World Health Organization

WHO Health Emergencies Programme

Quarterly Update
July to September 2019

Ebola Response North Kivu & Ituri
Democratic Republic of the Congo

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I. High level update– July to September 2019

Since July 2019, the Ebola outbreak has been successfully contained in several health zones in the DRC. Key public health achievements include an expansion of screening and contact tracing, strengthened infection prevention and control (IPC) operations, strengthening of Points of Entry, and intensified preparedness efforts in neighbouring countries. WHO continues to adapt its response efforts to a changing and challenging situation on the ground. This has included the implementation of new security measures to protect healthcare workers and improve community trust, as well as the development and deployment of the new field data collection tool Go.Data.

As of 1 July 2019, 2,354 confirmed and probable EVD cases were reported, including 1,586 deaths among confirmed and probable cases. During the three-month reporting period, a total of 840 confirmed and probable cases, as well as 550 deaths were reported, bringing the total as of 30 September to 3,194 cases and 2,136 deaths. The overall case fatality ratio (CFR) of 67% remained unchanged at the end of the reporting period.

During the last three weeks of the reporting period (11 September – 1 October) a total of 106 newly confirmed EVD cases were reported, compared with 242 reported during reported during the first three weeks (3 July – 23 July). The decline in case incidence over the past several weeks has been marked by a shift in transmission from urban settings to more rural, hard-to-reach communities across more geographically concentrated areas. While the decrease is encouraging, these trends should be interpreted with caution as localized security incidents have impeded response activities and timely reporting in some hotspot areas. The higher proportion of recent cases occurring in isolated, rural areas presents further challenges for reaching affected and at-risk populations and introduces additional uncertainty as to whether reported case numbers truly reflect the scope of the outbreak.

An increase in the number of reported cases is expected in the coming weeks as response activities resume in Lwemba Health Area (Mandima Health Zone), in which operations have been halted for more than one week due to unrest. This situation has resulted in a backlog of case reporting and impeded contact tracing efforts. Consequently, over 300 contacts in Mandima and Mambasa health zones have never been encountered or were lost to follow up. Efforts will continue to focus on stopping the chain of transmission in hotspot areas such as Mambasa, Mandima, and Kalunguta through early case detection, thorough investigation, contact identification and follow up, and engagement with the local communities.

II. Strategic Narrative by Sub-Pillar

As per SRP 4, activities cover the “public health operations” and “essential support operations to the response”, under the leadership of the Ministry of Health (MOH). They are grouped by sub-pillar of the response as follows:

Sub-pillar	Lead	Co-lead
1.1 Risk communication & community engagement	Ministry of Health /PNCPS	UNICEF
1.2 Surveillance, contact tracing & vaccination	Ministry of Health /DSE	**WHO**
1.3 Laboratory & research	Ministry of Health /INRB	**WHO**
1.4 Patient care, isolation & follow up of survivors	Ministry of Health /PNUAH	**WHO**

1.5 Infection, prevention & control	Ministry of Health /DNHP	**WHO-UNICEF**
1.6 Safe & dignified burials	Ministry of Health /DNHP	IFRC
1.7 Psychosocial care	Ministry of Health /PNSM, PRONANUT	UNICEF
1.8 Operational preparedness	Ministry of Health /DPS	**WHO**
1.9 Coordination	Ministry of Health	
1.10 Support to coordination	Ministry of Health /SG	**WB-OCHA-WHO**

1. Sub-Pillar: Surveillance, Contact tracing & Vaccination

Surveillance

Successful containment has been achieved in several former hotspots (e.g. Beni), as well as in high risk emerging clusters after little/no onward transmission: e.g. in major metropolitan Goma, Mwenga in South Kivu, and cross border in Uganda. These successes are in part due to strengthened surveillance and improved collaboration between response pillars and partners. The impact of improved surveillance and coordination was evident in the rapid response and containment demonstrated in major urban areas such as Mambasa and Goma.

During the reporting period, prioritized objectives under the surveillance pillar include strengthening investigation for all cases, streamlining contact follow-up, and reducing community transmission through earlier detection and isolation of cases. In support of this approach, protocols for improving integrated contact listing between surveillance and vaccination teams were developed and implemented, and vaccinated contacts are now being followed for 14 days following the last exposure. A progressive series of activities, including community-based surveillance, facility-based active case finding, and the prioritization of high-risk contacts have been realized towards the priority objectives and contributed to the following improvements:

- Median time from symptom onset to isolation decreasing from 5 days at the start of the reporting period to 3 days by week 39;
- 97% of alerts (3,242) investigated within 24 hours during week 39 compared with 92% of alerts (1,976) during week 27.
- An increase of contacts registered from 140,000 at the start of the reporting period to more than 221,000, and an average of 90% of contacts followed during the first and last weeks of the reporting period;
- Proportion of contacts lost to follow-up decreasing to 9%

Community-based Surveillance

WHO, together with the Ministry of Health (MoH) surveillance teams maintained the community-based surveillance implemented in Butembo, Katwa, Beni, Mambassa, Bunia, Mabalako and Komanda and more recently Goma and Mambasa. Community-based surveillance, which involves house-to-house visits, is activated in health areas that notify cases and continues up to 21-days after the last EVD case is isolated in the health area. Community members and “Relai Communautaires” are recruited, trained and given financial incentives to visit every household within their community to identify cases that could match the definition “possible case” (highly sensitive but simple definition). If a possible case is identified, an alert is given, through a specific phone number and reported to the epidemiologists in charge of the health area who will investigate and confirm the validity of the alert.

A validated alert corresponds to the definition of a suspect case and the person is then referred to a Transit Center (CT), Treatment center (CTE) and Decentralized Transit Center (CTD) (a small transit centre integrated in some health facilities) to be tested for Ebola Virus Disease (EVD). CTDs provide testing of EVD in places closer to the rural communities which facilitates the acceptance of being tested.

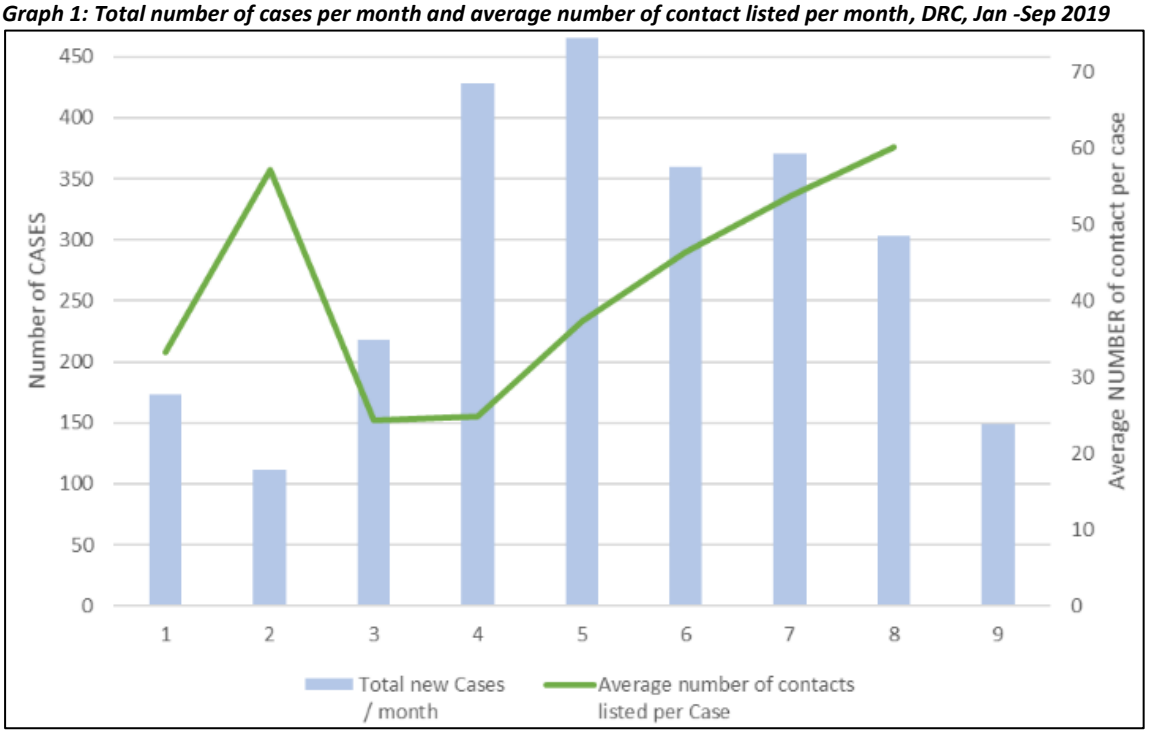
Facility-based Active Case Finding

Facility-based active case finding is implemented in all Sub-Coordination units. Case finding is either through the daily visits to health facilities, or through the head nurse of the facility alerting the epidemiologist in charge of the health area of a possible case, according to the Alert definition. An investigation team is then delegated to further investigate and validate the alert according to the Suspect case definition. During the reporting period (July 2019 to September 2019) the number of Alerts in the sub-coordination with active transmission continued to increase. However, a small decrease is observed in the months of August and September in some areas.

Contact tracing

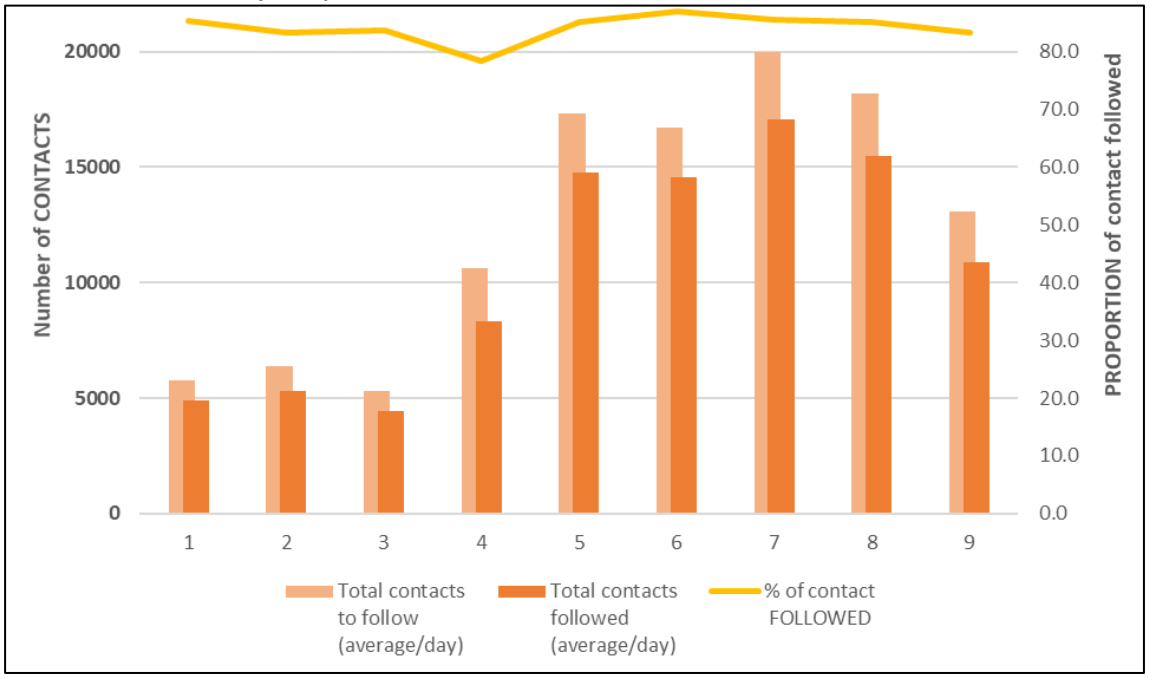
The listing of contacts has greatly and steadily improved from July to September. The proportion of cases not known decreased from 60% to 40% in August and to approximately 20% in September, which is a sign of improved listing of contacts.

Graph 1: Total number of cases per month and average number of contact listed per month, DRC, Jan -Sep 2019



Follow-up of contacts also increased dramatically in line with the increase in the number of cases passing from 5,000 contacts to follow per day in January up to 20,000 in the month of July. From July, with the decrease of cases, the total number of contacts also decreased, but the proportion of contacts followed was maintained above 80%

Graph 2: Daily average of the total number of Contact to follow and number of contact seen, and proportion of contact seen, DRC, January to September 2019



Lost to Follow-up Unit (LTFU)

The lost-to-follow-up unit was implemented in December 2018, and has grown in staff, activities and organization since then. In principle, the LTFU cell is composed of surveillance and Point-of-Entry focal points, psychologists and communicators who support the persons traced to explain the necessity of staying in contact and possibly returning to their place of origin, where daily monitoring and care is organized and available. In response to the cases reported in Goma in August, a large LTFU team was rapidly established at the sub-coordination level and jointly led by government and WHO. In addition, LTFU is supported by the national police, the National Office of Migration, the National Office of Internal Security (ANR), members of the civil society and MONUSCO agents. The LTFU works with phone providers to track high risk contacts, with the support of the MONUSCO police. For each specific case, authorization of the Ministry of Justice is sought.

The Sub-coordination unit communicates daily to the EOC the contact details of displaced, LTFU and 'never seen' contacts. For the displaced, coordination is also made directly with the sub-coordination unit of the contact's new location. If the contact returns to a non-affected area, the local MoH is informed and tracing is coordinated with the EOC Goma cell. Lost or displaced contacts are sought for up to 42 days. The general principle is to return all contacts to their place of origin to prevent the onset of symptoms in a non-affected health zone. Units are fully functional in the cities of Goma and Beni. In Mangina and Bunia, each unit functions with the support of an epidemiologist working with civil society, as well as member of the ANR and the national police.

Go.Data

Go.Data, a new contact tracing tool has been successfully deployed to the field. Developed in collaboration between WHO and GOARN partner institutions, the primary focus of Go.Data software is on case and contact data, including the visualization of chains of transmission and contact follow-up. Deployed at the beginning of August 2019, Go.Data rollout started in Beni Health Zone, commencing from AS Mabolio, and gradually expanding to other AS within Beni. Plans are in place to roll out Go.Data to other Health Zones in DRC, starting from hotspot health

areas with an ongoing transmission and where new cases and contacts are being reported. In addition, Go.Data is also in use in Uganda to support EVD Response activities in Kasese. It is critical to improve contact enumeration and tracing overall and in current hotspots to decrease delays from onset to isolation.

In addition, a team of 2-3 senior epidemiologists will be deployed in hotspot areas to support/ mentor epi teams on the ground to improve alert systems, and adapt alert strategy in current hotspots, especially with regards to community deaths, improve case investigation, and improve documentation of transmission chains.

KPI	Indicator description	Target	Achieved
Surveillance & Contact Tracing	Proportion of investigations completed within 24 hours of alert verification	100%	97%
	Proportion of contacts followed within the last 24 hours	100%	88%
	Proportion of contacts lost to follow-up	0%	9%
	Time between symptom onset and isolation	≤ 4 days	3
	Proportion of new cases that were known contacts and followed	100%	88%

Points of Entry and Control

During the reporting period of 1 July to 30 September 2019, over 30 million screenings were performed, resulting in 1,630 alerts. Following investigations, 611 were validated as suspect cases, and 7 were subsequently confirmed with EVD. Overall, 89% of functioning POEs and POCs reported screening daily during this period. At the beginning of July 2019, 85 POEs and POCs were operational in 9 provinces; 50 of them were in and around affected health zones and are classified under “Sphere 1”.
By the end of September 2019, 117 POEs and POCs are operational, 108 of which are in Sphere 1. The definition of Sphere 1 was also expanded to include all health zones with POE/POC operations in the three affected provinces: North Kivu, Ituri and South Kivu. The expansion of POE/POC operations, both in numbers as well as geographical coverage was necessary considering the evolution of the outbreak.

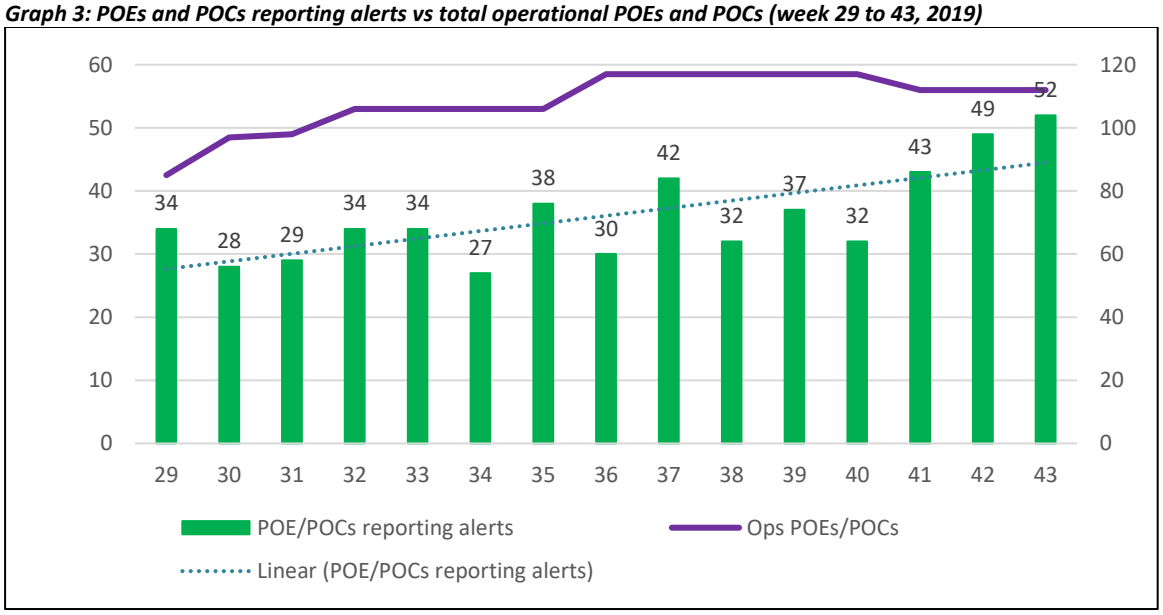
Despite the geographical expansion and increase in number of POEs and POCs, the proportion of alerts generated by POEs and POCs which are investigated within two hours of notification has remained similar at around 95%; efforts continue to be made to push this figure to 100%. Below is a monthly breakdown of screening at POEs and POCs.

	# of alerts from POEs/POCs	# of validated alerts from POEs/POCs	# EVD cases	# of POE/POC screenings
Jul	455	199	3	9,788,773
Aug	564	195	2	10,138,646
Sep	611	217	2	10,699,123
Total	**1,630**	**611**	**7**	**30,626,542**

During this reporting period, the number of health zones with operational POEs and POCs where targeted risk communication activities were implemented increased from 16 to 27. Targeted POE/POC risk communication activities include awareness sessions targeting communities living around POEs and POCs, as well as transportation and hospitality service providers to travellers

(bus companies, moto taxi unions, restaurants and accommodations frequented by travellers at congregation/transit points); they aim to increase awareness on the importance of, and adherence to, traveller screening, as well as encourage sick individuals not to travel. There are still seven health zones with POE and POC operations where these activities are not yet taking place. All operational POEs and POCs have at least one locally recruited staff. This was done to build local trust to POE/POC operations.

Graph 3: POEs and POCs reporting alerts vs total operational POEs and POCs (week 29 to 43, 2019)



The large volume of travellers passing through certain POEs and POCs also poses difficulties in the implementation of screening; travellers are also less likely to adhere to screening as they pass through multiple POEs and POCs along the same journey. As contact tracing activities are integrated in POE/POC operations, more effective ways to identify contacts among travellers, including the selection of most strategic POEs and POCs for the implementation of this activity are needed, and work is already ongoing to test new approaches (coordinated by WHO, PNHF – the national border health program, and IOM). These new approaches are monitored weekly and the next evaluation will be done at end of year. An update will be provided in the next quarterly report.

KPI	Indicator description	Target	Achieved
	Proportion of entry and checkpoints with uninterrupted operations within the last 7 days	100%	98%