Update (for the period of November 2018 to January 2019) of the

STRATEGIC RESPONSE PLAN FOR THE EBOLA VIRUS DISEASE OUTBREAK IN THE PROVINCES OF NORTH KIVU AND ITURI

DEMOCRATIC REPUBLIC OF THE CONGO

22 December 2018

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1. CONTEXT

EPIDEMIOLOGIC OVERVIEW

Responding to the Ebola virus disease (EVD) outbreak in North-Eastern parts of the Democratic Republic of the Congo (DRC) continues to be a multifaceted challenge. By utilizing proven public health measures (surveillance, contact tracing, laboratory confirmation/testing, infection prevention and control, engaging communities) as well as new tools at hand (vaccine and therapeutics), we remain confident the outbreak can be contained and brought to an end. With ongoing transmission accentuated by high density and great mobility within communities of North Kivu and Ituri Provinces, the risk of the outbreak spreading to other provinces in the Democratic Republic of the Congo, as well as to neighbouring countries, remains very high.

As of 18 December, a total of 549 cases have been reported, of which 501 are confirmed, and 48 cases are probable cases. The distribution of cases by health zones (HZ) is shown in **Figure 1a**. The outbreak started in the Mabalako and Mangina health zones, before moving to Béni and neighbouring health zones, and steadily progressing further south along the 'Mangina – Beni – Butembo corridor' to the larger urban centre of Butembo (health zones of Butembo and Katwa), as shown on **Figures 1a and 1b**.

While a general downward trend has been observed in Beni Health Zone in recent weeks, new and high risk hot spots are emerging in the cities of Butembo, Katwa, surrounding villages, and most recently in epidemiologically linked clusters in high security-risk and difficult to access villages in Komanda and Oicha health zones.

A total of 15 health zones across North Kivu and Ituri Provinces have active cases as of 18 December 2018.

Figure 1a: Distribution of cases by health zone over time

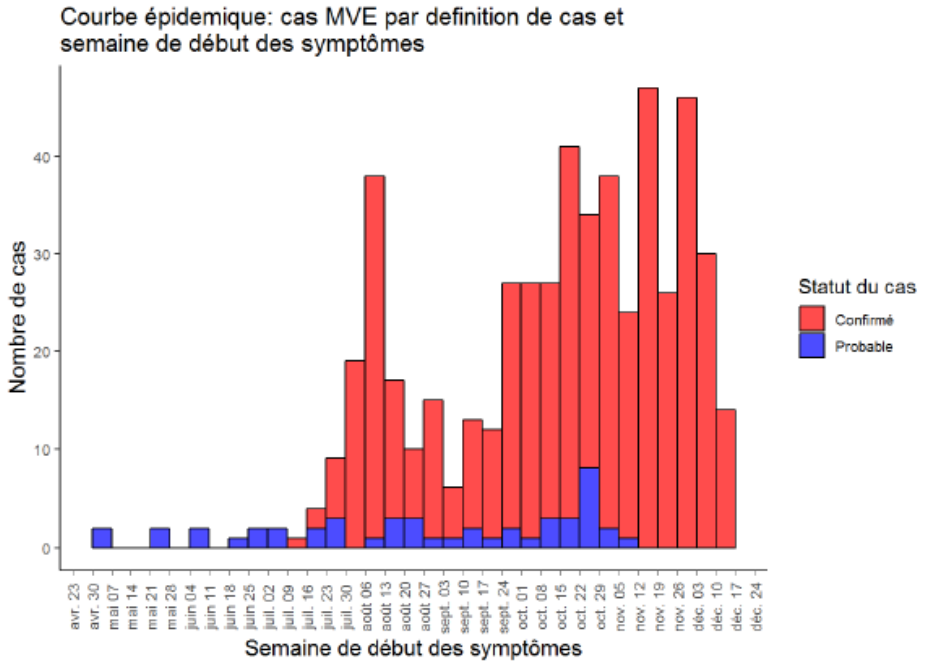
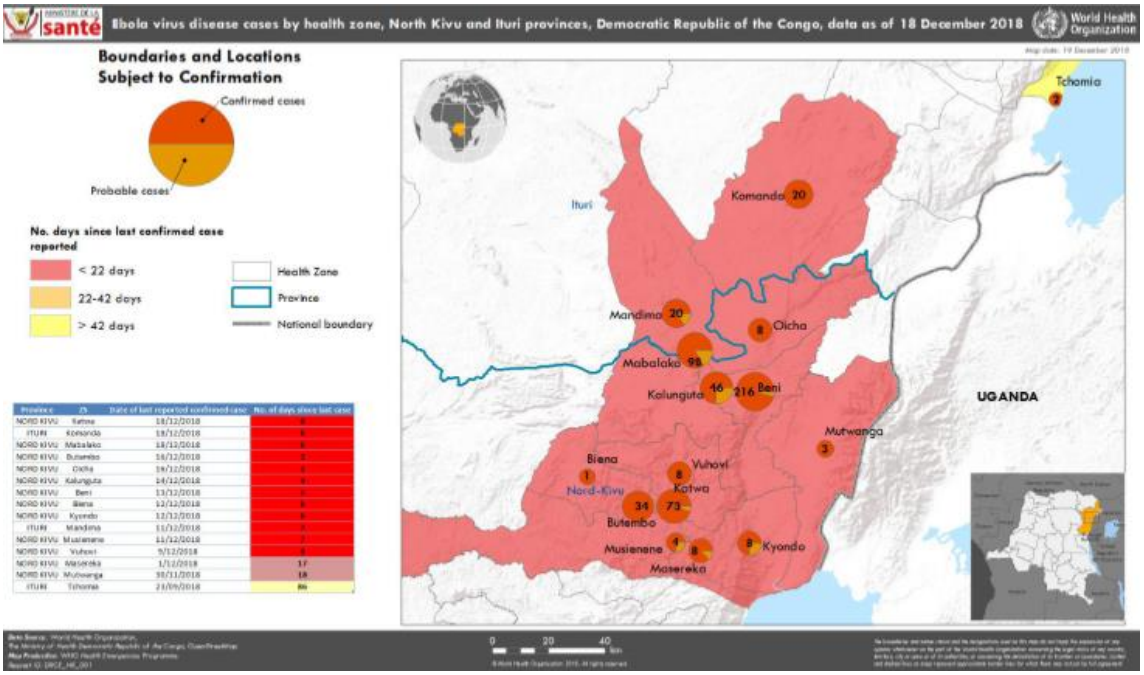


Figure 1b: Geographic distribution of cases by health zone, data as of 18 December 2018



BENI

The overall situation in Beni is improving with the number of cases decreasing weekly. Several key factors have led to improvements seen over the last few weeks and the steady decrease in onward transmission:

- Routine performance monitoring of contact tracing at the '*aires de santé*' (geographic health areas) level to guide investigation and identify areas that require strengthening, contributing to the increasing proportion of new cases who are known contacts;
- Steady volume of alerts with a proportion of validated alerts consistently around 70-80%;
- Delays from symptom onset to admission to an Ebola Treatment Centre (ETC) have decreased (median delay = 2 days); and
- No new healthcare worker infections over the past three weeks following implementation of an integrated healthcare facility approach.

BUTEMBO AND KATWA

The current situation in Butembo and Katwa remains worrisome given the number of weekly cases continuing to increase in both health zones.

- Majority of new cases are not known contacts, or are known contacts who were not followed, due in part to community resistance;
- Alert system remains sub-optimal, with the incidence of alerts lower in Beni and the proportion of validated alerts around 10%;
- Likely notable level of nosocomial transmission with 16.3% of cases across both locations involving healthcare workers from 11 different health facilities; and
- Under-reporting of cases with too few probable cases reported from Katwa and none from Butembo.

Over the last 21 days, only 55% of cases reported were known contacts, and of which only half were followed, bringing the proportion of new cases detected through contact tracing to 26%.

Nosocomial transmission remains a significant driver of transmission and challenges with the identification and listing of contacts in healthcare facilities, further significant driver of transmission, signals that a high proportion of new cases are unidentified contacts infected through nosocomial transmission. In addition, community resistance in both health zones has contributed to the low performance of contact tracing efforts.

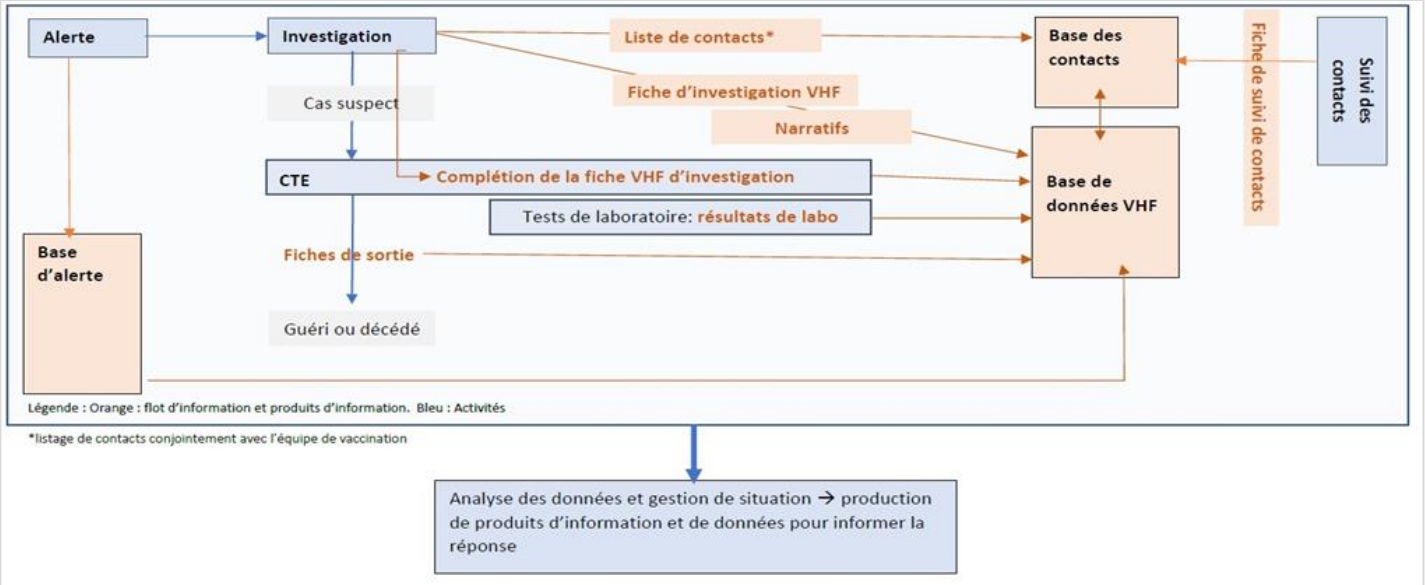
2. UPDATE ON THE RESPONSE OPERATIONS[1]

2.1 Surveillance and Active Case Finding

Aimed at ensuring the early detection and isolation of new cases and to prevent further spread of the outbreak, the current approach to surveillance and active case finding is comprised of the following elements:

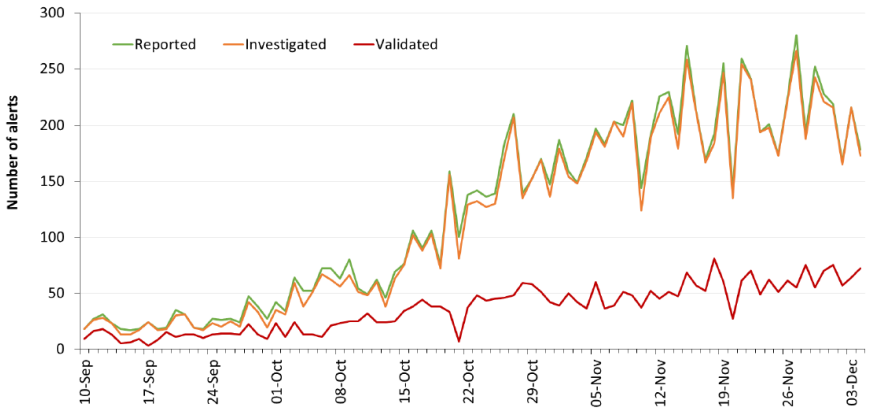
- Communication of alerts from several sources, including EWARS, community leaders, contact monitoring teams, and through coordination between surveillance and IPC teams to conduct active case finding in healthcare facilities;
- Investigation of all alerts within 24 hours, followed by deployment of a rapid response team once an alert is verified for further assessment;
- Narratives and precise mapping carried out by the investigation teams for the listing of contacts following classification of case as either confirmed or probable;
- Coordination with other response pillars to take forward vaccination, decontamination of households and health facilities, community engagement and referral to a treatment centre;
- Daily analysis of contact data, and identification of high-risk (‘*aires de santé’*); and
- Identification of high-risk ‘*aires de santé’* with contacts lost to follow up and strengthening of active case finding in these areas.

Figure 2: Overview of surveillance and active case finding



[1] Data provided under this section is as per latest information available at the time of the operational review (8-10 December)

Figure 3: Trends in the number of alerts reported and investigated per day, data as of 8 December 2018



Alerts per day in last 7 days:

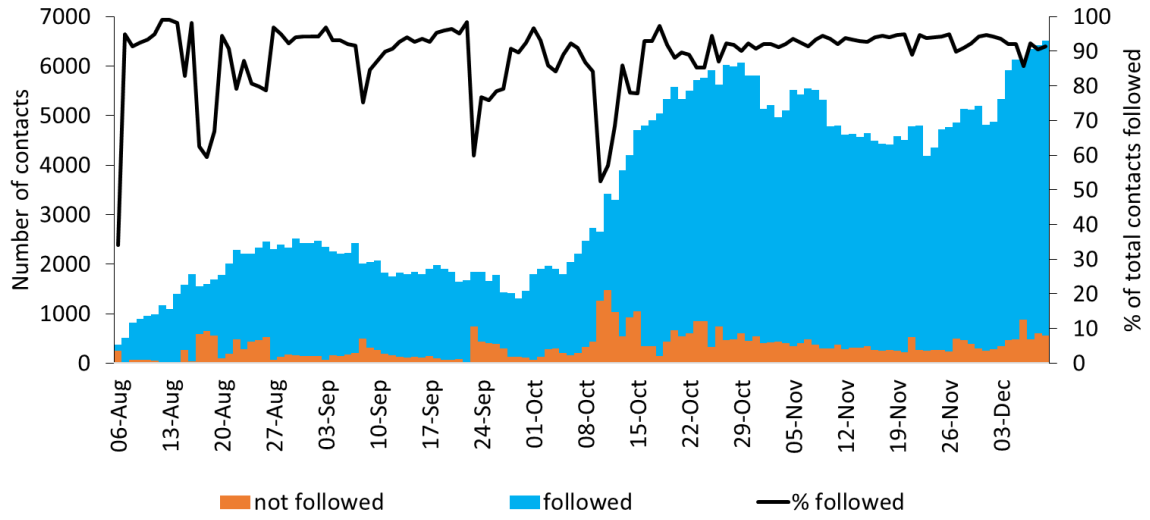
	Mean no. (range)
Reported	160 (101-216)
Investigated	154 (86-216)
Validated	68 (57-82)

2.2 Contact Tracing

As of 9 December, more than 27,500 of contacts have been registered, of which 6,509 remain under surveillance. Overall contract tracing performance for known contacts remains high, with 86-94% percent followed each day between 2 and 9 December 2018. Since the start of the outbreak, major security incidents followed by periods of community mourning, referred to as a Ville morte, severely hampered response activities, and affected the ability of teams to investigate alerts and follow contacts.

As shown in the graph below, substantial decreases in contact tracing performance in mid-September and early-October occurred following major attacks in Beni and Butembo by armed groups, and several days of Ville morte thereafter.

Figure 3: Trends in the number of confirmed contacts registered and followed-up per day



The current tracing of contacts remains challenging in all locations due high population mobility, community resistance, refusals for follow-up, and lack of reliable registers at health facilities. Teams dedicated to locating contacts lost to follow-up are in place, along with networks of community volunteers to follow contacts, and food assistance and psychosocial support being provided to contacts to encourage adherence to follow-up for known contacts. In addition, the weekly food assistance provided by WFP is expected to allow the identified contacts to limit their movements during the 21 days EVD incubation period.

During the period 12 November to 2 December 2018, 43% of confirmed cases were previously registered contacts, including those under surveillance at the time of onset and those lost to follow-up. While there has been an improvement in the proportion of confirmed cases coming from contacts, the overall trend has been fluctuating as new hotspots of transmission are recorded.

Figures 4 - 6: Confirmed and probable cases by contact status in Beni, Butembo/Katwa, and Kalunguta data as of 3 December 2018

Figure 4: Confirmed and probable cases by contact status in Beni

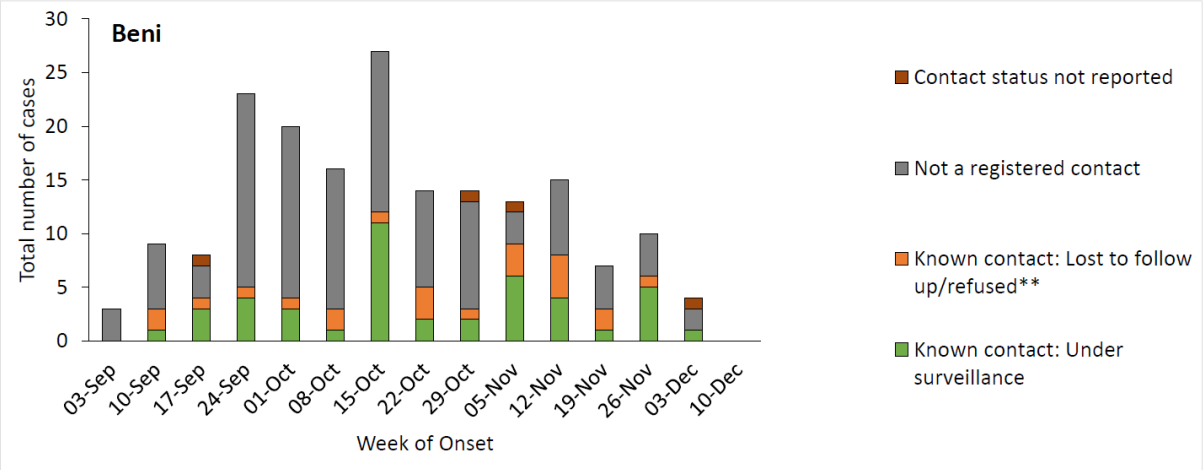


Figure 5: Confirmed and probable cases by contact status Beni/Katwa

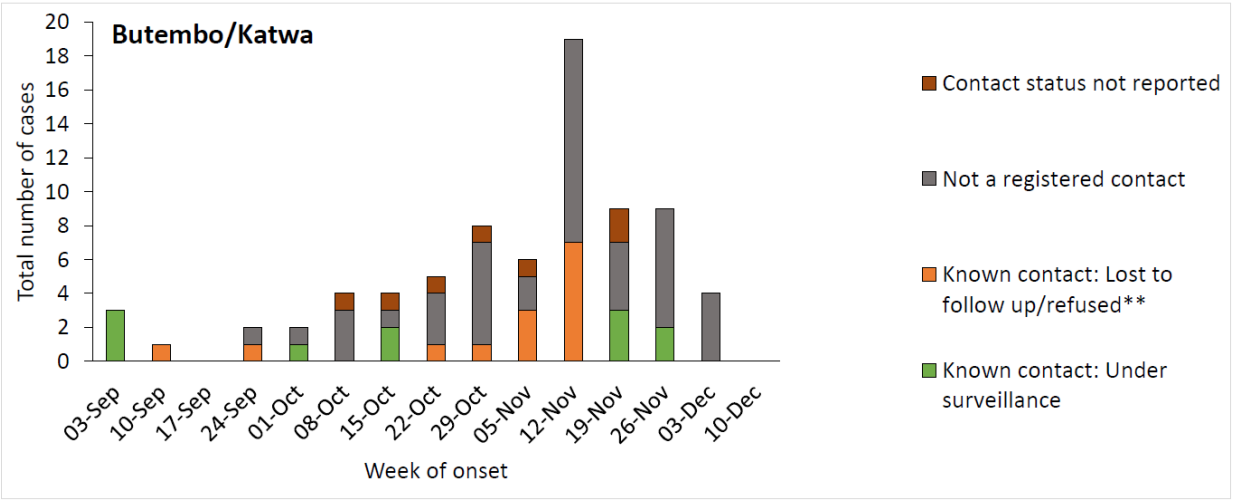
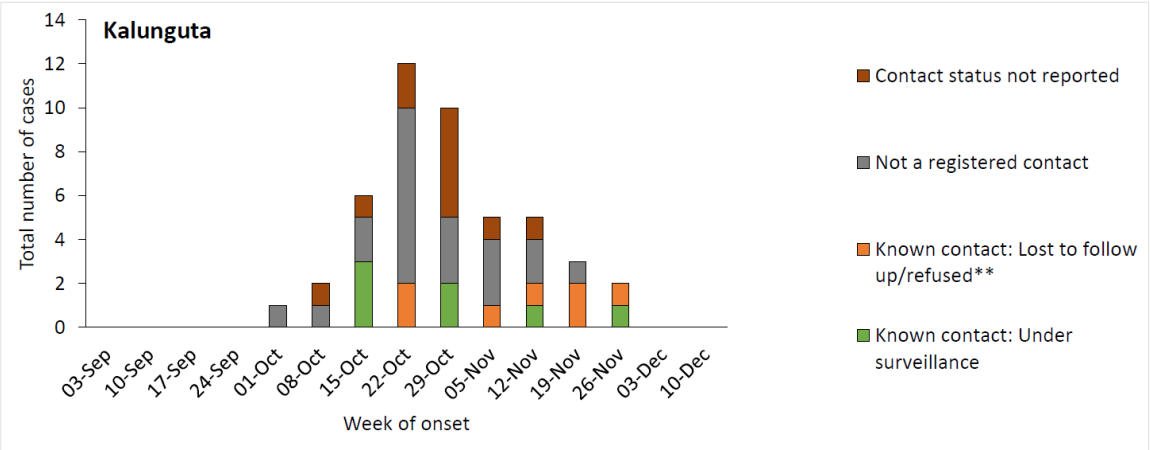


Figure 6: Confirmed and probable cases by contact status in Kalunguta



2.3 Points of Entry (PoE)

To date, a total of 71 points of entry (PoE) have been established across North Kivu and Ituri Provinces through the collaboration of the Ministry of Health, IOM, UNICEF, and WHO. While more than 19 million travellers screened, 18 million have washed their hands, and 16.5 million travellers sensitized on EVD to date, significant gaps have been reported in the quality of interventions provided at PoE and the ability of the PoE screening system to prevent further geographic spread of EVD.

Some of the key challenges noted include the limited availability of (1) adequate supervision at PoE stations, (2) functioning equipment (e.g. Thermoflash thermometers), and (3) WASH stations. Furthermore, delays in payments of PoE staff has been an ongoing challenge and contributed to the poor functioning of several PoE.

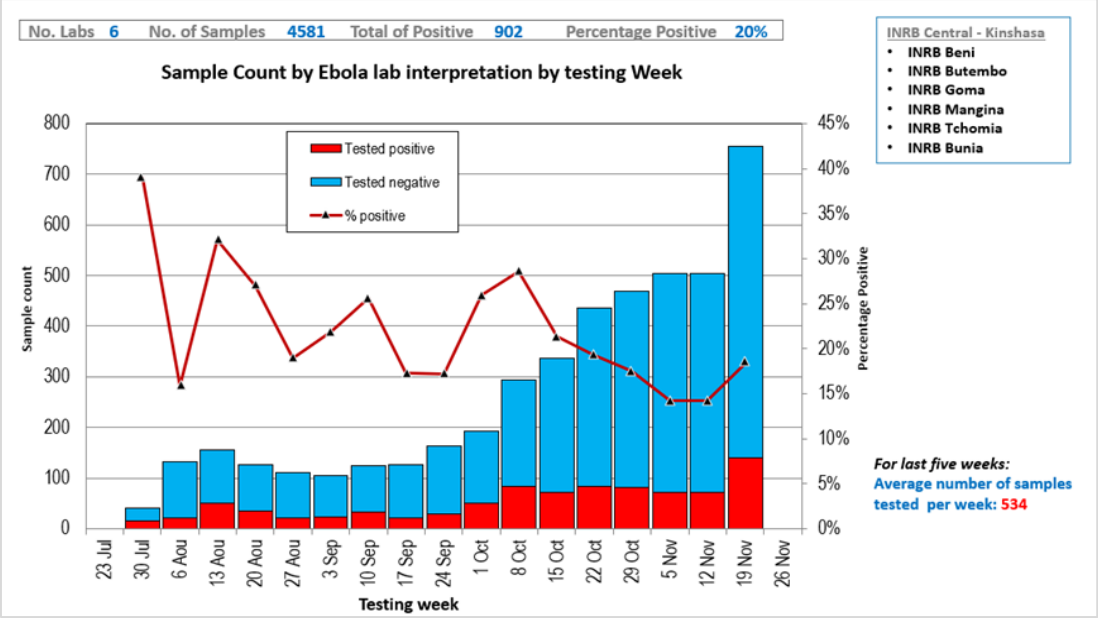
The following actions have been flagged as key recommendation for rapidly strengthening PoE capacity:

- To protect large cities and cross-border transmission, strengthen preparedness capacities, particularly in Goma.
- Strengthening activities by establishing priority PoEs in hot spots and strategic corridors and adapting a set of interventions according to epidemiological areas.
- Strengthen supervision at the PoE level by designating a dedicated focal point for each task (data management, risk communication, cleaning, logistics, filtering).
- Strengthen coordination with the various commissions and most particularly with the monitoring commission, in order to actively contribute to the findings of cases at the PoE level.
- Improve data management capacity by introducing a database and technical support at the PoE, sub coordination and Kinshasa levels (quality of data collection with a simplified data collection tool, sharing rapid analysis at the daily coordination meeting to prioritize actions.
- Rapid deployment of revised and simplified training materials for PoE staff (developed jointly by partners).
- Strengthen coordination mechanisms and leadership between the Ministry of Public Health and partners.
- Improved communication in communities with taxi and motorcycle drivers on the signs and symptoms of EVD, and the handling of reporting alerts.
- Use of thermal cameras at large assembly points and level crossings.

2.4 Laboratory

With support from the “Institute National de Recherche Biomedical (INRB)”, laboratory capacity has been established in all major operations centres, including Beni, Butembo, Mangina, Tchomia, Bunia, and Goma through the deployment of GeneXpert machines. Through daily reporting, testing capacity is under continuous review to ensure all locations can accommodate the number of samples collected daily. Laboratories in Bunia and Goma each have capacity to test five samples per day, followed by ten samples per day in Mangina. Additional GeneXpert machines were recently deployed to Beni and Butembo to increase daily testing capacity to 90 and 60 samples per day respectively. Given the current epidemiological situation, the laboratory in Tchomia will be relocated to Komanda.

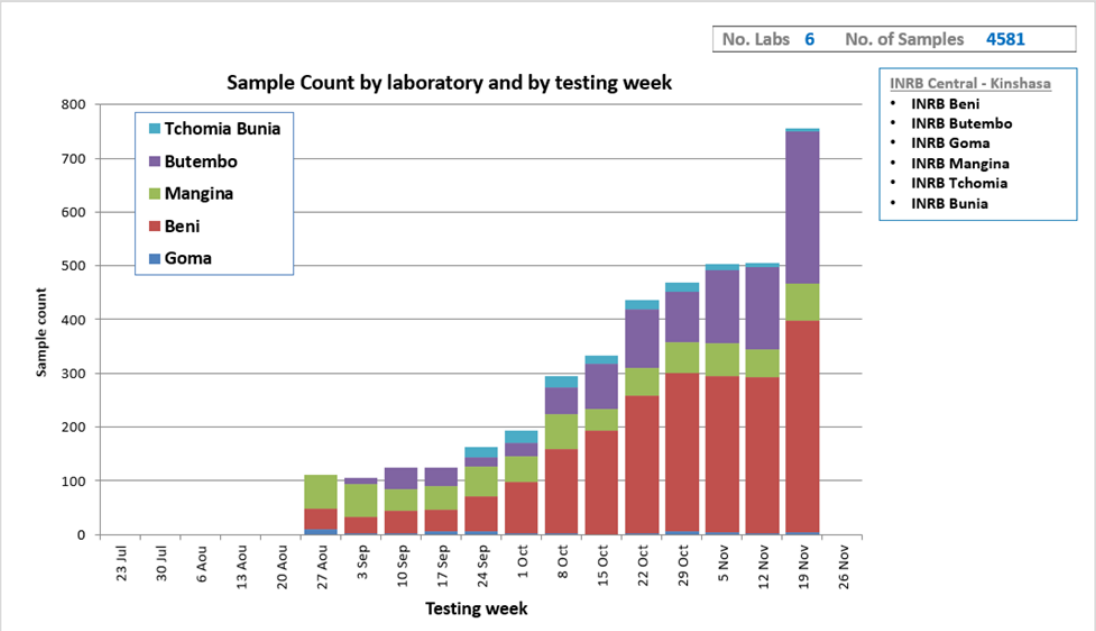
Figure 7: Sample count by Ebola lab interpretation by testing week, data as of 25 November 2018



The number of lab samples tested since the start of the outbreak has steadily increased from just under 200 samples tested during the first week of October 2018 to 756 samples during the week of 19 November 2018. Compared to the previous week, this represents a 50% increase in the number of samples tested.

Since epidemiological week 34 (19 August – 24 August) all laboratories have tested 100% of all samples received and have communicated all results within a 48-hour period of collection. Overall, the current rate of sampling and testing of alive and suspect cases are viewed as sufficient to support epidemiological investigation.

Figure 8: Sample count by laboratory and testing week, data as of 25 November 2018



To sustain existing operations and ensure the ability to rapidly deploy and scale laboratory capacity in newly affected locations, national staff have been trained since the start of the outbreak in the diagnosis of EVD. Through support from WHO, all laboratories are provided with the required reagents, consumables, and equipment for diagnosis of EVD as well as parasitology and for the differential diagnosis of yellow fever, dengue fever, and chikungunya. An in-country storage system for GeneXpert cartridges is also in the process of being finalized.

One of the key challenges to date has been the low sampling and testing of community deaths, with reporting during the period 19-25 November showing a 97% decrease in the number of swabs tested from community deaths. Daily sampling and testing of community deaths currently ranges from 5-10 in Beni and from 2-5 in Butembo, significantly lower than the expected number of death per day, 50 and 80 for each location respectively, based on population sizes.

2.5 Clinical Management

Through the combined support of the Ministry of Health, the Institute National de Recherche Biomedical (INRB), ALIMA, MSF, IMC, and WHO, a total of five Ebola Treatment Centres (ETC) have been constructed since 1 August 2018. Protocols on optimized supportive care and the use of investigational therapeutics under the Monitored Emergency Use of Unregistered Interventions (MEURI) approved during the Equateur EVD outbreak in May 2018, enabled access to high-quality, patient-centred care to suspect and confirmed EVD patients within days of the outbreak declaration including daily nutritious food for the duration of their treatment.

As of epidemiological week, 38 (16 September – 22 September) the intra-ETC case fatality ratio (CFR) for all ETCs, apart from Mekeke which has not treated an EVD confirmed case to date, has remained below target threshold of 50%. ETCs in Beni and Butembo, which currently care for the majority of confirmed EVD cases, have a CFR of 33% and 45% respectively. The low CFR as compared with previous EVD outbreaks is largely attributed to the availability of biochemistry laboratory testing, intravenous hydration therapy, hypoglycaemic monitoring, and close monitoring for all patients.

The time from symptom onset to presentation to an ETC has reduced significantly from 7 days in early August to a current average of 2 days, both through improved surveillance and increased community awareness and understanding of EVD and the importance of early treatment.

Figure 9: EVD hospitalizations by location, data as of 8 December 2018

Hospitalizations as of 8 December

Patient Status	Mangina (54 beds)	Beni ETC (60 beds)	Beni TC (48 beds)	Goma (30 beds)	Butembo (64 beds)	Tchomia (16 beds)	Total
SUSPECT	9	25	30	3	28	0	95
CONFIRMED	1	15	0	0	21	0	37
Total	**10**	**40**	**30**	**3**	**49**	**0**	**132**

Available to patients since August 10, a total of 203 patients have been treated with investigational therapeutic products in four locations. The ability to administer therapies and closely monitor patients is supported by a group of national clinicians deployed by the Ministry of Management and INRB to work under the supervision and technical advice of expert clinicians from partner organizations.

Following the installation of a 48-mile transit centre in Beni, supported by MSF and Ministry of Health, the capacity of beds for suspected and confirmed cases in Beni remains sufficient. With the increased capacity to manage suspicious patients, bed occupancy at Beni ETC (60 beds), managed by ALIMA, has stabilized and generally remains below 75%.

The ETC in Butembo (MSF and the Ministry of Health) has 64 beds and is currently concerned about suspects and confirmed cases of both Butembo and Katwa. The construction of an ETC in Katwa has been approved by the Ministry of Health Minister of Health and will contribute to increasing bed capacity at the Butembo ETC. An isolation centre was established at Katwa General Hospital until the construction of the new ETC was completed.

As a preventive measure, another ETC has been built in Goma to ensure that capacity is available to quickly isolate and treat suspected and confirmed cases if there is a new geographical spread of the epidemic south of Butembo.

To address the increase in infections in children, UNCIEF and the Ministry of Health deployed a pediatrician to the Ebola treatment centre in Beni to assist in the clinical management of children; finalized, with the support from the National Nutrition Program (PRONA), a clinical protocol for the nutritional care of infected adults and children in the Ebola Treatment Centre; and worked towards the finalization of technical guidance for infant and young child feeding practices in the context of the Ebola virus.

2.6 Infections Prevention and Control

Despite the efforts of a wide range of international and national partners to accelerate and rapidly improve infection prevention and control measures, nosocomial transmission in public and private health centres (including traditional and modern facilities) continues to be an important source of the epidemic's amplification. In Butembo and Katwa, health care workers currently represent 16% of all cases and come from 11 different institutions. In addition, Beni's transmission chain suggests that more than 60% of cases to date are related to nosocomial transmission.

Exposure to EVD in public and private health facilities is probably one of the key factors leading to a disproportionate number of women and children being infected during this epidemic. With respect to the December 4 data, women accounted for 62% of the cases where sex was reported, and children under 15 years of age account for 24% of all confirmed cases. A simultaneous increase in malaria cases in Beni and the lack of IPC accompanying the installation is also considered to have contributed to high EVD rates in children.

Community awareness of IPC/WASH, training of public and private health care providers on basic IPC standards and distribution of 147 IPC kits to health facilities in Beni and other affected areas have done little to reduce nosocomial transmission rates. There is a wide range of challenges that impede progress towards stopping nosocomial transmission, including:

- The strong local dependence on traditional-modern and private clinics, more than 200 of which are estimated to be in Beni alone.
- Limited ability of IPC/WASH teams to respond quickly to urgent requests to decontaminate homes and facilities where confirmed and probable cases have been identified.
- Priority facilities located in areas that are difficult to access due to insecurity and community resistance.
- More than 20 international and national partners support IPC/WASH activities, with some partners supporting the same facilities, limited visibility on how facilities are prioritized based on the risk, location and capacity of partners, as well as those who do what and where.

In response to the current epidemiological situation and the challenges noted, a new strategy for the rapid scaling up of IPC/WASH activities in priority health facilities was adopted by the Ministry of Health in mid-November. The objective of the new strategy is to establish a set of core IPC activities, including a system of mentoring and systematic monitoring of health care providers in priority and high-risk settings. The identified facilities, which include public, private and traditional modern centres, are (1) evaluated on a bi-monthly basis using a standardized IPC monitoring tool, (2) assigned a trained IPC focal point within the health care centre to support training and improvements, (3) provided with IPC supplies, and (4) supported by the establishment of triage and infectious waste management systems. A performance-based financing system for these facilities has been approved, and those who have scored above 50% on their bimonthly evaluations will be provided with financial incentives.

The implementation of the new strategy is underway in Beni with a total of 68 health facilities identified and initial scoring/baseline assessments completed. Each subsequent surveillance visit will be used to redefine the ranking of the health care facility, and based on the results, will have received a proportional incentive to the new ranking. Monitoring will provide an opportunity to prevent supply shortages, build capacity and monitor the referral of cases to ETC facilities.

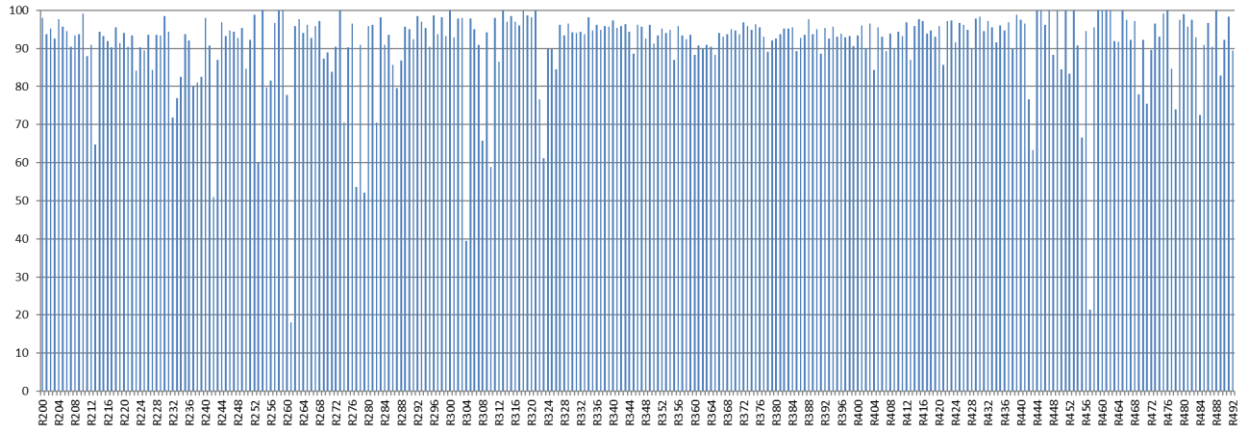
Community WASH services provided in identified community sites and schools to reduce the risk of infection in the community and in schools are complementary to these efforts.

2.7 Vaccination of at-risk groups

Vaccination of contacts, contact contacts, health care and front-line workers began on August 8. As of December 8, 43,552 eligible and consenting individuals have been vaccinated, including 13,375 health care and front-line workers and 10,870 children. Recently scaled up from 8 to 15 vaccination teams (14 in North Kivu and Ituri, 1 in Goma), a total of 293 belts have been defined to date, including 56 belts for health providers and frontline workers.

More than 90% of eligible and consented persons have been vaccinated to date. At the beginning of the outbreak, ring vaccination focused only on contacts and contacts of contacts from the most recent confirmed cases. Since then, vaccination protocols have been modified to allow vaccination around probable cases with a strong-EPI link. Targeted geographical vaccination has been carried out in two locations to date: Butanuka (Beni) and Kanyihunga (Butembo).

Figure 10: Percent vaccination among contacts of contacts and contacts listed, data as of 8 December 2018



Coordination and communication between surveillance and vaccination teams was strengthened in late October following concerns raised regarding inconsistencies between the two teams' data sets on contacts and contact of contacts. Through the creation of a joint data information unit, teams are regularly sharing information on case investigation, including detailed narrative to support further identification of contacts of contacts, and the locations of cases.

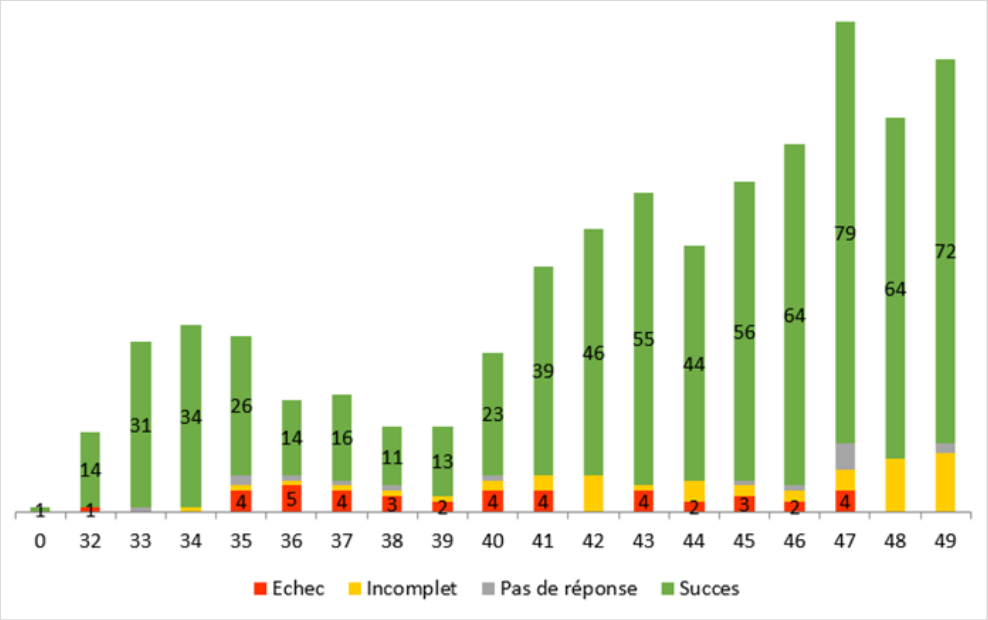
Due to ongoing instances of community resistance, joint-coordination between vaccination and community engagement teams has become critical to the success of vaccination activities. Community engagement teams work closely with communities to sensitize members on EVD vaccination and secure approval from community leaders for vaccination prior to the arrival of vaccination teams.

Both approaches for collaboration between surveillance and community engagement teams continues to work well in Beni and is in the process of being replicated in Butembo and Katwa.

2.8 Safe and Dignified Burials (SDB)

Despite security challenges, community resistance, and instances of violence and aggression toward safe and dignified burial teams, significant progress has been made in the coordination and implementation of safe and dignified burials across all affected areas. As of the 8 December, a total of 812 alerts have been received by SDB teams, of which 82% were successfully responded to. Incomplete and unsuccessful burials, as well as those not responded to, were due in large part to insecurity, community resistance, or burials being completed prior to the arrival of SDB teams.

Figure 11: Status of SDB alerts by epidemiological week, data as of 8 December 2018



Facilitated under the coordination of the MoH, SDB capacity is provided by the Red Cross and civil protection teams from the Ministry of the Interior. Trained and supported by the Red Cross with technical guidance and supervision, civil protection teams currently operate in areas inaccessible to Red Cross teams due to insecurity. In areas inaccessible to both Red Cross and civil protection teams, a new approach for facilitating SDBs is currently being piloted in Kalunguta where community members are trained and provided with the required materials to independently take forward SDBs. The community-based teams received remote teams are all vaccinated against EVD and receive remote support and supervision from Red Cross via phone and SMS.

The overall approach to SDB is under continuous review to ensure procedures in place reflect, to the greatest extent possible, the cultural practices and needs of the communities being served. Community feedback was a key factor in understanding that one of the drivers of community resistance toward SDB teams was the lack of communication regarding laboratory results prior to proceeding with burials. With support from community engagement teams throughout the entirety of the SDB process, laboratory results are now communicated within a 3-4-hour period of samples being taken. Only if the results are positive, will the SDB team proceed with the burial.

2.9 Risk Communication, Social Mobilization, and Community Engagement

Through the combined support of the Ministry of Health, UNICEF, UNFPA, IFRC, and WHO, and local NGOs/partners, the overarching risk communication and community engagement strategy shifted in early-mid October following several security incidents and significant community resistance towards investigation and safe and dignified burials teams in Ndindi.

Recognizing the overall context in terms of high population mobility, highly diverse community networks with over 20 ethnic groups represented in Beni alone, and ongoing instability and conflict, the revised strategy places a greater emphasis on targeted and proactive engagement with community influencers, civil society, and community networks (e.g. taxi drivers, youth groups, marginalized ethnic groups, religious groups, and women's associations).

Aimed at driving community ownership and support for the response in addition to understanding EVD prevention, response interventions for risk communication, social mobilization and community engagement employ a variety of approaches including, but not limited to, community dialogues, interpersonal communication through house-to-house visits, and community animations. There is also ongoing and significant work being done by Ministry of Health and partners to engage civil society, community associations, local leaders and experts in anthropology and psychosocial support to dispel myths and rumours about EVD, support conflict mediation, and facilitate engagement in areas with community resistance and tension.

Civil society members, community associations (taxi drivers, women's and youth groups), and local leaders are engaged to support a broad range of response activities. Working alongside response teams, community stakeholders play a critical role in addressing community concerns, improving understanding of EVD prevention and response activities, negotiating access to the community, preparing communities for the arrival of response teams (e.g. surveillance, vaccination, SDB, etc.), and ensuring family and community members are supported during response activities.

Community engagement and risk communication activities through door-to-door visits and outreach at markets, churches and schools has helped to reach more than 1.2 million people since the start of the outbreak with EVD-related information and dialogue. Results of two Knowledge, Attitude, and Practices surveys show an overall increase community knowledge of two ways of preventing EVD and two modes of transmission increased by a difference of 50% among respondents in Beni and Mabalako. Relais communautaires, a network of community volunteers who act as interface between communities and the healthcare system, play a significant role in promoting positive health seeking behaviours, reinforcing IPC and WASH principles in communities and health facilities, as well as the benefits of reporting alerts and seeking early treatment. Across Beni, Butembo, Katwa, Mabalako, Tchomia, and Oicha, relais communautaire have reported more than 185,000 household visits related to EVD.

Mass communication remains a critical component of the overall risk communication and community engagement strategy, particularly in newly affected areas, red zones, and health zones where community engagement measures require further scaling and human resources (e.g. Butembo, Katwa, Komanda, and Mambasa). A total of 46 radios stations across Beni, Mabalako, Butembo, Tchomia and Katwa include programming to dispel EVD rumours, increase awareness of the signs and symptoms of EVD, safe and dignified burials, and broadcast testimonies from survivors on the experience of patients in ETC.

2.10 Psychosocial Support

A package of psychosocial support is available to suspect and EVD confirmed cases, their families, and the families of contacts through the joint leadership of the Ministry of Health and UNICEF, and with close coordination of surveillance, clinical management, community engagement, safe and dignified burial, and logistics teams.

The objective of the psychosocial support strategy is to support cases and their families with (1) identifying and strengthening networks of community support, (2) access to a series of social kits and material assistance, (3) and facilitating mental health and psychosocial support, including professional services for children requiring a higher-level of psychological care and social support.

As of December 9, a total of 1,814 persons affected by EVD (suspect and confirmed patients, and their families) have received psychosocial support across all ETCs. This includes strengthened support to children admitted to the ETCs either as suspect or confirmed cases through the creation of child-friendly spaces and the recruitment of trained survivors to provide support and childcare services.

With children under the age of 15 representing 24% of all confirmed cases, there are ongoing efforts to strengthen the involvement of survivors to provide childcare as there's limited capacity available across all ETCs to meet the current level of need. In addition, UNICEF have established a creche near the ETC in Beni to care for the young children whose mothers are receiving treatment in the Ebola treatment centres. The children are cared for by Ebola survivors.

More than 520 EVD-affected families have been reached with psychosocial and/or material assistance in all affected health zones since the start of the response. Material assistance to date includes distribution of hygiene kits and food assistance to survivors, discharged patients and suspect cases (negative cases), funeral kits, NFI kits, and newborn kits.

Another critical component of the psychosocial support strategy is care to orphaned or unaccompanied children because of the EVD epidemic. A total of 406 of the targeted 600 orphaned and accompanied children been integrated in the community and receive material assistance when required.

2.11 Current Financial Overview

The revised national plan for the response to the Ebola virus disease epidemic in North Kivu and Itury provinces was published by the Ministry of Health on 18 October 2018 and covered the three-month period from November 2018 to January 2019. The total estimated resource requirement was US$61.3 million. The following table presents the funding situation to date (as of December 20, 2018) and the implementation rate expected at the end of December 2018.

Financial Overview Ebola North Kivu and Ituri

1. Plan (August-October)	**US$ million**
Planned Budget	43.84
Funds Available	44.19
Funds disbursed/committed (August-October 2018)	42.89
Funds to be reprogrammed to North Kivu (Nov-Jan)	**1.3**

2. Revised Plan (November 2018-January 2019)	**US$ million**
Planned Budget	61.28
Funds reprogrammed (August October)	1.3
Estimated new funds mobilized	60.14
Funding Gap/(Surplus)	**(0.2)**

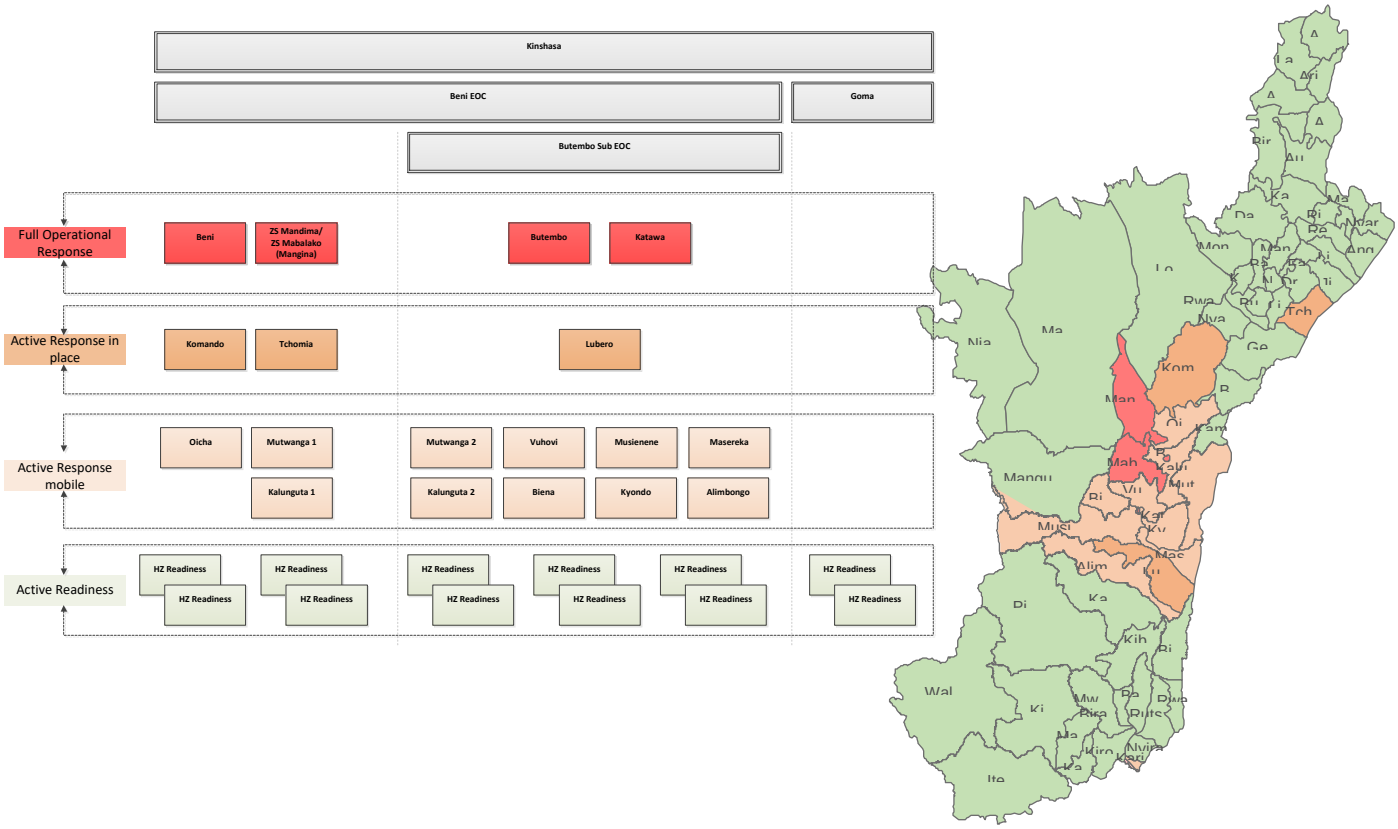
3. Revised Plan Implementation (Nov 2018-Dec 2018)	**US$ million**
Funds projected/received	61.44
Funds disbursed/committed (November-December 2018)	(50.39)
% of implementation	**82%**

3. UPDATED RESPONSE STRATEGY

3.1 Strengthened active response operations

Lessons from Beni and earlier outbreaks have demonstrated that the revised strategy has been effective in managing the outbreaks in Tchomia, Mangina and Beni within 6-8 weeks. However new epi-centres in Butembo and Katwa have highlighted the importance of scaling up active response operations and operational readiness in neighbouring Health Zones and Provinces while maintaining existing full response operations.

Figure 12: Concept of Operations-Impact of the operational intervention in North Kivu and Ituri



Based on this, in addition to the existing full response capacity in place in Beni, Mangina, Mabalako, Butembo and Katwa and active response teams in Tchomia and Komanda there is an urgent need to establish dedicated active response capacity in 10 additional Health Zones while scaling up active readiness in other Health Zones and Provinces. This will be based on a 4-Tiered concept of operations.

- Full Operational Response
- Active Response Operations – Deployed Teams
- Active Response Operations - Mobile Support Teams
- Active Readiness

A monitoring and assessment mechanism will be implemented to review the situation on a weekly basis to determine the appropriateness of the response levels in each Health Zone.

Full response teams in hotspot health zones

Target health zones: Beni, Mangina, Mabalako, Butembo, and Katwa

In areas with ongoing active transmission a full operation response capability (Ministry of Health, WHO and Partners) is required consisting of a Field Coordination Team established with the following elements:

- A surveillance team lead with a team of epidemiologists to take care of contact listing/search, construction of transmission chains, contact tracing, immunization. depending on the work load a specific team lead may be required for contact tracing.
- Vaccination teams.
- A laboratory for specimen analysis and provision of results.
- A team lead for infection prevention and control with emphasis on safety of health workers and their welfare (supported by the psychosocial team).
- A case management lead will also be in place supported by a treatment centre.
- A team lead for risk communication and community engagement including team of anthropologists.
- A team lead for safe burial teams.
- A team lead and experts in psycho-social support to contacts and survivors.
- Administration, human resources, finance and administrative assistants.
- Logistical support (team lead, fleet assistant, procurement, supply, warehouse), Ultra Cold chain & Vaccines Management), including security lead and assistants.

In areas where an active transmission has occurred but been managed or in Health Zones bordering ongoing transmission, a dedicated active response is required. Active response will be split into two categories based on the proximity and intensity of transmission as well as access due to security reasons.

Deployed teams for active response in high-risk health zones

Target health zones: Komanda, Tchomia, Lubero, Goma and Kisangani

The first group are Health Zones where there is either ongoing transmission or a high risk of transmission. In these locations capacity Ministry of Health, WHO and Partner capacity will be established and maintained in place, led by a field coordinator and supported by the following dedicated teams.

- A surveillance team lead with a team of epidemiologists to take care of contact listing/search, construction of transmission chains, contact tracing, immunization. depending on the work load a specific team lead may be required for contact tracing.
- Vaccination teams.
- A laboratory for specimen analysis and provision of results.
- A team lead for infection prevention and control with emphasis on safety of health workers and their welfare (supported by the psychosocial team), and WASH in health facilities and communities. A case management lead will also be in place supported by a transit centre.
- A team lead for risk communication and community engagement including a team of anthropologists.
- A team lead for safe burial teams.

- A team lead and experts in psycho-social support to contacts and survivors.
- Admin, finance and logistical support (administrative assistant and a logistician).
- Security.

Mobile support teams for active response in high-risk health zones

Targeted health areas: Oicha, Mutwanga, Kalunguta, Vuhovi, Biena, Musienene, Kyondo and Alimbongo

By strengthening and supporting national health capacities at the local level, the second group includes an active response, but is provided on a mobile basis mainly in areas where it is not possible to position international staff and where the distance to the area can be managed from an existing EOC or a sub-EOC as described above mainly due to security and lack of accommodation for teams (no water, no space for camp teams). The main objective of this mobile response will be to work with the local capacity to build the basis for a future response if necessary, strengthen community monitoring and ensure that communities are aware of the risks they face due to proximity. This function will focus on building local capacity in health zones and gradually transferring leadership for operations to health zone teams through training, advocacy and material support.

Although the main approach is a dedicated mobile capacity, the Ministry of Health will deploy an experienced epidemiologist who will be stationed in each of these health zones for continuous daily assistance in response operations, including the following:

- A surveillance team function of epidemiologists to take care of alerts, contact search, tracing and follow up.
- Vaccination teams.
- Infection prevention and control function with emphasis on safety of health workers and their welfare (supported by the psychosocial team), and WASH in health facilities and communities.
- Risk communication and community engagement function including anthropologists and local communicators.
- A safe and dignified burial function.
- Psycho-social experts and workers to provide support to contacts and survivors.
- Security (the teams have to be escorted most to the times).
- Administrational, finance and logistical support will be covered centrally through the sub-EOC in Butembo.

Mobile support for active readiness in at-risk surrounding health zones

In all other Health Zones within Ituri and North Kivu and in other Provinces, Health Zones will be supported to implement active preparedness measures. These sites have no confirmed cases, but they do surround the affected zones. They are usually at risk of known contacts travelling to these areas. Thus, there is need to make these areas ready to act as soon as contacts appears. In these areas, it is necessary to set up and implement an active surveillance system in all health facilities with daily reports on the number of alerts /suspected cases including zero reporting. A rapid response team for investigation, confirmation of alerts and possibly collection of samples for laboratory confirmation will be established. To this end, the Ministry of Health will deploy an experienced epidemiologist who will provide ongoing support to the Health Zone team on site, in addition to the support provided by the nearest mobile team from the EOC or sub-EOC.

The following elements are required in this zone:

- A surveillance team composed of epidemiologists to take care of alerts, contact search, tracing and follow up
- Risk communication and social mobilization for awareness raising and community alert
- Vaccination of first line responders

Considering lessons from the past five months, the overall response capability at all four levels will need to be maintained until at least the end of April 2019 followed by a 90-day period of enhanced surveillance and operational readiness.

3.2 Contingency planning to manage increased security and political risks

In addition to challenges posed by community resistance (including reported attacks on staff responsible for the response), continued deterioration in the general security situation coupled with the electoral period will pose additional serious challenges.

In the period leading up to the national elections on 23 December, political rallies and campaign events are likely to cause disruption for short periods in specific locations due to crowds and heightened volatility. There is likely to be increased population movement in the days directly before the election as people return to their registered locations to vote (while also conducting habitual movements for the holiday period). The period between voting day (23 December) and the scheduled announcement of the results of the presidential election (30 December) could be especially volatile.

Throughout this period, the unpredictability of the situation may lead to restrictions on movements, curfew and other security measures that may have a negative impact on the response. Contingency planning together with the implementation of specific mitigation actions will be vital to ensuring full operational continuity throughout this period. These activities will focus on the following:

- Immediate measures to ensure stable and predictable response during the election and holiday period (20 December 2018 - 4 January 2019) to sustain existing operations while continuing to scale up operations in Butembo and Katwa. This will include the establishment of strategic stockpiles and prepositioning of key supplies and equipment, increased dialogue with local communities and other stakeholders to reduce the level of risk and the implementation teleworking and remote operations through expanded use of national staff.
- Strategies to ensure operational continuity in areas of increased security risk including the establishment of dedicate trauma stabilization posts in all operational areas linked to appropriate casualty evacuation procedures and as needed the temporary relocation of staff and implementation of remote response operations.
- Strategies to limit the risk of spread of EVD to bordering regions caused by the movement of people in relation to political or security incidents, including the establishment of co-ordination and operation response structures in bordering health zones.

The large quantity of personnel deployed over an extensive geographical area further increases the risk through road traffic accidents. These health and security risks coupled with unavailability of high level care facilities and emergency response services pose a growing challenge to the staff health of WHO personnel and partners. The WHO and Partners in coordination with MONUSCO are putting in place a highly skilled trauma response capability to undertake high level pre-hospital stabilization including Mass Casualty Incident Response.

The primary role of the Trauma Response Capability will be to provide multiple highly mobile rapid response teams capable of providing advanced life support intervention for both national and international WHO Personnel and partners in the event of a life-threatening trauma emergency and/or Mass Casualty Incident. Medical emergency support will include:

- Provision of dedicated daily 24hrs emergency trauma support coverage at strategic locations where concentrations of WHO and Partner staff are work and live.
- Provision of mobile emergency trauma support to teams working in remote areas high risk areas.
- Provision of ongoing emergency first aid training to WHO personnel and Partners.
- Provision of Mass Casualty Incident Response training in the context of MIMMS.
- Revision and rehearsal of multiple casualty Incident plans for all areas of WHO Ebola response Operations with Acceptable Risk Level within the Democratic Republic of Congo and operate in compliance with all UNDSS security requirements.
- Coordination with all stakeholders to ensure aligned response capacity.

The teams will be stationed in main hotel residences and areas of operation including the Ebola Operation Centre. Five (5) units are expected to operate with 3 stationed in Beni, 1 in Butembo and 1 Roving Unit to supplement other teams but also deploy in far out areas as need arises.

The areas of operation and reallocation of teams will be reviewed on an ongoing basis considering the Epidemiological landscape of the Ebola response and Security.

To ensure alignment across response partners, including the development of common scenarios and assumptions contingency planning is implemented through the Ebola Response Strategic Committee in Beni.

3.3 Strengthened tracking of contacts lost to follow-up including across health zones and Provinces

Contact tracing is an essential measure to control an outbreak of Ebola virus disease (EVD). It allows for new cases to be identified as quickly as possible to:

- Increase the chances of survival of these patients through early management.
- Limit their infectious period in the community and thus reduce the risk of secondary transmission.

However, contact tracing in the current epidemic context remains difficult, due to (i) challenges in identifying all contacts, particularly in healthcare settings and in highly dense urban environments; and (ii) challenges in following up contacts, due to population movement and community resistance. A significant proportion of high-risk contacts are lost to follow-up (LTFU), leading to a significant risk of secondary transmission, and the potential for seeding an outbreak into new geographical area.

Enhancing contact tracing for high-risk contacts and further strengthen efforts to trace displaced contacts and contacts lost to follow-up is essential to contain the epidemic.

The objective is to establish an enhanced strategy to trace and track contacts lost to follow-up or displaced. This strategy will include:

1. Mobile surveillance teams dedicated to tracing contacts not seen and lost to follow-up (LTFU).
2. A Coordination, Tracking and Analysis Cell at the EOC dedicated to the analysis of unseen, lost and displaced contacts.

3. A strengthening of existing measures in place for the tracking of contacts not found and lost to follow-up at the sub-coordination level.
4. Involvement of civil protection, UNPOL and the National Intelligence Agency (ANR) in tracking lost and displaced contacts.

3.4 Strengthening and deepening risk communications and community engagement in acute response zones

Communications for Ebola needs to be understood as a dynamic intervention, with a strong focus on listening, empathizing, and adapting to thoughts and reactions of communities, in real time. One size does not fit all. What worked in North Kivu was the adoption of an action-anthropology approach, in which assessment, analysis and actions were taken and implemented almost immediately.

Ebola communication strategies should have as an objective to create community-led and self-managed surveillance and alert systems as soon as possible. This should be negotiated and put in place as soon as possible, depending on the acceptance of the community, and of course starting with the 'champion' community leaders first.

In this light, there is a clear and tangible advantage in developing an operational strategy to address how to more effectively place local influencers as key respondents to the response. The earlier communities accept to own the response themselves, the sooner it will end. We are there to support them once the information and training are completed.

It can be rightfully said that the integration of communications and psychosocial teams into the surveillance, vaccination and SDB teams has made an almost immediate impact on the control of the epidemic and reducing violent reactions from communities. The misinterpretations between the Ebola protocols and the conservative cultural and religious practices can only be addressed by those who are trained to do so. The more expertise in this area, the faster and more efficient our response will be.

Ebola needs the right expertise in the field, both in quality as well as quantity. Identifying and training the right personnel early is a critical contribution to future epidemics.

3.5 Strengthened IPC in both government and "e-modern" health facilities based on incentives

To date, EVD transmission in health facilities remains the main cause of infection among new cases (60%). To meet the challenge, the coordination of the response validated the implementation of a PBF with these structures as part of the operational strategies.

Each targeted health facility is committed to obtaining (purchasing or donating) IPC/WASH kits, managing them well, using them and reducing or eliminating cases of contamination for its staff member and service users. Targeted health facilities are categorized into 4 categories: Category 1 (40 beds and more), Category 2 (20 -39 beds), Category 3 (6 - 19 beds); Category 4 (0-5 beds).

Close support for health facilities in improving IPC/WASH practices, provision of kits, incentives for improvements if necessary, active case finding in health facilities, alerts and risk communication will be carried out by supervisors using the audit and evaluation form. The calculation of the IPC/WASH score and the performance in reporting alerts for payment is based on the biweekly audit and evaluation form

(Frequency: bi-monthly) by the mixed team. The evaluation considers the support expected from the EVD Response Team.

The Beni sub coordination/IPC/WASH Commissions/Monitoring and communication for the fight against EVD determines the targeted health facilities on the proposal of the prevention commission.

3.6 Strengthened coordination and training of workforce through Establishment of "Centre of Excellence Ebola" (CEE)

The frequent epidemics in DRC and the need to consolidate existing, but disconnected, public health programs under one structure to minimize fragmentation and promote efficient systems, highlight the need for the establishment of a National Public Health Institute (NPHI) in DRC: the CDC-DRC.

The Ministry of Health aims to establish a Centre of Excellence against Ebola (CEE), which will serve as the embryo for the future CDC-DRC. The CEE, as an embryo NPHI, would be housed within the Ministry of Health, and anchored to the DGLM, to facilitate coordination with critical health-related structures and programming such as surveillance, laboratory, and hygiene. It will maintain a level of administrative and financial autonomy that will allow the CEE to make decisions for the rapid deployment of resources (both human and financial), efficiently collaborate with partners (both internal and external) and ensure close collaborations with the provincial level.

The CEE will be built upon existing EVD response efforts and will integrate additional functions using a phased approach. It will serve the purpose to strengthen and institutionalize the ongoing Nord Kivu outbreak response. Phase one of the CEE will leverage current response structures and best practices through a CEE regional coordination antenna in Goma and a focus on high level strategic direction at the national level CEE in Kinshasa. Partners and stakeholders will continue to collaborate to identify relevant activities to support and strengthen coordination, such as improving linkages with information flow and briefing deployment teams.

3.7 Strengthened information management and operational planning

To ensure the concept of operations and overarching response strategy is achieving the required results, the following co-ordinational and leadership mechanisms together with key performance indicators and operational data sets will be used.

At Hub level (i.e. Beni or other Hubs):

- Daily coordination: The Hub Strategic Planning Unit working alongside the operational Information Management Unit and Incident Management Team to compile a daily contextual analysis of the general situation (Epi, Lab, Vaccination), as well as on issues related to quality of response activities not captured by the information management cycle. This may include information on challenges related to access, gaps in coordination within and between response pillars, logistics and human resources, financial resources, technical gaps, and emerging threats. The daily data pack will be made available to the Strategic Planning Unit in Kinshasa to be used as input daily coordination meetings of the strategic partners meeting with the Ministry of Health, presentations to the HCT and other ad-hoc meetings as required.

- Weekly analysis and operational planning: On a weekly basis, contextual changes in the evolution of the outbreak, the security analysis together with key performance indicators will be used to inform decision making against the concept of operations. This will include consideration for

scaling up or down of the response levels in Health Zones and other priority actions for the following week.

At Kinshasa level:

- The Strategic Planning Unit in Kinshasa will receive the outcome of the weekly meeting of the EOC and use specific recommendations for course corrections at the strategic-level for validation by the strategic group in Kinshasa. This will process be also supported by the Information Products released on a weekly basis by the Information Management Units at Hub level.

- Joint operational review: Every six-week s an operational review at the EOC in Beni (or other central field coordination site as appropriate) will be held among partners under the coordination of the Ministry of Health. The input for this review will include an analysis of main epidemiological trends, performance analysis of outcome (KPI), output and input KPIS, as well as of partner presence, readiness and other issues such as security, logistic. The outcome of the review will inform revisions to the EVD national strategic response plan to be undertaken by the Strategic Planning group in Kinshasa

3.8 Products and information management activities

In line with the co-ordinational and leadership mechanisms, the Information Management Unit in collaboration with the Strategic Planning Unite will produce some essential products derived by the process of data collection, processing and analysis. These will be shared to Incident Manager to facilitate decision making, prioritization as well as to the Kinshasa Strategic Unit and to partners and stakeholders to ensure transparency and information sharing according to the decision of the management team.
Main products will be:

- Daily data pack
- Key Performance Indicator table,
- Output monitoring report,
- Weekly Dashboard,
- 3W maps (who does what and where) per coordination hub (i.e. one for Beni, one for Butembo)
- Partners List.

A brief description of each service is provided below. Extensive guidance on methods and approaches is omitted from this document and will instead be collected in a series of annexes shared by partners involved in the Information Management process/activities.

Daily data pack

Produced by the Strategic Planning Unit at the EOC in Beni (or other central field coordination site as appropriate), in collaboration with Information Management and the Surveillance team, and in line with the EOC information process, the data pack will present a daily contextual analysis of:

a) Event specific data:
    - Epidemiological data (epi curve, summary table, contacts tracing performance, alerts)
    - Maps of cases
b) Event management information
    - IPC
    - Vaccination
    - Lab & Diagnostics
    - HR
    - KPIs
c) Context analysis
    - Security
    - Other challenges affecting response

This information will be presented during the morning meeting at the EOC in Beni (or other central field coordination site as appropriate) and will be used for decision-making. The daily data pack will be made available to the Strategic Planning Unit in Kinshasa to be used as input daily coordination meetings of the strategic partners meeting with the Ministry of Health, presentations to the HCT and other ad-hoc meetings as required.

KPI Outcome & Impact Monitoring table

The outcome & impact table is composed of a list of pre-established Key Performance Indicators previously agreed for the Strategic Response Plan. This list has been obtained through a consultative selection of indicators from previously validated registries (e.g. former Ebola Response Plans, IASC, Global Health Cluster), as well as from other sectors'/clusters' or agencies' outcome indicator repositories, adapted to the context. Data is obtained from daily collection and aggregation of KPIs from partners, particularly from those involved in surveillance. Final aggregation, analysis and visualization were provided at the beginning of each subsequent epidemiologic week. The outcome monitoring aims at assessing performance, as well as at providing record information for donors, partners and institutions to support analysis against the Strategic Response Plan. The table will be shared with partners to support weekly analysis and published on reliefweb.org and on the WHO website.

Output Report Monitoring

The *output* monitoring is composed of: a list of essential activities broken down by response 'pillars' (e.g. surveillance, IPC, case management) monitored against a series of pre-established criteria to define their implementation status as: 'operational', 'partially operational' and 'non- operational', according to a specific set of criteria. Data are obtained through a mobile data collection questionnaire-based interview. Key informants are selected among national coordinators of response activities as well as UN technical experts involved in the activities.

Output monitoring aims at prioritizing 'non-operational' activities for remediation, and at providing a qualitative analysis to be triangulated with outcome monitoring. The output report will contain a section of narrative to better explain the results of the analyses produced by the singular monitoring framework part. Specifically, this narrative will aim to offer clarification on those activities which, according to the outcome, output or input measurement, do not encounter the preestablished targets or criteria. The report will be shared with partners to support weekly analysis and published on reliefweb.org and on the WHO website.

Input Monitoring

The *input* monitoring is composed of key numbers on assets and resources (e.g. stocks, supplies, transportation, communication, vaccines, etc.…). This section aims at identifying gaps, offering an overall visualization of the situation, providing a recording system/tracking of main assets utilized in the response for future planning and accountability. A report will be shared with partners on a weekly basis and published on reliefweb.org and on the WHO website.

Dashboard

The dashboard will be an infographic synthesis of main and essential figures on total cases (confirmed, probable, suspected), KPIs and financial tracking. The dashboard will be shared with partners to support weekly analysis and published on reliefweb.org.

3W

The 'Who does What, Where?' (3W) matrix systematically maps HC partner activities across the crisis-affected population, thereby strengthening analysis of response gaps, planning and coordination of actors, including agencies new to the scene, who require guidance about where to position themselves geographically and what the service gaps are. A singular 3W map (who does what and where) will be produced per each coordination hub (i.e. one for Beni, one for Butembo) to map partners activities. This mapping might be combined with the sit rep analysis to identify main needs and priorities in partners activities and to inform operational and strategic decision making. The 3 W will be shared with partners and published on reliefweb.org website.

Partner list

The Partners' List (PL) is a constantly updated database of contact details for EVD response partners, observer agencies and other important stakeholders, including individual focal points for different areas of work, collected to both facilitate communication among agencies and the work of the Strategic Planning Cell. The list can be composed from contacts provided by the Ministry of Health, existing coordination mechanisms, organizations working in the response, etc.… As for the 3W, the Partner List will provide also where individual responders are geographically based to facilitate coordination. The Partner List will be shared with partners on a weekly basis.

3.9 Expansion of humanitarian response operations in support of Ebola response

The security situation around and inside the town of Beni has been deteriorating for several years due to the incursion of armed groups. In 2018, the level of violence reached a new high due to the intensification of military operations by the Congolese armed forces against non-state armed actors carrying out indiscriminate attacks against the local population. The crisis in Beni territory is first and foremost a protection crisis: between January and October 2018, 2,177 protection incidents were reported, approximately 145 people were killed, and 172 people were abducted. Insecurity increases the vulnerability of the affected population and leads to large-scale displacement.

Some 50,000 people were displaced by violence between January and October 2018 in the city of Beni. In total, in North Kivu, around 1,680,700 people (CMP November 2017) have been displaced in recent years, the majority of them living with host families, while nearly 10% of them are in IDP camps. Insecurity and lack of funding limit access to basic social services: health, water, food and education, especially for displaced persons and returnees, but also for host communities who share the burden of hosting displaced persons. Schools remained closed for nearly two months this autumn due to the teachers' strike, protesting the loss of civilian lives due to attacks by non-state armed groups. Health facilities are also affected by violence, significantly reducing access to basic primary health care. To date, the authorities and humanitarian actors have limited capacity to provide access to basic social services, particularly for the displaced population. In addition, an Ebola outbreak was declared in North Kivu on August 1.

During the review of the operational response plan and the Humanitarian Response Plan (HRP) review process, planning for the next six months, humanitarian workers prioritized WASH interventions in all priority areas affected by the Ebola virus. If funding is made available, it is planned to have interventions in all sectors through a community-based approach ensuring access to basic services. Priority will be given to neighbourhoods hosting displaced people. There is almost no humanitarian response in the city of Beni at this stage and historically Beni has been used as a field hub to organize interventions in all areas of the territory of Beni and Lubero where most conflicts have caused population movements occur.

However, many needs in Beni and Lubero remain unhelpful. The majority of humanitarian actors operating in both territories work on protection-related activities and the number of actors operating in other sectors (health, education, WASH, etc.) varies from two to seven who are active in ongoing projects. Much of the funding in both territories is tight in specific locations and sectors, making it difficult to respond to the new crisis.

Compared to the scale of the response to Ebola, the humanitarian funding and support provided is extremely limited. This may further alienate the local population, have a negative impact on the acceptance of Ebola response and humanitarian actors, and potentially make it difficult for actors to operate after the Ebola epidemic. Coordination between Ebola and humanitarian actors, as well as adequate communication with communities, is therefore crucial. In addition, it is of the utmost importance that Ebola's prevention and response activities consider the large and continuous population movements (displaced, returnees and refugees in Uganda).

UN agencies and humanitarian partners are also supporting the rapid needs of the population beyond the Ebola virus by conducting a rapid assessment of the humanitarian needs of populations displaced by the recent attacks in Beni. For example, UNICEF provided non-food items, WASH kits and multi-purpose humanitarian assistance to more than 6,000 displaced people. This humanitarian assistance, as well as investment in the reconstruction of primary health care services in affected health areas, as a contribution to strengthening the health system and providing quality health care for the population, are essential inputs to broadening the response to the needs of the community more broadly.

4. BUDGET

4.1 Additional funding requirements to the end of the month of January 2019

The initial resource requirements for the national response plan covering the period of November 2018 to January 2019 were estimated to a total of US$ 61.3 million. Following the strategic and operational review conducted in Beni and Butembo from 8-10 December, the additional estimated needs are as follows.

Basis for planning additional requirements :

- Food support to a total of 142,380 contacts and other beneficiaries reached
- 10,000 laboratory tests and additional supplies
- Increase in vaccination teams from 10 to 15 (14 in North Kivu and Ituri, 1 in Goma)
- Increase in capacity from CTE in Mangina to 60 beds (ALIMA) and operation of CTE in Mangina by IMC (54 beds)
- Increased flights and logistical support to cover needs in Butembo and Katwa
- Contingency plan to increase security
- EOC in Butembo
- 12 additional coordination teams in the field
- 310 additional active research officers in Katwa and Komanda
- 13 targeted communities in Komanda for IPC/WASH
- 42 targeted schools for IPC/WASH in Komanda
- 91 targeted health facilities

Table 1. Additional requirement budgeted by intervention

Additional requirements to end Jan-2019	USD $	Main Partner
Additional needs for current acute response operations consisting of:		
- Food support to 142 380 number of contacts and other affected beneficiaries	3,382,000	**WFP**
- Additional 10,000 laboratory tests supplies	300,000	**WHO**
- Additional costs for vaccination (staff and vaccine cold-chain (moving from multi-dose to single dose)	2,417,000	**WHO**
- Additional operations and logistics support	4,061,000	**WHO, UNICEF**
Additional costs for ETUs	700,000	**WHO**
Strengthened active response operations		
Strengthening operations at Butembo	1,200,000	**WHO, UNICEF**
12 Field Coordination teams	4,116,000	**WHO**
Contingency planning to manage increased security and political risks	1,080,000	
Strengthened tracking of contacts lost to follow-up including across health zones and provinces	760,000	**WHO, UNICEF**
Strengthening and deepening risk communications and community engagement in acute response zones (Katwa and Komanda)	1,344,000	**UNICEF, WHO**
Strengthening IPC/WASH in health centers, schools and communities	1,784,000	**UNICEF, WHO**
Strengthened information management and operational planning	697,000	**OCHA, WHO**
Strengthening operational readiness in surrounding provinces	1,700,000	**WHO**
Total additional requirements to end Jan-2019	**23,541,000**	

Table 2 below shows a current estimate of the supplementary budget by direct implementing partner. Amounts may change based on implementation requirements.

Funding is provided directly to the direct implementing partner/agency or through the lead partner through subgrant agreements, e.g. WHO subcontract to ALIMA for the ETC operation or invoicing for services provided, e.g. WFP invoicing to WHO for the provision of flights or MONUSCO for assistance in the establishment of life camps.

Table 2: Additional budget by direct implementing agency/partner

			Direct implementing agency/Partner						
Additional requirements to end Jan-2019	**USD $**	**Main partner**	**WFP**	**UNICEF**	**OMS**	**ALIMA**	**IMC**	**OCHA**	**MONUSCO**
Additional needs for current acute response operations consisting of:									
- Food support to 142 380 number of contacts and other affected beneficiaries	3,382,000	**WFP**	3,382,000						
- Additional 10,000 laboratory tests supplies	300,000	**OMS**			300,000				
- Additional costs for vaccination (staff and vaccine cold-chain (moving from multi-dose to single dose)	2,417,000	**OMS**			2,417,000				
- Additional operations and logistics support	4,061,000	**OMS, UNICEF**	1,355,000	306,000					2,400,000
Additional costs for ETUs	700,000	**OMS**				200,000	500,000		
Strengthened active response operations									
Strengthening operations at Butembo	1,200,000	**OMS, UNICEF**		240,000	960,000				
12 Field Coordination teams	4,116,000	**OMS**		423,000	3,693,000				
Contingency planning to manage increased security and political risks	**1,080,000**	**OMS**			1,080,000				
Strengthened tracking of contacts lost to follow-up including across health zones and provinces	**760,000**	**OMS, UNICEF**		290,000	470,000				
Strengthening and deepening risk communications and community engagement in acute response zones (Katwa and Komanda)	**1,344,000**	**UNICEF, OMS**		854,000	490,000				
Strengthening IPC/WASH in health centres, schools and communities	**1,784,000**	**UNICEF, OMS**		1,784,000					
Strengthened information management and operational planning	**697,000**	**OCHA, OMS**		36,000	331,000			330,000	
Strengthening operational readiness in surrounding provinces	**1,700,000**	**OMS**			1,700,000				
Total additional requirements to end Jan 2019	**23,541,000**		**4,737,000**	**3,933,000**	**11,441,000**	**200,000**	**500,000**	**330,000**	**2,400,000**

4.2 Operational requirements beyond January 2019

To define operational needs beyond January 2019, a process of updating the national plan is being planned to ensure the continuation of acute interventions (February 2019 to April 2019 and enhanced surveillance, response capacity and health systems strengthening (May-19 to Jul-19). An operational review and detailed strategic planning phase is planned for mid-January 2019.

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