Picture: S Carter 2019

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HEALTH-SEEKING BRIEFING

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Photo: Reuters

HEALTH-SEEKING

Context:

This briefing outlines the operational recommendations related to healthcare seeking for communities living in Ugandan border districts during the Ebola Virus Disease (EVD) epidemics and the current COVID-19 pandemic, with lessons for future infectious disease outbreaks.

Data Collection:

This document draws from research on building trust in epidemic response in the Uganda-DRC border region. Data were collected from 231 participants in Uganda's western border region, including Hoima, Kasese, and Kisoro districts in May 2021. This brief is based on a thematic analysis of power mapping workshops, in-depth interviews, focus group discussions, participant observation and field experience.

Identified Barriers:

Barrier 1: Low risk perception

"We have said that COVID-19 is not as dangerous as the government portrays it. Government's rigid policies are more disastrous and dangerous than COVID-19 itself. Its rigid emergency policies will lead to the death of many than the COVID-19 we are preventing." – Focus Group Discussion, Kasese District

At the time of research, COVID-19 was largely perceived as a disease in Kampala (the capital city) rather than in the border areas, despite the large amount of cross-border movement.

Rather, lockdown measures including border closures have had a deep and negative socioeconomic effect on vulnerable populations in border communities, and therefore there was some mistrust in the government's epidemic response. The response was perceived to be political by vulnerable groups including as a cover for political priorities, repression in opposition areas, and police-military enforcement and at worst, violation of rights under the mandate to "enforce COVID-19 rules."

****This document draws from research on building trust in epidemic response in the Uganda-DRC border region, focusing on experiences with Ebola (DRC epidemic) and COVID-19. Data were collected from 231 participants in Uganda's western border region, including Hoima, Kasese, and Kisoro districts in May 2021 primarily with Banyoro, Bakhonzo, and Bafumbira ethnic groups. Many recommendations apply to the current outbreak (20th September 2022, Ebola – Sudan strain), though we did not conduct research with the Baganda.****

This perceived politicization of the response generally affected communities' perception of COVID-19 in general. This perception, combined with the low number of cases in the border communities drove low perceptions of risk. Similar narratives persisted during Ebola, whereby Ebola was seen as a problem of Congolese neighbors, rather than on the Ugandan side.

However, in Hoima District, there was higher risk perception and broad support for government epidemic response measures and containment efforts.

Individuals seek care based on the perceived severity of symptoms, perceived benefit of medical care (versus seeking care from a pharmacy), and access (cost, distance to the clinic).

Recommendations:

· Dissociate the leadership of response from symbols of government enforcement groups like police and military personnel. The leaders of task forces at the lower levels such as at districts need not be from the uniformed forces.

· IEC for risk communication should encompass some information on the existence of symptoms, presence of patients within the area. That will reduce the perception that the disease is restricted to urban areas or Kampala capital city.

Barrier 2: Perceptions of government health workers and quality of care

"A government hospital is there but if you go to the hospital and you don't have money you will die, the treatment in Boma is not good at all, there are no drugs; you take your patient there treatment you have to buy the drugs, if you don't have money and you go to the hospital thinking that your patient will be treated for free that is completely not there in Boma." – Focus Group Discussion, Hoima District.

Our data suggest that community perception and usage of government healthcare services and low trust in those services shape health seeking behavior. Government health facilities at the community level (Health Centre I, II) were seen as offering limited care. Providers were often unavailable or perceived to be uninterested. There were long waiting times at these facilities except for individuals who are able to pay a small amount to a health worker for faster service. Instead, participants preferred private health facilities where you can go, pay, and quickly receive services and medication. Government health facilities often faced medication shortages and so any treatment would include a referral to purchase medication from a pharmacy. Government health workers are unpaid, paid late, or underpaid, and so this affects morale in the workplace.

Photo: WHO 2020

Participants preferred to go straight to a pharmacy, or to a private provider first, rather than “wasting time” at a government health facility. Further, government facilities were perceived to be selling donated medications across the border in DRC and this was perceived to be one reason for the medication stockouts, further compounding the lack of trust in government health providers.

Communication was also seen as a barrier, whereby government health workers were sometimes from other areas and so were not fluent in the local language.

Trusted sources of care include:

- Private health facilities and doctors, except in Kaiso landing site where private care was seen as insufficiently regulated and low quality. Private not-for profit facilities were seen as the best sources of care as they do not charge excessive fees for services

- Traditional healers and herbalists, especially for managing chronic diseases like diabetes, high blood pressure in rural areas

- Spiritual healers for mental health or ancestral issues

- Village Health Teams (VHTs) and workers who provide community-based information and care, although they were seen as needing additional training

It is not that government health workers are always mistrusted, per se, but rather they are not preferred sources of care, and so these differences need to be teased apart.

Indigenous communities (Batwa) are discriminated by health workers and so they prefer to use traditional herbal medicine over biomedical sources of care

Men tend to make decisions about where/when and who can go to the hospital to seek care

Photo: UNICEF/UNI342765/Wenga

Operational Recommendations:

COVID-19 programmatic recommendations based on this analysis

Across the barriers mentioned above is the importance of context-adapted strategies that are sustainable and engage with trusted community members, to reinforce COVID-19 risk communication messaging, encourage COVID-19 vaccination, and link suspected cases to testing and quarantine as appropriate. During the previous Ebola response, negative and fear-based messaging has increased stigma and discrimination of Congolese populations across the border. Among border communities with very close social and trade ties to DRC, Ebola rumors also spread and contributed to misunderstandings of Ebola etiology and survival. Communication on the severity of COVID-19 should be clear, including how to manage cases from home when appropriate. Messaging should not focus on stopping livelihood seeking, but rather, on positive actions like how to cross safely to DRC and how to interact safely with others (e.g., physical distancing and mask wearing).

Risk Communication

- Continue to explore and utilize other sources of information identified by the community in addition to the current, conventional avenues that are sometimes perceived to be inaccessible. For example, beyond radio and posters, explore if current trusted sources of information like VHTs, traditional healers can be engaged and equipped with the appropriate/right information and facilitated to increase their reach.

Community Engagement

- Engage with diverse and trusted actors, including private health workers, pharmacy staff, and traditional healers, who may be trusted sources of information or sources of referrals for COVID-19 testing within the government health system.

- Target CE activities toward highly vulnerable groups, including fishing communities, long-distance truck drivers, boda boda drivers, female sex workers, and indigenous Batwa.

- Engage local women's, youth, and trade's organisations and local leaders to ensure response activities have local buy-in and that messaging and behaviour change is promoted through their networks.

The brief was developed in response to a request from the Centre for Disease Control and Prevention (CDC) and UNICEF. It aims to provide actionable recommendations based on a realistic analysis of the available, local resources. It is one of a series of briefs focusing on Ebola preparedness efforts between DRC and Uganda. We would like to acknowledge the contributions made by research staff at Makerere University, research staff at Conservation Through Public Health, Alex Bowmer, Hannah Brindle & Shelley Lees at LSHTM and Christine Fricke at TWB.

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