JOINT EBOLA TABLE TOP SIMULATION EXERCISE BETWEEN THE UNITED REPUBLIC OF TANZANIA, DEMOCRATIC REPUBLIC OF CONGO, REPUBLIC OF UGANDA, REPUBLIC OF RWANDA, REPUBLIC OF BURUNDI AND THE REPUBLIC OF KENYA

EAST AFRICA PUBLIC HEALTH LABORATORY NETWORKING PROJECT (EAPHLNP)

MEETING REPORT

30TH SEPTEMBER TO 02ND OCTOBER, 2014,

RWIZI ARCH RESORT IN MBARARA DISTRICT, UGANDA

Collaboration of the EAC and ECSA-HC

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1.0 INTRODUCTION

The East, Central and Southern Africa Health Community Secretariat (ECSA-HC) is collaborating with the East African Community, EAC Partner States, the World Health Organization (WHO), the US Centers for Disease Control and Prevention (US CDC) in the implementation of the World Bank supported "East Africa Public Health Laboratory Network Project (EAPHLNP)" which is also contributing to the strengthening of the "East African Integrated Disease Surveillance Network (EAIDSNet)". This is a regional collaborative initiative of the EAC Partner States' national ministries responsible for human and animal health, including wildlife as well as the national health research and academic institutions in both the public and private sector.

Under article 118 of the Treaty on the Establishment of the East African Community, the Partner States undertake to take joint action towards the prevention and control of communicable and non-communicable diseases that might endanger the health and welfare of the residents of the Partner States, and to cooperate in facilitating mass immunization and other public health community campaigns.

The main objective of the "East Africa Public Health Laboratory Network Project (EAPHLNP)" is to establish a network of efficient, high quality, accessible public health laboratories for the diagnosis and surveillance of Tuberculosis (TB) and other communicable diseases. Specifically, the project will complement ongoing regional and global initiatives to improve Integrated Disease Surveillance and Response (IDSR) country systems which will enhance the availability of quality information by: (i) strengthening competence of lab and facility personnel to collect, analyze, and use surveillance data; (ii) reinforcing laboratory networking and district capacity (particularly those in border areas) to report, investigate, and adequately respond to disease outbreaks; and (iii) strengthening communications and data sharing to respond rapidly to outbreaks, including those which are: (a) *outbreak prone* (*cholera, meningitis, hemorrhagic fever*), (b) *endemic* (*multi-drug resistant TB*), or have (c) *pandemic potential* (*influenza*).

1. 2 Purpose of the Meeting

The table top simulation training meeting was convened in order to prepare the respective border districts in the Republic of Rwanda, Republic of Uganda, Republic of Burundi, Republic of Kenya, the Democratic Republic of Congo (North and South Kivu) and the United Republic of Tanzania on handling Ebola disease outbreak. The simulation is a joint collaboration between EAC, ECSA-HC and the EAC Partner States.

Undertaking the table top simulation exercise enhances preparedness and response to diseases outbreaks in the EAC region. In addition this exercise helps to identify gaps in the preparedness and response plans and make the appropriate remedies.

1.3 The Broad Objective of the simulation exercise

To assess the level of emergency preparedness and response capacity for Ebola/VHFs outbreak, in the EAC Partner States and North & South Kivu provinces of the Democratic Republic of Congo (DRC) and identify gaps so as to strengthen the surveillance and response system

1.4 The specific objectives of this table top simulation exercise were to;

1. assess the level of preparedness and ability to detect VHF and contain a VHF outbreak at the cross-border areas
2. raise awareness of the roles, responsibilities and immediate emergency response actions of the participants in:
    a. Surveillance
    b. Laboratory testing and confirmation
    c. Risk communication
3. test application of Best Practices of One Health Approach
4. strengthen partnerships and the emergency response capacity of the participants
5. test the efficacy of the preparedness tools- e.g WHO guidelines, selected SOPs, contingency plans of the participating organizations
6. test the coordination of emergency response at sub national, national and regional levels

1.5 Participation

Representatives from the National Ministries responsible for human health, animal health and custom officers of the EAC Partner States, and the Democratic Republic of Congo, The East, Central and Southern African Health Community Secretariat (ECSA-HC), East African Community Secretariat, Emergency Centre for Transboundary Animal Disease of United Nation-Food and Agricultural Organisation (ECTAD FAO) representatives attended the meeting. The list of participants is attached hereto as Annex I.

1.6 Constitution of the Bureau

In accordance with the EAC rules and procedures all the meetings in this current year are chaired by the republic of Kenya and rapporteured by the United Republic of Tanzania. Dr Shikanga O-tipo, from the republic of Kenya, therefore chaired this meeting and Mr. Elibariki Mwakapeje Epidemiologist, Ministry of Health and Social Well fare in Tanzania acted as the rapporteur assisted by ECSA-HC and EAC Secretariat. The participants

introduced themselves before the commencement of the meeting.

1.7 Adoption of the Agenda

The Agenda/programme was adopted as presented by the by Mr. Martin Matu from ECSA-HC Secretariat and it is attached hereto as Annex II.

1.8 THE OPENING REMARKS

Head of delegation from the Democratic Republic Congo (DRC), Dr. Guy Mutombo was glad to be part of the meeting. He informed the meeting that the participants from DRC were coming from North Kivu and South Kivu, he also reminded participants that DRC is bordering all the East African Countries except Kenya. He highlighted the organization structure of the Ministry of Health in DRC and reminded participants that Ebola disease started in DRC in 1976 and that the country has already established a committee for Ebola prevention and control. It has also established cross border health committees at border posts both at South and North Kivu which has improved cross border disease surveillance between DRC and other neighboring countries. The DRC has established infectious disease isolation centers across the country and improved disease surveillance at the major ports of entry i.e thermal scanners have been distributed at the border crossing points to facilitate active screening people for Ebola Hemorrhagic Fever

Head of delegation from the Republic of Burundi, Dr. Victor Bacumi, informed the meeting that following the West African Ebola Disease outbreak, Burundi has improved disease surveillance at Bujumbura International Airport and is currently working on strengthening the disease surveillance units at other border crossing points. The country has also developed Ebola contingency plan. He further informed the meeting that the disease surveillance team meets on weekly basis to review reports and monitor for occurrence of disease outbreaks

Head of delegation from the Republic of Rwanda, Mr. Alex Rutikanga, He was glad to be part of the meeting and thanked the republic of Uganda for hosting the meeting and ECSA-HC/ EAC for the overall coordination, he highlighted measures that Rwanda to prevent and control Ebola outbreak which included sensitization of the District Hospitals, improved disease surveillance at major ports of entry i.e established a passenger screening point at the Kigali airport and other border crossing points on which a nurses and doctors have been put in place.

Head of delegation from the Republic of Kenya, Dr. Shikanga O-tipo, thanked ECSA/EAC for convening all the EAC countries and DRC to work together in preventing and controlling Ebola, he informed the meeting that Kenya has done its best in strengthening disease surveillance and screening at the major ports of entry, particularly improved passenger screening at Jomo Kenyatta International Airport especially for the flights coming directly from West African. He also noted that there has been improvement at passport control centers where close investigations of passengers route before coming to Kenya is done, he also highlighted few challenges that Kenya is facing when it comes to strengthening the cross border disease surveillance along the borders with Somalia, Ethiopia and South Sudan.

Head of delegation from the United Republic of Tanzania, Mr. Elibariki Mwakapeje, thanked the ECSA-HC and EAC secretariat for organizing and convening the meeting, he informed the meeting that Tanzania has also strengthened its disease surveillance following the Ebola threats, he was also glad to meet with delegates from the DRC and noted that DRC is bordering 5 Regions of the United Republic of Tanzania and that it was very important to bring DRC on board in order to strengthen disease surveillance across the East African Countries

Head of delegation from the East Central and Southern Africa Health Community Secretariat (ECSA-HC), Mr. Martin Matu, on behalf of the ECSA Health community thanked the Ministry of Health of Uganda for hosting this important meeting and the partners' states of EAC as well as the MOH, DRC. He was glad that the teams were able to make for the exercise which showed their commitment to surveillance, control and prevention of communicable diseases. He highlighted a number of strategies that the East African Public Health laboratory Networking Project has put in place to strengthen disease prevention and response in the region. These included; establishment of a framework for join cross-border surveillance and response, establishment of cross-border committees, knowledge sharing platforms and is the process of developing a contingency plan for management of communicable diseases and Public Health Events of International Concern (PHEIC). He noted the importance of the table top simulation exercise to further strengthen the systems and build capacity of team in the region in prevention response of diseases. He finally wished the team fruitful deliberations and successful exercise.

Delegate from the United Nations Food and Agricultural Organization (UN-FAO), Dr. Sam Okuthe, was glad to be part of the meeting and highlighted that UN-FAO through the Emergency Center for Trans boundary Animal Disease (ECTAD) is partnering with countries on implementing the one health approach to disease prevention and control. He also explained

that ECTAD is aiming at working and dealing with diseases in a structured manner. He further noted that UN-FAO through the Framework for Emerging Animal Transboundary Diseases has been involved a lot on disease surveillance across the East African Countries

Delegate from the East African Community Secretariat (EAC), Dr. Stanley Sonoiya, thanked the Republic of Uganda for accepting to host the meeting and noted that it was an important meeting to happen as West African Countries are fighting with Ebola Disease that has infected nearly 6000 and claimed the lives of over 3,000 people including health care workers. He urged the EA countries to improve cross border disease surveillance through timely sharing of surveillance information and do a joint work plan. He further urged the African disease surveillance experts to be innovative enough and use their knowledge and skills in conducting operational research that will influence the disease outbreak investigations and management in the EA Regional. He informed the meeting that the EAC full Council of Ministers agreed and approved the establishment of the EAC integrated disease surveillance system.

Official Remarks from the Guest of Honor, Dr. Issa Makumbi from the Republic of Uganda, welcomed all participants to Mbarara District. He was glad to be part of the meeting and therefore thanked ECSA-HC and EAC Secretariat for organizing and facilitating the meeting. He highlighted the existing WHO Framework guiding the collaboration between the Republic of Uganda and the DRC on investigating diseases of unknown origin and urged participants to learn from each other. He also introduced participants to the simulation exercises, and reminded on the existing challenges posed by the emerging and re-emerging diseases such as Ebola, Avian Influenza e.t.c which calls for joint efforts between the partner states as disease do not have borders. He also urged the participants to take the simulation exercise seriously so that they can learn and improve their capacity and confidence on handling Ebola or other disease outbreaks

2.0 PROCEEDINGS OF THE SIMULATION EXERCISE

2.1. Presentation of the simulation exercise objectives

The presentation on the objectives of the simulation was made by Dr. Willy Were from ECSA-HC. The purpose of the exercise was to test national and regional Preparedness and Response Plans (PRP) for Ebola Virus Disease (EVD) and identify gaps in the preparedness plans with a view to making revisions to these plans in order to lay the groundwork for building future preparedness and response capacity owing to the threat posed by EVD. The main objective was to assess the level of emergency preparedness and response capacity for Ebola/VHFs fever outbreak, in the EAC Partner States, and North and South Kivu Provinces of the Democratic Republic of

Congo. The exercise also aimed at identifying gaps so as to strengthen the

surveillance and response. The objectives are as listed in section 1.2 and the presentation is hereto attached as Annex III.

2.2. Overview of EAPHLN Project (Regional Perspective)

The Monitoring and Evaluation Specialist, ECSA HC Dr. Mushi Benedict made a presentation on the progress made in implementation of the EAPHLN Project at the regional level. The presentation highlighted achievement in the following areas (i) improvement in laboratory quality of services with over 80% scoring 2 stars in the peer laboratory audits (ii) Trained mentors and laboratory auditors to support implementation of Improvement plans (iii) Supported the buy-in to services from TB Supranational Reference laboratory in Uganda (iv) Application of PBF to accelerate laboratory improvement at the project sites in some countries (v) Strengthened cross-border disease surveillance and outbreak management (Framework for cross-border disease surveillance, Cross border meetings & establishment of cross border surveillance teams (vi) building capacity in disease surveillance and management of public health events (simulation exercises, training in lab based surveillance, Joint IDSR and community based disease surveillance (vii) establishing knowledge exchange platform (website, bulletins and newsletters, internet access VC etc) (vii) training of over 6000 health workers so far (ix) developed training courses (x) progress in building research evidence for improving services (multisite studies, analytical studies – HRH, Economic impact study and PPP study) and; (xi) improved knowledge sharing and exchange , implemented multi-site studies and

The meeting took note of the achievements in the implementation of the regional activities of the EAPHLNP and;

i. Acknowledged the project efforts in strengthening laboratories in East Africa Region

ii. Recommended that the countries should start putting in place the sustainability plans for the project achievements

The presentation is hereto attached as Annex IV.

2.3. Introduction to management and control of Ebola

Dr Willy Were of ECSA provided a background on the basics about Ebola. The presentation highlighted the basic biology, transmission, diagnosis, case management, prevention and control. The presentation is hereto attached as Annex V.

Issues

- Clarification was sought whether an infected individual with Ebola Virus without signs and symptoms could transmit the infection to others. It was discussed and noted that from experience, a person can NOT infect others until the time he/she shows signs and symptoms
- The volume of blood required for testing was advised to be a minimum of 5ml of blood in an EDTA anticoagulant tube. This should be triple packed to ensure safety during transportation.

2.4 Uganda's Experience on VHF outbreaks: the Ebola and other VHF Outbreaks

Dr Luswa Lukwago gave an experience of the Uganda in management of VHF outbreaks in Uganda. This highlighted the various outbreaks that occurred in Uganda between the year 2000 and 2013. 2000 in Gulu (Ebola Sudan) that killed 225 people, in Ibanda, Kamwenge (Marburg) which killed 2 people and in Bundibugyo (Ebola Bundibugyo) which killed 37 in 2007, in 2012 in Kabale (Ebola Sudan) which killed 17 people; others included CCHF which killed two people on Agago and Wakisa as well as other lower magnitudes of Ebola and Marburg in 2011 and2012. The presentation highlighted the heightened preparedness and stronger coordination in managing the outbreaks in the country with previous experiences. The detailed presentation is attached as Annex VI.

Issues:

(i) Contrary to the earlier understanding that EBV presents with haemorrhage, it was discussed and noted that less than 50% of the Ebola patients presented with bleeding tendencies. Therefore health workers should NOT rely on haemorrhage as a salient sign of Ebola Virus Disease therefore they have to take precaution when handling any patient

(ii) The meeting discussed and advised that the key considerations when responding to Ebola outbreak may include but not limited to;
   - Establish a structure on who should do what at all levels;
   - Engagement of key stakeholders;
   - Coordination is important as there a lot of interested parties;
   - Response to Ebola should involve communities and then consider higher levels;
   - No need to put on full PPE if you are going to the field for case searching and contact tracing, until when you are convinced it's a VHF case then inform the management team for referral and then they have to come with full PPE.

3.0 Simulation exercise

3.1 Introduction

Dr Sam Okuthe, the chief facilitator made a presentation to lay background on the Table Top simulation exercise to set ground for the audience. The presentation described various types of simulations, how they are conducted, who is involved and the parties notified in each case. Dr Okuthe also gave outline of how the table top simulation was to be conducted. Dr Okuthe's presentation is hereto attached as Annex VII. The table top simulation contained three scenarios with different level of complexities beginning with simple to more complex moves. Scenario 1 (three moves), scenario 2 (two moves) and scenario 3 (three moves); the scenarios are hereto attached as Annex VIII.

Five groups were formed for simulation exercise as following covering the following coordination teams (list of group members is attached as Annex IX):

- Group I – Surveillance and Laboratory
- Group II – Case Management
- Group III – Risk Management
- Group IV – Coordination
- Group V - Supportive Services

The groups were tasked with developing response actions appropriate for their functional areas and to coordinate, as would be necessary, with other groups. This methodology proved to be effective in identifying response actions and providing participants with an opportunity to develop command, control and coordination of their action plans necessary for a meaningful response to an Ebola outbreak. The list of facilitators, the guidelines for the conduct of the exercise and the roles and responsibilities of the facilitators is attached as Annex X.

5.0. Key recommendations

Following the discussions during the exercise recommendations were made to strengthen further the preparedness for EBV and communicable diseases of public health concerns. The following recommendations were based on the team's observations during the exercise:-

i. Enhance sharing, publication and dissemination of surveillance information between neighbouring districts, regions and counties within countries and across the borders in the EAC region;

ii. Hold quarterly cross border meetings in the surveillance zones as indicated in the attached lists of current cross-border districts during inter- outbreak periods (peace-time) to build capacity and systems

iii. Establish communication inventory by exchanging personal and official contacts with each individual (mobile/email) to enhance free cross-border communication amongst participants and other officials on health matters;

iv. Exchange visits of country teams to learn from each other through the coordination of EAC, ECSA and other stakeholders;

v. Improve and harmonize country policies, strategies, laws, acts, rules, regulations, guidelines, Standard Operating Procedures (SOPs) or codes in order to facilitate smooth implementation of both the International Health Regulations (IHR 2005) and also the National Public Health Laws and

Regulations of each Country. This will empower the Rapid Response Teams (RRTs) to isolate and put other measures that may be provided under the relevant policies, laws and regulations to control Ebola Virus Disease (EVD) and other highly communicable diseases of International Public Health Concern (IPHC);

vi. Strengthen local community-based surveillance system to ensure early detection and rapid prevention, control and responses to communicable diseases in the region;

vii. Develop and/or finalize national and regional contingency emergency preparedness and response plans on Ebola Virus Disease (EVD) and other highly communicable diseases of International Public Health Concern (IPHC) and update them regularly through simulations and other experiences;

viii. Advocate for an in – country and regional emergency outbreak response fund that is readily/easily accessible (Ring fenced) during outbreaks of various highly communicable diseases of International Public Health Concern (IPHC);

ix. Plan and conduct regular Table Top, Drills and Field Simulation Exercises (semi-functional and fully functional) for Ebola Virus Disease (EVD) and other highly communicable diseases of International Public Health Concern (IPHC) at cross-border zones in order to improve the skills and confidence of the frontline health workers and Rapid Response Teams (RRTs) within and between the respective districts and Countries. The District Medical Officers of Health/Directors of Health Services and the District Health Management Teams (DHMTs) should take this up and ensure it is implemented within their respective districts in each Country;

x. Strengthen capacity for Infection Prevention and Control (IPC) targeting health facilities, communities and other stakeholders in the region through implementation of Total Quality Management (TQM) systems and practices at all levels in each Country;

xi. Create an archive website portal for Ebola Virus Disease (EVD) and other highly communicable diseases of International Public Health Concern (IPHC) and populate with Standard Operating Procedures (SOPs) and various national and international guidelines;

xii. Establish isolation facilities at regional, national and sub-national levels in each Country for Ebola Virus Disease (EVD) and other highly communicable diseases of International Public Health Concern (IPHC);

xiii. The EAC Secretariat in coordination with the EAC Partner States and various stakeholders and international collaborating development partners will facilitate the establishment and operationalization of a mechanism for joint use of public health laboratories within EAC region for specialized testing of Ebola Virus Disease (EVD) and other highly communicable diseases of International Public Health Concern (IPHC) by all the EAC Partner States and the neighbouring countries such as the Democratic Republic of Congo, Ethiopia, Somalia and South Sudan in order to facilitate rapid confirmation and response to outbreaks.

xiv. The EAC partner states and the Democratic Republic of Congo should establish cross-border committees and make follow up cross-border meetings to address issues of common interest in disease surveillance and outbreaks management;

xv. Urge all Countries to implement the recommendation of the signed communiqué of the regional high level multisectoral Ministerial meeting on Ebola Virus Disease emergency preparedness and response that was held in Nairobi Kenya on 16th – 17th September, 2014 hereto attached as Annex XI.

6.0. Conclusion

The exercise was considered as very successful by the participants, the evaluators and the observers. The Participant evaluation report was positive with respect to both process and outcome. The perceived success of the exercise was due in part to the participation of a wide variety of participants representing a spectrum of technical experts all of whom play a role in planning, prevention and response to Ebola Virus Disease outbreak in the region. The willing engagement of all participants and the application of their experience were critical to the success of this exercise and to the identification of the plans, policies and procedures critical to guide local, national or regional response to diseases, conditions and events of international public health concern.

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Republic of Kenya	*United Republic of Tanzania*	*Republic of Burundi*	*Republic of Rwanda*	*Republic of Uganda*

In attendance

Dr. Guy Mutombo Epidemiologist, Nord Kivu Ministere de la Sante du DRC
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Annex 1: Participants List

Ebola virus Disease Table Top Simulation Exercise
30th September to 2nd October 2014, Mbarara, Uganda

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Annex 2: Meeting programme for Ebola Virus Disease Table Top Simulation Exercise

30th September to 2nd October 2014, Mbarara, Uganda

30th September 2014	Day One
08.00 – 08.30	Registration
08.30 – 08.50	Introductions – Facilitator (Dr. Makumbi) Welcome remarks/opening by • Team leader Uganda – Dr. Issa Makumbi • PHEC – Dr. Issa Makumbi • EAC – Dr. Stanley Sonoiya • ECSA – Mr. Martin Matu
08.50 – 09.00	Objectives of the simulation – Dr. Willy Were
09.00 – 09.30	Ebola Virus Disease (EVD) and VHFs– Dr. Willy Were
9.30 – 09.50	Ebola outbreaks – Uganda experience – Lukwago Luswa
09.50 – 10.20	Health Break
10.20 – 10.50	Contingency Plans – Dr. Sam Okuthe
10.50 – 11.10	Simulation exercises– Dr. Sam Okuthe
11.10 – 11.20	Scenario setting and group formation – Mr. Benson Adul
11.20 – 12.00	*Scenario 1, Move 1 – Issa Makumbi*
12.00-1.00	Group discussions – Scenario 1, Move 1
1.00 – 14.00	Lunch Break
14.00 – 14.30	*Scenario 1, Move 2*
14:30 – 15.30	Group presentations and discussions – Scenario 1, Move 2
15.30 – 16.00	Health Break
1st October 2014	Day Two
8.30 – 9.00	*Scenario 1, Move 3*
9.00 – 10.00	Group presentations and discussions – Scenario 1, Move 3
10.00 – 10.30	Health Break
10.30 – 11.30	*Scenario 2, Move 1*
11.30 – 13.00	Group presentations and discussions – Scenario 2, Move 1
13.00 – 14.00	Lunch Break
14.00 – 15.00	*Scenario 2, Move 2*

15.00 – 15.30	Health Break
16.00 – 17.00	Group presentations and discussions – Scenario 2, Move 2
2nd October 2014	Day Three
8.30 – 9.00	*Scenario 3, Move 1*
9.00 – 10.00	Group presentations and discussions – Scenario 3, Move 1
10.00 – 10.30	Health Break
10.30 – 11.00	*Scenario 3, Move 2*
11.00 – 12.00	Group presentations and discussions – Scenario 3, Move 2
12.00 – 13.00	*Scenario 3, Move 3*
13.00 – 14.00	Lunch Break
14.00 – 15.00	Group presentations and discussions – Scenario 3, Move 3
15.00 – 15.30	Health Break
16.00 – 17.00	*Recommendations and Way Forward*

Annex VIII: Scenarios for Ebola virus Disease Table Top Simulation Exercise

INJECTS

Scenario one: Mysterious disease in Kabale, South western Uganda

Move / Inject 1

The Kabale West dispensary received a patient on the 16th September 2014 from the local village complaining of headache, severe muscle and stomach pains, diarrhea and vomiting. After examination by the nurse in charge (Mrs. Nsubuga), the patient, a 33 year old Mr. Ayebazibwe was found to have a temperature of 38.9^{0}C. He was treated for Malaria after which he went back home to rest and recover. He was also given pain killers, paracetamol^R to manage the severe pains. On reaching home Mr. Ayebazibwe was well received by his four children, mother, wife and his three elder brothers and his sisters in-law. The church members from the local parish (8) in number had also come to pray with their sick member. The church members were very happy to see their member back and they hugged him in joy thanking the Lord for his mercy that allowed him to come back home. The whole group prayed and had a meal together after which the church members left late in the evening for their homes.

Task: In the next 30 minutes:

Identify the first five actions/steps that your team/group is going to take. If your action involves another group/organization, ask questions or make requests by writing them down for the other stakeholders. Identify key strengths, weaknesses and challenges in this move.

- *What are the main weaknesses / challenges in performing these actions?*
- *How does your group address these challenges?*

Move/Inject 2: Deterioration of patient health and more infections

The condition of Mr. Ayebazibwe did not improve. He complained of more severe headaches, increased vomiting, generalized body weakness, this was two days after having come from the dispensary. He could not raise his head anymore and he had to be supported by his wife and brother most of the times. His uncle, Mr. John Robert advised for Ayebazibwe to be treated with a reputable local traditional healer. The patient Mr. Ayebazibwe was taken to the traditional healer using a motor bike *"boda boda"* in the presence of his uncle and brother. After being given local traditional medicines, he was taken back home using a different *"boda boda"* only in the presence of his uncle as his brother went back to Mbarara town where he was working as a casual labourer in one of the construction firms in town. Two days after coming from the traditional healer, Mr. Ayebazibwe had become very weak. The family decided to take him to the local Health Centre. His temperature

had risen to 39.5^{0}C. On examination by the Clinical officer, he was immediately admitted tentatively for Typhoid. A blood sample was taken for Widal test,that turned out to be negative. His condition deteriorated every other day. He started having bloody diarrhea and he was treated for food poisoning. His condition did not improve. He became weaker, the abdominal pains increased and persisted culminating in further loss of appetite completely. His condition did not improve after which he was then transferred to the district hospital, also within the confines of Mbarara town.

Task: In the next 30 minutes:

Identify the first five actions/steps that your team/group is going to take. If your action involves another group/organization, ask questions or make requests by writing them down for the other stakeholders. Identify key strengths and challenges in this move.

- *What are the main challenges in performing these actions?*
- *How does your group address these challenges?*

Inject 3:

In the next week i.e. 4th week of September, two patients presenting with a hemorrhagic syndrome to Kabigo Health Centre sends the Health Care Workers (HCWs) into a panic fearing they had been exposed to a Viral Heamorhagic Fever of unknown cause. Meanwhile Mbarara district hospital reports 30 suspected cases including Mr. Ayebazibwe, Isingiro district Hospital, 20 cases, Kabale district Hospital reports 50 and there are more reports of increase in number of patients with febrile illness. 10 critically ill patients in Isingiro have been referred to Mbarara hospital for advanced treatment.

A number of patients showing the same signs but are visiting traditional and faith healers for fear of being confined for long periods in the hospital facilities.

Task: In the next 45 minutes:

Identify the first five actions/steps that your group is going to take. If your action involves another group/organization, ask questions or make requests by writing them down for the other stakeholders. Identify key strengths and challenges in this move.

- *What are the main challenges in performing these actions?*
- *How does your group address these challenges?*

Scenario 2: Localized mysterious human disease in Kabongo Sub-county

Move/Inject 1:

On the 27th September 2014, the Catholic priest who had led the prayers during the church members visit to Mr. Ayebazibwe's home started complaining of severe stomach pains, fever, lack of appetite. He was rushed to the district hospital using the parish van accompanied by two nuns and three lay leaders. On examination for temperature and BP parameters by the nurse, the temperature was 38.8^{0}C with normal BP. He was given pain killers, treated for Malaria and left to go back to the local parish for rest and recovery. Meanwhile the boda boda cyclist (Mr Katarega) who had taken Mr. Ayebazibwe to the health centre started complaining of fever, sweating, severe muscle pains, vomiting and unexplained hemorrhage. He was taken to the local dispensary (health centre II) by fellow colleagues' i.e. two *boda boda* riders who sandwiched him so as to support him as he was weak. On reaching the dispensary, his temperature was at 40^{0}C . After examination, the nurse in charge advised for the cyclist to be transferred to the Health Centre. On reaching the Health Centre, blood smears were taken to test for malaria. The results were negative for Malaria. Widal test was also carried out for Typhoid. This was also negative. The patient was given pain killers and treated for Typhoid. After three days, his condition deteriorated. The health officers advised for his transfer to the district hospital. He was taken to the district hospital using public means. On reaching the final destination, his wife and the other fellow rider, took a *boda boda* to the district hospital. On reaching and after examination by the Medical officer, he was immediately hospitalized. Malarial and Typhoid tests were repeated but found to be negative. In addition, Mr. Katarega complained of severe stomach pains, high fever, vomiting and bloody diarrhea. He was given symptomatic treatment. Mr. Katarega produced bloody vomitus on the second day of his stay in the hospital. The MO became suspicious and isolated the patient in a separate room. The MO suspected a case of a VHF. Meanwhile the parish priest in the same hospital was also showing the same signs as Mr. Katarega. He was also isolated. Blood samples were taken and sent to the UVRI where the two cases were confirmed to be Ebola positive.

Task: In the next 45 minutes:
Identify the first five actions/steps that your group is going to take. If your action involves another group/organization, ask questions or make requests by writing them down for the other stakeholders. Identify key strengths and challenges in this move.

- *What are the main challenges in performing these actions?*
- *How does your group address these challenges?*

Move / Inject 2:

On the 30th of September 2014, the uncle of Mr. Ayebazibwe was also brought to the district hospital in critical condition with high fever, severe stomach pains, bloody vomitus and muscle pains. The Medical officer suspected the patient and isolated him where samples were taken and sent to the UVRI. After two days, the results were positive for Ebola. This third case created panic in the hospital and the hospital was not having adequate PPE to handle Ebola patients. The medical personnel were also reluctant to handle the three patients that had now been isolated in the district hospital. This led to a go slow in the hospital that stalled a number of activities. Some staff abandoned duty.

The message was leaked to the gutter press that reported of a major outbreak in the district hospital and the whole district. The paper reported that several homesteads had been affected by Ebola virus.

Task: In the next 45 minutes:
Identify the first five actions/steps that your group is going to take. If your action involves another group/organization, ask questions or make requests by writing them down for the other stakeholders. Identify key strengths and challenges in this move.

- *What are the main challenges in performing these actions?*
- *How does your group address these challenges?*

Session 3: Widespread human and animal infections

Inject 1:

0n 15th October 2014, cases of EDVF have been confirmed in 7 districts in South Western Uganda, in Kampala, Lira and Jinja. There is increased demand for Personal Protective Equipment (PPE) to support the districts in managing cases admitted in health facilities in different districts. Three days before, one leading national newspaper reported death of three health care workers (HCWs) from EVD and made reference to the Ebola outbreak from DRC that had affected many HCWs. This has raised serious concerns among HCWs in regard to their safety after handling EVD suspect cases without prior knowledge.

A mysterious disease with similar symptoms has also been reported in Northern Province Rwanda in Musanze district; Nyagatatare and Kayonza districts in the eastern province and eastern DRC near Goma town. Substantive diagnosis has not been made and rumours from local newspapers report of Ebola like disease in these localities, a situation that send the Health Care Workers into panic.

Task: In the next 45 minutes:
Identify the first five actions/steps that your group is going to take. If your action involves another group/organization, ask questions or make requests by writing them down for the other stakeholders. Identify key strengths and challenges in this move.

- *What are the main challenges in performing these actions?*
- *How does your group address these challenges?*

Move / *Inject 2:*

December 23rd: The current line list from Ministry of Health (MOH), headquarters has 1000 suspected cases of which 751 is laboratory confirmed and 331 deaths.

While the cases are from South Western, Western, Central regions, 50% of the deaths are from South Western region and there are concerns that enough care is not being provided to these communities. The civil society and politicians are demanding explanations on this trend. The line list does not account for deaths that occur at home. As a result of the media report, most health care facilities below the district level facilities are referring all patients who present with acute febrile illness to the referral hospitals resulting in serious congestion both in Out Patient Department (OPD) and wards. There is concern that other conditions such as malaria and cholera are being overlooked and most resources have been shifted to EVD. As a result of the referrals, it is noted that a number of patients are opting to go home and seek traditional treatment rather than make the travels to towns.

By March 2015, the Director General (DMS) estimated that 3000 suspected cases, 1500 confirmed and 420 deaths in the whole country. The civil society is up in arms blaming the government of complacency and unpreparedness to deal with emergencies. Demonstrations are ongoing in Kampala and Entebbe.

Task: In the next 45 minutes:
Identify the first five actions/steps that your group is going to take. If your action involves another group/organization, ask questions or make requests by writing them down for the other stakeholders. Identify key strengths and challenges in this move.

- *What are the main challenges in performing these actions?*
- *How does your group address these challenges?*

Move / *Inject 3:*

May 5, 2015: There is a news item that some regional airlines are considering pulling out of the Entebbe International Airport due to the EVD outbreak in Uganda. In addition, some embassies are restricting issuance of visas to Uganda due to perceived risk of spread of infections. In addition, the tourists have stopped coming to Uganda and the few who were in the country are leaving with the few airlines still operating The National parks and game reserves are not having any local or foreign tourist as there is a general fear that the parks could be the source of the Ebola outbreak. This has greatly affected the country's economy.

One Ebola confirmed patient escaped from the isolation ward in Mulago hospital. He has not been traced five days since his disappearance from hospital despite visits to his home village and an appeal has been made to his relatives. There is a fear that he could have been hidden by a relative.

The Uganda Cranes has a scheduled March with *Taifa Stars* on December 12 2014 to commemorate the Independence Day Celebrations at Amani Stadium Dar es Salaam that has been widely publicized.

Task: In the next 20 minutes:
Identify the first five actions/steps that your group is going to take. If your action involves another group/organization, ask questions or make requests by writing them down for the other stakeholders. Identify key strengths and challenges in this move.

- *What are the main challenges in performing these actions?*
- *How does your group address these challenges?*

Scenario 3 Decrease in the magnitude of outbreak:

September 2015 – Following massive support from the International community involving bilateral donors, technical organizations and the private sector, the disease has been progressively managed despite a few cases still being diagnosed.

Confirmed cased of EBDV are still being reported in neighboring Rwanda and DRC where desperate attempts are being made to contain the situation.

Task: In the next 20 minutes:
Identify the first five actions/steps that your group is going to take. If your action involves another group/organization, ask questions or make requests by writing them down for the other stakeholders. Identify key strengths and challenges in this move.

- *What are the main challenges in performing these actions?*
- *How does your group address these challenges?*

Annex IX: Thematic Groups for the Table Top Simulation Exercise

1. Surveillance and Laboratory

Members:

1) Dr Victor Bucumi (BUR)
2) Ambakisye Mhiche (TZ)
3) Dr. Matenda Jean (DRC)
4) Jean de Dieu (DRC)
5) Kente Emma (UGA)
6) Vedaste Masengesho (RWA)
7) Denis Kyabaggu (UGA)
8) Deka Kabunga (DRC)
9) John Massoro (TZ)
10) Mwebembezi William (UGA)

2. Case Management

Members:

1) Mr. Muneza Nick (UG)
2) Dr. Suuna Micheal (UG)
3) Dr. Tumusherure Edson (UG)
4) Dr. Kasozi Bruhan (UG)
5) Ms Namwanga Edwig (UG)
6) Dr. Zabron Masatu (TZ)
7) Dr. Sangala Freddy (RW)
8) Ms Ntirampeba Christine (BU)
9) Dr. Bulyana Ezekiel
10) Dr. Kakine Joy (DRC)

3. Communication

Members:

1) Agumeneitwe Herbert (UG)
2) Sam Nalwala (UG)
3) Besigensi Alfred (UG)
4) Everlyne Walela (K)
5) Benson Maina (K)
6) Dr. Claude Bahizire (DRC)
7) Shija Ganai (TZ)
8) Ahimbisibwe Nickson (UG)

4. Coordination

Members:

1) Dr. Kabagambe Bernard (UG)
2) Dr. Freddy Birembano (DRC)
3) Dr. Kalyesubura Simon (UG)
4) Alex Rutikanga (RWA)
5) Elibariki .R .Mwakapeje (TZ)
6) Dany Bulondo (DRC)
7) Nshabohurira Agatha (UG)
8) Dr. Gy Mutombo (DRC

5. Support Services

Members:

1) Dr. Akindavyi Cléophile (BDI)
2) Dr. Ntunzwenimana Thierry (BDI)
3) Dr. Ruta Thomas (TZ)
4) Dr. Yakayashi Andrew (TZ)
5) Dr. Laison Ntaka (TZ)
6) Dr. Mohamed Mpunjo (TZ)
7) Irama Max (UG)

Annex X: List of facilitators and clarification of roles and conduct of the exercise

Lead facilitators
1. Dr. Sam Okuthe
2. Dr. Issa Makumbi

Evaluator/Trainer
1. Dr. Shikanga O-tipo
2. Dr. Lukwago Luswa

Observer
1. Dr. S. Sonoiya
2. Dr. Francis Adatu

Injectors
1. Dr. Willy Were
2. Dr. Benedict Mushi
3. Martin Matu

Rapporteur
1. Benson Adul

Roles and Responsibilities of chief facilitator
1) Ensure that co-facilitators have all required materials to conduct the exercise and deliver maximum benefit to the participants.
2) Communicate with and assist group facilitators.
3) Facilitate the progression of the exercise scenarios through the control of information flow, including the introduction of scenarios moves/injects by the injectors.
4) Determine when corrective action is required (such as additional discussions) to achieve additional benefit for exercise participants.
5) Develop new moves/injects throughout the exercise as maybe required.
6) Ensure that appropriate risk management strategies are undertaken during the exercise to ensure a safe environment for exercise participants.

Co-Facilitators, Injecors, Rapporteur
1) Coordinate and monitor the activities of assigned groups, providing exercise information to facilitate group activities.
2) In conjunction with the chief facilitator, provide exercise moves/injects to the group.
3) Monitor group response to the exercise scenarios and exercise moves/injects
4) Assist groups response by providing a clear understanding of the scenarios and moves/injects as maybe required to achieve exercise objectives.
5) Maintain contact with the chief facilitator to provide periodic reports on group activities.
6) Maintain notes on group activities, points of contention, and/or key "lessons learned" and provide to the chief facilitator at the end of each exercise day to facilitate after action review and gap analysis.

Communication Methodology
The facilitators visited the participants in their working groups to assess progress but were not to influence their actions in any way so that group reports were independent.

Groups were provided with cards (A5 size) on which they wrote their requests for action or assistance from other groups and on which replies were also made. Groups were also encouraged to interact amongst themselves within and outside the meeting for exchange of ideas and to build contact networks for future communication and exchange of information.
Facilitators monitored inter-group communications to maintain situational awareness of participant actions.

Control Meetings
Adhoc exercise control meetings were convened as and when necessary in order to review the progress of the exercise and propose changes of approach where necessary. All facilitators were expected to attend these meetings. Such meetings were to as much as possible avoid interrupting exercise flow, and were held preferably during brakes, at the end of the day or early before the commencement of a days' schedule.

Distribution of exercise material
Exercise information which were made available to group facilitators prior to the exercise were not discussed with exercise participants and were secured to avoid disclosure.

Briefings
During the exercise, participants were required to produce group presentations/reports as part of the exercise scenario. These reports were preferably developed using PowerPoint or other similar software. Due to the short duration of the exercise and the heavy schedule, facilitators ensured that the primary focus of the participants was the content and not the aesthetics of the group presentations.

After Action Review/Gap Analysis
It is extremely important that the input of participants is received throughout the exercise and during the post-exercise gap analysis. The purpose of the after action review and gap analysis was to provide a forum for the capture of lessons learned and identification of any gaps in existing preparedness and response policies, procedures and plans. This process provided an opportunity for participants to discuss exercise activities and lessons learned with their group and to later share these observations in plenary sessions with all exercise participants and facilitators. Special emphasis was be placed on identifying revisions to existing preparedness, contingency or response plans.

Conduct of Scenario Sessions
<u>Plenary Sessions</u>
Each of the scenario "sessions" began by participants retreating to their groups after which they were provided with the moves/injects, which they were required to read carefully and understand before discussing their action that were captured for presentation to the plenary.

Timelines for completion of the sessions were provided as per the programme. It is notable that the initial two moves/injects of scenario 1 took more time than anticipated as nearly all participants had not taken part in a table top simulation exercise.