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
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

<table>
<thead>
<tr>
<th>District</th>
<th>Year</th>
<th>Cases</th>
<th>Deaths</th>
<th>Case fatality ratio (%)</th>
<th>Strain</th>
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<tr>
<td>Gulu</td>
<td>2000</td>
<td>425</td>
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<td>Bundibugyo</td>
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<td>2011</td>
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<td>1</td>
<td>100</td>
<td>Sudan</td>
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<tr>
<td>Kibaale</td>
<td>2012</td>
<td>24</td>
<td>17</td>
<td>71</td>
<td>Sudan</td>
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<tr>
<td>Luweero</td>
<td>2012</td>
<td>7</td>
<td>4</td>
<td>57</td>
<td>Sudan</td>
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<tr>
<td>Kasese</td>
<td>2018</td>
<td>4</td>
<td>4</td>
<td>100</td>
<td>Zaire</td>
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<tr>
<td>Mubende</td>
<td>2022</td>
<td>54*</td>
<td>19**</td>
<td>35**</td>
<td>Sudan</td>
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</tbody>
</table>

**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 of 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

15 Sep 2022
Onset of symptoms

17 Sep 2022
24 yrs old male index case admitted at Mubende RRH

19 Sep 2022
Tested positive, died, and was accorded supervised burial

20 Sep 2022
EVD Outbreak declared

20 Probable deaths occurred in the epicenter of Madudu and Kiruma Sub counties in Mubende. Outbreak appears to have started in August.
• 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: 30\textsuperscript{th} September 2022, and 3\textsuperscript{rd} 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

Legend
- **Road**
- **Category I - Atleast One Confirmed case (Epi center)**
- **Category II - Proximity to the epi center, Presence of a probable case, ease of mobility, and unique characteristics**
- **Category III - Rest of the Country (Moderate risk)**
Temporal distribution of confirmed and probable cases in the subregion (N=74)

- Probable case attended burial of probable case in Madudu, died in Kassanda, husband turned +ve

- Contacts of a probable death from Madudu who participated in nursing and burial preparations

- Case from Madudu operated a clinic and participated in burial of a customer who was a probable case

- Medical intern who was a contact of HWs of Mubende RRH who tested positive

**Distribution by Classification**

- Confirmed
- Probable
## Summary of confirmed cases and deaths by sub-county

<table>
<thead>
<tr>
<th>District</th>
<th>Sub-County</th>
<th>Confirmed Cases</th>
<th>Confirmed Deaths</th>
<th>Date of onset last confirmed case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mubende</td>
<td>Madudu</td>
<td>16</td>
<td>07</td>
<td>4th October 2022</td>
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<tr>
<td></td>
<td>Eastern Division</td>
<td>07</td>
<td>01</td>
<td>26th September 2022</td>
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<td></td>
<td>Southern Division</td>
<td>06</td>
<td>01</td>
<td>9th October 2022</td>
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<td></td>
<td>Bayeza</td>
<td>01</td>
<td>01</td>
<td>29th September 2022</td>
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<tr>
<td></td>
<td>Western Division</td>
<td>02</td>
<td>01</td>
<td>25th September 2022</td>
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<tr>
<td></td>
<td>Kasambya</td>
<td>03</td>
<td>00</td>
<td>17 September 2022</td>
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<td></td>
<td>Kibalinga</td>
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<tr>
<td></td>
<td>Kiruuma</td>
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<td>03</td>
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<td>Kitenga</td>
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</tr>
<tr>
<td></td>
<td>Kiyuni</td>
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<td>Kyegegwa</td>
<td>Kasule</td>
<td>03</td>
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<td>Kalwana</td>
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<td>00</td>
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<tr>
<td>Kagadi</td>
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<td>19th September 2022</td>
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<tr>
<td>Bunyangabu</td>
<td>Rwimi TC</td>
<td>01</td>
<td>00</td>
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</tr>
<tr>
<td>Total</td>
<td></td>
<td>54</td>
<td>19</td>
<td></td>
</tr>
</tbody>
</table>
Distribution of confirmed cases (n=54)
Distribution by Confirmed Cases by Status

No. of cases

Date of onset

Status
- Alive
- Dead

Stacked bars: Interpret bars independently; imputed DOO of 5 cases
Person Characteristic: Age and Sex distribution

Distribution of Confirmed and Probable Cases

Distribution of Confirmed Cases
Distribution of deaths by Age and Gender (n=19)
National and District Task Force activated.
Technical pillars (Surveillance & lab, Case management, IPC, Logistics, Risk Communication and community engagement)
Partner coordination

Alert management and rapid verification
Contact tracing
Case investigation
Active case search
Data management

Ebola Treatment Unit.
Non Ebola Treatment Centre
Community IPC (decontamination and ring IPC) and WASH

Public awareness through radio
Public awareness through print materials
Community engagement/dialogue

Ebola Treatment centre (Mubende)
Ebola Treatment centre (Madudu Health Centre III).
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 optimise 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**

### Alert Management
Data from 23-Sept-22 to 11-10-22

- **Graphs** display the number of calls, evacuations, alerts discarded, and alerts not evacuations over time for different locations.
- Locations include: Bunyangabu, Kagadi, Kakumiro, Kassanda, Kyegegwa, and Mubende.

**Source:** Alert Management Desk, Mubende
Contact Tracing: Percentage Follow Up

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

Source: Contact Tracing Desk
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”

Deductions
1. Transmission events highest in age groups 15-40 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
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 PI’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
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, 2014 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.
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 disproportionally affected by the crisis beyond EVD itself with declines of:

- 43% in antenatal care,
- 38% in institutional deliveries,
- 45% in measles
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).
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 through 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.
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.
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 disciplinary 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
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

Kenya

Tanzania

Legend
- Waterbodies
- County
- Other counties
- High Risk Counties

20/47 counties at risk

11/26 regions at risk
Risk Mapping cont....

A Map of South Sudan from 21.09.2022 To 06.10.2022

- Number of alerts
  - 1
  - 2
- No alerts
- International borders

06/79 Counties at risk

Rwanda

09/30 Districts at risk
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

Overall readiness is 76%. Rwanda would benefit from a simulation exercise to test the relevant competences.

Overall readiness capacity of 34%. Kenya needs urgent action to enhance readiness in several pillars.
South Sudan has moderate capacity at 51%. Urgent action is needed to enhance readiness for potential Ebola response.

Tanzania has moderate capacity at 53%. Urgent action is needed to enhance readiness for potential Ebola response.
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.
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.
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 average of 52% with major gaps noted in case management and POE.

➢ Need to leverage on the gains that we made during the COVID era and invest more in attainment of the minimum readiness capacities.

➢ IDSR remains the main vehicle for the preparedness and operational readiness now.
THANK YOU
Plan de préparation de la RDC face au risque d’expansion de l’épidémie de la maladie à 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 15ème 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 frontalières 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)

<table>
<thead>
<tr>
<th>Laboratoire</th>
<th>• Approvisionnement en intrants (Goma, Bunia et Kinshasa)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication des risques et engagement social</td>
<td>• Revision des message et supports en rapport avec la preparation MVE</td>
</tr>
</tbody>
</table>
| 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’échanges et partage des informations stratégiques sur la sécurité sanitaire,  
|             | • Partager quotidiennement en temps réel les données de surveillance épidémio-logique de la MVE (Sitrep) et la liste des contacts non vus entre les deux pays  
|             | • Améliorer d’avantage les investigations autour des cas confirmés  
|             | • Partage d’expérience et soutien entre les deux pays |

| Moyen et long terme | • Partager mensuellement les données des flambées, épidémies et catastrophes entre les deux pays y compris les données de suivi des guerres MVE  
|                     | • Initier des actions synergiques dans le domaine de la sécurité 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
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

National Emergency Response Committee

National Task Force

Secretariat

Incident Manager

EOC Manager

Planning
- Surveillance
- Data Management
- RCCE

Operations
- RRTs
- Laboratories
- Case Management
- MIHPCS
- IPC
- WASH

Finance & Administration
- Resource Management

Logistics
- Procurement
- Resource deployment
- Emergency supply chain
- Vaccines & Health Products and Technologies
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 developed 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

Thank you!
UPDATES ON EVD PREPAREDNESS IN RWANDA

Dr Tharcisse Mpunga
Minister of State MOH

12/10/2022
Geographical Location and risk category:- Rwanda

- 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)
Country’s Principles for consistent preparation and acting decisively

**01** Speed is essential
How quickly an outbreak is detected and responded to can mean the difference between an outbreak that is contained and one that spreads unchecked.

**02** Well coordinated action at the local level is crucial to preventing epidemics
Outbreaks begin and end in communities. Local efforts, supported by subnational and national public health bodies, are the building blocks for a world that is better prepared for the next epidemic.

**03** Community engagement pays off
Communities that trust the health system are more likely to report a problem and to work with officials to contain outbreaks.

**04** Health care workers need to be trained, supported and provided with access to resources and assistance to stop epidemics
Community health workers and health facility staff are at the front lines of outbreak detection. Building capacity at all levels is very crucial.
COUNTRY READINESS
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)

National Command Post (NCP)

Provincial Command Post (PCP)

Provincial Technical Coordination

Epidemiology & response
- Epi surveillance
- Point of Entry Screening
- Surveillance & response
- Case Management & Infection Control
- Laboratory
- Rapid Response Team
- Infection Prevention Control
- Isolation & treatment
- Sample collection & transport
- Testing
- Data science
- Data management

Administration, logistics & planning
- Transport
- Equipment & Materials
- Infrastructure
- Finance administration

Communication and public health enforcement
- Awareness & Community Engagement
- Security organs
- Local government
Strategies in place – POE
Population movement for travelers coming from Uganda in Rwanda

<table>
<thead>
<tr>
<th>Quarantine sites</th>
<th>Nyagatare HC and Kabare QS</th>
<th>Nkumba</th>
<th>Burera</th>
<th>Gihembe</th>
<th>Gicumbi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total in quarantine (250)</td>
<td>122</td>
<td>86</td>
<td>42</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Passengers from Uganda

Number of passengers coming from Uganda (22/09 - 07/10):
- 0 - 500
- 500 - 1000
- 1000 - 2000
- 2000 - 2500
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
<table>
<thead>
<tr>
<th>Indicators, Triggers, and Thresholds for and Alert System</th>
<th>Level 1: New Normal</th>
<th>Level 2: Low Alert</th>
<th>Level 3: Moderate Alert</th>
<th>Level 4: High Alert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average daily population movement to/from affected districts-Community transmission (Not bordering Rwanda)</td>
<td>0</td>
<td>1–30</td>
<td>≥30–50</td>
<td>&gt;50</td>
</tr>
<tr>
<td>Affected districts (Community transmission) is bordering Rwanda</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>Quarantining of Contacts</td>
<td>Proportion of new contacts under follow up in past 24hrs</td>
<td>&gt;90</td>
<td>80–90%</td>
<td>60–80%</td>
</tr>
<tr>
<td>Case Incidence</td>
<td>New cases during past 7-days/100,000 persons</td>
<td>&lt;1</td>
<td>1–3</td>
<td>≥3–5</td>
</tr>
<tr>
<td>At least one Imported confirmed case to Rwanda</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
</tbody>
</table>
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

Quarantine Monitoring devises

Tracing mathematical algorithm
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
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 convened 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

• 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 finalized and signed,
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 Kajojeji and it was discarded
  - 1 from Torit and it was discarded.

<table>
<thead>
<tr>
<th>No</th>
<th>Date of Sample Collection</th>
<th>Initials</th>
<th>Age</th>
<th>Gender</th>
<th>Location</th>
<th>State</th>
<th>Specimen</th>
<th>Lab</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>26/09/2022</td>
<td>S. A</td>
<td>48</td>
<td>M</td>
<td>Yambio</td>
<td>WES</td>
<td>Blood</td>
<td>NICD</td>
<td>Negative</td>
</tr>
<tr>
<td>2</td>
<td>28/09/2022</td>
<td>D. P</td>
<td>5</td>
<td>F</td>
<td>Yei</td>
<td>CES</td>
<td>Blood</td>
<td>URVI</td>
<td>Negative</td>
</tr>
<tr>
<td>3</td>
<td>29/09/2022</td>
<td>B. M</td>
<td>45</td>
<td>M</td>
<td>Adjumani</td>
<td>CES</td>
<td>Blood</td>
<td>NICD</td>
<td>Negative</td>
</tr>
<tr>
<td>4</td>
<td>06/10/2022</td>
<td>O. R</td>
<td>35</td>
<td>M</td>
<td>Shrikat</td>
<td>CES</td>
<td>Blood</td>
<td>NPHL</td>
<td>Negative</td>
</tr>
</tbody>
</table>
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 despite 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
Action taken by the Ministry

- Assessment of country preparedness and response in key areas such as:
  - Rapid Response Teams (RRTs) at all levels;
  - Stratifying regions at high, moderate and low risk
  - Risk Communication and Community Engagement (RCCE);
  - Infection Prevention and Control (IPC); Contact Tracing; Case Management;
  - Laboratory; Burial Teams;
  - Port of Entries; Logistics;
  - Coordination; Research and Vaccine pillars.
Action taken by the Ministry

- Conducting PPE need assessment
  - ✔ Redistribution 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 transportation of EVD samples
**Action taken by the Ministry**

- 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:
  - IPC,
  - Ebola health education,
  - Ebola education and information communication (EIC) materials,
  - Ebola frequent asked questions
Action taken by the Ministry

- Deploying 20 staff to border posts with migration and police officers.
  - For instance, Bugango border etc

- Planning of having X-border meeting

- Involvement of key sectors and partners in preparedness
Action taken by the Ministry

- Instructed regions to do
  - Self assessment (preparedness and response)
  - Prepare Contingency plans
  - Activate and prepare rapid response team, treatment and holding centres,
  - Strengthening the surveillance and reporting of alerts,

- Travellers' health screening has been strengthened and holding facilities identified in 25 borders including
  - Mtukula (Tanzania – Misenyi and Uganda),
  - Murongo (Tanzania - Kyerwa and Uganda),
  - Rusumo (Tanzania – Ngara and Rwanda), Kabanga, KIA, JNIA, Namanga etc.
Action taken by the Ministry

- 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 **first 72 hours** 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 *duration and magnitude* of the outbreak depend on the *level of preparedness, strength of the health system, economic status, level of community awareness*.

- The risk of the disease spreading beyond the borders of the DRC was assessed by WHO’s IHR 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*,
  - **There 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.

- Event 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 HF's 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.

- Procure PPE

- Deployment of Staff (Knowledge & Incentives)

- 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 handle Ebola outbreak.
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
  - 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
  - Cargo 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
  - Availability of big markets along borders four days in a week which bring together a big population of Tanzania and Uganda.
Case Scenario: Kagera

- Sharing of social places/events like worship, markets, health facilities, schools between Tanzanian and Ugandan

- Availability 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.

3. 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
  iii. **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

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Lead</th>
<th>Support</th>
<th>Due-Date</th>
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</thead>
<tbody>
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Thank You