Ebola outbreak in the DRC

Speaker key:

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JA  Jamie
BE  Ben
LA  Laurent
ST  Stephanie
CH  Christiana
SB  Stephane
JO  John

TJ  Good afternoon, everyone. Thank you very much for coming on such short notice. We are here to speak about the Ebola outbreak in the DRC, as announced. We have Dr Michael Ryan, who is our executive director for our Health Emergencies Programme and he will give you the update and then we will go to questions. Dr Ryan has some obligations back at WHO, so we'll try not to go beyond 30 minutes today. Dr Ryan, please.

IE  Thanks, Tarik, and I won't give you a long introduction; we'll leave the maximum time for questions and answers. I'm sure you have many to ask. As of 1st May, we have 1,510 cases of Ebola virus disease in North Kivu and Ituri provinces of the Democratic Republic of Congo, which includes 994 deaths. Dr Tedros and Dr Moeti, our Regional Director, have recently returned from the Democratic Republic of Congo, where they found the situation on the ground to be worse than it has been previously.

The operating environment on the ground has become increasingly insecure, as you've witnessed through the sad and tragic death of our colleague, Richard, in the field. The Director-General cannot be here today, nor Dr Moeti, as they're both attending the funeral of our colleague tomorrow and are currently en route to Cameroon to spend time with his family and we all mourn with them over the next few days.

Insecurity has become a major impediment to ensuring that we can access, engage with and serve the communities we wish to serve in Ebola control. From 01 January to 03 May there were 130 attacks on health care documented by WHO that caused 4 deaths and 38 injuries of
health care workers and patients in DRC. So, we are dealing with a difficult and volatile situation.

Fundamentally every time we have managed to regain control over the virus and contain its spread we have suffered major security events like the attacks in Beni, the attacks on the Butembo and Katwa ETCs and obviously the latest round of attacks in Butembo and Katwa. We are anticipating a scenario of continued intense transmission. We have managed to get our operations up to the level that they were before the unfortunate death of our colleague, Richard, both in terms of vaccination, surveillance and other interventions like IPC but it is not easy to sustain such an effort both in technical terms and financial terms at the current time.

We need stronger national and international efforts both at the technical and financial level to sustain this response, to scale this response and to finally end transmission and stop the outbreak. Our funding gap for all agencies is difficult. For WHO in particular we've had to, through the last number of months, deal with an escalating series of costs associated with having to take on roles and responsibilities - supply chain for Ebola treatment units, staff support for Ebola treatment units, extra security costs, extra transport costs - we've had to take on a number of responsibilities when other agencies haven't been able to continue.

At the present time, our original estimates for the Strategic Response Band Three were approximately $57 million dollars. They now exceed $88 million dollars and are continuing to grow. As of today, we have received $34 million dollars and have a current, urgent, critical financial gap of $54 million dollars. That's despite having spent over 35 million of our contingency fund since the beginning of the year. We continue to do that in order to stay in the response but that is not an inexhaustible fund and at the current time we have reached critical levels in our contingency capacity to support the response.

The response involves at the moment tracking over 12,000 contacts per day, over 1,000 alerts per day, vaccinating over 1,000 people per day in over 21 affected aires de santé, some of which are quite geographically separate and many of which are in extremely difficult security environments. We're adapting, we're scaling, we're evolving the response to adapt to the security situation so for example, instead of going into some of the most extreme areas we're bringing people out and vaccinating them in pop-up vaccination centres.

We're moving diagnostic capacity and early-care capacity closer to the community by having transit centres, smaller, community-led transit centres closer to the population. We're scaling up our vaccination initiatives and currently looking at various options for shifting current use of the RVSV vaccine and potentially introducing another vaccine into the epidemic zone in order to support containment.

We're scaling up the infection prevention and control efforts and many of you will have noticed a large grant from the Paul Allen Foundation in the last couple of days, which is specifically aimed at leveraging the medical student population in North Kivu and training them to participate in infection prevention and control activities in the hospitals.

We continue to work with the lead in this area, UNICEF, in community engagement to continue to scale the local Ebola virus committees, which are now established in all of the aires de santé affected. We still face major issues of community acceptance and trust but let me state clearly in this, we still have high levels of acceptance of vaccine; we still have high
levels of acceptance of safe and dignified burials and it's a testament to the people of Kivu and Ituri that they continue to accept at over 90%. I think for other vaccines like measles if we had over 90% coverage we would be doing quite well and wouldn't be facing the massive outbreaks we're facing right now.

Equally, having your loved ones taken away to be buried by a burial team is very difficult to accept. The fact that over 90% of families accept that again is a testament to the acceptance of individual families. A lot of the resistance, a lot of the acceptance issues are driven by political rivalries, communities being instrumentalised, a lack of bipartisan political engagement in driving this as a national crisis, as an epidemic that requires all political parties and all persuasions to come together to support the response.

We do welcome in the last few days that President Tshisekede has put in place a multi-sectoral ministerial committee for the coordination and response to this disease that includes ministries well beyond the Ministry of Health, including the Ministry of Interior, the Ministry of Defence, the Ministry of Social Affairs and others so that there will be more and more an all-of-government, government-owned response and we've received assurances from all parties that they will engage in a bipartisan, non-politicised approach.

Communities, especially in North Kivu and in Ituri, where there are large groups that support opposition parties, need to be assured that all parties are supporting the public health response and that Ebola should not become further politicised in this process. The Director-General has spoken of this many times in the last number of days.

So, scale, speed in what we do operationally, evolution of what we do, innovation of what we do is what WHO is trying to achieve with our partners. The security and political solutions need to come from elsewhere. The financial solutions need to come from elsewhere. We call on our international partners to support us in generating the necessary political, security and financial platform on which we can do our work in public health with our technical partners.

Thank you.

TJ Thank you very much, Dr Ryan. We'll start with questions. Jamie first and then Ben.

JA Good afternoon, Dr Ryan. I'm Jamie from Associated Press. I think you said the number was 994 deaths as of May 1st, which was Wednesday. What do you know about, in the interim, whether the tally has topped the significant symbolic milestone of 1,000 since then, please, what can you tell us about that?

IE As of yesterday, this morning it had not but we expect it to exceed those numbers likely today. Did I answer your question?

JA [Inaudible]

IE Yes, there're no predictions in this. We haven't exceeded the 1,000 as of this morning but we will likely exceed that today when we see the numbers later this evening.

BE Hi, Ben from AFP. I know it's a region that's extremely complicated, but I just want to parse a little bit about what you said about insecurity and resistance. Part of what you said seems to be post-election tension residue on a political basis but another part of it is militia groups that have been in that region for years and years before any of these politicians
emerged. Can you break that out? To what extent is something like a long-standing rebel group like the ADF the problem and to what extent is it political tensions that are the problem?

IE I think it's a mixture of all. I'm not a political scientist but I have been on the ground for nearly six months so probably have as much knowledge as most outsiders but as you know, it's a very deep, long-standing conflict in that part of the world. The ADF are based very much around the north, around Beni to the north and Oicha, Komanda and as an insurgent group are not of the community and tend to attack the community as much as attacking government forces or others.

In the last number of weeks, the insecurity has been around Butembo and Katwa and a lot of that has been generated by other anti-government forces, Mai-Mai forces which are much more disparate, many, many more groups. Many of those groups are in current negotiation to be normalised or reintroduced into the government system, into the army and other things.

Some groups are not in the process and it's not clear to what extent some of those groups may be associated with political objectives or otherwise and how many of those groups are involved in criminal activity and how much there is a mix between both. Coming from the country I come from, I fully understand how complex those issues are and many of the Mai-Mai groups, depending on the area you're in, have much more influence on them from the community. There are many areas in which Mai-Mai elements are much more localised and are much more likely to take the words of local chiefs, to take instruction to reduce activity based on what the community want.

In other areas, there are other groups that are less disciplined, less connected to the community and much more likely to engage in independent activity that may be against the community's wishes. That is that armed element. We had another attempted attack yesterday on one of our ETUs in Butembo, which was dispersed and repelled by the increased security presence that's been on the ground and nobody was injured and some of the assailants were captured.

That's very different to the understandable community tensions that have emerged but those community tensions can be driven and manipulated by political concerns. It's one thing being frustrated because you don't have enough resources, you don't have access to education, you don't have access to healthcare, you've lived in an unstable place for years and years and you feel that everyone has abandoned you as a community and you feel frustration.

When Ebola teams arrive people say, quite rightly, Ebola's your problem but we've got other problems here. Those community tensions exist in any situation in which you come in as an outsider and in general we're able to manage those tensions by dialogue, by engagement, by explaining what we're doing, by trying to bring other services. But when communities are being directly manipulated, when communities are being instrumentalised and driven down certain paths then that becomes directed and that's the difference in this case.

There's an element of natural, understandable and totally justifiable community frustration and we need to do every day a better job of explaining ourselves and ensuring that communities understand why we're there. But there is an element of political manipulation of the feelings and the emotions of those communities and that ability to amplify genuine
community concerns to generate responses that are politically motivated; I don't know that there's a country in the world where that's not happened at some point in the past.

I'm not there to judge that one way or the other. Our job in WHO is to protect and serve vulnerable people, to protect the world from Ebola and in doing that we can only identify the obstacles to that. We're not saying that the only thing in the world is security. We need to improve our performance too. We need more technical partners on the ground.

We need to focus on improving every single day what we do but it's very hard to focus on those improvements, it's very hard to focus on doing your job when you don't know what's going to happen in the next ten minutes, you don't know whether the next armed group that stops your vehicle is going to shoot someone, you don't know in the morning when you wake up how many of your friends will be coming home this evening unscathed or uninjured.

So we need the humanitarian space in which to do our job with our government partners, with the Ministry of Health, with the NGOs and, as I said, we call on all national and international actors to create the conditions in which we can do the job we have been asked to do, which is to stop Ebola.

TJ Thank you. There are a number of questions; first Laurent, then Stephanie, then Christiana, then Stephane and then John; there's the order.

LA Laurent, Swiss news agency. There was another attack two days ago in Ituri and it seems that a hospital was looted, and two docs were abducted. Do you know who these docs are? Has that anything to do with the response or not at all?

IE As far as I'm aware that is not to do with the response. I had a security briefing this morning and that wasn't part of it so there have been many, many attacks on healthcare and NGOs in Ituri and in North Kivu over the last five, ten years. We'll check but as far as I understand that was not related to Ebola, but we did have an Ebola-related attack yesterday on one of our ETUs in Butembo which was repelled and dealt with successfully.

TJ Stephanie.

ST Thanks. Reuters, Stephanie Nevahae. I want to come back to something we asked about previously, about rates of children's infection in this outbreak in Congo compared especially to 2014-16. The nosocomial infections have been a bigger problem this time around. Do you have any more data or any more information especially to compare rates in children and in nosocomial infections?

IE Thanks, Stephanie. I don't have the exact numbers to hand. We can certainly go through it together afterwards but consistently over the last number of weeks about 25% of all the cases have been associated or at least are linked to some form of nosocomial transmission. The rates that were very extreme of high numbers of young children and high numbers of pregnant women were very much centred around the outbreak in Beni, but we still see unusually large numbers of children under 18 years of age and particularly children under five.

Again, we believe that much of that is not necessarily due to exposure within the household where children are relatively well-protected but associated with nosocomial transmission
where children or pregnant women are accessing the healthcare system and are potentially infected in that environment.

Tomorrow we will be launching a major campaign with the government in Congo on infection prevention and control and the safe use of needles and really launching a massive public campaign around needle use and needle reuse in this setting. It's a major driver potentially of nosocomial transmission.

As I said, we're trying to scale up those activities to reduce the rate of nosocomial transmission because transmission within the healthcare facility is not only a tragedy in its own right but it really confuses the surveillance because when someone gets sick from Ebola and goes into a hospital and lies in a bed beside someone who has malaria and someone uses the same needle the person with malaria goes home cured of malaria but now incubating Ebola.

When the person gets sick they would, like any person, say, I have malaria again, that hospital was terrible, so they go to another hospital and they get into a bed and they get a blood test taken or get treatment and they infect somebody else. So, by the time we pick up the case, a case we find, it could be one or two generations later and then the detective story of going back, finding how those cases are linked...

So not only is nosocomial transmission driving part of the epidemic, not only is it a terrible tragedy that the healthcare system itself is implicated in driving transmission but it is also blinding the detectives who are trying to find the chains of transmission so it's really negatively affecting us in three key areas.

You'll see how many times on a daily basis we find cases that are not linked to a chain of transmission or that are not on contact lists. Many of those cases that have not been on contact lists have been people that we've eventually found are nosocomially infected by somebody else and then a week or two or three weeks later we do link them to a chain, but we only link them through individual intensive forensic investigation of the likely way in which they were infected.

Again when you look at the scale of work, can you imagine in this sense trying to individually meet and examine 12,000 people every day? Because that's the number of people we have to see every single day to verify whether they're sick or not. It's 12,000 people in a very insecure zone that we have to see every day. That is a tremendous burden on the staff and again over the last number of weeks because of the insecurity...

One of the biggest saviours for us in this response, in my view, has been our ability to use vaccine very tactically in vaccinating around cases, contacts, contacts of contacts and we believe that has reduced transmission significantly. Every time we fall behind in that process of vaccination the virus intensifies in its transmission. As of last week, we were over 100 cases behind in establishing vaccination rings. We've more than halved that over the last week, even including all the incident cases we've had in the last week.

Yesterday was the first day when the daily number of people vaccinated has been the highest so far in the whole epidemic so we've managed to recover from almost nobody being vaccinated for three to four days after Richard's death to now having the operation back at a stage where we're vaccinating more people than we ever have before in the field.
I think it was 970 people yesterday. I can't say here, don't quote me on that; I'll be quoted on it. I'll get the number before the end of the conference. We are looking at ways of scaling that up. We're looking at ways of more efficient use of the Merck vaccine; we're looking at how we vaccinate in targeted geographic ways, pop-up vaccination, bringing people to the vaccine rather than the vaccine to the people and the possible introduction of another vaccine into the epidemic zone, which we're working very, very hard on with the sponsors and with the principal investigators at INRB in Congo right now.

ST Can you say which vaccine?

IE The one we're using now is the RVSV Evo vaccine which is the Merck product and the one we're looking at now is the J&J vaccine which is the Prime-Boost vaccine. Currently, study protocols are being developed and the necessary regulatory, ethical and operational planning is underway and we're doing that in collaboration with the government, with INRB, with project sponsors at the London School of Hygiene and with funding and support from GAVI, from the Wellcome Trust and various other institutions.

What we hope to do is to be able to scale up the use of vaccine but using still ring vaccination as a very effective, targeted way of vaccinating but vaccinating around those rings in a targeted geographic way and then vaccinating outside those rings in a barrier using the other product.

It's an evolution in the vaccine strategy, still focusing on the core tactics but evolving and expanding and scaling up our capacity to vaccinate more people.

TJ Thank you, Christiana.

CH Hi, Christiana with the German press agency. You are saying that political solutions have to come from elsewhere but since this is so crucial to the success of your effort do you have one suggestion of what could be done on the political level to make your life, the WHO's work a lot easier?

I have one clarification question on the vaccine; do I understand correctly that you cannot vaccinate as many people as you would like because there is not enough vaccine available? Or how much is available on a monthly basis?

IE Thank you. What can be done to increase our capacity to work politically? I think the fact that the government has now established a multi-sectoral committee with an all-of-government approach is extremely welcome. Secondly, I think government and all political entities in opposition need to come together. The Director-General - and it's not like WHO stands aside and says, something must be done. The Director-General has engaged with opposition leaders, he's engaged with church leaders, he's engaged with businesspeople, he has met everybody; he has been to the field seven - I think nearly eight times.

He has spent hours and hours and hours in the field, right during the tragedy of Richard's death, in engaging everybody on this issue. But fundamentally we need the political forces, the political leaders in Congo to depoliticise this response and absolutely ensure that this response is not driving or being used to drive conflict and I think that's what can be done.
That is Congolese business; DR Congo's a sovereign country and it needs to focus on solving its own problems.

WHO is there to provide support to Congo in controlling Ebola as a member state of our organisation but equally other international actors and countries can support Congo in dealing with the political, dealing with the security and dealing with the financial and the operational challenges that we face and many are doing just that.

In terms of vaccine availability, we currently have enough vaccine supplies to continue with our current strategy. We are looking very seriously now and there have been a number of engagements and scientific discussions as to whether we can use adjusted doses of the Merck vaccine to make the vaccine go further; there's a lot of evidence to support that and that currently is under very careful scientific consideration by our SAGE Working Group on Ebola virus disease which met the other day. They will meet again on Monday and we will be making concrete proposals for how we could make our current vaccine go further. At the moment we have plenty of vaccine to do the job. The problem is not vaccine availability; the problem is access to communities to get the vaccination done.

Then with the J&J product there is adequate availability of the vaccine as well but obviously these are investigational products and we have to remember here, these products are not licensed and bringing unlicensed products into the field; we've done that highly successfully with the RSV Merck vaccine, but we also have regulatory and ethical barriers which are very important. They're not barriers, they're protections for populations so that we ensure that everything we do is in the best health interests of the populations we serve.

So we need to be extremely careful that everything we do is on the basis of adequate risk/benefit analysis and is done with the best possible scientific, regulatory and ethical standards.

SB Stephane. Just a follow-up as far as the vaccines are concerned; why do you justify the fact that you want to introduce a new vaccine, what was the fundamental reason? Second question, what's going on with the neighbouring countries, how does it look like? Thank you.

IE Justifying bringing in an extra vaccine; I think you want to use every tool in your toolbox or at least you want to have every tool available to use and we would not plan to use that second vaccine right in the heart of where transmission was occurring. If you can imagine families in a village being infected; we will continue to use the Merck vaccine to vaccinate the contacts and contacts of contacts. In insecure areas, we may vaccinate the whole village using that vaccine but there's a village next-door that doesn't have any disease yet and therefore it's difficult to justify using the Merck vaccine in that situation.

In that situation, there would be a benefit to using the other product as a way of laying down a barrier to the virus. It's not been used to control directly the transmission between people inside the mini-epidemic that's occurring around the family, but it can be used to lay down a barrier against the arrival of the virus in another area close by days or weeks later. So, it's a tactical approach, it's a supplementary strategy, it's not there to do the same thing as the Merck vaccine is there to do and what we're trying to do is align these vaccination strategies so that we're making the best possible use of every tool we have at our disposal.

TJ Neighbouring countries.
Jaouad might want to take this. Vaccination has commenced in Rwanda and it has been going on for months in the other countries of South Sudan and in Uganda. The other countries continue to increase their preparedness scores as evaluated by external, independent joint missions that have gone there, again and again, to look at that.

In fact, there was a meeting of all the surrounding countries in Kampala a couple of days ago in which all the surrounding countries came together to commonly evaluate all of their preparedness measures. We're very pleased with the way that preparedness is going but there are always gaps. Remember in this, in many ways people often look at epidemics and say a bad epidemic is a failure of response. Frankly, as Jaouad Mahjour has said to me many times - I'm here with Jaouad Mahjour, our Assistant Director-General for Emergency Preparedness - in fact, most epidemics are a failure of preparedness or most bad epidemics are a failure of preparedness so we need to look hard in all countries with high risk of epidemics, be it for cholera in Mozambique or Ebola in Congo, at really accelerating the levels of preparedness.

At WHO 80% of the high-impact epidemics that we deal with occur in about 30 fragile, conflict-affected and vulnerable countries. The reality is it's the new normal. People say, what will you do, Mike, when the Ebola outbreak is over? Well, we have many other outbreaks; we're dealing with nine grade-three emergencies at the moment; 30 other graded emergencies. If we look at the impact of the cyclones in Mozambique right now, we've had to vaccinate over a million people in cholera, implement a massive early-warning system, reconstitute and refurbish over 50 healthcare facilities just to keep the health system working during what has been a huge impact on infrastructure.

So, building the readiness and resilience of communities, building the readiness and resilience of the health system, building the readiness and resilience of the surveillance and laboratory and diagnostic systems is an investment we must make. We cannot keep responding and responding and responding; we must see a fundamental shift in what we're doing in terms of readiness and health security.

That's why WHO's main focus - although we only ever talk about our responses what we want to do is focus on the preparedness and you'll remember Dr Tedros in the last number of weeks has announced that in our programme we'll now have two divisions; a division of preparedness and the division of response. The division of preparedness will be under the leadership of my colleague, Jaouad, and it really fundamentally recognises that WHO, while we are very proud to be in the response business and supporting our member states, we really have to expand what we're doing in preparedness.

I think the surrounding countries are demonstrating what can be done with limited but effective resources invested in the right way and we shall see. I believe that the surrounding countries are much better prepared and if we have done nothing else in this response, we have given those countries the opportunity to get ready for Ebola and that is something that countries like Liberia and countries like Sierra Leone never got in West Africa.

We'll take one more question and then we'll have to go. Before I give the floor to John, just to be precise, Dr Tedros made eight visits to DR Congo.
TJ John, last question, please.

JO Hi. Yes, Dr Ryan, you mentioned you want to scale up the vaccine response. What sort of numbers are you looking at in the next three weeks or the next month, just to give us a perspective?

IE That's currently under discussion and I wouldn't like to give you the scaled-up number because that's...

JO Is it in the tens of thousands?

IE No, not right now. What we are going to do here is we are going to match the response to the need. There's no point - let's be frank here; these vaccines are precious resources and we need to be extremely careful how we use them because we don't necessarily know which way this outbreak is going.

I had a large number of people in October last year - I think I was here actually - saying, why don't we just use the Merck vaccine and vaccinate everyone in Beni? At that point there was disease in Butembo and Katwa and if we had done that we'd have had no vaccine left for Butembo and Katwa so we need to see both these vaccines as a precious global good and we need to use them very judiciously and, as much as possible, driven by the science and modelling that we have.

So, I wouldn't like to give you a figure because we'll be held to that figure. We will match the figure of vaccinations to what we believe is the epidemiologic need and what we believe is the best vaccine-sparing strategy that allows us to control the outbreak while still maintaining enough stocks to continue the response. So, it's a very fine balance but certainly, we expect to be vaccinating well in excess of 1,000 people a day in a couple of weeks' time.

TJ Let's end here. Thank you very much for being here. Stephanie, I will try to get numbers on children; we'll be in touch with your correspondent, and also on the number of people vaccinated yesterday. I wish everyone a very nice afternoon and a good weekend. Thank you.

*Corrigendum* On 14 May 2019, the numbers of attacks on health care in DRC documented by WHO was corrected. From 1 January to 3 May there were 130 attacks on health care documented by WHO that caused 4 deaths and 38 injuries of health care workers and patients in DRC.