EBOLA RESPONSE PHASE 3

Framework for achieving and sustaining a resilient zero

SEPTEMBER 2015

Photo: WHO/M. Winkler

World Health Organization

WHO/EVD/Guidance/Strategy/15.3

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Context for phase 3

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From a peak of over 950 confirmed cases per week at the height of the Ebola outbreak, current case counts in West Africa are the lowest in over 12 months. The geographical extent of the outbreak has been greatly reduced and since July 2015 the vast majority of cases in Guinea, Sierra Leone and Liberia can be epidemiologically-linked to known chains of transmission. There is strong evidence that the strategies and tactics employed to date are working.

Although the incidence of Ebola has significantly decreased, transmission is on-going and the risk of reintroduction due to virus persistence has emerged as a substantive near-term threat to achieving and maintaining zero Ebola in the region. The July 2015 outbreak in Liberia, which was likely due to virus persistence in a male survivor who had recovered months earlier, reaffirmed the possibility for transmission to re-start. While the risk of re-introduction due to virus persistence in some survivors is declining over time, it is significant due to the sheer number of people affected in this outbreak.

The purpose of this Phase 3 framework is to incorporate new knowledge and tools into the ongoing Ebola response and recovery work to achieve and sustain a “resilient zero”. Phase 3 of the response builds upon the rapid scale-up of treatment beds, safe and dignified burial teams, and behaviour

change capacities during Phase 1 (August – December 2014), and the enhanced capacities for case finding, contract tracing, and community engagement during Phase 2 (January to July 2015)[1].

This framework incorporates new developments and breakthroughs in Ebola control, from vaccines, diagnostics and response operations to survivor counselling and care. Many of the operational advances are already reflected in the latest national Ebola response initiatives, from "Operation Northern Push" in Sierra Leone, to the "cerclage" approach in Guinea, and the rapid response operation in Liberia.

As in previous Phases of the response, it is critical that the concerns of affected communities, households, and individuals are well understood and that they are fully engaged in implementation. The framework reflects the need for strong linkages across the response, early recovery and longer term health systems strengthening work outlined in the National Health System Recovery Plans.

While Phase 3 activities will require some adjustments to current response operations and recovery planning, it is crucial that the progress made in Phases 1 and 2 - and the underlying capacities - remain in place as the foundation for all response efforts. The scale and geographic prioritization of Phase 3 activities will be regularly reviewed and adjusted based on the evolving epidemiologic situation and understanding of virus persistence.

Phase 3 objectives:

Objective 1 - To accurately define and rapidly interrupt all remaining chains of Ebola transmission

Objective 2 - To identify, manage and respond to the consequences of residual Ebola risks.

[1] A full description of Phase 1 and 2 activities and capacities can be found in the "WHO Ebola Response Roadmap", the "Ebola Outbreak Overview of Needs and Requirements (ONR)" and the "WHO strategic response plan 2015: West Africa Ebola outbreak".

Objective 1 - Accurately define and rapidly interrupt all remaining chains of transmission

Photo: WHO/D. Licona

Building on the recent experience in identifying and stopping chains of transmission in Sierra Leone, Guinea and Liberia, three major additional activities will be prioritized and scaled-up in areas of active transmission:

1. *Risk-based event management:* to align under government leadership, and optimize the impact of, all partners operating in each country, the recently introduced 'event management' approach will be strengthened by:

    a. Treating each new transmission chain as an 'event' for which a coordinated and coherent multi-disciplinary response will be established under national leadership;

b. Assessing and managing all relevant chiefdoms/sub-prefectures, villages and households in each 'event' based on the risks associated with each chain of transmission (e.g. known contacts, missing contacts, 'unknown' contacts, probable cases, deaths in the community);

c. Enhancing the operational capacity to manage each new event and improve the quality of each new response through such mechanisms as forward operating bases, local incident management capacity, and independent monitoring of quarantine;

d. Alerting, assessing and supporting all health centers and referral facilities in the area surrounding a new transmission chain/event to ensure appropriate infection prevention and control measures (e.g. the 'ring IPC' approach);

e. Ensuring operational excellence and full implementation of standard operating procedures through increased supervision, effective reporting, and systematic feedback loops to promote continuous improvement.

2. *Enhanced identification, incentivization and management of cases & contacts:* the full investigation and management of both confirmed *and* probable Ebola cases will be improved to enhance the identification and engagement of all contacts, and the understanding of transmission chains, by:

   a. Systematically integrating medical and social anthropology into each case investigation;

   b. Using genetic sequencing of all viruses to determine more accurately the source of infection for each case, understanding of each transmission chain, and risks;

   c. Implementing "ring" vaccination for contacts and contacts-of-contacts in accordance with protocols established under the Ebola vaccine trial in Guinea and Sierra Leone;

   d. Ensuring optimal clinical management of and procedures for all Ebola cases to further improve patient survival;

   e. Improving, tailoring, and monitoring the package of benefits and incentives for contacts and communities (including food, water, sanitation and hygiene, livelihoods, psycho-social support, and health services);

   f. Prioritizing the tracing and recovery of missing contacts (including beyond 21 days to determine their ultimate welfare) and expanding the identification of likely destinations and priority villages for active case searching;

   g. Engaging specific community groups that could be potential drivers of the disease, such as traditional healers, taxi drivers, and border/wharf communities.

3. *Chieftain-led, community-owned, local response:* building on the growing experience in all affected countries, enhanced community ownership of the response will be prioritized by:

a. Giving local leaders (and/or those best placed to deliver reliable messages) the responsibility and accountability for working with households to ensure all contacts are identified, missing contacts are found and followed, quarantined households are properly managed, active surveillance is properly targeted, and safe and dignified burials are undertaken;

b. Supporting and building the capacity of local leaders to achieve agreed targets through deployment of integrated teams of anthropologists, epidemiologists, contact tracers, social mobilization and other experts; and

c. Continuing to identify and address core issues that create barriers between communities and the response, including through the reactivation of routine health services.