EVIDENCE FOR CONTACT TRACING (CT) ANALYSES FROM THE DRC EBOLA OUTBREAKS

GOARN CT PRESENTATION

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DISCUSSION ON EVIDENCE AND CT:
EXPERIENCE OF IMOA IN THE DRC EBOLA OUTBREAKS

1. What is IMOA for CT (DRC)

2. Key evidence on CT during the Ebola outbreaks in Equateur and Eastern DRC

3. Evidence of CE which improves CT

4. Take homes & recommendations
WHAT IS IMOA?
**Children under 5 most infected nosocomially**

- Parents reported increased use of small HCF and poor IPC in HCF

**Children more likely for community deaths post HCF**

**Increased use of health services for children under 5**

**IPCA data shows least support to small HCF & highest nosocomial infection in small HCF**

**Strategy for a better protection of children under 5**
IMOA FOR CT

(1) Differential trends in participation in contact tracing
(2) Percentage of cases listed as contacts
(3) Types of contacts listed
   - By age
   - By sexe
   - By location

**nb: data remain “reports” reliant on behavior of those reporting (their training/skillset)**

« Epi » data

Community perceptions and behaviours data

Barrier and enabler analyses

To identify specific dynamics in engagement with CT
(2) Comparing high vs. low engagement locations or groups
   - Interviews with CT teams and communities
   - Analysis continued until saturation
   - Triangulation of data with surveys and with field visits to accompany CTs

CASS DATA MAY INFORM EPI ANALYSIS AND VICE VERSA, DATA ARE DISCUSSED, SHARED AND REVIEWED TOGETHER
1. Epi data analyzed to understand differences in participation in CT by zones
   • “high” and “low” categories co-identified by analytics cell

2. Data collected in 04 health areas (aires de santé) in the health zones of Mbandaka, Bikoro and Ingende
   • Health areas identified based on epi analysis (Analysis Cell in Mbka)
   • 214 community members and healthcare workers were interviewed in 44 KIs and 24 FGDs
     o 28% aboriginal communities (autochthones)
     o 56% women
DATA META SYNTHESIS FOR THIS ANALYSIS

Eastern DRC (2018-20)

• CASS conducted 58 studies operating together with Epi Cell during the 2018-20 outbreak
• Specific barriers study conducted for CT
• 112 co-developed recommendations

Equateur (2020)

• 6 briefs, including specific brief for Surveillance developed (with all partners and MoH) - LINK
• HCW & HH surveys conducted in 7 health zones (representative)
• Specific barriers study conducted for CT
• 82 co-developed recommendations
• 13% of CASS codeveloped recommendations (Equateur 2020) specifically for surveillance teams
KEY RESULTS FROM INTEGRATED ANALYTICS
The majority of confirmed cases were not known as contacts for much of the outbreaks. The situation between health zones is quite heterogeneous.
• Both Easter and Equateur outbreaks – throughout the duration of the outbreak, children were significantly less listed as contacts.

- The risk of not being known as a contact was significantly higher for children compared to adults.

- Among these known contacts, the risk of not being followed up was higher for children aged 1 to 17 compared to adults.

<table>
<thead>
<tr>
<th>Age group</th>
<th>RR* of not being known as a contact (ET 95%)</th>
<th>RR of not being followed up (ET 95%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 an</td>
<td>1.18 (1.03 – 1.35)</td>
<td>0.98 (0.88 – 1.09)</td>
</tr>
<tr>
<td>1 – 4 ans</td>
<td>1.49 (1.34 – 1.66)</td>
<td>1.22 (1.13 – 1.32)</td>
</tr>
<tr>
<td>5 – 17 ans</td>
<td>1.33 (1.20 – 1.47)</td>
<td>1.33 (1.05 – 1.20)</td>
</tr>
<tr>
<td>≥18 ans</td>
<td>1.00</td>
<td>1.00</td>
</tr>
</tbody>
</table>
Children are not listed because (specific to children)

(1) They are not recognized as having been exposed or at risk
   • Early messages and training implied children rarely got Ebola
   • Nosocomial risks are rarely communicated (safe injections)
   • If the mother/parent or caregiver does not get Ebola, it’s hard to imagine the child would

(2) There is a fear that listing will result in either or both vaccination or a CTE referral
   • Perception that the vaccine is Ebola (misunderstanding of antibodies/how vaccines work) – fear of vaccine
   • Case fatality among children was higher = fear is understandable - fear that CTE = death

IN EQUATEUR, HH SURVEYS INDICATED THAT ONLY 22% OF PARENTS WOULD ACCEPT LISTING THEIR CHILD AS A CONTACT
1. (perceived) Lack of correct listing
- Lack of training and skills of CT teams to identify the right persons
- Not listing or asking for children to be listed
- Listing of friends (related to kits distribution/ materials)

2. Inability to explain transmission chains & relationships between exposure & being listed
- Incubation period, reasons for perceived exposure not explained at household or community
- Support families to understand when could have been the exposure and therefore who should be listed
- Relationship with symptoms: lack of communication on symptoms influences understanding of exposure

3. Not familiar, local or trusted teams = distrust
- Conducted by outsiders, lack of respect and trust
- Related to income generation which fuels distrust
- Language barriers
- Less than 50% women (no opportunity for women to speak to women)

4. Lack of training, inability to respond to questions
- Lacking training on vaccination, the steps following the listing of contact
- Inability to answer community questions

5. Approaches create stigma
- visibility, cars & teams
1. Proximity to the disease increases willingness to engage with / participate in CT
   • In Equateur, the majority of the contacts that have become confirmed cases are contacts who are socially close to the source case.
   • Communities & individuals who report willingness to participate express known/ having been close to the disease (common psychology of health behavior)

   **challenge: how to engage communities with a disease which does not affect them, when there are many other more critical diseases?**

2. Misunderstanding of transmission routes reduces self-identification as a contact
   • Lack of information (videos, communication) provided by all response teams negatively impact individual self-exposure identification

3. Fear of CTE and death
   • High fatality at onset of disease increase fear of being listed = being sent to CTE = death

   **attn: compared to W.Africa, listing is not associated with socio-economic burden of staying at home (march-June ‘20 COVID was!)

4. Stigmatization (community & response teams) will reduce willingness to engage

5. Perceptions of severity of the disease and support available will influence engagement
   • Similar to proximity, high perception of risk may increase engagement and participation in contact tracing
(4) UNDERSTANDING THE RELATIONSHIP BETWEEN PROXIMITY TO A DISEASE & TO CARE

**provenance-elastic behaviour**

**Proximity**

- Physical proximity to services/response
  - Trust in individuals
    - Same language
    - Know their education/families – greater belief
  - Ability to see the services (ETC) and trust the care provided
  - Trust because can see (easier to alleviate fear/rumours)
  - More likely to see survivors come out/to visit patients

- Familiarity with the disease
  - Some exposure = belief the disease exists
  - Demystifying of the illness
  - Less financial constraints to access – increase willingness to go

- Physical proximity to the disease
  - Understand severity/risks and exposure
  - Family/close member – seen impact of disease
  - Individual perceived risk higher: more likely to engage

**If an individual doesn’t have proximity to Ebola or the ETCs, information and communication and CE will remain challenging**
WHAT CAUSES DISTRUST AND DISENGAGEMENT IN CT?
WHAT THE EVIDENCE SAYS CAUSES DISTRUST AND DISENGAGEMENT IN CT?

1. Unknown CT team
   • Must be local – language
   • Representative/ reflective of communities: women, ethnic groups – proportionately representative (not just leaders)

2. Inconsistent approaches to CT
   • Definition for who is a contact should be presented and shared across communities both before and during CT activities
   • Who is a contact, what is the moment of exposure and incubation period must be explained to support families identifying their own risks

3. Poorly trained CT
   • 20-50% of HH respondents report response teams cannot explain process (“what will happen if I get symptoms”) in ways which build confidence/trust

4. Unequal distribution of support to households / communities
   • In one area, 100% of HH received high quality kits for staying home – because response perceived high risks. This resulted in community tensions and both communities refusing participation

5. Lack of access to HC/ HCF if symptoms arise (rural areas)

Strategies focused on “accept this intervention” vs. “Understand the disease, the mechanisms to stop the disease and let’s discuss what is best for you” undermine response success
WHAT CAN CT TEAMS DO?
WHAT THE EVIDENCE TELLS US WHAT MATTERS TO MAKE CT WORK

CT TEAMS.. What matters

1. Who you are
2. What you know
3. How you speak and engage
4. How you treat people
5. How patient you are

COMMUNITIES (INDIVIDUALS).. What matters

1. Their perceived “proximity” (psychological, geographic)
2. Who they trust
3. How they perceive the disease (risk)
4. Their perceived risk / benefit of participation
5. How they feel you will be treated

• Parentage of non-listed contacts is first put on the responsibility of the communities and listed as “engagement problem”, however there is often a lack of recognition of who should be listed

• There are multiple approaches to CT, and these must be addressed and discussed with communities (cars/ size of teams) – not just community leadership
WHAT EVIDENCE SUGGESTS CAN CT TEAMS DO

1. Work with governments to get local and representative teams
   • Especially as UN actors – huge responsibility to ensure locally hired, language, gender and ethnically representative and trusted teams

2. Get trained & be equipped
   • Set up systematic training for teams that include updating on key community questions (via RCCE feedback) and practice how to answer
   • Know the entire response: be able to answer questions on “what will happen if I show symptoms”? 
   • Have communication materials (videos on smartphones, photos of treatment centres- use GoData!l) to explain the process of “next steps”
   • Explain how communication with families will/ would happen if the person was diagnosed

3. Know your responsibilities
   • Communication and Community Engagement are everyone’s responsibility – be able answer all questions
   • Support an understanding at HH level of exposure to the disease and support talking through who and how different family members (including small children) could have been exposed
   • Be able to answer questions on vaccination, patient care, burials and food/ care for sick

4. Use data!!!! (and train teams to use evidence)
   • Do not be scared to report low participation – do not blame communities
   • Do not assume you know the causes – information does not equal behavior -- (requires training)
   • Work with epi and social sciences to compare high and low participation groups (by location, zone) and identify what are the drivers/ barriers and how to reinforce and improve → Pre & Post studies demonstrate impact 😊
Questions & discussions

Ressources, studies links online

Google drive Ebola 2018-20 (lien)
Google drive CASS (all outbreaks from 2020) (lien)

Thank you & Merci 😊

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