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EBOLA OUTBREAK IN WEST AFRICA: MISTRUST, TRADITIONAL CUSTOMS, AND MISCONCEPTIONS FUEL THE FIRE

By Dr. Ashley Neese Bybee

In February 2014, Ebola broke out in Guinea's southeastern region of Nzerekore. By March, the virus had spread to Liberia and Sierra Leone. As of July 12, the World Health Organization (WHO) reported 964 cases of the disease in West Africa, including 603 deaths, making this outbreak the worst in history. With a death rate of approximately 60 percent, however, this particular strain of Ebola is not as deadly as those that have afflicted the Democratic Republic of the Congo (DRC) or Gabon, where death rates were closer to 90 percent. A number of factors unique to the Guinea-Liberia-Sierra Leone sub-region have facilitated this contagion: the proximity of the outbreak to urban centers, mistrust of public and foreign health workers, and traditional customs that bring people into direct contact with infected individuals. *more...*

March 28, 2014—Health care workers from Médecins Sans Frontières (Doctors without Borders) prepare isolation and treatment areas for their Ebola, hemorrhagic fever operations, in Gueckedou, Guinea. (Source: AP Photo/Kjell Gunnar Beraas, MSF, File.)

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Protesters over kidnapping of Chibok girls hold vigil in Abuja, Nigeria in May 2014. (Source: AP)

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IDA's three federally-funded research and development centers provide objective analyses of national security issues and related national challenges, particularly those requiring scientific and technical expertise.

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This Ebola Strain

The Ebola strain currently afflicting West Africa is new and believed to be linked to human consumption of fruit bats carrying the virus. It has an incubation period of two to three weeks, during which time an infected individual it is not yet contagious. Transmission is primarily through direct contact with bodily fluids of infected people, making family members of victims and health workers the most vulnerable to infection.

The strain itself is not the deadliest, it is not particularly contagious, it doesn't disperse easily through the air, it doesn't live long on surfaces, and people don't typically spread it until they are already sick. Nevertheless, a host of other factors contribute to the rapid spread of the disease, the outbreak of which is the worst on record.

Factors Contributing to the Rapid Spread of Ebola in Guinea, Liberia, and Sierra Leone

First, the location of this outbreak has facilitated its rapid spread. Unlike the sites of previous outbreaks, which were in remote regions of the DRC or Gabon, the densely populated and relatively well-connected subregion of Guinea, Liberia, and Sierra Leone has made containment difficult. The first recorded outbreak was near Gueckedou in Guinea, which is not only a busy urban neighborhood but also a major trading hub near the borders with Sierra Leone and Liberia. This location has made isolating the virus practically impossible. To make matters worse, during the initial days of the outbreak, many rural dwellers brought their infected family members to cities in search of better medical care, unknowingly exposing urban populations to Ebola.

Second, efforts to contain the outbreak are being frustrated by the reluctance or refusal of family members to take infected persons to designated clinics. This problem stems from the widespread mistrust of public health workers. Dressed in high-tech protective clothing that sometimes alarms patients and their families, these workers administer clinics from which the majority of entering patients do not leave alive. Some patients have discharged themselves from clinics, thereby increasing the risk of infection to the public. Many think the disease is the result of witchcraft and therefore cannot be treated by man. In some cases, family members have "freed" relatives from health clinics, claiming that they needed traditional healings instead of western medicine. In Sierra Leone, locals burned down a treatment center over fears that the medicines given to victims were actually causing the disease. In Guinea's southeastern Forest Region, villagers have prevented medical workers from entering their towns by blocking roads and destroying bridges.

After some of its workers were violently threatened by a group of men who believed foreigners had brought the disease, the Red Cross no longer operates in that region. In one Liberian town, health workers were chased away by locals wielding knives and throwing stones. In an effort to counter these actions, Liberia and Sierra Leone have criminalized the concealment of infected individuals.

Third, the traditional custom of washing the bodies of deceased family members before burial is unnecessarily exposing people to the virus. But allowing foreign medical workers to dispose of bodies in mass graves without bestowing traditional honors is difficult to accept. In one case in Sierra Leone, police had to use tear gas to disperse crowds of family members that demanded the bodies of their sick relatives for customary burials.

The international Community Responds

Low literacy rates and poor education systems make it difficult to educate West African populations on matters of public health. Unconventional means used by some activists to raise awareness include teaching songs that contain information on how to prevent infection and transmission. The United Nations Children's Fund (UNICEF) is delivering culturally sensitive awareness messages via text messages and radio.

Countries in the region have adopted measures to prevent the entry of the virus into their territories. Mauritania has closed most border crossings on the Senegal River; Saudi Arabia has suspended the issuance of visas to Muslim pilgrims from Guinea and Liberia; and Morocco has imposed mandatory health checks at various entry points, particularly the regional transportation hub of the Casablanca airport.

Looking Ahead

History shows us that Ebola tends to recur once there has been an outbreak in a region. If properly studied and analyzed, this latest outbreak may offer opportunities for international health experts and local authorities to devise a long-term plan to control future outbreaks. A recent emergency conference in Accra convening health authorities from across the region was designed to formulate a regional, or at least common, approach to fighting the disease. The strategy will encompass better surveillance to detect Ebola cases, enhanced cross-border collaboration, closer cooperation with the WHO, greater resources dedicated to emergency response, and improved engagement with local communities. Based on lessons currently being learned from this outbreak, it appears that improved engagement with local communities will be the most important to containing its spread.

Having an effective communication and public education campaign at the ready—one that diplomatically debunks rumors and misconceptions while emphasizing the importance of treatment and containment—is imperative. Given the common cultural aversion to outsiders, this message may be best delivered by local elders, traditional leaders, and others who have the trust of local communities.

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Protesters over kidnapping of Chibok girls hold vigil in Abuja, Nigeria in May 2014. (Source: AP)

Women as Targets

The kidnapping of more than 270 schoolgirls from a boarding school in Chibok in April 2014 captivated the world's attention due to the audacity and barbarism of the attack, which was even decried by al Qaeda in the Arabian Peninsula. Shortly after the attack, Boko Haram leader Abubakar Shekau released a video in which he threatened to sell the girls into slavery, with some interpreting this to mean sexual slavery. The fate of the girls is still in question. It is believed that Boko Haram intends to use the girls as leverage in its negotiations with the government over the release of its currently imprisoned members, but it is unclear what the group ultimately plans to do with the girls.

Boko Haram had previously focused its attacks on security installations and various soft targets, including churches and the UN headquarters in Abuja. In 2012, however, Shekau issued his first threat to target women and children specifically as retaliation for the kidnapping and imprisonment of wives and children of Boko Haram members. In 2013, Boko Haram began a spate of kidnappings that culminated in the Chibok attack.

Why Target Women?

Attacks against women command the immediate attention of domestic and international audiences. The Chibok attack has been a persistent thorn in the side for President Goodluck Jonathan and has paid dividends to Boko Haram in terms of discrediting the Jonathan regime ahead of elections scheduled for February 2015. From a financial perspective, women can be used as sources of domestic labor and could be married off to members of the group. They could also be sold or ransomed to help finance the group. The downside is that attacks such as these severely undermine any latent support Boko Haram might enjoy from local populations.

Women as Operatives?

Since 2013, there have been a handful of unsuccessful attacks attempted by women in Nigeria. Most recently, in June a female suicide bomber prematurely detonated an improvised explosive device outside a military barracks in Gombe state, killing herself and a soldier. The bomb was concealed under her hijab. The arrest of three women on charges of recruitment less than a month later suggests that women are becoming an important feature of Boko Haram's overall strategy. One of the women, Hasfat Bako, is believed to have coordinated payments for other operatives. Bako's late husband, Usman, was a member of Boko Haram killed in a shoot-out with authorities. A man who was arrested in conjunction with Bako was reportedly using his involvement in the Civilian Joint Task Force, a vigilante group, as a cover. (See May 1, 2014, Africa Watch for more on vigilante groups in Nigeria.)

Women suicide bombers are an infrequent but not unheard of occurrence—from 1985 to 2006, 225 women committed suicide attacks around the world. Female terrorists are more frequently found in separatist or far-leftist movements, as opposed to Islamic fundamentalist movements, which tend to advocate more traditional roles for women. But Boko Haram is a uniquely Nigerian phenomenon and has adapted its strategies frequently in response to its environment. While still claiming to be aligned with the larger Islamist movements, Boko Haram is only loosely affiliated with al Qaeda, and the extent of the financial and logistical support Boko Haram receives from outside organizations is unknown. Moreover, the group does not appear to be bound by the "norms" of combat to which a fundamentalist group cast in the mold of al Qaeda is expected to adhere.

The Chibok attack demonstrates that Boko Haram is not a static movement—its strategy is evolving—and there is no strict code of conduct for insurrection. If the group were to believe that a significant tactical advantage could be gained by the continued recruitment of women and the utilization of women operatives, attacks such as what took place in Gombe state could become more common.

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