

EBOLA VIRUS DISEASE

Democratic Republic of the Congo

External Situation Report 13



EBOLA VIRUS DISEASE

Democratic Republic of the Congo

External Situation Report 13

Date of issue: 30 October 2018

Data as reported by: 28 October 2018

1. Situation update



The Ebola virus disease (EVD) outbreak in North Kivu and Ituri provinces, Democratic Republic of the Congo continues to be closely monitored by the Ministry of Health (MoH), WHO and partners. Of concern is the increased incidence of confirmed cases reported in the past four weeks, most notably in the city of Beni and communities around Butembo. Security remains the biggest challenge faced by the response teams in Beni and Butembo, undermining the response activities. Continued security incidents severely impact both civilians and frontline workers, forcing suspension of EVD response activities and increasing the risk that the virus will continue to spread. Moreover, with heightened transmission of the virus in outbreak affected areas, the risk of exportation of cases to neighbouring provinces and countries is increased. Neighbouring countries need to be ready in case the outbreak spreads beyond the Democratic Republic of the Congo.

Since WHO's last situation report issued on 23 October 2018 (*External Situation Report 12*), an additional 36 new confirmed EVD cases and 19 new deaths have been reported. As of 28 October 2018, a total of 274 confirmed and probable EVD cases, including 174 deaths, have been reported – a case fatality ratio (CFR) of 63.5%. Among the 274 cases, 239 are confirmed and 35 are probable cases. Of the 174 deaths reported since the beginning of the outbreak, 139 were among confirmed cases and 35 among probable cases. The proportion of deaths among confirmed cases is 58.2% (139/239). On 28 October, 32 new suspected cases were under investigation in Beni (22), Mabalako (3), Butembo (3), Mandima (2), Masereka (1) and Kalunguta (1).

As of 28 October 2018, 73 cases have recovered, been discharged from Ebola treatment centres (ETCs), and re-integrated into their communities. On 28 October, 32 new patients were admitted to ETCs, bringing the total of hospitalized patients to 77 (45 suspected cases and 32 confirmed cases). On that day, the ETCs in Beni and Butembo recorded a bed occupancy rate of 85% (51/60) and 70% (13/30), respectively.

Among the 271 cases with known age and sex, 56% (n=153) are female, and adults aged 15-44 account for 57% (n=155) (Figure 2). Four new confirmed cases have been reported among healthcare providers (one doctor and 3 nurses) working at various community health centres around Beni, bringing the total health workers affected to 25, including 24 confirmed and three deaths.

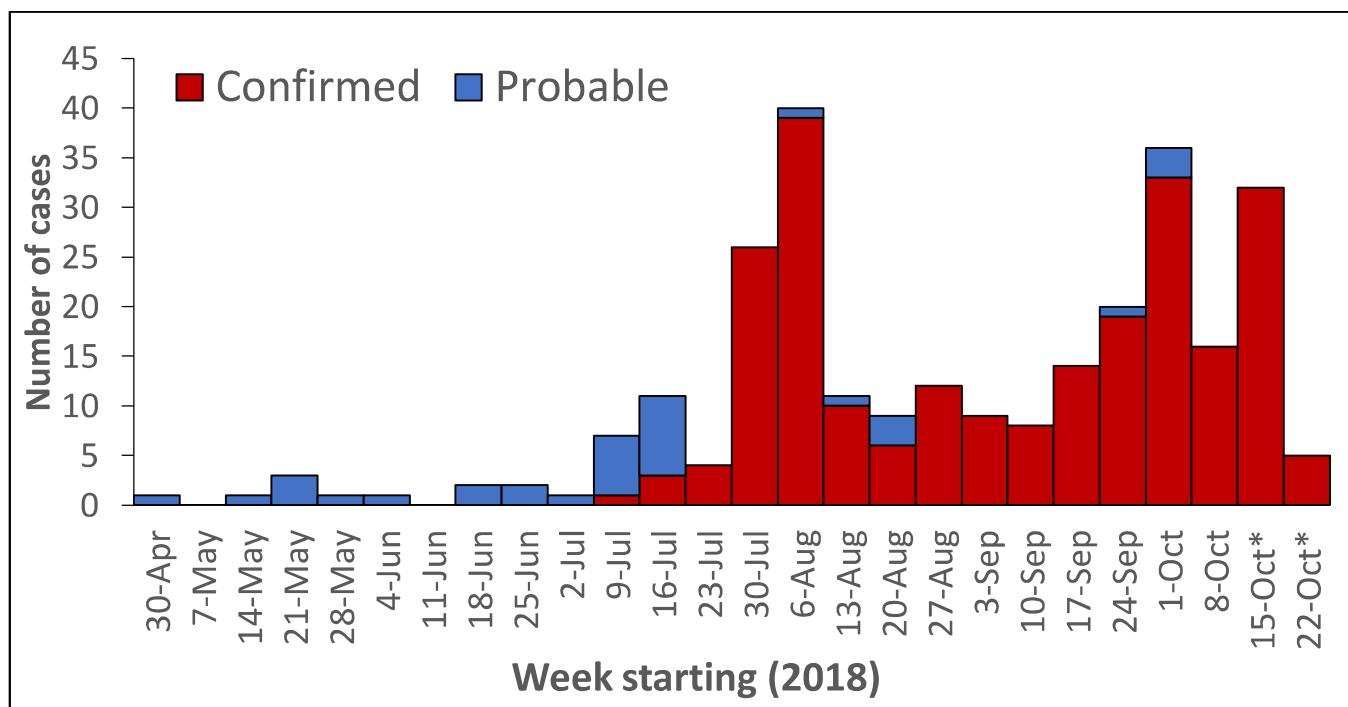
The confirmed cases were reported from six health zones in North Kivu Province: Beni (124), Mabalako (71), Butembo (24), Masereka (4), Kalunguta (2), and Oicha (2); and three health zones in Ituri Province: Mandima (9), Tchomia (2) and Komanda (1). Beni has surpassed Mabalako in terms of cumulative number of confirmed cases.

The MoH, WHO and partners are monitoring and investigating all alerts in affected areas, in other provinces in the Democratic Republic of the Congo and in neighbouring countries. Since the last report was published, alerts were investigated in several provinces of the Democratic Republic of the Congo as well as in the Gambia, South Sudan, Tanzania, and Uganda. To date, EVD has been ruled out in all alerts from neighbouring provinces and countries.

Table 1: Ebola virus disease cases by classification and health zones in North Kivu and Ituri provinces, Democratic Republic of the Congo, as of 28 October 2018

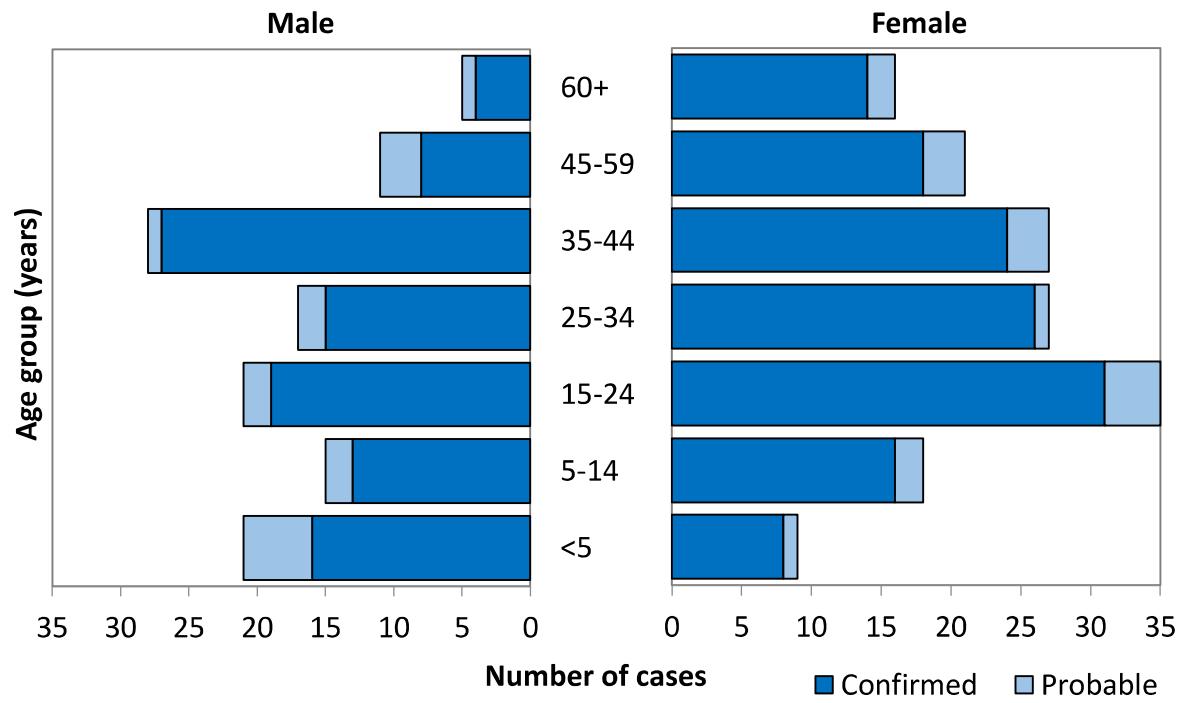
Case classification/ status	North Kivu							Ituri			Total
	Beni	Butembo	Oicha	Mabalako	Musienene	Masereka	Kalunguta	Komanda	Mandima	Tchomia	
Probable	8	2	1	21	1	0	0	0	2	0	35
Confirmed	124	24	2	71	0	4	2	1	9	2	239
Total confirmed and probable	132	26	3	92	1	4	2	1	11	2	274
Suspected cases currently under investigation	22	3	0	3	0	1	1	0	2	0	32
Deaths											
Total deaths	84	14	1	67	1	1	1	0	3	2	174
Deaths in confirmed cases	76	12	0	46	0	1	1	0	1	2	139

Figure 1. Confirmed and probable Ebola virus disease cases by week of illness onset, data as of 28 October 2018 (n=272)*



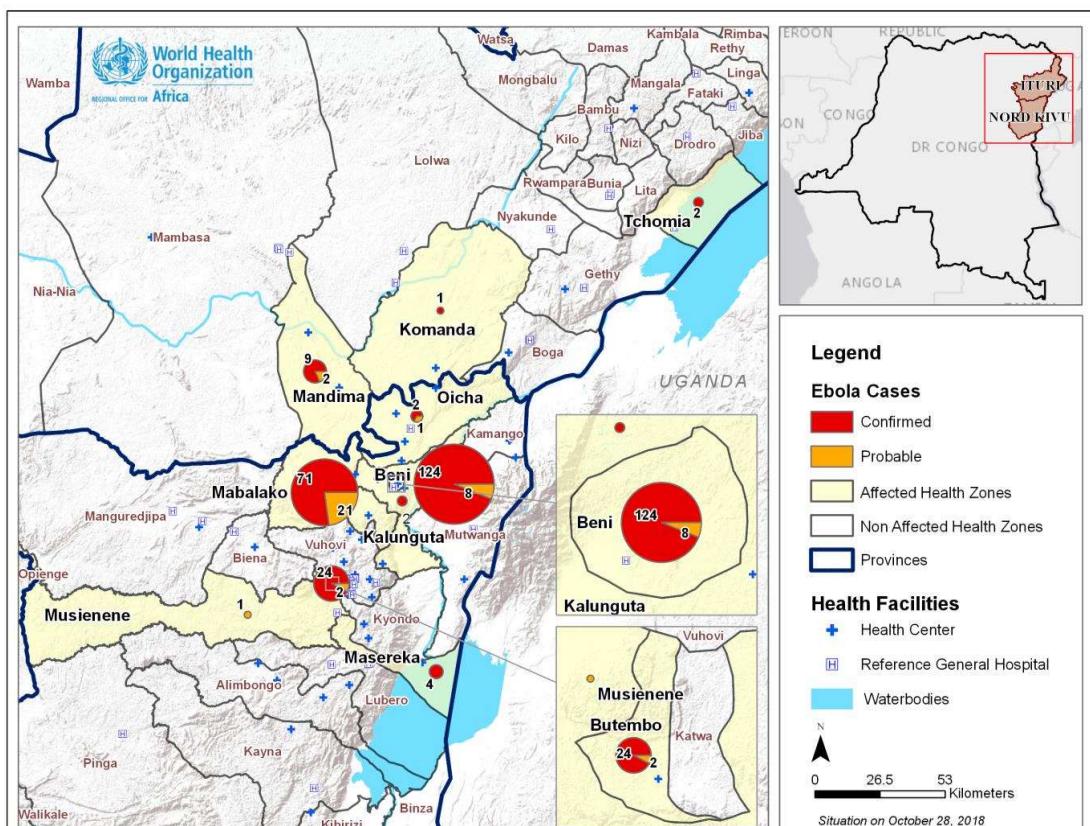
*Week of onset is currently unknown for n=2 cases. Case counts in recent weeks may be incomplete due to reporting delays.

Figure 2: Confirmed and probable Ebola virus disease cases by age and sex, North Kivu and Ituri provinces, Democratic Republic of the Congo, as of 28 October 2018 (n=271)



*Age/sex is currently unknown for n=3 cases.

Figure 3: Geographical distribution of confirmed and probable Ebola virus disease cases in North Kivu and Ituri provinces, Democratic Republic of the Congo, 28 October 2018 (n=274)



Context

North Kivu and Ituri are among the most populated provinces in the Democratic Republic of the Congo. North Kivu shares borders with Uganda and Rwanda. The provinces have been experiencing intense insecurity and a worsening humanitarian crisis, with over one million internally displaced people and continuous movement of refugees to neighbouring countries, including Uganda, Burundi and Tanzania. The Democratic Republic of the Congo is also experiencing multiple disease outbreaks, including three separate outbreaks of circulating vaccine-derived poliovirus type 2 (cVDPV2) in the provinces of Ituri, Mongola, Maniema and Haut Lomami, Tanganyika and Haut Katanga, and outbreaks of cholera, measles and monkeypox spread across the country.

Current risk assessment

This outbreak of EVD is affecting north-eastern provinces of the Democratic Republic of the Congo, which border Uganda, Rwanda and South Sudan. Potential risk factors for transmission of EVD at the national and regional levels include: the transportation links between the affected areas, the rest of the country, and neighbouring countries; the internal displacement of populations; and the displacement of Congolese refugees to neighbouring countries. The country is concurrently experiencing other epidemics (e.g. cholera, vaccine-derived poliomyelitis), and a long-term humanitarian crisis. Additionally, the security situation in North Kivu and Ituri may hinder the implementation of response activities. On 28 September 2018, based on the worsening security situation, WHO revised its risk assessment for the outbreak, elevating the risk at national and regional levels from high to very high. The risk remains low globally. WHO continues to advise against any restriction of travel to, and trade with, the Democratic Republic of the Congo based on currently available information.

Given the current context around the outbreak, including the volatile security situation, community resistance, the continued reporting of confirmed cases, and the risk of spread of the outbreak to neighbouring countries, the first International Health Regulation (IHR) Emergency Committee on the Ebola Virus Disease (EVD) outbreak in North Kivu, Democratic Republic of the Congo (DRC), was convened on 17 October 2018. At the end of the meeting, the Emergency Committee decided that the current EVD outbreak does not constitute a public health emergency of international concern at this time; although the outbreak is still deeply concerning and the risk of spread to neighbouring countries remains very high. The Emergency Committee has made a series of recommendations to address this situation. This will require resources to be made available immediately not only for the intensification of the response, but also for preparedness in surrounding provinces and countries. The committee also recognized that the complex security situation, including mistrust of some of the population, is a severe complicating factor for the response. The Committee commended the government of the DRC, WHO, and all response partners for the progress made under difficult circumstances.

Strategic approach to the prevention, detection and control of EVD

WHO recommends the implementation of proven strategies for the prevention and control EVD outbreaks. These include (i) strengthening the multi-sectoral coordination of the response, (ii) enhancing surveillance, including active case finding, case investigation, contact tracing and surveillance at Points of Entry (PoE), including adapting strategies to the context of insecurity and high community resistances(iii) strengthening diagnostic capabilities, (iv) improving the effectiveness of case management, (v) scaling up infection prevention and control support to health facilities and communities, (v) adapting safe and dignified burials

approach to the context with the support of anthropologists, (vi) adapting and enhancing risk communication, social mobilization and community engagement strategies, (vii) enhancing psychosocial support to the affected population (viii) improving coverage of risk groups by the ring vaccination.

2. Actions to date

An updated response plan was launched by the MoH of the Democratic Republic of the Congo on 18 October 2018. The plan lays out the approach for the response over coming months, with a greater focus on building local capacity to manage the response.

Surveillance

- ➔ A review of surveillance activities highlighted a number of challenges in case and contact detection and investigation, as well as in data management. WHO is working closely with the MoH at the field level, with remote analytical support provided by the WHO Regional Office for Africa and headquarters to address these. At the field level, strategies and standard operation procedures (SOPs) are being revised and staff retrained, to optimise systems and processes, better integrate activities of contact tracing and vaccination teams, enhance active case searching, and improve data management. Investigations continue around the latest confirmed cases not originating from known transmission chains.
- ➔ Over 15 000 contacts have been registered to date, of which 5991 contacts are under surveillance on 28 October 2018. The daily proportion of contacts successfully followed over the past week was 92% for all health zones. For Beni health zone only, the daily proportion of contacts successfully followed over the past week was 91%.
- ➔ The number of alerts reported daily continues to increase with the enhancement of case detection and active case searching at community and health facility levels. On average during the past week, investigators responded to 155 (range: 136-210) alerts reported per day, of which an average of 47 (range: 37-59) were validated as suspected cases for further investigation and testing.

Case management

- ➔ ETCs continue to provide therapeutics under the monitored emergency use of unregistered and experimental interventions (MEURI) protocol, in collaboration with the MoH and the Institut National de Recherche Biomédicale (INRB) together with supportive care measures. WHO is providing technical clinical expertise on-site and is assisting with the creation of a data safety management board.
- ➔ New patients continue to be treated in ETCs. All confirmed cases managed at ETC level have received an investigational therapeutic after evaluation by clinical expert committee, unless they died soon after arrival. All hospitalized patients received food and psychological support. A total of 109 patients have received treatment thus far.
- ➔ The Beni ETC managed by ALIMA has been expanded to a total of 60 beds. The ETC Butembo was expanded to 30 beds.

Infection prevention and control (IPC) and Water, Sanitation and Hygiene (WASH)

- ➔ There is reinforcement of the support for health structures in the implementation of infection, prevention and control (IPC) measures in Beni, with 10 IPC-WASH kits distributed in Beni (8), Butembo (1) and Komanda (1).
- ➔ Decontamination of health facilities as well as households continue to be performed where new cases are identified, along with supervision of IPC activities in health structures in Beni (9) and Mabalako (4).
- ➔ Four households, (3 in Beni and 1 in Butembo) have been decontaminated in connection with the last confirmed cases.
- ➔ Training of healthcare providers on IPC measures is continuing and IPC kits have been provided to health structures.
- ➔ IPC training and PPE kit distribution has also started to include practitioners in private FOSAs and traditional facilities.

Points of Entry

- ➔ Monitoring and sanitary control continues at entry points. On 28 October 2018, 62 of the 65 Points of Entry (PoEs) were functional with 162 794 travellers screened; a total of 11.5 million travellers have been screened since the beginning of the outbreak.
- ➔ The Kangote Butembo Health Checkpoint was disrupted by security incidents on the evening of 26 October.
- ➔ As of 28 October, 89 alerts have been reported from PoEs; 10 were sent for laboratory testing and all were negative for EVD.
- ➔ Joint supervision by Department of Cross-border health, MoH and IOM started at the PoEs in Pasisi and Mukulia in Beni.
- ➔ A new PoE in Ksangani and a new Point of Control in Mangina were installed with the support of UNICEF.
- ➔ In follow-up with the East African Union Cross-border meeting from 3-4 October 2018, a partners' workshop will take place on 7-9 November 2018, to review the SOPs for EVD cross-border screening. WHO, US CDC, CDC Africa, IOM, FHI 360 and others will participate. Following the workshop, the MoH will likely share the revised SOPs with neighbouring countries for harmonization, contextualization and/or usage.
- ➔ IOM will start operational research on the effectiveness of surveillance at PoEs during EVD outbreaks in mid-November.

Safe and Dignified Burials (SDB)

- ➔ Security remains a concern in Beni and Butembo, with consequences for SDB activities. Red Cross teams have resumed activities in Butembo for the first time since the security incident on 2 October 2018.

- ➔ In Beni Red Cross (RC) and Civil Protection (CP) teams are working in close coordination to ensure sufficient operational coverage for SDB.

Implementation of ring vaccination protocol

- ➔ As of 28 October 2018, a total of 24 142 people have been vaccinated since 8 August, including 12 464 in Beni, 4 391 in Mabalako, 1 962 in Katwa, 1 663 in Mandima, 1 295 in Butembo, 690 in Masereka, 434 in Bunia, 355 in Tchomia, 240 in Komanda, 227 in Kalunguta, 160 in Musienene, 121 in Oicha, 100 in Mutwanga et 40 in Vuhovi.

Risk communication, social mobilization and community engagement

- ➔ A total of 19 psycho-education sessions were held in Beni, Mabalako, Mandima, Butembo and Masereka, reaching 1 462 people, with the intention to raise awareness about EVD, to address rumours and engage with communities to avoid reluctance and resistance to response measures.
- ➔ A total of 1 734 people were sensitized on EVD during the community re-integration of 12 patients who recovered from Ebola and were discharged from ECTs in Beni.
- ➔ Community discussions on the importance of safe and dignified burials reached 117 people, following two deaths in the districts of Kalinda and Macampagne in Beni.
- ➔ A total of 36 local media outlets (10 in Beni, 3 in Mabalako, 8 in Butembo, 5 in Masereka, 2 in Tchomia, 2 in Musienene, 2 in Vuhozi and 4 in Oicha) broadcast daily messages about the response to EVD.
- ➔ Risk communication, social mobilization, and community engagement continues to support all response pillars through dialogue and sensitization to improve vaccine acceptance, negotiations during surveillance activities, training activities for medical staff and traditional practitioners on alert reporting, dialogue with patients and families at the Ebola treatment unit, reintegration support for discharged patients (non-cases and survivors), sensitization at points of entry, and training for hygienists on risk communication and rumour management.

Operational partnerships

- ➔ Under the overall leadership of the MoH, WHO is supporting all major pillars of the EVD preparedness and response. WHO is working intensively with wide-ranging, multisectoral, and multidisciplinary regional and global partners and stakeholders for EVD response, research, and preparedness.
- ➔ Several international organizations and UN agencies are involved in response and preparedness activities; the organizations and specific contributions are noted below.
 - **European Civil Protection and Humanitarian Aid Operation (ECHO):** MEDEVAC, logistics and operational support
 - **International Organization for Migration (IOM):** cross-border preparedness
 - **UK Public Health Rapid Support Team:** supporting deployments through GOARN (see below)

- **United Nations Children's Fund (UNICEF)**: community engagement and social mobilization; vaccination
 - **UN High Commission on Refugees (UNHCR)**: cross-border preparedness and PoE
 - **World Bank** and regional development banks: medical support
 - **World Food Programme (WFP)** and **UN Humanitarian Air Service (UNHAS)**: nutrition assistance; logistical and operational support
 - **UN mission**: logistical assistance and, together with **UN Department of Safety and Security (UNDSS)**, ensuring the safety of staff on the ground
 - Additional UN agencies include the **Inter-Agency Standing Commission**, the **United Nations Office for the Coordination of Humanitarian Affairs (OCHA)**, and the **United Nations Population Fund (UNFPA)**.
- ⇒ WHO is engaging **Global Outbreak Alert and Response Network (GOARN)**, **Emerging and Dangerous Pathogens Laboratory Network (EDPLN)**, **Emerging Disease Clinical Assessment and Response Network (EDCARN)**, and the **Emergency Medical Team (EMT)** initiative – as well as regional operational partners and collaboration centres in Africa – to deploy experts and multidisciplinary teams for the response, and to support intensive preparedness and readiness activities in neighbouring and at-risk countries.
- ⇒ Specialized agencies participating in Ebola response include:
- **Africa Centres for Disease Control**: Deployment of health professionals (of various professional categories and seniority levels) to support surveillance and contact tracing, training of local health workers in IPC and social mobilization activities; laboratory services; Central Coordination in Kinshasa; and support with laboratory diagnostic equipment.
 - **US Centers for Disease Control (CDC)**: Supporting deployments via GOARN; supporting incident management operations through staff deployments.
 - **UK Department for International Development (DFID)**: Supporting surveillance, IPC, risk communication, and community engagement.
 - **United States Agency for International Development (USAID)**: Supporting surveillance, infection protection and control, risk communication and community engagement, safe and dignified burials, coordination.
- ⇒ Non-governmental organizations involved in Ebola response are:
- **Adeco Federación (ADECO)**: Supporting IPC, risk communication, and community engagement.
 - **Association des femmes pour la nutrition à assise communautaire (AFNAC)**: Supporting IPC, risk communication, and community engagement.
 - **Alliance for International Medical Action (ALIMA)**: Supporting patient care and vaccination.
 - **CARITAS DRC**: Supporting vaccination, risk communication, and community engagement.
 - **CARE International**: Supporting surveillance, IPC, risk communication, and community engagement in DRC; CARE International is also supporting Ebola preparedness in Uganda.
 - **Centre de promotion socio-sanitaire (CEPROSSAN)**: Supporting surveillance, infection prevention and control, risk communication, and community engagement.
 - **Cooperazione Internationale (COOPE)**: Supporting infection prevention and control, risk communication, and community engagement.
 - **Catholic Organization for Relief and Development Aid (CORDAID/PAP-DRC)**: Supporting infection prevention and control, risk communication, and community engagement.
 - **International Medical Corps**: supporting surveillance, infection prevention and control, and patient care.
 - **International Rescue Committee (IRC)**: Supporting infection prevention and control, risk communication, and community engagement.
 - **INTERSOS**: Supporting surveillance, and infection prevention and control.

- **MEDAIR:** Supporting surveillance, and infection prevention and control.
- **Médecins Sans Frontières (MSF):** Supporting infection prevention and control, and patient care.
- **Oxfam International:** Supporting vaccination, community engagement and social mobilization, infection prevention and control, and patient care.
- **Red Cross of the Democratic Republic of Congo,** with the support of the **International Federation of Red Cross and Red Crescent Societies (IFRC)** and **International Committee of the Red Cross (ICRC):** Supporting infection prevention and control, safe and dignified burials, risk communication, and community engagement.
- **Samaritan's Purse:** **Supporting infection prevention and control as well as risk communication and community engagement.**
- **Save the Children International (SCI):** Supporting surveillance, infection prevention and control, risk communication, and community engagement.

Detailed weekly updates for the period 15-21 October have been provided by the following partners:

IOM

Democratic Republic of the Congo:

- IOM continues to support operations at 32 key PoEs, with flow monitoring being conducted at 16 sites and ongoing support to the National Program of Hygiene at Borders (PNHF).
- A revised PoE Supervision Checklist has been validated in the field and will be rolled out on 1 November.
- Delayed payments of government PoE staff salaries in Ituri and North Kivu sites remain a challenge for ongoing operations.

South Sudan:

- As of 28 October, a total of 12 752 individuals have passed through four active PoEs supported by IOM in South Sudan on the border with the Democratic Republic of the Congo with zero case alerts to date.
- IOM is preparing for the activation of two additional PoEs at Khorijo Internally Displaced Persons (IDP) Camp and Pure (Kajo Keji) in coordination with the Border Health Technical Working Group and in consultation with local commissioners, community leaders and County Health.

Red Cross

- In the past seven days, 54 SDBs alerts were received; of these, only three were unsuccessful and one was not completed.
- In Beni, participation in several communication sessions to engage various stakeholders in SDB activities and identify the challenges faced by the teams in the field. In Butembo, a briefing meeting was organized for the community leaders in SDB. Two SDBs were conducted without any incident in the communities within the town where there had previously been resistance.
- In Beni, the RC supported an IPC re-evaluation of five health facilities (FOSA).
- In Beni, a training was held for 28 volunteers on community engagement activities and risk communication. The second interactive radio show focus on SDB was produced. Door-to-door sensitization activities were conducted by 54 volunteers, plus the 28 newly-trained volunteers, twice a week. Mass sensitization is done in Beni and Oicha three times a week.
- In Bunia, sensitization activities are held twice a week.
- In Tchomia, a training on community engagement activities was held for 34 volunteers.
- In Butembo, door-to-door sensitisation activities reached 5345 people in 1412 households.
- In Beni, 48 volunteers for SDB and community engagement activities attended two briefing sessions on Psychological First Aid (PFA).

WHO encourages wider coverage of partner operations via this report in response to demand from our planning teams. If you would like to see the activities of your agency or organization appears in the report, please send an email to goarn@who.int.

IHR travel measures and cross border health

- WHO advises against any restriction of travel and trade to the Democratic Republic of the Congo based on the currently available information. WHO continues to closely monitor and, if necessary, verify travel and trade measures in relation to this event.

3. Conclusion

The cumulative number of EVD cases (confirmed and probable) reported in this outbreak has surpassed the number of cases reported during the 2007 outbreak in Mweka (264 cases including 187 deaths). The number of confirmed EVD cases is still increasing, especially in Beni and communities in and near Butembo city. Security incidents and community resistance also delay the implementation of response measures. These challenges highlight the need to keep strengthening community engagement activities (including partnership with armed groups). Furthermore, the recent confirmation of four EVD infections among health workers is concerning and shows that IPC measures need to be reinforced in all healthcare structures in the affected areas. Infection of healthcare workers increases the potential for transmission within healthcare settings, and also from health facilities to the surrounding community.