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Community Approaches to Epidemic Management in South Sudan

Lessons from the COVID-19 pandemic

This briefing summarizes findings from the Rift Valley Institute's (RVI) research project 'Community Approaches to Epidemic Management in South Sudan' (CAEMSS), which started in August 2020.[1] The project, which began in response to the global coronavirus pandemic, was designed to document how communities across South Sudan have created systems and structures to control the spread of epidemics and infectious diseases in the country. The briefing presents a number of key findings, and makes several policy recommendations, that are explored in greater detail in the project's final summary report.[2]

Research for the project was conducted by a team drawn from an extensive network of RVI-trained researchers.[3] Across the entire span of the project, the team conducted 114 in-depth interviews in the Yei, Juba, Wau, Malakal, Aweil West and Rubkona areas, both in-person and remotely, via telephone.[4] Interviewees included midwives and traditional birth attendants, male and female nurses, herbal experts, traditional healers, pharmacists, chiefs and community elders, elderly women, and local public health workers. The research also included an analysis of over 430 files and documents from the South Sudan National Archives in Juba (a close RVI partner), the Sudan Open Archives and academic databases. The health and wellbeing of the team and our interviewees was the priority throughout the project.

Community experience of infectious disease management

Across South Sudan, communities have extensive indigenous knowledge of infectious diseases born from long experience. Most people have experience of multiple epidemics within their households and neighbourhoods. Many informal healthcare providers have been involved directly in organized medical responses to past epidemic outbreaks: in several areas of the country people have been involved in contact tracing and infection management since the 1970s.

For this reason, there are multiple, locally specific methods used by communities for interrupting infection transmission and managing epidemics. For airborne diseases or infections spread through contact, people often organize houses for self-isolation, mark out separate food and water access points for households, make homemade rehydration salts, carefully manage dirty linen, bed spaces and drinking water provision to avoid cross-contamination, and use urine, hot water and ashes for disinfecting. Different communities across the country use crossed posts, rope barriers, or ash markings across paths to warn people away from sick households in quarantine. Particular care is taken to avoid transmission to high-risk residents, especially pregnant and post-partum women and young children. Across research sites, people are already working on developing local safety measures and strategies to prevent the further spread of COVID-19 in South Sudan.

People are able to put in place these local epidemic management measures when they have detailed knowledge about disease transmission and identifiable symptoms. In our study many people emphasized the problem of diagnosis of flu-like conditions. Coughs and fevers are not marked as particularly serious symptoms, and often diagnosed as malaria or typhoid. This is one reason why COVID-19 is often not viewed as a serious illness in communities across South Sudan. Some residents suggest that COVID-19 instead should be put into the local diagnostic category of TB, which is considered much higher-risk and more infectious, prompting more immediate isolation and community control measures.

South Sudan's healthcare system

South Sudanese communities have a realistic understanding of the limitations of the country's formal medical healthcare system. It is far from comprehensive, often misdiagnoses, is expensive or difficult to access, and does not

necessarily provide the patient with reliable answers. Many medical clinics across South Sudan blanket diagnose people with typhoid and malaria when the actual problem may be something else. Community infectious disease management and treatment plans take into account the inadequacies, expense and inaccessibility of formal health facilities and drug treatments.

Formal medical institutions, based on a Western model of healthcare, are only one part of the system in South Sudan. Most people rely heavily on African plant-based medical expertise and treatment plans, which are organized primarily by local herbal experts. They may also refer to residents with some Westernized medical knowledge but without formal employment (for example some birth attendants and men and women in the pharmaceutical trades). This sometimes includes witchdoctors, but the consultation of witchdoctors has become less frequent in many places. This being said, many people with divinities or spiritual connections are also healer experts with herbal knowledge. This wider medical system exists partly because of the intense poverty of the majority of the population: accessing formal medical centres and drugs is expensive even if treatment is free.

Geography and stages of medical care

In South Sudan's deep rural areas, peri-urban farms and villages, towns, cities and displacement camps, people take different paths to obtain medical care. In households this is often determined by an assessment of the severity and perceived risk level of the symptoms in question. These assessments are generally managed by women, who often have extensive symptomatic knowledge of cholera, measles, kala azar and/or sleeping sickness. They also often have experience of both herbal and medical treatment systems and what has previously worked (or not).

In different locations, people follow different pathways to seek medical advice, but most often local expert women are consulted first, then family elders, traditional healers, faith leaders or herbal experts, and then the formal medical system via pharmacists or local clinics. Traditional healers, midwives and pastors can also be particularly vulnerable to infection, as they are often the first point of advice that people seek out when they become ill.

Community leadership in epidemics

The people who decide what happens when an infectious disease strikes a neighbourhood are generally those who play a role in treatment pathways. These include: women running households, elderly medically-experienced women, herbal experts, local chiefs and elders, cattle camp leaders, pharmacists, faith leaders and spiritualists, depending on local societal organization.

These people have extensive experience of organizing responses to epidemics within wars and other crises. When epidemics break out, local action on epidemic control is generally decided by these key people via committee in an emergency meeting, with decisions on actions and details about the disease circulated through the community via elders, chiefs, women and students moving the information door to door.

Recommendations

Tap into existing community epidemic management practices and histories

Neighbourhood-level planning and discussion of potential COVID-19 prevention and treatment measures is already underway in both urban and rural communities across South Sudan. Organizing COVID-19 pandemic responses without connecting to these existing planning and discussion structures, and without building on the long history of epidemic management in the country, risks pushing people towards activities that are either impossible or inappropriate for their social and economic contexts. Top-down and disconnected pandemic planning also risks exacerbating the suspicion, misinformation and alienation that many South Sudanese people already feel in relation to the COVID-19 response.

Recommendation: International actors should learn about and build on the measures people are already taking to minimize the risks of transmission and to reorganize homes and workplaces to maximize social distancing and safeguarding of people in at-risk categories.

Build community epidemiological knowledge and support frontline caregivers

In most instances the first people to identify an infectious illness, determine a response and provide treatment are often women, midwives, herbal experts and local pharmaceutical sellers. These frontline caregivers help to plan epidemic management strategies, improvise personal protective equipment and provide care for the sick when and where the clinical system is unable to support them, despite information gaps and risks to their health. These non-clinical and formally unqualified (although experienced) members of the community are not, however, generally included in national-level public health planning or clinical healthcare systems and training. As such, in both South Sudan and across Africa, communities are urgently demanding more practical information and training on COVID-19 and other infectious diseases that builds on their existing levels of epidemiological knowledge. With a proper understanding of symptoms, disease progression and transmission risks, people can better protect themselves, identify suspected cases and care for sick patients more safely.

Recommendation: International actors should consider programmes that train and provide support for these informal first responders. Herbal medicine experts are generally very open to clinical training and advice. Supporting locally respected caregivers as part of the epidemic response will likely mean that the epidemic, and central epidemic management plans, will be taken more seriously. This collaboration will also help local public health teams identify the best local tactics for interrupting transmission, for COVID-19 as well as for other infectious diseases.

Localize public healthcare messaging

Epidemic messaging campaigns in South Sudan generally rely heavily on one-way public health communication, focused on the immediate disease risk, its symptoms and the individual case-by-case action needed. This approach, as with other pandemic messaging campaigns across Africa, has been widely criticized for unrealistic health advice that is disconnected with the lack of local services, economic circumstances and practical realities; for example, telling people to report to clinics that are not available or functioning in many cases, or to avoid markets.

Recommendation: Public health campaigns need to be designed in collaboration with local communities to have better take up. Local consultations that include women, chiefs, pharmacy and clinic workers, herbal experts and elderly people (especially women) would strengthen project design and better support the uptake of campaign information and actions. Localized campaign planning would also allow campaigns to incorporate community experience with disease outbreaks and epidemics, as well as include tested practices in infection interruption, into their advice.

Build confidence and trust through detailed and sustained information provision

The COVID-19 epidemic has not followed the worst-case scenarios predicted for South Sudan in early 2020. At the same time, communities have received limited public health information, focused mainly on preventative measures and the risks of the virus, and been subject to a national lockdown. This rapid and focused public health messaging has not fully explained why a flu-like illness should be so disruptive to economic and personal life. Fast-paced messaging focusing on individual risk mitigation has not addressed the reasonable doubts among many South Sudanese people that COVID-19 is only a risk for wealthy people who are able to travel and thus become infected, and that national politicians and aid workers are asking poor citizens to suffer major economic stress while breaking the regulations themselves.

Recommendation: Localizing messaging, collaborating with frontline caregivers and building local resilience against the potential risk of wider COVID-19 outbreaks in South Sudan takes more time than is currently allowed in the centralized public health and messaging strategies. Brief one-hit, one-way messaging campaigns are insufficient to address the information and planning needs that communities emphasize are critical for their ability to plan transmission minimization strategies appropriate for their local geographies, and to combat fatigue, doubt and misinformation within a sustained crisis.

Public health authorities should engage in sustained dialogue at a sub-county level that shares information about the progress of the epidemic nationally and globally, including new information on interrupting transmission and managing risk. This information could be translated into statistics that have significance for family livelihoods; for example, simple statistical models that show how many people of working age are severely physically impacted by COVID-19. Being

open and honest about the inequalities and systemic failures exposed by the pandemic will likely build trust in project activities rather than undermine them.

Localize healthcare system management

The administrative vacuum, systemic underfunding and the limited capacity of state and county-level civil service personnel across South Sudan is undermining the Covid-19 response. Central plans are not being effectively and collaboratively localized, partly because the wider field of non-clinical healthcare providers and caregivers are not included in clinically focused planning and because central plans do not recognize or incorporate local knowledge and experience.

Consequently, central epidemic planning risks authoritarian policing and surveillance methods. It is also often insensitive to local security dynamics that impact infection interruption strategies. It further struggles to mitigate the gendered risks of epidemic management to women, who are first responders to possible infectious disease cases and critical frontline caregivers, and as such are at greater risk of infection, exploitation and trauma.

Recommendation: Epidemic management planning should be decentralized to build local strategies that reflect community organizational histories of epidemic response, and which take into account local conflict and economic sensitivities. This collaborative planning should aim to build communities of leadership with remaining civil service and state healthcare staff, traditional authorities, NGO-funded clinic workers, herbal experts and pharmaceutical workers. This should prioritize the expertise and leadership of young and elderly women, who are so often primary health advisors and caregivers.

Localized response planning also needs to include the self-protection strategies of disabled community members and listen to families caring for people with severe mental health issues. Programmes should be open in acknowledging and attempting to address the added impact of repeated epidemic outbreaks on the mental health of community members.

Restructure funding frameworks

Current funding models limit holistic epidemic responses by funding responses to individual diseases and supporting reactive rather than proactive epidemic action (except where vaccination campaigns are possible). South Sudanese people deal with a multitude of medical issues and airborne diseases of which COVID-19 is just one more, even if it is particularly dangerous. Many people are frustrated and alienated by the specific Covid-19 emergency response because they feel that this demonstrates ignorance and contempt for the other, more pressing or as dangerous, threats to life and health that they face, which are chronically underfunded or receive no attention at all.

Recommendation: The donor community should develop grant and loan models that support integrated infectious disease responses and creative reconsideration of the interconnected clinical and non-clinical healthcare systems in South Sudan. Donors should also create funding models that include local leadership and community consultations to help maintain and improve local disease-preventative systems and to prepare localized plans for rapid responses to future outbreaks.

Review measurements of behavioural change

Efforts by South Sudanese people to take preventative measures against COVID-19 are collective, not individualized. Measuring only individual actions such as wearing face masks, hand-washing and social distancing does not capture these efforts.

Recommendation: Monitoring and evaluation of COVID-19 preparedness should adapt to measure collective community planning and preparedness. This should include monitoring community planning for area quarantine systems, household self-isolation practices and other effective infection interruption mechanisms.

Notes

1 CAEMSS is funded by the UK Foreign Commonwealth and Development Office (FCDO) via the East Africa Research Hub (EARF).

2 'Community Approaches to Epidemic Management in South Sudan', Juba/London: Rift Valley Institute, January 2021.

3 Team members were Peter Majiek, Stephen Othur, Deng Barjok, Emmanuel Luga, Elizabeth Nyibol, Alex Miskin, Chirrilo Madut and Joseph Diing Majok.

4 Interviewees were chosen both in a targeted manner and via randomized sampling, where possible. Full details on the project's methodology, including locations selected for case studies, are included in the final summary report.

Credits

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