



# STRATEGIC RESPONSE PLAN

FOR THE EBOLA VIRUS DISEASE OUTBREAK  
IN THE PROVINCES OF NORTH KIVU AND ITURI  
DEMOCRATIC REPUBLIC OF THE CONGO

JULY - DECEMBER 2019

# CONTENTS

1. INTRODUCTION.....	3
2. EPIDEMIOLOGICAL SITUATION.....	5
3. OPERATIONAL REVIEW OF SRP-3.....	7
Strenghts.....	7
Weaknesses.....	8
Opportunities.....	9
Threaths.....	9
4. RISK ASSESSMENT.....	10
Risk factors.....	10
Projecton of trends of the EVD epidemic in the next 120 days.....	11
5. OBJECTIVES AND STRATEGIC DIRECTIONS.....	12
5.1 General objective.....	12
5.2 Specific objectives.....	12
5.3 Strategic directions.....	13
5.4 Concept of operations.....	14
5.5 Planning assumptions.....	16
6. SRP-4 STRATEGIES AND OPERATIONS.....	17
6.1.1. Strenghtening surveillance, active case finding and follow-up of contacts, POE & vaccination.....	17
6.1.2. Risk communication and community engagement (RCCE).....	21
6.1.3. Strenghtening laboratory diagnostic capabilities and research.....	23
6.1.4. Clinical care, isolation of suspected cases and follow-up of survivors.....	24
6.1.5. Strenghten infection prevention and control measures (IPC / WASH).....	26
6.1.6. Psychosocial support.....	28
6.1.7. Safe and dignified burials (SDB).....	29
6.1.8 Operational preparedness of health zones and provinces adjacent to epidemic foci.....	30
6.2.1. Coordination of the response.....	31
6.2.2. Information management and monitoring & evaluation.....	32
6.2.2.1. Information Management Strategy and Implementation of the Joint Information and Analysis Unit (JIAU).....	32
6.3.1. Administrative management of human resources (HR).....	37
6.3.2. Planning and financial management of SRP-4.....	38
6.3.3. Logistics management.....	38
7. IMPLEMENTATION FRAMEWORK.....	40
7.1. Guiding principles.....	40
7.2. Organization of the response.....	41
7.3. Accountability.....	42
8. BUDGET.....	44
8.1. Methodology.....	44
8.2. Synthese du budget.....	44
ANNEXES.....	45
1. Projection of epidemic trends in the next 120 days.....	45
3. Organizational Chart of the Response.....	48

# 1. Introduction

The tenth epidemic of Ebola Virus Disease (EVD) in the provinces of North Kivu and Ituri was declared by the Ministry of Health of the Democratic Republic of the Congo on 1 August 2018.

Based on the evolution of the epidemic in the affected health zones, successive response plans (1, 2, 2.1 and 3) were implemented to enable the deployment of the resources required to support the Congolese Government and its partners.

More recently, and despite the implementation of the Strategic Response Plan-3 (SRP-3), the transmission of Ebola continues in both affected provinces. May 2019 saw the highest increase in the number of new cases recorded since the beginning of the epidemic.

Regrettably, insecurity continues to hamper the response in several health zones. Frequent security incidents have affected the response, some of which have had dramatic consequences.

In addition, the risk of spread of the virus to other towns in the Democratic Republic of the Congo and neighbouring countries remains very high. At the beginning of June 2019, several cases of EVD were exported to Uganda from the Mabalako Health Zone via the Congolese border of Kasindi. Despite the three recorded deaths, the progress of the epidemic to Uganda appears to be contained through good cross-border collaboration and preparedness activities undertaken with the Government of Uganda.

The increase in the number of new cases since epidemiological week n ° 19, combined with the persistence of insecurity, calls for major readjustments in response strategies.

In response to these new challenges the Government, supported by its partners, organized an operational review of SRP-3 in Goma from 14 to 15 June 2019. This participatory and inclusive review took stock of the level of achievement of activities against the pillars of the response, identified bottlenecks in the implementation of operational plans and enabled the development of new strategic directions.

The conclusions of this review guided the development of this fourth Strategic Response Plan (SRP-4).

SRP-4 takes into account the new strategy to scale-up the response in order to interrupt the epidemic. It focuses on the following main axes:

1. Detection and rapid isolation of cases;
2. Intensification of rapid multidisciplinary public health actions around any confirmed case;
3. Strengthening community engagement;

4. Strengthening the health system and effective coordination of the activities of local and international partners;
5. Synergies between public health activities and those of the security, humanitarian, financial and operational readiness sectors, and operational readiness of neighbouring countries, to create an enabling environment for the response.

The activities of the sectors mentioned above will form a strategy that will be presented in detail in a complementary document, and is structured around the following four pillars:

1. Strengthening political commitment, security and operational support to improve acceptance of the response and access to insecure areas;
2. Strengthening support for communities affected by EVD: In collaboration with the humanitarian and development actors present in the region, this pillar aims at strengthening the resilience of the population, fostering community ownership and involvement by the community in the response. This common framework will also develop synergies with social and humanitarian activities in order to respond to the primary needs of populations affected by EVD;
3. Strengthening financial planning, monitoring and reporting: The World Bank will work with major donors to identify financial needs and plan for early and sustainable financing;
4. Strengthened preparedness of the surrounding provinces and neighbouring countries to reduce the risk of spread of EVD.

The scale-up strategy requires maximum capacity in all sectors of the response and in all sub-coordinations for a minimum duration of 4 months. This is the precondition for responding immediately to all the epidemic development hypotheses, including the most pessimistic ones, and thus guarantees the availability of the necessary means to stop and prevent the return of the epidemic in the provinces of North Kivu and Ituri.

SRP-4 should thus be the last response plan or the "final push" to definitively defeat the epidemic by reinforcing current strategies and filling gaps, as well as introducing innovations that have demonstrated their effectiveness.

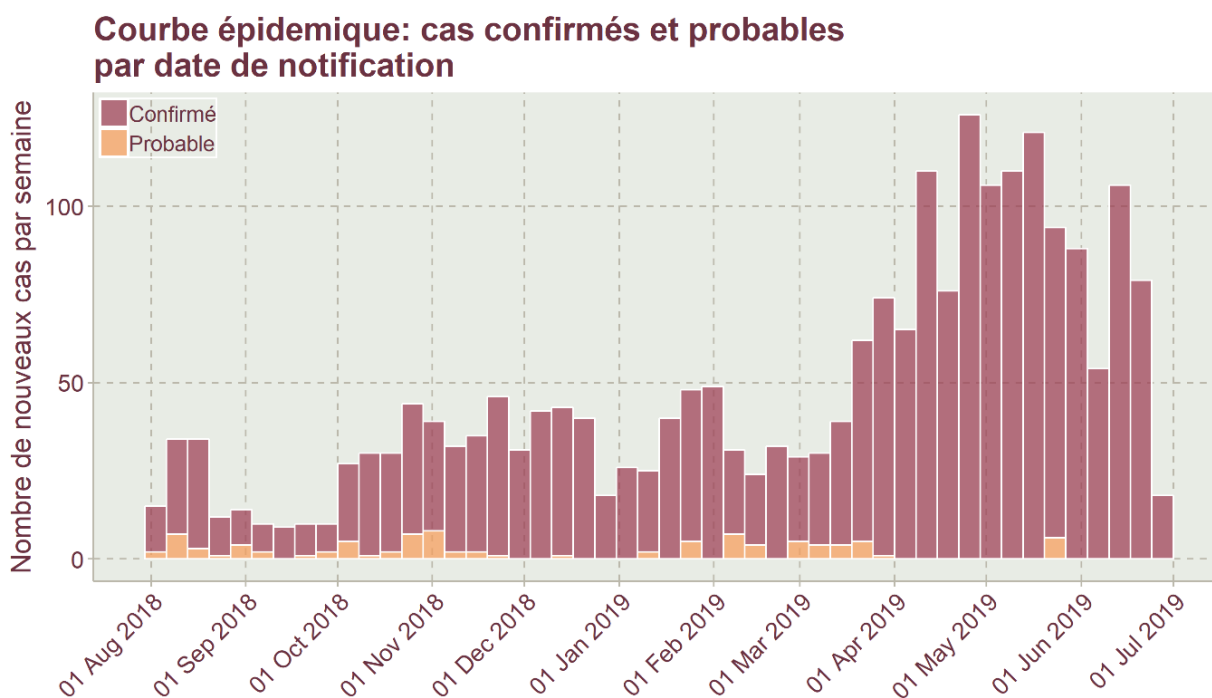
This strategic response plan (SRP-4) covers the period from 1 July to 31 December 2019 and takes into account the strengths and weaknesses as well as the orientations identified during the operational review of the implementation of the SRP-3, and other guidance based on lessons learned and risk analysis to which all partners contributed.

## 2. Epidemiological situation

As of 24 June 2019, the cumulative number of cases was 2 265 (2 171 confirmed and 94 probable), including 1 522 deaths (Figure 1), an overall case-fatality of 67%. Case-fatality among confirmed cases was 66% (1 428/2 074).

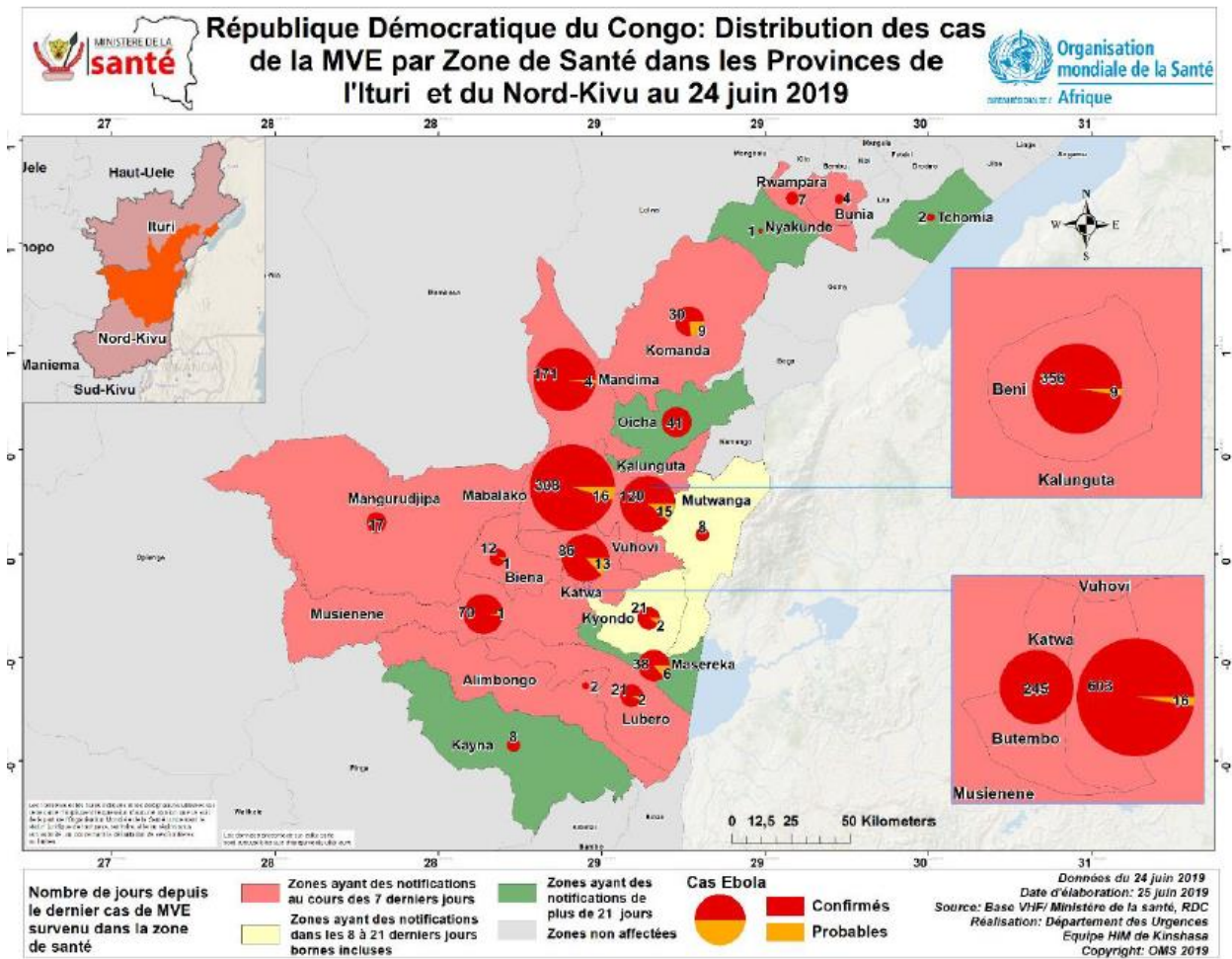
The sex ratio was 1.3 F / H, calculated from data from 2 191 confirmed and probable cases for which sex was reported (1 251 women / 940 men). Of the 1 251 women, 752 (60%) were of childbearing age (15-49 years). On the other hand, 368 confirmed and probable cases were children ≤5 years of age, or 16% of all cases, and there were 126 health workers, or 6%.

**Figure 1: Weekly Trend in Confirmed and Probable Cases of Ebola Virus Disease in the Provinces of North Kivu and Ituri from 1 August 2018 to 24 June 2019**



For the same period, 23 health zones reported at least one confirmed or probable case of Ebola virus disease in the North Kivu and Ituri Provinces. (Figure 2) A total of 189 health areas are affected out of a total of 359 health areas. So far, cases have been reported mainly in Katwa Health Zones (619/2 265, 27%), Beni (365/2 265, 16%), Mabalako (324/2 265, 14%), Butembo (245 / 2 265, 11%), Mandima (175/2 265, 7%) and Kalunguta (135/2 265, 6%).

Figure 2: Distribution of confirmed and probable cases of Ebola Virus Disease by Health Zone from 1 August 2018 to 24 June 2019



Furthermore, in June 2019, a shift in the epidemic hot spots from Butembo / Katwa to Mabalako / Mandima was observed, with a resurgence of cases in the Health Zones of Mabalako, Beni and Mandima.

### 3. Operational Review of SRP-3

A summary of the review of the strengths and weaknesses of SRP-3 results is presented in the Annex to this document by pillar of the response, however highlights include the following:

#### STRENGTHS

- The functionality of the coordination mechanisms of the response that enabled the involvement of partners, the exchange and dissemination of daily information relating to the implementation of various pillars of the response, as well as good coordination among partners;
- The implementation of the case-based approach that enabled synergistic actions by the different subcommittees around each confirmed case;
- The establishment of functional Ebola Treatment Centres (ETCs) following international standards, laboratories for rapid diagnosis, and the follow-up of patients' treatment with new therapies with more than 550 patients cured;
- The functionality of many Points of Entry / Control Posts (PoE / CP) that reported more than 1300 alerts including more than 500 validated and 21 confirmed, with good coordination of cross-border surveillance that enabled the rapid detection of confirmed cases who crossed to Uganda;
- The availability and rapid deployment of vaccines: 154 037 people immunized as of 7 July 2019 helped to limit the spread of the disease among the many contacts and contacts of contacts of confirmed and probable cases, as well as among front-line health staff;
- Organization of dialogues, community debates and public opinion platforms, involving community leaders who generated feedback that served as a platform for further interventions (ethical, behavioural, logistics, patient care, etc.);
- Identification of health zones and health area hotspots that led to the implementation of specific interventions, such as the establishment of local Ebola committees that facilitated the implementation of public health interventions (ring vaccination, decontamination of households and health facilities, etc.);
- Use of major influencers (rapid response teams): economic operators, bikers, students, pupils and education staff to break down reluctance);
- Development / updating and development of lay versions of validated standard operating procedures (SOPS) for infection prevention and control (IPC), and water and sanitation (WASH);
- Existence of a plan, training modules and shared SOPs and norms and standards for IPC-WASH;

- The commitment of affected communities under the leadership of their community leaders or other influential individuals, who set up local control committees to facilitate response actions, and management of community incidents in the Health Zones;
- The creation of a briefing unit, training and deployment of autonomous multidisciplinary Rapid Response Teams (RRT) to ensure rapid and holistic case management in health areas that are difficult to access due to their remoteness from target towns.

## WEAKNESSES

- Lack of communication between the sub-coordinations and the strategic coordination commissions concerning information-sharing, as well as the analysis of the key performance indicators (KPI) of the response;
- Delay in anchoring the response within the health system;
- Low number of community deaths tested;
- Weakness in the initial identification of contacts and in the follow-up of contacts, with a high number of lost contacts;
- Long delay between notification of suspected cases and their isolation;
- Little consideration of community feedback in the management of community resistance;
- Shortcomings in Infection Prevention and Control (IPC), relating in particular to the low level of staff training and to the precariousness of medical infrastructures and equipment;
- The information management system for the response remains weak, with fragmented databases and incomplete information;
- Very weak warning system in the HZs and insufficient preparedness capacity in at-risk health zones;
- Low integration of the response in the context of a complex humanitarian crisis;
- Alignment not yet systematic of all partners working in risk communications and community engagement (RCCE)
- Anarchic recruitment of communication actors by certain partners;
- Human resources management issues due to delays and non-payment of response personnel, lack of a deployment plan and database;
- Low implementation of prevention activities;
- Insufficient coaching / mentoring of care providers, and quality assurance;
- Insufficient consideration of health posts, tradi-modern centres and houses of prayer in IPC interventions;
- Continued increase in the number of people refusing to be vaccinated, who do not observe IPC guidance, and who therefore help the disease to spread due to exposure in health care settings;
- Insufficient preparation of unaffected health zones to deal with possible EVD cases or to rapidly take care of possible cases;
- Low application of care subsidies in health facilities (free healthcare).



## OPPORTUNITIES

- Appreciation of the high potential of local social networks to communicate on the response;
- Awareness by all actors that the response goes beyond the public health framework and must take into account other important aspects including humanitarian, security, community involvement, and requires significant funding;
- The availability of various partners to work in close collaboration with the national teams;
- The potential of the local health system to support the response and continue activities over the long term.

## THREATS

- The underlying social, political and security context leading to reluctance, refusal and resistance from the community to adhere to measures recommended by response personnel;
- Disruption of response activities due to the security situation, and attacks on response personnel and structures during community events;
- High mobility of the population;
- Many health facilities do not comply with IPC measures, including in their triage / isolation system, creating conditions for nosocomial spread of EVD;
- Delays in payment to front-line providers, which influences the quality of execution of activities;
- Non-operationalization of law enforcement texts regulating the organization of public health in the Democratic Republic of the Congo;
- The postponement of several measles and polio immunization campaigns in affected health zones due to the EVD outbreak increases the risk of vaccine-preventable diseases.

## 4. Risk assessment

The risk of transmission at the national level remains high as the affected provinces are connected to the rest of the country by air, river and road. In addition, most health zones bordering affected or affected areas remain silent in terms of alerts, highlighting persistent weaknesses in the epidemiological surveillance system and lack of access to areas with significant security risks.

The epidemic affects border areas with Uganda and Rwanda where there is a large cross-border flow for reasons of trade, access to health care, family and humanitarian visits. The export in early June of a few EVD cases to Uganda, quickly controlled, reminds us of the risk of transmission at the regional level.

The recent inter-ethnic clashes in Ituri and the subsequent mass displacements of population pose an additional risk of geographical extension. To this is added new Health Zones recently affected in Ituri (Ariwara).

### RISK FACTORS

Risk factors are:

- Insecurity in the two affected provinces;
- The rapid circulation of populations within the region, accentuated by inter-ethnic tensions and conflict between factions;
- Lack of access to areas in conflict, which limits surveillance and response;
- Pockets of reluctance, refusal or community resistance continue to be reported mainly in the areas of Katwa, Butembo and Mangina;
- The persistence of certain public health challenges such as:
  - o low participation of private health structures in the surveillance system;
  - o weakness of Infection Prevention and Control (IPC) activities, particularly marked in maternity wards, which continue to affect health structures and personnel;
  - o poor isolation conditions leading to nosocomial infections;
  - o weakness of the contact tracing system;
  - o long delay between the onset of symptoms and the notification and isolation of cases;
  - o very high proportion of community deaths;
- The geographical expansion of the area of intervention represents a major challenge for the organization and implementation of the response, which requires the permanent and sufficient availability of essential resources to control the epidemic;
- The re-infection of areas in which the epidemic tended to be under control, while resources are reallocated to hot spots;

- Insufficient financial resources to implement certain response activities, notably those related to women's health in affected health facilities and ETCs.
- Insufficient personnel, and dependence on partners in the health zone hot spots prevents immediate operations;
- Insufficient intervention by other sectors to create an enabling environment for public health interventions;
- The late payment of some state and community personnel is a demotivating factor ;
- The delay in deployment of personnel on the ground.

## PROJECTION OF TRENDS OF THE EVD EPIDEMIC IN THE NEXT 120 DAYS

Analysis by the epidemiological unit of the General Coordination office in Goma concludes that control of the epidemic depends on reducing the delay between the occurrence of EVD cases in new areas (or in previously controlled areas) and the speed of effective interventions around new cases.

Estimating the number of expected cases according to the statistical model used provides for 4 possible scenarios, between the shortest response time of 5 weeks and the longest of 14 weeks. Using the most pessimistic scenario (14 weeks to effective control in urban areas, as observed in the first epidemic wave in Butembo / Katwa), it is estimated that an average of 1 449 cases would occur over a period of 4 months (120 days).

However, a rapid intervention (5 weeks delay) could avoid 96% of cases in urban areas and 87% in rural areas.

These results show that each sub-coordination unit should maintain or put in place all the necessary resources (human, financial and logistic) required for rapid and effective control of outbreaks.

**It is important to note that the estimated figures of 1 449 cases and 69 552 contacts (48 contacts per case) will be used as a basis for planning public health activities for the next 6 months.**

Annex 2 provides more details on the methodology applied to achieve these results.

## 5. Objectives and strategic directions

### 5.1 GENERAL OBJECTIVE

The overall objective of SRP-4 is to interrupt the transmission of Ebola Virus disease in North Kivu and Ituri Provinces and prevent its spread to other provinces of the Democratic Republic of the Congo and neighbouring countries.

### 5.2 SPECIFIC OBJECTIVES

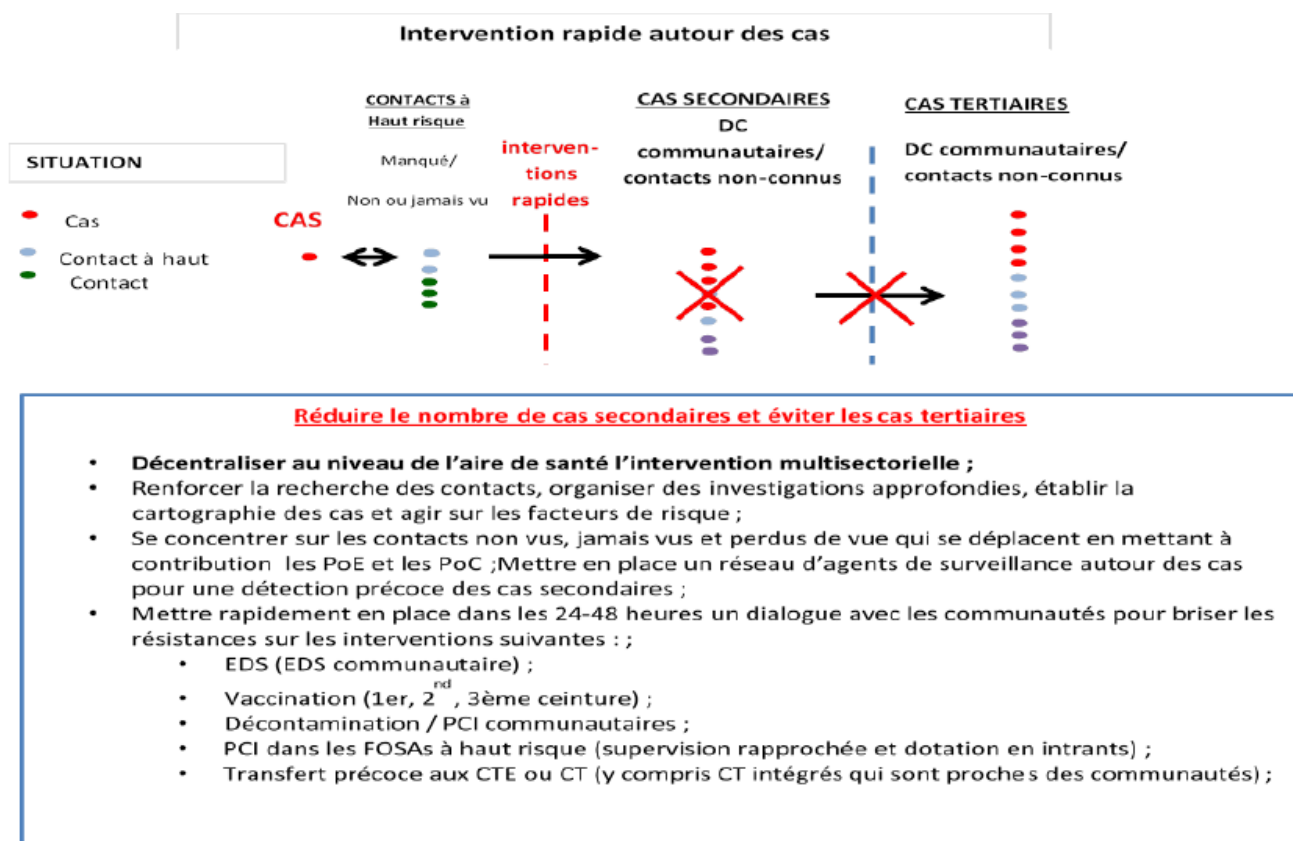
- Ensure early detection and holistic management (medical, nutritional, psychosocial...) of new cases of Ebola Virus Disease;
- Reduce the risk of transmission of Ebola Virus Disease through vaccination of at-risk groups;
- Control the geographical spread of EVD by reinforcing Points of Entry (POE), Control Points (POC), and decentralizing isolation of suspected cases to so-called transit centres that are integrated with health facilities, when possible;
- Strengthen the participation and engagement of local communities in their ownership of community EVD response activities, including community-based surveillance, District Health Services (DHS), and decontamination in affected or at-risk health areas;
- Improve the vital prognosis of patients with EVD by improving access to quality health care and reducing the time between symptom development and admission to the ETC / CT;
- Reduce nosocomial transmission by strengthening IPC measures in health facilities and in affected and at-risk communities;
- Ensure the psychosocial care of people affected by EVD and their families according to the national protocol;
- Provide psychological support to staff working in ETCs / CTs and nurseries, and commission members to ensure their well-being;
- Guarantee access to free care and services for EVD cases, contacts and survivors, and fixed compensation per validated alert for non-subsidized care structures;
- Ensure the dignified and safe burial of all deaths of confirmed and probable cases to break the transmission from community deaths;
- Strengthen the effective monitoring and evaluation mechanism of management of the EVD response, to support decision-making and adapt the pillar activities;
- Strengthen the effectiveness of coordination mechanisms and interaction between the commissions and the actors involved in the EVD response.

## 5.3 STRATEGIC DIRECTIONS

SRP-4 builds on a series of strategic directions, capitalizing on the lessons learned in SRP-3. Based on these lessons, an effective strategy around five key approaches is needed to guide the operations of SRP-4:

1. Detection and rapid isolation of cases;
2. Intensification of rapid multidisciplinary public health actions around all confirmed cases;
3. Strengthening community engagement;
4. Strengthening of the health system and effective coordination of the activities of local and international partners;
5. Synergy of public health activities with those of the security, humanitarian and financial sectors, and operational preparedness of neighbouring countries in order to have an enabling environment for the response.

The following diagram illustrates the method that has been applied to the response in Beni and Butembo Sub-Coordination units for rapid control of the spread of cases.



## 5.4 CONCEPT OF OPERATIONS

The SRP-4 operations revolve around Sub-Coordination units comprising of health zones classified into 3 categories:

- **Health zone hotspots** are areas of health zones where intense transmission has been in progress during the last 21 days and where the increased outbreak requires immediate, large-scale action;
- **Active health zones** are health zones that have reported cases for more than 42 days, that must be kept in 'response' mode;
- **At-risk health zones** are all other health zones that have never recorded cases, where preparedness must enable prevention and containment of the epidemic, should it occur.

The list of health zones by category are shown in the table below.

Zones de santé Hotspot	Zones de santé actives	Zones de santé à risque
<ul style="list-style-type: none"> <li>• Mabalako</li> <li>• Beni</li> <li>• Katwa</li> <li>• Butembo</li> <li>• Mandima</li> <li>• Komanda</li> <li>• Biena</li> <li>• Bunia</li> <li>• Kalunguta</li> <li>• Mutwanga</li> <li>• Ariwara</li> </ul>	<ul style="list-style-type: none"> <li>• Thiomia</li> <li>• Nyakunde</li> <li>• Kayna</li> <li>• Oicha</li> <li>• Kyondo</li> <li>• Allimbongo</li> <li>• Masereka</li> <li>• Vuhov</li> <li>• Lubéro</li> <li>• Musienne</li> <li>• Magurudjipa</li> <li>• Rwampara</li> </ul>	<ul style="list-style-type: none"> <li>• Goma</li> <li>• Karisimbi</li> <li>• Nyrangongo</li> <li>• Rutsuru</li> <li>• Rwanguba</li> <li>• Binza</li> <li>• Kibirizi</li> <li>• Kirotshe</li> <li>• Masisi</li> <li>• Mweso</li> <li>• Itebero</li> <li>• Pinga</li> <li>• Bambo</li> <li>• Birambizo</li> <li>• Katoyi</li> <li>• Kibua</li> <li>• Walikalé</li> <li>• Kamango</li> <li>• Drodro</li> <li>• Bambu</li> <li>• Nizi</li> <li>• Lita</li> <li>• Gethy</li> <li>• Boga</li> <li>• Mambassa</li> <li>• Nia-Nia</li> <li>• Kilo</li> <li>• Jiba</li> <li>• Lolwa</li> <li>• Aru</li> </ul>
<b>11</b>	<b>12</b>	<b>30</b>

Local and international partners are identified by health zone in the table of activities included in the SRP4, Annex.

These 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:

<b>Sub-pillar</b>	<b>Lead</b>	<b>Co-lead</b>
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

Other areas supporting the response:

- Security and political commitment under Government leadership with OCHA as co-lead;
- Humanitarian Actions (Community Engagement and Essential Support Services to EVD Affected Communities) under Government leadership with OCHA and UNICEF as co-leads;
- Fiduciary Management of operations under the direction of the Government and the World Bank as co-lead.

The overall coordination remains in Goma, around an Emergency Operations Centre (EOC) which will monitor the implementation of operations through links with the Sub-Coordination EOCs and in direct contact with the co-leads and partners supporting the Pillar activities.

## 5.5 PLANNING ASSUMPTIONS

The following planning assumptions apply:

- A six-month period for the implementation of interventions to contain and interrupt the transmission of EVD in the two affected provinces. The proposed duration takes into account the experience of the Sub-Coordination units to date in the response;
- Flexibility in the execution of the plan and budget is necessary to take into account the dynamics of the epidemic and make necessary adjustments. The Government, co-leads and partners develop agile plans given the highly variable nature of the response, to allow for rapid changes in planning and allocation of resources to activities, depending on the context;
- It is difficult to make a precise projection of the number of cases, due to constraints related to the dynamics of the epidemic, insecurity, and the capacities of Sub-Coordination units for rapid intervention;
- Financial estimates are made according to the projection of trends of the epidemic, as described in point 4.2 above and on the basis of the unit costs presented by partners and co-leads of the sub-pillars;
- Planning takes into account the total amount of resources required in all three categories of health zones to support operations for the time needed to prevent the return of the epidemic.



## 6. SRP-4 Strategies and Operations

The review of SRP-3 highlighted the need to consolidate the pillars of the response into three main strategic axes:

- Essential services of the response
- Coordination
- Administrative, financial and logistical support for coordination

### AXIS 1 - ESSENTIAL SERVICES OF THE RESPONSE

#### 6.1.1. STRENGTHENING SURVEILLANCE, ACTIVE CASE FINDING AND FOLLOW-UP OF CONTACTS, POE & VACCINATION

##### **Objectives of the response pillar:**

**Surveillance** provides reliable data to ensure early detection and isolation of new cases and prevent the spread of the epidemic. Key activities to be implemented include increasing alerts, including at Points of Entry (POE), prompt investigation of validated alerts and cases, contact listing and tracing, and active case finding both in the health structures and in the community, particularly around new cases.

**Contact tracing** is an essential measure to control an outbreak of EVD. It helps to identify new cases as quickly as possible, and to increase the chances of survival of these patients through early management. It also limits the infectious period in the community and thus reduces the risk of secondary transmission.

The activities carried out at **POEs and Control Points (POC)** enable filtering of population movements by identifying suspicious cases and raising alerts; disseminating EVD prevention and control messages to travellers and local communities; promotion of hand hygiene; and helping to find displaced and lost contacts.

In SRP-4, the following services will be implemented:

##### A) SURVEILLANCE

##### **The strategic approaches of SRP3 will be maintained:**

- Update the case definition including alerts and suspect cases that do not present fever, and disseminate to all Sub Ccoordination units;
- Build the capacity of personnel involved in surveillance, staff including IT / ITAs and community leaders, and ensure theirsupervision.

- Strengthen active case finding in health facilities;
- Strengthen community-based surveillance.

**Innovative strategic approaches in SRP-4:**

- Establish a unit responsible for the re-evaluation of all validated and invalidated alerts;
- Use multidisciplinary rapid intervention teams to quickly validate alerts and ensure their investigation.
- Build on the integrated results of social, behavioral and epidemiological analyses to better support surveillance approaches.

**B) CONTACT TRACING**

**The strategic approaches of SRP-3 will be maintained:**

- Strengthen the functioning of the coordination unit for monitoring and analysis of lost, never seen and displaced contacts (CCSA-PDV) and operationalise in each Sub-Coordination unit, including all stakeholders (Civil Protection, UNPOL, ANR, DGM, Ministry of Transport, etc.);
- Build on the integrated results of social, behavioural and epidemiological analyses to better support surveillance approaches.
- Provide references for the follow-up of each contact;
- Include resource persons (collaborators) both in the listing and the follow-up of contacts;
- Strengthen the psychosocial support measures for the listed contacts, and ensure their monitoring and well-being in order to encourage them to participate in the follow-up of contacts, to prevent them from moving to unaffected areas, and to put in place a rapid detection system for EVD;
- Food distribution by WFP to contacts to limit their movement.

**SRP-4 innovations :**

- Documentation and popularization of the "case intervention" approach at the Health Zone and Health Area level (validation of alerts, follow-up of contacts);
- Strengthen community representatives' (RECO) capacity to monitor contacts by providing them with data collection, analysis and transmission tools;
- Use food distribution points to complete the list of contacts.

## C) INVESTIGATIONS

### **Strategic approaches for Investigations in SRP3 to be maintained in SRP4:**

- Ensure Investigations training for multidisciplinary Rapid Response Teams (RRT) and implement them in all Sub-Coordination units;
- Set up teams to review and validate investigation reports at the Health Zone and Sub-Coordination levels.

### **Innovative strategic approaches in SRP-4 :**

- Set up of the Epidemiological Analysis Unit at the sub-coordination level;
- Strengthen capacity / authority for supervision, training and mentoring within the General Coordination Unit, and in the Rapid Response Teams in Surveillance and Immunization;
- Ensure thorough investigations, with digital assistance if possible, and study of transmission chains;
- Continue to train multidisciplinary RRTs at the sub-coordination level (Bunia, Komanda), as well as train RRTs in at-risk health zones;
- Increase the critical mass of qualified epidemiologists, and ensure a technical briefing for all new staff prior to deployment at Goma level by the analysis unit and RRTs;
- Organize hands-on training for RRTs with simulation exercises in at-risk health zones, and in at-risk towns not yet affected.

## D) POE / POC

PoE / PoC activities can filter out-of-town populations by identifying and reporting alerts and suspicious cases, disseminating EVD prevention and control messages to travellers and local communities, promoting hand hygiene, and contributing to the search for displaced, lost and unseen contacts.

### **SRP3 strategic approaches for PoE / PoC response activities maintained in SRP-4:**

- Organizing and updating PoE / PoC mapping and implementing new PoE / PoCs according to the dynamics of the epidemic;
- Protecting large towns and avoiding cross-border transmission by strengthening preparedness capabilities, particularly in Goma, through a strategy of encircling the city with 4 entry points operating 24 hours a day;
- Organizing the search for displaced, lost and unseen contacts in all PoE / PoCs that operate 24/7 with the support of security staff, to facilitate identification (with ID);
- Strengthening cross-border collaboration through regular meetings, sharing of surveillance data and development of standardized approaches to case management and referrals in border areas;

- Strengthening risk communication and community engagement in the PoE / PoC package of activities.

#### **SRP-4 Innovations:**

- Regularly evaluate PoE / PoC capacities via the introduction of an electronic tool (Kobbo Collect) and electronic data management;
- Establish an electronic search system for lost, displaced and unseen contacts;
- Integrate investigators for validation of alerts within PoEs that are far away from RRTs;
- Establish a mechanism for the exchange of information between PoEs located at airports (Goma, Kisangani, Lubumbashi, Kinshasa-ndolo, Kinshasa-N'djili, Kindu, Mbujimayi, Bunia) with a view to improved monitoring of lost, displaced and unseen contacts.

## **E) VACCINATION**

#### **SRP3 strategic approaches maintained in SRP4**

- Instant immunization: In the context of insecurity and community tensions, instant vaccination is carried out at an agreed, temporary and protected site, located at a distance from the place of residence of the contacts, often a health facility;
- Targeted geographic immunization: All contacts and the contacts of contacts of all reported cases in a village or a given neighbourhood are simultaneously registered and invited for vaccination.

#### **SRP-4 Innovations:**

- Advocate for strengthening routine immunization, incorporating reactive measles vaccination;
- Maintain follow-up on D21 pregnant women, CPN (1, 2, 3, 4), children under one year, and clinical and biological monitoring of newborns for two trimesters;
- Train 50 additional providers of GCP (Good Clinical Practice) according to the protocol;
- Vaccinate the survivors' entourage against Ebola.

## 6.1.2. RISK COMMUNICATION AND COMMUNITY ENGAGEMENT (RCCE)

### **Objectives of the response pillar:**

Based on the identification communication risks and lessons learned from SRP-3 on community engagement, communication teams implement RCCE interventions. These help to inform and train communities, improve their knowledge of EVD, and adapt interventions to the perception and feedback of communities in order to foster their engagement and ownership of the response.

The interventions of RCCE developed under SRP-4 were harmonized during a workshop organized in June 2019.

These interventions take into account :

- Analysis of risk communication for public health interventions in communities;
- Promotion of prevention activities and strengthening of existing services (vaccination, health care for the sick, etc.), available support and the means to access it;
- The establishment of a community feedback mechanism, and the capitalization of socio-anthropological analyses and CAP surveys to collect community perceptions and concerns about the implementation of the response to EVD and other humanitarian issues;
- Ownership of the response by communities.

### **SRP3 interventions maintained in SRP-4:**

- Systematically align and periodically update the mapping of all partners working in RCCE;
- Strengthen the functionality of community feedback management mechanisms by integrating them in sub-coordination units and General Coordination in order to better respond to people's concerns under the different pillars;
- Capitalize on the results of socio-anthropological surveys and risk behaviour analysis to improve the RCCE approaches and key messages of each pillar;
- Provide support to surveillance efforts by strengthening active research and community-based early warning systems for suspected cases and community deaths, in collaboration with the surveillance team (i.e. making available a toll-free number to the community, home visits, referral of patients / suspected cases to health centres);
- Promote partnership with political administrative authorities, notables and celebrities, community associations, NGOs, religious groups, women's associations and youth as key actors in the implementation of field communication activities;

#### **SRP-4 Innovations:**

- Establishment and operationalization of multipurpose and integrated **Community Engagement Units (CAC)** in some villages in the hotspots and active health zones. These CACs will be set up according to the following three scenarios:
  - Revitalize CACs in the affected health areas that have them in place;
  - Continue response activities in health areas in which local EVD control committees already exist;
  - Establish local control committees where there is no CAC in the event of notification of cases, and set up CACs in at-risk health areas that have not yet notified cases, as a preparatory measure;
- These CACs will work with versatile community health workers and other social actors, including hygienists, volunteers, teachers, parent and school management committees, educators and students.
- Standardization of training modules and data collection tools for RCCE activities and the establishment of a pool of RCCE trainers set up by the government and partners;
- Expansion of media activities mainly in rural areas, such as wireless radio and social networks using new information technologies (cellular phones);
- Creation of a team responsible for harmonizing media actions (broadcasting rates, dissemination formats, journalistic ethics control, etc.);
- Regular updating of messages to render the response interventions less traumatic for the population, taking into account the results from the analysis of community feedback, socio anthropological surveys, CAP etc.;
- Training and sensitization of the response teams for strict compliance with the Code of Conduct using existing mechanisms to promote protection from exploitation and sexual abuse, abuse and / or unethical behaviour and to ensure follow up of complaints from the population (Permanent Inter Agency Committee);
- Regular communication and community engagement training for stakeholders and the community on the response, so that they are able to answer questions on the multiple aspects of the response and humanitarian issues, and for building trust with communities.

### 6.1.3. STRENGTHENING LABORATORY DIAGNOSTIC CAPABILITIES AND RESEARCH

#### **Objective of the pillar:**

- Strengthen the capacity of laboratories to make available within 24-48 hours the results of the samples received.

#### **SRP3 Strategic Approaches maintained in SRP-4:**

- Continue supporting the operation of seven laboratories, and of new laboratories in reagents, consumables and materials for the securing of samples and the diagnosis of EVD, and the biological monitoring of patients and survivors;
- Continue sequencing activities;
- Maintain, with the support of the National Institute for Biomedical Research (INRB), laboratory capacity established in all major operations centres, including Beni, Butembo, Mangina, Tchomia, Bunia and Goma through the deployment of GeneXpert machines;
- Continue building the capacity of laboratory staff to meet current and future needs, including:
  - The assignment of additional units;
  - Training of local staff in EVD diagnosis and sample management;
  - Training of GeneXpert trainers;
- Continue deployment of technicians for equipment maintenance;
- Improve data management;
- Improve the management of biomedical waste;
- Ensure, through daily reports, monitoring of laboratory capacity to ensure they are all able to accommodate the number of samples collected
- Ensure waste management in accordance with existing WHO SOPs;
- Organize sample management (collection, storage, packaging and transport);
- Organize training for EVD diagnosis and sample management.

#### **SRP-4 innovations:**

- Establish a quality control system both internally and externally;
- Establish mechanisms for destroying GeneExpert cartridges (Incinerator >1,200 °C)
- Establish two flights per month to transport samples to Kinshasa / INRB;
- Put in place innovative and efficient mechanisms to improve the transport of Transit Centre samples to laboratories in the shortest time possible.

## 6.1.4. CLINICAL CARE, ISOLATION OF SUSPECTED CASES AND FOLLOW-UP OF SURVIVORS

### **Objectives of the pillar:**

The goal of **clinical care** for EVD patients is to provide high quality, safe care and individualized patient-centred care in a biosecure environment to minimize the risk of spreading the virus to other patients or health workers. Clinical care includes medical, nursing, nutritional, rehabilitation, psychosocial care and early childhood care services - taking into account the specific needs of children and women, including pregnant and lactating women.

Clinical care will continue to ensure quality care to suspected and confirmed cases to ETCs and transit centres (TCs) and to ensure follow up for survivors released from ETCs / TC, using international standards in order to maintain case fatality rate under 50%. To improve the quality of care and reduce the time between onset of symptoms and access to care, the following actions will be taken:

- The following specialties and innovations will be introduced: nutrition, paediatrics, obstetrics, resuscitation, and emergency
- Construction of transit centres in active health zones according to the dynamics of the epidemic, with the aim of bringing clinical care structures closer to the community and reducing the time between onset of symptoms and access to care;
- ETCs and TCs will ensure the availability of therapeutic agents with technical support from WHO;
- ETCs will have nutritionists on hand with technical support from UNICEF;
- Ambulances will be available in all affected health areas for the transfer of suspected cases and access to care as soon as possible.

In addition, this pillar covers the **survivors' follow-up programme**, which aims to provide integrated management of the medical, nutritional and psychological complications that affect Ebola survivors by integrating the clinical, screening and psychosocial support.

Survivors should be supported when they return to their communities to minimize the risk of stigmatization, transmission of EVD to those not already affected, and post-EVD complications. Given the variable duration of virus persistence in seminal fluid and other biological fluids such as breast milk, the risk of sexual and maternal transmission, although limited, exists. Therefore, monitoring of survivors is a priority to be able to contain all potential risks, including those of sexual transmission.

For these reasons, integrated and multidisciplinary monitoring is essential. The proposed programme is designed for a period of at least one year, but this duration adapts according to the clinical evolution of the cured, provides assistance to survivors in emergency Reproductive Health Kits their health and livelihoods through food assistance, clinical and biological



monitoring of fluids of cured men and women, distribution of dignity kits for women of childbearing age, monitoring of the nutritional status of the cured (including women and children) and is coordinated by the Ministry of Health and supported by different partners.

This service offer is part of the existing health structures and is free for people cured of Ebola and children born to women cured during the follow-up period.

### **Health care subsidy**

The Health Care Grant initiative in Ebola-affected health zones aims to eliminate financial barriers to accessing health services and therefore intercept suspected or confirmed cases of Ebola more rapidly.

Improving patient access to care would improve the early detection of suspected cases of Ebola and thereby facilitate the interruption of the chain of transmission.

Retaining patients in public health facilities, traditional and private clinics increases the risk of contamination.

As part of SRP-4, the PDSS (MOH Health System Development Project) will negotiate a flat rate to be paid to each health facility (public, private or traditional) for each validated and confirmed case notified to the surveillance team. To this end, the Ministry of Health will organize a workshop to consider the options for the subsidy of care.

### **Ebola Treatment Centres and Transit Camps (ETC and TC)**

#### **SRP3 strategic approaches maintained in SRP-4:**

- Harmonize the care protocol;
- Continue the operation of ETCs and TCs with the following areas of expertise and innovations introduced: nutrition, paediatrics, obstetrics, resuscitation and emergency; ensuring the supply of required inputs and therapeutics;
- Continue the assessment of quality of care;
- Improve biosecurity in ETC/ TC;
- Build triage centres in referral hospitals in hot and active health zones and / or in health facilities according to the dynamics of the epidemic.

#### **SRP4 Innovations:**

- Systematize the setting up of nurseries in ETCs;
- Strengthen the capacity of the Goma and Bunia Transfusion Centres to supply ETCs with qualified blood products;

- Set up a global management system specific to the case management structures under the management of the MOH (finance, logistics, administration, etc.)
- Decentralize transit centres in the health facilities that are far from the ETCs;
- Restructure the survivors' follow-up programme by fully integrating it into the clinical care commission;
- Integrate the PMNCH minimum package into ETCs;
- Institutionalize the use of isolation CUBEs for ETCs;

### 6.1.5. STRENGTHEN INFECTION PREVENTION AND CONTROL MEASURES (IPC / WASH)

#### **Objectives of the pillar:**

Prevent and control nosocomial and community transmission of EVD

- **SRP3 strategic approaches maintained in SRP-4:** Continue the use of harmonized assessment tools to measure and improve the performance of health facilities;
- Strengthen IPC in the community and in health facilities, including among traditional healers.

#### **The following activities will be carried out:**

##### a) Main activities in the health facilities:

1. Strengthen training activities of healthcare providers and IPC supervisors
  - Strict application of the National IPC Training Programme
  - National IPC Training Programme Harmonization Workshop with all stakeholders involved in IPC
  - Popularization of the training programme
  - Strengthen the training supervision system at all levels
2. Implement the IPC package that includes SOPs, tools, rapid diagnostic tests
3. Strengthen the IPC / WASH support system in health facilities based on health facility assessments, training supervision with corrective actions, and the establishment of a quality assurance system in close collaboration with the independent monitoring and evaluation team
4. Evaluate and implement WASH infrastructures and services in health facilities.
5. Provide health facilities with IPC / WASH inputs as needed and monitor their use.
6. Ensure the decontamination of health facilities that have received confirmed EVD cases.
7. Ensure implementation of the IPC ring approach around each confirmed case of EVD.

b) **IPC in the community**

In the community, the IPC activities will be carried out in households and in public places (schools, markets ...). These activities are:

1. Train community leaders on EVD prevention
  - o Evaluation of the level of community IPC
  - o Strengthening community engagement mechanisms for community-based activities for a better understanding of actions (messages, consideration of community feedback)
  - o Follow-up and coaching and mentoring of community actors for better ownership
2. Ensure decontamination of households and public places that have housed confirmed EVD cases
3. Provide hygiene kits to households, schools and public places
4. Ensure access to water and sanitation in schools and public places
5. Strengthen the monitoring and evaluation system in close collaboration with the General Coordination independent M&E team..

c) **Activities to support the establishment of IPC**

1. Develop a logical framework for the monitoring and evaluation system
  - o Periodic review of performance indicators
  - o Continuation of the development of standards in lay language
2. Set up tools for monitoring and evaluation (databases, standardized evaluation tools ...)
  - o Quality assurance of the whole pyramid of IPC interventions (training, services, supervisors, level test for service providers)

**SRP-4 innovations:**

- Move from the current intervention approach to a prevention approach;
- Update the mapping of the priority health facilities and systematize the performance evaluation of the IPC through harmonized assessment tools;
- Establish a harmonized system for inventory management and IPC input supply;
- Build on the integrated results of social, behavioural and epidemiological analyses to better support IPC / WASH approaches.

## 6.1.6. PSYCHOSOCIAL SUPPORT

### **Goal of the pillar:**

The aim of psychosocial care is to promote community cohesion and strengthen the resilience of children, young people and families, and to reduce stigma and self-stigma.

### **Under SRP-4, the following SRP-3 approaches will be maintained:**

- Strengthen psychological support for ETCs (for confirmed, suspected, and discharged cases) and assistance with hygiene kits for all discharged and cured patients;
- Strengthen psychosocial activities in schools and support teachers who can not only support prevention and monitoring of EVD in schools but also participate in the reintegration of orphans and psychosocial support of orphans.
- Support nurses at the ETC / nursery level to provide psychological support to people in isolation, especially children;
- Support affected households to anticipate the management of behavioural problems, which can generate tensions and resistance in the community;
- Ensure the capacity building of psychosocial workers and clinical psychologists of all Sub-Coordination units at a rate of at least 2 psychosocial workers per health area and 1 clinical psychologist for 3 to 4 health areas;
- Provide psychological support to confirmed cases, suspects and accompanying persons / families;
- Ensure material assistance following the assessment of affected families and orphaned / separated children;
- Provide nutritional assistance to survivors, discharged children, orphans and children separated from their families, and for contacts taking psychoeducation sessions to facilitate public health activities;
- Provide psychosocial support through visits to affected families and orphaned / separated children;
- Ensure nutritional monitoring in the structures (crèches) and in the community of orphaned and separated children with the IYCF (Infant and Young Child Feeding) approach under the supervision of clinical nutritionists and psychologists;
- Provide psychological follow-up for the survivors;
- Ensure that a space is reserved for a nursery when setting up the ETC.

#### **SRP-4 Innovations:**

- Organize and provide psychological support to the responders and to the health care staff who are confronted daily with difficult situations related to their work. Teach them to manage their stress and emotional suffering through training, briefing, speaking group, etc.
- Strengthen existing community structures in villages involving youth and adolescents who will develop and facilitate psychosocial activities for children and adolescents (recreational activities);
- Systematize the night shifts of clinical psychologists and psychosocial workers at the ETCs / TC level and in all sub-coordination units;
- Build on the integrated results of social, behavioral and epidemiological analyses to better support psychosocial care.

### **6.1.7. SAFE AND DIGNIFIED BURIALS (SDB)**

#### **Objectives of the pillar:**

Break the transmission of EVD through the safe and dignified burial of confirmed, probable or suspected cases.

#### **SRP-3 approaches maintained in SRP 4:**

- Promote SDB through low risk emergency community burials in hard-to-reach areas;
- Train and pre-position an SDB Team per Health Zone at risk (knowledge of EVD and SDB protocols and other activities including decontamination, community involvement and psychosocial support);
- Continue to build decontamination bases in areas where there are none (Rutshuru, Goma, Aloya, Komanda, etc.);
- Improve diagnostics and sample management processes to enable rapid decision making and avoid handling of body (Labo & Surveillance).

#### **SRP-4 Innovations:**

- Set up a geolocation system of houses in which there were deaths that were positive for EVD, and for their burial areas (graves);
- Develop unique identification codes for any death, with the laboratory;
- Set up cemeteries dedicated to the response to safeguard the dignity and memory of those who have died from EVD.

## 6.1.8 OPERATIONAL PREPAREDNESS OF HEALTH ZONES AND PROVINCES ADJACENT TO EPIDEMIC FOCI

### **Objectives of the pillar:**

Reduce the risk of spreading the epidemic to at-risk Health Zones adjacent to outbreaks.

### **Strategic Approaches for SRP-3 to be maintained under SRP-4:**

- Reinvigorate coordination at the level of each health zone and province at risk: provincial health division / extended expert group;
- Development and implementation of the preparedness plan for health zones not affected by EVD in North Kivu and Ituri;
- Strengthen community-based surveillance;
- Train, maintain and supervise multidisciplinary Rapid Response Teams (RRTs);
- Reinforce the skills of IPC/WASH providers in the health facilities and PoE / PoC;
- Train SDB teams;
- Train laboratory personnel on the safe collection and transport of samples;
- Encourage and facilitate cross-border meetings;
- Vaccination of population
- Strengthen RCCE;
- Maintain clinical management capacities of the ETC in Goma;
- Strengthen logistics.

### **SRP-4 Innovations:**

- Expand and strengthen preparedness in the 32 health zones affected by EVD;
- Strengthen monitoring at PoE in sphere 3 (Kisangani, Kinshasa, Bukavu, Kindu, Lubumbashi, Bunia and Mbuji Mayi);
- Develop and disseminate fact sheets and protocols for simulation exercises to support the response;
- Implement the STEER programme in the province of North Kivu (Goma) and Ituri (Bunia) with cascade training.

## AXIS 2 – COORDINATION

Under SRP-4, synergies between public health activities together with the other pillars (security, humanitarian, financial, and operational readiness of neighbouring countries) will be fostered to create an enabling environment for the response.

### 6.2.1. COORDINATION OF THE RESPONSE

#### **Purpose of the pillar:**

Strengthen the effectiveness of mechanisms for coordination and interaction between commissions and actors involved in the EVD response

#### **SRP3 Strategic approaches maintained in SRP-4:**

- Maintain overall coordination in Goma: strengthen analysis capabilities and provide rapid solutions to sub-coordination units; strengthen multisectoral approaches according to the command structure; the majority of partners are represented in Goma;
- • Embed the response in local institutions and in the community;
- • Maintain specialist units at different levels to support decision making;
- • Strengthen links between different levels of coordination;
- • Formalize and render the multisectoral approach effective at national and local level;
- • Formalize and strengthen the operational links between the different committees and sub-committees.

#### **SRP-4 Innovations:**

- Maintain maximum operational capacity of each Sub Coordination unit;
- Maintain the operational flexibility of General Coordination according to the evolution of the epidemic in order to troubleshoot based on priorities (shift General Coordination personnel to sub-coordination units facing problems)
- Link Rapid Response Teams to general coordination
- Strengthen the accreditation mechanisms of implementing actors in order to allow flexible integration of new partners while guaranteeing the control of the public authority;
- Formalize the accreditation and accountability mechanisms of partners in the management of the response. This involves the establishment of harmonized accountability mechanisms between state authorities, and technical and financial partners, and the Commissions, and deciding the process for sharing and feedback to support decision-making.

## 6.2.2. INFORMATION MANAGEMENT AND MONITORING & EVALUATION

The data and information management of the Ebola outbreak will focus on a systematic approach to the collection, analysis, reporting and interpretation of key operational data for the response.

As information evolves very rapidly during the EVD response, the key performance indicators (KPI) have been updated. A priority must be to agree on and adopt an appropriate information feedback mechanism to ensure everyone is 'on the same page'. Organizations and commissions will work together to create a common platform for sharing and reporting information. This platform will take into account new technologies and will facilitate the populating of Databases.

### 6.2.2.1. Information Management Strategy and Implementation of the Joint Information and Analysis Unit (JIAU)

An information management strategy was developed in February 2019 to facilitate the prioritization of activities and better support the authorities to make informed decisions.

A mid-term evaluation, based on a SWOT analysis, of the implementation of the SRP3 information management strategy was carried out jointly by the Ministry of Health, OCHA, WHO and UNICEF, and identified the following: 1) non-appropriation of information management systems by the Sub-Coordination units; 2) the existence of parallel information flows and multiple sources of information; and 3) information products that are poorly or not used by different levels of coordination.

With this in mind, under the framework of SRP-4 the Ministry of Health — with the support of its partners — plans to create a Joint Information and Analysis Unit (JIAU) that will involve the main actors on the ground at the level of the General and Strategic Coordination, to synergize the efforts of all concerned entities by improving the sharing and analysis of multi-dimensional, integrated information.

In concrete terms, the Unit will help to:

- Improve overall understanding of the operational environment and the means available to mitigate and stop the spread of the Ebola virus;
- Provide key information for planning, response strategy and budgeting in order to contribute to creating a conducive environment for stopping the chain of transmission of EVD;
- Identify problems arising from the "system-wide scale-up" pillars that could have negative consequences on the overall response;



- Provide a platform for information, coordination, analysis and advocacy;
- Disseminate results of social, behavioural and epidemiological analyses undertaken in communities, to inform decision-making at all levels and by all actors in the response.

In order to function well, the JIAU needs a common collaborative space composed of epidemiologists, information managers, anthropologists and humanitarian actors involved in the response. This common space will facilitate improved coordination and collaboration between actors, improved information management and analysis, and will create a common source of information for decision-makers, managers and team members.

The main products expected from the JIAU are:

**At the level of each sub-coordination unit**, a common space for key stakeholders will be allocated to solve problems such as internet access, workstations (computers) and a dedicated physical workspace.

The main products expected from the JIAU at this level are:

- The daily epidemiological report;
- Daily dashboard by sub-committee;
- Weekly dashboard of the sub-coordination unit;
- Monthly mapping of stakeholders;
- Updated inventories of materials, equipment and other specific inputs;
- Establishment of lists of human resources (names).

These products need to be used at this level of coordination to stimulate exchange of information and support decision making.

**At the level of the General Coordination**, the JIAU aims to improve coordination and collaboration between stakeholders, to improve the quality of management and analysis of information, and create a common source of information for decision-makers, managers and team members.

The main products expected from this JIAU are:

- Epidemiological report daily summary;
- Daily dashboard by Commission;
- Feedback on weekly dashboards of sub-coordination units;
- Weekly information products of the response;
- Visual of the update of the financial flow;
- Monthly mapping of stakeholders (3W);
- Updated inventories of materials, equipment and other specific inputs;
- Establishment of lists of human resources (names).

These products need to be used at this level of coordination to stimulate exchange of information and support decision making.

**At the Strategic Coordination level**, a small team will be set up consisting of 5 central level executives (DES, DEP, Cabinet MoH, SG Office and a Data manager) for the management of information on the response outside of the Financial Unit.

The main products expected from this team are:

- Weekly epidemiological report summary;
- Summary report of Sub-Coordination units dashboards
- Feedback to General Coordination on weekly dashboards of Sub-Coordination units;
- Monthly mapping of stakeholders (3W).

The Financial Unit will produce weekly and monthly reports on resource mobilization and expenditures for SRP-4.

#### **6.2.2.2. Monitoring and evaluation (M&E)**

Monitoring and Evaluation aims to strengthen the M&E mechanism for the management of the Ebola response, to support decision making and to adapt the activities of the pillars.

The results will be monitored by Sub-Coordination units and by the response pillars and cross-cutting interventions, including the management of human, material and financial resources (eg supply stocks, inventory of deployments, list of human resources, and mapping of partners).

The monitoring and evaluation mechanisms will be (i) periodic reviews (weekly for Sub-Coordination units, monthly for General Coordination), (ii) joint missions of the Ministry of Health with partners.

The main M&E products or activities, their frequency as well as the responsible units are listed in the table below:

## Monitoring and evaluation products frequency table

PRODUCTS	FREQUENCY	RESPONSIBLE AGENCY/IES
Epidemiological evolution	daily	Epi analysis cell
Key performance indicators (KPI)	daily	M & E data management unit
KPI dashboard	weekly	M & E data management unit
M & E dashboard	daily/weekly/ monthly	M & E data management unit
Partners' list & mapping	monthly	M & E data management unit
Output analysis	weekly	M & E data management unit
Epi bulletin	daily/weekly	MSP/WHO/UNICEF
Monitoring of incidents that impact the response	daily	M & E data management unit
Presentation of social science research results & follow up of recommendations	weekly monthly	Community perceptions & feedback analysis unit

**Table of key performance indicators (KPI)**

TYPE	INDICATOR	TARGET
General	Number of new confirmed cases	0
	Number of new health zones affected over the last 21 days	0
Surveillance	Percentage of investigations completed within 24 hours following a confirmed alert	100%
	Percentage of new confirmed cases registered as contacts	100%
	Percentage of lost contacts	0%
	Average delay between the appearance of symptoms and isolation in days	<-4 jours
Clinical care	Case mortality rate among confirmed cases in ETCs	<50%
IPC	Number of newly infected health staff	0
	Percentage of foci with a score card that is more than or equal to 80%	>-80%
	Percentage of cases resulting from nosocomial infections	0%
SDB	Percentage of deceased for whom a SDB was successfully carried out	100%
Psychosocial Clinical management	Percentage of households in which there were new confirmed cases/suspected cases admitted to a TC/ETC that received psychosocial support	100%
Vaccination	Percentage of eligible contacts vaccinated within 3 days	100%
Laboratory	Percentage of lab results available within 24 hours	100%
PoE/PoC	Percentage of PoE and PoC in Spheres 1 and 2 with uninterrupted operations for 7 days	100%
	Percentage of PoE and PoC in Spheres 1 and 2 that have notified at least 1 alert during the previous 7 days	75%
RCCE	Percentage of incidents related to the response that have been resolved within 72 hours	>75%
	Percentage of alerts originated from Community Engagement Units	>50%
Survivors' programme	Percentage of EVD survivors that are enrolled in the survivors programme and that receive follow up.	90%
Logistics	Number of day of days of depletion of one of the 4 critical items (epidemiology, vaccine, GeneXpert cartridges, IPC)	0 days
Preparedness	Percentage of health areas potentially at risk	0%

## AXIS 3 - COORDINATION OF ADMINISTRATIVE, FINANCIAL AND LOGISTICAL SUPPORT

This axis sets out new guidelines with regard mainly to information management, administrative management of human resources for the response, financing of SRP-4 and logistics management.

### 6.3.1. ADMINISTRATIVE MANAGEMENT OF HUMAN RESOURCES (HR)

One of the bottlenecks in implementing SRP-3 has been administrative management of human resources deployed for the response, including:

- Lack of a common database to enable a comprehensive overview of the number of employees that leads to the irregularity of payments;
- Lack of harmonization of the payment schedule for personnel on the ground, resulting in officials of the Ministry of Health leaving for better offers, poaching, demotivation of local actors, particularly community liaison personnel in health zone hotspots;
- Lack of a human resources deployment plan;

In view of the above, it is envisaged in SRP-4 to:

- Outsource human resources (HR) management and / or anchor it to the health system;
- Establish a common HR database;
- Harmonize incentives to be paid to national stakeholders;
- Develop a single quarterly plan for the deployment of national human resources. This plan will track related actions such as upgrading personnel, staff rotation and incentive payments, as well as good handover between outgoing and incoming teams;
- Put in place a rapid mechanism for developing, processing and validating lists of local service providers on the basis of a precise timetable, exchange of human resources data between partners to avoid double payments, and the alignment of financial agencies for the pay of local providers;
- Establish a mechanism for the accreditation of international experts in response activities;
- Effectively implement the Human Resources Management Manual for the response; Ensure that human resources management undergoes a review of information management for better information sharing.

### 6.3.2. PLANNING AND FINANCIAL MANAGEMENT OF SRP-4

The Preliminary Report of the World Bank's Mission for Strengthening Financial Management and Budget Tracking in June 2019 highlighted a low level of financial accountability, in particular the difficulty to quickly track what activities were funded through which funding agency and through which source of funding (donor).

In addition, the SRP-3 review held in June 2019 noted, in particular, the weak funding of the Operational Action Plans of the Sub-Coordination units and General Coordination. This situation may be explained on the one hand by the fact that part of the disbursements were made outside the activities mentioned in SRP-3 according to the aforementioned report of the mission of the World Bank, and on the other hand the method of financing which has prevailed (agency financing against action plans, and predominant payments for human resources and other inputs to the detriment of activities)..

To mitigate this situation, the launch of SRP-4 will be followed immediately by the development of the operational action plans. Thus, the financing of the Sub Coordination and General Coordination activities as well as the Strategic Coordination will be done through the "Fund Users" who will receive funds from the Financial Intermediaries. The latter will receive donors' funds. The budgeting of SRP-4 will be based on the activities planned by the Sub-Coordination units, the General Coordination and the Strategic Coordination. A regular monthly financial report by the relevant users and financial intermediaries is planned.

### 6.3.3. LOGISTICS MANAGEMENT

The review of SRP-3 in June 2019 identified some weaknesses, namely:

- The mismatch between the volume of leased vehicles at very high overall cost and the volume of work;
- Insufficient number of ambulances, and motorcycles, particularly in the new response areas;
- Lack of information regarding partners' stocks;
- Untimely breaks in the stocks of specific inputs;
- Absence of standard operating procedures (SOPs) for logistics that govern all response stakeholders, and the weak capacity of logisticians;
- Commissions' activity planning do not anticipate new international orders (ad hoc emergencies and new outbreaks);
- Intensive but unavoidable use of air transport that requires important financial resources.

Under SRP-4, the following measures are envisaged to address the logistical challenges of the EVD response for greater efficiency and effectiveness:

- Progressive purchase of vehicles in lieu of rentals;
- Standardization of inventory management tools and mechanisms in the Sub-Coordination units;
- Checking needs for medicines, specific inputs and consumables;
- The transfer of fleet management from each of the intervention pillars to the partners responsible for these pillars;
- Empowering partners to take over the supply of inputs for the activities for which they are responsible;
- Independent responsibility of each partner for its activities (logistical support: accommodation, means of communication and IT, transport, etc.);
- Establishment of a skills transfer system to guarantee the logistical autonomy of the partners that require it;
- Strengthening the package of shared logistics services for partner response and involvement;
- Maintaining air transport capacity for passengers and goods;
- Maintaining the road freight transport capacity;
- Creation and offer to partners of a common storage service (mainly for IPC);
- The maintenance / operation of existing infrastructures (temporary living accommodation for staff in Mangina, Komanda, EOCs in Beni, Butembo, Goma, Mangina, Bunia, Tchomia and Komanda, TCs, ETCs...);
- Maintenance of logistics response and contingency capacity (equipment positioning and availability of technical personnel).

## 7. Implementation Framework

SRP-4 will be implemented following the system set up since SRP-2, with the progressive involvement of organisational structures at the three levels of the national health system.

In addition, its implementation will be participatory and will be carried out jointly with all stakeholders, including civil society and members of affected communities, in order that health zones may benefit from the expertise of other levels of the public health pyramid.

The guiding principles for the implementation of SRP-4, the distribution of roles of the different stakeholders, as well as involvement in the allocation of available resources are specified below:

### 7.1. GUIDING PRINCIPLES

- The implementation of SRP-4 will be under the coordination of the Minister of Health. The structure of the National Coordinating Committee (NCC) set up by the ministerial decree of 2 August 2018 will be supplemented by a **core team for the monitoring and evaluation of the plan**.
- The SRP-4 response should contribute to strengthening the health system and the capacity of local health actors. To this end, the implementation of the various strategic axes of this plan is under the responsibility of the Ministry of Health with the support of implementing partners (Co-leads).
- In addition, community engagement — key to the success of the response — will be strengthened. Therefore, building capacity of local actors (community engagement units (CAC), local NGOs supported by international NGOs) for community alerts, for follow-up of contacts, for engaging people eligible for vaccination and for SDB will be a top priority. This component will be the subject of a specific support plan developed by the government with the support of the partners (sector or pillar 3).
- Ensuring security for the response will also be the subject of a specific synergistic strategy under SPR-4, led by the Government through the Ministries of the Interior and Security and National Defence (Sector or Pillar 2).
- SRP-4 funding is based on priority activities identified by pillar. The implementation of additional activities should be the subject of a specific request to the Ministry of Public Health, in case of emergency.
- Co-leads will act as financial intermediaries. They will identify, outside the health zones and provincial health divisions, NGOs with operational capacity to implement planned response activities in the field. Therefore, Co-leads will centralize the planned funds that will be made available to accredited "user" partners. The latter, in addition to channeling financial flows, will favour local and health system actors for the implementation of activities. However, they can fill gaps in implementation by putting forward their own operational capabilities.
- Monitoring of the response will be carried out through a **single channel of communication** and the regular exchange of critical information between the health zones, the sub-coordination units, coordination in Goma and strategic coordination in Kinshasa to guide



decision-making at the different levels of the response. To this end, each Sub-Coordination unit and General Coordination will monitor the implementation of their operational plan through daily sub-committee dashboards and dashboards containing key performance indicators (KPIs).

## 7.2. ORGANIZATION OF THE RESPONSE

### 1. Response entities

In accordance with Ministerial Order 020 bis of 2 August 2018, the coordination of the response is located in the Ministry of Public Health and comprises three entities, namely the National Coordination Committee (NCC) whose Secretary General for Health is the rapporteur, the Provincial Coordination Committee (PCC) with the provincial division head as rapporteur, and the Local Coordination Committee whose secretariat is run by the district chief medical officer.

Under the ministerial decree of August 2018, the National Coordination Committee bodies are supported by commissions to analyze specific aspects of their areas of action and offer guidance to the NCC. In principle, the **ten technical commissions** of the NCC should be led by the Central Directors or specialized programmes of the Ministry of Public Health.

### 2. Role of actors

- The Government of the Democratic Republic of the Congo will coordinate the response through the response structures (coordination, sub-coordination and technical commissions). It will ensure, through the Ministry of the Interior, the security of people and materials for the response. It will also mobilize part of the response budget as well as provide essential human resources.
- Donors will provide implementers, through transparent mechanisms, with financial and human resources (if needed) to support the response activities. The "financial intermediaries" as well as the "financial users" will provide them with justification of expenditure directly.
- The General Coordination and the Sub-Coordination units will lead the response in the field through the management teams of health zones, health centre teams and local actors (community engagement units ...). They are required to draw up operational action plans within two weeks. The provincial health division and provincial health inspectors will join the General Coordination to guide the preparation of the Health Zones and the inspection of health facilities, notably on the implementation of IPC.
- Co Leads will play a dual role. They will serve as "**financial intermediary**" and **technical support** to the various committees and sub-committees of the response, in particular by supporting the development and implementation of operational plans and the technical accreditation of implementing partners.
- Financial Users undertake, apart from their participation in the finalization of the single operational plan of the response, to:

- Participate actively in the various coordination meetings and technical committees
- Collect and report data related to the response pillar in which the actor participates, to feed into the information management system
- Participate in analysis of information and key performance indicators related to the response pillar they support
- Participate in the updating of strategies or standard operating procedures (SOP) in the response pillar they support
- Develop periodic financial reports (monthly).

### 7.3. ACCOUNTABILITY

Accountability will be achieved through the following main tools: Structural framework: organization chart; the Single Operational Plan; the Information Exchange Platform: symmetry of information for decision-making (dashboards and KPIs, Portal: website).

1. The General Coordination will propose to the Minister of Health, before the end of July 2019, an updated organizational chart of the response;
2. Each Sub-Coordination unit will elaborate, before end of July 2019, its operational plan drawing on Table 1 used for the budgeting of SRP-4;
3. Each commission will update, if necessary before the end of July, the indicators of the daily dashboard;
4. Strategic Coordination will put in place, by the end of September 2019, the portal (website) for information exchange on EVD.

#### **The Accountability Framework outlines reporting modalities**

For this purpose,

1. Commissions and sub-committees are required to draw up daily charts;
2. The Sub-Coordination units and the General Coordination must prepare the daily summary reports and the dashboards based on the KPIs;
3. Financial intermediaries and fund users should prepare monthly financial reports;
4. Each quarter, the Secretary General for Health will organize the deployment of Ministry of Health personnel in the field;
5. The Co-Leads will report monthly on the stock status of key materials and inputs to the response.

#### **Technical accreditation of response actors**

The implementation of SRP-4 will preferably be done by the health system personnel and by the local communities. If necessary, the expertise of international actors will be called upon. Therefore, it is essential that:

1. Each Sub-Coordination unit updates the mapping of local implementation actors on the ground on a monthly basis in order to propose their technical accreditation;

2. Co-leads assist the government in the preparation of the technical accreditation (assessment of the operational capacities of implementing partners through ad hoc tools) and thus participate in the said accreditation.

Accountability and accreditation of actors will be based on the following criteria:

- Operational capacity of response actors;
- Respect for different predefined activity packages;
- Geographic rationalization of the implementing actors;
- Implementation of the Human Resources Management Procedures Manual;
- An evidence-based response.

## 8. Budget

### 8.1. METHODOLOGY

To develop the SRP-4 budget, we used a methodology that provides an opportunity to introduce transparency and efficiency in financial management, accountability and reporting. The first step was to identify the critical activities needed to break the chains of transmission, as well as the targets according to the profile of the epidemic (health hotspot zones, active health zones and health zones at risk). Sub-Coordination units and Co-leads decided on the units and estimated unit costs. The amounts were calculated by activity, by target and not by partner. The summary of the budget is shown in the table below.

### 8.2. SYNTHÈSE DU BUDGET

The activities of the Response Plan for the next 6 months are valued at US\$ 287.6 million. This budget will be re-evaluated and adjusted periodically according to the evolution of the response. The implementation of this budget will be closely monitored by a dedicated team within the coordination.

<b>RESPONSE PILLAR</b>	<b>US\$ JULY-DECEMBER</b>
Coordination	71 948 990
Risk communication and community engagement	38 267 735
Surveillance, contact tracing, PoE & vaccination	42 675 034
Laboratory	3 182 640
Clinical care & survivors	54 686 912
Infection Prevention and Control/WASH	41 607 030
Safe and Dignified Burials	18 758 433
Psychosocial care	10 391 995
Operational preparedness	6 071 380
<b>TOTAL</b>	<b>US\$ 287 590 149</b>

# Annexes

## 1. Projection of epidemic trends in the next 120 days

### Goal

Evaluate the impact, in terms of avoided cases or reduction in transmission, a certain number of days after the onset of a new outbreak of EVD.

### Method

We used a simple branching process where the number of new cases at a time  $t$  follows a *Poisson* distribution with an infection rate  $\lambda t$ , calculated from the previous case numbers and reproduction rate  $Rt$ .

The difference with the models already used by the analysis unit is that this time we used two  $Rt$  values, before and after the effective control of the epidemic episode.

### Parameters of the statistical model

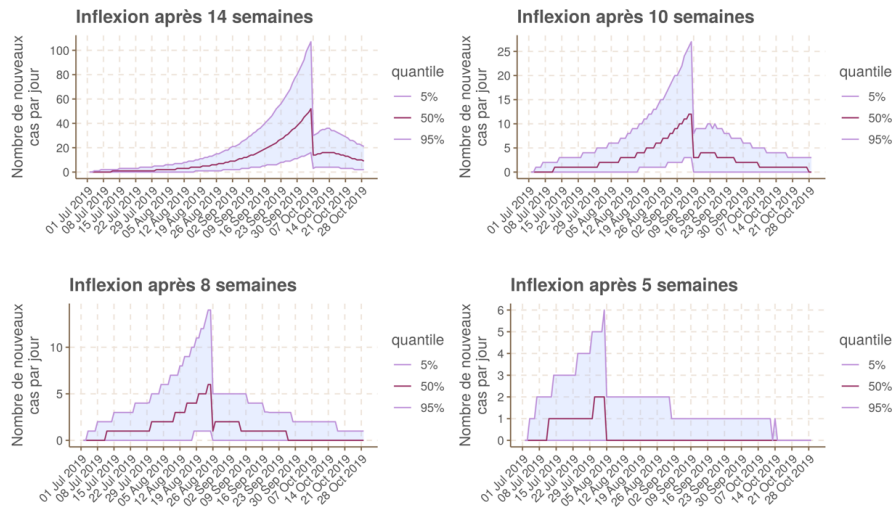
- Serial interval: estimated from transmission chains of Butembo sub-coordination health zones
- Number of Reproduction ( $R$ ): We used the following values, based on recent estimates from Butembo and in the literature:
  - 1.5: corresponding to the growth phase in Butembo
  - 0.5: corresponding to the decreasing phase in Butembo
  - 2: most pessimistic scenario corresponding to the higher estimates of  $R$  during the first 9 months of the epidemic in West Africa, used to simulate an epidemic in urban areas
- Time for effective control: values estimated from different epidemic waves during this epidemic
  - Long: 14 weeks
  - Medium: 10 weeks
  - Short: 8 weeks
  - Fast: 5 weeks

The projections presented here are based on the time taken for the reproduction number ( $R$ ) to fall below the value 1 during the different waves of the current outbreak (otherwise called *time to control*).  $R$  values of 1.5 or 2 were used for simulations respectively in rural and urban areas. Estimates are given for 4 months (120 days) from an arbitrary episode start date.

### Results

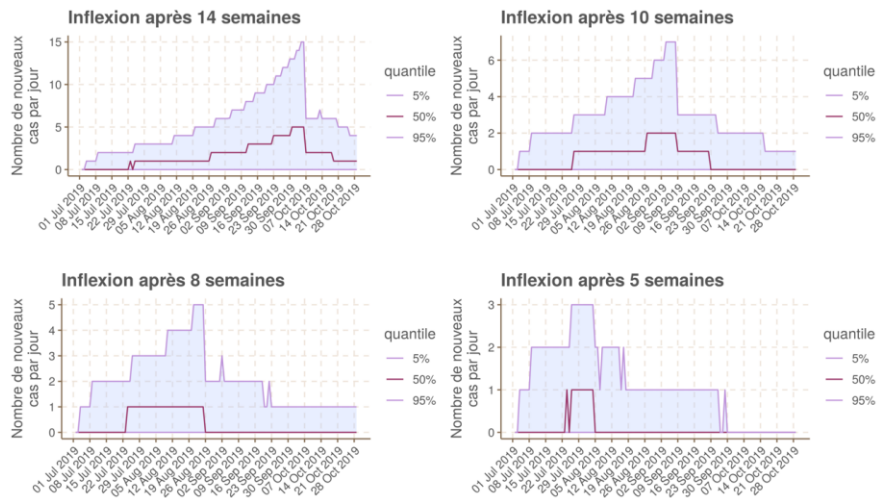
In urban areas (see Figure 1), the results show that a late intervention results in a sudden drop of about fifty cases per day on average to ten cases, and control of the outbreak in a few additional weeks. In the case of a rapid intervention, the average number of cases per day does not exceed 2 and the epidemic is controlled a few weeks later.

Figure 1: Simulations in an urban environment



In rural areas (see Figure 2), in a late intervention the average number of cases per day falls from 5 to 1, and the epidemic episode is under control a few weeks later. And after a quick intervention, the average daily number does not exceed 1 and the episode is under control a few weeks later.

Figure 2: Rural simulations

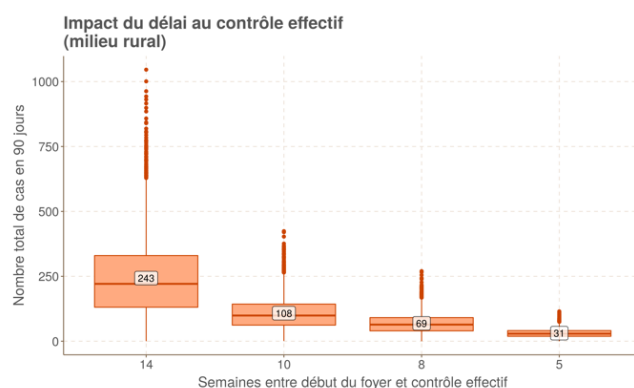
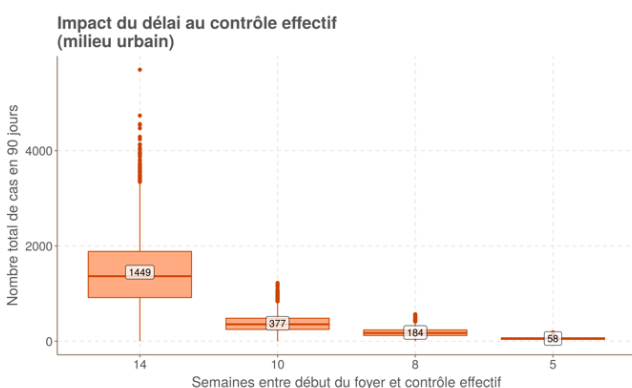


## Impact

Using the worst-case scenario (observed during the first wave of the outbreak in Katwa / Butembo) of a 14-week period for effective control, our projections estimate that the average number of cases generated was 243 and 1 449 respectively for urban and rural areas (see Figure 3 and Table 1). According to a "more optimistic" scenario (with a control time of 5 weeks), the projections estimate at 31 (13% of the most pessimistic scenario) and 58 (4% worst case scenario) the average number of cases for respectively urban and rural environments.

**Table 1: Average number of cases generated in the next 120 days depending on the time frame for effective control**

	TIME FRAME FOR EFFECTIVE CONTROL (WEEKS)			
	14	10	8	5
URBAN SETTING	1 449	377	184	58
RURAL SETTING	243	108	69	31



## Full report:

<https://my.pcloud.com/publink/show?code=XZYL737ZTEUH7JeI2bQFP1DUKEEnRayOEQH17>

### 3. Organizational Chart of the Response

#### ORGANIGRAMME DE LA RISPOSTE EBOLA 10 EN RDC

