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SHORT COMMUNICATION

A reconstruction of African social realities during the period of Ebola virus disease epidemic

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ABSTRACT

The 2013-2014 Ebola Virus Disease (EVD) outbreak in West Africa is widely regarded as the largest and scariest, with 28638 cases and 11316 deaths reported. While Africans have long been known to uphold social values and norms, the EVD outbreak may have affected some of these age-long practices. This paper did an exploratory study of the role of the 2013-2014 EVD outbreak in social reconstruction of realities in West Africa. A literature search of PubMed, EBSCO and Google Scholar for studies on "Ebola" and "social reconstruction" in "Africa" was conducted. Widespread stigmatization, rejection, and isolation of EVD cases, survivors and their relatives characterized affected communities. Social interactions, intimacy, acceptance and identity were the leading realities socially reconstructed. There is need for government, non-governmental organizations and relevant social groups to facilitate effective rebuilding processes within affected communities, geared towards a prompt return to normal ways of life.

***Keywords*:** ebola, epidemic, stigmatization, culture, social reconstruction, West Africa

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1. INTRODUCTION

Social construction of reality, as a concept, depicts how our personality and presentation may be shaped by our interactions and life experiences (Weinberg, 2014). Indeed, our beliefs, background and experiences tend to affect how we present ourselves, perceive others, and others perceive us. Hence, as we pass through different phases of life, tradition, technology, environment, social pressures, and disease outbreaks, among others, are main events that often socially reconstruct these realities. The 2013-2014 Ebola Virus Diseases (EVD) outbreak in West Africa had several consequences on many communities in the West African region, with population health, economic activities, and sociocultural values mostly affected (Rainisch, Shankar, Wellman et al., 2015; Fasina, Adenubi, Ogundare et al., 2015).

EVD is a viral haemorrhagic fever caused by genus Ebola virus of the Filoviridae family (World Health Organization, 2016). Ebola was first discovered in 1976 following outbreaks in Nzara in Sudan, and Yambuku in DR Congo (World Health Organization, 2016). The natural hosts of Ebola virus are fruits bats, especially of the species of the genera *Hypsignathusmonstrosus*, *Epomopsfranqueti* and *Myonycteristorquata* (Dixon and Schafer, 2014; World Health Organization, 2016). Other animals identified as possible hosts include monkeys, chimpanzees, gorillas, antelopes, and porcupines (Rainisch et al., 2015). The virus is introduced into the human population through contact with body, organs, blood, secretion and other bodily fluids of infected animals (Rainisch et al., 2015). Following the first outbreak of the virus in 1976, there have been 23 other outbreaks, occurring mostly in Central and Eastern Africa, with most of these confined to forests and rural areas (World Health Organization, 2016).

The 2013-2014 outbreak in West Africa, mainly in Liberia, Guinea and Sierra Leone, has been described as the scariest and most severe recorded since 1976, both in number of affected cases and fatalities. The World Health Organization (WHO) announced strategic plans to curtail the epidemic based on projections that the virus could infect about 20,000 people, with over 10 countries likely affected (Woida, Valenza, Cornejo, et al., 2015; World Health Organization, 2016). The first reported case was in December 2013, in Guéckédou, a forested area of Guinea that shares border with Liberia and Sierra Leone. Due to cross-border trading and other interactions, by March 2014, Liberia had reported eight suspected cases, with Sierra Leone reporting six **(**Dixon and Schafer, 2014; World Health Organization, 2016). By the end of June 2014, 759 cases and 467 deaths had been reported, making it the worst Ebola outbreak ever (World Health Organization, 2016). As at 17 January 2016, 28638 cases have been reported worldwide, with 11316 deaths, spreading across 10 countries, see **Table 1 (**World Health Organization, 2016).

Table 1. Distribution of Ebola Virus Disease in the 2013-2014 outbreak

Country	Cases	Deaths	CFR
Guinea	3804	2536	0.67
Liberia	10675	4809	0.45
Sierra Leone	14123	3956	0.28

Italy	1	0	0
Mali	8	6	0.75
Nigeria	20	8	0.40
Senegal	1	0	0
Spain	1	0	0
United Kingdom	1	0	0
United States	4	1	0.25
Total	28638	11316	0.395

CFR: case fatality rate
Source: (World Health Organization, 2016)

Reports from most affected communities during the outbreak showed that infected persons rapidly spread the disease to other people, especially family members and local health workers, through direct contact with their body, blood, secretions, organs or other bodily fluids (urine, semen, genital secretion, sweat, bloody stool and vomitus), and indirect contact with environment contaminated with infected body fluids (Dixon and Schafer, 2014; Rainisch et al., 2015). Another factor in these settings is unsafe burial practices, as people easily become infected when they touch, wash or come into close contact with dead bodies (World Health Organization, 2016)**.** Poor health systems and inability to co-ordinate effective response to epidemics are also major factors in Africa. In many local hospitals, poor infection control measures contributed to the spread of the disease to the general public (Walker and Whitty, 2015; Dixon and Schafer, 2014). In fact, epidemiologists reported that the re-use of contaminated needles in local district hospitals led to the first outbreak in Zaire and Sudan in 1976(World Health Organization, 2016). There are also reports of sexual transmission of the disease, noting that men who have recovered from the disease may still transmit the disease through semen for up to 7 weeks after recovery (World Health Organization, 2016)**.** This however may not have been a major factor in the current outbreak. In addition, reports of mosquito bites contributing to the current outbreak have also been downplayed, as there is currently no evidence suggesting the role of mosquitoes and other insects in EVD transmission (Dixon and Schafer, 2014)**.**

Meanwhile, with high case fatality rate (90%), poor health systems in countries affected, and the possibility of spread to other world regions, the World Health Organization (WHO), Centres for Disease Control and Prevention (CDC), and several international and non-governmental agencies responded accordingly (Dixon and Schafer, 2014; World Health Organization, 2016). The response did yield positive results, as major countries affected were declared free of the virus. Albeit, this may have not been unaccompanied with breakdown of some core social structures and cultural norms, which obviously are main pillars upholding daily lifestyles and togetherness in several African communities (Davtyan et al., 2014; Diallo, 2014a). Indeed, major challenges were encountered and several lessons learnt from the coordinated international response to the EVD outbreak in West Africa (Davtyan et al., 2014).

However, beyond this, it is important to examine in retrospect the changes in social realities prompted by this outbreak and many other related events. This study therefore aims to examine the role of Ebola Virus Disease (EVD) in the social reconstruction of realities (norms and values) in a typical West African community during the 2013-2014 outbreak of the disease.

2. METHODS

We conducted a literature search of PubMed, EBSCO and Google Scholar for studies on Ebola and social reconstruction of realities in Africa using the terms: '*ebola', 'stigmatization', 'culture', 'epidemic', 'social realities',* and *'social reconstruction'*. The terms were combined with the words '*AND*' or '*OR*', in line with the '*advance search*' templates of the three databases. Reference lists of relevant papers were further hand-searched for more useful articles. Other secondary sources of data were magazines, print and online news, the internet (employing search engines), and personal interactions with experts and researchers. A critical appraisal and evaluation of African social realities, and related social reconstruction during the Ebola outbreak, as identified in the literature was conducted. Through an indirect adaptation of core qualitative research techniques, relevant themes were identified from the literature, and this formed the background of our discussion.

In this study, "realities" is used interchangeably with cultures, traditions, values or experiences.

3. FINDINGS AND DISCUSSION

Understanding African Realities

Some basic social values in the African tradition are very important (Kanu, 2010). Values can be described as inherent standards and guidelines that guide community members through their personal as well as communal interactions (Kanu, 2010; Igboin, 2011). These values cover all facets of the social life, and actually regulate human relationships within the society. A known fact is that Africa has a unique value system contextualized to her environment and age-long traditions, and any attempt to break down this system, may negatively affect the society and the people (Azabre, 2015).

For instance, community elders are highly revered in typical West African communities; they have been useful in resolving conflicts and binding and smoothening, hitherto, soured social relations (Igboin, 2011). In fact, when conducting researches, community elders must be acknowledged to encourage acceptance and active participation. Indeed, social values are the binding pillars of most African societies (Kanu, 2010). Regardless of the adoption of western value-systems in Africa, her inherent core social values have remained unchanged (Kanu, 2010; Azabre, 2015).

The African culture accords an average African unparalleled benefits of psychological, ideological, social, as well as physical identity (or security) (Onwubiko, 1991).

The community will always remain, but the dwellers are temporary components, and are only secured within the confines of the community (Igboin, 2011). On this basis, the African society emphasizes community life and communalism as a living principle (Igboin, 2011).

The goal of this value is to produce and present persons as a distinct carrier of community culture. It is worthwhile to recognize that it is this culture that essentially defines what people do with their immediate environment (Igboin, 2011). Hence, personal values are closely connected with cultural values (Igboin, 2011). The African society has, over the ages, focused on peaceful co-habitation among man, with exchanging pleasantries, offering greetings, and according respects being peculiar core values. Some authors have regarded Africans as very caring and courteous people, welcoming strangers, respecting them, and treating them well (Azabre, 2015). Offering greetings in Africa is an important way of life, and has been regarded as an important tool in establishing long-lasting relationships. Moreover, there is also the collective (societal or communal) hospitality in the African society (Kanu, 2010). Many foreigners have been amazed at the hospitality and generosity of Africans; it has been described as an expression of the perception of our common humanity. Hospitality is one of the most important characteristics of the African values. Fellow Africans, visitors (or strangers) are always welcomed and given some sense of belonging. By this, Africans integrate strangers without difficulties, and even offer them lands for residential and developmental projects (Azabre, 2015). Okafor explained in his book that in a typical African culture, everyone is invited to dine even if the food was prepared for far less number of people (Okafor, 1974). According to him, it connotes bad manners to eat anything however small, without sharing it with other people present, or at least saying they are invited (Okafor, 1974).

One other basic value in Africa is offering help without asking for any precise corresponding reward (Okafor, 1974). The African society is mindful that life is "*give and take*" which implies that everyone has something to contribute to each other's welfare at one point or the other. Additionally, Africans also value conversation. Often, people feel free to discuss their problems with one another and even seek for counsels and solutions together. Many could interpret one's unwillingness to seek for advice as sign of pride.

Africans are certain that a project discussed with others will be void of difficulties or mistakes (Kanu, 2010). Hence, the African community emphasizes inter-personal communication in all human endeavours. This value has really been intriguing to westerners, who view many conversations as leisure talks rather than a means to solving problems (Wiens, 2011).

As noted above, everyone is accommodated in a typical African community. This value accounts for reasons why the weak, aged, helpless, and sick have been affectionately catered for within the comforts of an extended family atmosphere in many African societies.

This explains why the extended family system is prevalent among Africans. Within the extended family, it is the duty of every one to ensure the whole family is comfortable without any discrimination or segregation. The extended family system is still thriving in the contemporary African society despite the infiltration of the Western value systems. For example, a man will be highly criticized and condemned if he does not take care of the orphans or widows of his dead relations. The social security (a form of socioeconomic insurance) guaranteed by the extended-family system is about the most appreciated value in the traditional African society (Kanu, 2010).

The above have described basic social values in an African Society. The outbreak of Ebola virus disease reconstructed these social realities that have been long held across many African societies.

4. SOCIAL RECONSTRUCTION OF REALITIES IN AFRICA DURING THE EBOLA OUTBREAK

Some early concepts in sociology describes change as a product of human activity, noting that while realities are almost always socially constructed and defined, it is actually individuals and groups of individuals who construct and define them; although, another sociologist reported that this has not been fully addressed based on social constructionism. How we define and construct our everyday reality depends on our respective backgrounds and experiences. In the same vein, the ease of spread of EVD and associated high case fatality rates brought about a drastic change as it created much fear, anxiety and panic across many African communities, particularly in the West African region, during the 2013-2014 EVD outbreak (Diallo, 2014a). There were, no doubt, grave consequences in several communities, particularly those related to social realities - social cultures, traditions, or values (Walker and Whitty, 2015). The once hospitable, friendly, and respectful African people gradually became hostile, suspicious, and disrespectful. There was widespread fear, stigma and discrimination (Diallo, 2014a). The thoughts of survival amidst imminent death scenes led to isolation, and obviously, a drastic change in social lives and relationships. For example, a Liberian lady living in Magodo area of Lagos state, Nigeria, reportedly committed suicide over Ebola stigmatization (Punch News, 2014). She was neglected, avoided and isolated by Nigerians for fear she could be a carrier of the Ebola virus, given the fact that the index EVD case in Nigeria was a Liberian. Intimacy and social interactions, both highly valued in many African communities, are perhaps the most important social values reconstructed in Africa in the wake of the EVD outbreak.

Avoiding direct contacts was a key preventive measure adopted by public health officials in affected communities, but this had some socio-cultural implications in many African settings. Persons presenting with fever and vomiting in most health facilities were automatically quarantined or even isolated in some cases, even when these could just be non-fatal and curable illnesses. International flights and travels to countries affected were restricted. Persons with EVD, particularly the survivors (i.e. those who were infected and have been cured) struggled to be accepted in their communities, that is, a place where they have always identified with, had a sense of belonging, and enjoyed communal (societal) security (Gidda, 2014). In Uganda, a place not affected during the current outbreak, known Ebola survivors were secretly monitored, and many avoided contacts with them or their relatives (Diallo, 2014a). This created an apparent loss of identity, even among one's very own, with this obviously another reconstructed social reality during the EVD outbreak.

The fear of being marginalized or isolated further resulted in people concealing their illnesses (Fasina, et al., 2015). In Guinea, many residents started limiting their movements, refusing to go too far from their homes, and avoiding hospital visits even when they were visibly ill (Diallo, 2014b). Apparently, the community organized late-evening discussions and social gatherings that characterized most African communities dropped significantly.

In Monrovia, hospitals, schools, churches and mosques among others were closed. There was a near complete shutdown of social structures and public infrastructures, particularly the health system. Dead bodies littered the streets, infected areas were cordoned. In fact, over 80 health workers died from EVD in the current outbreak, more than recorded in any previous outbreak (Walsh and Sifferlin, 2014). A Liberian who survived Liberia's civil war of 14 years, believes Ebola was more dreadful than the war, which killed over 250,000

people (Walsh and Sifferlin, 2014). Testing positive for Ebola in Liberia was just like a death sentence (Gidda, 2014). In fact, the stigma associated with EVD took a different shape in some affected African communities, disrupting normal social integration (Diallo, 2014a). A Liberian Ebola survivor, who was psychologically traumatized and depressed, narrated his ordeal (Gidda, 2014). According to him, his cure from Ebola did not provide him the needed chance of being re-integrated into the society, as many still had doubts he was completely free of the disease. Barbers rejected him, family members neglected him, he was avoided by commercial drivers, and in market, religious cycles and most public places; he was completely stigmatized and alienated (Gidda, 2014). In some communities, survivors were even physically attacked and injured for fear that they could be lying about their healed health status (Diallo, 2014a; Gidda, 2014). There were similar cases of stigmatization in Guinea, Sierra Leone and Senegal (Diallo, 2014a). In Lagos, Nigeria, there were reports of termination of employment of staff that were listed as contacts, and some were ejected from their rented accommodation (Odunsi, 2014). The Nigerian authorities were advised to immediately react to this, warning that such acts constituted a violation of fundamental human rights, and that legal actions must be taken against perpetrators of such acts (Odunsi, 2014). Understanding the effects of stigmatization on social re-integration, the Liberian Minister of Health and Social Welfare, advised Liberians to welcome, accept and re-integrate EVD survivors, who could in turn educate the public on the disease and its treatment (Diallo, 2014a). The International Federation of Red Cross and Red Crescent Societies (IFRC) and Medicines San Frontieres also gave psychosocial supports to families and communities affected by the outbreak, and helped in ensuring safe burial practices (Diallo, 2014a; Diallo, 2014b).

5. CONCLUSION

EVD has indeed affected established social structures, values, culture, religion and relationships in many African settings. Our study is apparently limited by the lack of an appraisal of original population-based cross-sectional studies in communities affected; hence, the extent of social reconstructions may still be far from known. There is need for government, trade unions, social groups, non-governmental organizations to adequately educate people on the need to rebuild societies and the ebbing social values. African leaders, as demonstrated by the former US President Barack Obama, may need to organize press conferences (local or televised) in affected communities, and show a public acceptance of EVD survivors. It is by this and other community re-building initiatives that the traumatized social structures in many African communities may be soothed.

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