



**World Health
Organization**



Ebola Virus Disease Readiness Implementation Progress Report WCO Uganda

August – October 2018

1. INTRODUCTION:

The Democratic Republic of Congo (DRC) declared its 10th outbreak of Ebola in North Kivu, a province bordering Uganda on 1 August 2018. The outbreak has spread to several health zones in North Kivu and Ituri provinces. Beni located about 100km from the Uganda/DRC border is the current epicenter. In Ituri province the affected zone Tchomia is even closer than Beni to the Uganda/DRC border (less than 20Km). As of 1st December 2018, a cumulative total of 440 cases (including 392 confirmed and 48 probable cases) with 255 deaths (case fatality of 60%) had been reported. The hot spot areas are Mabalako, Beni and Butembo health zones. These areas are also affected by an armed civil conflict with internal displacement of over one million people, and recurrent flight of refugees to neighbouring Uganda, Rwanda, Burundi, and South Sudan. The civil war has inculcated a culture of community mistrust and rumours around EVD control interventions which is impacting negatively on the effectiveness of the Ebola response in DRC; some high risk contacts refuse to be followed up, some contacts and health workers refuse vaccination, and other community members keep away Ebola patients from health facilities. These actions contribute to sustenance of Ebola transmission chains in the communities.

1.1 RISK ANALYSIS/AT RISK GEOGRAPHIC AREAS:

Risk of spill-over of EVD to Uganda has been categorised as very high. On 28 September 2018, WHO elevated the risk at regional level which includes Uganda from 'high' to 'very high'. Uganda has a very long and largely porous border with the DRC. High population movements across the borders occur for various reason including for trade, social activities and services and asylum. There are cross-border markets in several border districts in Uganda and DRC that involve thousands of people crossing into and out of DRC and Uganda for trade purposes several days in a week. For example at the cross-border market at Mpondwe, in Kasese, Uganda, about 5,000 people cross from DRC to Uganda daily and up to about 20,000 on market days, which occur twice a week. Entry to Uganda happens through several formal and informal border crossing points in the districts bordering North Kivu and Ituri provinces, some of which are high volume crossing points. Furthermore the people on both sides of the border are related, have similar cultures, and often interact for social cultural reasons. Prolonged Civil conflict in North Kivu has also resulted in the disruption of health services with the consequences that many sick people cross the border into Uganda to seek health care. Health facilities near the border, like Bwera hospital in Kasese, report that about 30% of the patients seen at the hospital originate from DRC.

Uganda hosts refugees from several countries including the DRC. As of 30 October 2018, official figures indicate that the country is hosting 1,154,352 refugees. Influx is expected to rise during December 2018 and early 2019 according the OPM Contingency Planning with about 50,000 new refugee arrivals. The main points of refugees' entry into Uganda has been through Kisoro, Kanungu, Kasese, Bundibugyo, Ntoroko, Kyangwali and Nebbi and they are then settled in Kyaka II (Kyegegwa), Kyangwali (Kikuube), Nakivale (Isingiro) and Rwamwanja (Kamwenge).

Several buses move from Beni to Uganda on a daily basis making it highly possible that an infected person could move to Uganda during incubation or early illness stage. These high population movements between the DRC and Uganda is the bedrock of the risk of transmission of Ebola from DRC to Uganda. The upcoming national elections in December 2018 could ignite increased number of Congolese crossing into Uganda, with the possibility of populations from the Ebola infected areas moving into the country for safety. Given the imminent threat of cross-border transmission of Ebola in the districts bordering the DRC near the outbreak epicentre, and at the Entebbe International Airport, it is critical that Uganda heightens preparedness for Ebola and other viral haemorrhagic fevers.

Population movement studies conducted by CDC and IOM indicate that once the people from DRC enter Uganda, they go to different places within the country. While most stay in different villages near the border and further inland

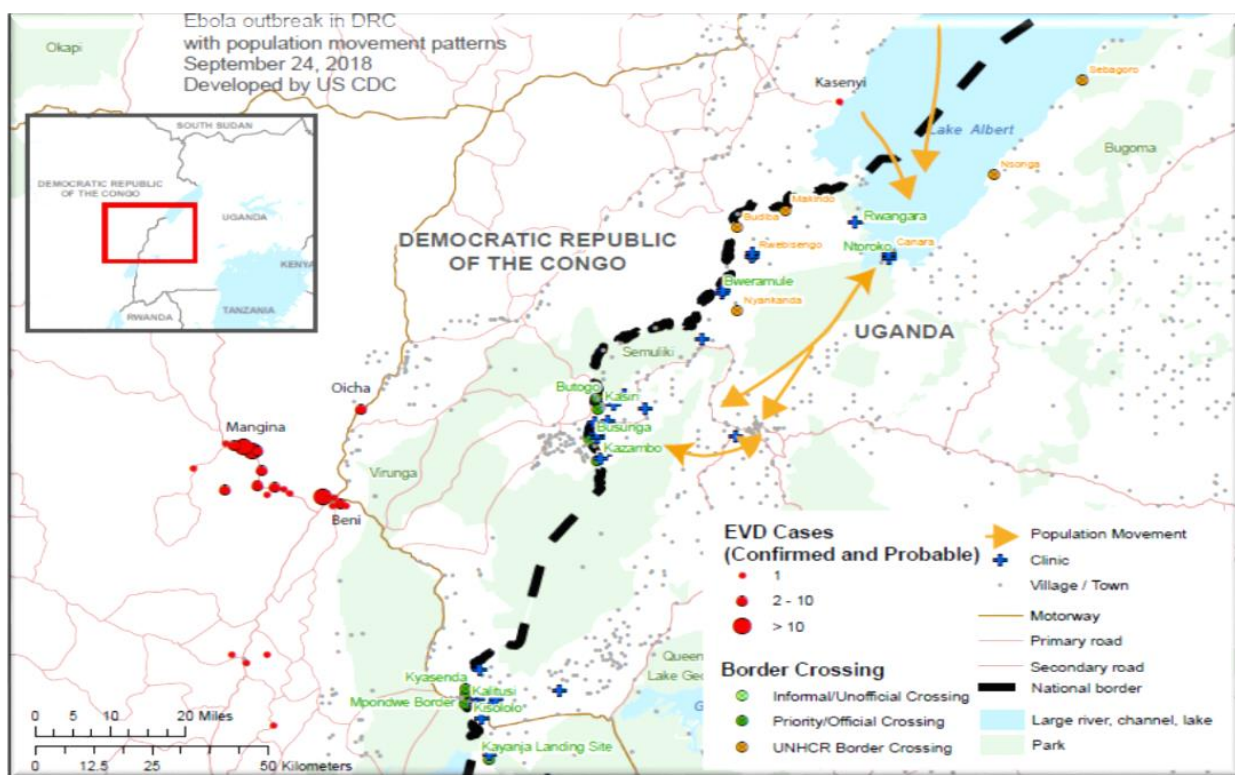
within the border districts, some travel to Fort Portal and others to Kampala and Nairobi. It is thus possible that a contact of an EVD case from DRC could end up in different parts of the very risk high districts in Uganda (5 in Rwenzori region (Kasese, Kabarole, Bunyangabu, Ntoroko, Bundibugyo) and 2 in central region (Kampala and Wakiso).

Figure 1: Population movements from DRC to Uganda and within Uganda

In view of this high population movement, the EVD outbreak in DRC positions the country at greater than normal risk of a spillover from DRC.

Internally, Uganda evaluated risk of EVD spread and identified at least 30 border districts as most at risk. The districts were sub divided into high risk, moderate risk and low risk based on geographic proximity, strategic locations, and common tribes and cross border mobility.

Risk categorization of districts for spill-over of EVD in Uganda is as below:



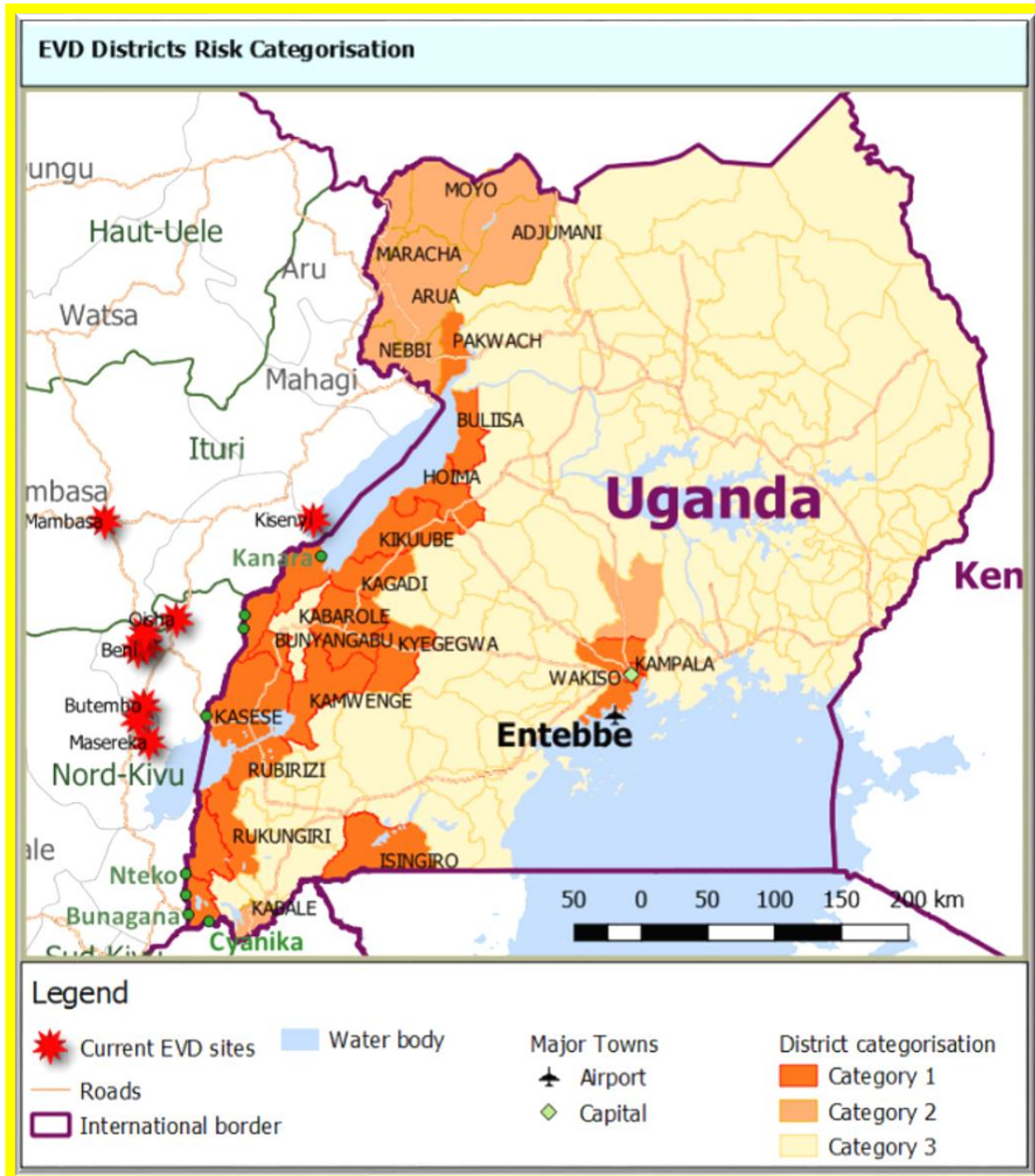
Category one (high risk): Districts with direct links with affected health zones in Ituri and North Kivu provinces and refugee hosting close to affected area: Ntoroko, Kasese, Kabarole, Bundibugyo, Bunyangabu, Kanungu, Kisoro, Rukungiri, Rubirizi, Kikuube, Kamwenge, Kyegegwa, Kyenjojo, Isingiro, Buliisa, Hoima, Kagadi, Pakwach, Kampala, Wakiso.

Category two (moderate risk): Districts with direct links with DRC but not with Ituri and North Kivu provinces, other refugee hosting): Arua, Nebbi, Zombo, Yumbe, Moyo, Adjumani, Koboko, Lamwo.

Category three (low risk): The rest of the districts in the country.

Each of the border districts have several formal and informal ground crossing points.

Figure 2: Map of Uganda showing the high risk districts



WHO, with support from DFID, USAID, and other partners has been supporting the Ministry of Health and districts to enhance preparedness, with the aim of ensuring the country is operationally ready to handle a spillover of Ebola from DRC. WHO support was targeted at most of the Ebola intervention pillars. Below is a summary of achievements and challenges in the first 3 months of support (August to October 2018)

2.0 MAIN ACHIEVEMENTS:

2.1 STRATEGIC LEADERSHIP AND MULTI-SECTORAL COORDINATION.



Joint partners' visit to the high risk districts involving officials from Ministry of Health, CDC, US Embassy and the World Health Organization

WHO supported the National Task Force (NTF) to convene the members for coordination of the response and strategic direction. The NTF began to meet twice a week and was effectively differentiated into technical sub-committees including Case management, Surveillance and Laboratory, Risk Communication, Logistics and supply chain, Vaccine and new technologies, and Coordination. The Ministry of Health identified an Incident Commander whom WHO has been actively supporting to coordinate the Ebola preparedness efforts.

WHO supported the National Rapid Response Team to conduct a rapid assessment in all the 5 very high risk districts in Rwenzori region plus Kampala and Wakiso which informed the development of the national Ebola preparedness plan. Baseline level of readiness in the very high risk districts were documented and have been extensively used in monitoring progress. A total of 25 districts were initially identified as at risk and categorized as Very High Risk (7 districts), high risk (7 districts) and Medium risk (11 districts). The Preparedness Plan, which initially targeted the 7 very high risk districts only, was developed with input from the high risk districts and WHO guidance and agreed on by all the partners in the NTF. Subsequently, as the outbreak in DRC evolved, WHO supported the MoH to review and expand the scope of the preparedness plan to cover all the at risk districts. The districts were re-categorized based on risk into high risk (20), medium risk (10), low risk (rest of the country). The revised plan covering all the districts was endorsed by the NTF but is yet to be disseminated officially.

The Ministry of Health convened the breakfast meeting in Kampala on 23 August 2018 to update partners, donors and other bilateral partners about the plan and to get the buy in of the stakeholders on mounting a response to the threat of EVD from the DRC. WHO provided technical and financial support for this very successful meeting, attended by over 40 delegates from EU, USAID, CDC, Swedish Embassy, Norwegian Embassy, Embassy of Japan, Netherlands Embassy, DFID, US Embassy, UN agencies, senior government officials among others. The main outcome of the meeting was the joint consensus to comprehensively address the EVD threat targeting high risk

districts. Partners agreed to contribute to and support the Ministry of Health to lead the implementation of this plan.



Health Development Partners were briefed Ebola outbreak Operational Readiness in the high-risk districts.

WHO Uganda staff were repurposed into a new IMS organogram to provide effective support to each of the NTF sub-committees. The sub-committees conduct separate meetings and provide reports to the NTF at every meeting. The PHEOC is still on watch mode but is actively providing the platform for effective coordination of the response. However additional 03 districts were included being recipients of new arrival refugees from the DRC.

Resource mobilization efforts were intensified to support the Ebola Preparedness Plan resulting in realization of USD 3,404,000 by WHO from CFE, DFID in Uganda, USAID, DFID (through AFRO) and Irish Embassy. Total funding mobilized by all partners to date is about USD 9,799,760.

Two WHO supervisory visits were conducted in the 5 very high risk districts in August 2018 and a Joint WHO and MoH visit was made to the districts in September 2018 to supervise and support Ebola preparedness efforts, to ensure districts keep the preparedness momentum and to troubleshoot on issues where necessary.

The Independent Oversight and Advisory Committee (IOAC) of the WHO Director General also visited the country and the very high risk districts in October 2018 to monitor the level of Ebola preparedness in the districts and report to member states their findings during the next IOAC meeting. The 5 member mission activities involved engagement with partners, UN agencies, and Government departments. In the districts, the team held discussions with district authorities, visited isolation centers and Points of Entry. Feedback provided to the Ministry of Health indicated that preparedness activities were on track, however there was need to more of the same (scale up) in some aspects especially community engagement and community based surveillance.

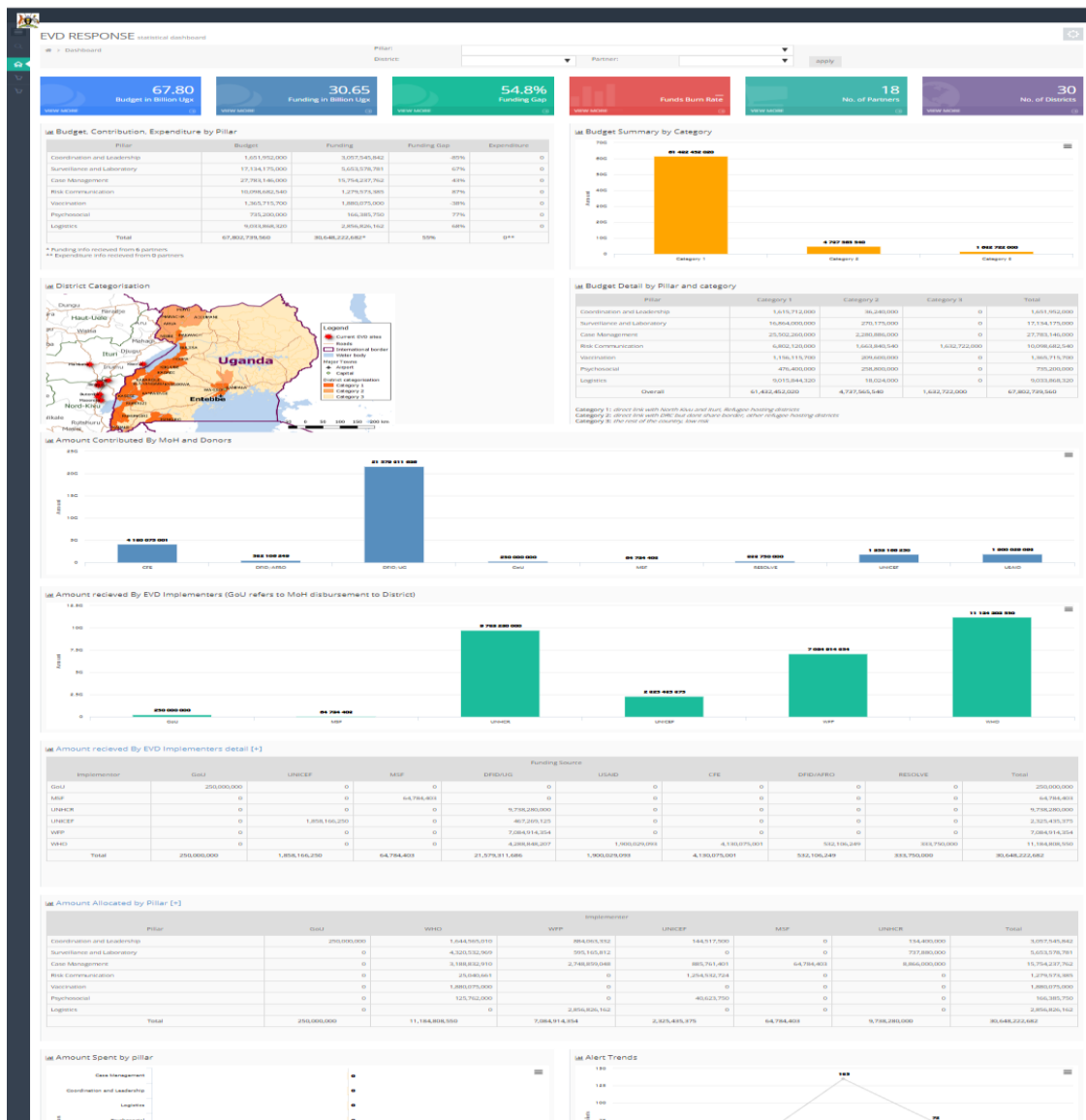
WHO has supported the Ministry of Health to produce and circulate regular updates regarding progress in implementation of EVD readiness activities. By 30th November, a total of 64 updates had so far been developed and circulated. At the beginning WHO led this process but this was later shifted and transitioned to the Ministry of Health. However, WHO continues to compile the daily reports and submit for final review, input, and distribution by the MOH/PHEOC.

WHO has also supported the printing and distribution of essential guidelines in all the critical areas including Case management, IPC, surveillance and risk communication. Through these guidelines and Standard Operating Procedures, the response efforts are harmonized and the standard of training and other interventions ensured.

WHO is also supporting the development and implementation of the 'who is doing what where and when' (4Ws) matrix to coordinate implementation of readiness activities in the field. The matrix is supported by an online dashboard which summarizes the progress in the implementation of the preparedness plan (see figure 4 below).

WHO is working with the MOH to strengthen cross-border collaboration. A regional cross border meeting for countries bordering DRC was organized in Entebbe and consensus was built on key action points to strengthen this collaboration. The pertinent decisions reached during the meeting include development an MOU to be signed by the Ministers of health, establishment of surveillance zones between Uganda and DRC and initiating information exchange between the bordering districts among others. A follow up high level ministerial meeting is planned for early December to take these recommendations into action.

Figure 3: Summaries displayed on the dashboard



At district level, the District Task Forces (DTF) have been reactivated in all the very high risk districts. Districts are holding regular DTF meetings and are slowly strengthening the functionality of the sub committees. All the very high risk districts submitted preparedness plans that have been submitted. At field level, WHO deployed experienced WCO staff to support district coordination of response. Since the start of the enhanced preparedness period, WHO has been deploying two dedicated staff to support district coordination of the readiness actions. This has resulted in effective engagement and ownership of readiness activities by the district. All the districts have regular meetings with all stakeholders involved in the exercises. In addition by end of November 2018, WHO had deployed in the field 3 experts for case management, 2 experts for community engagement, 5 surveillance officers in each of the 5 high risk districts, 2 epidemiologists/ district coordinators (one in Hoima and one in Kabarole/Bunyanagabu), 3 local and one international Infection Prevention and Control experts. Furthermore, surge capacity from HQ/AFRO was provided for coordination and cross border collaboration (4 officers).

2.2 SURVEILLANCE FOR EARLY DETECTION.

WHO supported orientation of health workers on EVD surveillance and contact tracing in the 5 plus 2 high risk district with funds DFID. These districts had 100% coverage of IDSR prior to this event. However, given the eminent risk of spillover, it was critical to identify and make a focused instruction for a small number of surveillance officers who can undertake the required EVD surveillance actions according to standards. The officers were identified by each district according to the criteria communicated to them by the Ministry of Health. Each group were instructed by 03 experienced epidemiologists deployed by MoH and WHO. The Instruction focused on EVD epidemiology, case definition, investigation and reporting and in-depth instructions on contact tracing to the subsequent group. In each district refresher was provided to 30 health workers on EVD surveillance and an additional 30 staff on EVD contact tracing. This translates into a total of 300 officers oriented in surveillance and the same numbers in contact tracing. The teams are equipped with case definitions and are conduct active surveillance at the health facility and community level and investigating alerts. Post training, the officers have been able to respond to alerts meeting EVD case definitions in the above districts. Figure 5 and 6 show alerts investigated by location and month respectively since the onset of the DRC outbreak in August.

Health facility visits for active case search and on-site orientation of health workers on EVD case definitions. Deployment of surveillance officers with funds from this DFID contribution allowed handy support to the districts. In all the very high risk districts, as well as in Hoima, at least every health facility has been reached by these trained surveillance officers during this period for on job orientation and mentorship of EVD case identification and reporting.

Figure 5: Alerts investigated by location

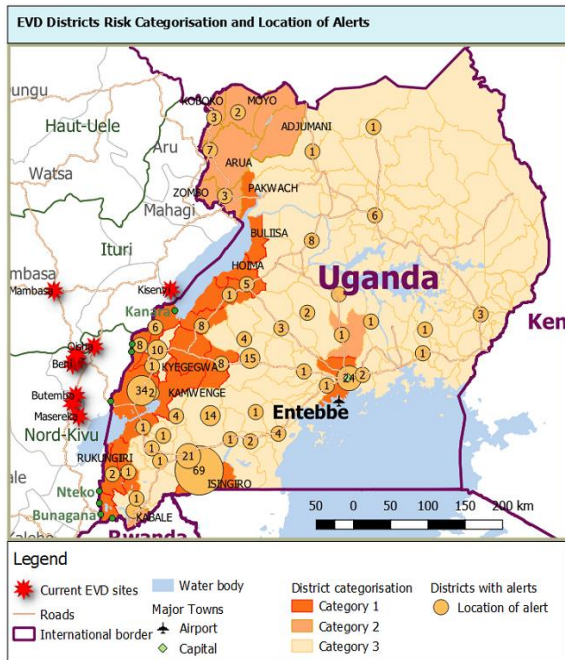
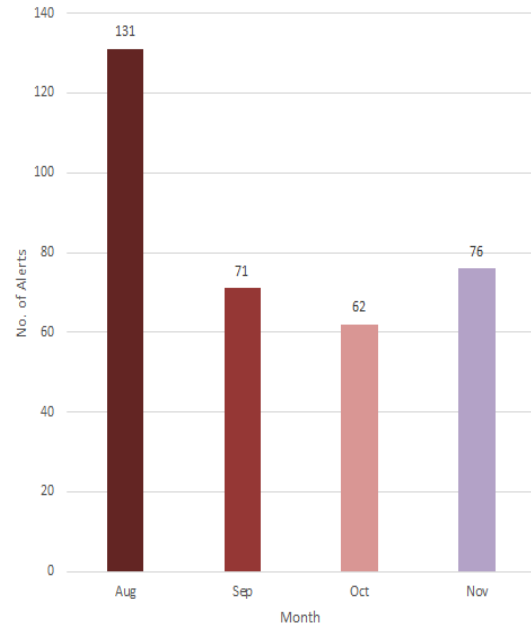


Figure 6: Alerts investigated by Month



2.3 SURVEILLANCE AT POINTS OF ENTRY.



Temperature screening at Busenga point of entry in Bundibugyo

Entry screening at Entebbe International Airport was reinforced. WHO support allowed the Airport to introduce initially targeted screening for all passengers from the DRC and South Sudan and Western Uganda during the aftermath of the EVD outbreak declaration. In November 2018, this has been scaled up to include all passengers

arriving at the airport. WHO support included training of 46 health workers from Entebbe hospital to provide required staffing strength for a full scale screening at the airport and procurement of two new thermo-scanners. One of the scanners was positioned at the arrival end of the VIP lounge and the other was sent to the field to support screening at Uganda–DRC crossing point in Kasese (Mpondwe).

The Uganda – DRC borders is one of the highest inflow points for commerce but also refugees because of the tensions in the DRC. The border market on the Uganda side of the border in Kasese (Via Mpondwe border point) attracts over 65,000 persons per week, up to 5,000 people crossing from DRC to Uganda daily and up to about 20,000 on market days, (which occur twice a week). There are 15 high volume and strategic border crossing points; Kasese – 5; Bundibugyo – 4 and Ntoroko – 6 conducting screening of passengers from DRC. WHO provided infrared thermometers and trained the Uganda Red Cross Volunteers to conduct screening at all these border screening points. This exercise has been jointly supported with other partners including Red Cross, UNICEF, WFP, and UNHCR.

2.4 RAPID RESPONSE TEAMS (RRT).

The support from different partners through WHO enabled RRTs to be mobilized and updated with essential skills to effectively support outbreak investigation in the country. The strategy was to ensure each of the technical staff within the RRT had good mastery of the requirements of their section in the field and that the skills were up to date to provide onsite support to health workers in the field. The objective was to instruct each team in depth in their specific sections. RRTs were therefore targeted with training and mentorship programs in specific practice areas: case management for the clinicians, Risk Communication in public health emergency situations for the risk communicators, Surveillance and contact tracing and safe lab sample collection and transportation.

A total of 46 clinicians of the RRT were trained in a five day workshop at Entebbe instructed by a joint team from WHO, MoH and WALIMU. The training also included new entrants in order to keep a rolling membership and to ensure that the strength is big enough to respond to the unlikely requirements for large deployment as may be necessitated in the country. Each team was equipped with the job aids, guidelines and contact information for ease of deployment. The database of all the RRTs trained were submitted to the EOC, Epidemiology and Surveillance Division and the Ministry of Health divisions that are responsible for ensuring standards and quality of practice in each of the sections, as well as their deployment when necessary.

At the beginning of the enhanced preparedness period, WHO supported exercise the RRT to conduct the baseline readiness assessment in the very high risk districts. As part of the assessment, the RRT were able to reactivate the District Task Forces for coordination of the implementation of readiness activities and to work with the districts to develop preparedness plan to fast track preparation of the districts to effectively respond to a possible EVD response. This multidisciplinary team were sent to the districts of Kasese, Ntoroko, Bundibugyo, Bunyangabu and Fort Portal for the rapid assessment. The reports from RRT informed the development of the National EVD preparedness plan that has been instrumental in guiding execution of readiness actions in the country.

As a result of this capacity building exercises, the RRTs have been able to effectively conduct training for the district health staff in the various skills and as well mapped potential high risk districts and health facilities. The RRTs have continued to function as the technical arm of the National Task Force conducting day to day follow up of implementation of readiness actions in the districts and reporting to NTF as required.

2.5 COMMUNITY BASED SURVEILLANCE

Plans are underway to strengthen community based surveillance in all the high risk districts to ensure that any suspected case in the community, indigenous or imported, is detected and reported timely for investigation. Village Health team members are being trained to conduct the event-based community based surveillance. Officers to oversee this in every district have been recruited.

2.6 LABORATORY DIAGNOSTIC CAPACITY.



Jmedic laboratory in Kabarole districts that carries out preliminary testing of samples

Forty (40) laboratory personnel from the high risk districts were trained on safe specimen collection from suspected Ebola cases, triple packaging and safe transportation to the laboratory; as well as biosafety and biosecurity measures to undertake while doing their routine laboratory work.

A total of 340 alerts have been investigated with samples to UVRI over that past 4 months. All alerts are so far negative for Ebola. Triple package materials have been prepositioned for specimen transportation in all the districts. Financing has been made available from WHO from the DFID contribution to keep within reach 01 vehicle dedicated for sample transportation in 5 high risk districts to the VHF lab in Entebbe. However, during times where there is no sample to transport the vehicles continue to support surveillance and supervision activities

2.7 RISK COMMUNICATION, SOCIAL MOBILIZATION AND COMMUNITY ENGAGEMENT.



Village Health Teams and Community health workers trained on Ebola risk communication

Risk communication is a quickly evolving field of practice influenced by rapid changes in communication and media platforms and community behaviours. In order to keep the RRT up to date with this changing landscape, a training exercise was organized as part of the preparedness initiative. A total of 40 risk communicators were trained over 5 days in July 2018 using the new WHO Risk Communication in Emergency curriculum. The training was facilitated by a joint team from WHO and Ministry of Health. This team has been instrumental in conducting risk communication and ensuring the risk communication teams in the districts are aware of the requirements to inform the current EVD readiness exercise through providing evidence on level of awareness and gaps. To achieve this target the team has extensively supported the districts in designing and executing a tailored risk communication program.

2.8 CASE MANAGEMENT AND INFECTION PREVENTION AND CONTROL (IPC).



One of the Ebola Treatment Units constructed to manage suspect or confirmed Ebola cases

Following a decision from the NTF to quickly install isolation and treatment facilities for EVD at Kasese and Bundibugyo, prompt deployment and procurement of the most essential supplies for patient care and IPC for

instant clinical care of the EVD patients was done. Case management experts were recruited by WHO and deployed to the districts to support training and mentoring of the case management teams in the very high risk districts. These staff expedited the assembly of the facilities into standard Isolation centres.

In order to ensure that health workers had the right skills, knowledge and attitude to function in an EVD patient care environment, WHO supported the Ministry of health and districts to conduct a 5-day training of case management training. In each of the 5 very high risk districts, a complete clinical team of 46 HWs; 6 clinicians, 18 Nurses, 12 Hygienists, 4 triage staff, 4 security, 1 driver and 1 Kitchen staff were trained. A total of 230 health workers; 46 staff for each of the districts Kasese, Bundibugyo, Ntoroko, Kabarole and Bunyangabu are now on standby for clinical care of any EVD patients in the districts. There is a vibrant collaboration between MoH, WHO, MSF, WFP, JMEDICC. These centres now handle on average 25 EVD alert cases a month all of whom have been negative for VHF

Supplies were procured including assorted IPC items for both the EVD Isolation facilities and also to quickly upgrade the IPC standards in some of the especially high risk primary health care facilities. Supplies procured included disposable gloves, heavy duty gloves, chlorine hypochlorite powder, aprons, alcohol hand rub, handwashing supplies for the beginning, additional N95 mask, digital thermometer. Additional supplies were procured for Entebbe Isolation facility in order to ensure that EVD suspected sick travelers arriving through Entebbe Airport has the facilities for their care according to standards until laboratory investigation is completed.

As part of the interventions there was printing of 300 copies of the VHF clinical case management pocket guide. These were provided to each health staff during training and are being used for care of patients admitted at the EVD Isolation and treatment centres.

In order to strengthen IPC a PDCA approach (Plan, Do primary intervention, Check progress and Act) was used

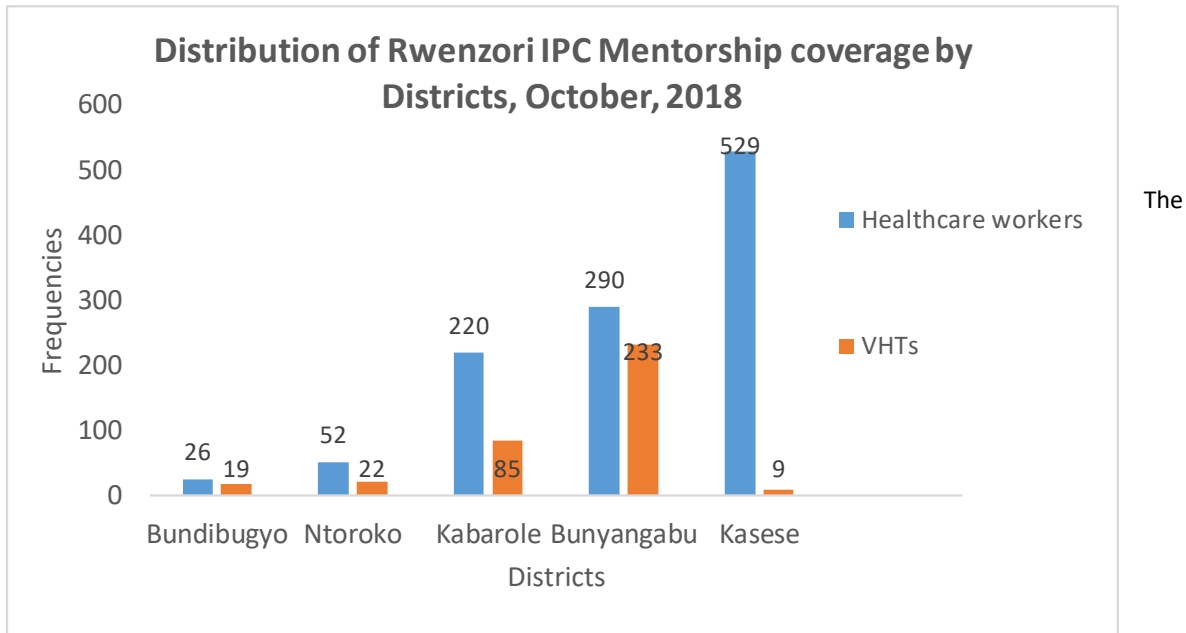
Based on this, the first step was a rapid assessment on the status of IPC in health facilities. Most of the health facilities in the 5 very high risk districts were assessed using a standardized checklist. Out of the 165 health facilities, 18 landing sites and 2 academic institutions assessed in the five very high risk districts, the results showed the majority of the health facilities had a score of less than 50%; with some having scores as low as 20%.

Fig 7: IPC assessment in Rwenzori region October 2018 IPC score by district

IPC Domains	Bundibugyo	Ntoroko	Kabarole	Bunyangabu	Kassase
	Scores (%)				
Formation of IPC Committees	6%	38%	34%	6%	17%
Compliance to Hand Hygiene	37%	56%	24%	23%	37%
Use of Basic Protective Equipment	42%	33%	18%	11%	24%
Waste Management Practices	62%	67%	55%	33%	61%
Isolation Unit Availability	9%	25%	13%	5%	12%
Availability of Clean Water Sources	100%	75%	100%	92%	82%

Following the assessment as part of the primary intervention a TOT for district IPC committees was organized; this was followed by an ongoing mentoring process in all health facilities in the very high risk districts. Fig 8 below shows the progress in October 2018

Fig 8: Progress of mentorship in Rwenzori Region, October 2018



assessment, training, mentorship and re-assessment to document progress and identify other interventions is being extended to the other districts in the next quarter.

2.9 VACCINATION



Vaccination of frontline health workers in districts adjacent to DRC

As part of the preparedness, vaccination of front line health workers (FLHW) in districts adjacent to DRC was identified as a very high priority. WHO has provided the technical and financial support in the development of the protocol for vaccination of the FLHW using the experimental vaccine rVSV-ZeBOV-GP under compassionate use based on the SAGE recommendations. This vaccine is one of the experimental vaccines that have undergone Phase I, II and III clinical trials and successfully demonstrated a high protective efficacy against EVD in West Africa.

By the end of October 2018, the protocol had been approved, permit for importation of the trial vaccine granted by NDA, procurement of vaccine completed, the micro plan for the vaccination developed, training of vaccination team (32 health workers centrally and 49 at district level) completed. In addition, identification of 1475 FLHW from 43 health facilities from districts bordering the epicentre in DRC was done. The vaccination started in November 2018.

2.10 LOGISTICS AND OPERATIONS SUPPORT.

Logistics and operations support is one of the priority areas in this preparedness interventions. This was especially true in the deployment of vaccination to FLHW. WHO provided technical and financial support for the logistics pillar through recruitment of logisticians, procurement of critical supplies and support supervision and mentoring at district level.

For the vaccination of the FLHWs, the vaccine requires a provision for a cold chain with a capacity to store at less than -80°C through international procurement. In addition, a regional sub store for vaccination supplies created at Fort Portal Regional Referral Hospital while at the district level a similar arrangement was made. A standby vehicle for logistics management including shipment of vaccines between NMS and the sub region within 48 hours was made available and a for the field team of 14 persons, a total of 4 vehicles each allocated to facilitate the vaccination exercise.

2.11 PERFORMANCE OF READINESS FINANCING:

Based on the revised preparedness plan the total budget required is USD 18,080,731. This will cover the period from August 2018 to March 2019. This budget is prepared based on the scenario that there will be no confirmed case but the EVD outbreak in DRC will continue unabated due to the security situation. By the end of October 2018 with the available information more than 52% of this budget have been contributed from MOH and all partners supporting the preparedness. Fig 9 below shows the budget and contribution by different partners

2.12 PARTNERSHIPS:

The NTF chaired by DG Health and WHO as a co-chair, with membership from all partners is providing the overall guidance on the implementation of the preparedness plan. The meeting is organized on a weekly basis and deliberate on key issues that require immediate attention. The NTF has 5 pillars (Coordination, Surveillance and laboratory, case management and IPC, risk communication and community engagement, logistics and operations support). All pillars have members from the different partners. In addition, the UN agencies have a weekly meeting to harmonize support to the NTF and avoid duplication.

3.0 KEY CHALLENGES:

Preparedness activities mainly in the very high risk districts; scale up to other high and medium risk districts with agreed package of interventions needs to be strengthened

There is need to strengthen surveillance in all at risk districts; the immediate need is to strengthen community based surveillance given the population movements between Uganda and DRC to different communities in many districts

IPC practices in most health facilities remain inadequate

Community engagement activities are not yet meeting the levels required

A long porous border with huge population movements, inadequate cross border collaboration with a very weak or nonexistent port health.

The turnaround time for the laboratory results remain high

Increasing trend of EVD in DRC with frontiers moving closer to Uganda border

4.0 LESSONS LEARNT:

WHO country office had supplies including rapid deployable Isolation facility, PPE kits and guidelines for EVD management from previous preparedness procurements. This enabled swift actions in the implementation of readiness exercise

Regular upgrading of the country's capacity for response to EVD emergencies has been a major agenda of the Ministry of Health and WCO over the years. Having skilled readily deployable expertise with vast experience in other EVD situations created confidence among the first timers in EVD response and therefore effective management of all alert cases. This provided confidence for the community to accept isolation without reservations.

Early engagement and coordination of partners in support of the Ministry of Health resulted in improved perceived credibility of the responders and robustness of implementation

It's possible to attract significant resources if WHO can demonstrate leadership, results and real effort in responding to an event. This requires early action, repurposing of WCO staff and leadership.

The introduction of the vaccination of the FLHW has been a huge challenge however a coordinated approach and engagement of the decision makers at various levels including timely technical support has enabled the importation and deployment of the vaccine.

5.0 RECOMMENDATIONS:

Extend intensified preparedness activities to more high risk districts, while sustaining the efforts in the very high risk districts

Support launch and partner engagement to support the revised preparedness plan covering all the at risk districts

Accelerate use of universal IPC precautions in all health facilities in high risk districts

Vaccination of high risk health workers to be accelerated

Community engagement and community based surveillance needs strengthening

Conduct more cross-border meetings with DRC to ensure adequate information sharing

END