
# SOCIAL, CULTURAL AND BEHAVIOURAL CONTEXT OF 201 EBOLA VIRUS DISEASE (EVD) OUTBREAK IN NIGERIA: COMMUNITY PERSPECTIVES AND NURSES' PREPAREDNESS

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# DISCLOSURE

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**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:

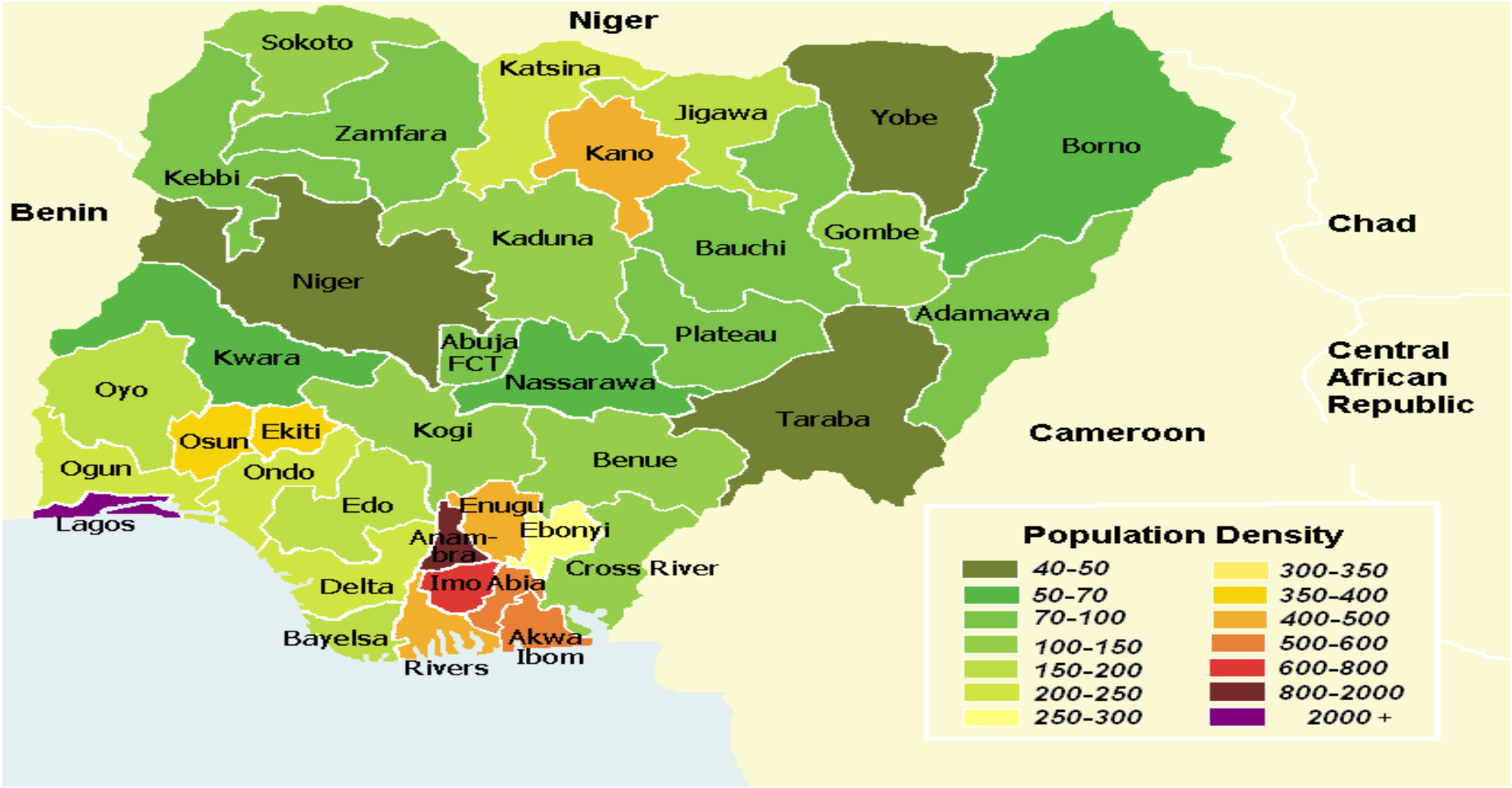
- **Identify social and cultural beliefs, practices and responses that may influence the spread and control of Ebola in the community**

- **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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Benue
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Bayelsa
Akwa Ibom
Rivers
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300-350
350-400
400-500
500-600
600-800
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2000 +

# 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

- **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**
  - **Labelling: “People stigmatise workers in the Isolation centres (‘Ebola nurses”, “evil grave diggers”)**
  - **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**

**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