What: The East African Community would like to notify the general public and the Partner States that the Uganda health authorities have confirmed an outbreak of Ebola Haemorrhagic Fever in Kibaale District in Western Uganda.

Ebola is a highly virulent disease that kills 25-90% of those infected but can be prevented.

Where: The outbreak is at Kibaale District, which is approximately 200 km from the capital city of Kampala.

When: The outbreak has been ongoing since July and as of 28th July 2012 a total of 20 cases with 14 deaths have been recorded.

How is it transmitted: Transmission is through direct contact with blood, secretions, organs or other body fluids (saliva, blood, stool, vomit, urine and sweat) of infected persons. It can also be spread using skin piercing instruments that have been used by an infected person. Similarly one can be infected by getting in touch with a dead body of a person who has died of the disease.

How can you know if one is infected: The infected person presents with sudden onset of fever, body weakness, headache, and sore throat. This is often followed up by vomiting diarrhea, rash and in some cases internal and external bleeding.

What has been done: The Uganda Ministry of Health in collaboration with stakeholders has taken the necessary measures to contain the outbreak. These include among others:
Notification of an Outbreak of Ebola in Uganda

- Isolation of suspected cases and barrier nursing instituted
- Tracing and follow up of contacts of those exposed to Ebola since 6th July 2012
- National and district task forces are already in place to coordinate the response.
- Necessary logistics and supplies including personal protective equipment have been mobilized already.

What can you do?

- Report and immediately take any suspected patient to a nearby health unit
- Avoid direct contact with body fluids of a person suffering from Ebola using protective material like gloves and masks
- Persons who have died of Ebola must be handled with strong protective wear and buried immediately, avoid feasting and funerals
- Avoid eating dead animals

The outbreak is still confined to Kibaale District and World Health Organization does not recommend travel ban or trade restrictions with Uganda
The Ebola virus belongs to the Filoviridae family (filovirus) and is comprised of five distinct species: Zaire, Sudan, Côte d'Ivoire, Bundibugyo and Reston. Zaire, Sudan and Bundibugyo species have been associated with large Ebola haemorrhagic fever (EHF) outbreaks in Africa with high case fatality ratio (25–90%) while Côte d'Ivoire and Reston have not. Reston species can infect humans but no serious illness or death in humans has been reported to date.

Human infection with the Ebola Reston subtype, found in the Western Pacific, has only caused asymptomatic illness, meaning that those who contract the disease do not experience clinical illness.

The natural reservoir of the Ebola virus seems to reside in the rain forests of the African continent and in areas of the Western Pacific. There is evidence that bats are involved, but much work remains to be done to definitively describe the natural transmission cycle.

Transmission

- The Ebola virus is transmitted by direct contact with the blood, secretions, organs or other body fluids of infected persons.
- Burial ceremonies where mourners have direct contact with the body of the deceased person can play a significant role in the transmission of Ebola.
The infection of human cases with Ebola virus through the handling of infected chimpanzees, gorillas, and forest antelopes – both dead and alive – has been documented in Côte d'Ivoire, the Republic of Congo and Gabon. The transmission of the Ebola Reston strain through the handling of cynomolgus monkeys has also been reported.

Health care workers have frequently been infected while treating Ebola patients, through close contact without correct infection control precautions and adequate barrier nursing procedures.

**Incubation period:** two to 21 days.

**Symptoms**

- Ebola is characterized by the sudden onset of fever, intense weakness, muscle pain, headache and sore throat.

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

- Laboratory findings show low counts of white blood cells and platelets as well as elevated liver enzymes.

**Diagnosis**

- Specialized laboratory tests on blood specimens detect specific antigens and/or genes of the virus. Antibodies to the virus can be detected, and the virus can be isolated in cell culture.
Tests on samples present an extreme biohazard risk and are only conducted under maximum biological containment conditions.

New developments in diagnostic techniques include non-invasive methods of diagnosis (testing saliva and urine samples) and testing inactivated samples to provide rapid laboratory diagnosis to support case management during outbreak control activities.

**Therapy and vaccine**

Severe cases require intensive supportive care, as patients are frequently dehydrated and in need of intravenous fluids or oral rehydration with solutions containing electrolytes.

No specific treatment or vaccine is yet available for Ebola haemorrhagic fever. Several potential vaccines are being tested but it could be several years before any is available. A new drug therapy has shown some promise in laboratory studies and is currently being evaluated.

Experimental studies using hyper-immune sera on animals have shown no protection against the disease.

**Containment**

Suspected cases should be isolated from other patients and strict barrier nursing techniques implemented.

Tracing and follow up of people who may have been exposed to Ebola through close contact with patients are essential.

All hospital staff should be briefed on the nature of the disease and its transmission routes.
Particular emphasis should be placed on ensuring that invasive procedures such as the placing of intravenous lines and the handling of blood, secretions, catheters and suction devices are carried out under strict barrier nursing conditions.

Hospital staff should have individual gowns, gloves, masks and goggles. Non-disposable protective equipment must not be reused unless they have been properly disinfected.

Infection may also spread through contact with the soiled clothing or bed linens from a patient with Ebola. Disinfection is therefore required before handling these items.

Communities affected by Ebola should make efforts to ensure that the population is well informed, both about the nature of the disease itself and about necessary outbreak containment measures, including burial of the deceased. People who have died from Ebola should be promptly and safely buried.

Contacts

As the primary mode of person-to-person transmission is contact with contaminated blood, secretions or body fluids, people who have had close physical contact with patients should be kept under strict surveillance.

Their body temperature should be checked twice a day, with immediate hospitalization and strict isolation in case of the onset of fever.

Hospital staff who come into close contact with patients or contaminated materials without barrier nursing attire must be considered as contacts and followed up accordingly.

Early history
The Ebola virus was first identified in a western equatorial province of Sudan and in a nearby region of Zaïre (now the Democratic Republic of the Congo) in 1976 after significant epidemics in Yambuku in northern Democratic Republic of the Congo, and Nzara in southern Sudan. About 1850 cases with over 1200 deaths have been documented since the Ebola virus was discovered.

Natural reservoir

The natural reservoir of the Ebola virus is unknown despite extensive studies, but it seems to reside in the rain forests on the African continent and in the Western Pacific.

Although non-human primates have been a source of infection for humans, they are not thought to be the reservoir. They, like humans, are believed to be infected directly from the natural reservoir or through a chain of transmission from the natural reservoir.

On the African continent, Ebola infections of human cases have been linked to direct contact with gorillas, chimpanzees, monkeys, forest antelope and porcupines found dead in the rainforest.

So far, the Ebola virus has been detected in the wild in carcasses of chimpanzees (in Côte d'Ivoire and the Republic of the Congo), gorillas (Gabon and the Republic of the Congo) and duikers (the Republic of the Congo).

Different hypotheses have been developed to explain the origin of Ebola outbreaks. Laboratory observation has shown that bats experimentally infected with Ebola do not die, and this has raised speculation that these mammals may play a role in maintaining the virus in the tropical forest.

Extensive ecological studies have been carried out or are under way in the Republic of the Congo and Gabon to identify the Ebola's natural reservoir.