

EBOLA VIRUS DISEASE

Democratic Republic of the Congo

External Situation Report 11



World Health
Organization

REGIONAL OFFICE FOR

Africa

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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. Significant improvements have been made over the past weeks, including strong performances by field teams conducting vaccinations and improved community engagement and risk communication in priority areas. However, as new cases continue to emerge from both Beni and near Kasenyi, which is in a security 'red zone' and close to internally displaced person (IDP) camps, it is clear that risks remain and that strong response measures need to be maintained. This is largely due to security conditions that severely impact both civilians and frontline workers, at times forcing suspension of EVD response activities and increasing the risk that the virus will continue to spread. There is evidence of ongoing transmission within communities, particularly in Beni. For more than half of new cases, investigations are ongoing to establish epidemiological links. Neighbouring countries continue to receive support to improve their readiness capacities for potential threats of EVD. Additional resources are necessary to both expand the response in the Democratic Republic of the Congo and increase preparedness in border nations. The MoH, WHO and partners continue to rapidly adapt to these challenging circumstances, with over 250 staff on the ground scaling up all pillars of the response – surveillance, contact tracing, community engagement, lab testing, infection prevention and control, safe and dignified burials, vaccination, and therapeutics.

Since WHO's last situation report on 9 October 2018 ([External Situation Report 10](#)), an additional 35 new confirmed EVD cases and 24 new deaths have been reported. As of 15 October 2018, a total of 216 confirmed and probable EVD cases, including 139 deaths, have been reported, resulting in a global case fatality ratio (CFR) of 64% (Table 1). Among the 216 cases, 181 are confirmed and 35 are probable. Among the 139 deaths, 104 are among confirmed cases and 35 among probable cases. The CFR among confirmed cases was 57% (104/181). On 15 October, a total of 32 new suspected cases are under investigation in Beni (21), Mabalako (6), Butembo (3), Tchomia (1) and Mandima (1).

As of 15 October 2018, 57 cases have recovered, been discharged from ETCs, and re-integrated into their communities. A total of 43 cases (20 confirmed and 23 suspected) remain hospitalized in the ETCs. The treatment centres in Beni and Butembo recorded an occupancy rate of 76% (31/41) and 42% (10/24) respectively.

Among the 207 cases with known age and sex, 54% (n=111) are female and adults aged 15-44 account for 60% (n=124). Recent cases in Beni include a disproportional number of cases in children aged ≤16 years; 47% (n=20) of 43 total cases reported since 1 October 2018, including 9 cases in infants and young children aged <5 years. Investigation teams are intensively reviewing potential sources of the recent increase in cases among children. To date, the total number of health workers affected in this outbreak is 20, including 19 confirmed. Three health workers have died from the disease. One case confirmed on 7 October 2018 is a MONUSCO civilian staffer working in Beni, who is currently hospitalized at the Beni ETC.

The confirmed cases were reported from six health zones in North Kivu Province: Beni (77), Mabalako (71), Butembo (13), Masereka (4), Kalunguta (2), and Oicha (2); and three health zones in Ituri Province: Mandima

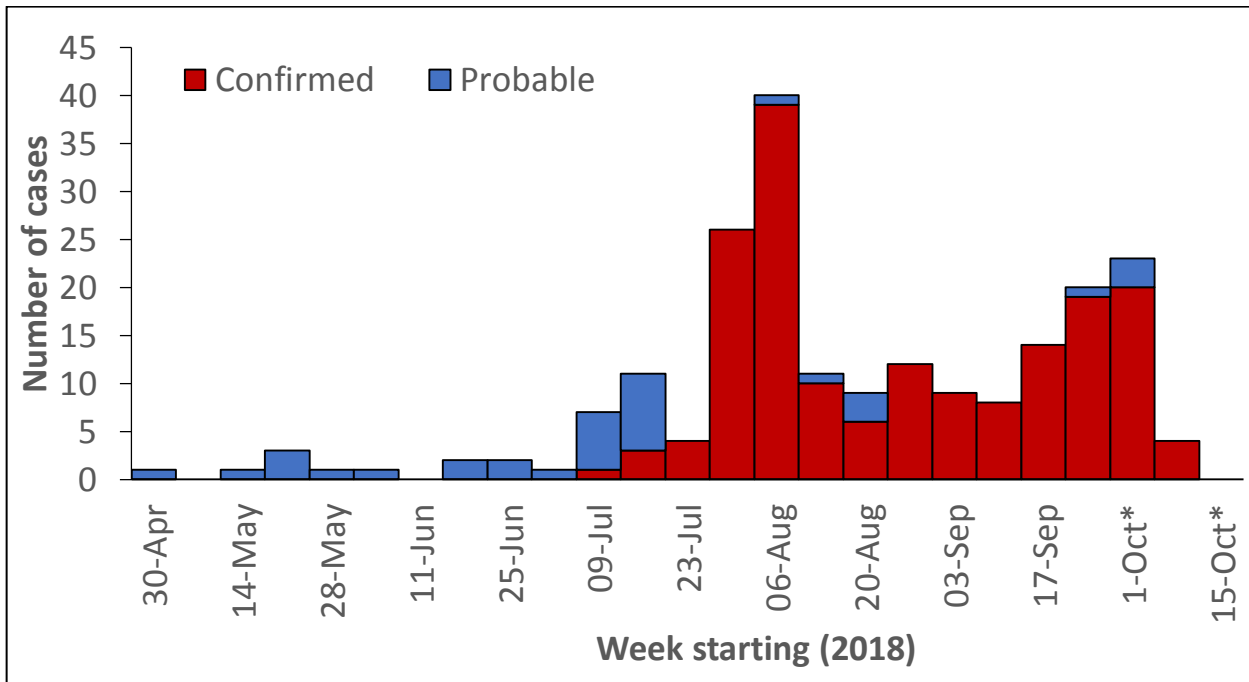
(9), Tchomia (2) and Komanda (1). The epicentres of the outbreak remain Beni and Mabalako Health Zones in North Kivu Province, reporting 39% (n=85) and 43% (n=92) of all confirmed and probable cases respectively. Beni, Butembo, Masereka and Mabalako continue to report an increasing number of new cases, indicating the persistence of Ebola virus transmission in these areas. The Beni Health Zone has reported 71% of all cases reported since September 2018. Of the total deaths reported to date, 48% (n=67) were from Mabalako, while 40% (n=55) were from Beni.

The Ministries of Health (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 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 15 October 2018

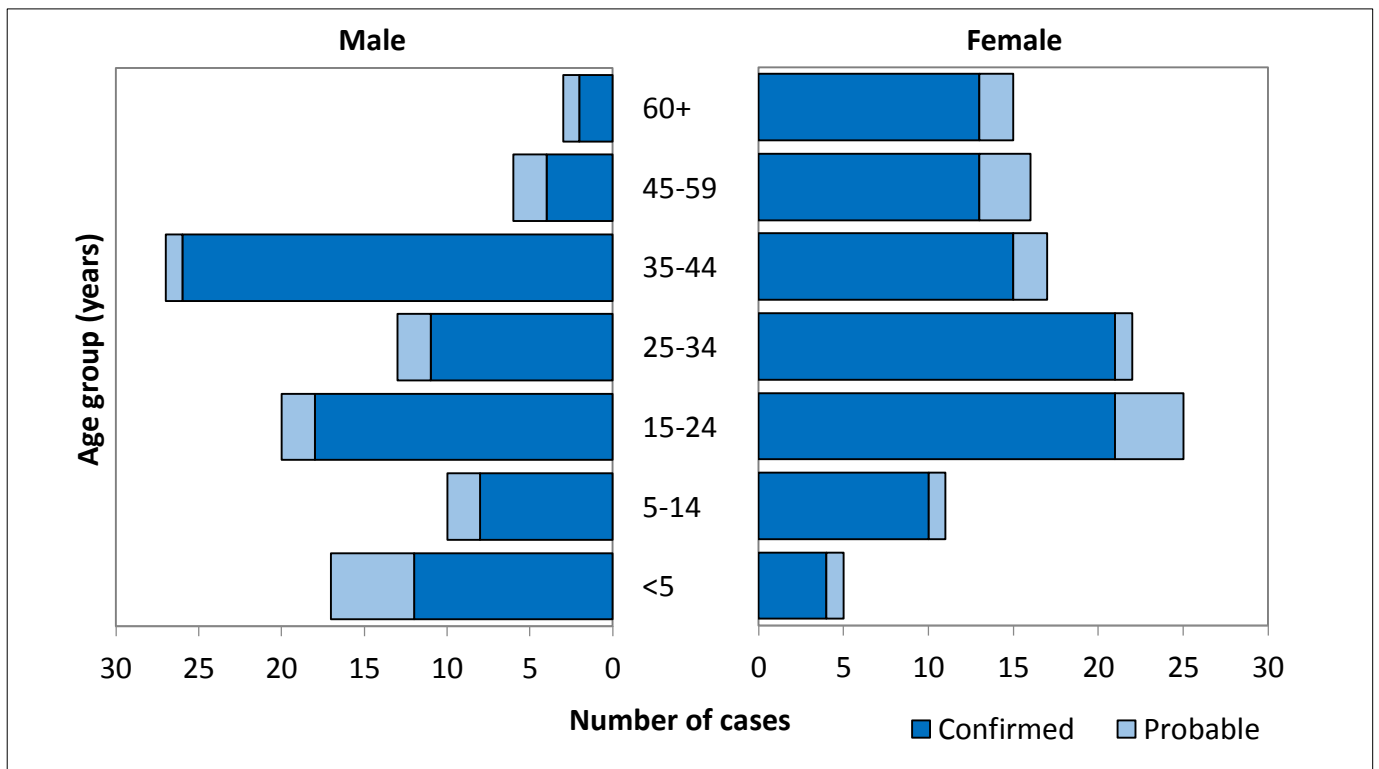
Case classification/ status			North Kivu					Ituri			Total
	Beni	Butembo	Oicha	Mabalako	Musienene	Masereka	Kalunguta	Komanda	Mandima	Tchomia	
Probable	8	2	1	21	1	0	0	0	2	0	35
Confirmed	77	13	2	71	0	4	2	1	9	2	181
Total confirmed and probable	85	15	3	92	1	4	2	1	11	2	216
Suspected cases currently under investigation	21	3	0	6	0	0	0	0	1	1	32
Deaths											
Total deaths	55	8	1	67	1	1	1	0	3	2	139
Deaths in confirmed cases	47	6	0	46	0	1	1	0	1	2	104

Figure 1. Confirmed and probable Ebola virus disease cases by week of illness onset, data as of 15 October 2018 (n=210)*



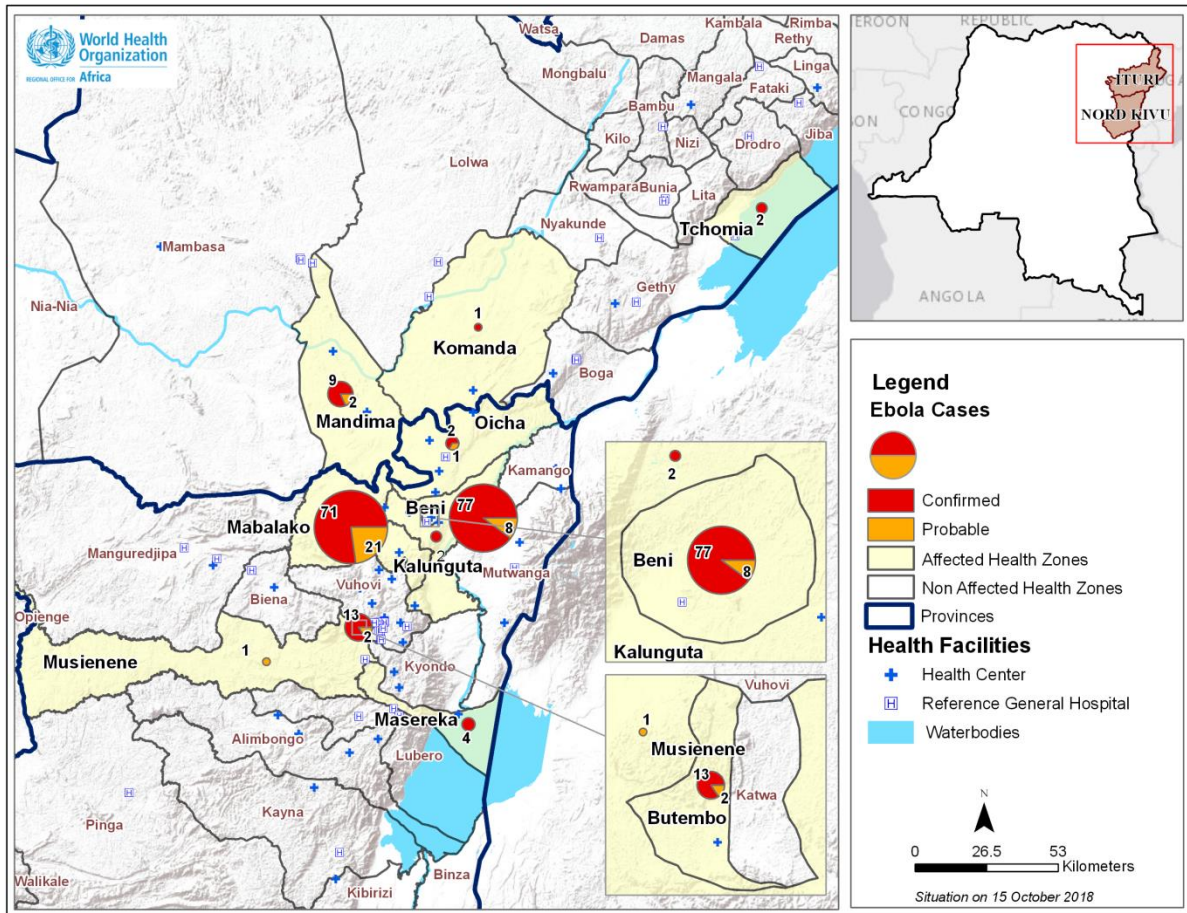
*Case counts in recent weeks may be incomplete due to reporting delays.

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 15 October 2018 (n=207)



*Age/sex is currently unknown for n=9 cases.

Figure 3: Geographical distribution of confirmed and probable Ebola virus disease cases in North Kivu and Ituri provinces, Democratic Republic of the Congo, 15 October 2018 (n=216)



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. WHO assesses the risk at national and regional levels as 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 neighboring 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 of EVD outbreaks. These include (i) strengthening the multi-sectoral coordination of the response, (ii) enhanced surveillance, including active case finding, case investigation, contact tracing and surveillance at Points of Entry (PoE), (iii) strengthening diagnostic capabilities, (iv) case management, (v) infection prevention and control in health facilities and communities, including safe and dignified burials, (vi) risk communication, social mobilization and community engagement, (vii) psychosocial care (viii) vaccination of risk groups (ix) research and (x) operational support and logistics.

2. Actions to date

Surveillance

- ➔ The overall contact tracing performance during last seven days varied between 52% to 87%. Contact tracing in Beni, which accounts for majority of contacts under surveillance, was severely affected by insecurity, resulting in relatively lower performance. Of the 4 707 contacts to follow on 15 October, 1 040 (22%) were not seen, most of which were recorded in Beni (n=1 007, 97%). A total of 574 new contacts were identified on 15 October 2018, of which 541 were in Beni, 20 in Butembo, and 13 in Musienene.
- ➔ There are continued investigations around the latest confirmed cases who are not originating from known transmission chains. In addition, there is on-going search for lost contacts in Beni and Komanda health zones.

Case management

- ➔ Ebola Treatment Centres (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). WHO is providing technical clinical expertise onsite and is assisting with the creation of a data safety management board.
- ➔ Twenty new patients were admitted to ETCs on 15 October 2018.
- ➔ The Beni ETC managed by Alima has been expanded to a total of 41 beds. The MoH and partners have met about strengthening triage and IPC at Beni General Hospital.

Infection Prevention and Control (IPC)

- ➔ MoH, WHO and partners continue to strengthen triage and pre-triage and IPC in health facilities in all affected areas. There is a strengthened focus on private health facilities run by traditional healers (tradi-modern health facilities), to ensure that owners are trained in triage, provided with personal protective equipment (PPE), and engaged in regular supervision. Representatives from these health facilities have joined the response coordination committee and have committed to the slogan “Ebola ne passera pas par ma structure. J’alerte.” (*Ebola will not go through my structure. I report an alert.*)

Points of Entry (PoE)

- ➔ Monitoring and sanitary control continues at entry points. As of 15 October, out of a total of 62 Points of Entry (PoEs), 48 were functional with 115 212 screened travellers; a total of 9.1 million travellers have been screened since the beginning of the outbreak.
- ➔ IOM conducted a participatory Population Mobility Mapping exercise in Mahagi, Ituri Province to capture information on cross border mobility between DRC/Ituri Province and Uganda. Key findings include: the identification of 12 official and two unofficial entry points connecting Ituri Province and Uganda; movement is primarily by road, and the same tribe of people reside on both sides of the border, engaging in regular trade. The three movement axes are: Mahagi – Bunia – Aru; Mahagi – Tchomia – Kasenyi; Mahagi – Uganda. Eight priority PoEs have been identified, six at the border and two internal points of control; IOM will support training of PoE staff and the establishment of a coordination mechanism among PoEs and border facilities.
- ➔ IOM in Uganda are establishing 10 flow monitoring points along the border with South Sudan and Democratic Republic of the Congo. IOM have activated four PoEs in South Sudan in Yei River State (Yei, Yei Airport, Kaya and Okaba). A further four PoEs are currently being established in Busia (Morobo), Tokori (Otogo), and Livolo and Keriowa (Kajo Keji).
- ➔ IOM continues to support operations at 32 key PoEs in Democratic Republic of the Congo, with flow monitoring conducted at 16 sites. IOM screening protocol requires a health declaration form and temperature check, observation of symptoms (if any), hand washing, and risk communication.

Safe and Dignified Burials (SDB)

- ➔ Current Safe and Dignified Burial (SDB) capacity, through Red Cross and Civil Protection (CP) teams, is operational in Mangina (RC), Beni (RC+CP) Butembo (RC+CP), Oicha (CP), Bunia (RC), Tchomia/Kasenyi (RC+CP). Trained RC SDB teams in Mambasa and Goma are on stand-by.
- ➔ Security remains a concern in Beni and Butembo, with consequences for SDB activities.
- ➔ In Beni, Red Cross and Civil Protection teams are working in close coordination to ensure sufficient operational coverage for SDB and more Civil Protection teams are in the process of being trained. Due to the continuing fragile security situation in Butembo, the Red Cross has not fully resumed its SDB activities since the security incident on 2 October 2018.
- ➔ Between 9 and 15 October 2018, a total of 42 SDB alerts were received, of which 31 came from Beni alone. Other reporting health zones included Mabalako (5), Mandima (3), Mangina (2), and Butembo (1).
- ➔ As of 15 October 2018, a total of 268 SDB alerts were received; of these, 222 were responded to successfully, with 39 unsuccessful due to community refusals or burials conducted by the community prior to the SDB team's arrival on-site. Seven SDB alerts had not been responded to due to security concerns. Out of the 268 SDB alerts received, 36 alerts (28 successful) have been responded to by Civil Protection teams. Training has started for three additional SDB teams.

Implementation of ring vaccination protocol

- ➔ Since 8 August 2018, 17 976 eligible and consenting participants were vaccinated.
- ➔ Through successful negotiations with an armed group controlling territory where a confirmed case had been lost to follow-up, the armed group has agreed to allow a response team into the territory in order to administer vaccinations. This is a critical step forward to reach populations in the red zones.

Risk communication, social mobilization and community engagement

- ➔ A radio broadcast popular expression platform on five radio stations in Butembo has been organized as part of activities to raise awareness of EVD and combat rumours and community resistance to the response to the epidemic.
- ➔ There is consultation with customary chiefs in Beni and Lubero territories.
- ➔ A motorized caravan, followed by artistic performances and contests have taken place to raise EVD awareness in Tchomia.
- ➔ A total of 1 160 households in Beni, 499 in Butembo, 454 in Tchomia, and 452 in Mabalako were visited on 15 October 2018 by community relays.
- ➔ Community feedback highlights the need for: stronger involvement of health workers in both formal and informal health facilities; improved access to WASH materials at the household level; and clarification provided by frontline workers on response operations.

Operational partnerships

- ➔ Under the overall leadership of the Ministry of Health (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 Infection Protection and Control (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, infection control and prevention (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.
- ➔ Nongovernmental organizations involved in Ebola response are:
- **Adeco Federación (ADECO):** Supporting infection prevention and control (IPC), risk communication, and community engagement.
 - **Association des femmes pour la nutrition à assise communautaire (AFNAC):** Supporting infection prevention and control (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, infection prevention and control (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 Internazionale (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 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.

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 increasing number of confirmed/probable cases and contacts to be followed, mainly in the Beni Health Zone, requires strengthening human and material resources as well as medical input. Cases emerging closer to insecure areas, as well as community resistance, high mobility of the population, and insecurity in some localities continue to pose a challenge to the implementation of the response activities. Response teams at every level, particularly those at the frontline of the response, have generated significant successes in community engagement, vaccinations, high-quality care at ETCs and contact tracing, despite challenges by working in close coordination with local leaders and community members. The rapid adjustment of the response teams' activities under these challenging conditions demonstrate the commitment of the Ministry of Health, WHO, and partners to stop this outbreak.