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# ‘No Ebola…still doomed’ – The Ebola-induced tourism crisis

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ABSTRACT

Many recent crisis and disasters affecting tourism have been studied, but few explicitly explore health related crisis in developing countries. This study analyses the effect of the Ebola Virus Disease Epidemic (EVDE) on The Gambia, where, despite no reported cases, EVDE had devastating consequences. A Rapid Situation Analysis is used to gain insights into responses to the EVDE, encompassing interviews with key stakeholders, field observations and follow up meetings with those involved in managing the crisis over 21 months. A crisis and disaster framework is used to understand the challenges encountered. Findings highlight the importance of consumer perception and preparedness and management failures’ consequences, contributing to the broader debate on the indirect threat of epidemics on tourism in developing countries.

## Introduction

An event that suddenly transpires into an unfavourable situation is known as a crisis (Laws & Prideaux, 2005). In recent years, many such crises have affected tourism (Breitsohl and Garrod, 2016) but despite the growth in the study of tourism crises, Mair, Ritchie, and Walters (2014) found that only four out of sixty-four studies conducted from 2000 to 2010 specifically related to health crises, while Jiang, Ritchie, and Benckendorff (2017) noted a focus on economic rather than health-related crises. Furthermore, the majority of these studies focused on crisis in developed countries. This study examines both the context in which the Ebola Virus Disease Epidemic (EVDE – later referred to as ‘Ebola’) outbreak occurred and its effect on tourism in the small developing nation of The Gambia. Despite no reported cases, tourism receipts more than halved for the 2014/2015 season (International Monetary Fund, 2015; Gambia Tourism Board, 2015), leading to what is referred to as the ‘Ebola-induced tourism crisis’ (EITC).

Tourist decisions and destination choices are influenced by personal and physical security perceptions (Lepp & Gibson, 2003; Taylor & Toohey, 2007), which are often fuelled by media imagery of destinations (Kozak, Crotts, & Law, 2007). Health related crises, such as epidemics, are prone to negative media coverage and graphic imagery, making them particularly challenging for the tourism sector to manage (Schroeder & Pennington-Gray, 2014). The graphic images portrayed in media coverage, combined with a lack of the source markets’ geographical knowledge of Africa, has led to the entire continent being ‘generalised’ as being risky. Furthermore, destinations may be unaffected directly by a crisis, but the consequence of being within its physical proximity (Henderson, 2007), can create a ‘spill over effect’ with damaging consequences (Cavlek, 2002; Ritchie, Crotts, Zehrer, & Volsky, 2013).

It is important to study tourism crisis management in developing countries for two main reasons. Firstly, the impact of crises can be devastating for the tourism sector in developing countries due to an overreliance on tourism receipts (de Sausmarez, 2004; Mansfield and Pizam, 2006; Ritchie, 2009). Declining visitor numbers, increasing unemployment, weakened profits, reduced

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investment, and less government revenue (Henderson, 2007; Ritchie, 2004) often exacerbate socio-economic conditions and may propel the country into a worsened state of fragility (Novelli, Morgan, & Nibigira, 2012).

Secondly, managing the recovery following a tourism crises is likely to be impaired by the state of fragility associated with developing countries compared to developed countries. This is due to limited human and financial resources for tourism marketing and development, poor governance structures and lack of tourism planning (Novelli et al., 2012). Furthermore, these destinations may rely heavily on outside support (i.e. NGOs, donors) for the development of their tourism industry (Novelli, 2016), and even more so in their preparation and response to tourism related crises.

The limited literature on crisis management in developing countries includes a few studies on tourist risk perceptions (Adam, 2015), on using online marketing to overcome risky stereotypes in Africa (Ketter & Avraham, 2010), and on image repair when responding to crises in Africa and other developing economies (Avraham & Ketter, 2016; Avraham & Ketter, 2017). The majority of studies focus on crisis communication and recovery marketing – just one aspect of crisis management. Understanding how an African destination responds to a tourism crisis from a supply side perspective is therefore important and timely, as it has implications for other developing countries.

Although tourism crisis and disaster frameworks exist to better understand tourism crisis management from a supply side perspective (see Faulkner, 2001 and Ritchie, 2004), these too have been developed and applied mostly in a developed country context. Furthermore, these frameworks are prescriptive, and the majority of studies compare what happened with what should have happened. Further studies focus on response and recovery only (Jiang et al., 2017), limiting our understanding of the effectiveness of strategies, especially when crises last beyond a few months and may have a significant impact.

This paper analyses the strategies adopted to stabilise and (re)position the destination based on a Rapid Situation Analysis (RSA). This included a retrospective review of personal diary entries, overt participant observations in the destination and semi-structured interviews with key stakeholders in The Gambia and the UK, conducted over a period of 21 months (November 2014 – July 2016).

## Literature review

### *Health related crises*

Numerous studies focus on the impact of crises on tourism sectors with specific reference to airlines (Henderson, 2003), hotels (Israeli & Reichel, 2003; Chien & Law, 2003), travel agents (Lovelock, 2004) and restaurants (Tse, So, & Sin, 2006). Other studies principally focus on terrorism, political instability and economic crises within specific geographical locations, for example the bomb attacks in Bali (Putra & Hitchcock, 2009), Egypt (Aziz, 1995), New York (Enz & Taylor, 2002), September 11, 2001 (Stafford, Yu, & Armoo, 2002), and the BP oil spill (Ritchie et al., 2013) amongst others (see Jiang et al., 2017).

As previously argued, few studies have focused on health-related disasters or epidemics, such as the Severe Acute Respiratory Syndrome (SARS) in South-East Asia (Dombey, 2003; McKercher & Chon, 2004), the Foot and Mouth Disease in the UK (Frisby, 2003; Irvine & Anderson, 2004), influenza in Mexico (Monterrubio, 2010) and bed bug issues (Liu, Kim, & Pennington-Gray, 2015). During the last fifteen years, there have been a number of health-related crises that have caused risks to local communities and significant damage to the tourism sector (Glaesser, 2006; Kuo, Chen, Tseng, Ju, & Huang 2008; Smith, 2006). As travel and tourism can facilitate the spread of epidemics, global bodies such as the World Health Organisation (WHO) and the UN World Tourism Organisation (UNWTO) are increasingly interested in understanding the cause, evolution and risk of an infection (Joffe & Haarhoff, 2002; Mason, Grabowski, & Du, 2005; Page, Yeoman, Munro, Connell, & Walker, 2006); and advocating swift precautionary actions to reduce a health risk, often at the expense of complete scientific understanding (Sunstein, 2005).

The SARS outbreak exemplified the link between travel, tourism and an infectious disease (Henderson & Ng, 2004; McKercher & Chon, 2004; Washer, 2004), that spread globally through international tourists returning home after visiting affected areas (Mason et al., 2005). In an unprecedented move in its forty-five-year history, the WHO issued a “general travel advisory”, the result of which was to effectively close many borders while discouraging tourism in the affected areas (Smith, 2006; Wall, 2006). Of the nine thousand people who contracted SARS, 870 died (McKercher & Chon, 2004). China, Hong Kong, Vietnam and Singapore lost an estimated US$20 billion in GDP and three million jobs in the tourism sector (Kuo et al., 2008). The WHO’s travel warnings, which labelled the condition as ‘pandemic’, together with the volume of media coverage and its sensationalist tone contributed to global panic (Mason et al., 2005; McKercher & Chon, 2004; Joffe & Haarhoff, 2002).

Similarly to SARS, Ebola was characterised by sensational reporting by the media. Joffe and Haarhoff (2002) researched media depiction in the UK of an Ebola outbreak in the Democratic Republic of the Congo, and suggested that it was portrayed as an African health issue. Although previous cases of Ebola had occurred in Africa, the scale and impact had been contained with limited impact on the wider perception about whether it was safe to travel in the African continent (Joffe & Haarhoff, 2002). The recent outbreak of Ebola in West Africa has had a different effect due to its scale and media attention. However, misrepresentation and public misconception about the geographical location of affected countries in Africa, negatively influenced international tourist arrivals to the entire African continent. Before the outbreak, Africa had experienced average increases in tourist arrivals of 5% per year in 2012 and 2013, but numbers were reduced by 2% in 2014 (UNWTO, 2015a), and a further 5% in October 2015 (UNWTO, 2015b).

Some commonalities in relation to the role of the media on risk perception can be found in the wider literature on crises caused by terrorism (Law, 2006; Santana, 2001; Sönmez, Apostolopoulos, & Tarlow, 1999). Fear, loss of confidence in institutions, unpredictability and pervasive loss of safety may emerge during an epidemic (Rittichainuwat & Chakraborty, 2009). While generally the media affects risk perception, an opposite reaction may occur as a result of a social process known as normalisation (Ananian-Welsh & Williams, 2014). Existing literature states that repeated risk experience desensitises individuals to risk over time, as the concept