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.

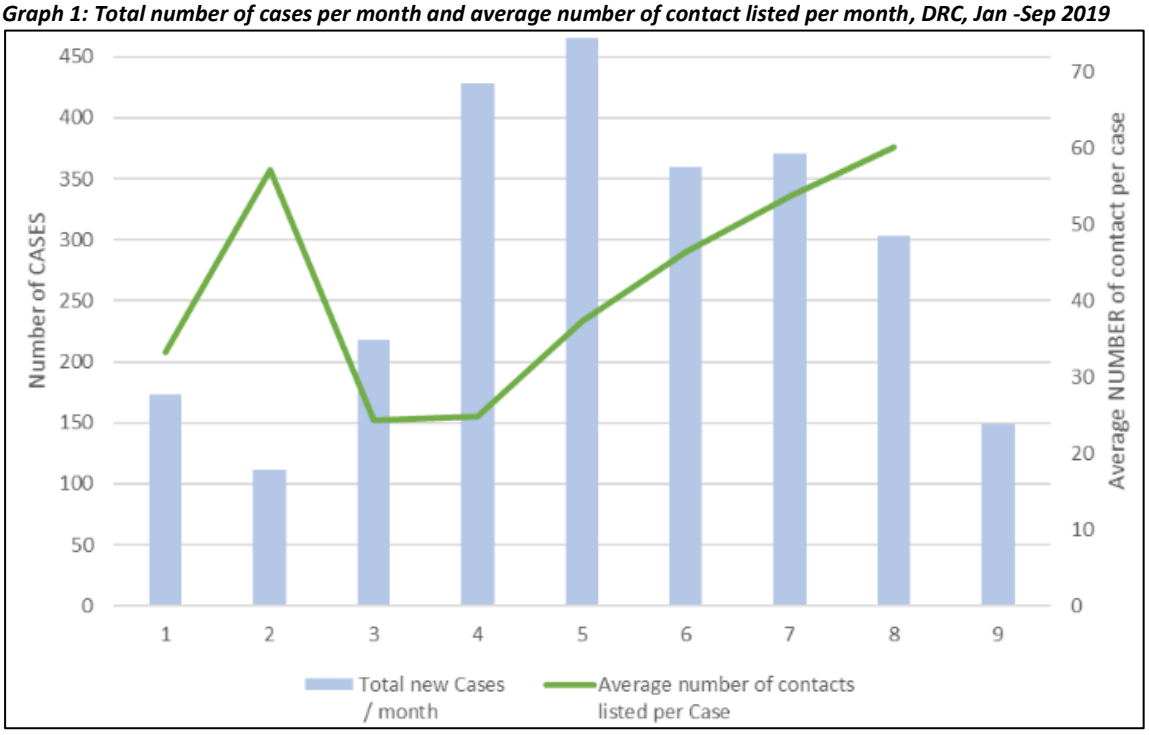
Facility-based Active Case Finding

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

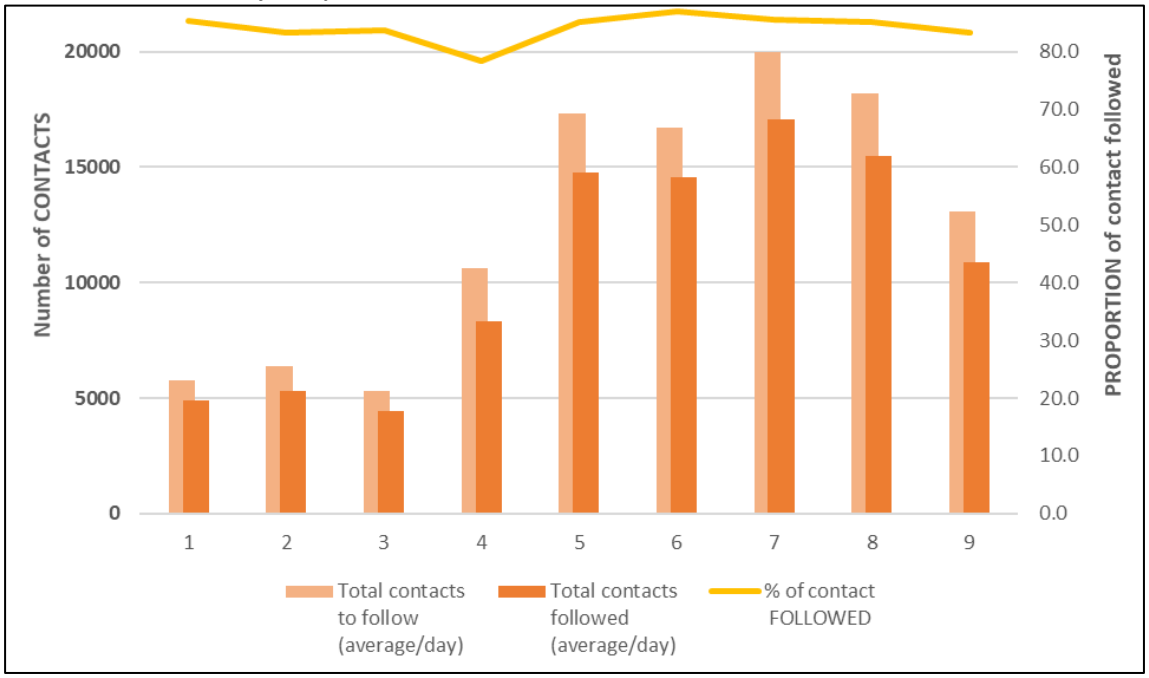
The listing of contacts has greatly and steadily improved from July to September. The proportion of cases not known decreased from 60% to 40% in August and to approximately 20% in September, which is a sign of improved listing of contacts.

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.

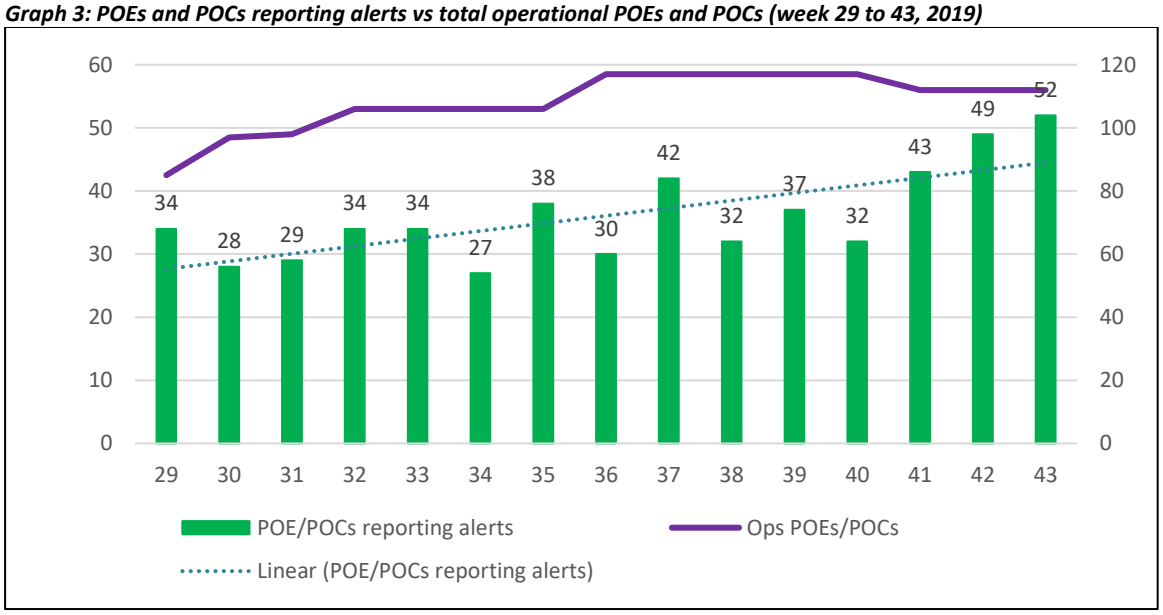
Despite the geographical expansion and increase in number of POEs and POCs, the proportion of alerts generated by POEs and POCs which are investigated within two hours of notification has remained similar at around 95%; efforts continue to be made to push this figure to 100%. Below is a monthly breakdown 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
Points of Entry/Control	Proportion of entry and checkpoints with uninterrupted operations within the last 7 days	100%	98%
	Proportion of entry and control points in Sphere 1 that have notified at least 1 alert within the last 7 days	75%	25%[1]

[1] This indicator aims at measuring screening effectiveness. In theory, all POEs and POCs should be reporting alerts every week because there are so many other diseases with fever and other signs and symptoms suggesting Ebola circulating in the population, including the population on the move. However, as EVD cases start to decrease, we have adjusted this target proportion to 75%. By week 43 (ending 27 October) the achieved value has gone up to 36%.

Vaccination

At the beginning of the reporting period, 154 037 people at risk have consented to and received the rVSV-ZEBOV-GP Ebola vaccine. Of those, 37 373 are contacts and 67 756 contacts-of-contacts. The total number of people vaccinated includes 31 016 health care workers (HCW)/front-line workers (FLW) and 34 522 children 1-17 years of age. Despite the challenges in the field and considering the cases reported between 30 April 2019 and 20 May 2019, only 31/337 (9.2%) of the cases do not have a ring defined and their contacts and contacts-of-contacts vaccinated. For 113/337 (33.5%) of the cases the ring vaccination was completed and for 193/337 (57.2%) ring vaccination was ongoing at the time of writing this report. This important progress is the result of the use of innovative delivery strategies (i.e. pop-up vaccination and targeted geographic vaccination) and strong community negotiations and engagement.

Consented and vaccinated (data as of 2 Oct)	**Number**	**%**
Total	**231 048**	
Contacts	56 255	24.6%
Contacts of contacts	158 221	68%
Possible Contacts	16 572	6.8%
Those vaccinated included the following populations		
HCWs/FLWS	49 094	21%
Children 6-11 months	2 084	0.9%
Children 1-17-year-old	74 091	32%
Pregnant women	892	> 0.1%
Breastfeeding Women	4 447	1.8%

As of the last week of the reporting period, 230 055 people at risk have consented to and received the rVSV-ZEBOV-GP Ebola vaccine. Of those, 55 801 are contacts and 154 689 contacts-of-contacts. The total number of vaccines includes 47 533 HCWs/FLWs. The Democratic Republic of the Congo health authorities have endorsed the use of a second investigational Ebola vaccine, manufactured by Johnson & Johnson. This vaccine, which is administered as a two-dose course, 56 days apart, will be circulated in at-risk populations in areas that do not have active EVD transmission.

Regular vaccination activities in EVD-affected areas will continue. The Merck/MSD vaccine will continue to be provided to all people at high risk of Ebola infection including those who have been in contact with a person confirmed to have Ebola, all contacts of contacts, and others determined to be at high risk of contracting Ebola.

KPI	Indicator description	Target	Achieved
Vaccination	Proportion of eligible people vaccinated	100%	99%

2. Sub-Pillar: Laboratory & Research

Laboratory

From July to September 2019, the main objectives were to maintain and strengthen the capacity of the seven established laboratories (Beni, Butembo, Mangina, Katwa, Bunia, Komanda and Goma) and to bring diagnosis operations closer to newly-affected or at-risk populations to ensure delivery of sample test results within 24 hours.

Throughout the period, the laboratories were fully operational in providing sequencing activities. Some laboratories were provided with additional GeneXpert equipment and human resources as demand increased. New mobile laboratories were deployed in response to the changing epidemic. The primary roles of the laboratory sub-pillar are to ensure early confirmation of patients and support clinical management. The strategic approach from INRB and its partners is to ensure response activities under the sub-pillar remain sufficiently flexible and adaptable to the evolution of the outbreak. As such, laboratories with GeneXpert technology have been established in Mwenga and Bukavu in South Kivu, as well as Mambasa in Ituri Province between July and September 2019. This brings the total number of operational laboratories with GeneXpert technology to 10.

Human resource capacity over the reporting period was further strengthened through the training of local workers on EVD diagnosis using GeneXpert technology, followed by integration into laboratories in Beni, Butembo, Goma, Mwenga, Bukavu and Mambasa. Of note, 32 health workers from 14 health zones in South Kivu were trained in collection, conservation, and transport of EVD suspected cases. A 12-day internship was also organized for 6 workers from South Kivu at the end of September in laboratories in Beni, Butembo, Mangina, and Katwa.

As of September 30, a total of 93 513 samples have been analysed since the beginning of the outbreak, of which 39 030 were tested during the reporting period. From the time of submission to the laboratory, results are communicated to clinicians within 24 hours, if not the same day depending on submission time. Around 40% of the samples are “repeat” submissions, which facilitates close monitoring of patients and enhances the level of optimized supportive care provided.
Sequencing capacity has been established in laboratories in Kinshasa and Katwa. To date, close to 50 000 samples have been shipped to Kinshasa to allow for whole genome sequencing, allowing response teams to monitor genomic evolution against therapeutics and vaccine efficacy. Preliminary results are regularly released on Next Strain (publicly accessible), and to date no genetic changes have been witnessed that would impact the delivery of either therapeutics or vaccine.

Laboratory consumables and equipment are managed through the WHO supply chain with no shortages in supply recorded during the reporting period. Work is also currently underway to operationalize SOPs for waste management of GeneXpert cartridges, which includes the establishment of an incinerator in Beni to safely facilitate cartridge destruction.

KPI	Indicator description	Target	Achieved
Laboratory	Proportion of lab results available within 48 hours	100%	100%

3. Sub-Pillar: Patient care, Survivor programme

Patient Care and Isolation

Capacity to provide high-quality, safe, and individualized care to patients with EVD has continued to evolve with the needs and geographic spread of the outbreak and is present in all major operational areas, including Beni, Butembo, Katwa, Komanda, Goma, Mangina, Bunia, Mambasa, and Chowe. All Ebola Treatment Centres (ETC) follow standard guidelines for providing optimized supportive care and have maintained an overall intra-ETC mortality rate around 35%, which is far below the target of 50%. The strategic approach to decentralize isolation capacity and facilitate timely referral to treatment has continued with the number of Transit Centres expanding to 20 between July and September. Within the scale-up of TCs, was the launch of a pilot project to bring care and laboratory diagnostics closer to communities through the establishment of Decentralized Transit Centres. Located at the Formation Sanitaire level (FOSA), the Decentralized TCs have been established in hot spot areas, include no more than 10 beds, and are integrated within existing health structures through the support of partners. Confirmed patients at these facilities are then transferred to established ETCs.

Maintaining sufficient adaptability within the approach to patient care and isolation was a critical component of being able to rapidly respond to new hot spots, such as Chowe (remote village in Mwenga Health Zone in South Kivu) and Mambasa (major transit hub in Ituri). The Case Management Rapid Response Team was repurposed as a mobile medical team composed of WHO and partners to enable care to patients in distant locations. In Chowe, for example, the mobile medical team began treatment for the first confirmed case (an infant) within one day at his home. In coordination with MSF, the mobile medical team established a temporary treatment centre within three days. In Mambasa, the team helped to expand a 3-bed isolation unit to a 10-bed TC within the span of one day to facilitate care for suspect cases.
During this reporting period, all EVD patients admitted to ETC had access to investigational therapeutics by enrolling into either the Monitored Emergency Use of Unregistered Interventions (MEURI) or the *Pamoja Tulinde Maisha* (PALM, Together Saves Lives) randomized controlled trial (RCT) protocols. Between 2 July and 24 September 2019, the number of consented and enrolled patients under the MEURI protocol increased from 696 to 761, while the number of consented and enrolled patients under the RCT increased from 421 to 872.

On 9 August 2019, the independent data and safety monitoring board (DSMB) that reviews interim safety and efficacy data of the RCT released preliminary results that individuals receiving REGN-EB3 or mAb114 had a greater chance of survival compared to participants in the other two arms. The study was terminated, and protocols were amended to use only Regeneron or mAb 114 for future EVD patients (link here). This is a hallmark accomplishment in the care of EVD patients as there are now two treatments that save lives in EVD infected patients. As of 7 October 2019, a total of 1676 patients with EVD have enrolled in one of these two protocols.
The expansion of the epidemic over this reporting period has posed major challenges, including the ability to build safe ETCs and TCs within the time required and with capacity to provide high-quality care. To ensure WHO and partners have sustained capacity to maintain operations in major operational areas, while also establishing isolation and treatment capacity in new hot spots, the following are required:

- rapid scale up of skilled staff to care for EVD patients,
- rapid scale up of staff to manage complex ETC/TCs operations,
- rapid scale up of staff in logistics and WASH to build safe and patient-friendly centres; and
- rapid scale up of strong supply chain for medicines, equipment and other essential supplies.

While NGO partners have greatly increased their case management activities, there continue to be gaps in response capabilities that require the WHO team to serve as the "provider of last resort." Limited capacity within the case management pillar further strains WHO's ability to remain nimble and adaptable, while also providing direct support to the Ministry of Health with the management of over 350 patient beds.

Survivor Programme

Building on the guidelines and procedures established as part of the EVD outbreak in Equateur Province, DRC in 2018, as well as lessons learning from the EVD outbreak in West Africa, the survivor programme established during the current EVD outbreak in North Kivu marks the first time a national EVD survivor programme was established during the early, acute phase of an outbreak.

Coordinated by the Ministry of Health and INRB, with support from WHO and partners, the survivor programme is in place to ensure support is available for those who have recovered from EVD to address and minimize the risk of EVD-complications (medical and psychological) as they return to their communities. Monitoring of patients through the programme also provides a critical platform to manage potential risks, including the risk of sexual transmission, albeit limited, from male survivors to their partners.

To date, more than 1,000 patients have recovered from EVD. The enrolment rate over the course of the programme (follow-up beginning in November 2018), has hovered around 80% of all survivors and with a follow-up rate over 85%. Three clinics are currently operational in Beni, Butembo, and Mangina, with a staffing component that each includes 1 physician, 1 psychologist, 2 laboratory technicians, 1 nurse, 2 hygienists, and 2 psycho-social assistants. Monthly consultations are offered to survivors for up to one year following their discharge from an ETC, and includes the following components:

- Clinical evaluation and physical examination, pregnancy and fertility monitoring, neurological follow-up, tailored follow-up for pregnant women and children;
- Counselling to reduce the risk of sexual transmission (script, evaluation form, HIV counselling); semen and vaginal fluids collection, testing, and analysis using approved protocols;
- Psychosocial evaluation and assessment, including a focus on signs of stress, quality of life, social situation and stigma, and an assessment of distress using the Impact of Event Scale (IES-R).

WHO has also supported the development and implementation of a tailored programme of care for women who were pregnant while EVD positive and have survived with a viable foetus. Thanks to the close follow-up available through the survivor programme, five babies were born to female survivors.

As we surpass the milestone of 1,000 survivors, the national EVD survivor programme will have the responsibility of caring for an increasing number of people. There will be a need to extend to an additional site (most likely in the Ituri province) and it is thus critical that adequate resources are allocated to ensure the continued quality of the programme. Plans and budgets have been prepared and the programme will be ready to operationalize the 4th site, once the MoH gives its approval. Data management and operational support will be scaled up to ensure timely data analysis and appropriate follow-up of all survivors enrolled.

Although the follow up rate is over 85%, some survivors do not attend the monthly sessions. This service is offered to the survivors at their will; nevertheless, some refuse to be followed. Others are hard to contact because they live in remote places, do not have phones or simply live too far from the follow up centres, mainly in the Ituri province. Closely working with the survivors' association, the MoH and INRB with support of WHO, will scale up the programme through the establishment of a 4th clinic and renewed communication, to ensure that all those willing to be enrolled can be treated.
Equally important, will be the sustainability of the programme, after the response is over. This has been made possible for the follow-up of EVD survivors in the Equateur Province, but year-long financial support will be required after the last confirmed patient is discharged from the ETC.

KPI	Indicator description	Target	Achieved
Patient Care	Case fatality among confirmed cases in Ebola Treatment Centres	<50%	34%
Survivor Programme	Proportion of people recovered from EVD who are enrolled and followed by the survivor programme	90%	91%

4. Sub-Pillar: Infection, Prevention & Control

Infection, Prevention & Control

Recognizing the impact of nosocomial transmission as an amplification point for the outbreak, WHO and partners have redoubled efforts to reinforce IPC and WASH activities in health facilities and EVD-affected communities. WHO has continued to reinforce a "ring" approach, targeting interventions around confirmed cases, high-risk facilities, and nosocomial events. Key activities within this approach include facility assessments, decontamination, supply provision, and assessment of adherence to key IPC indicators (e.g. EVD screening, PPE availability, isolation, and referral). Support provided to facilities included the development of improvement action plans based on identified gaps, standardized approaches to supportive supervision/mentoring, and training to health workers on basic EVD-specific IPC principles.

During the reporting period, a total of:

- 1,818 IPC kits were provided to selected healthcare facilities
- 28 717 briefings on EVD and basic IPC were provided to healthcare workers
- additional 2,249 healthcare workers were trained on IPC standard measures

Since its launch in mid-June, IPC teams have continued the rollout and implementation of an electronic IPC scorecard data collection tool designed to support the rapid assessment of healthcare facilities on 12 IPC standards. The results of the assessments are used to develop facility-based improvement plans that are then implemented through supportive supervision sessions. During the reporting period, the IPC scorecard helped to facilitate 3,548 evaluations conducted by IPC experts on 1,332 healthcare facilities, and 8,278 supportive supervision sessions. Whilst the KPI regarding scorecards remains far below the target, the process itself is critical in identifying gaps and challenges and enabled the implementation of functional triage units at 478 facilities, isolation areas at 45 facilities, and the installation of handwashing stations in 3,294 facilities. To strengthen coordination efforts, the IPC tool also supports the mapping of partner presence at facilities and their respective scores.

One of the highlights during the reporting period includes the revision of and alignment across MoH, WHO, and CDC on the definition of nosocomial infections. The revised definition was complemented by the implementation of standardized tools to validate and investigate cases and support the development of targeted interventions for facilities and the establishment of in-hospital surveillance systems.

KPI	Indicator description	Target	Achieved
Infection Prevention and Control	Number of newly infected health care workers	0	0
	Percentage of FOSAs with a scorecard greater than or equal to 80%	≥ 80%	33%
	Proportion of cases attributed to nosocomial transmission	0%	31%

In response to ongoing nosocomial and healthcare worker infections (161 as of 2 October) and lack of coherence in approach among partners to IPC, priority was given to the development of a national IPC/WASH toolkit to standardize expectations, tools, and best practices. Validated by the MoH, the IPC toolkit includes over 60 documents (training modules, SOPs, TORs, tools, and posters for display in health facilities during and post-outbreak).

A training of trainers on the national toolkit took place in Goma from 18-21 September and was attended by 70 participants. The training consisted of didactic, practical, and discussion sessions and will be followed by training at sub-commission level for IPC supervisors, implementing partners, and facility-based IPC focal points.

Safe and Dignified Burials (SDB)

More than 100 SDB teams are operational, including mobile, community-based (ECUMR), and civil protection components, and supported by the Red Cross and WHO. Scaling-up the number of teams, integrating all key representatives of the communities (youth, women, community elders, pressure groups), and ensuring local people are engaged in SDB activities have contributed to improved acceptance of SDB interventions in the affected communities. The response also continues to leverage the expertise of anthropologists and social scientists to support SDB teams with identifying factors that negatively impact SDB success rates though community feedback mechanisms. WHO continues to work with partners to increase the number of teams where appropriate, provide initial and refresher trainings, and ensure all teams have sufficient supplies and equipment to carry forward their work.

Key achievements during the reporting period include:

- Between 01 July and 28 July: 1,780 deaths alerts were recorded. Of those, 1,388 were successfully responded to by the SDB teams (77%). During the same period, 98 community deaths were confirmed to be EVD positive. Of those, 91 were successfully buried (93%);
- Between 29 July and 01 Sept: 2,157 deaths alerts were recorded. Of those, 1,780 were successfully responded to by the SDB teams (82%). During the same period, 92 community deaths were confirmed to be EVD positive. Of these, 87 were successfully buried (94%).
- Between 02 Sept and 29 Sept: 2,283 death alerts were recorded. Of those, 2,070 were successfully responded to by the SDB teams (91%).During the same period, 29 community deaths were confirmed to be EVD positive. Of those, 28 were successfully buried (97%).

Efforts to strengthen the approach to SDBs continued over the reporting period with a significant focus on training of SDB teams, including civil society representatives, community relays, religious leaders, traditional healers/practitioners, and pressure groups on SDB protocols, individual protection techniques and community engagement. In addition, 10 community-based teams operating in nine reluctant and inaccessible health areas were trained on SDB and comprised the following components:

Day 1	Day 2	Day 3
• Expectations and general objectives • Ebola – general information • Management - Prevention of SDB Stress • Communication and Community Engagement • Introduction of SDB goals. • Basic Civil Protection	• Techniques for handling and placing bodies • Anthropological overview • Early Warning System • Basic Terms on Civil Protection • Standard IPC/WASH methods	• 12 steps of SDB principles • Use of PPE (Dressing and Undressing) • The results of the training

KPI	Indicator description	Target	Achieved
Safe and Dignified Burials	Proportion of suspected and probable deaths for which a safe and dignified burial was performed	100%	87%
	Proportion of community deaths tested	100%	94%

5 Sub-Pillar: Operational preparedness

The innovative approach to readiness in SRP-4 is to strengthen readiness in 60 non-affected health zones (HZs) in DRC closest to or on major transport routes from the epicentre of the outbreak, including 30 HZs in North Kivu and Ituri, and an additional 30 HZs in the neighbouring provinces and Kinshasa depending on the movement of the epicentre of the outbreak.

During July to September in SRP-4 implementation, readiness teams rolled out a standard package of readiness activities in a total of 31 high risk, non-affected health zones (HZs) of North Kivu Province (11 HZs), Ituri Province (7 HZs), Tshopo Province (Kisangani plus 7 HZs) and South Kivu Province (Bukavu plus 4 HZs). Indicators for non-affected DRC high risk health zones are drawn from the EVD District Level Key Performance Indicators (KPI) tool developed in WHO/AFRO/WHE in collaboration with WHO/HQ. These indicators were reviewed first at HQ by Health Operations teams in March 2019. The first round of data was collected in July 2019 from a total of 31 high risk, non-affected health zones.

For the non-affected health zones in the 4 priority provinces (North Kivu, Ituri, Tshopo and South Kivu), over three quarters of the health facilities in the non-affected health zones have standardized EVD case definitions and surveillance tools, and nearly that many are reporting weekly surveillance data to the zonal level. Maintaining preparedness in all at-risk non-affected health zones around the epicentre of the outbreak in DRC requires a significant amount of human resources which is limited due to the number of affected health zones that require response teams to be active.

The readiness teams in Tshopo and South Kivu Provinces focused on the development of alert management systems, and weekly reporting of alerts increased from <10 weekly to 50-100 alerts

weekly in each Province. Laboratory capacity was developed in South Kivu Province and laboratory training on existing GeneXpert equipment was conducted in Tshopo. The number of alerts reported from the 11 non-affected HZs in North Kivu where preparedness had been implemented averaged 156/week/HZ during the last week of September 2019, while in the remaining 6 non-affected HZs without preparedness activities, <10 alerts/wk/HZ were reported.

Fifteen (48%) non-affected health zones in DRC have been covered with population movement mapping exercises, aimed at identifying areas at high risk of spread of EVD and therefore guide preparedness actions. Taking into consideration that these mapping exercises are a relatively new initiative, the high number of exercises done to date suggests that the activity has been well accepted as part of overall preparedness actions. KPI data on risk communications and community engagement were collected by WHO for the first time in the high-risk non-affected health zones. Teams in each HZ delivered a package of ongoing work to sensitise communities and health workers to the zonal governance which included training 100 community volunteers and 100 community leaders in each HZ followed by the contractual engagement of local radio and television for spot message delivery.

From July to September cases spread to both Goma in North Kivu and to Mwenga in South Kivu where preparedness activities had been implemented and outbreaks were averted. Over 5,000 frontline and healthcare workers were vaccinated in non-affected HZs of North Kivu and South Kivu Provinces.

KPI	Indicator description	Target	Achieved
Surveillance	Number of Health Facilities (HF) with standardized surveillance tools in in the nonaffected Health Zones (HZ), i.e., IDSR reporting forms, EVD case investigation forms, EVD contact tracing forms.	1069 HFs	923(86%)
	Number of HFs with standardized case definition in the Non-affected HZs	1069 HFs	906(85%)
	Number of HFs reporting weekly surveillance information to the non-affected HZ level	1069 HFs	766(72%)
POE	Number of high risk non-affected HZs covered with population movement and sociological patterns mapping exercises	31 HZs	15(48%)
RCCE	Number of community leaders trained on RCCE in the Non-affected HZs	100/HZ or 3100 total	2910(97%)
	Number of persons reached with RCCE activities in the Non-affected HZs in the past month		950,400

6. Sub-Pillar: Support to coordination

The United Nations scale-up strategy provides a framework for organizing the response by the United Nations system in support of the Government of the DRC's public health response priorities, as well as to enhance the overall enabling environment within which the response is situated. The implementation of this scale-up strategy is directed by the Ebola Emergency Response Team (EERT) chaired by the Ebola Emergency Response Coordinator (EERC) and the ADG of WHO for Emergency Response, serving equally as co-chairs, with the participation of all Heads of United Nations AFPs involved in the response and one representative of the INGOs.

The EERT oversees the implementation of United Nations support across five main pillars identified as essential for an effective response to end the Ebola outbreak. Primary among these pillars is the support to the public health response led by the Ministry of Public Health. This pillar informs and drives the four other pillars that aim to provide an enabling and conducive environment for a safe and effective response as well as enhance the overall effectiveness of United Nations support.

In relation to coordination within the pillars, the first pillar continues to be coordinated by the MoH supported by WHO at the national, provincial, and sub-coordination levels through the government Committee and sub-committee system. The EERC has the coordination lead for pillars two and three, with a strengthening of UN coordination with NGOs central to pillar three. The World Bank leads the coordination of the fourth pillar related to financial management. WHO and OCHA are leading the fifth on strengthened regional preparedness.

Collaborating with EERC office across the SRP4 pillar

Several mechanisms have been established and are ongoing:

- WHO (through the ADG) co-chairs the weekly meeting of the EERT and bi-weekly donor partner call.
- WHO updates a daily "heat map" that indicates health areas with active transmission together with information on security or community acceptance issues.
- WHO provides daily information on locations for response operations to the Tactical Operations Centre (TOC) in Butembo so that security issues can be addressed.

However, there are still a few issues regarding security coordination. Currently, there is only one TOC established in Butembo. This is a concern given the shift of the outbreak hotspots to Mandima and Mambasa. Outside of Goma, Beni and Butembo, UNDSS security presence is very limited making it more difficult to address security concerns in a timely manner.

Examples of Security collaboration

- A joint assessment on 27 – 28 Sept, by WHO SEC RFSO and DSS Senior Emergency Security Coordinator, in Byakato, on request from WFP through EERC. The purpose is to establish a logistic base in the area.
- A joint assessment (DSS/WHO/EERC) from 1 to 5 Oct, across the whole EVD response area to assess the security situation, operational need, and gaps in resources.

Operations Support and Logistics (OSL)

The ability of the operation to remain in alignment with the needs of the outbreak, and rapidly respond in remote areas with limited to non-existent infrastructure is underpinned by a strong operational and logistics platform. Between July and September 2019, the OSL team facilitated 82 international cargos, totalling 728 metric tons, and with a value of US$ 2 671 263. During the same period, 34 560 doses of Ebola vaccine and 25 200 GeneXpert cartridges were delivered.
While not precisely within the reporting period, WHO OSL support beyond supply chain and the provision of commodities increased significantly between May and September 2019. Despite the global call for support, WHO support to Ebola treatment centres, isolation facilities, camps, and fleet increased by the following between May and September:

- Increase in the number of treatment and isolation beds supported from 80 to 315
- Increase in the number of treatment/isolation facilities supported from 1 to 10
- Increase in the number of beds in accommodation camps supported from 345 to 645

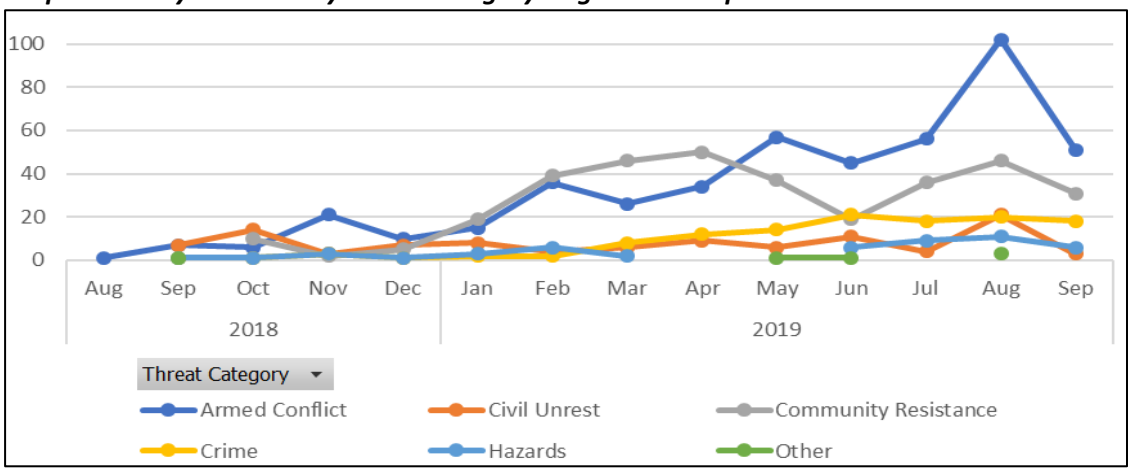
Security

The security situation in the EVD response operational area for the period July to September 2019 remained volatile and unpredictable, particularly at identified areas. The trend of incidents had been increasing with a peak in August, but tapered down in September though still at a significant level, comparable with those in May to July. Amongst the categories of security incidents recorded, Armed Conflict and Community Resistance remain the main threats, representing 73% of the cumulative record of security incidents. The Health Zones which incurred significant number of incidents include Beni, Butembo, Kalunguta, Katwa, Mabalako, Mambasa, Mandima, Musienene, Oicha and Vuhovi.

Armed Conflict

Significant increase in Armed Conflict incidents is attributed to the resurgence of ADF activities in Beni Territory (Oicha and the Beni-Kasindi axis). There also had been an increased activity of various MaiMai groups (at identified areas of Butembo and Lubero Territories and the bordering areas with Beni and Ituri). While movement and deployment of troops accordingly in preparation for military operations against the ADF had been reported in September, the number of Armed Conflict incidents in September had been 42% less than the previous month. The significant number of Armed Conflict incidents remains high and is likely to remain so or even increase, depending on the intensity and results of the military operations against the ADF and other non-state armed group activities in the coming period. While the military operations will likely impact on the EVD response primarily at the affected areas (likely at the vicinities of Oicha and the eastern parts of Beni up to the Beni-Kasindi axis), impact and/or repercussions elsewhere are also possible if resorted to ease pressure, or divert from the military engagement areas. Armed Conflict incidents, even if mostly just sightings of non-state armed groups (ADF and MM), if not promptly verified and mitigated, will continue to delay or restrict movements and activities of the response in those areas and proximity.

Graph: Security incidents by threat category Aug 2018 to Sep 2019



Community Resistance

Significant Community Resistance incidents occurred in Beni, Butembo, Kalunguta, Katwa, Kayna, Mambasa, Mandima, and Vuhovi. The recorded Community Resistance incidents in September had slightly decreased (8.6%) compared with the previous month. However, it remained about 29% of the total number of incidents. For September, most of the Community Resistance incidents were at Beni, Kalunguta, Katwa, Komanda, Mambasa, and Mandima; with Mambasa representing 33% for the month. All of these impacted on the continuity of EVD response with delays and/or cancellation of activities from a couple of hours or longer at the affected areas, the

longest having been the intense community resistance in Lwemba of Mambasa HZ which effectively rendered that particular village inaccessible for over two weeks.

About 40% of recorded Community Resistance incidents are verbal threats/resistance leaflets/roadblocks (i.e. no physical violence) with only minor and/or temporary impact on activities. However, about 23% involve physical violence (mainly beatings) resulting in injuries of various degrees; about 25% involve stone pelting causing minor injuries, and mostly damage to vehicles. The most significantly affected activities of the EVD response have been Safe and Dignified Burials, Infection Prevention and Control, and Vaccination in particular those linked to confirmed cases or deaths of pregnant women and children.
The significant number of Community Resistance incidents is expected to remain unless appropriately addressed and proactive engagement and sensitizing of local communities are conducted effectively, especially at new geographical areas of operations. Community Resistance will continue to be a major reason for delay or non-access into affected areas. While community engagement and sensitizing efforts are conducted, alternate operational modalities on the one hand, and prompt security and safety mitigation measures to facilitate continuity of critical EVD response activities at affected areas on the other, should be enhanced and followed up.

Security Management

While the overall security management is under Pillar 2 of the Strategic Response and is led by the EERC, WHO Security continued to provide daily and direct support to EVD teams in the field, and operations support led by EERC. The recruitment of WHO Local Field Security Assistants deployed at the High Security Risk Health Zones, where EVD responders are working, proved to have been an effective security operational adjustment. This provided timely and on-the-ground gathering of information and enabled the implementation of prompt security measures to ensure safety and security of personnel as well as to facilitate continuity of activities.
However, the level of impact on operational activities and inaccessibility to identified areas indicates the need for increased support and additional activities to facilitate an enabling environment throughout the entire operational area. Pre-deployment preparedness security training continues and is compulsory for all WHO personnel. During the period under review, eight SSAFE sessions have been completed, involving 75 participants. Due to the expansion of EVD operational zones, emergency communication equipment including HF/VHF radios and satellite phones have been purchased and regular maintenance for all security equipment (including armoured vehicles) were undertaken. WHO Security worked closely with the EERC/Security Coordination to ensure smooth and effective transition of security in the context of the scale-up to EERC.

Security Measures

To strengthen the participation and engagement of local communities, a WHO team of experts was set up to implement the Strategic Response Plan 4 (SRP4) approach and strategy, together with La Commission Communication de Risque et Engagement Communautaire (CREC) sub-commission. Increased security coordination for road movements/escorts was put in place for all areas of operation, which involved an integrated approach by all stakeholders, including MONUSCO and National Security Forces. Systematic armed escorts were required for movements to High Security Risk areas, basically controlled or dominated by Armed groups, such as ADF or Mai-Mai. WHO maintained an ongoing assessment and security upgrades of EVD sites with regular presence and imposed strict curfew hours from 1800 to 0600hrs in line with security threats and risks. Airport and helicopter landing zone security is in place as well as new night landing capacity for Butembo in case of medical evacuation.

A major security incident in Lwemba, within Mandima Health Zone took place in the third week of September in response to the death of a local healthcare worker. Due to the violence that occurred during the incident, all activities were suspended for over two weeks having a serious impact on the contact tracing in this hotspot area. Contacts were lost to follow up in Lwemba (169) and Mambasa (162). These incidents underscore the need for continued and proactive engagement and sensitizing of local communities, especially in the high-risk areas that may not currently be affected. During the last week of September, the security situation in the overall operational area of the EVD response was calmer with no major security incidents affecting operations. Some isolated incidents of community resistance were reported, and dangerous road conditions due to heavy rain prevented EVD teams from accessing certain operational areas, with delays of several hours reported.

III. Cross cutting issues

Capacity building

As part of its support to national coordination and set up of a national Incident Management system for the Ebola response, WHO will deliver a leadership training (November 2019) that focuses on acquiring core competencies for leadership, management, coordination, partnership and collaboration in a complex and fast changing context. On a subsequent phase, the training will be cascaded to sub-coordination level.

In the short-to-medium term, WHO will hire a capacity building coordinator as part of its strategic support to the Response to work with the technical and programme staff to identify areas of training needs/gaps and put in place a capacity building plan to respond to these gaps, undertake capacity building needs assessment, develop a database for training initiatives and pools of trainers of trainers, identify resources for capacity building, and support training exercises through quality assurance, among others. In the long-term, and contingent on availability of funding, WHO will assess the needs and capacity of the MoH at provincial and zonal levels and propose ways to strengthen/fill gaps in this area; support and develop partnership with local academic institutions (e.g University of Goma) to undertake capacity development initiatives and support local centres of excellence.

Information on gender disaggregation

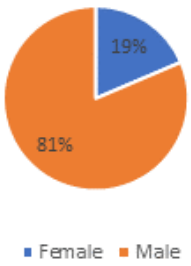
a. Number of cases of Ebola

Numbers of confirmed Ebola cases and demographic subgroups				
	Total (29/7/2018 to 30/9/2019)		**1/7/2019 to 30/9/2019**	
Subgroup	n	% of total	n	% of total
Gender breakdown				
Female	1734	56,3%	500	59,7%
Women 14-49 years	1088	35,3%	321	38,4%
Pregnant/ breastfeeding women	90	2,9%	12	1,4%
Male	1271	41,3%	337	40,3%
Unknown	75	2,4%	0	0,0%

Age subgroups				
<18 years	862	28,0%	241	28,8%
<5 years	449	14,6%	122	14,6%
<1 year	171	5,6%	43	5,1%
Deaths	1781	57,8%	377	45,0%
Total confirmed cases reported	3080	100,0%	837	100,0%

Numbers of deceased confirmed Ebola cases and gender breakdown				
	Total (29/7/2018 to 30/9/2019)		**1/7/2019 to 30/9/2019**	
Gender	n	% of total	n	% of total
Female	1035	58,1%	221	58,6%
Male	733	41,2%	156	41,4%
Unknown	13	0,4%	0	0,0%
Total deaths of confirmed cases reported	**1781**	**100,0%**	**377**	**100,0%**

b) Gender ratio - Responders



IV. Financial Reporting

The overall budget implementation rate for WHO current SRP 4 budget for pillars 1 and 2 is at 48% at the end of the first three months period (30 Sept 2019). There are however some variations of actual spend against budget for a number of the sub-pillars. Some of the factors contributing to the variations are described below. The current implementation of US$ 67.3 million include some front-loaded expenditures where contracts have been issued for the periods beyond the first three months of the response. WHO has also continued to cover substantial MoH commission payments as the World Bank lead platform for this is not yet operational. A change from the earlier SRP period is that WHO has not entered into agreements with NGO implementing partners. Common services provided by WFP/UNHASS and MONUSCO are being used as can be seen from the financial summary table, though the cost of MONUSCO services provided have not yet been booked.

As part of the regular 3 monthly operational review the plan and budget to take us to the end of the current SRP period will be updated. At this stage of the response, It is not expected that the overall budget figure will change significantly, but there will be adjustments between sub-pillar to reflect the current implementation rates as well as the expected future trends coming out of the review.

- Coordination: as part of the planning and budgeting exercise, the HR costs for technical team leads were included in the Coordination sub-pillar whereas actual expenditures are being charged to the relevant technical sub-pillar. The implementation against budget for this sub-pillar is therefore significantly lower than expected. There will be realignment of this during the upcoming operational review, where those items directly identifiable against one of the technical sub-pillars will be budgeted there.
- Surveillance, Contact Tracing & Vaccination: the continued broad-based surveillance and contract tracing across an expanding geographical area has resulted in a steady level of costs for this sub-pillar. Depending on the outcome of the operational review, there might be a need to increase the budget for this sub-pillar.

- Clinical Management & Transit: the decrease in cases means that ETCs are running at below full capacity level with a corresponding level of consumption of supplies. This is reflected in the relatively low implementation rate against budget for this sub-pillar and is likely to result in a budget reduction for the next 3 months period.

- Infection Prevention & Control: the full impact of the MoU with UNICEF where it was agreed that WHO would continue to carry out IPC in TC and ETC, with UNICEF concentrating on community-based IPC, can be seen in the relatively high implementation rate for this sub-pillar for which the budget may be somewhat increased depending on the outcome of the upcoming operational review.

- Operational Readiness: there has been a delay in the scaling up of the regional readiness activities which is reflected in the current low implementation rate for this sub-pillar. We do however already have indication that activities are now being implemented and expect to see an acceleration in spending in the coming weeks. The maintaining of the current budget will depend on the outcome of the upcoming operational review.

- Safer Work Environment and Common Support Services: At the outset WHO did not plan any budget for these sub-pillars as other partners were expected to provide the necessary security activities and services. However, the service provision has not been scaled up to the level initially expected, and WHO has therefore incurred significant costs in this area and might need to further increase the budget for this sub-pillar for the coming 3-month period.

Table 1: Budget requirements and funding received

Ebola SRP 4 requirements:	US$' 000
WHO funding requirement Pillar 1 & 2	140,000
WHO funding requirement Pillar 5	21,000
Total needs:	**161,000**
Funding received:	
Pillar 1	69,489
Pillar 5	4,300
Total received	**73,789**
Remaining funding gap:	87,211

Table 2: Funding received by donor:

Funding received		Pillar
USAID/OFDA	15,000,000	1
Italy	335 000	1
WB/PEF	30,000,000	1
DFID	9,600,000	1
CERF	3,903,000	1
USAID	1,151,000	1
CDC	500,000	1
ECHO	5,400,000	1
China	1,500,000	1
Denmark	2,100,000	1
SDC	500,000	5
Norway	1,100,000	5
USAID	1,400,000	5
USAID	800,000	5
China	500,000	5
	73,789,000	

Firm pledges		Pillar
World Bank/ IDA	40,000,000	1
Ireland	1,000,000	1
GAVI	12,000,000	1
Germany AA	4,400,000	1
DFID	13,800,000	1
ECHO	500,000	5
Ireland	1,000,000	5
S Buffett Foundation	5,000,000	1
Total Pipeline	**77,700,000**	

Table 3: Financial implementation - period July -September 2019 - in US$'000:

SRP 4 Sub pillar	SRP 4 budget	WHO implementation*						Partner implementation*			Total Implementation*	% budget implementation
		Equip, Veh, Furniture	HR	Supplies	Operational	Security	Subtotal WHO	MoH	Monusco	WFP/ UNHASS		
1.0 Coordination	39,380	38.6	4,579.4	30.8	276.8	-	**4,926**	101	-		5,027	13%
1.2 Surveillance, Contact Tracing & Vaccination	39,796	31.4	11,065.3	120.9	1,154.6	-	**12,372**	6,824	-	573	19,769	50%
1.3 Laboratories	2,935	-	444.4	703.5	284.3	-	**1,432**	79	-		1,511	51%
1.4 Clinical Management & Transit	12,019	2.9	1,089.2	1,198.1	894.5	4.3	**3,189**	1,068	-	148	4,404	37%
1.5 Infection Prevention & Control	23,075	142.8	6,198.4	1,792.1	1,987.3	-	**10,121**	3,328	-	469	13,918	60%
1.6 Safe & Dignified Burials	2,331	-	90.9	681.7	383.3	-	**1,156**	148	-		1,304	56%
1.8 Operational Readiness	6,065	-	143.9	-	611.3	-	**755**	-	-		755	12%
2.1Safer work environment	4,000	-	734.4	-	266.5	1,991.8	**2,993**	5	-		2,998	75%
2.3 Common Support Services	10,400	366.6	8,877.2	0.4	7,188.7	-	**16,433**	420	-	761	17,613	169%
Total	**140,000**	**582**	**33,223**	**4,528**	**13,047**	**1,996**	**53,376**	**11,973**	**-**	**1,950**	**67,299**	**48%**

**Includes firm committements for which goods/services have not yet been delivered*

Table 4: Number of staff by location

Location	July 2019	Aug 2019	Sep 2019
Beni	115	137	140
Bunia	31	0	35
Butembo	261	263	213
Goma	106	135	142
Kinshasa	26	22	26
Komanda	19	16	20
Mangina	67	80	98
Other	0	0	23
Total	**625**	**653**	**697**

Figure 1: Distribution of WHO staff by status (September 2019)

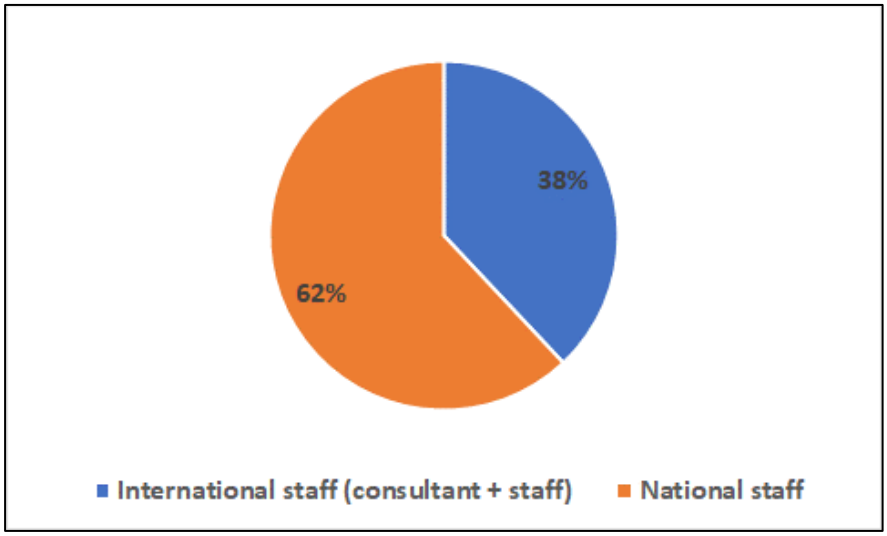


Table 5: Distribution of staff by expertise

Expertise	Share
Health expertise (surveillance, clinical management, EDS, etc.)	26%
Operations Support and Logistics	23%
Infection Prevention and Control	9%
Management, Administration, HR	9%
Security and Staff Well being	8%
Planning and Information	7%
Risk Communication	7%
Vaccination	6%
Leadership	5%
Grand Total	**100%**

Table 6: Number of cars by pillar

Function	Number
Surveillance	232
Vaccinations	144
Safe Burial	73
Infection Prevention and Control	70
Security	65
Operations Support and Logistics	58
Clinical management	57
Coordination	34
Risk Communication	23
Laboratory	10
Total	**766**

Table 7: Number of cars by location

Location	Cars			WHO
	WHO	Monusco	Rented	Armoured
Butembo	1	10	302	3
Beni/Mangina	2	8	228	
Goma	9	2	61	1
Mambasa		1	39	
Bunia		5	32	
Komanda	0	5	22	
Bukavu	1	1	22	
Coordination Beni	2	6		3
TOTAL	**15**	**38**	**706**	**7**

Table 8: Number of freight transport departing from Goma (September 2019)

Destination	Number of trucks	Number of flights
Butembo	8	10
Beni	6	19
Mambassa	2	7
Chowe		5
Kinshasa		3
Bunia	1	1
Bukavu		1
Pinga		1
TOTAL	**17**	**47**

Figure 2: Weight and volume sent per month

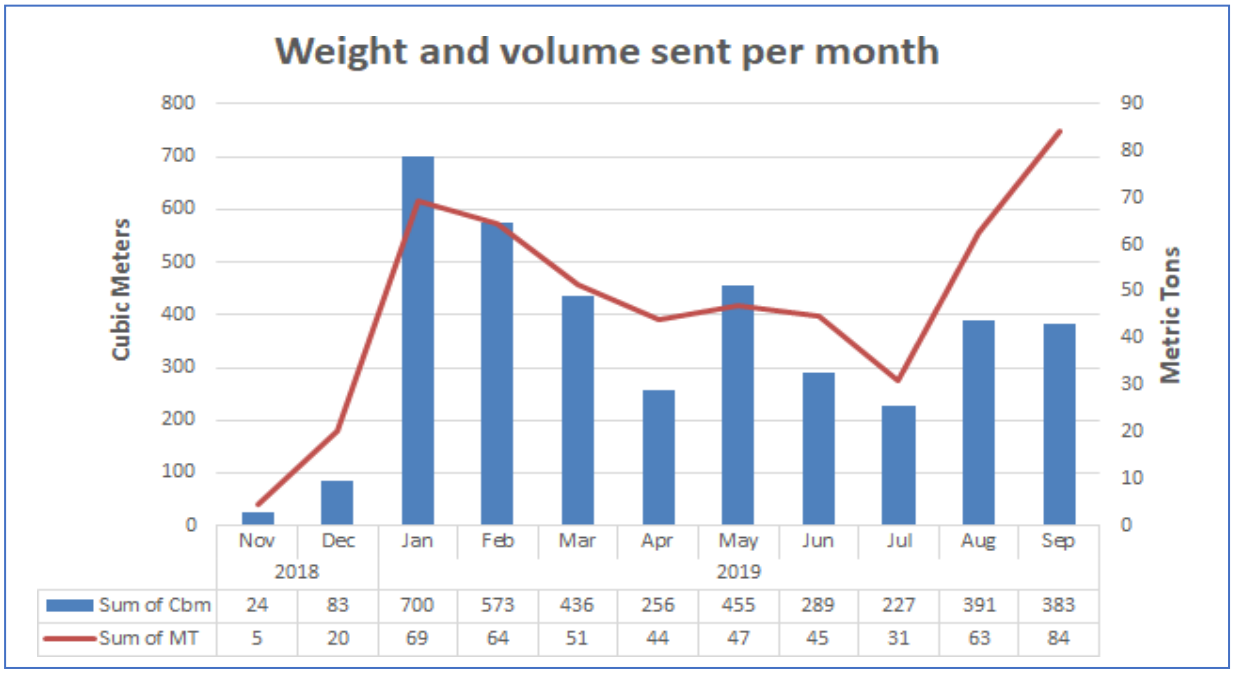


Table 9: Cost of national payment by commission

Commission	Beni*	Bunia**	Butembo	Goma	TOTAL
Surveillance	246,170	71,040	747,065	86400	**1,150,675**
Vaccination	1,080,110				**1,080,110**
Security	34,100	23,560	192,595		**250,255**
Community Engagement			207,620		**207,620**
Infection Prevention and Control	93,840	14,415	91,715		**199,970**
Safe Burial			142,800		**142,800**
Clinical Management	6,120	64,020	40,070		**110,210**
Logistics	46,230	6,795	28,350		**81,375**
Administration			67,830		**67,830**
Coordination	24,335	4,650			**28,985**
Laboratoire	2,015	3,565	14,355	6,300	**26,235**
Point of Entry			2,990		**2,990**
Grand Total	**1,532,920**	**188,045**	**1,535,390**	**92,700**	**3,349,055**

**incl. Mangina*
***incl. Komanda, Mambassa*

Table 10: Number of national provider by commission cost of national payment by commission

Commission	Beni*	Bunia**	Butembo	Goma	TOTAL
Surveillance	862	198	2,709	152	**3,921**
Community Engagement			2,092		**2,092**
Security	109	71	1,028		**1,208**
Infection Prevention and Control	268	36	194		**498**
Vaccination	464				**464**
Safe Burial			327		**327**
Logistics	197	15	74		**286**
Clinical Management	16	150	87		**253**
Administration			65		**65**
Laboratoire	4	3	33	21	**61**
Coordination	19	8			**27**
Point of Entry			10		**10**
Grand Total	**1,939**	**481**	**6,619**	**173**	**9,212**

**incl. Mangina*

***incl. Komanda, Mambassa*