (iii) *Influential men* in decision making positions within the programme area, e.g. community psychosocial facilitators, cultural leaders, religious leaders, and political leaders.
- Work with men as community psychosocial facilitators – use the role model men to engage with men from households to which role model men are attached and where they work through peer-to-peer relations and male mentorship sessions. The main focus is on improving communication among couples and strengthening gender relations at household level. The core method is a "Support Group Model" where a role model man facilitates reflective discussions on locally relevant psycho-social issues within the groups nearby most vulnerable households to which RMMB are attached.
- Work with men and boys as clients – recognize that not only women, but men can also have psychosocial distress issues, e.g., family conflicts, unemployment, lack of skills, poverty, role conflicts, interpersonal violence, etc. Men are socialized to disregard pain, to not show weakness and to believe that talking about personal problems is a sign of weakness. As a result, men who experience violence rarely discuss their problems with others, contributing at times to depression and even incidents of suicide. Men are targeted in this component so that they can benefit from various psychosocial support services. At one level, men in the household reflect/dialogue groups often engage in peer to peer support, encouraging one another to open up and share personal problems. At another level, some men have social support needs that need referral to external social support mechanisms – which may be facilitated by the RMMs or their supervisors.

Annex 14. Interim Guidelines For continuity of care and wellbeing of adolescent and young people during Covid-19 Outbreak

Introduction

The COVID-19 outbreak has come with it many changes in the way people work, associate and seek services and carry on day to day activities. Young people mostly who have been engaged in schooling activities have now to be at home or in isolation centers for those who are affected by the corona virus. Young people being confined in the different home environments comes with it some health challenges much as it may pose opportunity for more parent child interaction in the home setting. There is limited access health information including SRH . The care providers, the community and other care givers have manly shifted effort to COVID-19 containment. Confinement to home settings and social distancing have led to lack of transport means to access commodities and advise on issues concerning the health of young people. **Overuse and misuse of disinfectants may trigger negative health effects such asthma attacks and other problems arising from exposure and accidents** (*to pick evidence)*

This situation is therefore likely to increase young people vulnerability to diseases and poor health now and in future.

School is protective for most adolescents form risky behaviors , with adolescents not at home with no much activity , there is risk to substance abuse. Whereas there is a lock down on bars and most sources of alcohol, adolescents will have networks that ensure continuity to access substances. And with much inactivity this may increase substance exposure and use the community and its associated effects.

There are adolescents engaged in transactional sex who mostly engage with long distance drivers. This may increase their risk to acquiring COVID-19 and also spreading it into their families. It is against this background that these guidelines have been prepared .

Purpose

These guidelines provide additional strategies to promote the safety of young people and minimize harm from the effects of the COVID-19 pandemic on the wellbeing of young people but also contribute to the reduction of the transmission rates.

Overall Objective

To provide reference guidelines for the health sector response to young people's health needs and effects caused by COVID-19 strategies Specific Objective

Objectives

1. To Guide health workers on caring for adolescents during COVID-19.
2. To guide Communities and other institutions / relevant agencies and implementing partners on ensuring they contain the COVID-19 risk spread.
3. Provide guidance on prevention of other diseases and health effects and other illnesses that may take advantage of the COVID-19 prevention strategies.

Health needs , risks and challenges affecting adolescent and young people's health due to COVID-19 outbreak.

Needs

- Psychosocial support

- Essential health services (RH, Malaria, RTIs)
- Food
- Income
- Associate with peers

Health Risks

- Low risk perception towards covid 19
- Poor feeding, Hunger
- Inactivity and overweight
- Sexual and gender based Violence
- Unprotected and Transactional sex with high risk groups e.g trans-border cargo transporters, uniformed service men .

Challenges caused by COVID-19 response strategies

- Lack of transport to access health facilities
- Limited access to media for information.
- Lack of personal income.
- Lack access to SRH commodities and information
- Limited community support to access health services especially SRH.
- Hunger for urban poor.
- Separation from parents due to disruption of movement .
- Exploitation due to restricted movement

Health effects from COVID 19 interventions

- Poor mental health (Separation anxiety, Fear, Depression)
- Malnutrition
- Unplanned pregnancy
- RTIs

Care and management for adolescents and young people During COVID-19 outbreak

Special considerations for adolescents

1. No consent will be required to isolate admit or treat young people Diagnosed with COVID -19 who may not be accompanied by care takers. However, Health workers MIUST ensure that their families are informed.
2. Psychosocial and peer support is important for the sick hence Family members visiting adolescents should be limited in numbers and should maintain adequate social distance.
3. While admitted at health facilities Young people below 18 years shall not be in the same quarantine / isolation buildings or rooms with Adults.
4. While at home Care takers and parents should supervise the movement of the young people
5. Risk communication should include Special messages for adolescents. These should be developed for COVID-19 prevention in line with adolescent common risk behaviors

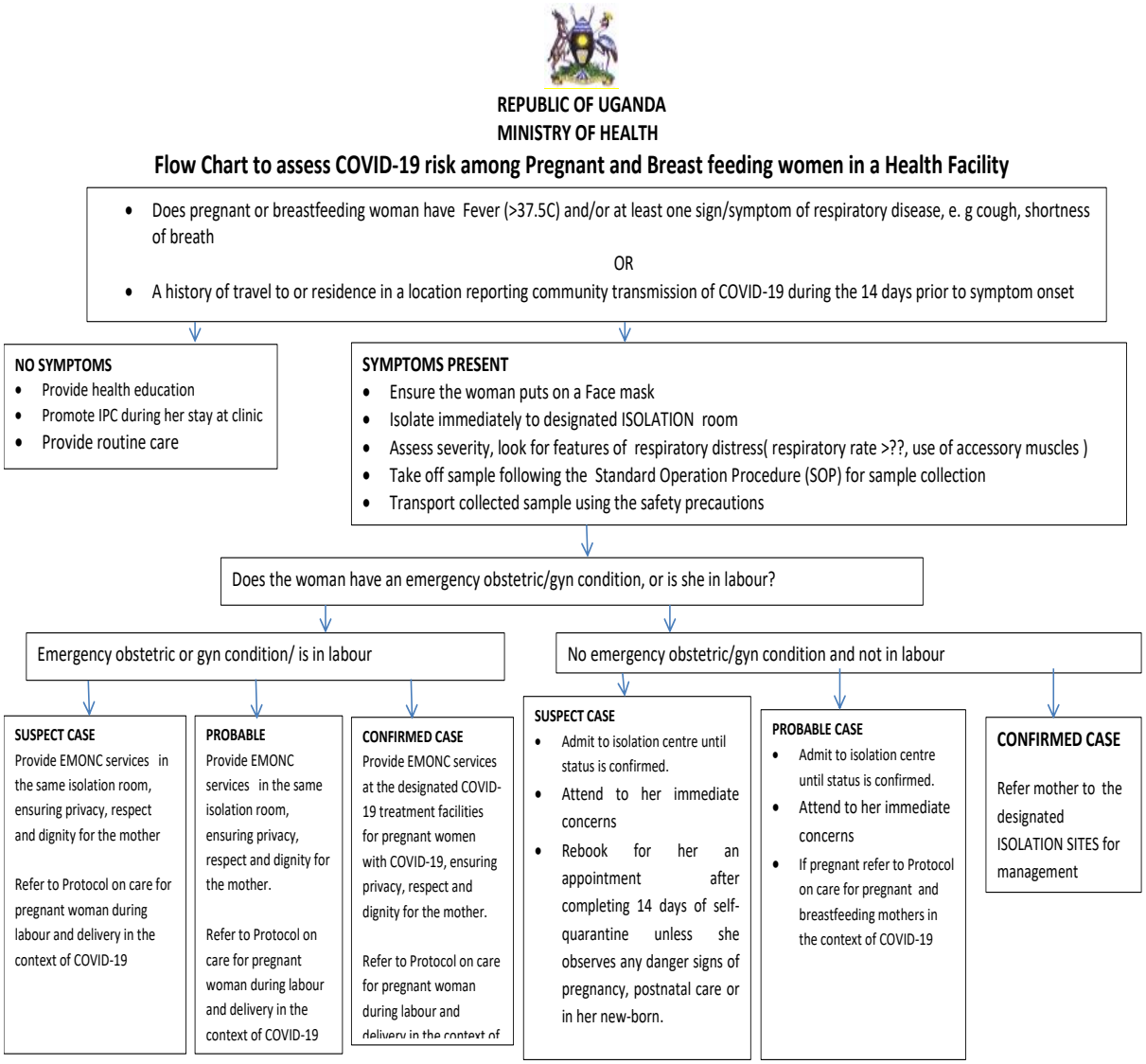
6. Health facility can organize outreaches for special categories of adolescents such as those on the streets , in hard to reach areas, refugee settings and observe COVID-19 community guidelines.
7. While at home or in hospital, or in School, Adolescents should be provided with adequate meals and be of balanced diet including citrus Fruits and vegetables to minimize the risk of other illnesses such as common colds. RTIs.
8. Communication should emphasize proper hygiene of hands but also the general body and sanitation to prevent other diseases like cholera especially where there is confinement and big numbers of young people living together such as schools, remand homes, markets ,hospitals including quarantine centers.
9. Life skills education should be integrated in other messaging platforms and continue to be provided to prevent sexual abuse and other forms of exploitation for things such as food and Shelter.
10. Child helplines and call centers will continue to operate to help children and young people facing violence.
11. Report call centers hotlines to be available and made known to adolescents and young people including their care takers
12. **For Adolescent and youth engaged in community activities and work** ,MOH Adolescent and School health Division shall develop guideline for all institutionalized young people (Schools , orphanages, remand homes, special needs homes, prisons, worksites) to ensure they keep safe from other infectious diseases and non-communicable diseases and seeking care for essential services in the context of COVID-19
13. **Health service providers offering the essential health care services** Shall ensure enabling environment at health facilities to access services , be non-judgmental , observe confidentiality and respect the young people.

Annex 15. District response and readiness checklist-COVID-19

	COVID-19: Operational Readiness Areas	Performance 1. Operationally ready 2. Moderately ready 3. Requires immediate support 4. Requires urgent support
Health Facility Readiness		
1	Health facility readiness assessment conducted to evaluate response capacity.	
2	Screening and triage protocols established and reinforced at all points of first access to the health facility (Gate/Emergency) including in PNFP and PFP facilities	
3	Capacity of all facilities to implement basic emergency care (BEC) for seriously ill patients and activate referral augmented.	
4	All HF's have developed a supply, procurement and distribution plan for personal protective equipment (PPE) and biomedical equipment (including oxygen, ventilators - HCVI's and District Hospitals), including contingency plan for shortages.	
5	All HF's have established and displayed a protocol for restricting visitors to wards. (Visitors to confirmed cases or visitors who are sick with acute respiratory infection (ARI), including for parents or caregivers accompanying minor patients).	
6	All HF's have assessed testing and lab capacity including for sample referral	
	Score	
Health Workers Readiness		
1	All HF's have staff dedicated to communicating with patients, visitors, and during morning health promotion talks	
2	All HF's are strengthening infection prevention and control (IPC) measures to mitigate health care worker (HCW) and nosocomial infection, this includes; 1. Identification of IPC focal points, 2. COVID-19 IPC training, 3. Ensuring availability of key documents at all levels of care (SOPs, communication materials – visual alerts for screening), 4. Visitors' policy 5. IPC supplies.	
3	Clinical management of COVID-19; 1. Training on clinical management of COVID-19 for clinical staff and support staff (cleaners, askaris) 2. Ensuring key documents are available (SOPs, guidance).	
4	Developing staffing plans to identify and appropriately supervise staff for repurposing and surge at health facility level, in designated isolation facilities and during threshold 3 (home care) - based on district and national strategy.	
5	Strengthen measures for protection of occupational health, safety, and security of health workers – prevention of violence, addressing fatigue, and access to health care and social support.	
	Score	
Referral Systems Readiness		
1	Communicated the details of COVID-19 designated health facilities (HCVI's, District/General Hospitals and RRH's) and designated isolation facilities (Threshold 3-Schools, churches etc.) to entire population in the district	
2	Dedicated transfer vehicles and ambulances for all suspected or confirmed COVID-19. (Ensure that IPC measures are always respected during patient retrieval and transport and that vehicles are disinfected properly).	

3	Identified and establish expanded screening and appropriate referral pathways in community settings (e.g. churches, schools).	
	Score	
Designate COVID-19 treatment/Isolation areas within health facilities & communities		
1	Established COVID-19 treatment areas within health facilities (isolation rooms/ward/unit) or designate separate COVID-19 facilities.	
2	COVID-19 treatment and isolation spaces/rooms have been designed to allow implementation of all required IPC interventions.	
3	COVID-19 treatment areas and isolation spaces/rooms have been designed to deliver life-saving oxygen therapy- District/General hospitals and RRH's (Most patients hospitalized with severe disease will need oxygen, and a smaller proportion will require ventilation).	
4	Establish COVID-19 surge plan. a. Has the district planned for repurposing of wards for severely or critically ill patients. b. Has the district planned for community facilities (designated isolation facilities e.g. schools, churches) for isolation of mild or moderate patients or for self-isolation at home.	
5	Do all HF's have the discharge protocol	
	Score	
Maintain essential health services		
1	Has the district task force been activated	
2	Has the district task force guided on continuity of uninterrupted essential health services as per national guidance	
3	Has the district task force guided on community based health services including iCCM and outreaches as per national guidance	
4	Has the district agreed on a plan to redistribute health workforce capacity as needed?	
	Score	
Community messaging and risk communication		
1	Has the district disseminated COVID-19 prevention and control messages COVID-19 disease presentation and HF level of care: 1. Mild disease - General hospital and HCIV; 2. Moderate disease - General hospital and HCVI; 3. Severe disease - RRH and General Hospital; 4. Critical disease - RRH and National RRH's	
2	Has the entire population been engaged in hand washing, respiratory hygiene, and physical distancing?	
3	Popularize COVID-19 case definitions for community based and facility based surveillance.	
4	Designate officers and disseminate widely dedicated telephone numbers to manage alerts.	
5	Involvement of multi-stakeholders for response - all existing government structures, HR, NGO's, CSO's, CBO's	
6	Understand community coordinated network with local government authority, public health unit/district medical officer, prehospital care services (including community health workers, community first aid responders, ambulance services) and hospitals.	

Health facility flow chart to assess COVID-19 Risk among pregnant and breastfeeding women in a health facility



REPUBLIC OF UGANDA

MINISTRY OF HEALTH

Information for Health workers to share with Pregnant women during Antenatal Care sessions during the COVID-19 pandemic

- Health workers should encourage pregnant women to increase their social distancing to reduce th risk of infection during their stay at the health facility and in the community.

- Pregnant women should pay particular attention to avoiding contact with people who are know to have COVID-19 or those who exhibit possible symptoms.

- Health workers should provide psychosocial counseling and support to suspected, probable or confirmed pregnant women with COVID-19

Key messages

- If you are infected with COVID-19, you are still most likely to have no symptoms or a mild illness from which you will make a full recovery.

- If you develop more severe symptoms or your recovery is delayed, this may be a sign that you are developing a more significant chest infection that requires enhanced care, you should contact your health worker for further information and advice.

REPUBLIC OF UGANDA
MINISTRY OF HEALTH

Advice to Health workers when providing care to Pregnant and postnatal women during the COVID-19 pandemic

- Care for pregnant and postnatal women is an essential service and should be planned for along with other essential services.
- Health workers should continue to provide antenatal care as a routine package but should practice appropriate Infection Prevention and Control (IPC) measures for COVID-19, including personal protective wear and social distancing.
- Health workers should advise pregnant women to attend routine antenatal care unless they meet current quarantine guidance for individuals and households of individuals with fever, symptoms of respiratory disease such as cough, shortness of breath suggestive of COVID-19.
- While in the community, if a pregnant or postnatal woman develops symptoms suggestive of COVID-19, and fits the criteria for case definition for suspect or probable case for COVID-19, she should contact the health care worker attending to her at the health facility to postpone the routine ANC visits. The health worker should contact surveillance teams to get intouch with the woman in this case and if confirmed as a suspect or probable case, they should be admitted at the COVID-19 facility for assessment.
- Maternity departments with direct entry for patients and the public should have in place a system for identification of potential cases as soon as possible to prevent potential transmission to other patients and staff. This should be at first point of contact (either near the entrance or at reception) to ensure early recognition and infection control. This should be employed before a patient sits in the maternity waiting area.
- At the health facility, if a pregnant or postnatal woman is a suspected, probable case and fits the criteria for case definition of COVID-19, the health worker should immediately isolate the woman and inform the laboratory staff to initiate testing for COVID-19. If the woman is negative but has been exposed, she should start quarantine for 14 days. The surveillance team shall conduct follow up checks until after the quarantine period is over.
- If a pregnant or postnatal woman is a confirmed case, the health worker will refer her to the designated treatment centre for further management. The patient needs to continue receiving obstetric care when there.
- In the event of a pregnant woman attending with an obstetric emergency and being suspected or confirmed to have COVID-19, maternity staff MUST first follow IPC guidance. This includes transferring the woman to an isolation room and wearing appropriate PPE. Once IPC measures are in place, the obstetric emergency should be dealt with as the priority.
- Do not delay Emergency Obstetric and Newborn care (EMONC) service delivery in order to test for COVID-19. Rather, health workers MUST observe the IPC standards as per confirmed patients.
- All confirmed COVID-19 postnatal women should be kept in the health facility until their test result turns negative
- Health workers should continue providing care for a woman confirmed with COVID-19, until a negative test result is obtained.
- If Ultrasound equipment is used, it should be decontaminated after use in accordance with IPC guidelines
- All pregnant women with or recovering from COVID-19 should be provided with psychosocial counselling and information related to the potential risk of adverse pregnancy outcomes.

REPUBLIC OF UGANDA

MINISTRY OF HEALTH

Information to Health workers when giving caring to Breast feeding mothers and their infants

- Infants born to mothers with suspected, probable, or confirmed COVID-19 should be fed according to standard infant feeding guidelines, while applying necessary IPC precautions
- All the breastfeeding women should at all times wear a face mask
- Health workers should encourage women to breastfeed and take necessary Infection Prevention and Control (IPC) precautions to limit viral spread to the baby.
- Health workers should encourage breastfeeding mothers to practice hand washing before touching the baby, breast pump or bottles; avoid coughing or sneezing on the baby while feeding at the breast; ask women to wear a face mask while breastfeeding.
- All post-natal mothers who are confirmed cases of COVID-19 and are in isolation should be managed using the existing postnatal guidance.
- Postnatal women with or recovering from COVID-19 should be provided with psychosocial counselling and information to enable them cope after discharge from the health facility.
- Women's choices and rights to sexual and reproductive health care should be respected regardless of COVID-19 status, including access to contraception.
- Health workers should encourage mothers to bring their children for immunization and growth monitoring services. They should maintain social distancing and IPC during their visit at the health facility.

THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

INFORMATION FOR HEALTH WORKERS TO SHARE WITH CLIENTS SEEKING FAMILY PLANNING SERVICES DURING THE COVID-19 PANDEMIC

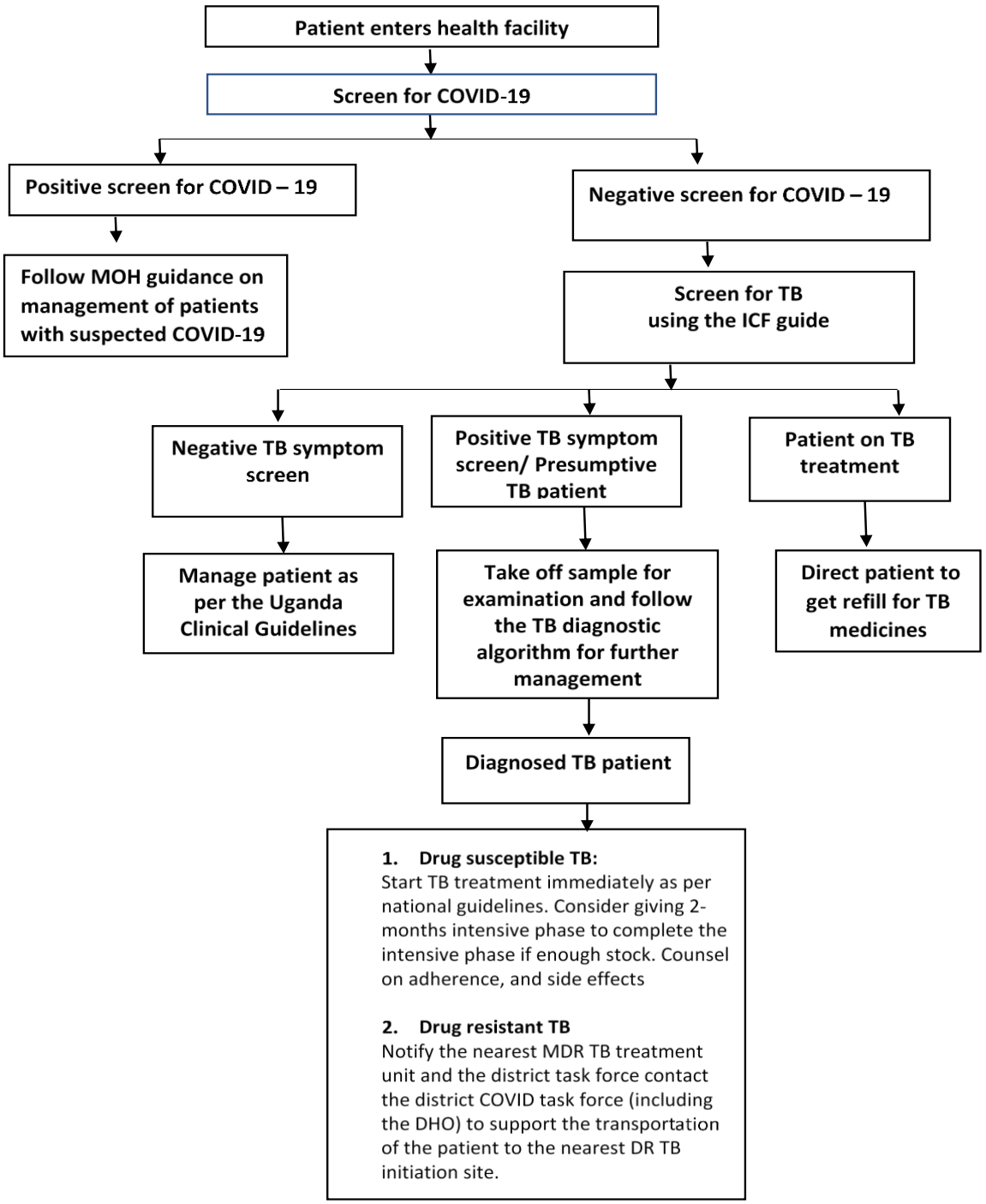
1. Health workers should continue to provide family planning services as a routine package but should practice appropriate Infection Prevention and Control (IPC) measures for COVID-19, including hand washing and personal protective equipment
2. Ensure social distancing at the different FP point of care points including maternity, immunisation, HIV, at community level of 4 metres and use of facemasks, among other IPC measures by all FP clients at service delivery points and in the community. Overcrowding MUST be avoided at the ANC clinics
3. Family Planning clients should wash their hands with clean water and soap or sanitizers for before they enter the consultation room.
4. The health workers should wash/sanitize hands before they examine clients and after they have examined the patient.
5. The health worker should put on a medical mask when examining clients.
6. All necessary examination should be done within the same space to avoid clients moving around the health facility too much, this will reduce their contact with possible other sources of infection or them spreading infection.
7. Give a wider spacing between visits up to three months unless absolutely necessary and give information on FP side effects to all clients and encourage them to return any time they get any of them.

Key messages

1. If you are infected with COVID-19, you are still most likely to have no symptoms or a mild illness from which you will make a full recovery.
2. If you develop more severe symptoms or your recovery is delayed, this may be a sign that you are developing a more significant chest infection that requires enhanced care; you should contact your health worker for further information and advice.

MINISTRY OF HEALTH

Health facility Tuberculosis (TB) Management Plan in the Context of COVID 19



MINISTRY OF HEALTH

A SEFETY PROTOCOL FOR CONDUCTINGG ADOLESCCENT HEALTH RELATED COMMUNITY EVENTS/OUTREACHES DURING THE COVID-19 OUTBREAK PERIOD

Ministry of Health is committed to ensuring that the health workers , stakeholders and beneficiaries stay safe from COVID-19 in the process of delivering services needed by young people through outreaches or any informal settings. MOH therefore issues the following guidelines to ensure safety of the providers, the clients and the host communities.

1. Community events must be Reported /known to the area authorities namely Subcounty chief if at subcounty level, the district Health officer and CAO if at district level.
2. Adequate space must be available to allow proper social distancing measures, be it indoors or outdoors.
3. There shall be adequate hand washing facilities with soap and water, or sanitizers if available. Linen shall not be shared at any one time.
4. All Participants to these events shall be screened by trained personnel for COVID-19 symptoms on entry .
5. The sitting area must contain IEC materials on precautionary measures for COVID-19 prevention
6. Persons must avoid handshakes and hugs .
7. Games that involve close body contact must be avoided during such activities – e.g “Energizers”
8. Practical sessions, demonstrations. Role plays, should also avoid human body contact
9. Indoor meeting activities should ensure space of 2 square meters between persons .
10. No outdoor or indoor activities shall take place after 5 pm, moonlight activities are suspended.
11. Travel to and from the venue shall follow guidelines issued by Ministry of Works. Through their respective works officers.
12. Distribution of commodities in the community shall be handled by persons screened and confirmed to be free form COVID-19.
13. Refills of medicines such as ARVs, Vaccines, contraceptives shall be taken to clients. Health workers shall follow up clients at home for refills. Telephone contacts of adolescent caretakers shall be taken the purpose of follow-ups.
14. Service delivery outreaches should not convene more than 50 people in one area, preferably these should be outdoor. Social distancing should be mentioned between each client and providers.
15. Community resource persons , peer educators, local council leaders shall engage after orientation on infection prevention measures