USEFUL TIPS FOR JOURNALISTS REPORTING EBOLA

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BASIC PRECAUTIONS TO TAKE

Reporting epidemics can be a dangerous task for journalists. Ebola is not different. It makes sense to take some basic precautions before going on the field. So, find below some tips about what to do even before you set out.

• Ensure that you are in robust health and that you do not have a condition that predisposed you to falling sick suddenly

• Do your research well. Learn as much as you can about the Ebola virus that would keep you safe – mode of transmission, symptoms etc. First person to protect is you.

• If you are reporting on the field - hospitals, isolation wards, airports etc, - get proper clothing, including the right accessories. Wear gloves and ensure your body is all covered up.

• Understand that it might be too dangerous to report Ebola outbreaks. If you must report from the field, do so from a safe distance. Never touch a patient or anything he/she has come in contact with. You do not need to touch one to write your story.

WHAT IS EBOLA VIRUS DISEASE
Ebola is one of the most virulent viral diseases known to man. Commonly known as Ebola viral disease, EVD, it is transmitted from an infected animal to man or from man to man. It is currently re-emerging after containment in November 2012 in Uganda, East Africa, and has ravaged countries in West Africa since March 2014. It has killed 1,145 persons with 2,127 confirmed or suspected infected people. It started in Guinea and has spread to Liberia, Sierra Leone and Nigeria. It was imported to Nigeria, Africa’s most populous nation, in July after 40-year old Liberian-born American, Patrick Sawyerr, who had the Ebola virus travelled to Lagos where he died. Nigeria currently has 10 confirmed cases of the disease with four deaths so far recorded as at August 15, 2014.

NUMBER OF CASES (AS OF AUGUST 14)

The confirmed or suspected number of those infected is 1,127 with 1,145 recorded deaths.

• Guinea, 519 cases, including 380 deaths;
• Liberia, 786 cases including 413 deaths;
• Nigeria, 12 cases, including 4 deaths; and
• Sierra Leone, 810 cases, including 348 deaths.

CURRENT OUTBREAK

MARCH, 2014

The current outbreak of Ebola virus disease was first reported in March in Gueckedou, a town in southern Guinea which shares borders with Sierra Leone and Liberia. Guinea’s Ministry of Health first reported a total of 49 cases including 29 deaths on March 22.
Gueckedou is known for its large weekly market, which attracts traders from neighbouring towns and across the border, thus, by March 29, the disease had spread to Liberia due to the geographical proximity, which leads to cross border movements.

As a result, by March 29, seven people were reported to be infected in Foya District in Lofa County, northern Liberia. WHO reported that out of these seven, two were confirmed to be Ebola and the two later died.

Going by the WHO daily Ebola Alert Update, in the month of March, Ebola claimed the lives of a total of 82 persons (80 in Guinea and 2 in Liberia), while a total of 129 people were reported in the two countries to be either already confirmed or suspected to be infected with the virus.

APRIL

In April, disease which started from Guekedou in March had spread to other locations in Guinea namely, Macenta, Kissidougou, and Dabola and Djingaraye. Sadly, in April, Sierra Leone also announced its first cases of Ebola infection. By 15th of April, the Sierra Leonean Ministry of Health and Sanitation, MOHS, had reported a total of 12 suspected cases.

However, going by the WHO estimates, in April, total number of both suspected and confirmed cases is 271. The breakdown is as follows;

- Guinea, 224 cases,
- Liberia, 35 cases.
- Sierra Leone, 12 cases.

The total number of deaths from both confirmed and suspected Ebola cases in the
three countries in April was 156. (143 in Guinea and 13 in Liberia)

MAY
In May, there were a cumulative of 304 cases of infection and 204 deaths attributable to Ebola.
Here is the breakdown:
- Guinea 291 cases and 193 deaths.
- Liberia 13 cases 11 deaths

JUNE
As of 30 June 2014, the cumulative number of cases attributed to EVD in the three countries stood at 759, including 467 deaths. The distribution of the cases are as follows:
- Guinea, 413 cases and 303 deaths
- Liberia, 107 cases and 65 deaths
- Sierra Leone, 239 cases and 99 deaths

JULY
The cumulative number of cases attributed to EVD in the four countries stands at 1,603 including 887 deaths. The distribution is as follows:
- Guinea, 485 cases including 358 deaths.
- Liberia, 468 cases, including 255 deaths.
- Nigeria, 4 cases (0 confirmed, 3 probable, 1 suspected) including 1 death (of Patrick Sawyerr, who imported it from Liberia).
- Sierra Leone, 646 cases (540 confirmed, 46 probable, and 60 suspected)
including 273 deaths.

AUGUST SO FAR

Journalists must be careful about quoting infection and casualty figures regarding the current outbreak because they keep shifting. Be specific about the date of the figures you quote.

As August 14, 2014 the cumulative number of cases attributed to EVD in four countries stands at 2,127 including 1,145 deaths. The distribution of the cases are as follows:

• Guinea, 519 cases, including 380 deaths;
• Liberia, 786 cases including 413 deaths;
• Nigeria, 12 cases, including 4 deaths; and
• Sierra Leone, 786 cases, including 413 deaths.

EBOLA IN NIGERIA

As of August 14, Nigeria had recorded a total of 10 confirmed cases of Ebola infection and 3 deaths. The WHO figures are different. The world body said that Nigeria had 13 cases of infection and 3 deaths as at this date. But Nigerian health minister, Onyebuchi Chukwu, had said a day earlier that there were only 10 confirmed cases and 3 deaths. He did not talk about suspected cases although he said over 100 persons were under watch.

July 20

This day, Patrick Sawyer, a Liberian/American health worker from Liberia flew into Lagos enroute to Calabar, Cross River State for a medical conference but fell sick and started manifesting symptoms of Ebola disease at
July 24
Patrick Sawyerr died in a Lagos hospital, few days after taking ill upon arrival in Nigeria. He becomes the first recorded fatality from Ebola on Nigerian soil.

July 28
Nigerian health officials announce that 59 persons who had contact with Sawyerr were being tracked to determine their status. 20 had been tested, all coming out clean.

July 28
Nigeria shuts its border with Liberia

July 29
Aviation authorities in Nigeria suspend the operations of Asky Airlines, which brought Patrick Sawyerr into the country.

August 2
Ban on Asky Airline lifted

August 3
The National Centre for Disease Control declared Nigeria free from Ebola, saying that none of the 70 persons who had contact with Patrick Sawyer, who had been tracked and tested, had tested positive to Ebola.
August 4
Nigerian health minister, Onyebuchi Chukwu, confirms the country’s second case of Ebola infection, the victim being a nurse who helped take care of Sawyer when he fell sick.

August 5
Nigeria records first case of death of a citizen from Ebola. One of the nurses who treated the late Liberian, Sawyerr, died from Ebola disease in Lagos.

August 5
Nigeria also confirmed seven new cases of Ebola infection among health workers who had contact with Sawyerr

August 8
The World Health Organisation declares the outbreak of Ebola in West African countries as an international health emergency, noting that countries affected did not have the health facilities to deal with the disease.

August 8
Nigeria announced two new cases of Ebola virus infection among persons who had contact with Sawyerr

August 8
President Goodluck Jonathan declares a national emergency on Ebola while also announcing a N1.9 billion special fund to fight the disease.
August 11
The health minister, Onyebuchi Chukwu announces yet another case of Ebola infection, bringing the total number of confirmed infections to 10, with two deaths.

August 13
Nigeria approves the use of the experimental drug, ZMapp, for the treatment of Ebola patients. A day earlier, WHO gave its go ahead for the use of the drug.

August 13
Nigeria records the third death from Ebola – this time protocol officer at the Economic Community of West African States, ECOWAS, Jatto Abdulqudir, who attended to Sawyerr at the airport in Lagos.

August 14
Yet another casualty from Ebola, another nurse who cared for Sawyerr died in Lagos.

**REGIONAL COMPARISONS**

East Africa
Total cases – 2,389
Total deaths – 1,570

West Africa
Total cases – 1,973
Total deaths – 1,070 and still counting
THE DISCOVERY


BRIEF HISTORY

Between 1 September and 24 October 1976, 318 cases of acute viral haemorrhagic fever occurred in northern Zaire. The outbreak was centred in the Bumba Zone of the Equateur Region and most of the cases were recorded within a radius of 70 km of Yambuku, although a few patients sought medical attention in Bumba, Abumombazi, and the capital city of Kinshasa, where individual secondary and tertiary cases occurred. There were 280 deaths, and only 38 serologically confirmed survivors.

The index case in this outbreak had onset of symptoms on 1 September 1976, five days after receiving an injection of chloroquine for presumptive malaria at the outpatient clinic at Yambuku Mission Hospital (YMH). He had a clinical remission of his malaria symptoms. Within one week several other persons who had received injections at YMH also suffered from Ebola haemorrhagic fever, and almost all subsequent cases had either received injections at the hospital or had had close contact with somebody who had. Most of these occurred during the first four weeks of the epidemic, after which time the hospital was closed, 11 of the 17 staff members having died of the disease. All ages and both sexes were affected, but women 15-29 years of age had the highest incidence of disease, a phenomenon strongly related to attendance at prenatal and outpatient clinics at
the hospital where they received injections. The overall secondary attack rate was about 5%, although it ranged to 20% among close relatives such as spouses, parent or child, and brother or sister.

Active surveillance disclosed that cases occurred in 55 of some 550 villages which were examined house-by-house. The disease was hitherto unknown to the people of the affected region. Intensive search for cases in the area of north-eastern Zaire between the Bumba Zone and the Sudan frontier near Nzara and Maridi failed to detect definite evidence of a link between an epidemic of the disease in that country and the outbreak near Bumba. Nevertheless it was established that people can and do make the trip between Nzara and Bumba in not more than four days: thus it was regarded as quite possible that an infected person had travelled from Sudan to Yambuku and transferred the virus to a needle of the hospital while receiving an injection at the outpatient clinic.

**Table: Chronology of previous Ebola virus disease outbreaks**

<table>
<thead>
<tr>
<th>Year</th>
<th>Country</th>
<th>Ebolavirus species</th>
<th>Cases</th>
<th>Deaths</th>
<th>Case fatality</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>Democratic Republic of Congo</td>
<td>Bundibugyo</td>
<td>57</td>
<td>29</td>
<td>51%</td>
</tr>
<tr>
<td>2012</td>
<td>Uganda</td>
<td>Sudan</td>
<td>7</td>
<td>4</td>
<td>57%</td>
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<tr>
<td>2012</td>
<td>Uganda</td>
<td>Sudan</td>
<td>24</td>
<td>17</td>
<td>71%</td>
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<tr>
<td>2011</td>
<td>Uganda</td>
<td>Sudan</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>2008</td>
<td>Democratic Republic of Congo</td>
<td>Zaire</td>
<td>32</td>
<td>14</td>
<td>44%</td>
</tr>
<tr>
<td>2007</td>
<td>Uganda</td>
<td>Bundibugyo</td>
<td>149</td>
<td>37</td>
<td>25%</td>
</tr>
<tr>
<td>2007</td>
<td>Democratic Republic of Congo</td>
<td>Zaire</td>
<td>264</td>
<td>187</td>
<td>71%</td>
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<tr>
<td>2005</td>
<td>Congo</td>
<td>Zaire</td>
<td>12</td>
<td>10</td>
<td>83%</td>
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<tr>
<td>2004</td>
<td>Sudan</td>
<td>Sudan</td>
<td>17</td>
<td>7</td>
<td>41%</td>
</tr>
<tr>
<td>2003</td>
<td>Congo</td>
<td>Zaire</td>
<td>35</td>
<td>29</td>
<td>83%</td>
</tr>
<tr>
<td>Year</td>
<td>Country</td>
<td>Ebolavirus species</td>
<td>Cases</td>
<td>Deaths</td>
<td>Case fatality</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------</td>
<td>--------------------</td>
<td>-------</td>
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<td>---------------</td>
</tr>
<tr>
<td>2003 (Jan-Apr)</td>
<td>Congo</td>
<td>Zaire</td>
<td>143</td>
<td>128</td>
<td>90%</td>
</tr>
<tr>
<td>2001-2002</td>
<td>Congo</td>
<td>Zaire</td>
<td>59</td>
<td>44</td>
<td>75%</td>
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<tr>
<td>2001-2002</td>
<td>Gabon</td>
<td>Zaire</td>
<td>65</td>
<td>53</td>
<td>82%</td>
</tr>
<tr>
<td>2000</td>
<td>Uganda</td>
<td>Sudan</td>
<td>425</td>
<td>224</td>
<td>53%</td>
</tr>
<tr>
<td>1996</td>
<td>South Africa (ex-Gabon)</td>
<td>Zaire</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>1996 (Jul-Dec)</td>
<td>Gabon</td>
<td>Zaire</td>
<td>60</td>
<td>45</td>
<td>75%</td>
</tr>
<tr>
<td>1996 (Jan-Apr)</td>
<td>Gabon</td>
<td>Zaire</td>
<td>31</td>
<td>21</td>
<td>68%</td>
</tr>
<tr>
<td>1995</td>
<td>Democratic Republic of Congo</td>
<td>Zaire</td>
<td>315</td>
<td>254</td>
<td>81%</td>
</tr>
<tr>
<td>1994</td>
<td>Cote d'Ivoire</td>
<td>Tai Forest</td>
<td>1</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>1994</td>
<td>Gabon</td>
<td>Zaire</td>
<td>52</td>
<td>31</td>
<td>60%</td>
</tr>
<tr>
<td>1979</td>
<td>Sudan</td>
<td>Sudan</td>
<td>34</td>
<td>22</td>
<td>65%</td>
</tr>
<tr>
<td>1977</td>
<td>Democratic Republic of Congo</td>
<td>Zaire</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>1976</td>
<td>Sudan</td>
<td>Sudan</td>
<td>284</td>
<td>151</td>
<td>53%</td>
</tr>
<tr>
<td>1976</td>
<td>Democratic Republic of Congo</td>
<td>Zaire</td>
<td>318</td>
<td>280</td>
<td>88%</td>
</tr>
</tbody>
</table>

**SIGNS AND SYMPTOMS**

EVD is a severe acute viral illness often characterized by the sudden onset of fever, intense weakness, muscle pain, headache and sore throat.

This is followed by vomiting, diarrhea, rash, impaired kidney and liver function and, in some cases, both internal and external bleeding.

Laboratory findings include low white blood cell and platelet counts and elevated liver enzymes.

The incubation period, that is the time interval from infection with the virus to onset of symptoms/sickness, is 2 to 21 days.
**DIAGNOSIS**

Other diseases that should be ruled out before a diagnosis of EVD can be made include: malaria, typhoid fever, shigellosis, cholera, leptospirosis, plague, rickettsiosis, relapsing fever, meningitis, hepatitis and other viral hemorrhagic fevers. Ebola virus infections can be diagnosed definitively in a laboratory through several types of tests, including antibody-capture, antigen detection, serum neutralization and virus isolation by cell culture. Samples from patients are an extreme biohazard risk and testing is usually conducted under maximum biological containment conditions.

**TRANSMISSION**

The virus is transmitted to people from wild animals and spreads in the human population through human-to-human transmission. Ebola is introduced into the human population through close contact with the blood, secretions, organs or other bodily fluids of infected animals or persons. In Africa, infection has been documented through the handling of infected chimpanzees, gorillas, fruit bats, monkeys, forest antelope and porcupines found ill or dead.

Ebola then spreads in the community through human-to-human transmission, with infection resulting from direct contact (through broken skin or mucous membranes) with the blood, secretions, organs or other bodily fluids of infected people, and indirect contact with environments contaminated with such fluids. Burial ceremonies in which mourners have direct contact with the body of the deceased person can also play a role in the transmission of the virus. Men who have recovered from the
disease can still transmit the virus through their semen for up to 7 weeks after recovery from illness.

Health-care workers have frequently been infected while treating patients with suspected or confirmed EVD. This has occurred through close contact with patients when infection control precautions are not strictly practiced.

VACCINE AND TREATMENT

No licensed vaccine for EVD is available. Several vaccines are being tested, but none are available for clinical use.

In the wake of the 2014 outbreak in West Africa, the United States in August, used an experimental drug ZMapp, which has only been tested on monkeys on Dr Kent Brantly and his colleague, Nancy Writebol, two U.S. health workers infected with the virus in the course of caring for Ebola patients in Liberia. The drug has passed its final stage of trials, but hoping to be approved by the U.S food and Drug Administration in 2015. Although they have shown improvements and could be used on compassionate grounds, the WHO says it cannot approve such a drug for public use yet.

Thus, for now, no specific treatment is available.

PREVENTION AND CONTROL

In the absence of effective treatment and a human vaccine, raising awareness of the risk factors for Ebola infection and the protective measures individuals can take is the only way to reduce human infection and death.

In Africa, during EVD outbreaks, educational public health messages are always important for risk and spread reduction.
Reducing the risk of wildlife-to-human transmission can be done by preventing contact with infected fruit bats or monkeys/apes and the consumption of their raw meat. Animals should be handled with gloves and other appropriate protective clothing. Animal products (blood and meat) should be thoroughly cooked before consumption.

Reducing the risk of human-to-human transmission in the community can be effected by preventing direct or close contact with infected patients, particularly with their bodily fluids. Close physical contact with Ebola patients should be avoided. Gloves and appropriate personal protective equipment should be worn when taking care of ill patients at home. Regular hand washing is required after visiting patients in hospital.

**CONTROLLING INFECTION IN HEALTH-CARE SETTINGS**

Human-to-human transmission of the Ebola virus is primarily associated with direct or indirect contact with blood and body fluids. Transmission to health-care workers has been reported when appropriate infection control measures have not been observed.

From the example of the two American care givers infected and the Nigerian nurse that died, it is obvious that health care workers are the primary persons at risk of contracting the disease.

It is not always possible to identify patients with EBV early because initial symptoms may be non-specific. For this reason, it is important that health-care workers apply standard precautions consistently with all patients – regardless of their diagnosis – in all work practices at all times. These include basic hand hygiene, respiratory hygiene, use of personal protective equipment (according to the risk of splashes or
other contact with infected materials), safe injection practices and safe burial practices.
Health-care workers caring for patients with suspected or confirmed Ebola virus should apply, in addition to standard precautions, other infection control measures to avoid any exposure to the patient's blood and body fluids and direct unprotected contact with the possibly contaminated environment. When in close contact (within 1 metre) of patients with Ebola, health-care workers should wear face protection (a face shield or a medical mask and goggles), a clean, non-sterile long-sleeved gown, and gloves.
Laboratory workers are also at risk. Samples taken from suspected human and animal Ebola cases for diagnosis should be handled by trained staff and processed in suitably equipped

THE MICROBIOLOGY OF EBOLA

Viewed through an electron microscope, Ebola viruses appear as long filaments sometimes branched or intertwined

FAMILY

There are four in the hemorrhagic virus family (that is viruses that cause bleeding)
1. Arena viruses (the popular Lassa Fever belongs to this family)
2. Bunya viruses
3. Fla viruses (Dengue fever belongs here) and
4. Filo viruses (Ebola virus belongs to this family along with two other sisters: namely; genus Marburg virus and genus Cueva virus.
STRAINS

Five Strains of Ebola Virus:

Ebola-Zaire (EBOV)

Ebola-Sudan (SUDV)

Ebola-Ivory Coast

Ebola Reston (RESTV)

Taï Forest Ebola virus (TAFV).

NOTE: EBOV, and SUDV have been associated with large EVD outbreaks in Africa, whereas RESTV and TAFV have not. The RESTV species, found in Philippines and the People’s Republic of China, can infect humans, but no illness or death in humans from this species has been reported to date. All of these strains have been known to cause disease in humans, except for Ebola-Reston, which has only caused disease in Non-Human Primates.

PATHOGENECITY

One often wonders why the virus is highly pathogenic, causing deaths in a matter of days. It is because once it enters the body, it attaches itself to the endothelial cells (which produce the greatest amount of a substance called furin). Endothelial cells are cells that form the endothelium, the thin layer of cells lining the interior surface of blood and lymphatic vessels. The molecular protein on this virus binds with furin (furin is a molecular protein, known to speed up the maturation of other proteins). Once the virus binds with this protein, it speeds up its maturation, thus it begins to multiply. Scientists have discovered that its multiplication also disables a cellular protein called tetherin, a form of the body’s immune response to foreign bodies.
which can block the spread of virus from cell to cell. It takes between two to 21 days (the incubation period) to do this depending on how lethal the strain is. As a result of this cellular activity, the person feels an elevated body temperature as in fever and an eventual rupture of the blood vessels, lymphatic vessels and damage to the liver cells. It literally punctures the blood vessels and that explains why it is called a haemorrhagic fever.

**EBOLA TREATMENT CENTERS**

1. Institute Pastur of Dakar, Conakry, Guinea

2. Ebola treatment centre in Telimele town, north of Guinea

3. Gueckedou, southwest Guinea, where the outbreak began

4. MSF’s Ebola treatment centre, in Kailahun, eastern province of Sierra Leone, (The district is located in the eastern region of Sierra Leone sharing borders with Gueckedou in Guinea and also with Liberia).

5. Daru Treatment Centre, a small town in Kailahun district in Eastern province of Sierra Leone

6. Kenema treatment centre, at the Government Hospital. Kenema is the third largest city in Eastern province of Sierra Leone

7. Samaritan’s Purse Ebola Case Management centre in Monrovia, capital of Liberia
8. Ebola Treatment Clinic, Foya (where two Americans Kent Brantly and Nancy Whitebol works. it is overseen by Samaritan’s Purse) Foya is in Lofa, northern county of Liberia

9. Infectious Disease hospital in Yaba, Lagos.

HEALTHCARE/AID WORKERS WHO HAVE BEEN INFECTED OR DIED FROM EBOLA

1. Dr. Sheik Umar Khan, a Sierra Leonean, was the chief doctor leading the fight against Ebola in Sierra Leone. He had treated more than 100 patients before he got infected with the Ebola virus. He was diagnosed with the disease and died a week later on July 29.

2. Dr. Kent Brantly, a 33 year old American, is the medical director of the Samaritan’s Purse Ebola Consolidated Case Management Centre in Monrovia and tested positive to the Ebola virus in July while treating scores of infected patients. He was flown back home to the US and is receiving treatment in the isolation unit of the Emory University Hospital, Atlanta, He is the first know patient of Ebola to receive the experimental drug ZMapp.

3. Nancy Writebol, A 59 year old American missionary also got the virus in July while caring for Ebola patients in Liberia. She works for a North Carolina – based aid group, SIM USA and is the second know person to have received the drug ZMapp. She was flown back home on August 5 and is also receiving treatment at the Emory Hospital in Atlanta.

4. Miguel Pajares, a 75 year old Spaniard, Chantal Pascaline Mutwamene of Congo
and Paciencia Melgar from Equatorial Guinea, all missionaries with the San Juan de Dios hospital order, a Catholic humanitarian group that runs hospitals around the world, tested positive to Ebola in Liberia in late July. They were all helping take care of Ebola patients when they tested positive at the at the San Jose de Monrovia Hospital in Liberia. Pajares was taken back to Spain on August 7 but he died on August 12.

5. Two Nigerian nurses, just a couple of the many health workers who cared for Sawyerr, tested positive to the disease in August and died within days on August 5 and August 14. At least seven others who helped treat Sawyer or had contact with him have also been confirmed infected with the virus.

WORLD HEALTH ORGANISATION ACTION ON EBOLA

Significantly, on August 7, the world body declared the Ebola outbreak in West Africa as a health emergency of international concern and on August 12, it approved the use of the experimental drug, ZMapp, for the treatment of patients. Before then, director general of WHO, Margaret Chan, had shared information from her recent meetings in Guinea with member states of the Mano River Union – Côte d'Ivoire, Guinea, Liberia, and Sierra Leone. She outlined that the response in West Africa would focus on three areas:

Treatment of Guéckédou, Kenema, and Foya as a unified sector, which will include public health measures meant to reduce movement in and out of the area.

Intensifying current measures in Guinea, Liberia, Nigeria, and Sierra Leone.

Taking steps to reduce international spread to other countries in Africa and outside of the continent.

The Sub-regional Ebola Operations Coordination Centre, SEOCC, in Conakry,
Guinea, reported on 5 August that the following actions are underway in the four affected countries:

In Guinea, new foci have emerged and case management facilities will be needed. Exit screening is currently being tested in Conakry, in partnership with the US Centre for Disease Control, CDC.

In Liberia, security issues continue to be of concern, notwithstanding the commitment of the government. Community resistance remains high.

In Nigeria, the government is focused on following up the contacts from the index case. Clinical support is urgently needed and a treatment centre is being set up for managing cases of EVD.

In Sierra Leone, efforts are underway to map where treatment centres are most needed and getting them set up. A similar exercise is underway for laboratories.

The SEOCC is assisting countries with these and many other response measures.

On 6 August, WHO convened an emergency committee meeting of international experts to review the outbreak and advise the director-general, in accordance with the international health regulations, whether the Ebola virus disease outbreak constitutes a public health emergency of international concern, PHEIC.

Finally, on Thursday, August 7, WHO declared the outbreak of the Ebola disease an international health emergency.

The world body said that the countries witnessing an outbreak of the virus had fragile healthcare systems and just did not have the resources to combat it and called for international assistance.
"Countries affected to date simply do not have the capacity to manage an outbreak of this size and complexity on their own," said Chan.

Content developed Abiose Adelaja Adams with references from the University of Pennsylvania School of Medicine, The Journal of Virology of the American Society of Microbiology, the US National Library of Medicine National Institutes of Health, the Nigerian Centre for Disease Control and Prevention and the World Health Organization, WHO factsheets