Rapid and Focused Ethnographies to Decrease Tensions in Guinea’s Ebola Crisis

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ABSTRACT This article is based on the personal experiences of the author as an anthropologist working for the WHO during the West African Ebola Virus Disease (EVD) outbreak between 2013 and 2016. As in earlier outbreaks in Central and East Africa, interventions by local and international institutional actors to control the EVD outbreak in West Africa faced resistance from populations, thus contributing to the spread and persistence of the epidemic. Distrust of health workers – sometimes resulting in aggressive attacks – presented an extreme challenge to the Ebola eradication initiative. Faced with a highly volatile situation, various international organisations decided to employ social scientists and particularly applied anthropologists, to help facilitate communication between the EVD response teams and the affected populations. By describing specific cases where ethnographical methods – specifically, rapid and focused ethnographies – contributed to the progressive subsiding of reluctance to EVD interventions in the prefecture of Kindia, Guinea, the author demonstrates how these tools can be effective methods for anthropologists to contribute to managing severe public health emergencies.

Keywords: Applied anthropology, rapid and focused ethnographies, Ebola, public health emergency, Guinea

Introduction
During the Ebola outbreak in West Africa from 2013-2016, the response from the anthropological community was one of the most rapid and expansive anthropological interventions made to a global health emergency in the discipline’s history (see Abramowitz 2017; Venables and Pellecchia 2017). As in earlier outbreaks in Central and East Africa (Hewlett and Hewlett 2007), interventions by local and international institutional actors to control the outbreak in West Africa faced resistance from populations, thus contributing to the spread and persistence of the epidemic. Distrust of health workers – sometimes resulting in aggressive attacks – presented an extreme challenge to the Ebola eradication initiative (see Niang 2014; WHO 2015; Coltart et al. 2017; Chandler et al. 2015). Faced with a highly volatile situation, various international organisations (e.g., WHO, UNICEF, Médecins Sans Frontières [MSF]) decided to employ social scientists and particularly applied anthropologists, to help facilitate communication between the Ebola Virus Disease (EVD) response teams and the affected populations (see Niang 2014; Anoko 2014; Amalaman et al. 2017; Wilkinson et al. 2017).

The overall aim of the article is to show the usefulness of applied ethnographic methods when there is a demand to produce results and useful advice during a very short timeframe. The fieldwork methods known as ‘rapid and focused ethnographies’ (cf. Trotter et al. 2015; Vindrola-Padros and Vindrola-Padros 2017; Gove and Pelto 1994) carried out by the author
during the EVD outbreak in 2015, are the particular focus of this article. I will first provide a short introduction to the problem and the field site, and then discuss the methodological challenges and how the methods were applied during the Ebola crisis. I used these methods as part of a consultancy assignment carried out for the WHO on social mobilisation and community engagement in controlling the EVD in Guinea. As I will show, I consider rapid and focused ethnographies to be effective and workable methodological tools during a severe public health emergency. I base this argument largely on two cases where anthropological methods contributed to the progressive subsiding of reluctance to EVD interventions in the prefecture of Kindia, which is in the center of Guinea (Figure 1).

**Background**

The largest EVD outbreak in history severely affected three West African countries – Liberia, Sierra Leone, and Guinea – from 2013 to 2016. By March 2016, there were more than 28,646 official cases of EVD and over 11,323 deaths worldwide. On June 1, 2016, the WHO declared the end of Ebola virus transmission in Guinea. Guinea was the country in which the outbreak (2013–2016) originated. By June 2016, Guinea had 3,355 confirmed and 456 probable cases, including 2,544 deaths (Keita et al. 2017).

During the first three months of the EVD epidemic, between late December 2013 and March 2014, the disease was new and unknown to the local communities, and many people started to attribute it to occult-related forces (i.e., sorcery, retaliation of ancestors) and curses laid on the affected families (Ouattara and Århem 2020). Initially, health workers investigating the deaths in the village of Meliandou where the outbreak originated, wrongly concluded that there was a cholera outbreak in the village (Ouattara and Århem 2020).
When the inhabitants of villages surrounding Méliandou started to accept that it was in fact the Ebola virus that was causing the deaths, they started to fear Méliandou and its inhabitants. The neighbouring villages interpreted Méliandou’s misfortune as something that the village had brought upon itself and cut off many of the roads and bridges to the village (see Fairhead 2016; Ouattara and Århem 2020).

After the formal declaration by the Pasteur Institute in France on 21 March 2014, that these deaths were caused by Ebola, the discourse stemming from the authorities rapidly became focused on the epidemic (see Faye et al. 2016). The NGO Medicines Sans Frontiers (MSF) helped Guinea’s Ministry of Health to establish an Ebola Treatment Center in the village of Macenta. People showing symptoms were transported to this location. As a result, youths in Macenta demonstrated en masse and attempted to destroy the MSF installations and attack the fifty or more expatriates working there, some arguing that Ebola was false or spread by outsiders (Anoko 2014; L’Obs 2014).

The discrepancies between professional/governmental, international institutions, and NGOs views of the epidemic and those of local populations initially led to some tragic events. In the village of Womey (see figure 2) eight members of an EVD prevention team were brutally murdered in September 2014 (see Bizot 2014). Resistance also escalated in the capital Conakry and the nearby prefecture of Forécariah and Kindia. Two members of the Ebola response teams were killed in Conakry in January 2015, as well as two police officers accused of spreading Ebola in Forécariah. In sum, an atmosphere of fear existed during the initial months of the outbreak in Guinea, and the EVD response team had two ‘enemies’ to face: first, the EVD; and second, the tensions and interpretations surrounding the Ebola response.

**FIGURE 2.** Womey in Guinea. Based on United Nations Map.
In this atmosphere of health crisis characterised by the fear and mistrust of the local population, anthropologists were deployed to facilitate communication between the EVD intervention teams and the affected communities. In other words, the goal was that the anthropologists would help to quickly find solutions for diminishing the resistance. This became clear as soon as I arrived at the WHO’s local office in Conakry. My supervisor, who was the Coordinator of Social Mobilisation and Community Engagement for the World Health Organization (WHO) in Guinea, said: “Syna, we are not asking you to offer us anthropological theories. What we need is practical solutions that can help stop the epidemic”.

Given the need to produce results and practical advice within a short timeframe, long-term participant-observation was not possible. It was necessary to put in place a method that suited the short timeframe and objectives of the intervention. I now turn to the methods used, namely rapid and focused ethnographies.

**Rapid and Focused Ethnographies**

In 1988, anthropologists Susan C. Scrimshaw and Elena Hurtado asked, “Must one spend a year in the field collecting ethnographic data in order to make useful recommendations for a health program?” (Scrimshaw and Hurtado 1988: 97). Since then, applied anthropologists have responded to the limitations of both surveys and classic ethnographies by developing ethnographic methods which are highly focused and intended to produce systematic data in a short period of time. These approaches aim at generating data which are easily accessible to development programme planners. They include rapid ethnography (see Beebe 2001; Reeves et al. 2013; Isaacs 2013; Trotter et al. 2015; Vindrola-Padros and Vindrola-Padros 2017) and focused ethnography (see Gove and Pelto 994; Higginbottom et al. 2013; Andreassen et al. 2020).

Rapid ethnographic research, broadly understood, is an approach whereby fieldwork is undertaken in a short and well-defined timeline (Reeves et al. 2013). Rapid ethnography (RE) consists of short cycles of in-depth interviews and observations at key time periods. The following terms indicate RE in applied health research contexts: ‘quick ethnography,’ ‘rapid ethnographic assessment,’ ‘rapid assessment response and evaluation,’ ‘rapid assessment procedures,’ and ‘focused rapid ethnographic procedures’ (see Isaacs 2013; Trotter et al. 2015; Vindrola-Padros and Vindrola-Padros 2017; Sangaramoorthy and Kroeger 2020).

RE requires extensive prior knowledge of the cultural setting and the social, political, and economic context, as well as prior knowledge of all of the important sectors contributing to the problem, from which researchers can draw representative samples of key informants and focus group respondents. This assessment can be made either by ethnographers familiar with the setting or by an interdisciplinary/intersectoral team responsible for the study and its uses (Trotter et al. 2015).

Challenges facing RE approach include the need to develop an accurate understanding of the problem and its context in a relatively short and cost-effective time period, the need to have systems for transforming the data into satisfactory solutions, and the need to produce socioculturally acceptable solutions (see Trotter et al. 2015). Rapid ethnography within applied health research have been criticised for reducing ethnography to a series of observations and not engaging the socio-political dynamics of knowledge production deeply (see Ingold 2014; Jowsey 2016).
Focused ethnography (FE) refers to a specific methodology that was developed initially at the WHO for the Programme for the Control of Acute Respiratory Infections (Gove and Pelto 1994). FE emerged as a methodology to answer specific sets of questions that are required by agencies, policymakers, program planners or by project implementation teams, in order to make decisions about future actions regarding social, public health, or nutrition interventions, and for public–private partnership activities (see Roper and Shapira 2000; Vougioukalou et al. 2019). Unlike classic long-term ethnography, FE explores a specific phenomenon, issue, or problem within sub-cultures and among small groups of people and is often used as an applied research approach to open up strategies for problem solving (Roper and Shapira 2000; Andreassen et al. 2020). In FE, the preparation phase is relatively long. Extensive background research prior to entering the field is essential as a relatively short time is spent in the field and observations have to be focused (Higginbottom et al. 2013). Thus, focused ethnography is a suitable tool for researchers who have prior practical experience or are otherwise embedded in the locality of the research (Andreassen et al. 2020: 298).

In focused ethnography, interviewing becomes a way to get participants' perspectives on what is happening. FE implies confirming observations through interviews, as well as collecting data on issues and phenomena that cannot be or have not been observed, including attitudes and feelings (Higginbottom et al. 2013; Andreassen et al. 2020). As in classic ethnography, the analytical steps in FE are characterised by identifying, collecting, and classifying the data and then progressing and creating generalisations and explanations of patterns. However, whereas classic ethnography makes use of a very open and exploratory analytic approach (Reeves et al. 2013), focused ethnography entails finding answers to the specific problem-oriented research questions posed by a governmental or non-governmental organisation, with the goal of offering specific recommendations (see Roper and Shapira 2000; Andreassen et al. 2020).

As I note above, both RE and FE are ideally based on extensive prior knowledge and research experience. In addition, many social scientists consider rapid ethnography and focused ethnography complementary, each method making up for the limitations of the other (Whyte and Alberti 1983; Inhorn and Brown 1997). Finally, RE and FE have also been subject to scholarly critique. For example, anthropologists Cecilia Vindrola-Padros and Bruno Vindrola-Padros (2017: 8) suggest that “future rapid ethnographic research needs to develop more robust processes for the reporting of study designs and findings and place greater emphasis on reflexivity”.

The Guinea EVD Mission

My main responsibility was to support the EVD Response Teams in the Prefecture of Kindia through the application of ethnographic methods to understand the factors that drove the spread of EVD in Guinea and resistance to EVD interventions. The terms of engagement for my three-month assignment stipulated:

In collaboration with the Ministry of Health, under the supervision of the WHO Country Office and the WHO team leader of the outbreak response team, the medical anthropologist will conduct the following activities: Join a medical intervention team and assist in efforts to control the outbreak; carry out investigation that will help to better understand the local cultural attitudes toward Ebola; identify beliefs and practices that may amplify or help control the outbreak; identify and incorporate local beliefs and practices into appropriate and
safe patient care and response efforts; contribute to conducting ecological studies in relation to primary cases, if possible, to identify the natural source of the Ebola virus; investigate social and anthropological issues that would support a better understanding of the outbreaks of Ebola; investigate cultural and social norms within communities that will contribute to developing better rapport and trust within the community; and support the Ministry of Health in documenting the anthropological aspects of the Ebola outbreak.

In other words, the expectations surrounding my contribution to a better understanding of and response to, the outbreak of Ebola were very high, especially considering the short time that I had for my assignment. To provide practical recommendations, it was necessary to quickly find answers to the following questions: What do affected populations think and feel about the EVD and its response teams? What beliefs and practices in the communities amplify the outbreak? What practices in the communities can enhance the efforts to control EVD? What beliefs or practices of the EVD response teams amplify the outbreak?

### Outline of the Mission Methodology

The WHO mission was conducted in several phases. The first step was documentary study and exploratory interviews in Conakry (2 days) and in Kindia (1 day). Here the most important steps were: first, planning of the fieldwork in the affected communities; second, fieldwork and data analysis; and third, presentation of the results at the Prefectural EVD Coordination Cell daily meetings.

Planning the fieldwork in the affected communities included identifying key trusted community leaders in the study location, such as leaders of local government authorities, communal authorities, healthcare facilities, socio-cultural organisations, traditional and religious organisations, youth associations, women's associations, etc. This was followed by presenting the purpose of the mission to these trusted community leaders, to get their
approval of the mission. After this, a date for conducting the fieldwork was decided. Meetings with these leaders also included discussions on expected support from them for carrying out the fieldwork. Overall, the duration of planning for fieldwork varied from 2 to 7 days.

The fieldwork involved interviews and observations. I used both RE and FE, which included formal, informal and semi-structured interviews. The fieldwork aimed at identifying the reasons behind peoples’ unwillingness to comply with the efforts for EVD control, community health needs, and community health facility use. Determining which specific villages and communities were at a high risk of being reluctant to interventions was important, as was targeting interventions in the early stages of the EVD epidemic and developing a rapid assessment tool so that these communities could be prioritised for prevention programs. I conducted in-depth interviews with members of affected communities, as well as with several members of the Ebola response teams to understand their perceptions of affected communities’ reactions, and the difficulties they faced.

A key element to this rapid and focused ethnographies approach was involving local researchers and actors who understood the realities “on the ground” and could provide useful information concerning the affected communities. I worked with two local sociologists (female and male) as assistants in the field, both of whom had a Master’s degree in sociology and spoke the main local language (Susu). They also spoke Malinké (which I also speak fluently), which was another of the languages spoken by several of our respondents in the field. The interviews were held in Susu, Malinké, or in French, depending on the language spoken by the respondent. I led the interviews, and the assistants took notes. In the cases of Susu, the assistants interpreted. Both of my assistants had been trained in rapid and focused ethnographies methods by one of the WHO’s senior anthropologists. They also had previously worked with the EVD response for UNICEF. When I arrived in Kindia, they were already working with the WHO EVD response teams. They had knowledge of the EVD response as well as local knowledge, which was very helpful. These RE and FE studies varied in duration from 1 to 3 days per setting.

Given the health emergency and insecurity in the country, all WHO staff were asked to be on site in Kindia city before 18:00. Each day, I left Kindia city with my team for fieldwork in villages after the WHO morning meeting, which ended around 7:30 a.m. We had to return to present the results and concrete recommendations at the Prefectural EVD Coordination Cell daily meeting in Kindia, which started at 16:30. This required very rapid and focused fieldwork, and data collection occurred concurrently with data analysis. During the first stage of the analysis, my assistants and I read and discussed the transcription of each interview at the end of each workday. These discussions helped us to build and revise respondents’ explanatory models for EVD and its response efforts as a team. Through this procedure, we were able to understand the problems from an emic, insiders’ perspective, and to prepare the results at the meetings.

The daily meetings provided opportunities for regular acquisition and transmission of information, especially on the planning activities with a special focus on the difficulties encountered by the EVD response teams in the field. At each meeting, the chairperson allocated speaking time systematically to me, for the daily fieldwork results and for anthropological discussions and analyses. These presentations also included the recommendations of the day. At these meetings we generally presented our daily findings in the form of quotations (on 1
to 3 slides) from key informants’ interviews, and images from the field. These results were useful for strengthening risk communication and further developing the response efforts.

As mentioned, I was deployed in the prefecture of Kindia which has nine sub-prefectures or sous-prefectures. I worked in all these sub-prefectures, although I spent most of my time in the sub-prefecture of Samayah. The main reason for this was that at the time of my deployment, the community’s resistance to the EVD response teams was greater in the Samayah sub-prefecture than in other Kindia sub-prefectures. I will mainly focus on my work in Samayah, which is located 44 km from the urban commune of Kindia.

Before conducting fieldwork in affected communities, I found it important and valuable to carry out in-depth interviews with several members of the Ebola response teams. My aim was to rapidly get a general overview of their perceptions of the affected peoples’ reactions and the difficulties they faced. This data informed my more-focused fieldwork in affected communities. Below, I present some voices from these in-depth interviews. The respondents mainly focused on communication problems and lack of transparency regarding what was taking place in the Ebola Treatment Centers. This was especially a problem during the initial months of the epidemic.

**Voices from Some Members of the EVD Response Teams in Kindia**

I focused my first interviews on staff who had extensive experience in the EVD response. During my first interview with my two assistants, who were members of the social mobilisation and community engagement team, one of them pointed out that the EVD was not the problem but rather the way it was managed. He explained:

> Communication was faulty from the start. People have been told there is no cure or vaccine for the EVD. So, they say to themselves, if the disease is incurable, why should I go to a hospital or ETC [Ebola Treatment Center]? When you enter an ETC, you never come out alive. He continued:

> The staff of the Red Cross was well received at the beginning of the EVD. But everything changed in a bad direction after there was a hostile situation between them [the Red Cross] and local communities in Forested Guinea [Figure 4]. There was a death in a village and the villages contacted the staff of the Red Cross. They came and initially said that it was not a case of EVD, and the family proceeded to the burial. Two days later, they came back and said that it was a case of EVD and that all members of the deceased’s family had to be quarantined. There was panic in the village! Some members of the deceased’s family fled, and those who were taken to the ETC did not return at all [i.e., they died in the center]. But those who escaped [the Red Cross intervention effort] came back safely to the village.

These problems with early communications, contradictory messages, and missteps were among the factors that made people distrustful and fearful of health workers and ETCs. Fear and mistrust of healthcare workers and the ETCs negatively affected the EVD efforts. A nurse who worked in an ETC reported that in the initial months of the epidemic most of the EVD patients refused to consume the drugs prescribed to them. They also refused to eat the food, as they thought the drugs and the food were contaminated and that the ETC personnel wanted to kill them by poisoning them.

Interviewees also mentioned the lack of transparency regarding the ETCs – people simply did not know what happened to relatives taken to the center. This lack of transparency created distrust between affected communities and the EVD response teams. A doctor who
worked in an ETC stated that at the beginning of the EVD, people were not allowed to see the bodies of their loved ones who had died from Ebola. He also explained that often, bereaved families were not even informed about the location of the buried corpses.

A hygienist told the following story:

A woman from the city of Faranah, Upper Guinea, was admitted to the ETC. When her brother came to enquire about her health condition, he was told that his sister was dead. He asked them to inform him about when the Red Cross agents would bury her and went home. However, the ETC staff forgot to inform the Red Cross agents about this. By the time the man returned to the ETC with a cross to place on the grave of his sister, the funeral was already finished. The saddest part was that no one could show her grave to him, so he left the ETC frustrated.

People did not know what happened to their relatives who had been taken to the centers. Doubt and distrust also emerged when people did not see the bodies of their loved ones and did not know where they were buried.

Using RE and FE, I quickly listened to several key persons and gained important insights into the interrelated problems. These could be summed up as the following: first, faulty early communication and missteps; second, lack of information to affected communities about ETC and caregiving to EVD patients; third, lack of transparency concerning several activities of the EVD efforts (such as a safe and dignified burial); and fourth, lack of confidence in local authorities and EVD response teams, which probably contributed to the creation of mistrust and fear. Mistrust and fear contributed to the resistance of the
affected communities against the EVD response teams and a lack of trust led some affected persons to avoid seeking medical help for suspected EVD. There was reluctance to engage in surveillance and contact tracing, as well as avoidance of the WHO’s ‘safe and dignified burial’ activities (described in WHO 2017).

Case 1: Applying Rapid and Targeted Methods to Rebuild Trust Through Stakeholder Engagement

In Samayah, nurses working in the sub-prefecture had been chased away by the inhabitants of the village and the sub-prefecture was ‘cut off’ from the rest of the world. The community’s resistance to efforts to prevent and response to EVD was particularly acute and required rapid solutions.

Before my deployment in the field on March 2015, an EVD Response Team went to the village of Samayah on December 31, 2014, to undertake a ‘safe and dignified burial’ of the body of a suspected Ebola victim, following the WHO burial protocol (WHO 2017). A group of young people chased the team away from the village. After this incident, Samayah and several villages in the sub-prefecture were in a kind of self-quarantine. The inhabitants of numerous villages including Samayah controlled all the entrances and exits to and from their villages. This caused the Guinean Government to install two mobile security teams and reinforce prefectural security to protect the EVD response teams (OMS 2015). However, after three months, the national newspaper Guinée Matin reported:

The two health workers who served in the Samayah sub-prefecture were hunted down and attacked by the population who considered them ‘accomplices’ of the Ebola awareness agents. Their motorbikes were confiscated by the mob. The health workers were able to escape and ‘take refuge’ in the town of Kindia. (Guinée Matin, 2015, my translation)

Faced with persistent active resistance in Samayah, the coordinator of the Kindia Prefectural EVD Coordination Cell asked the team of WHO anthropologists (led by me) to intervene. Given the urgency of the situation, we used rapid and focused ethnographic methods to investigate. The purpose was to listen to the community leaders and quickly find an adequate solution that would mitigate the reluctance of the local population to allow EVD work.

We began by locating and interviewing the two health workers from the sub-prefecture who had been attacked by the inhabitants. After this, and in collaboration with the mayor and the prefect of the city of Kindia, we identified and contacted (by phone) several key persons (the sub-prefect, the mayor, the heads of districts, and the customary leaders) in the sub-prefecture to organise a “mission” to Samayah. One of the conditions demanded by all these key persons was that the security forces (police, gendarmes, or military) should not escort us (my two assistants and I) to the sub-prefecture. We agreed to this demand. During my conversation with the sub-prefect concerning the mission, I asked him to describe the balance between the different social groups. A sample matrix with a list of social characteristics (e.g., districts and the customary leaders, traditional medicine practitioners, hunters, religious leaders (Christians and Muslims), schoolteachers, women leaders, youth leaders was created by the sub-prefect.

Upon arrival in the village, I first conducted an interview with the sub-prefect and the

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1 A contact is any person who had physical contact with a case (alive or dead) or the bodily fluids of a case within the last three weeks. A contact has no signs of the disease. Physical contact includes sharing the same room/bed, caring for a patient, touching bodily fluids, or closely participating in a burial (WHO 2014).
mayor. During this interview, the sub-prefect emphasised the widespread disbelief among
the villagers, telling us, “I believe the disease exists, but a large part of the population does
not believe, because they have never seen an Ebola patient”. After our meeting, we were
taken to the public square by the mayor, where 32 persons of different ages, genders and
sociocultural groups (10 male and 22 female) were waiting for us. The composition of this
group reflected the fact that most of the resistance towards EVD efforts in the prefecture of
Kindia was led by women and youth.

I started the conversation in French (translated into Susu by one of the assistants) with
questions about income-generating activities in the sub-prefecture, followed by questions
focused on socio-cultural activities. After a general overview of the economic and socio-
cultural activities, I focused on local understandings of the Ebola epidemic, prevention,
and control of the EVD; accounts of the way public health interventions to control the
epidemic were perceived; rumors concerning the EVD; and (concrete) proposals for a rapid
eradication of EVD. I began the discussions about Ebola with the following words: “We
want to know, what do you think about the Ebola problem? What makes you angry, hurts
your dignity and what are your deepest feelings? What the EVD response teams done or said
that shocks you?”

Most of the participants claimed that EVD probably did not exist, because there had
never been a case of Ebola in Samayah. For example, a woman alleged:

No one can tell me that Ebola exists. My father massaged and fed my brother-in-law when he
was sick. He was later declared dead from Ebola by the EVD response team. My father also
washed his body. My father and I, as well as all the other members of our family, have been
living without any EVD symptoms, or any illness for about two months.

One of the religious leaders stated, “This epidemic is the result of divine anger toward humans
because humans are increasingly abandoning their beliefs in God. To give us a warning, God
has sent a force that sows psychosis and death among us”. A hunter added, “We believe that
bush meat cannot be the cause of Ebola because our parents and great grandparents have
always eaten this meat without ever getting Ebola”. Another hunter stated, “I am a hunter,
my family subsists on that [hunting] and it is through hunting that I make an income. It
is this meat that we live on, both for direct consumption and for sale in the market for
money”. A traditional-medicine practitioner also related the epidemic to income-generating
activities, declaring:

The EVD response teams told us not to receive or treat patients. How do they want us to live
without the help that the patients give us? Those who tell us not to work, don’t they work?
We know that all members of the EVD response teams, even you [nodding at me], receive
money, and lots of it.

A youth leader added:

Even though Samayah houses the two largest hydroelectric dams in the Kindia prefecture, it
has never benefited from that: the sub-prefecture is not electrified. There is a lack of potable
water. There is no Ebola here in Samaya. What we are fighting for now is water and electricity.
Ebola is not a priority for us.

One of the youths asked, “Is the Ebola virus natural or is it created by humans”? Another
immediately responded by saying, “It’s a virus created to harm people. The evidence is that
the government has said that in 60 days Ebola will end. So, if the government can specify the end of the epidemic in the country, it means that they control the situation”.

Another area of resistance that participants brought up concerned burials. Community leaders insisted upon dignified funerals. Nobody saw any reason for carrying out burials according to the burial policy stated by the Health Ministry. As one leader of a women’s association emphasised, “We do our funerals as usual”.

In sum, there was a deep lack of trust and numerous respondents did not believe that EVD existed. Several respondents argued that the EVD was a divine punishment for violating traditional values and that it was God alone who could decide the end of the epidemic. EVD was perceived by many as a disease created intentionally by the government in order to make people suffer and for monetary purposes. People described this as “Ebola business”. The official position that Ebola would end in 60 days caused people to see Ebola as a human creation. The lack of electricity and potable water in the sub-prefecture had already created a crisis of confidence which was amplified during Ebola and created a divide between the communities, on the one hand, and the EVD response teams and the country authorities’ representatives (the mayor and the prefect of the city of Kindia, the sub-prefect, and the mayor of the sub-prefecture of Samayah), on the other.

RE and FE are intended to lead to interventions. One of my first recommendations was to continue the ethnographic investigation in all the villages of the sub-prefecture, in order to better understand the causes and factors associated with the lack of trust, reluctance, and denial of the EVD. Together with my assistants, I proposed: firstly establishing ‘listening sessions’ with representatives from several different social/age/gender groups, including women, midwives, and youth; and secondly organising consultation sessions with the customary leaders, to discuss and understand the difficulties that affected communities and make relevant recommendations that would reduce or circumvent reluctance toward cooperation with the EVD response teams. I also recommended undertaking a broad sensitisation and mobilisation program concerning the EVD in this sub-prefecture, with various themes such as safe and dignified burials, management of visitors from the outside, and referral of patients to health facilities. These recommendations were endorsed by the Prefectural EVD Coordination Cell. Samayah was now ‘opening up’ to the EVD response teams.

Case 2: Doing Rapid and Focused Ethnographies in a Hostile Context

The rapid and focused ethnographies methods that my assistants and I used became particularly vital and critical when we decided to go to the village of Maléa on July 13, 2015 to explore the community’s EVD awareness. At the entrance to the village, the road was blocked with a tree trunk and some large stones. As soon as our vehicle stopped, we saw young people coming out from the forest with stones, machetes, cutters, pieces of wood, axes, and batons. They blocked the road and told us to stop our car. Seeing these excited and angry young men, we stopped our car and asked what was going on. One of them explained: “We got a phone call from Conakry saying that the Red Cross agents are coming to our village to spread the Ebola virus”. At this point, we wanted to turn around, but they told us, “No, you cannot turn around. We are going to kill you”.

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This was no idle threat. Other cars belonging to EVD response teams had been burnt in several villages in Guinea. In the village of Womey, eight members of the EVD response teams had been murdered.

To defuse the encounter, we identified the leader of the group and asked him to search the vehicle to verify that we were not from the Red Cross. He did not find anything that could be associated with the Red Cross, and so reassured the others that we were not the real target. We were then allowed to enter the village and to meet several community leaders. At that point, we did not dare to speak about EVD. Instead, we talked about other issues, such as income-generating activities, socio-cultural activities, schools and education, and common diseases in the district. After a while, the villagers began to tell us about EVD and their concerns about the epidemic reaching their village. This allowed us to explain the real purpose of the mission in the village. We presented the customary cola nuts (figure 5) to the village elders (i.e., the customary leader, the district president, the imam, and other local elders) as a way to get their permission to work with the community. The imam then welcomed the team to the village, saying:

We are very sorry for our attitude toward you and, in particular, how our youngsters behaved toward you. We know that you are not from the Red Cross and that you are not doctors who have come to harm us. We know you are here for us and not against us. We are isolated here, abandoned by the sub-prefect; all development projects designed in our district are diverted by the sub-prefect. You have seen the state of the road between our village and Samayah yourself; even on a motorbike, it is difficult. Our children have not gone to school for months because of teacher shortages. You may feel at home here and may work here without any problems. I speak on behalf of the whole district.

The youth leader then told us, “Since his nomination, the sub-prefect of Samayah has not once set foot in our village and our community has never benefited from any development project”. The meeting ended with an exchange of phone numbers between our team and several influential people in the community (such as the head of the female organisations and youth leaders in the district) and a plan to set up an anthropological investigation in the village. My team and I left Maléa and drove back to Kindia.

In this community there was a deep ‘divide’ between the sub-prefectural administrative authority and the populations. Locals felt abandoned, excluded from development projects. Risk communication concerning the EVD was particularly difficult to deliver to the youths and women, due to the very low health literacy in the community. The prevailing attitude in

\[2\] In several West African countries, cola nuts are given as a symbol of hospitality, friendship, and respect. Cola nuts are also presented to guests at important social events such as weddings, funerals and infant naming ceremonies. Additionally, they are used for medicinal and divination purposes (Ouattara 2008).
the village could be described as a denial of the existence of the disease. No EVD response team had visited the village since the advent of the EVD in Guinea.

In this context, RE and FE became particularly valuable for building trust between the community and the EVD response teams. I recommended continuing anthropological studies to better understand the root causes of the local reluctance and denial and made proposals together with the district inhabitants to overcome the hindrances and ‘open up’ Maléa to the response teams. One of my main strategies was to be discreet when visiting an affected person, a family, or a new locality. Discretion had saved us from violence when entering the village of Maléa. The vehicle we used was neutral. It did not have a logo from an organisation responding to the EVD such as the WHO, UNICEF, or the Red Cross. We also did not have vests or WHO badges. As in the case of Samayah, the Prefectural EVD Coordination Cell approved these recommendations. Maléa was now also opening up to the EVD response teams. As required by the village residents, the EVD response continued in the village without the involvement of the sub-prefect. Two days later, I returned to Maléa with my two assistants and an UNICEF awareness team who distributed kits.

**Case 3: Using Rapid and Focused Ethnographies in Contact Tracing**

The two preceding cases were primarily focused on reducing resistance in affected communities, (re)building of trust between the local communities and the frontline EVD response staff and strengthening community mobilisation and engagement in the EVD response. I now turn to some specific methodological contributions in contact tracing, as this was vital in the effort to combat the spread of EVD.

During an EVD outbreak with established person-to-person transmission, new cases are likely to emerge among contacts. All potential contacts of persons with suspected, probable, and confirmed Ebola cases must be systematically identified and put under observation for 21 days (the maximum incubation period for the Ebola virus) from their most recent contact with the case. Potentially infectious contacts with signs and symptoms of the disease must be immediately evacuated to designated treatment centers or to the nearest healthcare facility in order to prevent high-risk exposure during home-based care, ordinary burial procedures, and other social activities. Rapid contact tracing is one of the most effective outbreak containment measures but must be implemented prudently (WHO and CDC 2015). Involvement and full cooperation of affected communities are critical for successful contact tracing (WHO 2014).

Contact tracing must also be considered in relation to stigma. Fear of EVD-related stigma was a key factor causing peoples resist the EVD response efforts (see Hofman and Au 2017). Fear of stigma negatively affected the involvement of affected communities in the EVD control activities and particularly contact tracing. One respondent in the sous-prefecture of Friguiaigbe in the Kindia prefecture highlighted this issue:

> The way in which 4x4 cars drove into villages to take away the dead bodies shocked and dishonored us. They are driving at full speed in a large procession supported by a siren that warns the entire neighborhood. People go out and look at the family, who are experiencing pain and shame. As a result, family members are subject to stigma and extreme exhaustion. We would like the Red Cross’ removal of the bodies to be more discreet. These cars arrive unexpectedly with too much noise and cause fear and anxiety.

Several affected people, including contact persons, ran away from these large white 4x4 cars. The vehicles were associated with EVD, even becoming known as ‘the Ebola vehicles’ (Les
véhicules d’Ebola). Identifying the need for changes in the use of these vehicles was one of the first findings we made with RE and FE.

We also used RE and FE in relation to other problems with contact tracing. At the daily WHO meetings between EVD response teams and the Prefectural EVD Coordination Cell, the contact tracing team often reported how many contact-persons they could not find during their daily mission. They had not tried to find out the reasons why these contact-persons did not follow the confinement procedures. It was our team of anthropologists who investigated this at the request of the Prefectural EVD Coordination Cell.

When investigating why contact persons or households did not follow the confinement measures, we discovered that socioeconomic issues negatively affected contact tracing. All the EVD patients (positive cases) who were recovering from the EVD were supposed to receive a sum of money per month. Additionally, all contact persons were also supposed to receive food, an amount of money for cooking expenses and a hygiene kit (hand-wash basin, soap, bleach and individual sprayer) for the 21 days of confinement (see Greiner et al. 2015; Desclaux et al. 2017). We met several individuals (EVD patients, survivors, and contact persons) who had not received in full what they were entitled to. This was particularly common among contact persons. The result was reluctance to agree to confinement procedures. Another problem we identified was that these measures in and of themselves could contribute to stigma, as EVD patients and contacts could not maintain routine activities. The stigma associated with this failure occasionally led to contact persons fleeing from follow-up or being ostracised from their communities (Greiner et al. 2015: 5).

Our reports on these socioeconomic issues created tensions between the team of anthropologists and those responsible for managing the funds allocated to the victims of Ebola. Nevertheless, we had the support of the lead coordinator of the WHO EVD response teams in the prefecture as well as the chief of the Prefectural EVD Coordination. As the terms of my employment stipulated, one of my main responsibilities was “to identify beliefs and practices that may amplify or help control the outbreak”. It was clear that a failure to deliver economic support complicated contact tracing and could amplify the outbreak.

Another factor that negatively affected contact tracing concerned so-called community watch committees. The National EVD Coordination Cell created 1,150 Community Watch Committees (Comités de Veille), which were expected to perform early warning and surveillance tasks and facilitate communication with people on how to quell the epidemic. There were five committee members per village. Each of these received a remuneration of US$50 per month (in local currency), a considerable amount by Guinean standards. Ideally, the members of these committees should have been elected from the bottom up by the community. However, RE and FE in several villages in the Kindia prefecture showed that in reality, most of the Comités de Veille were selected by (and thus loyal to) the government. They were not functioning as intended in many villages. We recommended to National EVD Coordination Cell that all social groups be involved in the community watch committees and each village be allowed to choose who should be part of this committee. The Prefectural EVD Coordination Cell approved this recommendation. All Comités de Veille were identified and reorganised in the Prefecture. It was now up to the village residents themselves to decide who would be included in the Comités de Veille.

3 These funds and kits were managed by the Direction préfectorale de la santé (DPS)/ Prefectoral Health Department.
Conclusion

In this article I describe how rapid and focused ethnographies (RE and FE) were useful research methods during an acute public health crisis (such as the Ebola epidemic) when prompt and highly focused interventions are required. Given the need to produce results and practical advice within a very short timeframe, long-term participant-observation was not an appropriate method. As an applied medical anthropologist working with an acute health problem where poor decisions could literally mean life or death, I had to rapidly develop ethnographic insights that could inform the containment practices and suggest solutions that could be accepted by both the EVD response team and local villagers. To this end, RE and FE approaches were useful methods for gathering affected people’s views and concerns about the epidemic and the outbreak response activities. RE and FE allowed me to keep focus on issues relevant to program planners, as well as work within the extremely short time between data collection and final report/recommendations. Based on my experience, I argue that RE and FE are highly effective tools in responses to local and global public health emergencies.

RE and FE highlighted a lack of information about Ebola Treatment Centers, a lack of transparency, and a lack of confidence in local authorities and EVD response teams, which contributed to the creation of rumors and suspicions as well as mistrust and fear. This led to a reluctance among affected populations to the EVD response teams. In the localities where I worked, attentive listening to the affected communities and taking into account their daily precautions, made it possible to improve EVD interventions. Strengthened community engagement (re)built trust between the local communities and the frontline EVD response staff.

The inclusive and participatory approaches that we employed, combining scientific and local knowledge, were vital to avoiding negative reactions, fear, distrust, stigmatisation, and even violence (Hewlett and Hewlett 2007). RE and FE were reliable, rapid research techniques that gave affected people a voice in how the disease was managed. We helped facilitate communication between the affected populations and the EVD response teams, which diminished resistance to public health interventions. RE and FE are useful methods for applied anthropologists operating in public health crises who seek to develop local response and resilience strategies, mobilise community engagement and increase collaboration between affected populations and health care actors.

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