Tenth Meeting of the WHO Advisory Group on the EVD Response
TC, Upper SHOC Room, WHO HQ
14:30 - 16:00, 6 July 2015

Members
Co-chair: Professor David Heymann, Head and Senior Fellow, Centre on Global Health Security, Chatham House, UK (USA)
Co-chair: Dr Sam Zaramba, former Director-General of Health (Uganda)
Professor Awa Coll Seck, Minister of Health (Senegal)*
Dr William Foege, former Director, Centers for Disease Control and Prevention (USA)
Ms Nyaradzayi Gumbonzvanda, General Secretary, World YWCA, Switzerland (Zimbabwe) *
Dr Luiz Loures, Deputy Executive Director, UNAIDS (Brazil)
Professor Jean-Jacques Muyembe, University of Kinshasa (Democratic Republic of the Congo)*
Professor Cheikh Ibrahima Niang, Cheikh Anta Diop University (Senegal)
Professor Peter Piot, Director, London School of Hygiene and Tropical Medicine, and Chair, WHO consultation on the science of EVD (Belgium) *
Dr Mike Ryan, Consultant and former WHO Director of Outbreak Alert and Response (Ireland)
Dr Viroj Tangcharoensathien, Senior Adviser, Ministry of Public Health (Thailand) *
*Unable to attend the meeting

WHO/UN/Partners
WHO: Margaret Chan (DG), Anarfi Asamoa-Baah (DDG), Bruce Aylward (Special Representative), Ibrahima-Socé Fall (AFRO), Alex Gasasira (WR Liberia), Emmanuel Musa (Deputy WR Liberia), N Mahmoud (WCO Liberia), A Baller (WCO Liberia), Mohammed Belhocine (Acting WR Guinea), Mamoudou Djingarey (Deputy WR Guinea), Margaret Lamunu (WCO Sierra Leone), Richard Brennan, Pierre Formenty, Scott Pendergast, Xing Jun, Munjoo Park
UN and Partners: Chadia Wannous (on behalf of David Nabarro), Barbara Bentein (UNICEF), Cesar Arroyo (WFP), Cindy Whitney (CDC), Oliver Morgan (CDC), Peter Graaff (UNMEER), Bintou Keita (UNMEER)

Summary of discussion and recommendations:
DG opened the meeting and welcomed members of the group. She recognized the participation of representatives of relevant UN and partner agencies at this meeting, and highlighted the need of good partnership in order to get down to zero case.
WHO country offices and HQ team provided updates of the current situation in three countries and a
global update. With 20-30 cases per week, improvements in case investigation and contact tracing,
together with enhanced incentives to encourage case reporting and compliance with quarantine measures
have led to a better understanding of transmission chains than was the case a month ago. This has
resulted in a decreasing proportion of cases coming from unknown sources of infection, as well as a
reduction in the number of transmission chains in Guinea and Sierra Leone. In both countries, major
initiatives have been launched in order to get down to zero case, including intensified surveillance, social
mobilization, and finding of missed contacts. All three confirmed cases in Liberia came from one
community and with a clear epidemiological link. Contacts of the cases have been closely monitored and
5 high risk contacts are being tracked down. The origin of infection of the cluster of cases is currently
under investigation.

Dr Heymann introduced topics for discussion at this meeting: 1) Strategic and tactical adjustments for
getting to zero: Phase 3 of the Ebola response, and 2) Application of the Ebola case definition in areas
that have been Ebola-free for 42 days plus 3 months.

Dr Aylward updated the group on the recent adjustments to overall strategy and field-level measures for
getting to zero case. In this context, he presented to the group a draft version of the Ebola Response
Strategy for Phase 3, which aims to accurately define and rapidly interrupt all remaining chains of
transmission; and to identify and manage the residual risks in all Ebola-free areas. Specific goals will be
developed to guide the accelerated effort to interrupt transmission and verify the achievement by end of
2015. This will require measures such as tracking down missed contacts, community based interventions,
adjustment of existing protocols, improved infection prevention and control and triage, establishment and
strengthening of rapid response teams, better understanding of transmission chains, and coordination of
various players, particularly new players on the ground.

The group expressed general support for this strategy and at the same time, highlighted the need to have a
clear road map to lay out the next steps and way forward. It is also important to identify where relevant
partners are needed, and with the departure of UNMEER, leadership should be established on the ground
in order to coordinate efforts of various partners. It was agreed that the Phase 3 document should not be
branded as a “new strategy” in order to avoid potential confusion.

Members reiterated the importance of community engagement to be guided by strengthened
anthropological analysis, particularly women’s role in the final phase of EVD response. There is also a
need to improve coordination of community engagement efforts, and to understand the communities
properly, identify community leaders, and speak the same language with the communities. Due to the
sensitivity related to sexual transmission, it is important to identify the appropriate counselors at the
communities.

Members highlighted the need to document experiences and lessons learned so far, which could
contribute to the success for the implementation of the Phase 3 strategy. With mobility of contacts being
the main driver of the epidemic, it was suggested to include and operationalize the mobility component in
the strategy. Punitive measures can be counterproductive and should be avoided, and it was therefore
important to have a right balance with the incentives provided. It was also agreed that genetic sequencing
data should be used to guide the response work.
A number of gaps were identified through a recent mission to Guinea Bissau, and members agreed to the need for the country to take relevant measures, including active surveillance at the borders areas with Guinea, establishment of isolation centres and national emergency operation centre, provision of ambulances, and stronger linkage between technical units and political leaders. It was also advised that relevant guidelines including for sexual transmission should be adapted and made available in Guinea Bissau rather than waiting for new guidelines to be developed.

With regards to the application of the Ebola case definition, Dr Brennan provided an brief update on the inconsistent application of case definition, and sought advice from the group with regards to the need to change the case definition, or to change the way that it is applied. Different options were presented depending on the presence of relevant risk factors.

Members of the group in principle regarded the proposed approach to be appropriate, while highlighting that the application of the case definition should be context-specific and a better understanding is needed of the underlying reasons for the inconsistent application of the case definition. As one of the risk factors, the consumption of meat from a sick animal needs to be clearly defined. It was also agreed that training and supervision of health care workers is necessary in order to ensure the quality of applying the case definition.

Dr Heymann in conclusion expressed his satisfaction to see UN agencies and relevant partners working together at this important juncture in getting down to zero case. DG thanked UN agencies and partners for their contribution and cooperation, and felt confident that we will get to zero case with all partners working closely together.

Follow up points:

- WHO Secretariat will revise the following documents based on comments received from the members and partners, and circulate the updated version to the group:
  - Ebola Response Strategy for Phase 3
  - Application of the EVD definition for a suspected case in areas that have been Ebola-free for 42 days plus 3 months
- One topic for discussion at the next meeting could be “Operationalizing the outcomes of the Ebola research”.