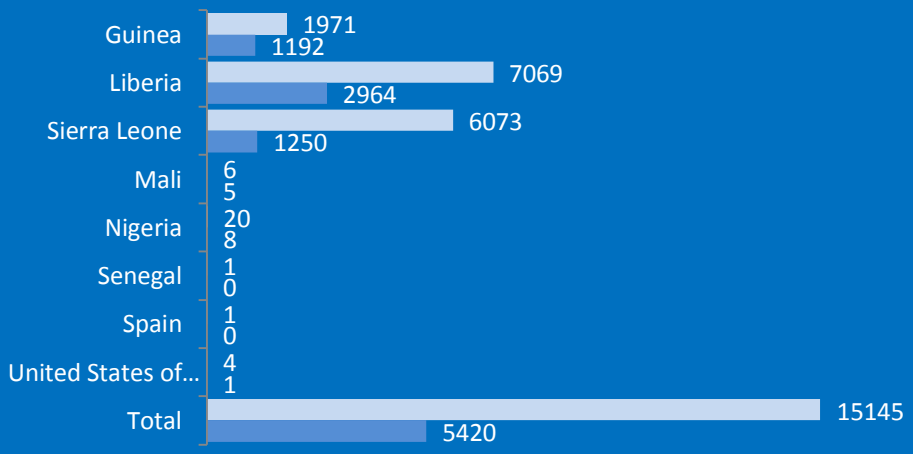
EBOLA RESPONSE ROADMAP SITUATION REPORT

19 NOVEMBER 2014

HIGHLIGHTS

- There have been 15 145 reported cases of Ebola virus disease, with 5420 reported deaths.
- Transmission is persistent in Guinea, Liberia and Sierra Leone.
- The response continues to evolve in the three most-affected countries, with increases in capacity for EVD case management and safe and dignified burials, and widespread access to laboratory services.
- A total of 6 confirmed and probable cases and 5 deaths have been reported in Mali.

CASES/ DEATHS



SUMMARY

A total of 15 145 confirmed, probable, and suspected cases of Ebola virus disease (EVD) have been reported in six affected countries (Guinea, Liberia, Mali, Sierra Leone, Spain and the United States of America) and two previously affected countries (Nigeria and Senegal) up to the end of 16 November. There have been 5420 reported deaths. Cases and deaths continue to be under-reported in this outbreak.

In the three countries with widespread and intense transmission, reported case incidence is no longer increasing nationally in Guinea and Liberia, but is still increasing in Sierra Leone. The outbreaks in Guinea and Liberia now appear to be driven by intense transmission in several key districts, whereas transmission is intense throughout the north and west of Sierra Leone. The number of new cases is highest in N'Zerekore in Guinea; Montserrado in Liberia; and in the western and northern areas of Sierra Leone, particularly the capital, Freetown, and nearby Port Loko. Lofa in Liberia, and Kenema and Kailahun in Sierra Leone have now reported no or a very low number of new cases for several weeks.

In Mali, there have been 6 reported confirmed and probable cases, and 5 deaths. The most recent cases have occurred in the Malian capital Bamako, and are not related to the country's first EVD-positive patient, who died on 24 October. All identified contacts connected with this initial case have now completed 21-day follow-up.

The response to the EVD outbreak continues to evolve in the three most affected countries. Over 1000 beds are now operational in 18 Ebola Treatment Centres. As this number increases, so does the capacity to isolate patients and prevent further transmission of the disease. The capacity to conduct burials in a safe and dignified manner of patients who have died from EVD is a crucial part of halting EVD transmission. More than 4800 safe and dignified burials have taken place since the outbreak began. Accurate, timely laboratory diagnosis of EVD cases is also an integral part of the response. Samples from all 53 EVD-affected districts of the three most-affected countries can be transported to a laboratory for testing within 24 hours of sample collection.

OUTLINE

This situation report on the Ebola Response Roadmap[1] contains a review of the epidemiological situation based on official information reported by ministries of health, and an assessment of the response measured against the core Roadmap indicators where available. Substantial efforts are ongoing to improve the availability and accuracy of information about both the epidemiological situation and the implementation of response measures.

Following the Roadmap structure, country reports fall into three categories: (1) those with widespread and intense transmission (Guinea, Liberia and Sierra Leone); (2) those with or that have had an initial case or cases, or with localized transmission (Mali, Nigeria, Senegal, Spain and the United States of America); and (3) those countries that neighbour or have strong trade ties with areas of active transmission. An overview of a separate, unrelated outbreak of EVD in the Democratic Republic of the Congo is also provided (Annex 3).

1. COUNTRIES WITH WIDESPREAD AND INTENSE TRANSMISSION

A total of 15 113 confirmed, probable, and suspected cases of EVD and 5406 deaths have been reported up to the end of 16 November 2014 by the Ministries of Health of Guinea and Sierra Leone, and 15 November by the Ministry of Health of Liberia (table 1). The data are reported through the WHO country offices.

Table 1: Confirmed, probable, and suspected cases in Guinea, Liberia, and Sierra Leone

Country	Case definition	Cumulative Cases	Cases in past 21 days	Cumulative deaths
Guinea	Confirmed	1698	308	982
	Probable	210	7	210
	Suspected	63	*	0
	Total	**1971**	**315**	**1192**
Liberia[§]	Confirmed	2643	340	‡
	Probable	1762	192	‡
	Suspected	2664	*	‡
	Total	**7069**	**532**	**2964**
Sierra Leone	Confirmed	5056	1389	1041
	Probable	79	5	174
	Suspected	938	*	35
	Total	**6073**	**1394**	**1250**
Total		**15 113**	**2241**	**5406**

*Data are based on official information reported by ministries of health, through WHO country offices. These numbers are subject to change due to ongoing reclassification, retrospective investigation and availability of laboratory results. *Not reported due to the high proportion of suspected cases that are reclassified. [‡]Data not available. [§]Data missing for 16 November.*

GUINEA

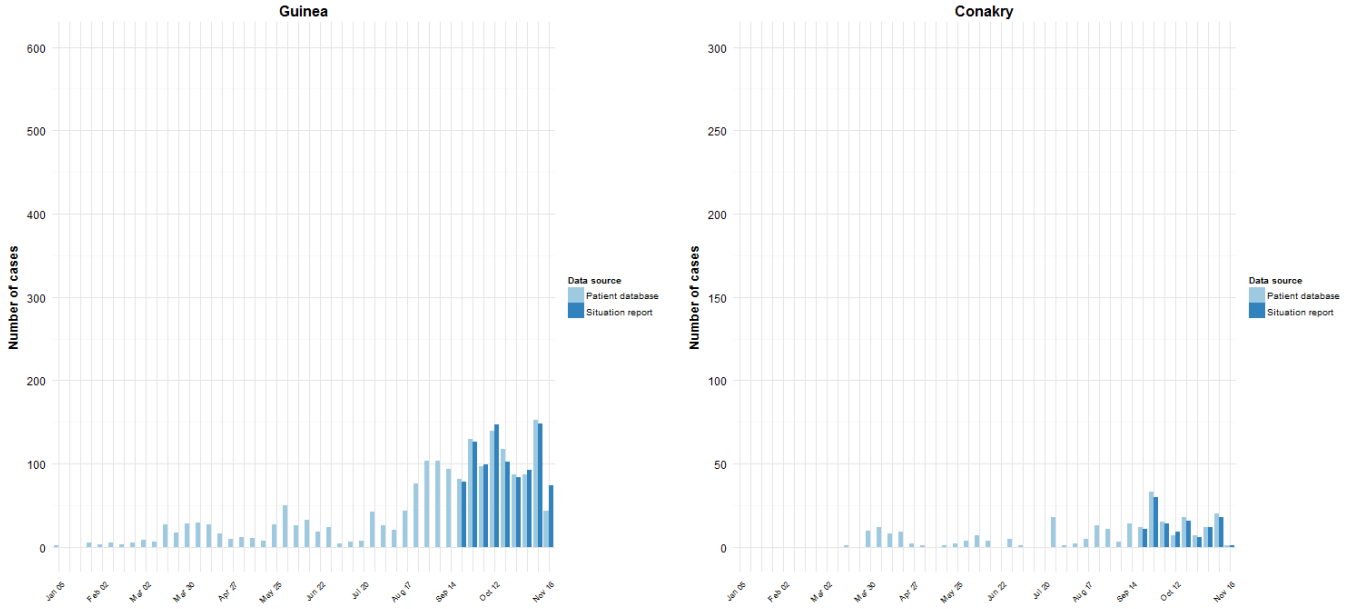
EVD transmission is persistent in Guinea, although case incidence is stable or declining in several districts. A total of 74 new confirmed and probable cases were reported nationally during the week to 16 November (figure 1). However, data are missing for one day (15 November). The vast majority of new cases were reported from the south-east of the country, near Liberia's northern border. Here, the neighbouring districts of Macenta (17 new confirmed and probable cases), N'Zerekore (21 new confirmed and probable cases), and Kerouane (12 new confirmed and probable cases) accounted for 67% of all new cases reported in the country during the past week (figure 4).

[1]For the Ebola Response Roadmap see: http://www.who.int/csr/resources/publications/ebola/response-roadmap/en/

In the west of the country, the capital, Conakry, reported a single new confirmed case in the week to 16 November (figure 1). Sustained efforts will be required to maintain this decrease. Transmission in the district of Coyah, adjacent to Conakry, is persistent, with 6 new confirmed and probable cases reported in each of the past 2 weeks. Faranah, in the centre of the country and on the border with the Sierra Leonean district of Koinadugu, reported 4 confirmed and 2 probable cases during the past week. The district of Siguiri, which borders Mali, reported 2 new confirmed cases.

Case incidence continues to decline in the outbreak's epicentre Gueckedou, which reported no new cases during the week to 16 November. Only 1 new case has been reported from Gueckedou during the past 21 days. It is unclear to what extent this reported decline may be attributable to the opening of new treatment facilities in neighbouring districts, and an associated reduction in the number of patients with EVD who seek care in Gueckedou. Of a total of 34 districts in Guinea, 10 are yet to report a case of EVD.

Figure 1: Confirmed and probable Ebola virus disease cases reported each week from Guinea and Conakry

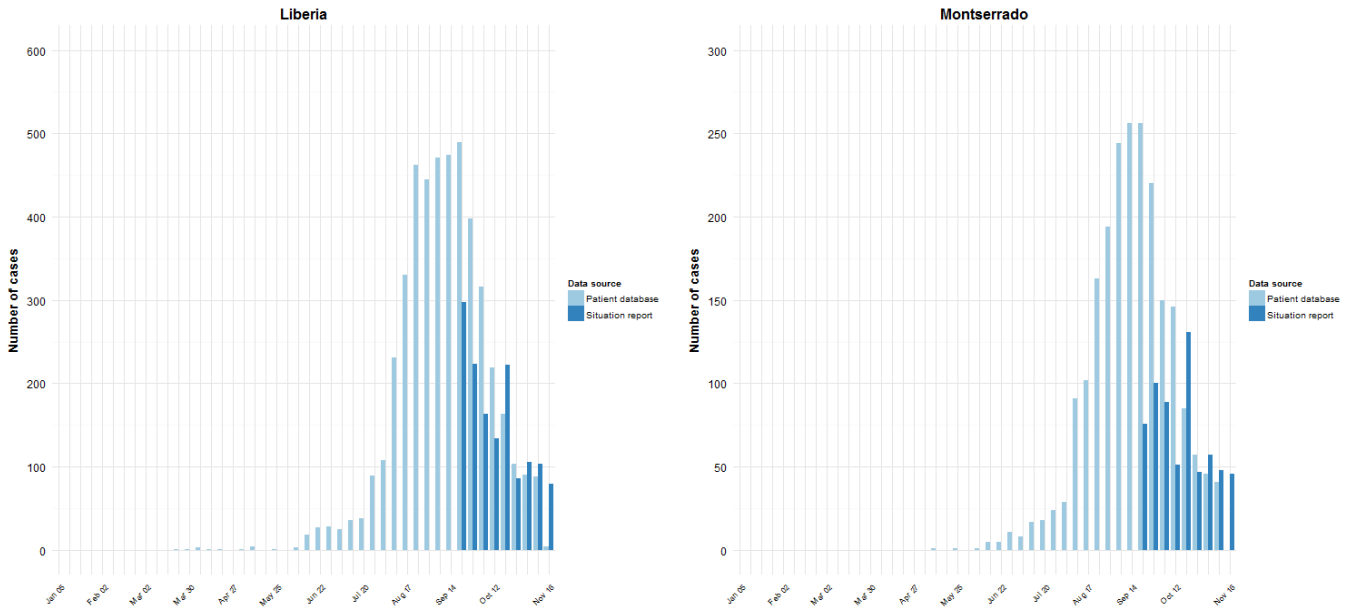


The graphs in figures 1-3 show the number of new cases reported each week in country situation reports (in dark blue; beginning from epidemiological week 38, 15-21 September) and from patient databases (light blue). The patient databases give the best representation of the history of the epidemic. However, data for the most recent weeks are sometimes less complete than in the weekly situation reports. These numbers are subject to change due to ongoing reclassification, retrospective investigation and availability of laboratory results. Data are missing from Guinea for 15 November.

LIBERIA

Case incidence appears to have stabilized over the past 4 weeks, after declining from mid-September until mid-October. A total of 80 probable cases were reported in the week to 15 November. Nationally, on average, between 10 and 20 laboratory-confirmed cases are being reported each day; the trend over time in the number of laboratory-confirmed cases reported each week has mirrored the trend shown in figure 2, with a decline followed by a levelling off in the past 4 weeks. With 46 newly reported probable cases, the Montserrado district, which includes the capital Monrovia, accounts for over half of all cases reported in Liberia during the past week. Bong (12 cases), Grand Bassa (2 cases), Grand Cape Mount (6 cases), Rivercess (13 cases) and Sinoe (1 case) are the only other districts to report a case during the past week. The district of Lofa, in the north of the country and on the border with Guinea, reported no cases for the third consecutive week.

Figure 2: Confirmed and probable* Ebola virus disease cases reported each week from Liberia and Monrovia



**Only probable cases have been reported in the country's situation reports since 26 October 2014.*

SIERRA LEONE

EVD transmission remains intense and widespread in Sierra Leone, with 533 new confirmed cases reported in the week to 16 November. Much of this was driven by intense transmission in the country's west and north. The worst affected area remains the capital, Freetown, which reported 168 new confirmed cases (figure 3). Transmission remains persistent and intense across the country with the exception of the south east, with the districts of Bo (33 cases), Bombali (52 cases), Koinadugu (25 cases), Kono (12 cases), Moyamba (10 cases), Port Loko (95 cases), Tonkolili (29 cases), and Western Rural Area (102 cases), all reporting high numbers of new cases during the past week. By contrast, several districts in the south east have reported very few new cases in recent weeks after previously reporting declines. Notably, Kenema and Kailahun reported 0 and 1 case, respectively, during the past week. Kenema has not reported a case since 1 November, and there is strong evidence that this is a result of response efforts.

Figure 3: Confirmed and probable Ebola virus disease cases reported each week from Sierra Leone and Freetown

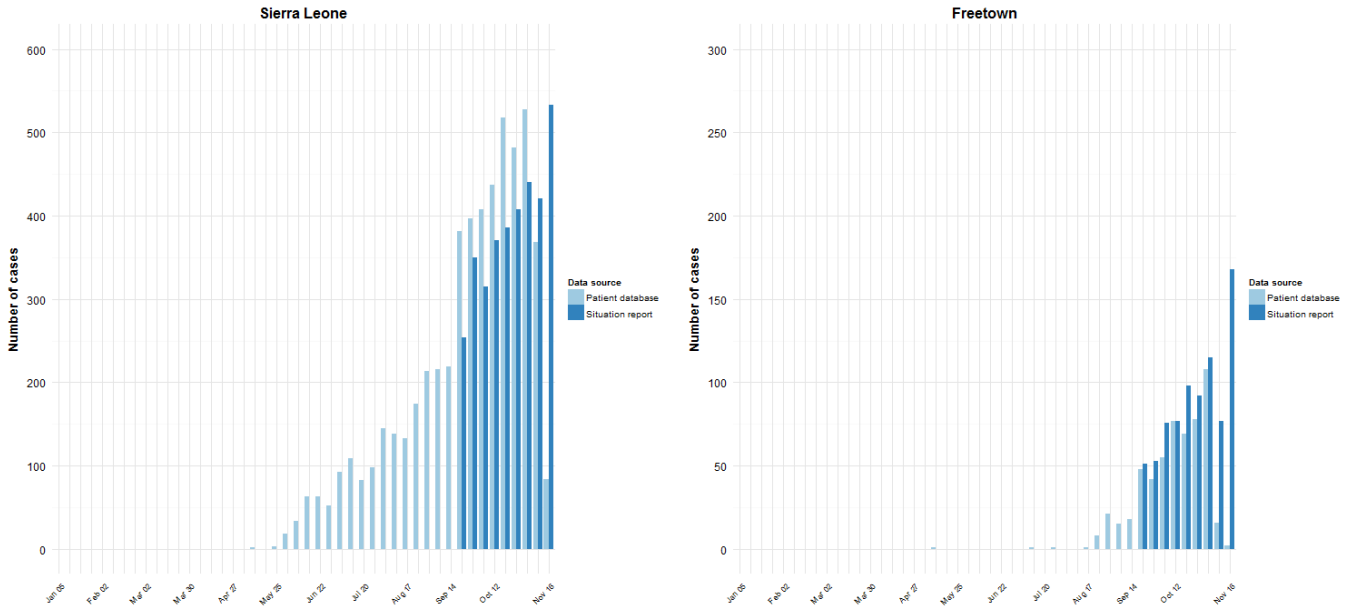
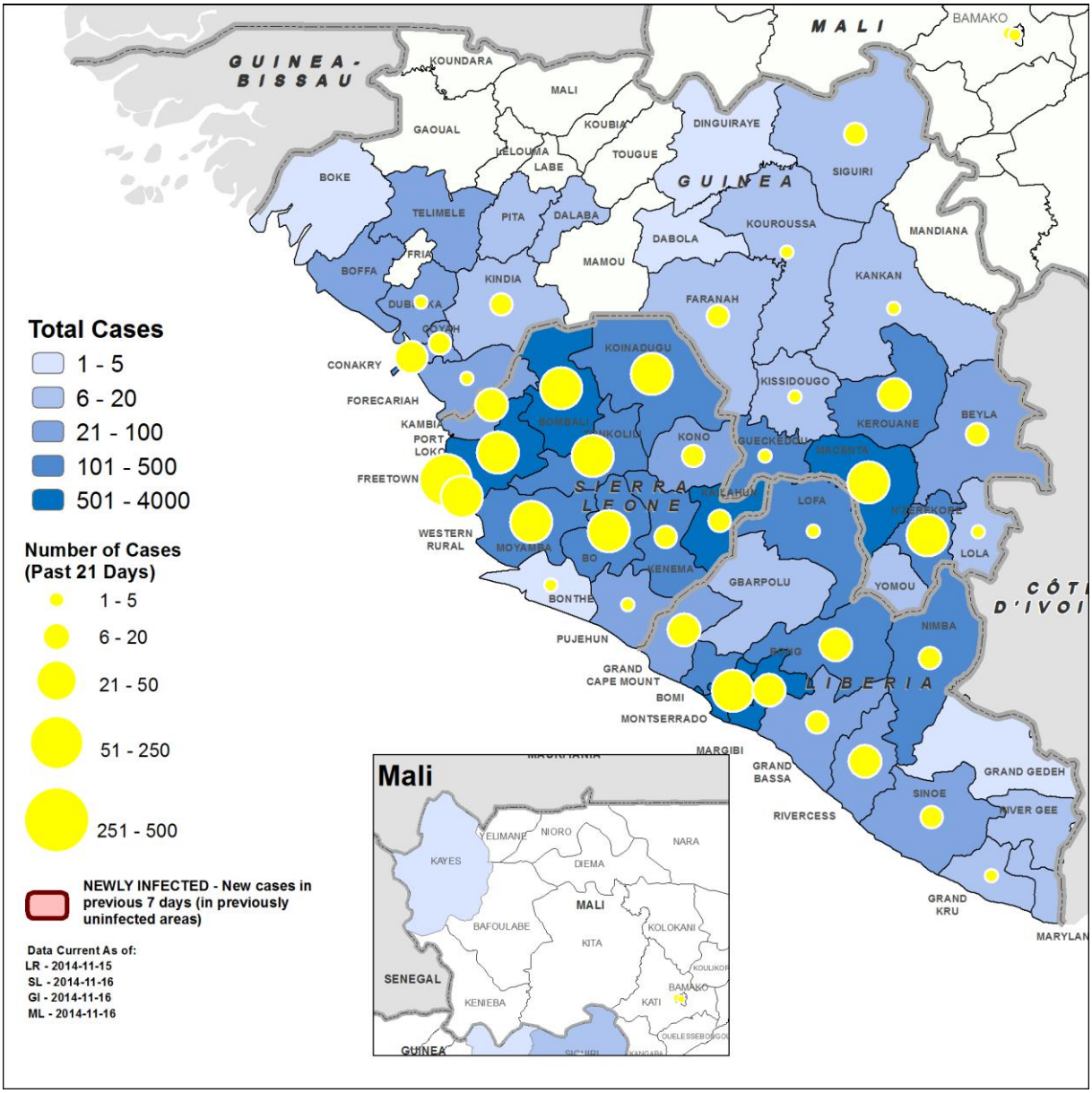


Figure 4: Geographical distribution of new and total confirmed and probable cases in Guinea, Liberia, Mali and Sierra Leone



Data are based on situation reports provided by countries. The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement. Data are missing from Guinea for 15 November.

RESPONSE IN COUNTRIES WITH WIDESPREAD AND INTENSE TRANSMISSION

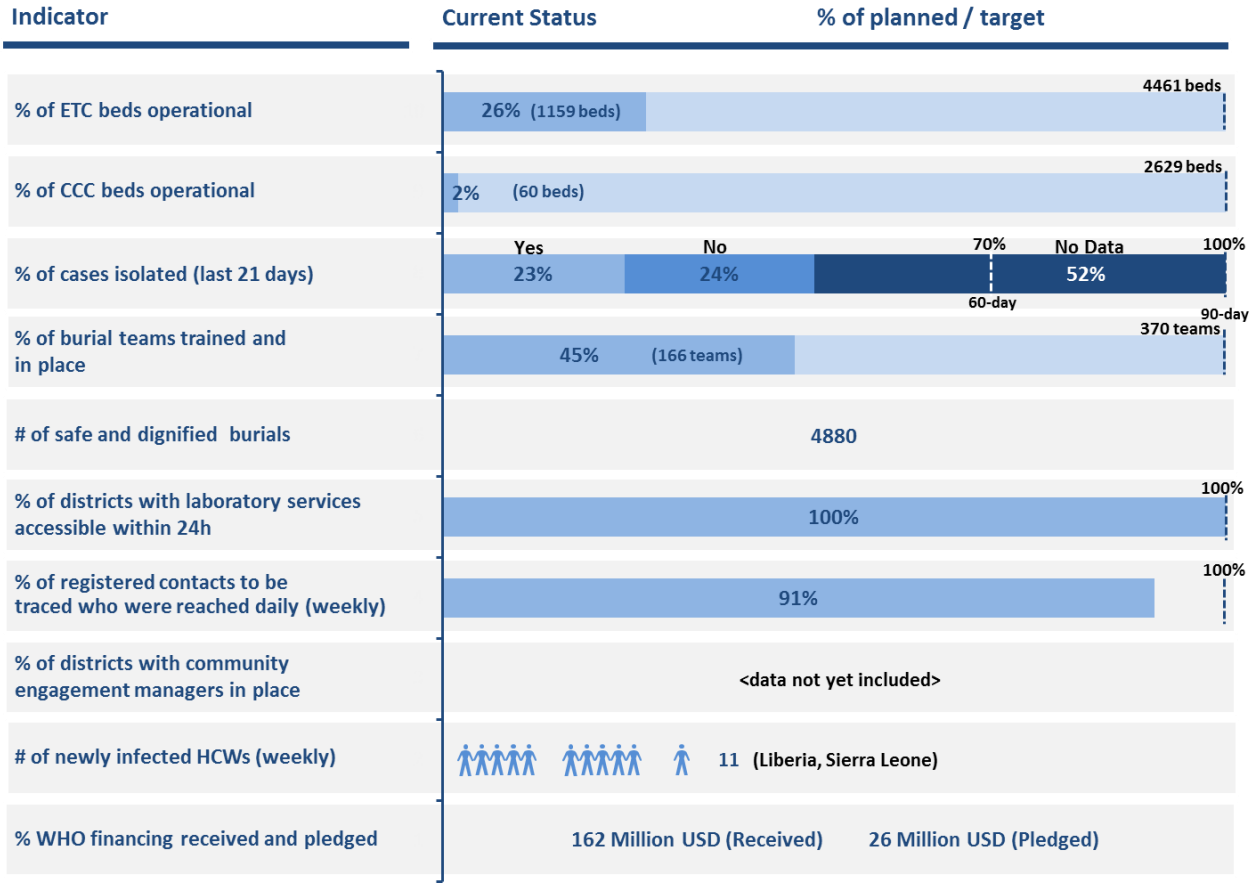
A comprehensive 90-day plan has been implemented to control and reverse the EVD outbreak in West Africa (see UN Mission for Ebola Emergency Response: Annex 2). Among the plan's key objectives is to have the capacity to isolate at least 70% of EVD cases and bury at least 70% of patients who die from EVD in a safe and dignified manner by 1 December 2014 (the 60-day target). The ultimate goal is to have capacity to isolate 100% of EVD cases and safely bury 100% of patients who die from EVD by 1 January 2015 (the 90-day target).

Table 2 provides preliminary data on the response thus far. Tables 3 to 5 provide this information for each of the three countries with widespread and intense transmission.

Case management

Isolation of patients with EVD in Ebola Treatment Centres (ETCs) and Community Care Centres (CCCs) is necessary to prevent further transmission of the disease. CCCs provide an alternative to care in ETCs in areas where there is insufficient capacity in ETCs, and remote areas that are not yet served by an ETC. Compared with ETCs, CCCs are smaller, with 8 to 15 beds per facility. This means they are easier to set up, which enables response coordinators to provide more rapid, flexible coverage dispersed over a wider geographical area.

Table 2. Key performance indicators for the Ebola response in the three most affected countries



The information in tables 2 to 5 represents preliminary data from different time periods, which are specified in the text. Definitions for these indicators are found in Annex 2.

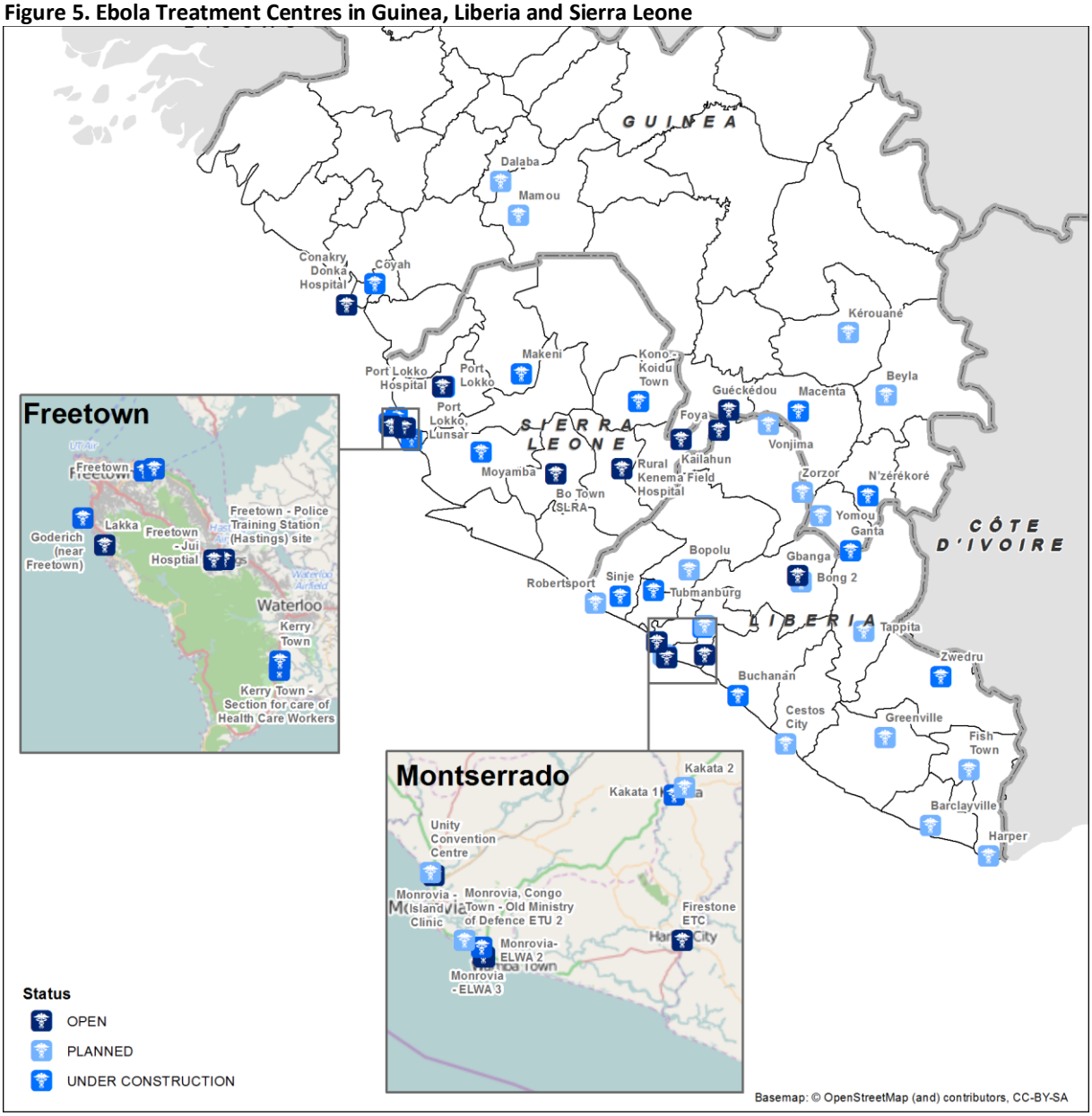
In Guinea 72% of all reported patients with EVD were isolated between 20 October and 9 November. The figure is 20% in Liberia and 13% in Sierra Leone during the same period. The high proportion of cases from Sierra Leone without hospitalisation or isolation data reported during the week to 9 November partially explains the low proportion of cases reported as isolated. Patients isolated at home are not included.

The proportion of EVD cases isolated in each country is defined as those cases that were hospitalized and isolated between 20 October and 9 November. The proportion of EVD cases defined as not isolated encompasses all patients who were reported hospitalized but not isolated, and also any patients who are reported not hospitalized. All other probable and confirmed cases are defined as “no data”. Patients for whom data is missing may in fact have been hospitalized, but their hospitalization was not recorded.

As of 18 November, 18 of 56 planned ETCs were open and operational in the three intense-transmission countries. 1159 ETC beds are operational (in a fully staffed facility and ready to receive patients; figure 5). The most recent figures show that there are fewer than 1000 total new reported cases of EVD every week across the three countries with widespread and intense transmission. In Guinea, 160 beds are operational in 2 ETCs; an additional 7 ETCs are either waiting for a partner to be identified to operate them, or are under construction. In Liberia, 643

ETC beds are operational in 7 ETCs. Sufficient additional foreign medical team (FMT) support has been identified to staff an additional 18 ETCs, comprising 1649 additional ETC beds. In Sierra Leone, 356 ETC beds are operational in 9 ETCs. FMT support has been identified to staff an additional 9 ETCs, comprising 853 additional ETC beds. These facilities are currently under construction, and will be ready to admit patients in the coming weeks.

Figure 5. Ebola Treatment Centres in Guinea, Liberia and Sierra Leone



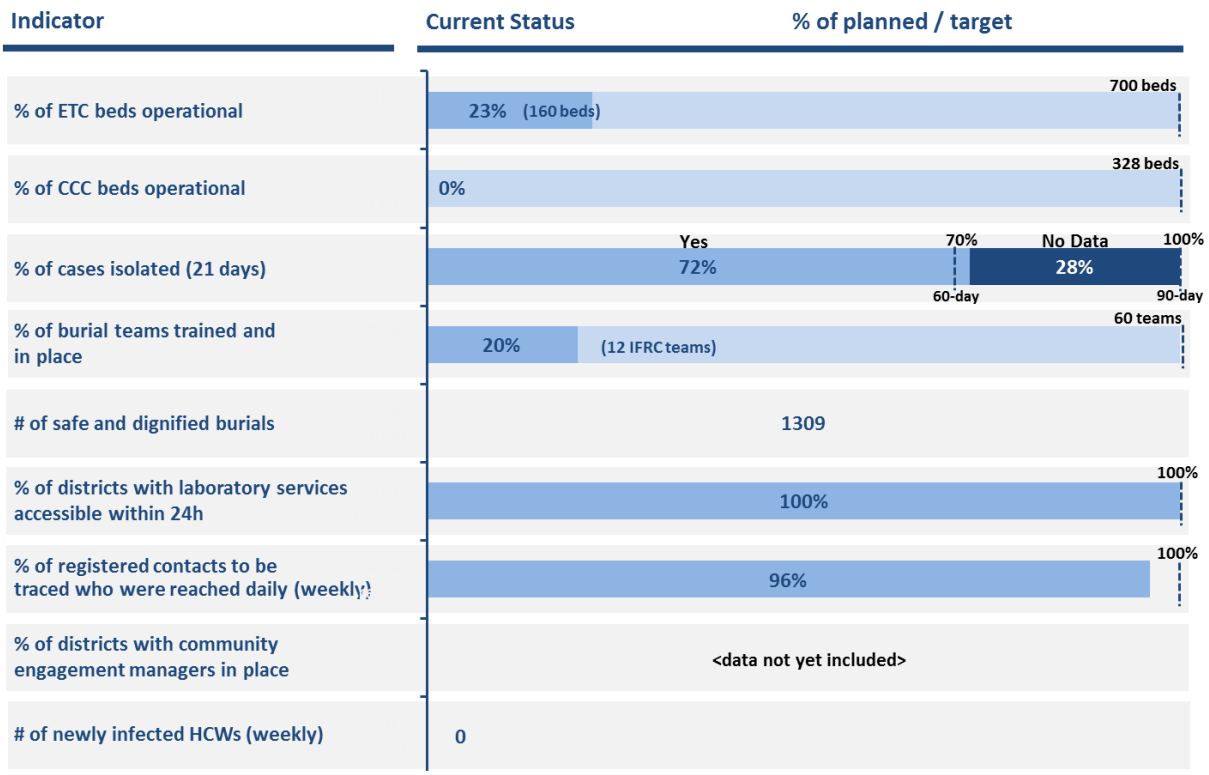
Of the 2629 CCC beds that are planned across the three intense-transmission countries, 60 beds (2%) are operational. There are 4 operational CCCs in Sierra Leone and 1 in Liberia. WHO is working with key partners, including the US Centers for Disease Control and Prevention, UNICEF, Médecins Sans Frontières, and others, to establish additional CCCs. Guidelines on the implementation of CCCs are being finalized.

Safe and dignified burials

The bodies of patients who have died from EVD are extremely infectious. Therefore, conducting burials in a safe and dignified manner is a crucial component of efforts to halt the transmission of the disease. Efforts are being made to ensure that burials are conducted safely and in a dignified manner in accordance with the religious beliefs of families. This includes the training of burial teams in safe practices. It is also important to engage with families and the wider to community to ensure that EVD deaths do not go unreported.

An estimated 370 trained burial teams are needed to provide adequate coverage across the three countries with widespread and intense transmission. As of 18 November, 166 trained teams were operational, including: 12 teams in Guinea, 57 teams in Liberia, and 97 teams in Sierra Leone. All reported burial teams in Guinea are organized by the International Federation of Red Cross and Red Crescent Societies (IFRC). The 97 active burial teams in Sierra exceed the 90 planned teams. The burial teams in Sierra Leone and Liberia are coordinated by multiple organizations, including the IFRC, the ministries of health and international non-governmental organizations.

Table 3. Key performance indicators for the Ebola response in Guinea



As of 12 November, there have been 4880 safe and dignified burials across the three intense-transmission countries: 1309 in Guinea, 2373 in Liberia, and 1198 in Sierra Leone reported by IFRC. However, many of these burials may have been patients who did not die from EVD. These have all been managed by IFRC, the lead agency managing burials and cremations. The number of burials managed by the IFRC may include EVD-suspected deaths that were later laboratory-confirmed as negative for the disease. However, the figures exclude burials carried out by military teams. Efforts are continuing to capture information on burials managed by other organizations.

Case confirmation and surveillance

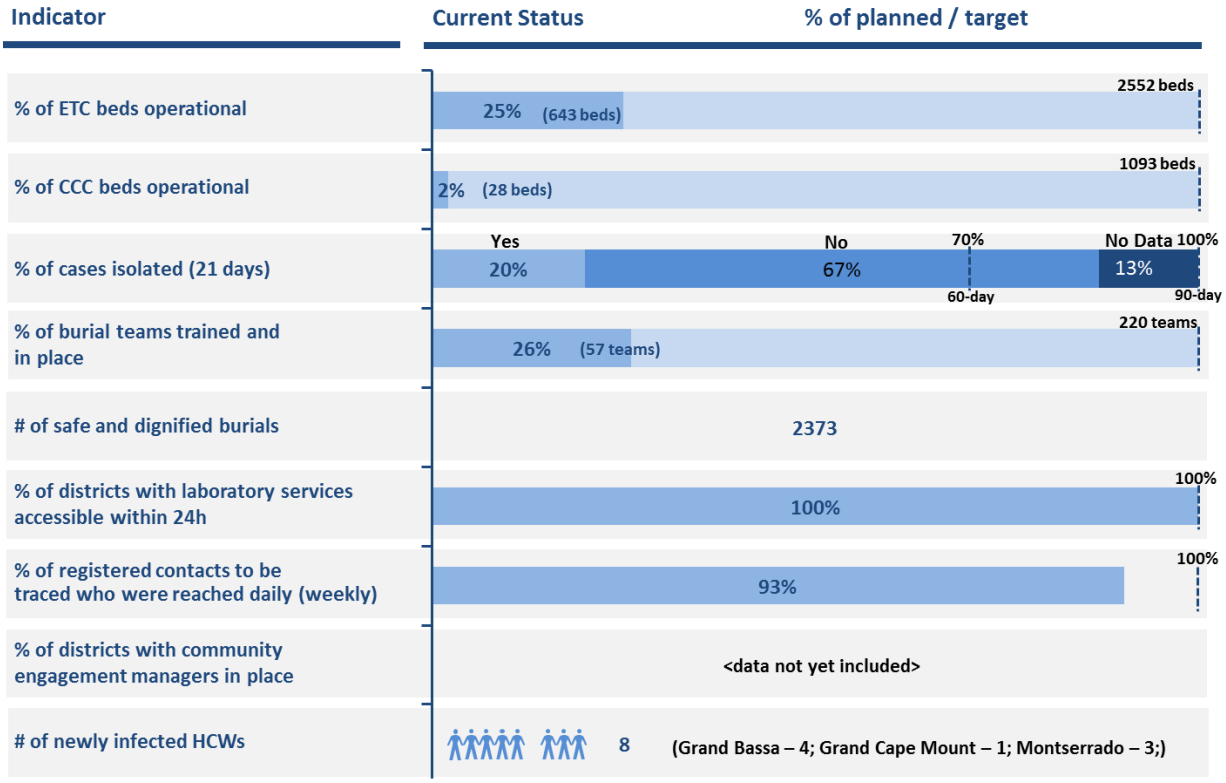
Providing capacity for prompt and accurate diagnosis of cases of EVD is an integral part of the response to the EVD outbreak. All 53 EVD-affected districts (those that have ever reported a probable or confirmed case) have access to laboratory support (figure 6). Access is defined as having the logistical capacity to transport a sample to a laboratory by road within 24 hours of sample collection.

Thirteen laboratories have the capacity to confirm EVD cases – 5 in each of Liberia and Sierra Leone, and 3 in Guinea. These laboratories serve 24 affected districts in Guinea, 15 in Liberia and 14 in Sierra Leone.

Between 1150 and 1170 samples are tested daily in laboratories in the three countries. The maximum testing capacity for each laboratory ranges from 50 to 100 samples per day.

Effective contact tracing ensures that the reported and registered contacts of confirmed EVD cases are visited daily to monitor the onset of symptoms during the 21-day incubation period of the Ebola virus. Contacts presenting symptoms should be promptly isolated to prevent further disease transmission.

Table 4. Key performance indicators for the Ebola response in Liberia



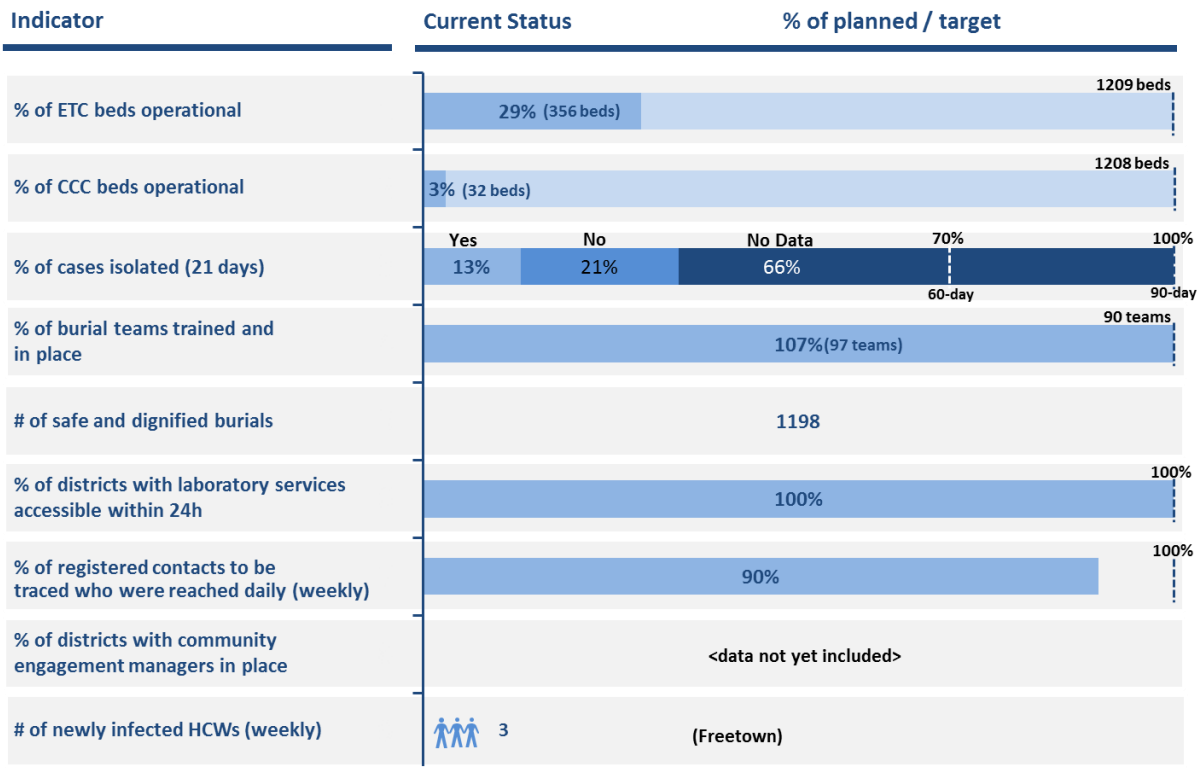
During the week to 16 November, 5301 new contacts were identified and traced in Guinea, Liberia and Sierra Leone, compared with 4067 new contacts in the previous week. Overall, 92% of all registered contacts were visited on a daily basis between 10 and 16 November. In Guinea, 96% (19 305 of 20 092) of registered contacts were reached on a daily basis. Similarly in Liberia, 96% (32 405 of 34 945) of registered contacts were reached on a daily basis. 90% of contacts (105 880 of 118 249) were reached daily in Sierra Leone. However, the proportion of contacts reached was lower in many districts. Each district is reported to have at least one contact-tracing team in place. On average, 5 contacts were listed per new case in the three countries during the past week. This relatively low number suggests that fewer contacts are currently registered in connection with each new case than are likely to have come into contact with each case in reality. Active case finding teams are being mobilized as a complementary case-detection strategy.

Health-care workers

A total of 584 health-care workers (HCWs) are known to have been infected with EVD up to the end of 16 November, 329 of whom have died (table 6). This includes 2 HCWs in Mali (1 of whom died), 11 HCWs infected in Nigeria, 1 HCW infected in Spain while treating an EVD-positive patient, and 3 HCWs in the US (including a HCW infected in Guinea, and 2 HCWs infected during the care of a patient in Texas). In the week to 16 November, 8 HCWs were reported infected in Liberia, and 3 in Sierra Leone. However, the cases in Liberia are unlikely to have occurred during the past week, and are instead likely to represent cases whose onset went unreported over the course of previous weeks.

Extensive investigations to determine the source of exposure in each case are being undertaken. Early indications are that a substantial proportion of infections occurred outside the context of Ebola treatment and care centres. This reinforces the need to adhere to infection prevention and control measures at all health-care facilities, not just EVD-related facilities. WHO has conducted a review of personal protective equipment (PPE) guidelines for HCWs who provide direct care to patients, and has updated its guidelines in the context of the current EVD outbreak. Comprehensive mandatory training in the use of PPE, and mentoring for all users before engaging in clinical care, is considered fundamental for the protection of HCWs and patients.

Table 5. Key performance indicators for the Ebola response in Sierra Leone



Social mobilization and community engagement

UNICEF is the lead agency in social mobilization during this outbreak. A joint WHO-UNICEF team has visited the three intense-transmission countries to review and assist them with their social mobilization plans. Data are not yet available on community engagement indicators.

Budget

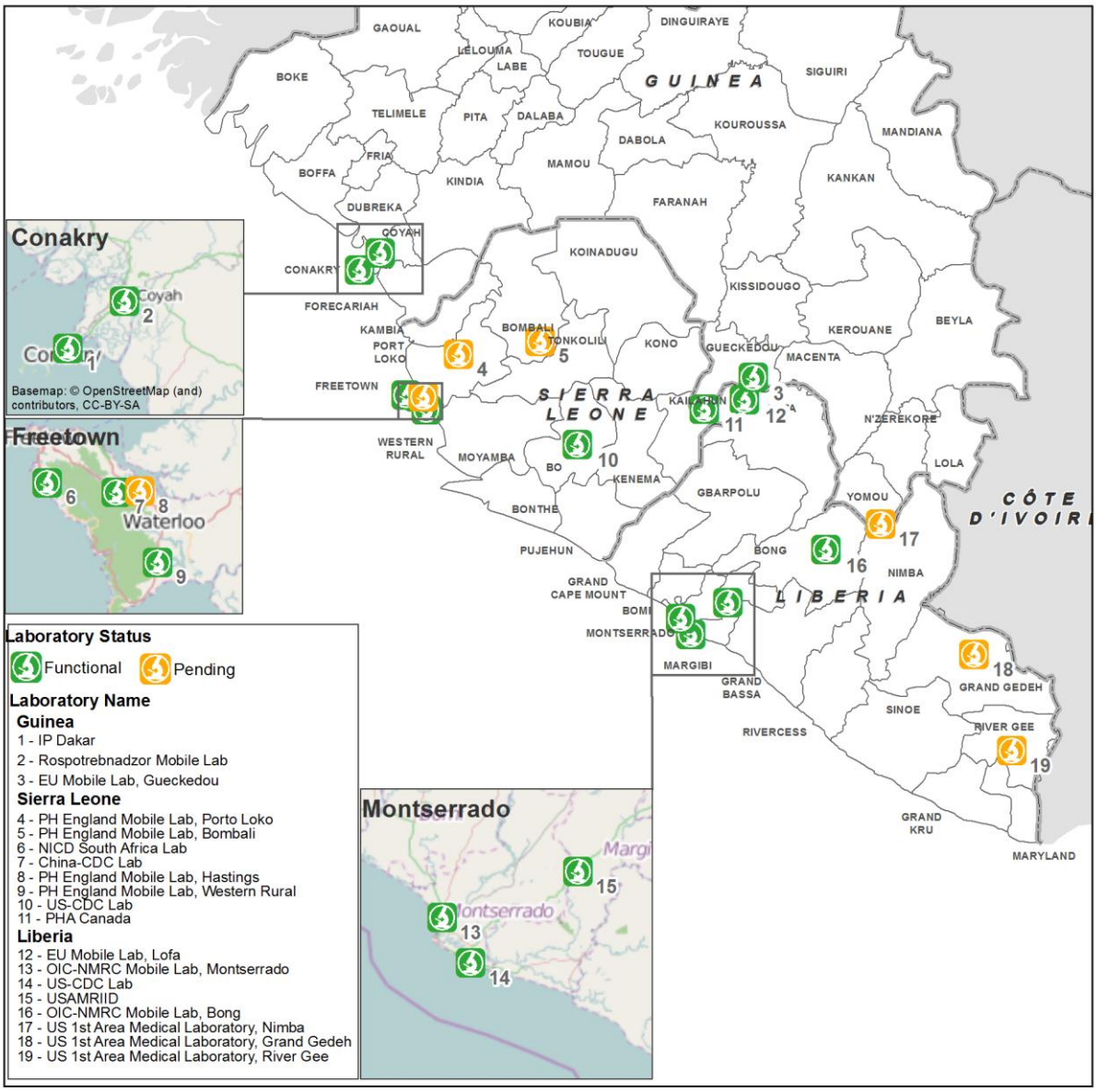
As of 17 November, WHO had received US$162 million, with a further $26 million pledged.

Table 6: Ebola virus disease infections in health-care workers in the three countries with intense transmission

Country	Cases	Deaths
Guinea	95	55
Liberia	341	170
Sierra Leone	132	104
Total	568	329

Data are based on official information reported by ministries of health. These numbers are subject to change due to ongoing reclassification, retrospective investigation and availability of laboratory results.

Figure 6. Status of laboratories deployed in the affected countries to support the Ebola outbreak response



2. COUNTRIES WITH AN INITIAL CASE OR CASES, OR WITH LOCALIZED TRANSMISSION

Five countries (Mali, Nigeria, Senegal, Spain and the United States of America) have reported a case or cases imported from a country with widespread and intense transmission (table 7).

A total of 6 cases (5 confirmed and 1 probable), including 5 deaths (4 confirmed, 1 probable), have now been reported in Mali (figure 1). The most recent cases are in the Malian capital Bamako, and are not related to the country's first EVD case, who died in Kayes on 24 October. All identified contacts connected with the initial case have all now completed 21 day follow-up. As of 16 November 2014, a total of 384 contacts have been identified and are under follow-up; 96 of the 384 contacts are HCWs.

In Spain, 28 days have passed since the HCW infected while caring for a patient with EVD in Madrid tested negative twice and was discharged from hospital. Spain will therefore be declared free of EVD 42 days after the

date of the second negative test if no new cases are reported. All 83 contacts of the HCW have completed 21-day follow-up.

In the United States of America, there have been 4 cases of EVD and 1 death. One HCW in New York and 2 HCWs in Texas have tested negative for EVD twice and have been released from hospital. All contacts in the country have completed the 21-day follow-up period.

Table 7: Ebola virus disease cases and deaths in Mali, Spain and the United States of America

Country	Cumulative cases					Contact tracing			
	Confirmed	Probable	Suspect	Deaths	Health-care workers	Listed contacts to be followed	Contacts completing 21 days of follow up	Date of the second negative test or death	Number of days since second negative test/discharge
Mali	5	1	0	5	33%	384 (96 are HCWs)	118	N/A	N/A
Spain	1	0	0	0	100%	0	83	21/10/2014	36
United States of America	4	0	0	1	75%	0	177	11/11/2014*	8

**Includes two HCWs infected in the USA while treating a patient with EVD from Liberia, and a HCW infected in Guinea. Data are based on official information reported by ministries of health. These numbers are subject to change due to ongoing reclassification, retrospective investigation and availability of laboratory results.*

In Nigeria, there were 20 cases and 8 deaths. In Senegal, there was 1 case and no deaths. However, following a successful response in both countries, the outbreaks of EVD in Senegal and Nigeria were declared over on 17 October and 19 October 2014, respectively. A national EVD outbreak is considered to be over when 42 days (double the 21-day incubation period of the Ebola virus) has elapsed since the last patient in isolation became laboratory negative for EVD.

3. PREPAREDNESS OF COUNTRIES TO RAPIDLY DETECT AND RESPOND TO AN EBOLA EXPOSURE

The evolving EVD outbreak highlights the considerable risk of cases being imported into unaffected countries. With adequate levels of preparation, however, such introductions of the disease can be contained before they develop into large outbreaks.

The success of Nigeria and Senegal in halting the transmission of EVD highlights the critical importance of preparedness. Key factors in preventing the spread of EVD in both countries included strong political leadership, early detection and response, public awareness campaigns, and strong support from partner organizations.

Fifteen countries that neighbour countries with widespread and intense transmission, or that otherwise have strong trade and travel ties with countries with widespread and intense transmission, have been prioritized for technical assistance on preparedness from specialist WHO teams and partners. These countries are: Benin, Burkina Faso, Cameroon, Central African Republic, Cote D'Ivoire, Democratic Republic of Congo, Gambia, Ghana, Guinea Bissau, Mali, Mauritania, Nigeria, Senegal, South Sudan, and Togo.

WHO and partners are supporting these countries to help increase their level of preparedness. A team was deployed to Mali and Cote d'Ivoire in October. This week, teams have been deployed to Benin, Burkina Faso, Gambia and Senegal.

WHO has developed the *Consolidated Ebola Virus Disease Preparedness Checklist* to help countries ensure they are ready to respond, should there be a case or cases of EVD. The checklist, along with other tools such as

simulation exercises, help countries to assess and test their level of readiness. They can be used as the basis to identify action to be taken by countries and the international community to close potential gaps. The consolidated checklist identifies 10 key components and tasks for countries and the international community that should be completed within 30, 60 and 90 days from the date of issuing the list. Components include overall coordination, rapid response, public awareness and community engagement, infection prevention and control, case management of ETCs, safe burials, epidemiological surveillance, contact tracing, laboratory capacity, and capacity building for points of entry.

WHO, the UN and other partners are accelerating the deployment of international preparedness strengthening teams to help countries build upon their existing work and planning. At the end of each mission, technical experts remain in country to support and maximize capacity-building efforts to prepare for public health emergencies, including EVD.

ANNEX 1: CATEGORIES USED TO CLASSIFY EBOLA CASES

EVD cases are classified as suspected, probable, or confirmed depending on whether they meet certain criteria (table 8).

Table 8: Ebola virus disease case-classification criteria

Classification	Criteria
Suspected	Any person, alive or dead, who has (or had) sudden onset of high fever and had contact with a suspected, probable or confirmed Ebola virus disease (EVD) case, or a dead or sick animal OR any person with sudden onset of high fever and at least three of the following symptoms: headache, vomiting, anorexia/ loss of appetite, diarrhoea, lethargy, stomach pain, aching muscles or joints, difficulty swallowing, breathing difficulties, or hiccup; or any person with unexplained bleeding OR any sudden, unexplained death.
Probable	Any suspected case evaluated by a clinician OR any person who died from 'suspected' EVD and had an epidemiological link to a confirmed case but was not tested and did not have laboratory confirmation of the disease.
Confirmed	A probable or suspected case is classified as confirmed when a sample from that person tests positive for EVD in the laboratory.

ANNEX 2: UN MISSION FOR EBOLA EMERGENCY RESPONSE: DEFINITIONS OF KEY PERFORMANCE INDICATORS

The first-ever UN mission for a public health emergency, the UN Mission for Ebola Emergency Response (UNMEER), has been established to address the unprecedented EVD outbreak. WHO is a partner in the mission. Its strategic priorities are to stop the spread of the disease, treat infected patients, ensure essential services, preserve stability, and prevent the spread of EVD to unaffected countries.

Response monitoring indicators are calculated using the following numerators and denominators:

Indicator	Numerator	Denominator
% of ETC beds operational	# of ETC beds operational	# of ETC beds planned (UNMEER)
% of CCC beds operational	# of CCC beds operational	# of ETC beds planned (UNMEER)
% of cases isolated (21 days)	# of cases isolated	# probable and confirmed EVD cases
% of burial teams trained and in place	# of burial teams trained and in place	# of burial teams planned (UNMEER)
# of safe and dignified burials	# of safe and dignified burials (IFRC)	
% of districts with laboratory services accessible within 24h	# of EVD-affected districts able to send samples to a laboratory within 24h	# of EVD-affected districts: reported a probable or confirmed EVD case
% of registered contacts to be traced who were reached daily (weekly)	# of registered contacts to be traced who were reached daily (weekly)	# of contacts currently registered
% of districts with community engagement managers in place	# of districts with community engagement managers in place	# of EVD- affected districts: reported a probable or confirmed EVD case
# of newly infected HCWs (weekly)	# of newly infected HCWs (weekly)	

ANNEX 3: EBOLA OUTBREAK IN DEMOCRATIC REPUBLIC OF THE CONGO

As at 11 November there have been 66 cases (38 confirmed, 28 probable) of EVD reported in the Democratic Republic of the Congo, including 8 among HCWs. In total, 49 deaths have been reported, including 8 among HCWs. No new reported contacts are being followed.

Forty-one days have passed since the last case tested negative twice and was discharged from hospital. Once 42 days have passed, the country can be declared free of EVD. This outbreak is unrelated to that affecting Guinea, Liberia, Mali, Sierra Leone, Spain, and the United States of America.