

# **Socio-cultural Factors Influencing the Ebola Virus Disease-related Stigma among African Immigrants in the United States**

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## **Abstract**

African immigrants, one of the fastest-growing immigrant populations in the United States (U.S.), face many unique challenges. Since December 2013, the Ebola Virus Disease (EVD) has been claiming lives and altering the societies of origin of West and Central African immigrants. Using the PEN-3 cultural model, a thematic analysis of mainstream U.S. news media was conducted to assess the socio-cultural factors influencing EVD-related stigma experienced by African immigrants. Results of this analysis revealed the perceptions and enabling/nurturing factors that exacerbated or prevented EVD-related stigma. Future interventions designed to address stigma experienced by African immigrants should include EVD-related stigma.

**Keywords:** Ebola, African immigrants, Stigma, Health

## **Introduction**

The 2014 outbreak of the Ebola virus disease (EVD) was the largest and most widespread outbreak of the disease in history (WHO 2014). Specifically, 22,092 cases of EVD and 8,810 EVD-related deaths had been reported between March 21, 2014, and January 25, 2015 from

Guinea, Liberia, and Sierra Leone (WHO 2015). The Ebola hemorrhagic fever is a disease caused by 1 of 5 different Ebola viruses (CDC 2016). It is a highly contagious disease that has the ability to spread quickly and has a high mortality rate (Merino 2014). Fruit bats are a known host of the virus typically affecting people living in or near tropical rainforests (Sawer 2014). The Ebola virus is introduced into the human population through close contact with the sweat, blood, secretions, organs, or other bodily fluids of infected animals (WHO 2014). The virus first appeared in 1976 in two simultaneous outbreaks, the first in Nzara, Sudan and the second in Yambuku, Democratic Republic of Congo (Muyembe et al. 2012). The culmination of the most recent outbreak was only officially declared in 2016 (WHO 2016). A number of socio-cultural factors have been cited as contributors to the spread of the current EVD including, but not limited to, the legacy of colonialism, developmental neoliberalism, inequality, an inadequate health care system, and the stigmatization of the infected individuals (Alexander et al. 2015). The first case of an Ebola diagnosis in the U.S. was identified as an African immigrant residing in Texas (Washington Post 2014).

Despite African immigrants being one of the fastest growing immigrant groups in the United States, the health of the African immigrant population remains, to a large extent, unmapped (U.S. Census Bureau 2010; Venters & Gany 2011). A large portion of U.S. immigrant health research has focused on Asian and Hispanic residents (Barrington et al. 2010; Singh et al. 2011). The limited studies examining health of African-born residents in the U.S. have resulted in contrasting findings. African immigrants have been shown to be less likely to access preventive health care than their counterparts (Carroll et al. 2007; Willis and Nwocha 2006); a majority has been shown to be either overweight or obese after residing in the U.S. for fifteen or more years. Moreover, length of stay in the U.S. has been shown to be inversely related to being

covered by a health insurance among Central African communities (Tshiswaka et al. 2014). Regarding infectious diseases, African immigrants appear to have lower rates of HIV infection than U.S.-born Blacks, but rates of infection and mortality increased greatly in the 1990s (Akinsete et al. 2007). Independent of shifting incidence and mortality statistics, rates of health-related stigma have been shown to be high among African communities (Rosenthal et al. 2003).

Health-related stigma has been the focus of several biobehavioral studies focusing on disease outbreak and prevention, care, and treatment (Hendler et al. 2016; Kleinman et al. 2008; Mak et al. 2009). Stigma has been defined as “an attribute that has a discrediting effect on an individual which renders society to view him/her as different from the other people around resulting in that person having a spoiled identity” (Goffman 1963). Moreover, three types of stigma have been identified— external physical deformation of the body such as scars, deviations of individual character, and ‘tribal stigma’ of race or ethnic group, which is perceived to be a deviation from the normative race or ethnicity (Goffman 1963).

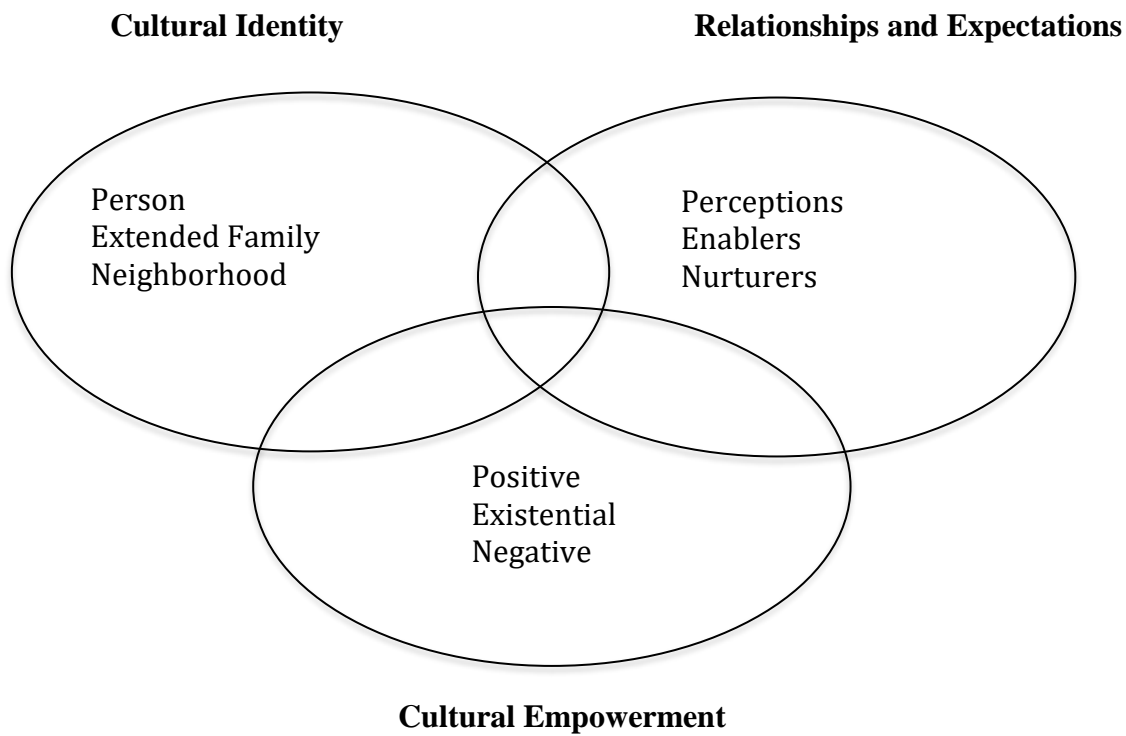
Furthermore, the recent cases of Ebola diagnosed in the U.S. led to an epidemic of fear among lawmakers, the media, and the public who were seemingly driven by misinformation, lack of scientific evidence, and demagoguery (Merino 2014). The fear of the virus played a significant role in the stigma associated with EVD, as it was popularly believed that the virus was deadly and could be contracted through methods that were not scientifically proven (Davtyan et al. 2014; Ropeik 2014). Panic was instilled into the U.S. population through the use of social media outlets (Gorski 2014). Subsequently, individuals of African descent residing in the U.S. reported being stigmatized because of the Ebola virus (Sanburn 2014).

Using the PEN-3 model, this study assessed the socio-cultural factors influencing EVD-related stigma experienced by African immigrants in the U.S. Moreover, we considered the extent to which socio-cultural factors have exacerbated or prevented this EVD stigmatization.

Figure 1. PEN-3 Cultural Model (Airhihenbuwa & Webster, 2004)

**Figure 1: Theoretical Framework: The Pen-3 Model**

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The PEN-3 cultural model was used as a guide to explore the EVD-related stigma experienced by African immigrants in the U.S. (see Figure 1) (Iwelunmor et al. 2014).

Developed by Airhihenbuwa (1989), the model examines culture and its impact on health behaviors and beliefs (Airhihenbuwa and Webster, 2004; Airhihenbuwa 2007). It posits that in order to centralize culture on health behaviors and decisions, three domains should be taken into

account: (1) Cultural Empowerment, (2) Cultural Identity, and (3) Relationships and Expectations. Each domain includes three factors that form the acronym PEN; Positive, Existential and Negative (Cultural Empowerment domain); Person, Extended Family, Neighborhood (Cultural Identity domain); Perceptions, Enablers, and Nurturers (Relationships and Expectation domain). The Cultural Empowerment domain captures practices that are positive, existential, or negative values that have health consequences. The Cultural Identity domain focuses on the points of entry for the intervention, which may occur at the level of persons, extended family members, or neighborhoods. The Relationships and Expectations domain considers elements that influence health behaviors and decisions. For this study, we employed the Relationships and Expectations domain to explore the perceptions, enablers, and nurturers that increased or dissipated EVD stigma among African immigrants residing in the U.S.

## **Methods**

A thematic analysis of mainstream U.S. news media was conducted. The Lexis-Nexis Database was searched for a period between February 2014, when the first reports of the outbreak appeared, and March 2015 using specific key terms ‘African immigrants’, ‘African refugees’, and ‘EVD’. Twenty-one articles that met the study criteria were retrieved and reviewed. All articles provided specific examples of social experiences faced by African immigrants in the U.S. upon the outbreak of EVD.

Several researchers reviewed the articles that met the study criteria and developed inductive codes. These codes were then, using the PEN-3 model, further developed and refined

into broader themes. Direct quotations from the analysis were included so reported experiences were clearly represented.

## **Results**

Analysis of the data showed that African immigrants in the U.S. routinely faced EVD-related stigma in their communities following the outbreak of the disease. The individuals described in the selected articles migrated from different West African countries, namely Liberia, Guinea, Sierra Leone, Nigeria, and Senegal. Immigrants reporting stigmatization were either employed in both the public and private sectors, or students receiving elementary or middle school education. The stigmatization became more widespread and tangible once mass media began spreading misconceptions about the disease instilling a sense of fear and panic within the population. The findings revealed that perceptions surrounding EVD coupled with a negative portrayal of the African continent were pivotal in shaping the stigma directed towards African immigrants.

### **Perceptions Surrounding the EVD and its Influence on Stigma**

The PEN-3 model defines perception as beliefs, knowledge or attitudes toward EVD linked to stigma (Airhihenbuwa and Webster 2004). In our analysis, perception of the African continent where this outbreak occurred was linked to stigmatization of the areas affected by the virus. This led U.S. lawmakers to call for a travel ban on people from the West African countries most affected by the disease (i.e. Sierra Leone, Liberia and Guinea) (Diamond 2014). A report showed that 58 percent of the surveyed population sampled in the U.S. supported a travel ban on

countries with confirmed cases of Ebola (Helsel 2014). This was despite the inefficiency claims of such travel bans made by U.S. Centers for Disease Control and Prevention (CDC).

Moreover, the African immigrant communities originating from afflicted regions experienced EVD-associated stigma. In Staten Island, NY, members of the largest Liberian community outside of Africa were stigmatized on a daily basis (Calabrese and Harshbarger 2014). A Liberian man who ran a community fitness-training practice lost clients and friends upon the EVD outbreak (Banks 2014). Alphonso Toweh, a Liberian, was riding the bus in Washington, D.C. and was asked where he was from; when he answered ‘Liberia’, his fellow-passenger removed himself from the seat next to Alphonso (Brown and Constable 2014). Alphonso went on to testify to *The Washington Post*, “If I’m on the metro, I don’t talk. If I’m on the bus, I don’t talk. If people hear the accent, they think you are Liberian, that you have Ebola.” Oretha Bestman-Yates, who had shopped at a West African market in Staten Island for more than 20 years made this candid observation about the state of local businesses after the number of vendors reduced from twenty-two to five:

It’s because they’re scared of the Ebola virus. It’s something we can’t even explain ourselves; we just try to hold our heads up high. People don’t want to talk with you, you walk in the street and they yell out ‘African, go back to Africa with your Ebola.’ (CBS News 2014)

### **Enabling Factors Influencing EVD-related Stigma Among African Immigrants**

According to Airhihenbuwa & Webster (2004), enabling factors refer to institutional support and assets at the structural level. Our analysis identified the enabling factors that contributed to EVD-related stigma. In particular, educational institutions were found to be a

common site, at which individuals experienced EVD-related stigma. Students at an elementary school called the sons of an African immigrant ‘Ebola’ and excluded them from playing basketball (Hagan 2014). The severity of the stigmatization even extended to attendance and admission requirements from various schools across the U.S.:

- Irrational fear of Ebola caused an elementary school in Milford, Connecticut to require a student to take 21 days off school, after attending a wedding in Nigeria (Kaminer 2014).
- At Navarro College in Corsicana Texas, officials stopped accepting applications from African students (CBS News 2014).

Alarmingly, there were multiple reports of safety being endangered as a result of the stigmatization. African immigrant students reported being teased, bullied, and assaulted in the school setting by peers. CBS News (2014) relayed a story of two Senegalese middle school students being harassed with Ebola taunts and physically beaten by other students.

In addition to the discrimination occurring in schools across the United States, numerous reports of stigmatization in workplace settings were reported during the outbreak. West African taxi drivers reported being shunned by New Yorkers who feared that the cab interiors might transmit the virus (Philips 2014). An office worker from Liberia was sent home because she coughed (Hartocolis and Schweber 2014). Another Liberian immigrant claimed that she was forced to take a temporary unpaid leave, presumably just in case she had any contact with the virus (Sanburn 2014). African healthcare professionals reported being stigmatized in hospitals. Oretha Bestman-Yates, a healthcare worker in New York said she was barred from returning to her job after a trip to Liberia despite 21 days of quarantine and no signs of illness (Bernstein 2014). Nurses and other staff who treated New York’s first Ebola patient, Dr. Craig Spencer,



reported being shunned by co-workers and banned from using certain elevators (Hartocolis and Schweber 2014).

### **Nurturing Factors Influencing EVD-related Stigma**

Following the PEN-3 cultural model, the influences of supportive and/or discouraging factors on EVD-related stigma were classified as nurturers (Airhihenbuwa and Webster 2004). Interestingly, it is now well understood that outbreaks can create a complex collective experience shared by communities (Iwelunmor et al. 2006).

Overall, social media intensified the EVD-related stigma and marginalization experienced by Africans in the United States. The sensationalized reports spread by media outlets, such as Twitter, contributed to the panic felt by large sections of the U.S. population (Gorski 2014). The role the media played in relaying and disseminating Ebola-related information “made people believe it was necessary to fear for their lives” (Ropeik 2014). The instilment of fear was arguably even more of a threat than the disease itself, as fear directly contributed to the perception of EVD and related stigma. Twitter played a major role in the spread of fear – led by then presidential candidate Donald Trump calling for the U.S. to ‘keep the Ebola-infected people out of our country’ and to ‘stop all flights from Ebola-infected countries immediately’ (Gorski 2014). Subsequently, these diatribes created a culture where African immigrants were blamed for the continuation of the epidemic (Davtyan et al. 2014).

Meanwhile, African communities responded strongly during this outbreak. Communities joined together to denounce the stigmatization faced daily. A social media awareness campaign with the slogan “I am a Liberian, not a virus.” was created; with Liberians around the world adopting the slogan and tweeting pictures holding up signs with the slogan catchphrase. In

Harlem, New York, a Liberian woman staged a march protesting the hardships affecting their communities and encouraged others to treat Liberians fairly and equitably (Bernstein 2014). The Minnesota African Task Force against Ebola was established to counter fear by providing education about the disease to surrounding communities (Goodnough 2014).

## **Discussion**

A limited number of studies have explored the socio-cultural factors associated with EVD-related stigma. Previous research suggests that EVD-related stigma was strongly correlated with the embedded social values regarding other ethnic minorities residing in the country and community breakdowns (Siu et al. 2015; Van Bortel et al. 2016).

A decade ago, a new sustainable theory of health-related stigma was proposed; this particular type of stigma was redefined as a social process that consists of blaming certain groups of people for having an illness (Deacon 2007). This new model argued that the shaming of others associated with health-related stigma allowed the stigmatizers an opportunity to distance themselves and their in-groups from risk of infection. In Europe, stigma has been shown to contribute to HIV serostatus nondisclosure (Whembolua et al. 2016). Furthermore, in the United States, among immigrants of African descent, the experience of Haitians illustrates vividly the significance of health-related stigma. In the context of the spread of HIV/AIDS in the 1980s, the link between Haitians and their country of origin was shown to negatively affect their experiences (McCormick 1993). Numerous negative consequences of this ethnic stigmatization were listed such as discrimination, status loss and lack of healthcare opportunities (Deacon 2007).

In the U.S. context, EVD-related stigma cannot be separated from the numerous issues already affecting African immigrants. Using the PEN-3 model as our theoretical framework, analysis of U.S. mainstream news media revealed that the perception of the African continent contributed to the stigmatization of the African immigrants in the U.S. Previous research suggests that Western media focuses on negative coverage of Africa and the perception of the continent and its inhabitants, which may influence the future of Africans residing outside the continent (Adekoya 2013; Mehta 2015); the relationship between the stigmatization experienced during the EVD outbreak and its region of origin paralleled the experience of Haitians and other African immigrants during the AIDS outbreak nearly four decades ago (Whiteside and Zebryk 2015). In both cases, the link between immigrants and their country of origin was shown to negatively affect their experiences in the U.S. Fear of the unknown proved to be an important factor in fanning the flames of anxiety during outbreaks of deadly diseases (Altman 2014). As a consequence of fear propagating a deadly virus, Haitians as a group were listed by the CDC as a group at risk for transmitting HIV/AIDS despite not exhibiting the specific at-risk behaviors related to HIV/AIDS (McMormick 1993). While the CDC did not officially issue a similar statement in the case of EVD and African immigrants, misinformation contributed to the stigmatization of African citizens and their activities. For example, Harlem-based African businesses reported losing customers at a growing rate during the August-October 2014 period (Philips 2014).

Similar to the experiences of Haitians in the 1980s, the negative effects of health-related stigma reported among African immigrants became associated with additional discrimination and a decrease in economic opportunities (Deacon 2007; Kaminer 2014). Moreover, as demonstrated by Okoror et al. (2014), the use of the PEN-3 model shifted the focus from the individual to the

cultural context of the stigma-enhancing behavior. Drawing from this approach, educational entities and places of employment were identified in this analysis as enabling factors that contributed to the stigma. Our results complement other findings, displaying that infectious disease-related stigma can lead to rejection in the domains of school and work (Lee et al. 2005; Sprague et al. 2011).

Finally, unlike in the case of Haitian immigrants with HIV/AIDS, our analysis identifies the role played by social media; as a voice that negatively amplifies the link between African immigrants and the Ebola virus. This is in contrast with work demonstrating how positive the use of social media can be in attenuating stigma (Brown et al. 2003). Moreover, these results revealed how significant community response, as a nurturer against stigma, can be when facing infectious diseases and their stigma. This response demonstrates the ability of the African immigrant community in contributing to the education of the masses about issues affecting its own livelihood. Our findings also support previous research, which accentuates the role of community advocates in mitigating stigma and/or changing policies geared towards immigrants in the U.S. (Galarneau 2010; Koku 2010).

There are several limitations to this study worth noting. First, this study only analyzed U.S. mainstream news media. Thus, it was unable to investigate the experiences of African immigrants residing in various countries worldwide. Hence, the findings raise awareness only for the African immigrants residing in the United States, and are only relevant to discussions about them. Furthermore, this study does not delve into the stress and hardships experienced by African immigrants, particularly from a mental health perspective.

## **Conclusions**

The 2014 Ebola outbreak in its reach to the United States of America highlights the need for research on neglected infectious diseases as well as for information regarding these diseases in the western world. The skewed, xenophobic, and jaundiced perceptions of the harsh realities behind an infectious disease resulted in negative stigma towards African immigrants residing in the U.S. The results of our analysis underscore how the stereotypical perceptions of the African continent, coupled with the influence of enabling and nurturing factors legitimated by the deep stigma against Africa and Africans, should be central in the design of interventions focusing on supporting the health of African immigrants residing in the U.S. Particularly in light of a politically charged atmosphere that witnessed the rise of nativism as political rhetoric during the U.S. 2016 presidential election (Caddell 2016; Wright 2016), Africanists and public health practitioners must continue to work with these newly formed vulnerable African communities to assess their sociocultural needs and influence social policy to respond appropriately to these needs.

## **Biographical sketch**

### **Guy-Lucien S. Whembolua**

Dr. Guy-Lucien S. Whembolua is the Director of the Africana Health Research Laboratory. Dr. Whembolua is a behavioral scientist with general areas of expertise in public health in low-income countries, immigrant health and substance abuse among underserved populations. He is currently an Assistant Professor of Health Policy and Management in the department of Africana studies at the University of Cincinnati and the Director of the Global Health Studies certificate.

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### **Donaldson F. Conserve**

Dr. Conserve is the Associate Director of the Africana Health Research Laboratory and is currently an Assistant Professor in the Arnold School of Public Health at the University of South Carolina. His research interests include Caribbean immigrant health, and HIV prevention worldwide. To date, much of his work has been on the impact of HIV/AIDS stigma on Haitian immigrants.

### **Daudet Ilunga Tshiswaka**

Dr. Ilunga Tshiswaka is a Senior Researcher at the AFROLAB, focusing on international health and minority health. He is currently an Assistant Professor in the Department of Public Health at the University of West Florida. Over the span of his career, he has worked on a variety of projects including studying health insurance status among minorities, understanding health behaviors in regards to high blood pressure among transnational Africans and inquiring spatial distribution of high birth weight and low birth weight among immigrant women. Previously, he coordinated HIV/AIDS awareness and testing programs in Kinshasa, D. R. Congo.

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