







High-Level Emergency Ministerial Meeting on Cross Border Collaboration for Preparedness and Response to Ebola Virus Disease

Meeting Objectives and Expected Outcomes

Wednesday 12th October 2022 Kampala, Republic of Uganda

Meeting Objectives and Expected Outcomes

General objective:

Strengthen and enhance collaboration and coordination for cross-border preparedness and response to the ongoing Ebola Virus Disease outbreak and other health emergencies

Specific objectives

- 1. Update on the current situation of the SVD outbreak, exchange experiences and key lessons learnt, and update the required minimum operational readiness capacities to manage SVD threats
- 2. Agree on mechanisms for cross-border coordination, collaboration and communication, including cross border management committees









Meeting Objectives & Expected Outcome

Specific objectives

- 3. Agree on a joint cross-border plan of action for emergency preparedness and response including joint cross border surveillance, cross border outbreak and alert investigations; and
- 4. Adopt timely data sharing mechanism focusing on Ebola and other public health threats of regional concern among neighbouring countries









Expected Outcome

Participating countries are expected to:

- Agree on priorities for bolstering preparedness and readiness for SVD threats across high risk countries
- Agree on cross-border collaboration and timely sharing of data related to Ebola and other emerging and re-emerging diseases of regional concern; and
- Establish a joint committee to coordinate and follow up on the implementation of the joint plan of action for cross border public health threats









Thank You











Ministry of Health STATUS UPDATE to

Emergency Ministerial Meeting on Preparedness and Response to Ebola virus Disease

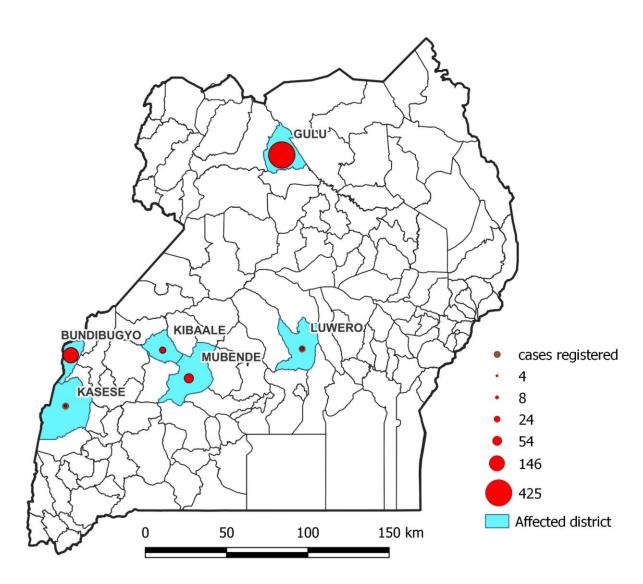
Dr Henry Kyobe Bosa Incident Commander 12th October 2022

History of Ebola Virus Disease in Uganda

District	Year	Cases	Deaths	Case fatality ratio (%)	Strain
Gulu	2000	425	224	53	Sudan
Bundibugyo	2007	146	39	27	Bundibugyo
Luweero	2011	1	1	100	Sudan
Kibaale	2012	24	17	71	Sudan
Luweero	2012	7	4	57	Sudan
Kasese	2018	4	4	100	Zaire
Mubende	2022	54*	19**	35**	Sudan

^{**}Confirmed cases

Distribution of the previous and current outbreaks in Uganda, 2000-2022

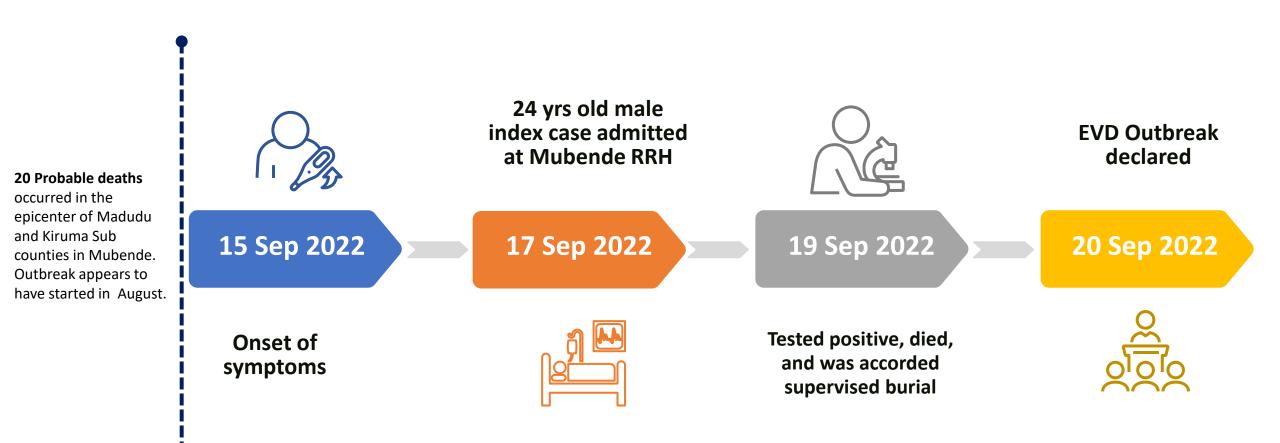


Understanding the preceding setting of the current outbreak

- Occurs after two and half years of a protracted COVID-19 pandemic
 - Devastating Delta wave of May-July 2021
 - Stagnated COVID-19 vaccination coverage
 - Two major lockdowns during the COVID-19 pandemic
 - Community apathy arising out stringent COVID-19 response measures
- This preceded two years of Ebola preparation for the 2017-18 outbreak in DRC
- NAPHS following the JEE that have largely been overtaken by events in the context of COVID-19

- The previous outbreaks occurred in largely different times, and places.
 - Current outbreak on a major high way to Kampala from the western part of the country
 - Transit route from Eastern DRC to Kampala
 - Rapid and fast inter-districts population movements facilitated by different means ot travel- Boda boda, and commuter taxis
- Community mobilisation is complicated by social media, and fast movement of information (and dysinformation)

The evolution of the current 2022 EVD outbreak



- Actual origin of the outbreak is not yet known
 - But we still believe it was a breach of wild-human interface in the areas around the epicenter

- The outbreak appears to have began around August 2022 in and around Madudu, the current epicenter
- Patients attended two private facilities in the same sub-county
- Preliminary epidemiological investigations show up 20 probable cases had occurred before the outbreak was unmasked.

Overview of 2022 EVD Outbreak in Uganda

(data as of 10 October 2022)

Highlights

- 06 new confirmed cases
- 54 cumulative confirmed cases
- 02 new confirmed deaths
- 19 cumulative confirmed deaths

10 Health worker infections | 04 deaths



05 affected districts

Mubende, Kagadi, Kyegegwa, Bunyangabu, Kassanda

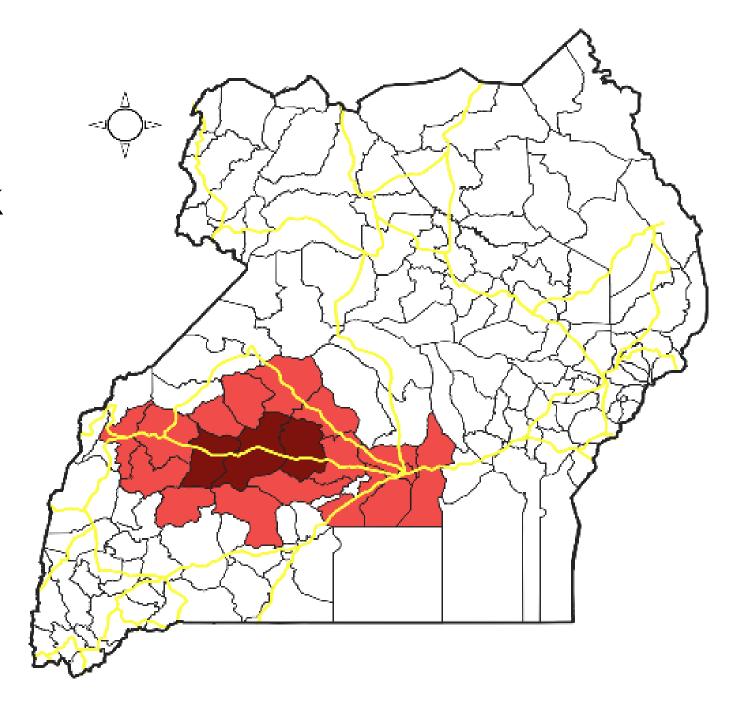
- Contact follow up: 93%
- Admissions
 - Current
 - 12 Confirmed | 13 suspect
 - 153 Cumulative
- 22 Recoveries

Description of the healthcare workers' cluster

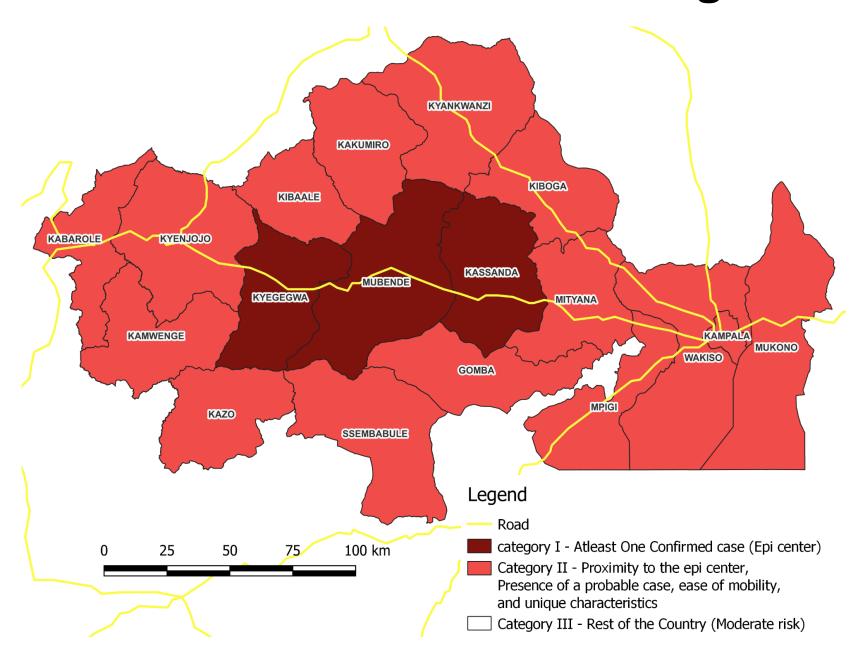
- Exposed through a major surgery of patient at Mubende RRH on 17th September 2022
 - This patient presented with symptoms of fever, abdominal pain, vomiting and bloody diarrhea
 - Suggestive of a surgical acute abdomen prompted the surgery
- Surgery team: Lead surgeon, an assistant, anesthetic officer among others

- All the six (6) health workers who participated in the surgery turned positive for Ebola
 - Two eventually died: 30th September 2022, and 3rd October 2022
- Additional one (1) health worker (a contact to one of the 6) turned positive.....secondary transmission
- Remaining five were discharged from ETU yesterday
 - Received MBP134 on compassionate use.
 - Convalescent plasma
- 120 contacts were listed in the hospital---- all have been discharged after 21 day follow up.

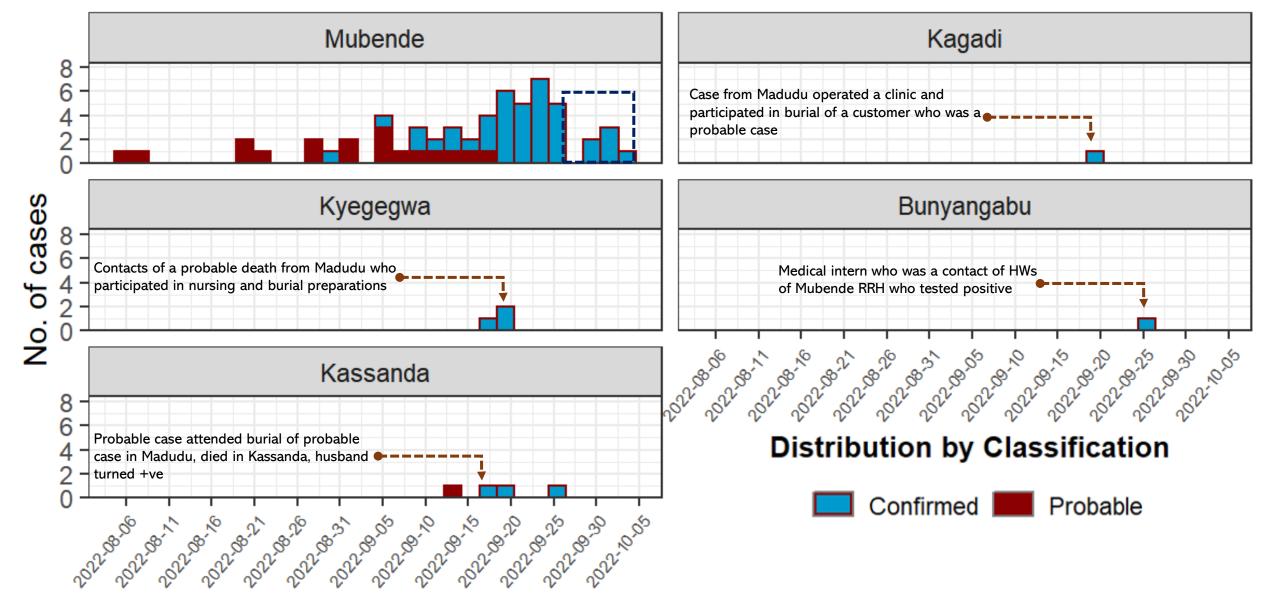
Geographical location of the outbreak and risk categorisation



Risk categorization



Temporal distribution of confirmed and probable cases in the subregion (N=74)

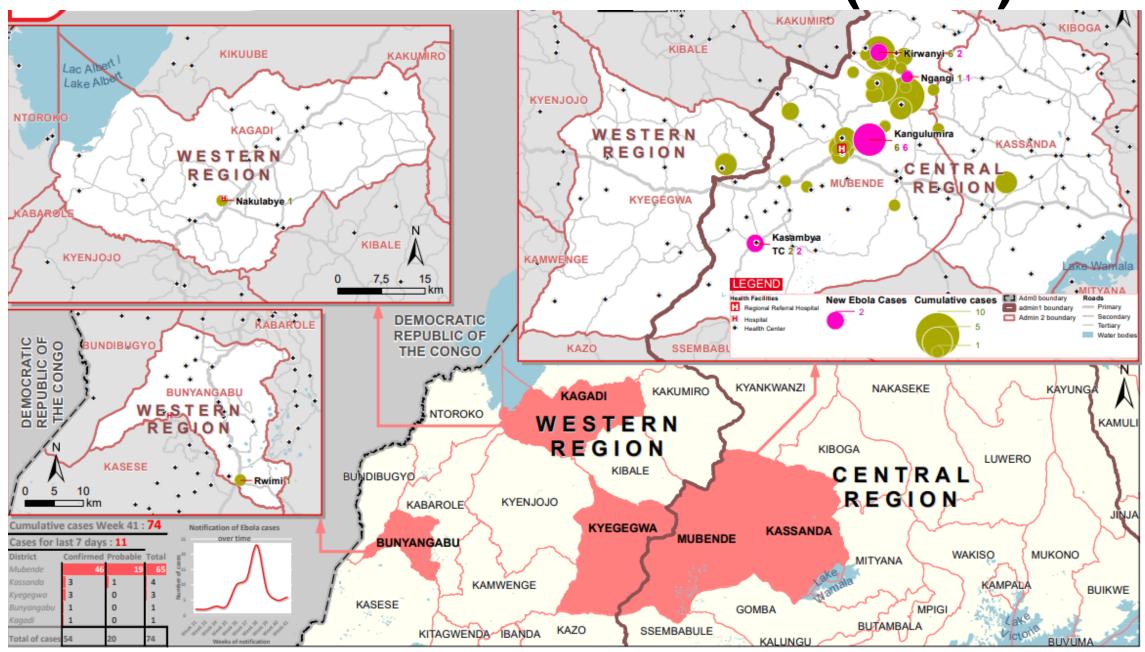


Date of onset

Summary of confirmed cases and deaths by sub-county

District	Sub-County	Confirmed Cases	Confirmed	Date of onset last
District			Deaths	confirmed case
Mubende	Madudu	16	07	4 th October 2022
	Eastern Division	07	01	26 th September 2022
	Southern Division	06	01	9 th October 2022
	Bayeza	01	01	29 th September 2022
	Western Division	02	01	25 th September 2022
	Kasambya	03	00	17 September 2022
	Kibalinga	01	01	20 th September 2022
	Kiruuma	06	03	2 nd October 2022
	Kitenga	01	00	20 th September 2022
	Kiyuni	03	02	24 th September 2022
Kyegegwa	Kasule	03	01	20 th September 2022
Kassanda	Kassanda	02	00	20 th September 2022
	Kalwana	01	00	-
Kagadi	Kagadi TC	01	01	19 th September 2022
Bunyangabu	Rwimi TC	01	00	-
Total		54	19	

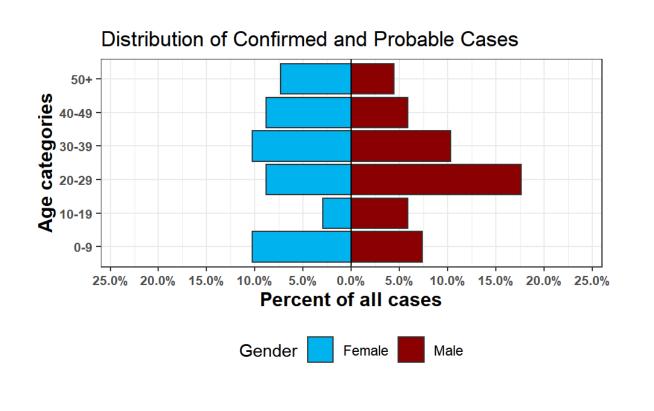
Distribution of confirmed cases (n=54)

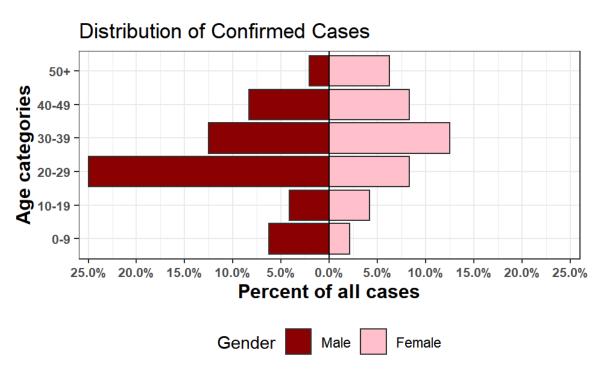


Distribution by Confirmed Cases by Status 9 -No. of cases Status Alive Dead 3 Date of onset

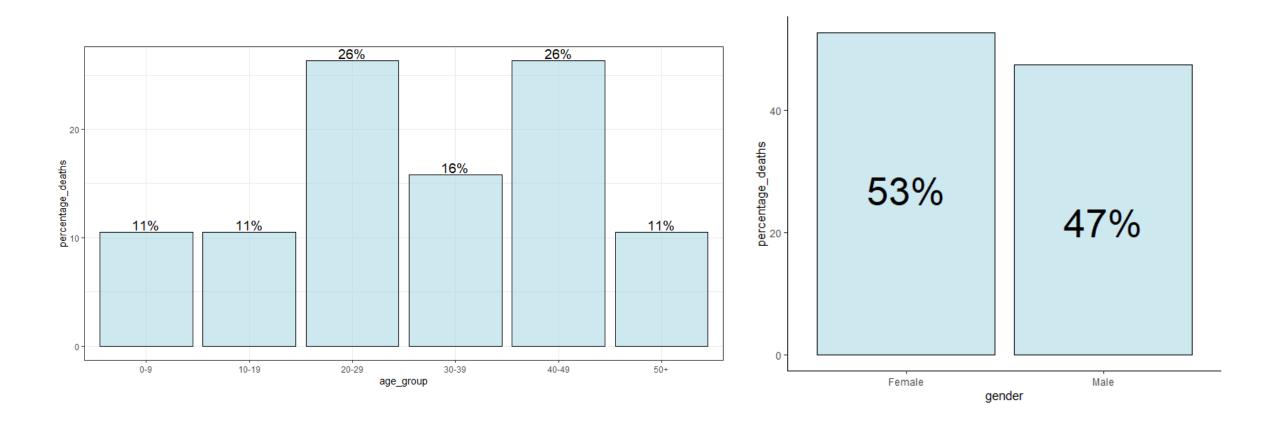
Stacked bars: Interprete bars independently; imputed DOO of 5 cases

Person Characteristic: Age and Sex distribution





Distribution of deaths by Age and Gender (n=19)



Organization of the EVD response pillars

Coordination

National and District Task Force activated.

Technical pillars (Surveillance & lab, Case management, IPC, Logistics, Risk Communication and community engagement)

Partner coordination

Surveillance & lab

Alert management and rapid verification

Contact tracing

Case investigation

Active case search

Data management

Infection Prevention and control

Ebola Treatment Unit.

Non Ebola Treatment Centre

Community IPC (decontamination and ring IPC) and WASH

RCCE

Public awareness through radio

Public awareness through print materials

Community engagement/dialogue

Case Management

Ebola Treatment centre (Mubende)

Ebola Treatment centre (Madudu Health Centre III).







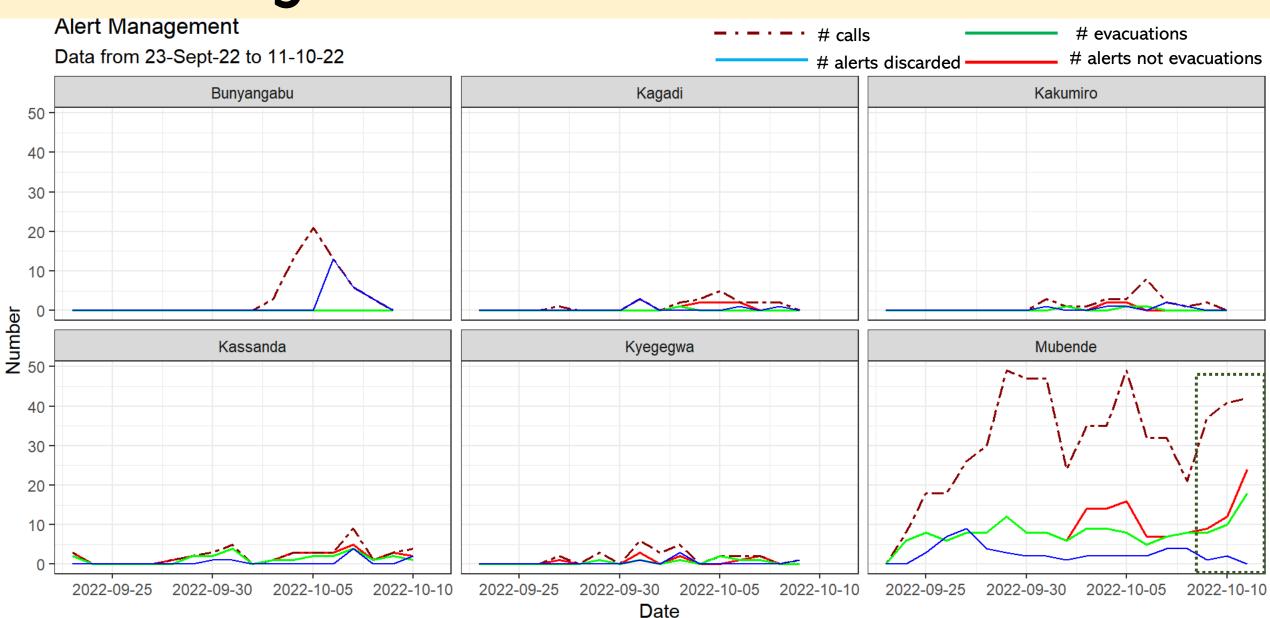


FIELD LAB in Mubende



- The lab continues to optimize processes and quality systems to ensure efficiency and accuracy of results
- TAT 4 6 hrs as the lab continues to optmise the processes to improve efficiency
- MUWRP has provided containment chambers and chemistry (piccolo) and hematology machines to support clinical tests in mubende
 - need to procure reagent

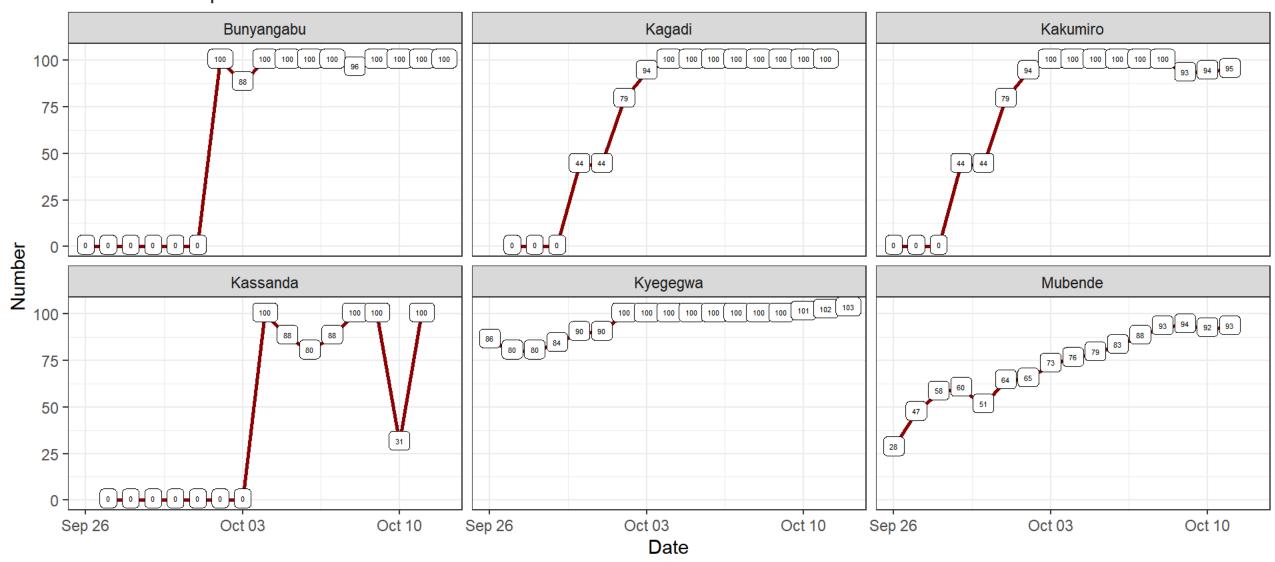
Alert Management: Alerts and Evacuations



Contact Tracing: Percentage Follow Up

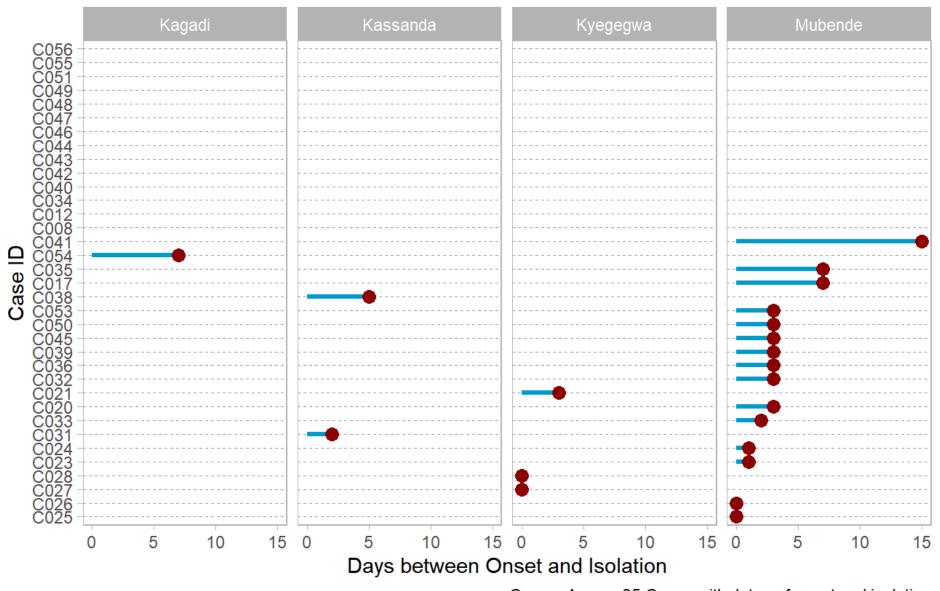
Percentage Followup

Data from 23-Sept-22 to 11-10-22



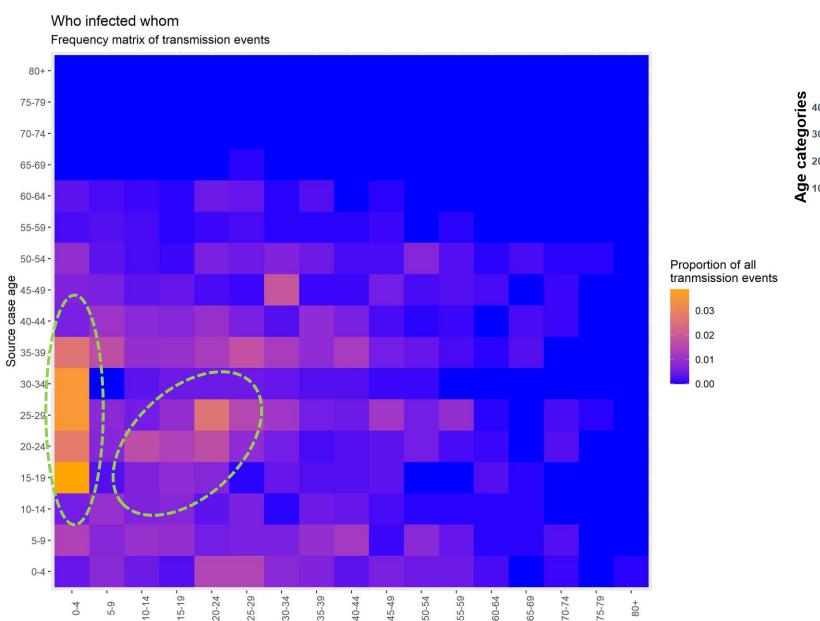
Duration of onset of symptoms to isolation

Time spent Infectious in Community

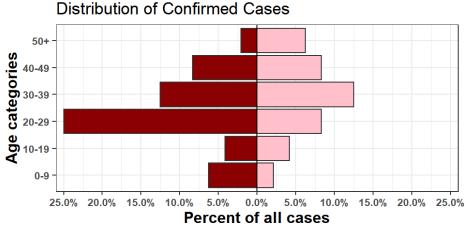


Cases: Among 35 Cases with dates of onset and isolation

Contact Tracing: Heat Map on "Who infects Who"



Target case age



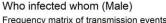
Deductions

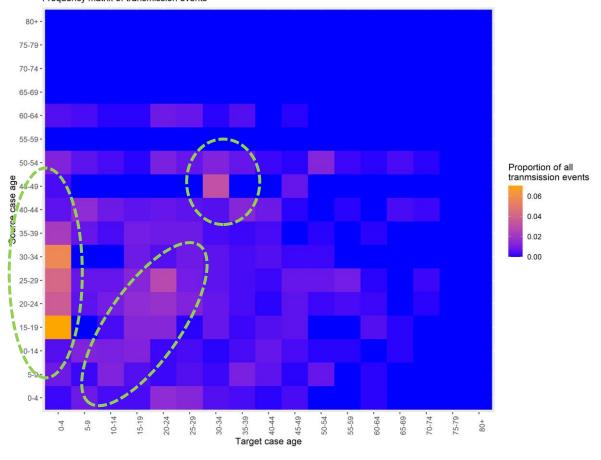
- 1. Transmission events highest in age groups15-40 years
- 2. Youths 20-39 transmitting to age group 15-35

Contact Tracing: Heat Map on "Who infects Who"



- Males 15-40 transmitting to children
- Males 15-30 transmitting to peers 15-30



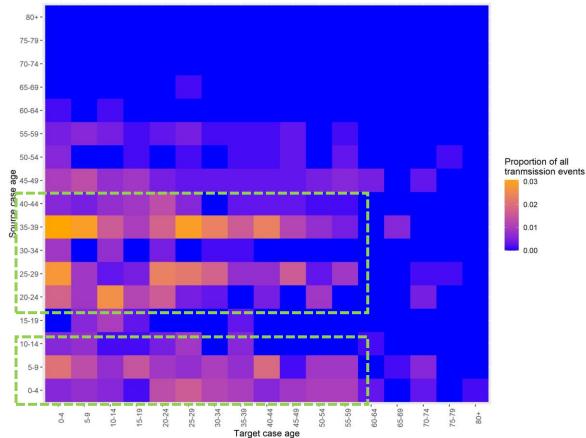




- Females 15-40 transmitting to all age-groups
- Maybe related to gender roles



Frequency matrix of transmission events



Update on the Sudan Ebola Vaccine trial

 From the outset of the current EBV outbreak in the country, the MoH engaged several scientists from different local and international institutions to identify possibility of Ebola vaccination.

 A review of the possibility of using vaccines available in country for rapid use to protect the health workers

 It was established that despite 56% homology between Ebola Zaire and Ebola Sudan, early studies did not indicate that vaccines against Ebola Zaire do protect against Ebola Sudan

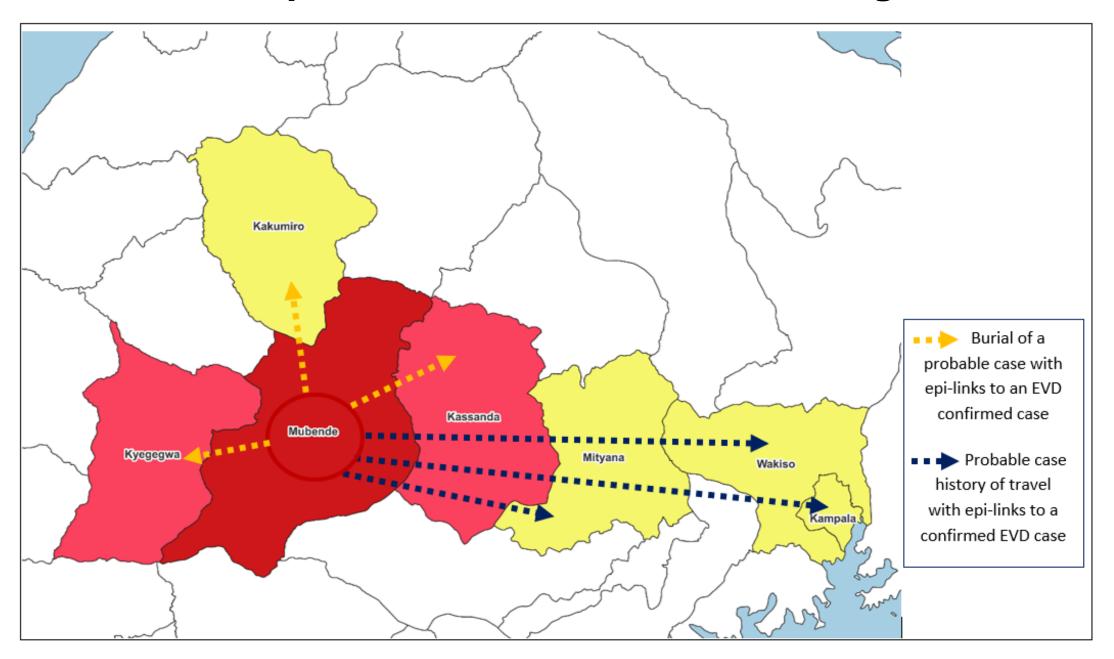
- Working with WHO and partners, 2 candidate vaccines have been identified
- WHO has deployed 2 officers with experience managing Ebola trials in West Africa to support the Pl's team
- PI has been identified and already working with WHO Blue Print
- Protocol development
 - Drafting ongoing
 - Design has been agreed upon
 - Candidate vaccines identified

Current and emerging response challenges

- Contacts (and symptomatic individuals) slipping out of the quarantine and response districts to far places in search of care to;
 - Traditional healers
 - Tertiary health facilities
- Contacts hiding identity, and denying having come from the epicenter

 Emerging pockets of community resistance driven by misconceptions, belief in witchcraft.

Potential spread of the outbreak in coming weeks



→Potential spread of the outbreak from the rural epicentre to urban and densely populated areas of

Mubende, and Kampala



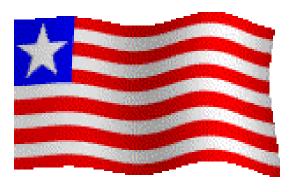
For God and my Country

LIBERIA 2014 TO 2016 EBOLA DISEASE OUTBREAK AND RESPONSE

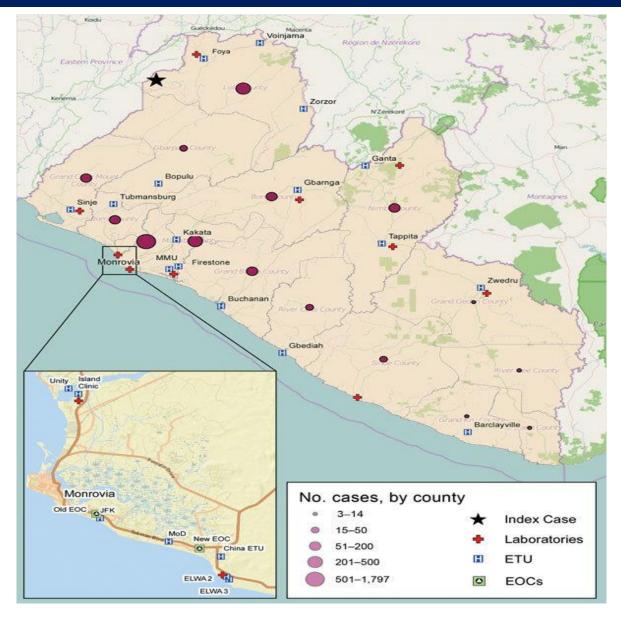
12 Oct 2022

Hon. Dr W.Jallah Minister of Health





EVD Epidemiology in Liberia



- ❖Index case as recorded on 4 March 2014 from Lofa county
- ❖A total of 10,678 confirmed cases with 4,810 deaths (CFR=45%) were recorded in Liberia from March 4, 2022 to 22 June 2016.
- Health workers infections were 372 including 184 deaths in Liberia
- ❖A total of 7,795 confirmed cases were treated in Ebola treatment centers where 5,685 and 2,110 died.
- ❖A total 293,817 contacts were recorded and followed up.
- Cumulatively 304,413 specimens were collected and tested during the pandemic.

IMPACT OF EVD IN LIBERIA

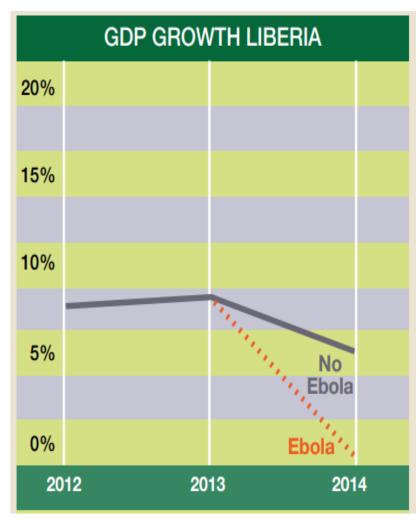
- ❖ Health services were rendered dysfunctional with health facility closures, fears and refusal of health workers to provide routine health services, and community distrust and fears.
- Communities sought care from traditional, private and informal health care providers, driving up out-of-pocket expenditure on health;
- ❖Outpatient visits reduced by 61% for Liberia.
- Women and children were disproportionately affected by the crisis beyond EVD itself with declines of:
 - 43% in antenatal care,
 - 38% in institutional deliveries,
 - 45% in measles
 - 53% in DTP3 vaccinations between in 2014-2015 compared 2012-2013.





IMPACT OF EVD

- The country GDP and progress across the health sector, including progress towards achieving the MDGs declined.
- ❖ Economic loss including: private sector growth decline, agricultural production decline leading to food security, & decrease in cross-border trade due to restrictions on movements, goods, and services
- ❖Increase in the mortality rate due to malaria, HIV/AIDS and tuberculosis mortality rates as a result of disruption to treatment interventions. Maternal and newborn deaths also increased.
- ❖ Post-EVD syndromes presented a challenge for health system as the science of EVD related symptoms is evolving.
- Mental health problems were frequently reported. 46% of the patients reported stigmatization. The main psychiatric diagnosis were moderate to severe depression and post-traumatic stress disorder (PTSD)



INITIAL CHALLENGES DURING THE RESPONSE

- ❖ The surveillance system was not able to pick the outbreak early leading to delay in instituting the response measures
- The country capacity to coordinate and respond to an outbreak of unprecedented magnitude was lacking in the country.
- There were no EOCs and skilled staff to coordinate major public health events was lacking.
- Multisectoral platforms to lead the national network were not well equipped and roles and responsibilities were not clearly defined.
- Leadership and coordination throught the Incident Management System were central to the response
- ❖ Weak public health system devastated by years of political instability & fragility;
- ❖ Weak surveillance system impeded the ability for early detection and timely response to public health threats

ACTIONS TAKEN

- GoL in collaboration with different partners, established Ebola treatment centers (ETCs) and strengthened referral systems between the regular health facilities and these treatment centers.
- Strengthened EVD surveillance in all the 15 counties. Epidemic preparedness and response measures including strengthening of laboratory capacity remain an asset post EVD for preventing and controlling other infectious diseases.
- ❖The level of community engagement and ownership was raised during the EVD response. This was leveraged to build trust, a strong voice and involvement of communities in health service planning and management as well as in community based health promoted and preventive activities
- Infrastructure developments to build appropriate regional isolation structures. Triage processes that were introduced strengthened efforts towards of safe essential health services restoration and strengthened effectiveness and timeliness of care and referral systems.

ACTIONS TAKEN

- The IPC measures were introduced both at the health facilities and within the population to cause impact positive behavior impact.
- ❖ Support for essential supplies for the safe delivery of health services for the health worker and the client/patient helped in restoring trust in the health system.
- A national public health Institute was established for coordinating epidemics preparedness and response.
- ❖ Establishment of survivors program for males using Reverse transcription polymerase chain reaction (RT-PCR) testing of semen to male EVD survivors' ≥ 15 years of age.
- ❖ Virus Persistence in semen was noted for 52 months for the last 2 survivors (these had co-morbidities) though majority cleared the virus between 6 months to 36 months

ACTIONS TAKEN

- *Capacity building Field Epidemiology Training Program (FETP); Basic training, Intermediated, Advanced (sponsored to Ghana); IPC, IDSR among others
- Established and functional multi displinary RRTs at national and sub-national levels
- Established and functional isolation capacity in all hospitals
- Established and functional EOCs across the 15 counties at the national level
- Supported community initiatives to control disease outbreaks

Lessons learnt and Best Practices

- Quick establishment of well-resourced ETCs is paramount to reduction of transmission and building community confidence. Isolating suspected cases based on their risk level effectively reduce new infections
- Reinforcing trust between leaders and the citizens is key; as well as community participation, ownership, and buy-in for any initiative to achieve its desired outcomes
- ❖ Early Ebola messaging emphasized lethality and incurability Several reports cited the early messaging as resulting in widespread fear, which contributed to people fleeing ETCs, and not cooperating with Ebola response activities
- Communications, community engagement, Safe Dignified Burial (SDB) and other response activities should be tailored to the local community including showing respect for local customs and cultures

Recommendations

- Strong national leadership and functional partner coordination mechanisms led by governments and ensuring that all interventions by partners are in line with relevant national guidelines
- Existence of a surveillance system that covers the country from community to national levels and can be adapted to relevant conditions, and has well-trained staff and effective information management systems;
- A central national emergency operations centre with capacities and resources to function as a central hub for national surveillance at all times, and as the central operational hub to be activated during health emergencies;
- Sustainable community engagement and multi-faceted risk communication strategies and resourced plans;
- Availability of critical laboratory diagnostic capacities with associated quality assessment processes

Recommendations

- Strong coordination mechanism with GoL commitment and ownership. Resources need to be committed by GoL (L)
- The relevant government ministries should take the lead in developing policies on emergency preparedness, response and mitigation, and ensure policy coherence across sectors and departments
- Cross border surveillance is effective when all stakeholders invest resources in joint activities. Stand-by rosters of health care specialists such as epidemiologists and phlebotomists should be developed for quick deployment to emergency response
- Legislation for public health law and improve health financing including Emergencies preparedness and response
- ❖ Establishment of the Incident Management System (IMS) and Public Emergency Operation Centers across the country was critical for accountability & coordination of multiple partners
- A threat in one country is a threat everywhere because people are connected. Hence, we need to improve collaboration and alignment of preparedness and control strategies.

Ebola Preparedness and Readiness in Countries Neighboring Uganda

Dr Allan Mpairwe Risk Management and Preparedness, WHO AFRO





Outline

- Introduction
- Risk Level and Risk Mapping
- Minimum requirements for readiness
- Assessment of capacities
- Challenges/gaps
- Recommendations
- Current efforts to enhance readiness





Introduction

- Experience from COVID-19 pandemic and previous epidemics has shown that a threat in one country is a threat everywhere.
 - Evident in the WA Ebola outbreak, Ebola outbreak in the DRC and COVID 19 pandemic
- Risks exist due to porous borders, cross border movements for trade, cultural and social ties and ease of international travel
- Hence the need for enhanced preparedness and operational readiness in countries neighbouring Uganda







Risk levels



WHO, in consultation with the countries, conducted a risk analysis in the region.

Criteria for risk characterization

- Proximity to the epicenter
- Trade and regional connectivity
- Cultural and social connections including refugee ties
- Ease of mobility and highways

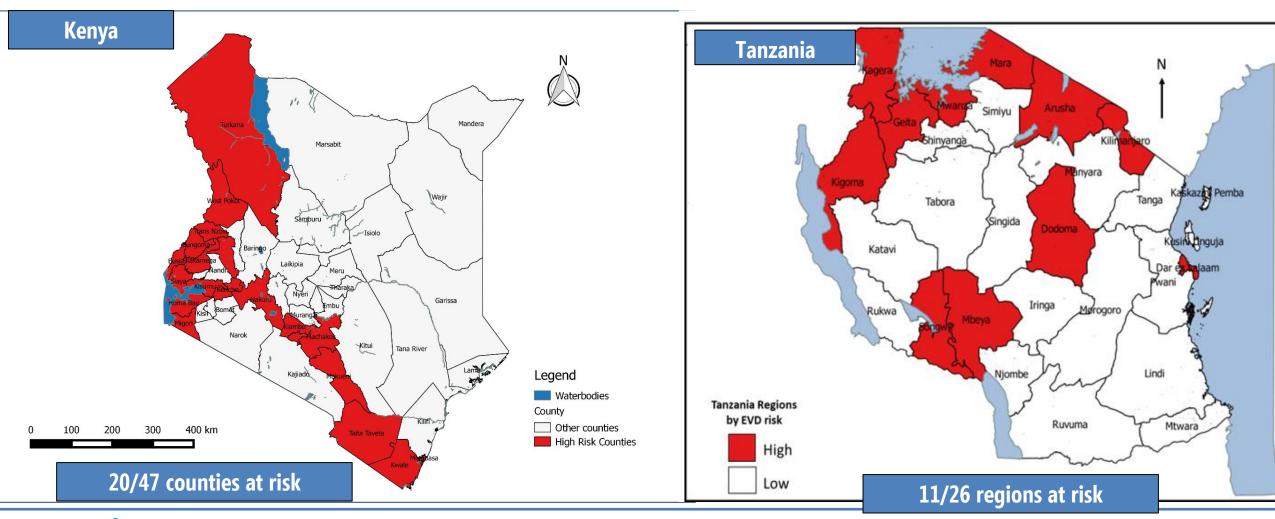
Six (6) Countries are prioritized currently:

- Priority 1: High risk Rwanda and South Sudan
- Priority 2: Moderate Risk Burundi, Kenya, Democratic Republic of Congo, and Tanzania
- The National Task Forces lead the in-country risk mapping





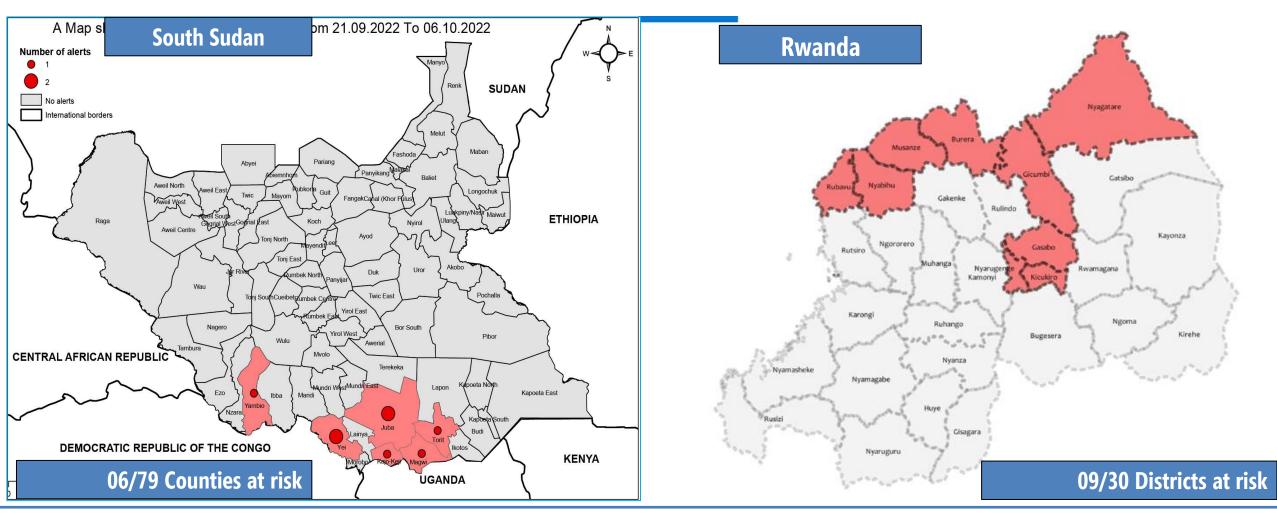
Risk Mapping at Country Level







Risk Mapping cont....







Minimum Requirements for Readiness

- **Increased awareness on SVD through RCCE** on different issues including dissemination of working case definitions to communities, private and public health sector, and partners
- **Enhanced active surveillance** for early detection
- Capacity for swift laboratory confirmation of suspected cases of SVD
- Ensuring readiness of the **Rapid Response Teams** for case investigation, contact tracing and sample collection;
- Preparation of health facilities and health workers for Ebola
 Case management and infection prevention and control.

- Preposition equipment and supplies including Personal Protective Equipment, VHF kits in high-risk counties and at the sub-regional level
- **Contingency planning** for an imported SVD case scenario, 72-hour planning, including incident management and response planning;
- Presence and activation of coordination structures at national and subnational level
- POE capacities to screen and identify cases, cross border sharing of information
- Competent health work force and readiness focal point available

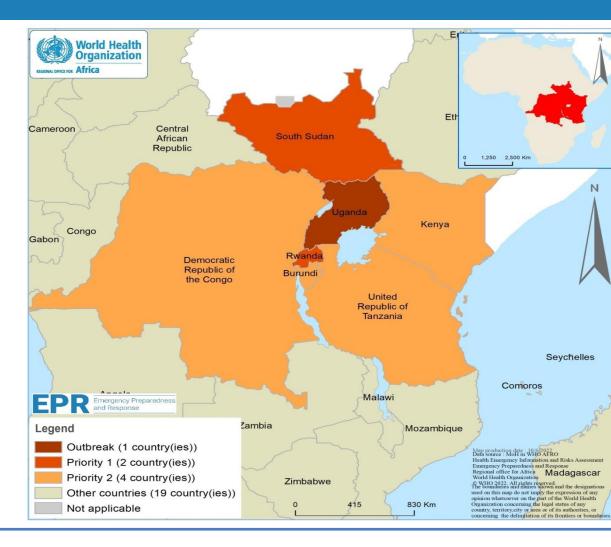






Assessment of the current capacities, September 2022

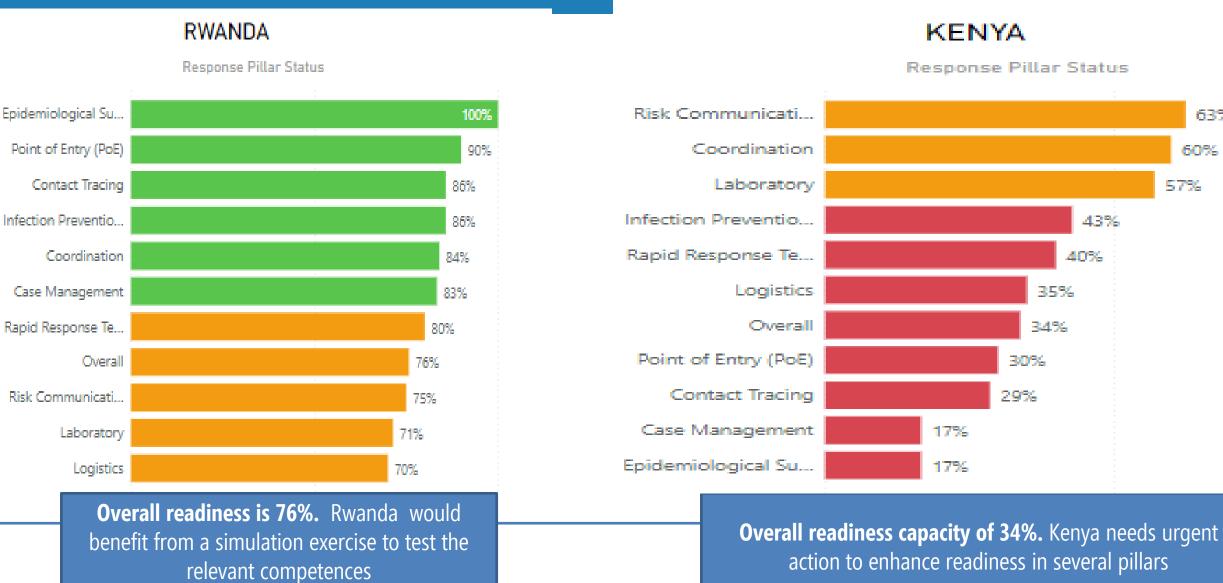
- **Self administered checklist** with indicators that assess the establishment of systems and capacities at the national/subnational level that;
 - Guides planning and readiness for Ebola response across levels in these countries
 - Assists member states in assessing their level of readiness for a potential Ebola response, identifying operational gaps and agreeing on recommendations to close the gaps
- SVD readiness dashboard publishes the KPIs that will be monitored every three months







Capacities by pillar by country

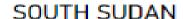


63%

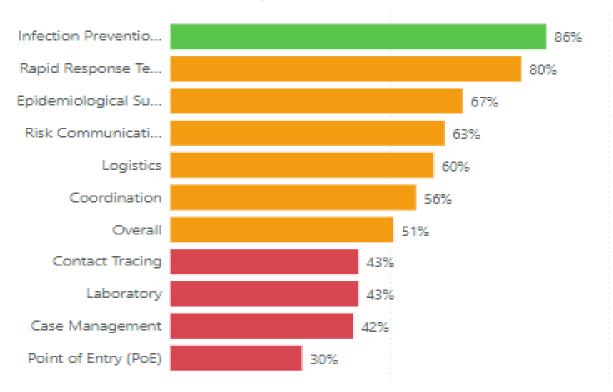
60%

57%

Capacities by pillar by country



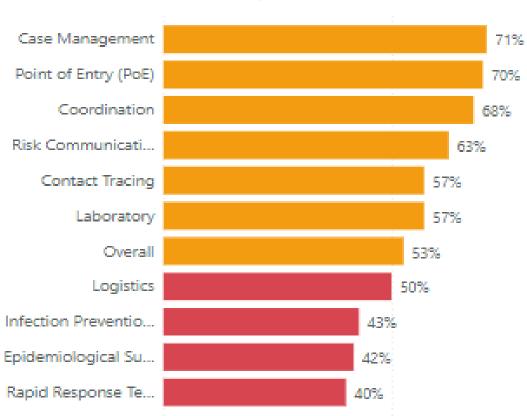
Response Pillar Status



South Sudan has moderate capacity at 51%.Urgent action is needed to enhance readiness for potential Ebola response

TANZANIA

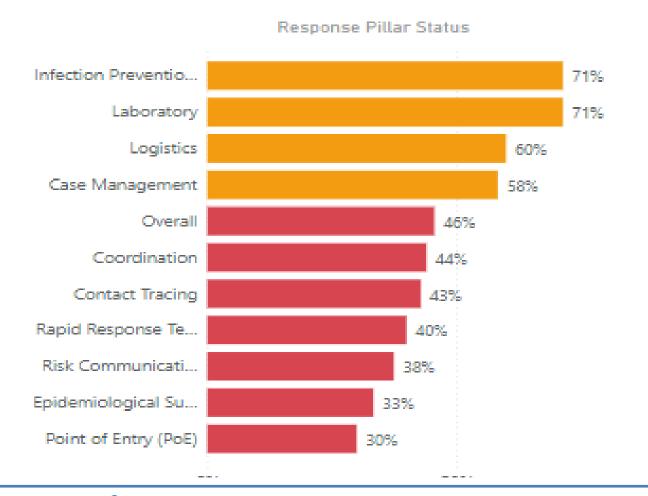
Response Pillar Status

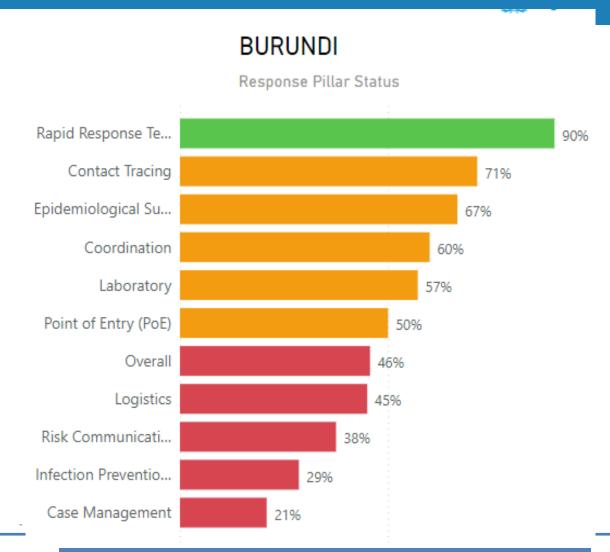


Tanzania has moderate capacity at 53%. Urgent action is needed to enhance readiness for potential Ebola response

Capacities by pillar by country

DEMOCRATIC REPUBLIC OF THE CONGO





Overall readiness 46% despite of several outbreaks. There is need for in-depth analysis and capacity building in several pillars

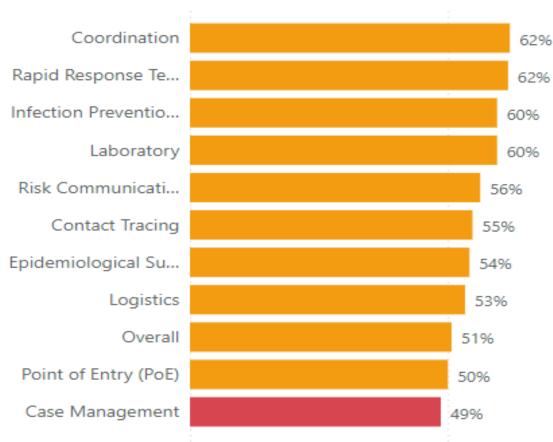
Overall readiness 46%. There is need for capacity building in several pillars

Average overall capacities

- The overall sub regional average capacity for readiness is at 51% which is slightly above average and calls for urgent attention and action.
- Coordination, RRT and IPC were rated high while case management, surveillance, contact tracing and POE capacities scored low

(Overall)









Gaps/ challenges/areas that need attention

Systems not tested and hence no prior experience on EVD management

Capabilities for contact tracing absent

POE capacities remain low and not fully resourced

Data on cross-border population mobility & mapping of POEs, convergence points, and key routes with the affected areas non existent

Logistics challenges (urgent need for PPE and reagents)

Funding gaps to conduct activities and for procurement of medicines and supplies





Gaps/challenges and areas that need attention

Competing public health events (COVID-19, flooding, Cholera, etc.)

Community engagement activities limited to a few high-risk regions/Lack of EVD-specific socio-anthropological data to inform RCCE interventions

The national and subnational PHEOCs are not fully operational due to some bottlenecks

Limited Health worker's capacity on case management and SDB

Poorly resourced community/event-based surveillance resulting in very low alerts





Key Recommendations for the Priority Countries

• Strategic leadership and multi-sectoral coordination

- Establish national **Emergency Operations Centers** for coordinating an emergency response, including the physical locations, infrastructure, plans and with identified and trained staff.
- > Sub-national **coordination hubs for high-risk regions** should be identified and made ready so that they can be activated if required.
- > Update of a costed SVD **contingency plan**, and development of a 72-hr plan
- Case management and infection prevention and control (IPC) capacities
- Establish at least one fully **functional and 5-10 bed Ebola Treatment Centre** with dedicated ambulance service and train case management team
- Establish two trained and equipped burial teams
- Operation Support and Logistics
- Maintain logistics expertise in country to provide operations support for preparedness and operational readiness; Establish warehouse and transportation capacities.





Key Recommendations for Priority Countries

- Surveillance for early detection (Reinforcing Integrated Disease Surveillance and Response (IDSR) systems)
- ➤ Identify and train a **pool of contact tracers** in all high-risk regions including community health workers and partners.
- ➤ Provide targeted training for **SVD detection** of Health Care Workers (HCW) and Community Health Workers in high-risk regions.
- Establish at least **two RRT teams** ready for deployments trained specifically for SVD response and preposition them in the capital or in proximity to a high-risk region.
- > Test RRTs through **field-based simulation** exercise to ensure their functionality.





Key Recommendations for Priority Countries

Capacity at Points of Entry

- ➤ Map and capacitate **relevant high-risk POE** with trained health workers who safely screen incoming travelers, collecting relevant information to enable contact tracing and minimize risk of infection
- ➤ Identify health **promotion needs at PoE** without official checking points in order to sensitize travelers of SVD risks
- Establish **adequate isolation capacity** at the POE where suspect cases can undergo secondary screening.
- ➤ Establish and test the **roles and responsibilities** of relevant sectors at POE before an incident and test them through simulation.





Key Recommendations for Priority Countries

- Risk communication, social mobilization and community engagement
- Train dedicated **risk communication teams** for high-risk regions to activate social mobilization and community engagement and to brief key groups such as community leaders, traditional leaders, traditional healers and other community groups on SVD preparedness.
- Conduct a rapid anthropological assessment on the social-cultural context of the community related to health seeking behavior, perception of SVD and related diseases, and funeral practices.
- > Initiate a public information campaign, including a hotline, for seeking information or reporting alerts
- Laboratory diagnostic capacity
- Training selected healthcare workers in high-risk regions on specimen collection, processing, packaging, storage, transport and manipulation as well as infection prevention and control strategies.
- Equip RRTs with supplies and PPEs for safe specimen collection





Current efforts to enhance readiness

- Regional Readiness plan developed, based on the submitted country contingency plans
 - Cost: \$29,465,000 for four months
- Contingency Fund for Emergencies availed \$3,000,000
- Capacity initiatives in place.
 - Training of case management experts in Tanzania, Uganda, Rwanda and South Sudan
- Available **technical assistance** to the countries to enhance the capacities
- Prepositioning of supplies (test kits and reagents)
- Deployment of mobile lab in selected high-risk regions





Conclusion

- We are in a global community and the current threat remains a critical concern to the region
- Proactive operational readiness pays off in terms of reducing the impact of emergencies on public health, reducing the cost of response and recovery
- There are varying levels of readiness across the countries with a subregional <u>average of 52%</u> with major gaps noted in case <u>management and POE</u>.
- Need to leverage on the gains that we made during the COVID era and <u>invest</u> more in attainment of the minimum readiness capacities.
- IDSR remains the main vehicle for the preparedness and operational readiness now











Plan de préparation de la RDC face au risque d'expansion de l'épidémie de la maladie a virus Ebola de l'Ouganda

Plan

- Contexte
- Structure et organisation de la préparation
- Objectifs
- Résultats

Contexte

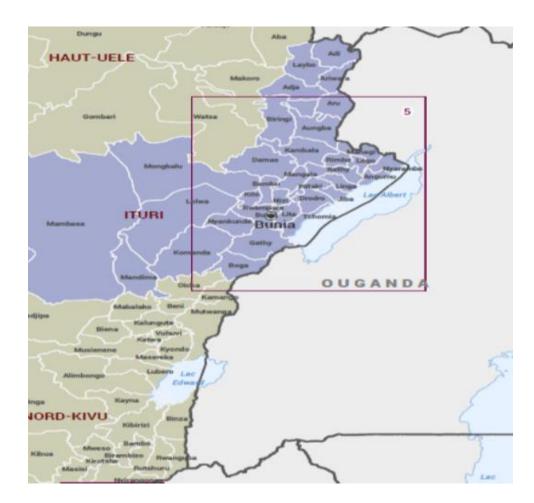
- 15 épidémies de la MVE en environ 46 ans depuis 1976
- 10ème épidémie fut la plus longue et la plus meurtrière en terme de nombre de décès.
- Plus de 1500 survivants pour la plus par sont entrain de fini leur suivi mais avec plusieurs questionnement autours de la rechute.
- Déclaration de l'épidémie de la maladie à virus Ebola le 20 septembre 2022 par le ministère de la Santé de la République de l'Ouganda
- Coexistence des activités de renforcement de la surveillance post 15^{ème} MVE dans la province du Nord Kivu/ Beni et ses environs
- Mobilité des communautés (commerce...)

Contexte

- Bonnes pratiques tirées de la gestion des Urgences avec les RIA et RAA (MVE, Covid-19 et Méningite)
- Elaboration en cours du **plan national multirisque** pour les USP pour une meilleure gestion des urgence afin de réduire la morbidité et mortalité
- Mise en place d'un INSP avec un COUSP pour l'amélioration de la détection et la réponse

Structure et organisation de la préparation

- Sous le leadership de l'INSP et le COUSP en gestation en mode 'alerte'
- 3 DPS et 27 ZS impliquées dans la préparation:
 - 2 DPS, 26 zones de santé (ZS) frontalières et 28 points d'entrée avec l'Uganda
 - 14 ZS de la Province de l'Ituri et 10 ZS de la province du Nord Kivu.
 - 1 DPS, 1ZS et l'aéroport international de Ndjili de Kinshasa



Objectif général

• Contribuer à renforcer les capacités de préparation opérationnelle dans les provinces à risques de transmission de la maladie à virus Ebola en République démocratique du Congo et les pays limitrophes.

Objectifs spécifiques

- 1. Mettre en place la coordination opérationnelle de préparation en RDC face au risque d'expansion de l'épidémie de MVE;
- 2. Renforcer la surveillance épidémiologique (aux PoE) face au risque d'expansion de l'épidémie de MVE
- 3. Améliorer la **prise en charge des cas dans les 27 zones de santé** à risque élevé (14 ZS de la province de l'Ituri, 13 ZS de la province du Nord Kivu, province Kinshasa) d'expansion de l'épidémie de MVE à Mubende en Uganda;
- 4. Renforcer la **prévention de la MVE dans les 24 zones de santé a risque** (les 14 ZS de la Province de l'Ituri et 13 ZS de la province du Nord Kivu) face au risque d'expansion de l'épidémie de de MVE de Mubende en Uganda ;
- 5. Améliorer la logistique avec le **Repositionnement des intrants**
- 6. Améliorer les capacités du système social y compris le système de santé face au risque élevé d'expansion de la MVE à partir de Mubende en Uganda ;
- 7. Mettre en **place une communication des risques** dans les 3 provinces d'Ituri, Nord Kivu et Kinshasa en rapport avec l'épidémie de MUBENDE

Resultats (1/2)

Coordination

- Mise en place d'une coordination nationale pour la preparation de 3 provinces, y compris 28 PoE frontalieres a l'Uganda (COUSP en alerte)
- Elaboration d'un plan de preparation des 3 DPS
- Mobilisation des ressources (Gouvernement et PTF)
- Evaluation des capacités des 27 Zones de santé

Surveillance

- Gestion des alertes (detection, isolement, diagnostic...)
- Mesures de renforcement de la surveillance au PoE
- Maintenir la capacité de Réponse avec les équipes d'Intervention Rapide (EIR)
- Recherche active des alertes
 - Dans les Etablissement des soins et la communautés (SBC)
- Renforcement des capacities des prestataires en SIMR3, Gestion des Urgences, EIR...

Resultats (2/2)

Laboratoire	 Approvisionnement en intrants (Goma, Bunia et Kinshasa)
Communication des risques et engagement social	 Revision des message et supports en rapport avec la preparation MVE
Prise en charge Médicale	 Pré-positionnement des kits PCI-WASH dans les 27 ZS et aux 28 PoE Dotation des kits de prélèvement Construction des Isolements Normés en durable.

Recommandations

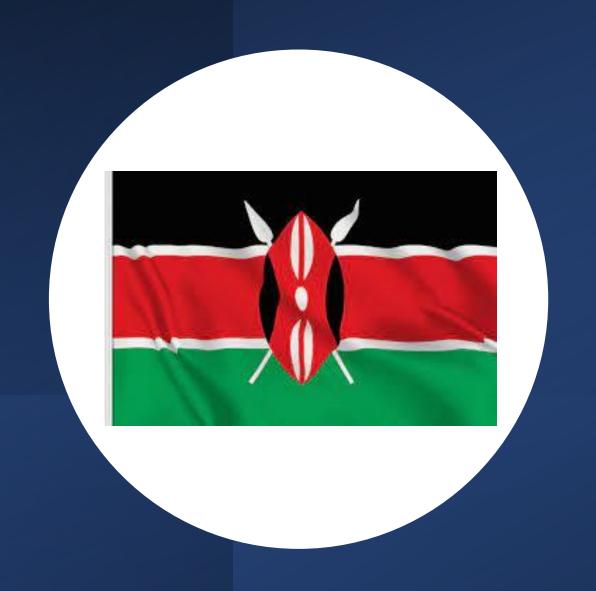
Court terme	 Mettre en place un cadre d'echanges et partage des informations strategiques sur la securite sanitaire, Partager quotidienement en temps reel les données de surveillance épidemiologique de la MVE (Sitrep) et la liste des contacts non vus entre les deux pays Ameliorer d'avantage les investigations autour des cas confirmés Partage d'experience et soutien entre les deux pays
Moyen et long terme	 Partager mensuellement les données des flambées, épidemies et catastrophes entre les deux pays y compris les données de suivi des guerris MVE Initier des actions synergiques dans le domaine de la securité sanitaire

Merci pour votre attention

Ebola Viral Disease (EVD) Preparedness, Kenya, October 12th, 2022

Dr. Patrick Amoth, EBS

Director General for Health



Uganda EVD Situation Update

- Uganda declared an outbreak of EVD on September 20, 2022 due to Ebola Sudan strain
- As of October 11th 2022, 12 alerts have been investigated all have so far tested negative had been reported:
- Alerts have been reported in the following districts:
 - Nairobi
 - Kiambu
 - Mombasa
 - Homabay
 - Kakamega
 - Busia

- Bungoma
- West Pokot
- Trans Nzoia
- Nakuru

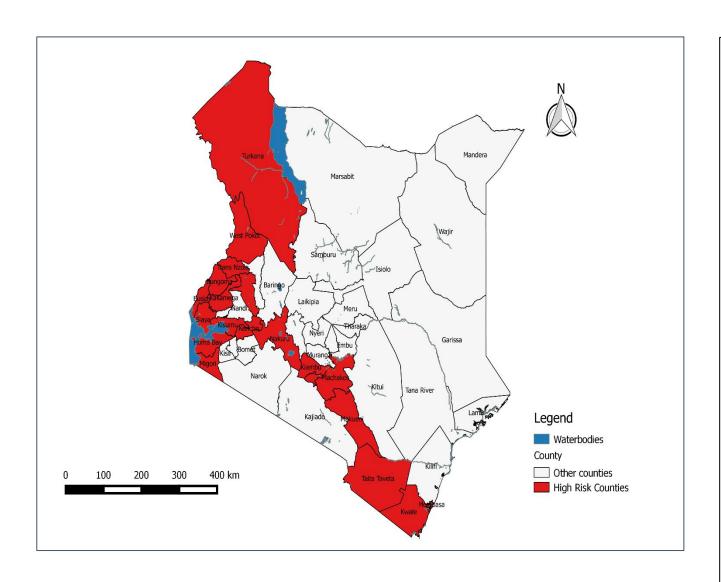
Country Preparedness Measures 1/3

- The MoH issued an EVD Alert on September 21, 2022, with the following Priority actions:
 - Enhanced surveillance and Screening at the PoEs
 - 58,242 travelers screened as of October 4, 2022
 - National PHEOC and County EOCs on Alert mode
 - Activation of National, County and sub county Rapid Response Teams (RRTs).
 - Initiated Health care worker sensitization on:
 - Infection Prevention Control (IPC)
 - Case management
 - Sample management
 - Key EVD messages have been developed
 - National EVD Response task force activated All Government approach

Country Preparedness Measures 2/3

- Shared working case definition with counties to facilitate early detection of suspected cases
- Mapping of relevant stakeholders to support prevention, preparedness and response measures
- The Incident management Team (IMT) structure has been established and activated
- Rapid Risk Assessment identified 20 high-risk counties
- EVD preparedness and response plan developed
 - Will run for six months
 - To be revised based on evolution of EVD outbreak

High risk counties



List of counties

1. Busia

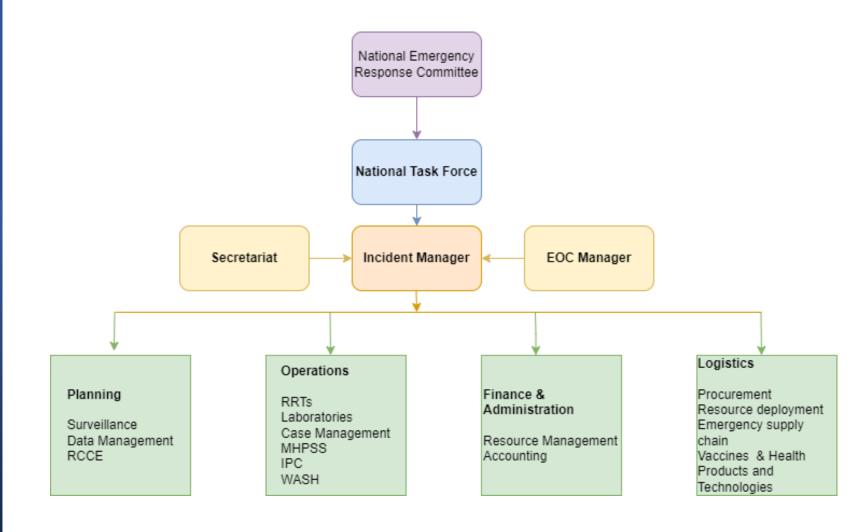
20. Uasin Gishu

- 2. Nakuru
- 3. Kiambu
- 4. Nairobi
- 5. Machakos
- 6. Makueni
- 7. Taita taveta
- 8. Mombasa
- 9. Kwale
- 10. Kericho
- 11. Bungoma
- 12. Kakamega
- 13. Siaya
- 14. Migori
- 15. Homa Bay
- 16. Kisumu
- 17. Trans Nzoia
- 18. West Pokot
- 19. Turkana

Country Preparedness Measures 3/3

- Resource mobilization ongoing
- Daily national technical meetings
 - Situational awareness
 - Development of relevant guidelines, protocols and SOPs
- Identified and designated testing laboratories:
 - KEMRI labs
 - CDC labs
 - More labs to be designated for EVD testing
- Training Materials for National and county Teams developed
- Counties are developing preparedness and response plans
- EVD data management tools developed

EVD Incident Management System (IMS) Structure



Preparedness And Response sub-committees

- Coordination
- Surveillance
- Rapid Response
- Case Management/IPC/WASH/Mental Health & Psychosocial Support
- Laboratory
- Risk Communication and Community Engagement (RCCE)
- Vaccination
- Medical anthropology
- Information Management System (IMS)
- Logistics

Priority Actions 1/2

- Coordination
 - Resource mobilization
 - Monitoring of preparedness and response activities

Surveillance

- Rapid Needs Assessment
- Enhanced screening at the PoEs

Case management

- Health care worker trainings on:
 - Case management
 - IPC
 - Active case search and contact tracing
 - Dignified burials
- Procurement and distribution of PPEs
- Designate adequate national and county isolation and quarantine facilities

Priority Actions 2/2

Rapid Response

- Capacity building of National and County RRTs
- National Simulation Exercise (SIMEX) to test preparedness and response plan

Risk communication and Community Engagement (RCCE)

- TV and Radio Key messages
- Training of community mobilizers Nyumba kumi initiative
- NGAO

Laboratory

- Counties working to designate more testing laboratories
- Procurement of laboratory reagents

Information Management System

Digitization of EVD data management tools

POE Activities

- Temperature screening, symptom and travel history screening
- Surveillance form digitization ongoing Jitenge platform develop during COVID-19
- Data sharing ongoing including sequencing data shared by UVRI
- Holding rooms at all high risk POEs Malaba, Busia and JKIA
- Isolation facilities established in high risk counties piggyback on COVID-19 infrastructure
- Travel advisory to public to avoid unnecessary cross-border movement

Challenges

- Resource mobilization
- EVD specific PPE procurement turn around time
- HRH

STOP EBOLA







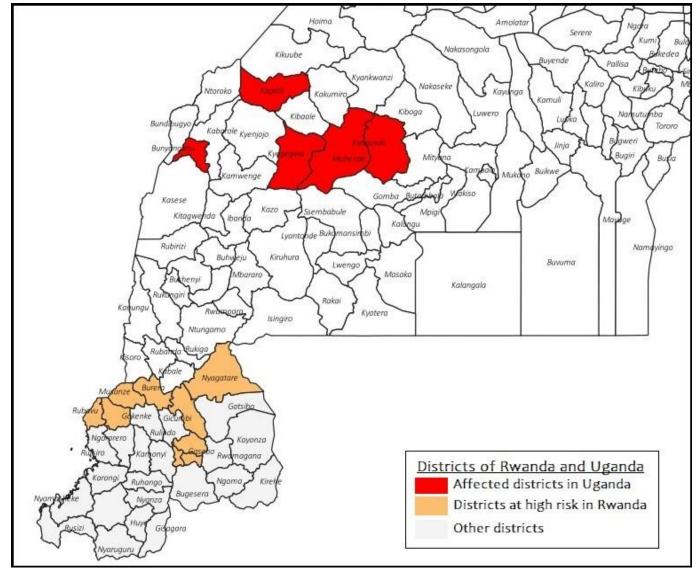
UPDATES ON EVD PREPAREDNESS IN RWANDA

Dr Tharcisse Mpunga

Minister of State MOH



Geographical Location and risk category:- Rwanda

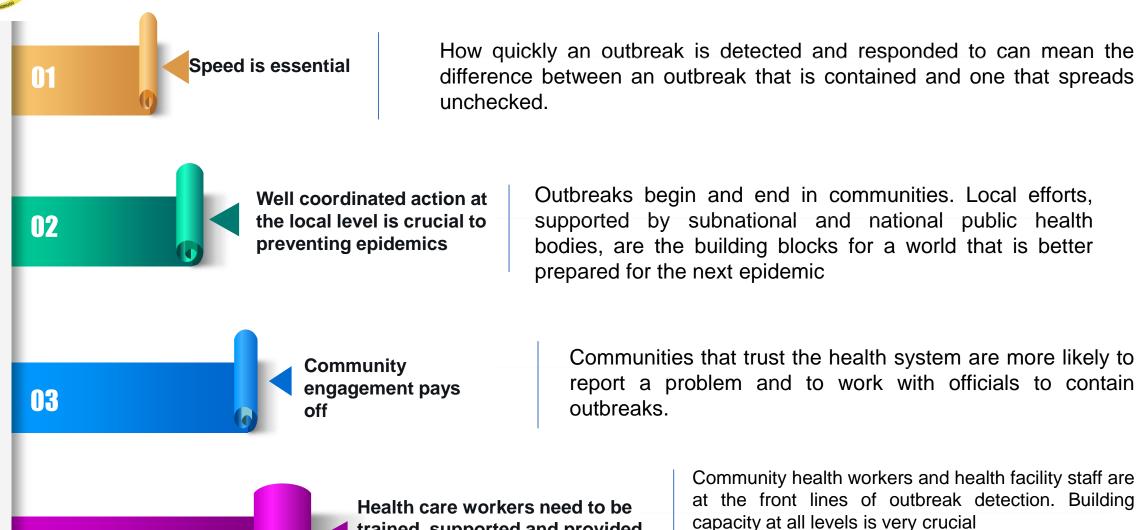


- o **No case has ever** been identified in Rwanda
- Affected districts in Uganda (5): Mubende, Kyegyegwa, Kassanda, Kagadi, Bunyangabu
- Districts at high risk in Rwanda: **Nyagatare**, **Gicumbi**, **Burera**, **Musanze**, **Nyabihu** and **Rubavu**
- Population movement placed Rwanda among high-risk countries category 1 (WHO)



04

Country's Principles for consistent preparation and acting decisively



trained, supported and provided

with access to resources and assistance to stop epidemics

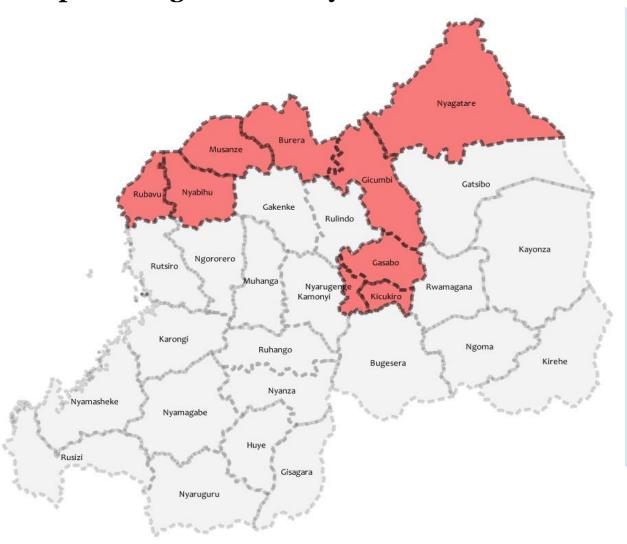


COUNTRY READNESS



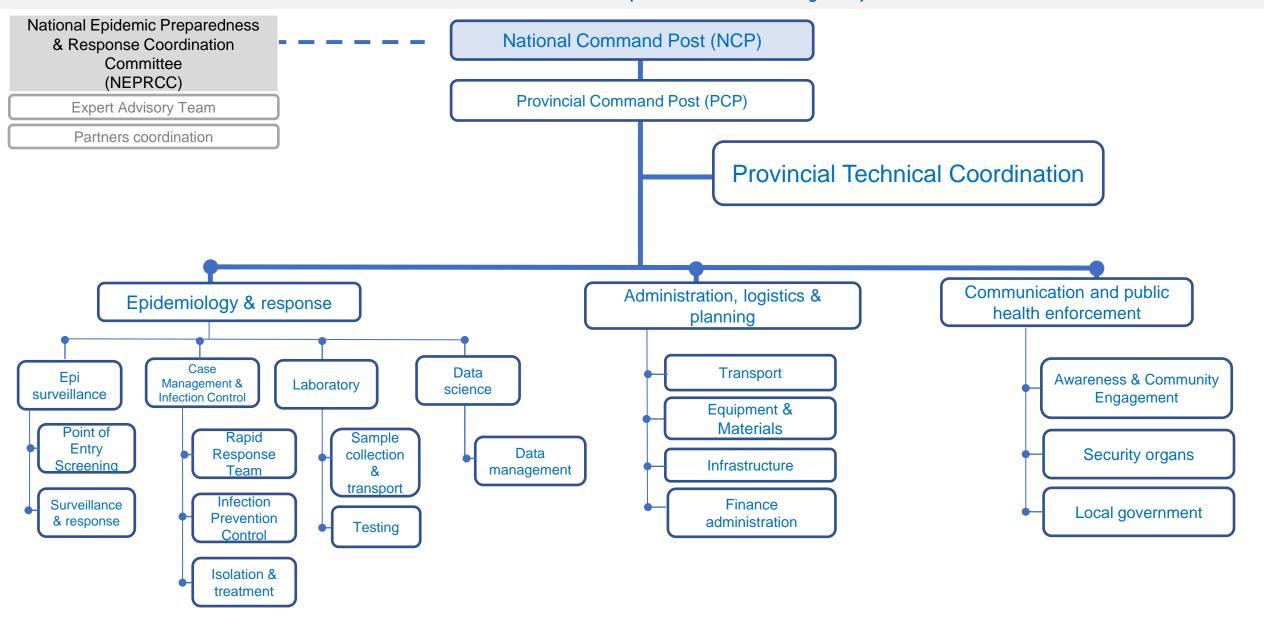
Strategies in place to identify, isolate and investigate suspect within 24hrs

Map showing EVD Risk by District



- Activate all command post in all districts
- Strengthening surveillance through
 - Temperature screening in all POEs
 - Map all people upon entry coming from affected districts to be quarantined for 21 days
 - Community screening for people with symptoms by
 CHWs
- Investigate and follow up of cases with unexplained fever who consulted health facilities
- Awareness to both community and health care workers
- Decentralization of EVD testing hubs

EVD Coordination Structure (Decentralized and Integrated)



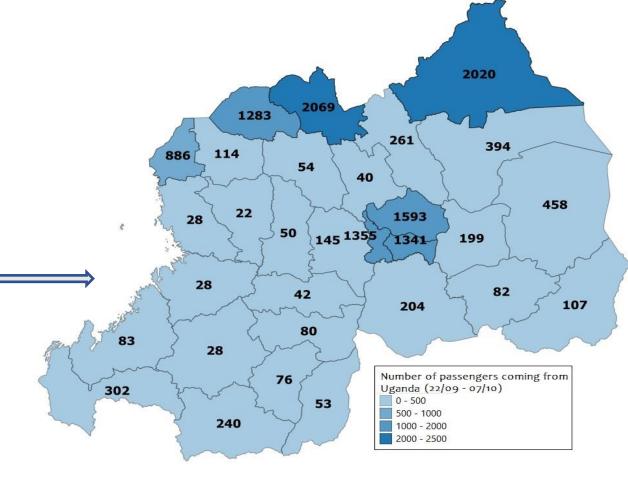
Strategies in place – POE

Population movement for travelers coming from Uganda in Rwanda



		97	7					
742	844 811	883	893 907	840	749 74	49 758	873 776	773 ₇₄ 8
								Ш

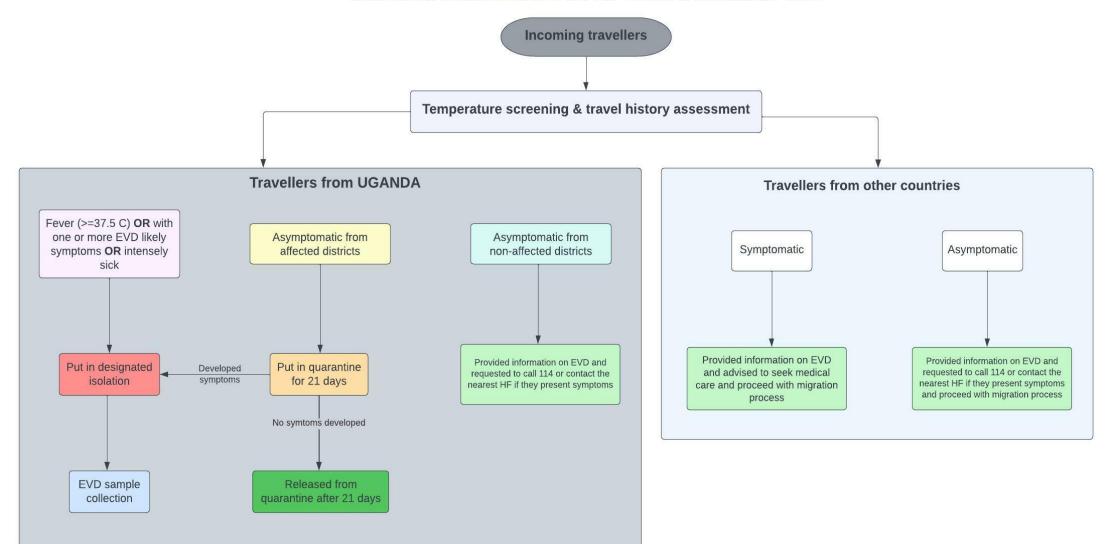
Quarantine sites	Nyagatare HC and Kabare QS	Nkumba Burera	Gihembe Gicumbi
Total in quarantine			
(250)	122	86	42





Strategies in place - POE

SCREENING ALGORITHM AT POINT OF ENTRIES IN RWANDA - 2022





Establishing EVD testing hubs- Rwanda

Preparing incase of outbreak to contain the spread



- Current maximum testing capacity: 48 samples/24hrs with shift of 6 staff at NRL
- 24hrs Activation of other 3 sites (Rwamagana, Gihundwe,
 Musanze) will increase testing capacity to a total Capacity:84
 samples/24hrs (12 samples/24hrs shift in 3 testing sites) if
 case identified
- Currently only NRL test for EVD since no case
- 12 Testing kits available (each 96 samples)>>To test 1152 where: and additional kits in pipeline
- 42 samples tested as of today who met eligibility criteria (unexplained fever with travel history)- **All tested negative**



Ongoing Simulation exercises (Case Management, IPC and surveillance)

Assessing/testing the system







Ongoing SIMEX (Case Management, IPC and surveillance)

Assessing/testing the system to manage case at decentralized level





- Leveraging on C19 resources for EVD (Coverall PPE: Total:210,000 in store)
- All 53 hospitals and 518 health centers done table top exercise
- 30 hospitals already done SIMEX

Gaps identified

- Need for more IPC training to all staff
- IPC Materials to be kept in every service and be used incase of emergency (Maternity, pediatrics..)

Plan for next steps | 4th-15th Oct

- Simulation exercise to continue in other districts (5 teams to conduct drills in 15 hospitals)
- Follow up with DG to bridge the gap and conduct weekly Simulation exercises
- Plan for SIMEX at POE including KIA



Rwanda Pre Epidemic Alert System (EVD outbreak in Uganda)

Indicators Threshold must be met to trigger change in alert level	Level 1: New Normal	Level 2: Low Alert	Level 3: Moderate Alert	Level 4: High Alert
Average daily population movement to/from affected districts-Community transmission (Not bordering Rwanda)	0	1-30	≥30–50	>50
Affected districts (Community transmission) is bordering Rwanda	-	-	-	Yes
Quarantining of Contacts Proportion of new contacts under follow up in past 24hrs	>90	80-90%	60-80%	<60
Case Incidence New cases during past 7-days/100,000 persons	<1	1–3	≥3–5	≥5
At least one Imported confirmed case to Rwanda	-	-	-	Yes

Indicators, Triggers, and Thresholds for and Alert System

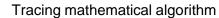


Best buys:- Leveraging from C19

Several public health measures initiated early:

- Community engagement pays off
- Public health measures (Temperature screening in public places)
- Widespread testing
- Leverage innovation









Call for More Collaborative Actions

- I. The need to do screening for temperature and Symptoms at POE in Uganda before crossing/boarding to Rwanda.
- II. Setting up information exchange framework both among technical teams and policy makers to enable quick interventions and mitigate further the spread in the region.
- III.Use of Passenger Locator Forms for passengers coming from Uganda to ease tracing
- IV.Limit movements from affected regions for symptomatic patients (Mubende)
- V. Sharing regular updates on EVD situation without delay(Daily)
- VI.Establish quarantine sites at POE in both sides for close contacts.
- VII. The need for field training of frontliners from bordering non affected countries



THANK YOU



SOUTH SUDAN EVD OPERATIONAL READINESS UPDATE



PRESENTED BY:

YOLANDA AWEL DENG JUACH

MINISTER

MINISTRY FOR HEALTH

REPUBLIC OF SOUTH SUDAN

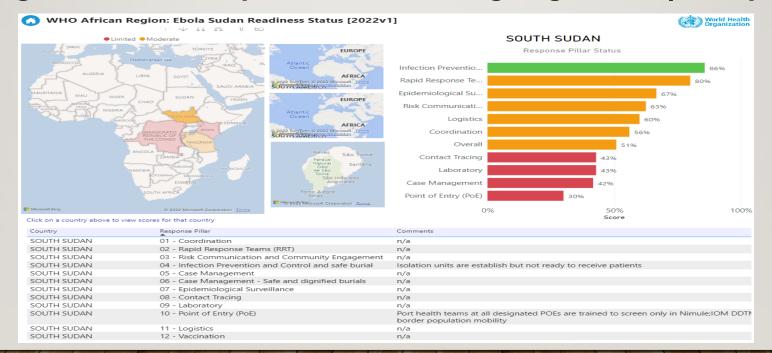
BACKGROUND

- On 20 September 2022, Uganda declared an outbreak of Ebola virus disease (EVD) caused by the Sudan strain,
- Following the official declaration, the Ministry of Health convene an immediate meeting and Ebola Virus Disease pillars were reactivated,
- A several teams were sent to borders to do assessment of the situation at the key crossing points,
- While the Northern and Eastern Regions of Uganda remain unaffected by EVD, an outbreak of Crimean Congo Hemorrhagic Fever (CCHF) has been confirmed in the Amuru district of Northern Uganda,
 - Amuru District has a border with Magwi County where Nimule border town (South Sudan) is very close to Elegu (border town on Uganda side), a major economical crossing point between the two Countries (Over 3,000+ people officially cross daily)

CHECKLIST SCORES FOR OPERATIONAL READINESS

National EVD readiness indicates a few pillar need urgent strengthening

PoE, case management, laboratory and contact tracing targeted for priority actions:



PUBLIC HEALTH COORDINATION

finalized and signed,

- The PHEOC (Public Health Emergency Operation Center) is activated with EVD pillars meeting at least once a week and NSC (National Steering Committee) meeting bringing all pillar leads and co-leads together with stakeholders, partners and implementing partners once a week,
- The President of the Republic of South Sudan, formed EVD High Level Taskforce to help with readiness and coordination,
- Structured template is used for operationalizing the outcomes of pillar meetings,
- There is a 72hrs plan costed at just under 3 million US\$ has been

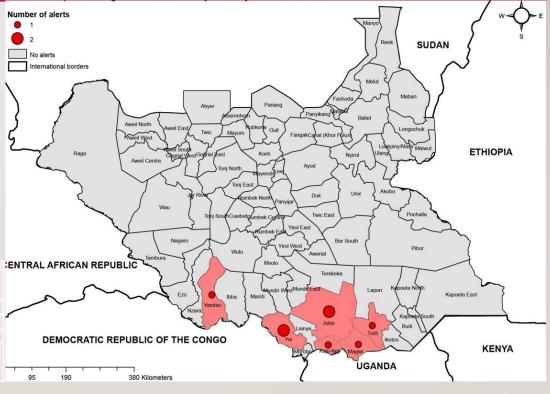
PUBLIC HEALTH COORDINATION (2)

- The National EVD preparedness and Response plan costed at USD 31.3 million has been reviewed. The government has demonstrated commitment by immediately making available USD 500,000 (funding gap \$30.8m) and partners have pledged to support implementation
- Sub-national taskforces at border areas of Nimule and Yei activated and meeting regularly
- ToRs for EVD task force and for subnational operational readiness strengthening have been updated and developed respectively, with team deployed.

SURVEILLANCE AND LAB UPDATES

- NPHL in Juba currently has EVD primers and probes capable of detecting filovirus strains (Marburg virus, Zaire EBV, Bundibugyo EBV, Sudan EBV) courtesy of EAC Mobile Lab
- A total of 8 alerts reported so far:
 - ✓ 2 from Yei (1 discarded and 1 investigated=negative)
 - √ 1 from Nimule-Investigated= negative
 - √ 1 from Yambio =negative
 - √ 2 from Juba (1 discarded and 1 investigated=negative)
 - √ 1 from Kajokeji and it was discarded
 - √ 1 from Torit and it was discarded.

No	Date of Sample Collection	Initials	Age	Gender	Location	State	Specimen	Lab	Result
1	26/09/2022	S. A	48	M	Yambio	WES	Blood	NICD	Negative
2	28/09/2022	D. P	5	F	Yei	CES	Blood	URVI	Negative
3	29/09/2022	B. M	45	M	Adjumani	CES	Blood	NICD	Negative
4	04/10/2022	O B	25	м	Juba Gumbo Shrikat	CES	Dland	NIBLII	Nazativa
	06/10/2022	O. R	35	M	Shrikat	CES	Blood	NPHL	Negativ



LAB CAPACITIES RAPIDLY ENHANCED

 With the support of the EAC, Africa CDC, WHO and other partners, the existing capacity has been leveraged to enable scale up and onsite conduct of screening and confirmatory testing for filovirus at Nimule POE, however, a few of the borders nearing countries with outbreaks do not have adequate screening and testing capacity/facilities



CASE MANAGEMENT

Case management; infection, prevention and control (IPC); surveillance and risk communication and community engagement (RCCE):

- The government has engaged a contractor to immediately complete the designated IDU with some support from WHO
- Refresher training on case management conducted for identified healthcare workers in all at-risk areas and have been deployed to the IDUs and holding facilities in all at risk areas



CROSS-BORDER COLLABORATION

- The border authorities at the busiest point of crossing between Uganda and South Sudan (Nimule) have leveraged and improved existing formal and informal collaboration in the wake of the emergency,
- Uganda and South Sudan are collaborating on some public health matters: For example:
 - We sometimes send samples to Uganda Virus Research Institute from the facilities closer to Uganda despites, their Country dealing with their own load:
 - However, the mechanisms (In terms of relationship between Public Health in South Sudan and the Institute in Uganda) needs to be formalized to adequately function.

CHALLENGES AND OPPORTUNITIES FOR IMPROVEMENT

- Inadequate screening activities at the major points of entry (Nimule, Kaya, Kajo-Keji, Yambio etc): as well as worn out/lack of EVD isolation facilities,
- Inadequate reagents to test for EVD in case of increased sample load and lack of reagents to rule out other VHF (viral hemorrhagic fever) pathogens
- Inadequate PPEs for most of the high risk border facilities as reflected in the readiness assessment conducted immediately after the declaration of the outbreak in Uganda
- Limited cross-border collaboration and the need to strengthen information sharing
- Limited emergency management capacity at sub-national level

SHUKRAN

ASANTINI

THAN YOU VERY MUCH

EVD PREVENTION AND PREPAREDNESS IN TANZANIA

Dkt Aifello Wedson Sichalwe

Chief Medical Officer

12/October/2022

Why EVD Preparedness in Tanzania

- Ebola outbreak in Uganda on 20th September 2022
- Quarantine escaped Contacts among them some are presumably to be positive
- In DRC there was also an EVD case reported in June 2022
- It is a zoonotic disease and spreads in the human population through human-to-human transmission.

All these Two countries borders with Tanzania

Economic activities going on between these countries

- Assessment of country preparedness and response in key areas such as;
 - ORapid Response Teams (RRTs) at all levels;
 - OStratifying regions at high, moderate and low risk
 - ORisk Communication and Community Engagement (RCCE);
 - OInfection Prevention and Control (IPC); Contact Tracing; Case Management;
 - OLaboratory; Burial Teams;
 - OPort of Entries; Logistics;
 - OCoordination; Research and Vaccine pillars.

- Conducting PPE need assessment
 - ✓ Redestribution of available EVD complete PPE set (500) to Kagera.
 - ✓ Procure and distributed other 4,000 sets to high risk region
 - ✓ Test kits for Ebola Sudan
- Conduct virtual and physical refresher training in regions on;
 - ✓ Travellers' health screening and response
 - ✓ Surveillance and contact tracing teams
 - ✓ Case management and IPC; and
 - ✓ Collection, storage and trasportation of EVD samples

- Mobile laboratory has been sent to Kagera to facilitate EVD sample testing within the region to minimize TAT
- National guidelines and other relevant documents (SOPs, Checklist, line list etc) were prepared and distributed, such as;
 - 0 1PC,
 - OEbola health education,
 - OEbola education and information communication (E1C) materials,
 - OEbola frequent asked questions

Deploying 20 staff to border posts with migration and police officers.

OFor instance, Bugango border etc

Planning of having X-border meeting

Involvement of key sectors and partners in preparedness

- Instructed regions to do
 - O Self assessment (preparedness and response)
 - O Prepare Contigency plans
 - O Activate and prepare rapid response team, treatment and holding centres,
 - O Strengthening the surveillance and reporting of alerts,
- Travellers' health screening has been strenghthened and holding facilities identified in 25 borders including
 - OMtukula (Tanzania Misenyi and Uganda),
 - OMurongo (Tanzania Kyerwa and Uganda),
 - ORusumo (Tanzania Ngara and Rwanda), Kabanga, KIA, JNIA, Namanga etc.

- We developed plans (Ebola contingency and 72 hours response plan)
- The **purpose** of this National EVD Contingency Plan is to provide a **guide for coordinated public health mitigation, preparedness and response measures** for EVD epidemic in Tanzania.
- Actions to be taken during the <u>first 72 hours</u> are not costed separately and are part of the National EVD Contingency Plan.
- The purpose of this scenario-based 72hrs Contingency Plan is to ensure that **rapid, prioritized and evidence-based response** activities are undertaken to contain the **possible spread of an outbreak**.
- It is triggered by a laboratory test result of a confirmed case

?Known

- Experience has shown that once declared, the <u>duration and magnitude</u> of the outbreak depend on the level of preparedness, strength of the health system, economic status, <u>level of community awareness</u>.
- The risk of the disease spreading beyond the borders of the DRC was assessed by WHO's 1HR Emergency Committee on 17th October 2018 and it was concluded as very high at the regional level
- Exposure to the disease in border regions and other parts of the country is increased by the fact that,
 - OThere is a likely community transmission of EVD in Uganda as there is a report of deaths due to unknown disease in the community which happened in a duration of more than 2 weeks prior to the confirmation of EVD case.

Challenges to detect, respond and to contain EVD in the country

- a) The sensitivity of the surveillance system to detect all suspected EVD cases remain moderate.
 - OEvent Based Surveillance in the country especially to the high risk regions
- b) Low/ moderate capacity of national and regional Rapid Response because of
 - Training on EVD was done 4 years ago to only 8 regions.
 - Lack of experience to manage EVD outbreak in Tanzania
- c) Utilization of Infection prevention and control practices among frontline HCWs poor private HFs and drugs outlets

Challenges to detect, respond and to contain EVD in the country

- d) The RCCE capacity vary in different regions due to variations in social cultural practices
- e) Lack of vaccine for preventing the disease, this makes the community especially from identified high risk regions and frontline health care workers more vulnerable
- f) Inadequate funding.
 - O Procure PPE
 - Deployment of Staff (Knowledge & Incentives)
 - O Developing and distributing the IEC Materials and the SOPs

?What do we have in hand

- Infrastructures and strategies which were put in place during COVID 19 response are being adjusted to address EVD
- One Language spoken throughout the country;
- Availability of local radios, TV and social media

Generally; there is an urgent need to increase the level of operational readiness in Tanzania to

<u>handle Ebola outbreak.</u>

Cross border measures

- Intensified screening at Point of Entries (PoE) by;
 - Activation of the emergency Preparedness Plan and measures specifically in Mutukula and Murongo Borders
 - Strengthened traveler screening at POEs and as of 10th October, a total of 3,905
 - Refresher training of POE Health personnel and staffs
 - Strengthened equipment availability eg. Screening tools including thermos scanners
 - Updated surveillance forms to incorporate Ebola

Cross border measures

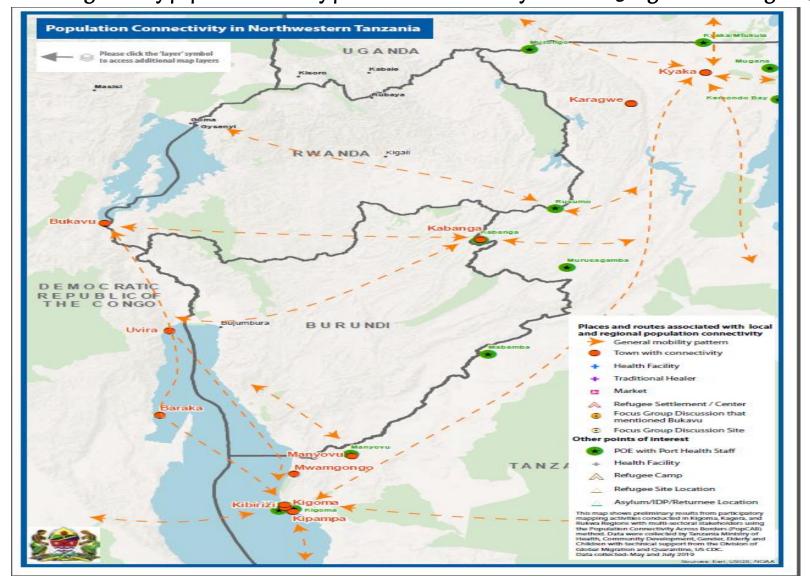
- Strengthen Indicator Based Surveillance at all levels including
 - Training surveillance officers and health care workers on the SCD of EVD and Contact tracing
- Strengthening Event Based Surveillance to enhance early detection through
 - Training CHCW's on the basic symptoms of EBV, they have been provided with a cell phone to communicate in case of any event
 - Training local leaders (ward, street, village leaders) on the presentation and modality of reporting Training of the Motorcycle drivers (Boda Boda) since this is the type of transport used by the majority
 - Sharing a toll-free number for reporting any event identified in the Community

Cross border measures

- •Strengthening health education through using various means Media, leaflets, physical training to ensure a message reach to every community member. To date a total of 3 press releases have been provided
- Involvement of political leaders, influential leaders and religious and local leaders in Ebola interventions

Case Scenario: Kagera

Map of Tanzania Showing Country population mobility pattern and connectivity across the 3-high risk EVD regions, Tanzania.



Case Scenario: Kagera

- High interaction due to
 - O Public transport by bus between Tanzania and Uganda. There are a total of four trips in a week to various destinations particularly Mwanza, Dar es salaam and Mbeya, some connect to Burundi
 - OCargo truck from Mutukula to Mubende in Uganda transporting maize, cassava and banana. Mubende is a large market for cassava, maize and banana for DRC, Southern Sudan, Tanzania and Uganda
 - OAvailability of big **markets** along borders four days in a week which bring together a big population of Tanzania and Uganda.

Case Scenario: Kagera

OSharing of social places/events like worship, markets, health facilities, schools between

Tanzanian and Ugandan

OAvailability of porous borders

On going activities

- 1. Strengthening of traveler's health screening at all borders
- 2. Conduct PHC meeting at all levels for **sensitization and awareness creation**
- 3. Make a press conference on Ebola in Kagera and National at large to increase awareness and prevention measures against Ebola
- 4. To increase **porous border** control through regular patrol by involving security officers
- 5. Continue with border surveillance data analysis for early detection of an increase of Ebola suspects
- 6. Strengthening hand washing using sanitizer and/or water and soap

Thank you for your attention



Framework to Coordinate Ebola Virus Disease Outbreaks and other Public Emergencies Preparedness and Response in At-Risk Member States

Dr Salam Gueye, WHO AFRO Regional Emergency Director
Ebola Ministerial Meeting
12 October 2022, Kampala, Uganda







Background

- In recognition of a shared threat to the health and economic security of the people of the sub-region, ten Member States, with support from the African Union and WHO, developed a collaborative framework, in October 2019, to enhance preparedness for EVD at border crossings and within their respective national boundaries.
 - Burundi, Central Africa Republic (CAR), Democratic Republic of Congo (DRC),
 Republic of Congo, Rwanda, South Sudan, Uganda, Tanzania and Zambia

Purpose of the Framework

 To facilitate cooperation to ensure effective collaboration between the Parties for implementing a comprehensive and coordinated sub-regional approach for responding to possible cross-border EVD transmission and other public health emergencies.

Duration of Framework: Five years (2019-2024)

Agreed Areas of Cooperation, Goma, October 2019

- i. Coordination: Strengthening cross-border activities; joint planning for EVD and other public health emergencies preparedness and response; review of legal and regulatory processes for rapid cross-border deployment.
- ii. Human resources: Jointly build workforce capacity through training, exchange learning and benchmarking visits and simulation exercises.
- iii.Information sharing: Prompt and transparent communication on EVD and other public health emergencies situation in accordance with the International Health Regulations IHR (2005).
- iv. Risk communication and community engagement: develop/adapt and share common key messages on disease outbreak.

Cooperation Approach, 2019

- 1. Establishment of the Africa Emergency Coordination Task Force (AfECT), under the leadership of the 10 Member States, with support from Africa CDC, WHO and other relevant partners.
- 2. Reinforcing national preparedness and response capacity.
- Coordinated deployment of national and other partner assets for cross-border preparedness and response.
- **4. Coordinated implementation of activities** supporting national, cross-border, sub-regional and regional preparedness and response.
- **5. Coordinated utilization** of national, inter-country, inter-regional and regional surveillance networks as the operational basis for AfECT activities.

Progress in Implementation of 2019 Framework

- Overall partial implementation of the Framework
 - Whereas the Africa Emergency Coordination Task Force (AfECT), was not established, there was some effort made in the other areas of collaboration, particularly during the COVID pandemic
 - Some investments were made in reinforcing preparedness and response capacity in the countries e.g. points of entry screening and cross border reporting/ sharing of information
 - Cross border deployment of HR for capacity building was done from Rwanda to DRC during the 2019-2020 Ebola outbreak
 - Cross-border simulation exercises conducted between Tanzania and Kenya
 - Coordinated information sharing and laboratory testing during COVID-19 pandemic e.g. cross border respect of laboratory results for COVID-19
- Lack of systematic mechanism for monitoring implementation of the framework

Proposed Amendments for Consideration

Coordination:

- Consider a more operational and practical coordination modality at all levels:
 - i. Local: establish Cross border Committees
 - ii. National: establish a link between the Heads of National Preparedness & Response Departments (or relevant body) with the counterparts in all the countries
 - **Sub regional:** create a platform that that links the Focal Points in each country to share information and monitor the collaborative areas quarterly or more frequently during an emergency
- Develop a joint action plan with indicators to monitor implementation, with oversight from WHO and Africa CDC.

Human Resources:

 Facilitate sharing of expertise between countries during an emergency to further build capacity to respond to future emergencies

Information Sharing:

Create a contact list on a feasible platform and share information among countries as they
occur in real-time.

Conclusion

- Cross border collaboration remains important for effective preparedness and response to public health emergencies
- Need to review and build on the existing framework to enhance collaboration.
- Need for reflection and adjustment of an optimal mechanism for implementation and monitoring of the agreed areas of collaboration
- The Ministerial Meeting provides an opportunity to further refine the collaboration for effective preparedness and containment of outbreaks

Draft Communique for Comments









High-Level Emergency Ministerial Meeting on Cross Border Collaboration for Preparedness and Response to Ebola Virus Disease

NEXT STEPS

Wednesday 12th October 2022 Kampala, Republic of Uganda

Next Steps

- 1. Establish the Africa Ebola Coordination Taskforce (AfECT), among at-risk Member States to facilitate strengthening of preparedness and response capabilities in order to mitigate the impact of EVD in Africa and beyond (within 2 weeks- end of October 2022)
- 2. Finalize a **Framework Document for Collaboration and Coordination** on Cross-border health emergency events, including EVD with inputs from Member States (within 4 weeks-mid-November 2022)
- 3. Agree on **joint resource mobilization** and integrated use of resources, assets and capacities in the region to better prepare for and respond to health emergencies
- 4. Virtual follow up call of Ministers on the agreed action points (in 4-6 weeks- last week of November 2022)









Next Steps

	Tasks	Lead	Support	Due-Date
1	Establish the Africa Ebola Coordination Taskforce (AfECT), among at-risk Member States to facilitate strengthening of preparedness and response capabilities in order to mitigate the impact of EVD in Africa and beyond - (within 2 weeks- end of October 2022)	MoH - Uganda	Africa CDC/ WHO/ partners	31 Oct. 2022
2	Finalize a Framework Document for Collaboration and Coordination on Cross-border health emergency events, including EVD with inputs from Member States (within 4 weeks-mid-November 2022)	Africa CDC/ WHO	All MS	15 Nov. 2022
3	Agree on joint resource mobilization and integrated use of resources, assets and capacities in the region to better prepare for and respond to health emergencies	All MS	Africa CDC/ WHO/ partners	-
4	Virtual follow up call of Ministers on the agreed action points (in 4-6 weeks- last week of November 2022)	MOH-Uganda	Africa CDC/ WHO/ partners	30 Nov. 2022









Thank You







