



Ebola-related stigma in Ghana: Individual and community level determinants



Eric Y. Tenkorang

Department of Sociology, Memorial University of Newfoundland, St. John's, A1C 5S7, Canada

ARTICLE INFO

Article history:

Received 7 August 2016

Received in revised form

19 March 2017

Accepted 31 March 2017

Available online 24 April 2017

Keywords:

Ghana

Ebola virus disease

Stigma

Risk perception

Myths

Knowledge

Multi-level modelling

ABSTRACT

Rationale: Although Ebola-related stigmatization continues to undermine efforts to re-integrate survivors, few studies have examined what influences such stigmatizing attitudes.

Objective: This paper explores the effects of both individual- and community-level factors on Ebola-related stigma in Ghana.

Methods: Data were collected from a cross-section of 800 respondents, nested within 40 communities in the Greater Accra Region of Ghana. Multi-level modelling was employed for analysis.

Results: Both individual- and community-level factors were significant determinants of stigma. Respondents who endorsed myths about Ebola were significantly more likely to also endorse Ebola-related stigma. Similarly, those who were worried about a potential outbreak of Ebola in the future, had moderate risk perceptions of contracting Ebola, had primary and secondary education, and were not confident of the quality of health care in the event of an outbreak, were more likely to endorse Ebola-related stigma. Knowledge of Ebola was significant at the community level, but not at the individual level. Communities with more knowledge were less likely to endorse Ebola-related stigma.

Conclusions: These findings underscore the need to increase the knowledge base while countering myths that undermine preventive behaviours to fight Ebola-related stigma. It is equally important to adopt multi-level interventions that emphasize community-based strategies.

© 2017 Elsevier Ltd. All rights reserved.

1. Introduction

The world witnessed the worst ever outbreak of the Ebola Virus Disease (EVD) in West Africa in 2014. Until then, pockets of the virus had mostly been found in East and Central Africa (WHO, 2014). Epidemiological data released by the World Health Organization (WHO) show about 28,616 cases and over 11,000 deaths in the recent outbreak (WHO, 2016). At this point, however, approximately 10,000 people have had the virus and survived, and the most affected countries (Guinea, Liberia, and Sierra Leone) have been declared free of the disease (WHO, 2016). These developments partially informed the WHO's declaration that EVD no longer poses an international public health concern. As the world, and specifically West Africa, began to recover from the pandemic, emphasis shifted from providing a cure to dealing with the stigma of the disease, manifested for example, in the discrimination met by Ebola survivors seeking to re-integrate into their communities. The

call to end Ebola-related discrimination is reflected in the WHO's recent priority of providing comprehensive psychosocial support for Ebola survivors, part of its bid to minimize the spread of the virus.

Unlike Guinea, Sierra-Leone, and Liberia, Ghana recorded no cases of EVD. Even so, Ghana's capital, Accra, was designated the Ebola response headquarters, housing the newly formed United Nations' Mission for Ebola Emergency Response (UNMEER). Although UNMEER is not currently operational, its location in Ghana was important for several reasons. First, it acknowledged Ghana's strategic role in stemming EVD spread and containment. Second, it underscored Ghana's vulnerability as a high-risk country, given its proximity to the more heavily affected countries. Perhaps the greatest risk was that Ghanaians, like their neighbours, were not knowledgeable about Ebola, endorsed misconceptions of the disease, and harbored attitudes that clearly undermined preventive behaviours. In all countries affected, a lack of understanding of the disease led people to stigmatize survivors, denying them jobs, restricting their movement, and even refusing to provide familial support. In Liberia, for example, survivors complained about

E-mail addresses: eytenkorang@mun.ca, ytenko@yahoo.com.

unemployment, fear and mistrust from immediate family members, and the destruction of their property, making their integration extremely challenging (UNFPA, 2015).

A few studies have examined Ebola-related stigma and discrimination in West Africa, but they focus on Ebola-affected countries (Monasch, 2014; Centre for Public Policy Alternatives (CPPA), 2014; Bah et al., 2015; Richards et al., 2015; Blair et al., 2017). While this is important, the lack of studies on unaffected but high-risk countries does not bode well for the containment of a disease that nearly devastated the West African sub-region. Curbing stigma is crucial to preventing and containing the disease, making it extremely important to conduct research and disseminate the findings. This study is the first to examine factors influencing Ebola-related stigma in Ghana, using survey methods. Its findings will equip policy makers with relevant information on levels of stigma associated with Ebola in Ghana and suggest possible interventions.

2. Conceptualizing Ebola-related stigma

Stigma is an important sociological concept often traced to the famous American sociologist, Ervin Goffman, but its historical origins are in ancient Greece, where it referred to the practice of marking the skin of slaves and criminals to denote them as 'undesirable' persons (Goffman, 1963). Now, stigma is generally defined as a trait, characteristic, or attribute that is undesirable and separates an individual or a group from others (Goffman, 1963; Stuart, 2005; Ulasi et al., 2009). According to sociologists, stigma is socially constructed, embedded in social relationships, and enacted in one's daily interactions with the immediate social environment (Alonzo and Reynolds, 1995; Pescosolido et al., 2008). In other words, it goes beyond an individual attribute to become a societal construct. Stigma is manifested overtly in several ways, including avoidance, dehumanization, social rejection, labelling, and stereotyping; it is manifested covertly in expressions of discomfort or failure to look into the eyes of the stigmatized (Bos et al., 2013; Dovidio et al., 2000).

Although the concept derives from an interactionist sociological perspective, it has been applied to disease and illness since the 1960s, especially mental illness (Link et al., 1989; Scheff, 1966). As individuals are diagnosed with diseases, and based on societal interpretation of the ailment, they are stripped of their old identities and take on a new identity consistent with their status as 'sick' persons; as Goffman (1963) puts it, they assume a 'spoiled identity.'

Goffman's theorizing of stigma in mental illness extends to other diseases; for example, HIV/AIDS (Parker and Aggleton, 2003; Holzemer et al., 2009; Ingram, 1999). Perhaps surprisingly, the framework has not yet been applied to EVD in the literature. In what follows, we begin to fill this gap. We conceptualize Ebola-related stigma to mean the labelling, stereotyping, and eventual ostracizing of survivors of Ebola and their families.

Lessons learnt from other diseases with similarly high levels of stigma indicate stigmatizing behaviours and attitudes are influenced by fear and worry, ignorance, incorrect knowledge, and misconceptions that accompany the transmission of diseases (Davtyan et al., 2014; Hillman, 2008; Qian et al., 2007; Tenkorang, 2013). Misconceptions associated with Ebola transmission include the following: it is a 'curse from God' that results from the pervasiveness of corruption and homosexuality; Ebola can be treated with antibiotics; it can be spread by mosquitoes; it is caused by witchcraft (Davies et al., 2015; Shittu et al., 2015; Tomori, 2014). In their assessment of Ghanaians' knowledge and awareness of EVD, Adongo et al. (2016) found that although knowledge was high among their participants, it often co-existed with myths and misconceptions about how Ebola was transmitted. More importantly,

such misconceptions fueled stigmatizing attitudes among study participants and communities. It has also been documented that the degree of contagion, fatality rate, and a lack of confidence in health professionals' ability to handle Ebola are important factors in high levels of stigma (Li et al., 2016).

Because Ebola affected certain communities in West Africa, the WHO has recommended taking a community-based approach to the prevention and containment of the disease, especially in high risk areas. The suggested approach involves encouraging communities to implement behaviour change programs addressing Ebola-related stigma and discrimination (WHO, 2014; WHO, 2017). Strategies recommended by the WHO include psychosocial counseling for victims, especially children orphaned by the epidemic. They also include working towards communities' acceptance of Ebola-infected and affected families and replacing the negative attitudes that make re-integration difficult (De Roo, Ado, Rose, Guimard, Fonck and Colebunders, 1998; Deen et al., 2015; Hewlett and Amola, 2003).

Communities often have the cultural mechanisms and competencies in place to deal with health emergencies, thus underscoring their utility in disease prevention and health promotion. Using data from Liberia, Abramowitz et al. (2015) demonstrated that local communities' informal strategies and knowledge were extremely important in containing the spread of Ebola, even in the face of a failed national and international response. By the same token, using 25 focus groups and 40 in-depth interviews, Adongo et al. (2016) discovered that community knowledge of EVD in Ghana was high. The knowledge influenced attitudes towards the disease – but the attitudes included stigma and discrimination, suggesting the coexistence of myths along with the knowledge.

The emerging evidence suggests we should consider complex models that combine individual- and community-level factors if we wish to understand Ebola-related stigma. The few studies to examine Ebola-related stigma have indicated stigma may vary by gender, socio-economic status, and the demographic characteristics of individuals within the population (Davtyan et al., 2014; Li et al., 2016). Yet, to date, scholarly efforts have been limited to individual level determinants with little insight into how community-level factors affect Ebola-related stigma. With our study, we have begun to fill this important gap in the literature.

3. Method

3.1. Study design and setting

For our study, we used data collected from a representative cross-sectional sample of 800 respondents aged 18–69 years from four randomly selected districts and 40 communities in the Greater Accra Region (GAR) of Ghana. The GAR is the smallest of the ten administrative regions, but the second most populous region in Ghana (Doan and Oduro, 2012; Government of Ghana (GOG), 2016; Ghana Statistical Service (GSS), 2012). The region is important to the administrative governance of the country: it is home to the seat of government and plays a significant role as a geographical hub in the sub-region. For example, as mentioned above, it is the site of UNMEER. The GAR is a good choice for this research for another reason: It reflects the socio-economic and demographic differences within the Ghanaian population.

Administered by a local government system, the GAR is divided into 16 districts. For the study, we randomly selected four of these: the Adenta municipal district, the Ga West municipal district, the Ga South municipal district, and the Ledzokuku-Krowor municipal district. We randomly sampled ten communities from each of the four districts, for a total of 40 communities. We then selected 20 individuals for interviews within each of the 40 communities. In

Download English Version:

<https://daneshyari.com/en/article/5046540>

Download Persian Version:

<https://daneshyari.com/article/5046540>

[Daneshyari.com](https://daneshyari.com)