



Preparedness, heightened response and systems strengthening for Ebola in Uganda

Firoz Lalji Centre for Africa
Policy Brief

Grace Akello & Duncan Green

Key Findings

- Uganda's response to Ebola Virus Disease (EVD) was uncoordinated, chaotic and over-bureaucratic, with little tangible benefit on the ground.
- Militarized, sometimes violent, responses destroyed public trust in the authorities' response.
- Donors preferred to pump resources into health messaging and neglected other vital areas of the response.
- Investing resources in tackling one disease is an expensive venture for a setting with numerous health threats.
- Henceforth, it is better to focus on systems strengthening to be able to tackle all health threats.
- Misdiagnosis due to a failure to differentiate between different EVD strands hampered the response.
- There was a lack of clarity over which 'travellers' were genuinely at risk.
- Double standards over sanitary safety measures undermined public trust.

Introduction

After an 11th Ebola epidemic was confirmed in August 2018 in the Democratic Republic of Congo (DRC), Uganda engaged in several activities to prevent the spread of Ebola within its boundaries. An ethnographic study over 12 months explored three key thematic engagements of these activities within Uganda: preparedness, heightened response and systems strengthening.

Preparedness covers activities conducted in a country readying itself to tackle an epidemic; heightened response comprises activities in response to confirmed cases; systems strengthening includes questions pertinent to the sustainability of activities, based on lessons learnt in previous emergencies, better ways to prepare and tackle health threats and alternative ways of dealing with impending deadly epidemics in the near future.

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Lessons learnt: Preparedness for EVD

After it was confirmed that DRC was experiencing a deadly infectious epidemic, and due to its shared and porous borders, Uganda put many mechanisms in place to protect its citizens from catching Ebola. Uganda's Ministry of Health (MOH), together with key partners in disease control such as CDC, DFID, UNICEF and WHO drew up a map categorizing the nation into high risk, mid risk and low risk areas. High risk areas were at the Points of Entry with DRC and districts bordering DRC including Kasese, Bundibugyo, Arua and Kikuube. Entebbe international airport was also categorized at a high-risk zone. It is in these areas where many Ebola Virus Disease (EVD) preparedness activities were implemented. Volunteer village health teams were deployed to screen, ensure hand washing in 0.5%



chlorine for feet and 0.05% chlorine for hands. Travellers¹ temperatures were taken and each traveller entering Uganda was recorded.

A national committee at the MOH called the National Task Force (NTF) was constituted and housed at a high-tech building, with monitors and disease containment tasks managed within the National Emergency Operation Centre (NEOC). The team is headed and directed by Ministry of Defence personnel to ensure that there is less disconnect between district level health systems, which currently report directly to Local Government, and the president's office. The NTF was supposed to work with the Ministry of Health's Disease Surveillance and Epidemiology Unit and the Primary Healthcare department. They were mandated by the Head of State to coordinate an emergency response, producing or verifying risk communication materials for EVD, raising funds, surveilling risk areas, overseeing sample transportation and diagnosis and ensuring that confirmed cases were treated.

The NTF was organized in 7 pillars: (i) coordination and leadership; (ii) case management, infection prevention and control/WASH, (iii) psychosocial support, safe and dignified burials (SDBs); (iv) logistics; (v) vaccination and investigational therapeutics; (vi) risk communication, social mobilization and community engagement; (vii) surveillance, laboratory support and points of entry (POEs).²

In response to the COVID 19 threat, another National Emergency Operation Centre (NEOC) pillar called IT & Information technology was added to guide pandemic preparedness. This particular pillar/committee will design apps to monitor rumours about pandemics, communicate WHO updates to the people at risk and be a contact point for risk communication, in effect digitizing pandemic preparedness and response.

Membership for the different pillars was blurred, with overlaps and duplication of tasks. Technical staff were regularly co-opted, dropped, recruited and fired. Their job descriptions were arbitrary, mostly overlapping with what officers at the MOH would do, but importantly, the NEOC team committed to working for 24 hours and seven days a week in preparing to tackle the impending EVD threat. One senior officer at MOH said, "When I see people at NEOC, I feel immense sympathy. I

¹ At the points of entry (POE) the term traveller was deployed loosely to cover every person crossing through the checkpoint from either side of the country- whether from Uganda or DRC. It was common to regard Ugandan women who go to farm in DRC as travellers. This is particularly in zones where Uganda and DRC are only separated by a river. Elsewhere, I show some of the impact of EVD response activities on peasant women. See Akello G (2020) Ebola response activities increase women's workload in Kasese district. IDS blog. Also, after 8 months of EVD response activities there were various community dynamics in high risk zones as discussed in Akello et al (2019) Social dynamics at the Uganda-DRC border during pandemic preparedness activities in Kasese district. IDS blog.

² During interviews it was possible to meet one person who sits and discusses issues in all sub-committees or pillars. Tasks were executed by few people with required skill. See DFID After Action Review EVD Report 2019. And most importantly, team members did not originate or direct ideas, because they sought technical assistance from CDC, WHO and UNICEF. The technical advice was couched in donor interests and after one year of NEOC and EVD pillars, little legacy was left and Uganda did not successfully manage one confirmed case admitted at Bwera ETU.



sometimes pull some aside and advise them to slow down before they experience mental breakdown. Nobody works like this in this modern day”.

But despite the NEOC’s 24hr work schedule at national level, there was little visible result in terms of heightened response and activities among high risk communities. For example, at the Ebola Treatment Unit (ETU) in Bwera, during the heightened response in June 2019, frontline healthcare workers and patients had nothing to eat and no basic equipment. They had to cut down the recommended 21 days for EVD case management to 10 days.

Lessons learnt: Avoid reactionary disease preparedness and response; advocate for system strengthening

Uganda’s health sector is heavily supported by donor funds. Policy makers draft and approve health sector strategic plans whose basic focus is on how to tackle common health complaints. Curative and preventive technologies are purchased, though Uganda also receives donations of equipment, pharmaceuticals and vaccines from philanthropists. But in the era of disease pandemics and epidemics, the preceding ways of tackling this country’s health issues are deficient. Having no health reserve budgets means in the event of a health threat, like Ebola, responses can only be couched in reactionary, short-term approaches – whereby outside humanitarian organizations define and guide responses. Reactionary approaches are not sustainable and the focus on one disease makes it difficult to replicate experiences. That is why when the NEOC and MOH currently hold meetings to evaluate preparedness and response, while they evoke the word reactionary activities, they advocate for systems strengthening and sustainable approaches.

Lessons Learnt: Skewed allocation of resources to IEC (Information, Education and Communication)

Health promotion messages needed to be disseminated to people at risk of catching Ebola. Many humanitarian and development agencies like DFID, the European Union and USAID invested in production and dissemination of risk communication materials. “The only parameters one needs in reporting success here are the number of posters distributed, the number of radio talk shows conducted, and the number of awareness seminars conducted. Donors like this aspect of preparedness very much”, argued one senior officer at the NEOC.

Although other crucial pillars for the Ebola response, such as surveillance, diagnostics, case management and psychosocial support, experienced immense difficulties in rolling out their activities, or even finding 10% of their budgets, risk communication was reporting numerous success stories and even covering low risk areas for EVD. “Sometimes over-promoting awareness creates problems for other pillars like surveillance, since many people will be calling them with particular complaints seen in the posters, and yet they do not have any resources to respond”, argued one senior officer at the NEOC/MOH.

Gap identified: Poor representation of EVD symptoms, Duplication of IEC materials, dissemination of conflicting messages

The most common posters distributed depicted signs of Ebola as vomiting, diarrhea and bleeding from all body openings. But these were based on Ebola outbreaks elsewhere. Noticeably, for all severe cases of the Zaire strain for EVD in Uganda, no bleeding was observed. Death occurred with



signs like fever, vomiting, diarrhea and body weakness. This led to widespread misdiagnosis, as surveillance officers were overwhelmed with invitations to handle symptoms of bleeding due to motor accidents and epilepsy-related seizures.

Many humanitarians distributed EVD awareness materials with widespread duplication of efforts, so that people at risk had access to numerous posters. Many hospital and health centre walls were covered from end-to-end with Ebola posters. These posters were distributed by UNICEF, MOH, URCS, Baylor Uganda, USAID, WHO and DFID, to mention only a few. Surplus posters were dumped in hotel rooms, at hospital gates and District health offices, wasting resources that could have been used for supporting other pillars, including surveillance, case management, and psychosocial support.

The multiplicity of agencies led to conflicting messages. We observed posters in hospitals stating “Wash hands with jik (a chlorine mixture) or Ash”. Clinicians questioned the suitability of such messages, which were distributed by the MOH/WHO, without first offering standard operating procedures for using ash in the hospital setting. At the National Emergency Operating Centre (NEOC)’s Risk Communication Unit, at the MOH, and at the DHO, nobody accepted responsibility for the distribution of such erroneous and misleading messages. Instead it was alleged that some humanitarians had bypassed standard operating procedures for preparing and disseminating materials and ‘done their own thing’.

It was common to distribute the same poster in different languages, arguing that if people could not read in English they would be able to read in their local language. But in communities whose population is 80% illiterate, they would not be able to read regardless of language.

Gap identified and recommendation: Selective deployment of the term ‘traveller’

In all Ebola checkpoints, there was a reference to the term ‘traveller’ and the need to subject the traveller to screening, washing hands, temperature taking and registering them prior to granting them permission at the POE to Uganda. But some travellers are in greater need of screening than others. By observation, the highest proportion of travellers³ were village women who cross to DRC through informal paths and cross the border River Lhubiriha to farm, buy household items and sell agricultural produce. They can do multiple trips per day. Similarly, at the Mpondwe border, the small-scale traders and smugglers crossed these POEs multiple times a day. Each trip was regarded as unique, disease-laden, and full of EVD risk. But to surveil a woman who has merely crossed the border to fetch dirty water from a river for domestic use is a waste of time. The disease surveillance team needs to screen people who come from a distant Ebola-infested area such as Beni.

It was possible to see many women exhausted under their heavy weight of agricultural products being subjected to screening and multiple surveillance. Despite the EVD risk, it is prudent to selectively deploy the term ‘traveller’ and only target visitors who pose a real threat with EVD routine screening activities at POEs.

Gap identified: Double Standards among Screeners

Each EVD screening unit had one huge umbrella or tent. There was a container of chlorinated water for people to wash hands, and disease-laden people were recorded by risk responders and screeners - who also had non-touch thermometers.

³ See Ibid, Akello 2020, IDS blog.



But communities started resisting EVD activities when they saw how health promoters, EVD screeners and EVD surveillance teams exhibited risky behaviours themselves when they had no sanitary facilities.

Militarization of response, dealing with refusal to wash hands.

Perhaps due to lack of sufficient awareness, or due to the frequency and harassment of screening processes – many people resisted Ebola control activities. To manage this resistance, the state deployed armed military personnel to enforce compliance. Soldiers' enforcement approach was to punish, arrest and beat up those deemed stubborn – oblivious of how the approach will actually ignite a desired response. It still remains to be seen how somebody already punished by the military, arrested, incarcerated or beaten-up⁴ for refusal to wash hands for EVD response will receive and willingly implement messages on an Ebola poster. And disgruntled people are unlikely to advise others to actively engage with its message in a bid to prevent catching Ebola in the desired message-cascading manner.

A focus on one disease that is only anticipated affected caregiving in health centres

After confirming an Ebola risk and that it could be transmitted quickly from DRC to Uganda, all national and district health activities, budgets and attention were diverted to one disease at the expense of all other health threats. Many health workers were selected from wards and assigned tasks specific for Ebola containment, such as instructing people to wash hands. Village health centres in Kasese were often closed because front line workers were invited for Ebola workshops and training. Even though they spent weeks being trained in Ebola response, including in how to use PPE, frontline health workers were then sent home without PPE. Therefore, lack of equipment made it difficult to operationalize knowledge acquired for disease containment. Additionally, the frequent invitations to frontline health workers to be trained as Ebola responders significantly disrupted health service provision.

Conclusion

Pandemic preparedness and response approaches in Uganda need considerable modification if they are to have genuine impact. In its current form, a humanitarian approach focuses only on short-term approaches, one disease at a time. Interventions are characterized by the duplication of activities. A mishandled response destroys trust and the social contract between state and people – vital to a pandemic response. The mishandling of Ebola makes future pandemic responses, like COVID-19, much harder.

Contact

For more information please contact Laurence Radford, Communications Manager, Firoz Lalji Centre for Africa, London School of Economics and Political Science: l.radford@lse.ac.uk

⁴ By Observation violence and punishment characterised EVD response activities in south west Uganda. People at risk reinterpreted the actions as state control, but also state heavy handedness implied a hidden agenda. The state, they argued planned to wipe away the ethnic groups in order to repossess their land-filled minerals. The state was working with foreign groups including the UN. WHO . MSF and other donors supporting EVD activities.