CHASE-i
Centre for Health and Social Economic Improvement

POLICY BRIEF

COVID-19: Awareness, Adherence and the Lived Experiences of Communities in Kampala Slums

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Key Messages

The people living in informal settlements are aware of COVID-19 signs, symptoms and its transmission. However, they have multiple - and sometimes contradictory - sources of information which affect their adherence to the preventive measures.

Compliance to COVID-19 SOPs is extremely low; with livelihoods and the need to make a living reported as the most common explanatory factor for non-compliance to guidelines such as physical distancing or staying home.

Government should now work on addressing the barriers of non-compliance to COVID-19 and emphasise personal responsibility and the community's own contribution in the fight against COVID-19.

There is a growing need for age-appropriate information for children and adolescents as well as providing the prerequisites for adherence for example fitting masks, soap, water and protection.

Local duty bearers and key stakeholders in child protection such as social workers and police officers need more support to effectively undertake their roles in child protection and wellbeing.

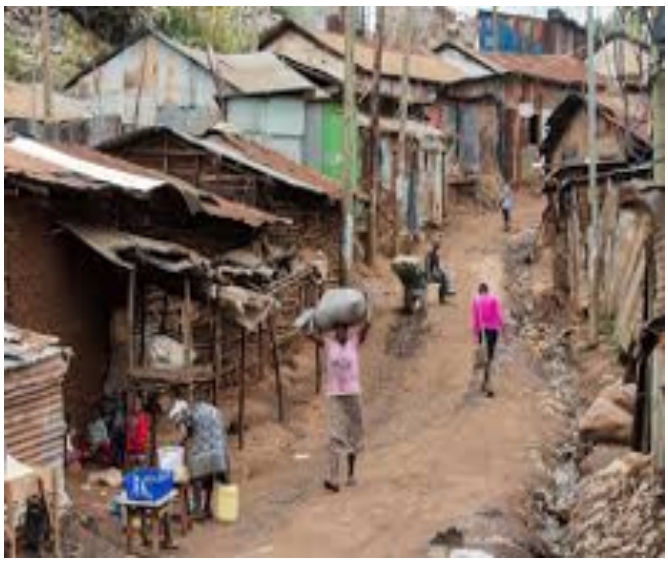
Adherence, Lived Experiences and Resilient Transformation among "slumdwellers" (ALERTs) in COVID-19: A study of Ki-Mombasa and Kabalagala-Kataba slums in Kampala.

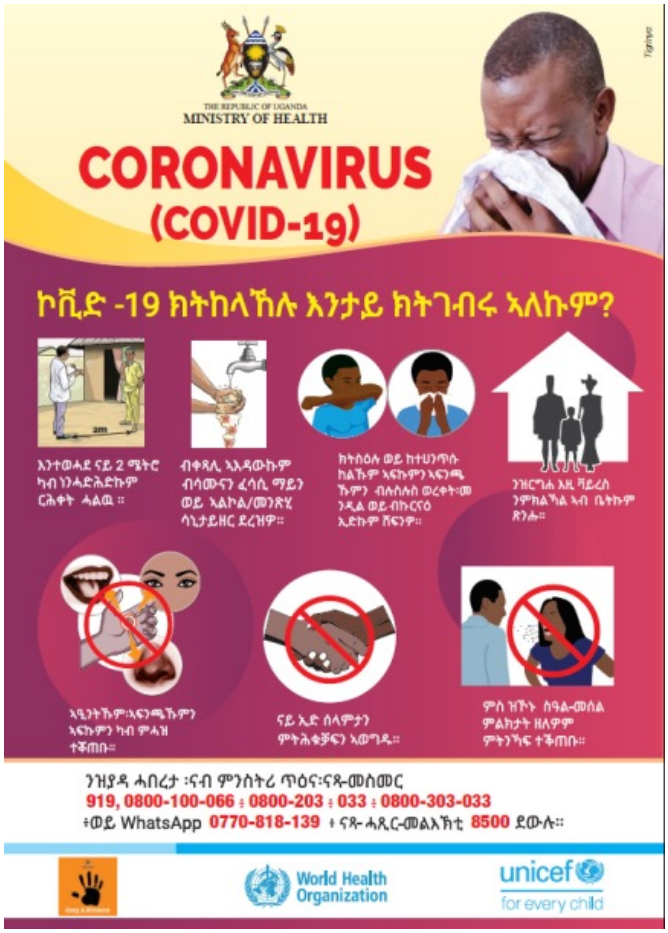
Urban Informal Settlements

Globally, over a billion people make their abode in an informal settlement. These people also constitute a significant percentage of the urban populations in LMICs – for example 60% of Kampala residents stay in an informal settlement. By virtue of their characteristics these areas are potential hotspots for COVID-19 transmission because all the amenities that support disease prevention are a luxury to this population. These include space to social distance or isolate or access to reliable sources of water, face masks, sanitizers and preventive information.

Uganda's Reponse to COVID-19

From March 18th, 2020 the government of Uganda instituted a series of public restrictions to fight the spread of COVID-19 within the population. Included in these restrictions was a ban on public gatherings and transport; closure of public spaces like schools, markets and places of worship; a lockdown and curfew that were ex-





A translated COVID-19 IEC material from MoH

tended over a significant period. The Ministry of Health also rolled out a comprehensive prevention strategy that was widely spread on mainstream media, social media, SMS alerts and posters among other channels. The government also set up and operationalized taskforces at different structural levels to ensure the implementation of these public health guidelines and restrictions.

We conducted a study to: 1) determine understand the Knowledge, Attitudes and Practices (KAP) on COVID-19; 2) assess adherence to preventive guidelines and Standard Operating Procedures (SOPs); 3) explore and understand lived experiences of urban informal settlement populations in light of the COVID-19 prevention guidelines. This study was titled Adherence, Lived Experiences and Resilient Transformation among "slumdwellers" (ALERTs) in COVID-19: A study of Ki-Mombasa and Kabalagala-Kataba slums in Kampala

Methods

The ALERTs study was multi-method and cross-sectional in design. Study sites were the two Kampala slums of Ki-Mombasa, Bwaise and Kabalagala-Kataba. This brief focuses on the key results from the study. We recruited 807 participants – 660 of whom were selected using a two-staged cluster sampling procedure with probability proportional to size (PPS) to participate in a survey electronically administered using ODK. Participants in the qualitative arm were purposively and we used key informant interviews and FGDs to collect data. For analysis data was cleaned in excel before transfer to SPSS and analyzed using relevant descriptive, bivariate, and multivariate statistical methods. Qualitative data was audio recorded, translated, transcribed and managed both manually and with NVivo 12 software.

Key Findings

1. Knowledge on the transmission, symptoms and prevention of COVID-19 is high for example:
   - Awareness that washing hands with soap and using sanitisers reduces transmission was 92.6% and 90.6% respectively
   - 90% agreed that crowded places increase transmission
   - 81.7% and 80.2% identified high fever and sore throat as symptoms for COVID-19
   - Only 10.3% associated COVID-19 to an evil spirit.

2. However, this knowledge has not been translated into preventive action:
   - Only 46.8% wash their hands with water and soap regularly
   - Just over 32% use a face mask often while in public
   - 63.6% shake hands with other people at least a few times
3. The main source of COVID-19 related information was mainstream media at 77.7% (including radio, and television), other sources included social media (13.8%) and neighbours (4.7%). However, study findings indicate that those who got information from social media were significantly less knowledgeable than those whose main source was neighbours.

4. More people in Ki-Mombasa practiced COVID-19 related preventive measures compared to those in Kataba as the table below illustrates.

Preventive Behaviour	Kataba	Ki Mombasa
Wash hands with water and soap	51.5%	42.1%
Cover while sneezing/ coughing	44.5%	30.9%
Use a mask while in public	47.3%	37.3%
Exercise weekly	20.6%	13%

5. Myths and misconceptions abound within this population – 46.5% of the participants think the black race is a protective factor against COVID-19. This, and other myths, were reinforced by the low fatality rate compared to other epidemics and recurring misinformation from social media and other multiple sources.

6. In the 14 days prior to the survey less people had interfaced with any of the enforcers of COVID-19 guidelines including: local leaders (28.9%), police (25.9%), LDUs (19.9%), health workers (12.7%) compared to 38.3%, 41.2%, 42.1% and 18.9% respectively in March – April 2020. Majority of those that interfaced with the police and LDUs had had a negative experience.

7. The COVID-19 public health message has been marred by politicking as this participant indicates:

   Politicians have done a great disservice in influencing people's understanding of COVID-19; today someone says we should social distance, the next day you find the same person mobilizing crowds without maintaining social distance. Other politicians say it openly that COVID-19 does not exist (KII Community Leader 1, Kataba)

8. Compliance to COVID-19 guidelines has also been hindered by a multiplicity of often contradictory messages from political and other categories of leaders.

   … we find so many challenges… and don't know who to follow now… police come tells us one thing and also the chairman comes tells us another and then the VHTs come and confuse us further, so we don't know who to follow." FGD Men Kataba.

9. The pandemic and its counter measures have increased the socioeconomic vulnerability of people within informal settlements and instigated negative coping behaviours including violence against children, intimate partner violence, alcoholism among others.

   Since corona came, there has been much domestic violence, women no longer understanding their husbands because of the prevailing conditions, men no longer leave money at home (FGD Men)

10. In terms of resources, community structures including the local council members and VHTs have played an important role in curtailing the spread of the disease. They promptly report cases to concerned authorities and have cascaded the preventive measures down to their community members.

Considering increasing community transmission and limited capacity at the health facilities, the role of community leaders – political, cultural, religious and others like VHTs – cannot be overestimated. Combating COVID-19 is largely dependent on them taking lead at the frontiers of prevention.

Courtesy James O'Donovan

Recommendations

1. All stakeholders need to focus on addressing the drivers of non-compliance and enforcement fatigue including; sustainable solutions for improving livelihoods, providing the amenities which support compliance e.g. soap, water, masks and tailored impact messaging.

2. In addition to the very comprehensive MOH public health prevention strategy, it is imperative to contextualise these messages especially for the vulnerable populations who view the current strategy as far-fetched for their reality. Focus on the feasible measures and enforce those.

3. Local and grassroots structures need to be engaged more in behavioural change campaigns. This includes supporting leaders and Village Health Teams (VHTs), for instance, to engage their communities in identifying alternative social norms for greetings, for showing love and kindness etc., without putting their lives at risk.

4. The MOH Community Health Engagement Strategy (CES) needs to be activated and functionalized through building capacity at the local levels e.g. through community structures like the VHTs, religious and cultural leaders, local council members among others.

5. Urban planning and socioeconomic development: In the longer term, the government and other stakeholders need to tackle the problem of while creating innovative socioeconomic activities that reduce the risk posed by the prevailing income generating activities within this population which are also risky e.g. commercial sex, sale of alcohol and drugs.

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