UGANDA

Community Epidemic and Pandemic Preparedness Programme (CP3)

Qualitative KAP Survey Results

Community Epidemic and Pandemic Preparedness (CP3) Qualitative Survey Results: Uganda

Introduction

The Community Epidemic and Pandemic Preparedness Programme (CP3) strengthens the capacity of communities, Red Cross National Societies, and other partners to prevent, detect, and minimise the impact of epidemics. It is working with communities to provide basic information about the spread of diseases and how to prevent them, simple and effective systems to detect outbreaks, and communication mechanisms to ensure timely information sharing.

As part of the Monitoring and Evaluation (M&E) Framework, a mid-line Knowledge, Attitudes and Practices (KAP) survey was conducted to generate evidence, measure changes and identify gaps to communities' knowledge, attitudes and practices about epidemic diseases. The process included household surveys, key informant interviews (KIIs) and focus group discussions (FGDs). The analysis of quantitative data from the household survey can be found at IFRC GO - Uganda. This report presents the results of the mid-line qualitative data collected through KIIs and FGDs, making comparisons with the quantitative data collected in the household surveys.

Method

The KAP assessment was conducted in August 2023, applying a mixed methods (qualitative and quantitative) approach to gather data. The qualitative methods applied a questionnaire of open-ended questions with individuals through KIIs and small groups of stakeholders through FGDs. The same thirteen questions were applied to both key informants and focus groups (see Annex 1). However, many of the questions had follow-up questions that were applied differently between the KIIs and FGDs. Data was analysed by sub-question, and as a result there are many responses that are categorized as "N/A" because there was no data for that specific question.

The questionnaire was carried out with 21 key informants and 18 focus group discussions (39 interactions in total). The KIIs and FGDs were held across 17 parishes/villages within 4 target districts, as well as interviews at the District Headquarters of health institutions (see Table 1).

Table 1: Number of KIIs and FGDs by district

District	Parish/village	Number of KIIs	Number of FGDs
Bundibugyo	Bundimasoli	0	1
	Busunga	1	1
	Kahambu	0	1
	Kisenyi	0	1
	Ntandi	2	1
	Bundibugyo Town Council	3	0
Kabale	Bugarama	1	0
	Buhara	**1**	3
	Burambira	1	0
	Katojo	3	0
	Rukore	1	0
	Nyakibande	1	0

	Rutooma	1	1
	Bukoora	0	2
	Lower bugongi	0	1
Kamwenge	Bigole	1	0
	Kamwenge	1	3
Kitagwenda	Kitagwenda	4	3
TOTAL		**21**	**18**

KIIs were held with people of varying roles in the district (see Table 2).

Table 2: Role of key informants

Role of key informant	Number of KIIs
District Health Educator	4
District Veterinary Officer	4
Surveillance Focal Person	4
Health facility worker	5
Health club patron	2
Religious leader	1
Role unknown	1

The FGDs were held with groups of people with similar characteristics (see Table 3). Data on the number of people per focus group was not in the dataset.

Table 3: Number of focus group discussions by type

Type of group	Number of FGDs
Boda boda riders[1]	6
Religious leaders	2
Local leaders	6
Market vendors	3
Primary teachers	1

Data was analysed from the KIIs and FGDs using qualitative methods. Common themes were identified, and the responses were tagged accordingly. Descriptive statistics were used to show the frequency of occurrence of the themes. The FGDs were counted as one respondent/entry, even though there were multiple people in a group. Percentages are calculated as a percentage of total KIIs (N=21) and a percentage of total FGDs (N=18). The dataset did not include complete information on the gender of the respondents or FGD participants. Data was disaggregated either by the type of data source (KII or FGD) or by district where relevant.

Engagement with Red Cross

The first question was about the respondents' frequency and type of engagement with the Red Cross. The key informants most commonly noted a frequent engagement (often) with the Red Cross, having engagements either monthly or weekly (see Table 4). The FGD respondents more commonly had an occasional or periodic engagement with Red Cross demonstrated with statements like "*we used to*

[1] *Boda bodas are bicycles and motorcycle taxis commonly found in East Africa. While motorcycle taxis like boda bodas are present throughout Africa and beyond, the term boda boda is specific to East Africa.*

meet them..." (Kabale), "*we have conducted several meetings...*" (Bundibugyo), and "*engagements used to happen much during COVID-19 periods...*" (Kamwenge).

Table 4: Frequency of engagement with the Red Cross

Frequency	Number of KIIs	Number of FGDs	Percent of KIIs	Percent of FGDs
Often	14	5	67	28
Occasional	0	10	0	56
Rarely	5	2	24	11
Not aware	1	0	5	0
N/A	1	1	5	6

On the type of engagement or contact they had with the Red Cross, the most common response of both key informants and focus groups was that they engaged with the Red Cross through meetings in the community or at town or district level (see Table 5). A third of the focus groups said they participated in community activities, such as health promotion, mobile cinema, sanitation, sensitization, and activities specifically during outbreaks. Examples of engagements are as follows.

> "*The Uganda Red Cross Society (URCS) team engages us whenever they have activities, they attend the district disaster preparedness meetings and other stakeholder meetings*" – KII respondent from Kabale.

> "*They meet physically through health promotions whereby they teach them not to eat meat from dead animals*." – FGD respondent from Kabale.

> "*We engage with the Red Cross volunteers in several activities, they sensitize to us health education*." – FGD respondent from Bundibugyo.

> "*In the last years, Red Cross volunteers came in our community for hand washing practices and other health promotion activities*." – FGD with leaders in Kamwenge.

Table 5: Type of engagement with the Red Cross

Type of engagement	Number of KIIs	Number of FGDs	Percent of KIIs	Percent of FGDs
Meetings	8	8	38	44
Activities (health promotion, sanitation)	2	6	10	33
Community-based surveillance	1	1	5	6
Immunization	2	1	10	6
No contact	4	0	19	0
N/A	4	2	19	11

A few respondents mentioned that their contact was during immunization activities. Two respondents noted that their contact was related to community-based surveillance (CBS) activities. The Surveillance Focal Point noted contact with Red Cross staff at the health facility and the focus group noted gathering CBS data.

> "*URCS volunteers support with home visits, mobilization for clinic outreaches, child health days, and vaccination campaigns*." – KII respondent from Kabale.

> "*These engagement meetings with Red Cross partners often take place weekly and this is true when gathering CBS weekly data*. – Focus group with market vendors from Kitagwenda.

Immunization

The household survey found that there was an overall positive perception of immunization. The majority agreed that vaccines are good for children's health (97 per cent), vaccines prevent serious diseases (95 per cent), and vaccines are safe (97 per cent). However, some mistrust became apparent when asked if vaccines are a secret way to make us sterile/infertile (86 per cent disagree), that they are dangerous to health (81 per cent disagree), and vaccines are a trick of the government (86 per cent disagree).

Key informants and focus groups were also asked about their opinion on immunization, with follow-up questions on whether vaccines prevent serious diseases and whether vaccines are dangerous to one's health. Nearly all of the key informants were positive about vaccines, either clearly stating that vaccines prevent diseases or commenting on the good uptake of vaccines among the population, which they say ranges between 80 to 90 per cent uptake (see Table 6). Although there was a positive perception of vaccines, the household surveys show that the uptake is not quite as high in target areas. The survey found that 70 per cent of respondents from Bundibugyo, 60 per cent from Kamwenge and 57 per cent from Kabale had an immunization card for his/her child.

> "*Yes, vaccines help to eradicate killer diseases like measles*." KII respondent from Bundibugyo Town Council.
>
> "*Community perception about immunization is generally good, especially the routine immunization of under 5 is about 90 per cent*." KII respondent from Kabale.
>
> "*We know about immunization, recently we have been receiving the yellow fever vaccine, so we think immunization is very important and very key for our communities*." – FGD respondent from Bundibugyo.

Table 6: Do vaccines prevent diseases and save lives?

Response	Number of KIIs	Number of FGDs	Percent of KIIs	Percent of FGDs
Yes	15	5	71	28
Good uptake	4	1	19	6
No	0	1	0	6
Mixed responses	0	2	0	11
N/A	2	9	10	50

The focus groups had more mixed opinions. Half did not answer directly, and just over a third expressed positive views of vaccines preventing diseases and having a good uptake. A couple groups had diverging views among participants, showing a distrust of immunizations, and one group did believe in them at all.

> *"(1) We do support immunization because it boosts our immunity. (2) Immunizations are tricks of the government to enjoy money from donors. (3) They're harmful to our health because the moment a child is immunized, there get sleepless nights*." – FGD of religious leaders in Bundibugyo.
>
> "*Community members think that the vaccines are fake*." – Respondent from FGD of boda bodas from Kabale.

Many of the key informants and focus groups did not answer directly the sub-question of whether vaccines are dangerous to one's health (see Table 7). Like the household surveys, many of those who responded, particularly the key informants, stated that vaccines are not dangerous or that that are safe.

> "*All vaccines are safe since they undergo approval procedures by WHO and other agencies. These have been effectively used to prevent and cure diseases*." – KII respondent from Kamwenge.

Table 7: Are vaccines dangerous to health?

Danger	Number of KIIs	Number of FGDs	Percent of KIIs	Percent of FGDs
No	12	1	57	6
Yes	0	4	0	22
Mixed	0	1	0	6
N/A	9	12	43	67

However, even among the key informants, there were two responses that showed an overall perception of safety, but with qualifications:

> "*The vaccines are not dangerous; they build immunity against diseases. They are good for our health. Yes, same as polio vaccine and measles. I don't think the Ebola vaccine works*." KII with a health worker from Bundibugyo.

> "*There is positive response to immunization activities. Vaccines have side effects, but at large, they are safe*." KII with a health educator from District HQ.

Among the focus groups, only one was clear that vaccines are not dangerous. Another quarter of focus groups perceived vaccines as harmful or presented mixed views among the group.

> "*[Ignorance] of the people who think that immunization is just modernity, and it is one way of reducing fertility*." – FGD of boda boda riders from Kitagwenda.

> "*There exists a negative attitude among the local people who believe that immunization causes infertility*." – FGD of market vendors from Kamwenge.

> "*People have negative attitude towards government programmes and some people fear these drugs that they could cause harm to their lives*." – FGD of community leaders from Kamwenge.

> "*Previously people had negative attitude because those who get immunised do not stay long*." – FGD of primary teachers from Bundibugyo.

The respondents were also asked about the main obstacles to implementing immunization programmes. On average, respondents identified two obstacles each, while sixteen per cent did not provide any response (see Table 8). Generally, the FGD participants identified obstacles to access of immunization, while the KIIs more often identified obstacles relating to the delivery of the programmes.

Table 8: Barriers to implementing immunization programmes

Barriers	Number of KIIs	Number of FGDs
Negative attitude	4	5
Access to community	8	0
Supply issues	7	0
Knowledge	3	3
Inconvenience	0	6
Human resources	5	1
Religion/culture	3	1
Poor sensitization	3	1
Resources/Funding	4	0
Misconceptions	0	2
Cost	2	0
N/A	1	5

A common response from both key informants and focus groups was that negative attitudes and misconceptions of immunization are major obstacles. These negative attitudes include fear of injections and their side effects, negligence and lack of interest, and distrust in the government. Two key informants specifically noted vaccine fatigue among communities following the recent COVID-19 pandemic and other outbreaks.

> "*Currently, people have lost interest in the pandemics such as COVID-19 and yellow fever, they complain that it's too much medicine and also there is need to facilitate outreaches for hard-to-reach communities*." – KII respondent from Kabale.

> "(1) *Rumours / poor perception about immunization. (2) False information that medicine can cause negative effects to children. Some people thought that some immunization can cause stunted growth to the future generation and barrenness to the mothers. (3) Some people expected money to take their children to the immunization centres that because nurses and doctors are being paid highly*. – FGD with community leaders Kabale.

> "*Fear of side effects is one of the greatest obstacles in implementing immunization programmes in their area*." – FGD with community leaders in Kabale.

Other barriers at the individual level include a lack of knowledge or ignorance about immunizations, as well as religious or cultural beliefs that are incompatible. Several focus groups also cited the inconvenience of getting vaccinations as an obstacle. The inconveniences include the distance to the health centre, the time it takes to get vaccinated, and the poor transportation and road network.

> "*Still health centres are located very far, so the local people find it difficult to move longer distances of about 30km to reach a nearby immunization point*." – FGD Kitagwenda

> *"There exists an obstacle of travelling long distances when taking babies for immunization*." – FGD Kamwenge boda boda riders.

> "*(1) It takes too much time during immunization. (2) Long distance away from homes. (3) Sometimes immunization cards are not given to people."* – FGD of religious leaders in Bundibugyo.

On the other hand, the most common response from key informants was the obstacle of poor access to the communities. The difficult terrain, long distances, and poor conditions during the rainy season make access challenging.

> "*Mountainous areas are the only obstacle because they are hard to reach*." – KII respondent from District HQ.

Other challenges in implementing immunization programmes were issues related to the human resources. The respondents identified a lack of motivation and limited number of trained health workers. There was also a lack of coverage of village health teams (VHT). One FGD group had a negative perception of the health workers themselves.

> "*Lack of motivation for the health workers during immunization implementation is the greatest challenge. The motivation is in terms of transport and allowances*." KII with a Health Assistant from Bundibugyo.

> "*(1) Sometimes the health workers arrive late at work. (2) The health workers do not issue out health cards for our children. (3) Some health workers are weak on job*." – FGD of boda boda riders in Bundibugyo.

"*The coverage of volunteers and VHTs is still small not all villages are covered, shortage of health workers and some are not trained, transportation challenges to collect vaccines from the district and also to outreaches*". – KII with a health worker from Kabale.

Similarly, respondents identified challenges related to poor or insufficient sensitization and community outreach efforts. This includes the lack of sensitization of community influencers in the community. A lack of resources was also an issue, namely the lack of transportation, fuel, equipment, personal protective equipment (PPE) and funding.

"*Lack of enough social mobilisations within our communities and lack funds to reach every household*." – KII respondent from Kabale.

"*We still have hard-to-reach communities, the lower-level influencers, e.g. LCs, local and religious leaders, not facilitated to support yet there are still misperceptions and misbeliefs among communities that need to be addressed*." – KII with a District surveillance focal person from Kabale.

"*Poor sensitization and organization campaigns, payment demoralizes next activities, community hesitancy due to poor communication, religious beliefs especially in Kanara*." – KII with District Health Educator from Kitagwenda.

Another major obstacle to implementing immunization programmes is supply issues. A few key informants identified that there was a limited supply of certain vaccines or that vaccines were out of stock. The supply issues were more pronounced with animal vaccines, as district veterinary officers (DVOs) cited problems with the cold chain system and a limited supply. The cost of animal vaccines is another barrier to immunization.

"*Few vaccines procured for the country. Animal vaccines are expensive to buy. Government caters for human vaccines and not animal vaccines*." – A District Veterinary Officer from District HQ.

"*Lack of standby cold chain system. Vaccines go bad due to cold chain system challenges*." – A District Veterinary Officer from Kitagwenda.

Ebola

The household surveys show a moderate level of awareness of Ebola, its mode of transmission, and its symptoms. Most respondents said that it can be transmitted by shaking hands with an infected person (81 per cent), as well as eating bush meat (54 per cent). To a lesser extent, they identified through the sweat of an infected person (39 per cent), burial practices involving contact (26 per cent), and blood of an infected person (12 per cent). With regards to the symptoms, survey respondents commonly identified high fever (66 per cent) and severe headache (60 per cent), followed by weakness (48 per cent), vomiting (47 per cent), and diarrhea. Relatively few mentioned bleeding (18 per cent).

Key informants were asked about the signs of epidemic diseases, specifically whether they could identify three signs of Ebola. Nearly all of the key informants could identify three signs of Ebola (see Table 9).

Table 9: Number of signs of Ebola identified by respondents

Signs	Number of KIIs	Number of FGDs
3 signs	19	0
2 signs	1	0
N/A	1	18

The signs most commonly identified were a fever that doesn't respond to treatment, bleeding from body openings, headaches, vomiting, and diarrhoea. Muscle ache and sore throat were also mentioned by a couple respondents, as well as cough, red eyes, and chest pain.

Table 10: Symptoms of Ebola identified

Symptom	Number of KIIs
Fever	19
Bleeding from body openings	16
Diarrhoea	12
Vomiting	10
Headaches	7
Joint or muscle pain	3
Sore throat	3
Cough	1
Red eyes	1
Chest pain	1

Participants were also asked about their perception about Ebola Treatment Centres (ETC) and whether people discharged from an Ebola Treatment Centre can safely come back to the community. In the household surveys the majority of respondents in Kamwenge responded that ETC will take care of a sick person (34 per cent), people from ETC come back to the community safely (30 per cent) or the ETC will definitely cure a sick person from Ebola (27 per cent). A small percent said that the ETC won't be able to do anything for a sick person (7 per cent) or ETC will find ways to kill a sick person (2 per cent). Similar results were found in Kabale and Bundibugyo.

In the key informant interviews and focus groups there was less certainty about ETC. Around half of the key informants and focus groups were positive that people can return safely to the community after being discharged from the Ebola Treatment Centre (see Table 11). The key informants noted that the patients can return safely because they have been treated and have recovered, but a couple of these respondents added that the return should be after receiving psychosocial support and only if the patient follows medical teams' advice.

> "*Yes, they can come back, they were cared for properly… They can also come back with caution and follow/maintain advice from the medical teams. However, if these people don't adhere, there could be another outbreak*." – KII with a veterinary officer in District HQ.

Table 11: Perspective of a persons' ability to return to the community from an Ebola Treatment Centre

Perspective	Number of KIIs	Number of FGDs	Percent of KIIs	Percent of FGDs
Safe return	12	9	57	50
Continue isolation	2	2	10	11
Misconceptions	3	0	14	0
Stigma	4	2	19	11
Mixed	0	4	0	22
N/A	0	1	0	6

The FGD respondents showed understanding that patients who are treated can come back safely:

> *"Those who survived Ebola can come back safely because patient has had enough treatment up to zero point transmission*." – FGD with community leaders in Kitagwenda.

"*Yes, those who have been discharged can come back safely because we believe that they have been treated well and have cured. Our Red Cross volunteer sensitized us on that issue during periods of COVID-19 and sometimes we also hear the same information on radio stations*." – FGD of boda boda riders in Kamwenge.

An additional ten per cent of key informants and focus groups respondents felt that the patients could return to the communities, but they would need to continue self-isolation and monitor for symptoms for a period between two weeks to a month.

"*Yes, but it depends on the time he/she has reported at the health facility... He/she should remain at home for more than 2 weeks after he/she has been discharged from hospital*." – FGD with opinion leaders in Kabale.

"*People should wait for 21 days in self-isolation before freely getting back to the community. This is because it needs time to see if there are no more symptoms*." KII respondent from Busubga.

A few key informants did not respond directly, but rather noted that there is a large population in the communities that have misconceptions about Ebola and simply do not believe that it exists.

"*Yes, 60 per cent believe Ebola exists however, the 40 per cent who don't believe, their risk perception is high*." – KII respondent from Kabale.

"*People still think that Ebola doesn't exist; it's political*." – KII respondent from Bukoora.

More than a quarter of the respondents gave answers that showed stigma or were part of an FGD with at least one respondent showing stigma towards patients recovering from Ebola. The FGDs revealed a range of stigmatizing attitudes, from very clearly not wanting the patient to return to accepting that they will come back, but people will be afraid of them. The KIIs mainly recognized that although patients could return, the communities would still show stigma towards them.

"(1) No, because they come back with the virus and transmit it to others. (2) People in the community may feel scared. (3) Community people don't want to be in contact again with such a person. (4) We cannot share food and drinks with such person." – FGD of religious leaders in Bundibugyo.

"(1) We do not feel safe. (2) It is not okay because transportation becomes expensive. (3) Because we think that treated persons may transmit the virus to other community members. (4) We do fear the person. (5) We wait for health confirmation from the hospital where the person has been discharged." – FGD of boda boda riders in Bundibugyo.

"*(1) Yes, they can come back well as they've been treated because they're cured. (2) However, they are not safe because the medicine they're given is for just boosting their immunity and not curing the virus. (3) We do not believe that they can cure Ebola*." – FGD of primary teachers from Bundibugyo.

"*(1) People may think that they are not safe, especially when they don't come with a clear document (certificate) to show that they were cured. (2) Family and community members may run away from him/her in what is called stigma*. – FGD of market vendors in Kamwenge.

Safe and Dignified Burial

Participants were asked about safe and dignified burials (SDB). In the household surveys, they were asked who the key community decision-makers are. The majority identified health workers (79 per cent) by a large margin. Other responses were authorities (20 per cent), family (19 per cent) and religious leaders (9 per cent).

Key informants and focus groups were asked who should be involved in SDB and who should lead. Respondents identified a variety of individuals who should be involved in SDBs, including health workers, doctors, nurses, community leaders, religious leaders, local councils, government officials, family members, community members, police, Red Cross volunteers, and village health teams.

Regarding whom should lead the SDBs, there was a wide recognition that health professionals should take the lead (see Table 12). Nearly three quarters of focus groups and more than a third of key informants identified trained health workers, including doctors, nurses, health assistants or health inspectors, as the ones to lead the SDB. Nearly half of the key informants specifically mentioned District Health Teams or District Health Officers as best placed to lead the SDB. Although they had identified many different types of people involved, in these cases they were clear that the health professionals should take the lead, with others providing supportive roles.

> "*The lead person is the district health team supported by the Trained Health workers. Religious and local leaders, VHTs support the sensitization and influence*." – KII respondent from Kabale.

> "*Well-trained health workers are needed on the issue of SDB because us people we are not trained to handle dead bodies and we lack equipment to use*." – FGD of boda boda riders in Kamwenge.

Table 12: Who should lead safe and dignified burials

Lead	Number of KIIs	Number of FGDs	Percent of KIIs	Percent of FGDs
Trained health worker	8	13	38	72
District health team	10	1	48	6
Mixed health workers and leaders	2	4	10	22
N/A	1		5	0

There were a few key informants and focus groups who responded that the lead should be a combination of health workers and other community stakeholders, such as community leaders, local councils, and/or family members.

> "*This should be led by doctors, family representatives, religious leaders, trained SDB personnel and government officials*." – FGD of boda boda riders in Kitagwenda.

> "*The person who is trained. Local leaders and trained personnel and educated, community members*." – FGD of local leaders in Bundibugyo.

The positive responses about the involvement of health professionals demonstrate the positive effect of sensitization efforts and an acceptance of SDB.

> "*There hasn't been any community resistance to SDB yet. Community health teams are doing a great work in sensitization. The district health teams are in place [to lead]*." – KII respondent from Kabale.

Respondents were asked about the consequences of not following traditional burial practices. In the household surveys the main consequences were sadness to the family (80 per cent), anxiety to the family (79 per cent), negative reactions from the community (72 per cent), and economic difficulties (61 per cent). Nearly half of respondents also mentioned land ownership issues (48 per cent), spiritual – related to God (47 per cent) and spiritual – the deceased's soul will not rest in peace (46 per cent).

In the KIIs and FGDs there was less emphasis on the negative reactions and sadness to the community. Firstly, nearly a third of respondents from both KIIs and FGDs said that there would be no consequences

at all (see Table 13). This was because of previous experience with Ebola, with successful sensitization efforts, or religious beliefs.

> "*We haven't had any incidences where communities have resisted MOH programmes, all that is needed is to strengthen sensitization*." – KII with District Veterinary Officer from Kabale.

> *"Nothing can happen because all the majority are Christian and believe in God*." – FGD with leaders from Kabale.

> "*No serious consequences given the Ebola experience in 2007/2008 in the district*." – KII from District HQ.

Table 13: Consequence of not following a traditional burial

Consequence	Number of KIIs	Number of FGDs	Percent of KIIs	Percent of FGDs
None	7	5	33	28
Rejection	3	3	14	17
Spirit returns	0	5	0	28
Negative reaction	2	2	10	11
Conflict	0	3	0	17
Transmission	1	0	5	0
Financial	0	2	0	11
N/A	8	0	38	0

In the FGDs, spiritual consequences were the next common response. Nearly a third of the focus groups noted that the spirit of the deceased would return and cause harm to the family or community if the proper rituals were not performed.

> "*Due to limited rituals performed, the spirit and ghost of the dead may raise leading to attacks to family members*." – FGD with market vendors in Kitagwenda.

> "*If traditional burial practices are not followed, some satanic cultural families can be disturbed by the family ghosts*." - FGD of boda boda riders in Lower Bugongi.

Several key informants and focus groups stated that there would be rejection of SDB, distrust and possible aggression towards the burial team. Some of them said that the burial teams would be chased away. Others noted that the process would be rejected, that they might not believe that it is the right body, and it could be followed by an exhumation and re-burial.

> "*Some community members can get worried. We can strike because the burial team may transmit the virus to our community. In case of us Muslims, we cannot agree because of our religion. The burial team can be chased away*." – FGD of religious leaders in Bundibugyo.

> "*They feel scared and there is fear…There could be fighting between the burial team and the community members*." – FGD of local leaders in Bundibugyo.

> "*The burial team should bury because they are the ones that killed the dead person. We cannot also agree because health workers want to scare us. Some of us we may cause strike because we want to bury our fellows traditionally*." – FGD of boda boda riders in Bundibugyo.

Other consequences identified were negative reactions among community members. These include psychological harm, feelings that their culture is undermined, or sadness and anxiety about not being able to bury the body. A few also mentioned the potential conflict within the family or community if there is insufficient information, understanding or agreement about the process. Focus groups also identified the financial consequences for the families who did not receive financial contributions as condolences.

"*The consequences might be family conflicts since majority might be there during burial, financial crisis due to lack of burial contributions and thus families will never be happy*." – FGD of market vendors from Kamwenge.

Response to an Outbreak

The household surveys asked about actions to be taken on a suspected case of high risk illness in humans. The majority said they would contact a health worker (67 per cent) or seek help from a community health worker (45 percent). To a lesser extent they would provide care (15 per cent), contact an elected official (10 per cent), contact religious leaders (6 per cent), or report to a hotline (3 per cent).

The household survey also asked about reporting health risks. Half of the respondents had never reported any health risks (50 per cent). Others noted reporting to a health worker (29 per cent), a Red Cross volunteer (30 per cent), community health assistant (22 per cent), and veterinary officer (21 per cent). The majority of respondents also said that in response to the report actions were taken by the local health facility staff (32 per cent), Red Cross (30 per cent), community health workers (22 per cent), or an NGO (8 per cent). Only 2 per cent said that no action was taken.

The key informants and focus groups were asked what they would do if they saw the signs of a serious possible outbreak of disease and specifically if they knew where to report a human or animal epidemic disease alert. All respondents said they were aware of the process for reporting an alert. On average, respondents of KIIs and FGDs identified two types of people to whom they would report alerts. Half of the key informants said they were aware of to whom to report but did not specify who that is (see Table 14). Another fifth of key informants said they would report to the District Health Officer.

Table 14: Where respondents would report a human epidemic alert

Report	Number of KIIs	Number of FGDs	Percent of KIIs	Percent of FGDs
Unspecified	11	0	52	0
Health workers	3	13	14	72
District Health Officer	4	0	19	0
Leaders	0	9	0	50
Village health team	2	11	10	61
Red Cross	2	9	10	50
Hotline	1	2	5	11
Do not report	0	1	0	6

Similar to the household survey, most of the focus groups said they would report to health workers, often in combination with local leaders. The local leaders identified include local council chairpersons, opinion leaders or religious leaders. There was recognition that community structures were in place to raise alerts. A third of respondents identified reporting to village health teams, and a third reported to Red Cross volunteers.

"*Yes, aware where to report and very confident to raise alerts; [there is] presence of active health task forces at all levels, community structures, community health workers, partner support, e.g. volunteers who send alerts, sensitize, and mobilize communities*." – KII respondent from Kabale.

"*Currently the community has the capacity to raise alerts given the fact that we use Village Task Force and Red Cross volunteer to send weekly CBS alerts*." – KII respondent from Kitagwenda.

"*Report to the local council chairman, VHTs and religious leaders so that they get help and clear information when they make alerts to those people*." – FGD of market vendors in Bundibugyo.

> "*If there is a human epidemic disease alert, they can report to the health workers, Red Cross people around and local leaders*." – FGD with boda boda and market vendors in Lower Bugongi.

A couple key informants and focus groups mentioned calling or texting a toll-free/hotline number. The number that was mentioned was the 6767 hotline.

It is also worth noting that respondents from one FGD said that they would not report cases or would report them to a witch doctor.

> "*Do not call because of rumour mongering... Do not report because people may get scared. Report to the witch doctors*. – FGD of religious leaders in Bundibugyo.

Just over half (54 per cent) of all KII and FGD respondents answered the question of where to report animal epidemic alerts. All of these respondents said they would report to a veterinary professional (officer, doctor, assistant, or inspector). A couple of them mentioned they would also report to local leaders or the Red Cross. One of the respondents identified the limited availability of veterinary assistants as a shortcoming.

> "*[For] animal alert, one should first inform the local leader and later to the veterinary officer for further help*."- FGD of community leaders in Kamwenge.

> "*We only have a veterinary assistant of this parish, but he is not commonly available in most of times*." – FGD respondent in Kabale.

This response is similar to the household surveys, which found that most respondents would report an animal illness to a veterinary officer (57 per cent), or they would contact a health worker (33 per cent) or seek help from a community health worker. A few would contact an elected official (9 per cent) or report it on the hotline (2 per cent).

Respondents also indicated their level of confidence in raising the alerts. Nearly all key informants and a quarter of focus groups were very confident in raising an alert, particularly the key informants (see Table 15). Another fifth was either moderately confident or confident in raising the alerts. Some of the confidence stems from knowing whom and how to report and knowing that they will receive a response. One of the reasons for more moderate confidence was related to the quality of the reports received:

> "*I have 50/50 confidence on raising the alerts because sometimes false alerts are received.*" – KII respondent from District HQ.

Table 15: Level of confidence to raise an alert

Confidence	Number of KIIs	Number of FGDs	Percent of KIIs	Percent of FGDs
Very confident	15	4	71	22
Moderately confident	4	1	19	6
Confident	0	4	0	22
Reluctant	0	3	0	17
N/A	2	6	10	33

A few of the focus groups demonstrated a reluctance to report. This was mainly due to the community's fear to report and that it would put them at risk, as noted above with the FGD of religious leaders who do not report alerts.

Community Preparedness

Participants were asked to what degree they feel the community is prepared to overcome epidemic outbreaks. The household survey found a relatively high perception of preparedness. More than three

quarters the respondents said they were either very prepared (51 per cent) or somewhat prepared (26 per cent). Only eleven per cent said they were not prepared at all, and eight per cent did not know. The main reasons for not feeling prepared were a lack of money or resources to do anything (36 per cent), they don't know how to prepare (22 per cent), or the Government has not told us what to do (20 per cent).

The KIIs and FGDs were less optimistic about the level of preparedness. Only a quarter of key informants and eleven per cent of focus groups felt that the community was well prepared to overcome emergencies (see Table 16). The reasons the community was seen as well prepared were because they had knowledge to prevent diseases and report alerts, and there was a functioning surveillance system with structures in the community to report alerts – village health teams (VHTs).

> *"The community is much prepared because they are well sensitized about the same epidemic diseases as malaria, Ebola by Red Cross volunteers."* – FGD respondent from Kamwenge

Table 16: Perception of the community's level of preparedness to overcome epidemics

Preparedness	Number of KIIs	Number of FGDs	Percent of KIIs	Percent of FGDs
Well prepared	5	2	24	11
Moderately prepared	7	8	33	44
Slightly prepared	3	4	14	22
Not prepared	0	3	0	17
N/A	6	1	29	6

Most commonly, respondents from both FGD and KIIs said that the community was moderately prepared. While they acknowledged that the community was more knowledgeable, the reasons for not being totally prepared are that the trained teams were only at the district level, poor communication channels for hard-to-reach communities, many community members have not changed behaviours or fear reporting, and there is a lack of financial and other resources to overcome emergencies.

> "*Our communities are moderately prepared because we lack equipment and health centres are very far.*" – FGD of market vendors in Kamwenge.

A few of the KIIs and FGDs said the community was slightly prepared and another few focus groups felt they were not prepared at all. The reasons for the lack of preparedness include:

- Lack of a safe water source
- No buildings for isolation
- Insufficient means of transport
- Ignorance or disregard of health information
- Open defecation and poor sanitation
- Cost of soap
- Low coverage of VHTs.

The participants recommended changes or improvements to increase preparedness (see Table 17).

Table 17: Suggested improvements to enhance community preparedness

Improvements	Number of KIIs	Number of FGDs
Sensitization	7	4
Resources	4	2
Training for VHTs	4	1
Human resources	2	1
Improve Sanitation	0	2

Infrastructure	2	0
Mosquito Nets	1	1
Safe water	0	1
Hotline	1	0
Coordination	1	0
N/A	9	8

Most commonly, participants suggested more sensitization for community members. This included more frequent/regular sensitization, as well as sensitization on specific topics like hygiene and sanitation. The next most common response was that more resources were required. This included resources like personal protective equipment and medicine at health facilities, as well as fuel and vehicles to do outreach.

Respondents also identified the need for either more human resources or additional training for the teams. This included the need for more village health teams, volunteers, or veterinary personnel to increase coverage. There was an identified need for more refresher training for the VHTs.

Improved infrastructure was another recommendation. These included the necessity for more health facilities, improved sanitation infrastructure, or the construction of boreholes. Other improvements identified were the need for more distribution or better use of mosquito nets, the need for a hotline to improve reporting, and better coordination at district and local levels.

> "*Support with resources such as transport to reach out to more communities, trainings, and allowances for community health workers and influencers, provision of hotlines for anonymous calls since not everyone making alerts would want to be disclosed for social reasons*." – KII respondent from Kabale

> *"Community exposure to diseases like COVID-19 have made them to become more knowledgeable. However more volunteers need to be trained and conduct more health education messages*." – KII respondent from Kitagwenda.

Major Health Risks

Participants were asked about the major risks that have an impact on the health of the community. In the household surveys, the main risks were related to environmental factors, such as lack of water (29 per cent), malnutrition (16 per cent) and malaria (16 per cent). To a lesser extent, they mentioned diarrhoea (7 per cent), women's health and pregnancy (5 per cent), fever illnesses (3 per cent) and dirty water (2 per cent).

Key informants and FGDs identified additional risks that affect community health (see Table 18). The most common risk factor identified was negative attitudes and behaviours. These behaviours include eating dead animals, not practising proper hygiene, alcoholism and gender-based violence, not seeking medical attention, and a general disregard for health advice.

Table 18: Major risks impacting health

Risk	Number of KIIs	Number of FGDs
Attitude/behaviour	8	7
Lack safe water	5	3
Lack information	2	6
Financial constraints	0	8
Proximity to forest/park	7	0

Climate risks	5	1
Access to facilities	3	1
Border	4	0
Supplies	3	1
Poor sanitation	1	3
Agricultural practices	2	2
Breeding ground	1	0
Religion	1	0
Leadership	1	0
Water source	0	0
N/A	6	2

The next most commonly identified risks were a lack of a safe water source for consumption and a lack of information or illiteracy. Financial constraints and poverty were common risk factors and barriers to adopting practices like using soap or improving sanitation facilities. A few said that poor sanitation was a risk factor.

> "*Negligence about good sanitation and hygiene makes it difficult to some community members to make improvements to address diarrhoea risks*." – FGD with boda boda and market vendors from Lower Bugongi.

Proximity to forests and national parks was another risk factor identified by several key informants. The proximity to wild animals increases the risk of animal attacks, the spread of animal diseases, or children getting sick from eating contaminated fruit eaten by animals. Border issues were mentioned by ten per cent of respondents as another risk factor for the spread of diseases. The proximity to the Democratic Republic of Congo and the flow of animals and people across the border increase the risk of diseases like rabies and measles.

> *"The presence of game reserves and Kibaale National Park acts as habitat for stray dogs and wild dogs, and these end up biting people and spread rabies*." – KII respondent from Kitagwenda.

Climate risks like flooding, droughts and landslides were other risks. A few respondents also noted that the steep terrain and geography of the area were challenges due to mudslides, difficult access to communities, and being mosquito breeding grounds.

Other risk factors identified are a lack of medical supplies in the health facilities, agricultural practices, such as the use of chemical sprays, religious beliefs, and a lack of leadership.

There was a follow-up question about the main serious outbreaks of human and animal epidemic diseases, but it was primarily the key informants who responded (see Figure 15). The most commonly identified diseases were malaria and measles, followed by cholera, COVID-19, Ebola and rabies. Rift Valley fever was identified only in Kabale. Respondents from Kamwenge were the ones that identified anthrax, brucellosis, Marburg and typhoid. Yellow fever was only mentioned at Bundibugyo.

Table 18: Major epidemic diseases identified by respondents

Disease	Number of KIIs	Number of FGDs
Measles	8	1
Malaria	5	0
Cholera	3	1
COVID-19	4	0

Ebola	3	1
Rabies	4	0
Brucellosis	2	0
Diarrhoea	2	0
Helminthiasis	2	0
Rift Valley Fever	2	0
Rubella	2	0
Sexually transmitted diseases	2	0
Tuberculosis	2	0
Anthrax	1	0
Marburg	1	0
Mumps	1	0
Typhoid	0	1
Yellow fever	1	1
N/A	3	16

The key informants also identified challenges to making improvements to address these risks. The challenges include:

- The challenging terrain and the geographic location near the border and parks cannot be changed
- Inadequate financial support, resources and logistics for outreach, sensitization, and training
- Poverty, financial problems
- Lack of control of animal markets across borders, instability in neighbouring countries
- Limited human resources, including veterinary personnel
- Lack of ownership of stray dogs
- Culture, difficulty changing behaviour
- Ignorance and misinformation

Influential People

Respondents of KIIs and FGDs identified the most influential people in the community regarding human health and animal health. Each respondent identified two to six influential people (see Table 20).

Table 20: Influential people in the community for human health

Influential person	Number of KIIs	Number of FGDs
Local/political Leaders	10	11
Health worker	12	9
Red Cross	3	14
Village Health Team	6	9
District Health Officer	11	0
Religious leader	6	5
Surveillance focal point	4	4
Community groups	2	1
Cultural leaders, elders	0	3

For human health, the most influential people are local leaders and health workers. Local leaders include mainly local council chairpersons, political leaders, and teachers. The health workers include nurses, health assistants, health inspector, and community health workers. Most of the focus groups also identified Red Cross volunteers as influential, while many of the key informants identified the

District Health Officer. Village Health Teams were also considered influential by both key informants and focus groups. To a lesser extent respondents also mentioned religious leaders, surveillance focal point, community groups, and cultural leaders or elders.

> "*Some of their leaders like local council, village health teams, Red Cross volunteers and even religious leaders are the ones who are most influential in their respective communities*." – FGD of boda boda riders in Kamwenge.

For animal health, any of the respondents that answered identified veterinary workers as influential, including the District Veterinary Officer, veterinary doctors and officers, and the veterinary extension workers (see Table 21). Some of the respondents mentioned other people in additional to the veterinary staff, including local leaders, Red Cross, VHTs, cultural leaders. One respondent also mentioned hunters.

> "*Veterinary officer but the hunters have more influence*."- KII with a health assistant from Bundibugyo.

Table 21: Influential people in the community for animal health

Influential person	Number of KIIs	Number of FGDs
Veterinary	18	16
Local Leader	0	4
Red Cross	3	0
Village Health Team	0	3
Cultural Leader	0	2
Health inspector	2	1
Hunters	0	1
N/A	3	2

Sources of Information

Participants were asked about the main sources of information about health concerns. Household surveys identified clearly that the main and preferred source of information is the radio (56 per cent). Other sources identified were health workers (37 per cent), community health worker (26 per cent) and community leaders (17 per cent). A small per cent of respondents also identified friends/family, community events, religious leaders, and mobile SMS.

Key informants identified several sources from which they receive health information. The respondents identified a range of sources, including people, media, or spaces (see Table 22). Similar to the household survey, radio is an important source of information. However, community gatherings were even more common.

Table 22: Sources of health information

Source	Number of KIIs	Number of FGDs
Community gathering	4	10
Radio	8	6
Village Health Team	7	4
Church	5	4
Social media	7	1
Leader	4	3
Red Cross	5	2

Megaphone	3	3
Poster	0	6
Community Health Volunteer	4	1
SMS/phone	3	2
Government	4	0
Religious leader	0	3
Health facility	3	0
Cinema drive	1	2
School	0	1

It was also common to hear announcements and information following church and through VHTs. Social media and applications were mentioned, such as WhatsApp groups and M-TRACK, an application of the Ministry of Health where health information is communicated. Other common means to receive information were through megaphone announcements, phone or SMS texts, and posters. A few respondents also mentioned the health facility, cinema drives, and through the school.

Communicating Key Messages

The participants were asked about the most important messages to give the community to inform them of how to stop outbreak diseases. Sixty-four per cent of the KIIs and FGDs identified important messages. (Some gave a means of communication, some gave a message, and some did not provide answers). The main messages identified are about the following:

- Adopt good hygiene and sanitation practices
- Prevention measures, such as sleeping under a mosquito net, wearing a mask.
- Get vaccinated and vaccinate your pets
- How to recognize the signs and symptoms of outbreaks
- Stop eating bush meat or dead animals
- Limit movement and avoid gatherings in case of an outbreak
- Seek medical care in case of illness
- Report illnesses in the community

Examples of messages that they would want to communicate are:

> "*Tell them to come for health services. Tell pygmies*[2] *to stop eating bush meat especially bats, baboons, monkeys, pigeons. The pygmies think Ebola doesn't exist because they have not died from eating bush meat for a long time*." – KII respondent from Bundibugyo.

> "*The most important messages to give community people in Ihimbi village to inform them of how to stop outbreak diseases are: the message on awareness of different outbreak diseases, symptoms, signs, management, where to report and how to protect against them, the message for preparedness, the message about sanitation and hygiene, and the message about food nutrition and food security*." – FGD of village leaders in Kabale.

> "*Encouraging people to wash their hands, reporting any unusual signs and symptoms, giving out toll free line to community members*. – FGD of market vendors in Kitagwenda.

They were also asked the most effective ways to communicate messages to the community. Respondents identified people to deliver the message as well as effective methods (see Table 23). Nearly half of the respondents identified local radio as the most effective method to communicate

[2] In-the-Name-of-Conservation-The-eviction-of-the-Batwa-from-Semuliki-Forest-Bundibugyo-@CCFU2017.pdf (crossculturalfoundation.or.ug)

messages. This corresponds to the household survey that found radio as the preferred source of health information (56 per cent). Other sources were only mentioned by a small per cent of respondents, such as television (10 per cent), health worker (7 per cent), loudspeaker (4 per cent), and mobile phone (4 per cent), among others.

By contrast, the KIIs and FGDs had a greater emphasis on delivering messages through face-to-face interactions, particularly in community gatherings, such as meetings, dialogues, barazas, and ceremonies. Delivering messages at places of worship and through religious leaders was also recommended by both key informants and focus groups.

> "*The most effective ways to communicate to the community people in Nyakirime village to inform them of how to stop outbreak diseases is through face-to-face interactions, through cinema drives, and communicating in places where there are different gatherings*." – FGD respondent from Lower Bugongi.

Table 23: Effective ways to communicate messages

Communication	Number of KIIs	Number of FGDs
Radio	12	6
Community engagement/meetings	8	9
Place of worship	4	6
Posters	3	6
Leaders	3	3
Home visit	2	4
Village Health Teams	3	2
Community volunteers	2	2
Drama	1	2
School	2	1
Religious leaders	1	2
Phone/MS	1	2
Megaphone	1	2
Health centre	2	0
Red Cross	1	1
TV	1	0
Mobile cinema	0	1
Health workers	0	1
N/A	6	1

Nearly a quarter of respondents said posters are an effective method, placed in central places in town or along roadsides and using pictorial messages. A similar number of respondents identified influential people to deliver messages, including the local leaders, village health team and community volunteers. To a lesser extent, respondents identified other methods such as community dramas, through schools and health centres, or sending messages by phone, text, megaphone or TV.

Conclusions and Recommendations

The findings from quantitative and qualitative data indicate that there is a moderate level of awareness of epidemic diseases and their prevention. There has been good engagement with the Red Cross, particularly through community meetings and activities. There is evidence that the key messages from the sensitization efforts are reaching some community members and stakeholders.

There was largely a positive view of immunizations and their ability to save lives, and there is a moderate uptake of vaccines. However, there is still a segment of the population that believe misconceptions that they are fake or that they cause harm like infertility, harm to children, or death. Communities face barriers of access, including the difficulties of the population (especially mothers with children) to reach health facilities and the lack of resource for health workers to access hard-to-reach communities.

There is some awareness of the Ebola virus, its symptoms, and its treatment. Respondents could generally identify key symptoms, like a high fever, but were less able to identify bleeding. There are persistent views that Ebola is fake. Though there seemed to be general acceptance that Ebola patients can return to the community from a treatment centre, there were many who are either afraid of them or who want them to continue isolation.

There was generally a good level of acceptance of safe and dignified burials led by health professionals. However, there is a segment of the population who would reject the SDB or show aggression towards burial teams. There was good understanding of the need to have health professionals lead the SDBs, though they would like to involve others, such as leaders and family.

There is a varying perception of community preparedness to respond to an epidemic from very well prepared to not at all prepared. However, there was a high level of awareness and confidence in the ability to report illness if there is an outbreak. There is also an understanding of many risk factors affecting health, including environmental factors, lack of safe water and sanitation, negative attitudes and behaviours, a lack of information, and financial constraints, and issues around access to health facilities.

Based on the findings of the KAP qualitative and quantitative surveys, key recommendations for the CP3 programme in Uganda are:

1. Scale up and enhance sensitization efforts by engaging influential people, particularly community leaders, religious leaders, health workers and VHTs. Share key messages on prevention through radio and through face-to-face interactions at community gatherings and in places of worship.
2. Combat vaccine fatigue and common misconceptions that immunizations are fake or that they cause harm like infertility or death.
3. Continue sensitization on the symptoms and prevention measures for measles, malaria, rabies, cholera and Ebola. Combat misconceptions about Ebola being fake and about the safe return of people from Ebola Treatment Centres.
4. Continue sensitization on importance of SDBs to increase acceptance and avoid negative feelings, spiritual and economic consequences, or aggression towards health personnel as a result of not following traditional burial practices.
5. Clarify and communicate the reporting routes available for reporting human epidemic diseases. Disseminate information on the toll-free hotline or other ways to enable easy, anonymous reporting, combined with information to combat the fear of repercussions from reporting.
6. Support advocacy efforts towards investments in WASH, addressing vaccine supply issues, increasing the network of VHTs, and supporting community outreach activities.
7. Continue sensitization efforts to increase awareness of zoonotic diseases like anthrax and rabies, promote the benefits of animal vaccines, reduce consumption of bush meat and dead animals, and encourage reporting of illnesses in animals.

Annex 1: Questionnaire for key informants and focus group discussions

1. **Participation in Red Cross activities**
- How often engagement meetings with partners and the Red Cross take place?
- How much contact do you have with the Red Cross?

2. **What is your opinion on immunization?**
- Are vaccines dangerous to our health?
- Do vaccines prevent serious diseases and save lives?
- What do you think is the greatest obstacle in implementing immunization programmes?

3. **Know the sign of Epidemic diseases**
- Can you please give me at least 3 signs of EBOLA?

4. **Perception of Ebola Treatment Centres.**
- Can the people discharged from Ebola isolation come back to the community safely? Why?

5. **Safe and Dignified Burial**
- If there is a need to do a safe burial because of an outbreak disease, who should be involved?
- Who is the best to lead SDB?
- What are the consequences if traditional burial practices are not followed?

6. **What would you do if you thought you saw the signs of a serious, possible outbreak disease?**
- Know where to report an alert i) human epidemic disease alert; ii) animal epidemic alert
- How confident are you about raising these alerts?

7. **Perceived current capacity of the community to raise alerts of potential human or animal disease outbreaks**
- How ready and able are you at the baseline?
- Or how vulnerable you are?

8. **To what degree do you feel that your community is well prepared and easily able to overcome epidemic diseases or emergencies?**
- If not prepared, why not?
- What changes / improvements are required?

9. **What do you feel are the most major risks that have most impact on the health of this community?**
- What are the main serious outbreaks or epidemic disease in your area?

10. **What makes it difficult for them to make improvements to address these risks?**

11. **Who is most influential on the people in this community, regarding their practices of**
- Human health
- Animal health

12. **What are the main sources from which you receive health information and updates?**

13. **What would be the most important messages to give community people here to inform them of how to stop outbreak diseases?**
- What would be the most effective ways to communicate those messages to them?