

EDITORIAL COMMENTARY

OF CHOLERA AND EBOLA VIRUS DISEASE IN GHANA

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CHOLERA OUTBREAKS

There are lessons to be learnt from cholera outbreaks in Ghana. In his inaugural lecture, Professor G. A. Ashitey¹ provides an account on the first cholera epidemic of 1970 in Ghana. Cholera outbreak in West Africa was first reported in Guinea. Although denied by the Government of Guinea the World Health Organisation had to break protocol and establish for the first time that “the health of the world’s people is more important than the sovereignty of member countries.”

The first case of cholera in Ghana was in a Togolese national in transit at the Kotoka international Airport from Guinea.² Two of the worst hit sites in Ghana, subsequently, were the fishing villages of Akplabanya (in the then Ada District) and Nyanyano (Winneba District). Cholera in these areas appeared to have been “smuggled in” by relatives of dead Ghanaian fishermen from Togo and Guinea, respectively, for burial despite a sanitary cordon on Ghana’s borders.

Attempts at controlling cholera were not successful because the needed long term approaches, such as potable water supply, proper disposal of solid waste etc. were not implemented. Cholera is now endemic with cyclical epidemics. These epidemics are now predictable but sanitary reforms have been inactive, ineffective and local authorities have failed in applying necessary bye-laws on food hygiene, sanitation, environmental health and waste disposal.

Cholera in Ghana is an urban problem with high impact on the urban poor. The unprecedented unregulated growth of urban areas has resulted in poor environmental conditions, lack of access to clean potable water and excruciating challenges in waste disposal. Urban authorities need to re-examine their strategies with a focus on explicitly pro-poor community-led orientation³ to provide lasting solutions to the now nearly annual epidemics of cholera.

EBOLA VIRUS DISEASE

The reality of Ebola Virus Disease occurring in Ghana has been heightened by the relentless spread of the disease and its associated high case fatality rate as seen in the initial three countries – Guinea, Sierra Leone and Liberia. Nigeria and Senegal have also acquired cases through importation from the index countries.

The high case fatality rate is associated with an apparent paralysis of the health systems to adequately respond to the epidemic and the deaths of health care workers have heightened the state of apprehension.

The prospect has been fuelled by the state of (un) preparedness in Ghana and the inability to control the spread of the epidemic, should it occur. Reactions to the outbreak are reflected in psychological, social, cultural, economic and above all health systems responses. There the need to design and implement appropriate information and communication approaches to address these concerns.

A striking observation is the weakness in the health systems of the three ‘index’ countries that have recent histories of social disablement through conflict. In this issue of the journal Professor Irene Agyepong presents a systems view and lessons from the ongoing outbreak in West Africa (page 168).

We should learn from the history of cholera in the country and the failure to effectively control it after its first introduction as we draw our Ebola preparedness plans. The preparation for the exclusion of Ebola from our boundaries should also take into consideration the opportunities it offers to strengthen weak infection control and surveillance systems and general epidemic control plans. The public health attitude should not only be Ebola control but institution of infection control and prevention, good surveillance and epidemic containment systems in general.

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