



# IMPROVING HEALTH COMMUNICATION, DEALING WITH STIGMA, AND COPING STRATEGIES IN THE CONTEXT OF THE COVID-19 PANDEMIC IN UGANDA

Policy brief 1, August 2021

## Summary:

*COVID-19 pandemic has had a huge detrimental effect on human health and healthcare systems. In some cases, it led to violence, stigma and discrimination against suspected cases largely because of information gaps. Besides, families where cases come were deeply stigmatized. This study used an exploratory sequential mixed-methods design to elucidate ways of improving health communication, dealing with stigma, and identify coping strategies among COVID-19 affected individuals and communities.*

## 1. INTRODUCTION AND CONTEXT

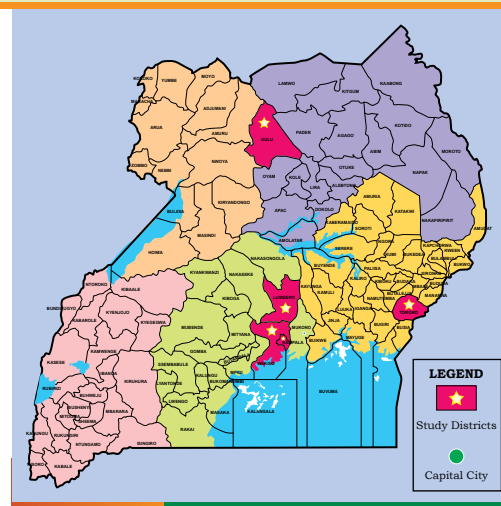
To date, the COVID-19 pandemic has had a huge detrimental effect on human health and healthcare systems. It has led to a global shutdown in socioeconomic and physical terms (WHO, 2020). As of July 1<sup>st</sup>, 2020 in Uganda when we conducted this survey, there were over 10,000,000 total confirmed cases with over 500,000 deaths globally. Based on the records Ministry of Health Uganda, as of 1st July 2020, there were no deaths, with 889 confirmed cases, and 808 recoveries, and 9,716 contacts listed (MoH, 2020). However, some suspected cases under quarantine did not adhere to COVID-19 prevention and control measures. Besides, the violence meted against suspected cases and varying knowledge gaps have been observed.

In addition, families, where cases come, were deeply stigmatized. The recovered cases as well as suspects that complete institutional quarantine faced community rejection, stigma, and discrimination. This aggravated suicide ideation during COVID-19 outbreak due to isolation and quarantine (Klomek, 2020). This outbreak has had physical, psychological, and economic consequences all over the world (Li, et al., 2020; Ding, et al., 2019). A year later by the 20<sup>th</sup> week of August 2021 Uganda had 44,074 cases and had lost 2,939 COVID-19 patients (Covid-19.gou.go.ug/statistics.html). Thus, there is a great need to manage this pandemic using the multidisciplinary team model (Ding, et al., 2019).



*There are several communication gaps especially to the families and host communities where the patients or contacts that have been in treatment and /or designated /self-isolation centers. The acceptability of these individuals is a great challenge that has led to further stigmatization of returning persons. This evidence gathers on communication, stigma and coping strategies informs Ministry of Health and other stakeholders on the best strategies for effectively communicating and dealing with stigma and coping among COVID-19 survivors and formally quarantined persons.*

Evidence was gathered using an exploratory sequential mixed-methods design where quantitative and qualitative data was collected. This study was implemented in five districts (Kampala, Wakiso, Tororo, Gulu, and Luwero). Our study participants were individuals who had undergone institutional quarantine, COVID-19 survivors, and key officials involved in mitigating COVID-19 virus disease on the scientific advisory committee and the National taskforce members. For the qualitative component, we conducted 38 key informant interviews (KIIs) and 32 in-depth interviews (IDIs) which were purposively sampled. For the quantitative data, a total of 473 respondents participated in this study of whom 240 were COVID-19 survivors while 233 were institutionally quarantined persons. This study will improve psychosocial well-being and quality of life for people that go through such experiences in the country.



Map of Uganda showing study districts



Training of the research team and conducting interviews with survivors while adhering COVID-19 standard operating procedures

## 2. KEY FINDINGS

**473**

Respondents who participated in the study

**240**

These were Covid-19 survivors

**233**

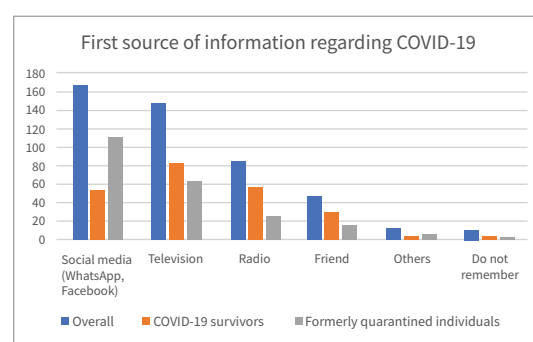
These were institutionally Quarantined persons

### First source of information



35.3% of all respondents mentioned social media (WhatsApp and Facebook) as their first source of information about COVID-19

Over a third of all the respondents, 35.3% (167/473) noted that social media (WhatsApp, Facebook) was the first source of information about COVID-19 followed by Television then radio. Higher proportions of the quarantine persons 48.1% (112/233) noted that they first heard about COVID-19 from social media compared to 22.9% (55/240) of COVID-19 survivors.



### Reported reliable source of information

In terms of the most reliable source of information regarding COVID-19, more than two-thirds of the respondents 67.2% (318/473) said television was their most reliable source of information followed by social media than radio. The communication before admission was characterized by information on the trend of the pandemic around the world, which was in terms of cases and deaths. More than half 55.8% (134/240) noted that they were told about the medication they were being given, only 3.9% (9/233) of the quarantined persons said they were told about the

medication they were taking. The COVID-19 survivors (patients then) felt that there was unclear information on their COVID-19 status (i.e. whether they were positive or negative) and on how they were reached out to. It was also reported that there was hardly any information communicated to families where the suspected cases and contacts were being taken for management once identified as confirmed cases or contacts. In addition, qualitative results revealed that there was a breach of privacy and confidentiality when COVID-19 test results were

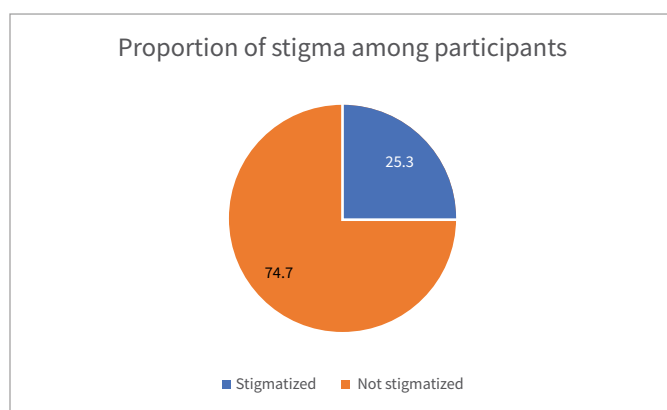
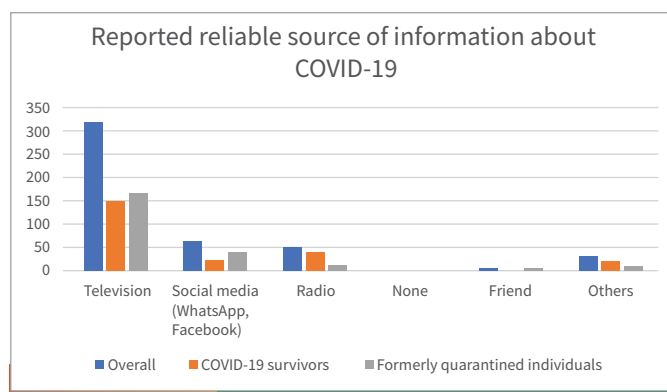


being disclosed. “COVID-19 survivors cited test results were received through friends:

*“Instead of a doctor or anyone else calling me, it was actually my colleague calling me and telling me I have received your results and, you are positive! It was one of those senseless things actually, because am imagining how unprofessional people can be with other people’s results with the whole stigmatization thing...” (IDI COVID-19 survivor\_Above 30 years Kampala)”.*

## Stigma and stress

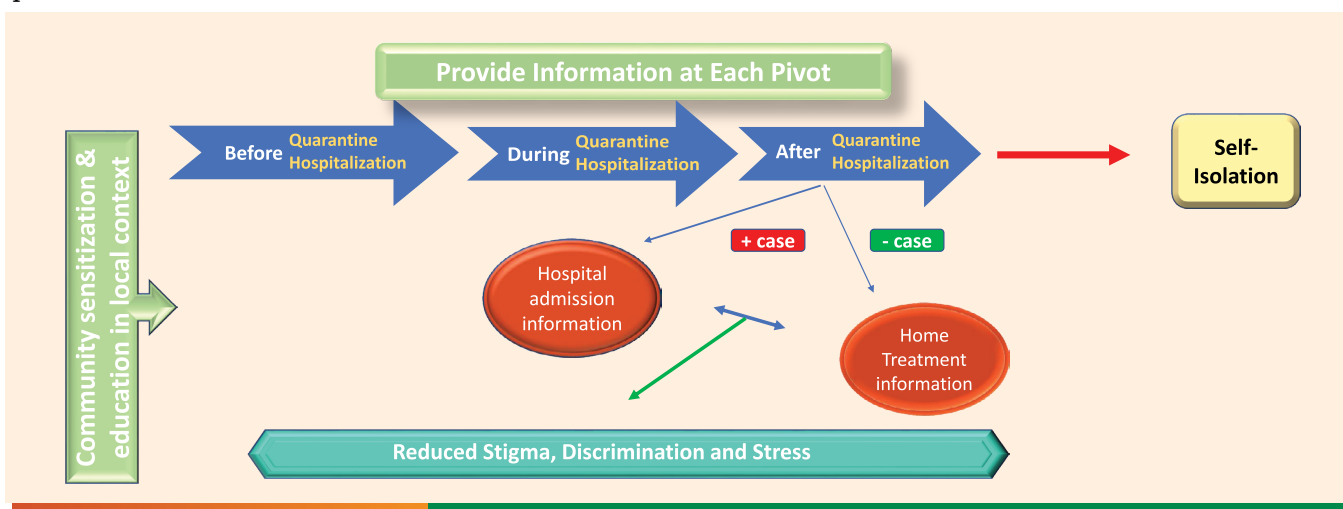
Due to this poor communication, contacts were exposed to stigma from fellow contacts. About a quarter of the respondents 25.3% (120/274) were stigmatized. Self-stigma that was characterized by the fear of interacting with community members was revealed by several survivors and contacts who felt the community members would still consider them infectious. The community stigma did not only affect the COVID-19 survivors and contacts but also their family members. Family members, including spouses and children to victims, experienced associative stigma which was exhibited by denied access to workplaces or public places, physical attacks, isolation among others. About two-thirds 65.1%(308/473) of the respondents were moderately stressed while less than ten percent (9.3%) were highly stressed.



There is slightly a higher proportion of COVID-19 survivors that exhibited moderate and high stress compared to quarantined persons.

## Communication model for COVID-19

Below is the proposed Health Communication Model for acute epidemics and pandemics in the low and middle income countries-A case for COVID 19 in Uganda. To prevent stigma, discrimination and stress among people who test COVID-19 positive, clear expected information should be provided at pre-testing, intra-testing, and post-testing of COVID-19 suspected cases. The testing outcomes and the next steps as either positive or negative should be communicated to the cases or exposed people. Hospital admission and home care strategies should be described to people who test positive. At all stages using the public and private media, the community should continuously be sensitized and educated in their local languages. It is anticipated that if the information is provided at each step and the communities educated, there will be reduced stigma and stress among people who test COVID-19 positive.



### 3. CONCLUSION AND POLICY RECOMMENDATIONS

#### a) Health communication challenges related to before, during and after COVID-19

Social media is a quick way of reaching communities but television and radio are more reliable information sources. Before and during COVID-19 tests counselling are generally low. Transparency about COVID-19 treatment to patients was average (with 55.8% of survivors reporting that the treatment they were undergoing was explained to them) while it was very poor among the quarantine persons (with less than 5% reporting to have been told the kind of treatment they were undergoing). There was unclear communication about COVID-19 prevention, transmission and treatment with no evidence was a key challenge as well. There are low staffing levels compared to the number of COVID-19 patients/quarantined persons compounded the communication gaps between the patients, COVID-19 patients/quarantined persons, their families as well as their host communities.

#### b) Readiness to reintegrate COVID-19 survivors and formerly quarantined persons

Generally, COVID-19 patients/quarantined persons are counselled before being discharged however their families were not well prepared to receive discharged persons.

#### c) Stigma among COVID-19 survivors and formally quarantined persons

Self-stigma (internal stigma) was revealed by several survivors and contacts who felt the community members would still consider them infectious. Stigma from the community (external stigma) was portrayed by being discriminated, forced to relocate, use of stigmatizing language like name- calling “COVID /CORONA man”, denial of access to public services and shunning away from the services offered by survivors and formally quarantined persons and contacts.

#### d) Coping mechanisms among COVID-19 survivors and formerly quarantined persons

Generally, COVID-19 survivors / quarantined persons were stressed moderately/highly. Some of the coping mechanisms adopted by both survivors and contacts focused on building a strong support system that involved close friends and survivors, keeping the COVID-19 status a secret, self-isolation, relocation, spending more time watching movies as opposed to news, physical exercise, acceptance and believing in God.

### POLICY RECOMMENDATIONS

1. All communication should be availed in the specific local languages in the community. Empowering the cases and contacts to be in a position to share their success stories this could help in addressing self-stigma and stigma at the community level
2. Involving stakeholders in identifying avenues where communication can be passed on.
3. Addressing the human resource gap especially the counsellors to support in the psychosocial wellbeing of the cases and contacts.

#### About the authors

**Lynn Atuyambe**, Ph.D Public Health, Associate Professor, Eastern Africa GEOHealth Hub, Makerere University, School of Public Health

**Agnes Nyabigambo**, MHSR Health Services Research Specialist, Research Associate, Eastern Africa GEOHealth Hub, Makerere University, School of Public Health

**Samuel Etajak**, MPH, Research Associate, Eastern Africa GEOHealth Hub, Makerere University, School of Public Health

**Felix Walyawula**, BEH, Research Associate, Makerere University, School of Public Health

**Richard Okwi**, MPH, Public Health Specialist, Ministry of Health Uganda.

#### References

Ding, S., et al., (2020) [Roles of the multidisciplinary team (MDT) in diagnosis and treatment of suspected cases of coronavirus disease 2019 (COVID-19)]. *Zhejiang Da Xue Xue Bao Yi Xue Ban*, 2020. 49(1): p. 0.

Klomek, A.B.(2020), Suicide prevention during the COVID-19 outbreak. *Lancet Psychiatry*, 2020. 7(5): p. 390.

Li, S., et al., (2020) The Impact of COVID-19 Epidemic Declaration on Psychological Consequences: A Study on Active Weibo Users. *Int J Environ Res Public Health*, 2020. 17(6).

WHO(2020a), 2019-nCoV outbreak is an emergency of international concern. <http://www.euro.who.int/en/health-topics/health-emergencies/international-health-regulations/news/news/2020/2/2019-ncov-outbreak-is-an-emergency-of-international-concern>, 2020.

#### Acknowledgment:

The Implementation of this study was made possible with funding from the Government of the Republic of Uganda through Makerere University Research and Innovations Fund (REF: MAK/DVCFA/151/20).