'No Ebola…still doomed' – The Ebola-induced tourism crisis

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A B S T R A C T

Many recent crisis and disasters affecting tourism have been studied, but few explicitly explore health related crisis in developing countries. This study analyses the effect of the Ebola Virus Disease Epidemic (EVDE) on The Gambia, where, despite no reported cases, EVDE had devastating consequences. A Rapid Situation Analysis is used to gain insights into responses to the EVDE, encompassing interviews with key stakeholders, field observations and follow up meetings with those involved in managing the crisis over 21 months. A crisis and disaster framework is used to understand the challenges encountered. Findings highlight the importance of consumer perception and preparedness and management failures' consequences, contributing to the broader debate on the indirect threat of epidemics on tourism in developing countries.

Introduction

An event that suddenly transpires into an unfavourable situation is known as a crisis (Laws & Prideaux, 2005). In recent years, many such crises have affected tourism (Breitsohl and Garrod, 2016) but despite the growth in the study of tourism crises, Mair, Ritchie, and Walters (2014) found that only four out of sixty-four studies conducted from 2000 to 2010 specifically related to health crises, while Jiang, Ritchie, and Benckendorff (2017) noted a focus on economic rather than health-related crises. Furthermore, the majority of these studies focused on crisis in developed countries. This study examines both the context in which the Ebola Virus Disease Epidemic (EVDE – later referred to as 'Ebola') outbreak occurred and its effect on tourism in the small developing nation of The Gambia. Despite no reported cases, tourism receipts more than halved for the 2014/2015 season (International Monetary Fund, 2015; Gambia Tourism Board, 2015), leading to what is referred to as the 'Ebola-induced tourism crisis' (EITC).

Tourist decisions and destination choices are influenced by personal and physical security perceptions (Lepp & Gibson, 2003; Taylor & Toohey, 2007), which are often fuelled by media imagery of destinations (Kozak, Crotts, & Law, 2007). Health related crises, such as epidemics, are prone to negative media coverage and graphic imagery, making them particularly challenging for the tourism sector to manage (Schroeder & Pennington-Gray, 2014). The graphic images portrayed in media coverage, combined with a lack of the source markets' geographical knowledge of Africa, has led to the entire continent being 'generalised' as being risky. Furthermore, destinations may be unaffected directly by a crisis, but the consequence of being within its physical proximity (Henderson, 2007), can create a 'spill over effect' with damaging consequences (Cavlek, 2002; Ritchie, Crotts, Zehrer, & Volsky, 2013).

It is important to study tourism crisis management in developing countries for two main reasons. Firstly, the impact of crises can be devastating for the tourism sector in developing countries due to an overreliance on tourism receipts (de Sausmarez, 2004; Mansfield and Pizam, 2006; Ritchie, 2009). Declining visitor numbers, increasing unemployment, weakened profits, reduced

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investment, and less government revenue (Henderson, 2007; Ritchie, 2004) often exacerbate socio-economic conditions and may propel the country into a worsened state of fragility (Novelli, Morgan, & Nibigira, 2012).

Secondly, managing the recovery following a tourism crises is likely to be impaired by the state of fragility associated with developing countries compared to developed countries. This is due to limited human and financial resources for tourism marketing and development, poor governance structures and lack of tourism planning (Novelli et al., 2012). Furthermore, these destinations may rely heavily on outside support (i.e. NGOs, donors) for the development of their tourism industry (Novelli, 2016), and even more so in their preparation and response to tourism related crises.

The limited literature on crisis management in developing countries includes a few studies on tourist risk perceptions (Adam, 2015), on using online marketing to overcome risky stereotypes in Africa (Ketter & Avraham, 2010), and on image repair when responding to crises in Africa and other developing economies (Avraham & Ketter, 2016; Avraham & Ketter, 2017). The majority of studies focus on crisis communication and recovery marketing – just one aspect of crisis management. Understanding how an African destination responds to a tourism crisis from a supply side perspective is therefore important and timely, as it has implications for other developing countries.

Although tourism crisis and disaster frameworks exist to better understand tourism crisis management from a supply side perspective (see Faulkner, 2001 and Ritchie, 2004), these too have been developed and applied mostly in a developed country context. Furthermore, these frameworks are prescriptive, and the majority of studies compare what happened with what should have happened. Further studies focus on response and recovery only (Jiang et al., 2017), limiting our understanding of the effectiveness of strategies, especially when crises last beyond a few months and may have a significant impact.

This paper analyses the strategies adopted to stabilise and (re)position the destination based on a Rapid Situation Analysis (RSA). This included a retrospective review of personal diary entries, overt participant observations in the destination and semi-structured interviews with key stakeholders in The Gambia and the UK, conducted over a period of 21 months (November 2014 – July 2016).

Literature review

Health related crises

Numerous studies focus on the impact of crises on tourism sectors with specific reference to airlines (Henderson, 2003), hotels (Israeli & Reichel, 2003; Chien & Law, 2003), travel agents (Lovelock, 2004) and restaurants (Tse, So, & Sin, 2006). Other studies principally focus on terrorism, political instability and economic crises within specific geographical locations, for example the bomb attacks in Bali (Putra & Hitchcock, 2009), Egypt (Aziz, 1995), New York (Enz & Taylor, 2002), September 11, 2001 (Stafford, Yu, & Armoo, 2002), and the BP oil spill (Ritchie et al., 2013) amongst others (see Jiang et al., 2017).

As previously argued, few studies have focused on health-related disasters or epidemics, such as the Severe Acute Respiratory Syndrome (SARS) in South-East Asia (Dombey, 2003; McKercher & Chon, 2004), the Foot and Mouth Disease in the UK (Frisby, 2003; Irvine & Anderson, 2004), influenza in Mexico (Monterrubio, 2010) and bed bug issues (Liu, Kim, & Pennington-Gray, 2015). During the last fifteen years, there have been a number of health-related crises that have caused risks to local communities and significant damage to the tourism sector (Glaesser, 2006; Kuo, Chen, Tseng, Ju, & Huang 2008; Smith, 2006). As travel and tourism can facilitate the spread of epidemics, global bodies such as the World Health Organisation (WHO) and the UN World Tourism Organisation (UNWTO) are increasingly interested in understanding the cause, evolution and risk of an infection (Joffe & Haarhoff, 2002; Mason, Grabowski, & Du, 2005; Page, Yeoman, Munro, Connell, & Walker, 2006); and advocating swift precautionary actions to reduce a health risk, often at the expense of complete scientific understanding (Sunstein, 2005).

The SARS outbreak exemplified the link between travel, tourism and an infectious disease (Henderson & Ng, 2004; McKercher & Chon, 2004; Washer, 2004), that spread globally through international tourists returning home after visiting affected areas (Mason et al., 2005). In an unprecedented move in its forty-five-year history, the WHO issued a "general travel advisory", the result of which was to effectively close many borders while discouraging tourism in the affected areas (Smith, 2006; Wall, 2006). Of the nine thousand people who contracted SARS, 870 died (McKercher & Chon, 2004). China, Hong Kong, Vietnam and Singapore lost an estimated US$20 billion in GDP and three million jobs in the tourism sector (Kuo et al., 2008). The WHO's travel warnings, which labelled the condition as 'pandemic', together with the volume of media coverage and its sensationalist tone contributed to global panic (Mason et al., 2005; McKercher & Chon, 2004; Joffe & Haarhoff, 2002).

Similarly to SARS, Ebola was characterised by sensational reporting by the media. Joffe and Haarhoff (2002) researched media depiction in the UK of an Ebola outbreak in the Democratic Republic of the Congo, and suggested that it was portrayed as an African health issue. Although previous cases of Ebola had occurred in Africa, the scale and impact had been contained with limited impact on the wider perception about whether it was safe to travel in the African continent (Joffe & Haarhoff, 2002). The recent outbreak of Ebola in West Africa has had a different effect due to its scale and media attention. However, misrepresentation and public misconception about the geographical location of affected countries in Africa, negatively influenced international tourist arrivals to the entire African continent. Before the outbreak, Africa had experienced average increases in tourist arrivals of 5% per year in 2012 and 2013, but numbers were reduced by 2% in 2014 (UNWTO, 2015a), and a further 5% in October 2015 (UNWTO, 2015b).

Some commonalities in relation to the role of the media on risk perception can be found in the wider literature on crises caused by terrorism (Law, 2006; Santana, 2001; Sönmez, Apostolopoulos, & Tarlow, 1999). Fear, loss of confidence in institutions, unpredictability and pervasive loss of safety may emerge during an epidemic (Rittichainuwat & Chakraborty, 2009). While generally the media affects risk perception, an opposite reaction may occur as a result of a social process known as normalisation (Ananian-Welsh & Williams, 2014). Existing literature states that repeated risk experience desensitises individuals to risk over time, as the concept

appears normal, particularly with hazardous activities undertaken voluntarily (Ananian-Welsh & Williams, 2014; Breakwell, 2014).

Thus, normalisation can explain why tourists return to destinations that are perceived as unsafe (Morakabati, 2007; Saha & Yap, 2014). Fletcher and Morakabati (2008) argue that tourists quickly return to destinations that have been touched by terrorism, as tourism demand is influenced by factors such as travel motivation, tourist type and tourism life cycle (Plog, 2001). There does not appear to be any conclusive literature around the normalisation process and health epidemics. Health epidemics tend to be infrequent, yet can spread rapidly across geographical boundaries (i.e. SARS and influenza). Due to their infrequency and rapid spread, health epidemics can exert even more negative pressure on tourism demand than terrorism (Breitsohl and Garrod, 2016). Regardless of type, all crises need appropriate management so that the destination and tourism businesses can respond, recover, learn lessons, improve future planning and implement effective strategies.

Tourism crisis management

Handling the negative impact of crises can be achieved through crisis management; the process by which the impact of a crisis may be reduced and recovery supported (Armstrong, 2008; Glaesser, 2006). Crisis management can be defined as: "An ongoing integrated and comprehensive effort that organisations effectively put into place in an attempt to first and foremost understand and prevent crisis, and to effectively manage those that occur, taking into account in each and every step of their planning and training activities, the interest of their stakeholders" (Santana, 2004, p.308). Devising and implementing successful crisis management policies and strategies are complex, due to the fragmented nature of the tourism sector, political and social context of the crisis location, as well as the unique characteristics and duration of each crisis (Henderson, 2007; Prideaux, Laws, & Faulkner, 2003). McKercher (1999) argued that while many general crisis models provide management guidance for a particular crisis, these remain linear and fail to acknowledge complexity in responding specifically to health crises.

Crisis management must address the immediate challenge, ensuring the safety of tourists and the community, and sustaining and/ or rebuilding the tourism sector (Burnett, 1998; Prideaux, 2004; Speakman & Sharpley, 2012). Destinations need to engage with immediate and long-term planning, recognising how tourists typically react to a crisis situation (Ritchie, 2004). As a crisis unfolds, the perspective towards the situation will differ based on the context and in turn, be influenced by culture, organisation and politics (Pforr, 2006). Culturally shared beliefs about risks and precautionary standards, as well as the degree to which diverse outcomes are acceptable, also vary (Beck, 2006; Morakabati, 2007; Breakwell, 2014).

Strategies to handle crises will vary depending on time pressure, the degree of control and the scale of the event (Ritchie, 2004). However, the decisions made during a crisis can be crucial to the overall long-term recovery of the destination and is especially important for engagement and management of the media (Armstrong, 2008; Beirman, 2003). Most tourism recovery strategies are reactive and generally include government aid packages; which (re)focus on domestic tourism and development of new niche tourism products, as well as cost-cutting measures by the sector as a result of a crisis (Tse et al., 2006; Enz & Taylor, 2002). Finally, destination recovery is highly dependent on the perception of risk, a field that is crucial to understanding what is important for tourists in relation to personal safety and security (Lepp & Gibson, 2003; Reisinger & Mavondo, 2005; Taylor & Toohey, 2007; Williams & Baláz, 2013; Yang & Nair, 2014).

General crisis and disaster management theory, models and frameworks have been established to understand crisis and disaster management. These are prescriptive or descriptive, or a combination thereof (Armstrong, 2008). Prescriptive models outline how a crisis should be handled based on pre-set standards, while descriptive models indicate how an event was actually handled (Burnett, 1998). Few case studies delineate the impact, recovery and lessons learnt from actual crises (Paraskevas & Arendell, 2007; Hystad and Keller, 2006). Furthermore, such management strategies are devised and implemented within a political, cultural and social context, and process (Prideaux et al., 2003) – such as a developing country.

A number of conceptual frameworks have been developed for the tourism sector, with the overall purpose of assisting destinations and businesses in managing a crisis at various stages. Ritchie's (2004) prescriptive framework incorporates the lifecycle of a crisis or disaster alongside a strategic management framework. Ritchie's (2004) framework (Fig. 1) covers three main stages: (1) pre-crisis planning, (2) crisis response and recovery, and (3) resolution and future learning. While there are many parallels to Faulkner's TDMF, Ritchie's framework provides flexibility and feedback loops, recognising that diverse approaches are needed to manage crises; as each crisis differs in terms of impact, strategy and recovery period (Armstrong, 2008). Further, Ritchie's (2004) model can be applied to both crises and disasters, while Faulkner's (2001) model was designed for tourism disaster management only. Ritchie's (2004) model is used in this paper as a framework to understand the response to the EITC in The Gambia across the crisis lifecycle, as well as what strategies were used and how this compares with suggested approaches.

However, limited research has been used to test this prospective model in a developing country context. Further, the longitudinal nature of this research provides an opportunity to understand long-term recovery, and identify changes in crisis planning and preparedness for future crises in The Gambia and beyond – thus all three phases of Ritchie's (2004) CDMF. The complete framework is specifically used to evaluate management responses within a health crisis and in a developing country context, addressing the gaps by examining the response of the Gambian government and the tourism sector to EITC.

Research context and methodology

One of the criticisms of tourism crisis management literature is that it does not provide enough detail on the background context of case studies (Ritchie, 2009). Yet the broader social, economic and political context is also important. It can help understand the underlying vulnerabilities of the sector or country, the impact of a crisis and explain why certain strategies were implemented.
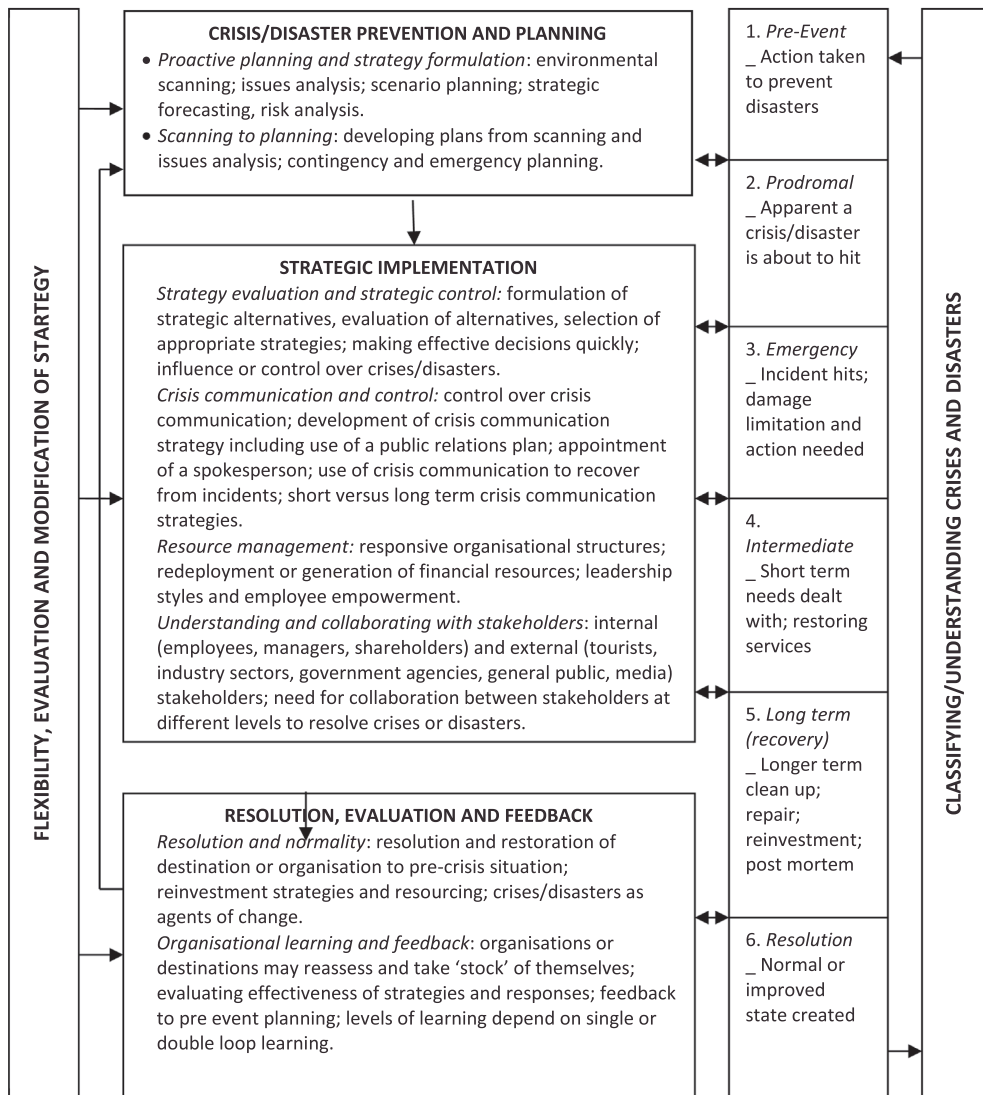
Strategic Management Framework   *Anatomy (stages) of a Crisis/ Disaster*

CRISIS/DISASTER PREVENTION AND PLANNING
- *Proactive planning and strategy formulation*: environmental scanning; issues analysis; scenario planning; strategic forecasting, risk analysis.
- *Scanning to planning*: developing plans from scanning and issues analysis; contingency and emergency planning.

STRATEGIC IMPLEMENTATION
Strategy evaluation and strategic control: formulation of strategic alternatives, evaluation of alternatives, selection of appropriate strategies; making effective decisions quickly; influence or control over crises/disasters.
Crisis communication and control: control over crisis communication; development of crisis communication strategy including use of a public relations plan; appointment of a spokesperson; use of crisis communication to recover from incidents; short versus long term crisis communication strategies.
Resource management: responsive organisational structures; redeployment or generation of financial resources; leadership styles and employee empowerment.
Understanding and collaborating with stakeholders: internal (employees, managers, shareholders) and external (tourists, industry sectors, government agencies, general public, media) stakeholders; need for collaboration between stakeholders at different levels to resolve crises or disasters.

RESOLUTION, EVALUATION AND FEEDBACK
Resolution and normality: resolution and restoration of destination or organisation to pre-crisis situation; reinvestment strategies and resourcing; crises/disasters as agents of change.
Organisational learning and feedback: organisations or destinations may reassess and take 'stock' of themselves; evaluating effectiveness of strategies and responses; feedback to pre event planning; levels of learning depend on single or double loop learning.

FLEXIBILITY, EVALUATION AND MODIFICATION OF STARTEGY

CLASSIFYING/UNDERSTANDING CRISES AND DISASTERS

1. *Pre-Event* _ Action taken to prevent disasters

2. *Prodromal* _ Apparent a crisis/disaster is about to hit

3. *Emergency* _ Incident hits; damage limitation and action needed

4. *Intermediate* _ Short term needs dealt with; restoring services

5. *Long term (recovery)* _ Longer term clean up; repair; reinvestment; post mortem

6. *Resolution* _ Normal or improved state created

Fig. 1. Ritchie's (2004) Tourism Crisis and Disaster Management Framework (CDMF).

The Gambia

The Gambia, one of Africa's smallest countries nested within Senegal (Fig. 2) with a population of just under two million, has few natural extractable resources, poor soil quality and relies heavily on foreign aid to balance its budget. Its predominant crop and main source of foreign currency are peanuts (Williams, 2015). Tourism accounts for 12–16% of The Gambia's Gross Domestic Product (GDP) (Williams, 2015). It is the second largest foreign-exchange earner, employer and exporter, "accounting for more than US$80 million in earnings on average in the three years before the crisis" (IMF, 2015a; IMF, 2015b).

The Gambia's tourism sector was launched fifty years ago as a package winter-sun destination and still caters to a mass market wanting to escape Europe's winter season (Bakker, 2011; Williams, 2015). Tourism in The Gambia is seasonal with approximately three-quarters of all visitors arriving between November and April, and staying, on average, for seven nights (Bakker, 2011). Most visitors arrive on charter airlines, like Brussels Airlines and Thomas Cook. In 2014 and 2015, The Gambia's largest source market was the UK, which accounted for approximately 35% of all charter arrivals (Gambia Tourism Board, 2015). Other key markets included the Netherlands, Sweden, Spain, and Germany. Nigeria was also developing into a significant regional source market (GTB, 2013–2015) supported by the regional Arik airline connection.

Over the past thirty years, tourism has faced several challenges including over-reliance on international charter flights and package visitors, limited range of tourism products, competition from other winter-sun destinations (i.e. Cape Verde, Egypt, Tunisia
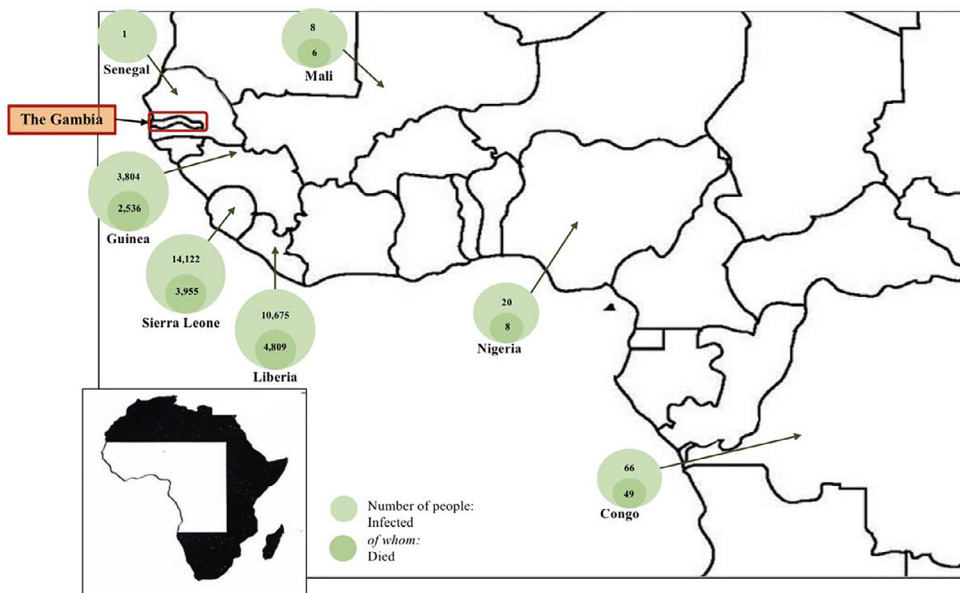
Fig. 2. The Gambia in relation to Countries affected by Ebola Outbreaks (Source: Adapted from The Economist, 2016).

and the Canary Islands), high airport and fuel fees and insignificant domestic demand. In addition, periodic political instability, starting with the 1994 coup d'état and 22 years of subsequent dictatorship, and a more recent change in government in December 2016, has also impacted tourism. Despite these challenges, the destination has shown resilience and is widely perceived as more peaceful compared to other African destinations. In fact, Gambian tourism had been growing steadily before the regional Ebola outbreak (Table 1), receiving 171,200 visitors in 2013, which was one of its most successful tourist seasons. This insinuated significant future growth to the public and private sectors resulting in increased investment in hotel facilities and bed spaces.

The EITC resulted in a rapid decrease in tourist arrivals, −60% in 2014 (Hussain, 2014) which was a significant shock to the sector, evidenced by a tourism direct GDP contraction from 9% to 5.1% and an estimated drop of −40% in direct employment from 49,500 to 29,000 jobs (WTTC, 2014; WTTC 2015). The IMF (2015a), IMF (2015b) reported that The Gambia was not fiscally sound, due to a reduction in foreign currency earnings, which were accrued through tourism and the on-going EITC recovery process. This also highlighted broader national socio-economic challenges, which would hinder any pre- and post- Ebola crisis planning and management actions.

The Ministry of Tourism and Culture (Ministry of Tourism & The Gambia, 2015) is responsible for tourism policy and planning, overseeing the Gambia Tourism Board (GTB), the National Council for Arts and Culture and The Gambia Tourism and Hotel Institute, and works in collaboration with several private and public stakeholders (i.e. Gambia Hotel Association; Association of Small Scale Enterprise in Tourism).

The Ebola outbreak

Ebola outbreaks have occurred in the Democratic Republic of Congo and Uganda, but this was the first time it surfaced in West Africa (Fig. 2) resulting in its deadliest incidence since its discovery in 1976 (BBC, 2015).

The outbreak was traced to Guinea in December 2013 (Knapton, 2015). In March 2014, local hospital staff informed the Ministry of Health and Médecins Sans Frontières (MSF) of a mysterious disease causing fever, vomiting and diarrhoea with a very high death rate. Eventually, this illness was confirmed as Ebola by the WHO (Regan, 2015). In August 2014, WHO declared an "international public health emergency" fearing that the rapidly transmittable virus might become a global epidemic (BBC, 2015). The outbreak continued to escalate until January 2015, when the infection rate finally reversed (BBC, 2015). In June 2015, WHO reported the lowest number of confirmed cases since May 2014 (Table 2). Subsequently, the international community deployed resources to build hospitals and treatment centres.

Deaths from Ebola also occurred in Nigeria (8), Mali (6), Spain (2), Germany (1), and US (1). Concern amongst the international community intensified as media coverage increased once Ebola had spread into the US and Europe (Cullen, 2014). Thus, both within

Table 1
Tourist Arrivals by air 2010 – 2016 (Source: GTB, personal communication, 2017).

	2010	2011	2012	2013	2014	2015	2016
Tourist Arrivals	84,390	99,158	157,323	171,200	155,721	134,560	161,127

Table 2

Key Events during the 'Ebola-Induced Tourism Crisis' (Source: interviews; BBC, 2014a; BBC, 2014b; BBC, 2015a; BBC, 2015b; Telegraph, 2014; WHO, 2015).

| Date	Events
December 2013	• First fatality in Guinea disease spreads to Liberia and Sierra Leone
March 2014	• Ebola outbreak in West Africa first reported in international press
April 2014	• Gambia bans entry of flights from Guinea, Liberia, Sierra Leone
Spring/Summer 2014	• Procurement of medical supplies and personal protective equipment positioned at strategic regions in the country • Local internal campaign sensitising Gambians to Ebola • Surveillance at border areas to screen nationals from affected countries entering The Gambia
Summer 2014	• Massive cancellations and fewer bookings for upcoming season • Tour operators decide to cancel several flights for the upcoming high season and code-share flights with each other to continue to service the destination • Stakeholders recognise that The Gambia is facing a crisis as a result of Ebola in the region
August 2014	• WHO declares the outbreak a public health emergency of international concern • Nigeria bans entry of Gambia Bird • Gambia Bird suspends services to Liberia and Sierra Leone • Upcoming season 2014/2015: Thomas Cook cancels all four flights to The Gambia from Scandinavia; UK/Dutch cancels 50% of flights and Poland cancels its one flight
Autumn 2014	• Communication strategy: GTB issues a letter to overseas tour operators and travel agencies • Most international air carriers stop servicing the three effected countries • Engagement, collaboration and support continues from The Gambia's key tourism partners for the upcoming season with all stakeholders creating incentives (e.g. hotels reduce rates by 20%, government ceases landing rights for three months, carriers subsidise air passengers)
November 2014	• Senior Gambian delegation attends World Travel Market to promote the Gambia as 'open for business' • Focus on meetings with airlines to identify new flight routes
December 2014	• Attend World Routes conferences; meet with Monarch, Jet2 and British Airways to discuss flights to The Gambia • Air Bird ceases operations
January 2015	• WHO reports fewer than 100 new confirmed cases in the three most effected countries (first time since week ending 29 June 2014)
March 2015	• Decrease of -50.45% for Jan-Mar 2015 compared to Jan-Mar 2014; with tourist arrivals of 24,814 in 2015 compared to 50,081 in 2014
May 2015	• Liberia officially declared Ebola-free, after 42 days without any cases; however new cases reported in late June and early July
Summer 2015	• Rate freeze by hotels for 2015/2016; other financial incentives no longer on offer • More flights added for upcoming high season commencing in October 2015 • Sales/marketing activities by the destination increases with press trips and planned e-marketing campaigns with key tour operators • IMF reports that in addition to Ebola, delayed summer rains in 2014 led to a 15% decline of crops serious implications for food security • 100% effective Ebola-jab in preliminary trials in West Africa • Sierra Leone's last Ebola patient ends treatment in mid-August; now it has to wait for 42 days to be declared Ebola-free. However, new case was reported on September 1 • Only Guinea continues to report a few weekly cases of Ebola
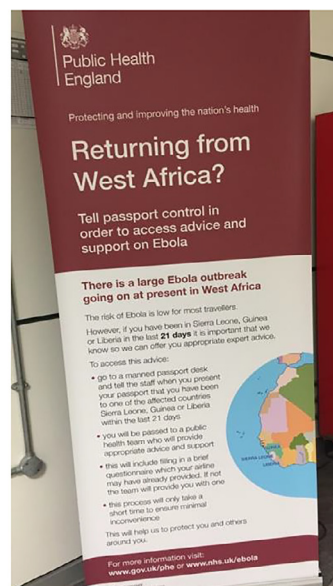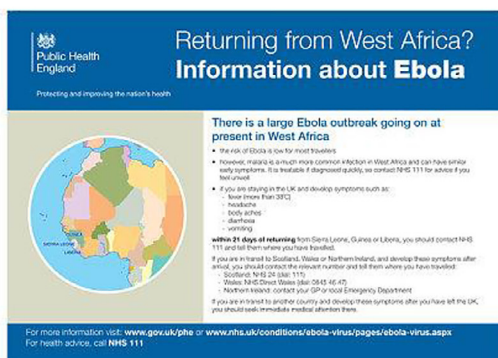
Fig. 3. Public Heath England – Ebola Information at UK Airports and other Ports of Entry (Source: Novelli's personal collection October 2015).

and outside Africa, misconceptions of risk during the epidemic led to unsuitable priorities and policies being set by governments. Africa became stigmatised as a continent, which was perceived as a potential source of infection leading to a reduction in willing volunteers offering help (Rübsamen et al., 2015). The response by national authorities to control the spread of Ebola varied considerably. In April 2014, all flights to and from The Gambia to the three affected countries plus Nigeria were suspended. Most charter carriers halted their service to The Gambia and Brussels Airlines remained the only link from Europe throughout the crisis (Telegraph, 2014). In the UK, entry information stations (Fig. 3) and screening for passengers travelling by air and train in were introduced in November 2014 (BBC, 2014) and continued until early 2016.

The UNDP (2015) estimated that as a result of Ebola, West Africa could lose US$3.6 billion per year between 2014 and 2017 due to decreased trade, closed borders, cancelled flights, reduced foreign direct investment and tourism. In fact, while the Ebola outbreak exacerbated an already vulnerable situation in The Gambia, it also spread fear, the repercussions which were widely felt in the tourism sector across the African continent (Duckstein, 2014; Paris, 2014).

Methodology

Drawing upon evidence emerging from a longitudinal cohort study conducted in The Gambia over 21 months – between November 2014 and July 2016, this paper reports on fieldwork undertaken in informal settings using a Rapid Situation Analysis (RSA) as the research methodology. The RSA is "a hybrid, participatory, bottom-up [qualitative and interpretative] research approach" (Koutra, 2010, pp.1016). Typically, the analysis of those on the ground allows for a more in-depth and defined understanding of the crisis and opportunities in relation to destination recovery and tourism development. RSA interprets and consolidates the feedback from local participants which, when shared back with the community, allows for reflection, ownership and transformation (Koutra, 2010). As a result, the trustworthiness, representation and reliability of the research increased; as data is reviewed through probing questions with those providing the information. The RSA consisted of five stages:

- Desk research (i.e. government statements, GTB and tourism providers' website, press releases)
- Retrospective analysis of field diary entries
- Semi-structured interviews with identified research partners in The Gambia and UK
- Overt participant observations during public and private sector workshops and meetings
- Feedback through probing informal discussion and study refinement

The intention was to use this participatory research method to explore perceptions and practices of tourism stakeholders, and co-create knowledge and understanding with the research partners based in The Gambia and the UK. This was then consolidated through feedback received during the meeting held in the last stage of the field research (July 2016). It was deemed important to include stakeholders with differing levels of influence and interest, and geographical spread from the capital Banjul to the peripheral areas of Kartong.

Fieldwork in The Gambia commenced in November 2014 (the beginning of the high-season), and in December 2014 and December 2015 (the peak of the high-season). The research continued in the UK between May and August 2015, with follow up fieldwork occurring twelve months later in July 2016 to further assess the post-EITC situation. While field diary entries and participant observation records served as framing evidence of the EITC during the period under investigation; nineteen in-depth semi-structured interviews (see Table 3) allowed respondents to provide insights into their experience with the EITC. This facilitated data triangulation with field diary entries and participant's observational findings.

This study focuses on research questions that contribute to understanding how and why things happened, rather than testing a hypothesis with theory derived from generated data (Hart, 1998; Robson, 2011). As the aim of this study is to understand how people construct reality as they engage with their world (Ritchie, Burns, Palmer, & NetLibrary (Eds), 2005; Robson, 2011); the social interpretation of recovery and repositioning of The Gambia following the crisis lends itself to a holistic inductive RSA approach, focusing on the entirety of destination recovery, as a series of complex inter-related pieces, rather than assessing individual parts (Armstrong, 2008).

Identified research partners were approached by email for a phone, Skype or Facetime interview with twenty questions grouped according to Ritchie's framework (Fig. 1), which would drive the conversations and provide insight into their experiences (England, 1994). Open conversation was encouraged to establish rapport, which proved invaluable when analyzing and contextualizing the

Table 3
Study Research Partners.

Type of Stakeholder	Code	Number Interviewed
Government Officials	Gov1-Gov5	5
International Consultants	IC1	1
International Development Organizations	IDO1	1
Local Sector Associations	LSA1, LSA2	2
Tourism/Retail Providers	TRP1-TRP8	8
PR agencies	PR1, PR2	2
Total		19

interview transcripts, in conjunction with retrospective diary entries and field notes. The interviews lasted between one to two hours and were conducted in English, largely in the research partner's working environment (in The Gambia) and by Skype/Facetime (from the UK). They were audio recorded, transcribed and analysed using qualitative content analysis to "identify core consistencies and meanings" which structured the analysis themes (Patton, 2002, p. 453). In order to maintain anonymity, research partners were coded as indicated in Table 3. Photographic evidences supplemented the interviews.

Research findings

The key events occurring since the outbreak of Ebola (Table 2) have had a significant impact on The Gambian tourism sector. The analysis of the findings emerging from the RSA are discussed using the three thematic areas in line with Ritchie's (2004) CDMF stages: Crisis/Disaster Prevention and Planning; Strategic Implementation; and Resolution, Evaluation and Feedback.

This enables reflection on the literature in relation to what occurred in The Gambia and the usefulness of the model for other developing countries.

Crisis disaster prevention and planning

There was no environmental scanning or issues analysis and although some tour operators "raised the issue in spring 2014" (Gov5), both the public and private sector did not recognise the urgency as 'no apparent proactive planning or strategy formulation' (TRP2) was in place. "Over the past 30 years, the destination has coped with several challenges…for many it was a shock…many were expecting a bumper season" (TRP1). The lack of contingency and emergency planning, risk analysis or crisis preparedness was evidenced by "the inexistence of a crisis team even at the start of the crisis" (IC1). This indicated the state of play that generally characterises many unprepared destinations (Beirman, 2003; Faulkner, 2001; Ritchie, 2004; Hystad and Keller, 2006). The increase in "the levy fee imposed in October 2014, despite the tourism crisis" (TRP1) was symptomatic of the local authorities underestimating the gravity of the EITC.

While every crisis is different, Ritchie (2004) and Henderson (2007), advocate that destinations should proactively plan and formulate strategies, in order to facilitate rapid and effective decisions making; a crucial factor during the emergency stage. The lack of preparation and proactive planning evidenced in this study, ultimately resulted in The Gambia not recognising the crisis signals sufficiently early, and delaying the recovery process (Paraskevas & Altinay, 2013).

A significant criterion for effective crisis management is being swiftly alerted to the possibility of such an occurrence, but while there was some awareness of a possible problem, the alert was raised by a few, but ignored by most (Gov5). However, the EITC was recognised as an "issue only in summer 2014 when bookings went down by 30% and £1 million in cancellations" (TRP1). This highlights the importance of having a clear two-way communication plan in place, whereby all stakeholders can be made aware of a possible crisis and, subsequently swiftly act upon such information with responsibility and authority. The over reliance on international tour operators compounded the issue of crisis identification, as they did not always share all information.

Strategic implementation

The strategic implementation phase consists of formulating and evaluating strategic options in order to mitigate and manage the crisis (Armstrong, 2008; Ritchie, 2004; Sharpley, 2005). The first step was to prevent Ebola entering the country. Gambia's Ministry of Health (MOH) initiated timely action through "Surveillance at border areas to screen nationals from affected countries entering the Gambia" (PR1). The fact that The Gambia only shares a border with Senegal that "was taking necessary precautions" (LSA2) was reassuring. To further secure the country from possible spread of the outbreak, the "banning of airline travel from Guinea, Sierra Leone, and Liberia to The Gambia in May 2014" (PR1) was noted as a positive preventive measure.

With the imminent possibility of Ebola having a significant impact on the country, a National Task force comprising members from the United Nations (UN), MOH, MOTC, Ministry of Defence (MOD), non-governmental organisations (NGOs), and other stakeholders was set up to address the crisis. "Weekly updates on the status of the epidemic in affected countries by the Ministry of Health and Social Welfare through the support of the WHO" (Gov1) provided information about external events.

The tourism containment and recovery efforts of the taskforce were spearheaded by the MOTC. The scale of the unfolding EITC was evidenced by the termination of Thomas Cook's entire Scandinavian programme and a 50% reduction of flights from UK and the Netherlands. Local tourism stakeholders (specifically hotels) started engaging in cost-cutting strategies to reduce the impact of the crisis on their businesses (Gov1). For example, a hotelier shared that he had cancelled hiring an operations manager and all seasonal staff had been placed on rotation (TRP2). The crisis was having an impact on the wider supply chain, with new hotel constructions being delayed or cancelled. Cost cuts included delaying investments in improvements and "working with suppliers to manage costs" (Gov5).

Alongside strategy formulation, evaluation and control, there is a need to manage and control communication. Addressing tourist perceptions of the destination's real and alleged risk is crucial in a crisis, which is partly achieved through communication and media management (Armstrong, 2008; Beirman, 1998; Fuchs & Reichel, 2011; Glaesser, 2006; Henderson, 2007; Kozak et al., 2007; Sönmez & Graefe, 1998). This has been found to be particularly challenging in an African context (Ketter & Avraham, 2010; Avraham & Ketter, 2016). For The Gambia, it was a "very tricky situation as the whole of Africa was being put into the Ebola basket, impacting all destinations" (PR1). An immediate priority was "to try to counter the negative media coverage on the Ebola (outbreak)" (IDO1). There were many issues that the crisis communication strategy needed to consider. The GTB did not want its members "to become

spokespersons on the Ebola outbreak and didn't want to start linking The Gambia and Ebola when they [were] not actually linked" (Gov2). The fact that the destination was Ebola free created an additional dilemma in regards to communication (PR1).

This conundrum of whether and how to counter the incorrect portrayal of the threat of Ebola was not limited to the media but also to the travel trade. The crisis communication literature advocates a proactive approach to countering sensationalist media (Ritchie, 2004; Hystad and Keller, 2006; Glaesser, 2006; Henderson, 2007) and was endorsed by this comment: "The first thing in such a crisis is to communicate the right message in a convincing way" (IDO1). However, the GTB strategy did not address, disassociating the destination with the epidemic, but rather promoted a "business as usual" message. To this end, "the GTB distributed video clips that showed day to day normal life in The Gambia" (PR1); "sent [government] health updates to tour operators and travel media every few weeks" (Gov4); and "convened a press conference at World Travel Market 2015 in London and released a series of news-based interviews resulting in the CNN broadcasting The Gambia as 'open for business'" (PR1). Collaborations amongst the Economic Community of West African States (ECOWAS) members resulted in the launch of UNITEDWESTAFRICA (PR1); promoting the region with a unified voice to counteract the stereotypical sensationalist, and hysterical narrative about West Africa perpetrated by the global press, which has been widely acknowledged as an issue (Avraham & Ketter, 2016).

Resource management and (re)allocation was focused on stopping a wave of cancellations by tourists, created by a lack of confidence in the destination by tour operators, who were concerned that they would be unable to fill their charter planes. There was a need to continue to attract tourists to the destination. Thus incentives to travel were created by "hotels discounting their rates by 20% and airlines providing subsidised seats". Fiscal support was also introduced as "payments due to Government and GTB were deferred to help ease pressure on local businesses involved in tourism" (Gov5). A "reduction in landing charges was agreed by the Government and central funds were also made available to support GTB and TMC, to increase joint marketing support with tour operators from various source markets and raise further awareness of The Gambia as Ebola free" (PR1).

Within Ritchie's framework, a multi-level collaboration is advocated between internal and external stakeholders. Although good collaboration emerged "once everyone agreed there was a crisis, this took a while" (Gov4). Reflecting the idea that a centralised leadership by an established authority would be beneficial (Henderson, 2007), there was an expectation that the GTB would take the lead in emergency planning (RPP10). However, the disconnect between private and public sectors' understanding of the severity of the crisis resulted in disjointed recovery actions producing mixed results (Beirman, 2003; Ritchie, 2004).

Resolution, evaluation and feedback

Restoration of the destination to normality is the first step of the final stage of Ritchie's (2004) framework. However, various stakeholders interpreted sector recovery differently. Most respondents viewed this qualitatively and generally aspired to a return to 2013/2014 tourist arrivals, or by setting higher targets in line with the government Vision 2020's aspirational targets, viewed by some as optimistic. Promotion of the destination continued primarily with a focus on PR. The UK PR Agency team resumed its media visitation programme, intensified media liaison and increased visibility in more travel features (Gov1, Gov2, PR1); whilst "conducting several roadshows to share information about the destination" with the intention to re-instil confidence in the destination (Gov2).

Evidence emerged of a steep learning curve, and the numerous challenges posed by the crisis provided positive opportunities to seek change. "We have learned our lesson during the Ebola crisis and realised that tourism is a very fragile business. A crisis could emanate from other sources too…[and] working together rather than individually was more important than ever" (PR1). Despite the limited resources usually set aside for tourism, there is recognition of the importance of conducting risk assessments (IC1). To achieve this there is a "need to educate stakeholders on risk/reputation management" (LSA2), whilst also giving consideration to "the cultural context of the destination when looking at risk, decision-making and change" (IDO1).

As a result of this crisis, for which the destination was not at all ready, an emergency fund was created, to better prepare for future crisis. "This is based on a voluntary contribution by the sector, which may need to become a mandatory percentage based contribution" (Gov4). The development of a fund that is voluntary also raises questions about its effectiveness and commitment by sector stakeholders. The EITC exacerbated underlying vulnerabilities of the tourism sector in The Gambia, which is historically linked to fragile socio-economic conditions, industry structure and limited product. This still requires addressing, and there is clear recognition that the tourism product needed upgrading and upscaling (IC1, IDO1, LSA1), which will require time and major infrastructure investments (TRP2).

One core aspect that emerged from the EITC was the need for "regional collaboration to deal with health and other risks" (LSA1). While funds may be limited to engage in extensive and comprehensive crisis prevention and planning, one of "the real value of the crisis is when a crisis happens a second time, stakeholder may be better prepared to deal with the situation" (Gov4). Some funds may have been set aside to foster inter-country collaboration or to develop more effective communication strategies. Evidence of the latter was demonstrated during the transition of leadership between December 2016 and January 2017, where it appeared that The Gambia was able to communicate more effectively with the public, manage the political crisis, and negotiate the swift return of tour operators to full operations in just over a month.

Conclusions

Whilst most literature on African tourism crisis analyses terrorism, political instability and violence (Aziz, 1995; Fletcher & Morakabati, 2008; Pizam & Smith, 2000), this study contributes to the limited knowledge on health and epidemic related crises. The longitudinal study, using RSA, enables a holistic examination of the planning, response and resolution phases of Richie's (2004)

framework. Reflecting on the experience of The Gambia's response to the effect of the EITC provides lessons for other destinations encountering similar situations, especially in developing countries.

Heath related crises could influence tourist risk perception, resulting in a sudden decrease in tourism demand, with significant socio-economic repercussions, especially in tourism dependant countries. This paper also demonstrates that such events can occur in destinations not directly affected by an epidemic, with very severe consequences (Beirman, 2003; de Sausmarez, 2004; Mansfield and Pizam, 2006) exacerbating an already fragile situation, a problem found in many developing countries. It might be some time before The Gambia is able to make these vital changes to reduce its vulnerability to future crises.

The Gambia did not have a tourism crisis management plan in place or method of alerting it to possible crises, such as the EITC. It had to formulate a containment and recovery strategy as the situation unfolded. At the start of the crisis, The Gambia's Ministry of Health implemented a series of initiatives to prevent Ebola from entering the country. Such measures, not only protect the local population, but help safeguard the destination's perceived safety, an important consideration for tourists in their decision making (Lepp & Gibson, 2003; Sönmez & Graefe, 1998; Taylor & Toohey, 2007). Thus, the issue of perception, destination image and communication, had to be carefully considered in The Gambia's overall recovery strategy, especially when confronting images of Ebola being portrayed in the world media. The generalizability effect meant that the broader region, or even the whole continent, was negatively tarnished.

Ritchie's (2004) CDMF provided a valuable framework to evaluate each phase of the EITC and to understand what occurred over the three main phases of the crisis. The benefits are the adaptability of the framework to reflect the specifics of each destination and crisis. This is especially important when considering the different issues faced by tourism stakeholders in developing countries, with related changes of emphasis to the framework suggested below.

The study supports the proposition that tourism destinations' crisis and disaster preparation and planning are essential. In the specific case of The Gambia, the destination would have benefited from a comprehensive risk assessment to identify any substantial hazards associated with the Ebola outbreak. The GTB was the organisation responsible to take the lead in emergency planning, but did not have the resources or competency to do so. This was symptomatic of limited funds for risk assessment or crisis planning and, indeed, lack of awareness about the potential impacts of the epidemic led to ignoring the concerns voiced by some sector's stakeholders.

Crises may be located in neighbouring countries, over which the host destination has limited influence and no direct control. A regional and cross boarder approach to tourism crisis planning may be beneficial to help prevent spill over effects from future crises, and to improve the capabilities of governments and the tourism sector to respond in a coherent and co-ordinated manner to any crises. Collaboration is outlined as vital in Ritchie's (2004) CDMF for developing countries with limited resources and knowledge. This is especially important in both preparing for crises and managing their effects, an area that may require specific international donor agencies' support for technology and knowledge capacity building. In this case, the private sector took a key leadership role in altering and managing the crisis. Whereas in developed countries, tourism crisis management is often led by the government, thus suggesting the CDMF could be altered for developing countries, to ensure relevancy, engagement and commitment, crisis plans should also be prepared involving multiple stakeholders within a country. A well-structured plan and task force committee can assist in earlier detection, which generally results in better response and faster recovery. Once completed, the crisis plan should be reviewed regularly, with training provided to key stakeholders.

In order to enable the sector to respond quickly and effectively in any future crisis, processes and financial resources need to be in place. In this instance, the establishment of an emergency fund, to be administered by the MOTC, to lead recovery efforts is a possible way forward, a solution not considered by Ritchie (2004). However, the source and collection of such funds in The Gambia was yet to be finalised at the time the research was conducted. Given the high taxation, business operational costs, limited resources available and dependency on donors' funding, any further contribution by the private sector would need to be carefully considered, as this may possibly reduce their competitiveness.

It is recommended that destinations should communicate promptly and openly about any crisis, and should ensure that accurate and regular information is disseminated. Although the GTB opted not to be openly vocal about Ebola, respondents felt that acknowledging concerns would have improved confidence to potential visitors during the crisis. Cost-effective communication tools, such as the internet and social media should have been effectively used to inform interested parties about the crises. The option of switching and developing other source markets, presented in Richie's (2004) framework, proved to be not viable for The Gambia, given the limited nature of the product on offer.

Based on our findings, future research avenues can be identified. Firstly, this study suggests that a crisis affects investment and may cause further economic problems for tourism, especially in developing countries where capital may be scarce. Past research on tourism crisis management has not explored the impact of crises on investment choices and future research should examine this. Secondly, the communication message of 'open for business' may not be appropriate if the crisis is continuing in neighbouring countries (Walters & Mair, 2013) and the credibility of such a message would need to be assessed alongside the development of possible ad hoc strategies. Finally, although lessons appear to have emerged from the EITC, there has not been any formal recording or sharing of the knowledge to date. Hence, further research is required on lessons learnt and more broadly issue of fragile destinations' resilience at times of crisis.

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