Yassaba’ or the Fear of Being Abandoned
Health Promotion Messages and Local Meanings in Guinea

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ABSTRACT: Health promotion is dependent upon sharing information with local populations and adapting health-care services to make them more acceptable, and is an essential part of any Ebola intervention. Listening to the concerns of local communities and engaging them as active participants ensures that health promotion messages are relevant, acceptable and understandable as well as culturally appropriate. Ebola is associated with fear and death, thus understanding the significance and meanings of life, death, disease and sickness for the Kissi of Guinea Forestière (Guinea) is essential for ensuring acceptable health services. Community engagement was essential for this research to gain the trust of the Kissi and to facilitate the sharing of knowledge and information to reduce the transmission of the Ebola virus. This technical account is based on three periods of ethnographic fieldwork and health promotion activities conducted in Guinea between May 2014 and February 2015.

KEYWORDS: community engagement, Ebola, Guinea, health promotion

The first cases of the Ebola Virus Disease (EVD) in Guinea were confirmed in March 2014 after rumours about the emergence of a strange new disease were reported. When a retrospective investigation was conducted, the index case was linked to December 2013. After the first case of EVD in Guéckédou, cases were then reported in Macenta, Télimélé and Conakry. The Guinean Ministry of Health received support from international organisations and agencies including the World Health Organization (WHO), Médecins Sans Frontières (MSF) and European Union-based researchers who funded mobile laboratories in Guéckédou and helped to set up prevention strategies, contact tracing, surveillance, referrals of suspected Ebola cases and ongoing training for local staff and other organisations took place outside of the EMC in the wider community. The outbreak happened in a country with a difficult political context, the constant threat of civil and political unrest, and a weak health system which left many services outside of primary health care, especially those of higher quality, inaccessible to much of the population. At the time of conceptualising this article, the latest WHO figures for Guinea reported a cumulative total of 3,804 cases and 2,536 deaths with no new cases reported in the country since November 2015 (WHO 2015). The last patient in Guinea was discharged in December 2015 (MSF 2015). Guinea was declared free of Ebola transmission linked directly to the original
outbreak on 29 December 2015, but new cases were identified in 2016, meaning that Guinea completed its 90-day period of enhanced surveillance in March 2016.

In this article, I present my reflections and experiences as a Health Promotion Coordinator working for MSF in Guinea, where I conducted three separate missions between May 2014 and February 2015. As a health promoter with an anthropological background, my core methodology for establishing a framework in which to work was to participate in local community life and understand people’s thoughts and perceptions surrounding Ebola (Hewlett and Amola 2003; Epelboin 2009; Hewlett and Hewlett 2008). The Ebola epidemic has highlighted the need for dynamic, flexible health promotion interventions to help reduce the transmission of the virus, and studying the local meanings and knowledge of the disease and how both the community and health-care workers responded to unprecedented situations helped with the implementation of these activities. My aim in this article is to discuss some of the challenges I faced when adapting health promotion strategies and messages to the specific dynamics of those affected by the epidemic, and reflect upon the need for a dialogue between formal health promotion activities and socio-cultural awareness.

In my role, I was responsible for quickly understanding the context and the local community; organising and developing a local team and understanding and solving contextual challenges relating to Ebola. In addition, I was responsible for coordinating health promotion messages, communicating with communities and regularly reviewing health promotion activities.

During my three periods of fieldwork in Guinea, I organised focus group discussions and conducted interviews with local people including health-care workers, survivors and the relatives of those who were sick with Ebola. I worked with a health promotion team consisting of Guinean nationals, whose dual roles as local experts and co-workers with whom I could share my questions and concerns were essential to all our activities. Our approach changed from day to day and our activities were continuously revised and updated, as we responded to epidemiological trends and learnt of new information and findings. We were denied entry to some villages due to their concerns over security, which made the team feel very uneasy and, as discussed elsewhere in this special issue, made fieldwork difficult to conduct (Anoko 2014; Fairhead 2015). As a team, we created innovative and alternative solutions to such challenges, directly involving local leaders in our activities and gathering information through health promoters who were based in their own villages. In addition, we worked directly with the local population by holding small group sessions in which we discussed their fears and concerns about Ebola. Many of these questions were then answered through the screening of a film which was developed directly in response to the issues people discussed.

The health promotion team was made up of 30 health promoters, each divided into sub-teams of 10 people who rotated between working in the Ebola Management Centre and in the surrounding communities. At the end of each day there was a team meeting to review the day’s activities and revise messages and information if required. The activities they performed can be summarised into three main areas:

1. Inside the EMC to support sick people and their families;
2. In communities to sensitise, give information, answer questions and provide support to those who refused to be admitted to the EMC;
3. In communities, in collaboration with the Water and Sanitation team responsible for the disinfection of the houses of people who had tested positive for and/or were suspected of having Ebola.

Each health promotion activity – from education sessions to public gatherings – was implemented after carefully listening to what people already knew about EVD, as well as what they feared about the outbreak. Through participatory gatherings held in community venues, the health promotion team listened to people’s worries and ideas, confronted the rumours that were circulating through villages, answered questions and shared information. All the information gathered at these events was discussed between the team and myself, and became the basis of every strategy implemented.

Moreover, since infection with EVD occurs through being in contact with infected bodily fluids, the body (and consequently, other people) became a possible source of danger. We were faced with the challenge of expressing empathy without using social greetings that involved touch and had to change our behaviour accordingly. The use of specific words, gestures that did not involve touching and simply spending time explaining and talking to people were small but es-
sentential components of the health promotion approach implemented.

**Yassaba: The Power of Words, Places and Networks**

Studying the health promotion activities with an anthropological lens led to the emergence of three conceptual themes – words, places and local networks – which helped to formulate a comprehensive health promotion approach during my three periods in the field.

**Words**

The impact of words and expressions was critical when communicating health promotion messages during the epidemic, and in many cases the language used to talk about Ebola was confusing and misleading for local communities, as it was a new virus that they had not previously encountered. Reflecting on how messages and biomedical terminology are translated and communicated can make a huge difference to the population's perceptions of a disease, how people care for the sick as well as how, later in the epidemic, survivors were treated when they returned home.

One example which gave me the idea for this critical reflection is how referring to the EMC as an ‘isolation centre’ raised profound apprehension within local communities. The EMC was initially called the ‘isolation centre’, a biomedical term for the facility in which patients were cared for and isolated to avoid further transmissions of the virus. In Kissi, the word ‘isolation’ was translated with the word ‘yassaba’, meaning a place reserved in communities during the dry season to rest, or a place where intense agricultural activities take place. Yassaba can also be used to refer to a place of isolation for people who are carrying infectious or contagious diseases, or who are suffering and need to be isolated and separated from their family.

In talking about isolation, I found that people said they were reminded of a recent TB epidemic (which we could not confirm or find epidemiological record of), where the local population were forced to build huts to house the sick far from their villages in the bush, with only irregular visits from a community volunteer. The rest of the villagers would wait for the rare returns of those who were cured, knowing that the majority of those who were sick, abandoned and left to themselves would not survive. The use of the phrase ‘isolation centre’ thus reminded people of their previous experiences of the TB outbreak and the yassaba they experienced: a time when the sick were left to fend for themselves without any help or contact with their families. Such associations can be damaging for health promotion interventions – and the successful running of an EMC.

Other messages were misinterpreted and led to widespread fear, such as one of the more clinical, technical messages used during the initial phase of the epidemic, in which communities were informed that:

The Ebola haemorrhagic fever is a contagious and deadly disease. It must be taken seriously since it brings death. At the moment, there is no treatment and no cure. The word Ebola is taken from the name of a river in Congo where the disease was at first discovered in 1976.

This was the first message to be disseminated by many organisations across Guinea. It was used on posters and leaflets, as well as being transmitted on local radio stations. Posters were displayed in key public places as well as in houses, schools and health centres. In response to this kind of message – which was initially the only information shared with the local population – people raised their doubts and concerns about the capacity of the health-care system and started fearing what they understood to be an incurable disease. The main thoughts in the minds of the people I spoke with were: ‘If Ebola is a deadly disease and there is no cure, why should I go to the EMC?’ or ‘If I have to die anyway, I would prefer to stay at home with my family.’

The example of the message above contributed to the panic, as did the contradictory information provided by the different organisations that assisted with the response in Guinea. MSF, for example, advised people not to eat bush meat (specifically bats, but also other wild forest animals such as monkeys) in earlier messages about animal–human transmission. Other organisations added that people should avoid eating other animals too, even if they were unrelated to the spread of Ebola – one leaflet circulated included an image of a rabbit, even though this was not considered to be a dangerous animal linked with EVD transmission. During a public health emergency such as an Ebola outbreak, confusing messages such as these made it even more difficult for people to understand the situation and how to avoid transmission and access care if they are sick.

Different organisations working in Guinea during the Ebola outbreak of 2014–2015 had different health
promotion strategies, and it was only in January 2015 that these agencies were able to agree on a harmonised set of messages and information to disseminate. One aspect of communication that is not always considered when developing a health promotion strategy is that the messages and information are not always interpreted in the way that was intended.

In Guékédou, the so-called intellectuals are described as young people who know how to read and write, speak French and have studied in the city. They are considered in contrast to the powers of elders and local leaders, which in turn creates divisions in the communities. During the Ebola outbreak, these ‘intellectuals’ assumed an important role in reinterpreting health promotion messages, which in turn contributed to the spread of rumours as a form of counterculture. These rumours – including that NGOs were responsible for the epidemic or selling the organs of the deceased – spread among the local population through public meetings and radio stations. It was very difficult to manage and counteract their views with reliable information. Rumours such as these were not limited to Guinea, and indeed the authors of the other articles in this special issue have heard similar stories across their own West African field sites.

**Places**

‘What is inside?’, ‘What are you doing in there?’ were some of the questions asked during information-sharing sessions in villages, as the EMC in Guékédou raised fear, mystery and curiosity amongst the local community. The negative impressions people had of the EMC were fuelled by the real and visible problems that they experienced: high walls, losing contact with friends and family members who had been admitted and not being able to visit their relatives due to the high risk of contracting Ebola all led to feelings of fear and concern. The link with yassaba was also very real. The high mortality rate associated with the virus was observed by people in their own communities and served to confirm some of these rumours. It was believed that the EMC was a place where inevitably people would die.

When survivors returned home, they too became the source of rumours and unexplainable events. In one instance, when I accompanied a group of survivors from the EMC to their home, they were referred to as ‘the dead who came back’ or ‘the purchased’ as it was believed that they had been paid by EMC staff not to talk about what was really happening inside the EMC. In some cases, such as in Tolobengo in April 2014, the community reacted violently to the death of one of their members and the family asked to see what was inside the body bag used to seal the corpse to make sure that the body was not cut into pieces and replaced with ‘clothes or dolls’.

**Networks**

The reciprocity between the living and the dead and between humans and gods is a key cultural component of the Kissi people, one of the main ethnic groups with whom I was working in Guinea. In caring for someone who is sick, the carer becomes involved in following his/her friend or relative along a path and joining him/her on a journey that could lead to death. Death is not considered a simple change of state from living to dead but a complex social and spiritual dimension in which dying and living are interconnected. Honouring the dead is not merely a case of showing sympathy to the family of the deceased: it involves the reinforcement of social ties of affinity and reciprocity in which society, especially in remote areas, is rooted. The celebration of the dead protects the living from the shame and chaos of the loss. If not properly honoured, people fear that the dead might return as phantoms and disturb the living, bringing misfortune with them.

The announcement of a death is a very public event, and involves the whole community. Women scream and weep as they roll on the ground to mark the path towards the dead person’s family house, and mourners visit the family of the deceased for days after the death. If the person is Muslim the funeral is performed within 24 hours even though the mourning period lasts longer. The more important the person is considered to be, the more attention, hugs, caresses, gifts and prayers are received. In some instances, the body is carried around from village to village for those who could not reach the house where the initial grieving ceremony was performed. The dead body is usually washed and cleansed by specific people appointed to this task on the basis of their gender. Afterwards, the grave is prepared close to the house (or in a local cemetery) and the body is buried, wrapped in clothes and surrounded with gifts.

If the deceased was an initiate or an ‘inhabitant of the Sacred Forest’ it was also the duty of his group to care for him whilst he was sick, keep him away from the family and bring him into the forest. The initiated are highly hierarchical and the higher their position, the more elaborate the funeral. All ceremonies of initiates are performed in the forest, and this may explain why in some cases of Ebola the contacts were not part of the direct family. An Ebola epidemic
collapses family and social networks, as well as the reciprocal relationship between the living and the dead. The ban on traditional funerals and caregiving during the Ebola outbreak, as well as the obligation to report the sick, have contributed to this sense of distance and indeed yassaba.

Adapting Health Promotion Activities to Community Views and Needs

After an in-depth ethnographic exploration of the area around the EMC in which I was working in Guéckédou, we saw that each neighbourhood, village and community had its own social and political dynamics, ethnic composition and spiritual beliefs, all of which required the adaptation of health promotion materials. The first type of community engagement that was implemented was ‘door-to-door’ mobilisation, as it allowed the health promoters to understand the needs of the people they were working with better, and build a relationship of trust with them. This individual and family-level health promotion strategy was carried out alongside larger events, such as the screening of films or documentaries to gather groups of people together and create a forum for discussion. The films showed what was happening inside the EMC and, rather than just being educational films about Ebola transmission, were meant to unmask rumours and misconceptions and stimulate debate amongst the audience. Strategies were also oriented to their target audiences: to reach young people we asked a very well-known local musician to write songs for us and participate in our Ebola-related health promotion activities.

Health promotion activities, adapted to community views and needs, included the following:

1. Changing the height of the walls surrounding the EMC to let the people witness what was happening inside;
2. Opening the EMC according to a specific schedule to allow community members to visit the facility. Two health promoters guided the visitors through the EMC, showing the different functions of the centre and educating them about transmission and symptomatology;
3. Allowing family members to visit their relatives inside the EMC, with the proper protective clothing. We showed them that their relatives were not abandoned but, on the contrary, assisted by professionals;
4. Allowing family members to pay their respects to the dead, by showing them the face of their deceased relative;
5. Contacting families through phone calls to update them on the health status of their relatives;
6. Creating a specific prayer to accompany the dead on what was considered to be their final journey;
7. Creating support groups to re-establish reciprocity and community links that had been threatened or destroyed by the outbreak;
8. Supporting survivors when they returned home by organising feasts and involving community members in their reintegration.

In this way, despite all the challenges, the health promotion team with whom I worked in this particular area of Guinea attempted to build a more community-orientated strategy which aimed to reduce fear through a careful understanding of places, words and networks.

Health Promotion in an Ebola Context

The field of health promotion has changed and grown since its inception, and more and more anthropologists (not just within MSF but across other organisations) are occupying the role of health promoters, a role once reserved for medical personnel such as doctors or nurses. Health promotion has been adopted in a variety of humanitarian contexts including war zones, refugee camps, epidemics and natural disasters: as I have discussed above, health promotion is not a simple matter of ‘education’ to encourage people to change their behaviour but involves an in-depth understanding of the context and of the resources available to find solutions to health problems (WHO 1986).

Communication messages – whether about Ebola, malaria, HIV or other important health issues – should not simply be translated into local languages. Health promoters work to ensure that health services are culturally orientated and relevant to the needs of the local population, and people are thought of less as the empty recipients of information that ‘experts’ have to fill and more as partners with their own knowledge and experience. This is the shift from a ‘monologic model’ to a ‘dialogic model’ based on the interchange of knowledge and aimed at creating collaboration between health actors.
In the context of the Ebola epidemic in Guinea, the sensitisation of the population and the widespread communication of messages was, for me, a real battle against time and against a disease with no cure. Tackling an outbreak of the scale seen across West Africa in 2014 and 2015 involves more than simply the building and equipping of an EMC: it requires the coordination and synchronisation of a variety of activities – including health promotion – that need collaboration between different stakeholders, whether international organisations, local governments or authorities and local communities. In Guinea, the EMC was at the heart of our work and was considered a place that evokes hopes and fears, and a space where the struggle for life and death feeds the collective imaginary.

In this kind of scenario, the main challenge – and one I encountered in all of my missions as a health promoter in Guinea – was to find the right words to ‘reach’ the population and be able to frame EVD within a narrative that does not trigger and create uncontrollable fear. Gaining an in-depth knowledge of the situation on the ground and offering continuous training for local Guinean staff were implemented whilst simultaneously seeking to understand the meaning of Ebola and negotiating with local communities about adapting practices which could increase their risk of contracting the virus. The health promotion strategy and approach I coordinated were based on a careful and all-encompassing understanding of the cultural, historical, geographical, economic and political context.

Health promotion is an essential activity linked to community engagement. The sharing of information on Ebola, the practical application of anthropological fieldwork and critical reflections on the process can help the development and implementation of health strategies which are relevant, appropriate, supported by and understandable to local populations.

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Notes


References


