SOCIAL, CULTURAL AND BEHAVIOURAL CONTEXT OF 2014 EBOLA VIRUS DISEASE (EVD) OUTBREAK IN NIGERIA: COMMUNITY PERSPECTIVES AND NURSES’ PREPAREDNESS

MILDRED E. JOHN; RN,RM, BSc, PHD, FWACN
DEPARTMENT OF NURSING SCIENCE, UNIVERSITY OF CALABAR, CALABAR, NIGERIA
LEARNER OBJECTIVES: ATTENDEES WILL:

- HAVE KNOWLEDGE OF THE SOCIO-CULTURAL BELIEFS AND PRACTICES AND BEHAVIOURAL RESPONSES THAT INFLUENCED THE CONTROL OF 2014 EBOLA VIRUS DISEASE IN NIGERIA
- UNDERSTAND NURSES' KNOWLEDGE OF THE SOCIO-CULTURAL COMPONENTS OF EBOLA CARE AND THEIR LEVEL OF PREPAREDNESS TO PROVIDE SOCIO-CULTURALLY RELEVANT CARE
BACKGROUND

• 15 isolated outbreaks of Ebola in sub-Saharan Africa since 1976
• The 2014/2015 Ebola Virus Disease (EVD) outbreak in West Africa was unprecedented in magnitude and persistence
• Most widespread (22,500 cases in 8 countries as at February 2015)
• Affected the Mano River Union countries (Guinea Conakry, Sierra Leone and Liberia) and others (Nigeria, Mali and Senegal)
• Most prolonged (up to 15 months in some countries)
• Most severe and most deadly (over 9,000 deaths)
• High morbidity among health workers (815 infected)
• High mortality among health workers (500 died, more than 55% were nurses and midwives)

• 68% case fatality among nursing personnel
These caused:

• Heavy toll on already weak health system and scarce health resources in affected countries

• Declaration of the outbreak as “public health emergency of international concern” by WHO
STATEMENT OF THE PROBLEM

• The EVD outbreak in Nigeria was from July 15 to September 15, 2014 (2 months), before the nation was declared Ebola-free on October 20, 2014 (42 days after the last case)
The outbreak had:

- **20 cases** (19 confirmed, 1 probable; 16 in Lagos, 4 in Rivers)
  - (11 health workers)

- **8 deaths** with **40% case fatality ratio**
  - (5 health workers)
• **898 contacts under follow-up** (349 in Lagos, 549 in Rivers)

• **Contact follow-up higher in Rivers** (though only 4 cases) because of a wedding which known suspected cases attended
• Ebola is a "people" problem because community responses to it are driven by socio-cultural beliefs/practices and people in the affected countries live communal social life.
• Both outbreak and extensive contact follow-up had profound social impact on infected persons, contacts, their families and communities. Caused:

• Intense stress and social tension
• Relocation of contacts and families to avoid stigmatization

• Low morale among health workers (subject to same issues as patients - sickness, stigma, loss of colleagues, surveillance)
Despite the social impact of Ebola:

• Local views and social responses to the outbreak not adequately considered and targeted by containment programmes.
• Government anti-stigma campaign came only towards the end of outbreak (to protect survivors)
• Behavioural, psychological and socio-cultural interventions were not holistic
• Control strategies by health facilities neglected socio-cultural aspects

• Nurses not trained to focus on socio-cultural care during the outbreak
• This aggregate of socio-cultural issues served as the impetus for the study

• Moreover, few studies exist which have looked at socio-cultural aspects of EVD
AIMS

2 aims:

• Identify social and cultural beliefs, practices and responses that may influence the spread and control of Ebola in the community
• Determine nurses' knowledge of the social and cultural perspectives of EVD and their preparedness to provide relevant socio-cultural care
METHODS

• **Design:** Mixed method was used:
  - Qualitative explored the socio-cultural and behavioural influences of EVD spread and control
  - Quantitative assessed the knowledge and preparedness of nurses on the socio-cultural aspects of EVD
• **Setting:** 4 randomly selected communities in Rivers and Akwa Ibom states of Nigeria and 6 community health centres in the 2 states
Why the 2 states?

• Outbreak in **Rivers** (4 cases, 2 deaths but 549 contacts under surveillance)
• Many contacts migrated to nearby states, including **Akwa Ibom** State, to avoid quarantine and stigma

• “Bush meat" is a prized delicacy in the 2 states
• Ethical approval from HREC of the 2 states, permission from health facilities and informed consent from participants
• Participants:
  – 178 conveniently selected consenting adults living in the selected communities
  – 85 randomly selected nurses from 6 community health centres
Data collection:

• Qualitative: Focus-group discussion (FGD) and semi-structured interview recorded on audio-tapes and field notes
• Quantitative: Pre-tested Questionnaires with Cronbach’s alpha of 0.75)
• Knowledge and socio-cultural readiness items were weighted (5 points per item with maximum score of 60 for each variable)
Data analysis:

• Qualitative data transcribed and analysed using NVivo 7.0.

• Quantitative data were analyzed using descriptive statistics on SPSS 20.0.
• Scores of 45 to 60 on the knowledge and readiness schedules indicated good knowledge and adequate preparedness (readiness)
RESULTS

• Socio-demographic characteristics

1. Community members (n = 178)

• Age: 42.7% (31 to 40 years)
• Gender: 59.0% (Male)
• Education: 46.6% (High School /Secondary education)
• Occupation: 29.2% (Farming), 28.7% (Trading)
2. Nurses (n = 85)

- Age: 40.0% (31 – 40 years)
- Gender: 69.4% (Female)
- Professional qualification: 42.4% (Community Health officers)
- Position/rank: 70.6% (senior cadres)
QUALITATIVE DATA

5 themes emerged

1. Notions of the disease
2. Naming of the disease
3. Social issues of Concern
4. Beliefs/Socio-cultural practices that enhance spread & impede control measures
5. Behavioural responses that enhance control
Notions of the disease

Outbreak is:

• A “deception by the whites to destroy our cultural heritage”
• “Caused by angry gods, evil spirits and witchcraft affliction”
Naming the disease

• “Ebo-Lie” – “a deception”
• “Touch and die” disease
• “Virus of quick death”
• “Hug and get”
• “Kill-fast virus”
Beliefs that could enhance spread and impede control of Ebola:

• “Acceptable traditional greeting must involve hugging, touching and shaking hands”
• "Family members should be in close contact with one another"
• “Not touching or caring for sick relatives is culturally wrong and means abandonment”
• “Not performing proper burial rites is dishonouring the dead and may bring repercussions"
Social and cultural practices that could enhance spread and impede control

• Heavy reliance on physical contact even in death
• Traditional greeting practices
• Traditional burial rites (touching, kissing, washing, dressing the corpse)
• Family members sleeping on same bed or mat, sharing clothes etc.
• Close physical care of sick relatives with symptoms of EVD
• Eating of “bush meat”
• Belief in / practice of “fake Ebola cure” measures
Messages of fake Ebola cure
Social and behavioural responses that enhanced control:

- Suspension of public funerals and traditional funeral rites
- Suspension of traditional way of greeting and following the "no touching" rule
KEEP CALM
AND
KEEP YOUR HANDS TO YOURSELF

Ebola greeting......
• Ban on transportation of corpses from one community to another
• Delay in re-opening of schools
• Strategically placed hand washing kits & hand sanitizers in public places
• Carrying of hand sanitizers in handbags and pockets (self protection)

• Community mobilization, education and engagement in control efforts
Social issues of Concerns:

• Stigmatization
  – Eviction from residence
• Burial of the dead

– “They bury the dead in a manner not culturally acceptable”

– “Hmm they may be using the body of our dead relatives for their research”
• Isolation/quarantine:
  – “They just take sick people to an unknown place and the family cannot visit”
  – “If they suspect contact with a sick person, they just keep you under house arrest.”
QUANTITATIVE DATA

1. Nurses’ knowledge of Socio-cultural care of patients with Ebola

- Only 29.4% nurses had adequate knowledge of Ebola-related socio-cultural factors
• 55.3% did not see socio-cultural factors as playing any important role in Ebola care
• 36.5% agreed that they need training in socio-cultural care of Ebola patients
2. Nurses' preparedness to provide relevant Socio-cultural care of patients with Ebola

- 72.9% had low readiness scores
- 100% reported no training or preparation on socio-cultural aspects of Ebola care
• Only 12.9% actually gave care based on social and cultural considerations

These results signify low level of preparedness for providing socio-cultural care
Implications for health policy, nursing education and practice

• Adapt health messages to dominant socio-cultural beliefs, and behaviours

• Intensive anti-stigma campaigns to tackle negative labelling
• Psychosocial support to survivors, families, stigmatized care workers

• Training and capacity building for nurses
CONCLUSION

• Certain socio-cultural beliefs and practices influenced Ebola control in Nigeria

• Nurses working in the community:
  – Had inadequate knowledge of Ebola-related socio-cultural issues
Had no training on socio-culturally relevant Ebola care
– Had low level of preparedness for culturally relevant Ebola care
I present this paper in honour of all our colleagues who lost their lives in the fight to contain Ebola world wide
Your views?

Let’s share