



World Health
Organization

REGIONAL OFFICE FOR **Africa**



WHO REGIONAL STRATEGIC PLAN FOR EVD OPERATIONAL READINESS AND PREPAREDNESS IN COUNTRIES NEIGHBORING THE DEMOCRATIC REPUBLIC OF THE CONGO

June 2018 – February 2019

WHO Regional Strategic EVD Readiness Preparedness Plan

SUMMARY

On 3 May 2018, the Provincial Health Division of Equateur, Democratic Republic of the Congo (DRC) reported 21 cases of fever with haemorrhagic signs including 17 community deaths in the Ikoko-Impenge Health Area in this region. The Ministry of Health in Democratic Republic of Congo (DRC) notified WHO Country Office of Ebola Virus Disease (EVD) outbreak in Bikoro health zone, Equateur province on 8 May 2018. As of 2 June 2018, there are a total of 53 cases (37 confirmed, 13 probable, 3 suspect) with 25 deaths.

The ongoing outbreak poses a significant risk of spread to countries neighbouring the DRC. WHO has prioritized 9 countries neighbouring DRC based on the proximity to the current outbreak epicentre, and the existing capacities of the health system to cope with EVD. These countries are:

- ➔ Priority 1: Central African Republic and Republic of Congo
- ➔ Priority 2: Angola, Burundi, Rwanda, South Sudan, Tanzania and Zambia
- ➔ Priority 3: Uganda

The recommendations of Preparedness Support Team missions, results of EVD Preparedness checklist and the Joint External Evaluation (JEE) have been taken into account in identifying gaps in 7 countries out of 9. JEE has not been carried out in ROC and CAR where the outcome of EVD preparedness checklist was used to underscore the priority actions of preparedness.

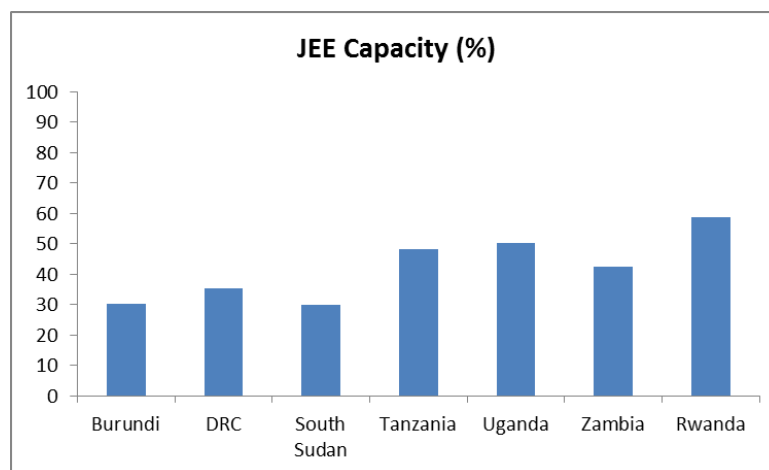


Figure 1 – Joint External Evaluation Capacity scores

The graph shows that all the 'at risk' countries have between 20% and 60% scores in emergency, preparedness and response capacities. WHO support the strengthening of these emergency preparedness capacities in order to ensure that the nine targeted countries are operationally ready to detect and respond to a potential importation of an EVD case, and be prepared to detect and manage EVD cases beyond the initial three months, ensure sustainable preparedness to manage EVD, strengthening of IHR core capacities to manage outbreaks and other health emergencies, and build resilient health systems.

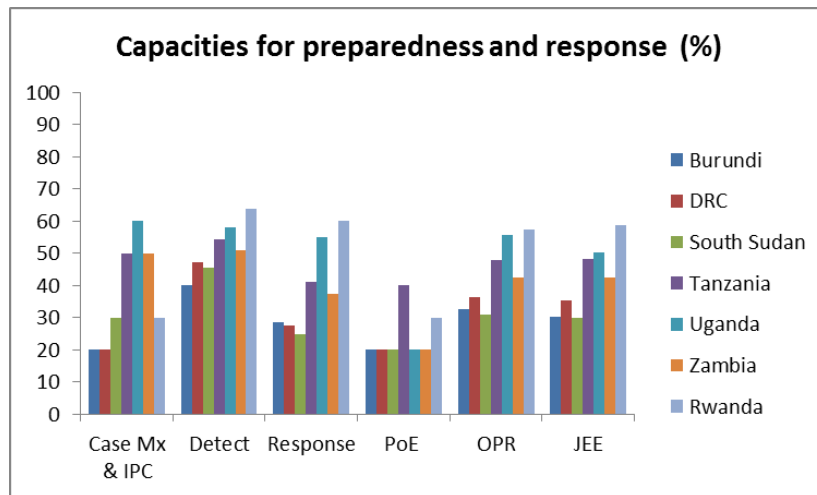


Figure 2 – Capacities for preparedness and response scores on a scale of 5

WHO along with the countries have developed a strategic regional plan for 9 countries including two phases of priority actions. Phase I which aims to be implemented in next 3 months to enhance the capacities for the countries to be operationally ready to respond should there be any importation of EVD cases while the Phase II of the plan is to scale up the preparedness actions to ensure sustainability of the operational readiness capacities linking to the ongoing longer term emergency preparedness. Operational Readiness takes place in a broader context of emergency preparedness and therefore also responds to the needs of countries to build sustainable capacities to manage outbreaks including from Ebola Viral Disease, and other health emergencies.

Over all the purpose of the WHO Regional Strategic Plan is to ensure that the countries bordering DRC are prepared, and ready to implement timely and effective risk mitigation, detection and response measures should there be any importation of EVD cases.

Investing in preparedness and operational readiness is imperative as this will generate momentum towards the commitments the 9 countries have made towards longer term emergency preparedness and implementation of IHR core capacities.

Led by the Ministries of Health, preparedness actions are already underway in the 9 countries with the critical support and collaboration with the interagency mechanism and partners in country. The WHO Regional Strategic Plan aims to ensure alignment of preparedness and readiness actions in support of the 9 countries in the coming months in 8 technical areas: strengthening the multisectoral coordination; surveillance for early detection; laboratory diagnostic capacity; points of entry; rapid response teams; risk communication & social mobilization and community engagement; case management and infection prevention and control capacities; and operations support and logistics.

The estimated budget for the WHO Regional Strategic Plan (June 2018 – February 2019) in total is around USD 25,026,502 which includes Phase I the initial priority actions which is USD 16,269,383 for three months followed by USD 8,757,119 to cover the subsequent 6 months. The budget has taken into account the national contingency plans for the 9 countries.

Current Situation of EVD

On 3 May 2018, the Provincial Health Division of Equateur, Democratic Republic of the Congo (DRC) reported 21 cases of fever with haemorrhagic signs including 17 community deaths in the Ikoko-Impenge Health Area in this region. A team from the Ministry of Health (MoH) supported by WHO and partners have visited the Ikoko-Impenge Health Area on 5 May 2018 and detected five suspected cases (two were admitted to Bikoro General Hospital and three were admitted in the health center in Ikoko-Impenge). Samples were taken from each of the five active cases and sent for laboratory testing at the Institute National de Recherche Biomédicale (INRB), Kinshasa on 6 May 2018. Of these, two tested positive for Ebola virus, Zaire ebolavirus species by reverse transcription polymerase chain reaction (RT-PCR) on 7 May 2018. As of 2 June 2018, there are a total of 53 cases (37 confirmed, 13 probable, 3 suspect) with 25 deaths.

The Ministry of Health in the Democratic Republic of Congo (DRC) notified WHO country office of Ebola Virus Disease (EVD) outbreak in Bikoro health zone, Equateur province on 8 May 2018.

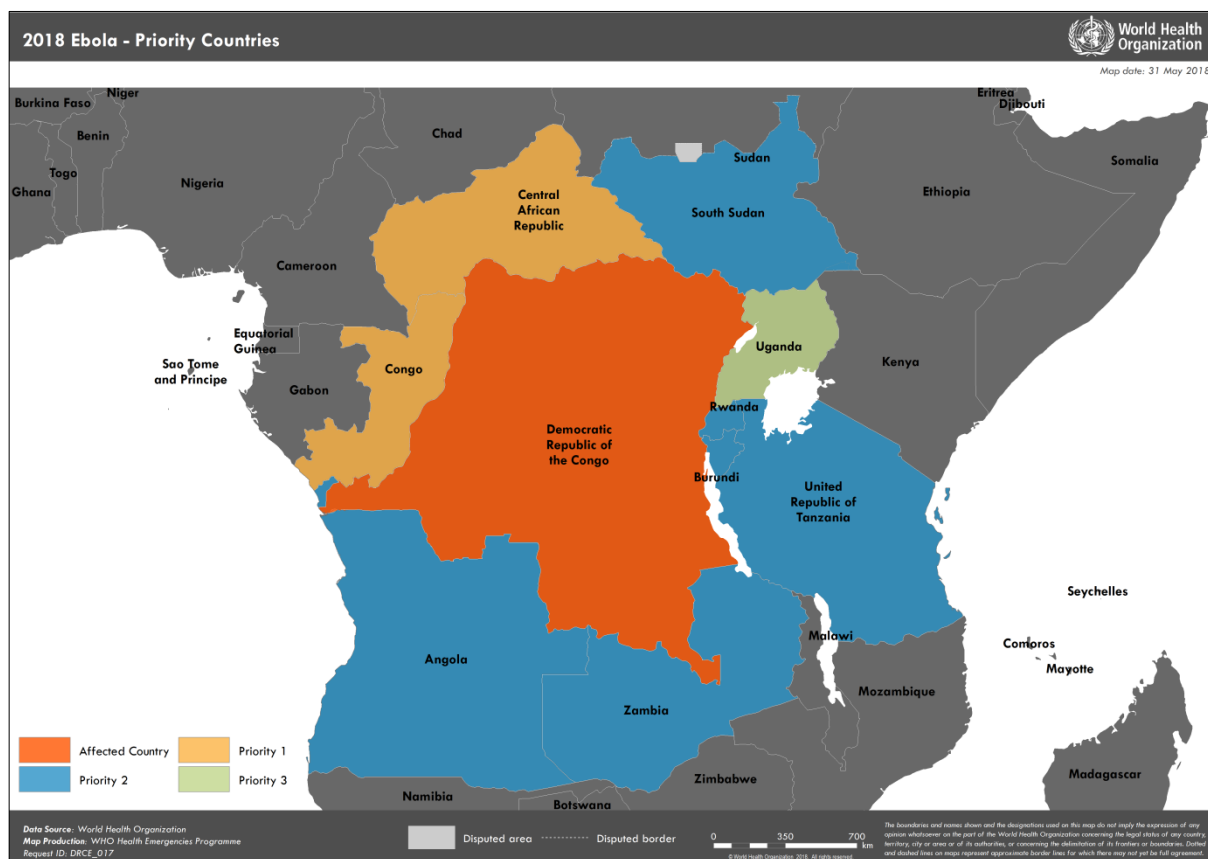


Figure 3: Risk of regional spread of EVD

In line with the Emergency Response Framework (ERF), WHO reached a decision to grade the event as an Internal WHO Grade 3 Public Health Emergency. As part of the grading process, WHO assessed the public health risk at the regional level to be high as the confirmed cases in Mbandaka, DRC, a large urban area with high density of population, has significant circulation through river, road and air routes. Approximately over 1000 people travel per day by river, road and air at the major points of entry connected to the affected Bikoro health zone in DRC. Mbandaka is located on a major national and international river, increasing the risk of local propagation and spread to neighbouring countries. Furthermore, low capacity in the DRC to manage the outbreak may result in spread of cases beyond its borders. The risk assessment will be systematically re-evaluated by the three levels of WHO according to the evolution of the situation and the available information.

Table 1. Movement of population from affected zones

| FROM | TO | MEANS | NO. OF POPULATION MOVEMENT |
|----------------------------|----------------------------|--------------------------------|---|
| Lukolela | Mbandaka | River | 30 pax/day |
| Bikoro | Mbandaka | Road | 75 pax/day |
| Ngombe | Mbandaka | Road | 50 pax/day |
| Mbandaka | Kinshasa | Flight (3 flights/day) | 150 pax/week (approximately 21 pax/day) |
| Lukolela | Poe (Congo Brazzaville) | River | 20 pax/day |
| Bikoro | Poe (Congo Brazzaville) | River | 50 pax/day |
| Ngombe | Poe (Congo Brazzaville) | River | 75 pax/day |
| Poe (Congo Brazzaville) | Lomsjasa | River | 700 pax/day |
| Kinshasa | Poe (Congo Brazzaville) | Flight (3 flights/ week) | 450 pax/week (approximately 65 pax/day) |
| TOTAL | | | 1086 pax/day 7602 pax/week |

The Republic of Congo and Central African Republic share borders over the river with the Equateur region along the River Congo which goes up to the North West border of Angola. DRC also shares land borders with Burundi, Rwanda, South Sudan, Tanzania, Uganda and Zambia.

Current EVD preparedness activities

Ministries of Health, in country partners and WHO are already supporting the implementation of EVD preparedness actions in all 9 countries. This includes Preparedness Strengthening Team (PST) missions to assess the state of preparedness, training of rapid response teams, establishment of intersectoral coordination mechanisms, strengthening of community-based surveillance systems, community engagement and sensitization, reinforcement of points of entry and the establishment of screening, and the identification and rehabilitation of health facilities to manage EVD cases, among other activities.

Through this plan, WHO will closely work with the Ministries of Health and wider government stakeholders, the intersectoral and interagency mechanisms and partners in each country to, and will harness the emergency preparedness and response mechanisms in place including those such as the Emergency Medical Teams, Health Clusters, and GOARN, to build preparedness to respond to EVD risks. This plan intends to provide a framework for collaboration and coordination for on-going and planned partner activities aligning towards the central purpose of establishing operational readiness in the countries neighbouring DRC.

WHO is monitoring the implementation of activities across the 9 countries based on an on-going update of the risk profiles including the level of capacities in place and gaps, and will support the countries to plan and prioritize preparedness actions accordingly.

WHO Regional Strategic Plan for EVD Operational Readiness and Preparedness in countries neighboring the Democratic Republic of the Congo

i. Goal

To ensure high risk countries bordering DRC are operationally ready and prepared to implement timely and effective risk mitigation, detection and response measures for EVD.

ii. Objectives

- ➔ To assess and identify existing capacities and gaps and strengthen countries' capacities to prevent, rapidly detect, investigation and respond to EVD
- ➔ To provide countries with a minimum level of capacities that needs to be in place to respond to a first EVD case
- ➔ To continuously monitor countries' preparedness and readiness

iii. Priority countries

On the basis of proximity to the current outbreak in DRC and the current capacity of the health system to cope with EVD, 9 bordering countries have been classified into 3 priority levels. They are as follows:

- ➔ **Priority 1:** Central Africa Republic and Republic of Congo (*proximity to the current event, potential population movement across the borders and weak health system capacity to manage EVD*)

DRC Equatorial region share borders with the Republic of Congo and the Central African Republic with continuous population movement through porous borders by land and through the River Congo. These 2 countries are therefore at high risk of importation of Ebola cases and require proactive support to ensure the capabilities are in place.

- ➔ **Priority 2:** Angola, Burundi, Rwanda, South Sudan, Tanzania and Zambia (*neighbouring countries with DRC*)

Bikoro Lake is directly connected through the river Congo, which flows through DRC to North West of Angola. Furthermore, DRC shares borders with these countries through which there is often a high level of traffic through porous borders.

- ➔ **Priority 3:** Uganda

Despite having land borders with DRC, Uganda has demonstrated a functional capability to manage EVD and other viral haemorrhagic fever outbreak in the recent past.

iv. Operational readiness and preparedness

Building on lessons from the West Africa EVD outbreak in 2014 and 2015, this operational Readiness plan focuses on ensuring countries neighbouring DRC are ready to prevent the importation of suspected EVD cases and contain any potential outbreak that may ensue. In view of the imminent risks, it gives highest priority to the establishment of capacities in the Priority 1 countries, namely, the

Republic of Congo and the Central African Republic.

Operational Readiness, however, takes place in a broader context of emergency preparedness and therefore also responds to the needs of countries to build longer-term capacities to manage outbreaks including from EVD and other health emergencies. Building on the operational readiness plan, WHO in collaboration with Member States and partners, are developing a regional plan, that seeks a greater investment in longer-term emergency preparedness capacities, to ensure that countries are better prepared in future to manage the outbreaks associated with EVD, other outbreaks and health emergencies. This plan will be based on Preparedness Support Team missions, Country EVD Contingency Plans and other forms of assessments such as the Joint External Evaluations to meet priority needs for investment in emergency preparedness. Proactive operational readiness pays off in terms of impact on public health and cost of preparedness

v. **Technical areas of the WHO Regional Strategic plan**

1. Strategic leadership and multi-sectoral coordination

A multi-sectoral coordination mechanism and structure at national, sub-national and local levels involving, as necessary, the interagency mechanism and partners, is required to rapidly mount an effective response to any emergency, including an EVD outbreak.

All countries will:

- Establish an emergency coordination mechanism at the national level and reproduced it in high risk-regions and border areas with DRC. The emergency coordination mechanism will be responsible for the implementation and testing of EVD preparedness measures.
- Support planning functions, including response planning and development of SOPs, with all relevant national stakeholders and partners.
- Develop an EVD contingency plan with a monitoring framework, providing training where necessary for its implementation.
- Test key capabilities to implement the EVD contingency plan through simulation exercises.

In addition, priority 1 countries will:

- Establish national Emergency Operations Centers for coordinating an emergency response, including the physical locations, infrastructure, plans and with identified and trained staff.
- Sub-national coordination hubs for high-risk risk regions will be identified and made ready so that they can be activated if required.

2. Surveillance for early detection

Rapid detection and isolation of EVD cases is key to preventing onward transmission and the ability to initiate appropriate control measures in a timely manner.

2.a. Reinforcing Integrated Disease Surveillance and Response (IDSR) systems

Early detection of EVD cases is based on strong links between public health surveillance systems, communities and local health facilities and reinforced Integrated Disease Surveillance and Response (IDSR) systems and processes. Event-based surveillance enables a timely follow up on alerts and rumours from any source.

All countries will:

- ➔ Update EVD risk profiles on systematic basis taking into account the dynamics and evolution of the outbreak in DRC in order to prioritize preparedness actions.
- ➔ Accelerate surveillance and early warning activities in high-risk regions through the strengthening of IDSR-based surveillance systems
- ➔ Develop and disseminate surveillance tools and resources at all high-risk regions.

In addition, priority 1 countries will:

- ➔ Identify and train a pool of contact tracers in all high-risk regions including community health workers and partners.
- ➔ Provide targeted training for EVD detection of Health Care Workers (HCW) and Community Health Workers in high-risk regions.
- ➔ Support regular supervision/mentoring of Surveillance Officers and community-based focal points

2.b. Capacity at Points of entry

Points of entry are the first line of defence against the international spread of disease and are important nodes in disease detection and sensitization of travellers crossing borders. A wide variety of public health events ranging in severity may occur at the Points of Entry (PoEs), and require different actions for emergency preparedness and response. It is crucial to strengthen IHR public health core capacities at POEs. Capacities will be made available at main airports as well as water and road PoEs. The following specific activities will be carried out by priority countries:

All countries will:

- ➔ Map and capacitate relevant high-risk POE with DRC with trained health workers who are safely screening incoming travellers, collecting relevant information to enable contact tracing and are providing appropriate messages on how to minimize risk of infection (eg. avoid exposure to EVD, practice good hygiene).
- ➔ Identify health promotion needs at PoE without official checking points in order to sensitize travellers of EVD risks and symptoms through the diffusion of appropriate messages on how to minimize risk of infection (avoid exposure to EVD, practice good hygiene) and where to seek medical assistance should they develop symptoms consistent with EVD.
- ➔ Establish adequate isolation capacity at the POE where suspect cases can undergo secondary screening.
- ➔ Equip POEs with alcohol based hand rub solution to promote hand hygiene

- ➔ Establish and test the roles and responsibilities of relevant sectors at POE before an incident and test them through simulation.

2.c. Rapid Response Teams (RRT)

A rapid response capability is critical to be able to act immediately once a suspected case is reported and can initiate the first investigation and control measures as the response mechanisms are activated. These functional multi-disciplinary RRTs will be ready to support case investigation, specimen collection and transport, contact tracing, social mobilization and safe and dignified burials.

All countries will:

- ➔ Establish at least one fully equipped Rapid Response Teams (RRT) trained specifically for EVD response and preposition it in the capital or in proximity to a high-risk region.
- ➔ Train RRT teams in case management, specimen collection and transport, contact tracing, decontamination, investigation, social mobilization and safe and dignified burials.
- ➔ Test RRTs through field-based simulation exercise to ensure their functionality.

In priority 1 countries, two teams will be established.

3. Laboratory diagnostic capacity

Laboratory capacity to conduct EVD testing using appropriate tools and new technologies supported by appropriate plans and procedures, and strengthening intra and inter-country safe specimen collection and transport is an essential component of a response.

All countries will:

- ➔ Strengthen national laboratory capability for EVD confirmatory testing. The facility should be equipped with trained laboratory staff, as well as with supplies to safely perform diagnostic testing. If dedicated resources for EVD testing are not available in an existing laboratory, appropriate laboratory capacities in other programmes can be leveraged.
- ➔ Establish an efficient and safe system for specimen shipment to the national reference laboratory within and outside the country including sufficient stock of consumables for specimen collection, packaging and transport.
- ➔ Establish arrangements with international reference laboratories and agreements in place for shipping and confirmatory testing.

In addition, priority 1 countries will:

- ➔ Provide training selected healthcare workers in high-risk regions on specimen collection, processing, packaging, storage, transport and manipulation as well as infection prevention and control strategies.
- ➔ Equip RRTs with RDTs in order to screen alerts and to allow early initiation of isolation and contact tracing (for test positive patients with suggestive clinical symptoms). All RDT test results (positive or negative) will be confirmed with nucleic acid amplification testing.

In addition, the laboratory capacities of two Regional Reference Laboratories for EVD and other Viral Haemorrhagic Fever (VHF) (CAR and Uganda), members of the Emerging Dangerous Pathogen Laboratory Network (EDPLN), will be strengthened, as necessary for confirmation of EVD from neighbouring countries. Furthermore, the countries will be supported to conduct confirmation of Ebola using GeneXpert.

4. Risk communication, social mobilization and community engagement

Improving the knowledge of populations by informing, influencing, and motivating individuals, institutions, and the general public about important health attitudes and EVD risk mitigation practices is key to stopping the transmission of an EVD outbreak. Proactively engaging with affected and high-risk communities to provide timely and accurate health advice to encourage positive health seeking behaviours and to address community concerns and rumours that may impact the control of the outbreak is critical.

All countries will

- ➔ Develop a national plan on risk communication, social mobilization and community engagement and mapping of key partners, stakeholders and capacities.
- ➔ Initiate public awareness activities on EVD (how it spreads, signs and symptoms, how treatment is usually arranged, what the key risk factors are, etc) to raise awareness about the disease.
- ➔ Activate risk communication, social mobilization and community engagement coordination mechanism at the national level.

In addition, priority 1 countries will:

- ➔ Train dedicated risk communication teams for high-risk regions to activate social mobilization and community engagement and to brief key groups such as community leaders, traditional leaders, traditional healers and other community groups on EVD preparedness.
- ➔ Conduct a rapid anthropological assessment on the social-cultural context of the community related to health seeking behaviour, perception of EVD and related diseases, and funeral practices.
- ➔ Initiate a public information campaign, including a hotline, for seeking information or reporting alerts.

5. Case management and infection prevention and control (IPC) capacities

Case management, Infection Prevention and Control (IPC) capabilities and safe and dignified burial procedures and protocols allow the delivery of quality care to patients, as well as a safe and culturally acceptable management of deceased patients. They contribute to preventing onwards transmission of EVD.

All countries will:

- ➔ Establish triage and isolation capacity in regional hospital(s) in high risk areas. Triage units and isolation facilities will be equipped with essential equipment and staff will be trained.
- ➔ Identify appropriate transportation capacity for suspect/confirmed cases and ensure the safety of all involved in the referral pathways

In addition, priority 1 countries will

- ➔ Establish one fully functional and 5-10 best Ebola Treatment Centre etc.
- ➔ Dedicate one ambulance with trained staff for the safe transport of suspect/confirmed cases to an identified ETC.
- ➔ Establish two trained and equipped burial teams.

6. Operation Support and logistics

Operational and programme support logistics is critical to scaling up operations rapidly and effectively. Assessing current capacities and establishing gaps in operations support and logistics is one of the priorities in preparing to respond.

All countries will:

- ➔ Develop and adopt an operation support logistics (OSL) plan with Ministry of Health, relevant partners and sectors, including points of entry.
- ➔ Maintain a sufficient stock of essential medicine and medical supplies including personal protective equipment (PPE) and body bags.

In addition, priority 1 countries will

- ➔ Maintain logistics expertise in country to provide operations support for preparedness and operational readiness.
- ➔ Establish warehouse and transportation capacities.

vi. Monitoring Evaluation and Reporting

The WHO Regional Office for Africa in collaboration with WHO HQ will oversee the project implementation, monitoring and evaluation. At the country level, national multisectoral EVD task force/committee, of which the MoH is the lead, will oversee the implementation and monitoring of the preparedness checklist with the support of WHO country office.

The EVD Preparedness Checklist and EVD Preparedness Dashboard will be utilized to assess the achievement of preparedness/readiness requirements in the 9 priority countries. WHO will regularly review progress on the implementation of the plan and impact using the EVD preparedness checklist and the monitoring framework below. A progress report will be generated and shared regularly clearly indicating the progress and level of operational readiness, the strengths, weakness, gaps and recommendations on how to address the challenges.

Monitoring framework

Table 2: EVD Preparedness checklist key performance indicators for Phase I and Phase II

| Type | Indicator | Target |
|--|--|--|
| Multisectoral Coordination | A national multisectoral coordination mechanism/taskforce | All countries within 30days |
| | A multisectoral coordination mechanism/taskforce with clear terms of reference at National and Subnational levels | Priority 1 countries in 30 days |
| | Coherent plans and procedures for coordination and incident management to include liaison between the Health EOC and National Disaster management structures | All countries within 30 days |
| | Contingency plans developed and shared with all key stakeholders | All countries within 30 days |
| Rapid Response Teams | National RRT established and trained with clear lines of responsibilities for activation and coordination | 9 RRTs trained |
| | Number of subnational levels/districts with trained RRT (only in high risk districts) | 2 Regional RRTs in priority countries 100% |
| Surveillance for early detection | Percentage of alerts verified and investigated | 100% |
| | Number of health facilities with EVD case definitions (in priority 1 countries) | In high risk areas |
| | Number of health workers trained on IDSR including EVD identification | In high risk areas |
| Laboratory diagnostic capacity | Number of trained laboratory personnel for management of sample collection and transportation | In high risk areas |
| | A national referral laboratory with capacity for analysis or specimen handling of biological samples and testing for EVD | All countries within 30days |
| | Number of countries with mechanisms in place to ship EVD samples out of the country | All countries |
| Case management including Safe, dignified burials and Infection prevention and control | Number of functional Ebola Treatment Centres identified and equipped | 1 in each priority 1 countries |
| | Number of Health facilities with identified and prepared as isolation units | All countries |
| | Number of high risk districts with list of one burial team identified and sensitized / trained and equipped | 2 in each priority country |
| | Number of regional hospitals in high-risk region with appropriate triage in place and appropriate IPC | In priority countries |
| | Number of health workers trained and practicing appropriate IPC in high risk regions | In high risk regions |

| | | |
|--|--|---|
| Point of Entry | Number of high risk ¹ PoEs with DRC having screening and referral capacity is available | In priority 1 countries |
| | Number of high risk PoEs with DRC with equipped and functioning isolation facilities | In priority 1 countries |
| | Number of high risk PoEs for which health promotion information and alcohol-based hand solution free-touch dispenser is available | In priority 1 countries |
| Risk communication, social mobilization and community engagement | Number/Percentage of high risk communities at the border with DRC are targeted for communication and community engagement activities | priority 1 countries 100% |
| | Number of countries with risk communication plan | All priority countries |
| | Establish 24/7 hotline or ensure existing emergency numbers can manage alert | All priority countries |
| Operational Support | Number of countries received logistics supplies for EVD management including PPEs | Priority 1 countries in 30 days Priority 2,3 countries |

vii. PLANNING ASSUMPTIONS for Phase I

The plan is covering resource requirements for a 3 month period

Priority 1 countries (requirements per country)

- ➔ 1x National EVD coordination mechanism
- ➔ 1x National laboratory
- ➔ 1x Ebola treatment centre
- ➔ 1x Hospital strengthened for triage/IPC
- ➔ 2x Rapid Response Teams (fully functional)
- ➔ 2x Burial teams
- ➔ High-risk points of entry airports, water and road
- ➔ 1 x Simulation exercises
- ➔ 1x Warehouse and transportation capacity

Priority 2 and 3 countries

- ➔ 1x National EVD coordination mechanism
- ➔ 1x National laboratory
- ➔ 1x Hospital strengthened for triage/IPC
- ➔ 1x Rapid Response Team (equipped and trained)
- ➔ Surveillance at points of entry (main airports in capitals only)
- ➔ 1x Simulation exercise

Other: 4x Regional reference laboratories

¹ POEs bordering the provinces in DRC where EVD cases are reported

viii. **PLANNING ASSUMPTIONS for Phase II**

- ➔ Sustaining the capacities beyond 3 months and linking to the ongoing preparedness
- ➔ Technical capacities required in RO and HQ to support countries in implementing the plan
- ➔ Coordination, reporting, monitoring and evaluation of the readiness and preparedness actions to be implemented
- ➔ Technical support to be required at RO and HQ to facilitate the implementation of priority actions in countries

ix. **BUDGET**

Estimated budget for the EVD preparedness and readiness for WHO over 9 months is USD 25,026,502. The budget has taken into account the national contingency plans for the 9 countries as well as the technical expertise and other support that will be provided by the regional and headquarters offices.

Table 3: Budget requirement for WHO Regional Strategic Plan Phase I and Phase 2

| Angola | Brundi | CAR | Congo | Rwanda | South Sudan | Tanzania | Uganda | Zambia | AFRO | Total Budget (USD) |
|-----------|-----------|---------|-----------|---------|-------------|-----------|-----------|-----------|-----------|--------------------|
| 1,315,795 | 2,040,426 | 468,796 | 2,026,978 | 646,778 | 2,542,200 | 2,398,577 | 5,943,357 | 4,764,440 | 2,879,155 | 25,026,502 |

Table 4: Budget requirement for WHO Regional Strategic Plan Phase I: Operational Readiness for 3 Months in 9 countries

| Strategy | Priority1 | Priority 2+3 | Budget (US\$) |
|---|-----------|--------------|-------------------|
| Strengthening the multisectoral coordination | 223,280 | 1,098,090 | 1,321,370 |
| Surveillance for early detection | 731,634 | 2,763,783 | 3,495,417 |
| Laboratory diagnostic capacity | 144,170 | 1,423,084 | 1,567,254 |
| Risk communication, social mobilization and community engagement | 292,335 | 1,748,225 | 2,040,560 |
| Case management and infection prevention and control capacities | 870,355 | 3,146,770 | 4,017,125 |
| Operations support and logistics | 24,000 | 1,931,958 | 1,955,958 |
| Sub Total for the 9 countries | 2,285,774 | 12,111,910 | 14,397,684 |
| WHO technical support to countries and backstopping in 9 countries | | | 1,871,699 |
| TOTAL BUDGET | | | 16,269,383 |

Table 5. Budget Summary of Phase I

| Strategy | Priority 1 | | Priority 2 | | | | | | Priority 3 | Total by strategy |
|--|------------|---------|------------|-----------|---------|-------------|-----------|-----------|------------|-------------------|
| | Congo | CAR | Angola | Brundi | Rwanda | South Sudan | Tanzania | Zambia | Uganda | |
| Coordination | 206,733 | 16,547 | 86,990 | 410,000 | 300,000 | 66,100 | 112,000 | 40,000 | 83,000 | 1,321,370 |
| Surveillance | 660,975 | 70,659 | 381,965 | 260,596 | 148,645 | 469,100 | 512,000 | 683,100 | 308,377 | 3,495,417 |
| Laboratory | 107,861 | 36,309 | 125,000 | 868,330 | 45,754 | 100,000 | 124,000 | 100,000 | 60,000 | 1,567,254 |
| Communication & social mobilization | 132,129 | 160,206 | 84,000 | 94,500 | 69,524 | 410,000 | 201,000 | 684,100 | 205,101 | 2,040,560 |
| Case management and IPC | 708,285 | 162,070 | 252,840 | 268,000 | 67,234 | 569,000 | - 337,423 | 50,240 | 2,276,879 | 4,017,125 |
| Operations support and logistics | 10,995 | 13,005 | 20,000 | 8,000 | 2,958 | 199,000 | 532,000 | 800,000 | 370,000 | 1,955,958 |
| Total by country | 1,826,978 | 458,796 | 950,795 | 1,909,426 | 634,115 | 1,813,200 | 1,143,577 | 2,357,440 | 3,303,357 | 14,397,684 |
| WHO technical support to countries and backstopping in 9 countries | | | | | | | | | | 1,871,699 |
| TOTAL (USD) | | | | | | | | | | 16,269,383 |

Table 6. Budget requirement for WHO Regional Strategic Plan Phase II: Sustaining Preparedness for 6 Months for 9 countries

| Strategy | Budget (USD) |
|--|------------------|
| Coordination | 292,663 |
| Surveillance | 1,425,000 |
| Laboratory | 305,000 |
| Communication & social mobilization | 1,240,000 |
| Case management and IPC | 3,195,000 |
| Operations support and logistics | 1,292,000 |
| Sub Total | 7,749,663 |
| WHO technical support to countries and backstopping in 9 countries | 1,007,456 |
| Total Budget | 8,757,119 |

Grand Total of the Plan: USD 25,026,502