



Lessons from the Ebola Crisis in West Africa

Community engagement, crisis communication and countering rumours

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KEY TAKE AWAYS

- Context-sensitivity is key
- Include communities in the design and management of the response
- Sensitivity to local narratives and knowledge systems
- Counter myths and rumours
- Transparent and legitimate crisis communication

What lessons can we draw from the 2014-2016 Ebola crisis in Guinea, Liberia, Sierra Leone? While both the outbreak itself and the context is different, there are enough similarities between the Ebola crisis and COVID-19 to extract useful lessons and best practices. In this research note, the focus is on three key lessons from the Ebola experience: community engagement, crisis communication and countering the rumour mill. In the world's most fragile states, an uncontrolled outbreak of COVID-19 would have devastating consequences for the population. In a scenario where the spread of the coronavirus is under control in large parts of the world, the survival of COVID-19 in fragile states would also most certainly be a source for new waves of infections to the rest of the world. Not only do fragile states lack capacity to react adequately on their own, but their ability to utilise external support and assistance is limited due to low absorption capacity.¹

The Ebola outbreak: a brief overview

28,616 cases of Ebola were detected, and 11,310 people died during the outbreak in Guinea, Liberia and Sierra Leone.² One factor these countries had in common were weak health systems, including hospitals lacking both electricity and running water, making them poorly equipped to deal with an epidemic of this scope. With an extremely low ratio of physicians per inhabitant, the deaths of 513 doctors, nurses and midwives during the crisis added to the severity of the situation. Healthcare workers were up to 32 times more likely to be infected by Ebola than the general population.³ In Liberia, 0,11% of the general population was killed versus 8,07% of the country's healthcare workers.⁴ In Sierra Leone, this led to a 23% decrease in health service provision.⁵ Strengthening health systems in fragile states through the strategic use of ODA has therefore been outlined as a key recommendation for the international community to better prepare for future global health crises.⁶ However, three key lessons that had a significant effect on bringing an end to the Ebola crisis in West Africa in 2016 was community engagement, strategic communication and countering rumours and myths.

Communication, Accessibility, Logistics

Medical research identified the origin of the Ebola virus in local consumption of bush meat.⁷ While this explains the index case, the sole source of infection during the epidemic was human-to-human transmission. To stop the spread of the Ebola virus the key was to disrupt this pattern.⁸ The same is true for COVID-19. The breakthrough in disrupting this pattern during the Ebola crisis came about when the response shifted from a purely medical response focused on people infected with the virus to one that involved local communities in preventing the spread of the virus.⁹ The key lesson for COVID-19 is that international and national responses have to be sensitive to the local community context, the role of cultural practices in the transmission and that community engagement in the design and management of this kind of public health emergency is critically important.

During the Ebola outbreak, burial practices, marriages, land-management, migration, trading patterns and dispute-settlement played a prominent role in the spread and amplification of the virus. Family and kin relationship played a major role in homecare and self-reliance networks particularly in rural regions, where the rudimentary health facilities that existed prior to the outbreak were hit hard by Ebola. Family and kin-based homecare and self-reliance networks will be just as important in the case of a major COVID-19 outbreak as they were during Ebola, and international responses need to find efficient ways of working with community and traditional structures. This is particularly important in fragile states where peoples' trust in government, and the international community, often is very low¹⁰, and where family and kin relations are almost always seen as more trustful.

The establishment of isolation wards in the form of Ebola Treatment Units (ETUs) to which only health personnel and patients had access was necessary to quell the outbreak, but experience shows that such response must come in tandem with effective and legitimate crisis communication. During the Ebola, relatives saw family members disappearing into the ETUs, never to be seen again, just receiving a message that their loved ones had died. This combined with the military approach of the ETUs, with health personnel in protective gear never seen before in these countries, started a rumour mill that made international and national efforts less effective. Targeted information in local languages transmitted through locally trusted sources helped to counter rumours and myths after a while, but there are important lessons learned here about context-sensitivity and how to conduct crisis communication transparently that must be included in the planning of COVID-19 responses in fragile states.

Mistrust, fear, rumours

Widespread mistrust in governments, outsiders and international organisations and the circulation of negative rumours shaped reactions to preventive measures taken. Early responses over-communicated the lethality of the disease but offered few concrete measures to avoid contagion. Combined with a distrust of foreign aid workers, rumours about Ebola began to spread across platforms such as social networks, religious leadership, media publications, and social media.

Circulated conspiracy theories included accusations of Ebola having been introduced by foreign health- and aid workers; governments fuelling the spread of the virus in order to receive foreign aid; and rumours of organ theft and cannibalisation.¹¹ Failure to sufficiently address local care- and burial practices significantly hampered the efforts made by national and international actors to contain the disease, as these were sites with high risk of contagion.¹² Funeral practices should be targeted with sensitivity as they provide the frame for the regulation of access to lands, lineage rights and tenure - issues that are key for the survival of households, but also often hotly contested in West Africa and most other fragile states.

The introduction of safe burial-routines eventually reduced distrust among local communities, and conflicts arising from burial practices, but was hampered by an initial failure of crisis communication that the international community should avoid repeating. Communications calling for 'flexible burial rites' should therefore be properly conveyed by trusted opinion-leaders following WHO protocols, while an effective burial team composed by health agents should be provided promptly with proper biohazard instruments.

Engaging community, traditional and religious leaders was central in managing transmission through religious or traditional practices, combining epidemiological guidelines with trusted sources of information. Already existing inter-faith structures, such as inter-religious councils, made it easier for religious leaders to maintain unified positions. Recent surveys indicate that the

average African citizen trusts religious leaders more than politicians.¹³ Investing resources not only in the medical response, but also in strategic communications to counter rumours and myths, especially in local languages are thus key. It is promising to see that the WHO and the African Centre for Disease Control has already started to invest in this area and further support to them should be encouraged.

Conclusion

The framing of local traditions and religious beliefs as a problem to overcome, risks to further aggravate the situation. To ensure efficiency of containment and treatment, interventions should take local contexts into consideration and work closely with local communities. Knowing the risk posed by mistrust and rumours, and the importance of clear public health-information, community, religious and traditional leaders are therefore central actors that need to be involved in efforts to quell COVID-19 in fragile states. Having access to perception data at the community level is key in this regard, and further analysis is needed to understand more comprehensively lessons learned from the West African Ebola outbreak, the current one in DR Congo,¹⁴ and from several vaccine campaigns that also has struggled to establish credibility and acceptance.

Endnotes

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