

Receiving and Responding to Community Feedback During Health System Crises: Lessons from Early days of the COVID-19 Pandemic Response in Kilifi County



Key messages

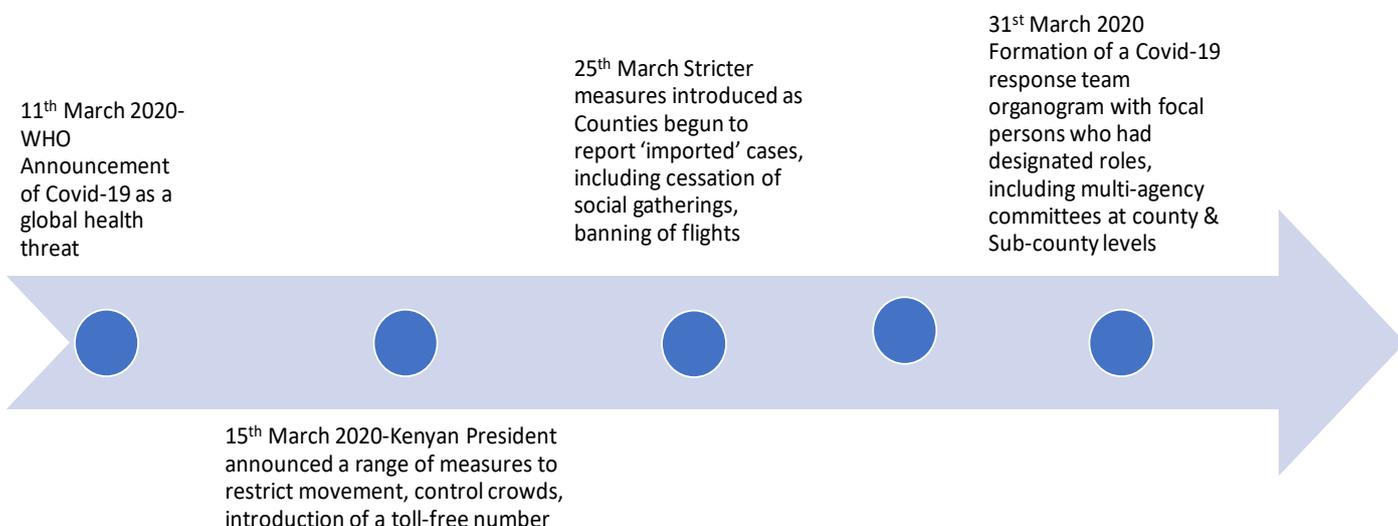
1. During crises, health systems have an opportunity to leverage community ideas, needs and support through pre-existing public and community engagement mechanisms, especially those that allow direct interaction such as health facility committees and meetings with community health volunteers.
2. In Kilifi, the use of multiple feedback mechanisms and approaches allowed for a range of issues and concerns to be picked up and responded to in the early days of the COVID-19 outbreak response. The approaches used have varied with the evolution of the pandemic.
3. Where new feedback mechanisms are introduced during a crisis, there needs to be adequate resource allocation, coordination and monitoring of these mechanisms to ensure responsiveness to community concerns and needs.
4. Careful co-ordination and planning at various health system levels and with wider stakeholders is critical when implementing public health interventions during health system crises to ensure that communication and co-ordination challenges do not undermine community input into, trust and support for health system interventions.

Introduction

Health system responsiveness, defined as how the health system reacts to input from the public or citizens is one of the goals of the health system alongside fairness in financing and health service outcomes. Listening to and responding to public inputs and feedback can lead to a health system that is stronger and fairer to all segments of the population, where policy and practice is more appropriate for and accessible to citizens. Responsiveness is closely tied to the broader idea of citizen, public, or community participation in health systems. However, responsiveness is likely to be undermined, especially for vulnerable and marginal populations in periods of unexpected shocks and crises to the health system such as disease outbreaks or health worker strikes. In the current COVID-19 crisis, there has been more focus globally on health system control interventions; with minimal consideration of community views about these interventions. In this brief, we report early findings on health system responsiveness to community feedback in implementation of the COVID-19 crisis response in Kilifi County, drawing on publicly available national and county level documents, press briefings, in-depth interviews and observations of County Health Management Team (CHMT) COVID-19 briefings in the Kilifi learning site. We consider what community engagement and citizens feedback channels were utilised, what concerns were raised by the public, how they were handled by health system actors and highlight lessons learned.

Context

Fig 1 below summarises some of the global and national events in the early days of the COVID-19 response.



Soon after the first case was announced in Kilifi, the CHMT developed an organogram (Fig 2) with focal persons responsible for different aspects of the COVID-19 response. The organogram evolved over time and had links to other stakeholders through multi-agency committees at county and sub-county levels. The County multi-agency committee was co-chaired by the Governor and County Commissioner and included stakeholders such as other county government departments, business groups representatives, religious leaders and Non-Governmental Organisations (NGOs). The sub-county multi-agency committee included the Sub-County Medical Officer of Health (SCMoH), the Sub-county Commissioner and sub-county level stakeholders.

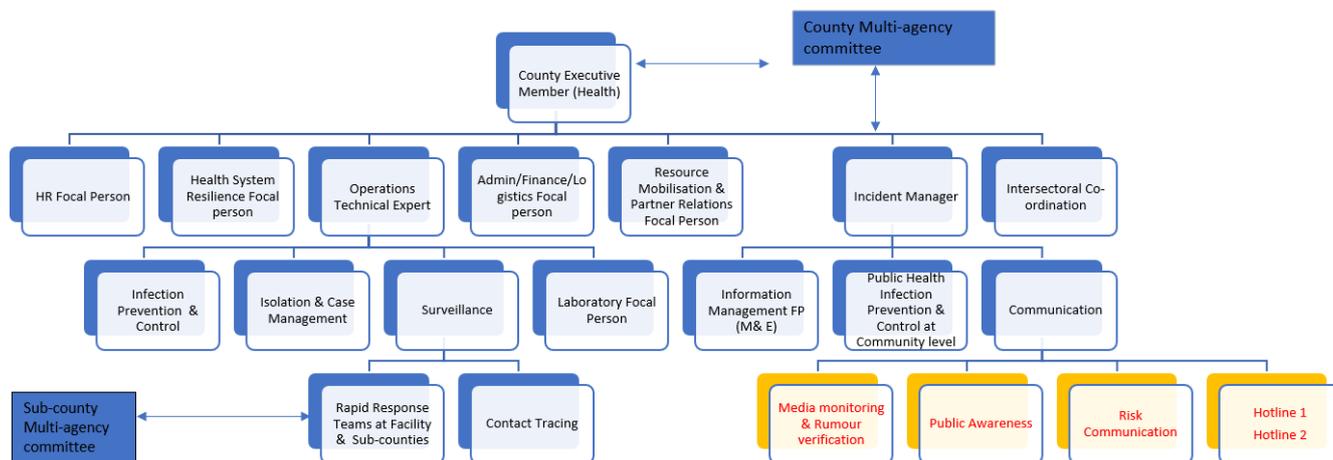


Figure 2: Organogram of the Kilifi Covid-19 response team showing links to county and sub-county multi-agency committees (as at March 2020)



Findings

Mechanisms for receiving and responding to community concerns and feedback

During the early days of the response in Kilifi County, 'information provision' by County Department of Health (CDoH) officials was the most heavily utilised way of engaging the community. Messages were passed through public address systems by public health and health promotion officers, who traversed all the 35 electoral wards in Kilifi county. Radio -mostly local FM stations- was also utilised. Periodically, the County Governor (joined by other senior county officials) issued press briefings on the status of the response in the county and encouraged the public to adhere to prevention measures. The decision to involve the senior county leadership in conducting messaging around COVID-19 was informed by a perception that their involvement would signal to the community the importance of the control measures that were being put in place. Messages that were shared with community members included:

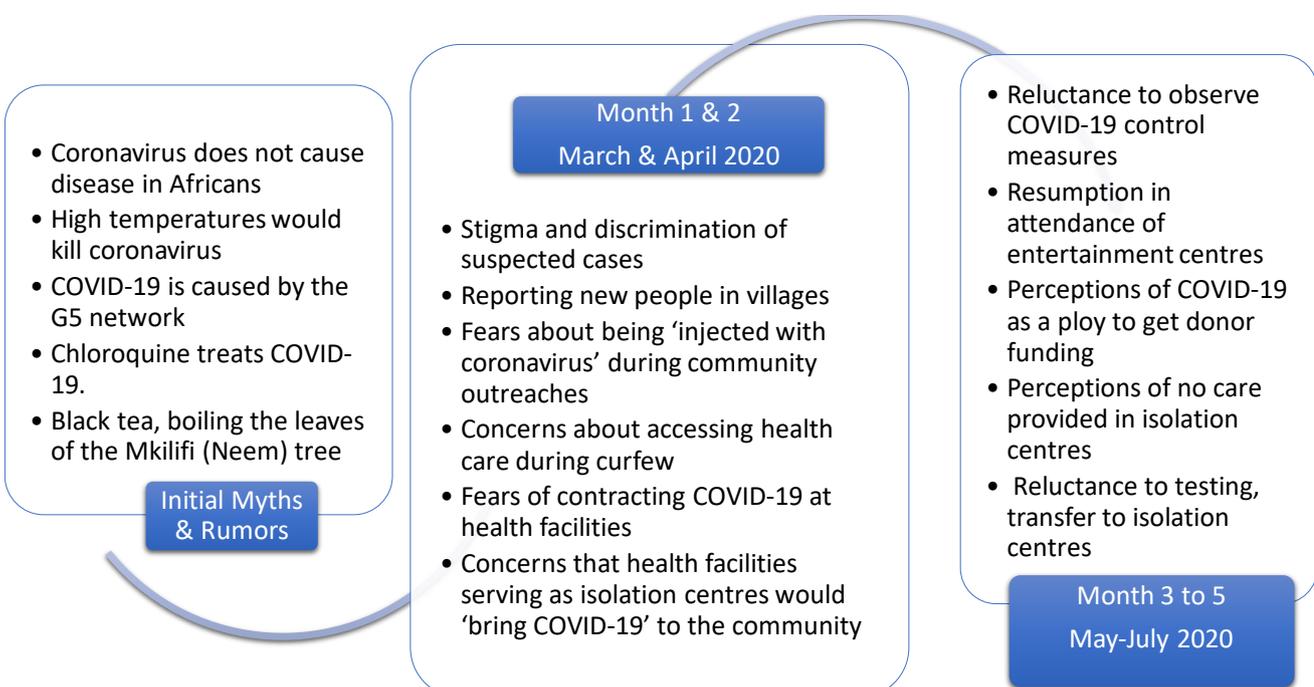
- The signs and symptoms of COVID-19 and what to do if one had such symptoms
- Advice to stay at home, wash hands, wear face masks and practice physical distancing as measures to control the spread of COVID-19
- Importance of quarantine and isolation as a part of the supportive management for COVID-19 and a prevention strategy to reduce transmission
- Providing hotline numbers where members of the public could call to report concerns and ask questions

The county response team used pre-existing channels (such as county Facebook pages, existing Whatsapp groups), and a newly introduced channel (two hotline numbers) to keep track of community concerns and rumours. A CHMT member was tasked to scour media outlets including social media to keep track of rumours and myths. Some rumours were shared directly with the county response team through personal interaction with community members and healthcare workers close to community level such as ward public health officers. A register was maintained in which identified community issues were documented including the source, details of the rumour or community concern and action taken in response.

Early community sensitization efforts were generalised with little specific messaging strategies and packaging for different groups. Youth for example, continued to sit in groups without observing physical distancing measures. There was little mention of engagement with other marginalized groups such as people living with disability (PLWD). However, at the time of data collection, there were ongoing efforts to develop a proposal for engagement with PLWD and youth groups.

Community concerns and feedback

Community concerns and feedback changed over time as shown in Fig. 3 below



In the early days of the COVID-19 response, there was significant fear, which reportedly resulted in community compliance with the COVID-19 transmission measures. Community members frequently called the hotline numbers to report new entrants to their villages and request testing for COVID-19. One manager observed:

"During the first wave of infection, the three hotline numbers would receive up to 200 calls in 24 hours but now, calls have reduced to about 20 to 50 calls across all the hotline numbers." County Health Manager

Unfortunately, this fear also resulted in stigmatization of community members who were suspected cases. For example, a person suspected of having COVID-19 was denied use of water points and shops in one village. In another village, community members almost burned down the home of a COVID-19 suspect. Communities also raised concerns about the use of their health facilities as isolation centres, with perceptions that they were 'being brought COVID'.

Concerns about contracting the virus reportedly contributed to a decline in service delivery in across health facilities. One respondent observed:

"They [community members] are calling our health facilities a hub of COVID, so we have experienced a decline in service delivery. This doesn't mean we don't have clients who are suffering from other illnesses but they are afraid of catching the virus in our facilities". County Health Manager

There were also reports from the community of mothers delivering at home due to difficulties in getting transport to the health facility. The majority of respondents linked poor outcomes among pregnant women to transport challenges due to restrictions on travel as part of the control measures.

As the pandemic evolved, there were reports of community fatigue with adherence to control measures illustrated by resumption of public gatherings such as funerals, repopulation of entertainment centres, reduced observance of physical distancing and wearing of face-masks. There were also cases of resistance to testing, transfer to isolation centres, closure of business premises and reports of community members hiding people who had tested positive with the belief that positive results were made up.

One factor attributed to the reported community

fatigue and emerging resistance was scepticism about the continued existence of COVID-19. This scepticism was linked to a press briefing that announced the discharge of the last COVID-19 patient in the county in the 'first wave' (lasting between 26th March 2020 when the index case was reported and 29th April 2020, when the last contact was discharged). Following the briefing, community members adopted the view that 'Kilifi County has no Coronavirus'.

The characteristics of the outbreak in Kilifi may also have contributed to this scepticism. For example, the majority of COVID-19 cases reported in the County were asymptomatic and at the time of data collection, some parts of Kilifi County had not reported a single case. Where there were reported cases, often they remained unknown to the public. These characteristics coupled with the economic impact of staying at home, meant that many community members reportedly opted to 'take the risk of contracting COVID-19, rather than die of hunger in their homes'.

Actions in response to community concerns and feedback

Various actions were taken by CDOH officials in response to community concerns and feedback, ranging from increased information provision, through organising community consultations, to ensuring modifications to support access to care during curfew hours.

In response to fears about COVID-19 being brought to the community, CHMT members engaged directly with community leaders in specially organised meetings, observing social distancing, to get their buy-in for use of identified facilities as isolation centres. These community leaders included village elders, sub-county and ward administrators, chiefs, community health committees and health facility committees. Concerns and feedback raised through the hotline numbers were handled by designated CHMT members (Fig 2). In response to reports of new entrants to community reports of suspected cases, the hotline handlers notified respective sub-county response teams to visit the affected households. Rumours, myths and calls seeking information about COVID-19 were mapped to identify regions where they originated. These were shared with the communication team (Fig 2) who engaged community members through their local leaders. The risk communication team was

comprised of people who spoke the local languages. Often, they spoke in vernacular when explaining the importance of COVID-19 transmission prevention measures to community members. While on the ground, the communication team responded to myths and rumours by acknowledging the beliefs of the community members (because some were not harmful practices) but provided additional explanation of why prevention measures were important and emphasized that no cure for COVID-19 had been found yet.

In some cases, community concerns resulted in multiple responses at various health system levels. In response to concerns about accessing care during curfew hours, some Sub-county Health Management Teams (SCHMTs) identified together with community members, transporters who were given passes by the police that would allow them to transport a patient. To supplement these efforts, at county level, the hotline numbers (initially set up for the COVID-19 response) were shared again through radio and social media for community members to call and request pick-up by ambulance during curfew hours.

Challenges related to community engagement and citizen feedback processes

Trust and governance are considered essential components of good pandemic response. Over time there appeared to be high levels of mistrust within communities, with perceptions that *'COVID-19 is a creation of government to attract donor funding'* and allegations of extortion of money from business owners. There was also a perception among community members of selective application of enforcement measures, particularly of business closure. For example, a manager at a private health facility for which a closure directive had been issued noted that no public health facilities were closed for reporting a COVID-19 positive case, and threatened to stop reporting COVID-19 cases. Eventually, the closure directive for the private health facility was retracted. The county COVID-19 response team then adopted a strategy to conduct risk assessment rather than effecting outright closure when a private health facility reported a COVID-19 case.

Challenges in co-ordination and communication were observed between departments and within the multi-agency committees responsible for enforcement. For example, a team of enforcement officers would go out with the CDoH staff to ensure

adherence to transmission measures (these included closure of business premises in some cases), but questions about who gave the directive for closure of premises would later arise. This contributed to a perception of unfair treatment among business owners and reluctance among enforcement officers to accompany CDoH staff during inspection of facilities and business premises, leading to loss of sustained enforcement efforts.

Hotline numbers were a newly introduced channel for receiving community concerns. While the hotlines provided important feedback, challenges related to their use might have undermined responsiveness to community needs and concerns. For example, the hotline phones could not make outgoing calls and were inconsistently loaded with airtime. The persons handling them sometimes used their own phones to respond to community members' calls or messages. It is therefore likely that some community members without airtime, might have lost an opportunity to raise their concerns.

There were also challenges in 'closing the feedback loop' to ensure that community members who needed an ambulance were reached in good time. First, there was reluctance among a few facility managers to release ambulances to pick mothers and community members from their homes. Second, even when ambulances were released, there were delays, and in one case a woman who needed transport to the hospital delivered on the way. Third, there were no measures to track implementation of the directive that ambulances could pick community members from their homes such as expected turn-around time to deliver the labouring mother to a health facility. Finally, there were no mapping of ambulances to determine which were nearest to which facilities to enable efficient deployment based on need. The hotline handlers often stayed on the phone for hours trying to find an ambulance for a community member who had called in.

Use of community participatory structures such as Community Health Volunteers (CHVs and health facility committees for COVID-19 community engagement happened later rather than earlier in the pandemic response. Community members frequently had follow-up questions, which they mainly asked CHVs, but CHVs were not any better informed than other community members as they were sensitized on COVID-19 later. The low and late utilisation of CHVs was linked to the low coverage

of community units (community health service delivery structures within which CHVs work). At the time of the COVID-19 outbreak in Kilifi, community unit coverage was approximately at 30%, and therefore CHVs could not be used in all parts of the county. In addition, a challenge of working with CHVs was the inability to support their daily stipend due to budgetary constraints. Furthermore, there was inadequate Personal Protective Equipment (PPE) to ensure the protection of CHVs when they went out to households. This may all have begun to change, because with support from the national government the coverage of community units has recently increased to 78%, with 1500 CHVs trained on both general CHV roles and COVID-19.

Conclusion and Recommendations

Overall, in Kilifi County, multiple mechanisms and approaches were used to receive and respond to community concerns and feedback during the COVID-19 outbreak response. The approaches used have varied with the evolution of the pandemic, and some of the challenges experienced provide an opportunity for learning. Although, the pandemic continues to unfold, some recommendations based on learning from recent experiences include:

1. While one-sided information sharing may reach large audiences, the use of more interactive mechanisms (such as health facility committees and meetings with CHVs) that allow interrogation by community members about what is happening should be strengthened as these have greater potential to build and maintain public support for health system actions.
2. Consistency in messaging and application of measures across all levels of the community is important to build community trust and to overcome resistance to response efforts. This can be achieved by strengthening communication and co-ordination at higher health system levels, including with stakeholders.
3. Introduction of new mechanisms for receiving community concerns and feedback during a health system crisis requires adequate support and close monitoring to ensure that responsiveness to community feedback is not undermined.
4. Public health responses and interventions during times of health system crises may have un-intended consequences. Care is therefore needed in planning and implementing them including anticipation of short term and longer term implications and mitigation measures for any negative consequences.

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