



Public health and public trust: Survey evidence from the Ebola Virus Disease epidemic in Liberia



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ABSTRACT

Trust in government has long been viewed as an important determinant of citizens' compliance with public health policies, especially in times of crisis. Yet evidence on this relationship remains scarce, particularly in the developing world. We use results from a representative survey conducted during the 2014–15 Ebola Virus Disease (EVD) epidemic in Monrovia, Liberia to assess the relationship between trust in government and compliance with EVD control interventions. We find that respondents who expressed low trust in government were much less likely to take precautions against EVD in their homes, or to abide by government-mandated social distancing mechanisms designed to contain the spread of the virus. They were also much less likely to support potentially contentious control policies, such as “safe burial” of EVD-infected bodies. Contrary to stereotypes, we find no evidence that respondents who distrusted government were any more or less likely to understand EVD's symptoms and transmission pathways. While only correlational, these results suggest that respondents who refused to comply may have done so not because they failed to understand how EVD is transmitted, but rather because they did not trust the capacity or integrity of government institutions to recommend precautions and implement policies to slow EVD's spread. We also find that respondents who experienced hardships during the epidemic expressed less trust in government than those who did not, suggesting the possibility of a vicious cycle between distrust, non-compliance, hardships and further distrust. Finally, we find that respondents who trusted international non-governmental organizations (INGOs) were no more or less likely to support or comply with EVD control policies, suggesting that while INGOs can contribute in indispensable ways to crisis response, they cannot substitute for government institutions in the eyes of citizens. We conclude by discussing the implications of our findings for future public health crises.

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1. Introduction

Trust in government has long been viewed as an important determinant of citizens' compliance with public health policies, restrictions and guidelines. In the late 1990s in the UK, hesitancy towards the measles-mumps-rubella (MMR) vaccine was linked to “historic levels of distrust” in the British government, which magnified existing fears about the vaccine's safety and precipitated the spread of the virus around the country (Larson and Heymann, 2010, 271). The 2015 measles outbreak in Orange County, California was linked to similar fears, again compounded by parents'

distrust of public health agencies in the US (Salmon et al., 2015). Similar patterns emerged with the outbreak of HIV/AIDS, which some Americans believed to be a “man-made weapon of racial warfare” (Whetten et al., 2006, 716).

The public health risks posed by distrust may be especially severe in less developed countries, where mechanisms for mass communication are unreliable, health care is often inaccessible, and suspicions are compounded by long legacies of state weakness, absence or predation, and potentially by unfamiliarity with Western medicine as well. In these settings, even small-scale outbreaks can escalate into large-scale emergencies, affecting thousands of people and spilling across borders. In Nigeria in 2003, for example, a boycott of the polio vaccine precipitated a resurgence of cases not just in Nigeria, but also in multiple neighboring countries previously certified polio-free (Jegede, 2007). As Larson and Heymann (2010, 272) write in a commentary in the *Journal of the American*

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Medical Association, “times of uncertainty and risk are times when public trust is most needed.” When that need goes unmet, “lack of trust can cause health programs to fail with harmful consequences.”

Most research on the relationship between public health and public trust has been anecdotal or based entirely on qualitative evidence. In a study of HIV-positive patients in the US, Whetten et al. (2006, 716) write that they were “unable to find any peer-reviewed studies of associations between patients’ level of trust in systems of care ... and their use of health services.” Ten years later, empirical evidence on this relationship remains scarce. Of the more systematic studies (qualitative or otherwise), most have focused on vaccine hesitancy in the US and UK (Freed et al., 2011; Marlow et al., 2007; Salmon et al., 2005). Research in less developed countries is rare, and quantitative research rarer still. (For partial exceptions, see Barnhoorn and Adriaanse, 1992; Hewlett and Amola, 2003; Onyeneho et al., 2015).

We report results from a large-N representative survey conducted in the midst of the 2014–15 Ebola Virus Disease (EVD) epidemic in Monrovia, Liberia. Media and non-governmental organizations (NGOs) have consistently emphasized the deadly role that distrust of government played in precipitating the spread of EVD (see, e.g., Epstein, 2014; Leaf, 2014). Existing scholarship, however, has tended to focus either on modeling EVD’s transmission dynamics (Chowell et al., 2004) or on assessing its economic costs and consequences (Bowles et al., 2015; Fallah et al., 2015). In their review of epidemiological models of EVD, Chowell and Nishiura (2014, 11) write that they “cannot overemphasize the importance of collecting data relating to population behaviors influencing disease spread and control,” and of recording the “level of adoption of preventive and social distancing measures in the community.” Our study is, in effect, a response to this call, and is one of only a few quantitative studies on the relationship between trust and public health in the developing world.

We find that Liberians who expressed low trust in government were much less likely to comply with EVD control measures or to support contentious EVD control policies, including restrictions on travel and “safe burial” of EVD-infected bodies by government health workers. Contrary to stereotypes, and to the findings of some previous research on vaccine hesitancy (e.g. Raithatha et al., 2003; Salmon et al., 2005), we find no evidence that Liberians who distrusted government were any more or less likely to hold erroneous beliefs about EVD transmission, symptoms and treatment. While only correlational, these results suggest that respondents who refused to comply may have done so not because they misunderstood how EVD is transmitted, but rather because they did not trust the capacity or integrity of government institutions to promote mechanisms and implement policies to slow EVD’s spread (at least at the time of the survey).

The EVD epidemic imposed myriad hardships on Liberians, which may have further exacerbated distrust of government. Consistent with this intuition, we find that respondents who experienced hardships such as losing their jobs or foregoing health care expressed much less trust in government than those who did not. Again, while this is only a correlation, it raises the possibility of a vicious cycle: if those who experienced hardships were less likely to trust government and therefore less likely to comply with EVD control policies, then they may have exposed themselves to a higher risk of infection, and thus a higher risk of suffering further hardships.

Finally, we find that trust in international NGOs (INGOs) was not correlated with support for, or compliance with, EVD control interventions. INGOs such as Médecins Sans Frontières and the American Red Cross were intimately involved in the response to the EVD epidemic. While they did not have the legal authority to

impose curfews, restrict travel or ban public gatherings, they nonetheless encouraged compliance with these policies, and issued guidelines for preventing the spread of the virus (e.g. using hand sanitizer). Our results suggest, however, that while INGOs may have contributed in indispensable ways to ending the crisis, ultimately they could not substitute for government institutions in the eyes of citizens.

Our results are broadly consistent with intuitions underlying the health belief model (HBM, though studies using the HBM typically do not consider trust in government), and more specifically with studies arguing that the spread of EVD and similar diseases may be determined as much by social, cultural and political factors as by characteristics of the virus itself (Abramowitz et al., 2015; Chowell and Nishiura, 2014; Hewlett and Amola, 2003; Modarres, 2015). We conclude by arguing that scholars and policymakers should take these factors more explicitly into consideration when designing control interventions in future, and when modeling the spread of otherwise easily preventable diseases like EVD.

2. Background

2.1. The 2014–15 EVD epidemic in West Africa

The 2014–15 EVD epidemic in West Africa was unprecedented in magnitude, duration and geographical scope. Over 28,000 cases were documented over the course of the epidemic, resulting in over 11,000 deaths in Guinea, Liberia and Sierra Leone. Even months before the epidemic was over, its toll had already far surpassed the total number of cases reported in all previous outbreaks combined (Chowell and Nishiura, 2014).

The crisis had devastating effects on the economies and health care systems of the three most severely affected countries. At the peak of the epidemic, most employers, government agencies and local NGOs ceased operations, exacerbating unemployment and creating food shortages. Hospitals closed due to a lack of staff, many of whom stayed home for fear of contracting the virus. Quarantines, nighttime curfews and bans on public gatherings further limited social and economic activity. Many citizens lost their jobs, forewent treatment for even the most common illnesses, or witnessed EVD-infected bodies lying uncovered in the streets (Morse et al., 2016). Incidents of civil unrest were common.

Compliance with government-mandated social distancing policies was crucial to slowing the virus’s spread. In weak states like Guinea, Liberia and Sierra Leone, however, these policies constituted a dramatic and largely unprecedented intrusion of government authority into citizens’ daily lives. Citizens were mandated to comply with quarantines, case reporting and contact tracing, and were instructed not to care for loved ones suffering from EVD-like symptoms, or to wash the bodies of the dead prior to burial (as is customary). In Liberia, public gatherings were banned from July 2014 to January 2015; schools were closed; a 6:00 p.m. curfew was put into effect; and handshaking, kissing and touching were all strongly discouraged.

By most accounts, compliance with these restrictions was low in the early months of the epidemic (Chan, 2014). EVD was mysterious and compliance was costly and inconvenient, and in some cases contravened cultural norms and basic human instincts to care for the ill and honor the dead. Rumors that government officials either manufactured EVD or facilitated its spread found a receptive audience among citizens accustomed to government corruption and dysfunction. Liberians who lost their jobs or struggled to find treatment for common illnesses may have blamed government institutions for their hardships, exacerbating distrust and non-compliance, which is believed to have been a key contributor to EVD’s proliferation throughout the region (Epstein, 2014; Leaf,

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