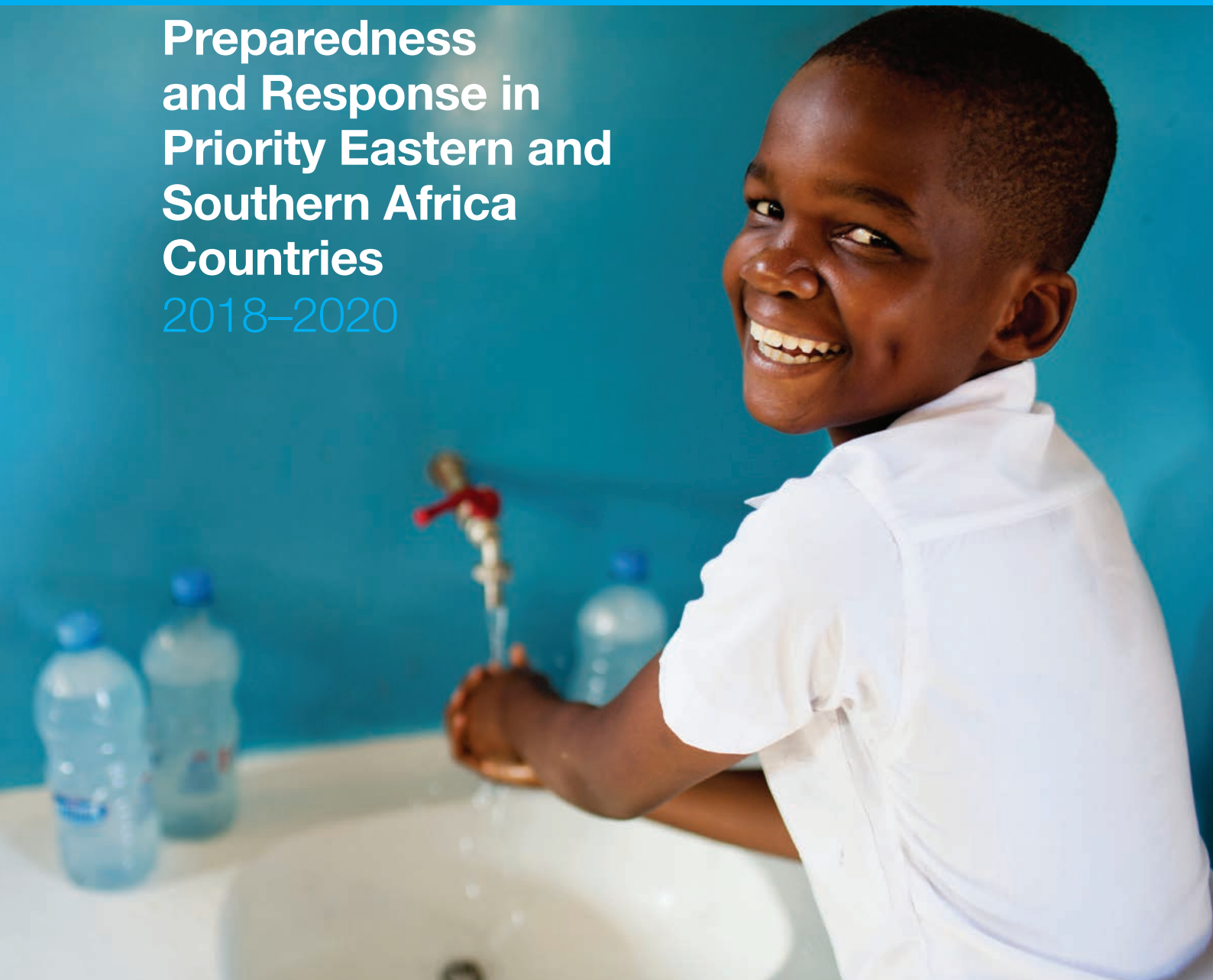


UNICEF Eastern and Southern Africa Regional Office

Ebola Virus Disease

**Preparedness
and Response in
Priority Eastern and
Southern Africa
Countries**

2018–2020





Cover Photo: Hans Hasan, a participant of the SWASH club; poses for a photograph while washing her hands at Kingugi School in Dar es Salaam, Tanzania. The SWASH club teaches children the importance of hand washing before eating and after visiting the toilet and encourages children to educate their families and peers of the importance of having clean hands.

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Executive summary

Ebola virus disease (EVD) was first reported in 1976 in present day South Sudan and the Democratic Republic of the Congo (DRC), with the tenth EVD outbreak in DRC, declared on 1 August 2018, proving to be the country's longest outbreak – lasting almost two years – and the second largest outbreak in the world, after the 2014-2016 EVD outbreak in West Africa. It was also the first to be reported in an active conflict area.

The World Health Organization Regional Office for Africa (WHO AFRO) conducted an assessment which identified neighbouring countries at risk, Burundi, Rwanda, South Sudan, and Uganda and categorized them as Priority 1 countries. Angola, Central African Republic¹, Congo¹, the United Republic of Tanzania, and Zambia were designated Priority 2 countries. In May 2020, after almost 18 months of implementing EVD preparedness activities in the four countries, UNICEF Country Offices and the Regional Office agreed to review and document achievements, challenges, lessons learned and best practices to inform future preparedness for EVD and other public health emergencies. This report is a collation of presentations from the EVD stocktake webinar, reports and feedback from the ESARO EVD cross sectoral response team, Burundi, Rwanda, South Sudan, Uganda, Tanzania and Malawi country teams over the 18-month period. The report is presented in three sessions, aligned with the webinar:

Session one sets the scene, providing a background to the EVD preparedness and response, including developments in DRC and explored, strategic, policy level and procedures at the regional and global level that facilitated readiness in countries.

- The EVD outbreak affected 29 health zones in the DRC, North Kivu and Ituri Provinces, with importation to South Kivu Province – these border Burundi, Rwanda, South Sudan, Uganda and Tanzania. Malawi had a peace keeping mission in North Kivu during the outbreak. By the end of the outbreak, a total of 3,470 cases had been reported, with 2,287 deaths and 1,171 survivors. Two small outbreaks of EVD were exported from North Kivu Province, DRC to Uganda (Kasese district): on 12 June 2019 and 29 August 2019. Rapid containment of these outbreaks was attributed to enhanced preparedness measures, including strong cross-border collaboration with DRC. This was reinforced at the Goma meeting convened by WHO and Africa Centers for Disease Control with ministers of health of DRC its nine neighbouring countries and partners, including UNICEF.
- On 19 July 2019, following the declaration of a public health emergency of international concern, UNICEF extended the Level 3 Emergency in DRC to cover EVD, and activated Level 2 Emergency procedures for Priority 1 countries. It facilitated rapid scale up, application of emergency procedures, resource mobilization and enhanced cross country and regional coordination. The L2 was extended twice and deactivated on 19 May 2020.
- Following outbreak declaration in DRC, and in line with UNICEF internal guidance for Ebola preparedness, ESARO developed guidance for priority 1 and 2 countries covering: (i) priority actions for management to ensure staff safety, (ii) office management covering internal and external coordination mechanisms, leadership for preparedness/response and business continuity, and (iii) cross sectoral programmatic preparedness and response. The EVD programmatic preparedness approach was three pronged covering: (i) scenario-based planning, (ii) differentiated support according to country capacity, typology and engagement with government and (iii) a /two tier approach that prioritised initial lifesaving actions for scaling up readiness to respond.

¹ Central African Republic and Congo are part of the UNICEF Western and Central Africa region (WCAR).

- The main areas of EVD national preparedness and response supported by UNICEF were: (i) coordination and leadership with focus on UNICEF mandate areas – WASH, Nutrition, Child protection and C4D and, strengthening district-level leadership for EVD and other public health emergencies in Uganda and South Sudan only. (ii) Risk communication and social mobilization and community engagement (iii) Case management, with UNICEF led interventions in subgroups for: infection prevention and control; Nutrition for EVD-affected children and adults; psychosocial support and Child Protection. (iv) Surveillance – where UNICEF-supported platforms were used for community-based surveillance.

The ESARO health emergencies team (led by health, with HARP support) provided technical, resource mobilization and human resource/surge support to the EVD priority countries. ESARO contributed to the regional EVD preparedness plan developed by WHO and member states. ESARO worked closely with WCARO and Emergency Operations Programme and Public Health Emergency teams at UNICEF headquarters.

Key regional level support included participation or support for: interagency joint EVD preparedness support and monitoring missions to countries; full-scale simulation exercises and after-action reviews in selected countries; preparedness planning and resource mobilization; technical assistance, including capacity building and facilitation of cross-country learning and experience sharing; cross border social science evidence reviews and internal monitoring and response review

Session two examined achievements, challenges and lessons learned to facilitate cross country learning. Internally, availability of the Emergency Programme Fund rapidly support governments to scale up readiness. ESARO support helped countries and country offices to develop, cost and monitor implementation of their preparedness and response plans. Support was delivered remotely as well as through on the ground technical assistance, surge deployments, cross country collaboration including for emergency supplies.

Country offices reported major achievements in coordination and leadership pillar, which also facilitated gains in other UNICEF led areas, such as RCCE, WASH and MHPSS. For example:

- Strategic positioning of UNICEF staff within Government decision-making teams resulted in better Government and agency outputs. Additionally, deploying and embedding staff in district task forces and, support for co-chairing pillars improved performance. Timely cross-border collaboration contributed to sharing of experiences, and resources resulting in effective preparedness and response.
- Under WASH/IPC: UNICEF ensured that emergency response contributed to structural improvements in water and sanitation facilities at health centres, points of entry, schools, and communities, which were delivered collaboratively with other partners. Supportive supervision and monitoring fostered integrated approaches and enhanced programme quality. Direct partnership with districts provided a platform for sustainability beyond EVD.
- The role of MHPSS became more prominent, with improved coordination, standardised training, and harmonised case management rolled out to high risk districts.

Session 3 focused on what went well, less well and why, and what can be improved, moving forward. The common themes identified in all countries are listed below.

What went well

- Internal coordination in all priority countries was strong. In emergency prone countries, this was largely due to the existence of the Emergency Management Team internal coordination mechanism. The quality of the response was linked to strong leadership and good information sharing.
- Recruitment of staff and deployment of surge capacity from Liberia, Sierra Leone and Uganda country offices with good previous EVD experience contributed to enhancing country response. This was facilitated by the Level 2 SoPs.
- Early development of a preparedness and response plan facilitated timely resource mobilization and scale up of priority interventions in high risk areas.
- EVD preparedness and response supplies were procured and prepositioned at the national level and in priority districts. This included personal protective equipment, drugs for supportive treatment, and triple packaging for sample transportation.
- Outbreak-related events stipulated in the International Health Regulations (2005) were conducted with UNICEF participation. This included accountability fora, simulation exercises, joint monitoring missions, and after-action reviews. Findings were used to enhance preparedness efforts.
- Generation of social science evidence contributed to designing strategic approaches and messaging for behaviour change.
- Contingency Programme Cooperation Agreement (PCA) supported rapid scale up of field interventions.

What went less well

- Stronger cross pillar coordination and collaboration could have further enhanced response.
- Coordination of EVD preparedness and response did not sufficiently engage line ministries beyond the Ministry of Health.
- A formal After Action Review in the four priority countries was not conducted at the end of the outbreak, and planned phase out/exit processes were interrupted by COVID-19.
- The prolonged EVD preparedness phase led to message fatigue – there is a need to balance risk-informed messaging and other challenges that communities often find more serious (for example insecurity, lack of basic services).
- Almost all countries were affected by limited funding for what became a protracted crisis.

What to improve

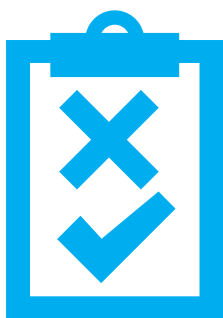
- Information about the supply strategy and anticipated delays should be made available timely to allow countries to adapt their programming accordingly.

Key recommendations

Building on the EVD experience in countries and reflections from the field response from 2018 to 2020, the ESARO EVD team recommends the following, with focus on programme preparedness, funding and staff safety:



- **Staff safety:** Working with senior management, human resources and programmes, institutionalise pre-deployment training for consultants and staff going to the ‘frontlines’ for response. A range of online courses already exist, and various packages can be further tailored by ESARO and country offices, building on the orientation package developed for the priority 1 countries. Field teams and any staff going to the field should do these courses, similar to requirements for security clearance. Prior to deployment, ensure that insurance policies adequately address treatment (including potential medical evacuation) and other potential issues, based on local knowledge of response areas. Senior management should ensure that internal response plans adequately address surge needs so that response staff (national and field levels, both national and international) do not burn out.



- **Programme preparedness:** Identify and address programme areas that still require capacity strengthening to facilitate an optimal and cross sectoral response to public health emergencies. Key examples include: infection prevention and control, MHPSS and child protection in infectious disease outbreaks, logistics and supply for outbreak preparedness and response and case management. Ensure that national staff are prioritised for capacity building including cross country learning, as they remain the bedrock of UNICEF work in countries in both emergency and development. Approaches for preparedness and response should be cross sectoral and at the same time appropriately address the health emergency focus. Continue to build on social science evidence generation both in emergency preparedness and response, as it often influences the course of response at the community level and is within the remit of UNICEF’s C4D work.



- **Funding:** Advocacy for access to more flexible funding to facilitate preparedness with focus on countries that do not traditionally receive much funding, yet are high risk for emergencies (e.g. Uganda, Burundi). In this regard, explore development of a national resource mobilization plan that will map out potential national partners including private sector partnerships — which tend to — make in kind contributions especially on RCCE/C4D interventions (mass media production and messaging) and supplies (for case management). During EVD preparedness, Rwanda and Burundi reported excellent examples of local producers making in kind contributions of soap. Consider the possibility of estimating minimum associated costs of preparedness for the commonest public health emergency in selected countries with focus on UNICEF key response areas and use this information to inform future planning including resource mobilization efforts with government. These fund estimates should be cover both acute and prolonged scenarios.

Abbreviations

AAR	After Action Review
BCP	Business Continuity Plan
DRC	The Democratic Republic of the Congo
C4D	Communication for Development
CEAP	Corporate Emergency Activation Procedure
CERF	Central Emergency Response Fund
CP	Child Protection
EAC	East African Community
eLMIS	electronic Logistics Management Information System
EMOPS	Office of Emergency Programmes
EMT	Emergency Management Team
ESA	Eastern and Southern Africa
ESARO	Eastern and Southern Africa Regional Office
EPF	Emergency Programme Fund
EVD	Ebola virus disease
FSX	full-scale simulation exercise
GEC	Global Emergency Coordinator
HAC	Humanitarian Action for Children
HARP	Humanitarian Action, Resilience and Peace (<i>Emergency section of UNICEF ESARO</i>)
IASC	Inter-Agency Standing Committee
IHR	International Health Regulations
IPC	Infection Prevention and Control
IYCF	infant and young child feeding
JMM	Joint Monitoring Missions
L2/L3	Level 2 or Level 3 Emergency
MHPSS	Mental Health and Psychosocial Support
NTF	National Taskforce
PHEIC	Public Health Emergency of International Concern
PST	Preparedness Support Team
RBC	Rwanda Biomedical Centre
RCCE	Risk Communication and Community Engagement
RCO	UNICEF Rwanda Country Office

RHCC	Rwanda Health Communication Centre
RUIF	Ready-to-Use Infant Formula
PIF	powdered infant formula
PPE	Personal protective equipment
PSS	Psychosocial Support
SAG	Strategic Advisory Group
SSCO	UNICEF South Sudan Country Office
SOPs	Standard Operating Procedures
TWG	Technical Working Group (<i>elsewhere called pillar or committee</i>)
UCO	UNICEF Uganda Country Office
UNCT	United Nations Country Team
US-CDC	United States Centers for Disease Control
VAC/W	violence against children and women
WASH	Water, sanitation and hygiene
WCAR	Western and Central Africa region

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Disclaimer: While the EVD preparedness and response was built on UNICEF guidance, this report is a reflection of the field experiences teams supporting preparedness and response in their different contexts and not of UNICEF’s official position.

A Congolese lady is washing her hands with water and chlorine, helped by a red cross volunteer in Bwera border town in Kasese district.



1 Background

Ebola virus disease (EVD) is a serious, often fatal disease in humans. It was first reported in 1976 in two simultaneous outbreaks: in Nzara, present-day South Sudan, and in Yambuku, a village on the Ebola river in the Democratic Republic of the Congo (DRC). Ten outbreaks were confirmed in the DRC between 1976 and early 2020, the tenth declared on 1 August 2018 in North Kivu Province, less than a week after the end of an unrelated outbreak in Mbandaka, Équateur Province, on the western side of the country. This tenth EVD outbreak proved to be the country's longest outbreak – lasting almost two years – and the second largest outbreak in the world, after the 2014-2016 EVD outbreak in West Africa. It was also the first EVD outbreak reported in an active conflict area.

As soon as the tenth outbreak was declared in DRC, the World Health Organization Regional Office for Africa (WHO/AFRO) conducted an assessment which identified neighbouring countries at risk. Burundi, Rwanda, South Sudan, and Uganda were categorized as Priority 1 countries for the scale-up of Ebola virus disease preparedness, while Angola, Central African Republic², Congo², the United Republic of Tanzania, and Zambia were designated Priority 2 countries. On 17 July 2019, the International Health Regulations (IHR) (2005) Emergency Committee for Ebola Virus Disease in the Democratic Republic of the Congo, advised the WHO Director-General to declare a Public Health Emergency of International Concern. This was due to continued intense spread of the disease, including to the city of Goma, which serves as a gateway to the rest of East Africa. The declaration prompted intensified scale-up of preparedness actions in neighbouring Priority 1 countries.

At the end of July 2019, UNICEF declared a Level 3 (L3) Emergency for DRC and a Level 2 (L2) Emergency for all Priority 1 countries, i.e. Burundi, Rwanda, South Sudan, and Uganda. One Priority 2 country, the United Republic of Tanzania, implemented EVD preparedness activities and this was in response to a suspected outbreak situation. The other Priority 2 countries, Angola and Zambia, did not implement an EVD preparedness scale up. Malawi (not categorised), scaled up EVD preparedness in response to the perceived dual risk of regular movement of migrants from eastern DRC and Malawian peacekeepers deployed to North Kivu.

Justification for EVD Stocktake

In response to the high risk of EVD spreading across national borders, the UNICEF Eastern and Southern Africa Regional Office (ESARO) encouraged Country Offices in all four Priority 1 countries to develop and implement EVD contingency plans covering three scenarios – (i) preparedness (ii) with limited geographic spread and (iii) diffused outbreaks – aligned with national contingency plans. Offices in Priority 1 countries started this process as soon as the outbreak was declared in August 2018 and scaled up preparedness efforts following the UNICEF L2 Emergency classification in July 2019. In June 2020, after over 18 months of implementing EVD contingency plans in the four countries, Country Offices and the Regional Office agreed to review and document achievements, lessons learned, challenges and best practices to inform future preparedness for EVD and other public health emergencies. A light version of documentation extended to Malawi and the United Republic of Tanzania, which started to implement preparedness actions in late 2019.

² Central African Republic and Congo are part of the UNICEF Western and Central Africa region (WCAR).

Meeting objectives and proceedings

An stock taking meeting was held on 30 June 2020 to review UNICEF contribution to EVD preparedness and response. The focus was the four Priority 1 countries (Burundi, Rwanda, South Sudan, and Uganda), the United Republic of Tanzania (a Priority 2 country), and Malawi.

Objectives

The objectives of the meeting were to:

- Conduct a critical review of UNICEF support to the government response across the range of thematic areas, identifying successes, risks, constraints, and opportunities for the response.
- Identify lessons, experiences, examples, and models for EVD preparedness and response replicable to other public health emergencies in the future.

Proceedings

The webinar was divided into three sessions: (1) Setting the scene (2) Deep dive: achievements, challenges and lessons learned from EVD preparedness in priority countries (3) What went well, less well and how it could be improved with the last section addressing next steps.

The meeting – a webinar - held online due to COVID-19 pandemic related travel restrictions, was conducted using an adapted after-action review (AAR) methodology covering EVD preparedness and response efforts in the region. At the meeting, UNICEF country offices made presentations which were a collation of various progress reports, assessments, and reviews conducted during the preparedness and response period.

Participation

The webinar was organised by ESARO health, with support from C4D, HARP, Nutrition, WASH, and Child protection. In addition to participation by health, communication for development (C4D) and water and sanitation (WASH) teams, which are the traditional responders during public health emergencies, the webinar also drew participants from child protection, nutrition, and emergency sections in Burundi, Rwanda, South Sudan, Uganda, Tanzania and Malawi country offices and ESARO.

This report is a collation of the webinar presentations, feedback from country teams and progress reports over the 18-month implementation period.



Uganda Red Cross members organise Batwa Cultural Group to present song and drama to pass on messages on Ebola Virus Disease in Kisoro district.

2 Session 1

Setting the scene

The opening session included an overview of EVD preparedness and response in Eastern and Southern Africa 2018–2020; reflections from the ESAR Risk Communication and Community Engagement (RCCE) for EVD Preparedness and Response Review and Stocktake Meeting; a summary on Nutrition in the context of EVD preparedness and response, and a short question and answer session, which was used to clarify presentation content.

2.1. Overview of Ebola virus disease preparedness and response in Eastern and Southern Africa 2018–2020

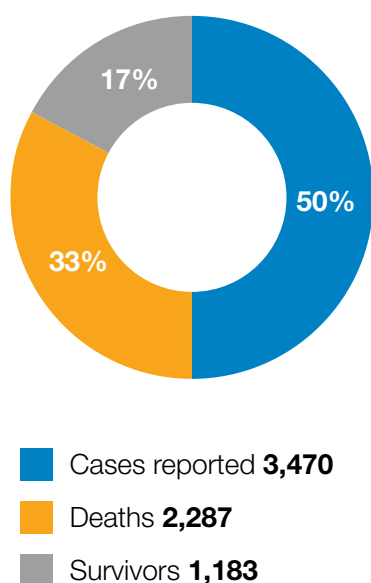
The EVD outbreak in the east of the Democratic Republic of the Congo was declared by the Ministry of Health on 1 August 2018. It was declared over, almost two years later, on 25 June 2020. Except for the two cases imported into Uganda, there were no cases reported in any of the other neighbouring countries.

2.1.1 Epidemiological summary

The EVD outbreak affected 29 health zones in DRC, mainly in North Kivu and Ituri Provinces, with some importation to South Kivu Province.

By the end of the outbreak, a total of 3,470 cases had been reported, with 2,287 deaths and 1,171 survivors. A total of 153 of the deaths were considered 'probable cases' as no samples had been collected for laboratory confirmation. Around 33 per cent of the deaths occurred outside of treatment centres. In terms of distribution among key populations: 29 per cent of cases were among children, 57 per cent among women. Around 5 per cent of cases occurred among health workers.

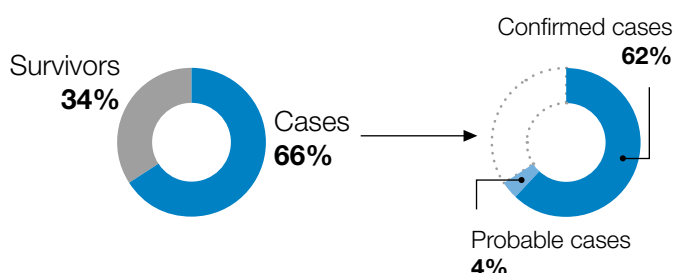
Cases, survival and deaths



Distribution of cases among key populations



Distribution of cases, deaths and survivors



Two small outbreaks of EVD were reported in Kasese district, Uganda, both imported from North Kivu Province, DRC:

- The first outbreak was reported on 12 June 2019 in Kasese district. A total of three imported cases/deaths were reported - two children aged 3 and 5, and their grandmother.
 - No local transmission was reported.
 - A total of 175 contacts were followed up, and 1,602 people (contacts, their contacts, and health workers) were vaccinated.
 - The outbreak was declared over on 25 July 2019, 42 days after the death of the last confirmed case.
- A second outbreak was declared on 29 August 2019 when another case was imported into the country through Kasese district, a 9-year-old child, who subsequently died.
 - No local transmission was reported.
 - A total of 39 contacts were listed and followed up, and 259 people (contacts, contacts of contacts, and health workers) were vaccinated.
 - The outbreak was officially declared over on 28 October, after completion of the mandatory 42 days of follow up of contacts of the case.

Rapid containment of these outbreaks was attributed to enhanced preparedness measures, including cross-border collaboration with DRC.

Key risks for Ebola virus disease transmission

- Insecurity due to attacks by non-state armed groups on communities, responders, health workers, treatment units, and points of entry.
- Considerable cross-border population movement, including displacement and travel for trade, education, or health services.
- Healthcare-acquired (nosocomial) infection linked to suboptimal infection prevention practices.
- Multiple community transmission routes, including delayed treatment-seeking, unsafe burial practices, and use of traditional healers.
- Persistent delays in isolation of confirmed cases, reports of community deaths, further exposing families and contacts. This was attributed to a number of factors including: fear, stigma and insecurity.
- Challenges in contact tracing affecting timeliness of downstream operations – such as vaccination of contacts.
- Additional factors: community resistance, misinformation, and politics.

2.1.2 Cross-border collaboration for EVD preparedness and control

Collaboration between Priority 1 and Priority 2 countries with the Democratic Republic of the Congo contributed to enhanced cross-border management of EVD. The most remarkable of these was the Goma meeting, which resulted in the Goma Communique signed by the Ministers of Health of the nine neighbouring countries bordering the Democratic Republic of the Congo. Key points from the communique are listed on the next page.

Key points of the Goma Communiqué on Ebola virus disease

WHO Regional Office for Africa convened a nine country High-level Ministerial Meeting on Cross Border Collaboration to prepare for and respond to the Ebola Virus Disease Outbreak on 21 October 2019 in Goma, Democratic Republic of Congo. The purpose of the Goma meeting was to address the risk of importation of Ebola virus disease from the Democratic Republic of the Congo which would affect the health and economic security of surrounding African Union countries: Angola, Burundi, Central African Republic, Congo, Rwanda, South Sudan, Uganda, the United Republic of Tanzania, and Zambia.

Supporting frameworks, protocols, and agreements that underpin the Goma communiqué include: the International Health Regulations (2005); the African Union Declaration on Accelerating Implementation of the International Health Regulations in Africa (2017); the WHO Regional strategy for integrated disease surveillance and response 2020–2030; and the Statute of the Africa Centres for Disease Control and Prevention (2016).

The meeting resulted in the Goma Communiqué signed by the Ministers of Health of the nine countries, which included commitments for:

- **EVD case and laboratory surveillance**, including contact tracing and monitoring of cases, as well as data sharing.
- **Capacity development**, including joint simulation exercises, exchange learning, and training.
- **Sharing of information** on potential security threats and issues in affected areas.
- **Sharing of technical expertise, resources and assets for EVD preparedness and control.**
- **Joint planning** for preparedness and response, including risk communication and community engagement.
- **Facilitation of movement of people across borders** while ensuring implementation of recommended measures as per IHR 2005.
- Processes and planning for **rapid cross-border deployment of experts** involved in the response.
- Establishment of the **Africa Ebola Coordination Taskforce at the African Union secretariat** in Addis Ababa, Ethiopia, facilitated through a coordination centre in Nairobi.

2.2. Activation of UNICEF Level 2 corporate emergency procedures

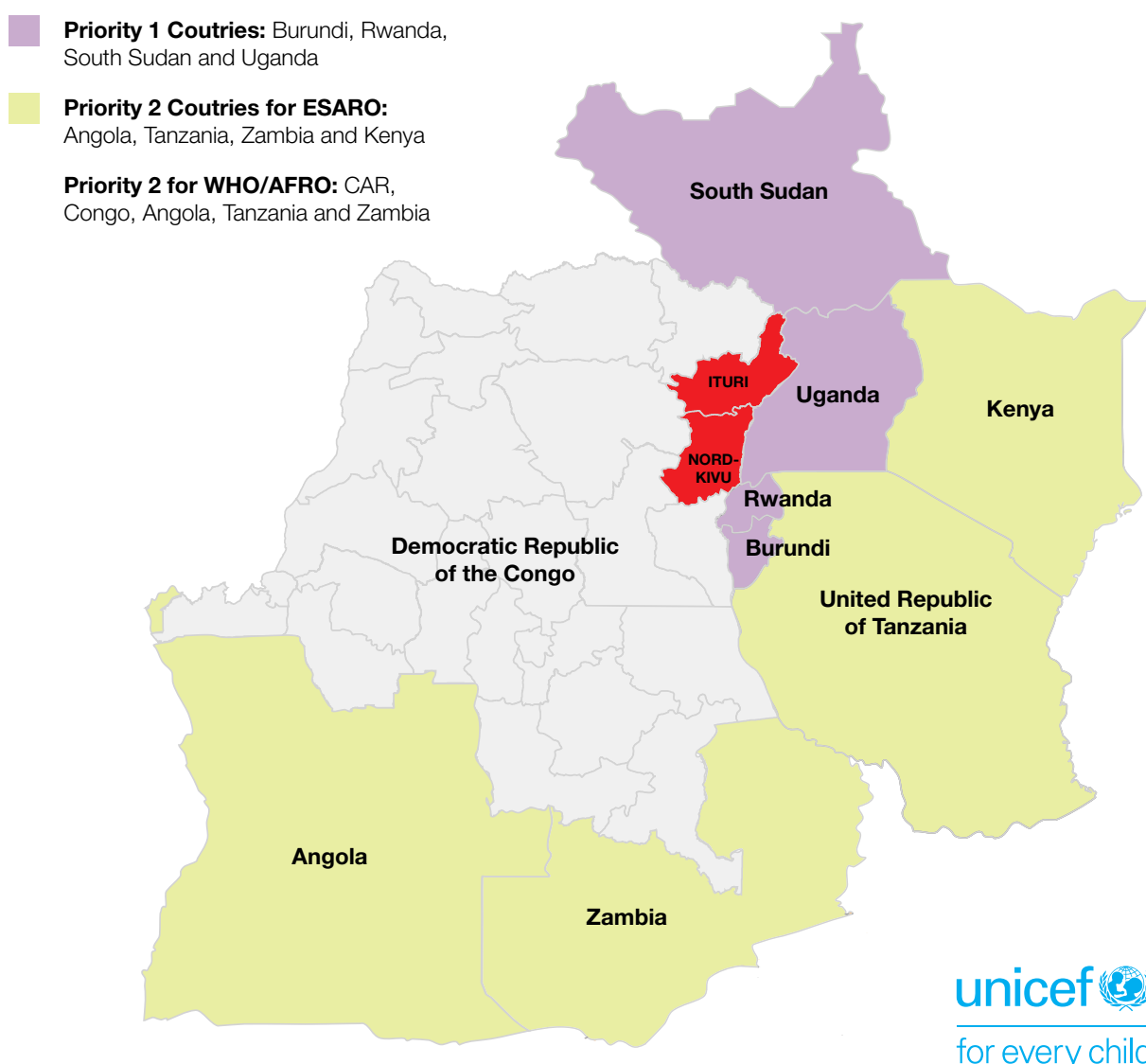
The Inter-Agency Standing Committee (IASC) activated the Humanitarian System-Wide Scale-Up for Infectious Disease Events for DRC on 29 May 2019. This was followed by the declaration of a Public Health Emergency of International Concern (PHEIC) by the WHO Director-General on 17 July 2019. This was following escalation of the situation which met the IHR (2005) definition of a PHEIC “an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease, and to potentially require a coordinated international response”³.

3 IHR Procedures concerning public health emergencies of international concern (PHEIC), www.who.int/ihr/procedures/pheic/en/

In response, on 19 July 2019, UNICEF applied its Corporate Emergency Activation Procedure (CEAP), extending the Level 3 Emergency in DRC, in place since 2017, to cover Ebola virus disease, and activating Level 2 Emergency procedures for Priority 1 countries – the first time a corporate emergency was declared for countries in the preparedness phase. The L2 Emergency was extended twice after the initial three-month period, and finally deactivated on 19 May 2020.

Activation of an L2 Emergency enabled the four Eastern and Southern Africa (ESA) Priority 1 Country Offices to rapidly scale up preparedness efforts facilitated by application of emergency procedures, including emergency programme funds, human resources (HR) surge, and simplified partnership processes. In addition, the Director of the Office of Emergency Programmes (EMOPS), designated by the Executive Director as the Global Emergency Coordinator (GEC) to oversee the L2/L3 Emergency, chaired monthly joint Emergency Management Team meetings with Country Offices in the DRC and the four L2 countries, the two Regional Offices (ESARO and WCARO), and EMOPS, to ensure preparedness and response efforts were effectively coordinated across countries. As per normal practice, the Regional Director ESARO oversaw the L2, while the L3 was directly overseen by the GEC with WCARO support.

Figure 1. Priority countries for EVD preparedness



2.3. UNICEF approach to EVD preparedness in Eastern and Southern Africa

In line with the 2017 Ebola Quick note and the 2016 Preparing for Ebola: A guide for UNICEF, ESARO developed guidance for Country Office EVD preparedness focused in three areas: (a) staff safety; (b) office management; and (c) programme preparedness in support of the national response in August 2018 following outbreak declaration in DRC. ESARO reached out to Representatives, Deputy Representatives and EVD technical teams of country offices and provided a quick orientation of these key focus areas for EVD preparedness and response. actions taken by focus area are detailed below.

(a) Staff safety:

- Senior management provided staff with regular updates and key messages to all staff in line with developments in the outbreak in DRC, other high-risk countries and in country. The frequency of these updates changed over time, in line with the country office risk perception, which was informed by regular national and WHO AFRO risk assessments.
- In addition, management communicated with EVD teams about two mandatory courses for frontline staff: (i) ePROTECT Ebola for all staff deployed to respond ; and (ii) Agora Ebola Safety e-Course. Health specialists were encouraged to complete the Ebola: Knowledge resources for responders (which covers both basic and more advanced courses, targeted at clinical staff). Additional course links shared with CO health professionals included: MSF e-briefing course; Emory University's Ebola Virus Disease; An Evolving Epidemic and Universities of Utrecht & Amsterdam's Ebola: Essential knowledge for health professionals.
- Human resource offices at ESARO and Country offices ensured that new staff (including national consultants) being deployed to support EVD preparedness and response completed the two mandatory courses and submitted their certificates as part of onboarding.
- Some country offices, like South Sudan, went further to monitor staff completion rates of the mandatory courses – by August 2019 at least 94% of all staff had completed both mandatory courses.

(b) Office management:

- Country office senior management adapted pre-existing internal emergency coordination mechanisms for EVD preparedness. Countries that had recently responded to similar public health emergencies, like Uganda (Marburg in 2017), had experienced teams and mechanisms that had been tested. The country offices had variations in leadership of these internal coordination mechanisms, ranging from the chief of health in charge at the technical level, to the Chief of Emergency/Field operations or the Deputy Representative.

The approaches had different advantages – countries where MoH had strong leadership in preparedness/response with strong epidemic preparedness and response coordination mechanisms (notably in non crisis countries like Uganda), technical oversight by the Chief of Health held the most benefit for the country office because it allowed for a strong public health response. In countries with humanitarian crises, coordination by either the Deputy Representative or the Chief of Emergency/Field Operations was thought to facilitate a more multisectoral response.

- Deputy Representatives called for a review of key programme documents and arrangements and the development of a Business Continuity Plan (BCP) aligned with the United Nations country EVD Business Continuity Plan (BCP) which covers medical evacuation and other duty of care arrangements.

(c) Programme preparedness in support of the national response:

- **Key approaches:**

- **Scenario-based planning.** Support from ESARO to Country Offices comprised i) development of generic EVD preparedness plan templates in line with 2017 and 2016 adapted guidance and ii) technical support for alignment with national plans. UNICEF and partners worked with Ministries of Health to ensure that the national plans were scenario based. The following were the three scenarios for EVD importation: (1) preparedness for the threat of EVD importation; (2) EVD importation, with a (geographically) localized outbreak; and (3) a diffused outbreak. Scenario 3 was further nuanced at country level to consider the following possibilities: an outbreak occurring in a large urban area, refugee settlement, or in multiple districts at once; an exponential increase in cases exhausting local capacity for response; and an EVD outbreak in a location not previously considered at risk.
- **Different roles in countries.** Depending on internal capacity and prior levels of engagement in public health emergencies with the local Ministry of Health in the country, Country Offices assumed different roles: technical assistance, direct support in the field, or both. Technical support from ESARO was then tailored accordingly.
- **Two-tiered programme approach.** The main government response pillars were frequently grouped as: coordination and leadership; risk communication and community engagement; case management – often including subgroups on infection prevention and control and WASH, mental health and psychosocial support as well as nutrition in the context of EVD; surveillance and epidemiology – often including subgroups on contact tracing, laboratory support, and points of entry; and logistics and supply.
 - Tier 1 – the immediate response – covered sectoral responses in the areas of Health; Communication for Development (C4D); Water, Sanitation, and Hygiene (WASH); Nutrition (only interventions for infant and young child feeding for children infected with/affected by EVD); and Child Protection (only interventions for mental health and psychosocial support and child protection linked directly to case management), with all programme responses supported by Supply and Communication teams.
 - Tier 2 were areas meant to be activated during scenario 3. It included other areas of Child Protection (like violence against children and women – VAC/W), Nutrition (food security), and Education (remote learning and other areas) which were not linked to immediate preparedness.
- **Main areas of the national response supported by UNICEF:**
 - **Coordination and leadership,** with a focus on UNICEF mandate areas/sectors (WASH, Nutrition, Child protection and C4D) and, in some cases – for example in Uganda and South Sudan - support for strengthening district-level leadership for EVD and other public health emergencies. Support for coordination and leadership necessitated the recruitment of additional staff/consultants, as well as technical assistance delivered through both regular field visits and deployments to the subnational level.
 - **Risk communication, social mobilization and community engagement** (also referred to as social and behaviour change communication elsewhere), with the response led by C4D.

- **Case management** also covering nutrition, infection prevention and control, as well as safe and dignified burials, with UNICEF led interventions in: infection prevention and control through WASH and Health; Nutrition for EVD-affected children and adults; psychosocial support and Child Protection, and participation in case management by health.
- **Surveillance, laboratory support, and points of entry** – this was only implemented where the Country Office had the capacity for this type of support and/or where UNICEF-supported community structures were being used for community-based surveillance. A key example was Uganda, where UNICEF and WHO supported districts to conduct joint RCCE and community surveillance training for village health teams (VHTs). The VHTs then covered both areas of work in the communities that they served⁴.
- **Operational logistics and supply.** Various degrees of support for forecasting, procurement, last mile distribution of supplies and capacity building for warehouse staff/storekeepers were provided by the country offices.

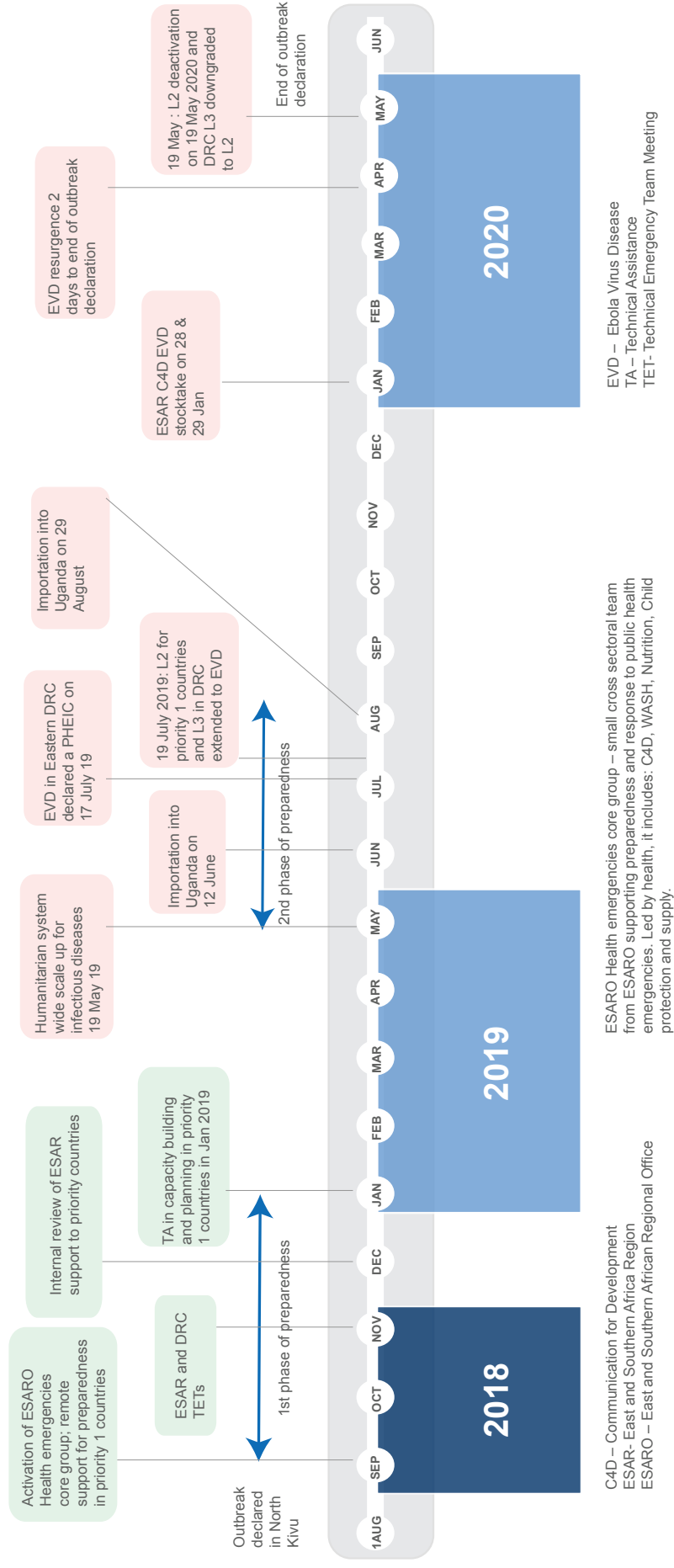


Red cross volunteers are screening travellers from DRC with infrared thermometer in Bwera border town.

⁴ VHTs are a community cadre established by Government of Uganda. They are lay workers who are nominated by their communities to promote their health and wellbeing. Activities conducted include: RCCE, community-based disease surveillance for priority diseases which include EVD.

Below is a timeline showing key EVD related events and summary preparedness and response activities in the priority one countries.

Figure 2. Timeline of key events in the EVD outbreak and UNICEF response



Preparedness Support Team (PST) missions in Burundi and Rwanda whose role was to assess gaps in readiness across all pillars and develop a plan of action for addressing them. UNICEF focus in the PSTs was on enhancing RCCE capacity. ESARO teams joined the 5-day Joint Monitoring Missions (JMMs) conducted in Burundi, Rwanda, South Sudan (2 missions each), and Uganda (1 mission). The JMMs were aimed at monitoring cross pillar progress toward readiness to respond to EVD importation.

- Full-scale simulation exercises and after-action reviews. Full-scale simulation exercises and after-action reviews are International Health Regulations (2005) activities conducted during or after disease outbreaks with the aim to strengthen country capacities to respond to public health emergencies.

ESARO health participated in a three-level⁵ full-scale simulation exercise (FSX) conducted in Uganda on 11 and 12 April 2020 to test the system's readiness to respond to EVD. Around two months after the FSX conducted on 12 June 2019, the first EVD case was imported through an unofficial point of entry in Kasese, seeking treatment at Kagando Mission Hospital. The FSX played a key role in enhancing readiness to respond to the importation, which did not result in local transmission.

Following the end of the outbreak declaration, at the Ministry of Health request, on 28 August ESARO led the RCCE part of the after-action review of the EVD outbreak in Kasese district, Uganda. The AAR identified what worked and what worked less so – providing useful lessons for responding to the next importation, which occurred on 29 August, on day two of the AAR.

- Preparedness planning and resource mobilization: ESARO supported the development and review of Country Office EVD contingency plans in the four priority one countries, Tanzania and Malawi. In selected countries, namely Uganda, Tanzania, the cross sectoral team provided direct support to Ministries of Health to develop national EVD contingency plans. The Regional Office also supported Country Offices with internal and external resource mobilization efforts.
- Technical assistance, including capacity building:
 - ESARO provided onsite, cross-sectoral EVD planning, capacity building, technical assistance, and monitoring in Burundi (3 missions), Rwanda (1 mission), South Sudan (1 mission), and Uganda (3 missions).
 - Cross-country and regional learning:

A Technical Meeting on Nutrition in the Context of EVD organised by UNICEF DRC with participation from other UN agencies in DRC including WHO, and other implementing partners. Also present at the meeting were: UNICEF ESARO, WCARO, Programme Division - Nutrition, Burundi, Rwanda, and South Sudan country offices. While DRC presented on its experience in nutrition in EVD response, ESARO together with priority 1 countries, shared the preparedness experience, including progress around guidance development and implementation, using nutrition in emergencies as an entry point for building capacity for public health emergencies among nutrition stakeholders.

The Goma meeting with 9 neighbouring countries, whose details are presented under the section on cross border collaboration for EVD preparedness. ESARO's role was to liaise with WHO/AFRO and mobilize country office participation in the event, including working with Ministry of Health and partners to prepare for the meeting.

⁵ The simulation exercise was conducted at the point of entry, Community and Kagando Mission Hospital in Kasese, Entebbe International Airport and the Public Health Emergency Operations Centre

- Social science evidence reviews in Uganda, South Sudan, Rwanda and Burundi. ESARO coordinated the evidence reviews which were conducted by Anthrologica in collaboration with the social science in humanitarian action platform (SSHAP). The specifics included identifying focus countries and key informants, concurrence on topics relevant to each country, and a review of the reports.
- Response review: A cross-sectoral preparedness review was scheduled for the last quarter of 2019 but cancelled due to lack of funds. In line with these plans, the C4D team carried out a stocktake for selected countries in January 2020, and ESARO conducted the cross-sectoral webinar on 30 June to take stock of EVD preparedness in priority countries.



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Engaging the media for responsible communication on EVD preparedness in Rwanda.

2.4.2 Risk Communication and Community Engagement (RCCE)

A regional Risk Communication and Community Engagement (RCCE) review meeting took place in January 2020, organized by ESARO Communication for Development (C4D) together with Health, with participation of Nutrition, Child Protection, and WASH teams. The purpose of the meeting was to take stock of progress, lessons, challenges, and best practices in RCCE for EVD preparedness and response. Participants included UNICEF staff from Priority 1 countries and their Ministry of Health counterparts, as well as the UNICEF Democratic Republic of the Congo, Kenya, and United Republic of Tanzania Country Offices. Other participants included: DFID, WHO Emergency Department east and southern Africa Hub, Regional Offices for Save the Children, the International Federation of Red Cross and Red Crescent Societies (IFRC) and the United Nations Office for Coordination of Humanitarian Affairs (OCHA). The full report is available on the UNICEF ESA reports page.

Themes covered at the meeting included establishing a multi-level coordination mechanism for effective EVD preparedness in Uganda; mobilizing the media for at-scale EVD awareness in Rwanda; engaging communities to prevent EVD in high-risk areas in Burundi; collecting and managing community feedback in South Sudan; and generating evidence to inform EVD preparedness in the United Republic of Tanzania.

Key findings and recommendations

Key findings

- The prolonged period of community awareness regarding Ebola prevention resulted in ‘message fatigue’. This calls for innovative strategies around messages, format and delivery platforms to keep audiences engaged while maintaining a high perception of risk during preparedness.
- Social science evidence reviews on cross-border dynamics were crucial in informing the development of interventions addressing community issues in border locations.
- Strong coordination mechanisms for RCCE ensured optimization of resources, harmonization of public messages, and clear division of labour among partners.
- The secondment of consultants to local government in high-risk districts to provide direct support and mentorship enabled skills transfer and contributed to systems strengthening.
- The pairing of key community influencers with district technical officers during radio talk shows and call-in programmes ensured audience engagement, fostered trust and provided a good opportunity to respond to rumours and provide feedback to the communities.
- The creation of a dedicated RCCE pillar of EVD preparedness and response ensured that due attention was given to RCCE work, while the integration of RCCE into all pillars ensured clear understanding of community perspectives and cross-pillar technical support, while also allowing for feedback to other pillars from community interactions.
- Too much community feedback without corresponding mechanisms to respond can lead to a ‘feedback bloat’.

Key recommendations

Country level

- Community feedback should be systematically collated, analysed and presented to/fed into the national task forces.
- RCCE preparedness plans should be scenario-based to provide clear guidance for a nuanced transition of activities between preparedness and response.
- Cross-border collaboration and coordination should be strengthened to ensure the harmonization of messages and community engagement interventions.
- Community engagement interventions for EVD and other public health emergencies should consider health workers and support staff as priority audiences for engagement. Surveys from different countries showed limited knowledge and awareness of prevention measures among these groups.
- Social science (anthropological) research should be incorporated into RCCE preparedness for public health emergencies.
- Specific strategies should be developed for urban communities. Rural communities were more likely to be aware of EVD prevention measures than their urban counterparts.

Regional level

- A regional toolkit for community feedback that can be adapted to different country contexts during outbreak preparedness and response should be developed to support Country Offices/countries.
- Efforts should be made to establish or strengthen a regional coordination mechanism for RCCE, with systematic inclusion of international non-governmental organizations as key collaborative partners.
- RCCE should be a core part of the global health security agenda, and key RCCE actors should be included in all International Health Regulations (2005) processes – such as Joint External Evaluations, joint monitoring missions, joint assessment missions, and after-action reviews.

What went well

- Existence of partnerships to scale up community engagement.
- Involvement and goodwill of national governments.
- Radio communication – reassuring during the outbreak phase (interactive talk shows).
- Cross-border collaboration, e.g. between Uganda and DRC, which enabled synchronisation of border activities.

What went less well

- Lag in community feedback and rumour tracking across all preparedness countries.
- NGOs seen as implementing partners and not collaborators in EVD preparedness and response activities.
- Message fatigue resulting from prolonged exposure to EVD prevention messages.
- It was difficult to secure longer-term funding for EVD preparedness.
- Feedback bloat – too much bad news.

2.4.3 Nutrition in the context of EVD preparedness and response

EVD outbreaks may have a direct negative impact on nutrition, including on individual nutrient needs and infant and young child feeding (IYCF), and less directly on feeding practices and household food security. The following are priority preparedness and response actions to address these impacts:

- Enhancing policy guidance on key programming areas which are: infant and young child feeding, nutrition care for EVD patients, management of acute malnutrition, and food assistance.
- Continuous contextual analysis to facilitate dynamic preparedness and response.
- Nutrition supplies assistance as needed.
- Capacity development of partners and frontline health providers to enhance response capacity.
- Strengthening information systems, including aspects of surveillance and monitoring.
- Strengthening programme resilience and planning for alternative delivery mechanisms, if required.

Regional nutrition EVD preparedness support

Key achievements of the regional nutrition response included:

- a. Development of regional standard operating procedures (SOPs) for nutrition management in the context of EVD; a decision tree for health workers on infant and young child feeding in the context of EVD; and an interagency joint statement on infant and young child feeding in the context of Ebola virus disease.
- b. Capacity building in infant and young child feeding in emergency, and nutrition in emergency – with a specific module on EVD.
- c. Remote and onsite country-level technical support.

Country-level EVD preparedness

Achievements

South Sudan

- Nutrition EVD Taskforce established under the Nutrition Cluster with linkages to the Case Management Technical Working Group of the EVD National taskforce.
- EVD nutrition strategy developed drawing on regional guidance.
- Contingency Plan for Nutrition in place.
- Health workers trained on nutrition in the context of EVD through an integrated approach in case management.
- A poster / job aid with summary guidance on infant and young child feeding in the context of EVD developed and distributed.
- Nutrition actors sensitized on infant and young child feeding in the context of EVD.
- Ready-to-use infant formula (RUIF) and infant formula (in local market) pre-approval finalized.

Uganda

- Nutrition EVD Taskforce established under the Nutrition sector with linkages to the Case Management Technical Working Group of the EVD National taskforce.
- Nutrition integrated in broader EVD preparedness and response.
- Development and dissemination of SOPs and job aids.
- Capacity development of 66 Training of Trainers and 296 frontline health workers on nutrition in the context of EVD through an integrated approach in case management.
- Procurement of supplies:
 - Contingency stock of 2,160 RUIF aseptic cartons/tetra packs with 2,200 nifty cups⁶ prepositioned for emergency deployment.
 - Contingency stock of 768 RUIF procured and prepositioned for deployment based on need.

Rwanda

- Nutrition integrated in broader EVD preparedness and response.
- Technical support, training, development of guidance, and capacity building of Ministry of Health officials on the role of nutrition in the EVD response.

⁶ Nifty cup: reusable silicone cup designed to optimise hand expression and feeding of newborns with breastfeeding difficulties Source: <https://laerdalglobalhealth.com/products/nifty-feeding-cup/>

What went well, what went less well and what can be done better

What went well

- Availability of nutrition-specific guidance (at the global, regional and country level).
- Prepositioning of supplies in Uganda.
- Pre-approval of RUIF and powdered infant formula (PIF) in Burundi, Rwanda, South Sudan, and United Republic of Tanzania.
- Inclusion of nutrition in regional and national EVD coordination mechanisms.
- Inclusion of nutrition in EVD preparedness and response plans.
- Continuous contextual analysis of needs.
- Regional learning – with DRC and through calls with priority countries.

What went less well

- Gaps in protocols, for example on provision of food assistance.
- Community level engagement.
- Lack of clarity on breastfeeding safety and vaccination at the beginning resulting in conflicting guidance.
- Lack of clarity on the roles of nutrition/nutritionist in the response.
- Absence of links with social protection programmes for children without appropriate family care.

What can be done better

- Timely capacity building of nutrition workforce in health emergencies.
- Inclusion of nutrition from the beginning of the response.
- Information and data management.

Key lessons from Nutrition EVD preparedness and response efforts

- Enhanced sectoral and interagency coordination with links to the NTF contributed to timely development of a coherent EVD nutrition strategy and a timely response.
- Government ownership and leadership at national and subnational levels is key for enabling functionality, coordination, effective programming, and sustainability of EVD interventions.
- Availability of updated, coherent guidance, and preparedness plans facilitates an effective response. Further, inclusion in national SOPs and preparedness plans enhanced nutrition visibility in response.
- Nutrition capacity building for health workers, programme managers and other sectoral keys helped reinforce nutrition programming. That said, the roles of nutritionists and psychosocial support workers in the area of infant and young child feeding need to be more clearly defined.
- Procurement and prepositioning of essential nutrition supplies supported a timely response.
- Availability of nutrition information and a functional information system facilitated optimal response.
- Cross-country collaboration and learning between ESAR priority 1 countries facilitated fast-tracking of EVD nutrition preparedness and response.



Feeding a child in a crèche, Democratic Republic of the Congo.

A Uganda Red Cross volunteer teaches people about dangers of Ebola using a banner provided by UNICEF as people from Democratic Republic arrive at a screening facility set up at point of entry at Uganda-DRC border town of Bunagana in Kisoro district.



3

Session 2

Country deep dives: achievements, challenges, and lessons learned in implementing EVD preparedness

Session two examined achievements, challenges and lessons learned by preparedness and pillar to facilitate cross country learning.

3.1 Achievements and lessons learned in EVD preparedness and response

3.1.1 Coordination, leadership, and cross-border collaboration

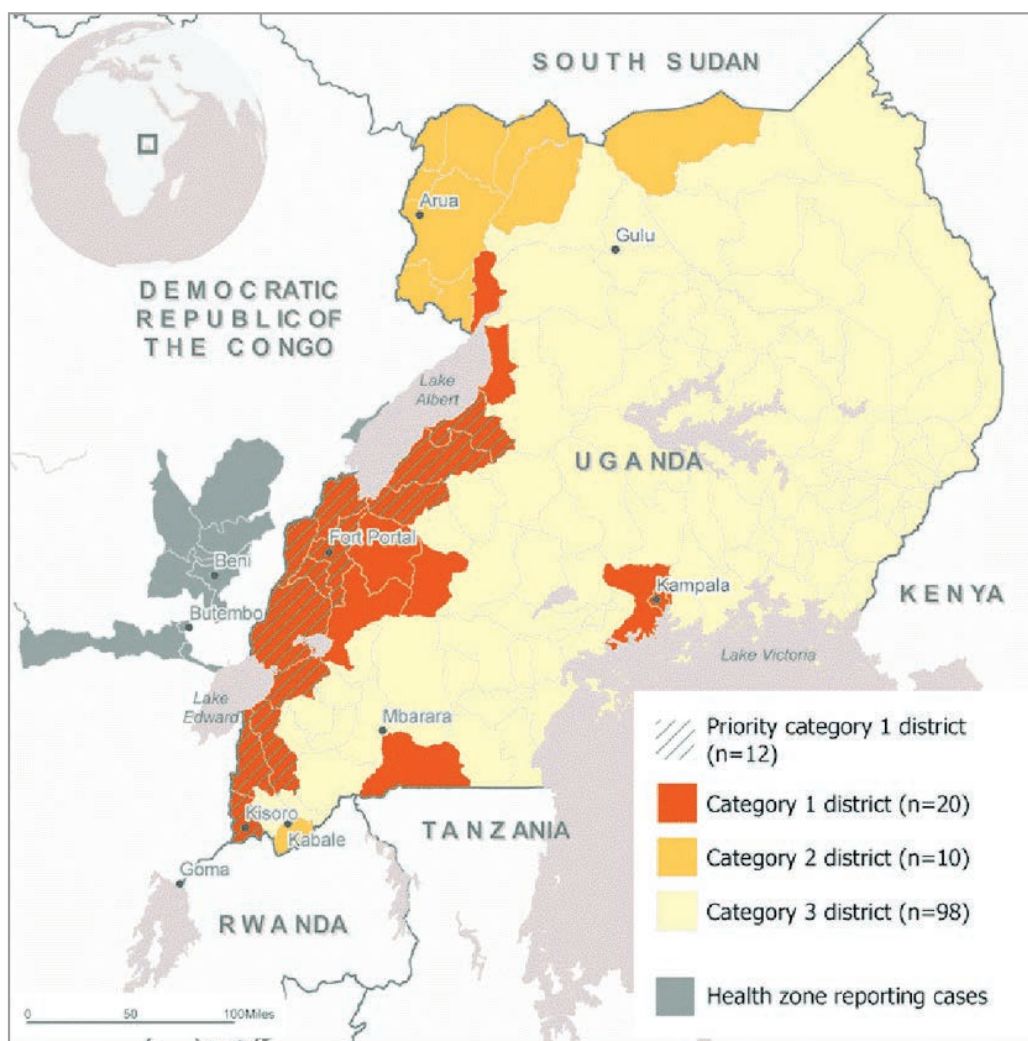
Uganda

In 2018, the Ministry of Health identified 30 districts considered to be most at risk of EVD transmission from the DRC, of which 17 share a border with DRC. Almost 30 per cent of the population was considered at risk. In addition, Uganda is host to the second largest refugee population in Africa, and faces various recurrent outbreaks including cholera, measles, and viral haemorrhagic fevers.

The Uganda Country Office provided support to national EVD preparedness planning and response efforts and was part of Government-led coordination structures at both national and district levels. UNICEF support, which had a system strengthening focus, was provided in coordination with other United Nations agencies and partners. The main pillars were: Risk Communication; Social Mobilization and Community Engagement; Case Management: Infection Prevention and Control /WASH and Child Nutrition; and Psychosocial Support with a focus on Child Protection.

Risk mapping was adjusted following outbreaks on 12 June and 29 August 2019 in Kasese district. A further revision was made in February 2020 to address further changes in the outbreak situation, mainly reduced risk of importation.

Figure 3. Ebola virus disease risk distribution in Uganda, April 2019



Source: Ebola Virus Disease Preparedness Assessment and Risk Mapping in Uganda, August-September 2018 From Nanziri et al (2020) [accessed 19 Nov, 2020]

Key achievements

- UCO contributed to strengthening national and subnational level coordination and oversight, especially in UNICEF led pillars.
- Key fundraising, advocacy, and strategic documents in place to support the response.
- Strengthened capacity to develop costed district-specific micro-plans with clear priorities.
- Improved service delivery and information (logistics and last-mile delivery).

Lessons learned

- Strategic positioning of UNICEF staff within Government decision-making teams resulted in better Government and agency outputs.
- Deploying and embedding staff in district task forces and support for co-chairing pillars improved performance.
- Joint field visits under Ministry of Health leadership had greater impact on personnel and activities.

After the EVD outbreak declaration on 1 August 2018, the Government of Rwanda prioritised EVD preparedness to address the risk of importation from neighbouring North Kivu and scale up readiness to respond to a potential outbreak, which it had not experienced before. Its phase three plan covering 2019 to 2020 prioritised 15 districts along the borders with DRC, Uganda and Burundi, and Kigali, which hosts the International Airport.

Figure 4. Ebola virus disease risk distribution in Rwanda, Phase III Plan (2019)



- Joint planning and coordination with the United Nations Country Team (UNCT), donors, and the Government.
- UNICEF leadership, multisectoral approach, and representation in key areas: Risk Communication, Community Health, Infection Prevention and Control, Education, and Child Protection.
- RCO participated in cross-border dialogue and implemented joint EVD preparedness and response actions with DRC, other East African Community (EAC) Member States, and Priority 2 countries.

- Availability of Emergency Programme Fund (EPF) allowed RCO to respond quickly to the needs in the country. Fundraising with the Central Emergency Response Fund (CERF), USAID, and DFID resulted in the Humanitarian Action for Children (HAC) appeal for Rwanda being 100 per cent funded.
- Well-coordinated effort to engage media with WHO, RBC and RHCC resulting in improved EVD reporting.

Lessons learned

- Timely cross-border collaboration contributed to sharing of experiences, resources and an effective preparedness and response.
- A health system strengthening approach should have been deployed from the beginning.
- Schools were effective platforms for interventions. Moving forward, the education sector in national in public health and other emergency preparedness and response efforts.
- Internal emergency funding facilities contributed significantly to gap filling and the rapid scale up of preparedness activities.

South Sudan

The WHO risk assessment categorised South Sudan as high risk for EVD importation from North Kivu and Ituri provinces, subsequently, the country identified high risk/ priority sites in 6 states for preparedness activities. In addition to facing a protracted humanitarian crisis from 2013, South Sudan also faces acute shortages of skilled health workers, food insecurity, and recurrent disease outbreaks including seasonal malaria, hepatitis E, cholera, meningococcal meningitis, and yellow fever.

Figure 4. Areas at risk of EVD importation from the Democratic Republic of the Congo



Source: SS EVD Preparedness National Taskforce (Areas at risk of EVD importation in yellow).

The Minister of Health established the EVD national taskforce and delegated its leadership to an Incident Manager, who was supported by pillar leads and the Emergency Operations Centre staff. The following preparedness pillars were established: strategic leadership and coordination; RCCE; border screening and points of entry; surveillance and laboratory support; case management, infection prevention and control and safe dignified burials; vaccination, therapeutics & research and safety and security established to facilitate access and ensure security of responders. State taskforces were established, with some pillars. UNICEF South Sudan Country Office (SSCO) was co-lead for RCCE, IPC/WASH technical working groups (TWGs) and participated in logistics, and case management at both national and state levels. The UN Humanitarian Coordinator constituted a Strategic Advisory Group (SAG), with UNOCHA as chair and WHO as co-chair, to provide strategic direction and advice on EVD preparedness activities to the NTF. The SAG membership included UNICEF and other UN agencies, key humanitarian partners and donors⁷. Key achievements and lessons learned in EVD coordination, leadership, and cross-border collaboration are presented in the table below:

Key achievements

- Leadership by the Ministry of Health and UNICEF co-leadership of RCCE, Psychosocial Support (PSS) and IPC WASH Technical Working Groups contributed to improved coordination and ownership.
- Effective coordination improved the quality of interventions, harmonized approaches, and reduced overlap.
- There was an effective cross-border collaboration initiative between South Sudan and Uganda.

Lessons learned

- An inter-pillar coordination platform was helpful in promoting integration across the pillars.
- Linkages between national and state-level Task Forces and Technical Working Groups improved the implementation of activities.
- The EVD preparedness coordination mechanism facilitated a rapid rollout of COVID-19 preparedness and response activities.
- Cross-border collaboration with Uganda Country Office facilitated access to hard-to-reach at risk areas along the borders.



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Students at Kinji Primary School are studying the banners with information about Ebola Virus Disease. River Yei State, South Sudan.

7 WHO, UNOCHA, UNICEF, WFP, IOM, UNHCR, DFID, CDC, USAID-OFDA, ECHO, SCI, WVSS and MEDAIR

3.2 Infection prevention and control through Water, Sanitation, and Hygiene (WASH)

Burundi

Key achievements

- UNICEF ensured that emergency response contributed to structural improvements in water and sanitation facilities at health centres, points of entry, schools, and communities. This was a good example of work along the humanitarian -development nexus.
- The WASH section worked collaboratively with other sections and agencies to deliver an integrated service package at health centres, schools, and in communities.
- UNICEF demonstrated leadership in the IPC/WASH sector, complementing WHO work, as appropriate.
- The C4D team successfully launched mass communication programmes, exploring communication in emergency for the first time in Burundi.

Lessons learned

- It was important to advocate for the prioritisation of WASH component of the IPC subcommittee, which was not initially 'obvious'. UNICEF advocacy kept WASH visible in the response.
- Working with private contractors ensured better quality and reduced risk – this was particularly the case for construction of toilets and water supply points.
- Prefabricated containers were installed at points of entry to provide screening, isolation and office space. Unfortunately, they took up too much space and reduced options for construction of other facilities, such as latrines.
- Laundry rooms should be part of the WASH/IPC package support to health facilities.
- In terms of supplies, it is important to know what is available locally instead of only focusing on international (off shore) procurement.

South Sudan

Key achievements

- UNICEF coordinated the work of more than 30 IPC/WASH partners at national and subnational levels.
- SOPs for IPC/WASH were developed and disseminated at all high-risk locations and in targeted health facilities.
- IPC/WASH assessments were progressively conducted in over 200 health facilities.
- IPC/WASH support is now available at 192 health facilities.
- IPC training reached 434 health workers – both medical and non-medical staff.
- IPC measures and basic WASH services were sustained at 10 isolation and holding units.
- Hand-washing facilities were installed and maintained in 295 public places.
- Approximately 500,000 people were reached with integrated hygiene promotion messaging to reduce the risk of EVD transmission in 295 public places.

Lessons learned

- Greater involvement of the Ministry of Health in planning, implementation, and monitoring of IPC/WASH activities improves outcomes and promotes sustainability.
- Supportive supervision and monitoring fostered integrated approaches and improved programme quality.

Uganda



Pupils of Nyabugando Parents Primary School near the Uganda-DRC border wash their hands as part of the EVD prevention.

Key achievements

- Strengthened IPC through targeted WASH interventions in 6640 health facilities, 384 schools, 44 points of entry, and public places.
- Strengthened coordination among district partners implementing IPC.
- Strengthened district capacity to plan, supervise and mentor.
- Access to a sustainable onsite source of chlorine solution for disinfection at district hospitals and Health centre IVs (HC IVs) in 15 districts thanks to innovation by UCO – installed 50 solar-powered chlorine generators.
- Improved WASH facilities installed at 28 health centres and 13 schools and enhanced capacity to maintain it through training of 769 health workers and 613 teachers.

Lessons learned

- Direct partnership with districts provided a platform for sustainability beyond EVD.
- WASH assessments and microplanning of WASH in health facilities provided tools for more strategic and sustainable investments.
- Joint implementation strengthened WASH component in case management and improved understanding of synergies and performance.
- Innovations, such as the use of chlorine generators, have a potential for lasting impact beyond EVD preparedness.

3.3 Mental Health and Psychosocial Support (MHPSS) and Child Protection in preparedness and response to infectious diseases

3.3.1 Positioning MHPSS and Child Protection in preparedness and response to infectious diseases – Uganda

Key achievements

- Improved national and subnational level coordination of Mental Health and Psychosocial Support.
- Integrated national Mental Health and Psychosocial Support and Child Protection strategy and standardized training packages developed and disseminated.
- Training held for district probation and mental health staff who in turn trained community-based para-social-workers to provide psychosocial support and child protection services.
- Integrated MHPSS and Child Protection and implemented joint trainings and a harmonised case management approach.

Lessons learned

- Limited understanding of the difference between MHPSS and CP.
- Lack of a national MHPSS strategy limits its operationalization at the subnational level.
- Integration and joint implementation of MHPSS-CP activities resulted in better outcomes.
- Use of existing community and formal social service structures (para-social workers, district probation and welfare officers) improved access to MHPSS-CP services and sustainability.



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Rwebisango Health Centre III, Ntoroko district isolation centre for suspected EVD cases.

3.3.2 Mental health and psychosocial support can help in disease outbreaks

Mental health and psychosocial support services can make an important contribution in the context of disease outbreaks. Such services can support local actors with accurate knowledge about a disease and help to prevent stigma; provide continued access to care and support for people dealing with mental health, substance abuse, or psychosocial issues; contribute to stopping transmission; and help prevent long-term negative impacts on a person's well-being. Additionally, Mental health and psychosocial support services can include dedicated expertise, which can facilitate coordination of the response.

The table below details opportunities for collaboration with other pillars of the response.

Pillar	Area for collaboration
Risk Communication and Community Engagement	<ul style="list-style-type: none"> • Mitigate the risk of stigma by providing factual and positive messages. • Adapt messages to various target populations (communities, frontline workers, children, caregivers). • Disseminate messages to mitigate risk of gender-based violence, as well as messages on available services for survivors (helplines, legal services, MHPSS services).
Case Management (covering Health, Nutrition, and MHPSS interventions in clinical settings)	<ul style="list-style-type: none"> • Integrate mental health and psychosocial aspects of EVD into clinical case management protocols to mitigate the impact of stressors associated with positive cases. • Build capacity of clinical case management actors on the detection of distress and mental health problems (e.g., panic, anxiety) associated with positive cases, and first-line approaches as part of a supportive response. • Build capacity of community health workers on Psychological First Aid and referral pathways. • Contribute to the continuum of care within the four tier MHPSS pyramid of interventions, which includes (i) basic services and security, (ii) community and family support, (iii) focused non specialised support and (iv) specialised services (Snider & Hijazi, 2020)⁸. • Ensure continuity of care for people with mental health conditions. • Integrate mental health, psychosocial, and nutrition interventions to improve the development of infants and young children.
Surveillance	<ul style="list-style-type: none"> • Mitigate the risk of stigma by engaging with communities before and while conducting contact tracing. • Mitigate the risk of psychosocial stress by providing clear and factual messages around the disease, contact tracing, and available options, e.g. for quarantine, to strengthen positive coping mechanisms.

8 Snider L., Hijazi Z. (2020) UNICEF Community-Based Mental Health and Psychosocial Support (MHPSS) Operational Guidelines. In: Song S., Ventevogel P. (eds) Child, Adolescent and Family Refugee Mental Health. Springer, Cham. https://doi.org/10.1007/978-3-030-45278-0_7

3.4 Supporting Ministries of Health to enhance case management capacity for EVD

3.4.1 Enhancing case management capacity for EVD – South Sudan

Key achievements

- Five implementing partners maintained 4 existing isolation facilities and 7 holding units⁹.
- Referral pathways and linkages with other pillars were established.
- Four dedicated EVD ambulances were equipped with supplies and 8 trained ambulance teams.
- Critical medical equipment, drugs, and other supplies were procured and distributed as needed.
- The national EVD case management and ambulance SOPs were revised.
- Training on basic comprehensive EVD clinical care benefitted 65 health workers, and 97 health staff received refresher trainings using the revised materials.
- Rapid assessment tools for isolation facilities and holding units were developed, and progress reports and case summary reports shared for action.
- A total of 24 drills and 16 mentorship sessions aimed at increasing health worker confidence in EVD case management were conducted in isolation facilities.
- Holding units⁹ were upgraded to meet minimum structural and IPC/WASH standards.
- UNICEF developed phase out and exit strategies to facilitate a smooth transition and handover of facilities to the Ministry of Health.

Lessons learned

- Effective leadership and coordination at national and subnational levels is critical for successful implementation of emergency preparedness and response plans.
- Integration of related pillars (e.g., Infection Prevention and Control, Case Management, and Safe and Dignified Burials) contributes to overall achievement of programme goals by fostering synergy and avoiding duplication.
- Clear strategies, a set of minimum standards, regular supportive supervisions, and simplified tools are key to effective operation of EVD isolation and treatment facilities.

3.4.2 Supporting the Ministry of Health to enhance case management capacity for EVD – Uganda

Key achievements

- Personal protective equipment was procured and distributed to selected health facilities.
- Surge staff was deployed to district logistics teams to operationalize eLMIS (electronic Logistics Management Information System) and stock management.
- IPC/WASH training sessions and orientation were integrated and jointly implemented with case management.

⁹ Also referred to as isolation areas. These are areas within health facilities where patients suspected of having EVD were isolated until their test results were received. If negative, they were moved to the Ebola treatment unit/centre.

- Training of trainer workshops conducted for district health management teams to enhance capacity to mentor and supervise health-facility-based and community-based workers.

Lessons learned

- Case management should be patient centred. Integrating case management with IPC/WASH resulted in better IPC outcomes.
- Over 60 per cent of facilities could not meet the recommended IPC standards, pointing to an urgent need to invest in improving infrastructure.
- Empowering integrated district teams to mentor health workers and other community structures improved performance, particularly in terms of IPC.



A health worker takes temperature of a woman as people from Democratic Republic line up at a screening facility set up at point of entry at Uganda-DRC border town of Bunagana in Kisoro district.

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3.4.3 Supporting the Ministry of Health to enhance case management capacity for Ebola virus disease – Malawi

Key achievements

- A total of 30 trainers cascaded training to 9 high-risk districts, enhancing the capacity of 525 health workers in Case Management, Infection Prevention and Control, and Surveillance.
- Adequate isolation capacity at points of entry was established to facilitate secondary screening for EVD.
- The national laboratory specimen referral network was strengthened.
- An EVD simulation exercise was conducted in November 2019 to test readiness of at-risk districts and EVD treatment centres.

A Red Cross volunteer takes the temperature of a Congolese man with an infrared thermometer in Bwera border town.



4 Session 3

What went well, less well, and why? What can be improved?

The session focused on what went well, less well and why, and what can be improved, moving forward. These questions are adapted from the after action review methodology. It was selected because (i) it is a component of the IHR (2005) monitoring and evaluation framework, and (ii) has been historically used for supporting collective learning and improvement following public health response (WHO, 2019; Stoto et al, 2019).

4.1 Common findings in all countries

What went well

- Internal coordination in all the priority countries was strong. In emergency prone countries, this was largely due to the existence of the Emergency Management Team mechanism, with regular meetings instituted for EVD coordination. These were chaired by the Representative, Deputy Representative or delegated to the Chief of Health or chief of Emergencies. The quality of the response was therefore linked to strong leadership and good information sharing.
- Recruitment of staff and deployment of surge capacity from Liberia, Sierra Leone and Uganda country offices with good previous EVD experience contributed to enhancing country response. This was facilitated by the Level 2 SoPs.
- UNICEF played a leading technical role in the Water, Sanitation, and Hygiene component of Infection Prevention and Control, Risk Communication and Community Engagement, and in strategic EVD preparedness fora.
- Early development of a preparedness and response plan facilitated timely resource mobilization to support priority interventions in identified high risk areas.
- EVD preparedness and response supplies were procured and prepositioned at national and district levels, prioritising border districts. This included personal protective equipment, drugs for supportive treatment, and triple packaging for sample packaging and transportation.
- Outbreak-related events stipulated in the International Health Regulations (2005) were conducted with UNICEF participation. This included accountability fora, simulation exercises, joint monitoring missions, and after-action reviews. Findings were used to enhance preparedness efforts.
- Generation of social science evidence contributed to designing strategic approaches and messaging for behaviour change.
- Contingency Programme Cooperation Agreement (PCA) supported rapid scale up of field interventions.

What went less well

- Stronger cross pillar coordination and collaboration could have further enhanced response.
- Coordination of EVD preparedness and response did not sufficiently engage line ministries beyond the Ministry of Health.
- Formal After Action Reviews were not conducted at the end of the outbreak, planned phase out/exit processes were also interrupted by COVID-19.
- The prolonged EVD preparedness phase led to message fatigue – there is a need to balance risk-informed messaging and other challenges that communities often find more serious (for example insecurity, lack of basic services).
- Almost all countries were affected by limited funding for what became a protracted crisis.

What to improve

- Information about the supply strategy and anticipated delays should be made available timely to allow countries to adapt their programming accordingly.

4.2 Burundi

What went well

- The consortium led by UNICEF with the World Food Programme (WFP), the International Organization for Migration (IOM), and the World Health Organization (WHO) proved very useful for joint delivery in points of entries and health facilities, in the One UN spirit, and attracting donors.
- Mainstreaming EVD in existing programmes through networks of community-based organizations (CBOs) and non-governmental organizations (NGOs) was particularly relevant in the areas of Child Protection and Education.

What went less well

- National coordination revolved chiefly around fundraising rather than strategy and operationalization.

What to improve

- The overlaps between sections could be avoided with clearer division of roles, e.g. one section taking the lead on a multisectoral package delivered in schools (Education), another in health facilities (Health), and another through hotlines (C4D).
- A Beyond Ebola reflection was planned but not conducted.

4.3 Malawi

What went well

- The Country Office procured, distributed and installed equipment, such as thermo scanners, hand washing stations, and alcohol-based hand rub dispensing points at priority facilities jointly identified with government.

What went less well

- Points of entry did not have sufficient isolation capacity for secondary screening of suspected cases.
- The electronic Integrated Disease Surveillance and Response system (eIDSR) had not yet been fully operationalised and there was limited real-time reporting of alerts and inefficient contact tracing.

What to improve

- The capacity of health workers in case management should be strengthened.
- Support for systematic IPC assessments in health facilities and mentorship of health staff.



Farida Ramadhani a participant of the SWASH club; poses for a photograph while washing her hands at Kingugi School in Dar es Salaam, Tanzania

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4.4 United Republic of Tanzania

What went well

- An integrated process within UNICEF, as well as close coordination with WHO and partners including U.S. Centres for Disease Control and Prevention (CDC), preparedness efforts more effective.

What went less well

- EVD preparedness and response efforts were undertaken by UNICEF and partners in an unusual context, where information sharing was highly sensitive and very limited. A call centre established for alerts and run by EOC did not generate the information and feedback required to inform community engagement. Mass media messaging and other feedback platforms, such as U-report were hindered by the national position on information sharing.
- Activities were limited by limited availability of funds.
- Preparedness efforts were restricted by lack of WASH materials for case management, decontamination, and training in health facilities and isolation/treatment centres.
- The division of labour between UNICEF and WHO on implementing Infection Prevention and Control (IPC) measures was not sufficiently clarified to donors and sector partners (WHO focused on case management aspects, while UNICEF focused on WASH aspects of IPC.)
- Resource mobilization for EVD preparedness in the country was hampered by the country's Priority 2 classification despite a high level of threat, and lack of Government ownership of the preparedness process.

What to improve

- Further internal capacity strengthening for preparedness and response to public health emergencies.
- There is a need to have in place a strategic approach to address various public health risks.



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Nasla Jamadi (right), a participant of the SWASH club; poses for a photograph while washing her hands at Kingugi School in Dar es Salaam, Tanzania.

4.5 South Sudan

What went well

- Good linkages between national and state level Task Forces and Technical Working Groups and effective partnership and coordination with community structures supported an effective response. UNICEF contributed to this directly through RCCE, IPC/WASH, pillars that it co-led.
- Research projects generated evidence which informed the messages and choice of RCCE interventions. Psychosocial support (PSS) was well represented under this pillar in the national Technical Working Group.
- UNICEF directly contributed to planning and implementation of simulation exercises in IPC/WASH and RCCE pillars.
- UNICEF supported tailored, well-designed and practical capacity building activities in case management, IPC/WASH and RCCE contributed to enhancing readiness for EVD response. Key support was provided by UNICEF in the coordination of training, including identification of trainee cohorts, relevant curricula, and development of training materials. Protocols were put in place for prior endorsement of training activities, to promote standards and consistency. This contributed to addressing uncoordinated training by various partners.

What went less well

- Weak health systems, conflict, population displacement, and the occupation of health facilities by armed groups created challenges in implementing EVD preparedness efforts. In some areas, notably in Yei River State, access to health facilities was difficult due to both insecurity and poor roads.
- Baseline information gaps about the number and functionality of health facilities made planning challenging.
- Limited WASH infrastructure and low numbers of skilled health workers constrained progress – efforts to identify qualified and motivated IPC focal points at each facility were only moderately successful.

What to improve

- Limited staffing affected the representation of the WASH, case management pillars, and the PSS at the state-level Task Force. While UNICEF had a field presence, this limited government and partner representation delayed the planning and implementation of preparedness activities.
- Preparedness was very costly due to limited or no Government investments – this became discouraging for partners.

4.6 Uganda

What went well

- Strong government led coordination, with support from partners including UNICEF at the national level enabled an efficient response.
- Introduction of the electronic Logistics Management System (eLMIS) and UNICEF last-mile delivery supported effective management of operations and supplies.
- Monitoring and evaluation activities included joint multi-agency field monitoring visits.

What went less well

- EVD preparedness and response efforts at the district level were slowed down by lengthy processes used in the Government funds management systems for emergency disbursement.
- Monetization of response – volunteers, and various cadres of government workers required payment of allowances/stipends and this proved costly for multidistrict response (UNICEF was supporting >20).
- Over-dependency of districts on national teams for guidance and leadership of preparedness and response.

What to improve

- Coordination of all pillars should be decentralized.
- Fundraising should be decentralized to facilitate local private partnerships for responses.
- Management of points of entry.



Uganda Red Cross Society (URCS) volunteers on a villages awareness exercise about Ebola preparedness and prevention in Mirami village near the Point of entry between Uganda and DRC, as part of the involvement and response in Interventions for Ebola Virus Disease (EVD) activities.

4.7 Rwanda

What went well

- Strong government led national level coordination, with clear mandate and responsibilities for partners including UNICEF, contributed to an effective EVD preparedness effort.
- UNICEF worked with the private sector to increase the reach of the response. Examples include soap distribution coupled with hand-washing demonstrations in various communities; and working with tea plantations on infection prevention and control at early childhood development centres on their premises.
- Ministry of Education and the Rwanda Education Board supported capacity building in EVD prevention among Education stakeholders in priority districts.
- Joint training of frontline Health workers and Child Protection staff facilitated cross-sectoral understanding and collaboration around protection of children during EVD outbreaks .
- Efficient supply management was achieved by keeping central stock in the capital, some stock at the level of district pharmacies, and some at the health centre level.
- A UNICEF consultant provided support to the Ministry of Health on WASH, including Ebola Treatment Centre construction, assessments, development of SOPs, guidelines and training materials.

What went less well

- The Internet of Good Things could have been used for EVD prevention and mass messaging – a missed opportunity.
- Supply information was not shared among partners, making it difficult to avoid duplication and conduct effective monitoring.

What to improve

- Additional information on key concepts relating to public health emergency preparedness and response, such as preparedness benchmarks, exit strategy, risk-informed programming, and management.
- Better coordination between the Ministry of Health/Rwanda Biomedical Centre (RBC) and the National Commission for Children, especially advocacy to include Child Protection within the frame of the overall national response to infectious disease outbreaks. Further support from ESARO in various aspects of Child Protection and Mental Health and Psychosocial Support (MHPSS) in this regard is also needed. It would be a good idea to sustain local capacity in preparing and responding to sudden outbreaks by formalizing refresher training on EVD and other outbreak risks, e.g. COVID-19.
- Conducting comprehensive, structured assessments or evaluations in health centres was difficult. In addition, private health centres were not prioritised distribution of supplies or training.
- The Government's choice of expensive options over more cost-effective models limited the reach of already scarce resources.
- Trainings on WASH in the context of Infection Prevention and Control could be integrated with those on Case Management.
- Disease preparedness efforts would benefit from reinforcement of IPC programmes through Social and Behaviour Change Communication (SBCC) / RCCE support and strengthened emergency interventions, coordination, monitoring and evaluation systems.

5 Recommendations

Building on the EVD experience in countries and reflections from the field response from 2018 to 2020, the ESARO EVD team recommends the following, with focus on programme preparedness, funding and staff safety:



- **Staff safety:** Working with senior management, human resources and programmes, institutionalise pre-deployment training for consultants and staff going to the ‘frontlines’ for response. A range of online courses already exist, and various packages can be further tailored by ESARO and country offices, building on the orientation package developed for the priority 1 countries. Field teams and any staff going to the field should do these courses from this, similar to requirements for security clearance. Prior to deployment, ensure that insurance policies adequately address treatment (including potential medical evacuation) and other potential issues, based on local knowledge of response areas. Senior management should ensure that internal response plans adequately address surge needs so that response staff (national and field levels, both national and international) do not burn out.



- **Programme preparedness:** Identify and address programme areas that still require capacity strengthening to facilitate an optimal and cross sectoral response to public health emergencies. Key examples include: infection prevention and control, MHPSS and child protection in infectious disease outbreaks, logistics and supply for outbreak preparedness and response, and case management. Ensure that national staff are prioritised for capacity building including cross country experience sharing, as they remain the bedrock for UNICEF work in countries in both emergency and development. Approaches for preparedness and response should be cross sectoral and at the same time appropriately address the health emergency focus. Continue to build on social science evidence generation both in emergency preparedness and response, as it influences the course of response at the community level and is within the remit of UNICEF’s C4D work.



- **Funding:** Advocacy for access to more flexible funding to facilitate preparedness with focus on countries that do not traditionally receive much funding, yet are high risk for emergencies (e.g. Uganda, Burundi). In this regard, explore national level private sector partnerships – many companies take corporate responsibilities seriously during outbreaks, and make in kind contributions especially on RCCE/C4D interventions (mass media production and messaging) and supplies (for case management). During EVD preparedness, Rwanda and Burundi reported excellent examples of local producers making in kind contributions of soap. Consider the possibility of estimating minimum associated costs of preparedness for the commonest public health emergency in selected countries with focus on UNICEF key response areas and use this information to inform future planning including resource mobilization efforts with government. Ensure that these needs estimates are developed for both acute and prolonged scenarios.

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Annex 1. Meeting agenda

Regional Stocktake Webinar: Ebola virus disease preparedness and response in priority countries				
Date: 30 June 2020 Venue: Zoom Time: 10.00–13.00				
Time	Session	Method	Presenters/Lead	Moderator
10.00-10.10	Welcome remarks	Plenary	Gabriele Fontana, Regional Health Adviser	Ida-Marie Ameda, Health/ESARO
Setting the scene				
10:10-10:15	Objectives of the webinar	Presentation	Paulin Nkwosseu, HARP	Paulin Nkwosseu, HARP/ESARO
10:15-10:25	Overview of EVD preparedness and response in ESA (2018 to 2020)	Presentation	Ida-Marie Ameda, Health/ESARO Hannah Scott, HARP/ESARO	
10:25-10:35	C4D presentation on findings of the EVD preparedness stocktake in selected countries	Presentation	Lead – Charles Kakaire, C4D/ESARO with Burundi, Rwanda, South Sudan, Uganda, United Republic of Tanzania	
10.35-10.45	Nutrition in the context of EVD	Presentation	Lead – Marjorie Volege, Grainne Moloney, Nutrition/ESARO	
10.45-11.10	Discussions/Q&A	Discussion	Mohamed Omer, Health/ESARO	
Deep dive: achievements, challenges and lessons learned from EVD preparedness in priority countries				
11:10-11:25	Country deep dive: achievements and lessons learned on coordination and leadership, and cross-border collaboration	Presentation	Co-leads: Uganda, Rwanda, South Sudan	Hannah Scott, HARP
11.25-11.40	Country deep dive: achievements and lessons learned on IPC/WASH	Presentation	Co-leads: South Sudan, Uganda, Burundi	Pierre Fourcassie, WASH/ESARO

Time	Session	Method	Presenters/Lead	Moderator
11.40-11.55	Country deep dive: positioning MHPSS and CP in preparedness and response to infectious disease	Presentation	Lead – Uganda	Ndeye Marie Diop, CP/ESARO
11.55-12.05	Country deep dive: supporting improvement of case management capacity	Presentation	Co-leads: Uganda, South Sudan, Malawi	Ida-Marie Ameda, Health/ESARO
12.05-12.50	What went well, less well and why? What can we do better?	Presentation – 5 minutes	Burundi, Malawi, Rwanda, South Sudan, United Republic of Tanzania	Mohamed Omer, Health/ESARO
12.50-12.55	Next steps	Plenary	Mohamed Omer, Health Specialist, ESARO	
12.55-13.00	Wrap-up and closure	Plenary	Paulin/HARP and Ida/Health	Mohamed Omer, Health/ESARO

UPDF soldiers and red cross volunteers are directing the people crossing in to Uganda towards the Ebola screening process. Red cross volunteers are screening Congolese people with infrared thermometers in Bwera border town.





