



Outbreak READY 2!: Thisland in Crisis

A Digital Readiness and Response Simulation



FACILITATION MANUAL FOR GROUP EVENTS



ACKNOWLEDGMENTS

The Outbreak READY 2!: Thisland in Crisis digital simulation was developed by the READY initiative. We would like to thank the Johns Hopkins Center for Humanitarian Health for their leadership and all READY consortium partners, as well as serious game consultant Rex Brynen for their time, input, and efforts throughout all stages of development. In addition, we would like to thank all the humanitarians from agencies and locations around the world who took the time to play each version and provide critical feedback to strengthen both the design and the content of **Outbreak READY 2!: Thisland in Crisis**.

Outbreak READY 2!: Thisland in Crisis was created in collaboration with the game development studio, **&RANJ**. The simulation would not be possible without their team's innovative design and creative contributions.

Facilitation Manual Design by: **Re:Design** (andrea@redesign.co.za)

READY Initiative
Save the Children
899 North Capitol Street NE, Suite 900
Washington D.C. 20002

***Outbreak READY 2!: Thisland in Crisis** and this corresponding facilitation manual were made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of the READY Initiative and do not necessarily reflect the views of USAID or the United States Government. Led by Save the Children, the READY initiative is implemented in partnership with the Johns Hopkins Center for Humanitarian Health, the Johns Hopkins Center for Communication Programs, UK-Med, and the Humanitarian Leadership Academy. READY is augmenting global capacity for non-governmental organizations to respond to large-scale infectious disease outbreaks. For more information, visit our website at <http://www.ready-initiative.org>.*





TABLE OF CONTENTS

OVERVIEW

Introduction.....	4
Purpose.....	4
Learning Objectives.....	4
Intended Audience.....	4

PREPARING FOR A FACILITATION EVENT

Fast Facts.....	5
Facilitator Preparation: What you need to know.....	6
Preparing Participants.....	6
Preparing Necessary Materials.....	7
Preparing the Venue.....	7

STEP-BY-STEP FACILITATION GUIDE

AGENDA.....	8
PART I: WELCOME AND INTRODUCTION.....	9
PART II: SIMULATION EXERCISE.....	13
Chapter 1.....	13
Chapter 2.....	16
Chapter 3.....	19
Epilogue.....	22
PART III: FACILITATED DISCUSSION.....	23
Warm-up.....	23
Discussion Questions.....	24
Closing.....	26

SUPPORTING MATERIALS

Annex 1: Suggestions for Adapting the Agenda or Format of the Event.....	28
Annex 2: Tips for Facilitating a Virtual Event.....	29
Annex 3: Background Documents.....	30
A. Thisland Country Brief.....	31
B. Map of Thisland.....	34
C. Profile of Communities in the Eastern Province.....	35
D. READY Humanitarian Program Portfolio.....	39
Annex 4: Materials Needed to Facilitate.....	42
Annex 5: Sample Email to Participants.....	43
Annex 6: Background Quiz.....	44
Annex 7: Key Decision Matrix.....	45
Annex 8: Facilitator Handout for Part III Facilitated Discussion.....	66
Annex 9: Information on Enni Virus Disease.....	74
Annex 10: Additional Resources.....	82



OVERVIEW

This manual is designed to provide guidance for the facilitation of an **Outbreak READY 2!: Thisland in Crisis** in-person simulation event. Specifically, it helps facilitators prepare for and deliver a half-day event consisting of independent or team play of **Outbreak READY 2!: Thisland in Crisis**, A Digital Readiness and Response Simulation, followed by a facilitated group debrief and discussion. While the manual is designed for **in-person** events, guidance on suggested adaptations for **virtual facilitation** can be found in **Annex 2**. Further suggestions for adapting the format of the event or agenda can be found in **Annex 1**.

PURPOSE

The purpose of **Outbreak READY 2!: Thisland in Crisis** (Outbreak READY 2!) is to strengthen the health technical readiness of non-governmental organizations (NGOs) to respond to large-scale infectious disease outbreaks in humanitarian contexts. Through a unique, digital interpretation of an outbreak simulation, **Outbreak READY 2!** brings the complex nature of a humanitarian outbreak health response to life by utilizing a computer-based serious game that allows participants to strengthen their readiness and response skills and knowledge. It builds upon, but is independent from, **Outbreak READY!**, our first digital outbreak simulation, in which the learner takes the role of a Team Lead during an influenza epidemic.

LEARNING OBJECTIVES

The **Outbreak READY 2!** digital simulation and proposed facilitation discussion provide learners with an opportunity to test and apply the following skills in a humanitarian outbreak context:

1 Implementing and coordinating a data-driven health response to an evolving infectious disease outbreak.



2 Developing and implementing a Risk Communication and Community Engagement (RCCE) strategy using a data-driven approach.



3 Minimizing risks and vulnerabilities to crisis-affected people, staff, and partners throughout an outbreak response.



INTENDED AUDIENCE

While many humanitarians will benefit from **Outbreak READY 2!**, the simulation was specifically developed for the following team members from national and international non-governmental organizations (NGOs) preparing for or responding to outbreaks in humanitarian contexts:

Health Program Managers/ Coordinators and Technical Advisors responsible for both clinical and nonclinical health response activities

Staff with lead roles in Risk Communication and Community Engagement (RCCE) (e.g., RCCE, social behavior change, and health promotion focal points)

Community Health Worker (CHW) Supervisors/Leads

Health staff working as Child Safeguarding/ Protection Focal Points

Outbreak READY 2! was developed for participants who already have knowledge and experience working in humanitarian contexts. However, practitioners in non-humanitarian, low-resource settings and public health students may also find it relevant.



PREPARING FOR A FACILITATION EVENT

As facilitator(s), you should take the necessary time to prepare so that the event runs smoothly. This includes preparing yourself, participants, materials and handouts, the venue, as well as information and communications technology equipment and support.



FAST FACTS: FACILITATING THE SIMULATION

How long is the simulation event?

- The simulation event takes an estimated **5 hours** for both play and discussion. However, it is important to note that participant play time will vary due to reading speeds, levels of computer literacy, and language proficiency.
- A detailed proposed agenda for the event can be found in the Step-by-Step Facilitation Guide section of the manual (page 8).

Does the simulation require internet?

- The simulation is run on a web-based platform and is designed for low-bandwidth settings. **Participants at the venue will need an internet connection to take part in the simulation.**
- Each participant will need their own computer (recommended) or tablet. The simulation is **not** designed to be played on a phone. (See **Annex 1** for adaptations including playing in pairs/groups).

How is the simulation organized?

- The simulation is divided into **three chapters**: Chapter 1 (initial outbreak), Chapter 2 (rapid assessment), and Chapter 3 (outbreak peak). It ends with an **Epilogue** that provides participants with a final update on how their actions impacted the outbreak.
- Within each chapter, participants must gather information to make several important decisions about the outbreak, called **Key Decisions (KDs)**. There are three KDs in Chapter 1, three KDs in Chapter 2, and five KDs in Chapter 3.
- At the end of each chapter, participants will receive a **Feedback Screen** with feedback on the Key Decisions made during the chapter. **Chapter Debriefs** allow participants to discuss their choices and this feedback with one another.
- After the Epilogue, all participants will take 5 minutes to complete a brief feedback **survey** with a link provided at the end of the simulation.
- After playing the simulation, all participants will engage in a **facilitated discussion**, with a focus on how the main learning points apply to their current/future work or organization.

PREPARATION CHECKLIST

1. FACILITATOR PREPARATION: WHAT YOU NEED TO KNOW

- Ensure you have played through the simulation at least once, available here: <https://www.outbreakready-thislandincrisis.com/>
- Familiarize yourself with the Step-By-Step Facilitation Guide (page 8) and prepare for any necessary adaptations. **See Annex 1 for guidance on adapting the event's format or agenda (e.g., due to resource limitations).**
- Identify a co-facilitator(s). **It is strongly encouraged that you have at least two facilitators for a simulation event** to address technical issues, answer questions, and facilitate small group discussion. For larger groups, additional facilitators may be needed to allow for one facilitator per small discussion group.
- Prepare to facilitate the simulation portion live and in-character (playing a role as if you were a part of the simulation). As facilitator(s), you should prepare to play the role of Health Program Officer(s). **After introductions, you will need to shift to your "Health Program Officer" character and continue playing that role until all participants have completed the simulation.**
 - As the simulation event takes approximately 5 hours, facilitator(s) will need to maintain a high level of energy and engagement to maintain the in-character setting and the overall experience.
- Familiarize yourself with the **Key Decision Matrix (see Annex 7)**. This matrix provides a detailed breakdown of each Key Decision, its answer options, and feedback provided in the simulation. It should be used during Chapter Debriefs, when participants may want to discuss why certain answers were "optimal," "sub-optimal," or "bad." This document is for facilitators only - **please do not share the Key Decision Matrix with participants.**
- Familiarize yourself with participants in advance, including their organizations, professional background, level of experience, and any accessibility needs.

2. PREPARING PARTICIPANTS

- Once participants are confirmed, follow-up with an email that outlines details of the event and expectations for their participation. A sample email can be found in **Annex 5**. **This communication should include Background Documents for participants to review in advance of the simulation (see Annex 3).**
 - It is strongly recommended that participants review the background documents in advance of the simulation. Participants who do not read them in advance can still participate in the event, as the documents are provided again within the simulation. However, it may take them approximately 15 minutes longer to play Chapter 1.

3. PREPARING NECESSARY MATERIALS

- Review “materials needed” listed under each section of the Step-By-Step Facilitation Guide (page 9), adapting as needed. A consolidated list of materials needed for the event is also provided in **Annex 4**.

- Ensure that all participants will be able to complete the digital simulation as planned. Each person will require individual personal computers or laptops with internet access, chargers (or batteries that can support at least 4 hours of continuous use), electricity and outlets, headphones, and a strong reliable internet connection. **If you need to adapt the event to account for limited equipment, resources, time, or space, please consult Annex 1.**

4. PREPARING THE VENUE

- Become familiar with the physical venue and any associated safety and security protocols, as applicable.

- If the venue has an IT department, send them the link to the simulation well in advance to ensure their network will not block the website.

- Ensure adequate space for the number of participants to be comfortable.

- Chairs and tables should be set up in a way that allows for group discussion, if possible.
 - Example 1: If you are planning to have the majority of discussions occur in plenary (one large group), organizing seating in a large U-shape can make people more likely to participate in discussions than many rows of seating facing the front of the room.
 - Example 2: If you are planning to have small group discussions, organize chairs and tables so that they are already in these small groups (we recommend 4-6 people in each group, depending on the number of participants).

- Ensure there are enough outlets for participants to charge their laptops if necessary. Note the number and length of extension cords and electric outlets the venue may require.

- Set up signs, projector/whiteboard, handouts, and other materials found in **Annex 4**.

- Offer refreshments suitable for the length of the event.



STEP-BY-STEP FACILITATION GUIDE

PROPOSED AGENDA FOR HALF-DAY SIMULATION EVENT

OVERVIEW	DURATION	TOPIC/ACTIVITY	TIME
PART I: WELCOME (25 MIN)	25 MIN	Welcome and Introduction <ul style="list-style-type: none"> • Introductions • Agenda • Tech Setup & Troubleshooting 	00:00 – 00:25
	PART II: SIMULATION EXERCISE (3 HR 35 MIN)	40 MIN	Chapter 1: Self-paced simulation
10 MIN		Chapter 1: Debrief	01:05 – 01:15
05 MIN		Energizer/Stretch	01:15 – 01:20
40 MIN		Chapter 2: Self-paced simulation	01:20 – 02:00
10 MIN		Chapter 2: Debrief	02:00 – 02:10
10 MIN		Break	02:10 – 02:20
60 MIN		Chapter 3: Self-paced simulation	02:20 – 03:20
15 MIN		Chapter 3: Debrief	03:20 – 03:35
15 MIN		Epilogue	03:35 – 03:50
10 MIN		Break	03:50 – 04:00
PART III: FACILITATED DISCUSSION (1 HR)		45 MIN	Facilitated Discussion <ul style="list-style-type: none"> • Reflecting on outbreak response • Lessons learned
	15 MIN	Closing <ul style="list-style-type: none"> • Action Steps • Resources for Operational Readiness 	04:45 – 05:00

*Please see [Annex 1](#) for guidance on adapting this agenda for your event.

By the end of this session, participants should:

- Be familiar with other participants and facilitator(s).
- Understand the format, agenda, and expectations of the simulation event.

Materials Needed

- High-level agenda of event for participants.
- Sign-in sheet
- Name tags
- Refreshments
- Laptops/tablets with internet access and headphones for all participants to complete the simulation (if participants do not have headphones, they can mute the simulation using the button in the top right-hand corner of the interface.)
- OPTIONAL: Printed Background Documents (**See Annex 3**)
- OPTIONAL: Background Documents Quiz (**See Annex 6**)
- OPTIONAL: Poster or slide with the link and instructions for loading the simulation

**Facilitator Tip:**

As participants arrive, we strongly recommend having them load the simulation on their laptops using the displayed link, with explicit instructions to pause the introduction video. This will help speed up the set-up process. Please refer to “Tech Setup and Troubleshooting” section for additional guidance.

INTRODUCTION10
MIN

As facilitator(s), introduce yourself by name and affiliation (i.e., institution or organization), and briefly share your relevant experience.

While being mindful of time, begin a round of introductions among participants by asking them to briefly share:

- Their **names**.
- Affiliations** (or role within their organization if participants are from the same NGO).
- A **simple, culturally appropriate icebreaker** of your choice. For example:
 - *What interested you in this simulation?*
 - *What is one interesting fact (or “boring” fact) your colleagues do not know about you?*
 - *What is your favorite breakfast food (or “comfort food“)?*

Try to keep introductions brief (no more than 10 min total), especially with larger groups.

AGENDA

02
MIN

Briefly review the agenda for the day with participants. The agenda should be general to avoid sharing too much about the simulation.

Sample Agenda

00:00 – 00:25 – Welcome and Introductions

00:25 – 03:50 – Simulation (with break at 02:10)

03:50 – 04:00 – Break

04:00 – 04:45 – Facilitated Discussion

04:45 – 05:00 – Closing Remarks

NOTE: Facilitators should remind participants that the simulation is designed to be a **fully immersive experience**. They should **strongly discourage participants from checking their phones** or doing other work for the duration of the simulation, as doing so will take away from the experience of the participant and the group.

OPTIONAL: BACKGROUND DOCUMENTS QUIZ

03
MIN

SCRIPT

Everyone should have read the background documents for today's simulation, including the Thisland Country Brief, Map of Thisland, Profiles of Communities in the Eastern Province of Thisland, and the READY Humanitarian Program Portfolio. These are critical for your role as Health Program Manager in the simulation. If you did not read them in advance, they can be found in your "File Explorer" once you start the simulation.

First, we will go through a brief quiz as a group to ensure you are ready to assume your new roles.

Now that you are ready to assume your role as READY's Health Program Manager, we will each open the simulation using the link <https://www.outbreakready-thislandin crisis.com/>.



Facilitator Tip:

This quiz should be done very rapidly as a whole group. This can be done by displaying questions on a projector, or by distributing handouts (see **Annex 6** for quiz questions) and asking participants to "shout out" the answer.

TECH SETUP & TROUBLESHOOTING

10
MIN

Share the simulation link with all participants using a whiteboard, poster, PowerPoint slide, or email: <https://www.outbreakready-thislandin crisis.com/>.

- Please note that the simulation may take time to load, depending on internet speed and the number of participants accessing the simulation at the same time. It is recommended to test the loading speed of the website prior to the event (see "Checking Network Feasibility").
- We strongly recommend that participants load the simulation as they arrive. This will help speed up the set-up process.



Checking Network Feasibility

The simulation requires a download speed of:

- ~20MB (megabyte) or 160Mb (megabit) during the title screen.
- ~55MB or 440Mb for each chapter.
 - Chapter 1 loads after pressing the Start button. Chapters 2 and 3 each load after finishing the previous chapter.
- At least 1.7mbps (megabits per second) for video.
 - Videos are streamed (loaded on demand) and adapt their quality based on the available bandwidth. A minimum of 1.7mbps (megabits per second) is required to stream the lowest quality of video.



Please click the link sent to your email or displayed on the whiteboard.

Once you reach the opening screen [pictured below], you may click "Start simulation." When the simulation has finished loading, the introduction video will start. Please do NOT watch the introduction video yet. To pause the video, press anywhere on the screen. We will let you know when to press play.

PLAY button
SKIP button



Troubleshooting guidance:

- Ensure participants have the right URL.
- Ensure participants are opening the URL on a supported browser and that the most updated version of the browser is being used: the simulation is supported on Google Chrome, Firefox, Microsoft Edge, and Safari.
- Ensure participants do not have many browser tabs or windows open. Close any additional browser tabs/windows so that only the simulation website is up.
- If none of the above works, try opening the simulation in an "incognito" window.
- The initial splash screen [pictured above] may take time to load, depending on internet speed. If participants are able to see this screen, then they have access and must wait for the progress bar to load before clicking 'Start.'

SCRIPT

Before we begin, please take a moment to make sure that your computer is charging or has enough battery to support at least 4 hours of use.

This event will take approximately 5 hours: 4 hours for the simulation and 1 hour for group discussion. This simulation is structured in three chapters and an epilogue, which are further broken down into weeks. There will be a team meeting at the end of each chapter.

*This simulation is player-led, meaning you direct the pace and the order of the actions you take. Throughout the simulation, you will be presented with a series of Key Decisions. It is your job to search for the information you will need to make that Key Decision. The simulation will not tell you exactly what information you need, or in what order you will need it. You must think critically about how you should go about making each Key Decision, just like you would in real life. The goal of each decision is not to identify the “right” or “wrong” choice, but rather to reflect on what might be the **most appropriate response** given the context.*

While the simulation cannot include all possible actions, you will have many options available to you when responding to various situations. Proceed in whatever way you think is best!

We will provide prompts throughout the simulation to help the group keep pace together.

*The simulation is very fast-paced. You will receive a lot of information, just as you would in a real response, and **you will not be able to read all of the information provided**. You will need to prioritize what you read in-depth and what you read quickly for key information.*

Please do not exit the webpage or press the ‘back’ button until the full simulation is completed.

If you are forced out of the simulation due to technical issues, you can reload it using the same link, as your progress in the simulation is automatically saved after you complete all Key Decisions for that day or week.

If you have technical issues at any point, please raise your hand, and we will come to help you.

Check to see if participants have any remaining questions.

What questions do you have?

If there are no additional questions, we will transition into the roles that we will be playing throughout the simulation. You (the participants) will all be playing Health Program Managers with the NGO READY and we (the facilitators) will be playing Health Program Officers.

By the end of Part II, participants should have:

- Finished Chapters 1-3 of the simulation.
- Tested and practiced applying the following skills in an outbreak context:
 - Implementing and coordinating a data-driven health response to an evolving infectious disease outbreak.
 - Developing and implementing a Risk Communication and Community Engagement (RCCE) strategy using a data-driven approach.
 - Minimizing risks and vulnerabilities to crisis-affected people, staff, and partners throughout an outbreak response.

Materials Needed

- Any clothing items (e.g., READY vest, lanyard, or name tag with role), clipboard, documents that help indicate you are the Health Program Officer.
- One handwritten sign that says "READY Murelle Sub-Office."

At this point, you and/or your co-facilitator should put on a character uniform and hang a sign in the room to indicate where the simulation is taking place.

CHAPTER 1

40
MIN**By the end of Chapter 1, participants should have:**

- Finished Key Decisions 1-3 in Chapter 1.
- Considered initial priority steps and program adaptations at the beginning of the outbreak.
- Reviewed their feedback on Key Decisions made in Chapter 1.

SCRIPT

Good morning/afternoon, Health Program Managers. My name is [your name], and I am the READY Health Program Officer. This is [name of co-facilitator], and they are the Program Assistant.

We will be supporting you in the READY sub-office in the city of Murelle.

You are the Health Program Manager (or HPM) at the READY sub-office in Murelle in the country of Thisland. You started this position a few months ago. When you started, you were given background documents to familiarize yourself with the organization and with the local context. If you have not reviewed the briefing materials already, I recommend first reading the Country Brief, map of Thisland, READY Program Portfolio, and Community Profiles in your File Explorer.

We will have a scheduled team meeting at the end of Week 2, in 40 minutes.

We will check in periodically; if you need our assistance, please raise your hand, and we will come to help you.

You may now start the simulation. Click the Play button in the center of the screen to watch the Introductory Video.



Facilitator Tip:

You can also play the video on a projector screen for everyone to watch together. If participants click on the button on the bottom right-hand side of the introductory video (see image on page 11), they will skip the video.

Monitor playtime for Chapter 1, making announcements at designated times to help pace the participants and keep the full group progressing at about the same speed. The **table on page 15** provides an overview of the Key Decisions in Chapter 1, including what causes them to appear (in case a player gets “stuck” and is not progressing) and the maximum amount of time suggested to spend on each decision.

After the first 15 minutes have passed, announce to participants:



I just got a call from Nia, and she is still waiting for emails from some of you. We need to decide on priority steps as soon as possible.

Please send your email to Nia now if you have not already.

30 minutes into Chapter 1 (10 minutes left), give participants the following reminder:

*We will have a team meeting in 10 minutes. We need your recommendations about case management and the CHW program by then. Also, at the end of Week 2, you will receive some feedback on your actions taken thus far. We will discuss these during our team meeting, so please review them if you have time. Do **not** click “Finish” until I direct you to do so.*

38 minutes into Chapter 1 (2 minutes left), give participants the following reminder:

*We will have a team meeting in **2 minutes**. Please send Nia and Lydia your recommendations about case management and CHW surveillance if you have not done so already. Again, please review your feedback if you have time, but do **not** click “Finish” to start the next chapter.*



Facilitator Tip:

To add realism, pretend as if you are receiving an actual phone call from Nia (“Hey, Nia.... What? Really? I’m with them now. I’ll pass on your message. Talk to you later.”) before making the announcement.

CHAPTER 1 KEY DECISIONS

	Key Decision 1	Key Decision 2	Key Decision 3
Topic	Initial priority steps	Case management decisions	Community Health Worker (CHW) surveillance recommendations
Week	Week 1	Week 2	Week 3
Appears after	Opening the email from READY Internally Displaced Persons (IDP) Clinic Supervisor, Isaiah	Opening the email from the READY Response Team Lead, Nia	Opening the email from Thisland Relief Program Manager, Lydia
Suggested Time	20 min	20 min (see Notes)	
Notes	If the participants have not read the background documents in advance, you may need to add additional time here.	KDs 2 and 3 can be available simultaneously. You do not need to make KD 2 in order to move on to KD 3. You can also make them in any order. As such, the timing is combined for both KDs.	

CHAPTER 1 DEBRIEF: TEAM MEETING

**10
MIN**

Playing the role of the READY Health Program Officer character, welcome participants to the meeting and begin a group discussion on the Key Decisions they made during the chapter. These discussions can be in plenary (one large group) or in small groups, although participants may be more likely to admit what they did sub-optimally in smaller groups.

Stay in character for the entire debrief. **Annex 7** (Key Decision Matrix) provides details on each Key Decision answer choice, the rating, and the rationale behind the rating.



Facilitator Tip:

Participants may be hesitant to admit they chose a suboptimal/bad answer. Remind participants that the goal of this simulation is to help with learning. The simulation is meant to be difficult – if everyone got every answer correct, then it would be too easy! Also, some answers may have been suboptimal in this particular scenario, but they may be optimal in other scenarios. Sharing why you chose that answer choice (even if it's suboptimal in this simulation) helps others learn why it was suboptimal, and whether there could be a scenario in which it might be an optimal choice or decision.



Welcome to the READY team meeting!

We have had to change the agenda for today's meeting to discuss the new Enni Virus outbreak in the Tamdu region of Thisland.

- What initial priority steps did you take in Week 1 when you first learned of cases with strange symptoms at your clinics? Why did you prioritize (or not prioritize) what you did?
- Did anyone choose something else? Why?
- Once the pathogen was identified to be Enni Virus, what case management decisions did you make? Why did you decide what you did?
- Did anyone choose something else? Why?
- What recommendations did you make to Thisland Relief about their CHW program? Why did you recommend what you did?
- Did anyone choose something else? Why?
- What resources helped you make your decisions?

Thank you all for sharing this valuable information. We will have to monitor this situation very closely and prepare accordingly. **You may now click "Finish,"** but do not click "Start Next Chapter" until we tell you to do so.

We will now take a quick 5-minute break. Outbreaks unfortunately do not take breaks, so please be seated at your desk in the READY sub-office at exactly [INSERT TIME] so that we can continue our response efforts before the situation gets worse.

ALLOW FOR A 5-MINUTE BREAK



Facilitator Tip:

A group energizer or stretch is also a great idea during this 5-minute break.

CHAPTER 2

40
MIN

By the end of Chapter 2, participants should have:

- Finished Key Decisions 1-3 in Chapter 2.
- Considered how to tailor rapid RCCE assessments to different target audiences.
- Engaged with community members effectively to gather insightful information about knowledge, attitudes, perceptions, and behaviors related to the outbreak.
- Considered how to adapt an RCCE strategy and other programming based on new evidence.
- Reviewed their feedback on Key Decisions made in Chapter 2.



Welcome back, Health Program Managers! The READY team is anxious to get back to work. Please take your place and continue to work with your team. It is now Week 5 of the outbreak, and READY is hard at work responding to the Enni Virus Disease outbreak.

We will check in periodically; if you need our assistance, please raise your hand, and we will come to help you.

We will have a team meeting at the end of Week 6, in 40 minutes.

You may now click “Start Next Chapter” to start Chapter 2.

Monitor playtime for Chapter 2, making announcements at designated times to help pace the participants and keep the full group progressing at about the same speed. The **table on page 18** provides an overview of the Key Decisions in Chapter 2, including what causes them to appear (in case a player gets “stuck” and is not progressing) and the maximum amount of time suggested to spend on each decision.

After the first 10 minutes have passed,
announce to participants:

I just ran into Sarah in the hall, and she said she is still waiting for feedback from some of you on the draft rapid assessment survey. Hearing directly from the community is critical and it will take some time to finalize the survey before the community visits, so please send your feedback to Sarah right away.



Facilitator Tip:

To add realism, leave the room and walk back in as you make your first announcement, pretending like you just ran into Sarah in the hall. You can shout, “Thanks, Sarah, I’ll let them know!” behind you as you walk inside.

25 minutes into Chapter 2 (15 minutes left), give participants the following reminder:

*We will have a team meeting in **15 minutes**. You may want to finish your community visits in the next 5 minutes so that you can act on the information you have learned.*

Like before, at the end of Week 5, you will receive some feedback on your actions taken thus far. We will discuss these during our team meeting, so please review them if you have time. Do not click “Continue” to start the next chapter until I direct you to do so.

38 minutes into Chapter 2 (2 minutes left), give participants the following reminder:

*We will have a team meeting in **2 minutes**. Please make your decisions about the RCCE strategy and CHW program adaptations if you have not done so already.*

CHAPTER 2 KEY DECISIONS

	Key Decision 1	Community Visits	Key Decision 2	Key Decision 3
Topic	Rapid assessment survey adaptations	4 community visits: Internally Displaced Persons (IDP) leader, IDP mother, CHW, and community member focus group discussion	Input into RCCE strategy	CHW program adaptations
Week	Week 5	Week 6	Week 6	Week 6
Appears after	Opening the email from RCCE Officer, Sarah	Completing Key Decision 1	Opening the email from RCCE Officer, Sarah	Opening the email from Thisland Relief Program Manager, Lydia
Timing	10 min	10 min	15 min (see Notes)	
Notes		The only sequencing that matters is visiting the IDP leader before the IDP (if not, you get scolded by the IDP leader)	KDs 2 and 3 appear after finishing the community visits. They are triggered by different actions but can be available simultaneously; you do not need to make KD 2 in order to move to KD 3.	

CHAPTER 2 DEBRIEF: TEAM MEETING

10
MIN

Playing the role of your READY Health Program Officer character, welcome participants to the meeting and begin a group discussion. As before, these discussions can be in plenary (one large group) or in small groups. Stay in character for the entire debrief. **Annex 7** (Key Decision Matrix) provides details on each Key Decision answer choice, the rating, and the rationale behind the rating.

SCRIPT

Welcome to the READY team meeting! Thank you for your hard work on the rapid assessment. It's important to understand the knowledge, perceptions, and behaviors of the community when developing and adapting response efforts.

How did you tailor the rapid assessment survey for your different audiences?

- *Did anyone choose something else? Why?*

How did the visits in the community go? What is some of the key information you learned?

How did you update the RCCE strategy?

- *Did anyone choose something else? Why?*

What did you recommend to Thisland Relief regarding how they could adapt their CHW surveillance program?

- Did anyone choose something else? Why?

Thank you all for sharing this valuable information. We will have to monitor this situation very closely and prepare accordingly. **You may now click "Finish,"** but **do not** click "Start Next Chapter" until we tell you to do so.

We will now take a 10-minute break. We just heard about some possible new suspect cases in Murelle, so please come back to the READY sub-office in Murelle no later than [INSERT TIME] so that we can update everyone accordingly and continue our response efforts.

ALLOW FOR A 10-MINUTE BREAK

CHAPTER 3

60
MIN

By the end of Chapter 3, participants should have:

- Finished Key Decisions 1-5 in Chapter 3.
- Considered case management adaptations, including where and how to establish isolation and treatment centers (ITCs).
- Address challenges in ITCs.
- Taken actions to ensure staff safety.
- Reviewed their feedback on Key Decisions made in Chapter 3.

SCRIPT

Welcome back, READY Health Program Managers. Unfortunately, despite our efforts thus far, the outbreak seems to be getting worse. You are urgently needed in a Health Coordination meeting, so we should get started right away.

We will check in periodically; if you need our assistance, please raise your hand, and we will come to help you.

We will have a team meeting at the end of Week 15, in 1 hour.

You may now click "Start Next Chapter" to start Chapter 3. Please note there are 5 Key Decisions in this chapter.

Monitor playtime for Chapter 3, making announcements at designated times to help participants move along. The **table on page 20** provides an overview of the Key Decisions in Chapter 3, including what causes them to appear (in case a player gets "stuck" and is not progressing) and the maximum amount of time suggested to spend on each decision.



Facilitator Tip:

To add realism, pretend as if you are receiving an actual phone call from Nia (“Hey, Nia... Uh oh, I’m sorry Sonia called you. I’m with them now. I’ll pass on your message. Talk to you later.”) before making the announcement.

After the first 10 minutes have passed, **announce to participants:**



Nia just got a phone call from Sonia at the MoH wondering why she has yet to receive a response from some of you.

*Please send Sonia your recommendations right away if you haven’t already. We will have our team meeting in **50 minutes**.*

30 minutes into Chapter 3 (30 minutes left), give participants the following reminder:

| *We will have our final team meeting in **30 minutes**.*

45 minutes into Chapter 3 (15 minutes left), give participants the following reminder:

| *We will have our final team meeting in **15 minutes**.*

*At the end of week 15, you will receive some feedback on your actions taken thus far. We will discuss these during our team meeting, so please review them if you have time. **Do not** click “Finish” until I direct you to do so.*

55 minutes into Chapter 3 (5 minutes left), give participants the following reminder:

| *We will have a team meeting in **5 minutes**. Please make sure you have made all 5 Key Decisions by that time.*

| *Again, please review your Chapter 3 feedback if you have time. **Do not** click “Finish.”*

CHAPTER 3 KEY DECISIONS

	Key Decision 1	Key Decision 2	Key Decision 3	Key Decision 4	Key Decision 5
Topic	MoH case management strategy	ITC set up	Data interpretation	ITC challenges	Sick doctor at ITC
Week	Week 7	Week 7	Week 11	Week 12	Week 15
Appears after	Opening file titled “MoH Meeting Notes” (found in the “READY documents” folder in the laptop’s File Explorer)	Speaking to READY Team Lead, Nia, after submitting KD1	Opening the email from the Team Lead in Week 11	Visiting the ITC at IDP Settlement #1 in Week 12	Opening the text message from IDP Clinic Supervisor, Isaiah, in Week 15
Timing	12 min	12 min	15 min	15 min	6 min
Notes	The epidemiological and clinic data (in the dashboard, situation reports, and clinic reports) begin to diverge/branch in Chapter 3. This means that learners may have different epidemic curves and other data points depending on the decisions they make.				

Playing the role of your READY Health Program Officer character, welcome participants to the meeting and begin a group discussion. As before, these discussions can be in plenary (one large group) or in small groups. Stay in character the entire debrief. **Annex 7** (Key Decision Matrix) provides details on each Key Decision answer choice, the rating, and the rationale behind the rating and should be used by the facilitators to help in the debrief discussions.



Welcome to the final READY team meeting! I know it was a stressful last several weeks.

Pick 3 of the 5 Key Decisions to discuss:

Key Decision 1: *What case management recommendations did you make to the MoH and why?*

- *Did anyone choose something else? Why?*

Key Decision 2: *How did you set up your ITCs? Did anyone think they should have been set up differently than what Afreen and Nia decided?*

- *Did anyone choose something else? Why?*

Key Decision 3: *What insight did you provide to Nia?*

- *Why did you think the case fatality rate was declining?*
- *What did you think should be done in response to the decline in non-EnVD respiratory cases among children under 5?*
- *How did you think READY should use the projected additional funding for essential health services?*
- *Did anyone choose something else? Why?*

Key Decision 4: *How did you respond to the challenges at the READY ITCs in Week 12?*

- *How did you think Monica should counsel the mother with confirmed EnVD, whose infant tested negative?*
- *Did you accept the referrals from the other NGO's clinic?*
- *How did you manage children with severe acute malnutrition?*
- *What did you tell families who wanted to take bodies home for burial?*
- *Did anyone choose something else? Why?*

Key Decision 5: *How did you all handle the sick doctor (Jo) at the ITC?*

- *Did anyone choose something else? Why?*

Did anything else surprise you during Chapter 3?

Thank you all for sharing this valuable information.

You will now jump to Week 19, when you will see a final dashboard and hear from Nia about how the outbreak progressed based on your actions. We will discuss these outcomes as a group. After you review your final feedback and officially complete the simulation, please complete the online evaluation survey. You may now click "Finish."

SCRIPT

You will now jump forward a month and learn about how your actions have directly and indirectly impacted both the outbreak and general health system. You will first listen to a voicemail from READY Team Lead, Nia, before seeing your final data dashboard. In the dashboard, you will also see what your cumulative EnVD case count and monthly number of non-EnVD consultations could have been, had you made other decisions.

After the 3 minutes have passed, **announce to participants:**

At this point, you should be reviewing your final dashboard results. Once you finish, please complete the online evaluation survey while you wait.

2 minutes later (after 5 minutes total have passed), **announce to participants:**

How did you all do? Many of you likely have different outcomes based on how you handled different decisions.

How did your epidemic curves behave?

At the end of the session, **announce to participants:**

This marks the end of the simulation. Thank you for engaging with your role in the scenario so fully! You are more than welcome to replay the simulation at another time to see the outcomes of alternate decisions.

If you have not already done so, please complete the online evaluation survey with the link provided to you on the final acknowledgment screen.

We will now take a 10-minute break before beginning a facilitated discussion.

ALLOW FOR A 10-MINUTE BREAK

PART III: FACILITATED DISCUSSION

45
MIN

By the end of Part III, participants should have:

- ☐ Think critically about challenges that arise in outbreak response and how to address them.

Materials Needed

- ☐ Printed facilitator discussion handouts (**Annex 8**) - one per group facilitator.
- ☐ OPTIONAL: Participant handouts for small group discussion
- ☐ OPTIONAL: Whiteboard or large format sticky notes



Facilitator Tip:

This part of the discussion is intended to be out of character. Remove any clothing or articles that were part of your Health Program Officer/assistant character.

Begin by welcoming participants back to the event.

WARM-UP

05
MIN

Ask participants to share what it felt like to complete this simulation. This can be done rapidly by asking for one-word answers. For example:

- *If you could describe what this simulation felt like to you **in one word**, what word would that be?*

Typical responses may include “frustrating,” “overwhelming,” or “stressful.” If time permits, **invite a few participants to elaborate** on their responses: For example:

- *What made it overwhelming?*
- *What aspects of the simulation were stressful to you?*

Acknowledge these feelings as normal responses and connect them to the purpose of the simulation exercise:

- *This simulation was designed to prepare you for the many stressors you would encounter in a real-world outbreak response situation.*

Ask additional questions if there is time:

- *Who was your favorite character?*
- *Who was your least favorite character?*
- *Did anyone get in trouble with the IDP leader in Chapter 2? What about clinic supervisors in Chapter 3?*

DISCUSSION QUESTIONS

40
MIN

Depending on the room setup, number of facilitators, and number of participants, you may choose to discuss as one large group or divide people into smaller groups.

Distribute **Annex 8** to each group facilitator.



Now we are going to discuss and reflect on a number of topics related to the events that occurred in the simulation you just played.

Below is a list of possible discussion questions, categorized into four “thematic areas”: General, Program Design and Adaptations, Epidemiology, and RCCE. **Select at least 4 questions from the list below, based on your audience’s background and most needed skill development. We strongly recommend picking questions across multiple thematic areas (e.g., one from each thematic area).**

Monitor time for each question (e.g., with 4 questions, there will be 10 minutes per question) and select additional questions if you finish early or have more time.



Facilitator Tip:

NOTE: If you divide into smaller groups, you will need one facilitator per discussion group to guide reflections.



Facilitator Tip:

Record key discussion points on a whiteboard or large sticky note. Direct the conversation to how these lessons apply to participants’ own organization and context.

Facilitator Notes for all questions can be found in **Annex 8**.

Discussion questions:

THEMATIC AREA: GENERAL

- 1) What were some of the data you used in the simulation? How did the data help you make decisions in the outbreak response? What additional types of data did you wish you had?
- 2) During the simulation, you had to make several decisions about staff safety. What are some challenges you have had to face with staff safety during an outbreak? How did you go about making your decision?
- 3) Throughout the simulation, you engaged with many different types of actors. Who were the most important actors you engaged with, why were they important, and what did you learn from them? In your context, who would you prioritize coordinating with during an outbreak?

THEMATIC AREA: PROGRAM DESIGN AND ADAPTATIONS

- 1) Maintaining essential services is critical in an outbreak, but it can be challenging. Can you think of a time when you had to balance priorities in an outbreak? Did you have to deprioritize any activities or services in order to take on the additional response activities? How did you go about making those difficult trade-offs?
- 2) In the simulation, the outbreak shifted from being linked to contaminated simberri sap to primarily respiratory droplet transmission. How does a shift to primarily respiratory transmission change response efforts in an outbreak?
- 3) In this outbreak, the MoH chose not to use home-based care partly due to how deadly the virus was (among other factors). Depending on the context, home-based care may be an effective solution. In what kinds of situations would home-based care be appropriate? If home-based care had been used in this outbreak, what are some considerations we would have to make?
- 4) In the simulation, the MoH decided to set up decentralized isolation and treatment centers (ITCs). Do you agree with this decision? What are the pros and cons of each approach?

THEMATIC AREA: EPIDEMIOLOGY

- 1) What are some factors that can bias, or influence, epidemiological data? For example, the initial Global Health Organization guidance said the Case Fatality Rate (CFR) of Enni Virus was 15%, but at the beginning of the outbreak, the CFR is significantly higher. Why might that be? What other examples can you think of in the simulation?
- 2) At the beginning of Chapter 1, you had a chance to tell Onneetse, the READY Health Data Management Officer, to either actively reach out for case information from clinics or to wait for the next routine reports. Passive and active surveillance have different strengths and limitations. When might you want to use one or the other?
- 3) If you or your organization has been involved in the implementation of surveillance activities, what challenges did you face? How did you address them? Looking back, would you have done anything differently?

THEMATIC AREA: RISK COMMUNICATION AND COMMUNITY ENGAGEMENT (RCCE)

- 1) During the simulation, you had access to a trained RCCE Officer. However, many NGOs do not have a designated RCCE team. What knowledge, skills, or relationships do you or your organization need to develop to be prepared to undertake RCCE interventions at the outset of an outbreak? What actions might your organization take?
- 2) At the beginning of an outbreak, staff and community members may be looking at you to provide them with information about the outbreak and how they can protect themselves. What are some important principles to consider when communicating at this early stage?
- 3) Community engagement during an outbreak can be very challenging. Sometimes things do not go according to plan, or they have unintended consequences. Can you think of an example of a community engagement activity during an outbreak that went poorly? Why did it not go well, and what could have been done differently?

- 4) Different groups of people may face different challenges during an outbreak. This is especially the case for marginalized populations. What are some ways that you or your organization has included marginalized groups in past outbreaks? How did you tailor messaging and/or programming?
- 5) What are some ways that you or your organization has identified the trusted sources in a community and how have you engaged with them during an outbreak?



Thank you for sharing your experiences with us during this part of the session. We hope that you have been able to learn from each other during this time. For our final exercise, we will directly apply these lessons to identify the next steps for you or your organization.

CLOSING

15
MIN

By the end of this session, participants will be able to:

- Identify at least one action step that can be taken to enhance their operational readiness.
- Identify resources for operational readiness.

Action steps

For their final exercise, **ask participants to identify at least one action step:**



Take the next 2 minutes to think of and write down at least one action step you plan to take to enhance your readiness for an infectious disease outbreak. This can apply to yourself, your team, or your organization.

Set a timer for 2 minutes. After 2 minutes have passed, **ask for a few volunteers to share their answers**, as time allows (they can also share within their small groups). **Ask prompting questions**, such as:

What key operational and programmatic readiness actions could you and your organization take to be prepared for a health response to a large-scale outbreak in your context?

What steps has your organization and/or health team already taken?

What obstacles do you anticipate?

How can you overcome these obstacles?

Ask one final question:



We know that there are so many more people who would benefit from the simulation but could not be here today. Take one minute to brainstorm two colleagues you think would benefit from participating in the simulation. Can you help make people aware of this new learning tool and commit to sharing the simulation with at least two colleagues?

Set a timer for 1 minute. After 1 minute has passed, **ask for a few volunteers to share their answers, as time allows.**

Did you know that people can also play the simulation using the link on our website? They can play it all in one single session or break it up over the span of several days.

Resources

Distribute handouts to participants on additional resources for improving outbreak preparedness and response (found in **Annex 10**).



We know we could not possibly cover everything related to outbreak response in the brief time we have together, so we encourage you to reflect on what challenged you the most during the simulation and take some time to consider the implications of some of what you experienced today for your organization and your work in other contexts.

You may also find resources for operational readiness, RCCE, and other important topics, including checklists and technical guidance – available on the READY website: www.ready-initiative.org. In particular, we encourage you to visit READY's resource library, www.ready-initiative.org/resource-library/ and the Outbreak Readiness and Response Learning Hub, <https://kayaconnect.org/course/info.php?id=4272>. More information is provided on the handouts we're passing around now.

Thank you for sharing your insights with us and with each other during this event – we hope that you have been able to learn from the collective experience in this room!

END OF OUTBREAK READY 2!: THISLAND IN CRISIS FACILITATION EVENT

ANNEX 1

SUGGESTIONS FOR ADAPTING THE AGENDA OR FORMAT OF THE EVENT

Below are possible adaptations you can make to the event's format/agenda based on resource or time constraints you may face:

Adaptation	May Help With	Details & Considerations
Participants can play in groups of 2 or 3, using shared computers/devices.	Resource limitations	<ul style="list-style-type: none"> • Be mindful of how this may impact the simulated experience and noise level. • Estimated simulation time should be longer to allow for in-game discussion between group members. • Groups larger than 3 are not recommended since it is harder for everyone to participate.
All participants complete the simulation ahead of time and in-person facilitation is used for debrief and discussion.	Resource limitations Time limitations	<ul style="list-style-type: none"> • Part III of the original event can be adapted into a 2-hour session that combines the Chapter Debriefs (from Part II) and the facilitated discussion (Part III). • Request that participants take screenshots of their feedback screens at the end of each chapter and the final epilogue dashboard results and bring those screenshots to the session for reference. • At the start of each Chapter Debrief, remind participants of the context of the chapter and each key decision.
Split the event up into 2-4 days, by Part or Chapter.	Time limitations	<ul style="list-style-type: none"> • Consider splitting by Parts. An example agenda is below: <ul style="list-style-type: none"> - Day 1: Welcome (Part I) + Simulation play (Part II) - Day 2: Discussion (Part III) • Consider splitting by Chapter. An example agenda is below: <ul style="list-style-type: none"> - Day 1: Welcome/Introduction, Chapter 1 and Debrief - Day 2: Chapter 2 and Debrief - Day 3: Chapter 3 and Debrief - Day 4: Facilitated Discussion • Provide additional time at the beginning of each session to recap the main events of the prior day(s).
Adapt the agenda to replace one of the 10-minute breaks with an extended lunch break.	Time limitations	<ul style="list-style-type: none"> • Consider starting the post-lunch session with a recap of the main events before lunch.
Conduct all or parts of the event virtually.	Resource limitations Time limitations	<ul style="list-style-type: none"> • See Annex 2 for more details.

ANNEX 2

TIPS FOR VIRTUAL FACILITATION

Tip	Details & Considerations
<p>If allowed by your virtual meeting platform, create separate “breakout rooms” for each group of participants (we recommend 4-6 participants per group).</p> <p>(Note: Some platforms, like Zoom, may require you to enable breakout rooms in the settings when first setting up the virtual event URL.)</p>	<ul style="list-style-type: none"> • Determine how many breakout rooms are needed and assign participants to breakout rooms in advance. • Divide up facilitators. For example, you may want to have one facilitator stay in the main “room” and at least one facilitator move among the breakout rooms monitoring simulation play. • Chapter Debriefs should take place within the breakout rooms. • Participants can then return to the main room for the facilitated discussion in Part III, or have smaller group discussions in those breakout rooms.
<p>During simulation play, ask participants to mute themselves.</p>	<ul style="list-style-type: none"> • Ensure the “host” of the meeting has the ability to mute participants, in case the participant is unable to do that themselves. This may need to be done on the back-end when first creating the meeting invitation.
<p>Consider adapting the agenda by having all participants complete the simulation ahead of time.</p>	<ul style="list-style-type: none"> • The virtual event can then just be an adapted version of Part III, combining the Chapter Debriefs in Part II with the facilitated discussion in Part III. This would take approximately 2 hours. • Consider requesting that participants take screenshots of their feedback screens during the simulation and bring those screenshots to the session for reference. • At the start of each Chapter Debrief, remind participants of the context of the chapter and each Key Decision.

ANNEX 3

BACKGROUND DOCUMENTS

ANNEX 3A
THISLAND COUNTRY BRIEF

ANNEX 3B
MAP OF THISLAND

ANNEX 3C
READY HUMANITARIAN PROGRAM PORTFOLIO

ANNEX 3D
PROFILES OF COMMUNITIES IN THE EASTERN PROVINCE OF THISLAND





Thisland Country Brief

Thisland is a low-income country that has experienced periods of violent conflict over the last several years. State capacity is limited outside the capital and corruption remains a serious problem. Thisland—like other countries in the region—suffered thousands of deaths during the HxNy influenza epidemic three years ago. The country’s public health infrastructure remains weak, further undermined by a growing fiscal crisis.

General Information

Population: The population of Thisland is estimated at 18 million. Life expectancy is 66.5 years, with an infant mortality rate of 40 per 1,000 live births. The country’s Human Development Index value of 0.579 places it 160th in the world.

Some 10 million Thislanders live in Eastern Province, primarily along the southern coast, while 8 million live in Western Province. Some 38% of the population of Thisland live in urban areas. Myro—Thisland’s capital, largest city, and primary port—is located on the eastern coast.

The population of Thisland is religiously diverse. Religion has not been a major source of social division.

Over the past five years, an estimated 342,000 persons have been displaced from Western Province to Eastern Province. Most now reside in informal settlements or urban areas.

Economy: Thisland has a Gross Domestic Product of \$3,782 per capita. Its primary exports are agricultural goods, although some natural resource extraction occurs in the western mountains. Unemployment is high, estimated at 13% of the labor force. Women, who form 40% of the paid labor force, have been most impacted by the rise in unemployment, and there are reports of increasing child labor in the informal economy. Approximately 70% of the population lives below the poverty line. Inflation is high throughout the country due to ongoing instability.

History of the Current Conflict: Five years ago, contentious elections led to widespread clashes between militias in Western Province and national security forces. Over a quarter of a million persons were displaced during this time, most fleeing from Western Province to areas in the east of the country. Although the subsequent formation of a coalition power-sharing government reduced the worst

READY

of the fighting, sporadic violence has continued in the western border region, leading to periodic displacement and making it difficult for internally displaced persons (IDPs) to return to their homes.

The situation is further aggravated by poor economic conditions and a growing fiscal crisis which has left the government unable to reliably meet many of its obligations (such as civil service payroll and social benefit payments) and undermined its popular legitimacy. The governing coalition remains fragile. Government authority has especially weakened in the countryside, where real power often lies in the hands of local politicians, landowners, and former militia commanders. Fighting and insecurity has worsened this year, mainly in the west, and there has been additional forced displacement.

National Public Health Emergency Capacity: Thisland's public health infrastructure throughout the country is weak. An Emergency Operations Center (EOC) and an Incident Management System were established during the HxNy response with support from the Global Health Organization (GHO). Infectious disease surveillance activities, including a sentinel surveillance network for measles, polio, cholera, and influenza exist but still need increased capacity and resources. Thisland depends on a regional reference laboratory for the identification of novel pathogens and has enhanced the capacity of a central lab in the capital to be able to identify, confirm, and sequence specimens for notifiable diseases. During the HxNy outbreak, polymerase chain reaction (PCR) testing facilities were established in a few district hospitals, and other healthcare investments were made, although budget cutbacks have left these inadequately resourced. Many rural clinics have been closed, forcing rural communities to travel to the nearest town for care.

Humanitarian Situation

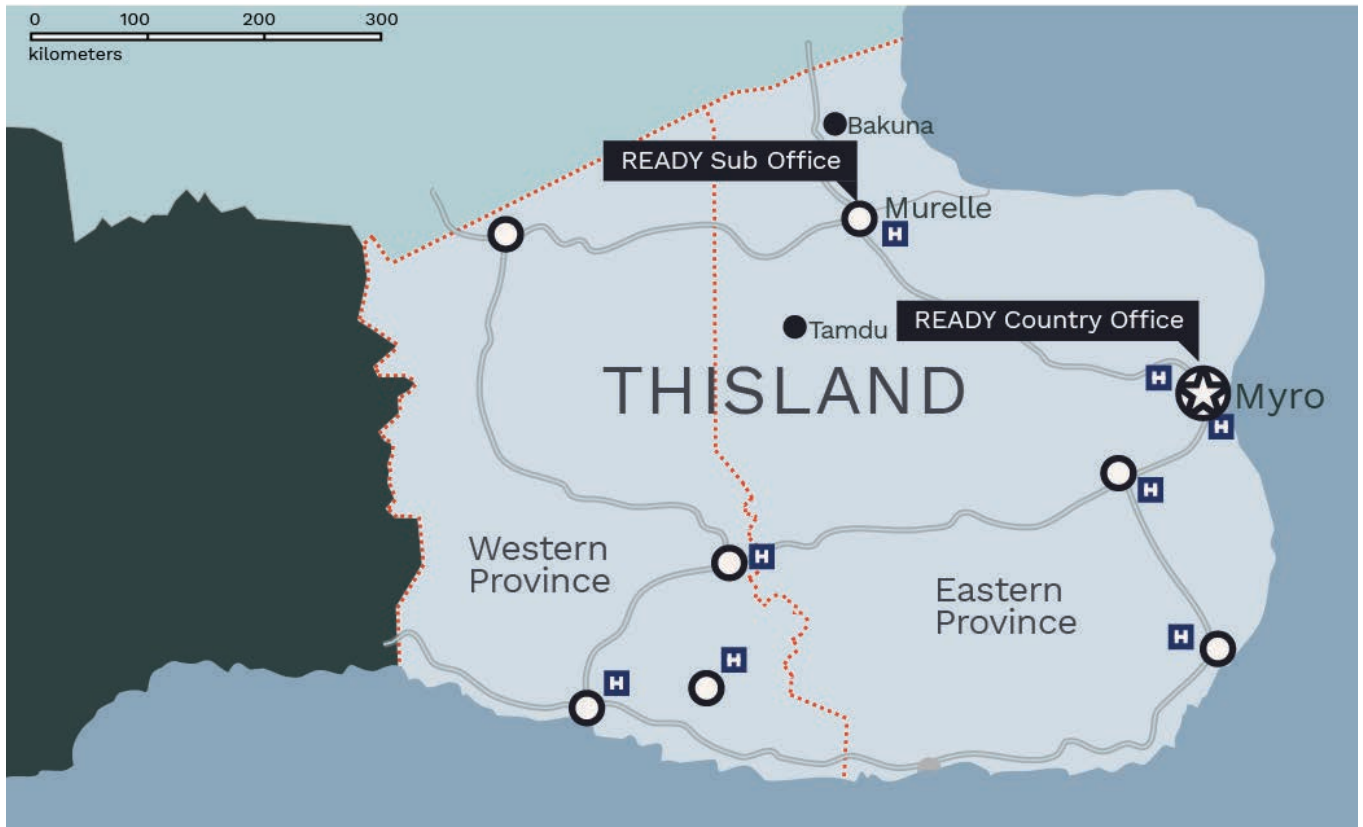
Overview: An estimated 342,000 persons have been internally displaced from the northwest of the country to the northeast (173,000 people), southeast (137,000 people), and southwest (32,000). In the last year, an escalation in conflict in the northwest has resulted in the displacement of approximately 32,000 refugees to camps in Neighborland.

Within Thisland, IDPs are located primarily in urban areas (55%), informal settlements (30%), and formal camps (15%). There are nine informal IDP settlements and three formal IDP camps in the northeast of the country, and 65,000 IDPs displaced within the city of Murelle. Tensions are increasing between the host community and IDPs, as it is unlikely the IDPs will be able to return to their home communities soon due to the sporadic and ongoing conflict in the northwest. There is a high percentage (26%) of female- and child-headed

households in the displaced population.

Security: Security in major towns and cities and along the country's primary highways is adequate. However, in rural areas of the west and northwest, the situation is considerably more dangerous, and it is from here that most forced displacement has occurred. Continued political tensions and the widespread availability of firearms suggest that any future occurrence of political violence could rapidly escalate.

B. MAP OF THISLAND



○ Larger city

● Smaller city

★ Capital city

H District hospital

READY



READY Humanitarian Program Portfolio

READY NGO Global Overview

- READY is an international humanitarian relief and development non-governmental organization (NGO) working in rapid-onset disasters and conflict settings, ongoing complex humanitarian crises, and long-term development contexts in 19 countries.
- Programmatic focus areas include:
 - Health: primary, community, and sexual and reproductive health
 - Nutrition
 - Food security and livelihoods (FSL)
 - Cash and voucher assistance (CVA)
 - Water, sanitation, and hygiene (WASH)
- Community engagement, social and behavior change communication, and child protection are mainstreamed throughout programs.
- READY's annual global budget is \$226 million, with 4,300 staff worldwide.

Thisland Country Office Profile

The annual country budget is \$29 million, with \$27.5 million allocated for humanitarian response programs.

READY Country Office in Myro

- READY's country office in Thisland is located in the capital of Myro.
 - Program areas include:
 - Long-term economic development and recovery activities, including vocational training and small business loans targeting young adults
 - Smaller scale humanitarian assistance to internally displaced persons (IDPs) located in the urban area of Myro and in surrounding IDP settlements. Sectoral response areas include health, nutrition, and WASH.
 - Myro office: 28 staff including the Country Director and development program staff



READY Sub-office in Murelle: Humanitarian Program Portfolio

- As a result of the election conflict and the influx of IDPs from the Western to the Eastern Province four years ago, READY established a sub office in the city of Murelle to lead READY's humanitarian response programming. With the continued conflict and displacement, and the outbreak of HxNy, READY has well-established humanitarian activities in informal IDP settlements and urban areas, targeting host and IDP communities.
- READY humanitarian programs operate in four informal IDP settlements outside of Murelle (populations 15,000; 14,250; 16,000; and 12,000) and within the urban area, where approximately 95,150 IDPs are currently displaced.
- READY also operates in two towns outside of Murelle: Bakuna and Tamdu.
 - Murelle office: 52 staff, including a Team Lead and operational and programmatic staff (see organizational chart in file explorer).
 - Program areas:
 - Health
 - Nutrition
 - Food security and livelihoods (FSL)
 - Water, sanitation, and hygiene (WASH)
 - Cross-cutting focus areas:
 - Child protection (CP)
 - Risk communication and community engagement (RCCE)
 - Mental health and psychosocial support (MHPSS)
 - Program funding comes from major international government donors and private foundations.

Health and Nutrition

Total program participants: 34,450 households/177,250 individuals (45% IDPs; 55% host community members).

Goal: Prevent mortality and morbidity (including disability) in affected populations (IDP and host communities) while contributing to the overall wellbeing of the community.

- READY supports seven Ministry of Health (MoH) primary healthcare centers (PHC).
 - PHC locations and catchments outlined below:
 - Murelle PHC: 20,000
 - Bakuna PHC (N of Murelle): 50,000
 - Tamdu PHC (SW of Murelle): 50,000
 - Informal IDP Settlement #1 PHC (SW of Murelle): 15,000
 - Informal IDP Settlement #2 PHC (W of Murelle): 14,250
 - Informal IDP Settlement #3 PHC (NW of Murelle): 16,000
 - Informal IDP Settlement #4 PHC (SE of Murelle): 12,000

READY

- The MoH provides the clinic buildings and oversees the collection and management of data on health service utilization.
- READY provides the budgetary support to cover the salaries of the PHC staff.
- PHC facilities services include:
 - Antenatal and postnatal care, deliveries, basic emergency obstetric care, and pediatric care; five-bed capacity for delivery services;
 - Health promotion, community engagement, and preventive services through community health workers (CHWs); the CHWs are managed through READY's national NGO partner, Thisland Relief;
 - Integrated management of neonatal and childhood illnesses, sexual and reproductive health, mental health and psycho-social support (MHPSS), and general communicable and non-communicable diseases;
 - Infant and Young Child Feeding (IYCF) programs;
 - Detection and out-patient treatment of acute malnutrition and anemia for children 6-59 months and pregnant and lactating women;
 - Referral for complicated malnourished cases to in-patient clinic;
 - Limited testing capacity for measles, dengue, and priority sexually transmitted infections.
- READY has an agreement with the district hospital to ensure continuum of care for emergency cases. A referral pathway has been established.
- READY is a core member of the national and sub-national Health Coordination Group under the leadership of the MoH.
- RCCE is integrated into READY's response planning, capacity building, and standard operating procedures (SOP) and guidelines.

Food Security and Livelihoods

Total program participants: 12,130 households/60,650 individuals (70% IDPs; 30% host community members).

Goal: Deliver life-saving assistance to IDPs through the provision of unconditional cash assistance targeting IDPs and Cash for Work (CfW) targeting IDPs and host community.

- Unconditional cash assistance using cash-based modality:
 - Utilizes established financial service providers (mobile money agents, banks, or vendors);
 - Enables families to access the minimum nutritional requirement while also reducing exposure to further risks;
- Cash for Work program:
 - Projects include digging hand-dug wells, latrine upkeep and maintenance, and serving as water point attendants, contributing to

READY

- improved hygiene and sanitation;
- Implementation managed in collaboration with Thisland Relief, a national NGO partner.
- READY has expanded its successful livelihoods project which targets 880 IDPs and vulnerable households in the host community. Households are provided with goats and livestock rearing training.

Water, Sanitation and Hygiene

Total program participants: 8,000 households/40,000 individuals (95% IDPs; 5% host community members).

Goal: Reduce water related illness through the provision of adequate water supply, sanitation, and the promotion of safe hygiene practices. As water quality at the household level is essential for nutrition outcomes in emergencies, activities are designed with a nutrition related outcome focus utilizing a market-based approach.

- Prioritizes the IDPs in four informal IDP settlements
- Ensures WASH services in seven READY PHC facilities
- Focus on access to safe drinking water through increasing the number of hand-dug wells and the rehabilitation of six existing deep boreholes in IDP settlements. Household water storage and treatment products are being incentivized with CVA.
- Community mobilizers conduct hygiene campaigns and control the water quality at the point of use.



Profiles of Communities in the Eastern Province of Thisland (Northeast District)

Murelle

Demographics

- Almost one million people live in and around Murelle, the largest city in Northeast district. The population is more ethnically diverse than surrounding towns. It is estimated 100,000 IDPs are currently living in Murelle. Additional details below.

Infrastructure

- Murelle has many multi-level buildings and is home to many national and international non-governmental organization (NGO) sub-offices.
- Most households have running water and electricity (although there are sporadic power outages), and most roads are paved.
- Mobile phone coverage is good.

Economics and Livelihoods

- The primary sources of employment in Murelle are agriculture (21%), services (20%), quarrying and manufacturing (18%), commerce (18%), construction (14%), and public sector employment (6%). Unemployment rates are high. Many work in the informal sector.

Tamdu

Demographics

- Tamdu is a town 90km southwest of Murelle. Approximately 30,000 people live in the town, with 20,000 people living in the surrounding rural communities. It is estimated 5,000 internally-displaced persons (IDPs) are currently living in Tamdu. Additional details below.

READY

Infrastructure

- Tamdu has mostly single-level buildings made of concrete. Around 60% of households have a private latrine.
- There is a mix of paved and dirt roads.
- Infrastructure (electricity, water, and roads) has been deteriorating in recent years.
- There are commercial buses and shared taxis available between Tamdu and Murelle, but transportation costs have been increasing. Only around 6% of households have their own vehicle.
- Mobile phone coverage is good in Tamdu but more limited in outlying areas.

Economics and Livelihoods

- The primary sources of employment in the Tamdu area are agriculture (44%), quarrying and small-scale manufacturing (18%), and commerce (11%).
- Most people in the surrounding rural communities farm grain, vegetables, and simberri trees (for their sap production), grown for subsistence and local markets.

Internally Displaced Persons (IDPs)

Demographics

- Since the conflict began in Western Province five years ago, an estimated 342,000 people have fled to the northeast (Eastern Province), where nine informal IDP settlements and three formal IDP camps now exist. Fear of continued attacks in Western Province have kept many IDPs from returning.
- Many of the displaced are in densely populated informal settlements (30%) or formal camps (15%), while others reside within host communities in urban areas like Murelle (55%).
- The IDP population is mostly from the same ethnic group, but they speak at least five different languages. The IDP population is generally of a different ethnicity than people in Murelle and Tamdu.
- There is a high percentage (26%) of female- and child-headed households in the displaced population.

Infrastructure

- Camps initially consisted of tent shelters, although in many cases IDPs have improved these or made them more permanent. Settlements mostly contain shelters that are poorly constructed of branches and plastic sheeting or mud and zinc coated iron.
- Shared taxis run along the major roads connecting the settlements and camps to the city of Murelle, but transportation costs have doubled since HxNy.
- To date, IDPs have been one of the most vulnerable groups for communicable diseases, including measles, cholera, and HxNy, because of overcrowding,

READY

poor access to handwashing facilities, sanitation and hygiene, and limited resources to protect themselves from disease.

Economics and Livelihoods

- Prior to displacement, many IDPs were farmers and agricultural laborers.
- Many IDPs work in the informal sector, generally as small traders or casual day-labourers in agriculture or construction. Employment discrimination is widespread.

Relationship Between Host and Displaced Communities

- Many long-term residents in Northeast District blame IDPs for adding pressure on limited resources and services and see them as a source of infectious disease spread. Many are not willing to continue hosting IDPs if they do not receive extra support from the government to do so.
- The mayor of Tamdu claims they have not received promised compensation for the land that was given to create Settlement #1 and blames political figures in Murelle for pushing for IDPs to be hosted in the region rather than nearer to Murelle.

Social and Cultural Considerations

Social science research data from late last year indicates widespread suspicion about the government. Religion plays a major role in the daily lives of both IDPs and host communities, and respected religious leaders are consistently cited as trusted sources of information by all groups. Perceptions about health among some IDPs and local communities tend to be rooted in religious and cultural beliefs rather than biomedical science.

Documented lessons learned from the HxNY outbreak indicate that two-way dialogues emphasizing respectful listening helped establish trust with both IDP and host communities and gave greater consideration to community priorities. Direct interaction with community and religious leaders, response volunteers, community members, and elders was also important. The local realities of livelihood activities and customs that make up the fabric of daily life should be addressed and integrated into interventions. These efforts require a degree of logistical flexibility, and allocating additional resources is critical to ensuring hard-to-reach populations are served.

ANNEX 4

MATERIALS NEEDED TO FACILITATE

The following materials will be needed in order to facilitate an in-person **Outbreak READY 2!** simulation event as it is outlined in this manual:

- Personal computers, laptops, or tablets with chargers and headphones for all participants
 - Adjust accordingly if playing in pairs or teams. For headphones, participants playing in pairs/teams may share headphones, use an audio jack splitter, or mute the sound.
- Access to an internet connection
- Prepared agenda with estimated times
- Any clothing items or props (clipboards, name tags, documents, etc.) for “Health Program Officer” character(s)
- One sign that says “READY Murrelle Sub-Office”
- Facilitator Guide materials, either printed or on a charged tablet
 - Step-by-Step Facilitation Guide
 - Key Decision Matrix (**Annex 7**)
 - Facilitator Handout for Part III Facilitated Discussion (**Annex 8**) - one per group facilitator
- Printed sign-in sheet
- Pens for sign-in sheet
- Name tags for participants
- One sign that says “Phone-Free Zone”
- Refreshments

OPTIONAL:

- Printed Background Documents (**Annex 3**)
- Printed Background Documents Quiz for Polling Participants (**Annex 6**)
- Printed handout for each small group (if applicable) with the selected discussion questions
- Paper and pens for each participant
- Whiteboard or large format sticky notes

ANNEX 5

SAMPLE EMAIL TO PARTICIPANTS

BCC: ALL PARTICIPANT EMAILS

SUBJECT: *Outbreak READY 2!: Thisland in Crisis* Simulation Event

BODY OF EMAIL:

Dear participants,

We look forward to your participation in the **Outbreak READY 2!: Thisland in Crisis, A Digital Readiness and Response Simulation** event. Please find details of the event below, including venue information, necessary materials to bring, and required reading to complete in advance of the event.

Event Details

Date: [INSERT DATE]

Time: [INSERT TIME] – The simulation event will begin promptly. Please arrive no later than [INSERT TIME].

Venue: [INSERT LOCATION]

Venue Details: [INSERT DETAILS about access, finding the room, entry requirements, etc., if relevant]

Additional Information: [INSERT DETAILS about any refreshments or meals that will be served during the planning event. Include details on how to share dietary considerations with event planning team.]

Necessary Materials

Please bring with you the following materials:

- Laptop or tablet, plus charger
 - We recommend playing the simulation on a laptop, but a tablet is also possible. **You cannot play the simulation on a mobile phone.**
- Headphones that connect to your laptop/tablet
- [INSERT ANY OTHER ITEMS THEY NEED]

Note: Your laptop/tablet will need one of the following internet browsers: Google Chrome, Firefox, Microsoft Edge, or Safari. If you do not have one of these browsers and do not know how to download it, **please arrive early to the event** so that we can assist you.

Required Reading in Advance

Please review the attached documents in advance. They will provide critical background information that you will need in the simulation.

- Thisland Country Brief
- Profiles of Communities in the Eastern Province of Thisland
- READY Humanitarian Program Portfolio
- Map of Thisland

We look forward to seeing you on [INSERT DATE AND ARRIVAL TIME]! Please let us know if you have any questions.

Sincerely,
[INSERT FACILITATOR OR HOSTING ORGANIZATION]

ANNEX 6

BACKGROUND QUIZ

Q1: WHERE IS MURELLE LOCATED?

- A) Along the eastern coast.
- B) In the northeast of the country.
- C) In the Western Province.

Q2: HOW WOULD YOU DESCRIBE THE CURRENT POLITICAL AND ECONOMIC CLIMATE OF THISLAND?

- A) Stable. All conflict has ceased in recent years and the economy is getting stronger.
- B) Unstable. Sporadic violence has increased in the western region, leading to new waves of displacement and making it difficult for IDPs to return home. Unemployment is high across the country.
- C) Active conflict. There is no recognized government and fighting has escalated to the point of civil war. Inflation has made basic needs too expensive and the majority of Thislanders live in severe poverty.

Q3: WHAT IS THE RELATIONSHIP BETWEEN IDPS AND EASTERNERS?

- A) They come from the same ethnic group, and there are no major tensions between the groups.
- B) They come from the same ethnic group, but prolonged displacement is creating new tensions that have led to mistrust and discrimination.
- C) They come from different ethnic groups, and prolonged displacement is creating worsening tensions that have led to mistrust and discrimination.

Q4: WHAT WAS HXNY?

- A) A READY acronym standing for Health & Nutrition.
- B) The region's seasonal influenza that causes morbidity and mortality each year.
- C) An influenza epidemic that occurred three years ago and killed thousands of people in Thisland and across the region.

Q5: WHAT IS THE STATE OF THE HEALTH CARE SYSTEM AFTER HXNY?

- A) Budget cutbacks have caused many rural clinics to close. A few district hospitals gained PCR machines during HxNy, but many are in need of repair.
- B) The HxNy epidemic led to a significant increase in public health funding that has sustained for the last 3 years. Clinics and laboratories are well-staffed and -resourced.
- C) While funding has declined, it has not largely affected communities' access to health care or the capacity of laboratories to test for infectious diseases.

ANSWER KEY: Q1: B; Q2: B; Q3: C; Q4: C; Q5: A

ANNEX 7

KEY DECISION MATRIX

Note: The decisions made in an outbreak are complex and context-specific. The following ratings (*optimal, sub-optimal, bad*) are based on the specific context within the simulation. Every outbreak response should be considered within its own context.

CHAPTER 1:

KEY DECISION 1: PRIORITY ACTION ITEMS

Context: You received information about a possible infectious disease outbreak in the northeast of Thisland. After hearing about unknown cases with respiratory symptoms and altered levels of consciousness during your Health Coordination Group meeting, you learned about similar cases at two READY clinics. You then recommended priority readiness actions to your Team Lead, Nia. Acting prematurely could spark panic or disrupt essential health services. Underreacting, however, would position you poorly for a later outbreak response.

Unlock: This Key Decision becomes available by opening the email from the READY IDP Clinic Supervisor, Isaiah.

Dilemma	Options	Rating	Feedback From Sim
Based on current data, I recommend the following initial priority steps... (Select 3 of 6)	Immediately notify the Ministry of Health of cases in READY clinics and request guidance.	Optimal	This is of essential importance. The MoH has the leadership role in responding to any possible disease outbreak in Thisland.
	Direct Thisland Relief to have CHWs notify community members of a potential new virus.	Bad	You work in collaborative partnership with Thisland Relief, and therefore, you should not “direct” them. Moreover, while timely communication is important, this is premature and should be done in close collaboration with the MoH.
	Temporarily reduce clinic services to only emergency patients to limit potential spread of the disease.	Bad	This would have detrimental impacts on the community and the current situation was not yet clear, nor severe enough to warrant considering this.
	Update health staff on the situation and remind the team to follow standard Infection Prevention and Control protocols.	Optimal	It is critical to prioritize staff safety and wellbeing from the outset of a potential outbreak, and one aspect of this is to ensure that timely and frequent situation updates and clinical IPC guidance be provided to staff.
	Reach out to other NGO health program managers to exchange information about cases and resources and to coordinate next steps.	Optimal	Sharing information and coordinating strategies and plans with partners is crucial for an effective response.
	Reach out to donors to discuss potential health program adaptations and additional funding opportunities.	Sub-optimal	This action would be premature, given that you did not yet know what you are dealing with. Also, it would not be the role of the health program manager to bypass the Team Lead and Country Director to reach out to donors.

KEY DECISION 2: CASE MANAGEMENT STRATEGY

Context: The Ministry of Health (MoH) announced that the ongoing outbreak was being caused by a relatively novel pathogen called Enni Virus. Following this declaration, you needed to adapt READY's case management strategy and the referral pathway for READY clinics.

Unlock: This Key Decision becomes available by opening the email from the READY Team Lead, Nia.

Dilemma	Options	Rating	Feedback From Sim
<p>Based on the MoH's confirmation of EnVD, READY should adapt our case management and referral pathway in the following ways:</p> <p>(Select 3 of 6)</p> <p><i>*Participants will receive different options based on the choices they've made prior to this Key Decision.</i></p>	Increase the number of daily PHC hours to limit overcrowding in health facilities.	Sub-optimal	There was no evidence that READY clinics were overcrowded at this point due to the EnVD outbreak.
	To limit infection risk for PHC staff, immediately refer all suspect cases to the district hospital without allowing them to enter the PHC.	Sub-optimal	While PHCs should refer all suspect cases to the district hospital, some cases may need medical attention. If a case needs immediate medical attention, it should be provided to the patient in accordance with IPC protocols.
	Train PHC staff on the referral pathway for unaccompanied children with suspect EnVD, and on child protection coordination with the district hospital.	Optimal	Good. The Child Protection Coordinator has identified concerns about unaccompanied children. Addressing these concerns will require all staff to be trained on case identification and referral procedures, prioritizing coordination with the clinic CP focal points.
	Inform the district hospital when unaccompanied children with suspect EnVD have been referred and sent to their facility.	Sub-optimal	An unaccompanied child should never be sent to the hospital without a caregiver or member of READY staff to accompany them. A discussion with the Child Protection Coordinator would have revealed a more comprehensive approach.
	Reduce routine health services and primarily allow urgent or emergent visits to prevent the spread of EnVD within READY PHCs.	Bad	READY provides critical health services to the community. These should not be limited at this time. Provided there is an adequate supply of PPE and appropriate IPC measures are in place, the risk of EnV transmission to staff and patients can be safely managed.
	Have staff provide immediate care to suspect cases in a designated isolation area in PHCs before transferring them to the hospital.	Optimal	If a case needs immediate medical attention, it should be provided to the patient in accordance with IPC protocols. Setting up isolation areas within PHCs and ensuring an adequate supply of PPE are important safety steps.

	Have staff provide any basic care to suspect cases within the PHC before transferring them to the hospital.	Sub-optimal	While providing immediate care is important, a discussion with the IDP Clinic Supervisor would have revealed a better approach, including setting up an isolation area within the PHCs where suspect cases can receive immediate care and await referral to the district hospital.
	Train clinic staff on proper triage, PPE usage, and other infection prevention and control (IPC) measures for EnVD.	Optimal	Refresher training on the proper use of PPE and appropriate IPC measures is important, given the concerns that have been raised by one of the clinic supervisors.
	Rely on previous infection prevention and control (IPC) trainings that staff received during the HxNy outbreak.	Sub-optimal	A discussion with the Tamdu Clinic Supervisor would have highlighted IPC concerns and revealed a more optimal choice to provide refresher IPC trainings to staff.

KEY DECISION 3: COMMUNITY HEALTH WORKER (CHW) SURVEILLANCE PROGRAM

Context: The MoH announced that the ongoing outbreak was being caused by a relatively novel pathogen called Enni Virus (EnV). Following this declaration, Thisland Relief was asked by the MoH to add active Enni Virus Disease (EnVD) surveillance to their existing CHW program. Lydia, Program Manager at Thisland Relief, asked for your recommendations on how to best implement this request.

Unlock: This Key Decision becomes available by opening the email from the Thisland Relief Program Manager, Lydia.

Dilemma	Options	Rating	Feedback From Sim
This Key Decision becomes available by opening the email from the Thisland Relief Program Manager, Lydia.	Add EnVD surveillance and education to existing CHW activities.	Bad	Lydia informed you that adding EnVD surveillance and expanding into new areas would exceed current CHW capacity, and it would take a few weeks to recruit and train more CHWs. While not ideal, we ultimately need to prioritize activities due to our limited resources.
	Temporarily deprioritize non-EnVD health educational activities to allow more resources to be used for EnVD surveillance and education.	Optimal	While not ideal, we ultimately need to triage our limited resources. In this context, we would rather prioritize monitoring for child malnutrition, antenatal care, or vaccinations, over general non-EnVD educational activities.
	Temporarily deprioritize engagement with community leaders and organizations to allow more resources to be used for EnVD surveillance and education.	Sub-optimal	Engaging with community leaders and organizations becomes even more critical during an outbreak. Reducing this will only hinder the effectiveness of the response.
Managing all the additional data and reporting will certainly be challenging. I recommend that Thisland Relief: (Select 1 of 3)	Pilot a new reporting system to try to make data collection and management more efficient. The resulting data will be of higher quality and will be sent to MoH faster.	Bad	A new reporting system would take time and money to develop and would require new training for staff. At this point, it would likely be safer, more cost effective, and faster to modify an existing system.
	Use the paper line list the MoH provided, as it's similar enough to those used by CHWs in past outbreaks. Onneetse can support Teo in compiling the data at the end of each day.	Optimal	This is a sensible recommendation. It can be implemented quickly and easily, since the line list is already familiar to CHWs. Also, the READY HDMO told you she has time to support Thisland Relief while they hire additional support.

	Gather the paper line list data from CHWs on a weekly basis. If Teo collects them daily, he won't be able to see any trends and properly prioritize areas. Compiling the data weekly will also make the overall workload more manageable.	Sub-optimal	While using the paper line lists is sensible, as they are already familiar to CHWs, the MoH requested data be submitted daily so they can make timely decisions based on the most current data possible. Data should be submitted daily, not weekly.
Lastly, it will be critical to build trust with the communities. I would recommend the following approach: (Select 1 of 3)	Move forward immediately with the surveillance program, as Thisland Relief and READY already have a strong relationship with the community.	Bad	You should always take active steps to engage community members, no matter how strong you think your relationship is. Actively involving the community builds trust and can help mitigate misinformation and rumors, especially during an outbreak.
	Meet with community leaders regularly throughout the surveillance program and actively collect and incorporate their feedback, in coordination with other partners.	Optimal	Listening to community concerns and responding with two-way communication while linking with other partners who are collecting and addressing feedback is important for building trust and meeting community needs.
	Hold large events to educate community members on the surveillance program, and wait for their approval before starting any surveillance.	Sub-optimal	While community engagement is critical, large public events can be dangerous in an outbreak with respiratory transmission. Also, listening to and acting on feedback builds trust and empowers communities better than simply presenting information.

CHAPTER 2:

KEY DECISION 1: RAPID ASSESSMENT QUESTIONNAIRE

Context: Now in Week 5, the outbreak has been expanding, with a recent rise in cases. To support response efforts, READY is engaging in a rapid assessment to identify knowledge, attitudes, behaviors, and perceptions surrounding Enni Virus Disease. Sarah, the READY RCCE Officer, asked you to provide input into the rapid assessment questionnaire.

Unlock: This Key Decision becomes available by opening the email from the READY RCCE Officer, Sarah.

Dilemma	Options	Rating	Feedback From Sim
<p>When interviewing people from the IDP settlements, we need to tailor the assessment survey by including more questions about:</p> <p>(Select 1 of 3)</p>	<p>Past traumatic events and how they might impact care-seeking and perceptions of the disease and prevention.</p>	Bad	<p>Probing for specific details on past traumatic events can be highly distressing and may trigger mental anguish. As well, there is no evidence-based reason for burdening IDPs with this question when it might not produce useful information.</p>
	<p>Barriers to disease prevention and how feelings of stigma might influence prevention and care-seeking behaviors.</p>	Optimal	<p>IDPs tend to face increased vulnerabilities due to crowded conditions and limited access. They also tend to experience stigma. Knowing how barriers prevent IDPs from accessing prevention and care helps READY to plan better responses.</p>
	<p>Knowledge, perceptions, access and use of WASH facilities and practices, with a focus on critical handwashing with soap and water.</p>	Sub-optimal	<p>While WASH access and use is important, particularly for this area, there was another WASH survey being conducted here at the same time. READY needs to coordinate with partner activities, and not overburden people with duplicate questions.</p>
<p>When interviewing community members from rural areas outside of Tamdu, we need to tailor the rapid assessment questionnaire to the context by including questions on:</p> <p>(Select 1 of 3)</p>	<p>Behaviors and practices related to livestock activities and poultry farming that might impact the outbreak.</p>	Bad	<p>There are no reported cases of transmission of EnVD via livestock or poultry farming. We do not want to burden people with questions that will not improve care-seeking or support interventions to mitigate the risks of infection and impacts of the outbreak.</p>
	<p>Funding and resource gaps for community health services.</p>	Sub-optimal	<p>It is unclear how community members can address a question about this funding. Also, we want to prioritize questions that will improve care-seeking and support interventions that empower people to protect themselves from disease and the outbreak's impacts.</p>

	Barriers to accessing community health services, and practices and behaviors around respiratory transmission and simberri sap.	Optimal	Knowing these barriers will provide essential insights that outbreak response teams and rural communities can use to improve care-seeking and support interventions that empower people to protect themselves from infection and the outbreak's impacts.
Finally, when interviewing community health workers, we should include questions on: (Select 1 of 3)	How well the public understands EnVD transmission and the progression of the outbreak.	Sub-optimal	While this is important, this question is less subjective, and better addressed in a population-based or community survey where we can disaggregate the data. With CHWs, we should focus on their own knowledge of EnVD, safety and referrals.
	Public perceptions of CHWs, including whether they are trusted by the community.	Sub-optimal	Community health workers' responses about how much they are trusted by the community might be biased. Instead, we should focus on their own knowledge of EnVD, safety and referrals.
	Their perspectives on care-seeking behavior in the community.	Optimal	Good choice! CHWs have a great deal of front-line knowledge of how communities are responding to the disease.

KEY DECISION 2: READY'S ENVD RCCE STRATEGY

Context: Following the community visits, Sarah requested your input on updating READY's RCCE strategy for the EnVD outbreak.

Unlock: This Key Decision becomes available by opening the email from the READY RCCE Officer, Sarah.

Dilemma	Options	Rating	Feedback From Sim
<p>Based on the epidemiological and community-level data from the rapid assessment, some of which was highlighted during our community visits, we need to:</p> <p>(Select 1 of 3)</p>	<p>Increase fear of the severity of the disease and the consequences of inaction to encourage care-seeking and prevention, while also increasing knowledge of EnVD symptoms and transmission through respiratory droplets.</p>	Bad	<p>While the aim is to increase community perceptions of the risk of getting EnVD, intensifying fear of the disease and the outbreak should not be a goal, as this can lead to increased stigma, rumors and hopelessness.</p>
	<p>Increase knowledge of EnVD symptoms and modes of transmission (including through respiratory droplets); build confidence in prevention actions; and increase early care-seeking behaviors.</p>	Optimal	<p>Good suggestion. Data indicated that EnVD modes of transmission and people's perception of risk are areas to focus on to facilitate desired prevention and care-seeking behaviors.</p>
	<p>Increase knowledge about EnVD transmission (including through respiratory droplets) and prevention practices related to simberri sap, and increase care-seeking when symptoms are severe.</p>	Sub-optimal	<p>Based on the data, people need to get to the facilities early, rather than when symptoms are severe. Also, a focus on prevention of respiratory transmission is a clear priority for the general population (rather than simberri sap).</p>
<p>We need to tailor messages and approaches to our different audiences identified in the plan. Starting with the IDP communities,</p>	<p>(1) Outreach with loudspeakers and SMS to promote prevention and care-seeking; (2) Radio spots to discourage consumption of simberri sap among IDP casual workers; and (3) Social media campaigns to inform about EnVD and dispel rumors and stigma.</p>	Bad	<p>Planning for safety in outbreaks is critical, but one-way communication is not as effective. In-person dialogues in Thisland can occur, but only if safety guidelines are strictly followed and supervised.</p>

we should use the following approaches: (Select 1 of 3)	(1) Community meetings to create action plans to address respiratory spread and early care-seeking; (2) Radio with survivor testimonials to increase trust in health centers; and (3) Outreach with community and religious leaders and health workers on EnVD and care-seeking.	Optimal	This is a good choice. Together these interventions help create solutions that address key actions to reduce cases and deaths among IDPs, particularly by promoting early care seeking behavior.
	(1) Community outreach about simberri sap using megaphones and flyers in crowded markets where IDPs go for supplies and (2) Recruit government leaders for campaigns promoting the importance of disease prevention and early care-seeking	Bad	Data show that simberri sap is less of an issue among IDPs and respiratory transmission should be more of a focus; assessment results also show that government leaders are not regarded as trusted sources of information among these IDPs.
In the affected rural communities, we should conduct: (Select 1 of 3)	(1) Radio and print (leaflet) campaigns; (2) Outreach with traditional healers and religious leaders to promote early care-seeking and reduce stigma; and (3) Community dialogues with action plans and activities addressing respiratory transmission, health access, and simberri sap production.	Optimal	Well done. Using a mix of communication channels can engage the community and promote behavior change around key prevention methods and health seeking behaviors.
	(1) Communication campaigns to increase fear of severe EnVD to encourage care-seeking; (2) Community dialogues to design ways to address EnVD knowledge and care-seeking; and (3) Dialogues with health workers and traditional healers to discuss EnVD and early care-seeking.	Bad	Increasing fear of EnVD should not be the aim, as this may intensify stigma, rumors, and hopelessness. Instead, help people know the risks and consequences of inaction, and give them feasible actions to take to stay safe.

	<p>(1) Outreach using loudspeakers and SMS to discourage simberri sap consumption; (2) EnVD messaging guides distributed to local government officials, religious leaders, traditional healers, and community leaders; and (3) Social media campaigns to dispel rumors and reduce stigma.</p>	<p>Sub-optimal</p>	<p>Participatory engagement methods are the most effective and preferred if safety measures can be followed effectively and with supervision.</p>
--	---	--------------------	---

KEY DECISION 3: ADAPTATIONS TO THISLAND RELIEF'S CHW PROGRAM

Context: Following the community visits, Thisland Relief requested READY's recommendations as to how they could adapt their CHW program to address suspect EnVD cases not going to PHCs.

Unlock: This Key Decision becomes available by opening the email from the Thisland Relief Program Manager, Lydia.

Dilemma	Options	Rating	Feedback From Sim
<p>It's concerning that CHWs are reporting a high number of suspect EnVD cases that stay home and avoid the PHCs. Based on what we learned this week, READY recommends the following</p> <p>(Select 3 of 6):</p> <p><i>*Participants will receive different options based on the choices they've made prior to this Key Decision.</i></p>	Instruct the CHWs to report suspect cases who refuse to go to the PHC to their community leader, who can help convince them to seek care.	Bad	This threatened patient confidentiality and could increase stigma, potentially causing cases to hide their illness and subsequently, increase transmission.
	Meet regularly with community leaders and traditional healers to encourage them to refer suspect cases to health facilities.	Optimal	Good. Traditional healers are widely trusted in the community. Working with them and community leaders is key. When traditional healers treat EnVD symptoms themselves, it can increase transmission and delay access to appropriate care.
	Develop a campaign to urge the community to avoid traditional healers and instead consult with CHWs and visit PHCs when sick with EnVD.	Bad	Traditional healers are widely trusted in the community. Alienating them from response efforts would be a mistake.
	Coordinate with READY's FSL PM to ensure that affected households are linked to support services such as food basket or cash and voucher provisions.	Optimal	Community visits revealed that many are concerned about how they would care for their family if they had to isolate at an ITC. By easing this concern, you make it more likely they will seek care at an early stage of infection, before their symptoms are severe.
	Have CHWs distribute flyers in Settlement #1 that deny rumors that IDPs who go to the hospital will be sent back to Western Province.	Sub-optimal	Research has shown that simply denying rumors can be ineffective and repeating them may lead to the rumor spreading further. Also, literacy rates may be low within the target populations so communication in this way might not be effective.

	<p>Hold refresher trainings for CHWs on how to effectively address misinformation with community members.</p>	<p>Optimal</p>	<p>Regular trainings are important to ensure accurate understanding of a new pathogen and address incorrect internalized beliefs. The CHW meeting highlighted a need for more training on how to address rumors and misinformation.</p>
	<p>Have CHWs accompany suspect cases to the hospital via public transportation to ensure they arrive at the facility.</p>	<p>Bad</p>	<p>While patient accompaniment can improve access to care, in this case this would increase the risk of community transmission and force CHWs to deprioritize other important activities. CHWs should continue to notify the MoH's RRT of any suspected cases.</p>

CHAPTER 3:

KEY DECISION 1: RECOMMENDATIONS TO CASE MANAGEMENT PILLAR

Context: It's Week 7. With case numbers increasing, the MoH invited READY and other key health NGOs to the Case Management Pillar meeting to discuss the next phase of the response now that community transmission seems likely. The discussion included options for expanding isolation and treatment centers (ITCs) to respond to the growing caseloads. As READY operating areas remain the epicenter of the outbreak, READY was asked to give their recommendations for how to manage cases moving forward.

Unlock: This Key Decision becomes available by opening the file titled "MoH Meeting Notes" which can be found in the "READY documents" folder in the laptop's File Explorer.

Dilemma	Options	Rating	Feedback From Sim
What approaches do you recommend to the Case Management Pillar? (Select 3 of 6)	Set up one large ITC at the district hospital, with all PHCs setting up triage areas for isolation of suspect cases and referral to the hospital.	Sub-optimal	Setting up one central ITC contradicts the RCCE data which shows the community are reluctant to go to the district hospital. There would also be challenges in transporting patients.
	Manage mild cases at home, with support from CHWs.	Bad	Managing cases at home will put caretakers and family members at risk and may lead to increased spread of EnVD.
	Establish a decentralized network of smaller ITCs linked to the district hospital.	Optimal	This is an excellent recommendation. Decentralized ITCs will be more accessible and more accepted by the community.
	Concentrate MoH resources in the rural areas.	Sub-optimal	While the Tamdu region continues to be a hotspot, cases have also spread to Murelle. Resources also need to be allocated in Murelle to avoid a rapid escalation of the outbreak in such a densely populated area.
	Establish a dedicated, free ambulance system to transport suspect and confirmed cases to and between ITCs.	Optimal	Using dedicated ambulances limits the risk of infection to others and allows for cost-free transport for those who cannot afford taxis.
	Concentrate limited resources for severe cases at the district hospital, including ventilators and oxygen.	Optimal	This is a very good choice. Severe cases require resources such as critical care training, oxygen, ventilation, water and sanitation infrastructure, and a power supply, which PHCs do not have.

KEY DECISION 2: ESTABLISHING NEW ITC BEDS

Context: Following recommendations to the Case Management Pillar, the MoH decided to expand capacity at the district hospital while also establishing smaller decentralized isolation and treatment centers (ITCs) at some of the primary healthcare centers (PHCs). ITC capacity in the Northeast would now be 200 beds at the district hospital, 120 beds operated by Relief Action in western Murelle, and 100 beds operated by READY. You had to meet with Nia (Team Lead) and Afreen (Country Director) to decide where and how to establish these 100 ITC beds, given READY's resources and the key characteristics of the outbreak.

Unlock: This Key Decision becomes available by talking to the READY Team Lead, Nia (by clicking on her icon in the bottom right of the screen).

Dilemma	Options	Rating	Feedback From Sim
Where should the beds be located? (Select 1 of 3)	We should distribute the beds across all 7 READY PHCs. The outbreak is spreading, and every PHC should have an ITC.	Bad	Not all READY PHCs had EnVD cases or the capacity to rapidly set up an ITC. IDP Settlement #1 and Tamdu PHCs had the most cases, worst access to the district hospital, and the best infrastructure.
	We should distribute the beds across IDP Settlement #1 PHC and Tamdu PHC. They have high case counts and poor access to the district hospital.	Optimal	These 2 PHCs reported the most EnVD cases, and feedback from staff and community members highlighted that ITCs within the Tamdu region would be more accessible and trusted. While cases were rising in Murelle, other partners were already increasing ITC capacity there.
	We should put the beds in the IDP Settlement #1 PHC. IDPs are very vulnerable in this outbreak, and they are too often deprioritized by the MoH.	Bad	Communities around Tamdu also had high cases, poor access to Murelle, and mistrust of the district hospital. Beds should have been split between IDP Settlement #1 and Tamdu PHCs.
What severity of patients should these ITCs accept? (Select 1 of 3)	We should only accept mild and moderate cases. Severe cases should be treated at the district hospital.	Optimal	READY did not have the equipment, supplies, or human resources to provide the level of critical care required for severe cases.
	We should only accept severe cases. They need treatment the most and should be prioritized at our ITCs.	Bad	READY did not have the equipment, supplies, or human resources to provide the critical care required by severe cases. Accepting severe cases would have resulted in deaths that may have been avoided if they had been cared for at the district hospital.

	We should accept all cases, whether they are mild, moderate, or severe. Treating cases of any severity will improve access to care and community trust.	Sub-optimal	READY did not have the equipment, supplies, or human resources to provide the critical care required by severe cases. Accepting severe cases would have resulted in deaths that may have been avoided if they had been cared for at the district hospital.
Where do you think staffing should come from? (Select 1 of 3)	We should close Settlement #1 and Tamdu PHCs and have them only operate as ITCs. All current PHC staff would work as ITC staff.	Bad	During an outbreak it is critical that people still have access to essential services. Closing PHCs should be avoided.
	We should assign both new and existing staff to the ITCs, with existing staff being redistributed from other READY PHCs.	Optimal	Having all new staff can introduce a number of operational challenges. Having a mix of new and existing staff can help alleviate these concerns. Experienced staff could help support the new hires at the ITCs.
	We should hire all new health and non-health staff for the ITCs to take pressure off the PHCs. We will need new expertise and extensive training to be able to run the ITCs.	Sub-optimal	Having all new staff can introduce a number of operational challenges. Having a mix of new and existing staff can help alleviate these concerns. Experienced staff could help support the new hires at the ITCs.

KEY DECISION 3: TRENDS IN ENVD AND NON-ENVD DATA

Context: Now Week 11, Nia (Team) was going to meet with Afreen (Country Director) to discuss broader programmatic adaptations within READY as a result of the outbreak. Before her meeting, she requested your insight into some EnVD and non-EnVD data as well as some possible program adaptations.

Unlock: This Key Decision becomes available by opening the email from the READY Team Lead, Nia.

Dilemma	Options	Rating	Feedback From Sim
The CFR of confirmed cases is most likely dropping because... (Select 1 of 3)	A higher percentage of cases are among younger people, who have a lower risk of dying from EnVD.	Sub-optimal	It is true that younger people were at lower risk of dying from EnVD, so the age distribution of cases might certainly affect CFR. However, there was not a shift in the age distribution of confirmed cases, so this would not explain the change in CFR over time.
	New treatments from the GHO are making the disease more survivable, leading to fewer deaths.	Bad	While new treatment methods would likely impact CFR, the sit-reps showed there were no new treatments for EnVD. Supportive care remained the only form of treatment.
	With testing capacity expanding, we are likely now testing more people at lower severity levels, meaning fewer confirmed cases are dying.	Optimal	Over time, testing increased and positivity rates declined. This suggests that more mild and moderate cases were being tested. Confirmed cases thus likely included a higher proportion of mild and moderate cases than before.
Regarding the decline in non-EnVD respiratory infections among children under-5 years at READY PHCs, I believe that... (Select 1 of 3)	Our priority right now needs to be the outbreak response. Respiratory cases are not coming to the clinics due to fear of getting EnVD or being sent to the isolation and treatment centers.	Bad	Non-EnVD illnesses should not be ignored. This changing trend should be further investigated and addressed. For example, the RCCE team may have information from the community, and Thisland Relief can re-train CHWs on non-EnVD referral pathways.
	We should reach out to the RCCE team to see what they know. We may also want to work with Thisland Relief to conduct refresher trainings for CHWs on referral pathways for when they identify respiratory cases that don't match the EnVD case definition.	Optimal	It is important to maintain essential services during an outbreak. Non-EnVD health indicators should be monitored and any changing trends investigated for timely action.

	We should raise this at the next briefing to make sure the MoH is aware. They can further investigate what is going on and will have a better sense of what is happening across the northeast.	Sub-optimal	The decline is greatest among READY PHCs, so it would be better to investigate further before notifying the MoH. For example, the RCCE team may have insights into whether this is due to a true decline in incidence, or reduced care-seeking behavior.
Regarding additional funding for essential health services, I think we should...	Focus any additional funding on EnVD response. EnVD cases are still rising. We can focus resources on non-EnVD health care after EnVD cases start to decline.	Bad	It is critical to maintain delivery of essential services during an outbreak. Essential services should not just be an afterthought at the end of an outbreak.
(Select 1 of 3)	Use the additional funding on community engagement around the importance of non-EnVD health care and the precautions PHCs are taking to keep patients safe from EnVD.	Optimal	It is critical to maintain essential services during an outbreak. Clinic data show that non-EnVD consultations have declined and RCCE reports further support the conclusion that people are worried about going to clinics.
	Use the additional funding to build a new PHC. This would help provide additional capacity for non-EnVD health care.	Sub-optimal	Clinic data show that non-EnVD consultations have declined and RCCE reports further support the conclusion that people are worried about going to clinics. Building a new PHC will not address these concerns. Additional community engagement is needed first and foremost.

KEY DECISION 4: CHALLENGES AT READY ITCS

Context: In Week 12, READY clinic supervisors were facing technical and ethical challenges at the recently established ITCs and needed your support to address them. They sought guidance on breastfeeding, management of children with Severe Acute Malnutrition, referrals from nearby NGOs, and safe and dignified burials.

Unlock: This Key Decision becomes available by visiting the IDP Settlement 1 Clinic and speaking with the READY Clinic Supervisor, Isaiah.

Dilemma	Options	Rating	Feedback From Sim
<p>We have a new mother with confirmed EnVD with a 2-month-old baby who is negative, and we're unsure what to do. How do you recommend we counsel the mother?</p> <p>(Select 1 of 3)</p>	<p>We should counsel her not to have contact with the baby until her isolation ends. Formula should be provided instead—the risk of EnVD is too high.</p>	Bad	<p>Separating a mother from her child has health and protection risks. Additionally, there is no evidence of transmission of EnVD via breastmilk, so a mother can breastfeed with precautions, such as handwashing and wearing a mask.</p>
	<p>The mother should be supported in expressing her own breastmilk. We can deliver the breastmilk to the baby, who should stay with an alternative caregiver.</p>	Sub-optimal	<p>While breastmilk does not transmit EnV, there are significant health and protection risks with separation. The mother should be supported in making an informed decision, even if that means keeping the baby in the ITC.</p>
	<p>We should counsel her to breastfeed, if well enough, using IPC measures. She can also decide if the baby stays in the ITC or with an alternative caregiver between feeds.</p>	Optimal	<p>There is no evidence of EnV transmission via breastmilk, and there are significant health and protection risks with any kind of separation. The mother should be supported in making an informed decision, even if that means keeping the baby in the ITC.</p>
<p>We are experiencing pressure to accept severe cases because families do not want their loved ones to go to Murelle District Hospital. How should READY handle this?</p> <p>(Select 1 of 3)</p>	<p>We should accept the referrals but explain to the families that we can't provide the level of care that Murelle hospital can.</p>	Sub-optimal	<p>While the concern of families is understandable, the ITCs are not equipped to deal with severe cases.</p>
	<p>We need to refuse referrals for severe cases. Please direct the NGO to use the MoH referral pathway.</p>	Optimal	<p>This is your best option. While the concern of families is understandable, the ITCs are not equipped to deal with severe cases.</p>
	<p>We should train our staff to use oxygen cylinders and ventilators, so the ITC to accept the severe cases.</p>	Bad	<p>Unfortunately, this critical care equipment is beyond the capacity of your ITC to use. Your decision needs to be realistic and responsible, and in this case, it wouldn't be.</p>

<p>We are concerned about some children with EnVD who have been admitted to the ITC and also have Severe Acute Malnutrition (SAM). Can you advise us on the best way to handle this?</p> <p>(Select 1 of 3)</p>	<p>We need to prepare staff and resources to be able to treat SAM for those that come in with EnVD to the ITCs.</p>	<p>Optimal</p>	<p>This is a sensible recommendation. Both EnVD and SAM are deadly threats to affected children. Nutrition is essential in supporting immune response.</p>
	<p>We should transfer them straight to a specialist inpatient Therapeutic Feeding Center.</p>	<p>Bad</p>	<p>Your recommendation here would increase the risk of spreading EnV infection to other, already vulnerable, children.</p>
	<p>We need to prioritize treatment of EnVD first and consider transfer to a Therapeutic Feeding Center later.</p>	<p>Bad</p>	<p>Your recommendation here would put severely malnourished children with EnVD at higher risk, as well as hampering their ability to fight the infection.</p>
<p>We had some patients die recently, and the families wanted to take their bodies home for burial. What do you think is the best way to handle this?</p> <p>(Select 1 of 3)</p>	<p>You should explain to the families that it is not safe to allow the body to be taken home, and the burial will need to be done by the MoH.</p>	<p>Bad</p>	<p>While safe and dignified burial is key to reducing transmission with certain diseases, there is no evidence of post-mortem transmission with EnVD. Families and communities should be allowed to bury their loved ones as long as they avoid large, unmasked gatherings.</p>
	<p>You should release the body back to the family, but with guidance around mass gatherings and advice to religious leaders on how to keep everyone safe.</p>	<p>Optimal</p>	<p>While safe and dignified burial is key to reducing transmission with certain diseases, there is no post-mortem transmission with EnVD. Families and communities should be allowed to bury their loved ones as they wish, while taking precautions.</p>
	<p>Since there is no post-mortem transmission, you should release the body back to the family as soon as possible.</p>	<p>Sub-optimal</p>	<p>While safe and dignified burial is key to reducing transmission with certain diseases, there is no post-mortem transmission with EnVD. Families should be allowed to bury their loved ones as they wish as long as they take precautions on mass gatherings.</p>

KEY DECISION 5: SICK DOCTOR AT ITC

Context: Now Week 15, Isaiah (IDP Clinic Supervisor) notifies you that Jo, a doctor at the ITC, had developed EnVD symptoms. Isaiah requested your immediate guidance on what to do next.

Unlock: This Key Decision becomes available by opening the chat message from the IDP Clinic Supervisor, Isaiah.

Dilemma	Options	Rating	Feedback From Sim
<p>The following actions should be taken in response to a possible case of EnVD among the medical staff at IDP Settlement #1 ITC:</p> <p>(Select 3 of 6)</p>	Transfer patients and temporarily shut down the ITC. Without the doctor, there are not sufficient staff to guarantee quality care.	Sub-optimal	This was an overreaction—the clinic supervisor has not suggested this is necessary.
	Inform the MoH that we can continue caring for existing patients but cannot accept new patients at the ITC until a replacement doctor is found.	Optimal	This was a prudent response. The MoH should certainly be informed if the ITC cannot take new cases. They may have also had additional guidance for you.
	Isolate the doctor while you await results. Quarantine the nurse who had contact with the doctor without PPE.	Optimal	This was a correct decision. You needed to immediately reduce the risk of onward transmission if the doctor might have EnVD.
	Have Nia or myself assess the doctor. With such a serious situation, I want to ensure she meets the EnVD case definition before taking drastic	Bad	This was unnecessary. The clinic supervisor is a trained clinician, and the case definition was straight forward. Overruling him delayed decision-making and contributed to the spread of the disease among staff.
	Be more vigilant in the daily symptom screening of staff.	Optimal	This was a sensible precaution given the possibility that a staff member might have been infected.
	If the doctor feels well enough, allow her to continue working until the laboratory tests are back.	Bad	This decision contributed to further spread among staff. The pressure to maintain full staffing at the clinic should not have led you to put staff and patients at risk. Ultimately, the clinic would be forced to close.

ANNEX 8

FACILITATOR HANDOUT FOR PART III FACILITATED DISCUSSION

THEMATIC AREA: GENERAL

Question 1: What were some of the data you used in the simulation? How did the data help you make decisions in the outbreak response? What additional types of data did you wish you had?

FACILITATOR NOTES:

- Ask additional prompting questions such as:**
 - How did you decide what data to prioritize for different decisions?
 - Did you use only one type of data at a time, or did you refer to multiple types of data when making a decision? How did that help or hinder your decision-making?
- Epidemiological Data:**
 - Types of data: incidence (new cases), case fatality rates, testing, positivity rates, symptoms, age distribution of cases, geographic location of cases, ITC bed occupancy, etc.
 - Sources: clinic line lists, dashboard, situation reports
- Clinical Data:**
 - Types of data: clinic attendance, services provided (e.g., immunizations, ANC)
 - Sources: monthly clinic reports, speaking with clinic supervisors and other colleagues
- RCCE Data:**
 - Types of data: knowledge about the virus, perceptions and beliefs (including rumors), practices, attitudes, barriers to practices and care, trusted sources of information
 - Sources: community listening channels, rapid assessment results, meetings with community leaders and members, dashboard
- Used in** initial response priorities, program initiation, program adaptation
 - Identifying what actions to take, when to take them, who to target, and how to implement them
- Importance** of using all kinds of data when making programmatic decisions
 - It's hard to get the entire picture when only using one type of data. Bringing together multiple types of data provides a more detailed and holistic understanding of the outbreak.

Question 2: In the simulation, you had to make several decisions about staff safety. What are some challenges you've had to face with staff safety during an outbreak? How did you go about making your decision?

FACILITATOR NOTES:

- Ask probing questions such as:
 - What made the decision challenging?
 - Why did you make the decision you did?

- Did anyone at the time disagree with that decision? Why?
 - Looking back, would you have done anything differently?
 - How are these decisions regarding staff safety similar or different from others you have to make in humanitarian settings?
- Duty of care: Ensuring staff safety also helps protect patients and community members.
- Ethical dilemmas:
- Risk aversion: Many NGOs will develop strict risk averse protocols that create ethical dilemmas for staff. For example, in an outbreak with bloodborne transmission, an NGO may prevent staff from placing IVs even if it would provide better rehydration for the patient.

Question 3: Throughout the simulation, you engaged with many different types of actors. Who were the most important actors you engaged with, why were they important, and what did you learn from them? ? In your context, who would you prioritize coordinating with during an outbreak?

FACILITATOR NOTES:

- Ask additional prompting questions including:
- How did you weigh the importance of different actors? Were there times you weighed the same actor as more/less important, depending on the situation?
- Coordinating partners included:
- **Government:** Ministry of Health
 - **NGOs:** Thisland Relief (READY's national NGO partner), ASSIST Together, Helping International, Relief Action, HCN Aid, and Feed the World
 - **Other External:** Global Health Organization (GHO), Case Management Pillar, Surveillance Pillar, RCCE Pillar, Infection Prevention and Control Pillar, Nutrition Cluster
 - **READY Office-Based Colleagues:** Team Lead (Nia), Health Data Management Officer (Onneetse), Child Protection Officer (Hasim), RCCE Officer (Sarah), Country Director (Afreen)
 - **READY Clinic Supervisors:** Isaiah (IDP Settlement #1 PHC) and Monica (Tamdu PHC)

THEMATIC AREA: PROGRAM DESIGN AND ADAPTATIONS

Question 1: Maintaining essential services is critical in an outbreak, but it can be challenging. Can you think of a time when you had to balance priorities in an outbreak? Did you have to deprioritize any activities or services in order to take on the additional response activities? How did you go about making those difficult trade-offs?

FACILITATOR NOTES:

- Ask prompting questions such as:
- Looking back, what would you have done differently? Was there additional information or context that would have helped you make those decisions?

Question 2: In the simulation, the outbreak shifted from being linked to contaminated simberri sap to primarily respiratory droplet transmission. How does a shift to primarily respiratory transmission change response efforts in an outbreak?

FACILITATOR NOTES:

- Possible things to consider:
 - Controlling respiratory droplet transmission requires interventions like masking, physical distancing, and improved ventilation, which present their own challenges.
 - Person-to-person transmission increases the size of the susceptible population at risk, since now it's not just those exposed to simberri sap.
 - Respiratory droplet transmission creates an increased risk to healthcare workers.
- Changes in personal protective equipment (PPE) and other infection and prevention control (IPC) measures are needed.
 - With respiratory droplet transmission, people may be exposed without realizing it. You typically cannot see respiratory droplets reaching your eyes/nose/mouth. In comparison, people know when they have consumed simberri sap, making exposure identification easier.
- In the simulation, cases were only contagious when symptomatic. Identifying possible exposures (including as part of contact tracing) is even more challenging when cases are infectious prior to developing symptoms.

Question 3: In this outbreak, the MoH chose not to use home-based care in part due to how deadly the virus was (among other factors). Depending on context, home-based care may be an effective solution. In what kinds of situations would home-based care be appropriate? If home-based care had been used in this outbreak, what are some considerations we would have to make?

FACILITATOR NOTES:

- Situations in which home-based care may be more appropriate:
 - Disease-specific factors:
 - Lower disease severity
 - Lower transmissibility
 - Factors like airborne transmission and pre- or asymptomatic transmission make controlling transmission significantly more challenging.
 - In wide community spread transmission scenario with high proportions of mild and moderate disease severity cases, managing all cases at a hospital/ITC would severely compromise the existing health system.
 - Home-based care may be a long-term solution or may provide a temporary reprieve. The health system may need more time to build out case management before taking responsibility for all cases.
 - If housing supports the isolation of cases from other family members.
 - If social support can be provided to cases at home.
- Considerations to make when implementing home-based care include (but are not limited to):
 - How to protect other household members (e.g., what if people share rooms or beds?)
 - Providing social support (e.g., food, medications, and other necessary supplies)
 - Establishing a referral pathway that includes a clear way for home-isolated cases to request and receive medical attention (e.g., a phone number to call).

- Effectively communicating to patients/families what home-based care is, how they can protect household members, when one should seek medical attention, and how they can request said medical attention.
- When might it be better for a case to be isolated at a facility, even if their illness doesn't necessarily require hospitalization (e.g., a case has relatively mild symptoms but is disabled and requires more daily support than household members can safely provide).

Question 4: In the simulation, the MoH decided to set up decentralized isolation and treatment centers (ITCs). Do you agree with this decision? What are the pros and cons of each approach?

FACILITATOR NOTES:

- Pros of decentralized ITCs include but are not limited to:** easier access by the community; if close to an existing facility, easier transport of patients from that facility to the ITC; possible increased trust by the community; could be tailored more to the needs of that specific community
- Cons of decentralized ITCs include but are not limited to:** multiple appropriate sites are required (which also necessitates increased resources for finding and assessing possible sites); resources (including staffing and supplies) are stretched across multiple sites; challenges for oversight of multiple sites vs. one

THEMATIC AREA: EPIDEMIOLOGY

Question 1: What are some factors that can bias, or influence, epidemiological data? For example, the initial Global Health Organization guidance said the Case Fatality Rate (CFR) of Enni Virus was 15%, but in the Thisland outbreak, the CFR is significantly higher. Why might that be? What other examples can you think of in the simulation?

FACILITATOR NOTES:

- Consider what proportion of cases are actually being identified and reported in Thisland. Data become less reliable the more cases are missing.
- Data biases include but are not limited to:
 - What is the testing rate (number of tests per population)?
 - What is the time delay between sample collection and results? Is your data relatively current, or is it a delayed picture of the outbreak?
 - Who is more likely to be tested, e.g., due to illness severity, access to health facility, or other physical or cultural factors that would influence the chance that someone would get tested?
 - For example, in some cultures, men may have lower health-seeking behavior and thus be less likely to be tested. In other cultures, women may have lower access to health facilities.
 - Is case data linked to case addresses, or solely to the health facility? For example, in the beginning of the simulation, the majority of the cases reported by Tamdu PHC were not actually from the town, but from outlying rural communities. If you only look at where the facilities are, rather than where the cases live, you may miss the true hotspot(s).
 - Data quality – How is the data collected (e.g., manually or electronically)? How complete is it? Has it been cross-checked or verified (if possible)?
- In the simulation, the CFR of the first outbreak in Kwaland was 15% when they identified all cases.

However, in the outbreak in Thisland, there were challenges identifying all cases (e.g., testing limitations, mistrust of health facilities, access to the clinics); instead, we were more likely to identify severe cases that had a higher chance of dying (leading to a higher CFR).

Question 2: At the beginning of Chapter 1, you had a chance to tell Onneetse, the READY health data management officer, to either actively reach out for case information from clinics or to wait for the next routine reports. Once the outbreak was announced, the MoH initiated active surveillance using CHWs. Passive and active surveillance have different strengths and limitations. When might you want to use one or the other?

FACILITATOR NOTES:

Passive Surveillance:

- Routinely gathering data from health providers, e.g., through monthly reporting.
- Most common surveillance system used.
- Advantages include: Requires fewer resources and time.
- Disadvantages include: Data is more limited. Underreporting is common. Reporting also occurs in longer intervals.

Active Surveillance:

- Involves requesting data from health facilities or community members.
- Often used when an outbreak is suspected or has begun.
- Advantages include: Often results in more timely and complete data. More in-depth data on the specific disease can be collected, at a higher frequency.
- Disadvantages include: Requires more resources and time.

Sentinel Surveillance:

- Involves collecting detailed data from select sources/health providers.
- Can help identify changes in disease incidence/epidemiology.
- Advantages: Allows more in-depth data to be collected with fewer resources than is required by more universal active surveillance.
- Disadvantages: Sentinel sites may not be representative of the larger population.

Question 3: If you or your organization has been involved in the implementation of community surveillance activities, what challenges did you face? How did you address them? Looking back, would you have done anything differently?

FACILITATOR NOTES:

Ask prompting questions such as:

- Who did you partner with?
- Who was conducting the surveillance activities in the community? Did they come from the same community, or were they from another community? If the latter, did this present any challenges?
- What training did staff/volunteers receive?
- How did you engage with the community before, during, and after the surveillance activities?
- Were there any logistical challenges like transport and communication?

Question 1: During the simulation, you had access to a trained RCCE Officer. However, many NGOs do not have a designated RCCE team. What knowledge, skills, or relationships do you or your organization need to develop to be prepared to undertake RCCE interventions at the outset of an outbreak? What actions might your organization take?

FACILITATOR NOTES:

- Ask prompting questions such as:
 - What skills do you or your organization need to develop or strengthen to do this work? How could you develop or strengthen them?
 - Social and behavior change
 - Community-led approaches
 - Data collection and analysis (e.g., rapid assessments, community feedback)
 - Selecting RCCE interventions and tailoring them to different audiences
 - Developing effective messaging
 - Managing rumors and uncertainty
 - Measuring program outcomes
 - What RCCE systems do you need to put in place now? (e.g., tools and resources such as survey tools for different outbreaks, standard operating procedures for community engagement during outbreaks, etc.)
 - What steps can you take to gain more participation from communities now?
 - What stakeholders should you coordinate with during the preparedness stage?
 - What community data would be useful in an outbreak? What steps can you take now to facilitate rapidly collecting and analyzing that data during an outbreak?
 - READY's RCCE Readiness Toolkit is a useful tool for NGOs to strengthen their RCCE readiness. <https://www.ready-initiative.org/rcce-readiness-kit/>

Question 2: At the beginning of an outbreak, staff and community members may be looking to you to provide them with information about the outbreak and how they can protect themselves. What are some important principles to consider when communicating at this early stage?

FACILITATOR NOTES:

- **Early** – Early communication in an outbreak is critical. People need to know about the outbreak and how to protect themselves and their families with the best information that is available. Also, our brains tend to put more weight on earlier information, and if we as official responding agencies don't communicate quickly enough, people will find information elsewhere (and that might not be accurate information).
- **Transparent** – Be transparent about what is known and unknown. Explain what you're doing to resolve the unknowns and when they will get additional updates.
- **Coordinated** – There should be a united front/message so that official agencies are not providing conflicting information.
- **Clear** – Messaging should be clear and easy to comprehend and remember. They must be communicated in the right language, literacy level, and format to reach vulnerable populations. Remembering the Rule of 3 is helpful -- Breaking messaging down into 3 key parts makes it easier for people to remember.

- Actionable** – Provide actionable steps people can take now to keep themselves and their loved ones safe.
- Adaptable**– Guidance may change as health officials get new information about the outbreak. People’s perceptions and practices may also shift, as may rumors and stigma. It is important to continuously listen to communities and adapt to the evolving changes.
- Targeted** – These messages should be tailored to the specific needs and concerns of different groups. Messages and materials should be pre-tested with a select subset of people to ensure comprehension and appropriateness.

Question 3: Community engagement during an outbreak can be very challenging. Sometimes things do not go according to plan, or have unintended consequences. Can you think of an example of a community engagement activity during an outbreak that went poorly? Why did it not go well, and what could have been done differently?

FACILITATOR NOTES:

- Community engagement activities can face challenges for a number of reasons including:
 - Implementing activities that are top-down, rather than community-led/bottom-up
 - Not engaging with that group early and often enough
 - Not identifying and collaborating with trusted sources
 - Using communication channels that are irrelevant or inappropriate for that group
 - Not pre-testing messages with a sub-group in advance
 - Not having an adequate understanding of the structural barriers and the group’s knowledge, attitudes, perceptions, and behaviors
 - Making assumptions about how a group might behave

Question 4: Different groups of people may face different challenges during an outbreak. This is especially the case for marginalized populations. What are some ways that you or your organization has included marginalized groups in past outbreaks? How did you tailor messaging and/or programming?

FACILITATOR NOTES:

- Ask prompting questions such as:
 - How did you identify these groups?
 - How did you ensure you engaged with them responsibly (e.g., language considerations, protecting privacy, getting parental/guardian consent, protecting against exploitation)?
 - How did you consider and incorporate their unique needs, challenges, and behavioral determinants such as knowledge, attitudes, practices, and so on?

Question 5: What are some ways that you or your organization has identified the trusted sources in a community and how have you engaged with them during an outbreak?

FACILITATOR NOTES:

- Ask prompting questions such as:
 - Did any of the trusted sources surprise you? If so, why?
 - Did you face any challenges identifying or engaging with trusted sources? What were they, why were they challenging, and how did you address them?
 - Some sources who are trusted in the community may not always be the most trusted for information about the outbreak. Did you have this experience?
 - Looking back, is there anything you wish you had done differently?

ANNEX 9

INFORMATION ON ENNI VIRUS DISEASE

Enni Virus Disease is a fictional disease based on real-life henipaviruses including Nipah Virus. Many aspects of transmission, symptoms, and challenges when testing and treating Nipah Virus were incorporated into our fictional virus. However, we made epidemiological adjustments (including increased transmissibility) as required to support the simulation's narrative and key learning objectives.

The following files from the simulation are included in this manual so that the facilitator can easily refer to key information about Enni Virus Disease. Participants can access these files in their File Explorer during Week 2 of Chapter 1.

- A.** Information on Enni Virus (EnV) and Enni Virus Disease (EnVD)
- B.** Initial Guidance on Enni Virus Disease (EnVD) Outbreak for Health Facilities



Global Health Organization

Information on Enni Virus (EnV) and Enni Virus Disease (EnVD)

Developed by the Global Health Organization

The following is general information and guidance about Enni Virus (EnV) and Enni Virus Disease (EnVD), developed following a small outbreak four years ago in Kwaland, a country to the north of Otherland. Please note that this serves as background information on EnV/EnVD to aid local health agencies in developing appropriate guidelines. Please refer to your local ministry of health for official guidance.

Clinical and Epidemiological Information on EnV/EnVD

Disclaimer: The outbreak in Kwaland occurred in a small rural community that had little interaction with other larger communities, so the outbreak was quickly contained. It is not known how this pathogen will react in communities that are more densely populated.

Signs and symptoms

Evidence suggests **all cases became symptomatic**. Symptoms, listed from most to least common among cases, included:

- Fever (100%)
- Cough (80%)
- Fatigue (70%)
- Headache (60%)
- Difficulty breathing, mild to moderate (50%)
- Myalgia (40%)
- Altered level of consciousness (37%)
- Vomiting (30%)
- Difficulty breathing, severe (25%)
- Seizures (20%)

Transmission

- Transmission was primarily associated with two types of exposure:
 1. Consuming **simberri sap** that had been contaminated by either saliva or urine of fruit bats infected with EnV.
 2. Direct contact with **large respiratory droplets** from people who are infectious.
 - Respiratory transmission in the last outbreak occurred primarily via large respiratory droplets. However, it is thought that certain environmental conditions (e.g., shouting, crowds, low ventilation) can lead to aerosolized transmission of EnV.
- There was no evidence of transmission via contact with dead bodies of infected individuals or via any other bodily fluids including blood, breastmilk, sweat, or seminal and vaginal fluids.
- There was no evidence that human cases were infectious before they became symptomatic. In other words, **there was no evidence of asymptomatic transmission.**
- $R_0 = 1.3$

Incubation period

- 4-14 days, median 8 days

Mortality

- 15% case fatality rate (CFR)
- Individuals aged 50 years and older were at greater risk of severe morbidity and mortality than other age groups.
- Note: In the prior outbreak, extensive case detection activities occurred, so the chance of missing cases was deemed by the authorities to be low.

General Guidance on EnV/EnVD

The following guidance should aid ministries of health in developing their own appropriate guidance.

Treatment

- There is currently **no EnVD-specific treatment or cure**.
- **Supportive treatment** is known to reduce morbidity and mortality:
 - Symptom management
 - Supplemental oxygen
 - Ventilation of those in severe respiratory distress

Isolation and Quarantine

- Cases should be **isolated for 14 days** after symptom onset and be fever free for at least 48 hours before ending isolation.
- Asymptomatic close contacts should **quarantine for 14 days**.
- There has been no evidence of ongoing transmission from cases post-isolation period.

Prevention and Control Measures

- Avoid consuming raw simberri sap. Boiling the sap into molasses makes it safe to consume.
- Avoid contact with bats.
 - The GHO strongly advises against harming bats in response to an EnVD outbreak. Bats are important pollinators and are vital for the local ecology. Bats will naturally avoid contact with humans. Destroying bats or their habitat will be detrimental to the local ecosystem and increase risk of zoonotic exposure.
- Avoid contact with people displaying EnVD symptoms.
- General respiratory precautions:
 - Wear face masks indoors.
 - Practice physical distancing.
 - Practice regular handwashing with soap and water.
 - Health care workers should wear N95 masks where possible when treating suspected or confirmed cases, since the GHO is still evaluating the potential for aerosolized transmission.
- Apply skirts (covers) over simberri collection containers to prevent contamination by bats.
- Isolate suspected cases immediately.
- Conduct rapid contact tracing and quarantine any close contacts.
- There is no vaccine yet available.



Initial Guidance on Enni Virus Disease (EnVD) Outbreak For Health Facilities

Thisland Ministry of Health

The Ministry of Health (MoH) has consulted with the Global Health Organization (GHO) to develop the following initial guidance for health facilities regarding the recent Enni Virus Disease (EnVD) outbreak.

Note: For definitions of “suspect case” and “confirmed case” please refer to the Case Definition section at the bottom of this document.

Disease Surveillance

- All health clinics in Northeast Province must screen patients for EnVD symptoms upon arrival.
- Suspect cases must be immediately referred to the district hospital.
- Thisland Relief and ASSIST Together will support the MoH’s Rapid Response Team (RRT) with active case surveillance and contact tracing.
- Points of Entry and Exit screening have been established between Murrelle and Myro to prevent EnVD from spreading to the capital.
- Otherland MoH has also established a screening checkpoint at northern border crossings.

Isolation of Cases

- People who develop symptoms should immediately self-isolate and travel to the nearest health facility as soon as possible for evaluation. People with symptoms should avoid public transportation and should wear masks when around another person. If private transportation is unavailable, call the EnVD hotline at 123.
- All individuals who meet the definition of a suspect case must be isolated for 14 days after symptom onset or until they are negative for EnVD via PCR testing.
- The district hospital in Murelle has converted a ward with 100 beds into an isolation and treatment center (ITC).
 - All suspect and confirmed cases will be referred to this facility for isolation.
 - Suspect and confirmed cases will be appropriately separated into different sections in the ITC.

Quarantine of Contacts

- All close contacts will be required to quarantine at home during the incubation period. Close contacts can end quarantine if it has been more than 14 days after their exposure and they have not developed any EnVD symptoms.
 - **Exception:** Health care workers who come into contact with a suspect or confirmed case, while wearing appropriate PPE (see Infection Prevention and Control section), are exempt from quarantining as long as they remain asymptomatic.
- Close contacts must mask around others while in quarantine.
- Close contacts should contact the EnVD hotline (123) if:
 - They develop symptoms.
 - They require transportation to the clinic.
 - They require other urgent medical attention.

Testing

- Oral swab samples from suspect cases will be tested for EnV via PCR testing, as long as testing is available.
- Sample collection and testing will occur at the ITC at the district hospital.

Infection Prevention and Control (IPC) Precautions for Health Workers

- Wear surgical masks at all times when treating patients not suspected to have EnVD.
- When treating a suspect or confirmed patient with EnVD, wear the following personal protective equipment (PPE):
 - Surgical masks
 - N95s during aerosol generating procedures
 - Eye protection
 - Gloves
 - Gowns/aprons
- Handwashing with soap and water, or use of an alcohol-based hand sanitizer that contains at least 60% alcohol.
- Chlorine 0.5% for contaminated surfaces and objects

Case Definition Enni Virus Disease (EnVD)

Confirmed case: An individual presenting with clinically compatible illness that is laboratory-confirmed via PCR test.

Suspect case: An individual who meets the criteria below:

Clinical Criteria

An individual with the following symptoms:

- Fever AND one of the following:
 - Altered level of consciousness
 - Seizures

OR

Clinical Criteria with an Epidemiological Link

An individual with the following symptoms:

- Fever AND one of the following:
 - Cough
 - Difficulty breathing

And at least one of the following exposure histories:

- Close contact with a confirmed or suspected case in the 14 days prior to symptom onset
 - Close contact defined as being within 6 feet of a confirmed or suspected case for at least 15 minutes
- Has consumed simberri tree sap in the last 14 days

ANNEX 10

ADDITIONAL RESOURCES

Looking for additional resources to improve your or your organization's outbreak preparedness and response? Check out the READY Initiative's website for resources on operational readiness, RCCE, child protection, and other important topics: www.ready-initiative.org.

READY Outbreak Readiness and Response Learning Hub: The READY Learning Hub provides a variety of courses, digital simulations, and resources for humanitarian actors to strengthen their readiness and response to major disease outbreaks. With over 60 technical and operational courses across a wide variety of topics, sectors, and providers, the READY Learning Hub (and included courses!) are available at no cost to users. The READY Learning Hub is available in [French](#), [Arabic](#), and [Spanish](#). (Check out the READY Learning Hub - www.ready-initiative.org/learning-hub/)

• Featured READY courses and simulations include:

- [WASH in Epidemics](#) - A 2-3 hour, free online eLearning course for all humanitarian responders, introducing learners to the role of WASH in preventing, mitigating, and breaking the transmission routes of infectious diseases commonly encountered in humanitarian settings.
- [IYCF-E Remote Counseling](#) - A one-hour, free online eLearning course for infant and young child feeding (IYCF) counselors, designed to equip learners with the knowledge and skills to remotely counsel clients to understand, adopt, and sustain optimal IYCF behaviors during infectious disease outbreaks and in other remote settings.
- [Outbreak READY! A Digital Readiness and Response Simulation](#) is strengthening the operational readiness of non-governmental organizations to respond to large-scale infectious disease outbreaks in humanitarian contexts. The purpose of Outbreak READY! is to improve the learner's ability to make data-driven and community-centered decisions in an outbreak response, and to help the learner understand the significant relationship between programmatic and operational readiness actions and response outcomes.

Resource Library: READY maintains and updates this library of multi-sectoral resources for outbreak readiness and response in humanitarian settings. The library is searchable by topic, disease, and resource type. Over 40 new tools and guides were recently added to this growing repository – take a look! (Check out the Resource Library - www.ready-initiative.org/resource-library/)

• Featured READY resources include:

- [Risk Communication and Community Engagement \(RCCE\) Readiness Kit](#). This guides users through outbreak preparedness and response phases and readiness actions to help them better prepare and plan to use RCCE in an outbreak response.
- [Infectious Disease Outbreak Response Coordination: An Introductory Guide for Non-Governmental Organizations](#). The purpose of this guide is to help NGOs understand the basic elements of a major disease outbreak response coordination.
- [Sexual and Reproductive Health and Rights during Infectious Disease Outbreaks: Operational Guidance for Humanitarian and Fragile Settings](#). This guidance provides practical advice for health staff undertaking infectious disease preparedness and response activities to ensure that the SRH needs of the population are met when an outbreak occurs.