EDITORIAL

Ebola in West Africa: a forgotten epidemic



On 23 April 2015, the World Health Organization (WHO) reported that the Ebola epidemic that started in West Africa about 18 months ago had infected 26 079 people, of whom 10 823 had died. The three worst hit countries were Guinea (2 358 deaths), Liberia (4 573 deaths) and Sierra Leone (3 877 deaths), and accounted for 99.86% of the fatalities.

It is amazing that the West African Ebola epidemic is no longer headline news, and it appears as if life is back to normal in these three countries. However, the WHO has indicated that the decline in confirmed cases appeared to have stagnated, but warned that there was a need to increase efforts to stop Ebola virus transmission.

Liberia has not reported any new cases of Ebola since the last confirmed case died on 27 March 2015, and if no new cases emerge, it will be declared Ebola free by the WHO on 9 May 2015, after waiting for two incubation periods of 21 days each after the burial of the last confirmed case. The story is different in Sierra Leone as 12 new confirmed cases were reported recently. Guinea, where the first case of the West African Ebola epidemic was reported, had a total of 21 new confirmed cases.¹ As the weeks go by, there has been a decline in the number of new reported cases. Is this the true picture, or are the cases being concealed, especially in the rural areas owing to the stigma associated with the disease?

The three countries are still in danger in terms of the Ebola epidemic, the worst recorded in modern day history. At the height of the epidemic in October 2014, the World Bank warned that it would cost the West African economy \$32.6 billion (£20.3 billion) by the end of 2015 unless the epidemic was quickly contained.² The actual cost of the Ebola epidemic is unknown, especially for the three countries worst hit, as tourism, trade, investments and air travel have been severely curtailed. The weak health systems of these countries were only boosted during the epidemic by the erection of emergency field hospitals and treatment centres, small-scale laboratories and outbreak surveillance centres. Once

the epidemic has subsided, the sustainability of these facilities remains unknown, especially after volunteer healthcare staff members return to their countries of origin and the remaining local healthcare staff members assume control of the healthcare system. Over decades, these countries have experienced an exodus of locally trained healthcare professionals to other countries with better and more functional healthcare systems. Attracting them to rebuild the health systems in their countries of origin will be a challenge.

What are the lessons learnt from the Ebola epidemic that can assist with the early detection and curtailment of future outbreaks? Firstly, countries with weak health systems and a basic public health infrastructure in place cannot withstand a sudden shock. Secondly, preparedness, including a high level of vigilance for imported cases and a readiness to treat the first confirmed case as a national emergency, is paramount. Thirdly, no single control intervention is, all by itself, sufficiently powerful to bring an Ebola epidemic of this size and complexity under control. Finally, community engagement is the one factor that underlies the success of all other control measures.³

As the WHO certifies and declares each of these three countries Ebola free over time, their governments must capitalise on the lessons learnt to build strong public healthcare services and efficient disease surveillance systems, while the international community supports them by opening up trade and investment, lifting travel bans and completing the mandate of developing an effective vaccine for this disease. We cannot afford to be ill-prepared for another Ebola epidemic in Africa.

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