Background

- The EVD outbreak in Liberia began in March 2014, after the Index case travel from Guinea to Foya, Lofa county in northern Liberia.
- This outbreak led to an estimated 10,564 probable, confirmed, and suspected cases of Ebola Virus Disease (EVD) while approximately 4,716 deaths were reported by early May 9, 2015.
- There have been 3 subsequent chains of transmission since, which have been limited, due to early detection and efficient control measures.
- The outbreak destroyed families and communities, led to the closure of schools and businesses, reduced GDP by approximately 3.8%, and devastated an already fragile health system.
- Cases of EVD among healthcare workers (HCWs) and within healthcare facilities led to reduced provision and utilization of essential health services.
EVD Trends In Liberia

Number of Confirmed Ebola Cases/Day up to 7th May 2015
as moving average per day in the last 21 days
Background

• In August 2014 an Incident Management System (IMS) was set-up to coordinate the Ebola response.
• The IMS focused on several priority areas to interrupt the transmission of Ebola virus:
  • Immediate laboratory testing (Fast turn around time for results)
  • Contact tracing and active case finding
  • Safe transportation of the ill
  • Isolation and treatment of patients
  • Safe burials
  • Promotion of infection control throughout the health care system
  • Clear and effective communication to affected communities and the general population.
Control Measures

Successful interruption of EVD transmission in Liberia required adapting strategies to safely isolate symptomatic patients.

- **Ebola Treatment Units (ETUs)** - provided isolation capacity, with high IPC standards, However, it’s effectiveness was limited by bed availability near and acceptability within communities.

- **Community Care Centers (CCCs)** were designed to provide local acceptable and temporary isolation.
Control Measures

- The Rapid Isolation and Treatment of Ebola (RITE) strategy - prevented transmission in remote populations and prevented emerging outbreaks from spreading.
- Community Engagement - The effectiveness of all the response activities depended on acceptability within communities.
- Precautionary Isolation - This intervention became more acceptable as quarantine changed to voluntary isolation as a precaution. With the provision of food, water, and psychosocial support.
Current Preparedness Measures

• Implementing WHO’s Phase 3 strategy- I.e. Interrupt all chains of transmission and manage residual risk
• Survivors Natural History study
• Men’s health Screening Program
• Triage and permanent Isolation facilities
• Training of all health workers in IPC practices(KSKS,SQS)
• National and sub-national Epidemic Preparedness and Response Plans
  • Concept of operations
  • Vulnerability of Endemic diseases and initial response activities
  • The response pillars- TOR and SOPs
Current Control Measures

• Surveillance activities for all IDSR/IHR priority diseases
  • Port of Entry
  • County and District level
  • Community Event based surveillance (CEBS)
  • Swabbing of all dead bodies

• Network of Laboratories for early confirmation of case
  • Five Laboratories currently for EVD testing

• Rapid Response Teams
  • Multidisciplinary
  • Trained
  • Equip (Prepositioned essential supplies)
  • Available logistics for immediate deployment
Labs With EVD Testing Capacity

Redemption Hospital Lab, Montserrado
ELWA-III, Montserrado
Charlesville, Marbigi (LIBR)

Gbarnga, Bong (Phebe hospital)
Tappita, Nimba (Jackson F. Doe Hospital)
• Thank You