



## **REVISED NATIONAL PLAN FOR THE RESPONSE TO THE EBOLA VIRUS DISEASE EPIDEMIC**

IN NORTH-KIVU AND ITURI PROVINCES

**DEMOCRATIC REPUBLIC OF THE CONGO**



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# 1. INTRODUCTION

## Context

Following the notification of the 10th Ebola Virus Disease (EVD) outbreak on 1 August 2018 in the health zone (ZS) of Mabalako, North-Kivu province, a strategic response plan was rapidly developed and implemented by the Ministry of Health, in collaboration with all technical and financial partners.

This initial plan covers interventions for a period of 3 months (August-October 2018). Typically, a response can control the epidemic in 5-6 weeks when the activities are properly conducted and the community appropriates the response. This was the case in almost all previous epidemics in the Democratic Republic of the Congo.

An operational review of the EVD response activities was conducted in mid-September by the response coordination in Beni to review the response operations including the use of deployed resources and to make recommendations to strengthen the response. Significant progress has been made, including a meaningful decrease in cases recorded around the Mangina epicenter and in the Mandima SZ. However, since the beginning of October, there has been a notable increase in the incidence of new cases.

This second wave of the epidemic reflects a multitude of challenges, in particular the insecurity and resistance in some communities of Beni who refused the vaccination, the follow-up of the contacts and the carrying out of the safe burials of the deceased persons of continuation of the EVD.

The revision of the strategic plan of the response is necessary to take into account the specificities of the current situation and the risks.

## 2. ANALYSIS OF THE STRENGTHS AND WEAKNESSES OF THE RESPONSE

### Strengths

- The operations of the response have allowed to quickly control the situation around the initial epicenter of Mangina / Mandima. The total number of registered cases is well below projections made at the beginning of the epidemic, which predicted 400 cases in September.
- The availability and rapid deployment of vaccines has helped to limit the spread of the disease among the many contacts of confirmed and probable cases and among front-line staff. As of October 13th, 16 973 people at risk have been vaccinated.
- The use of new molecules has prevented high lethality.

### Weaknesses

- In organizing the response, one should highlight the absence of a sub-coordination in Beni, separated from the strategic coordination currently in place for the overall response in the region.
- The coordination of the response has not developed a detailed work plan that specifies for all the actors and agencies present on the ground: who does what, where, when and how.
- The information system for the response remained weak, with fragmented databases, incomplete information and siloed information.
- The absence of some specialized skills in project management is also worth noting.

### Opportunities

- Increasing general awareness in the population of the dangerousness of the disease.
- Awareness by all actors that the framework goes beyond public health.
- Availability and commitment of managers and members of the response teams at all levels.

### 3. RISK ASSESSMENTS

As of 13 October 2018, 211 cases have been reported (including 135 deaths) in ten ZS -Malalako (92), Beni (81), Oicha (3), Masereka (4), Butembo / Katwa (14), Kalunguta (2), Mandima (11), Tchomia (2), Komanda (1) and Musienene (1). The risk of transmission at the national level is very high because the affected provinces are connected to the rest of the country by air, river and road. The risk of transmission at the regional level is high. Indeed, the epidemic affects border areas with Uganda and neighboring Rwanda, where there is a high cross-border migration flow for reasons of trade, access to health care, family and humanitarian visits.

The overall security situation gradually deteriorated during the epidemic period with clashes between rebels and Congolese armed forces, street demonstrations by residents and the observation of so-called "dead cities". The security dimension, however, has not been comprehensively approached, thus impeding the implementation of response activities such as contact tracing, alert investigations, and secure burials.

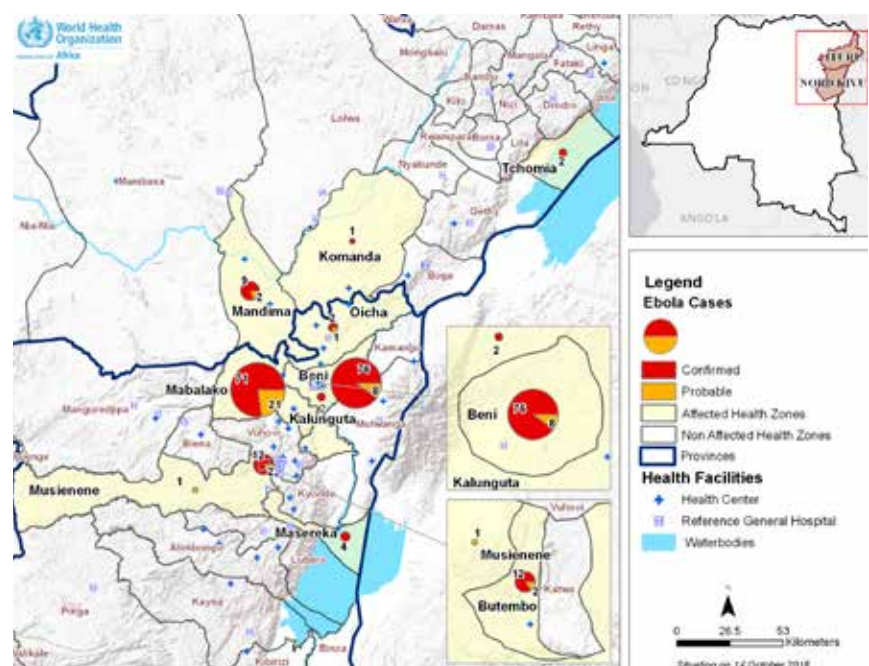
The pockets of community resistance often associated with urban delinquency continue to be reported, particularly in the Beni and Butembo SZs. Attacks on the staff responsible for the response have been noted several times. A regular evaluation of the causes of these incidents is necessary in order to be able to provide targeted and specific control measures and improve relations with the communities.

Important public health challenges are noted, characterized in particular by a low percentage of regular contacts, lost contacts, unsolved transmission chains, late arrival of patients to ETCs, low notification of community alerts and deaths. These challenges are due to multiple causes, including those mentioned above. It should be noted, however, the low commitment of traditional healers who are passing many confirmed cases of EVD.

Stacked bar chart showing the number of confirmed and probable cases by the first day of the week of onset of illness. The y-axis is 'Nombre de cas' (0-50). The x-axis is '1er day of week of onset of illness' with dates from 30/04/2018 to 08/10/2018. Blue bars represent confirmed cases, and red bars represent probable cases.

1er day of week of onset of illness	Confirmed cases	Probable cases
30/04/2018	1	0
07/05/2018	1	0
14/05/2018	1	0
21/05/2018	3	0
28/05/2018	1	0
04/06/2018	0	0
11/06/2018	1	0
18/06/2018	2	0
25/06/2018	2	0
02/07/2018	1	0
09/07/2018	6	0
16/07/2018	8	3
23/07/2018	0	5
30/07/2018	0	27
06/08/2018	0	40
13/08/2018	1	10
20/08/2018	1	4
27/08/2018	1	14
03/09/2018	0	7
10/09/2018	0	13
17/09/2018	0	10
24/09/2018	3	17
01/10/2018	3	20
08/10/2018	0	2

**Figure 2: Confirmed or Probable Cases of Ebola Virus Disease by Health Zone, May 1 to October 14, 2018, North-Kivu and Ituri Provinces, Democratic Republic of the Congo**





## 4. STRATEGIC OBJECTIVES AND REORIENTATIONS

### Main objective

Interrupt the spread of Ebola virus disease in the Provinces of North-Kivu and Ituri and prevent its spread to neighboring areas / provinces and neighboring countries.

Specific objectives:

- Strengthen response capacity for all strategic areas in active households to stop the epidemic by the end of November 2018.
- Continue monitoring, community engagement, psychosocial care, PCI / WASH and free healthcare in all affected health areas until the end of January 2018.

The revised plan will build on the following strategic directions:

- Implementation of integrated, early and effective multidisciplinary interventions around each confirmed and probable case.
- Increase involvement of politico-administrative authorities (APAs), community leaders and civil society to accelerate community ownership and engagement.
- Linking of the elements of the response in the organization and functioning of the local health system and the gradual transfer of the management of the response to local actors.
- Preparation of health zones and peripheral provinces of outbreaks to prevent the spread of the epidemic.

## 5. MAIN STRATEGIES AND REVISITED ACTIVITIES

### 5.1 Strengthening coordination of multisectoral response at different levels

Coordination mechanisms and collaboration among the different coordinating bodies will be strengthened to improve the effectiveness of the response. The aim is to improve interaction between commissions and coordinating structures on common and cross-cutting issues, and to ensure more effective communication with all implementing partners.

In addition, it is important to involve more local actors, namely political and administrative authorities, community leaders and civil society.

The following core activities will be carried out by all the coordination and sub-coordination of the response:

- Strengthen the effectiveness of the EVD coordination mechanisms at the national level (Kinshasa), provincial (Goma, Bunia), and local level (Mangina, Beni, Butembo, Tchomia, Bunia and Makeke) according to their respective roles and facilitate the deployment of multidisciplinary teams in the field;
- Deepen daily analysis of response status at all levels with updated information to improve operational planning;
- Regularly evaluate and document the management of the epidemic (KPIs and weekly outputs);
- Set up a centralized data bank based on commission and sub-coordination databases; and
- Create and make functional Beni's sub-coordination.

Specific activities for the Beni sub-coordination are as follows:

- Establishment of a planning cell for all the activities of all the actors present in the field according to the new approach of co-targeting to know: who does what, where and how and to measure the results - effects - impact.
- Strengthening the information system of the response.
- Planning of activities, prioritization, monitoring of achievements.
- Database for each subcommittee.
- Reconciliation of databases.
- Sitrep documentation.
- Links with EOC in Kinshasa and visualization team.
- Integrate visualization experts into Beni's surveillance team
- Organize multidisciplinary interventions in each of the 18 health areas with co-piloting between the nurse / health area physician and an Ebola expert supervisor.

## 5.2 Strengthening surveillance, active case finding, contact tracing and vaccination

Key activities to be implemented include increasing alerts, rapid investigation, listing as complete as possible, monitoring and vaccination of contacts, and active case finding.

Database management will need to be strengthened, epidemiological analyzes deepened, including the complete constitution of epidemiological links, and laboratory analysis of samples in a safe and reliable manner.

There is also a need to strengthen the search for unseen contacts and the detection of suspected cases and community deaths through community networks (including networks of traditional practitioners and taximotards) and contacts with politico-administrative authorities.

The co-targeting of teams of epidemiologists, vaccinators, PCI / EHA and those in charge of food distribution will be strengthened with a view to a better synergy.

The essential activities are:

- Reinvigorate rapid response teams in each operational cluster (sub-coordination) for a rapid multisectoral assessment of alerts transmitted by the monitoring mechanism;
- Strengthen community-based surveillance through an appropriate communication system (toll-free number);
- Increase training and staffing of health facilities in monitoring tools;
- Strengthen active case finding (communities and health facilities) and follow up contacts by increasing the number of agents;
- Strengthen procedures for prompt investigation of alerts and cases;
- Ensure the effective supervision of contact tracing teams;
- Increase alerts through the door-to-door approach by relying on community relays and community leaders of "10 houses" called nyumba kumi;
- Empower nurses, members of health committees and pressure group members of insecure and inaccessible health areas in active case finding and follow-up of contacts;
- Strengthen preparedness surveillance in high-risk areas including unaffected health areas in Ituri and North-Kivu as well as in adjacent provinces (South-Kivu, Tshopo, Haut-Uele, Maniema, Tanganyika);
- Ensure immunization to further control the risk of spreading through the population through immunization of high-risk individuals. In this perspective, care must be taken to:
  - move forward with the certification of Congolese vaccinators in view of the large number of people to be vaccinated on the one hand and ensure sustainability on the other.

- ensure the immunization of contacts and contact contacts of any new confirmed and probable cases within 48 to 72 hours and vaccinate front-line staff including traditional healers.
- continue to monitor post-vaccination adverse effects, secure waste management and the organization of immunization data.

### 5.3 Strengthening laboratory diagnostic capabilities

The diagnosis of the disease is definitive only if the samples analyzed in the laboratory are positive for the Ebola virus. Deployment of mobile laboratories in the affected provinces can accelerate the confirmation of diagnosis and improve the effectiveness of epidemiological investigations.

The aim is to mobilize more partners to strengthen measures to ensure the transport of samples, prepare and organize the training of additional laboratory personnel in the areas of intervention, plan to increase the laboratory capacity for Bunia, Mambassa, Kisangani, Lubero and others.

The essential activities are:

- Continue supporting the operation of the 6 laboratories (Goma, Beni, Butembo, Mangina, Tchomia and Bunia) in reagents, consumables and equipment for the diagnosis of EVD and differential diagnosis of yellow fever, dengue, chikungunya; for hematology, biochemistry and parasitology;
- Deploy a mobile laboratory in Bunia;
- Acquire 5 mobile laboratories (3 reserve and 2 for training);
- Organize sample management (sampling, storage, packaging and transport);
- Train new teams of laboratory technicians in the diagnosis of EVD.

### 5.4 Establishment of points of control and sanitary measures specific to Entry Points (PoE)

Cross-border surveillance at entry points in at-risk / neighboring areas / provinces / countries and at major passenger gathering locations will be continued as the epidemic evolves.

The essential activities are:

- Set up the PoE database including alerts.
- Continue monitoring population movements at ports of entry.
- Ensure information sharing with neighboring countries (Burundi, Rwanda, Uganda, and South Sudan).
- Strengthen the integration of multi-sectoral teams at PoE level.
- Identify experts to evaluate the effectiveness of activities in the field.

## 5.5 Medical management of patients and suspected cases

The goal is to isolate and offer quality, humanized services and care to EVD patients and suspected cases in a way that minimizes the risk of subsequent spread of the virus, including to health workers.

To cope with additional needs, it will be necessary to have standard CTE plans, stockpiles in stock, organize construction teams and train clinicians (doctors and nurses) in case management.

The essential activities are:

1. Continue support for the operation of all Ebola Treatment Centers (CTEs) (Beni, Mangina, Tchomia, Butembo, Makeke, Goma)
2. Strengthen the early referral system of suspected patients to CTE
3. Support the construction and operation of the CTE in Bunia
4. To guarantee the quality of care through the use of validated protocols including protocols for the application of investigative therapies and nutritional protocols
5. Arrange transitional care structures in risk areas (Oicha, Komanda, Kalunguta, Vuhovi)
6. Acquire and deploy support kits
7. Provide general referral hospitals with infection prevention kits including transfusion safety
8. Set up the survivor monitoring program (Beni, Mangina, Butembo, Tchomia)
9. Continue training of care providers on Ebola virus disease
10. Continue staff training and triage in HGRs, CSRs and CSs that have generated a confirmed case
11. Provide care for health care workers and other health personnel after a risk of infection

## 5.6 Reinforcement of prevention measures and infection control

Infectious disease control in public and private health facilities aims to halt the transmission of infectious diseases to other patients and health workers by rapidly isolating suspected cases, creating isolation zones that ensure patient flow while keeping suspect cases out of the way; and providing facilities for handwashing and waste management, as well as PPE for health workers. Intervention strategies in priority health facilities will be intensified to bring together the range of activities and equipment to ensure compliance with standard measures.

Strong anti-infective measures and practices must be in place in communities. The increased involvement of local authorities and partners should accelerate the implementation of WASH activities, particularly through the training of staff from local structures such as civil protection who can operate even in so-called unsecured areas.

In the face of pockets of community resistance, it is important to strengthen community outreach and engagement activities including social marketing approaches to better target and understand different segments of the population.

In the context, efforts will be strengthened to ensure safe burials, rapid diagnostic tests (Oraquick) for any deaths in the community, previously, both civil protection actions and engage traditional leaders.

Protective measures in schools and universities will also be intensified to reduce the risk of transmission in schools and for schoolchildren and students in the fight against the Ebola epidemic. Schools should be mapped according to the proximity of confirmed cases and the implementation of control measures.

The essential activities are:

- Redefine the roles of all actors;
- Identify strategic targets and specific actions for each target: FOSA, Schools and Churches;
- Identify strategies for involving healers and traditional healers to gain commitment to the response;
- Extend coverage of PCI / EHA interventions to other affected areas (Beni, Tchomia, Bunia, Butembo, Masereka) by training providers in the different themes (burial teams, hospital hygiene / infection control / standard precautions, disinfection techniques, chlorination);
- Accelerate staffing of HGRs and CSs and other health facilities frequented by equipment (PCI), sterilization equipment. Inputs for the control of infection and hospital hygiene;
- Disinfection and maintenance of the Health Facilities (FOSA) premises (CS and HGR) and replace contaminated materials;
- Supply sanitary facilities in drinking water, handwashing points and increase storage capacity in priority health structures;
- Ensure the decontamination and replacement of household goods where confirmed or probable cases are notified (24h principle) and raise awareness of good hygiene practices;
- Rehabilitate Water Points in communities, schools and FOSA;
- Make operational the 6 EDS teams of the civil protection for the insecure zones;
- Form 12 community DHS teams in Kanyihunga, Supa Kalau, Kasindi, Kantine, Mangina, Makiki, Makeke, Mambasa, Komanda, Mabalako, Masereka and Mutwanga;
- In schools, train teachers in hygiene measures related to Ebola disease and raise students' awareness of the prevention of Ebola through playful trainings; and
- Provide schools with hygiene kits and hand washing stations.

## 5.7 Risk Communication, Social Mobilization and Community Engagement

For all aspects of the response to be most effective, it will be necessary to be responsive to community concerns and provide them with appropriate and targeted information. The resistances observed require activities aimed at engaging the community for the acceptance of response actions including DHS, effective contribution to prevention activities and contribution to the warning system. The involvement of the media (radios) in raising public awareness, managing rumors and supervising the activities of communication officers in the field will be intensified with a view to better community engagement. It is important to support and strengthen the integration of communicators in all other committees.

The essential activities are:

- Diligent rapid assessments of social structuring especially in new affected localities (Rapid Socio-anthropological Studies) and CAP Surveys.
- Intensify the mobilization of community leaders (district / village leaders, street leaders, local committees, CACs, RECOs, prayer house leaders and traditional practitioners) in the control of the epidemic.
- Intensify sensitization activities aimed at improving the population's perception of the response, taking into account the specificity of the target groups and using people who have been cured, discharged and guided tours of ETCs.
- Continue production and intensify the broadcasting of radio and TV programs, spots and microprograms on the prevention of Ebola Virus disease in the media.
- Strengthen public communication (press briefings, forums, public information) local authorities: mayors of the cities of Goma, Bunia, Beni, Butembo and the TAs of Beni, Lubero, Mombasa and Irumu.
- Train supervisors and strengthen supervision missions of RECOs, community leaders and other communication actors involved in the response.
- Set up a community-based early warning system for suspected cases, community deaths in collaboration with the surveillance team (toll-free number to the community).
- Organize home visits (VAD) by the relays in the households at risk of problematic health areas (non-compliance with EDS, lost contact cases, rumors, cases of reluctance) including information on vaccination and its benefits.
- Support the integration of OACs, NGOs, Religious Confessions, Women and Youth Associations as key actors in the implementation of field communication activities.
- Strengthen communication activities through community dialogues, focus groups, community debates and community expression platforms in communities by engaging local leaders.

- Involve and involve celebrities, celebrities, celebrities (First Mayor of BUTEMBO City, Champion Team of CONGO AS NYUKI of BUTEMBO, Musicians for Mass Awareness.
- Support the integration of police unit commanders as outreach officers in the points of entry and in the control at the ports of entry.
- Support the setting up of the Speakers with pre-recorded messages in the entry points and control points.
- Develop and disseminate appropriate messages on DHS.

## 5.8 Psychosocial care

Psychosocial assistance is an essential element of the management of EVD cases. Survivors and their family members are often stigmatized and prevented from resuming their activities after their recovery.

In addition, it is important to ensure the psychological briefing of the participants on the attitudes to be displayed on the ground and the stress management as well as a psychological debriefing in group of the speakers (a brief preventive therapy after 2 months of participation in the response). It is therefore important to integrate psychosocial care into the response as quickly as possible in all affected areas.

The essential activities are:

- Strengthen psychological support for ETCs (confirmed, suspects, and unloaded) and assistance with hygiene kits for all non-case and recovered cases. Activity to be intensified for the nurses at the level of the CTE and / or affected households in order to anticipate the management of the problems of behaviours posed often by them, likely to generate tension and resistances in the community;
- Continue psycho-social support and / or material assistance (food kits, NFI kits, recreational kits) to affected families (any family whose member has been through the ETC);
- Continue psychosocial and nutritional support to contacts with psychoeducational sessions to facilitate the work of the surveillance and vaccination teams;
- Continue psycho-social support, food, material and school reintegration of orphaned and separated children due to EVD;
- Conduct Behavioral and Practical Behavior analyzes in areas with pockets of community resistance;
- Intensify psycho-education activities with a particular focus in the areas or areas targeted by the mapping of areas of resistance to reduce anxiety and increase acceptance of the disease and control measures;
- Intensify support for other areas of intervention for a holistic approach to community response;
- Provide briefing and debriefing with providers;



- Provide written documentation of interventions; and
- Conduct research on the psychosocial impact of the epidemic on populations.

## 5.9 Free access to health services

As part of the response to the EVD epidemic, free healthcare is one of the most important pillars in the strategy for implementing an effective response. Free medical care covers consultations, hospitalization, paraclinical examinations and medications. The removal of direct costs of care has increased attendance among those potentially infected with Ebola.

A cursory review shows that the use of health services has increased since the introduction of free healthcare in about 50 health care facilities. The package includes the provision of drugs, health care subsidy and operating costs of targeted FOSAs, as well as the motivation of FOSAs staff.

It should be noted that during the outbreak of EVD some common medical interventions such as injectable vaccinations, injections and surgical procedures are often avoided or minimized.

The essential activities are:

- Pursue and consolidate free healthcare in the 152 ongoing health facilities of the program until the end of January 2019;
- Identify other FOSAs according to the dynamics of the epidemic, particularly in Ituri (Bunia, Tchomia);
- Contribute to the quality of patient care through integrated supervision and vaccination of health personnel in risk areas; and
- Evaluate the impact of free education on the dynamics of the epidemic.

## 5.10 Preparation of health zones and provinces adjacent to the epidemic outbreak

Given the geographical spread of the epidemic, the existence of unrecognized transmission chains in the community, the loss of contacts and the high mobility of the population in this region of the Democratic Republic of the Congo, the risk of the epidemic remains high in the unaffected health zones of the provinces of North-Kivu and Ituri and in the neighboring provinces (Haut and Bas Uele, Tshopo, Maniema, South-Kivu and Tanganyika). It is therefore necessary to accelerate preparedness activities in these health zones and provinces.

The key activities at the provincial level are:

- Strengthen the coordination structures, including the technical sub-commissions set up by the Governors and the Provincial Ministers of Health.
- Strengthen surveillance measures, particularly the investigation and follow-up of alerts.
- Strengthen infection prevention and control capacities in health zone structures (include at least 1 referral hospital and 5 health centers in 5 health zones in each province).
- Intensify and decentralize community outreach and mobilization activities.
- Strengthen the capacity for rapid management of suspicious cases, including the monitoring of contacts, secure care, dignified and safe burials in high-risk health zones.
- Strengthen screening, outreach, isolation and referral activities at entry points with intensive passage that are unsupported (average of 30 PoE / province).
- Ensure the availability of technical, logistical, security and administrative support and tools for the smooth running of the aforementioned activities.

## 5.11 Human Resources, Operational Support and Logistics

Strengthening the monitoring and efficient use of the human, material and financial resources mobilized for the response remains essential at all levels. Major infrastructure, critical procedures and operational support mechanisms need to be strengthened to support response operations on all fronts.

The essential activities are:

- Increase human resources in number, expand skills, ensure regular payment of bonuses for all personnel deployed for the response;
- Rotate field staff in a coordinated manner;
- Consolidate the establishment of a unified response logistics with a regular compilation of the stock status of all partners;
- Continue the transport of personnel, management and maintenance of the fleet and motorcycles;
- Continue support to the restoration and accommodation of the personnel of the response in the camps of life (Mangina, Tchomia); and
- Continue to purchase office supplies, personal protective equipment, rolling stock, generators, tents or materials for the construction of temporary shelters and / or rehabilitation, beds and other equipment necessary for the setting up of the camps of life (preposition for a camp eventually).

## 5.12 Distribution of food

Considered as a significant incentive, it must continue and be organized with the contribution of contact monitoring teams in particular. In addition, effective monitoring should be done through the implementation of performance monitoring indicators that all coordination and sub-coordination will take into account.

## 5.13 Ensure the security of human and material resources acquired for the response

This involves putting in place interventions to enhance the security of the teams and assets involved in the response by protecting the hosting sites, providing escorts to the field agents, sharing security information at the site on time and the use of local capacity in place of international capacity.

- Continue to set up intervention teams (vehicles and means of transmission) in Butembo, Tchomia, Bunia.
- Establish think-tanks (with politico-administrative and law enforcement authorities) on acts of violence affecting the response and the teams.
- Equip the MSP teams deployed in the field with communication equipment.
- Strengthen the quality and safety of the living environment for stakeholders.

## 6. MONITORING AND EVALUATION

The Ministry of Health and WHO, in collaboration with their partners, publish daily epidemiological updates, supplemented each week by detailed status reports and periodic reports on the response indicators. In Annex 1, the Table of Key Performance Indicators.

## 7. BUDGET

The following assumptions underpin the budgeting of this revised action plan:

- The scenario of 300 cases until the end of the epidemic.
- Estimated 70 contacts and approximately 75 contacts for each confirmed or probable case.
- Two additional health zones affected.
- The interruption of human-to-human transmission of EVD by the end of November 2018.
- Continuation of consolidation / vigilance activities, including free health services until the end of January 2019.

STRATEGIC RESPONSE (REVISED INTERVENTIONS)	BUDGET US\$ (August - October)	BUDGET US\$ (November - January)	PRINCIPAL SUPPORT PARTNERS
<b>Strengthening the coordination of the multisectoral response with different committees at different levels</b> <ul style="list-style-type: none"> <li>• 3 x provincial Emergency Operations Centers</li> <li>• 6 x field coordination</li> <li>• 1 x national coordination committee</li> <li>• Monitoring and Evaluation</li> </ul>	5 130 000	6 891 000	WHO, PDSS
<b>Surveillance, active case-finding and contact tracing</b> <ul style="list-style-type: none"> <li>• 16 rapid response teams / case investigation teams</li> <li>• 60 x supervisors for surveillance</li> <li>• 1190 x contacts tracing agents</li> <li>• 54 x points of entry monitored</li> </ul>	4 095 000	6 553 000	WHO, GOARN, MSF, IOM
<b>Strengthening the diagnostic capabilities of mobile laboratories</b> <ul style="list-style-type: none"> <li>• 1 x national reference laboratory</li> <li>• 11 x mobile laboratories</li> <li>• Logistics for transporting samples</li> </ul>	612 000	598 000	WHO, EDPLN, PDSS
<b>Medical management of patients and suspected cases</b> <ul style="list-style-type: none"> <li>• 7 x EVD treatment centers (15-20 beds)</li> <li>• 600 x triage units in hospitals / health centers</li> </ul>	8 308 000	9 392 000	WHO, MSF, EDCARN, ALIMA, Emergency medical teams
<b>Strengthening of prevention and infection control measures, as well as water, sanitation and hygiene services in health facilities and communities</b> <ul style="list-style-type: none"> <li>• 600 x health facilities</li> <li>• 600 x in schools</li> <li>• 900 x in the communities of the affected area</li> <li>• 23 x teams for safe and dignified burials</li> <li>• 17 x decontamination teams</li> </ul>	4 116 000	11 465 000	WHO, UNICEF, FICR, Red Cross
<b>Strengthening communication and social mobilization</b> <ul style="list-style-type: none"> <li>• 18 x risk communication</li> <li>• 800 x teams for community engagement</li> <li>• 10 x anthropological study teams</li> </ul>	1 578 000	2 988 000	WHO, UNICEF, FICR, Red Cross, UNFPA
<b>Psychosocial support</b> <ul style="list-style-type: none"> <li>• 10 x psychosocial support teams</li> <li>• 1 x Nutritional and food support for those affected</li> </ul>	711 000	2 763 000	UNICEF, WFP
<b>Vaccination of at-risk groups and the response of research</b> <ul style="list-style-type: none"> <li>• 10 x vaccination teams</li> </ul>	3 598 000	3 489 000	WHO, MSF, GOARN, UNICEF
<b>Support for free health services</b>	3 323 000	6 093 000	PDSS
<b>Operational, logistical and security support</b> <ul style="list-style-type: none"> <li>• 2 x operational bases</li> <li>• 6 x field operational bases</li> <li>• 1 x national logistics base</li> <li>• Implementation of security measures</li> </ul>	12 366 000	7 517 000	WHO, WFP, MONUSCO, UNICEF
<b>Preparation in the provinces bordering North-Kivu and Ituri</b> <ul style="list-style-type: none"> <li>• 6 x province</li> </ul>	-	3 526 000	WHO, UNICEF
<b>TOTAL BUDGET US\$</b>	<b>43 837 000</b>	<b>61 275 000</b>	

## ANNEXE 1. TABLE OF KEY PERFORMANCE INDICATORS

TYPE	INDICATOR	TARGET
General	Number of suspected, probable, confirmed cases	0
	Number of new health areas affected	0
Surveillance	% of inquiries completed within 24 hours of a verified alert	100%
Contact tracing	% of contacts completing 21-day surveillance period	100%
	% of registered contact under surveillance during the preceding 24 hours	100%
	% contacts lost of follow-up	0%
	% of new confirmed and probable cases previously registered as contacts	100%
Laboratory	% of samples received that have been tested	100%
	% of laboratory results for specimens from suspected cases available within 48 ours	100%
Case management	Fatality rate among confirmed cases admitted to Ebola treatment centres	< 50%
Infection prevention	Number of newly infected health workers/patient carers	0
	% of deceased suspected and probable cases for whom safe and dignified burials have been carried out	100%
	% of persons with access to a source of drinking water in affected areas	100%
Vaccination	% of eligible individuals vaccinated against EVD	100%
Community involvement	% of respondents who know at least 3 ways of preventing EVD infection in the communities affected	100%
	% of school-age children who have received information about preventing EVD	100%
Psychosocial care	% of families of confirmed an probable cases affected, including children receiving protection and psychosocial support, including a support kit	100%

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