



Republic of Rwanda  
Ministry of Health



# NATIONAL EBOLA PREPAREDNESS AND CONTINGENCY PLAN

EBOLA VIRUS DISEASE

October 2022 - March 2023

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# ACKNOWLEDGMENTS



The Ministry of Health and the Rwanda Biomedical Centre (RBC) wishes to acknowledge the concerted efforts of partners and all stakeholders to develop and update the National Contingency Plan in response to the ongoing outbreak of Ebola in Mubende District in Central Uganda.

The Ebola Virus Disease (EVD) is considered to be a persistent and serious public health concern for the Government of Rwanda, the increased risk of transmission to Rwanda calls for the need for sustained and prolonged EVD preparedness activities, strengthened cross-border collaboration, and the flexibility to adapt to emerging needs.

Based on the current EVD outbreak in Uganda and the continuing risk for spread, the Government of Rwanda, in collaboration with the WHO and partners are reviewing and evaluating the gaps and activities required to strengthen operational readiness and capacity.

This plan is one critical step towards ensuring effective national capabilities for the prevention, timely detection, response and immediate containment of a potential EVD case in Rwanda. It also provides a roadmap as well as an opportunity for all stakeholders to engage and contribute to its implementation in line with the International Health Regulation (IHR), 2005.

Whilst much has been gained and achieved through the concerted efforts and supports from all stakeholders to establish and strengthen the core EVD capabilities and capacities since the declaration of the EVD outbreak in the DRC in August 2018, it is recognized that more still needs to be undertaken to reach an optimal and sustained level of operational readiness.

The MoH appreciates the financial support from all donors and partners who have supported and continue to support Rwanda with Ebola preparedness activities.

I am confident that with all your support and good collaboration, we shall together move forward to achieve our common goal for a safer, healthier and secure Rwandan nation and the global community.

Thank you all.



**Dr Daniel M. NGAMIJE**

**Minister of Health**



## EXECUTIVE SUMMARY

Rwanda is one of the bordering countries to Uganda, which is dealing with the most recent outbreak of EVD declared on the 20th September 2022.

Rwanda has regular cross-border movements of people, goods and services at different points of entry and exit with Uganda. Considering this factor Rwanda is at high risk for an Ebola outbreak.

In reflection of the growing risks and in an effort to advance the critical preparedness measures, the Rwandan MoH is reassessing their EVD preparedness plans, making the necessary adaptations.

The ongoing aim and objective of the National EVD Contingency and Planning is to build the capabilities for operational preparedness. This plan will aim to build capacities for leadership and coordination of Ebola preparedness activities at all level (National, Provincial and District); ensure the early detection and reporting of any suspected Ebola case; strengthen prevention, and operational readiness capabilities for response; strengthen cross border collaboration; and enhance capacities for a timely, effective and efficient response to any confirmed EVD case in Rwanda.

Within this document, the plan presents a consolidated summary of the urgent activities that have been identified as being required, to be able to advance and complete on preparedness and its sustainability.

The preparedness and contingency planning has focused on the strengthening of the recommended core capacities for EVD preparedness and response, as recommended by the WHO and include the following components:

- Strategic Leadership and Coordination
- Enhanced Surveillance and Epidemiology (including laboratory & Points of Entry (PoE's)
- Entry (PoE's)
- Rapid Response Team Capabilities
- Risk Communication and Community Engagement
- Case Management and Safe & Dignified Burials
- Infection, Prevention and Control (IPC) and Water, Sanitation and hygiene (WASH)
- EVD Vaccination and Therapeutics
- Medical and Operational Logistics

Due to the continual cross border risk, the EVD preparedness activities will be implemented across all of the 30 districts and will be specific to their priority level rating (i.e. 9/30 (30%) of the districts within Rwanda are considered a Priority 1 high risk district, with the remaining 21/30 (70%) districts being considered as a Priority 2 district).

Additionally, EVD preparedness efforts have been designed to be sustained for the duration of the outbreak, or until the risks for potential spread beyond the national border is eliminated.

**The specific objectives of the EVD preparedness and contingency plan in Rwanda are:**

1. Mobilize partners and resources for coordinated and effective implementation of the national EVD preparedness and contingency plan to attain the national EVD operational readiness capabilities.
2. Sustain public awareness about the EVD threat and establish a sustainable information and communication system to all citizens about the threat and dangers of EVD.
3. Institutionalize enhanced capacities for sustainable EVD preparedness in 9 priority districts to ensure timely detection, and response to potential EVD cases through:
  - a. Institutionalizing enhanced surveillance systems at community, Points of Entries, Transit Centers and at health facility levels.
  - b. Sustaining capacities for EVD sample collection, transportation, testing and confirmation.
  - c. Sustaining IPC and WASH capacities at health facilities, POEs, and at community level that will meet the basic requirements for EVD prevention.
  - d. Strengthening capacities for EVD case management, including mental health and psychosocial support (MHPSS) to affected individuals, families, communities and to health care and frontline workers.
  - e. Establishing capacity for provision of adequate nutritional needs for EVD patients, particularly, pregnant women and children.
  - f. Building capacities for completing vaccination of high-risk health care and frontline workers and providing EVD therapeutics once available, and coordination of operational research.
  - g. Improve and sustain capacities for operational logistics, both medical and non-medical, including ensuring adequate security measures during EVD response.
4. Develop and implement the EVD preparedness monitoring framework and test the preparedness capabilities and system to assess level of operational readiness.

## ABBREVIATIONS AND ACCRONYMS

AFRO	Regional Office for Africa (World Health Organization)
CDC	Centre for Disease Control
DFID	Department of Foreign International Development
ESR	Epidemic, Surveillance and Response
ETC	Ebola Treatment Centre
EVD	Ebola Virus Disease
FDA	Food and Drugs Authority
Govt.	Government
HCW	Health Care Workers
IDSR	Integrated Disease Surveillance
IHR	International Health Regulations
IHREC	International Health Regulations Emergency Committee (IHREC),
IMS	Incident Management System
IMS	Incident Management System
INGO	International Non-Governmental Organization
IPC	Infection, Prevention & Control
IPC/CM TWG	Infection Prevention and Control and Case Management Technical Working Group
ISO	Isolation Unit
J & J	Johnson & Johnson
KAP	Knowledge, Attitudes and Practices
KPI	Key performance indicators
KPI	Key Performance Indicators
MEURI	Monitored Emergency Use of Unregistered and Investigational Interventions
MHPSS	Mental Health and Psychological Supports
MINALOC	Republic of Rwanda: Ministry of Local Government
MoH	Ministry of Health
MoU	Memorandum of Understanding
P1	Priority 1
P1	Priority 2
PCP	Preparedness and Contingency Plan

PHEIC	Public Health Emergency of International Concern
PHEOC	Public Health Emergency Operations Centre
PHEOC	Public Health Emergency Operations Centre
PoE	Point of Entry
RBC	Rwanda Biomedical Centre (national health implementation body)
RCCE	Risk Communication and Community Engagement
RKI	Robert Koch Institute
RNP	Rwanda national police
SAG	Strategic Advisory Group
SAGE	Strategic Advisory Group of Experts
SDBT	Safe and Dignified Burials Team
SOP	Standard Operating Procedure
SOP	Standard Operating Procedures
ToR	Terms of Reference
TWG	Technical Working Group
UNHCR	United Nations High Commissioner for Refugees
UNICEF	The United Nations International Children's Emergency Fund
UNICEF	United Nations International Children's Emergency Fund
USAID	The United States Agency for International Development
WHO	World Health Organization



# 1. INTRODUCTION

The health authorities in Uganda declared on 20th September 2022 an outbreak of EVD after a case of the Sudan EVD was confirmed by the Uganda Virus Research Institute. According to the report from Ugandan authorities, the outbreak has been detected in Ngabano village of Madudu Sub County, Mubende District in Central Uganda.

This is the first time in more than a decade that Uganda is recording an outbreak of Sudan EVD. There have been seven previous outbreaks of the Sudan EVD, with four occurring in Uganda and three in Sudan. Uganda last reported an outbreak of Sudan EVD in 2012.

According to the International Classification of Disease for filoviruses (ICD-11) released in May 2019, EVD disease is now sub-categorized depending on the causative virus. Outbreaks of EVD disease caused by Sudan virus are named Sudan Virus Disease (SVD) outbreaks. Prior to May 2019 all viruses causing EVD disease were grouped together.

Sudan virus (SUDV) was first reported in southern Sudan in June 1976, since then the virus has emerged periodically and up to now, seven outbreaks caused by SUDV have been reported, four in Uganda and three in Sudan.

According to WHO, the virus is introduced into the human population through close contact with the blood, secretions, organs or other bodily fluids of infected animals such as fruit bats, chimpanzees, gorillas, monkeys, forest antelope or porcupines found ill or dead or in the rainforest. The virus then spreads through human-to-human transmission via direct contact (through broken skin or mucous membranes) with either blood or body fluids of a person who is sick with or has died from SVD or objects that have been contaminated with body fluids (like blood, faeces, vomit) from a person sick with SVD or the body of a person who died from SVD.

The incubation period ranges from 2 to 21 days. People infected with Sudan virus cannot spread the disease until they develop symptoms, and they remain infectious as long as their blood contains the virus. Symptoms of SVD can be sudden and include fever, fatigue, muscle pain, headache, and sore throat later followed by vomiting, diarrhoea, rash, symptoms of impaired kidney and liver function. In some cases, the patient might present both internal and external bleeding (for example, bleeding from the gums, or blood in the stools).

The diagnosis of SVD can be difficult, as early nonspecific manifestation of the disease may mimic other infectious diseases such as malaria, typhoid fever, and meningitis. Confirmation is made using numerous diagnostic methods including RT-PCR.



## 1.1. DESCRIPTION OF THE SVD OUTBREAK IN UGANDA

On 20 September 2022, the health authorities in Uganda declared an outbreak of EVD disease caused by Sudan virus (SUDV), after a case was confirmed in a village of Madudu sub-county in Mubende district, central Uganda.

The case was a 24-year-old male who developed a wide range of symptoms on 11 September including high-grade fever, tonic convulsions, blood-stained vomit and diarrhea, loss of appetite, pain while swallowing, chest pain, dry cough and bleeding in the eyes. He visited two private clinics, successively between 11-13 and 13-15 September without improvement. He was then referred to the Regional Referral Hospital (RRH) on 15 September where he was isolated as a suspected case of viral hemorrhagic fever. A blood sample was collected on 17 September and sent to the Uganda Virus Research Institute (UVRI) in Kampala where RT-PCR tests conducted were positive for SUDV on 19 September. On the same day, the patient died.

Results of preliminary investigations identified a number of community deaths from an unknown illness in Madudu and Kiruma sub-counties of Mubende district reported in the first two weeks of September. These deaths are now considered to be probable cases of EVD caused by SUDV.

As of 19 October 2022, a cumulative number of 64 confirmed cases have been reported from Mubende, Kyegegwa, Kassanda, Bunynagabu and Kagadi districts, including 25 deaths, of which four were healthcare workers (CFR among confirmed cases 39%). Since its declaration, there have been 25 recoveries, including six healthcare workers. According to the WHO declaration of 19 October 2022, the eight most recent EVD cases reported during the outbreak in Uganda have no known links with current patients.

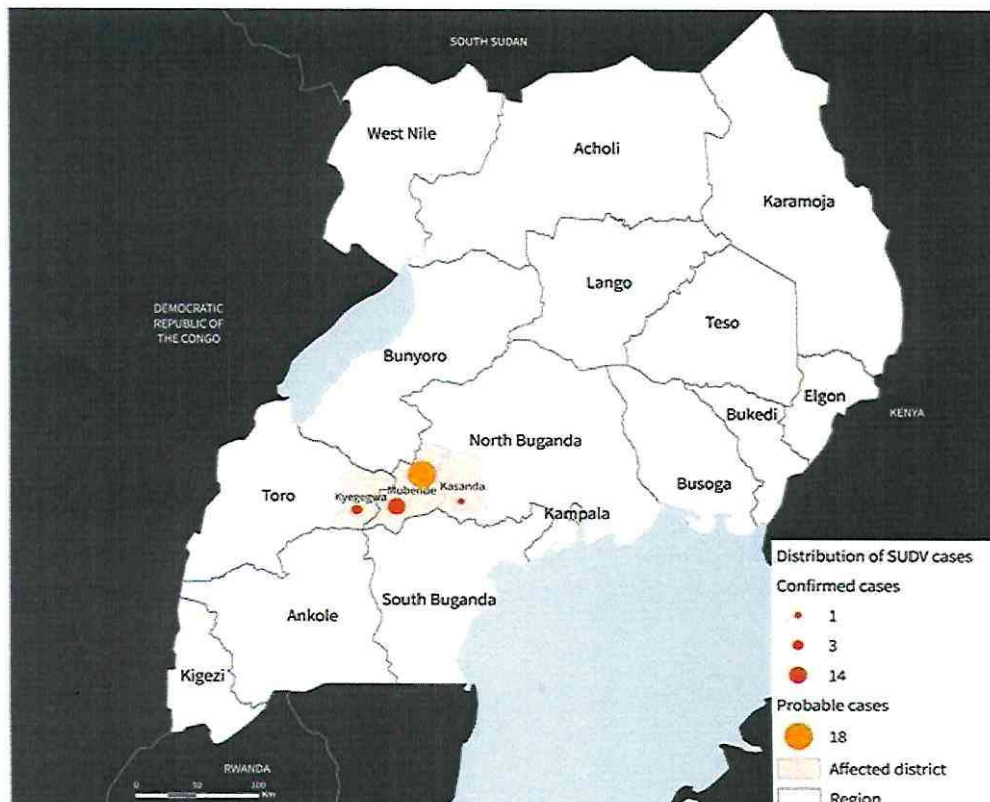


Figure 1: Map of confirmed (n=64) and suspected (n=18) cases of EVD disease caused by Sudan virus

## 1.2. CONTEXT OF RWANDA

Rwanda is a geographically small (26,338 sq. km) land-locked country, located in the great lake's region of Sub-Saharan Africa. The country shares borders with Burundi in the South, Tanzania in the East, Uganda in the North, and the DRC in the West. The population of Rwanda is currently estimated at 13,051,778 (is equivalent to 0.16% of the total world population), with one of the highest population densities in Africa (507 inhabitants/km<sup>2</sup>) and a high population growth rate (2.4% per annum). About 34.0 % of the population (4,255,257) is urban.

This great lake region is characterized by civil wars and natural disasters such as volcanic activity, landslides and mudslides, and increasingly unpredictable weather patterns. Furthermore, 70% of the emerging and re-emerging infectious disease outbreaks in the last decade have originated from the Congo Basin, in which Rwanda lies.

The Republic of Rwanda is administered by the Central Government based in Kigali, and a presidential system. The country consists of four provinces (Northern, Western, and Eastern, Southern) and Kigali City, the country's capital. These are subdivided in districts, sectors, cells and villages. The district is the basic political-administrative unit of the country. The village is the smallest politico - administrative unit of the country and hence closest to the people .

The health sector in Rwanda is led by the Ministry of Health (MoH), whose primary objective is to improve the health of the population of Rwanda. The MoH supports, coordinates, and regulates all health interventions. There are fifteen (15) other Government Ministries that implement activities that either directly or indirectly impact on health. Development partners, faith-based organizations, non-governmental organizations, professional organizations, and a host of regulatory bodies also support the health sector.

At the district level, there are district hospitals, pharmacies, community-based health insurance and HIV/AIDS committees. All these entities are technically supervised by the director of the district hospital, but administratively report to the deputy mayor in charge of social affairs. The country has five (5) National Referral Hospitals, provincial hospitals, district hospitals, a network of ambulance services (SAMU), as well as private health facilities. Rwanda has a successful health insurance scheme.

At the village level, community health workers (CHWs) are supervised administratively by those in charge of social services and technically by the in-charges of health centers. CHWs receive compensation for their work from the Performance Based Financing (PBF) mechanisms through formally established local cooperatives. There are health posts at cell level, and health centers at sector level, which are governed by health posts or health centers Committees respectively. These committees provide oversight on the work of various units within the health center, its outreach and supervision services and general financial control.

For refugees' health, UNHCR remains responsible for providing routine health care and also that of EVD awareness and preparedness to the refugee populations in the refugee settlements, in coordination and collaboration with the national Government, as per the national policy and requirement. However, in the event of an EVD outbreak, the national Government will take the lead in coordinating the response in collaboration with UNHCR and other partners involved.

### **1.3. CONTEXT OF EVD IN RWANDA**

To date the Republic of Rwanda has never experienced an outbreak of EVD. The existing EVD preparedness capacities have been developed largely as part of the preparedness intervention in response to the past outbreaks in the AFRO region, and to a limited extent, as part of implementation of the Integrated Disease Surveillance and Response System (IDSR), focusing on preparedness for multi-hazards.

Notable progress has been realized since 2018, starting with limited EVD focused preparedness interventions in response to the May EVD outbreak in the Equator Province in DRC, during which Rwanda was considered a priority 2 risk country. More structured and extensive EVD preparedness has been realized during the preparedness activities in response to the North Kivu/South Kivu/Ituri in DRC, in which Rwanda was considered a priority 1 risk country.

Within the national borders of Rwanda, a risk criterion for the prioritization of the districts is undertaken bi-annually, in line with each review of the national preparedness and contingency plan. The risk criteria include the following: proximity to the outbreak affected areas in the neighboring country (notably border districts); population movements to and from the neighboring country, as well as the presence of refugee settlements and transit centers.

Currently within this plan, due to the continual cross border risk, 9/30 (30%) of the districts within Rwanda are considered a Priority 1 high risk district, with the remaining 9/30 (30%) districts being considered as a Priority 2 districts. Whilst all of the 30/30 (100%) districts are considered a priority, they have been sub-categorized into a two-tiered priority level. It is also important to note that the priority level of each district is dynamic and dependent on known risks at the time, changing context of neighboring countries and the status of the EVD outbreak in Uganda.

### **1.4. JUSTIFICATION OF THE CONTINGENCY PLAN**

Currently there is an ongoing EVD outbreak in central Uganda. WHO assessed the risk of the outbreak spreading into neighboring countries; and Rwanda and South Sudan were found to be at highest risk and were classified as category one (1) countries. This therefore calls for Rwanda to urgently enhance operational readiness to minimize the level of risk posed by the outbreak spreading into the country and strengthen capacities to detect and respond timely and efficiently to any imported outbreak.

The International Health Regulations (IHR) 2005 which Rwanda is Party to, requires State Parties to strengthen routine indicator and event-based surveillance and response capabilities as well as prepare for unexpected public health events. Each country is expected to put in place a robust system to prepare for and promptly detect events of public health concern including infectious agents like EVD. Countries are also expected to work individually and collectively to contain any outbreaks of such events and limit their spread that would affect international travel and trade. This plan builds on the previous contingency plans for EVD threats from West Africa, multiple outbreaks in DRC, Uganda as well as for other viral hemorrhagic fever outbreaks.

The Ministry of Health purposes to meet its obligation within the IHR (2005) to protect both the local and international community by taking measures that will prevent introduction of the EVD virus to Rwanda as well as ensure readiness for prompt detection and appropriate response to limit morbidity and mortality. These measures are contained in this EVD contingency plan that proposes investment in ensuring capacity and focus on prevention, heightened surveillance and response to the EVD threat.

Proactive operational readiness pays off in terms of reducing the impact of emergencies on public health, reducing the cost of response and recovery, and serves as a long-term investment in the capacity of the health system to manage emergencies, in line with the International Health Regulations (IHR 2005).

## **1.5. POTENTIAL RISK FOR THE SPREAD OF THE EBOLA OUTBREAK**

According to the WHO event report of September 25, 2022, the SVD outbreak in Uganda is a serious Public Health Emergency caused by the Sudan EVD strain, against which no vaccines or other pharmaceuticals are licensed. SVD is a severe, often fatal illness affecting humans. The estimated case fatality ratios of SVD have varied from 41% to 100% in past outbreaks. The current SVD outbreak in Uganda is characterized as unusual and not unexpected. Additional, although the currently affected districts have no international borders, but, the risk of international spread exist due to the active cross-border population movement. It is in this framework that WHO categorized Rwanda in 1st priority as well as South Sudan based on proximity with Uganda, and the cross-border movement and flow of people, goods, and services across porous borders. In fact, the Population connectivity across the border survey conducted in July 2022 showed that people in Rwanda and Uganda are interconnected as there is back and forth movements between communities of both countries. Rwandan travel to Uganda for many reasons including fishing in Lake Victoria, farming (especially in Kabogo) and Mubende, schooling, trade (especially in Kisoro), and for health care (dentistry, ophthalmology, maternity) service because of ease of access.

Gicumbi district is in the Northern Province and borders Rwanda and Uganda with Gatuna One Stop Border Post (Gatuna OSBP) and Byumba District Hospital. The majority of those from Uganda travel into Rwanda through Gatuna/Katuna border while other use unofficial POEs. The main reasons of travel include visit to markets and trading centers to sell tobacco, salt, clothes, livestock ie: Gicumbi, Rushaki, Gatuna, Yaramba, Maya, Rukomo commercial centers and Rutare, Gaseke and Byumba market, social (family, friend, religious observations –Kibeho Holy Land, celebration, sports), seeking health care services (CHUK and KFH for in Rwanda and Kamuganguzi health facility in Uganda) and education (Kabale City, Uganda).

Some of the most visited health care facilities in the Gatuna area by travelers from Uganda are CHUK, KFH and Gatuna health post. People are known to use the Gatuna-Nyabugogo taxi park as the main route of transit from Uganda to Kigali and will stop at various markets along the way. Nyabugogo bus park is a central location for those entering or exiting Uganda.

Nyagatare district is in the Northern Province and borders Rwanda and Uganda with Kagitumba One Stop Border Post (Kagitumba OSBP). It has many health centers (Nyagatare District Hospital, Bishenyi hospital), commercial centers, and many different markets. Well-visited commercial centers and trading centers are Nyagatare market, Sofia, Lubale, Ntoma, Bugaragara, and Tabagwe. Kwepa (Kazaza) Center is a well-known business center frequented by Ugandans crossing the border to Rwanda unofficially.

In Nyaruguru, the following areas - Maraba HC, Nyantanga HC, Ngera HC, Cyahinda HC and Ngoma HC - were labeled as "hot zones" for infectious and communicable disease spread due to the volume of people coming to the areas from neighboring countries like Burundi and Uganda.

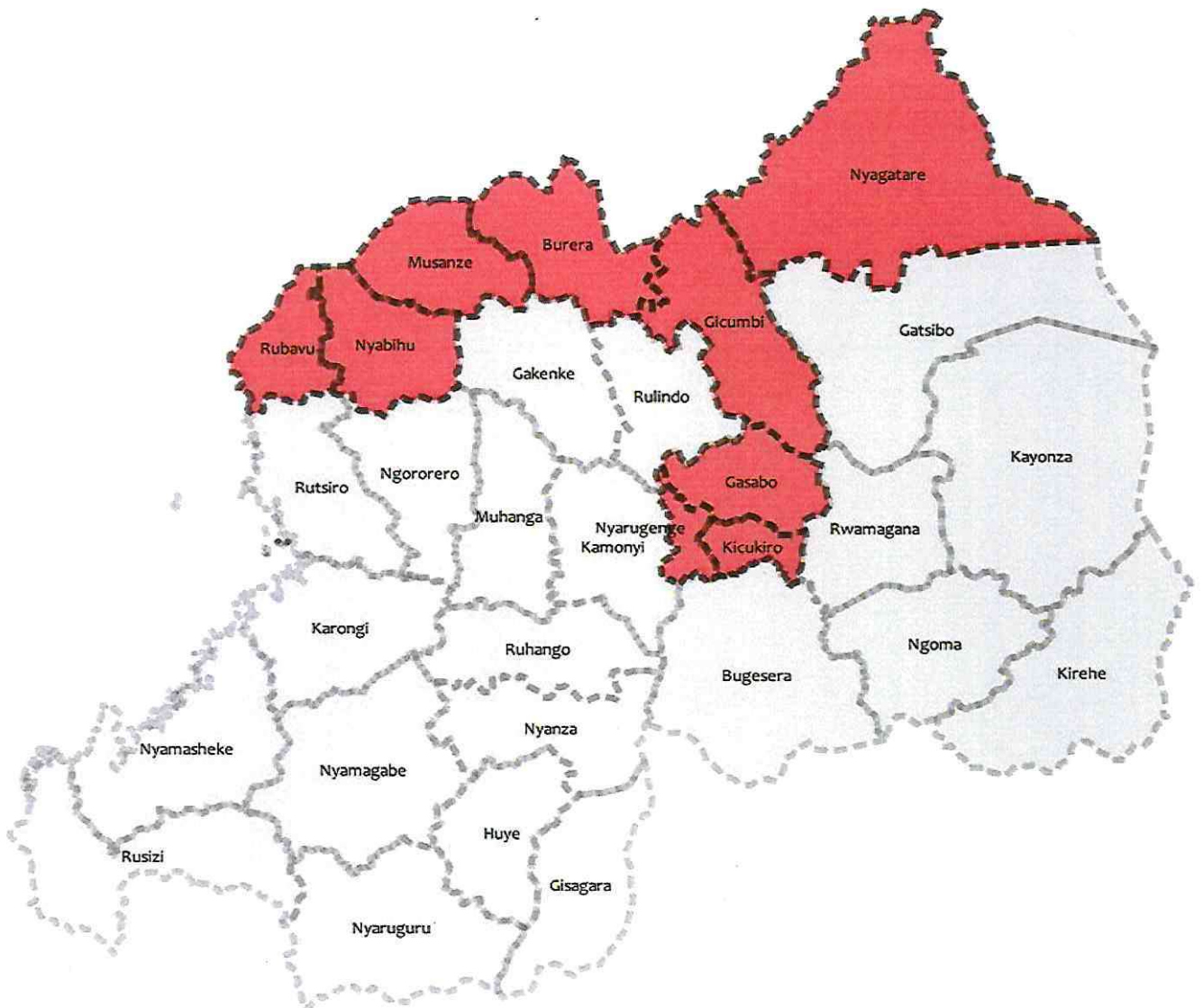
Uganda hosts the third largest refugee population in the world (around 1.5 million in 2021), many of whom come from DRC, Burundi, and Rwanda (UNHCR). While a refugee camp was mentioned in one FGD, transit through Rwanda to and from refugee camps in Uganda may be a topic that wasn't adequately captured by the data collection as it was recorded as "visiting family/friends" or wasn't recorded at all due to populations only transiting through Rwanda. Further, many refugees from Rwanda reside in the Kyaka II refugee settlement which is in Kyegegwa district, a district with 2 confirmed Sudan virus cases as of 24 September 2022.

Up to date, WHO does not recommend any restrictions on travel and/or trade to Uganda based on available information for the current outbreak. However the outbreak is classified as very high risk

The following have been identified as risk factors for importation of SVD from Uganda to Rwanda.

- I. Rwanda shares a border with Uganda, with close proximity to the epicenter of the outbreak. Even though the affected districts in Uganda have no international borders, the risk of importation is related to the high movement of persons and goods from the epicenter of the outbreak across the borders through both formal and informal crossings
- II. A substantial Rwandese population is reported to be residing in Mubende District and its environs. The rapidly evolving outbreak may cause some of the residents already incubating the disease to flee and return to their families in Rwanda.
- III. Socio-cultural practices including handshaking and poor health seeking behavior

## 1.6. DISTRICTS AT HIGH RISK FOR EVD INTRODUCTION INTO RWANDA



**Figure 2: EVD Priority of Districts**

Following a risk assessment, nine (9) of the 30 districts in Rwanda are considered to be at high risk. These include Nyagatare, Gicumbi, Burera, Musanze, Nyabihu, Rubavu and Kigali City (Gasabo, Kicukiro and Nyarugenge)



## 2. EVD CONTINGENCY PLAN FOR RWANDA

This EVD contingency plan is intended to guide preparedness, early detection and early response for EVD in Rwanda. Additionally, EVD preparedness efforts have been designed to be sustained for the duration of the ongoing outbreak in neighbouring Uganda, or until the risks for potential spread beyond the international borders are diminished and eliminated. In the event of an outbreak a rapid risk and needs assessment will be conducted and the plan updated. This plan proposes activities and provides guidance on roles, responsibilities and procedures that would be necessary to facilitate the process of decision-making.

### 2.1. GOAL

To ensure that Rwanda has the required readiness capacities and capabilities to manage EVD outbreak in a timely and effective manner to stop the spread of Ebola virus.

### 2.2. OBJECTIVES

The objectives of this plan are to:

4. Facilitate coordination of preparedness and response efforts for a potential EVD outbreak
5. Mobilise resources for the effective implementation of national operational readiness for EVD prevention and control based on potential identified risks.
6. Enhance capacities for prevention, timely detection, and prompt and effective response to potential EVD cases.
7. Monitor and track implementation of planned activities and test the preparedness capabilities and system.

### 2.3. STRATEGIES

The following strategies will be used:

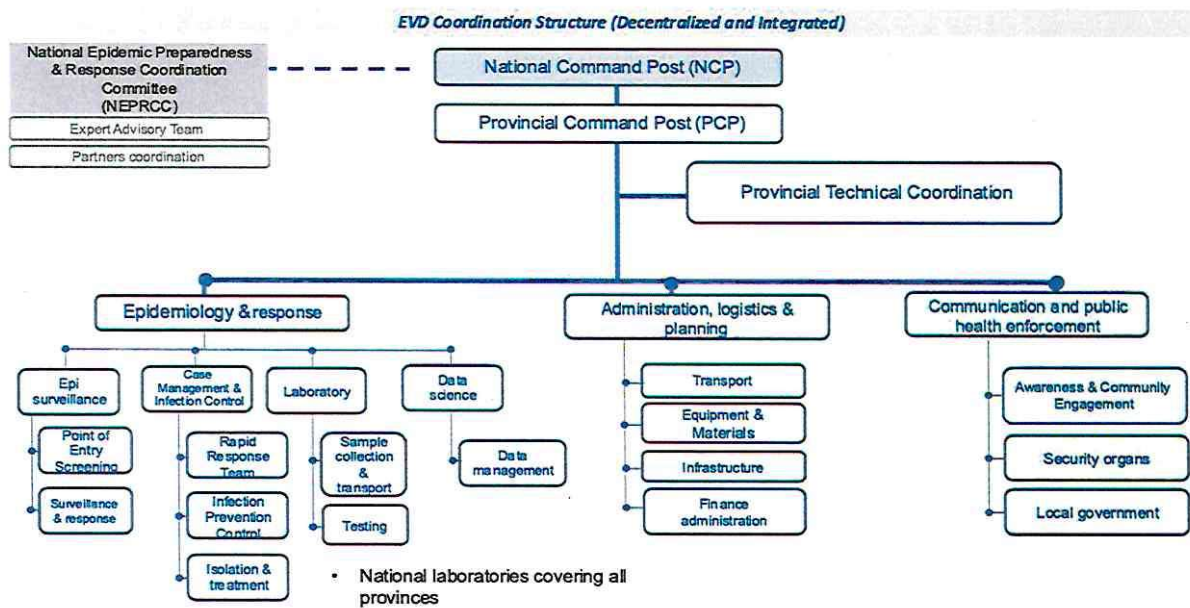
1. Supporting the establishment of EVD outbreak readiness coordination, joint planning, communication and information management structures at all levels.
2. Strengthening collaborations and partnerships with key sectors, UN agencies and partners for a coordinated response.
3. Identifying risk factors for Ebola introduction in the country through regular risk assessments
4. Ensuring prompt availability of information and risk communication to all levels including communities.

5. Strengthening national and subnational capacity for EVD prevention, preparedness, timely detection, investigation and prompt effective response
6. Engaging communities to build positive relationships, strong collaboration, trust, and respect to increase the positive impact of our messaging.
7. Mobilizing resources; financial, human, logistical, technical to fill critical gaps

## 2.4. COORDINATION MECHANISM

### 2.4.1. EVD Coordination Structure

The figure below is a chart showing the national coordination structure for EVD operational readiness.



### 2.4.2. Executive oversight

The effort to strengthen operational readiness and response to the potential importation of an EVD case from Uganda will be led by the Office of the Prime Minister under the National Epidemic Preparedness & Response Committee (NEPRCC) along with the Ministry of Health, Ministry of Local Government and Security organs.

### 2.4.3. National EVD Taskforce

The National EVD Task Force is established with membership drawn from the Ministry of Health and other relevant Government agencies. The mandate of the taskforce is to review the evolving threat from the EVD outbreak situation in Uganda and regularly offer technical advice on appropriate measures to secure the country, joint planning and monitoring of the response as well as information management. The Task Force will have technical working groups (TWGs) with clear terms of reference (TOR) based on key pillars/technical areas which are Leadership and coordination; Epi surveillance



(POEs, health facilities and community); case management, IPC/WaSH and SDB; risk communication and community engagement operational support and logistics (OSL); and Research for EVD investigational therapeutics and vaccines.

Rwanda Biomedical Centre (RBC) will be responsible for planning, coordinating of technical areas of work, tracking implementation, and reporting to the National command centre and externally. Additionally, RBC will harness and coordinate efforts of partners in support of plan implementation. The TWGs will be responsible for directing implementation, coordination and reporting on the planned activities, as well as guide and support resources mobilization efforts. Additionally, the TWGs will support rolling out implementation of planned activities to the priority districts, tracking progress, and reporting nationally within the technical coordination mechanism, and to the overall Command Centre on a weekly basis.

Both the command centre and the TWGs coordination mechanism will provide the framework and operational platform for multisector and multi-partner engagement in support of plan implementation, monitoring and evaluation. The command post, together with the technical arm, will be responsible for updating and reporting to the sectoral and inter-ministerial coordination mechanism that reports directly to the Head of State. Similar coordination structures will be established at the district level.



## 3. THE PREVIOUS EVD PREPAREDNESS AND CONTINGENCY PLANS

### 3.1. ACHIEVEMENTS & THE KEY GAPS IDENTIFIED DURING THE PREVIOUS PREPAREDNESS AND CONTINGENCY PLANS PREVIOUS PREPAREDNESS AND CONTINGENCY PLANS

#### 3.1.1. Strategic Leadership and Coordination

Since the beginning of the preparedness planning following the EVD outbreak in DRC, multiple policy documents and guidelines have been developed to provide an interim framework for coordination and operations.

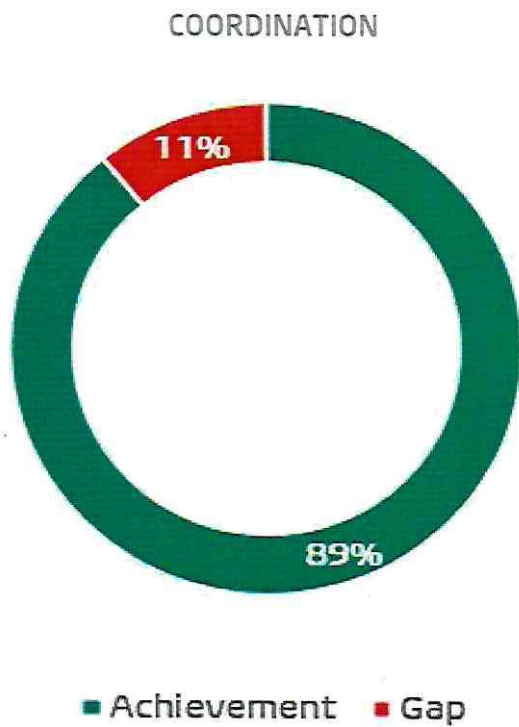
The Terms of Reference (ToR) for tactical coordination and establishment of inter- sectoral and cross border coordination has been adopted. All Standard Operating procedures (SOPs) have been developed, approved and were disseminated. The SOPs will be reviewed as part of the current planning.

The rest of the legal framework documents required, which include the Ministerial Order, Public Health Emergency Operations Centre (PHEOC) Charter and the Public Health Law, have been drafted and are planned to be ratified and integrated directly into PHEOC. Whilst awaiting ratification, the PHEOC will continue to operate within an interim ToR and staffing organogram.

Within the current PHEOC coordination methodology, there is an agreed EVD specific Incident Management System (IMS) structure, that is supported by the established EVD Technical Working Groups (TWGs). The Rwanda Biomedical Centre (RBC) is providing technical oversight through the tracking of activities that are implemented through the coordinated efforts of the technical partners, who in turn report into the PHEOC.

Financial and technical resources to support the daily operations and functionality of the PHEOC continue to be provided.

Partner coordination is being facilitated and managed at different levels. At the top is the establishment of the Strategic Advisory Committee (SAG), which is composed of donors and key implementing partners. This is a high-level platform where the Rwandan Government interacts with country heads of institutions. Partner coordination is then undertaken within the TWGs that will be coordinated through the PHEOC.



**Key Achievements**

1. The National PHEOC is established as well as the Provincial PHEOCs that are being established
2. Tracking the progress of the activities implemented was maintained through the reporting on the agreed WHO Key Performance Indicators (KPIs)

**Key Gaps**

There is insufficient capacity and resources at the sub-national and district level to be able to decentralise leadership and coordination (i.e. operational set up, resources and mentorship)

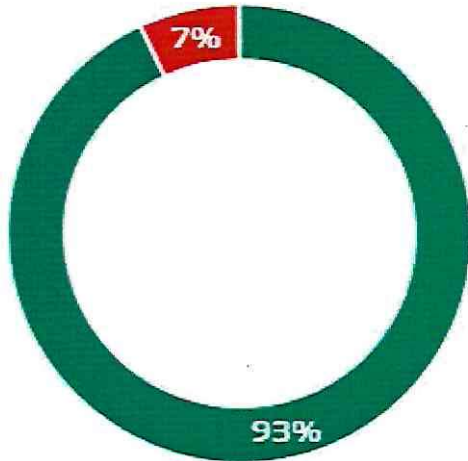
**3.1.2. Enhanced Surveillance and Epidemiology**

Quarantine of people at high risk, rapid detection of suspect cases and isolation of EVD cases is key to the prevention and onward transmission and it allows for the initiation of appropriate control measures in a timely manner. In Rwanda, the strategy for achieving timely detection and response has been based on the existing national strategy for Integrated Disease Surveillance (IDSR), with a primary focus on strengthening case detection and the alerting mechanisms from the community, the health facility level, and at high-risk points of entries (PoEs).

To date interventions have focused on enhancing EVD surveillance at high risk POEs, Health facilities and Communities in the 9/9 High-risk districts, as well as the improvement of the Laboratory diagnostic capacity for EVD nationally. A strong emphasis was placed on the establishment of RRTs, screening at POEs, and an alert communication system.

Rwanda has developed an electronic community event-based surveillance (eCEBS). However not yet rollout to all users including CHWs.

EPI-SURVEILLANCE



■ Achievement ■ Gap

**Key Achievements**

1. updating of case definitions to the Uganda outbreak context and dissemination at the community level.
2. Simulation exercise conducted at 50 hospitals, aiming to improve case detection and management.
3. All districts have identified and trained contact tracers.
4. Provided targeted training for EVD detection of Health Care Workers (HCW)
5. Undertook and supported regular supervision/mentoring of the surveillance officers and community-based focal points

**Key Gaps**

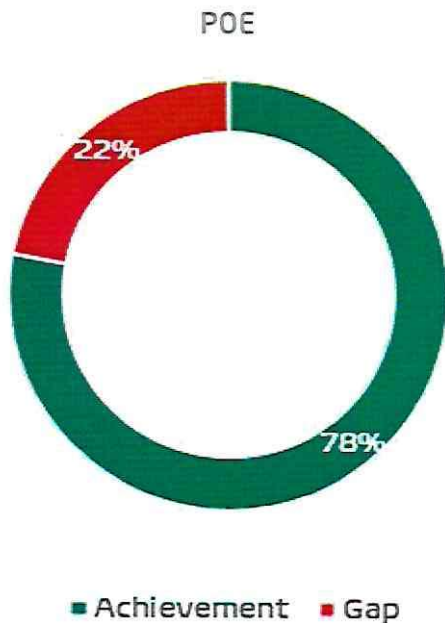
1. Community health workers have not yet trained on surveillance of EVD Virus Disease
2. Insufficient Equipment at decentralized/regional Laboratory for testing EVD Virus Diseases (Glove boxes and testing Kits)
3. No electronic tool for contact tracing available
4. eCEBS and EBS not yet rolled out in all districts including the 9 high districts

**3.1.3. Point of entries**

PoEs in Rwanda, Cyanika, Gatuna and Kagitumba are characterized by large movements of people between them. The checkpoints connecting them are some of the most at-risk areas for the transmission of EVD into Rwanda from Uganda.

Screening for EVD symptoms at PoE has been ongoing since the beginning of the outbreak in the DRC and has been reinforced since the confirmation of a case in Uganda. A major undertaking has been the provision of surge capacity in terms of staffing to support health facilities and screening at POEs.

At the end of 14th October 2022, a cumulative number of 13,599 people had crossed the border and been screened since the start of the EVD outbreak in Uganda and a total of 250 were put under quarantine as part of public measures. Among people in quarantine, 6 showed symptoms and were isolated and all tested negative for EVD.



### Key Achievements

1. Effective transportation protocol in place for movement of individuals to quarantine and isolation facilities
2. EVD messaging at PoEs has significantly improved with billboard and audio communication accompanying the posters which had not been present previously
3. Support team has been deployed and screening using questionnaire is ongoing which allows people with symptoms, contacts to be identified and quarantined

### Key Gaps

1. Lack sufficient human resources (i.e. Hygiene promoters) to be able to actively promote handwashing at persons passing through the PoE
2. Cross-border activities with the Ugandan POEs
3. Testing of the roles and responsibilities of relevant sectors at the PoE needs to be undertaken through simulation exercises
4. Simulation exercise at all POEs that are not yet conducted

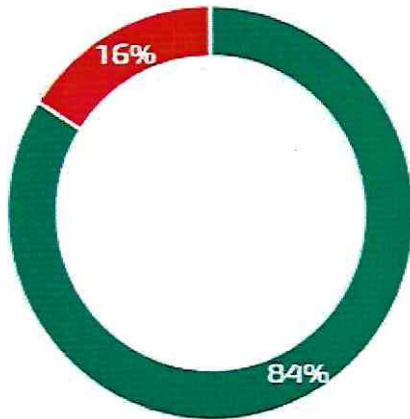
### 3.1.4. Laboratory

Laboratory capacity to conduct EVD testing using appropriate tools and new technologies supported by appropriate plans and procedures has been strengthened to ensure that the safe EVD specimen collection, transportation and sampling continues to be undertaken.

A needs assessment conducted in October 2022 indicated that the capacity for VHF diagnostic capacity was in place with more than 10 staff trained on testing using Transcriptase Polymerase Chain Reaction (RT-PCR), and at least one laboratory technician trained on sample collection and use of triple packaging. The confidence of the staff team tasked to handling EVD specimens continued to be strengthened but more support is required to enhance their knowledge and skills.

So far 17 suspected specimens have been tested at the National Reference Laboratory and results were received in real time. The resident staff were trained and certified to carry out the routine maintenance, servicing, and certification of the biological safety cabinets. The end user maintenance and troubleshooting of the equipment are performed by the staff. The WHO has supplied the reagents.

### LABORATORY



■ Achievement ■ Gap

#### Key Achievements

1. A total of Sixty-two (62) laboratory professionals have received refresher training on safe Ebola virus disease sample collection, packaging, shipment, biohazardous clinical waste management, biosafety and biosecurity including audits and quality assurance
2. An inventory management has been established at National Reference Laboratory (NRL)
3. Successful management of simultaneous samples were undertaken through a drills exercise
4. For external reference laboratory support there is an MoU in place.

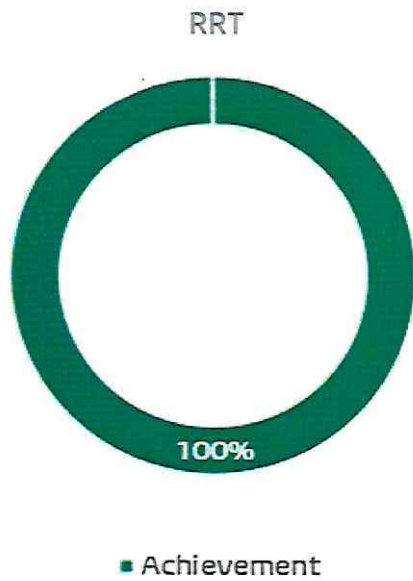
#### Key Gaps

1. Lack of laboratory data management system integrated in DHIS2
2. Lack of sufficient laboratory testing kits and equipment at decentralized satellite laboratory
3. Lack of sufficient skills to test EVD at decentralized testing hubs.

### 3.1.5. Rapid Response Teams (RRT) Capabilities

A rapid response capability is critical for Rwanda to be able to act immediately once a suspected case is reported, so that actions can be initiated, and the first investigation and control measures can be actioned under the Rwandan 72 hr Response plan. In Rwanda the RRTs are multi-disciplinary and are ready to support the case investigation, specimen collection and transportation of a suspect EVD sample, as well as supporting contact tracing, social mobilization with the reinforcement of the key EVD messages and the SDD.

The priority of the preparedness planning has continued to focus on the training and refresher training of the national and 9/9 (100%) high priority district level. Further strengthening of capacity was undertaken through integrated drills that were successful undertaken in the summer months. A 24-hour reporting and referral mechanisms for alerts and suspected cases is in place throughout the dedicated national 'hot-line', which operates 24/24.



### Key Achievements

1. All 30 districts have RRT in place.
2. Simulation Exercises done in all public hospitals in 30 districts

### Key Gaps

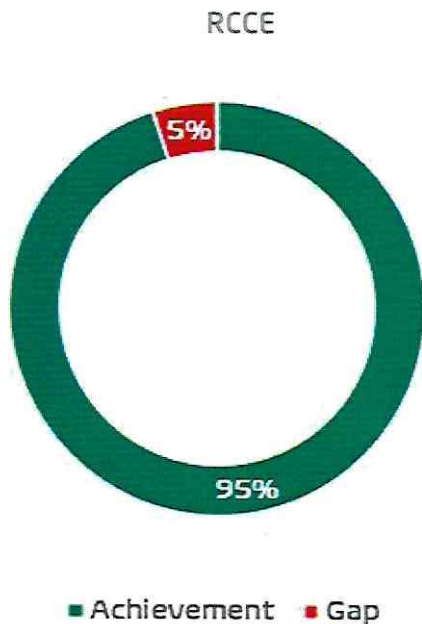
1. There is no integrated national EVD training strategy or training plan for field-based simulation exercises to ensure functionality is maintained of the RRTs and the other disciplines
2. No Rapid response team established in private hospitals

### 3.1.6. Risk Communication and Community Engagement

The sophisticated system of administrative decentralization in Rwanda, means that there are channels already in place, through which information can be readily disseminated to the population at large. In addition to that, the recent outbreaks of EVD in DRC (2018-2021) and COVID-19 pandemic have considerably strengthened information sharing channels and risk communication strategies.

Community engagement measures continue to be implemented by the Rwandan Govt. with the support of partners including UNICEF. The pre-epidemic phase should be used to prepare the public for potential risk behaviours that would favour the spread of infection and promote standard infection prevention and control precautions e.g: hand washing. Health education activities are to be reinforced targeting everyone but with a special focus on specific groups, such as hunters, drivers, market places, borders, etc. Nationally, there has been sustained and integrated media communications, with the strategic use of information to increase public awareness and participation in Ebola prevention and control activities, including the Ebola vaccination campaign.

A number of activities to remobilize communities and raise their awareness vis-a-vis the current EVD outbreak for better surveillance and prevention include a Rapid Knowledge, Attitudes and Practices (KAP) surveys, training communities to improve their knowledge on EVD and allow proper engagement for ownership of community interventions and timely cases reporting, Avail Information-Education-Communication (IEC) materials, Radio and TV spots, among others.



### Key Achievements

1. EVD key messages are displayed at x 4 LED screens fixed at the borders of Rubavu, Gatuna, Cyanika and Kagitumba x 6 LED screens in Kigali city (INC. airport inside & outside, checking point)
2. Airing awareness messages through Radio and TV stations are ongoing

### Key Gaps

1. A review of the national 72 hr. Response Plan identified that the process steps for activation of RCCE need to be updated
2. Lack of Human resource funding for the 'Hot line'
3. An additional KAP is required to assess the impact of the last awareness campaign and to provide new tangents of the of the knowledge, attitudes and practices, particularly with regards the vaccination campaign
4. Key influencers have not been trained to engage the community
5. Printout of educational materials for CHWs not yet done

### 3.1.7. Case Management and Safe and Dignified Burials

The core actions under the thematic area of case management have continued to focus on enhancing the capacity of HCW's and frontline health workers in the early case recognition and detection, and management at community, PoEs, Health Centres, Hospitals, Isolation Units and ETC of any suspect or confirmed case of EVD.

A series of ongoing EVD preparedness and response simulation training exercises that are undertaken, resulted in a review of the EVD Pre-Epidemic Screening and Decision-Making Flowchart and the decision to maintain the management of suspect patients in isolation facilities, with only confirmed EVD cases are designated for transfer to treatment center within the hospital or at regional centre

Additional IPC/ Case Management and cascade trainings with simulation exercises were delivered periodically by the Rwandan MoH and RBC, supported by the WHO and various partners across the 15 priority districts identified in the previous plans with EVD outbreaks in DRC (and Uganda back in



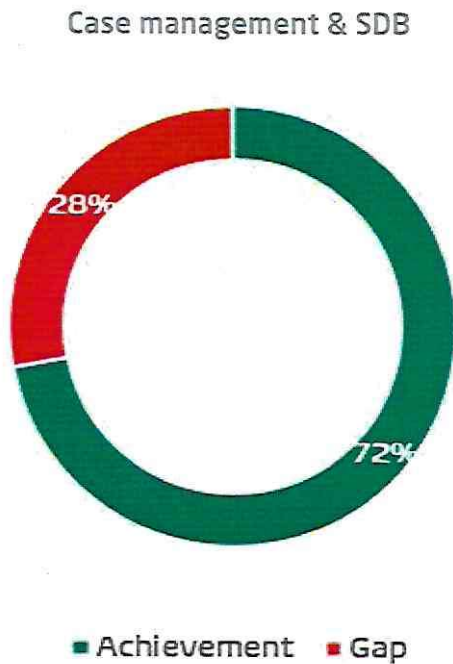
2018), which also included that of private health facilities. Several Training evaluations and learning continued to be incorporated into the agreed training curriculum.

Specialist and more targeted trainings within Mental Health and Psychological Support (MHPSS) were integrated into both the preparedness and response plans (i.e. with the training of HCW within health facilities within multiple workshops and training delivery for CHW and other members of the community to provide MHPSS). Total of 14 hospitals has planned ETCs and are currently considered operational including Nyamata Mobile treatment Center. Nyamata treatment Center has the capacity of 92 beds.

8 of 9 hospitals that are considered high risk have isolation rooms that are either designed for Ebola management or can be repurposed since they were built during COVID19 pandemic. Only Butaro hospital doesn't have isolation rooms since the hospital is under renovation and Mobile tent can be established in case of the confirmed case or consider Ruhengeri Hospital for all cases that can be identified in Butaro hospital catchment area.

The move to incorporate the use of isolation facilities for suspect patients until point of confirmation and transfer, necessitated a switch from the identification of a designated temporary space to needing an identified building that could be repurposed or a new purpose-built isolation (ISO) unit was needed to be constructed. Even some availed hospital purpose-built isolation units are now serving for COVID-19 treatment units.

Great gains have been made with building the capacity for the management of safe and dignified burials (SDB) in the event of an EVD death (or otherwise) in the case of an outbreak scenario. At the district level the 9 priority districts, either have a dedicated or they have access to an SDB, and several burial sites have been identified and secured. However, we expect possible turnovers among SDB team members and a need for refresher training to strengthen their capacities.



### Key Achievements

1. All hospitals in 30 districts have identified isolation areas for the safe clinical management of suspect cases until EVD is confirmed or are discharged
2. • The management of suspect patients in isolation facilities/units has been incorporated into the national policy
3. • Clinical guideline on management of EVD has been developed and disseminated
4. • All public hospitals have conducted simulation exercises on case management
5. • Atleast 14 hospitals have isolations readily built for Ebola management (Kibagabaga, Mibilizi, Kirehe, Masaka, Ndera, Kibuye, Gakoma, RMH, Ruhengeri, Gicumbi, Nyamata, kanyinya, KFH, Gisenyi)

### Key Gaps

1. There is no overarching EVD specific national training strategy, training curriculum and annual training delivery plan, that also takes into consideration private health care facilities
2. No Monoclonal treatment yet available in the country
3. No hands-on skills on management of Ebola Cases

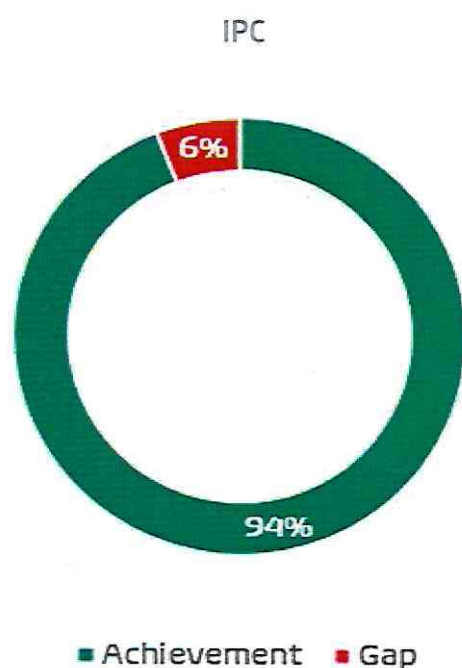
### 3.1.8. Infection, Prevention and Control and Water, Sanitation and Hygiene (WASH)

After the identification of COVID19 case in Rwanda in March 2020, Investments were made to procure IPC materials and ensure all hospitals are well equipped with all necessary materials for IPC. Routine assessment done during ongoing simulation exercises have observed some recommendations such ensuring all services are trained and have equipment in store. Dedicated Isolation (ISO) units built for COVID19 can be repurposed as isolation for Ebola

All health facilities had functional incinerators /burns pits, however these are not necessarily EVD specific incinerators/burns pits as they are shared with the general waste management of the health facility. There were ongoing works being undertaken with the development of an EVD specific IPC

and WASH evaluation tool, that can be used at health facility level to either self-assess or be used by the IPC 'Focal Point' to assess and evaluate the quality of IPC and WASH standards within the health facility.

A new assessment will be conducted to evaluate how the existing facilities will be serving for the management of both EVD and COVID-19 outbreaks.



### Key Achievements

1. National policy has agreed to establish ISO units at all district hospitals, where suspected cases are to be held pending confirmation
2. The Chlorination SOP has been finalised between partners and the Rwandan MoH
3. 3/10 redesigned ambulances are available for EVD specific use and the ambulance team and hygienists have been trained in decontamination
4. A good number of IPC focal persons, EHO and other Rapid Response Teams members have been trained and got experience from COVID-19 interventions. Each hospital is capacitated in terms of IPC training. However the outbreaks are not similar in everything, a refresher training might be needed.

### Key Gaps

1. Lack of specialist and available EVD IPC/WASH expertise
2. More consistent presence and supervision of IPC activities in health facilities is required, and would benefit from identifying dedicated roles and or focal persons who can support EVD IPC and WASH at health facility level
3. A refresher training for Rapid Response Teams is needed to ensure or strengthen compliance to transmission-based precautions, and IPC standards in general.
4. Additional IPC materials and commodities are required for the continuity of preventive measures.

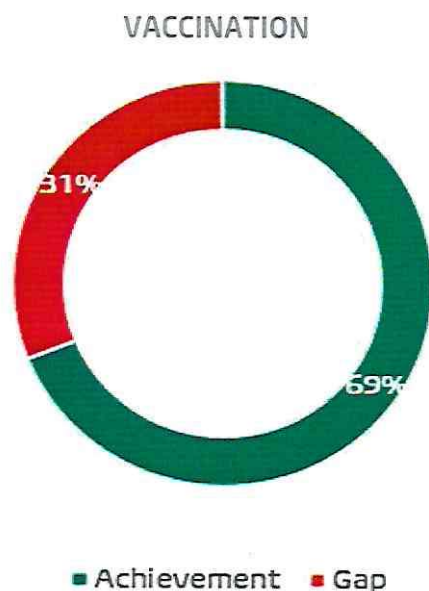
### 3.1.9. EVD Vaccination and New Therapeutics

At the beginning of 2019, the Rwandan FDA granted conditional approval of the Ad26.ZEBOV (ERVEBO – Merck) and more recently in October, the MVA-BN-Filo (J & J) Ebola vaccine.

A vaccination campaign was launched in April, under the Phase II plan, with the support of WHO and other partners with the ERVEBO vaccine for HCW and frontline health workers, in the Rubavu and other districts that were considered to be in a high-risk zone (i.e. near the borders with the DRC).

Recognising that there is a global shortage of the ERVEBO vaccine, the Rwandan and the DRC MoH launched a joint vaccination campaign for Ebola prevention with the MVA-BN-Filo Ebola J&J vaccine on the 8th December. This important event highlights the progress in Ebola disease fighting in a joint cross-border manner, the first ever cross-border vaccination of EVD. The immunization program in Rwanda named Umurinzi was implemented by an agreed partner with the MoH. More than 200,000 people received at least two doses of J&J.

J& J vaccine Ad26.XEBOV, MVA-BN-Filo is a monovalent vaccine 2 doses of 56 days apart was approved in 2020 in EU and prequalified by WHO in 2021 for prevention of Zaire EbolaVirus disease. The potential protection Ad26.XEBOV, MVA-BN-Filo against Sudan Ebolavirus is raised because MVA-BN-Filo contains SUDV glycoprotein, Zaire Ebolavirus, Tai Forest Ebola virus and Marburg virus Musoke variant while the initial dose of Zabdeno provides protection against Zaire Ebola Virus To date, in clinical studies we have observed immune responses to SUDV glycoprotein but there is evidence of protection and a single dose of MVA might not be sufficient to induce a protective response



#### Key Achievements

1. A total of have received two doses of J&J in Rubavu and Rusizi that might have some effect against Sudan Ebola as part of the Umurinzi vaccination campaign

#### Key Gaps

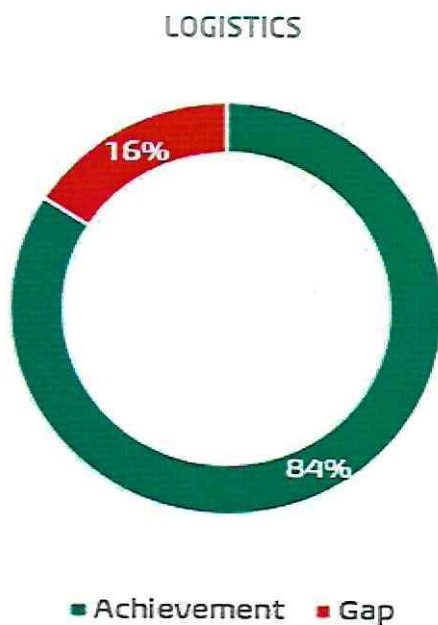
1. Frontliners from the 9 high-risk districts are not yet vaccinated

### 3.1.10. Medical and Operational Logistics

The logistics team worked across all of the EVD technical disciplines to support with their varying operational and logistical needs. This was mainly with the procurement, installation and delivery of logistics to IPC/WASH, Case Management and Surveillance.

All of the 30 districts received the agreed minimum package of prepositioned EVD specific stocks. At national level, the dedicated ISO units core kit and consumables logistics have been pre-prepared for distribution.

The PHEOC is now fully equipped and running costs have been factored in. The decentralized Command post are not yet fully operational with every sub cell tasked. All high risk districts have EVD adapted ambulances are available for use and have been prepositioned at strategic points (i.e. high-risk areas). there is still gaps for more EVD adapted ambulances.



#### Key Achievements

1. Additional supplies were dispatched to the remaining health facilities and replenishment will continue.
2. A total of 60 health worker who have been supporting the Command post for EVD have now shifted the focus on countrywide EVD preparedness activities.

#### Key Gaps

1. The Emergency Logistics team, needs to be enhanced at the central and district level
2. Existing supply management system is being used from central to district level and more effort is therefore required to be able to fully integrate the EVD supplies
3. There is need to plan for sufficient time for procurement and clearance of PPE and SDB kits.



## 4. IMPLEMENTATION OF THE EVD CONTINGENCY PLAN

The implementation of the EVD preparedness activities will be at the national level and in priority districts. Based on proximity and population movement, 9 districts bordering Uganda have been prioritized for readiness activities in response to the ongoing EVD outbreak in central Uganda.

### 4.1. LEADERSHIP AND COORDINATION

The leadership and coordination pillar will ensure proper command and control, coordinated joint multi-stakeholder and multi-partner efforts working harmoniously to implement and scale up EVD readiness activities as outlined in the national plan. This will be achieved through the establishment of operational and coordination platforms at national level, and coordination hubs in strategic locations in prioritized districts; leading, facilitating and overseeing the development and implementation of the national EVD preparedness plans; mobilizing operational, technical, financial and logistical resources as dictated by needs; facilitating partner engagement in support of national efforts; facilitating key decision making in consultation with key partners and stake holders; facilitating the development and implementation of a monitoring framework with regular updates, and facilitating the conduct and implementation of simulation exercises to test the preparedness capabilities established at the national and district levels.

### 4.2. EPI SURVEILLANCE (POE, HEALTH FACILITIES AND COMMUNITY)

The primary focus is to enhance EVD surveillance and ensure quarantine of people at risk of SDV, early identification of potential cases, isolation and timely response to mitigate further spread and effectively contain the outbreak. The strategy for achieving timely detection and response will be based on existing strategy for Integrated Disease Surveillance (IDSR) with a primary focus on strengthening the case detection and alerting mechanisms at the community, the health facility level, high risks points of entries, and at hotspots revealed by the PopCAB survey. The Event Based Surveillance will be reinforced, Community health workers and health facility staff will be trained on EVD case detection, verification, investigation and reporting. Rapid response teams will be trained at national and in the priority 9 districts to facilitate rapid verification and investigation of alert cases. The surveillance of fever of unknown origin will be strengthened through VHF sentinel surveillance. Additional staff will be recruited and deployed at health facility level and at the designated POEs to conduct screening and surveillance for possible EVD cases, and trigger verification and investigation mechanism if required

### 4.3. LABORATORY TESTING AND DIAGNOSTICS CAPABILITIES

The focus will be on enhancing national capabilities for EVD testing using appropriate tools new technologies and appropriate procedures; and on strengthening intra and inter-country safe specimen collection, packaging and referral. This will be achieved through upgrade and purchase of equipment, laboratory logistics and supplies; recruitment and deployment of additional staff, training

and mentorship; partnerships; establishment and implementation of a system for proper specimen collection, packaging and referral from the districts and border areas to the national. Appropriate linkages with reference EVD testing laboratories will be established.

#### **4.4. RISK COMMUNICATION AND COMMUNITY ENGAGEMENT (RCCE)**

General public awareness on EVD will focus on increasing awareness about possible importation of EVD cases from Uganda, associated risks, prevention and control measures established in Rwanda, and the need to maintain vigilance to identify and notify suspect cases. A comprehensive strategy and plan, that includes dissemination of tailored and targeted Information, Education and Communication (IEC) materials; community outreach through regular mass gatherings events such as sports, schools, church services, Umuganda, etc.; media relations using print and electronic channels such as radio, television, social media, etc.; and advocacy and mobilizing community action to enhance reach of key populations like people with disabilities such as the blind, illiterate, mentally unable to access and understand regular interventions. A national plan on risk communication and community engagement will be implemented in collaboration with different stakeholders.

#### **4.5. CASE MANAGEMENT, INFECTION PREVENTION AND CONTROL (IPC)/WATER SANITATION AND HYGIENE (WASH) AND SAFE AND DIGNIFIED BURIAL**

The preparedness actions under case management and IPC focuses primarily on enhancing capacities of health care workers to manage EVD cases and minimize mortality, and to promote good IPC practices to minimize transmissions in health care settings and in the affected communities. This will be achieved through multiple strategies that include:

- Ensuring access to EVD specific guidelines and standard operating procedures (SOPs) for case management, IPC, WASH, and waste management, and management of dead bodies, and psychosocial support;
- Establishment of at least 3 fully equipped and properly staffed 5 – 10 bed capacity EVD treatment centers (ETCs) in strategic locations (including at least one in Kigali);
- Strengthening capacities for WASH and waste management in ETCs, and at health facilities in high risk districts.
- Establishment and implementation of screening and triage systems in health facilities;
- Training and mentorship of frontline health care and public health workers; and
- Procurement and distribution of EVD PPE, other medical and non medical supplies;
- Designation of ambulances for safe transportation and referral of EVD cases; and
- Training and equipping of safe and dignified burial teams

## **4.6. OPERATIONAL LOGISTICS AND SUPPORT**

The aim of the operational logistics and support function is to ensure timely and continuous availability and proper management of the required logistics and supplies. The logistics will comprise of operational, medical and non-medical logistics. The Logistic needs will be defined in coordination with each of the thematic areas, needs estimated and quantified for the duration of the plan, procured and distributed and managed according to standards, timelines and needs.

A contingency stock of essential medicine, medical supplies and IPC materials will be distributed to the designated isolation facilities, and some prepositioned in district hospitals for ease of access. Donations will be accepted in line with the needs indicated on the plan, and subject to validation of the quality and standards.

Additional human resources may be required at the national level and to support identification, procurement and management of the required logistics.





## 5. EVD FINANCIAL PLAN

This is a 6-month plan. The priority activities to prevent importation of EVD into the country and strengthening capacity for operational readiness and early response will be carried out from October 2022 to March 2023 focusing on the high-risk districts.

No	Priority Activities	Total cost (FRW)	Total cost (USD)	Timeframe							
				Oct	Nov	Dec	Jan	Feb	Mar		
<b>5.1</b>	<b>LEADERSHIP AND COORDINATION</b>										
1.	Activate the National Command Post, IMS and functional TWGs	0	0	X							
2.	Complete EVD readiness checklist	0	0	X							
3.	Develop and disseminate the National EVD Preparedness and Response Plan including a 72 hour response plan	0	0	X							
4.	Activate national and district Rapid Response Teams	0	0	X							
5.	Activate multi-sectoral and multi-partner coordination mechanisms	0	0	X							
6.	Support the National Command Post operations (ambulances, vehicles, communication and meals)	1,094,666,667	1,032,704	X	X	X	X	X	X	X	X
7.	Support District Command post operations in high-risk districts	270,000,000	254,717	X	X	X	X	X	X	X	X
8.	Hire surge staff and support incentives for staff at POEs, quarantine sites, call centers, national command post and treatment centers	2,142,640,000	2,021,358	X	X	X	X	X	X	X	X
9.	Conduct initial capacity assessment and regular risk assessments	15,000,000	14,151	X							
10.	Facilitate integrated regular support supervision and mentorship activities* [For the high-risk districts visits are per month while for the rest of the districts visits will be per quarter]	58,032,000	54,747	X	X	X		X	X	X	X
11.	Support cross-border coordination activities (1-day monthly meetings for the 6 high risk districts bordering Uganda)	6,480,000	6,113	X	X	X		X	X	X	X
12.	Conduct EVD field simulation exercise in high risk Districts	40,000,000	37,736		X						

13.	Monitor the implementation of the National SVD Preparedness and Response Plan	0	0	X	X	X	X	X	X
14.	Meeting to mobilize resources to implement the SVD plan	3,000,000	2,830	X					
15.	Print and distribute EVD (All pillars) technical guidelines, SOPs, case definitions, case investigation forms, contact listing and follow up forms, and associated data collection and reporting tools etc	51,000,000	48,113	X					
	<b>Subtotal Leadership and Coordination</b>	<b>3,680,818,667</b>	<b>3,472,470</b>						
<b>5.2</b>	<b>EPI SURVEILLANCE AT POE, HEALTH FACILITY AND COMMUNITY</b>								
1.	Review and update existing surveillance guidelines and SOPs (POE, health facility and community)	0	0	X					
2.	Mass production and distribution of surveillance job-aids and SOPs								
3.	Procure thermo scanners and PPE for POE surveillance team	150,000,000	141,509	X					
4.	Procure Thermo Flash/guns for public space screening	7,950,000	7,500	X					
5.	Virtual training all health care workers working in all districts on case definition/detection and reporting (both public and private facilities)	0	0	X					
6.	Train POE staff (medical & non-medical) on screening, EVD case detection, reporting, isolation and referral (onsite)	5,500,000	5,189	X			X		
7.	Train RRT teams on EVD case investigation and management in all districts	64,050,000	60,425	X			X		
8.	Train district surveillance teams on contact identification, tracing and follow up (Both public and private health facilities) including drills	15,600,000	14,717	X			X		
9.	Rollout of community event based surveillance countywide (Training, IT, Communication, incentives)	2,700,961,700	2,548,077	X			X	X	X
10.	Orientation/sensitization of CHWs on follow-up of people in quarantine, case detection/identification, active case search and reporting of suspected cases in high-risk districts	81,000,000	76,415	X			X	X	X

11.	Procure Thermo-flash, Sanitizers and Basic PPE (Mask, Gloves, Face shield, Goggles, Boots) for CHWs and Volunteers									
12.	Procure IT material for reporting (tablets, laptops, desktops)									
13.	Provide communication and internet connectivity to the RRTs, CHW and Volunteers									
	<b>Subtotal</b>	<b>3,025,061,700</b>	<b>2,853,832</b>							
	<b>Data management</b>									
14.	Adopt and adapt SVD data management and contact tracing electronic system (SORMAS)	1,00,000,000	94,340	X						
15.	Train district surveillance teams on use of the data management electronic system	5,060,000	4,774	X						
16.	Procure IT material for data management and analysis (computers, laptops, tablets, software, dashboard-screens )									
	<b>Subtotal</b>	<b>105,060,000</b>	<b>99,114</b>							
	<b>SUB TOTAL SURVEILLANCE</b>	<b>3,125,061,700</b>	<b>2,948,171</b>							
<b>5.3</b>	<b>LABORATORY</b>									
	Review and update existing laboratory guidelines and SOPs	0	0	X						
	Training of lab technicians from all districts on sample collection, triple packaging, and transportation	12,000,000	11,321	X						
	Onsite Training of Lab technicians working in 7 testing hubs	7,875,000	7,429	X						
	Dedicated vehicles for sample transportation (at Testing hub)	115,290,000	108,764	X	X	X	X	X	X	X
	Procurement of Laboratory testing supplies and equipment	2,415,372,022	2,278,653	X	X	X	X	X	X	X
	Cascaded training for health workers on specimen Collection, sample collection, triple packaging, and transportation (on site)	20,000,000	18,868	X						
	<b>SUB TOTAL LABORATORY</b>	<b>2,570,537,022</b>	<b>2,425,035</b>							
<b>5.4</b>	<b>CASE MANAGEMENT, IPC/WASH AND SDB</b>									

	<b>Infection prevention and control (IPC)</b>																		
	Review and update existing national IPC guidelines and SOPs	0																	
	Set up functional triage and screening areas in all health facilities	0																	
	Set up isolation rooms in all health facilities and ETUs in strategic locations in the high-risk districts	0																	
	Conduct IPC capacity assessment in all health facilities and provide tailored support to the health facilities based on the findings	16,536,000																	
	Monitor IPC and WASH implementation in healthcare facilities and public spaces using the IPC assessment framework, hand hygiene compliance observation tools and WASH facilities improvement tools	15,600,000																	
	Training and equipping of burial teams in high-risk districts	16,200,000																	
	<b>Subtotal IPC</b>	<b>48,336,000</b>																	
	<b>Case Management</b>																		
	Review and update existing national IPC guidelines and SOPs	0																	
	Comprehensive training of clinical teams in high-risk districts on EVD case management including drills	40,500,000																	
	Cascade comprehensive case management trainings to other districts	81,000,000																	
	Train dedicated ambulance teams to transport suspected and confirmed cases in the 9 high risk districts (2 teams of 4 persons per district)	12,960,000																	
	<b>Subtotal Case Management</b>	<b>134,460,000</b>																	
	<b>Sub Total IPC &amp; Case Management</b>	<b>182,796,000</b>																	
	<b>RISK COMMUNICATION AND COMMUNITY ENGAGEMENT</b>																		
	Develop National risk-communication and community engagement plan for EVD	0																	
	Update RCCE Standard Operational Procedures (SOPs) and guidelines	0																	
	Train Risk Communication and Community Engagement teams at national level	2,100,000																	

	Train Risk Communication and Community Engagement teams at District level for all districts	22,950,000	21,651	X					
	Train journalists on EVD pre and during outbreak reporting	2,000,000	1,887	X	X				
	Conduct rapid EVD KAP assessment to understand key community KAP, target audience and preferred communication channels	10,000,000	9,434	X					
	Develop and pre-test messages on prevention of EVD	0	0	X					
	Production of an educative radio and TV spots on EVD prevention	5,000,000	4,717	X					
	Production of a short educative video on EVD prevention	10,000,000	9,434	X					
	Support dissemination of EVD key messages using different channels	150,000,000	141,509	X	X	X	X	X	X
	Print IEC materials, banners etc to be displayed in public places of all districts and POEs	50,000,000	47,170	X	X				
	Engaging Key Influencers oriented at Community level (10 per high-risk district)	40,500,000	38,208	X	X	X	X	X	X
	<b>Sub-Total RCCE</b>	<b>292,550,000</b>	<b>275,991</b>						
<b>5.6</b>	<b>OPERATIONAL SUPPORT AND LOGISTICS (OSL)</b>								
	Review and update OSL SOPs and guidelines								
	Procure PPE for Case Management (Complete Kits)	4,042,000,000	3,813,208	X	X				
	Procure other IPC supplies and equipment	500,000,000	471,698	X	X	X	X	X	X
	Procure medical supplies and commodities for isolation facilities/ETUs	300,000,000	283,019	X	X	X	X	X	X
	Procure non-medical supplies and equipment for isolation facilities and burial teams	500,000,000	471,698	X	X				
	Install a waste treatment unit, construct a laundry area and a pit for infected wastewater at Nyamata Isolation facility	15,900,000	15,000	X					
	Procure test kits (extraction and amplification kits) for EVD	60,000,000	56,604	X	X				
	Procure assorted EVD lab equipment	56,800,000	53,585	X					
	Procure and preposition mobile ETUs (2 complete sets) [tents, generators and other equipment]	600,000,000	566,038	X					
	Procure Heavy tents for POEs (5)	150,000,000	141,509	X					

	Logistical costs for quarantine sites (150 returnees per month)	141,750,000	133,726	X	X	X	X	X	X
	<b>Sub Total Operational Support and Logistics</b>	<b>6,366,450,000</b>	<b>6,006,085</b>						
<b>5.7</b>	<b>RESEARCH</b>								
	Designate a principal Investigator (PI) for research on EVD vaccines and therapeutics	0	0	X					
	Meetings to adapt/develop protocols and submit to national regulatory authorities for approval once candidate vaccines and therapeutics are available (work closely with WHO R&D team)	5,000,000	4,717	X	X				
	<b>Sub Total Research</b>	<b>5,000,000</b>	<b>4,717</b>						
	<b>GRAND TOTAL</b>	<b>16,228,273,389</b>	<b>15,309,692</b>						

**Table 1. Summary Budget by Pillar/Technical Area**

Pillar/Technical Area	Estimated Budget in (RWF)	Estimated Budget in (USD)
Leadership and coordination	3,680,818,667	3,472,470
Epi Surveillance at POE, Health facility and Community	3,125,061,700	2,948,171
Laboratory	2,570,537,022	2,425,035
Case Management, Infection Prevention and Control (IPC) & Safe and Dignified Burials	182,796,000	172,449
Risk Communication and Community Engagement (RCCE)	292,550,000	275,991
Operational Support and Logistics (OSL)	6,366,450,000	6,006,085
Research	5,000,000	4,717
<b>Grand Total</b>	<b>16,223,213,389</b>	<b>15,304,918</b>



## 6. MONITORING OF THE CONTINGENCY PLAN

A framework for the monitoring and evaluation of this plan has been developed, along with performance indicators. The national multisectoral EVD task force will oversee the implementation and monitoring of the national contingency plan with the support of partners.

Indicator reports will be produced and updated weekly. The information will be used to track progress of the implementation of the plan and guide decision making and taking corrective action to ensure quality implementation. Additionally, the indicator reports will be used to monitor and provide traceability on use of funds. Information on the following minimum set of indicators will be collected and reported on routine at least weekly.

**Table 2: Indicators for monitoring and tracking progress of implementing EVD activities**

Pillar/Technical Area	Indicator	Measurement	Target	Freq. of reporting
Leadership & coordination	Existence of a & functionality of a national multi-sectoral /technical coordination mechanism	Y /N	C	Weekly until established
	Proportion of high-risk districts that have a functional emergency multi-sectoral coordination mechanism	Number (Percentage)	9(100%)	Bi-weekly
	Availability of clearly defined TORs for the coordination mechanisms at national and district levels	Y /N	100% at national level; 100% at district level	Bi-weekly until established
	Proportion of contingency plan budget that is funded	Percentage	75%	Bi-weekly
	Existence of regular and documented coordination meetings with partners and stakeholders at national level	Y/N	100%	Bi-weekly
	If the district has an international border, is cross-border coordination in place with agreed activities to be jointly implemented	Y/N/Not Applicable	100% for districts with international borders	Monthly
	No, and proportion of villages with trained CHW,	Number (Percentage)	Number of villages in the 9	Bi-weekly



Pillar/Technical Area	Indicator	Measurement	Target	Freq. of reporting
Epi Surveillance (POE, Health facility and Community)	and equipped with EVD alert lay case definition		priority districts (100%)	
	Number and proportion of health facilities with EVD case definition displayed in the consultation rooms, wards and other strategic areas	Number (Percentage)	Number of health facilities the 9 priority districts 100%	Bi-weekly
	Number of health workers trained on EVD identification/detection and reporting	Number	80% of health workers in both public and private facilities	Weekly
	Number/proportion of health facilities, and POEs having surveillance tools including case investigation form and contact listing forms	Number (Percentage)	Number (100%)	Weekly
	Number /proportion of HFs providing zero weekly reporting of EVD cases	Number (Percentage)	Number (100%)	Weekly
	Proportion / Number of high-risk districts with trained and function RRT	Number (Percentage)	9 (100%)	Bi-weekly
	Proportion of EVD alerts verified and investigated within 24 hours	Percentage	100% (# of alerts investigated within 24 hours/total # of alerts	Weekly
	Availability of 24/7 hotline for reporting of alerts	Y/N	100%	Weekly

Pillar/Technical Area	Indicator	Measurement	Target	Freq. of reporting
	Number/proportion of high risk PoEs in priority districts having screening and referral capacity	Number (Percentage)		Bi-weekly
	Number/proportion of priority POEs with appropriate and equipped holding area (close to screening area). Equipped with bed, table, chairs, toilet.	Number (Percentage)	(100%)	Bi-weekly
	Number of high-risk PoEs with information (and SOPs) for IPC practice, health promotion, and alcohol-based handwashing solution	Number (Percentage)	(100%)	Bi-weekly
Laboratory	The district has SOPs for SVD sample collection, packaging, and transportation	Y/N	100%	Weekly
	No of trained personnel for management of sample collection and transportation in the district	Number		Weekly
	Number of NRL staff with documented proficiency with all components of EVD assays	Number	5	Bi-weekly
	Timeliness of receipt of specimens at NRL/Regional Labs after collection	Time	6	Bi-weekly

Pillar/Technical Area	Indicator	Measurement	Target	Freq. of reporting
	Number/Proportion of districts that have sample collection equipment for at least 10 suspected cases, triple packaging and means of transportation to the next level (i.e., triple packaging kit, sampling kits, PPE, and transport for samples)	Number (Percentage)	30 (100%)	Weekly
	Existence of capacity for analysis or specimen handling of biological samples and testing for EVD at the national referral laboratory	Y/N	100%	Weekly
	Proportion of high-risk districts with capacity for dead body sample collection	Percentage	100%	Weekly
Case management, IPC/WaSH and Safe and Dignified Burials	Number of health workers trained on EVD case management in the district	Number		Weekly
	Number of functional Ebola Treatment centres identified and equipped	Number	3	Bi-weekly
	Proportion of high-risk districts that have a dedicated ambulance with trained staff for the safe transport of suspected/confirmed cases to the ETC	Number (Percentage)	9 (100%)	Weekly

Pillar/Technical Area	Indicator	Measurement	Target	Freq. of reporting
	Number/Proportion of hospitals in priority districts with EVD designated isolation units	Number (Percentage)	(100%)	Weekly
	Number/proportion of high-risk districts with at least one trained and equipped team for safe and dignified burial	Number (Percentage)	9 (100%)	Bi-weekly
	Number/proportion of hospitals in high-risk districts with appropriate screening and triage station	Number (Percentage)	(100%)	Bi-weekly
	Number /proportion of hospitals in high-risk districts with EVD specific and comprehensive IPC materials /measures in place	Number (Percentage)	(100%)	Bi-weekly
	Number and proportion of district HF that have conducted IPC assessment and are implementing corrective measures	Number (Percentage)	(100%)	Bi-weekly
Risk communication and community engagement (RCCE)	Availability of national RCCE plan	Y/N	100%	Weekly
	Number/proportion of high-risk districts with district level plan for RCCE activities.	Number (Percentage)	9 (100%)	Bi-weekly
	Functional risk communication partners forum responsible for	Y/N		Weekly

Pillar/Technical Area	Indicator	Measurement	Target	Freq. of reporting
	coordination, planning and reviewing of strategies			
	Number of community leaders trained on RCCE in the district	Number		Weekly
	Numbers /proportion of high-risk district having EVD communication tools for public awareness message (banners, billboards, flyers, pull up banners	Number (Percentage)	9 (100%)	Bi-weekly
	Number of persons reached with RCCE activities in the district in the reporting week	Number	048968	Weekly
Operational Support and Logistics (OSL)	Proportion of priority districts with transportation capacity for patient referral	Number (percentage)	9 (100%)	Bi-weekly
	Availability of adequate and appropriate logistics and supply for EVD case management stockpile	Y/N	100%	Bi-weekly until achieved
	Number /proportion of district hospitals /Health facilities /POs reporting no stock out of required supplies and logistics	Number (Percentage)	(100%)	Bi-weekly
	Number /Proportion of high districts with designated	Number (Percentage)	9 (100%)	Weekly

<b>Pillar/Technical Area</b>	<b>Indicator</b>	<b>Measurement</b>	<b>Target</b>	<b>Freq. of reporting</b>
	and trained Emergency logistics officer			
	Number/Proportion of districts with established and functional stock management system in place	Number (Percentage)	30 (100%)	Monthly
	Number of ready to use ETCs	Number	3	Weekly

