

How can Communities be Empowered to Steer Sustained Compliance to COVID-19 Guidelines? A Guide to Action

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Introduction

Following the outbreak of the novel Corona Virus disease (COVID-19) which was declared a global pandemic by WHO in early 2020, the government of Uganda announced a set of preventive and mitigation measures to curb the spread of the pandemic. Despite the announcement, promotion and enforcement of these measures, there have been variations in compliance levels from the general public. Due to contextual factors, compliance levels also tend to vary among particular vulnerable populations such as refugees.

This policy brief is based on the results of a study conducted among refugee populations in three Uganda sites in Uganda between August to November 2020. The key message of this policy brief is:

As government retreats from the day-to-day enforcement of compliance with COVID-19 measures and leaves this responsibility to individuals and communities, **there is need to empower individuals and communities** to effectively play this role if sustained compliance to COVID-19 SOPs is to be realised.

Background

President Yoweri Museveni and the Ministry of Health (MoH) announced a number of containment measures in response to the COVID-19 pandemic in mid-March 2020, and soon after on March 21st, Uganda identified its first confirmed case of COVID-19. The measures announced included among others: regular handwashing using water and soap or using alcohol-based hand sanitizers; avoiding crowded places and keeping a social distance of at least 2 metres; not shaking hands or hugging; not coughing or sneezing in public; not touching the eyes, mouth and nose with unwashed hands; and wearing of face masks when in public spaces.

Subsequently, stricter measures were introduced including lockdown measures that included movement restrictions, night curfew, and closure of schools, business premises, places of worship, public transport, closure of borders, and suspension of all gatherings. Those suspected to have been exposed to Corona Virus were put under quarantine, and their contacts either quarantined or advised to self-isolate. In addition, a vibrant communication strategy was implemented to create awareness and promote behaviour change to embrace the above outlined measures.



Community leaders being sensitised on Covid-19 prevention

Key Findings

1. **High Knowledge, Low Compliance:** There was a sharp divergence between the high levels of knowledge of COVID-19 prevention measures and compliance with recommended measures and guidelines.
2. **Sociocultural Norms:** Socio-cultural norms significantly impact behaviour; while some local lifestyles and norms changed, others remained the same and posed major risks for infection. These include visiting and/or hosting, meeting for prayers, child naming, traditional marriages, rites of passage for girls, funerals, and cross-border movements especially among in Adjumani. Some social norms played a positive role; for example, Somali women reported easy adaptation to wearing face-masks because they are used to covering their heads and faces, a mandated Muslim practice. In this case, pre-existing social norms seemed to favour desired behavioral change for COVID-19 prevention.
3. **Improper mask use:** Mask wearing was found to be inappropriate, inconsistent and some risk behaviour was also reported like sharing masks and wearing them only to pass police checks or to enter premises where they were mandatory.

Overall, there were declining levels of compliance amidst a heightening epidemic, signalling increased risk of exposure to infection for many people.

Explanatory Factors for Non-Compliance

- **Livelihoods & Food Security:** The need to look for a living and food to eat and was the most common reason for non-compliance with lockdown and other guidelines
- **Feasibility:** Some measures like distancing are dictated by structural factors and not feasible in refugee contexts which are very crowded
- **“Survivor” Mentality:** Compliance was low because refugees reported they had gone through tougher harder situations than COVID-19.

Refugees and COVID-19

While everyone living in Ugandan has been directly or indirectly affected by COVID-19 and responded in various ways, we throw the spotlight on the response of refugee persons, given their unique vulnerabilities as people in a foreign country with limited social networks and livelihood sources. The REFLECT study was conducted to assess the lived experiences and compliance of refugee persons to COVID-19 guidelines in urban and rural settings of Uganda. We established the extent to which refugee communities are aware of COVID-19 prevention measures and their compliance levels. We also made comparisons between urban and rural refugee settings.

How the Study was Conducted

This study was conducted in 3 refugee hosting communities and settlements in Uganda, namely, Kisenyi in Kampala, with predominantly refugees of Somali origin; Kyaka II, a rural refugee settlement in Kyegegwa district, Western Uganda; and 11 settlements in Adjumani district, West Nile with predominantly South Sudanese. The study was cross-sectional, and mixed method with both quantitative and qualitative approaches. For its qualitative arm, data was collected from a total of 1,014 participants - 115 key informants and 34 focus group discussions with various categories of population groups and stakeholders.

- Infodemics, myths and superstition
- **Facility-based Management of COVID-19** cases, leading to limited or no interface and fuelling the myth that COVID is not real.

Lived Experiences

- **A Top-down Approach, Multiple & High-handed Enforcers:** Whereas implementation and enforcement of COVID-19 containment measures included multiple actors it has been largely top-down, depending heavily on high-handed and sometimes violent enforcement by police and local defence units (LDUs) – especially at the start, while it marginalized grassroots participation.
- **Harassment and Extortion** by law enforcers, reported especially in the urban Kisenyi.
 - Followed by **enforcement fatigue**. By the time of the study, little was being done in terms of enforcing compliance, except at institutional premises such as health facilities and public offices where hand-washing and wearing of face masks were still a requirement.
- **High Potential for Community-Led Implementation and Enforcement:** Community structures supported awareness and innovated positive coping mechanisms e.g. managing access to water points under supervision of the Water Use Committees (WUC), installing handwashing facilities at the household level.

- Other community-resources and systems have been used, and can be better leveraged, include grassroots structures e.g. local leaders in refugees and host populations, community agents such as VHTs and LDUs, religious and cultural leaders, social services, and existing community norms and values.
- There is also a level of social capital in form of associations, such as that found among the Somali community in Kisenyi, that has been instrumental during the COVID-19 period, translating information into their local language and distributing relief items and PPE.

These various resources provide an opportunity to reverse the current top-down response to COVID-19 and leverage them to deploy a more participatory and community-based response to the epidemic. However, the resources in form of human resources need information, training and supervision to effectively support their communities.

- **Sectoral Support from Public, Private and Civil Society:** NGOs and international agencies have supported the response by distributing soap, handwashing facilities, face masks and other relief items. In Kisenyi, the National Water and Sewerage Corporation installed public hand-washing points.

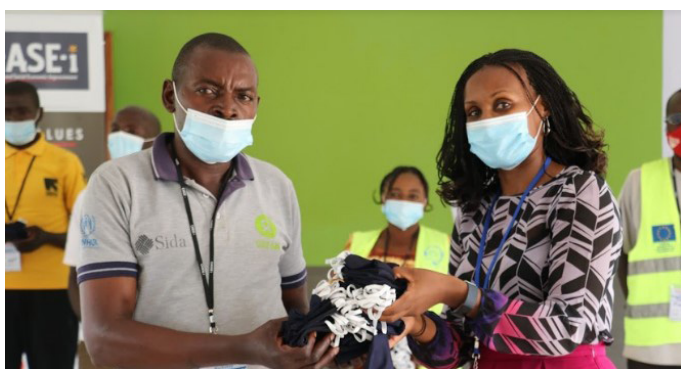
Considering declining compliance levels, increasing community transmission and a constrained health system, a top-down approach to implementation and enforcement of COVID-19 measures is no longer the most feasible or effective. However, **there is room for a more community-driven approach and individual responsibility.**



Activating Uganda's Community Engagement Strategy / CES (2020) with community leaders in Kyaka II Refugee Settlement, Kyegegwa District

Implications for Policy and Practice

- The inappropriate use of face masks reported is both a marker of high risk of exposure to Corona virus but at the same time an indicator of low risk-perception and lack of individual responsibility for self-protection. This means that recommended practices have not been fully adopted to become a 'new normal', and probably only a change in norms would make this possible.
- The evidence shows that behavioral change measures may be more feasible if they resonate with pre-existing sociocultural norms, as exemplified by the case of Somali women who found the use of face masks easy and acceptable as it aligned with Muslim female dress-code of covering their heads and faces.
- In addition, enforcement led by police and other law enforcers has limitations, e.g. enforcing hand-washing inside households or out of hours.
- The finding that compliance with certain measures such as social distancing is constrained by structural factors such as the congested nature of refugee settlements means that the local communities are better placed to find ways around this constraint or to devise alternative means of self-protection.



Availing community leaders with behavioral change products (face masks)

Recommendations

Government and other actors should:

1. Leverage the agency of local leaders: - LCs, religious, cultural leaders and local structures such as Refugee Welfare Committees (RWCs), Water User Committees (WUCs), Village Health Teams (VHTs) and the recently launched COVID-19 Village Health Task Forces to increase local acceptance of the COVID-19 preventive measures. Train and equip them in basic COVID-19 prevention and mitigation, and in their roles.
2. Revitalize behaviour change communication to refugee communities, with emphasis on taking individual responsibility to prevent the spread of COVID-19 and mitigate its effects. This calls for reversing the current top-down response to COVID-19 and building on the community's own vigilance to promote a more participatory and community-based response to the pandemic.
3. Support refugee communities with regular supplies of basic items such as food, face masks, hand-washing containers, soap and hand sanitizers.
4. Avail, support and allow for livelihood interventions for refugee and other vulnerable communities.
5. Leverage the recently launched Community Engagement Strategy (2020) to involve communities more in the response to COVID-19.

The leaders of Refugee & local communities should:

- Facilitate and undertake a process to agree on new norms to re-align people's behaviors in ways that minimize the risk of COVID-19 transmission
- Promote community and individual responsibility to prevent the spread of COVID-19 and mitigate its effect.

About the Study

The REFLECT study was conducted by researchers from Makerere University in collaboration with Gulu University, ACORD Uganda, Lutheran World Federation (LWF), the National Association of Social Workers of Uganda (NASWU) and the Ministry of Health.

Study Partners



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