World Health Organization
Uganda

WHO RESPONSE PLAN FOR THE EBOLAVIRUS DISEASE OUTBREAK

IN UGANDA

September 2022 – February 2023

(This document is aligned with National Ebola Response Plan and WHO Emergency Response Framework – Second Edition)

Introduction

On 20 September 2022, WHO was notified by the Uganda Ministry of Health of an outbreak of Ebolavirus Outbreak. This followed identification of a confirmed a case in Ngabano Village of Madudu Sub- County, Mubende district. Concurrently, two sub-counties; Kiruma and Madudu reported a cluster of six unexplained deaths that had occurred between 1 and 15 September 2022 that have been classified as probable cases. This is the eighth EVD outbreak that has been declared in Uganda, and 5th by the Sudan strain.

Current situation

On 15 September 2022, a 25-year-old male from the Ngabano village of Madudu Sub- County in Mubende district was admitted and isolated in Mubende Regional Referral Hospital (MRRH). Prior to admission He presented at the St Florence Medical Centre in Mubende District with symptoms high grade fever, tonic convulsions, loss of appetite and pain on swallowing for which he sought medical care on 11 September 2022. He was admitted and managed as Malaria.

On 13 September he was referred to St Johns Medical Centre showing no improvement following treatment. Here he presented with worsening symptoms and had developed diarrhea, chest pain, dry cough, and difficulty breathing and managed as Bronchopneumonia. On 15 September he was referred to MRRH for further management. On admission, presented with blood-stained vomit, diarrhoea and had progressed to coma. On 17 September, a blood sample was collected and transported to the Uganda Virus Research Institute (UVRI). On 19 September, UVRI confirmed EVD (Sudan). The patient died on 19 September 2022, following a five-day hospitalization and a safe and dignified burial was accorded.

As of 6 October 2022, a total of 44 EVD case-patients had been reported. In addition, 20 probable cases have been reported. A total of ten deaths had been reported (case fatality rate [CFR]: 22%)

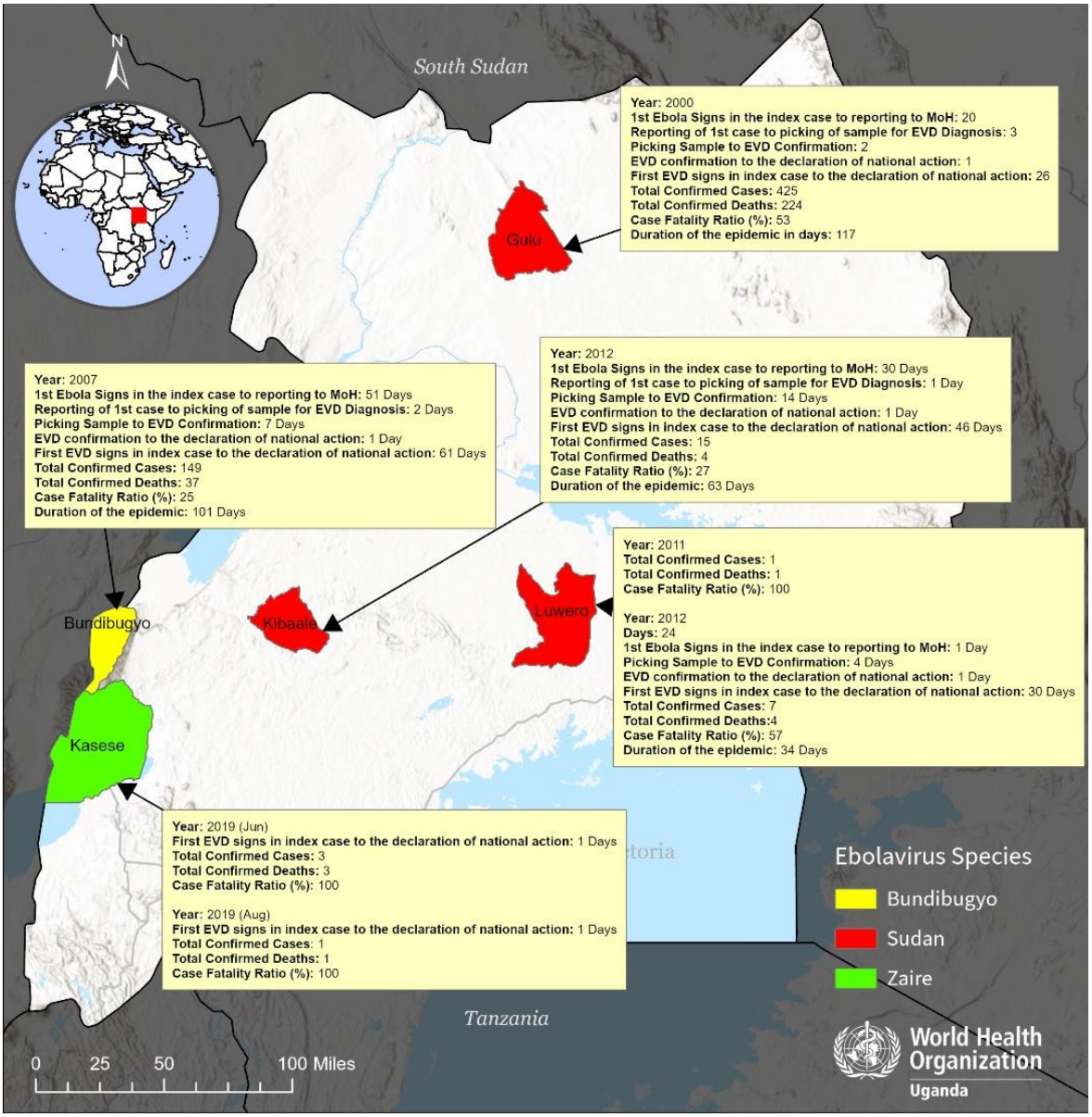
WHO Risk assessment and Grading: Following the declaration of the Ebola outbreak on 20 September, WHO immediately carried out a rapid assessment and grading of the public health risks from this outbreak. Based on this assessment, the outbreak was high at national- Grade 02.

Historical context

SVD is a serious, often fatal disease in humans. The virus is transmitted to humans from wild animals and spreads amongst populations through human-to-human transmission. The average case fatality rate is more than 50% without supportive care. During previous SVD outbreaks, estimated CFR ranged from 41% to 100%.

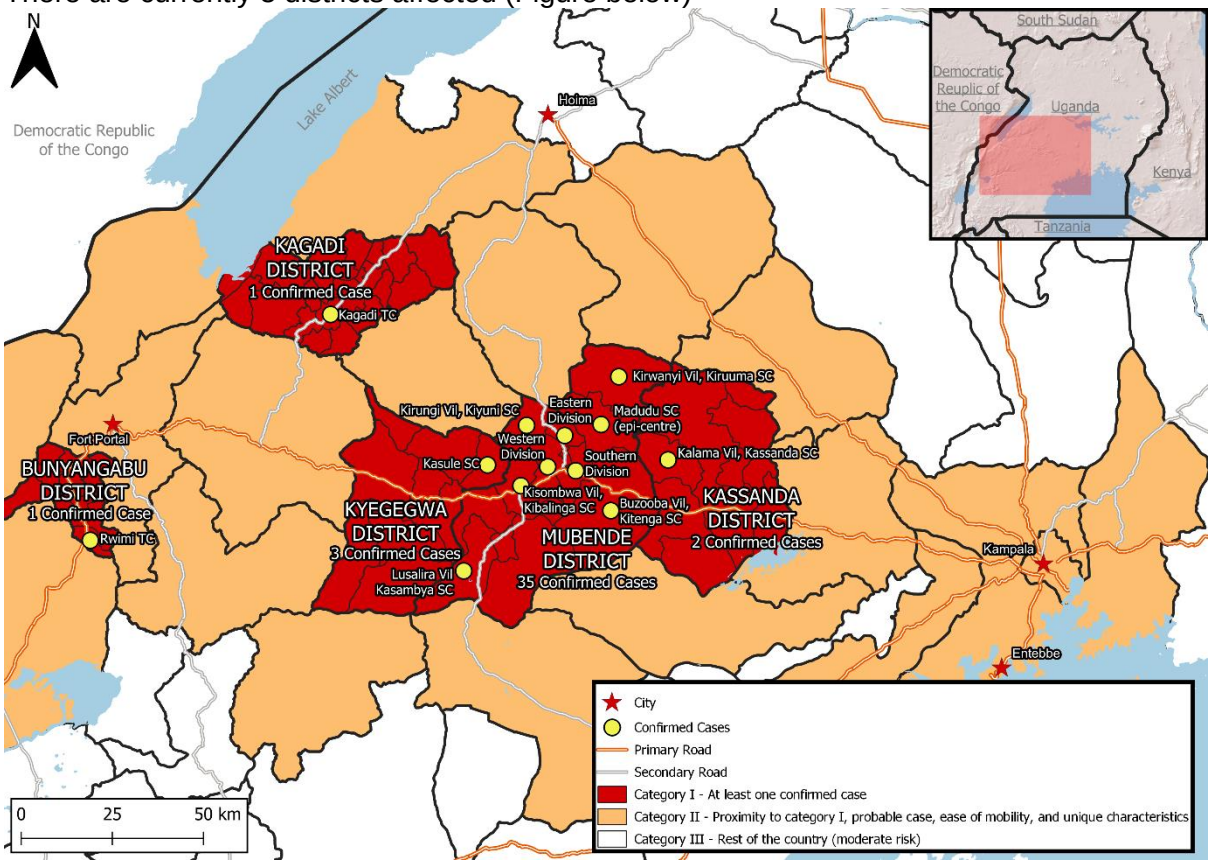
Since 2000, Uganda has experienced 7 Ebola Virus Disease outbreaks in Northern, Western and Central Uganda. Four of the outbreaks were caused by Ebola Sudan, 1 by Ebola Bundibugyo and 2 by Ebola Zaire. Uganda has reported four previous SVD outbreaks, in 2000, 2011 and two outbreaks in 2012.

Since then, the country has built capacity through preparedness many such as expansion of laboratory capacity for VHF detection, and has a cadre of health responders trained to manage the situation including rapid response team.


N
South Sudan
Year: 2000
1st Ebola Signs in the index case to reporting to MoH: 20
Reporting of 1st case to picking of sample for EVD Diagnosis: 3
Picking Sample to EVD Confirmation: 2
EVD confirmation to the declaration of national action: 1
First EVD signs in index case to the declaration of national action: 26
Total Confirmed Cases: 425
Total Confirmed Deaths: 224
Case Fatality Ratio (%): 53
Duration of the epidemic in days: 117
Gulu
Year: 2007
1st Ebola Signs in the index case to reporting to MoH: 51 Days
Reporting of 1st case to picking of sample for EVD Diagnosis: 2 Days
Picking Sample to EVD Confirmation: 7 Days
EVD confirmation to the declaration of national action: 1 Day
First EVD signs in index case to the declaration of national action: 61 Days
Total Confirmed Cases: 149
Total Confirmed Deaths: 37
Case Fatality Ratio (%): 25
Duration of the epidemic: 101 Days
Year: 2012
1st Ebola Signs in the index case to reporting to MoH: 30 Days
Reporting of 1st case to picking of sample for EVD Diagnosis: 1 Day
Picking Sample to EVD Confirmation: 14 Days
EVD confirmation to the declaration of national action: 1 Day
First EVD signs in index case to the declaration of national action: 46 Days
Total Confirmed Cases: 15
Total Confirmed Deaths: 4
Case Fatality Ratio (%): 27
Duration of the epidemic: 63 Days
Year: 2011
Total Confirmed Cases: 1
Total Confirmed Deaths: 1
Case Fatality Ratio (%): 100
Year: 2012
Days: 24
1st Ebola Signs in the index case to reporting to MoH: 1 Day
Picking Sample to EVD Confirmation: 4 Days
EVD confirmation to the declaration of national action: 1 Day
First EVD signs in index case to the declaration of national action: 30 Days
Total Confirmed Cases: 7
Total Confirmed Deaths:4
Case Fatality Ratio (%): 57
Duration of the epidemic: 34 Days
Luwero
Kibaale
Bundibugyo
Kasese
Year: 2019 (Jun)
First EVD signs in index case to the declaration of national action: 1 Days
Total Confirmed Cases: 3
Total Confirmed Deaths: 3
Case Fatality Ratio (%): 100
Year: 2019 (Aug)
First EVD signs in index case to the declaration of national action: 1 Days
Total Confirmed Cases: 1
Total Confirmed Deaths: 1
Case Fatality Ratio (%): 100
Ebolavirus Species
Bundibugyo
Sudan
Zaire
Tanzania
0 25 50 100 Miles
World Health Organization
Uganda

Operational context

There are currently 5 districts affected (Figure below)



Thus far, all cases outside of Mubende district have shown linkage to the Mubende district.

Risk mapping and categorization

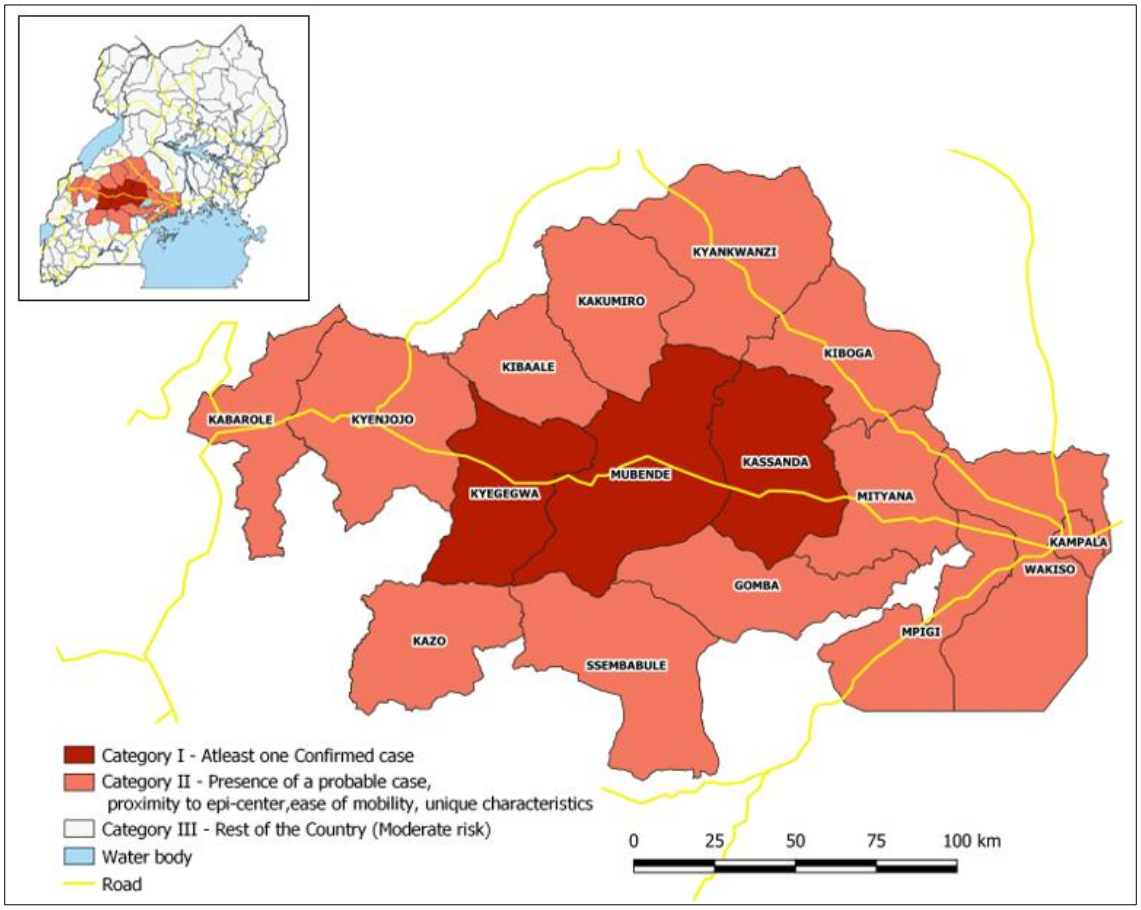
Following the detection of the index case, the Ministry of Health with support from WHO and partners conducted a rapid risk assessment to support risk categorization and planning. Mubende is a district with high population movement, thus there is risk of further spread if the outbreak is not controlled in the early stages. Mubende is approximately 2 hours from Kampala and other regional towns.

The following criteria informed the risk categorization:

- Presence of confirmed cases (Epicentre)
- Proximity to the epicentre
- Presence of probable cases
- Unique characteristics of the districts

Figure 2. Map of affected districts with risk classification

466 × 350



Below is a summary of the categorization of districts

Category	District
1 – Very high risk	Mubende, Kyegegwa, Kassanda, Kagadi, Bunyangabu
2 - High risk	Kakumiro, Mityana, Mpigi, Kampala, Kiboga, Kibaale, Kyankwanzi, Gomba, Sembabule, Kazo, Wakiso, Kyenjojo, Kabarole, Kamwenge, Fort Portal City, Mukono, Kamwenge
3 – Moderate risk	Rest of the country

Potential Scenarios

Based on the risk categorisation criteria, 3 scenarios;

Scenario 1 (Best case Scenario): Early ending.

- Early detection of all cases (suspect and confirmed), isolation all the cases and follow-up all the contacts to trace all transmission.
- Limited to the current geographical location, with no spread beyond the currently affected districts (or health regions).
- Based on scenario, incubation period of the disease the estimate of response would last approximately 105 days (5 incubation cycles).

Scenario 2 (Most Likely Scenario) : Sustained

- Delay in detection of cases with spread of outbreak beyond the current 5 districts reporting cases, to high-risk districts but containment within these 21 districts (3 health regions) currently affected by the outbreak.
- Given the vast mobility of this community across the high-risk districts for cultural, and trade reasons this provides most likely scenario.
- Estimate the response running from 6 to 8 months.

Scenario 3: Worst case scenario.

- In this case, based on mobility and inadequacy of contact tracing this worst-case scenario involves spread beyond the epicenter and high-risk districts and 3 health regions to affect new geographical foci or a complex urban setting.
- In addition, identification of a case in a neighboring country would equally warrant scenario 3.
- This would stretch human resource requirements given the specialized care required and isolation levels to avoid wider spread.

Immediate response

National and local authorities, WHO and partners have moved quickly to respond to the outbreak. Rapid response teams from the national level have been deployed to carry out case investigation, support capacity building for local contact tracing, put in place case management and other control measures. The country has also made deliberate steps to contain the outbreak, including; the activation of the national task force for outbreak response; the official declaration of the outbreak by the Ministry of Health as a public health emergency (announced on 20 September 2022); the deployment of a multidisciplinary field team; and the inventory of available logistics and supplies kits. In addition, the country has developed a National Response Plan for Sudan Ebolavirus (Sep- Dec 2022). The response plan builds on lessons learn from previous outbreaks and deploys the basic minimum packages of activities across the districts according to risk.

WHO internally classified the SVD outbreak as a Grade 2 Emergency on 21 September 2022 and released US$ 500,000 from its Contingency Fund for Emergencies (CFE) to immediately scale up its response. Immediately, a WHO team was deployed to Mubende district and mobile technical staff from the operational hubs in Hoima and Rwenzori to support the response. WHO has also supported additional surge deployment across all response pillars. WHO continues to provide operational and technical support for the SVD response in Kampala, Mubende and any other affected areas.

RESPONSE PLAN

Goal

The plan provides priority actions to be implemented during the EVD response. The goal of the plan is to contribute to measures to rapidly contain transmission and reduce morbidity and mortality related to SVD.

Response objectives

1. Support and strengthen strategic and operational coordination, leadership and partnership at national and district levels.
2. Enhance capacity to rapidly detect, investigate and follow up contacts Reduce the risk of SVD transmission in the community and nosocomial transmission in health facilities
3. Promote good individual and collective practices through risk communication, social mobilization, and community engagement to prevent the spread of SVD in other districts
4. Support capacity of the national laboratory response

5. Support provision of clinical supportive and psychosocial care of patients, convalescents and staff involved in the management of the outbreak
6. Integrate research in the outbreak response to evaluate candidate vaccines and therapeutics.
7. Ensure maintenance of essential health services in affected areas

Response strategy

This SVD response plan is based on the major pillars and interventions outlined below. The implementation of this plan will be carried out in support to the MOH, in close collaboration and coordination with partners. The Government of Uganda has set up an Incident Management System to implement the plan through operational pillars. These pillars include:

- Coordination
- Surveillance
- laboratory
- Case management and infection prevention and control (including safe and dignified burials and emergency medical services)
- Risk communications and social mobilisation
- Community engagement
- Strategic Information, Research and Innovation
- Logistics

Pillar 1: Strengthening the coordination, leadership and accountability

Key infrastructure, procedures, technical and operational support mechanisms must be put in place and supported on a daily basis to enable and coordinate all aspects of the EVD response

Priority Actions:

Activity 1.1	Deploy WHO technical experts in EVD management and coordination at the national and subnational levels.
Activity 1.2	Support National Task Force and District Task Force in the affected districts to coordinate the response and engage communities.
Activity 1.3	Support MoH to enhance partner coordination, resource mobilization and accountability for resources based on implementation of the response plan.
Activity 1.4	Conduct support supervision and monitoring of response efforts at district levels, including joint monitoring missions.
Activity 1.5	Build capacity of partners involved in the response on Prevention and Response to Sexual Exploitation, Abuse and Harassment (PRSEAH).
Activity 1.6	Support the development of the national response plan and its revisions.
Activity 1.7	Deploy technical experts to support the EVD Response at the national and subnational levels.
Activity 1.8	Support the coordination of cross border collaboration activities/meetings.

Pillar 2: Surveillance, active case finding, contact tracing and investigation of cases

Rapid detection and isolation of new cases is the key to preventing onward transmission of the virus.
Key activities are as follows:

Activity 2.1	Support the deployment of Rapid Response Teams in affected districts through covering allowances, transport, and related costs.
Activity 2.2	Support deployment of teams at sub-national level to rapidly support alert management, case investigation, and contact tracing.
Activity 2.3	Build capacity of Village Health Teams to enhance contact tracing and event-based surveillance in affected communities.
Activity 2.4	Support active case search in health facility.

Activity 2.5 Print and distribute tools and technical guidelines to support surveillance activities.
Activity 2.6 Support on collating and disseminating information products to the national task force and other relevant stakeholders.
Activity 2.7 Support cross boarder surveillance activities.

Pillar 3: Strengthening laboratory and diagnostic capabilities

Key activities are as follows:
Activity 3.1 Orient district laboratory teams on safe sample collection, packaging, transportation, and laboratory testing.
Activity 3.2 Support sample transportation to referral laboratories for testing.
Activity 3.3 Support quality assurance and quality control mechanism for laboratory testing for both static and mobile labs.
Activity 3.4 Contribute to the procurement and distribution of laboratory logistics.
Activity 3.5 Support genomic surveillance at national level

Pillar 4: Case management

The pillar provides guidance for standards of care for EVD management and prevention of transmission in healthcare settings and communities based on the optimized supportive care guidance.

Key activities are as follows:

Case management

Activity 4.1 Establish, operationalise, and maintain ETUs to effectively manage EVD cases.
Activity 4.2 Deploy technical experts to support in provision of care to cases.
Activity 4.3 Conduct training for health workers and auxiliary staff on care of patients in an ETU setting.
Activity 4.4 Support ambulance services to facilitate referral of suspect cases from community and non-ETU health facilities.

Safe and Dignified Burials

Activity 4.5 Build the capacity of Burial Teams on the process of Safe and Dignified Burial including the donning and doffing, decontamination in line with IPC standards.
Activity 4.6 Support Burial Teams to conduct safe and dignified burials with necessary logistics and supplies.
Activity 4.7 Provide logistical capacity for disinfection and decontamination of vehicles, and homes of confirmed cases in affected communities as per national guidance.

Pillar 5: Infection prevention and control and WASH in health facilities and communities

To strengthen adherence to principles and practices of infection prevention and control in order to reduce transmission of Ebola virus and other infectious organisms to health workers, care givers, patients and the community.

Key activities are as follows:
Activity 5.1 Build capacity of health workers on IPC in ETU and non-ETU settings.
Activity 5.2 Improve IPC and access to WASH facilities in affected communities as per national guidance.

Pillar 6: Risk communication, social mobilization, and community engagement

Past experience has shown that affected communities hold the key to preventing the transmission of SVD.

Key activities are as follows:

Activity 6.1 Train health educators, health assistants and VHTs on Sudan ebolavirus risks, preventive, and control measures.

Activity 6.2 Engage, sensitize, and equip VHTs with educational material on EVD to conduct community sensitization in affected districts.

Activity 6.3 Update, redesign, print and disseminate Information, Education and Communication (IEC) materials.

Activity 6.4 Develop key messages on prevention, detection, and control and facilitate dissemination through mass media and social media.

Activity 6.5 Support the activation of Sub- County, Parish and Village Task Forces for increased vigilance and community awareness, early case identification and reporting.

Pillar 7: Point of Entry

Key activities are as follows:

Activity 7.1 Support high level coordination meetings between the neighbouring countries of the EAC

Activity 7.2 Support cross border surveillance

Pillar 8: Psychosocial care

An essential component of case management is psychosocial assistance. EVD survivors and family members of EVD cases are often stigmatized, and unable to resume their lives following their recovery. It is therefore important that psychosocial care is integrated in the response at the earliest stage.

Key activities are as follows:

Activity 8.1 Train providers and community leaders on essential psychosocial care

Activity 8.2 Equip teams with appropriate trainings, tools and support

Activity 8.3 Provide food / nutrition and non-food support to affected individuals and families

Activity 8.4 Establish a psychosocial action plan to combat stigma and other consequences

Activity 8.5 Assist in the care and social reintegration of survivors and orphans

Pillar 9: Integrating Research in the response

An accurate knowledge of SVD is essential for an effective response to SVD outbreaks. It is therefore important that SVD research is integrated into the outbreak response. The aims of such research are to contribute to the development and evaluation of rapid diagnostic tests, improve clinical management of patients and identify more effective therapeutics for SVD, better understand the risk factors of the disease, as well as test the safety and efficacy of the candidate Sudan Ebolavirus vaccine and therapeutics. This pillar includes access to experimental antivirals and vaccines, its implementation through monitoring, data management, trial, the shipment of vaccines and supporting requirements for the shipment of the vaccines.

Key activities are as follows:

Activity 9.1 Appoint a national research coordinator and establish a research coordination platform within the outbreak response committee

Activity 9.2 Update diagnostics guidelines, and conduct testing of key candidate diagnostics

Activity 9.3 Evaluate and update the WHO guidelines and tools for clinical management

Activity 9.4 Carry out operational research on risk factors

Activity 9.5 Conduct randomized clinical trials of key candidate therapeutics and vaccines

Pillar 10: Operational and programme support

Key infrastructure, procedures, and operational support mechanisms must be put in place to enable all aspects of the response.

Key activities are as follows:

Activity 10.1 Provide logistics and supply chain management at national and sub-national levels.
Activity 10.2 Procure, preposition, and distribute lifesaving medical supplies.
Activity 10.3 Deploy a team of experts to support logistics management in epicentre and high-risk districts.

Pillar 11: Continuity of Essential Services

Key activities are as follows:

Activity 11.1 Provide guidance on maintenance of essential health services through response to p public health emergencies.
Activity 11.2 Conduct monitoring of health services performance in non- ETU care.
Activity 11.3 Engage partners and key stakeholders to promote access to essential services during public health emergencies.
Activity 11.4 Conduct readiness assessments of health facilitate to inform resilient health system.

Monitoring, reporting and evaluation

It is crucially important that all partners involved in the response are kept up to date with accurate information in order to direct response efforts where they will be most effective. Thus, the objective of the health information management and reporting will be to ensure that all partners responding to the outbreak are updated on the latest information regarding the health status of the population (i.e. epidemiology) and threats, health service availability, and healthcare utilization and outcomes, in order to inform further response operations and planning. WHO, working with partners, will provide daily epidemiological updates, complemented by weekly comprehensive situation reports and periodic reporting of response indicators. It will also support the production of ad hoc information products as needed by response partners, donors and others.

Project Implementation Arrangements

Management Arrangements

- WHO has graded this outbreak as Grade 2. Therefore, this intervention will be majorly managed and coordinated under the leadership of the Ministry of Health with support from WHO Uganda Office and AFRO regional office with support from HQ.
- A WHO Incident Management Team has been activated and an Incident Manger is assigned to oversee the implementation under the leadership of the WHO Representative.
- Funds will be managed by the country office through the WHO Direct Financial Cooperation process and partner collaboration.
- Financial accountability and monitoring including the use of technology such as Go Data will be used.
- All WHO staff, consultants and surge teams will be oriented on PRSEAH and SGBV before deployments.
- Fuel cards, vehicle mileages and Car Tracking System will be used for proper monitoring of fuel consumption.
- Attendance sheets will be used to register participants for funds disbursements to enable proper accountability and value for money.

Monitoring, Evaluation and Reporting

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WHO, working with partners, will provide daily epidemiological updates, complemented by weekly comprehensive situation reports and periodic reporting of response indicators. It will also support the production of ad hoc information products as needed by response partners, donors and others. Accountability is vital for WHO's success, and it is considered as a responsibility being entrusted on funds allocated to improve health globally. WHO follows a result based managerial framework that calls for delegated responsibility, authority, and accountability at all levels of the organization. This means that decisions on the use of financial and other resources are taken by managers at all levels in all locations. Integrity is a key element of WHO's accountability framework which is supported by a sound internal control framework. A policy that covers both fraud prevention and the contingency measures that may be taken to prevent fraud is an integral part of the internal control framework.

- Regular supportive supervision will be done by technical officers and leadership to the affected areas to provide the necessary guidance and capacity building but also to support on the monitoring of the response.
- Intra and After-Action Reviews will be conducted.
- Reports will be provided to donors regularly.
- A feedback mechanism will be put in place at the different levels to ensure feedback from different stakeholders.
- Lessons learned will be recorded so that future responses are designed taking into consideration registered feedback and lessons.

Communication and Visibility

- Internal and External communication will be ensured for timely and quality information is shared to the relevant audience and through the correct channels. In addition to promoting key activities undertaken under the response to ensure awareness is raised among communities and stakeholders on the Sudan ebolavirus, its signs and symptoms, prevention and control measures aiming at preventing future outbreaks. Communication products will include articles, sitreps, briefs, bulletins, human interest/impact stories, press releases, media coverage, social media posts, photos, and brochures.
- For visibility of all actors, all materials for the response will be labelled with logos of MOH, WHO, and the funding organisations. WHO will take an extra mile to give press statements, reports, and announcements in connection with increasing visibility and acknowledgment of WHO and its funders.
- Train journalists for responsible reporting.

Prevention of Sexual Exploitation, Abuse and Harassment (PRSEAH)

The current Ebola outbreak in Uganda poses a unique situation for PRSEAH mainstreaming in Public Health Emergency operations and in non-humanitarian setting which means, WHO will need to be prepared to also take on the leadership role to engage with and coordinate the efforts of other partners on Joint PSEAH actions mainstreamed into the response operations. Consequently, WHO will be supporting coordination of all PRSEAH activities in the emergency while working closely with the other UN agencies.

In addition, the WCO has built structures that will support the implementation of PRSEAH activities at country office and field levels. Focal Points have been identified and trained and

all deployees are being briefed about PRSEAH before deployment. The collaboration between the Ministry of Health and RC's office is seen as pivotal to the accomplishment of the PRSEAH work plan and with WR's support, progress has been made in this direction.

The activities listed below will be implemented and tracked by the PRSEAH team based at the WCO with regular progress reports to management.

- Ensure that right skills to fulfil their responsibility on SEAH matters
- Selection and training of WCO PRSEAH Regional/Hub Focal Points
- Monthly orientation of the staff
- Follow up with Staff on i-Learn mandatory Trainings completion
- Monitoring, evaluation and learning

Develop a training plan and schedule to ensure that each person employed by WHO goes through the required training to address all matters related to SEAH and that all communities served by WHO have access to training or briefing sessions on SEAH

- Training on PRSEAH for the new staff of WHO as and when they come in
- Assess and build up implementing partners' PRSEAH capacities and hold them accountable

Ensure close interagency collaboration through the full engagement of WHO focal points in the in-country PRSEA network under the leadership of the Resident Coordinator or Humanitarian Coordinator's office

- Inter-agency 3-day training of Focal Persons (2 pax)
- Participate in monthly meetings and activities
- Develop communication products to maintain SEAH on the radar at all times to ensure that all WHO personnel are fully aware of it
- Production of a pocket guide and card on core principles, Dos and Don'ts including tolerance recommendations and distribute them among the personnel and beneficiaries of WHO projects
- Design and printing of pull up stands for all WHO workshops
- Dissemination of important PSEA related information whenever it is received from elsewhere WHO and WHO

Key Performance Indicators

Nr.	Pillar	Indicator	Target
1	**Surveillance**	Proportion of alerts verified within 24 hours of alert notification	100%
3	**Surveillance**	Percentage of new confirmed cases from verified alerts	100%
2	**Surveillance**	Percentage Contacts listed eligible for follow-up successfully followed up during previous 24 hours	100%
3	**Surveillance**	Percentage of new confirmed cases previously listed on contact lists	100%
4	**Laboratory**	Percentage of laboratory results for specimens from suspected cases available within 12 hours	100%
5	**Case management**	Case fatality ratio for all confirmed cases admitted into Ebola Treatment Units	< 25%

	IPC	Percentage of health facilities receiving IPC mentorship	100%
8	**IPC**	Percentage of health facilities with an IPC score above 80%	100%
6	**IPC**	Number of healthcare workers infected	0
7	**IPC**	Proportion of deceased suspected and confirmed cases for which safe burials were conducted	100%
9	**IPC**	Proportion of households disinfected within 24 hours among households to be disinfected in connection with a case of EVD	100%
10	**Community Engagement**	Proportion of sub-counties with greater than 80% of villages reached with interpersonal community engagement activities	100%
	Risk Communication	Percentage of respondents who know at least 3 ways to prevent Ebola infection in affected communities	100%
11	**Psychosocial care**	Percentage of families of confirmed and probable cases receiving protection and psychosocial support, including a solidarity kit	100%
12	**Psychosocial care**	Proportion of hospitalized patients that received psychological care	100%

Budget summary*:

Pillars	Area of work	Budget for 3 months (USD)	Budget for 6 months (USD)	MoH and Key partners
Pillar 1	**Strengthening the multi-sectoral coordination**	1,500,000	3,000,000	All partners
Pillar 2	**Surveillance, active case finding, contact tracing and investigation of cases**	1,625,000	3,250,000	MoH, WHO, MSF, Baylor, IDI
	Alert Management	300,000	600,000	
	Case Investigation	300,000	600,000	
	Contact Tracing	600,000	1,200,000	
	Active case search	175,000	350,000	
	Surveillance Readiness	250,000	500,000	
Pillar 3	**Strengthening laboratory and diagnostic capabilities**	940,293	1,880,587	MoH, WHO, CDC, USAID, UVRI, CPHL
Pillar 4	**Case management**	5,477,783	10,955,566	MoH, WHO, MSF
	Clinical Care	2,500,000	5,000,000	
	Emergency Medical Teams	1,500,000	3,000,000	
	Setting up new ETUs	1,000,000	2,000,000	
	Safe & Dignified burials	477,783	955,566	
Pillar 5	**Infection prevention and control and WASH in health facilities and communities**	744,341	1,488,683	MoH, WHO, IFRC, UNICEF
Pillar 6	**Risk communication and social mobilization**	700,000	1,400,000	MoH, WHO, UNICEF IFRC, MSF
	Community engagement	500,000	1,000,000	
Pillar 7	**Point of Entry**	152,000	304,000	MoH, WHO, IOM
Pillar 8	**Psychosocial care**	845,178	1,690,356	MoH, WHO
Pillar 9	**Research in response****	6,000,000	12,000,000	MoH, WHO, Lung Institute
Pillar 10	**Operations and programme support**	1,000,000	2,000,000	MoH, WHO, WFP
	Health Supplies	10,422,824	20,845,647	
	Transport	468,271	936,542	
Pillar 11	**Continuity of Essential Services**	699,247	1,398,494	All partners
	Communication, External Relations and Visibility	500,000	1,000,000	All partners
	PRSEAH (Training, Feedback, Hotline)	200,000	400,000	All partners
	Total	**31,774,938**	**63,549,876**	

**This budget is based on Scenario 2 planning which covers the 5 affected districts and the high risk 21 districts for 6 months.*

***This budget also includes the vaccine research component.*