

Health Epidemics Evaluation Report

A report on the an evaluation conducted for Uganda Red Cross to document lessons learnt in health epidemics response and to document their organizations capacity to respond.



March
2013

Introduction

The International Federation of Red Cross and Red Crescent Societies (IFRC) is the world's largest humanitarian network, reaching 150 million people each year through its 187 member National Societies. The Organisation acts before, during and after disasters and health emergencies in order to meet the needs and improve the lives of vulnerable people. Our work is guided by seven fundamental principles (humanity, impartiality, neutrality, independence, voluntary service, unity and universality) and by Strategy 2020, which voices our collective vision and determination to move forward in tackling the major challenges that confront humanity in the present decade.

In 2009 the International Federation of Red Cross and Red Crescent Societies adopted a 10 year strategic direction - Strategy 2020. Specifically the strategy lays out three strategic aims:

- 1) Save lives, protect livelihoods and strengthen recovery from disasters and crises.
- 2) Enable healthy and safe living.
- 3) Promote social inclusion and a culture of non-violence and peace.

The IFRC's Eastern Africa Regional Representation (EARR) endeavours to support National Societies (NS) in the Eastern Africa region and the Indian Ocean Islands to better serve their communities based on the three strategic aims above. By virtue of location, the region supports National Societies prone to health epidemics such as Measles, Cholera, Ebola, Yellow fever, Marburg fever, Meningitis and more. In meeting held with health coordinators from NS in the region, epidemic preparedness was expressed as a priority by the health coordinators who asked for support to develop contingency plan for health epidemics and technical support on how to improve their preparedness to health epidemics.

To start the process, Uganda Red Cross society was selected for an evaluation that would lead to lessons learnt and shared on how health epidemic preparedness can be improved for NS in the region. The evaluation would also begin the process of contingency planning for the NS through a three-day lessons learnt and contingency planning workshop.

URCS Strategic plan for 2011 – 2015 clearly says that the NS commits to improving the health status of vulnerable and affected communities by reducing morbidity and mortality arising from common diseases and health emergencies. They will do this by building community capacity to manage common health emergencies and disease outbreaks, and enhance road and water transport safety (Strategic Direction 2, Objective 1.) The plan also says that the NS commits to strengthening community resilience and institutional capacity to ensure disaster risk reduction, response and impact reduction is in place by (i) designing effective risk mapping for timely and appropriate response to man-made and natural disasters and (ii) developing and implementing appropriate disaster risk reduction interventions for the vulnerable communities including food security and environment management (Strategic Direction 2, Objective 2.)

Background

In 2012 Uganda experienced many disease outbreaks including Measles, Ebola, Marburg and Nodding disease. Two Ebola outbreaks and one Marburg event were in quick succession and placed the

Ministry of Health and the Uganda Red Cross (URCS) as well as other partners under significant pressure to respond to one of the world's deadliest diseases in three separate locations.

The Uganda Red Cross responded in all three outbreaks with assistance from the IFRC Disaster Relief Emergency Fund (DREF) in support of clinical interventions from the Ministry of Health and other partners. The key activities of the URCS included social mobilisation and communication of disease prevention messages to communities, support of surveillance and case tracing activities for suspected cases, support to affected families with distribution of non food items to replace those that had been destroyed as part of the infection control and prevention activities, as well as providing psychosocial support to both community members affected by the outbreak and staff and volunteers engaged in response activities.

Given that URCS had most recently concluded their Ebola DREF operation, the opportunity was seized to evaluate the operation and document lessons learnt. A three person evaluation team was formed that comprised of (i) a representative from a NS, (ii) a representative from IFRC and (iii) a psychosocial consultant.

Objectives of the evaluation

The objectives of the evaluation included:

1. Review current operating procedures of URCS' epidemic response including the roles and responsibilities of URCS in relation to MoH, WHO and other partners as well as internal structures for coordination and integrations of activities across departments.
2. Review the operational effectiveness and accountability of the response against planned outcomes and the use of DREF funds against proposed activities
3. Evaluate the response of URCS to epidemics, against the needs of beneficiaries and communities focused on the areas of most 'added value' of the URCS; community engagement mobilisation and support., documenting any unintended outcomes and best practice related to the operation.

Components of the evaluation

The evaluation was conducted against the following four components:

- Coordination and Resource Mobilization
- Social Mobilization
- Community Surveillance
- Case Management

Under **Coordination and Resource Mobilization**, the scope of work was as follows:

- Review current alert threshold for epidemic response and the role of the RCRC in relation to MoH and other partners.
- Review current procedures for identifying the need for URCS epidemic response and the process for decision making related to application for DREF funding.

- Were the correct procedures for DREF followed?
- Review internal coordination mechanisms to ensure effective response between DM Health and Care and community preparedness teams.
- Review external coordination mechanisms and the engagement of RCRC in these. How effective was the coordination and did it enhance communication between partners that resulted in improved response.
- Review the perceptions and expectations of external partners in relation to the role of the RCRC and how closely did this match actual implementation.
- Review procedures for decision making process related to the type of activities, roles and responsibilities including the support and supplementation of key activities of other agencies such as MOH MSF and WHO
- Document the current operating procedures used by the health dm and PSS teams in responding to VHF
- Review the monitoring and evaluation plan of URCS. Make recommendations on how it could be improved to assist the URCS document impact in future responses

Under **Social Mobilization and Community Surveillance**, the scope of work was as follows:

- Was URCS able to quickly deploy sufficient numbers of appropriately skilled staff to respond adequately to the emergency including planning, implementing and reporting of activities?
- Review the use of PSS in supporting social mobilisation and behaviour change interventions. Did the use of PSS improve BCC impact and beneficiary outcomes? Where communication channels effective?
- Review the PSS support to beneficiaries. What is the value added of PSS in this type of epidemic response and what should be the RCRC role in providing this? How does PSS contribute to the overall objective of reducing morbidity and mortality of VHF? Does PSS have any other impact in this type of response, and if so is it something that should or could be developed further?
- Review current training materials for effectiveness and relevance making recommendations for areas of improvement if needed. Include materials developed by other agencies used in this response, noting any changes or adaptations that would be useful for volunteer base.
- Review relevance and effectiveness of key activities of RCRC supported by the DREF. Did they meet the needs of beneficiaries and add value to the overall response through all disease phases?
- Review the PSS support to volunteers and staff. Why this was necessary and what impact did it have? What lessons learnt can we draw from this increased focus on support of RCRC volunteers and staff?
- Review the distribution of NFI goods. What role does the distribution of NFI's play in the response? Is it a key role for the Red Cross and what other value besides replacement of material goods does this have? (reports that NFI for discharged patients have significant PSS effect)
- Were URCS current emergency procedures for VHF outbreaks implemented in a way that ensures efficiency accountability and safety of staff, volunteers and beneficiaries?

Under **Case Management**, the scope of work was as follows:

- Review infection control strategies of RCRC volunteers – where the volunteers trained effectively and provided with enough information and material to protect themselves from infection. Was this done in a timely and effective manner? How was this supervised and what control mechanisms are in place for staff or volunteers that think they may have been contaminated
- Review the RCRC role in the isolation units and make recommendations related to this in future epidemics.
- Review current RCRC response and evaluate the potential for further academic research or documentation related to the impact of the activities in Ebola response. Outline possible research questions and next steps to implementation.

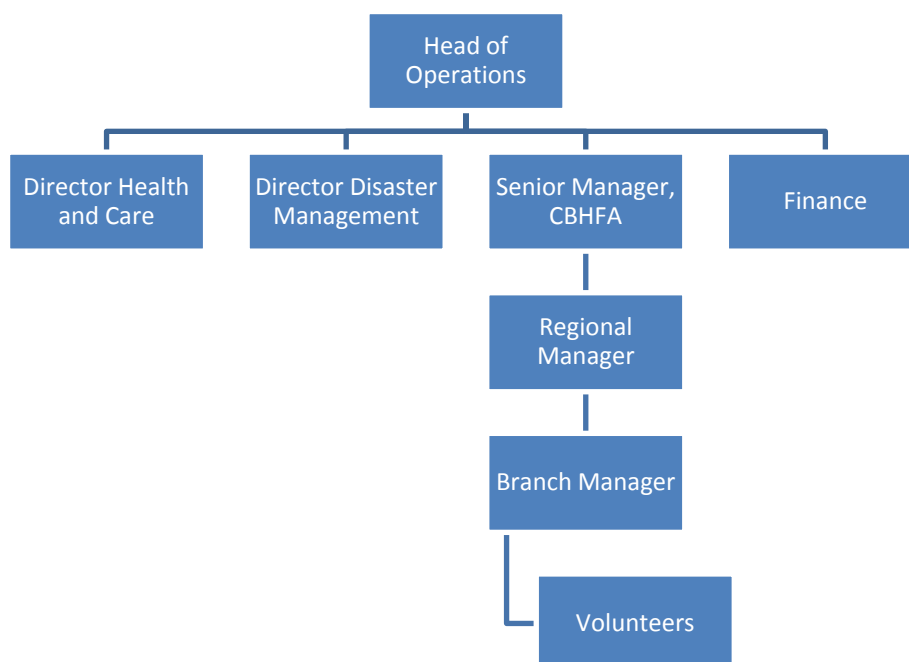
A. EVALUATION FINDINGS

1. Coordination and Resource Mobilization

Internal Coordination and Resource Mobilization: URCS has a well structured internal coordination mechanism. In case of reports from branches of an unusual sickness or death in a community, the head of operations convenes a meeting to be attended by (i) senior manager, community health, (ii) head of disaster management and (iii) head of health and care. The main discussion item is to discuss how credible information from the field is and if URCS should act.

Notable finding: As a matter of policy, URCS does not put its employees and volunteers in harms way. As such, there can be no response from URCS on any disease outbreaks unconfirmed and unannounced by the Uganda government. In case of strong evidence from the community that there is a disease outbreak yet the government has not confirmed it, URCS can mobilise volunteers and ask them to be on stand-by.

Internal Coordination Mechanism, Uganda Red Cross, Disease Outbreak



When a disease outbreak is confirmed and announced by the Ministry of Health, a similar meeting is again convened by the head of operations and is attended by (i) senior manager, community health, (ii) head of disaster management and (iii) head of health and care. Since this meeting is to discuss response to the outbreak, (IV) a finance representative is also invited to attend. This meeting is held at a national level and the senior manager for community health maintains the communication with the field.

Documents reviewed:

- URCS Emergency Fund Guidelines
- URCS SOPs in Emergencies
- URCS Response Protocol
- Epidemic Control for Volunteers

DREF process

During this meeting, decisions are made on the response of URCS to the announced outbreak and instructions forwarded to the field. In case a DREF is to be written, the lead is the senior manager, community health. He writes the DREF in close collaboration with finance and the regions and branches involved.

In case it is determined that the outbreak requires immediate response, URCS may pre-finance the initial early response activities as a DREF is being written.

Notable finding: A clear need for an emergency fund to be used for early response is now recognized by URCS. This is a fund that finances initial early response activities before resources for the actual response are mobilised. This fund is then replenished to fund the next emergency. URCS has an Emergency Fund which has some funds but need more to cover the possibility of concurrent emergencies. The fund has guidelines for usage and replenishment and has recently been reviewed and updated. **ACTION** is needed to help them fundraise and populate the fund.

DREF process: The case of an Ebola outbreak, July 2012	July							August									
	25	26	27	28	29	30	31	1	2	3	4	5	6	7	8	9	10
Initial reports of an unusual death and illness in the community																	
Official announcement and confirmation of Ebola outbreak from MOH																	
DREF application submitted																	
IFRC confirmed receipt of DREF																	
URCS pre-finances response																	
Funds transferred to URCS																	
DREF funds received by URCS																	

External Coordination: National Level

At a national level, URCS is active in coordination bodies set forth and led by the government. At a national level, the government has established a decision making body called the National Task Force

that is the coordinating and decision making body for health epidemics preparedness and response. URCS is an active member of this task force. Under this task force, the government has created four thematic sub-committees namely

- Social mobilization sub-committee
- Surveillance and psychosocial support sub-committee
- Logistics and administration sub-committee
- Case management sub-committee

URCS is the lead for the social mobilization sub-committee and is active in the other three.

At a national level, URCS partners mostly include Ministry of Health (MOH), World Health Organization (WHO), Centers of Disease Control (CDC), Médecins Sans Frontières (MSF), the African Field Epidemiology Network (AFENET) and the Uganda Virus Research Institute (UVRI)

Partner perception of URCS' role: National Level

Government (Ministry of Health): The government perceives URCS as the lead agency in **social mobilization** for communities in the case of a disease outbreak. They also perceive the URCS to play an active role in community surveillance as part of the Village Health Teams (VHT). Provision of Psycho Social Support (PSS) and referral of cases was another role that the government perceives as a role for the URCS.

When asked what their perception of the URCS's role isolation units is, the government representative said that they have seen URCS in isolation units but is not sure what their role is at the units.

When asked how URCS can improve in their roles, the government said that URCS should be provided with mega phones so that they can mobilise more people with less contact and that there needs to be better training of their volunteers on how to provide PSS to communities.

World Health Organization (WHO): The WHO perceives the URCS as a leader in social mobilization, case tracing and follow-up. They also perceive the URCS to have an active role to play in community surveillance, provision of Personal Protective Equipment (PPE) and in the provision of discharge packages and NFIs.

When asked what their perception of URCS's role in isolation units is, the WHO representative said that URCS is involved in PSS and well as the provision of PPE and non-food items (NFI).

When asked how URCS can improve in their roles, WHO said that community surveillance needs to be strengthened. He cited an example where Ebola cases were discovered after the epidemic had been declared over.

Centres of Disease Control (CDC): The CDC perceives URCS as having a role mostly in social mobilization. CDC's role is in outbreak investigation, confirmation of disease, case tracing and patient management. Their main partners in their work are the National Health Labs and the Uganda Virus Research Institute (UVRI). Due to the nature of their work, interaction with URCS at a national level is mostly at coordination meetings such as the National Task Force meetings.

District and Community Level Coordination

At a district level, the main partners for URCS include District Health Management Teams (DHMT), Ministry of Local Government, Ministry of Internal Security, Médecins Sans Frontières (MSF), Plan International, African Medical Research Foundation (AMREF) and World Vision.

The district level coordination process closely mirrors the national level where you have a main coordinating body called the District Task Force. Under the district task force is the following sub-committees:

- District social mobilization sub-committee
- District surveillance and psychosocial support sub-committee
- District logistics and administration sub-committee
- District case management sub-committee

URCS is the lead for the district social mobilization sub-committee and is active in the other three.

Partner perception of URCS' role: District and Community Level

Government (District Health Management Team, DHMT): The DHMT perceives URCS as the main partner in social mobilization and community surveillance and case trace tracing. The DHMT also recognizes URCS role in helping recovered or released persons integrate back into the society as well as in performing the 21 day follow-up. The discharge package given to people released from the isolation centres was also highly regarded and was discussed as a component of PSS.

In addition to the provision of the discharge package, the DHMT also perceives the URCS as a major supplier of other medical supplies such as PPE and sometimes logistics.

On case management, the URCS is perceived to play an active role in managing call centers and triaging of patients. URCS is also perceived to be involved in the disinfection of people going into the isolation centres.

Notable findings: *The URCS's role in case management and logistics is undefined. In case management, URCS has mostly performed its role in conjunction with other clinical partners such as MSF and the MOH. In logistics, URCS fills in a logistics gap in cases where the need is too much for the government to meet or in cases where logistics help from government is delayed.*

AMREF perceives URCS as a ready first responder to any health emergency. URCS role in door-to-door sensitizations and contributions was also recognized by AMREF as well as efforts in social mobilization.

During the Uganda Ebola outbreaks of 2012, **Plan International** was a strong partner to the DHMT and URCS. According to them, URCS is a key player in community surveillance, social mobilization including door-to-door sensitization campaigns, PSS and case tracing. They also recognize the role of URCS in the provision of PPEs and discharge packages to people coming from isolation centres.

Conclusion on Coordination and Resource Mobilization

Good coordination structures are functioning within URCS and among their partners. Partner perception of the role of URCS is in line with what they do as an organization but URCS needs to clearly define their role in case management and logistics.

Ebola outbreak was confirmed on 28 Jul 13, funds were transferred and received by URCS on 10 Aug 2013; 13 days later.

2. Social Mobilization

URCS is considered the lead agency for community social mobilization efforts in Uganda. Social mobilization efforts are carried out at a community level by URCS volunteers and some of the activities include:

- Raising community awareness of the disease especially the “**Ebola is not witchcraft concept**”. There is a deep-rooted belief that Ebola is not a disease but ill luck brought about by witch craft on a person who has done wrong. This belief is further spread by witch doctors and traditional healers who take advantage of an outbreak to make money by promising to heal or protect people from the ongoing outbreak. URCS performs community awareness activities such as door to door sensitizations and radio shows to give accurate information about the disease and to ask people who think that they may be exposed to seek health care from health facilities and professionals.
- Another activity carried out by URCS at a community level is **destigmatizing Ebola**. Given that Ebola is still very misunderstood, there is a lot of stigma around people suspected to have it, those confirmed and recovered, family members of suspect or confirmed cases and people responding to the outbreak such as health workers and volunteers. URCS at a community level raise awareness on the transmission of Ebola and what one should do if they think they may have been exposed. They also sensitize the neighbours of people returning from health care centres so as to allow recovered or suspect cases integrate back in their communities. In previous cases, where neighbours have not been sensitized, people suspected or recovering from Ebola have been isolated and not allowed to leave their homes and/or their properties have been burnt.

Other social mobilization activities included:

- Discouraging social gatherings – emphasising that the people should sit at least at a distance from each other where necessary.
- Educating people on the use of Jik as a disinfectant when necessary.
- Encouraging communities to refer suspected cases immediately.
- Hygiene education to the communities to minimise spread of infection- volunteers took the opportunity to talk to the communities about use of latrines, and construction of latrines.
- Disseminating the hotline number- dispatch/alert desk number to the members of the community.
- Discouraging communities from eating game meat e.g. monkeys as well as not consuming dead animals; discouraging hunting.

Training: Social Mobilization volunteer teams were trained by URCS. IEC materials used were developed by MOH.

Notable Findings: Focus group discussions with URCS volunteers made it clear that the volunteers felt happy and proud to have engaged in social mobilization efforts however, some of them lacked clear identification that identified them as a URCS volunteer. As such, they were turned away by community members who did not trust them. They requested URCS red vests and at a bare minimum, a URCS name badge that displayed their name and title.

URCS volunteers also expressed a need for PSS for them and their families. During the focus group discussions, volunteers expressed the fear they felt as they worked in social mobilization within the community and how stigmatized they felt. Many of them were nicknamed Ebola. They also expressed the rejection they felt from their family members who isolated themselves from them. The volunteers also felt afraid that they may have been carrying the disease and were scared of spreading it to their family members so many of them bathed before entering the house and disinfected their shoes and clothes with Jik. Others sent their families to live with relatives during the operation.

3. Community Surveillance:

Though as part of a wider team which included Village Health Teams (VHT) and the DHMT, URCS volunteers were involved in the following community surveillance activities:

- **Tracing Contacts**– Ebola is transmitted from person to person by close contact and the possibility of exchange of bodily fluids. Due to this kind of transmission, when a person is confirmed with Ebola, people that he may have been in close contact with are identified and screened as suspect cases. URCS volunteers received information of these people and contacted them urging them to seek care at a health facility.
- **Case follow-up** –Once people have been identified as suspect cases of Ebola, there is a mandatory 21 days of follow-up to monitor the development of any developed of signs and symptoms of Ebola. URCS volunteers were active in the 21-day follow-up period where they identified suspect people in the community and visited them consistently for 21 days.
- **Follow up of discharged patients** – for 21 days to ensure that they did not develop signs and symptoms of Ebola, if they developed, then they were referred back to the health facility.

Training: Training for community surveillance volunteer teams was done by Ministry of Health and World Health Organization.

Notable Finding: URCS volunteers engaging in community surveillance felt adequately trained to perform community surveillance activities and felt safe and protected. When a volunteer would recognize a possible case, he had a number to call and an ambulance would be in his location to pick-up the suspect case. However, the volunteers did not feel adequately prepared for psychological effects they faced as they responded to the Ebola operation. One volunteer said that at the end of her

first day, when she got to her house, she started hyperventilating and started feeling the symptoms of Ebola. She called her field partner for support.

4. Case Management:

In disease outbreaks, URCS may be called upon by the government to perform some case management duties. In the case of Ebola, URCS was called upon to partner up with MSF or MOH to perform duties such as:

- Manage the call centre and document information coming in from the field as well as dispatch response teams to a possible case.
- Manage the triage area and client flow, to maintain order at the reception of isolation centres.
- Disinfect people going into the isolation centres to reduce the chance of transmission.
- Maintain order outside the isolation centres by guiding patients and relatives to relevant areas. This includes controlling traffic in and out of the isolation area.

Notable Findings: URCS as an organization should clearly define its role in clinical or case management in health epidemics. In the case of an Ebola outbreak, volunteers should be physically and psychologically prepared and protected to work in isolation centres. A clear MOU on the roles of responsibilities of the volunteers should be discussed and agreed upon by all partners. The MOU should also detail the conditions acceptable or not acceptable for URCS to allow its volunteers to engage in case management activities.

B. LESSONS LEARNT

1. Coordination and Resource Mobilization

1. Internal coordination structures within the URCS are well laid out and function well. Vertical and horizontal information flows well within the organization.
2. Clear instructions need to flow from HQ on engagement with partners especially if URCS is asked to partner up in clinical or case management duties.
3. External coordination of URCS and national partners is good and functions well. National partners seem to know what URCS' contributions and roles are in a health epidemic.
4. An opportunity to highlight URCS role in community surveillance should be taken advantage of where URCS branches get information from communities on a disease outbreak before it has been confirmed by the MOH. URCS should advocate for CDC to strengthen the link from when communities through URCS report an outbreak of an unusual disease or death to DHMTs.
5. At a district level, district partners' perception of the role of the URCS is also clear and in line with that the Red Cross does. However, there is heavy reliance on URCS for logistics and case management.
6. In terms of roles and responsibilities, clear instructions need to go to branches on what they can and cannot do. As an integral member of their communities and local government, branches need to be clearly instructed on their roles in case management and logistics.
7. On resource mobilization, URCS usually writes DREF to respond to health epidemics. In the case of the Ebola outbreak, 2012, the process of DREF writing, submission and took 14 days from when MOH announced an outbreak to when the money was received by the responding branch. It took eight days

from when the DREF was submitted to when the money was received by the responding branch. For a fast-changing, highly fatal health epidemic, this is a long time.

8. Due to the unique nature of a health epidemic, the DREF rule of 60/40 does not apply and URCS needs to know that and argue it clearly with IFRC next time the organization writes a DREF for a health epidemic response.
9. Similarly, as previously noted, due to stigma, many of the people who had or were suspected of having Ebola, were isolated and were unable to leave their homes. Neighbours and friends did not visit them and they were not allowed to leave their homes to go buy food. During the 21-day follow-up, volunteers felt obligated to take small amounts of food to the people they visited. They did this spending their own money; it is important for URCS to know that such expenses should be budgeted for and spent under DREF. Food expenses are an allowable DREF cost in the case of health epidemics.

2. Social Mobilization

1. Volunteers recruited as part of the mobilization team were in communities promoting the message that Ebola was a disease and not witchcraft. They raised awareness on the signs and symptoms of the disease as well as transmission and where to seek healthcare. These volunteers received a lot of training to be able to perform these duties.
2. URCS needs to recognise the training received by the volunteers in terms of a training certificate.
3. Also, due to the nature of the outbreak, the volunteers endured a lot of stigmatization. URCS needs to formally acknowledge and appreciate their participation in form of a thank you ceremony where the training certificates could be presented..
4. All volunteers, being deployed to such a response by URCS should receive PSS for themselves and should be given key messages and talking points to address with their families before they are deployed.
5. While in the field, volunteers should have contacts for a URCS official they can call when they feel exposed or would like to speak to a counsellor.
6. While in the field, and especially if doing door-to-door visits, all volunteers deployed should have proper and visible identification.
7. During the end-of day briefings, a URCS branch representative should be present in order to show support.

3. Community Surveillance

1. URCS does a lot of work in community and active surveillance. For community surveillance, URCS needs to source for long-term programming during non-emergency times. This is because, especially for Ebola and nodding disease, a lot of work needs to be done within the communities to raise awareness of the disease and to destigmatize it away from witchcraft.
2. On community surveillance, URCS should advocate for capacity building to strengthen the DHMTs and local health labs so as to react urgently and investigate a disease when there is a report from the community about an unusual disease or death. As previously noted, in the case of the Uganda Ebola outbreaks of July 2012, URCS branches and volunteers knew of the unconfirmed outbreak five days before it was confirmed by MOH.
3. Lessons learnt for social mobilization above apply as the community surveillance teams are usually out working within communities also. Refer to points 1 – 7 above.

4. Case Management

1. URCS HQ should be clear and firm with the branches on the clinical and case management duties they should engage their volunteers in. Branches should feel empowered to say no to govt or partners when requested to perform duties outside their standard operating procedures or response plans.
2. If a responding branch feels compelled to get involved in clinical or case management duties through a partner, HQ should issue guidance on the rules of engagement with the partner and discuss and issue an MOU with the partner.

C. RECOMMENDATIONS

1. Due to the regular occurrence of health epidemics in Uganda, URCS has recognized the need to have a well resourced emergency fund to be used for initial response activities. URCS has developed guidelines for the emergency fund. However, the guidelines does not cover crucial information like the measures put in place to make sure the funds are used only for an emergency and how the fund will be replenished once money has been spent. IFRC East Africa regional DM and health unit will work with URCS to add this information to the guidelines then mobilise to put resources in the fund.
2. URCS should develop a contingency plan for health epidemics to guide all levels of the organization on how to prepare for and respond to a health epidemic. The contingency plan should cover the following topics:
 - Identification of health hazards and risks in Uganda
 - Identification of vulnerabilities and capacities of URCS
 - Role, mandate of URCS in health epidemics control and response
 - Role of HQ
 - Role of regional and district branches
 - Role of volunteers
 - Services that URCS will not provide
 - Rules of engagement with partners
 - Actions at different phases of epidemics
 - Preparedness phase (Early warning and alert systems)
 - Response
 - Recovery phase
 - Health Emergencies Management Team
 - Composition of team
 - Roles and responsibilities
 - Communication structure

D. CONCLUSION

The health epidemics evaluation performed on the 2012 Ebola outbreak response by URCS has provided good lessons learnt on the unique nature of health epidemics should advise URCS next time there is a disease outbreak a a DREF is written. A well written and approved contingency plan for health epidemics will make it clear for all levels of URCS the specific roles and functions that URCS should provide or not provide. A well funded and functioning emergency fund will allow URCS respond early to a disease outbreak as the organization plans the full response. During response, URCS will first offer PSS to its own people, volunteers and staff, before sending them out to respond. URCS will encourage the team to be deployed to prepare their families on the response and discuss the measures

that URCS has put in place to protect them. Once such a PSS program is developed and is working well, URCS can offer it to their partners as a fee.

Annex I: Summary of notable evaluation findings

1. As a matter of policy, URCS does not put its employees and volunteers in harm's way. As such, there can be no response from URCS on any disease outbreaks unconfirmed and unannounced by the Uganda government. In case of strong evidence from the community that there is a disease outbreak yet the government has not confirmed it, URCS can mobilise volunteers and ask them to be on stand-by.
2. A clear need for an emergency fund to be used for early response is now recognized by URCS. This is a fund that finances initial early response activities before resources for the actual response are mobilised. This fund is then replenished to fund the next emergency. URCS has an Emergency Fund which has some funds but need more to cover the possibility of concurrent emergencies. The fund has guidelines for usage and replenishment and has recently been reviewed and updated. **ACTION** is needed to help them fundraise and populate the fund
3. The URCS's role in case management and logistics is undefined. In case management, URCS has mostly performed its role in conjunction with other clinical partners such as MSF and the MOH. In logistics, URCS fills in a logistics gap in cases where the need is too much for the government to meet or in cases where logistics help from government is delayed.
4. Focus group discussions with URCS volunteers made it clear that the volunteers felt happy and proud to have engaged in social mobilization efforts however, some of them lacked clear identification that identified them as a URCS volunteer. As such, they were turned away by community members who did not trust them. They requested URCS red vests and at a bare minimum, a URCS name badge that displayed their name and title.

URCS volunteers also expressed a need for PSS for them and their families. During the focus group discussions, volunteers expressed the fear they felt as they worked in social mobilization within the community and how stigmatized they felt. Many of them were nicknamed Ebola. They also expressed the rejection they felt from their family members who isolated themselves from them. The volunteers also felt afraid that they may have been carrying the disease and were scared of spreading it to their family members so many of them bathed before entering the house and disinfected their shoes and clothes with Jik. Others sent their families to live with relatives during the operation.

5. URCS volunteers engaging in community surveillance felt adequately trained to perform community surveillance activities and felt safe and protected. When a volunteer would recognize a possible case, he had a number to call and an ambulance would be in his location to pick-up the suspect case. However, the volunteers did not feel adequately prepared for psychological effects they faced as they responded to the Ebola operation. One volunteer said that at the end of her first day, when she got to her house, she started hyperventilating and started feeling the symptoms of Ebola. She called her field partner for support.
6. URCS as an organization should clearly define its role in clinical or case management in health epidemics. In the case of an Ebola outbreak, volunteers should be physically and psychologically prepared and protected to work in isolation centres. A clear MOU on the roles of responsibilities of the

volunteers should be discussed and agreed upon by all partners. The MOU should also detail the conditions acceptable or not acceptable for URCS to allow its volunteers to engage in case management activities.

Annex III: Lessons Learnt and Contingency Planning Workshop

Annex II: List of people met

Name	Organization	Title	Contact
Michael Richard Nataka	URCS, HQ	Secretary General	natakam@redcrossug.org
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Health Epidemics Evaluation; Lessons Learnt Workshop and Contingency Planning Worksp

Feb 25th – 27th, 2013

Location Uganda Red Cross Conference hall

Day	9:00 – 10:30 am	TEA BREAK	11:00 - 1:00pm	LUNCH	2:00 pm – 3:30pm	TEA BREAK	4:00 pm – 5:00pm
Monday 9:30 - 10:00 10:00 -10:45 10:45 – 11:00	<ul style="list-style-type: none"> • Briefing with Dr. Baguma, Under S G, URCS • Introductions • Opening speech, Dr. Baguma • Opening speech, Ken Kigguda, Director DM • DREF review findings 	TEA BREAK	<ul style="list-style-type: none"> • Disaster Management and Health review • Discussion and Q & A 	LUNCH	Lessons learnt, PSS	TEA BREAK	Role of PSS in health epidemics response Way forward
Tuesday 9:00 – 9:15 9:15 – 9:45 9:45 – 10:30	Opening & review – Rose Identification of hazards and risks Identification of vulnerabilities and capacities of URCS	TEA BREAK	Role, mandate of URCS in health epidemics Role of national, district and volunteers in epidemic control and response	LUNCH	Identification of essential services to be provided during a health epidemic Support needed to provide support Services that URCS will not provide	TEA BREAK	Identification of key actors per service Rules of engagement with partners SOPs needed
Wednesday 8:30 – 9:15 9:15 – 10:00	Actions at different phases of epidemics <ul style="list-style-type: none"> • Preparedness phase (Early warning and alert systems) • Response phase • Recovery phase 	TEA BREAK	Health Emergencies Management team Composition of team Roles and Responsibilities Communication structure	LUNCH	Presentation of plan Presentation of plan	TEA BREAK	Way forward