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EXECUTIVE SUMMARY

The Democratic Republic of the Congo is grappling with one of the largest and most complex humanitarian crises in the world. Due to an intensification of conflict, the number of people in need of humanitarian assistance in 2017 increased from 7.3 million to 8.5 million. This number is projected to reach 13.1 million in 2018. The Kasai crisis affects five provinces (Kasai, Kasai Central, Kasai Oriental, Lomami and Sankuru). At the height of the crisis, the number of internally displaced people (IDPs) reached 1.4 million. Violence has led to an increase in acute food insecurity across the Kasai region and will compromise the food security situation for 2018.1

Access to health services remains a challenge, only 74% of the country is covered by primary health care (PHC), and 64% by hospital services. It is anticipated that the level of morbidity and mortality for all diseases will increase significantly in the immediate future due to the lack of access to health services compounded with the deteriorating living conditions, violence and ongoing displacement.

In addition, the Democratic Republic of the Congo is constantly faced with multiple disease outbreaks, including prolonged cholera outbreaks, Ebola, yellow fever and measles. The deteriorating humanitarian situation has resulted in the disruption of vaccination campaigns in many locations. Malaria remains the leading cause of death, notably among children.

In response to the deteriorating crisis this year, the World Health Organization (WHO) has surged additional technical expertise in the field of coordination, surveillance, case management, social mobilization and water, sanitation and hygiene (WASH). Through its sub-offices, WHO provides technical and field operational support for disease surveillance and response. Such support includes the verification, harmonization, compilation and reporting of surveillance data, as well as verification of alerts reported by the community.

WHO is providing technical and operational support for coordination to the Ministry of Public Health (MOPH) and partners. This has led to a more streamlined response, preventing duplication and enabling timely identification of resource gaps and unmet needs in the field. WHO works with partners to deliver health services to the displaced population and their vulnerable host communities.

In 2018, the response by WHO and the health sector to the ongoing complex emergency in the Democratic Republic of the Congo remains focused on reducing excess mortality and excess morbidity of people affected by the crisis, as well as contributing to the resilience and strengthening of the national health system. The response is anchored within WHO’s long-term emergency management objective.

WHO is currently taking action using the following strategies:

• Increasing access to essential health services for the most vulnerable populations, including by strengthening the capacity of health partners to provide a minimum package of services;
• Improving prevention, detection and response to epidemics and other public health events;
• Strengthening disease surveillance and reporting, as well as the broader management of health information, including monitoring of, access to and availability of services in crisis-affected areas;
• Strengthening coordination of the health sector, within the MOPH platform and the humanitarian system.

In order to serve the vulnerable and protect public health, WHO requires funding of US$ 30 million.

To date, the health sector remains chronically underfunded.

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SITUATION OVERVIEW

HUMANITARIAN SITUATION

For over two decades, the Democratic Republic of the Congo has faced one of the largest and most complex humanitarian crises in the world.

In 2017, this situation has dramatically deteriorated, most notably in the greater Kasai region, the Kivu region, and Tanganyika province. A surge in violent conflict and intercommunal tensions has had an impact on people in areas previously considered stable, and stretched the coping mechanisms of people in areas already affected. It forced more than 1.7 million people to flee their homes in 2017 – an average of over 5500 people per day. By January 2018, the total number of internally displaced people in the Democratic Republic of the Congo had reached 4.5 million, which is the highest number of any country on the African continent.

Across the country, at least 8.5 million people were in need of humanitarian assistance and protection by the end of 2017. Humanitarian partners estimate that in 2018 this number will increase by almost 5 million, and that 13.1 million Congolese, out of an estimated total population of 94 million individuals, will require humanitarian assistance and protection as a result of the heightened violence in hotspots across the country and the already precarious food security situation. Close to 2 million children are projected to be affected by severe acute malnutrition (SAM) in the coming year, based on the latest integrated food security phase classification analysis (IPC).

Population movement – including the 4.5 million people internally displaced and some 600 000 refugees from South Sudan, Central African Republic and Burundi – generated over half of the humanitarian needs. Furthermore, approximately half a million Congolese have sought refuge in neighbouring countries. Along with continued displacement, there have been a significant number of returns to the Kasai region, where basic services have become non-existent as a result of the conflict. The lack of capacity to support these returnees presents a significant risk of a vicious circle of displacements and inter-community violence. Returnees, unable to survive in their places of return, will be pushed to leave once again; on the other hand, vulnerable communities receiving returnees will need to compete more intensely for basic resources, triggering violence.

1 UNOCHA, Democratic Republic of the Congo Humanitarian Snapshot, January 2018
2 UNOCHA, Democratic Republic of the Congo Overview, November 2017
3 In June 2017
Kasai Region

The crisis in Kasai, which started in August 2016, affects five provinces (Kasai, Kasai Central, Kasai Oriental, Lomami and Sankuru). At the height of the crisis, in mid-2017, the number of IDPs in the region reached 1.4 million. While improved security conditions in the Kasai region have encouraged the return of 631 000 people to their homes, there are still 762 000 IDPs and 34 000 refugees in Angola. The violence has led to an increase in acute food insecurity across the Kasai region, caused by the loss of two agricultural seasons, further compromising the food security outlook for 2018.

Tanganyika

The conflict in Tanganyika has spread in Haut-Katanga and South Kivu, the latter bringing together increased activity by groups linked to Burundi, Congolese Mayi-Mayi militia and other armed groups. The number of IDPs resulting from intercommunal conflict is estimated at 65 000, and the number of refugees in Zambia at 6000.

North and South Kivu

Conflicts between armed groups in these two provinces have resulted in several waves of displacement. The number of internally displaced persons is estimated at one million in North Kivu and 600 000 in South Kivu, representing more than 40% of the total number of IDPs in the country.

HEALTH SITUATION

In 2015, the life expectancy at birth of Congolese people stood at 58 years for men and 62 years for women; the country’s maternal mortality ratio (MMR) was 693/100 000 live births; the neonatal mortality rate (NRM) was 44/1000 live births; the infant mortality rate (IMR) was 58/1000 live births; and the under-five mortality rate (U5MR) was 146/1000 live births. The complex humanitarian crisis faced by the Democratic Republic of the Congo has further deteriorated the already poor health status of the Congolese people.

Access to health care

According to the latest information (from 2014), only 74% of the country is geographically covered by primary health care (PHC), and 64% by hospital services. The complete minimum package of

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7 Updates are expected to take place during 2018.
services is only available to 4.3% of the population covered by PHC, and the complementary package of services is available to 4.8% of the population covered by hospital services. The utilization rate stands at 39%, with 20–39% of the population surveyed in the 2014 demographic health survey (DHS) reporting financial restriction to access health care. The government’s expenditure on health stood at 4.3% of the country's gross domestic product (GDP) in 2015.

A service availability and readiness assessment (SARA) was carried out in 2013, and the report released in 2014. The assessment revealed that the mid-level operational capacity of all health facilities combined stood at 27% (trained staff, supplies, SOPs, equipment, etc.). Essential medicines were available in 20% of health facilities, and IPC materials in 58% of facilities. Eighty-nine per cent of all health facilities provided safe delivery services, but fewer than 12% of these provided basic emergency obstetric care (BeMOC). Vaccination is available in 75% of health facilities, malaria services in 99% of health facilities, and tuberculosis services in 30% of facilities, although only 11% implement DOTS (directly observed treatment, short course). Eighty-two per cent of surveyed households reported poor satisfaction with the health services provided.

In October 2017, WHO led a rapid evaluation of all health facilities in the five provinces most affected by the Kasai humanitarian crisis (Kasai, Kasai Central, Kasai Oriental, Lomami and Sankuru). This evaluation was carried out jointly with the Division Provincial de la Santé (DPS), the provincial representation of the Ministry of Public Health (MoPH), as well as with the participation of the Management Science for Health (MSH) organization, a long-standing development health partner in the Kasai region.

The following table illustrates the level of functionality of all health facilities in the five provinces.

<table>
<thead>
<tr>
<th>Province</th>
<th># Health Zone (HZ)</th>
<th># of HZ affected</th>
<th>%</th>
<th># Health Facilities (HF) in affected HZ</th>
<th>%</th>
<th>HFs destroyed and/or looted</th>
<th>%</th>
<th>HFs with displaced personnel</th>
<th>%</th>
<th>HFs with increased demand for services</th>
<th>%</th>
<th>Total HFs affected</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kasai Central</td>
<td>26</td>
<td>26</td>
<td>100</td>
<td>480</td>
<td>150</td>
<td>31%</td>
<td>65</td>
<td>14%</td>
<td>16</td>
<td>3%</td>
<td>272</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td>Kasai</td>
<td>18</td>
<td>18</td>
<td>100</td>
<td>372</td>
<td>79</td>
<td>21%</td>
<td>63</td>
<td>17%</td>
<td>229</td>
<td>62%</td>
<td>371</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Kasai Oriental</td>
<td>19</td>
<td>4</td>
<td>21%</td>
<td>52</td>
<td>21</td>
<td>40%</td>
<td>0</td>
<td>0%</td>
<td>30</td>
<td>58%</td>
<td>51</td>
<td>94%</td>
<td></td>
</tr>
<tr>
<td>Lomami</td>
<td>16</td>
<td>7</td>
<td>44%</td>
<td>150</td>
<td>59</td>
<td>39%</td>
<td>16</td>
<td>11%</td>
<td>60</td>
<td>40%</td>
<td>135</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Sankuru</td>
<td>15</td>
<td>2</td>
<td>13%</td>
<td>23</td>
<td>8</td>
<td>35%</td>
<td>0</td>
<td>0%</td>
<td>9</td>
<td>39%</td>
<td>17</td>
<td>74%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>95</td>
<td>37</td>
<td>60%</td>
<td>1077</td>
<td>317</td>
<td>29%</td>
<td>145</td>
<td>13%</td>
<td>344</td>
<td>32%</td>
<td>806</td>
<td>75%</td>
<td></td>
</tr>
</tbody>
</table>
The result of this evaluation shows that 60% of all health zones (HZ) in the five provinces have been touched by the crisis. Out of a total of 1077 health facilities in these affected HZ, 806 have experienced either serious damage or looting (317 facilities), displacement of their healthcare providers (145 facilities), or an overwhelming increase in demand for services as a direct result of the crisis (344 facilities). Of those facilities destroyed or looted, 150 are located in the Kasai Central province.

Figure 1. Health facilities affected by the Kasai humanitarian crisis in the provinces of Kasai, Kasai Central, Kasai Oriental, Lomami and Sankuru

Considering these alarming figures on access, availability and utilization of health services, compounded with continuously deteriorating living conditions, ongoing displacement and the occurrence of violence, it is anticipated that the level of morbidity and mortality for all diseases will increase significantly in the immediate future.

**Epidemic-prone diseases**

The Democratic Republic of the Congo constantly faces multiple disease outbreaks, among them prolonged cholera outbreaks, and outbreaks of Ebola, yellow fever and measles. The following table shows the total number of cases reported throughout 2017 for each of the monitored epidemic-prone diseases, from Epi week 1 to 52. What the system shows, as described below, are the alarmingly high number of malaria cases and reported deaths attributable to
malaria.

Table 1. Total number of cases (suspected and confirmed) and deaths attributed to all notifiable diseases in the Democratic Republic of the Congo in 2017 – Epi weeks 1-52

<table>
<thead>
<tr>
<th>Disease</th>
<th># Cases</th>
<th># Deaths</th>
<th>CFR (in %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute flaccid paralysis</td>
<td>1,380</td>
<td>5</td>
<td>0.3</td>
</tr>
<tr>
<td>Acute respiratory infection</td>
<td>4,757,204</td>
<td>2,526</td>
<td>0.1</td>
</tr>
<tr>
<td>Bloody diarrhoea</td>
<td>28,608</td>
<td>73</td>
<td>0.3</td>
</tr>
<tr>
<td>Cholera</td>
<td>55,000</td>
<td>1,190</td>
<td>2.2</td>
</tr>
<tr>
<td>Dracunculiasis</td>
<td>7</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Haemorrhagic fever</td>
<td>39</td>
<td>11</td>
<td>28.2</td>
</tr>
<tr>
<td>Malaria</td>
<td>15,908,848</td>
<td>18,645</td>
<td>0.1</td>
</tr>
<tr>
<td>Measles</td>
<td>45,147</td>
<td>535</td>
<td>1.2</td>
</tr>
<tr>
<td>Meningitis</td>
<td>8,260</td>
<td>719</td>
<td>8.7</td>
</tr>
<tr>
<td>Monkeypox</td>
<td>2,511</td>
<td>60</td>
<td>2.4</td>
</tr>
<tr>
<td>Neonatal tetanus</td>
<td>347</td>
<td>426</td>
<td>45.0</td>
</tr>
<tr>
<td>Pertussis</td>
<td>1,602</td>
<td>9</td>
<td>0.6</td>
</tr>
<tr>
<td>Plague</td>
<td>10</td>
<td>2</td>
<td>20.0</td>
</tr>
<tr>
<td>Rabies</td>
<td>122</td>
<td>30</td>
<td>24.6</td>
</tr>
<tr>
<td>Typhoid fever</td>
<td>1,100,872</td>
<td>531</td>
<td>0.0</td>
</tr>
<tr>
<td>Yellow fever</td>
<td>1,934</td>
<td>54</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Cholera

The current cholera outbreak has reached 22 of the Democratic Republic of the Congo’s 26 provinces, with active transmission reported in 14 provinces by the end of December 2017 (Epi week 52). It has resulted in a total of 1190 deaths out of the 55,000 cases reported in 2017 (Epi weeks 1 to 52). The outbreak has also reached the Kasai region, where it has never been reported before.

Figure 2. Weekly trend of cholera cases (suspected and confirmed) and deaths in 2017: Epi weeks 1-52
Cholera – Outbreak in Kinshasa

From the first to the last Epi week of 2017, the city of Kinshasa notified 697 cases of cholera, with 53 deaths (case fatality rate/CFR 7.6%). The number of cases reported from Kinshasa started to increase in Epi week 47, at the beginning of November. This increase was first reported in the health zone of Binza Météo. The outbreak eventually spread to 21 of the 35 HZ, as a result of intensive rain and consequent flooding. From November 2017 to 11 January 2018, 531 cases were recorded from 12 health zones, with 32 deaths (a CFR of 6%).

Figure 3. Annual comparison of cholera cases (suspected and confirmed) in DRC from 2014 to 2017

Figure 4. Daily trend of cholera cases reported from the city of Kinshasa, 25 November 2017 to 9 January 2018
Considering Kinshasa’s high population density and its status as a major transportation hub, compounded with its poor water and sanitation status, WHO’s rapid risk assessment of the outbreak in Kinshasa categorized the risk of internal spread of cholera as very high. Spread from Kinshasa may rapidly re-ignite outbreaks along the Congo River and beyond, in provinces that have reported a decreasing trend of cholera in recent months.

Neighboring countries have historically experienced outbreaks of cholera following exportation of the disease from the Democratic Republic of the Congo. With Kinshasa situated on the banks of the Congo River, just a few kilometres from Brazzaville in the Republic of Congo, the risk of regional spread is considered to be high. However, the risk of global spread is deemed to be low.

**Measles**

Measles outbreaks are also recurrent in the Democratic Republic of the Congo. Despite past successes in bringing measles outbreaks to an end, the deteriorating humanitarian situation in the country has resulted in the interruption of routine vaccination in many locations. Compounded by malnutrition and poor water and sanitation, the number of reported measles cases steadily increased in 2017, reaching 45,147 cases and 535 deaths from January 2017. The following graph depicts the multi-year trend of measles cases – from 2011 to 2017.

Figure 5. Weekly trend of measles cases and deaths in 2017: Epi weeks 1-52

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1 The rapid risk assessment was carried out at the beginning of January 2018.
Cases of measles are mostly reported from the Kivu region (27%), followed by the Maniema province (22%), the greater Kasai region (20%) and Tanganyika (13%).

Figure 6. Weekly trend of measles cases by key provinces in 2017: Epi weeks 1-52

Ebola Virus Disease

The Democratic Republic of the Congo has faced five outbreaks of Ebola Virus Disease (EVD) over the past 10 years, and the risk for future outbreaks remains high since environmental risk factors continue to be present in the country. The last outbreak occurred in May 2017 in Likati. A joint effort by the Ministry of Public Health, WHO and other partners allowed a timely and effective management of the outbreak. The following map illustrates the locations of Ebola outbreaks since 1976.
Other communicable diseases

Notwithstanding the impact of the diseases described above, it is important to remember that malaria remains the leading cause of death, notably among children (≥ 40% cause of deaths). A total of 14,933,493 cases were reported in 2017, with 17,576 attributed deaths.

The problem of tuberculosis is equally alarming with a country-wide tuberculosis incidence rate reported at 324 cases per 100,000 people per year, while the treatment coverage is only 48%. There is also a generalized HIV epidemic in the Democratic Republic of the Congo, with an HIV prevalence of 1.2% in 2014.

Furthermore, although the Democratic Republic of the Congo has been declared polio free since 2011 for cases caused by wild polio virus (WPV), cases caused by vaccine-derived polio virus (VDPV) continue to be reported at a low rate – 10 cases to 1 December 2017.
Lastly, 14 neglected tropical diseases (NTDs) are endemic in the Democratic Republic of the Congo, which has the highest caseload of African human trypanosomiasis in the continent.

**Malnutrition**

The multiple rounds of conflict has resulted in severe agricultural loss. The most recent integrated food security phase (IPC) analysis⁹ shows a serious deterioration in food and nutrition security, with 7.7 million people facing acute food insecurity and livelihood crisis, compared to 5.9 million at the same time last year.¹⁰ The prevalence of chronic malnutrition is at 43% among children, affecting more than 6 million children. An estimated 1.9 million of those children had severe acute malnutrition in 2017, based on the current food insecurity status and other determinants of malnutrition.

**Non-communicable diseases**

The country also faces a double burden of disease with incidence of metabolic disease rising. Metabolic diseases are particularly difficult to manage in a context of conflict and displacement since continuity of care cannot be assured. Other common non-communicable diseases include substance abuse, road traffic accidents, and health problems associated with environmental degradation and pollution.

**Gender-based violence**

Still in relation to conflict, 52% of women and girls above 15 years old have reported at least one incident of gender-based violence (GBV) according to the 2014 nation-wide survey led by the Ministry of Public Health.² Among those who have had at least one sexual encounter, 27% reported experience of sexual violence. According to reports obtained from health facilities, 6160 survivors of sexual violence were attended to during September and October 2017, of whom 4658 (90%) were females. For reasons yet to be fully understood, only 50% of the survivors received health services within the first 72 hours following their experience of violence. Thirty per cent of cases were reported from the Greater Kasai region, South Kivu and Tanganyika provinces, with the breakdown in numbers shown in Figure 8.

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⁹ Conducted in June 2017
¹⁰ IPC 3 and 4, which refer to critical and emergency states respectively
CURRENT WHO RESPONSE TO THE HUMANITARIAN CRISIS

With the support of the Central Emergency Response Fund (CERF), WHO worked with the Adventist Development and Relief Agency (ADRA) to deliver health services to displaced populations and their vulnerable host communities in 50 health centres and nine district hospitals in the three Kasai provinces from April to August 2017. As a result of this collaboration, more than 38 000 people have had access to free and safe health services, enabling 1462 deliveries and 43 caesarean births to be carried out by trained health workers. The following table describes the number of beneficiaries reached through this partnership.

<table>
<thead>
<tr>
<th>Description</th>
<th>Kasai</th>
<th>Kasai Central</th>
<th>Kasai oriental</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDPs and host communities covered with free access to essential health care</td>
<td>20 326</td>
<td>13 850</td>
<td>4132</td>
<td>38 308</td>
</tr>
<tr>
<td>Number of caesarean sections</td>
<td>16</td>
<td>24</td>
<td>3</td>
<td>43</td>
</tr>
<tr>
<td>Number of assisted deliveries</td>
<td>445</td>
<td>561</td>
<td>456</td>
<td>1462</td>
</tr>
</tbody>
</table>

The problem of sexual violence is expected to increase as families are separated, their members are wounded/killed, and everyone struggles to meet basic needs.

Figure 8. Survivors of sexual violence treated in the three priority humanitarian zones – Tanganyika, South Kivu and the Greater Kasai region – in September and October 2017
Additionally, WHO has recently finalized a partnership agreement with the Alliance for International Medical Action (ALIMA) to further expand the provision of essential health services to three health zones in the province of Lomami. There, ALIMA supports 13 health centres and three district hospitals, which are hosting numerous IDPs from the Kasai region. WHO has also distributed 43 basic and malaria kits, seven laboratory kits, and three health post kits in the three Kasai provinces between April and October 2017.

Finally, WHO continues to provide technical and operational support for disease surveillance and response through each of its 11 sub-offices. This support includes the verification, harmonization, compilation and reporting of surveillance data, as well as verification of alerts reported by community members. WHO also supports the supervision of Ministry of Public Health surveillance officers in the field. In the Kasai region, WHO’s support has contributed to the increase in integrated disease surveillance and response (IDSR) coverage, from 75% of HZs submitting their reports in September 2017 to 92% in October 2017.

In October 2017, WHO has also completed a rapid assessment of all health facilities in the five provinces most affected by the Kasai conflict: Kasai, Kasai Central, Kasai Oriental, Lomami and Sankuru. This assessment was conducted jointly with the Division Provinciale de la Santé (DPS) and was the first evaluation of health facilities to be conducted in the Kasai region following the onset of the conflict last year. WHO is now exploring possibilities to replicate the assessment in other regions through other health partners with field presence.

CURRENT WHO RESPONSE TO THE CHOLERA OUTBREAK

In response to the ongoing cholera outbreak, WHO is providing technical and operational support for coordination to the Programme National d’Elimination de Cholera et des Autres Maladies Diarrhéiques (PNECHOL-MD) and to the sub-commissions of the Direction de Lutte Contre Les Maladies (DLM) involved in the cholera outbreak response in the following capacities: coordination, epidemiologic surveillance and laboratory, vaccination, social mobilization, case management and WASH. This operational support is also provided at the provincial level, notably in North Kivu, South Kivu, Haut Lomami, Kwilu, Tanganyika and Congo Central, where the epidemic is still active and from where most cases are reported.
Moreover, because the magnitude of the outbreak requires a clear understanding of the sector’s capacities and sound distribution of roles and responsibilities, WHO is also coordinating the efforts of health partners outside the national government, notably MSF and UNICEF. This has resulted in the improved streamlining of response activities and solutions, thereby preventing duplications and enabling timely identification of gaps and unmet needs in the field. WHO is also supporting one cholera treatment centre (CTC) and two cholera treatment units (CTU)\(^{11}\) in South Kivu, as well as supporting three CTCs and seven CTUs in Kongo Central, and four CTUs in Haut-Lomami. In November 2017, the Organization expanded its support to CTCs and CTUs in two health zones in Lomami, three health zones in Kasai, and one health zone in Sankuru, before handing over to MSF Belgium and ALIMA. In all these facilities, WHO provided supplies, equipment and medical kits, supported logistics, and supervised case management. WHO also distributed five complete inter-agency diarrhoeal diseases kits (IDDK) to North Kivu, South Kivu, Haut Katanga, Tanganyika and Kasai in October 2017.

WHO’s support also extends to the WASH sector where it relates to health facilities. WHO experts support the supervision of water chlorination, as well as the evaluation of and response to WASH needs in health facilities. Information about gaps in community WASH is passed on to the WASH Cluster. WHO’s WASH support is not restricted to CTCs and CTUs, but as part of prevention and preparedness measures also encompasses health facilities in high-risk areas not yet affected by the outbreak.

In Haut Lomami, 60 communication agents were identified and trained by the WHO expert deployed in the province in mid-2017. These agents were trained to deliver risk communication messages door to door and at community events on prevention and case management. They were also trained to perform active case finding in the communities where they work. This approach to social mobilization will be streamlined in all provinces where WHO implements cholera response.

Finally, WHO experts, along with counterparts from the DPS, are directly involved with the verification, harmonization and compilation of patient information from CTCs and CTUs all the way to national level reporting. They participate in the investigation of community alerts, notably those coming from HZ not previously affected. This support has directly contributed to more reliable and

\(^{11}\) CTCs are usually larger, independent facilities, while CTUs are smaller and usually found within existing health structures
timely reporting of cholera cases and deaths from the four provinces.

However, despite these efforts, additional resources are required to scale-up the level of response in order to bring the current cholera outbreak to an end. The reinforcement of community-based interventions, as well as increased preparedness and readiness activities in the other at-risk provinces, are essential.
2018 HEALTH RESPONSE PLAN

GOALS AND STRATEGIC OBJECTIVES

Goal

In 2018, WHO’s response and that of the health sector to the ongoing complex emergency in the Democratic Republic of the Congo will remain focused on:

1. Reducing excess mortality and excess morbidity of people affected by the crisis
2. Contributing to the resilience and recovery of the national health system

Strategic objectives

In order to achieve these response goals jointly, WHO and health sector partners have articulated the following four strategic objectives:

1. Increase access to essential health services for the most vulnerable populations
2. Prevent, detect and respond to disease outbreaks and other public health events
3. Strengthen early warning systems, surveillance of public health events and health information management
4. Strengthen health sector coordination and WHO’s operations in support of the health sector response

The extremely complex operational environment of the Democratic Republic of the Congo requires WHO to adopt at all times a flexible approach to implementing its health response. The four objectives and their respective activities (detailed below) will adapt to the dynamics of the crisis, including unpredictability of access, attacks on health (patients, health workers and health facilities), population displacement, disruption of communication and transportation, and many others. As such, this document will be periodically updated, to take into account changes to the country context.

The following activities are also planned based on known challenges related to protracted crises and instability, and on previous experience of operating in similar settings. Throughout
the implementation of the response, WHO will endeavour to continuously update its needs assessment and evaluate the feasibility of operations in order to find the best solutions to deliver its commitments.

The implementation of the response will be done gradually; first focusing on the humanitarian hubs where needs are most pronounced, i.e. the Kasai region, the Kivu region and Tanganyika province. Subsequently, target provinces and HZs will be selected based on the size and vulnerabilities of the population in need, and on the health risks and capacities.

Figure 9. Priority humanitarian hubs for health response in 2018: Greater Kasai region, Kivu region and Tanganyika

**Objective 1: Increase access to essential health services for the most vulnerable populations**

The health sector response will endeavour to meet the healthcare needs of all vulnerable populations in the Democratic Republic of the Congo at the three levels of services: community, primary and referral. Up to 50 HZs in 15 provinces will be identified for assistance,
based on prevalent needs, starting with the three humanitarian hubs. The target number reflects WHO’s operational scale-up capacity at the beginning of 2018, and may be revised in subsequent planning documents based on evolving context, needs and capacities.

Partnership among public, private, humanitarian and development health actors will be critical, to ensure multiple and back-up options for extending access to health, notably in localities where there is still active conflict. Access to health will be increased by supporting existing health facilities, particularly those that have been affected by the multiple rounds of conflict; setting up new facilities in areas where the population is not sufficiently covered; and bringing health services closer to communities through mobile services and the empowerment of community health workers.

At the same time, investments will be made to increase the quality of services by setting up minimum standards for essential services and mechanisms to monitor compliance to these standards. WHO will work with the Ministry of Public Health and health partners to define and update these standards, according to the evolution of the crisis.

Access to essential health services

Partnership between WHO, the Ministry of Public Health and health partners will be the cornerstone of health-service delivery, to ensure the provision of a complete range of services provided by each facility and for each targeted health zone. To this end, WHO’s role in partner coordination, as provider of technical expertise, and in operational support, will be critical.

Capitalizing on the different expertise, field presence and operational capacities of the health partners, all facilities, at all levels of care, will need to ensure each of the following areas of services:

1. General clinical and emergency care
2. Child health, including nutrition and immunization
3. Management of communicable diseases
4. Sexual and reproductive health, including maternal and newborn care, basic and comprehensive emergency obstetric and neonatal care (BEmONC/CEmONC), family planning, management of sexually transmitted infections, HIV/AIDS, and cases of sexual/ gender-based violence
5. Management of non-communicable diseases, mental health and injuries
6. Environmental health, including waste management, water and sanitation, and health promotion

**Access to essential nutrition services**

Food insecurity, displacement and disrupted health services have led to a significant increase in acute malnutrition among children. Severe acute malnutrition (SAM) is of particular concern since it directly increases the risk of dying in under-fives. The capacity to manage SAM with medical complications remains inadequate, with major gaps in human resources and technical capacities and materials. In line with the approach to extending access to health care, appropriate referral of complicated SAM cases will be implemented in collaboration with the Nutrition Cluster and its partners.

**Key activities under this objective will include:**

- Identification of HZs and health facilities with the highest need and lowest capacity for health service provision, for targeting of activities – such assessments will be repeated periodically to monitor trends and identify new needs
- Strengthening primary and referral health facilities, through:
  - Technical and logistics support to target primary healthcare facilities, including provision of essential medicines, support to operating costs of health facilities, support for supervision activities of targeted HZs management teams
  - Definition and consequent capacity-building of minimum standards for services and clinical management of priority diseases for healthcare providers
  - Strengthening of target health infrastructure and referral systems, including rehabilitation of destroyed health facilities, support for transferring patients from primary health centres to a district hospital, reimbursement of hospitalization expenses Capacity-building activities to manage SAM with medical complications, including strengthening of stabilization/therapeutic feeding centres in strategic locations, training on SAM management, procurement and distribution of SAM kits based on needs
- Operations of mobile health clinics to increase population coverage to hard-to-reach areas
Objective 2: Prevent, detect and respond to disease outbreaks and other public health events

In a country as vast as the Democratic Republic of the Congo, where transportation infrastructure is weak and access is further constrained by eruptions of violence, investment in community resilience to disease outbreaks should be made, in addition to strengthening the capacity of health facilities and DPS to prevent and respond to these outbreaks and other public health events.

Outbreak prevention

The ongoing cholera outbreak in the Democratic Republic of the Congo has been difficult to control because of the generally limited access to clean water and adequate sanitation facilities. Such limitations are risk factors for the evolution of many other diseases into outbreaks.

To address this, a system to monitor the quality of water at the community level and in health facilities will be put in place, for which the participation of community members and local authorities will be actively sought. This monitoring system will inform water and sanitation interventions through coordination with the Health and WASH clusters, the inter-Cluster Network and other related platforms. At health facilities, this monitoring system will be extended to include all other measures for infection prevention and control (IPC).

Vaccination campaigns and reinforcement of the regular vaccination programme will also be a focus of outbreak prevention. WHO and health partners will facilitate the implementation of oral cholera vaccine (OCV) campaigns, aiming to reach at least 80% of the targeted population. Additionally, periodic evaluations will be made to assess need, with the consequent implementation of vaccination campaigns for measles, polio, yellow fever and other vaccine-preventable diseases.

Case management / treatment centres

The effective control of an outbreak requires the availability of qualified staff, of diagnostic capacities, and of structures and materials. In the context of the Democratic Republic of the Congo, the presence of trained personnel and pre-positioning of essential materials at field-level health facilities, as well as the ability to surge
case management capacity locally will be critical. This is regardless of operational challenges such as disruption to transportation and communication, access constraint, and so on. Therefore, at a minimum, capacities need to be built at the provincial level. Throughout 2018, WHO envisages the establishment of such capacity in 15 provinces.

Community engagement /social mobilization teams

Improving community knowledge and practices for prevention, detection and community management of waterborne and other priority diseases through health risk communication and community health education is also a priority intervention under this strategic objective. At the same time, community engagement needs to take into account not just the unpredictable nature and progression of the crisis in the country, but also existing local coping mechanisms such as the presence of local civil society and non-governmental organizations.

Key activities under this objective will include:

- Supporting vaccination campaigns
- Developing reference isolation wards/treatment centres for cholera and other priority diseases including training health facility staff in case management
- Pre-positioning of essential medicines and supplies in high-risk areas for CTCs and other treatment centres, including cholera central reference kits (drugs and renewable modules), cholera community kits, as well as other disease-specific commodities and kits
- Building staff capacity for IPC and WASH, and supporting the MoPH and partners to establish a system for water quality monitoring at zonal level and at health facilities
- Development of a multi-hazard communications strategy in line with the Emergency Preparedness and Response Plan (EPRP), including through:
  - Support to the production of communication and advocacy materials on cholera, malnutrition and other pertinent health problems in multiple formats according to most-used media, including through local radio
  - Support to local NGOs to conduct risk communication and community engagement in selected areas
Objective 3: Strengthen early warning system, surveillance of public health events and health information management

Public health information analysis and reporting

A key prerequisite for any effective humanitarian response is the availability of timely, robust and reliable information. In order to make sound decisions in a humanitarian health response, decision-makers need public health information to assess and monitor the health status and risks faced by the affected population, the availability and actual functionality of health resources, and the performance of the health system. In a volatile context such as the Democratic Republic of the Congo, adequate resources need to be put in place to monitor changing needs and risks continuously, particularly since eruptions of violence are frequently unpredictable, both in scale and duration. This information-management capacity also needs to be built at the local level – in health zones and provinces – to curb the frequent disruption to access.

WHO will continue to strengthen the national integrated disease surveillance and response (IDSР) and early warning (EWAR) system at the health facility level, as well as at the DPS (provincial) and Ministry of Public Health (national) levels. WHO and health partners will invest in optimizing the IDSR system through trainings, technical and operational support, and monitoring and supervision. Moreover, to strengthen this system, a community-based mechanism to detect and report public health alerts will be established. To support the operations of this system, partnerships with private sector and community elements will be identified and capacities built accordingly; for example, a collaboration with phone network providers. In addition to disease surveillance, the management of other health information will also be strengthened.

Health services monitoring

Health services play a crucial role in reducing preventable deaths, illnesses and disability in emergencies. When health facilities and
services are damaged and left without medicines, equipment and basic amenities, they cannot serve populations in heightened need. The health resource availability monitoring system (HeRAMS) will be set up to map health capacities at the zonal level, thereby providing quick information about gaps in the response. As an initial step, a HeRAMS evaluation will be carried out in the three priority regions affected by this complex humanitarian crisis: the greater Kasai region, Tanganyika, and the Kivu region. This evaluation is critical to take stock of what and where the gaps in health services are and to inform planning and response.

WHO’s HeRAMS reports will help identify:

1. The geographical areas that lack healthcare services
2. The types of healthcare services that are available (or not available)
3. The type and number of healthcare staff, and their level of skills
4. The underlying causes of disrupted healthcare services.

Additional contextual analysis will be made to enrich the HeRAMS results, specifying local socio-political, conflict and security dynamics. Health workers be trained in the methodology of collecting HeRAMs data, and workshops will be conducted at the national, regional and zonal levels in order to verify the data collected. The results of the HeRAMS will be used to guide the DPS and health partners to deploy scarce resources and technical support appropriately.

**Rapid response services**

For a country as large and complex as the Democratic Republic of the Congo, with multiple outbreaks occurring at any given time, it is essential to strengthen and expand rapid response teams (RRT) at national, provincial and zonal levels for the verification and timely initiation of response to outbreak alerts. This is required not only where the outbreak is ongoing, but also in all high-risk areas, to prevent geographical expansion of diseases. Rapid response teams will be deployed to ensure that all outbreak alerts and rumours are verified via investigation and risk assessment, with the aim to identify the etiology of the event, the source and ways of transmission; to support diagnosis and case management (including timely referral); to initiate containment measures; and to evaluate local response capacities versus projected needs continuously. Protocols will be developed for standardized and predictable responses, staff will be
trained, and resources will be provided for rapid alert investigation and response activities.

**Strengthen laboratory capacity**

Laboratory testing for each alert is essential during the initial investigation by rapid response teams. Swift results enable faster deployment of teams to prevent and control outbreaks. WHO will support national and regional laboratories by procuring and distributing rapid diagnostic tests for cholera, measles, dengue, meningitis, etc. WHO will also support sample collection and transportation, the development of a national lab strategy and guidelines, and will in addition train laboratory personnel and provide supervision.

Key activities under this objective will include:

- Strengthening public health information analysis and reporting through:
  - Development of tools and guidance to standardize structures of health facility data, streamline reporting channels, and maintain a sustainable mechanism for dissemination and sharing of information
  - Development and implementation of facility-based surveillance supervision mechanisms
  - Setting up of and capacity-building for a community event-based surveillance system and operations
  - Generation of a set of regular information products in line with the health-sector priorities and work-plan, including statistical/analytical reports, snapshots, infographics, comprehensive geo-spatial analysis, and maps and bulletins by region

- Support to health services monitoring through:
  - Implementation of HeRAMS to clearly map the available human resources and services at the zonal levels, at least in the three priority hubs, i.e. the greater Kasai region, Tanganyika and the Kivu region
  - Capacity strengthening of the national health information management staff by conducting training workshops on data collection, management and analysis
  - Implementation of additional rapid assessment, as needed, including multi-sectoral assessment in the other at-risk provinces, are essential.
• Support rapid response, surveillance and outbreak investigations through:
  - Establishment/revitalization of provincial and zonal level rapid response team (RRTs), including the provision of training
  - Support to field outbreak investigations in priority zones, with appropriate supplies and equipment
  - Monitoring and support for supervision activities

• Support to laboratory facilities though:
  - Development of a national/provincial laboratory strategy and network within the country
  - Provision of essential equipment and supplies, and support for laboratory specimen collection, storage and transportation
  - Provision of refresher training for laboratory health workers on specimen processing and shipment for selected epidemic prone diseases

Objective 4: Strengthen health sector coordination and WHO’s operations in support of the health sector response

Health sector coordination

Effective partner coordination is key to maximizing collective health impact, especially in such a complex environment where access to populations in need is constrained and resources are limited. Scarce resources should be channelled where needs are most pronounced and duplications should be prevented at all costs. It is also important to identify and respond to gaps in the response promptly since they affect coverage of patients/beneficiaries, as well as the range of services/assistance available.

WHO’s role in partner coordination will be strengthened at the national level and in the three humanitarian hubs and key provinces. It will encompass not only health sector coordination but also cross-cutting and inter-sectoral issues such as WASH, protection, preparedness and early warning. This coordination function is equally important in non-humanitarian platforms, such as those led by the Ministry of Public Health, development actors and donors, among others.
WHO programme support

An effective response can only be ensured if the essential personnel, systems and processes are present and functioning. To this end, WHO has developed a structure for its three levels of operation – national, humanitarian hubs and provinces – which will benefit the health sector as a whole, as well as WHO’s own operations.

WHO’s programme management area covers coordination of finances and grant management to ensure that funds are used appropriately and in accordance with donor agreements and operational plans, adjusting with the evolving situation. This area also supports activity implementation and overall coordination across functions to ensure coherence, and to reduce gaps and overlaps in responsibilities.

The core services area will be responsible for implementing policies and procedures across the Organization that are fit for purpose. This area supports effective management, sustainable staffing and financing of the response in the Democratic Republic of the Congo, while at the same time ensuring interoperability and consistency during coordinated emergency response efforts through partnerships.

Key activities under this objective will include:

- Establishment of a coordination structure and mechanism for the three levels of operations (national, humanitarian hub and provincial), and development of health cluster work plans for the three levels of operations, with clear deliverables that are monitored and periodically reported.
- Development of an inter-cluster collaboration workplan with clear deliverables that are monitored and reported. This mechanism will also serve as a platform to address cross-cutting issues, such as protection mainstreaming, early warning, preparedness, contingency planning, environmental protection, accountability to affected populations (AAP), etc.
- Participation in other coordination mechanisms outside the health cluster and humanitarian system, such as MoPH-led initiatives, donor forums, development partner coordination, etc.
• Establishment of a health cluster information management system for the three levels of operation. This system will be responsible for collecting information and providing monthly analysis of health sector response gaps, challenges and lessons learned, as well as monthly updates of partners’ presence/4W matrix, disaggregated data on patients/beneficiaries reached, coordination of supply chains, etc.

• Recruitment of essential technical experts and operational staff, based on the structures established for the three levels of operations, and establishment of systems and procedures for procurement and logistics that are monitored and supervised, for all three levels of operations.
WHO CONCEPT OF OPERATIONS

PHASES OF OPERATIONAL SCALE-UP

To increase the health sector capacity to respond to the extremely complex and multiple crises faced by the Democratic Republic of the Congo, WHO will expand its presence at the national and operational levels. Given limited resources, the implementation and intensification of operations will be gradual, but will, at the same time, ensure all required competencies are present to fulfil its critical functions nationally and in the hubs:

1. Leadership
2. Partner coordination
3. Information and planning
4. Health operations and technical expertise
5. Communication
6. Resource mobilisation
7. Operational support and logistics

WHO will temporarily transfer its emergency coordination from Kinshasa to its hub in Kananga in order to be closer to the populations in need and to create a better synergy with its partners. From the first quarter of 2018, three humanitarian hubs will be established in the three major hotspots: Kasai, Tanganyika and South Kivu. These will align with the humanitarian system in-country. Gradually, as funding becomes available, the existing 11 sub-offices will be strengthened with surveillance and rapid response capacities.

Figure 10. Phases of WHO’s operational scale-up, Q4 2017 – Q4 2018
At this operational level, WHO will also strengthen the capacity of the DPS to better prevent, detect and respond to disease outbreaks, as well as to respond to the complex health needs resulting from the humanitarian crisis. WHO teams and their DPS counterparts will reinforce community-based surveillance, carry out field investigations immediately following notifications of an alert, monitor water quality and other risk factors in high-risk areas, and surge diagnostic and case management capacities at the local level to contain the spread of outbreaks rapidly. WHO will provide its technical expertise and normative advice to the DPS, and train its personnel in monitoring and supervision so as to increase the quality of health services and the performance of providers.

Fifty isolation/treatment centres will be identified and reinforced in critical areas where the cholera outbreak is active. Such centres will also serve as models and training centres for future outbreak response, with a focus on IPC, isolation and case management. Additionally, WHO will support an evaluation of needs for reconstruction and/or rehabilitation of damaged health facilities in priority health zones, and provide infrastructure and material support to a selected group of facilities.

Figure 11. WHO’s concept of operations, Q4 2017 – Q4 2018
PROTECTION AND GENDER MAINSTREAMING, AND ACCOUNTABILITY TO AFFECTED POPULATIONS

The health sector is committed to mainstream gender and protection into its response. Needs assessments will take into account the different circumstances and vulnerabilities of women, men, girls and boys, as well as individuals with special needs and protection issues. Subsequently, response activities will be tailored to the specific requirements of these different groups, within a no-harm approach. All information collected, analysed and reported on beneficiaries and activities will be disaggregated by gender, age groups and different vulnerabilities, as applicable.

In support of the framework for accountability for affected populations (AAP), patients and beneficiaries will be consulted and actively involved in all stages of the response, from needs assessment, planning and implementation to monitoring and evaluation. The health sector will endeavour to establish a community feedback and complaints mechanism in partnership with other health and humanitarian partners in order to promote ownership of the response by target populations.

As the humanitarian crisis evolves, the health sector response will be monitored to ensure that it remains accountable to the affected people, national authorities, donors, and the general public. Risks and needs will be continually assessed to identify any required changes to operational plans. Information about response activitie
will be assessed against the overall strategy, leading to informed decision-making in the adaptation of the operational plans.

**Humanitarian-development nexus**

Re-establishing functional, staffed and equipped health facilities to deliver quality health services to vulnerable populations, including host communities, is one of the key objectives of the health sector transitional strategy for 2018. Health system recovery efforts will be done in close partnership with health development partners. These would include all the building blocks of the health system, with the underlying principle of “building back better”, and investment in health resilience at both institutional and community levels. Furthermore, recovery support will be aligned to existing development approaches that have proved to be effective. Humanitarian assistance will be delivered as such, not to jeopardize progress made in long-term development.

**Planning framework and timelines**

This operational plan covers a period of 12 months from January 2018 to December 2018. The interventions are aligned to address the immediate needs during the initial periods of emergency as well as to preparing the ground for sustainable medium- and longer-term interventions. There will be a quarterly review of this plan.

**Monitoring**

The health sector response will be tracked against its targets using internal monitoring and information obtained from government counterparts, site visits and monthly situation reports. WHO staff in the field will visit project sites on a regular basis to review the quality of service delivery, and will prepare detailed monitoring and progress reports. Additional monthly supervision missions will be carried out for quality assurance and adherence to international standards.

WHO will host a project kick-off meeting to refine the health sector response monitoring and implementation plans. WHO will hold mid-term and final joint partnership reviews of the response to take stock of progress, achievements, challenges and ways forward.

Key performance indicators have been identified for each strategic objective to ensure rigorous implementation and achievement of
the response targets. These indicators and targets are elaborated below. Additionally, WHO will monitor changes against common humanitarian indicators, such as access and security, population in need, etc., in to adjust its response accordingly.

1. Increase access to essential health and nutrition services to the most vulnerable populations, through effective partnership
   a. At least 80% of targeted health zones in priority areas have at least one health centre per 50,000 population
   b. At least 80% of targeted health facilities are providing SAM stabilization based on the standard nutrition database
   c. At least 80% of targeted health zones have a diarrhoea/cholera treatment facility within 5 kilometres of affected communities

2. Better prevent, detect and respond to disease outbreaks and other public health events
   a. Monthly water quality testing is implemented in at least 80% of targeted health facilities
   b. At least 80% of communities in targeted health zones reached by health workers/volunteers to address community concerns and health needs
   c. At least 95% of children under five years are vaccinated against measles in targeted health zones

3. Strengthen disease surveillance and reporting, as well as the larger health information management
   a. At least 80% of alerts reported through the IDSR system and/or community alert mechanisms are verified within 48 hours
   b. At least 80% of verified alerts are responded to within 72 hours
   c. At least 80% of health facilities supported by health sector partners submit weekly surveillance reports on time
   d. At least one baseline HeRAMS assessment is carried out and reported on for each target province

4. Strengthen health sector coordination and WHO’s operations in support of the health sector response.
   a. One health cluster coordination performance monitoring (CCPM) exercise is carried out and reported on in 2018, addressing all six core functions of the Health Cluster, and with at least 50% participation of partners from all target provinces
   b. A Health Cluster bulletin and a 3W (who, what and where)
matrix of health partners are produced and disseminated each month, encompassing health response at the national and provincial levels in the other at-risk provinces, are essential.
The following table includes the costs to achieve WHO’s objectives and support activities for meeting the health humanitarian needs in the Democratic Republic of the Congo in 2018.

<table>
<thead>
<tr>
<th>Strategic objectives</th>
<th>Cost (US$)</th>
<th>Funds available (US$)</th>
<th>Funding Gap (US$)</th>
</tr>
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<tbody>
<tr>
<td><strong>1. Increase access to essential health and nutrition services</strong></td>
<td>8,642,000</td>
<td>531,000</td>
<td>8,111,000</td>
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<td>Support to primary and referral health facilities</td>
<td>3,684,000</td>
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<td>3,684,000</td>
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<tr>
<td>Operations of mobile health clinics</td>
<td>691,000</td>
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<td>691,000</td>
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<tr>
<td>Technical expertise and capacity for health service delivery</td>
<td>4,067,000</td>
<td>531,000</td>
<td>3,536,000</td>
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<tr>
<td><strong>2. Prevent and control outbreaks</strong></td>
<td>4,855,000</td>
<td>266,000</td>
<td>4,589,000</td>
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<tr>
<td>Support to vaccination campaigns</td>
<td>660,000</td>
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<td>660,000</td>
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<tr>
<td>Setting up of isolation wards/ treatment centres</td>
<td>795,000</td>
<td>28,000</td>
<td>767,000</td>
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<tr>
<td>Prepositioning of essential medicines and supplies</td>
<td>500,000</td>
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<td>500,000</td>
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<tr>
<td>IPC and WASH material support and capacity building</td>
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<td>Public risk communications campaigns</td>
<td>200,000</td>
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<td>200,000</td>
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<tr>
<td>Technical expertise and capacity for outbreak prevention and control</td>
<td>1,628,000</td>
<td>228,000</td>
<td>1,400,000</td>
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<td><strong>3. Strengthen surveillance, early warning and health information management</strong></td>
<td>6,739,000</td>
<td>2,807,000</td>
<td>3,932,000</td>
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<td>Public health information analysis and reporting</td>
<td>259,000</td>
<td>2,000</td>
<td>257,000</td>
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<tr>
<td>Health services monitoring</td>
<td>638,000</td>
<td>358,000</td>
<td>270,000</td>
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<tr>
<td>Support to rapid response, surveillance and outbreak investigations</td>
<td>855,000</td>
<td>1,000</td>
<td>855,000</td>
</tr>
<tr>
<td>Support to laboratory facilities</td>
<td>2,695,000</td>
<td>2,000,000</td>
<td>695,000</td>
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<tr>
<td>Technical expertise and capacity for surveillance and information management</td>
<td>2,270,000</td>
<td>436,000</td>
<td>1,834,000</td>
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<tr>
<td><strong>4. Establish effective coordination and operations support</strong></td>
<td>9,790,000</td>
<td>1,569,000</td>
<td>8,221,000</td>
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<tr>
<td>Support to inter-cluster collaboration and other coordination mechanisms</td>
<td>37,000</td>
<td>8,000</td>
<td>29,000</td>
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<tr>
<td>Management of operations</td>
<td>2,977,000</td>
<td>16,000</td>
<td>2,961,000</td>
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<tr>
<td>Technical expertise in coordination and operations</td>
<td>6,775,000</td>
<td>1,545,000</td>
<td>5,231,000</td>
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<tr>
<td><strong>Grand total</strong></td>
<td>30,000,000</td>
<td>5,173,000</td>
<td>24,827,000</td>
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## ANNEX 1: MONITORING FRAMEWORK

<table>
<thead>
<tr>
<th>Type of key performance indicators (KPI)</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Context</td>
<td></td>
</tr>
<tr>
<td>C1 Access and security</td>
<td>Total number of incidents (including attacks on health workers)</td>
</tr>
<tr>
<td>C2 Food insecurity (mln)</td>
<td>Number and percentage of population in integrated food security phase classification (IPC) 3-5 areas</td>
</tr>
<tr>
<td>C3 Population in need (mln)</td>
<td>Number and percentage of population in need (total caseload)</td>
</tr>
<tr>
<td>C4 Population in need (mln)</td>
<td>Number and percentage of population in need for the health sector</td>
</tr>
<tr>
<td>C5 Population targeted (mln)</td>
<td>Number and percentage of population targeted by health response</td>
</tr>
<tr>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td></td>
</tr>
<tr>
<td>O1 PHC</td>
<td>Percentage of targeted health zones with at least one health centre per 50,000 population</td>
</tr>
<tr>
<td>O2 Nutrition</td>
<td>Percentage of targeted health facilities providing SAM stabilization based on an E-CAMR database</td>
</tr>
<tr>
<td>O3 Communicable diseases</td>
<td>Percentage of targeted health zones with a diarrhoea/cholera treatment facility available within 5 km of all affected communities</td>
</tr>
<tr>
<td>O4 WASH</td>
<td>Percentage of targeted health facilities implement monthly water quality testing</td>
</tr>
<tr>
<td>O5 Risk/communication/ community engagement</td>
<td>Percentage of communities in targeted health zones reached by health workers/volunteers to address community concerns and health needs</td>
</tr>
<tr>
<td>O6 Vaccine coverage</td>
<td>Percentage of targeted health zones with at least 95% administrative coverage of measles vaccine</td>
</tr>
<tr>
<td>O7 IDSR/EWARS</td>
<td>Percentage of new alerts verified within 48 hours</td>
</tr>
<tr>
<td>O8 IDSR/EWARS</td>
<td>Percentage of verified outbreak alerts responded to within 72 hours</td>
</tr>
<tr>
<td>O9 IDSR/EWARS</td>
<td>Percentage of health facilities submitting weekly surveillance reports on time</td>
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<tr>
<td>P</td>
<td></td>
</tr>
<tr>
<td>Partner coordination</td>
<td></td>
</tr>
<tr>
<td>P1 Partner coordination</td>
<td>Number of HIRAMS assessment carried out and reported on</td>
</tr>
<tr>
<td>P2 Partner coordination</td>
<td>Number of health cluster coordination performance monitoring (CCCP) exercise carried out and reported on</td>
</tr>
<tr>
<td>P3 Partner coordination</td>
<td>Percentage of health cluster partners participating in the CCCP exercise</td>
</tr>
<tr>
<td>P4 Partner coordination</td>
<td>Frequency of update of the 3W matrix at national and provincial levels</td>
</tr>
<tr>
<td>P5 Partner coordination</td>
<td>Frequency of publication of health cluster bulletin at national and provincial levels</td>
</tr>
</tbody>
</table>
ABBREVIATIONS AND ACRONYMS

AAP: Accountability for affected populations
ADRA: Adventist Development and Relief Agency
ALIMA: Alliance for International Medical Action
AWD: Acute watery diarrhoea
BEmONC: Basic emergency obstetric and neonatal care
CCPM: Cluster coordination performance monitoring
CEmONC: Comprehensive emergency obstetric and neonatal care
CERF: Central Emergency Response Fund
CFR: Case fatality rate
CTC: Cholera treatment centre
CTU: Cholera treatment unit
DHS: Demographic health survey
DLM: Direction de Lutte Contre la Maladie
DPS: Division Provinciale de la Santé
Epi week: Epidemiological week
EPRP: Emergency preparedness and response plan
GAM: Global acute malnutrition
GBV: Gender-based violence
GDP: Gross domestic product
HeRAMS: Health Resource Availability Monitoring System
HF: Health facilities
HZ: Health zones
IDDK: Inter-agency diarrhoeal diseases kits
IDP: Internally displaced persons
IDSR: Integrated disease surveillance and response
IMR: Infant mortality rate
IMS: Incident management system
IPC: Infection prevention control
IPC: Integrated food security phase classification
MIRA: Multi-indicator rapid assessment
MMR: Maternal mortality ratio
MoPH: Ministry of Public Health
MSF: Médecins sans Frontières
MSH: Management Science for Health
MUAC: Mid upper arm circumference
NRM: Neonatal mortality rate
NTD: Neglected tropical diseases
OCV: Oral cholera vaccine
ORP: Oral rehydration point
ORS: Oral rehydration solution
OTP: Outpatient therapeutic programme
PHC: Primary health care
PNECHOL-MD: Programme National d’Elimination de Cholera et des Autres Maladies Diarrhéniques
RRT: Rapid response team
SAM: Severe acute malnutrition
SARA: Service availability and readiness assessment
SC: Stabilization centre
US: Under 5 years old
UNICEF: United Nations Children’s Fund
UNOCHA: United Nations Office for the Coordination of Humanitarian Affairs
VDPV: Vaccine-derived polio virus
WASH: Water and sanitation for health
WPV: Wild polio virus
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