2014 West Africa Ebola Virus Disease Outbreak

Briefing Pack:
Foreign Medical Teams International Response

"Our people are dying, children are being orphaned, most of the dead are women and over two-thirds of those infected belong to the most economically active age category of 15 to 50. Children are not going to school; farmers are being felled by the disease in the food production and commercial crop centers of the land; doctors and nurses are dying, and non-Ebola illnesses are adding to the toll of death and suffering due to further strains and weakening of the healthcare delivery system in the country. The existence of my country is at stake; the future of our region is in peril. By the time I get home from this meeting, there would be over 50 new cases of my people contracting the disease, and based on case fatality rates, more than half of them may die.

I have refused to attend international meetings during this time, in order to lead the fight on the ground in Sierra Leone. But this meeting today in London is very important for us, the fight on the ground in Sierra Leone urgently needs the support of people gathered here today to combat this virus; without you we cannot succeed, without your quick response, a tragedy unforeseen in modern times would threaten the wellbeing and compromise the security of people everywhere."

STATEMENT BY HIS EXCELLENCY

DR ERNEST BAI KOROMA

PRESIDENT OF SIERRA LEONE

AT THE LONDON CONFERENCE ON EBOLA

2ND OCTOBER 2014

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Response Background

The Ebola Virus Disease (EVD) outbreak continues to evolve. The most severely affected countries are Guinea, Liberia, and Sierra Leone, with a total combined population of approximately 20 million. The escalating outbreak is set against the backdrop of already severely compromised health systems and significant deficits in capacity, and is characterized by a high number of localised outbreaks ('hot spots' or 'transmission hubs'). The original 'hot spot' lies in the forest region along the border areas of the three countries, and is exacerbated by intensive commercial and social interactions in these areas. The most severe hot spots are now situated in densely populated urban areas (including the capitals) and in several rural locations in the 3 affected countries.

The national authorities in the affected countries are working with WHO and other partners to implement several outbreak control measures. Despite this, the EVD outbreak remains grave and transmission is still on-going. The limited number of health facilities are severely under-staffed and overwhelmed with the continued increase in the number of patients.

A massively scaled and coordinated international response with qualified high-caliber FMTs is needed to set-up and maintain effective ETCs to support affected countries, stabilise the situation and help prevent further spread across the region.

Required international response:

1. **EARLY ACCESS TO TREATMENT SAVES LIVES**. The response model implemented in Guinea has successfully proven that early treatment can decrease mortality from 90% down to 40%. Partners have implemented successful ETC care in several locations since the onset of the epidemic, and continue to scale-up engagements in Liberia, Sierra Leone, and Guinea.
2. Encouragement of Ebola patients to seek treatment in ETCs and when not available, Community Care Centres is the only mechanism available to isolate patients from transmitting the virus to others. This is key to halting the epidemic.
3. Without access to ETCs, the effects of essential epidemic control activities including contact tracing and social mobilisation are severely compromised. Public confidence in health authorities must be restored to ensure the cooperation of communities. This requires maintaining a reliable provision of services for suspected and confirmed cases of Ebola.
4. Dedicated ETCs decreases risk of infection for Health Care Workers by strict infection control practices, and will allow the health system to resume normal functioning.

In a strategic decision, WHO and the Ministries of Health in the affected countries are appealing for assistance and expertise from FMTs to manage high-functioning ETCs.

The Structure of an FMT: At a glance

Standard Requirements of FMTs:

International Standards Compliance	• Team is compliant with the Principles and Core Standards of FMT deployment ref. page 18-19 inclusive, of the WHO FMT classification and minimum standards book found at: http://www.who.int/hac/global_health_cluster/fmt_guidelines_september2013.pdf?ua=1
Team Travel/ Logistics	• FMTs are self-sufficient and should not put demand on logistic or financial support from the affected country Government, unless agreed otherwise before deployment. • FMTs are responsible for their own travel and logistics arrangements, including accommodation, food & water logistics for their team, unless by prior arrangement. • FMTs must ensure their own security plan, evacuation and medical repatriation arrangements.
Language	Proficient in the language of the deployment site [ENGLISH: Liberia, Sierra Leone; FRENCH: Guinea]
Qualifications	FMTs will adhere to professional guidelines: all staff must be registered to practice in their home country and have licence for the work they are assigned to by the agency.
Safety & Infection Control	• Team competent in PPE and infectious control measures appropriate for the ETC as per published WHO standard, for the duration of deployment. • Specialised water & sanitation support for the treatment/isolation unit. • Ambulance capacity or through national providers. • Safe dead body handling protocol must be adhered to.
Staff & skill sets required	**Nurses (and or paramedics)** • Experience in emergency and/or critical care, with ability to insert peripheral intra-venous catheters. At least two should be experts in infection control measures. At least one per shift should have experience in paediatric practice. • 1 Nurse per 4 beds per shift, allowing for breaks due to PPE requirements in hot and humid conditions. **Doctors** • Expertise in infectious disease management, acute/critical care, emergency medicine or similar. Ideally several will have specific tropical medicine experience and all should be clinically current to practice and of senior or specialist level. • Ratio of 5-10 Nurses to every 1 Doctor. **Logistics & Security Support Staff** • Staff to check set up of ETC, and ensure water, sanitation, & power to the unit. • Staff to ensure the security of the ETC. ***National staff to be hired on-demand, in country as needed.**
Medical & laboratory supplies required	• Medical supplies and consumables required to run an inpatient facility with case load can be delivered through logistics support (eg UNMEER) if required and articulated by FMT. • Laboratory- point of care and rapid testing for electrolytes, Malaria etc. (Ebola testing done by specialised labs and is not the FMT's responsibility). • FMTs will ensure that all pharmaceutical products and equipment they bring comply with international quality standards and drug donation guidelines.

Foreign medical teams are expected to provide a fully self-sufficient team, but will be supported by other service providers

Support provided by UNMEER, WHO & major donors

Pre-deployment

Outreach to donors and matching of needs from local government with supply from donors

Funding assistance if needed *(case by case basis)*

Provision of ETU facilities designed to minimize risk (e.g., with clear flow systems)

Logistics from airport to ETU if needed *(case by case basis)*

Pre-deployment and in-country training of medical staff on IPC measures, Ebola clinical standards and protocols

FMT responsibilities

- Provision of a team of **medical and non-medical personnel** of >25-35 people including leadership, medical staff (10-20 nurses, 3-5 doctors), 3-5 logisticians who can independently run an ETU
- Management of **daily logistics, habitat and administration**, including inbound and outbound flights; hotels / post-mission R&R requirements; payment of salaries; procurement of insurance
- Co-ordination to ensure **sufficient contingency** for national and/or foreign HCW Ebola infection (e.g., in-country care, medevac)
- **Hiring and management of all national medical and non-medical staff** required for ETU (e.g., security, sanitation, medical staff) including funding and paying salaries
- **Reporting of epidemiology** to WHO and local governments

During deployment

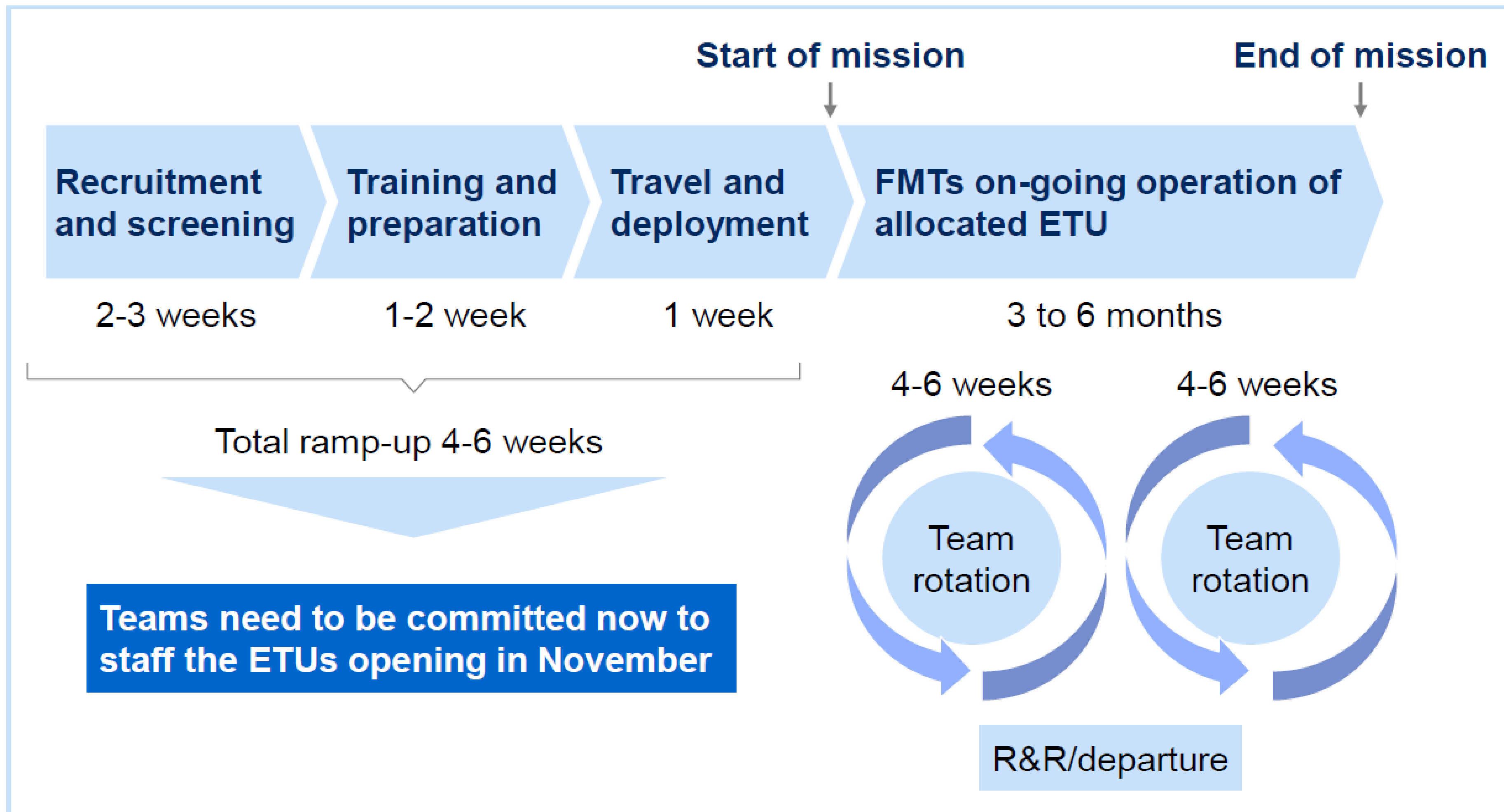
Epidemiological support including contract tracing, safe burials and analysis of epidemiological statistics reported by clinics

Management of on-going ETC operations (e.g., fuel, water, waste)

Provision and restocking of medical supplies

Management of laboratory and diagnostics with a target 24 turnaround time

FMT start-up has a significant lead time; teams need to be committed now to staff ETUs under construction



How does an FMT fit into the structure of an ETC?

<table>
<tr><th></th><th>Ebola Treatment Centre (ETC)</th><th>FMT</th></tr>
<tr><td>Services provided</td><td>In-patient care providing:
• Intravenous and/or oral rehydration therapy.
• Essential care of significant co-infections in Ebola patients.
• Isolation/quarantine (including separation of suspected from confirmed cases).
• Strict infection control measures.
• In-patient sustenance (provision of food & water).
• Proper waste disposal.
• Handling of dead bodies.</td><td>FMT to lead and ensure all services are provided to safety standards for both staff and patients in the ETC.
WHO Guidelines & electronic links:
1. Ebola Virus Disease: Occupational Safety and Health - http://www.who.int/occupational_health/publications/ebola_osh/en/
2. Infection prevention and control (IPC) Guidance Summary - http://apps.who.int/iris/bitstream/10665/131828/1/WHO_EVD_Guidance_IPC_14.1_eng.pdf?ua=1
3. Interim Infection Prevention and Control Guidance for Care of Patients with Suspected or Confirmed Filovirus Haemorrhagic Fever in Health-Care Settings, with Focus on Ebola - http://apps.who.int/iris/bitstream/10665/130596/1/WHO_HIS_SDS_2014.4_eng.pdf?ua=1&ua=1&ua=1
4. WHO Clinical Management of Patients with Viral Hemorrhagic Fever: A Pocket Guide for the Front Line Health Worker - http://apps.who.int/iris/bitstream/10665/130883/2/WHO_HSE_PED_AIP_14.05.pdf?ua=1
5. Ebola and Marburg virus disease epidemics: preparedness, alert, control and evaluation – Interim manual version 1.2 http://apps.who.int/iris/bitstream/10665/130160/1/WHO_HSE_PED_CED_2014.05_eng.pdf?ua=1&ua=1</td></tr>
<tr><td>Staffing</td><td>Medical staff required (comprised of FMT International staff and National staff) <u>Average total of 200-250 staff per 100 bed ETC</u>
• Minimum 1 Nurse/Paramedic per patient bed
• Minimum 1 Doctor per ten Nurses.</td><td>Suggested that <u>at least</u> 10% of total ETC clinical staff are provided by FMT (estimated minimum of 10-15 nurses + 3-5 doctors)

<u>International FMT of at least 25 personnel is best:</u>

<u>Designated Leadership Positions (5)</u>
Team Leader, deputy team leader and leaders of medical, nursing and logistics

<u>Nurses (and or paramedics) (10-20)</u></td></tr>
</table>

	For example: 100 bed ETC = 100 Nurses/Paramedics/Hygienists & 10 Doctors **Logistic support staff** (over 100 national staff, led by FMT technical experts in logistics, water and sanitation in field hospitals) • Cleaners • Sprayers • Security • Drivers • Laundry • Cooks • Etc… **Other roles required:** • Infection control • Psychological support • Community liaison (5) • Etc….	• Experience in emergency and/or critical care, with ability to insert peripheral intra-venous catheters. At least two should be experts in infection control measures. At least one per shift should have experience in paediatric practice. • 1 Nurse per 4 beds per shift, allowing for breaks due to PPE requirements in hot and humid conditions. **Doctors (3-5)** • Expertise in infectious disease management, acute/critical care, emergency medicine or similar. Ideally several will have specific tropical medicine experience and all should be clinically current to practice and of senior or specialist level. • Ratio of 5-10 Nurses to every 1 Doctor. **Logistics, Water & Santiation, and Security (3-5)** Technical experts in logistics, water and sanitation in field hospitals to lead national staff, and oversee and ensure • The final set-up of ETC, and water, sanitation, & power to the unit. • The security of the ETC (to ensure red and green zones are controlled and theft is discouraged).
Infection Control	Equipment to ensure hygiene and infection control, Personal Protective Equipment (PPE), and extensive supplies of such equipment for several months of activity.	• Team competent in PPE and infectious control measures appropriate for the ETC as per published WHO standard, for the duration of deployment. • Specialised water & sanitation support for the treatment/isolation unit. • Ambulance capacity or through national providers. • Safe dead body handling protocol must be adhered to.
Logistics & Equipment	Field hospital facilities, beds, and equipment including all medical equipment for supportive clinical care of severe gastro intestinal	• Medical supplies and consumables required to run an inpatient facility with case load can be delivered through logistics support (eg UNMEER) if required and articulated by FMT. • FMTs will ensure that all pharmaceutical products and equipment they bring comply with international quality standards and drug donation guidelines.

	infection and fluid losses. This will be provided for the responding FMT by Donor Government and UN partners to ensure smooth functioning of the facility.	
Laboratory Support	Each ETC has an identified laboratory designated to provide Ebola testing services to the ETC as required. These laboratories are in separate locations from the ETC itself.	Laboratory- point of care and rapid testing for electrolytes, Malaria etc. (Ebola testing done by specialised labs and is not the FMT's responsibility).

National Staff

National medical and paramedical staff will be available through negotiation with the Ministry of Health of the affected country. The negotiation for such staff can be arranged directly between the FMT and the Ministry or with the assistance in this negotiation by WHO. Payment of such staff is directly by the FMT in most cases unless by specific arrangement, and should include the agreed incentive for ETC work with or without the base wage according to agreements with the relevant ministry. It is expected a 100 bedded facility will hire up to 100 national health care workers (HCW) to work alongside the international HCWs of the FMT.

Logistic and support staff such as cooks, cleaners, drivers, security etc should be through direct local employment by the FMT or through a contractor working with the FMT providing logistic support. An estimated 100-150 staff are usually required in this category.

The Ebola Treatment Centre (ETC)

EVD response should occur in purpose built facilities, as multiple examples of national HCW infection have occurred in ETCs and “holding centres” within existing and adapted health care facilities. The specific operational guidelines are found on previous FMT correspondence describing ETC construction in Monrovia, Liberia 28th August 2014 (can be provided upon request).

ETCs are currently being built for all responding FMTs, decreasing the burden on the deploying teams. The facilities will be according to a WHO suggested blue-print drawing heavily on MSF experience and advice, and adapted for local terrain and conditions at each site. The US Government through DoD have agreed to build up to 17 such sites and up to 1,700 beds, while the UK Government will construct up to 700 beds in at least 7 sites. The FMT taking on an ETC will be handed over the site for their management.

Ministry of Defence site, Congo-town, Monrovia, LIBERIA

Ebola Treatment Centres (ETCs)

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.

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MAP DATE: 20 October 2014

Ebola Treatment Centers

Status

- OPEN
- UNDER CONSTRUCTION
- PLANNED
- UNDER DISCUSSION

Dalaba
Mamou
Conakry Donka Hospital
Coyah
Forécariah
Kérouané
Port Loko
Makeni
Kono - Koidu Town
Port Loko, Lunsar
Géuckédou
Macenta
Beyla
Foya
Vonjima
Moyamba
Bo Town SLRA
Kailahun
Rural Kenema Field Hospital
Kenema (City) Hospital
Zorzor
Nzérékoré
Yomou
Ganta
Bopulu
Gbanga
Bong 2
Tubmanberg
Robertsport
Sinje
Tappita
Zwedru
Buchanan
Cestos City
Greenville
Fish Town
Barclayville
Harper

Freetown

Freetown
Freetown
Goderich
Freetown - Police Training Station site
Lakka
Freetown - Jui Hospital
Waterloo
Kerry Town
Kerry Town - Section for care of Health Care Workers

Montserado

Kakata 2
Kakata 1
Unity Convention Center
Monrovia - Island Clinic
Monrovia - JFK
Monrovia, Congo Town - Old Ministry of Defence ETU 2
Firestone ETC
Monrovia - ELWA 3
Monrovia- ELWA 2

Basemap: © OpenStreetMap (and) contributors, CC-BY-SA

Laboratory Status & Coverage

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.

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MAP DATE: 20 October 2014

GUINEA

Louis Pasteur / National Reference Lab

NICD South Africa

China Mobile Unit

SIERRA LEONE

CDC Team 1

PHA Canada

EU Mobile Lab

EU Mobile Lab 2

US-Navy/NMRC mobile labs team 1

US-Navy/NMRC mobile labs Team 2

MOH-USAMRID

LIBERIA

CDC-NIH Team 2

Laboratory Status

Functional

Pending

Laboratory Coverage

Number of Labs Covering

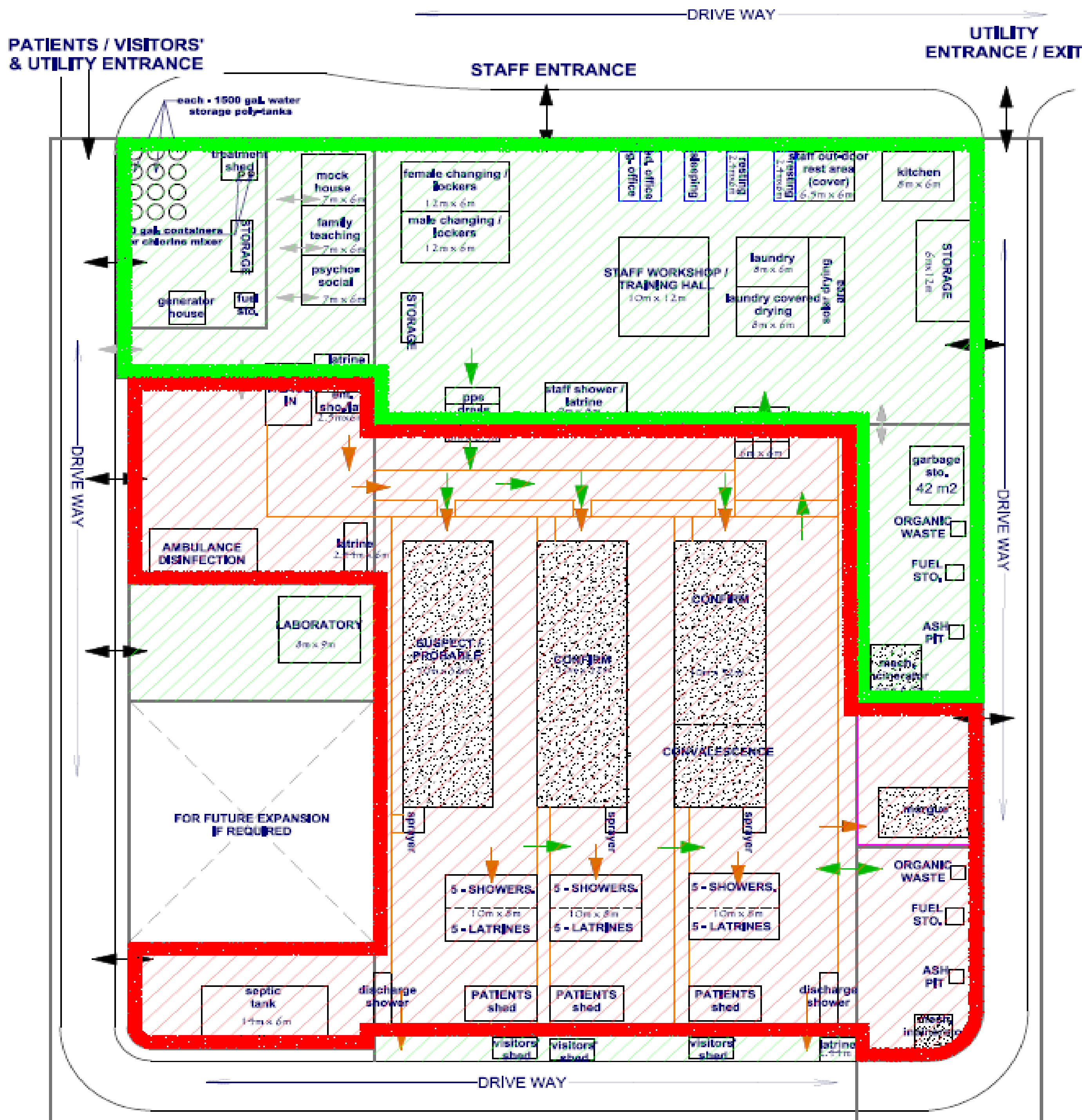
1

2

3

Affected Countries

Infection Control in and around the ETC



Infection Control in and around the ETC

Ebola Virus Disease: Occupational Safety and Health - http://www.who.int/occupational_health/publications/ebola_osh/en/

ETC design and clear delineation of Green and Red zone dramatically decreases the risk of infection to Health staff. The design allows staff entering to work to be in a safe "green zone" which is kept secure from the general public and from patients. They dress to scrub suits in gender specific change areas before attending briefings and/or teaching sessions etc and getting dressed in their PPE using a buddy system and using mirrors and other tools to ensure correct PPE donning. Staff flow is from suspect to confirmed areas to ensure less cross contamination between patients. On finishing a rotation staff doff in the specifically designed PPE removal areas with close supervision by the spray team. All contaminated single use PPE is left within the red zone bins while reusable equipment is placed in buckets of chlorine, boots are dipped and hands are washed.

Red zone waste must remain and be destroyed within the red zone including all unused food and materials that have had patient contact are not amenable to cleaning. Green zone waste is generally managed in the green zone or nearby. The emergency response requires extraordinary measures, including burning of all waste, but a transition to more environmentally acceptable practices is encouraged over time. This may include high rather than low temperature incineration and the use of autoclave/shredder systems for the destruction of high volume plastic waste. Test systems will be placed in country with the assistance of UN agencies (UNDP) and if found suitable will be rolled out across multiple sites.

Infection control procedures and significant breaches will be investigated with assistance by the WHO ETC/FMT coordination team. This team will also provide clinical and other practical advice and assistance on frequent site visits and on request by the FMT.

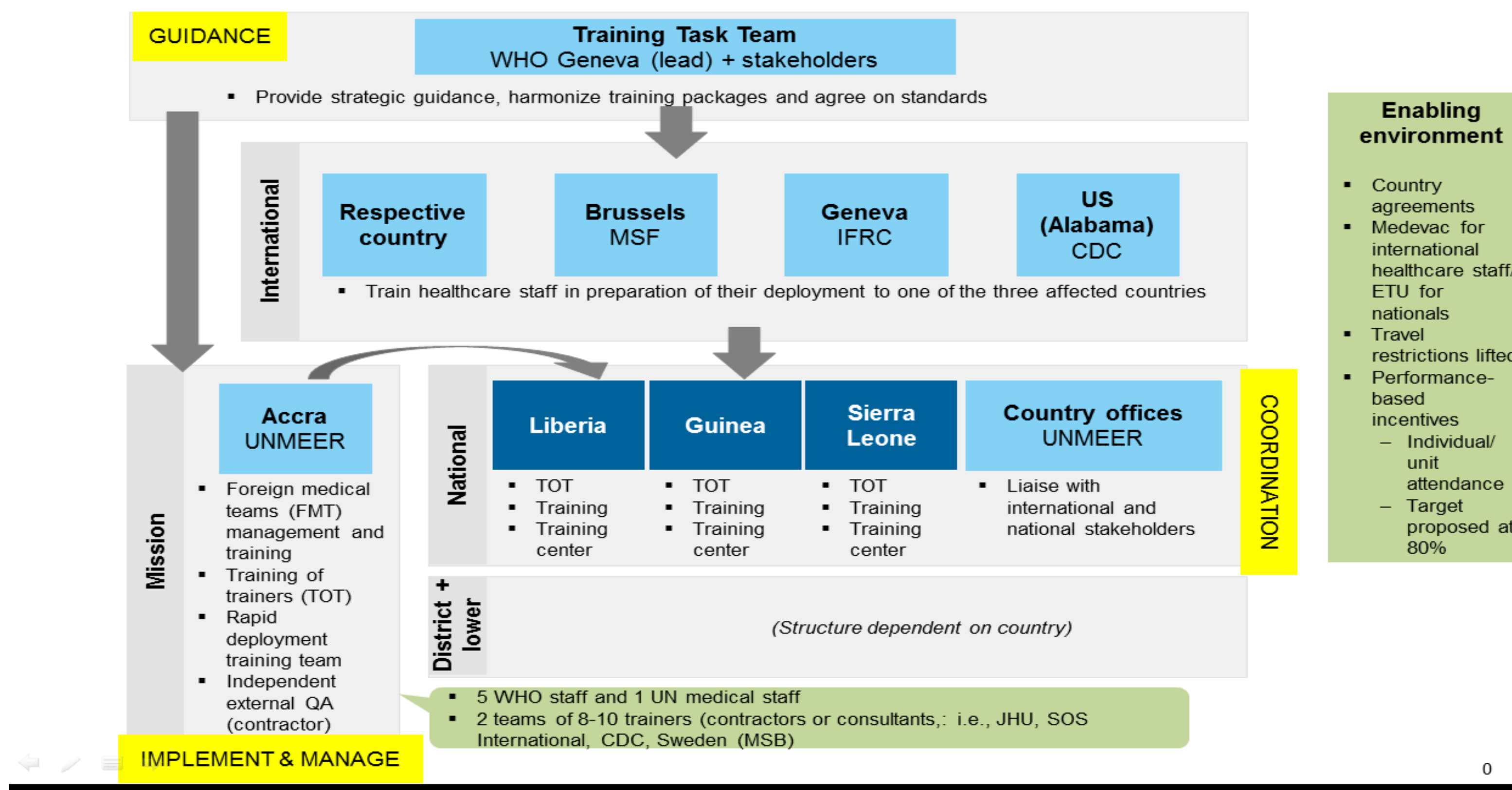
Logistics

While initial stocks and equipment will be made available by the agency building the ETC the FMT will need to review all stocks and either request or provide additional equipment as it sees fit for the response. Ongoing logistics support will be in the form of two parts;

1. Logistics contractors may be provided by a donor partner to support the maintenance of the site and hiring and management of those charged with waste management, incineration, power and water supplies etc. Exact details and requirements will be negotiated between the FMT and the donor building the ETC and are particularly applicable to Liberia.
2. Ongoing logistics resupply will be provided by the donor building the ETC for between one and three months before becoming the responsibility of UNMEER using specialist UN partner agencies such as WFP etc.

WHO Essential Medicines and Health Products Department:
http://www.who.int/medical_devices/meddev_ebola/en/

Training



Training

This packet outlines options for preparing incoming foreign medical teams (FMT) and national staff to form safe and effective clinical teams to manage new ETCs in EVD affected countries. Ideally, training and mentoring will occur in each phase of deployment.

The target audiences of FMT training include:

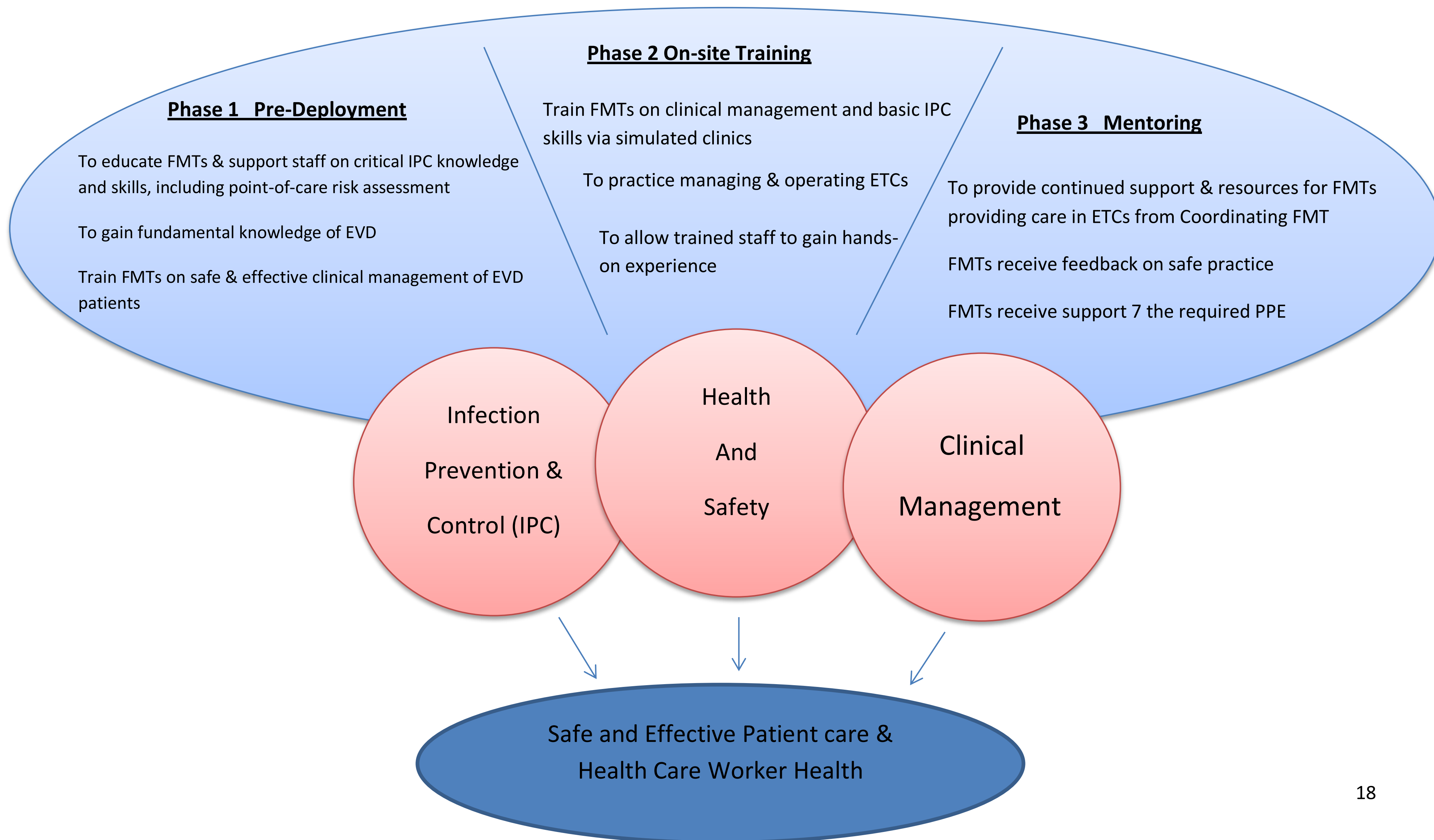
- Care delivery teams to include foreign, national and expatriate staff
    - Clinicians (doctors, nurses, physician assistants)
    - Leadership elements
    - Logistics, hygiene, environmental health and water and sanitation Staff will receive trainings in the three areas of IPC; clinical management and Health & Safety. These trainings will occur in the following three stages:

- Phase 1: Pre-deployment
- Phase 2: On Site Training
- Phase 3: Mentoring in ETC
    - Coordinated with country response team and operating FMT

Materials include:

- WHO IPC pre-deployment package includes for high risk EVD contact:
    - *WHO IPC Guidance Summary (2014)*
    - *Key Infection prevention control (IPC) measures (2014)*
- Summary recommendations on the use of PPE (currently being updated)
- Manuals
    - *WHO Interim Infection Prevention and Control Manual*
    - *WHO Clinical Management of Patients with Viral Hemorrhagic Fever: A Pocket Guide for the Front Line Health Worker - Interim*
    - *WHO Ebola Outbreak Response handbook for Health & Safety in the Field (2014)*
    - *WHO Ebola and Marburg virus disease epidemics: preparedness, alert, control and evaluation. Interim manual version 1.2*
- Medical kit (eg. Mosquito net, malaria prophylaxis)
- International Travel & Health Guide (2012) - Recommended
- Contact List

Training



Training

Ebola Virus Disease clinical training includes the following modules:

1. **Ebola overview: biology, this outbreak, new treatments**
2. **Strategies to stop Ebola transmission**
3. **Infection prevention and control for the clinical team**
4. **PPE for Ebola**
5. **Screening and overall organization of the Treatment Center**
6. **Collecting blood samples from suspect or confirmed Ebola patient**
7. **Clinical care in the Ebola Treatment Unit**
8. **Preparing health centre, health post, or hospital outpatient for Ebola surveillance**
9. **Health worker preparation for work in an Ebola outbreak**

Training

Update on Training in the three affected countries:

All trainings are open to national and expatriate staff from FMTs that will work in ETCs. The WHO uses a 3 phase approach for the WHO Ebola clinical team curriculum.

a. Phase 1: Didactic Skills station (1-3 days)
b. Phase 2: Simulation lab in mock ETC (2 days)
c. Phase 3: Ongoing mentoring in real ETC

1. Sierra Leone

WHO/DFID/ MOD are sponsoring and coordinating the Ebola Training Academy in Sierra Leone to provide clinical and IPC training to local health care workers. Train the Trainer courses will also be offered with the intent to deliver more national trainers. Curriculum will be provided by the WHO who will help facilitate training in country along with MOD and other partners using DFID support.
DFID has planned a 9 day training program for NHS staff hosted in the UK using a 3 phase approach. After the 9 day training, medical professionals are then sent for 3 day of training in Sierra Leone. This is followed by a third phase which is ongoing mentoring while FMTs are in country. Within this third phase, subsequent in-coming teams will be mentored by the out-going team. Thus, there will always be an overlap of teams during the first few weeks and the last few weeks. Deployments will last from 6 weeks – 2 months.

2. Liberia

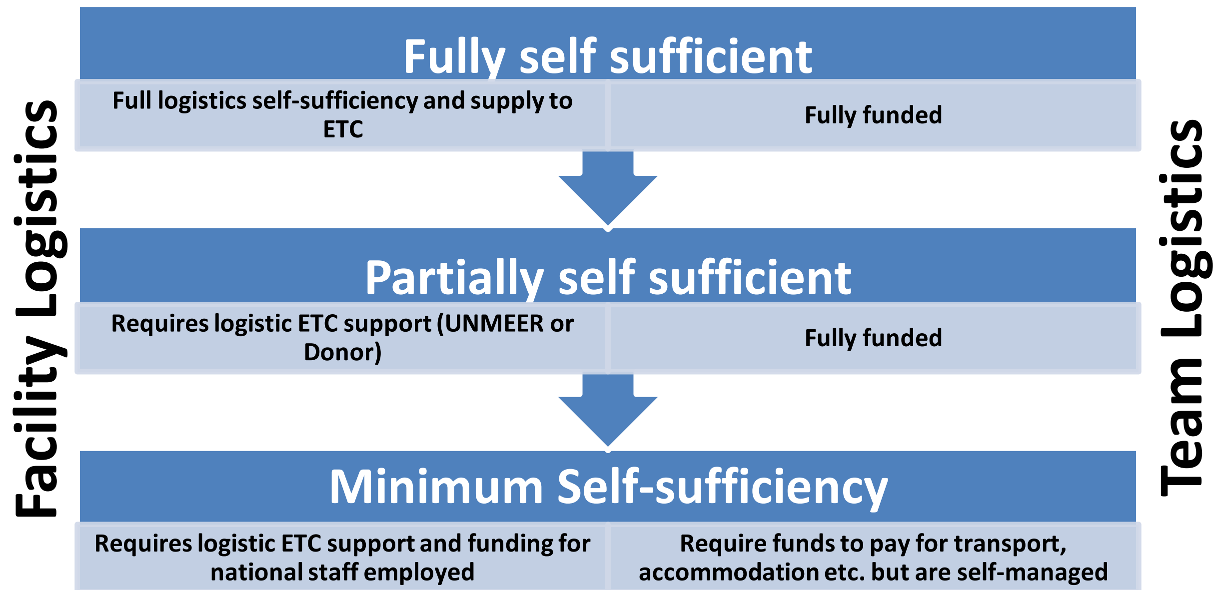
In Bong, WHO trained 35 Liberians so that IMC could open their ETU several weeks ago. WHO and MOH have been training clinicians in Monrovia on a continual basis since 29 September. The US Army (DoD) has also contributed trainers to deliver phase 1 and 2 of the training. In Monrovia, training is currently located in a hotel with a mock ETU on the ground. DoD facilities are expected to be completed soon, increasing training capacity significantly, including 4 new classrooms and up to 300 HCWs trained per week.

3. Guinea

Unknown status of training.

FMT: Self-care/Self-management

While FMTs have historically been required to be fully self-sufficient it has become clear that the UN and major donors would be required to support FMTs in their efforts to combat EVD due to their unfamiliarity with the disease, and because of its unique logistic requirements. While some flexibility is described below there is a minimum standard of self-sufficiency required to achieve the status of an FMT.



Minimum standard for FMTs responding to Ebola is managerial self-sufficiency

The scenarios above show logistics support to the ETC and its management can be completely provided by the FMT or can be supplied through UNMEER or alternates. Teams are also expected to be self-sufficient in their own care, medical insurance, and administration/transport. Flexibility is possible in this form of self-sufficiency in terms of funding, with FMTs welcome to seek such funding either through their Government or donors, but it is expected that the team self-administers this money and is self-managed.

FMT Team Care: in and out of the ETC

FMTs are expected to have their own policies and procedures for team care and be self-managed in this regard. Specific protocols are encouraged for the prevention and management of heat illness and dehydration, such as twice daily weight checks to alert team members to fluid losses if not recognized. Careful policies surrounding health and welfare are necessary for international and national staff. It is strongly encouraged to have an onsite basic health clinic for staff with an incentive to present early with any form of illness, particularly involving fever. Incentives could include continuation of all pay while unwell, preferential treatment for non-Ebola type complaints or referral for appropriate care, care of family members to encourage declaration of illness at home, and offering of universal precaution equipment at home in case visitors or neighbours present with Ebola symptoms at the staff members house. International team members requiring fever care, out-ruling of Ebola, and the management of in-country care and possible evacuation should be carefully planned.

Specific protocols and procedures are encouraged at the place of residence of the team, to ensure all national support staff are healthy or declare they are unwell. Simple precautions surrounding food preparation and general Water and sanitation quality is a priority and should be managed by the logistic support team of the FMT or designated provider.

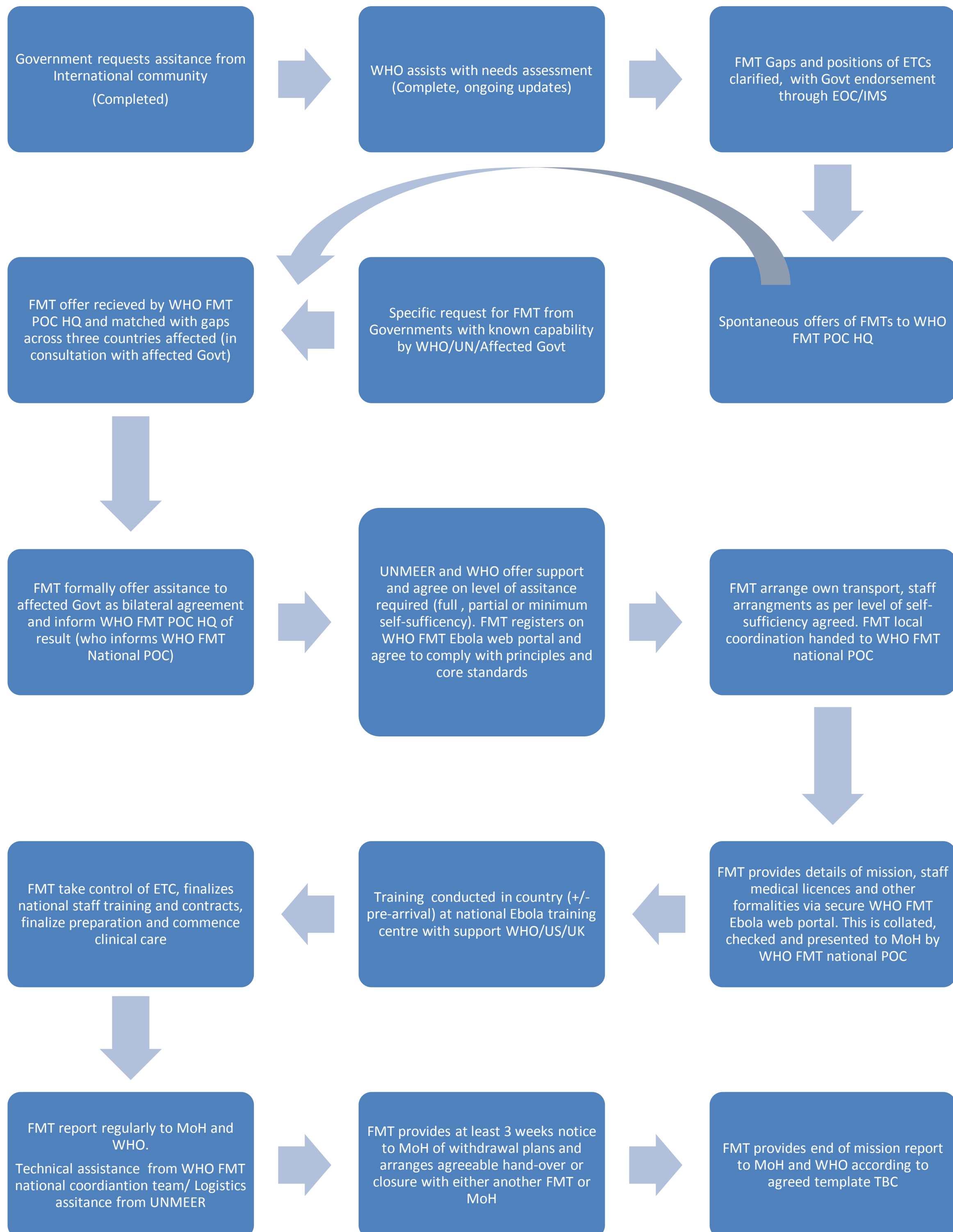
Medevac and in-country care for responders

Final discussions are ongoing on medical evacuation plans for international responders, but undertakings by several Governments should reassure FMTs that this will be provided. http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/EN/foraff/145195.pdf provides a link to a recent announcement by the European Union (see point 10).

Care provision for HCWs with suspect or confirmed Ebola will be provided by UK Government in Sierra Leone and by the US Government in Liberia from end of October. Care of other illness and injury is currently provided by UNMIL in Liberia, but work is ongoing by the UN to provide Ebola care to responders in Guinea, and for non-Ebola care to responders in all countries.

Mechanism for requesting and offering FMTs

The Government and Ministry of Health will be supported in the process of FMT recruitment and deployment by WHO and UNMEER, but retain overall control of the decision to accept or reject offers of assistance. The deployment of FMTs in defined units must be needs based, and matched to assessed epidemiological trends as far as possible.



National FMT coordination will be managed by the WHO FMT National POC and available via the HQ POC.

FMTs arriving as defined and self-sufficient are the preferred option. WHO will perform the role and function of identifying FMTs and matching them to need within ETCs, in support of the affected Governments. WHO will not deploy clinical staff to operational roles. FMTs will be required to act as programme managers and lead of each ETC, and have a recommended minimum number of 25 staff to partner with an estimated total work force of 200-250 per 100 bedded ETC.

Individuals seeking to volunteer in clinical or support roles for the Ebola response, or small groups of clinical management teams (CMTs) that do not reach the minimum standards of self-sufficiency as an FMT are asked to volunteer with an FMT that is managing an ETC.

Points of contact

Initial offers of assistance by FMTs, or requests for further information of the technical specifics, needs and gaps for FMT should be directed to the WHO FMT Point of contact:

Dr. Ian Norton nortoni@who.int +41795965730

Or Ms Christine Tretter tretterc@who.int