

Lessons from Uganda's Successful Combat of Ebola Scourge: The Strategic Communication Approach

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Abstract

This case focuses on how Ugandan health sector players (both public and private) under the leadership of the ministry of health managed to combat the Ebola scourge that hit the nation in the year 2000 in comparison to the Ebola scourge in West Africa in 2014. The case starts with a brief background of the then state of health in Uganda that comprised of a relatively weak health system with inadequate health and wellbeing promotion campaigns. This challenge has continued to the extent that up to date, 75% of the disease burden in Uganda is preventable through health awareness campaigns. The case study shows that with the weak health system in 2000, the health sector managed to use strategic communication approaches like relational cohesion, information adequacy and interaction quality to combat the Ebola scourge that had spread to nearly the whole country within only 144 days, claiming over 224 lives. The case ends with a discussion of the lessons that can be drawn from Uganda's successful combat of Ebola basing on the understanding of social network theory and a conclusion that sets direction for future studies.

Keywords: management, communication, strategy, strategic communication, Ebola

The state of Health in Uganda

The Health Sector in Uganda constitutes of all institutions, structures and actors whose actions have the primary purpose of achieving and sustaining good health. These institutions deliver curative, preventive, promotive, palliative and rehabilitative services to the people of Uganda under the leadership of Ministry of Health (MoH). The ministry uses a decentralized system, with districts and health sub-districts managing the delivery of health services at district and health sub district levels. The health sector is made up of the public and the private health providers. At the time of Ebola scourge in 2000, the public sector comprised of 2242 government health centers and 59 public hospitals. These were structured from top to bottom as National Referral Hospital, Regional Referral Hospitals, General Hospitals, Health Centres IVs, IIIs, IIs and Is (MoH, 2010). The Health Centre Is were in 2010 turned into the Village Health Teams (VHTs) which up to today work as a link between health facilities and the community without any physical structures (VHT Strategy and Operational Guidelines, 2010). The public sector also comprises of health services of the ministries of defense, internal affairs (police and prisons) and ministry of local government.

The private sector however, consisted of 269 private health centers and 8 private hospitals. This sector also included 613 health Facilities and 46 hospitals under the category of Private Not for Profit providers. Up to date, both the public and private sectors play a tremendous role in improving health conditions of Ugandans, with the private sector delivering about 50% of the health services yet over 60% of Ugandans seek care from the informal health category of Traditional and Complimentary Medicine Practitioners (MoH, 2009; MoH, 2016). The Ministry of Health divided health services into four clusters for easy administration, these include; Cluster 1 which focuses on health promotion, environmental health and community health initiatives. Cluster 2 focuses on maternal and child health, Cluster 3: Communicable diseases control and Cluster 4 focuses on prevention and control of Non Communicable Diseases like disabilities, injuries and mental health problems (MoH, 2009).

Under Cluster 1, though the ministry acknowledges that 75% of the disease burden in Uganda is preventable through health promotion campaigns (MoH, 2010), there has been tremendous achievement in terms of distributing Information Education and Communication (IEC) materials in all health facilities in Uganda. Many of these materials though, are not well translated into local languages and many times they are transferred to the health facilities late. The implementation of the Village Health Teams (VHT) strategy is also not satisfactory with only 31% of the districts having trained VHTs in all the villages. However in areas where VHTs are functional, they have contributed to increasing health awareness, demand and utilization of health services and significantly led to decongestion at health facilities as they timely treat minor illnesses. In regards to environmental health, evidence shows that at the time of Ebola, the latrine coverage was still low with more than 12% Ugandans not having toilet facilities and only 67% having access to improved water sources. The situation was worse in rural areas where three quarters of households had floors made of earth, sand or dung and 72% of the households in Uganda living in more 5km away from either a public or private health facility (MoH, 2016).

Ebola Management in Uganda in 2000

In 2014, West Africa was attacked by the largest outbreak of Ebola in the history of the world causing 20,800 deaths in only six months, prompting a declaration of state of international health emergency by United Nations.

Similarly, in October 2000, for the first time in the history of the world, Uganda was attacked by the largest outbreak of a severe acute viral illness called Ebola EHF that claimed over 224 lives within 144 days. This epidemic was first recognized in a remote village (Rwot Obilo) in the far north of Gulu district in the northern part of Uganda and later spread to other districts like Masindi and Mbarara in the western part of Uganda. When this epidemic broke up, some communities attributed the illness to poisoning yet others attributed it to soldiers of the Gulu ethnic minority group, who had contracted the disease from their new Congolese wives whom they had returned with after fighting in the Republic of Congo (DRC). This community therefore felt that the current government had little interest in the North so when Ugandan soldiers became infected from DRC, the government decided to send them to military bases in Gulu. However, like in West Africa, majority communities in Uganda attributed the disease to gods' misfortune and witchcraft claiming that the gods were not happy with the villages thus calling for demonstration of respect to the gods.

As a result of these beliefs, most communities used indigenous healers to treat the epidemic. For every sick family member, it required sacrificing four to five goats or sheep and one chicken on addition to paying 150,000 Ugandan shillings, an equivalent of 100\$ by that time which was about half the annual income for a rural Acholi family in northern Uganda. As was the case in West Africa, for the few community members who managed to visit the village health centers, the health workers treated the symptoms of the disease as a regular illness that required malarial drugs or antibiotics. In both cases, when people died, they would be buried following cultural practices. For example in Uganda, the body would be washed and prepared by the paternal aunt, all family members ritually washed their hands in a common bowl and gave a final touch (a love touch) on the face of the deceased. The deceased would then be buried next to their houses or at the edge of the village if died of witchcraft. Therefore those who thought they had contracted witchcraft, because of fearing to be buried at the edge of the village an act of shame, would not reveal their sickness to the friends to the extent that even when the hospital ambulances started taking people to hospitals they could run and hid whenever it arrived to pick them yet others ran from the ambulance on the way to hospitals. As a result of these practices, the disease spread very fast to all the neighboring communities attracting the attention of the government and other stakeholders including United Nations, World Health Organization and other Non-Governmental Organizations.

In Uganda, after testing and confirming that it was an outbreak of Ebola, the government through ministry of Health (MoH) reacted by setting up three coordination committees: National Task Force (NTF), a District Task Force (DTF) and an Inter-ministerial Task Force (IMTF). The NTF and DTF were responsible for coordination and follow-up of implementation of activities at the national and district levels, respectively. This involved surveillance, community mobilization, case and logistics management and communication to all stakeholders including community members. The IMTF however, provided political direction and international relations. At the local level, the setup committees started by building voluntary participation and partnership with major stakeholders in the region like NGOs (Uganda Red Cross and World Vision), local and religious leaders, health workers, local government officials, security agencies and the community at large. These were mainly trained in information gathering and dissemination, and identification of cases and referring them to the hospital.

After the necessary trainings, the selected stakeholders were grouped into three teams; a mobile team, an ambulance and burial teams. The Mobile team was responsible for door to door teaching and disseminating information concerning causes and ways of preventing Ebola. The team was also responsible for convincing community members to report Ebola cases to the hospital and drop their norms that were against the health guidelines. These norms included funeral and burial rituals, handshake greetings and use of traditional healers. An ambulance team was responsible for quick transportation of patients and the burial team offered professional burring of those diseased of Ebola. The mobile team could notify the ambulance team in case of a suspected case or the burial team in case of community deaths through established radio communication systems. The ambulance teams transported the suspects to the isolation units for further evaluation and screening. Burial teams buried the dead in the community after collecting specimens for laboratory confirmation.

In order to increase public awareness, The Ministry of Health patterned with the media to provide prompt and factual public information concerning Ebola. The media was trained in Ebola management and after which charged with providing factual updates about the disease on a daily basis in order to curb rumors, myths and risks associated with the disease. Public information dissemination involved using channels like local and national radio station (over 200) and television stations whose national coverage was more than 60% of the population. Regular press briefings coupled with frequent preaching by religious leaders in places of worship were also carried out. Political leaders at all levels including members of parliament and local councilors plus ministry officials conducted public dialogues to discuss Ebola. There were local drama, music groups and aggressive film shows of documentaries of previous outbreaks to local communities and in institutions in the affected districts.

Different posters and guidelines on Ebola were widely circulated to all public places including taxis and buses. Timely dissemination of appropriate information was also encouraged through instituting toll free mobile phone numbers where any community member in the affected region could call the medical workers or

ambulance to report any suspected case of Ebola. Motorized and foot patrols at the community level also enhanced urgent dissemination of information. At the national level, dissemination and management of information was centralized and announced daily to the media by the NTF committee through interviews, update reports, fact sheets and press releases. According to the MoH report, this timely provision of information and open discussion among the various concerned players instilled confidence in the public. It also created more solidarity and response to public health interventions at all levels, to the extent that even the antigovernment rebels who had been fighting government suspended their activities and supported the interventions against Ebola.

Individual confidentiality was breached promoting shared confidentiality in the community and information about affected individuals was now shared freely with health worker, relatives and the community. In order to promote continuation of togetherness, an association called “Gulu Ebola Association of Survivors” was formed to follow-up the life of those who survived the disease and council them against any stigmatization. The scourge was condensed within 144 days of outbreak and Uganda was announced free of Ebola on 27 February 2001 and ready to fight any future outbreak of such an epidemic (Okware, Omaswa, Zaramba, Opio, Lutwama, Kamugisha, Rwaguma, Kagwa and Lamunu, 2002; Hewlett & Amola, 2003).

Discussion

In this section we draw lessons from Uganda’s successful combat of Ebola in the year 2000 basing on the social network theory. The theory explains that the social structures of relationships (ties) around a person, group, or organization affect beliefs and behaviors of members (actors). These relational ties result from network properties like cohesion and embeddedness to affect the feelings people have for each other, the communication structures used (formal and informal), the communication patterns (channels and media), and the communication-related roles thus influencing the exchange of information to result into cognitive awareness and emotional attachment to the purpose for communication (Rogers & Kincaid, 1981; Barnes, 1954; Granovetter, 1973). Basing on social network theory, the following lessons are drawn from Uganda’s story of Ebola combat;

Channel mix

Channel mix is one of the communication practices that were used by health organizations to create audiences’ awareness of Ebola communicated messages. We note from the story that a wide spread of channels of communication were used to ensure adequate circulation of Ebola management information. The channels used comprised of Electronic Communication (IEC) materials, dialogue, posters in all public places, media houses like radios and televisions, drama and religious leaders. The mix of channels was aimed at reaching all categories of audiences including literates and illiterates, faith and entertainment inclined audiences among other categories. This ensured that there was no chances of the audience missing the information as the messages were in all walks of the audience’s life. Some messages target audiences when at home, others when in community gatherings and entertainment places, yet other messages targeted those in places of worship and at work. As social network postulates that the nature of communication structures used influences audiences’ behaviors, the adequacy of Ebola information influenced audiences’ behaviors to start following Ebola management guidelines. It is a lesson to organizations to always use a wide range of communication channels whenever communicating strategic messages.

Having timely feedback mechanisms

The practice of instituting toll free mobile phone numbers and open discussions like dialogues was an efficient feedback mechanism to enable frequent interactions. This indicates that a communication system that allows two way communications enables audiences to interact with the organization frequently and on a timely basis. According to social network theory, this kind of continuous interaction among parties create a bond among them which influences the meaning that parties attach to the message exchanged. In the Ebola case, the more parties interacted, the easier it was for the audiences to get all the necessary information and to be persuaded to follow Ebola management guidelines.

Disseminating audience specific messages

The practice of moving door to door talking to community members about Ebola management convinced the audiences to drop their cultural norms like the burial practices which were against the health guidelines of combating the disease. From this practice we learn that target audiences are inclined to messages if they feel singled out. This means that every time an organization is communicating to the audience, it should categorize the audiences and send unique messages to every audience category and whenever possible interact with the recipients on a one-on-one basis.

Empowering audiences through involvement

The practice of involving all stakeholders in the region like community members, local and religious leaders, health workers, local government officials, security agencies and Non-Governmental Organizations operating in the region empowered stakeholders to work vigorously towards combating Ebola scourge. We learn from this practice that organizations should empower their target audiences because an empowered audience will take the

necessary actions without any external forces. Empowering the audience can be through involving them in all levels of communication from planning, message crafting, and transmission to dissemination. It is this involvement that builds a sense of ownership of communication objectives thus warranting achievement of the purpose for communication.

Using opinion leaders to inspire audiences

As a strategy of Ebola management, religious leaders based in their places of worship to preach against faith based practices of pecking, handshaking and any other form of body conduct. Also, politicians, artists and ministry officials participated in organizing community dialogues. Such practices inspired audiences to drop all practices that were against the Ebola management guidelines. This is because, according to social network theory the centrally structured individual in a network can easily influence group member's perception and attitudes by virtue of their position (Barnes, 1954; Granovetter, 1973). We therefore learn that organizations should use important and respected persons in the communities to champion the communication campaigns. Such persons can easily build audiences' trust in the message communicated as the audiences attach importance of the message to the relevance of the communicating party in the community.

Using "similar others" as communication agents

The practice of using community members as communication agents who moved door-to-door convincing community members to accept Ebola management guidelines helped to promote audiences' acceptance of the message. Under the theorem of structural equivalence, social network theory postulates that actors always compare themselves with equivalent others and can easily develop similar behaviors and attitudes towards the message of interaction. When community members realized that those urging them to drop the wrong beliefs about Ebola are part of their community, they believed in their messages and joined the struggle against Ebola. We therefore learn that organizations should use communication agents who have similarities with the audiences to disseminate complex messages in order to promote acceptance of the message.

Building audiences' Confidence through message consistence

The practice of disseminating the same messages using different channels of communication and training the different stakeholders about Ebola management before disseminating Ebola information was a drive towards building audiences' confidence in the messages circulated. We therefore learn that organizations should always provide consistent messages until such a time when the audience has top of the mind recognition and recall of the message whenever in a situation that requires behaving in accordance to that message. We further learn that the audience can believe in the message if has confidence in the sources of the message. The starting point of achieving this confidence is usually through providing factual information to the audience. This is why all the parties that involved in disseminating Ebola messages were first trained in dissemination of Ebola messages and the general management of Ebola.

Designing appropriate communication structures

The practice of setting up three coordination committees: National Task Force, a District Task Force and an Inter-ministerial Task Force, each with clear but complimentary communication responsibilities and operating environment ensured effective flow of communication. This practice can be explained by the social network theory which implies that in order to influence beliefs in a network, the social structures of relationships around a person, group, or organization should have clear structures of communication used whether formal and/ or informal, understandable patterns of communication and clear communication roles of members (Rogers & Kincaid, 1981; Barnes, 1954; Granovetter, 1973). The lesson to organization is that before rolling out any communication campaigns, clear line of communication should be drawn and patterns of communication observed in order to manage the flow of information among the different stakeholders and be able to change the communication roles and practices whenever communication complexities emerge.

Conclusion

Basing on Uganda's successful combat of Ebola, it can be argued that managing communication practices strategically is a major determinant of the institution's achievement of set goals (Hallahan, Holtzhausen, Van-Ruler, Vercic & Srirames, 2007; Mahoney, 2010; Christensen, 2014; Florea, 2014; Lee, Park, & Cameron, 2018; Scott, 2018). According to Hallahan et al. (2007), strategic communication is the purposive use of communication to achieve organization mission. Uganda's successful management of Ebola therefore implies that communication as a function of management can be used purposively to achieve the organization mission by focusing on building relational ties with the target audiences, ensuring circulation of adequate factual and consistent information and focusing on high quality of interactions among parties. It is these practices that build audiences' acceptance of the communicated messages thus enabling the organization to achieve its mission. Future communication studies should examine in details and using different contexts how relational cohesion, information adequacy and interaction quality influence each other to achieve organization mission.

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