

# Key considerations for the implementation of an Ebola Care Unit at community level

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Complementary approach - West Africa Ebola  
Outbreak

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# **Ebola Care Unit (ECU): a complementary approach to control the Ebola outbreak**

## **Introduction**

The standard recommended public health actions implemented for stopping the Ebola outbreak include the early identification of cases, isolating and treating all patients in Ebola Treatment Centers (ETCs), rigorous contact tracing, and safe burial practices, supported by strong social mobilization and sound risk communication practices. These actions remain critical for stopping the Ebola outbreak in West Africa and should continue to underpin operational response plans. However, over the past few weeks, the epidemic has evolved rapidly and there has been an exponential rise in the number of Ebola cases reported with half of the approximately 5,000 total cases in this outbreak reported in the last three weeks. Available epidemiological data and modelling suggests that the number of cases will continue to rise in the coming weeks. Even with the current case load, the capacity of the ETC's have been stretched and the number of beds in available ETC's are inadequate to treat all reported case patients. In many places, infected patients remain in their family homes, with no other option of care, increasing the risk of infection for their families and contributing to continued transmission of Ebola.

Consequently, WHO, with the support from a variety of UN, NGO and government partners is proposing a complementary strategy to slow down and eventually stop transmission in affected areas. This will be done through the establishment of controlled settings, called **Ebola Care Units (ECU)**, where infected persons can be moved to so that they do not further transmit the virus within their households and communities and where they can receive basic curative and palliative care in an environment supported by members of their family and their respective communities.

Such an approach would complement, and not replace, current disease control efforts including the ETC's. If properly implemented it will slow down the progression of the epidemic by reducing community contact with infected persons and offering care to Ebola patients close to their homes, thus reducing transportation of infectious patients which, in some instances has led to significant infections among taxi drivers.

Home-based care has been put forward as an option. However, this will likely require an intense medical supervision and unmanageable medical supply chain of personal protective equipment (PPE) to families and significant challenges for dangerous waste management. Unless large-scale decentralised laboratory testing

is available, it would leave families guessing as to whether an ill household member should be treated as an Ebola-infected patient at home or has another illness that can perhaps be treated by seeking care outside the house. In addition, this approach may present greater risks to other members of the family as it is unrealistic to expect families, living in a confined environment to adequately protect themselves from infection even if extensive awareness raising and community training of infection control can be rolled out quickly at community level.

By contrast, a well-run ECU may be a realistic option and one that could draw upon community will and support, and at the same time offer a level of basic care above what can be provided at home, including presumptive treatment for malaria and infection prevention and control. Another major advantage of this approach is the fact that ECU could be operated via trained community health workers rather than a reliance on formal health workers thus minimizing the risk of pulling out already health workers, who are already limited in number, from essential functions (e.g., operating ETCs or in primary health care facilities) in order to run the ECUs.

**This brief paper provides the guidance and considerations that need to be taken into account when introducing the ECU strategy. The document is not prescriptive in nature but aims to provide the parameters within which these ECUs can successfully operate. While flexibility in the strategy is paramount to allow its adaptation and delivery in a range of different environments and contexts the document hopes to ensure that certain safety standards are maintained.**

### **Main principles of Ebola Care Units (ECU)**

**Community & Family Engagement:** the site and design of an ECU should be decided by the community. Care should be provided by a member of a patients' family following appropriate training on infection prevention and control practices and supervised by community health workers.

Without agreement with the community on the need to isolate sick patients or that there is a greater risk of infection when treating family members at home, the ECU's will not be accepted. Preparation and agreement with communities becomes especially important in areas where resistance and aggression is openly being shown towards response and health workers. With community participation and buy in ECU's should use local knowledge and practices to deliver Infection, Prevention, Control (IPC) using culturally acceptable behaviours.

**Designated Structure:** ECUs should be simple, inexpensive, existing (e.g. hut) or purpose-built (e.g. tent) structures where people with Ebola infection can be housed separately from their families and community. ECUs would be very small

(8 to 15 beds) to reduce risks of transmission and avoid complex management structures. They should be low tech and manageable by 2-3 community health workers at any given time. Waste management and disinfection procedures would be established, including procedures for the safe disposal of dead bodies.

**Separation of Suspect & Confirmed Cases:** Ebola and non-Ebola patients (esp. suspect cases) would be housed separately, with a supervision team coming regularly (preferably daily) to assess ECU safety and adherence to standards and to collect swabs for laboratory testing of suspected patients.

**Standard of Care:** Patients are treated with respect and provided with decent and compassionate care. Patients will receive food, water, oral rehydration, presumptive treatment for malaria (where appropriate) and analgesia.

**Supervision, Safety & Support:** The ECU is supervised by the supervision team with 1 Health care worker trained on IPC who is able to mentor community health workers and family members on safety practices (e.g. use of PPE), to educate the community, take swabs, and provide PPE.

**Associated Activities:** Each ECU will have a designated team for the management of dead patients, ensuring they are safely put in body bags and safely buried in respect of family wishes. In addition, there will be team, also appointed by the communities, who will monitor the community for suspect cases.

## **Establishment of ECUs**

### **a. Preparation & Planning**

A team of public health and social mobilisation specialists should engage with each community to discuss and seek consensus with local decision makers on the need for establishment of an ECU in their locality. This first step would involve listening to the community, addressing their concerns and fears about Ebola and obtaining agreement on who should be involved throughout planning, delivery and evaluation of the strategy.

To ensure community buy-in and ownership of the ECU strategy, steps should be taken during the preparatory and planning phases to:

- Conduct community mapping to understand existing community care mechanisms and cultural factors around care practices.
- Facilitate opportunities to listen to and dialogue with the affected community and seek their opinion on the provision of care for suspected Ebola patients and how best to protect others in the community from exposure.
- Identify influential local networks or groups (religious/traditional leaders; associations, etc) that could contribute to the establishment of ECUs.

- Ensure participation of relevant local network leadership during training of community health workers, care givers and those involved in critical support functions like cleaning, disinfection and safe burial of dead bodies.
- Establish a community-based monitoring system for referral, contact tracing and addressing rumours and fears regarding Ebola.

Once there is community acceptance, define the location of the ECU and what factors need to be considered to ensure communities will identify people and networks to ensure a safe functioning of the ECU. This will help to assess community contributions to the ECU which may include enhancing awareness and social acceptance of bringing suspected cases, provision of logistic support, security, etc, at the ECUs.

The appropriate geographical location of the ECU is critical and given that it is likely to be context specific, should be determined through strong engagement with the community and health professionals who are familiar with the area and the health needs. In some cases, it may need to be located close to ETCs, where ETCs have inadequate bed space. In other situations, ECUs may have to be established in areas with no ETU facility and where referral to an ETC is not possible for logistic, access or capacity reasons. Given that the ECUs will be small they need to be prioritized in high transmission areas rather than aiming for full coverage in order to keep them at a manageable number so that quality and appropriate supervision can be ensured.

Finally, a partnership will need to be convened and roles and responsibilities assigned to support the establishment and optimal management of these ECU to ensure adherence to safety standards and quality indicated in this protocol.

### **b. Characteristics of an ECU**

- ECUs may vary in size and locations depending on local decisions. However, it is preferable to keep them small (no more than 8 – 10 beds) which would limit the technical and logistic demands in their establishment and management. In addition, smaller ECU are believed to limit virus transmission at these facilities..
- Each bed should be separated by a minimum of 1 metre (ideally 1 to 2 metres).
- ECUs should be simple, inexpensive, existing (e.g. hut) or purpose-built (e.g. tent) structures where people with Ebola infection can be housed separately from their families and community.
- They should be low tech and manageable by 2-3 community health workers at any given time. Waste management and disinfection procedures would be established, including procedures for the safe disposal of dead bodies.

- They need to have adequate water and sanitation facilities for use by patients and caregivers.
- There should be adequate security at these ECUs, ideally provided by the community.
- Only highly probable cases should be admitted to these ECUs. They should have separate areas for suspect cases and Ebola patients or in absence of laboratory confirmation, dry and wet patients (see ECU design in Annex One) where patients can be directed following a detailed assessment and triage (using algorithms outlined in Annex Two).
- If the ECU is overloaded, patients showing up at the ECU with fever only and no history of contact with Ebola patients are treated presumptively for malaria and other common endemic infections (Annex Two) and sent home. If the fever persists they are reevaluated and admitted in the observation area.
- Cleaning and disinfection procedures are needed and relevant persons trained (See Annex Four). In addition adequate waste disposal facilities are also critical.
- An incinerator and power supply is desirable.
- One family member/caregiver per patient allowed, whenever possible provided with PPE and counselled on basic infection control and cleaning/disinfection procedures.

### **c. Services provided at the ECUs**

The proposed range of services at the ECUs includes:

- Round the clock care via family members assisted by community health workers
- Water & sanitation facilities.
- Food provided by community kitchen incentivised by programme.
- Patient assessment, triage and management in accordance with defined algorithms.
- Provision of ORS, antipyretics and presumptive treatment with antimalarials (and broad-spectrum antibiotics when medical supervision is available). No injectable drugs or intravenous fluids will be administered in the ECUs.
- Specimen collection (swabs or other non-invasive method) for laboratory confirmation of Ebola virus. No phlebotomy will be done at these ECUs.
- Psychosocial support for patients and their families.

### **d. Staffing of ECUs**

The suggested staffing levels to support the ECUs are as follows:

- Five community health workers to support round the clock operation (three during the day and two during the night).

- Three cleaners (two during the day and one during the night).
- At least one guard to ensure security at all times.
- At least one trained community member with social mobilization skills to welcome families and answer the questions of the community at the entrance of the ECU.

In addition, the ECU will need to be supported by:

- Burial teams, assigned by the community to ensure safe disposal of dead bodies in line with procedures outlined in Annex Four.
- A monitoring and supervisory team which is further described in the next section.

All staff supporting the ECU will be provided:

- Incentives appropriate to each individual context.
- Training on IPC, and is able to answer simple questions about Ebola disease.

As mentioned, the ECU will be supported by patients' family members and members of the community. A family member will assist in the provision of all direct patient care and clean their individual area. Persons who have been infected with Ebola and survived are likely to have some immunity and may be good candidates to provide such care or assist in the management of the ECUs. However, they should be provided with protective equipment.

### **e. Monitoring & supervision**

Appropriate monitoring and supervision is critical in ensuring the success of the approach. Given that there is a lot of responsibility and expectation placed on low level community health workers and members of the community, many of whom have never before undertaken such tasks, the monitoring and supervisory roles are critical to ensure that adequate standards are followed. Any deficiencies in the quality of implementation could present major risk of virus transmission within the ECU thus exacerbating a situation it is set out to address.

- The composition of the monitoring teams should be defined at the outset. The exact composition will vary by context but it should include health professionals.
- A minimum of once daily supervisory visits is recommended and an even higher frequency desirable if this is feasible. These visits should include direct observation of patient care and interactions with the community health workers and community members in order to identify problems and address them on the spot.

- When an Ebola laboratory is available nearby, daily supervisory visits will need to include collection of samples (swabs) for the laboratory testing, feedback on laboratory results and compilation of records.
- Monitoring should be done with the community to ensure their concerns are addressed, that there is real acceptance and adherence to the approach and they understand what is working well and what should be improved.

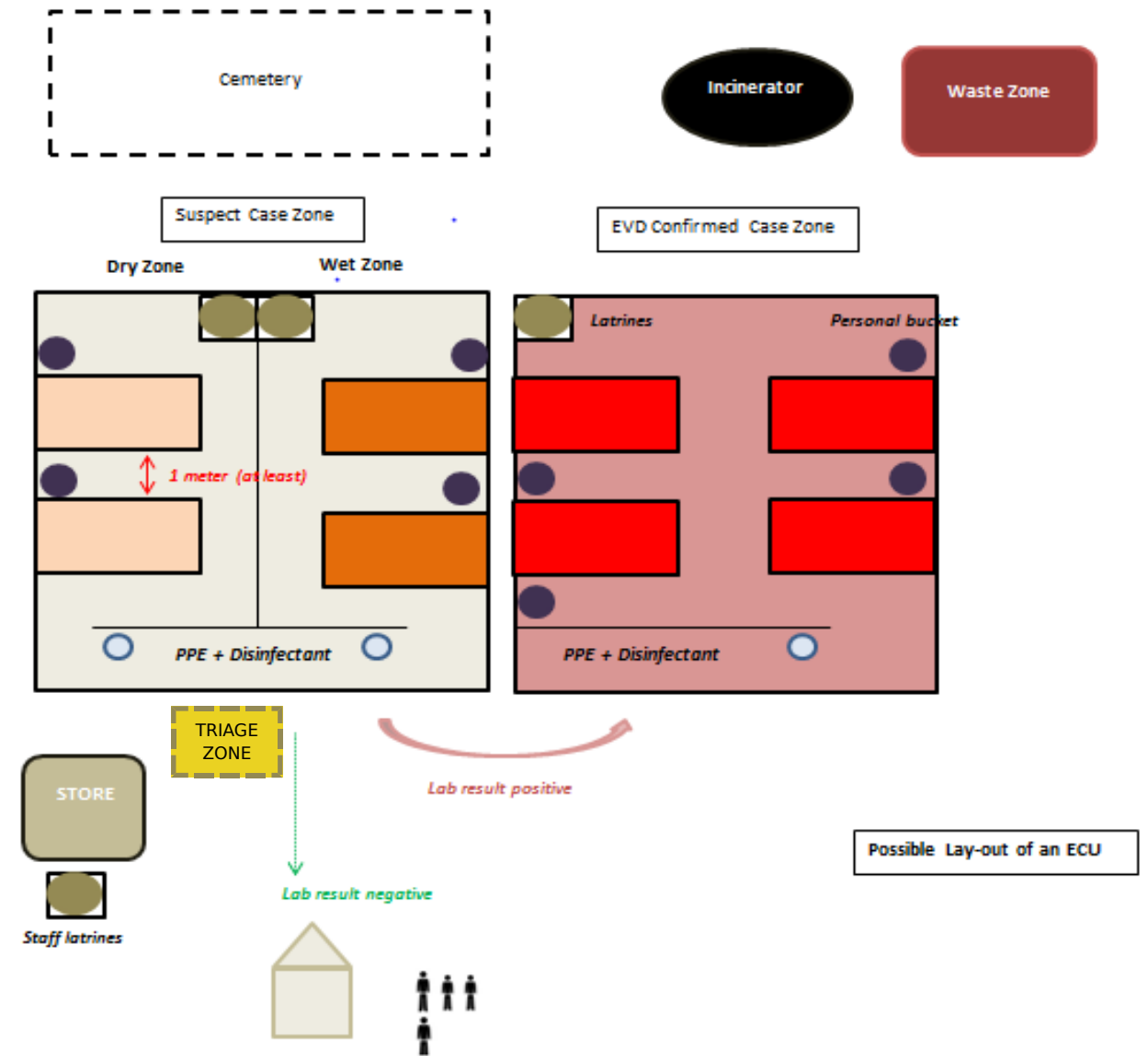
#### **f. Implementation of the approach and next steps**

- Ministries of Health in affected countries are advised to embark on this approach in an incremental manner e.g. starting with a few pilots which are well monitored before taking it up to scale. It is recommended that ECUs be prioritized in areas of intense transmission where they are most needed or in areas where there is no access to ETC's
- An immediate next step is the development of simple, user-friendly training material for use in the affected countries. Specific packages will be needed for:
  - o Community Health Workers
  - o Family members of patients and community members
  - o Waste disposal and disinfection personnel
  - o Supervisory teams
  - o Social mobilizers
  - o Burial teams
- Partnerships are critical in ensuring the success of this approach. All government and non-government partners should be consulted and their capacities and resources mapped in order to optimize their comparative advantage.
- Finally, given that this is a new approach that has never been tried on a large scale in the past, it needs to be carefully monitored and evaluated. It is strongly recommended that a lessons learned exercise, facilitated by WHO with the support of a wide range of partners, and with the full cooperation and involvement of affected communities, be conducted after one month of implementation of the "pilots". This will require the involvement of stakeholders from all affected countries where this approach has been rolled out and form the basis of revision of this guidance document. WHO will develop a set of predefined criteria for the review and lessons learnt exercise.

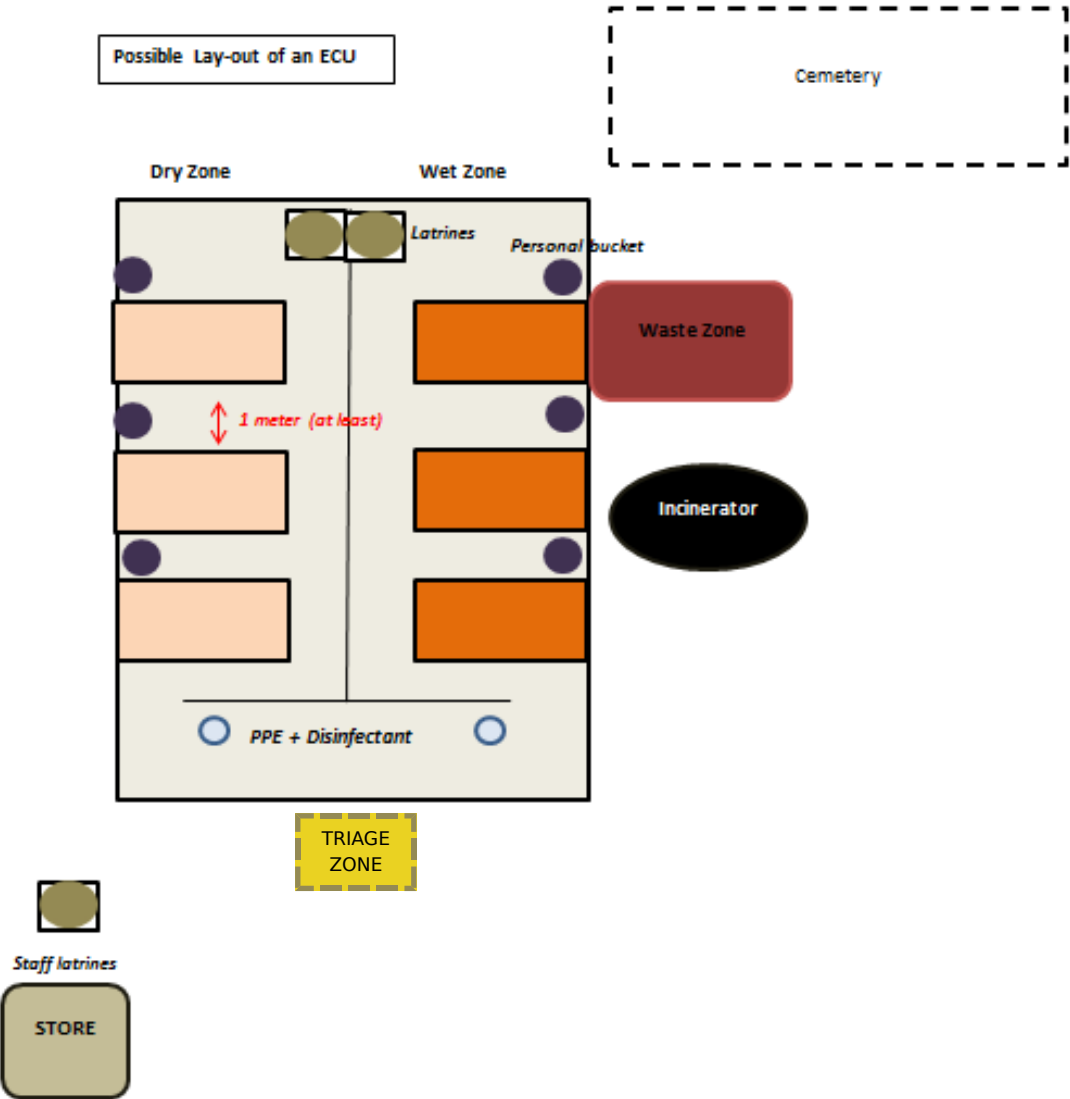


# ANNEX 1: Design of ECU

## ECU with laboratory confirmation available



# ECU with no laboratory confirmation



## ANNEX 2: Triage protocol and patient flow

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### Precautions for Ebola patients

There are 2 safety principles for ECU in order to reduce transmission:

- **Prevent transmission from Ebola to non -Ebola patients**
- **Protect care givers form the disease**
  
- Ebola and non-Ebola patients should be separated.
  - o In absence of laboratory confirmation, given that Ebola symptoms are not specific, , it is suggested to separate patients in 2 categories: Dry patients (patient with only fever) and Wet Patients (patients with diarrhoea, vomiting or bleeding). Where possible, wet and dry patients should be separated in two different areas (rooms, huts, tents, ...) .
  - o If laboratory testing is available, confirmed EVD cases should be separated from suspected cases and moved to separate area of the ECU as soon as the result is available.
- Community supervisors are properly trained on how to make triage decisions (i.e., deciding if suspect or confirmed; wet vs. dry), how to put on and take off PPEs, and on basic hygiene measures (e.g. hand hygiene). They should then train family members assisting their relatives.

### (1)Triage protocol at an ECU with laboratory capacity

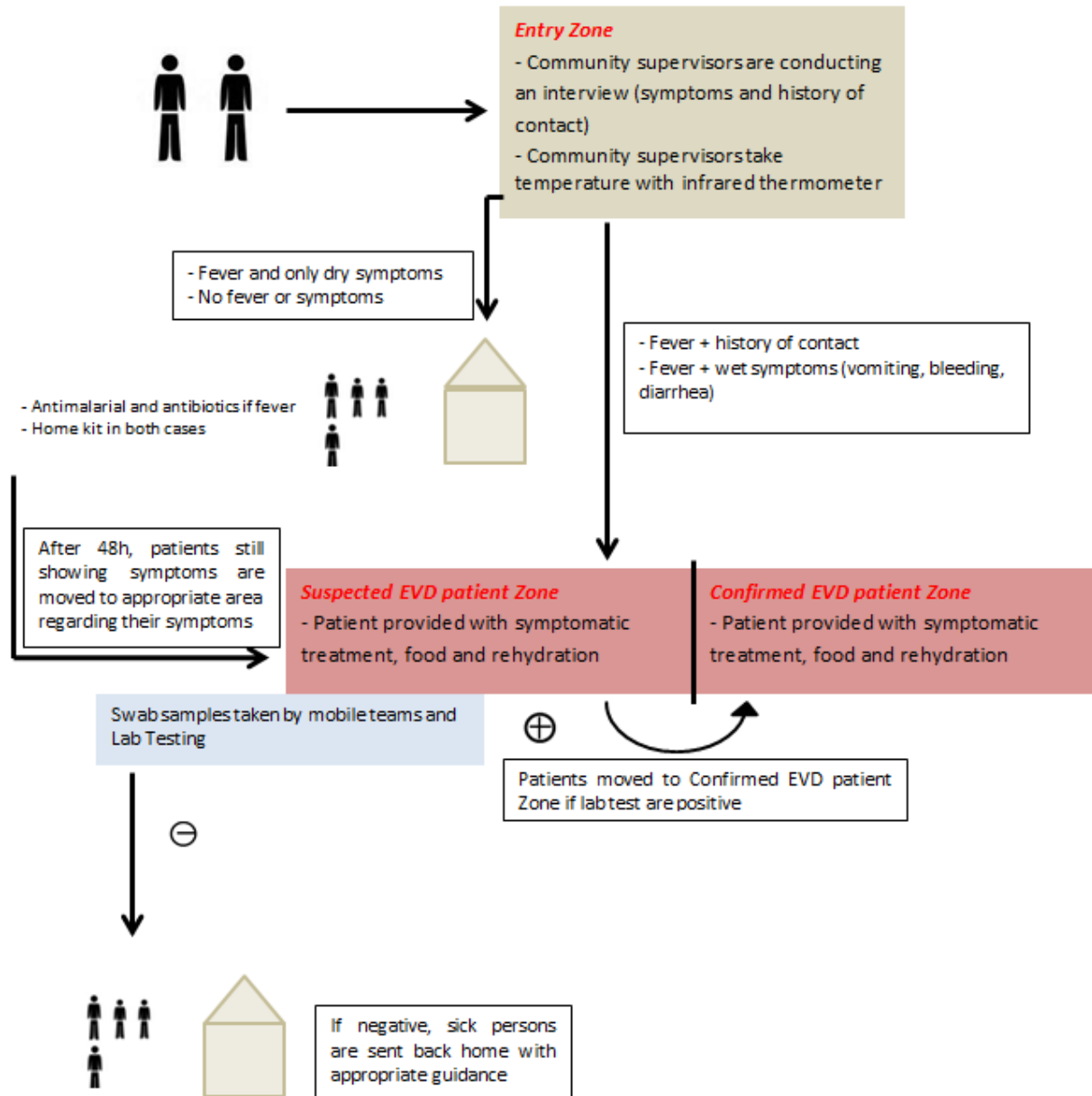
- In the triage zone, the community supervisor will conduct an interview:
  - Description of symptoms: **Fever, wet symptoms ( diarrhoea, nausea and vomiting, bleeding** (in vomiting, stool or urine)), “dry symptoms” (headaches, stomach pain, sore throat, breathing difficulties, muscle pain, joint pain or hiccups)  
(most concerning symptoms are in bold)
  - History of Contact with an Ebola patient: Did the sick person have a contact with an EVD case in the past 3 weeks (21 days)?
- The community supervisor will take sick person temperature with an infrared thermometer
  - If the sick person **shows fever and one of the following symptoms (wet symptoms): diarrhoea, vomiting or bleeding**, he/she should be considered as an Ebola patient and be admitted in the ECU priority should be given to wet patients
  - If the **sick person shows fever and/or “dry symptoms” and does report history of contact with an Ebola patient**, he/she should be considered as an Ebola patient and be admitted in the ECU
  - If the sick person **only shows fever and does not report history of contact with an Ebola patient**, he/she is provided with ACT (anti-malarial) and sent back

home for 48 hours of observation. The sick person is also provided with a home kit and advice to prevent transmission of disease.

- o If the fever still persists after 48 hours, the sick person comes back to the ECU and would be admitted as an Ebola patient.

- A mobile team that comes ideally everyday (at least twice a week) takes samples and provides lab results
- Patients with lab results pending are waiting in the “suspect case zone” and are separated in two different areas between “dry” and “wet” patients.
- Patients with positive lab results are moved to the “EVD confirmed case” area. Patients with negative lab results are sent back home with home-kit, advice (e.g. referral to other health facility) and medicines (if appropriate and available)
- In the ECU, patients are considered as Ebola patients and precautions for Ebola patients should be applied
- To reduce transmission within the family, only one designated family member can accompany the patient and should limit movements out of the ECU.

If Laboratory diagnosis is available

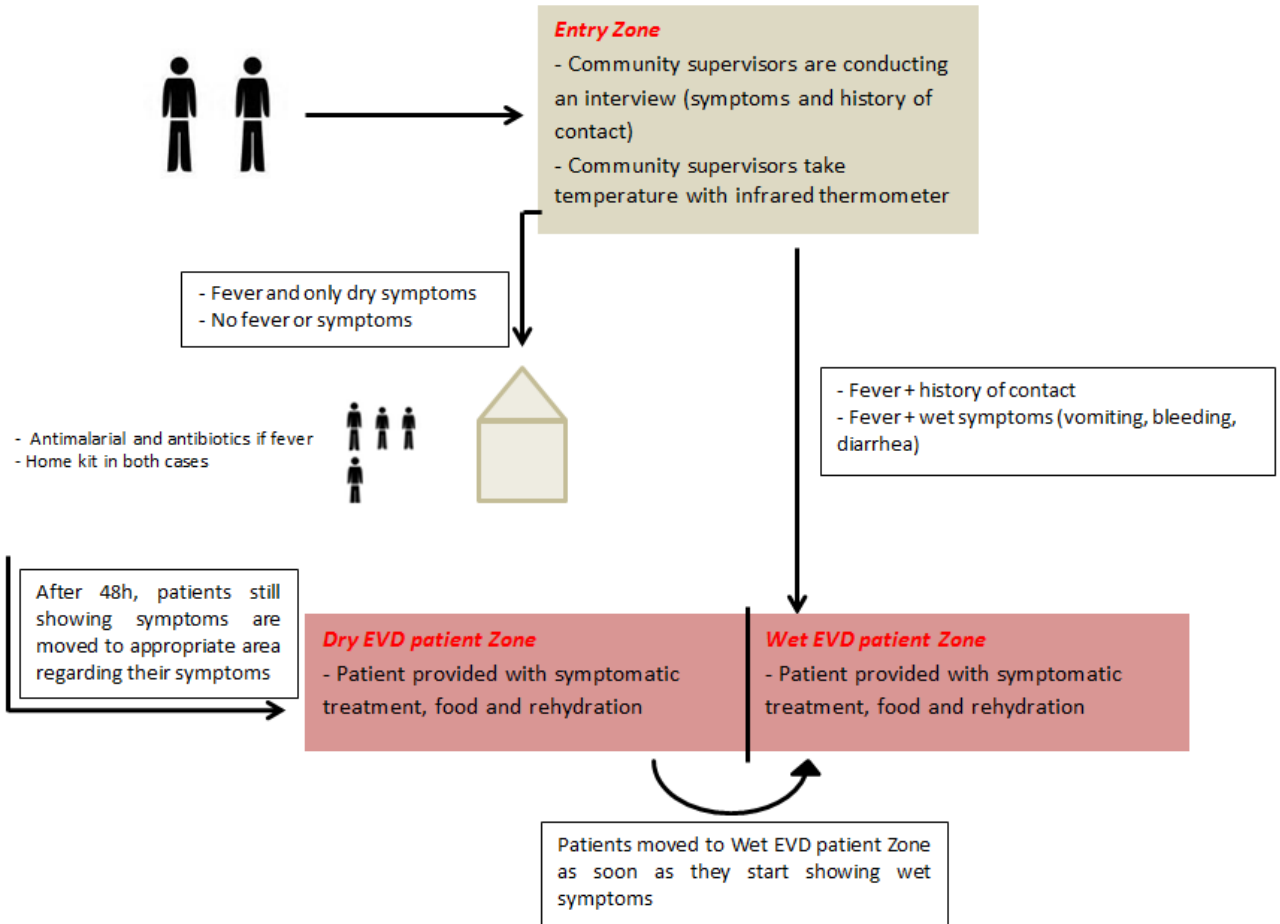


## (2) Triage protocol at an ECU with no laboratory confirmation possible

- The community supervisor will conduct an interview:
  - Description of symptoms: **Fever, wet symptoms (diarrhoea, nausea and vomiting, bleeding** (in vomiting, stool or urine)), “dry symptoms” (headaches, stomach pain, sore throat, breathing difficulties, muscle pain, joint pain or hiccups)  
(most concerning symptoms are in bold)

- History of Contact with an Ebola patient: Did the sick person have a contact with an EVD case in the past 3 weeks (21 days)?
- The community supervisor will take sick person temperature with an infrared thermometer
  - If the sick person **shows fever and one of the following symptoms: diarrhoea, vomiting or bleeding,** he/she should be considered as an Ebola patient and be admitted in the ECU
  - If the **sick person shows fever and does report history of contact with an Ebola patient,** he/she should be considered as an Ebola patient and be admitted in the ECU
  - If the sick person **only shows fever and does not report history of contact with an Ebola patient,** he/she is provided with ACT (anti-malarial) and sent back home for 48 hours of observation. The sick person is also provided with a home kit and advice to prevent transmission of disease.
    - If the fever still persists after 48 hours, the sick person comes back to the ECU and would be admitted as an Ebola patient.
- In the ECU, patients are considered as Ebola patients and precautions for Ebola patients should apply.
- To reduce transmission within the family, only one designated family member can accompany the patient.

*If Laboratory diagnosis is not available*



## Key necessary conditions to ensure safety and IPC in ECUs:

- Set up the ECU infrastructure to allow separation between suspected, dry and wet patients and confirmed EVD cases.
- Equip the ECU infrastructure with separate latrines for suspected and confirmed cases areas, adequate sewage system and water supplies
- Make all necessary PPE to be used by HCWs, cleaners and family members (Table) available at the ECU before opening the ECU and have clear plans for continuing inventory and delivery of PPE and materials before opening the ECU
- Provide basic IPC training to family members and community health workers providing care in the ECU about essential IPC precautions, performing hand hygiene and using PPEs. Give community health workers the task to always train new family members.
- Organize appropriate cleaning and waste management
- A mobile, IPC-trained supervision team should visit the ECU regularly (ideally every day) to
  - o Collect samples for testing and waste
  - o Support safe burials
  - o Bring supplies as needed, and
  - o To assess safety and IPC.

## Key IPC measures recommended for ECUs:

### Facility infrastructure and equipment

- Organize a triage area where patients are assessed (fever measurement, rapid interview, ideally **no touch activities**).
- ECUs should have at least 6 areas able to be separated by walls or by other physical separation (portable walls, fencing) into (i) triage, (ii) “clean” entry area (to put on PPE), (iii) ‘dry’ suspect EVD patients, (iv) ‘wet’ suspect EVD patients, (v) confirmed patients, and (vi) ‘dirty’ exit area (to remove PPE and disinfection). In addition, a designated sheltered area nearby should be provided for caretaker family members to sleep.
- Allow a 1 meter distance between patients
- For wet patients, use cholera beds (with hole for bedpan in the middle), if available.
- Provide a bucket and a bedpan to all patients
- Ensure safe patient flow from ‘clean’ to ‘dirty’. When circulating within the ECU (only if strictly necessary) patients, family and workers enter via the “clean” entry area, may move to the suspected cases area (from the dry to the wet patient areas) and then to the confirmed cases area (or from the dry to the wet patient areas if laboratory confirmation unavailable), and finally leave through a “dirty” exit area where equipment removal and disinfection occurs.
- Set up an area for waste management and laundering
- Organize daily collection of waste by the supervision team to be managed at the associated health-care facility. If possible, set up an incinerator besides the ECU.
- Provide hand hygiene facilities according to the Table in the triage area, in the “clean” entry area, in the patient areas and ‘dirty’ exit area
- Provide necessary PPE to be used by HCWs, cleaners and family members according to the Table



## **Patient care considerations**

- No more than one family member may provide care for each patient from the start to the end of their tenancy in the ECU (unless the family member themselves fall ill, in which case they can be replaced)
- Family members caring for Ebola patients should receive food and water sufficient for their needs for the duration of their stay at the facility, to prevent them from community interactions
- Basic IPC training (wear gloves, don't touch body fluids, etc.) should be provided to family members providing care in the ECU
- A dedicated toilet or latrine must be available, separate from the toilet facilities for the ECU patients, for family members to use. Family members must be instructed to use only this facility.
- The family member providing supportive care to the patient must not go back and forth between the ECU and the community; instead, they should sleep in a designated area near but outside the ECU. Bodies of dead persons should not be touched by family members and ECU staff. Either the supervision or the burial team should safely prepare all bodies for safe burials (see Annex 4).

## **Hand hygiene should be performed:**

- before donning gloves and wearing PPE on entry to the isolation room/area,
- before any clean procedures being performed on a patient,
- after any exposure risk or actual exposure with the patient's blood and body fluids,
- after touching (even potentially) contaminated surfaces/items/equipment in the patient's surroundings,
- and after removal of PPE, upon leaving the care area

## **Waste management:**

- Waste should be prepared and disposed in a designated area by workers or cleaners using PPEs and perform hand hygiene according to the Table
- Each individual bed should have her own bedpan and the contents emptied safely into the designated sewage area/latrine. Environmental decontamination of the sewage area/latrine should be continually conducted to minimize contamination.
- Sharps vs non-sharps
  - o All solid, non-sharp, infectious waste should be collected using leak-proof waste bags and covered bins.
  - o Any sharp objects (e.g. malaria RDTs) that have been in contact with blood or body fluids should be placed inside puncture resistant waste containers.
- Waste (both human waste and PPE waste) should be collected DAILY by the supervision team and burnable waste should be incinerated at the nearest associated healthcare facility
  - o If possible, the ECU should be close to the incinerator

## **Cleaning**

- Cleaners should wear PPE and perform hand hygiene according to the Table
- The ECU floors and surfaces should be regularly cleaned using a moistened cloth at least once a day with water and a detergent and then disinfected with a 0.5%

chlorine solution (or a solution containing 5 000 ppm [parts per million] available free chlorine)

- Environmental surfaces or objects contaminated (e.g. bedpans) with blood, other body fluids, secretions or excretions should be immediately cleaned with water and a detergent and then disinfected with a 0.5% chlorine solution (or a solution containing 5 000 ppm [parts per million] available free chlorine)
- If locally prepared, cleaning and disinfectant solutions should be prepared every day. Change cleaning solutions and refresh equipment frequently while being used during the day.
- Cleaning should always be carried out from “clean” areas to “dirty” areas
- Occupied and unoccupied clinical areas should not be cleaned with spray disinfectant. This is a potentially dangerous practice that has no proven disease control benefit.

**Management of linen**

- It is preferable that linen and patient clothes soiled with blood and body fluids are washed in a facility equipped with washing mashines.
- Workers managing soiled linen or clothes should wear PPEs according to the Table
- If washed elsewhere, soiled linen or clothes should be placed in clearly-labelled, leak-proof bags or buckets and the container surfaces should be disinfected with a 0.5% chlorine solution before transport.
- If washed at the ECU by hand, cleaning should occur in the following order:
  - o Solid excrement such as faeces or vomit should be scraped off carefully using a flat firm object and flushed down the toilet or in the sluice before linen is placed in the ‘dirty’ container.
  - o Soiled linen or clothes should next be soaked (totally covered with water) in a large drum container of hot water and soap. Use a stick to stir; then throw out the water and refill the drum with clean water and add 0.1% chlorine solution (or a solution containing 1 000 ppm [parts per million] available free chlorine) and allow to soak for 10- 15 minutes.
  - o Remove the linen and then rinse in clean water.
  - o Remove excess water and spread out to dry.

Recommended precautions and	Triage at the ECU	Care to dry patients	Care to wet patients and	Cleaning, laundering	Disp
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<b>PPEs</b>		<b>(HCWs and family)</b>	<b>all EVD confirmed cases (HCWs and family)</b>	<b>waste management activities (cleaners)</b>	
Hand hygiene with ABHR* or soap & water	X	X	X	X	NA
Examination gloves	X	X	X Double gloving		Dispo Char Poss alcoh inner repla betw
Face shields	X	X			Dispo Char and ECU
Goggles*			X	X	If reu and soak min befo
Face masks			X	X	Dispo Char and ECU.
Head cover			X**	X**	Dispo Char and ECU.
Disposable gown		X	X***	X***	Dispo Char and ECU.
Gum boots			X	X	Disin bloo leavi with soak min.
Reusable rubber aprons			X***	X***	Char Disin bloo leavi with

					soak min.
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\*If unavailable or uncomfortable to use, a face shield can be used.

\*\*Optional. Use hood if preferable, but cap acceptable.

\*\*\*If impermeable gown, rubber apron not needed

## **ANNEX 5: Management of dead bodies in ECU and safe burials**

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Burial ceremonies often carry a high risk of Ebola transmission, as a result of the gathering of large numbers of people either during the preparation of the body or during the funeral. It is essential to reduce transmission that may occur during burials through contact with dead bodies.

Management of dead bodies and burials should be performed by a team trained in infection prevention and control measures. The team should have all the necessary material such as personal protective equipment, body bags, disinfectant and transportation.

Other considerations are incineration of bodies and adequate management of waste. The respect of cultural practices and beliefs is essential for the success of this intervention.

Please refer to ***“How to safely conduct burial of patient who has died from suspected or confirmed Marburg or Ebola virus disease: outreach”*** guidance.

## **ANNEX 6: Indicative supply list for ECU**

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- **Basic supplies:**
  - a. Beds
  - b. mattresses with disposable plastic covers
  - c. Linen
  - d. Mosquito net
  - e. Utensils
  - f. Buckets
  - g. Body bags
  
- **IPC equipment:**
  - a. PPE
    - Hoods
    - Gloves
    - Face shields
    - Masks
    - Gowns
    - boots
    - Aprons
  - b. Hand hygiene supplies:
    - Soap & clean water
    - Alcohol based hand sanitizer
    - Chlorine water
  
- **Environmental cleaning and management of linen**
  - a. Heavy duty/rubber gloves
  - b. Detergent
  - c. Chlorine
  - d. Cleaning tools
  - e. Bags for waste disposal
  - f. Rags and paper towels
  
- **Basic Medical Supplies**
  - a. Infrared thermometer
  - b. Oral Rehydration Solution
  - c. Paracetamol
  - d. Antimalarials (where applicable)
  - e. Broad spectrum antibiotics (where applicable)

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