How Experts Speak Matter: A Narrative Analysis of the WHO Ebola Diaries

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Spring 2021

University of Washington

ABSTRACT

In 2014, the WHO began to publish the Ebola diaries, detailing the accounts of experts as they responded to the 2014-2016 West Africa Ebola outbreak, While the diaries offer unique insight into outbreak and public health communication is formed and the narratives present, very little work has been done on the diaries thus far. The diaries make evident the need to create and individualize public health communications for specific populations, highlighting the importance of narrative analysis in understanding the context within which these messages work. In the Ebola diaries, I find the presence of the cultural narratives, historical narratives of colonialism and neocolonialism, and narratives of sickness and health created to help understand the Ebola outbreak evident through the tensions between local communities and international aid workers, geopolitical borders, and the manifestation of fear between healthy and sick individuals. Since narrative analysis requires an understanding of the sociocultural and historical narratives and values of the communication and the creator of the public-facing message, it shows that it will be a valuable tool as public health seeks to become more interdisciplinary and equitable within the era of public health 3.0.

INTRODUCTION

The increase in prominent and widespread outbreaks of infectious disease such as HIV/AIDS, SARS, and Ebola has prompted public health scholars and practitioners to rethink their approach to outbreak communication. This has helped the transformation to public health 3.0 which refers to a new era of public health practice that focuses on achieving equitable health outcomes by broadening the traditional realm of public health (DeSalvo, 2017). They are hoping to engage other sectors and community partners to focus on addressing the social determinants of health include factors such as discrimination/ racism, income, risk markers (i.e., age, race, ethnicity), environmental pollution, and community context (i.e., crime, housing) to name a few (Braveman & Gottlieb, 2014). This is a shift from public health 1.0 in the late 19th c. and the majority of the 20th c. which focused making public health an essential governmental role (e.x., sanitation, water safety, vaccines), and public health 2.0 in the late 20th c. that emphasized the creation of state and local public health agencies in response to the increasing burden of chronic disease as characterized by the HIV/AIDS epidemic (DeSalvo, 2017).

Recent pandemics such as those seen in the HIV/AIDS, Ebola, and COVID-19) have catalyzed the transition towards public health 3.0, encouraging a focus on equity and the social determinants of health. This is highlighted through the CDC changing its 10 Essential Public Health Services (EPHS)—which describes the public health practices that all communities should be engaging in—model for the first time since its creation in 1994. In 2020, “equity” was placed at the center replacing “research” (Centers for Disease Control, 2021). As a result, public health is currently trying to broaden their reach and work with other disciplines and departments to address these upstream determinants of health. Focusing on narratives within the framework

of health communication will help the advancement and public health 3.0 as it seeks to work with other disciplines and communities.

As highlighted through the shift to public health 3.0, health communication between public health organizations, their departments, and their audience is essential to improving individual and community outcomes through prevention and crisis (U.S. Department of Health and Human Services, 2020). Health communication as a filed as highlighted through it being allocated a chapter in the Healthy People 2010 objectives: "health communication includes disease prevention, health promotion, healthcare policy, and the business of healthcare as well as enhancement of the quality of life and health of individuals within a community" (Parrott, 2006, p. 752). Through this definition, they show that communication is vital to health outcomes, emphasizing that health communication, not only encompasses individuals' daily health and emergency responses, but also includes environmental health, workplace health and safety, environmental health, injury and violence prevention, and mental health.

To better understand the social determinants of the health and the context within which public health operates, public health scholars should also consider evaluating the health communication, particularly the narratives present. Moreover, this works within the desire of public health to focus on equity as a narrative analysis encourages one to account for community-level differences. By performing a narrative analysis, public health researchers and practitioners will be able to better understand various cultures, underlying ideologies, and the public-facing representation of the community (Mikkonen et al., 2018; Tettagah & Garcia, 2016).

Up until now public health has been focusing on interdisciplinary work to better address the social determinants of health and health disparities, however they have not paid as much

attention to the specific narratives present which will help them to better understand the underlying cultural values, ideologies, and histories such as a colonialism as viewed in the WHO Ebola diaries. But to make more effective messages, we must understand these things to wholly engage with them and present accurate health communications. We must understand why different messages may need to be sent.

Although public health communication impacts our daily lives, pandemics provide a prism through which we can review the efficacy of and current strategies in health communication. They place public health under the spotlight and allow us to view the development and distribution of public-facing messages at high speed, highlighting the understanding of narratives and culture. Therefore, performing a case review of the Ebola outbreak in West Africa will help to gain a more comprehensive understanding of the effectiveness of health communication by allowing us to understand the impact of narratives on the outcome.

From March until October 2014, the WHO published 19 Ebola diaries from a variety of scientists, doctors, and public health officials. The diaries—which are, arguably, a public health strategy—were used to introduce professional perspectives into the public sphere, documenting what they saw on the ground and allow a glimpse into their thinking.

Overall, these diaries provide valuable insight into the Ebola outbreak in West Africa as an extremely rich case study in health communication because the outbreak was well-documented, emphasizing many of the existing tensions evident when Western countries attempt to intervene, and the outcome of the pandemic is known.

By evaluating the themes present across the accounts of 19 diaries, I analyze what narratives are present and evaluate their differences. My research answers the following

question: What were the narratives apparent in the WHO “Ebola diaries,” and how do they reveal incongruent world views? This project will be situated in the Rhetoric of Health and Medicine literature, which uses critical theory and rhetorical criticism to understand how language and power affect social constructions of health. Thus, the completion of this project will help to increase the understanding of the factors contributing to public-facing communication by health professionals in the age of social media in addition to providing recommendations for future communication.

In this essay, I show why narrative analysis is a useful tool within the realm of public health 3.0 to analyze the current practices that do not appear to be as community nor culture focused as showcased through outbreak communication efforts. Therefore, I offer narrative analysis as a tool to help understand the effectiveness of public-facing health communication and craft individualized messages. Therefore, I then, contextualize this paper within its rhetorical context and the historical context of colonialism and neocolonialism by drawing on communication and historical experts. In the follow sections, I elucidate the influential role that experts play in effecting public understanding. I analyze the narratives present within the WHO Ebola diaries as highlighted through the conflicts between Western and West African medicine, the geopolitical borders, and the manifestation of fear in relation to the healthy and sick. This case study shows the need of creating and individualizing public-facing health communication for the specific audience and suggests that narrative analysis offers itself as a tool to better understand why we need different messages and what they should be. Doing so, will help advance public health 3.0 as it seeks to become more interdisciplinary and community-focused to address the upstream factors of health.

LITERATURE REVIEW

Communication and Public Health

Effective health communication is essential for improving individual outcomes and promoting safety and prevention (U.S. Department of Health and Human Services, 2020)). The absence of the individualization of public health messages within the frame of narrative analysis can be highlighted through texts aimed at the public via newspaper publication being rejected on the basis of being too technical, suggesting that they were not created for a non-expert audience (Salmon & Poorisat, 2020). Perhaps, as a result, much public-facing communication focuses on an appeal to pathos by generating fear which, while sensational, had "extremely little effect upon the [sexual] behavior of the men who see it" (Lashley, 1922). Although, they may also choose a pathos-focused since it is easily generalizable: To highlight facts such as mortality or transmission rates, there does not need to be as much emphasis on the community's culture, identity, nor ideology.

Emergency risk communication has received the greatest amount of attention in this area, however. This emphasis is likely due to the immediate and tangible nature of health emergencies in addition to novel challenges, such as limited preparation time, that emerge in particular crises. Additionally, like all of health communication, crisis communication can impact the social norms, behaviors, and the spread of information. The importance of public health communication in crises and importance of grasping context—"social, economic, political and cultural factors influencing people's perception of risk and their risk reduction behaviors"—is emphasized by the publication of the WHO Guideline for Emergency Risk Communication (ERC) (WHO, 2018, p. ix).

Outbreak Communication

Outbreak narratives have social and political consequences through the narratives that they create, outstripping the epidemiological nature (Weldon, 2001). The public understandings and attitudes created in response to a public health crisis does not end when the outbreak does. It informs and shapes existing narratives, highlighting the far-reaching implications of the outbreak communication that informs these outbreak narratives. Therefore, by understanding the persistence and appeal of narratives created and supported by epidemics, we are able to understand how it affects social values and norms of morality and power to name a few (Finnegan & Keränen, 2011). Pandemics offer an opportunity to shift blame onto certain groups, highlighting who is considered a part of the community.

Rhetoric and Ebola

Luisi, Barker, & Geanea (2018) argues that the WHO exacerbated the Ebola epidemic through the emphasis on scientific knowledge (Luisi et al., 2018)l. By emphasizing the scientific advances and understanding, it painted civil unrest as emotional and irrational. This portrayal created a barrier between the health care personnel and the communities that they were working with and led to the downplaying of health care sites and officials as vectors of transmission, prolonging the infection (Condit, 2016).

The ethos, character, of the public health officials also played an integral part in the epidemic's progression (Condit, 2019). The complexities that arose as a result of the international and national dimensions as well as the progressing scientific knowledge created a gap between the interests, the information necessary, and what was available, impacting the credibility of health workers in the eyes of the local populace. This resulted, partially, from varying expectations and misunderstandings about the information and resources available. These experts had to make scientific concepts accessible and address emotional and social

concerns that were only exacerbated by politicization of the health experts in media (Condit, 2019).

This hesitancy and fear towards disease is also evident in popular culture and accounts of the 1976 Ebola epidemics. The subgenre of apocalyptic plague films proliferated fear through its graphic imagery and popularity. It has enlarged the dangers of an infectious disease in the minds of its audience despite viruses "actually compris[ing] such a small threat to humanity" (Weldon, 2001, p. 7). Furthermore, accounts like those seen in *The Hot Zone: A Terrifying True Story* by Richard Preston focused on the "predatorial virus" rather than the effects of actions such as poor implementation of public health policy (Weldon, 2001).

Therefore, as rhetoric has an impact on how humans construct their reality, we can highlight how the authors' perceptions about the outbreak and the local population influenced the success of the healthcare response and public health communication during the 2014 epidemic. Outbreak communication provides a good opportunity to examine the political, social, and cultural factors that impact health communication and its ability to inform and impact individual, group, and societal change. However, as emphasized by the WHO guideline for emergency risk communication and recent papers, it is essential that these messages are personalized for the geographical audience (Bol et al., 2020; International Federation of Red Cross And Red Crescent Societies, 2016). Work has focused on comparing outbreak responses (i.e.,. Zika, Yellow Fever, Ebola) and the publications in Western and West African media. There has not been any work done on the "Ebola diaries" specifically which provide an opportunity to evaluate the narratives present as well as assess public-facing health communication by experts.

Historical Context

While it is important to note that international efforts were helpful with addressing the logistics of the outbreak, particularly supplies and personnel shortages, they operated within the context of postcolonial fears. Furthermore, much of the lacking infrastructure and economic capital can, arguably, be traced back as early as the 1400s when the Portuguese first claimed ownership of Guinea, making it the center of their slave trade ("European Empires in Africa," 2012). But the shift from colonialism to an "informal imperialism" can be marked by the Berlin conference in the mid-1880s that sought to allocate African regions among the U.S. and 13 European countries (Pakenham, 1992). Ironically, the abundant mineral and oil wealth that could significantly improve countries' political and economic capital and alter the scale of power, was the reason for stagnated growth. Their abundant resources attracted outside domination, contributing to economic disparity and oppression. Historically, this can be first seen in the post-WWII era when neo-imperialist countries (e.g., USA and USSR) appeared in African states, leading to the start of decolonization—" acknowledgement that societies that were once colonized still suffer from the ideological and material impacts of colonial or imperial practices, and that we need to openly recognize those impacts" – in the 1960s (Bulhan, 2015; Rahaman et al., 2017, p. 9).

This pattern has continued into the 21st century. While African states have achieved political independence, they continue to remain dependent on high-income countries both economically and socio-culturally, suggesting that the continued economic disparity and oppression (Lee, 2006). While the political and economic reasoning is most evident, there is also a socio-cultural goal: "a colonization of values," that promotes the value of European culture and peoples over that of West Africa. It paints "Europeans and their descendants as the sole dispenser of aid and compassion for victims of violence and oppression in Africa" (Bulhan, 2015, p. 247).

Neocolonialism can be seen in Western businesses through unfair trades and with some production utilizing child labor and in China's belt and road initiative.

The gap between West African and Western values is highlighted through the 2014-16 Ebola outbreak in West Africa. It was the "largest and most complex Ebola outbreak since the virus was first discovered in 1976" (World Health Organization, 2020). Ebola virus disease (EVD) is an RNA virus that causes a type of hemorrhagic fever with comorbidities including destruction of internal organs and internal bleeding from various body parts such as eyes, gums, and nose (Baseler et al., 2017). In past outbreaks, case fatality rates have varied from 25% to 90%; however, the EVD case fatality rate during the West Africa outbreak averaged 50% (World Health Organization, 2020).

Since the onset of the infection, health care professionals and officials struggled with combating high public fear, anxiety, rumors, and misperceptions in addition to having the capacity to diagnose, prevent, and contain rising cases of EVD. According to the CDC and the WHO, there was a slow initial response to the Ebola outbreaks in Liberia, Sierra Leone, and Guinea due to "weak infrastructures and underfunded health systems which were further compromised during the epidemic" (Marston et al., 2017). As a result, the local governments' outbreak responses received assistance from organizations like the WHO, African Union, CDC, United Kingdom, and Public Health Agency of Canada in the form of policy assistance, supplies, and personnel (Marston et al., 2017).

The Ebola outbreak was exceptionally demanding not only for the fatality rate but for the challenges faced on the ground. Difficulties arose when attempting to manage the outbreak, such as lack of resources (at the beginning, professionals were only able to run 50 tests a day), language barriers, borders, and social resistance (Hugonnet, 2014). During the outbreak, there

were violent protests in Liberia, Sierra Leone, and Guinea in the forms of "rocks thrown at Red Cross vehicles to a massacre leaving eight dead at Macenta"(Bulhan, 2015, p. 1). Mistrust was also personified in concealment of EVD cases, unsafe burial practices, and disruption at clinics, stemming from "failures of communication, lack of engagement with local communities, adverse publicity, and strained relations between local populations, government authorities, and outside agencies"(Cohn & Kutalek, 2016).

Narrative Analysis as a Tool to Understand the Ebola Outbreak

Narrative criticism is used as the theoretical and methodological framework for this analysis of the narratives present in the WHO "Ebola diaries." Relying on the interpretative paradigm, this centers on the idea that narratives help us to understand how people construct their social realities through the "central belief that humans are storytellers" (Merrigan & Huston, 2019). Unlike quantitative research, this paradigm emphasizes the idea of multiple realities and perspectives (Merrigan & Huston, 2019). As a result, narratives can be utilized to understand how the speakers make meaning and understanding, under the assumption that their experiences are meaningful, human, and represent an experience (Andrews et al., 2013). Furthermore, narratives exist on a continuum, allowing them to have effects after formation through influencing beliefs and actions that extend beyond the outbreak's timeline. Despite the diaries only being published between March and October 2014, the narratives themselves do not follow such deadlines. The context within which they operate—for example, colonialism—predate the Ebola outbreak, suggesting that public-facing health communication must fit within existing cultural narratives. Since the outbreak coverage operated within such narratives while informing international audiences, they influenced and informed opinions surrounding West Africa.

Moreover, much of the work completed have focused on how the communication of EVD developed in comparison to other diseases such as Zika and Yellow Fever (Co hn & Kutalek, 2016; Toppenberg-Pejcic et al., 2019). Studies have also emphasized the different narratives apparent in the U.S./U.K. and West African media during the EVD outbreak: The U.S./U.K. focused on how their countries were helping an *inadequate* government drawing on ideas of colonialism and the "white savior" complex, whereas the African media looked at the cooperation and the longstanding impacts of the pandemic (Luisi et al., 2018). Although, there has been other work done on these communications and press conferences performed by health care experts for the public, there has not been much work done with the WHO Ebola diaries. The diaries offer an opportunity to see the impact of crisis communication within an international context, showcasing the need to personalize these texts for their audiences. Therefore, this analysis will be able to provide a helpful analysis of this particular public health strategy, informing future actions and contributing to the understanding of health communication in the digital world.

ANALYSIS

From March until October 2014, the WHO published 19 Ebola diaries from a variety of scientists and doctors, social science experts, and public health officials. By highlighting the perspectives and observations of these workers and volunteers, they allow the public a glimpse into their work and its difficulties. However, the diaries are unique in that many individuals experiencing the outbreak may not read the diaries, therefore it can be implied that they have another purpose. The diaries were used as a public health strategy to introduce professional

perspectives into the public sphere, documenting what they saw on the ground and allow a glimpse into their thinking.

The preservation of their observations allows us to see what these workers and volunteers thought of the West African communities that they worked with, what stood out to them, and what they felt. These diaries show that the Ebola outbreak in West Africa is an extremely rich area to study health communication because the outbreak was well-documented, emphasizing many of the existing tensions evident when Western countries attempt to intervene, and the outcome of the pandemic is known.

The WHO Ebola diaries show how power plays out between Western countries and West African narratives and medicine, between healthy and sick, and between academic disciplines, providing information for future outbreak communications and interventions. This will help to highlight how socioeconomic and cultural realms, particularly those surrounding health, that impact power and control. Since culture impacts power, the public health messages must be localized and sensitive to their audience and the contexts within which they operate. In this instance, they must be sensitive to the histories of colonialism and cognizant of the narratives that they draw on and perpetuate.

Colonial and Cultural Narratives: Tension between West African and Western countries

From the onset of the outbreak, scientists and international and local officials were forced to reckon with each other in order to determine a course for combating the disease. International organizations attempted to work with local ones to identify the virus and contain it. Throughout these joint efforts, there appear to be underlying tensions between culturally enforced ideologies based on historical themes of colonization and decolonization.

This is evidenced through emphasis on the necessity of outside intervention due to a lack of preparation, limited infrastructure, and funding challenges. However, these funding and infrastructural challenges have been influenced by residual colonialism and Western stereotypes about Africa. This is highlighted through a logistician showing how difficult it was to even find somewhere to house Ebola patients. Eventually, they ended up rehabilitating an existing cholera treatment center: “Rehabilitation included everything, even installing electricity” (Rovira-Vilaplana, 2014) Furthermore, many local healthcare workers did not have proper infection prevention training, partially due to there being “no culture among health workers of self-protection” (Vallenas, 2014). As a result, WHO and international workers were tasked with training local healthcare professionals (and communities) in proper prevention practices, occasionally in direct contrast with cultural influences such as burial practices.

Many regions did lack resources and infrastructure. However, there was arguably too great of an emphasis placed on their inability to control the outbreak themselves, justifying the need for outside involvement. This emphasis on their inability is partially rooted in Western stereotypes of Africa as an “underdeveloped,” “poor,” and “corrupt.” And, while outside intervention was absolutely necessary for assistance, the way in which it was presented suggested that this sort of assistance was unique: “It is not so common for WHO to send in clinicians-- doctors and nurses-- to assist Ministries of Health to provide direct clinical care…” (Fowler, 2014). However, as evidenced through the recent COVID-19 pandemic, the hospitals and infrastructure can be easily overwhelmed in any country. This is echoed by Dr. Ian Norton, an emergency physician, “Ebola would have overwhelmed any country in the world if it hit their capital and went through the streets like it did in Monrovia, Conakry, and Freetown” (Norton, 2014).

While invention by the WHO and international community undoubtedly helped to control the spread of Ebola and save lives at great personal risk and struggles of scientists and healthcare professionals, the way that they framed their observations showcased historical tensions between West Africa and Western countries. A bit ironically, many of the countries that once kidnapped and enslaved the populations from West Africa were now aiding them with the outbreak containment. Furthermore, many Western businesses and governments continue to interfere with these regions. All-in-all, this does not lay the groundwork for a relationship of trust. The narratives in the Ebola diaries pointed towards an outside influence-- in this case, WHO workers-- needing to interfere and teach the countries, instead of working with them, throughout the outbreak response. They indirectly presented themselves through the framework of paternalism guiding them in the correct direction instead of the partner working alongside them, drawing on narratives surrounding interventionism. High-income countries such as the U.S. continue to interfere with these resource-rich regions at the cost of those living there (Lee, 2006). While those assisting in the Ebola response did not in any way have similar intentions, they unconsciously drew on this idea by presenting themselves as the more knowledgeable entity teaching a less knowledgeable one, perpetuating local distrust of foreign intervention. This can be seen through many well-intentioned international workers coming in to *teach* locals about infection control (i.e., sanitation, contact tracing), telling them what to do without taking the time to explain why, alter the medical messages for their communities, or work with locals to create practices that will work with them. However, as a professor of medical and social anthropology at the Cheikh Anta Diop University in Dakar, Senegal showed, listening and empowering communities was more effective:

> "Before you can create effective messages, you need to listen first. And even then, communities will translate medical messages into their own terms. You have to give them the knowledge that gives them power to make their own decisions" (Niang, 2014).

Niang then goes on to emphasize that the WHO was the only international organization that took the time to listen and communicate with the villagers, however this is not really evident until the later diaries (Niang, 2014). Despite this, there were still misunderstandings and miscommunications within the outbreak response rooted in conflicting narratives.

In addition to this emphasis on the lack of preparation, there was also severe mistrust between local individuals and scientists and healthcare professionals. People struggled to believe that the countries that once enslaved them and continued to exert their influence through large business could have their best interest in mind. Furthermore, the locals were taught to fear Ebola because of its high mortality rate and horrifying symptoms (ex. Fever, hemorrhaging, bruises, and rashes) (Baseler et al., 2017). As a result, they struggled to understand how people who worked with the sick on a daily basis could avoid infection themselves, especially in light of the lack of self-protection measures among healthcare workers: "'There wasn't a sense of infection control, so I spent the next 12 days going to the main hospitals and health centres in Conakry explaining and demonstrating infection control: how the disease is transmitted, how workers could protect themselves, and so on. It was tough'" (Vallenas, 2014). Once again, international workers are presenting themselves as more knowledgeable and needing to "indoctrinate" the locals with their knowledge of Western medicine. This notion could have prevented them from seeing an opportunity to work with local communities and culture, creating a biomedically safe and more effective practice.

Many of those within West Africa feared stigmatization and mistreatment in treatment centers, leading to resistance with cooperation, continued burial practices with sick bodies (which is a health hazard), and hiding illness. This was emphasized by a summary of the interviews done with local wise people during the outbreak: “They were not saying they were sick because they believed they would be neglected, would not be fed, they would die, and when they died their bodies would be deprived of their organs and their blood” (Salvi, 2014). And, this belief was not unique. The locals did not know how what to think about EVD. Therefore, it makes sense that they fit it within their pre-existing narratives of colonialism. Marie Claire Therese Fwelo Mwanza, a social mobilization expert, shows this: “‘When you go to an Ebola treatment unit (ETU), your heart is punctured and 20 litres of blood are drawn, Your genitals are cut off and your body and organs are sold on the international black market” (Mwanza, 2014). Unfortunately, there is some historical validity to their claims, particularly in reference to slavery: People, white men, would come and steal people from their homes and forcibly relocate them. Since locals did not see many leave the ETUs due to the high mortality rate of the virus, they inferred these international workers could, once again, be stealing their friends and family.

This idea exists within colonial and culturally based narratives. It is understood that the individual body is part of the community, implying that the community has a responsibility to this body: “when you give blood, when you give lab samples, these things express the person as a whole” (Niang, 2014). Therefore, while a treatment plan may be necessary for Ebola testing, it also clashes with the individual and the community. This was the framework international professionals had to work with. As a result, the fact that messages were not tailored to specific communities and did not utilize existing infrastructure was detrimental to establishing trust between the WHO workers and locals, impacting the legitimacy of the virus. Since they did not

trust the health care workers, they could not trust their claims about EVD. Instead, some believed that Westerners who came to help control the outbreak manufactured disease, frankly a denial that goes hand-in-hand with pandemics. People do not know what to do and are fearful, so they deny the existence of the disease to protect themselves, their sanity. They were, justifiably, scared, and it is hard to blame an intangible virus that cannot be confronted, exacerbating the reluctance to be treated by foreign assistance.

Furthermore, this highlighted cultural disconnects that were emphasized through the debate over the burial practices of bodies infected with Ebola. People did not understand that they could not proceed with normal practices if a body was infected due to the ability of the body to infect others. However, these burial practices are an ingrained aspect of their culture, something that is very difficult to just ask people to stop doing. The individual body is viewed as a collective, making the community responsible for its care; it was essential to the local communities that they were able to confirm the body with their own eyes, something made impossible by the Ebola outbreak. In fact, it was a customary obligation for women to "care for the ill and prepare the dead for burial" (Salvi, 2014). The burial is a "purification rite and a metaphor. The body has to be clean so that the person is pure when he or she goes to heaven. The strings around the shroud, another metaphor: when the deceased unties these strings, his or her soul is freed and ascends. And the lightness of this ascending soul yet another metaphor; the deceased has released any anger and anxiety that was weighing him or her down" (Niang, 2014). Therefore, they had to address this as a cultural problem, not something that they haphazardly enacted.

However, Western narratives about importance, culture, and medicine may have prevented them from finding a way to continue the religious practices in a safe manner. It may be

difficult to find a Western equivalent to these burial practices, preventing us from understanding the importance. There is a reason why many people continued their practices in secret despite understanding that people could get hurt. Their pre-existing narratives automatically framed the burials, themselves, as the problem, preventing them from seeing other viable solutions. As a result, this may have prevented them from exploring other avenues that would have increased adherence and safety as well as build trust between the aid workers and local communities.

This is emphasized through the need a local authority to explain why, otherwise they could assume that this was a ploy by Westerns to take their bodies. After all, distrust was rampant: “villagers said, ‘Ebola doesn’t exist. Ebola is a poison that Westerners are sending us'” (Niang, 2014). Therefore, arguably, using the “wise people-- those people who were part of the community and very much respected, very much trusted-- who could open the doors of the villages to the responding teams” was more effective (Salvi, 2014). It helped to address historical tensions, especially since bodies were either cremated or, eventually, buried by burial teams after samples were taken to help further research and address the outbreak (Mulemba, 2014). The very act of taking samples and swabs for the laboratory buys into the historical narratives of colonialism and slavery, the stealing of body parts. It confirmed some of the fears of people who were worried about Westerns taking their body parts, highlighting tensions between Westerns and West Africans.

Furthermore, communication was necessary to help people understand how to protect themselves and why certain cultural practices such as burial rituals could not be maintained (i.e., the bodies had to be disposed of in other means as it was a biohazard; International Federation of Red Cross and Red Crescent Societies, 2015). This is emphasized in a quote from Birte Hald, the head of the International Federation of Red Cross’s (IRFC) Ebola coordination team:

> There's no point coming here thinking: why don't these people just stop all their dangerous practices? If you do, you will fail because you don't understand. You'll never get rid of the virus. You must get to the root of what people believe, what they are all about. You listen to them and then you have a chance of getting your strategies correct (International Federation of Red Cross And Red Crescent Societies, 2016, p. 15).

The need to personalize health communication can be exemplified through the national language of Guinea being French and the majority of individuals practicing Islam which favors washing dead bodies as part of burial rites (Oloke & Kochhar, 2018). In the case of Guinea, they were forced to reconsider the public health outbreak communication due to language barrier, resulting in arguably, a better EVD response, highlighting the value of necessity of working with communities to create a shared understanding. By having to adapt the communications to French, it encouraged them to account more for the cultural and historical contexts within which they were operating.

However, as evidenced in the diaries, this was not always the case. Instead, it appeared that many volunteers did not hold West African medicine in high regard, leading to the immediate dismissal of it and any contributions that it may make. Therefore, this blocked off an avenue that could have worked with local medical tradition to create different public health practices that draw from both cultures. However, this would help to validate West African medicine, something that is very difficult to do when working within colonial narratives that argue for the dominance of Western biomedicine. This theme is also seen in conversations surrounding the complete discontinuation of their traditional burial practices. By misunderstanding the value of these burials within West African culture—and what an

equivalent may be within the volunteers' cultures—they once again may have barred another potential avenue of collaboration, illuminating the need to personalize messages.

Furthermore, the high levels of volunteer mistrust out of a belief that were stealing body parts re-emphasize the need to acknowledge the local narratives and what narratives international workers bring with them. By taking the time to understand the local culture and work with community leaders, they could work to dissuade this belief. However, since they are still working within the narratives of colonialism, this will have to seek to "myth-busting" without reinforcing false norms.

Public Narratives Negotiate the Manifestation of Fear Between the Healthy and Sick

During outbreaks, there are tensions between those who were sick and healthy. This has been evident in every pandemic, and it makes sense. People are scared. They do not want to risk themselves or their families. As a result, they would attempt to hide if they, themselves, or someone they knew was sick. Conversely, there were also groups of individuals who would call and report illnesses during the night, and while this is beneficial from a public health perspective, it highlights tensions between those who are healthy and sick: "If they [youth in the Moyamba district] identified someone-- even if it was midnight-- the youth would isolate the person, call you, and give you all the information" (Kobie, 2014). While these actions helped with early detection, it appears that many people were reluctant to report their illness because they did not want to be targeted by their neighbors and because of historical-embedded mistrust of Westerners.

As previously stated, communities did not trust healthcare providers. They accused them of spreading Ebola. While this has since been shown to be a factor with 8% of the infections originating with healthcare workers, much of the rhetoric at the time downplayed the effects that

they have had in promoting disease (World Health Organization, 2014). This is reinforced by Dr. Ngoy Nsenga, a WHO specialist deployed to the region: "'The community is threatening us. They accuse us of bringing Ebola.' The community even started to call him [another doctor at the hospital in Kailahun] Dr Ebola, because they thought that he was the one spreading the disease" (Nsenga, 2014). There was a distrust of healthcare professionals regardless of whether they were local or international, highlighting the extent of the "stigma of Ebola." People were unwilling to even associate with individuals who even worked with those who were ill out of fear for their own safety.

Furthermore, they did not want to be identified as someone who had Ebola even if they recovered. Infected people were seen as bad, someone to be avoided and even shunned, and Ebola, itself, is associated with "underdeveloped" and "poor" nations. It is not a disease that is seen in regions such as Europe or the United States. Formenty emphasizes this in the first Ebola diary when they highlight why people do not want Ebola: "There is a lot of stigma around Ebola Zaire" (Formenty, 2014). Ironically, people did not want to be associated with any form of illness despite recovering from and surviving infection even though this speaks to the effectiveness and robust nature of their body's immune system. However, research suggests that people were stigmatized post-infection through verbal abuse, social isolation, and neglected healthcare (Arwady et al., 2014; James et al., 2020). This suggests that not only is there pervasive fear, but that people seem to have created an association between illness and bad, evil, drawing on one of the ways that people originally utilized to explain disease and why people were infected. However, current understandings of biology and infection suggest that this previously held belief is not true. Here, they are invoking a moral model of disease instead of a medical one. Rather than focusing on the biomedical nature of the disease and treating it as a

medical problem, they are incorporating social, cultural, and political issues to fit the diagnosis (Heather, 2017). Since they are fearful of the disease, communities wish to isolate themselves from those who are associated with it; they want to make them outsiders. In order to effectively separate someone from the community, they must provide a moral judgement. While many people understand that infection is not related to character, they make a statement about mortality in order to protect themselves, justifying stigmatization. This may be partially due to messages "at the beginning of the outbreak what was needed was to alert the population about this new and dangerous disease, so the accent had been on its severity and fatality" (Salvi, 2014). The health communication helped to reinforce and create this association, consequently also helping the propagation of stigmatization. They taught people how to fear the disease and how to protect themselves, instead of emphasizing the potential for recovery.

This tension between the healthy and sick was rooted in fear. "They [the local population] had not seen this kind of emergency before, and they were really scared" (Olushayo, 2014). People did not know how to react; however the initial messages framed the situation as dire, emphasizing factors like mortality and downplaying the rumors of doctors and nurses being infected, exacerbating distrust. They highlighted the mortality rates, told them that they had to wear personal protective equipment (PPE), and could not perform traditional burial practices.

Many of the international workers operated within a Western biomedical context and, instead, of taking the time to explain the scientific groundwork for the disease, they focused on the symptoms and mortality rates, supporting the culture of fear which, in turn, advanced the conflict between the healthy and sick. Rather than take the time to explain the importance of protective public health practices, they told the locals what to do which was not as effective due to operating within the context of historical mistrust. Moreover, by connecting with

communities, they could have worked to combat misinformation and help to demystify Ebola, supporting widespread understanding and community cohesion. By taking the time to work with and understand local culture, they could have increased the understanding of EVD and how infection spread, decreasing the fear and isolation of those who have recovered. This highlights the need to personalize outbreak messages as how information is presented can influence adherence to public health practices and sociological interactions as highlighted through the post-illness disparity between the healthy and sick, between healthcare workers like "Dr. Ebola" and the public. Taking this approach, could have helped to promote trust between Western volunteers and healthcare workers with the local populace, suggesting that it is essential to pay attention to the existing context and narratives and emphasize working with populations.

Colonial Narratives Enable the Geopolitics and Borders During the Outbreak Response

The political boundaries of African states do not follow social, cultural, or linguistic groupings, rendering the borders almost arbitrary. Furthermore, these borders remained largely untouched since they were first demarcated in the late-1800s by the Berlin Congo Conference of 1885 and the Organization of African Unity, and both organizations have been "instrumental in establishing the decision-making rules and created the boundaries and promoted their stability" (Herbst, 1989, p. 673). The creation of these borders largely coincided with colonial interests as many European powers (e.g., Great Britain, France, Belgium, Germany) scrambled to secure their economic, military, and geopolitical interests, ignoring the demographic, ethnographic, and topographic factors (Griffiths, 1986). This idea that these borders are not followed by local peoples can be highlighted through an anecdotal example from Aminata Kobie, a health promotion officer in WHO's Sierra Leone Country Office: "Looking back at how the disease started, the first confirmed case in Sierra Leone was a woman, a traditional healer who was going

back and forth to and from Guinea. People living across the border are the same people. They do not recognize international boundaries" (Kobie, 2014).

Since the arbitrary drawn borders are largely ignored in practice, it was difficult to track individuals' movement and encourage governments to police their borders. However, many outbreak volunteers had a large desire to maintain the borders in order to control the outbreak response: "The borders were not closed yet and there were still a lot of people and goods crossing, including motorbikes and huge boatloads of cassava" (Strong and Grolla). Therefore, despite it being common practice to close borders in the midst of an outbreak response, it may not have been possible to do so in this case as it would dissect those from the same tribes and communities. This is emphasized through the struggle to limit border-crossings even once cases of EVD were identified: "The borders were not closed yet and there were still a lot of people and goods crossing, including motorbikes and huge boatloads of cassava" (Strong and Grolla, 2015).

Furthermore, there was an emphasis on outbreak management in relation to the countries' borders despite them running through particular communities: "When an outbreak crosses borders, it's even more difficult to manage, even if those infected are from the same tribe and speak the same language" (Hugonnet, 2014). While this makes sense in terms of national-level cooperation, it may have been more effective to focus on containing the outbreak between communities. In terms of infection, closing a border that transect a close-knit community will likely not have a large impact on transmission rates. This helps to personify some of the continued effects of colonialism, the conflict between (West) African and Western ideals. However, because it highlights this social and ideological conflict, it also emphasizes the power of Western countries and their narratives in Africa. Despite not working for the people who live within Africa nor really even being followed, they continue to keep the same borders drawn with

an eye to European interests in mind. They have not changed within the last ~140 years, emphasizing the lingering effects of colonialism within the framework of Ebola.

The inability to fully close the borders, emphasizes a cultural disconnect that must be addressed within the public-facing communication. As highlighted, the borders in West Africa do not act similar to those in many high-income regions. It is not a matter of simply telling people to close their border, therefore the dialogue must be adapted. By taking the time to understand the colonial narratives that these geopolitical lines are operating in, it could have allowed the outbreak volunteers to see alternatives: They could have communicated directly with locals within positions of power in their communities or looked to draw containment boundaries around communities, themselves. Therefore, taking the time to personalize public health and outbreak communications for the locals is imperative to bolstering our outbreak response in that it allows locals to better understand and adopt public health practices and forces Western volunteers to understand more about the context and narratives within which they are working.

CONCLUSION

This paper sought to better understand the importance of creating and individualizing public health communication for a particular audience through the context of the 2014 West Ebola outbreak. Furthermore, it sought to analyze the WHO Ebola diaries, evaluating the narratives present and their potential implications. By viewing the Ebola diaries through a narrative lens, we are able to highlight how narrative analysis can not only help to understand why different messages may be needed but also how to create them.

Overall, the paper determined that that there were three main conflicts within the diaries, rooted in historical and cultural tensions. There is a tendency for international aid workers from

Western countries to, perhaps unknowingly, utilize their narratives about Western medicine and ideals, particularly those surrounding colonialism and neocolonialism when creating health implementations. This is especially salient through the tensions apparent in conflicts between West African and Western narratives about medicine. From the diaries, it appeared that many workers did not exactly hold traditional West African medicine in high regards, therefore, they took the approach of a paternalism, teaching and guiding their younger sibling through the outbreak. While there are infrastructural and remnants of colonialism that we must acknowledge, by coming in with this perspective, the international workers may have overlooked opportunities to work with and incorporate traditional practices. This is also seen in the discussions surrounding the discontinuation of traditional burials. International workers promoted the discontinuation of traditional burials to help control the spread of EVD, however their Western biomedical lens may have prevented them from exploring alternate options that account for their cultural importance.

Moreover, the concerns about bodies, people, being stolen after being admitted to ETCs are very much a product of the environment. In this vein, ideas about containing people within Western-made borders to contain the Ebola epidemic is unrealistic since these geopolitical boundaries bisect. The borders do not work for the people there, so the dialogues must be adapted for the context within which they operate. Therefore, it may have been helpful to adapt the conversation by communicating directly with community leaders or creating containment boundaries that fall along demographic, ethnographic, or geographic lines. Furthermore, like other instances of infectious disease outbreaks, there was a fear associated with the sick, creating a disconnect between those who are sick and healthy. However, while this is partially rooted in the nature of there being an outbreak, these fears were heightened through the public health

communication. Rather than focusing on mortality and morbidity rates, it may have been more beneficial to take the time to explain the disease, how transmission worked, and what steps they can take to protect themselves. Connecting with communities could have helped to demystify Ebola, decreasing the conflict between the sick and healthy.

Since this is a case study in rhetoric, this work may be less generalizable. But this study can be utilized as a tool that help to showcase the importance of individualizing public health communication to specific communities, particularly through being aware of the narratives present within the communities and those that individuals outside of the community with them.

But, by looking at the Ebola diaries, we can see the importance and value of accounting for existing narratives when implementing public health practices. Moreover, since the diaries were written throughout the outbreak response, it provides a unique glimpse into many of the challenges that these professionals faced on the ground and how they responded to them. Therefore, we were able to see their growth throughout the process as some individuals within the diaries began to have conversations with pillars of the community such as wise women, looking at areas to improve while simultaneously implementing a crisis plan and troubleshooting. This highlights the magnitude of personal beliefs and narratives within daily life, suggesting that this is an area that we need to be aware of for future outbreaks and communication with different communities. Furthermore, it would be useful to investigate a potential variation between living narratives within the communities, the ones that we may perceive to be there, and the potential implications of future outbreak communication. There is no question as to the usefulness of acknowledging and working with communities and evaluating our personal beliefs. Narrative analysis encourages us to understand, reflect, and account for

these differences as seen in the WHO Ebola diaries, suggesting that this will be a valuable tool as we transition into public health 3.0.

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