THEMATIC ANALYSIS ON THE LISTING AND FOLLOW-UP OF CONTACTS

EVD Outbreak, Equateur Province, DRC

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PRESENTATION

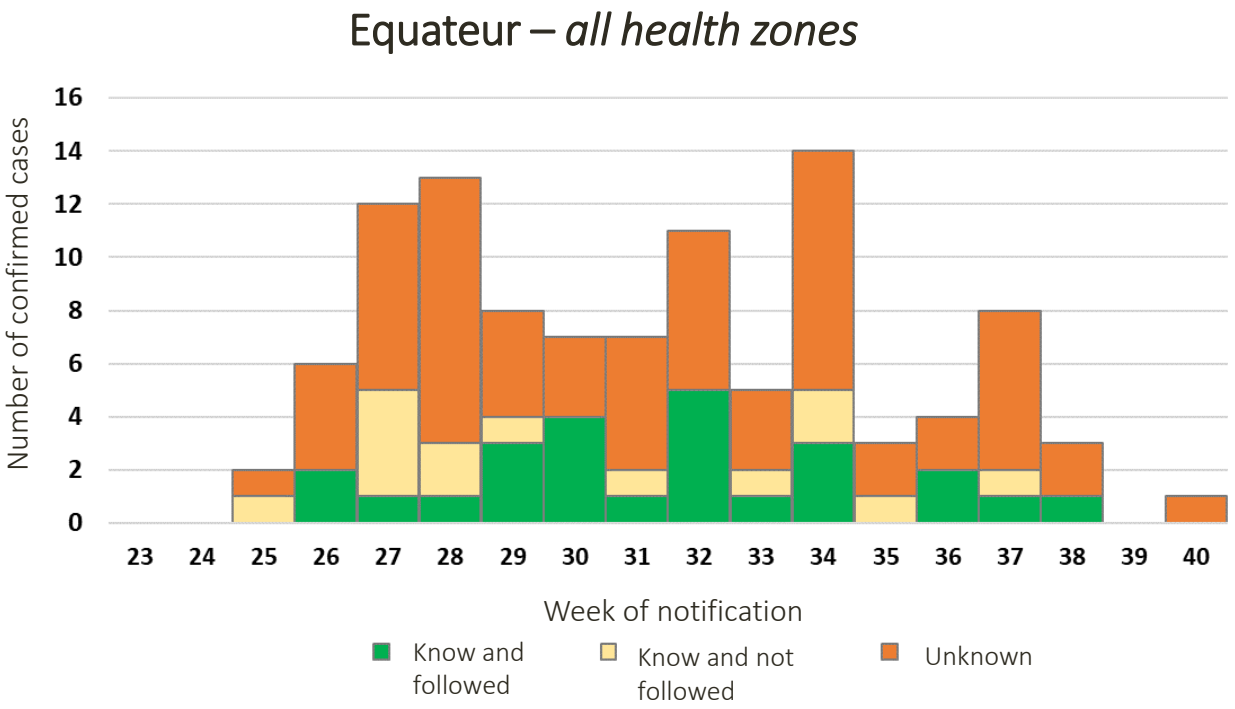
1) Detailed epidemiological situation of contact tracing

- Epi curve according to the follow-up status of cases
- Characteristics of the listed contacts
- Contact listing (HZ and HA)
- Quality of monitoring by HZ

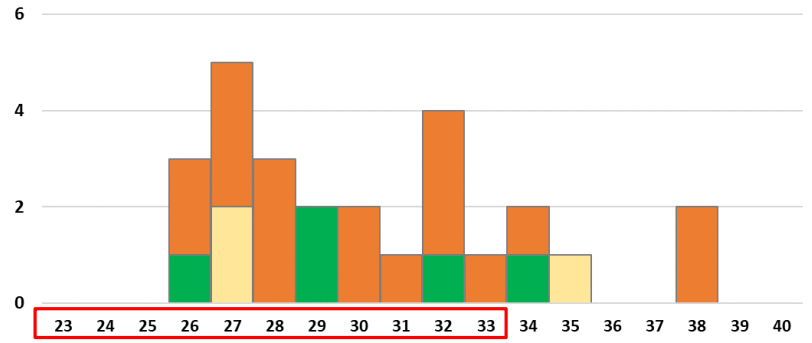
2) Barriers and motivators to participation in contact tracing

1) IN-DEPTH EPI ANALYSIS ON CONTACT TRACING

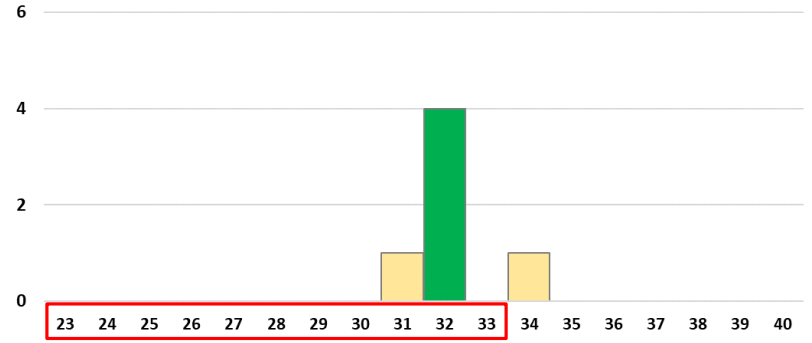
STATUS OF CONFIRMED CASES – KNOWN AND FOLLOWED CONTACTS



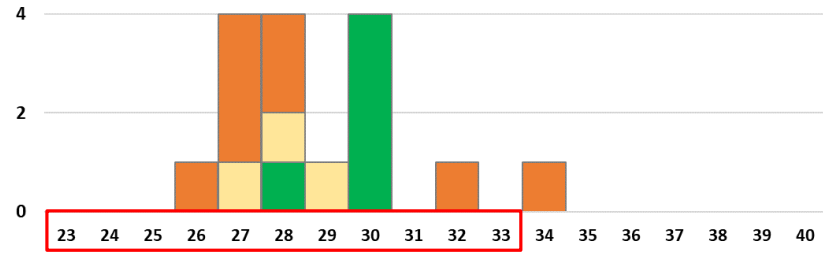
Bikoro



Ingende

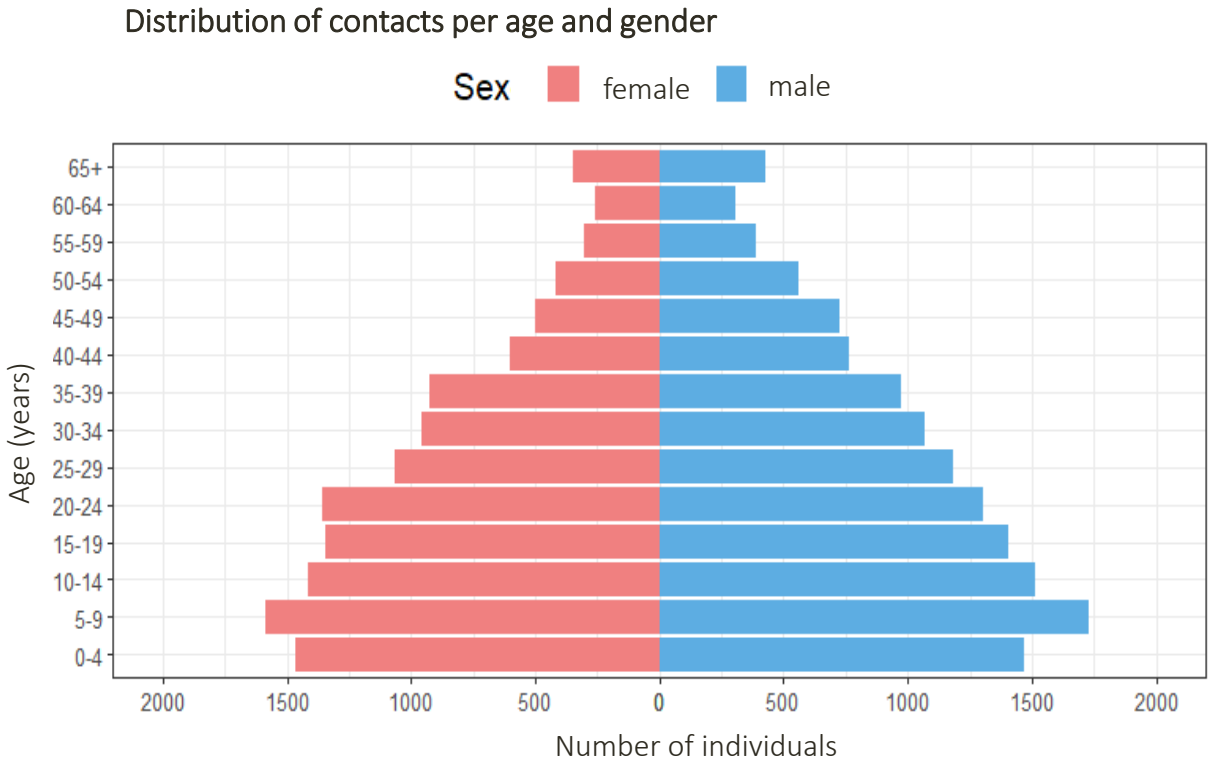


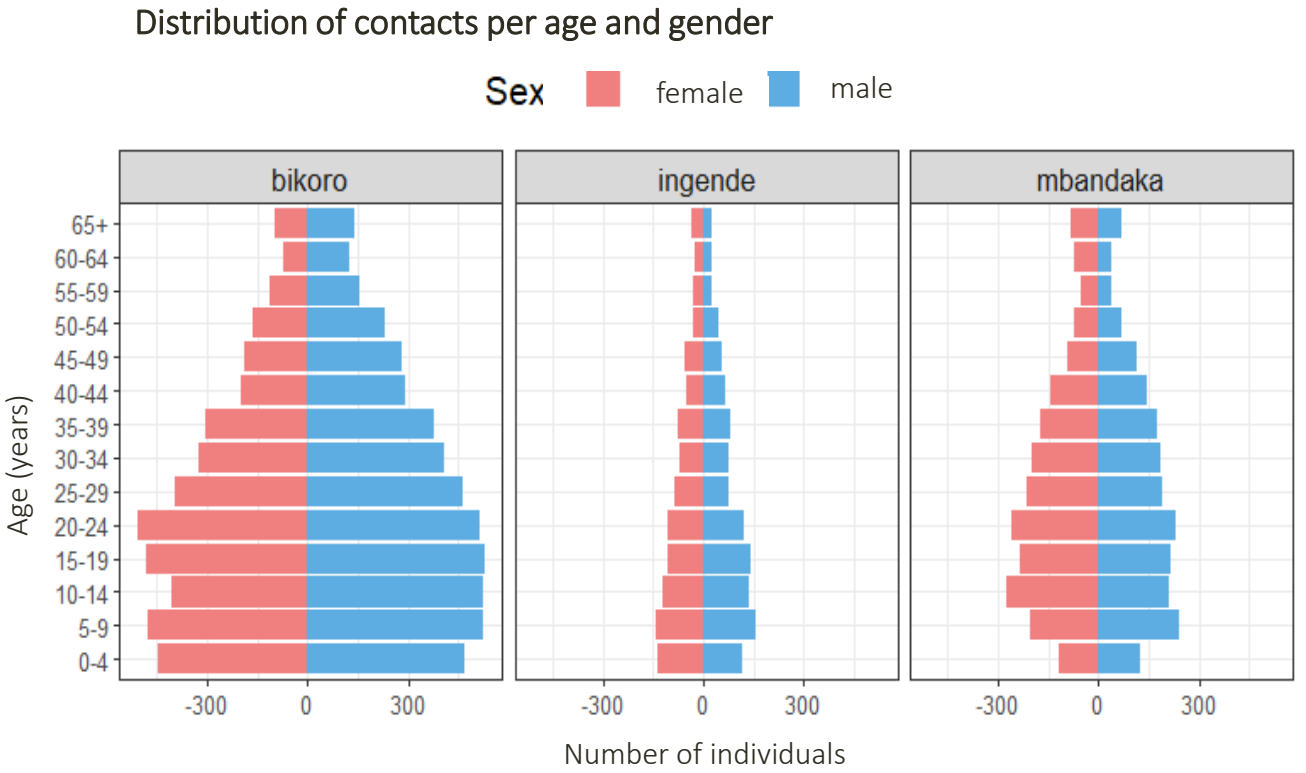
Mbandaka



- *Overall, the majority of confirmed cases were not known as contacts – even the more recent ones*
- *The situation between health zones is quite heterogenous.*

CARACTERISTICS OF CONTACTS (1) : ALL CONTACTS





- *No significant difference between men and women*
- *++ children between 5-9 listed as contacts overall*
- *In Mbandaka however, few children between 0-4 listed as contacts : significantly less than in other health zones with more than 01 case.*

*waiting for data from the governmental vaccination programme on global population age distribution

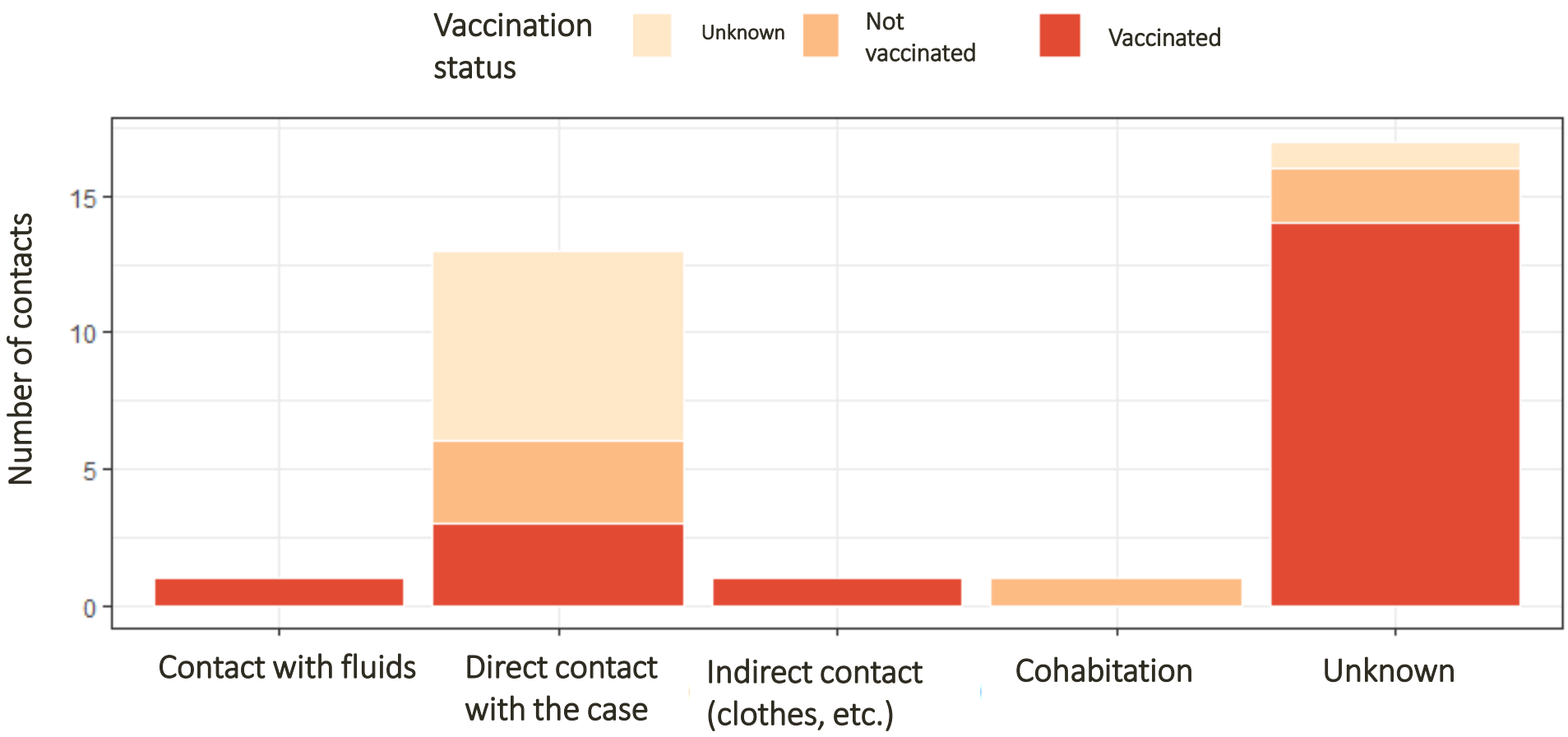
➢ 30 contacts in the database became confirmed cases

- On average, they were confirmed on day 8 of follow-up *[Min-Max: 1-19, IQR:2.25-14]*
- The majority were relatives to the index case (family relations : 16, neighbors : 6) ; 04 were co-patients with the index case ; and for 04, the relation was not specified.
- 07 of them (23%) were not seen for the 3st days of follow-up.
- 10% were lost to follow-up at one point during the 21 days
- 20 were reported to be vaccinated (67%)
- 26% were from Bolomba, 23% from Mbandaka, 20% from Bikoro.

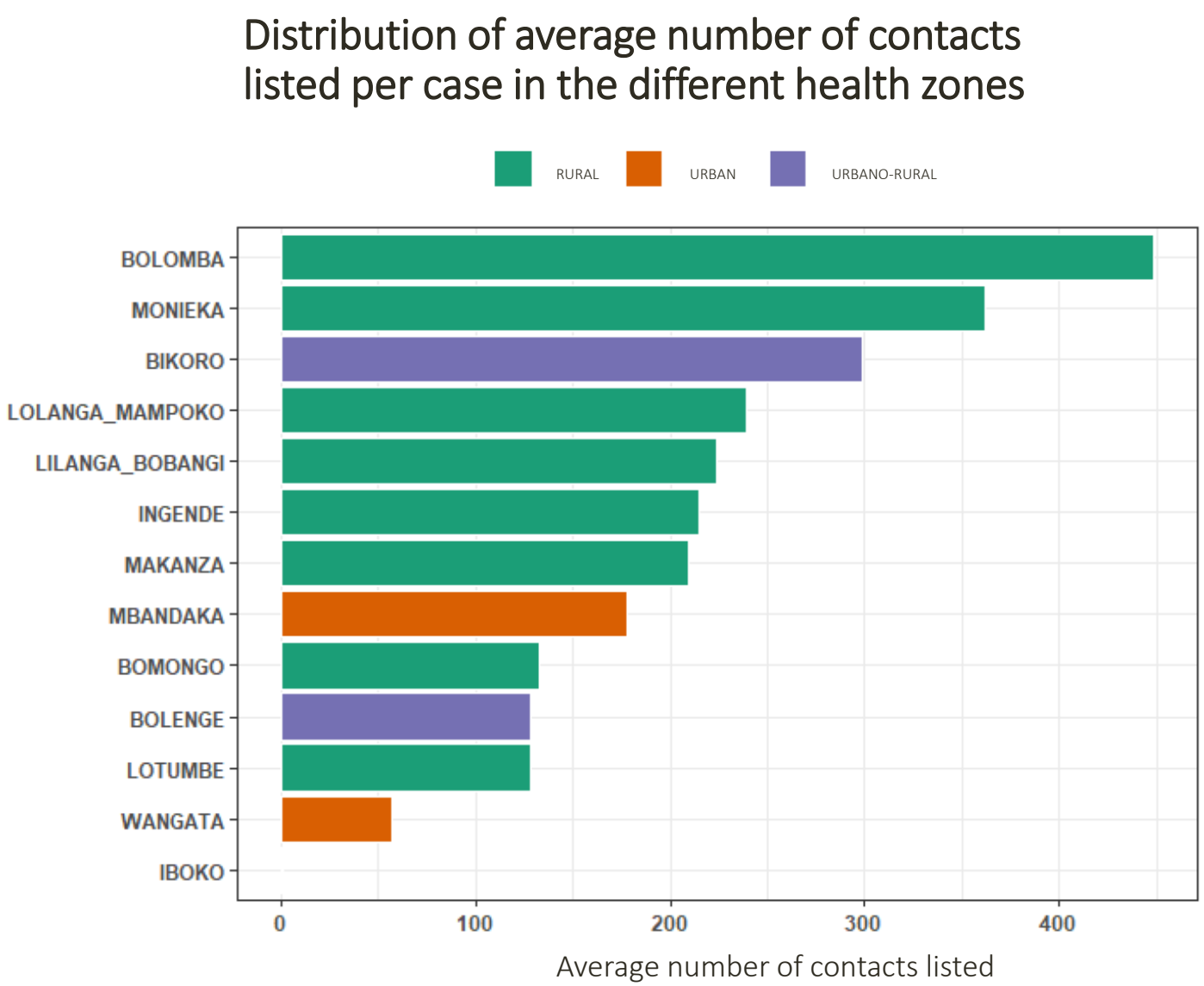
CARACTERISTICS OF CONTACTS(3): CONTACTS NEVER SEEN IN MAKANZA

- 1 lost to follow-up on day 7: co-patient of confirmed case, vaccinated
- 33 contacts classified as « never-seen » in the linear database

Distribution of never-seen contacts in Makanza by type of contact with index case and vaccination status



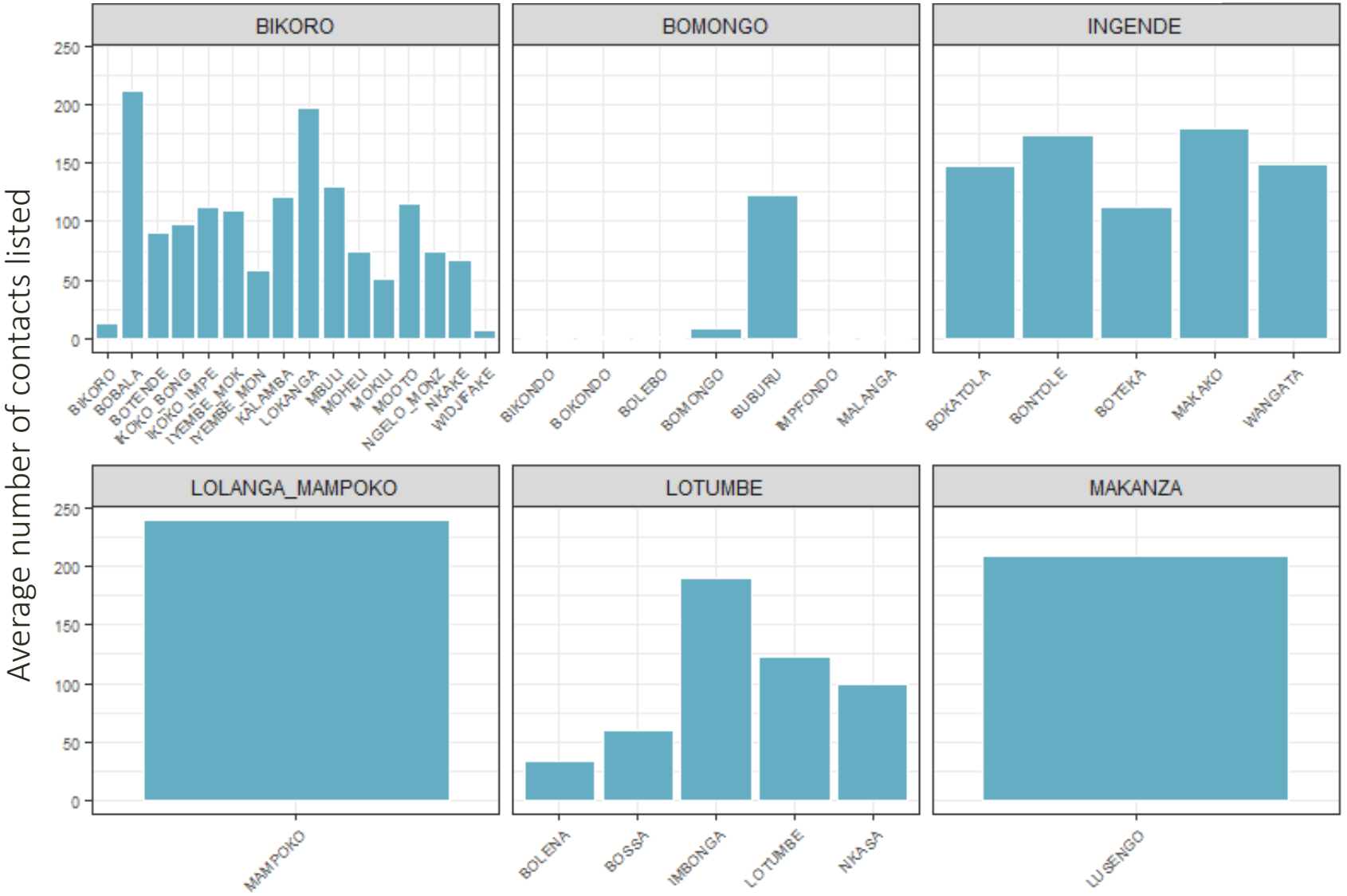
LISTING OF CONTACTS (1): AVERAGE NUMBER OF CONTACTS PER CASE AND PER HZ



- Average of 100 to 200 contacts listed per case in Lotumbe, Bolenge, Bomongo and Mbandaka (average close to what was estimated in some ZS of the 10th outbreak).
- Makanza, a still active outbreak, falls within this range (only 1 case).
- Bikoro, Monieka and Bolomba stand out with an average of >= 300
  - . Presence of three outliers: Bikoro (RDCEQT002153 and RDCEQT002117) and Bolomba (RDCEQT003001) with more than 1000 contacts listed.
- In Wangata, on the other hand, listing is lower than in the other ZS (~50 contacts per case).
- Data not compiled for Iboko.

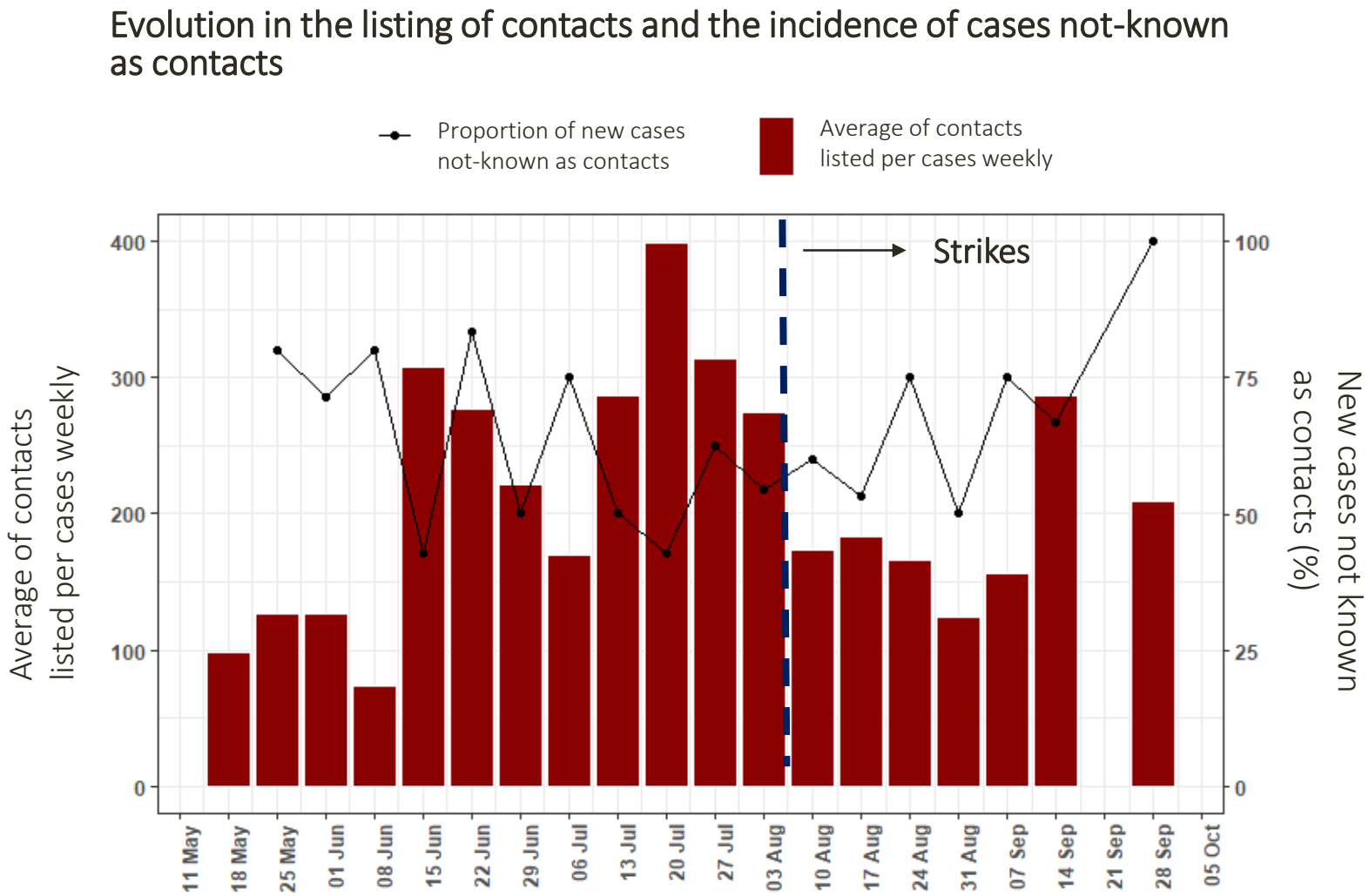
LISTING OF CONTACTS (2): AVERAGE NUMBER OF CONTACTS PER HEALTH AREAS

Average number of contacts listed per cases in different health areas in the last active hotspots



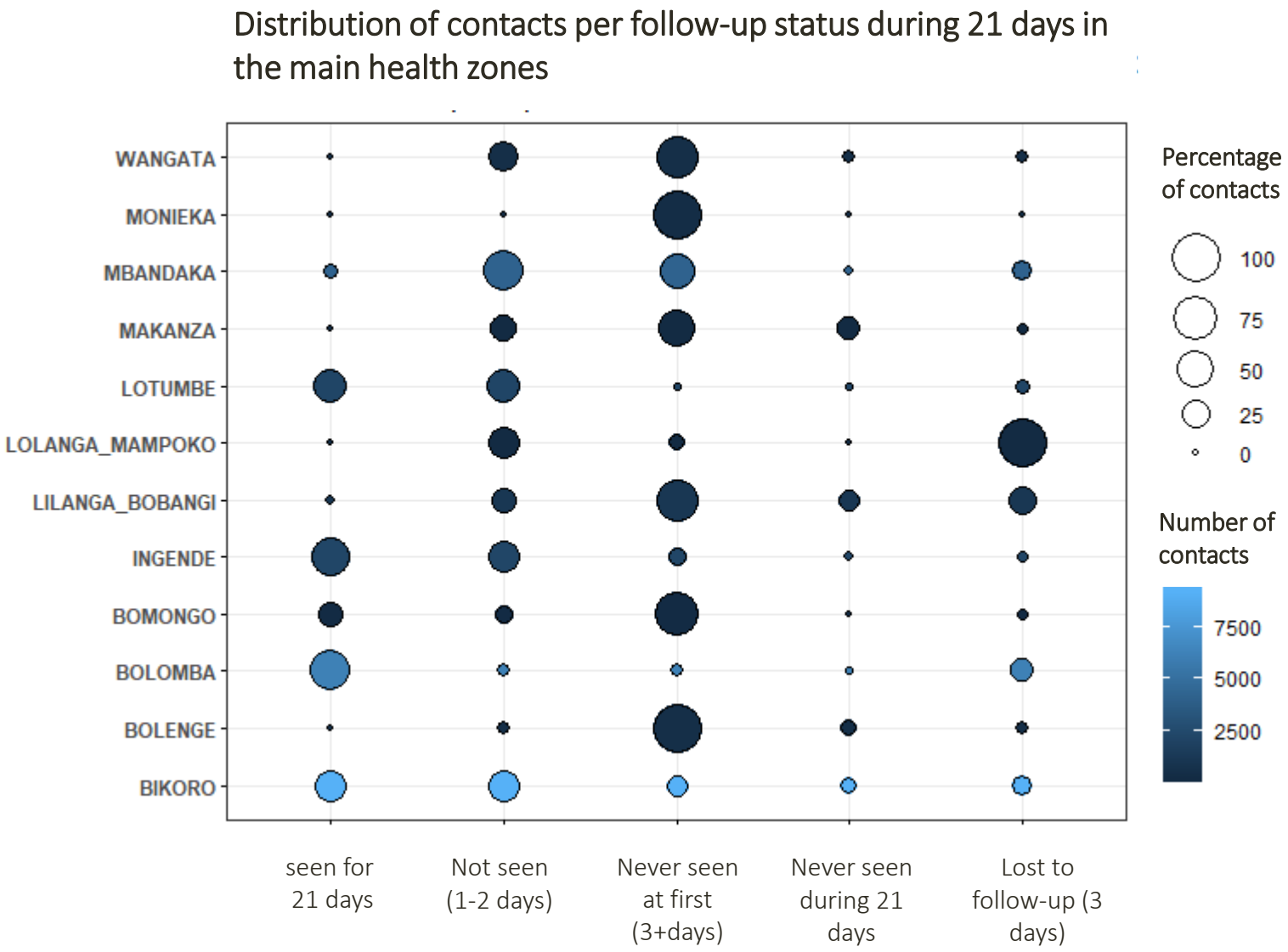
- Concentration of contacts in only one health area in Makanza, even though the case "worked at the riverbank with clients from several localities".
- Homogeneous listing in the different health areas affected in Ingende (even in Bontole which had only one case).

LISTING OF CONTACTS(3): Evolution in listing and in the occurrence of cases not known as contacts



- The number of contacts has known several increases ; however, the proportion of new cases not-known as contacts was never less than 40 %

QUALITY OF FOLLOW-UP PER HEALTH ZONES



- More than 50% of the contacts listed in Bolomba and Ingende were seen during the 21 days of follow-up. And between 30 and 40% in Bikoro and Lotumbe.
- In the majority of HZs, more than 40% of contacts missed the first three days of follow-up and 15 to 40% of contacts missed 1 to 2 days of follow-up.
  - This is the case with Makanza which is the currently active HZ where 48% of contacts missed the first 3 days of follow-up (time for the deployment of the team).
- Lilanga Bobangi has the highest proportion (12.7%) of listed contacts who were never seen in 21 days, while in Lolanga Mampoko, almost all listed contacts were not seen for 3 successive days at any point in their follow-up.

DISCUSSIONS

- Even if the listing seems consistent, the proportion of cases not known as contacts is still high.
- The majority of the contacts that have become confirmed cases are contacts who are socially close to the source case. Is listing done beyond the close circle?
- In Makanza, the listing is in the average of the other zones, even if concentrated in one health area.
- 1 never-seen contact was repoted in Makanza, who had direct contact with fluids of the index case, and vaccinated.
- For an urban area, Wangata had a low average number of contacts listed per case compared to the other health zones
- More attention to the listing of children in the event of a new case is needed (Mbandaka).
- The quality of the linear database still needs to be improved: Iboko data to be included, date of vaccination to be specified, date when the lost contact was found...

2) SOCIAL SCIENCE STUDY ON CONTACT TRACING

DRAFT

BARRIERS AND MOTIVATORS TO PARTICIPATION IN KEY RESPONSE INTERVENTIONS

LISTING AND FOLLOW-UP OF CONTACTS

MBANDAKA, BIKORO, INGENDE

SOCIAL SCIENCE ANALYTICS CELL (CASS)

EBOLA RESPONSE IN EQUATEUR

SEPT 2020

OBJECTIVE OF THE STUDY

1

Understand the underlying, common or recurrent factors of refusal and participation according to health areas ;

Comparison of health areas with more refusal with those with more participation may highlight these common and motivating factors.

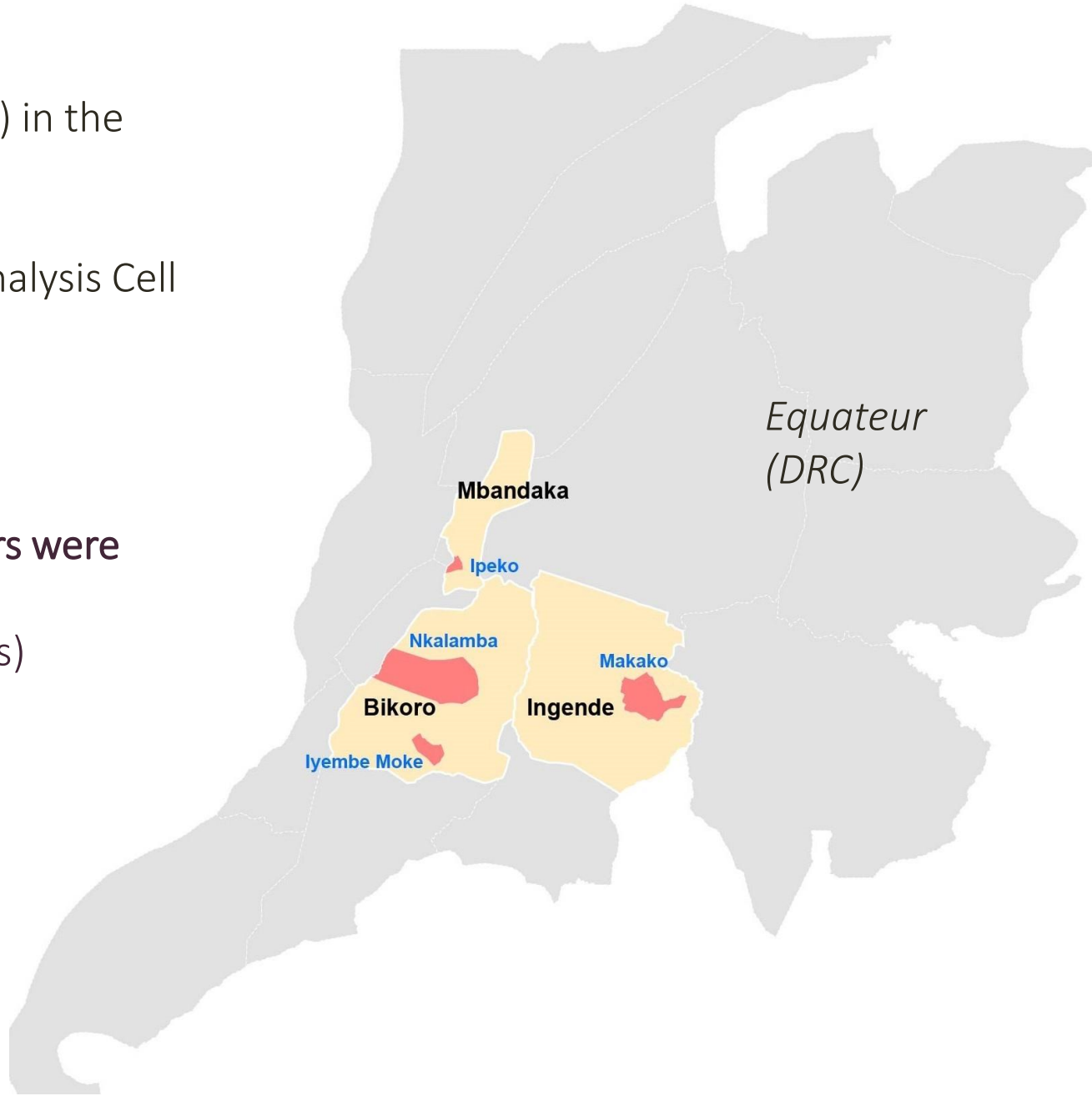
2

Identify ways to mitigate these barriers and increase the acceptability and acceptance of interventions ;

Through analysis, highlight “what is working" so that these practices can be learned and replicated.

METHODOLOGY

- 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)
- Between 16-27 September 2020
- **214 community members and healthcare workers were interviewed in 44 KIIs and 24 FGDs**
  - 28% aboriginal communities (autochthones)
  - 56% women



KEY RESULTS

PRELIMINARY ANALYSIS

MAIN REASONS FOR REFUSING CONTACT LISTING AND FOLLOW-UP

- **Doubts about the reality of the disease**
- **Fear of the vaccine**
- **Fear of stigmatization**
- Response teams are seen as “strangers”, not inclusive of community members (lack of trust)
- Fear of being transferred to the ETC and fear of SDB
- Communication not efficient enough (explaining contact tracing)
- Delays in follow-up visits or not appropriate timing (conflicting with other activities)
- Barriers in accessing healthcare (if symptoms during follow-up)

REASON FOR REFUSING : DOUBT IN THE "REALITY" OF THE DISEASE (1/3)

Ebola is seen as an invention of health authorities (doctors, nurses), politicians, partners, etc., to make money.

Distrust towards doctors and politicians

- The intentions of local health authorities (doctors, nurses), politicians are believed to be dishonest
- Complicity with the Response and international actors to receive money

Feeling that communities are not included

- Health authorities are believed to be interested in their personal enrichment
- Community members are not part of the Response

« It is not Ebola, ***nurses are lying to make money (…), by giving false information to partners*** *so they would send money. »*

- FGD, Young men, Kalamba/Bikoro

« People were coming to take my name. ***I didn't know them, what did they want to do with my name ? To benefit from it, but not for my own interest*** *»*

- KII, Female, 35 years, Ipeko/Mbka

« Since they were cases in our village, ***they should have included us in response activities****, but they (the doctors)* ***were only thinking about their own families****»*

- KII, Female, 48 years, Kalamba/Bikoro

Perceptions of Ebola as a business result from feeling of exclusion ; and feeling of exclusion fuels distrust

REASON FOR REFUSING : DOUBT IN THE "REALITY" OF THE DISEASE (2/3)

Belief that Ebola is a "traditional" illness

The signs are linked to witchcraft 'mauvais sort'

- Belief that only traditional cures can cure these signs – as strong in rural and urban areas
- Reinforced by cases of spontaneous healing

« For some people, the EVD is a bad spell (…). ***This spell manifests by people vomiting blood (…), it's called Isasi and it can be cured by indigenous products****, without going to the ETC »*

- FGD, Young men, Kalamba/Bikoro

Similar diseases existed before

- Symptoms similar to the ones described for Ebola are common and were treated with traditional cures
- Perception of a disproportion in the response to these common diseases

« People don't want to be listed as contacts because rumours are saying that Ebola does not exist. ***We are used to community diseases : diarrhea, fever, vomiting, muscle and stomach pains. How did these diseases become Ebola now ? »***

- FGD, Men, Kalamba/Bikoro

How are we explaining symptoms ? Acknowledging that they are similar to other diseases known by communities?

REASON FOR REFUSING : DOUBT IN THE "REALITY" OF THE DISEASE (3/3)

Individual and community experience of low contagiousness and mortality

Low contagiousness

- *Experience that high-risk contacts were not infected*

> *"What good in being listed, let it be, Ebola does not exist. My husband who dug the grave (of a confirmed case who died), look, he is there, we are all in good health »*
>
> - KII, Female, 50 years, Kalamba/Bikoro

Low mortality

- *Comparison with the 2018 outbreak*

> *« (…) in 2018, in Bikoro, we had to flee because Ebola was not a joke and it was terrible. But how do you explain now that in one village, Ebola only kills 2 people ? »*
>
> - KII, Female, 30 years, Kalamba/Bikoro

Ebola is communicated as deadly, fearful and highly contagious.

Interventions and messages also imply it transmits easily and everywhere.

A lack of nuance when explaining transmissibility and risks fuel distrust and disbelief.

THE ROLE OF PROXIMITY IN ACCEPTING CONTACT TRACING

Seeing confirmed cases and deaths is a key determinant to explain acceptance and refusal.

Proximity = better acceptance

- Acceptance of the reality of the disease
- Acceptance of Response intervention
- *Example : in the village of Iyembe Moke, all the villagers accepted contact tracing following the deaths of 5 individuals in the village. They prepared the lists of contacts themselves.*

≠

No proximity

When individuals and communities have not experienced (seen) the disease :

- More disbelief in the disease
- More refusals to take part in interventions

No need for intrusive interventions to identify contacts
Letting communities and individuals come to the Response and not the opposite

Intrusive interventions to identify contacts fuel the idea that "everything is Ebola" = vicious circle of distrust

REASON FOR REFUSING (2/3) : FEAR OF THE VACCINE

Belief that the vaccine kills or harms

The fears seem to be linked to the side effects of the vaccine

« Others were refusing because of the side effects people who had been vaccinated experienced »

KII, Female, 48 years, Kalamba/Bikoro

Belief that the vaccine is used to inject Ebola

Belief that people who get vaccinated will die eventually

They were scared to take the vaccine, to be injected with Ebola and to die »

KII, Female, 35 years, Ipeko/Mbka

Rumours that the vaccine is made to kill people in order for others (not specified) to take the forests from communities and exploit them for resources.

« Partners are giving us a fake vaccine so that they can exploit our forest in our absence. A friend from Kinshasa told me this »

KII, Female, 26 years, Makako/Ingende

What communication is being used on the vaccine?

Focusing on "acceptance", versus understand how it works, who gets it and why there are side effects, cause distrust

Fear of stigmatisation

- The risk of stigmatisation comes from the daily (sometimes twice a day) follow-up visits by RECO to the houses of the contacts. It draws attention to the house.
- **Made worse when cars are being used**.
- Fear of being associated with a confirmed case or of people thinking they have the disease (seen as **shameful**).

*« **People who are doing the follow-up don't come by feet, they always use cars. It is very upsetting because every one will know that you were in contact with people who had Ebola**. It causes stigma in the neighborhood. »*

- KII, Female, 52 years, Ipeko/Mbka

*« **If they know that you were listed, they will say that you were infected that you will die**. Others will start talking badly about you (…).*

- FGD, Men, Iyembe Moke/Bikoro

*« (…) in the beginning when people started getting sick, **teams who were coming to the village scared us. People I didn't know were walking around the neighborhood and asking about sick people**. If you were sick, they took you to Ingende. »*

- KII, Male, 45 years, Makako/Ingende

KEY POINTS

- There appears to be **a lack of nuances** in the Ebola response and in the communication about Ebola.

- **Communities are seeing the "atypical" characteristics of this outbreak** : low mortality, low transmission.

- However, response interventions **are identical and the communication is still generic and out of local context** : Ebola is depicted as a very contagious, deadly disease.

→ Are interventions adapted to the context ?

> *« Appropriate communication is missing. Here, we only saw people on motorbikes with megaphones, shouting about Ebola and saying we need to wash hands »*
>
> - FGD, Young men, Ipeko/Mbka

CASS RECOMMENDATIONS

1) **Reduce visibility**: do not use cars, or leave the vehicles at a distance - before entering the villages.

2) Consult with contacts to determine with them **how to minimize the risk of stigmatization.**

3) **Adapt interventions and protocols to the characteristics of the epidemic** and the context: avoid using coercion against individuals to follow interventions (testing, isolation, etc.).

4) **Adapt communication** to the characteristics of the epidemic: for all teams in contact with communities (not only RCCE - surveillance teams are also in direct contact with individuals).

CODEVELOPPED RECOMMENDATIONS

- The recommendations with the actors and stakeholders are currently being co-developed on the ground.

- The recommendations resulting from this study and other CASS studies in Equateur are compiled online in the MONITO tool (available here).

DRAFT

QUESTIONS?

THANK YOU

The complete study will be made available within the coming days

Ressources, studies links online

Google drive Ebola (lien)

Google drive CASS (global) (lien)

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