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Centre for Health and Social Economic Improvement

POLICY BRIEF

Compliance to COVID-19 Guidelines in Uganda: Insights from a Multi-site Study in 13 Refugee Settlements

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INTRODUCTION

Since confirmation its first COVID-19 case on March 21 2020, Uganda's confirmed cases have risen to 37,808 to date [1,2]. The government instituted several preventive measures to counter the spread of the novel Corona Virus including; a lockdown restricting movement within and at border points; and several public health measures such as handwashing, sanitising, face masking, physical distancing and mandatory quarantine of suspected cases or people with recent travel history [2].

South Sudanese refugees practice social distancing as they wait to access a food distribution. © UNHCR/Samuel Otieno

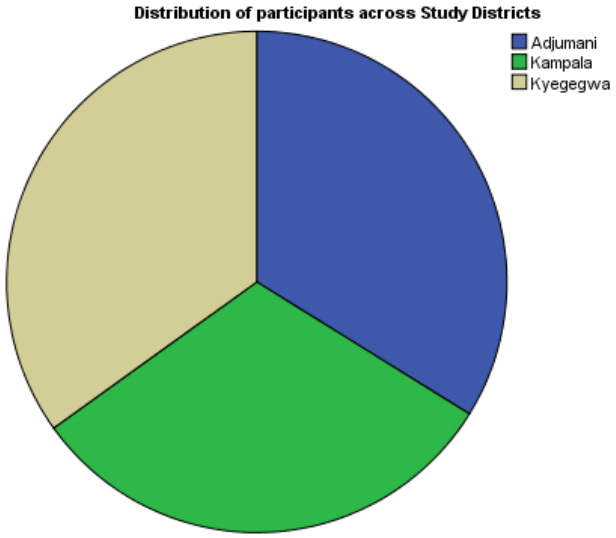
Due to public outcry and the socioeconomic impact of the lockdown, most of the restrictive measures were lifted successively. However, this has been followed by a surge in COVID-19 cases, community infections and mortalities. Current evidence shows extreme levels of non-compliance to COVID-19 preventive measures across all communities in Uganda, with even more disturbing behaviours and drastically reduced compliance being observed in crowded contexts like slums and refugee settlements.

This brief presents some highlights from the quantitative arm of a multi-site study to provide actionable recommendations for improving compliance and policy inclusivity in the era of COVID-19.

The REFugee Lived Experiences, Compliance and Thinking (REFLECT) in COVID -19 study was undertaken in 13 refugee settings where compliance to some guidelines like physical distancing, sanitizing or isolation are naturally not feasible. Comparatively, refugee communities face multiple challenges including food insecurity, violence, language barriers, and limited access to basic services. Moreover, COVID-19 was initially thought of as a "foreign" disease and Uganda's borders remain porous with refugees having families on either side – leading to increased risk and stigma towards the refugee community. The overall study aim was to assess awareness, lived experiences and behaviour including compliance to COVID-19 guidelines.

METHODS

The study was cross-sectional and used mixed methods where both quantitative and qualitative data was collected simultaneously. Overall, the study enrolled 2,092 participants - 319 qualitative and 1,773 quantitative including; (1,014) households, (370) healthcare workers and 389 children across 13 refugee settlements in the Central, West Nile and South Western regions of Uganda. Data were collected between September – November 2020. Data was analyzed quantitatively using T-test, Analysis of Variance (ANOVA) and Multivariable Linear Regression. Statistical significance was assumed at $p<0.05$.



STUDY RESULTS

Knowledge of COVID-19 & Risk Perception among Refugees

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

- Refugees are generally knowledgeable about COVID-19, although up to 40% exhibit knowledge gaps in specific areas including signs, causes, risk/protective factors and treatment.
- Additionally, between 25-70% of refugees adopt risky behaviour likely to lead to transmission of COVID-19. These include low use of sanitizers and disinfectants; extremely low adherence to social distancing, handshaking, hugging and other physical contact, uncovered sneezing/coughing, rare and improper use of facemasks; poor practice of immune boosting activities such as exercise and proper nutrition.
- Key variations exist in knowledge and compliance behaviours across different sociodemographic characteristics

Gender

Men are more knowledgeable than women and children; but women more compliant than men.

Male HCWs with degrees exhibited more knowledge than female peers and diploma/certificate holders respectively.

Age

Younger refugees (not children) are more knowledgeable than the elderly.

Children ages 7-17 are not fully knowledgeable on causes, transmission, risk factors & management of COVID-19.

Technical Skill

90% of lower cadre healthcare workers had low knowledge on COVID-19 case management compared to medical officers and consultants.

Geography

Rural refugees are more prone to COVID-19 related risk behaviors compared to urban based refugees.

Religion

Muslims are more knowledgeable about COVID-19 and compliant than the Christian faiths.

Social Economic Status (SES)

The low educated (70%), low income earners (66%) and unemployed (70%) more likely to adopt risky behaviors.

Adherence to COVID-19 Guidelines in Refugee Communities

The study found a serious disconnect between the high knowledge levels and compliance with the recommended COVID-19 preventive measures. Compliance levels have drastically declined, which is also depicted by the increasing number of COVID-19 cases and deaths at the community level – although many remain unreported in light of the constrained health system capacity.

- 55% of refugees were properly and consistently wearing facemasks; 40% adhere to social distancing; 80% reported staying home; 63% were fully complying with handwashing guidelines.
- Inappropriate use of facemasks (45%) was found in some of the study sites – including sharing of masks, "chin" masking, inconsistent wearing and quasi-compliance where community wore masks only when meeting leaders or enforcers.
- On trends, enforcement of guidelines was also found to be on the decline, although the declining trend was not as steep as the observed non-compliance.
- Food insecurity, livelihoods, culture and social norms are the major barriers to non-compliance.
- Non-compliance among leaders have greatly contributed to a declining trend in compliance among the led; and also contributed to the growing perception (35% of participants) that COVID-19 is not real.
- Refugee connections with the diaspora and social media also significantly contributed to non-adherence

WHAT DOES THE EVIDENCE SAY?

With up to 40% existing knowledge gap, drastically declining compliance to guidelines and increased community transmissions, innovative interventions are required. Health is created through the interplay of biology and social determinants interactions. Robust social and behavior change communication programs (SBCC) should be adopted to positively influence these social dimensions of health and wellbeing. Evidence-based communication programs can increase knowledge, shift attitudes, cultural norms and produce change in a wide variety of behaviours.

Exclusion of refugees is believed to be the key explanatory factor for why they are among the most vulnerable to the COVID-19 pandemic [3]. In order to ensure refugees inclusivity, involvement, access to accurate and relevant information in appropriate languages, government and other stakeholders should ensure COVID-19 messages are translated to refugee languages [4]. This will in turn lead to full participation of refugees in national preparedness plans, prevention and response measures to the COVID-19 pandemic. Only an all-inclusive approach [5,4] to public health with meaningful community involvement and socio-economic response will suppress the virus, restart the economy and keep Uganda on track to attain its global (e.g. SDG) and national targets.

CONCLUSION AND KEY RECOMMENDATION

Our findings are indicative of high risk for transmission in crowded settings like slums and refugee settlements. Government and all stakeholders should focus on addressing the drivers of non-compliance and enforcement fatigue in all refugee and host populations.

LONG-TERM POLICY RECOMMENDATIONS

1. To address the drivers of noncompliance, the following actions will be critical:
    - Reviewing the feasibility of interventions: Guidelines like physical distancing are not feasible in crowded refugee settings and need to be revisited. For crowded settings emphasis needs to be put on some guidelines and not others, for example handwashing and consistently wearing fitting face masks instead of physical distancing or sanitizing.
    - Debunking myths and negative perceptions: 35% of the community has not fully bought into the seriousness of COVID-19 and think it is not only a joke but is also a political and monetary ploy advanced by politicians, some scientists, supremacists or population control enthusiasts. These myths need to be debunked and instead replaced with factual information about COVID-19.
    - More profiling of COVID-19 trends and cases should be undertaken for behavioural change impact. This is because more than 90% of study participants had not seen a single COVID case. However, stigma and other potentially related dilemmas should be carefully managed.
    - Leaders, implementers and enforcers of COVID-19 guidelines should be consistent and "walk the talk". This is especially needed now with the political campaign season where masses are gathering and politicians are not leading by example. And beyond the political season.
    - The issue of livelihoods and food security must be resolved as a key bottleneck to compliance.
    - Culture: Local leaders, cultural leaders and grassroots organisations should be recognised and engaged more in behavioural change campaigns – for instance to engage their communities identify alternative social norms for greeting or showing love and kindness without putting their lives at risk.
    - Government needs to work together with humanitarian and development organisations to devise sustainable means to access and availability of WASH services and amenities.
2. The "invisible and forgotten": Adolescents, children and the elderly should be effectively targeted with tailored COVID-19 interventions. For example, while children need awareness, products (e.g. fitting face masks), visibility, voice and protection from the effects of COVID-19 including being witnesses and victims of different forms of violence; adolescents' critical needs were heavily skewed to SRH[1] including contraception and MHM[2], MHPSS[3], relationships and protective livelihood options.
3. Key sociodemographic factors and COVID-19 risk should guide tailored impact messaging and other interventions.

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1 Sexual and Reproductive Health

2 Menstruation Hygiene Management

3 Mental Health and Psychosocial Support

4. The timeliness and critical role of the recently launched 2020 Community Engagement Strategy (CES) should be leveraged whereby:
    - The local health system capacity is strengthened to effectively take up the implementation and enforcement of SOPs for COVID-19 prevention.
    - Community health systems and other enforcement structures are equipped with knowledge, skills, supplies and adequate infrastructure.
5. The regional variations observed in COVID-19 related knowledge and practices among HCWs is likely a reflection of differences in experiences in dealing with epidemics of infectious diseases. Therefore, good practices need to be shared and adopted in less-experienced facilities, to fill knowledge gaps and standardise healthworkers/ facility practices across the country.

THE COST OF INACTION

Uganda's "open-door" policy to refugee hosting has won it international acclaim, partners, resources and several other advantages. With over 1.3 million refugees and a spot among the world's top three (3) refugee-hosting nations, the country has several lessons to share on forced migration and an effective refugee response. Moreover, initially Uganda's unparrarelled record in enduringly controlling COVID-19 with zero, and then very few, infections sealed its position as a global leader not only in refugee-hosting but also in effective pandemic management.

- With poor COVID-19 outcomes in refugee settlements, the nation's reputation and population health hangs in balance.
- Sub-optimal attention to the plight of refugees will not only exacerbate the related devastating impacts of COVID-19 within this group but it also poses greater risks and challenges to host communities.

Uganda's integration strategy in service delivery for refugee-host populations can be leveraged to address low compliance to COVID-19 guidelines and improve health outcomes and demonstrate resilience in the era of COVID-19. This call embraces the principle of 'leaving no one behind' that is promoted by the United Nations (Lancet Migration, 2020).

SOME REFERENCES

1. Olum, R., & Bongomin, F. (2020). Uganda's first 100 COVID-19 cases: trends and lessons. International Journal of Infectious Diseases, 96, 517-518.
2. Ministry of Health Uganda. (2020). MoH Uganda: COVID-19 information portal [Internet] [cited 2020 Apr 10]. Available from:
3. Truelove, S., Abrahim, O., Altare, C., Lauer, S. A., Grantz, K. H., Azman, A. S., & Spiegel, P. (2020). The potential impact of COVID-19 in refugee camps in Bangladesh and beyond: a modeling study. PLoS medicine, 17(6), e1003144.
4. Hargreaves, S., Zenner, D., Wickramage, K., Deal, A., & Hayward, S. E. (2020). Targeting COVID-19 interventions towards migrants in humanitarian settings. The Lancet. Infectious Diseases, 20(6), 645.
5. Inter-Agency Standing Committee (IASC). (2020). Interim guidance: scaling-up COVID-19 outbreak readiness and response operations in humanitarian situations, including camps and camp-like settings.
6. Mwenyango, H., & Palattiyil, G. (2019). Health needs and challenges of women and children in Uganda's refugee settlements: Conceptualising a role for social work. International Social Work, 62(6), 1535–1547.
7. Kluge, H. H. P., Jakab, Z., Bartovic, J., D'Anna, V., & Severoni, S. (2020). Refugee and migrant health in the COVID-19 response. Lancet, 6736(20), 1237–1239.

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