Thirteenth Meeting of the WHO Advisory Group on the EVD Response
TC, SHOC Room, WHO HQ
14:00 - 15:30, 12 January 2016

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
Margaret Chan (DG), Anarfi Asamoa-Baah (DDG), Peter Clement (Acting WR Liberia), Nuha Mahmoud, April Baller (WCO Liberia), Mohamed Belhocine (WR Guinea), Miriam Nanyunja (WCO Sierra Leone), Richard Brennan, Pierre Formenty, Christopher Dye, Peter Graaff, Nathalie Broutet, Xing Jun

Summary of discussion:
The Director-General opened the meeting and welcomed members of the group. Dr Heymann (Chair) proposed that vaccination for survivors and contacts, as well as the future of the Advisory Group be added to the agenda items, which was agreed by the members. The Chair then asked WHO country offices to provide updates on the current situation in three countries.

So far, Guinea, Liberia, and Sierra Leone have all succeeded in interrupting human-to-human transmission linked to the original outbreak in West Africa. In Sierra Leone, human-to-human transmission linked to the primary outbreak was declared to have ended on 7 November 2015. The country has now entered a 90-day period of enhanced surveillance scheduled to conclude on 5 February 2016. On 29 December, WHO declared that human-to-human transmission of Ebola virus has ended in Guinea, after the completion of 42 days with zero cases since the last person confirmed to have EVD received a second consecutive negative blood test for Ebola virus RNA. Guinea has now entered a 90-day period of heightened surveillance. Human-to-human transmission linked to the most recent cluster of
cases in Liberia will be declared to have ended on 14 January 2016, 42 days after the 2 most-recent cases received a second consecutive negative test for Ebola virus, if no further cases are reported. Comprehensive programs for survivors testing and counselling have been set up and rolled out in the three countries, with the involvement of multiple sectors. There has been improvement in survivors’ access to services as well as national capacity for alert and response with the support of relevant partners on the ground.

Members of the group congratulated the three countries for the achievement and tremendous improvement from last year. They also highlighted the need for more information on survivors and sexual transmission, as well as the need for clear guidance and counseling services for vulnerable groups, such as women and sex workers, and the need to take the necessary measures to ensure that there is not discrimination against survivors.

Dr Chris Dye briefly introduced the surveillance strategy following cessation of the original transmission chains. Based on the current data, it was proposed that each country needs to observe only one 90-day period of heightened surveillance after the cessation of the initial chain of transmission. For subsequent outbreaks due to re-emergence from survivors, the usual 42-day period of monitoring (2 incubation periods after the final 2 negative tests) is considered sufficient. Members of the group were asked to commented on the appropriateness of this approach.

Members of the group agreed in principle to the approach as proposed, with a reasonably good surveillance system in place, but should be quick to make necessary adjustment if there is such a need. In this context, the sensitivity of the IDSR should be further improved in order to cope with possible flare-ups. It was also pointed out that this approach should take into account potential change in people’s perception with relatively fewer cases in the three countries, as well as the social dimension, including stigma and discrimination against survivors. It was therefore recommended that community engagement be strengthened in the implementation of the IDSR.

Dr Pierre Formenty gave a brief update on the latest study results on viral persistence, which shows that Ebola virus RNA can persist in the semen of male survivors for as long as 1 year post EVD symptom onset. It therefore proposed that safe sexual practices should be observed for a period of 12 months for those male survivors who do not have access to testing. Advice was sought from the group on this approach.

The group agreed in general to the proposed approach and also highlighted the sensitivity involved. They stressed the need to conceptualize it in the bigger context of the safe sex program, taking into account other aspects including family planning, trust, sex relationship etc. In this context, the group highlighted the need to work closely with UNAIDS and UNFPA, as well as the need to put in place a sex education program for women to deal with issues including sex transmission of the Ebola virus.

Dr Richard Brennan gave a brief update on disease relapse as a cause of re-emergence, highlighting the work that is being done at the country level to strengthen rapid response capacity in order to manage residual risks in the implementation of the Phase 3 strategy. Ring vaccination is currently being done for intimate partners of survivors as well as household members and close contacts.

The group recommended ring vaccination should only be undertaken as part of a well-designed study/trial, and with consent of countries; and should be properly communicated to the communities to get their
understanding including of the need for continued safe sexual practices in survivors, and buy-in and avoid any negative social effect, such as stigma and discrimination. In addition to the current groups for vaccination (intimate partners, household members and close contacts), a third group, i.e. relatives and work colleagues should also be considered for vaccination.

As the last agenda item, the Chair suggested decommissioning of the Advisory Group considering the current situation and progress made in EVD response and that the group has so far made its due contribution as expected. Members of the group supported the Chair’s proposal and expressed willingness to support WHO as needed in the future. The group was satisfied with the way of providing advice to WHO through virtual meetings, which they felt could be replicated as a model for supporting relevant WHO activities in the future. Members of the group also noted the importance of mobilizing funds to support ongoing studies on survivors, and the need to make use of the Ebola crisis to upgrade infrastructure of the health systems and strengthen IHR core capacities in countries, as well as to find ways to better fund WHO in order to protect the world in times of disease outbreaks.

In her closing remarks, DG thanked the Chair and members of the group for their advice which has helped to ground WHO’s work and strategies in best available science. She also spoke highly of the effectiveness of the group working through teleconferences, and despite closure of the group, DG will call upon relevant members to support other groups on broad aspects including the WHO Health Emergencies Program, support to countries in building robust public health infrastructure and strengthening IHR core capacities, as well as support to WHO in improving performance as part of the WHO reform process. One important area of work going forward is R&D investment which should be planned in advance in preparing for future health emergencies.

Dr Heymann thanked the members for their time and contribution, and announced the meeting close.

Key recommendations:

- Sensitivity of the IDSR should be further improved in order to cope with possible flare-ups, and community engagement be strengthened in the implementation of the surveillance strategy.
- The requirement for safe sexual practices for 12 months for male survivors without access to testing, should be conceptualized in the bigger context of the safe sex program, and a sex education program for women is needed to deal with issues including sex transmission of the Ebola virus.
- Ring vaccination should only be undertaken as part of a well-designed study/trial, and with consent of countries; and should be properly communicated to the communities to get their understanding of the need for continued safe sexual practices in survivors, and buy-in and avoid any negative social effect, such as stigma and discrimination.
- In addition to the current groups for vaccination (intimate partners, household members and close contacts), a third group, i.e. relatives and work colleagues should also be taken into account.
- The Ebola crisis should be used as an opportunity to upgrade infrastructure of the health systems and strengthen IHR core capacities in countries, as well as to find ways to better fund WHO.