Communicating in a Public Health Crisis: The Case of Ebola in West Africa

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New and emerging diseases are at the fore front of global health issues as the recent Ebola outbreak in West Africa and recently Zika in the Americas have shown that such issues are not only health issues but also border on security, justice, development, economy and globalization. The Ebola outbreak in particular tested the global world's ability to address a humanitarian issue that had the potential to become a global pandemic. What stood out most in the Ebola outbreak was the fact that medical approaches are not enough to address any health issue; communication, culture, traditional norms and customs, etc. all play a role in being able to work with communities to address their health concerns.

Liberia was one of the countries that was badly affected by the Ebola outbreak and recorded 10,666 cases with 4806 deaths (WHO situation report, March 2016). Ghana on the other hand did not record any cases but was pulled into Ebola management when it was made the host of the first ever United Nations Mission on Emergency Ebola Response (UNMEER), the first ever of such missions for health to be set up. As a health and development communicator, I was interested in how risk/crisis communication during the Ebola outbreak was managed and received by the community members. This is against the background that existing guidance on risk/crisis communication are not based on systematic evidence based research (Many publishing, 2015). Again the emerging area of risk and crisis communication has been noted to have inadequate rigorous empirical evidence and evaluation research (Infanti et al., 2013).

My interest in this area was stoked as I kept hearing about a strange disease in some West African countries from family members who were always calling to alert me. This was as early as March 2014 when not much was being done by way of communication and the outbreak was still confined to the three worst affected countries in rural areas. I tried to follow how the outbreak was being communicated but only heard about medical terminologies and approaches to addressing the disease without much focus on communicating about the disease itself and how to prevent it. Communication came into the picture much later in August when the outbreak had spread to capital cities. By this time, normal social interactions had become deadly particularly in the countries affected and even in unaffected countries such as Ghana. The fear in Ghana was about the possibility of transmission through air travel (Bogosh et al., 2015) and the existence of huge colonies of fruit bats in Ghana, coupled with the desire for bushmeat as a delicacy.

I was interested in evaluating how communication was adopted and used in the two countries and it was received by the target audience. My research therefore addresses three questions:

A) What communication strategies were adopted and used in the 2014 Ebola outbreak in the two countries?

B) What were respondents' risks perception regarding the outbreak?

C) How did community members respond to the communication messages and what (if any) alternative communication approaches were adopted and used by community members?

The SRA grant enabled me to spend time in Ghana and Liberia interviewing community members, health officials in government, humanitarian aid workers and community leaders on the risk/crisis communication during the outbreak. I was also able to hold six focus group discussion sessions to learn from community members how they would prefer communication be done in future health crisis situations and suggestions for improving communication in addition to community level initiatives developed and used during the outbreak. I also survey 600 community members on their risk perceptions and their sources and trusted channels of information in addition to their self–efficacy with regards to preventing Ebola based on the communication messages they received. I worked in the Dolotown and Unification Town health center catchment areas in Mamam Kabah in Margibi county in Liberia and in the Dodowa main health facility and its environs in the Shai Osudoku District in the Greater Accra region of Ghana.

My initial findings suggest that at the initial stages of the response, a media campaign was used in both countries with messages suggesting that Ebola is real, deadly and has no cure. This approach was found to be inadequate in both countries but particularly in Liberia, it served to reinforce rumors that the outbreak was a move by the government to manage population growth and to get funding from international partners. Furthermore, community members with suspected cases refused to take their family members to health centers and designated holding areas since the disease had no cure and their family members would die any way. They rationalized that, at home, their family members could die surrounded by loved ones. Communication therefore had to change (and subsequent communication was modified to address rumors in communities and improvement in understanding about Ebola) to say that early detection and treatment can lead survival and communication channels now focused on using interpersonal avenues --trained community volunteers. Risk perceptions were however high in Liberia and majority of respondents knew how to protect themselves from getting infected.

In Ghana, however, the media enjoy a certain level of credibility and this helped to send out the message about Ebola. But because there was very little funding for the campaign, the survey showed that risk perceptions about Ebola in Ghana (compared to other disease such as malaria, diabetes, HIV/AIDS, food poisoning) was low and knowledge levels were also low. This is disconcerting as it suggests that should another outbreak surface, Ghanaians might not have the required preventive information to protect themselves.

Some lessons from this study include the fact that rumors and mistrust can make it challenging to communicate during emergency risk/crisis situation. It is therefore imperative that public health communicators develop community level communication channels and sources that are trusted, which can be used in emergency situations. A key take-away from the study so far is that communities are resilient and innovative in the face of crisis situations and would come together to work out systems to sustain themselves. These must be leveraged in public health policy development and implementation.

References

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