KEY CONSIDERATIONS FOR RCCE IN THE 2022 EBOLA OUTBREAK RESPONSE IN GREATER KAMPALA, UGANDA

SSHAP
Social Science in Humanitarian Action Platform

On 20 September 2022, an outbreak of the Sudan strain of Ebola Virus Disease – SVD – was announced as the first laboratory-confirmed patient was identified in a village in Mubende District in central Uganda. Uganda's Ministry of Health (MoH) activated the National Task Force and developed and deployed a National Response Plan, which includes the activation of District Task Forces. The target areas include the epicentre (Mubende and Kassanda districts) and surrounding areas, as well as Masaka, Jinja and Kampala cities. This is of great concern, as Kampala is the capital city with a high population and linkages to neighbouring districts and international locations (via Entebbe Airport). It is also a serious matter given that there has been no outbreak of Ebola before in the city.

This brief details how Risk Communication and Community Engagement (RCCE) activities and approaches can be adapted to reach people living in Greater Kampala to increase adoption of preventive behaviours and practices, early recognition of symptoms, care seeking and case reporting. The intended audiences include the National Task Force and District Task Forces in Kampala, Mukono, and Wakiso Districts, and other city-level RCCE practitioners and responders.

The insights in this brief were collected from emergent on-the-ground observations from the current outbreak by embedded researchers, consultations with stakeholders, and a rapid review of relevant published and grey literature. This brief, requested by UNICEF Uganda, draws from the authors' experience conducting social science research on Ebola preparedness and response in Uganda. It was written by David Kaawa-Mafigiri (Makerere University), Megan Schmidt-Sane (Institute of Development Studies (IDS)), and Tabitha Hrynick (IDS), with contributions from the MoH, UNICEF, the Center for Health, Human Rights and Development (CEHURD), the Uganda Harm Reduction Network (UHRN), Population Council and CLEAR Global/Translators without Borders. It includes some material from a SSHAP brief developed by Anthrologica and the London School of Economics. It was reviewed by the Uganda MoH, University of Waterloo, Anthrologica, IDS and the RCCE Collective Service. This brief is the responsibility of SSHAP.

KEY CONSIDERATIONS

- Perception of Ebola risk is low in Kampala, for reasons including fatigue from COVID-19 and public inexperience with urban Ebola outbreaks. Risk communication must be widespread and emphasise clear and coherent prevention and awareness information.
- Mass media can be used more effectively to increase awareness about the SVD outbreak. Journalists should continuously be engaged to incorporate SVD prevention messages into popular TV and radio programming in Luganda, English, other relevant local languages, and languages spoken by refugee or immigrant populations. Other channels, including social media and newspapers, are also important. Audio and visual formats will support risk communication to people not able or comfortable to engage in written information in English or Luganda.
- Consider testing comprehension of risk communication material with intended audiences to ensure key messages are understood and to avoid risks of inadvertent misinterpretation, especially for material containing complex terminology or information, or that which has been translated.
- Informal or creative means of communication should be considered, building on robust social infrastructures in Kampala. This could include engaging street entertainment and public digital screens. Information is also needed along highways in and out of Kampala, such as in rest stops.
- Risk communication emphasising basic SVD prevention and care is needed across a range of channels including networks among transport workers (*boda boda* and taxi drivers, large transporters), local authorities, market traders, trade unions, salon operators, food takeaways, teachers, etc.

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- While the MoH and the Kampala Capital City Authority are well placed to facilitate local response, including RCCE activities, they cannot maintain intense engagement with all communities. Other local leaders and grassroots influencers (see p. 10) should receive training to support RCCE. Risk communication actors should map the individuals who are trusted and listened to, and provide them with training to be direct communicators and positive role models for the wider public around preventing SVD.
- The informal sector dominates urban Kampala and includes busy markets, taxi parks, and shopping centres. Informal, influential self-governing bodies and networks exist and should be effectively engaged to communicate about risk behaviours, support preventive measures in the workplace, and encourage their workers to take up SVD guidance.
- The psychosocial effects of Ebola, including stigma, should be considered by responders, particularly for survivors and their families and contacts of cases or suspected cases. These effects will not be experienced equally across demographic groups in Kampala. Further mapping should be conducted to understand how this affects reporting of possible symptoms and/or cases/alerts, and RCCE activities adapted appropriately.
- Communication about Ebola needs to take a realistic approach to people's ability to prioritise viral risks above other socioeconomic risks (particularly for precarious and low-income populations). Messaging should target preventive action that can be interwoven with the type of movement and mixing upon which livelihoods rely. RCCE actors should also emphasise that the need for preventive measures is temporary, and that they may help avoid further restrictions.
- Risk communication efforts must consider the disparities in service provision in informal settlements. Pending necessary government investment in these areas, NGOs may be able to provide certain improvements and/or needed resources and information that can support residents to protect themselves and access care and support when needed.
- Risk communication strategies should be tailored to the diverse groups living in Kampala and developed in consultation with them. For example, informal workers need to know how to work safely in their specific jobs to the extent possible (e.g. how to drive a taxi or safely ride a motorbike, work in closed market spaces, or engage in sex work).
- Early SVD symptoms can be confused with malaria or flu symptoms. It is critical to communicate this broadly, specifically to Kampala's wide range of health service providers, including private sector providers – such as drug shops, private clinics and herbalists – where people may seek initial care or medicine for self-treatment. These groups should also be trained in screening and referral, and supported to protect themselves with personal protective equipment (PPE).
- In general, stronger links are needed between the public-private health sector and the response. Public and private sector health workers and support staff, including faith and especially traditional herbal healers, should also be involved in RCCE activities. They can play important information-sharing roles and participate in community engagement activities.
- Social peer groups found in community membership associations (e.g., savings and loan associations) or workplaces can be enlisted by RCCE actors to help drive community adoption of preventive measures. Champions and peers, including SVD survivors and those formerly under quarantine, could also be encouraged to speak positively and publicly about their experiences. However, this must be done in a way that minimises stigma.
- Social science evidence should be a key part of RCCE work and should be shared across response pillars to enable better understanding of the dynamic contextual and social factors driving Ebola prevention, care, and transmission in Greater Kampala. As the outbreak spreads, the situation on the ground will also change rapidly, and there will be a need for engagement and improved understanding around issues such as safe and dignified burials.

RISK PERCEPTION

It is not known what the risk perception of SVD is among residents of the Greater Kampala region. There appear to be some who may take the risk seriously (as evidenced by the numerous work and social venues with SOPs in place), whereas for many it would appear they have low risk perception. It is common to hear of people attending mass entertainment events, bars staying open until late, and other crowded spaces, despite strengthening of the response efforts. Others who do take the threat seriously have said they need more information about Ebola, including how to protect themselves and where to seek care if symptomatic.

The impact of COVID-19 restrictions

The COVID-19 pandemic, and particularly lockdown measures imposed to prevent the spread of the virus, have had significant impacts on Ugandans in terms of livelihoods and education. These effects have been exacerbated by food and fuel price inflation. These experiences present complications for SVD response including:

- **Limited public patience for additional lockdowns or restrictions** (e.g., on movement within Kampala or between districts) to contain transmission of SVD, due to the ongoing impact of the COVID-19 lockdowns.[1]
- **Limited ability of people to adhere to prevention recommendations,** particularly in high-risk occupations (i.e., *boda boda* (motorcycle taxi) or taxi driving) due to impoverishment resulting from pandemic lockdowns.
- **Potential for reduced trust in/uptake of Ebola response measures** due to limited support offered during COVID-19 lockdowns.

The role of the military and police in response. The military and police were the most public-facing COVID-19 responders. Earlier research showed that this has implications for public trust in epidemic response measures in the country.[2] This practice needs to be considered carefully and adapted in circumstances where there is potential for negative impact. Although the government relies on uniformed security personnel, their involvement in SVD response may further erode public trust in government institutions, including public health institutions.

A political disease. COVID-19 was labelled a 'political' disease by many,[3] as the stringency of measures did not appear to match the relatively low number of cases in Kampala or the high costs associated with the response.

Factors fuelling low risk perception, mistrust and misinformation

Similarly, there are emergent and widespread perceptions amongst Kampala residents that SVD is also a 'political' disease, with rumours arising that:

- **SVD is a cover for gold and resource extraction.** The current outbreak originated in a mineral- and resource-rich area, with initial cases identified in and near gold mining communities. Because of this, rumours have spread about the outbreak, and that the subsequent lockdown of Mubende and Kassanda Districts, was imposed for elites to steal resources from the area. These rumours have spread within Kampala,[4] likely contributing to low SVD risk perception amongst many.
- **The current SVD outbreak is not real, because it is the Sudan strain of Ebola and neither South Sudan nor Gulu were affected.** Because it is the Sudan strain, there are perceptions that it must have geographically come from South Sudan, and thus that if real, it should have first affected Gulu, or other northern districts, or South Sudan.[4] Some people believe it cannot be SVD as it is perceived that Ebola outbreaks begin in border areas. Strategic messaging can be disseminated widely to improve understanding of how and where Ebola can originate, including locally in Uganda. Messaging can also explain the Sudan strain does not indicate geography.
- **SVD (and Ebola more broadly) is a 'business,' and the government of Uganda is using it as an opportunity to obtain international funds.** As with COVID-19, there are suspicions the

disease has been fabricated or inflated by the government in order to get money. **Funders are bypassing the MoH, indicating it is untrustworthy or incapable.** Rumours are circulating that international donors (e.g., the US or UK governments) are sending funds to international organisations in Uganda, rather than to the MoH,[5] raising public suspicion about the legitimacy of the government's response. Some Kampala residents question why they should trust the government if it 'cannot even be trusted' by international donors.[4]

These kinds of rumours indicate an 'atmosphere' of mistrust, as seen in the DRC, where people voicing mistrust can shape the way that other people (mis)trust Ebola response.[6] Importantly, this has been found in previous research to mean that people do not reject scientific information, but they do lack trust in response measures.[6] Continued community engagement efforts can help to mitigate this, however, this may not be enough to gain community trust.

Economic challenges. For many who do believe SVD is 'real', the response is seen as legitimately trying to curb its spread. However, many Kampala residents lack the financial means to stop or limit their movement and feel they would need to continue working, even if this meant breaking a lockdown order. The SVD outbreak follows two years of COVID-19-related hardship, food and fuel inflation, and general high cost of living. This makes it very difficult to limit economic activity in Greater Kampala, which is itself the economic hub of the country.[7–9]

Improving low risk perception. Risk communication should provide practical recommendations, including for individuals who cannot stop working due to the economic situation. There is demand for more information on prevention, case identification, and where and how to seek care. The urban Kampala population accesses outbreak-related information on TV, radio, social media, newspapers, and social networks. Accurate information should continue to be made available across all platforms. RCCE efforts should continue leveraging popular programmes like NTV's *Akawungeezi*, Bukedde's *Agataliko Nfuufu* or NBS's *Amasengejje*. UNICEF has begun training journalists in Kampala and, building on this, RCCE actors should also deploy other innovative approaches like street entertainment and digital screens in public places, whilst creating opportunities for two-way communication such as through community dialogues. In addition to Luganda and English, information should be made available in other local languages used in the southern central region, non-Bantu languages like Luo, Arabic and Somali, and other languages spoken by refugee, migrant and minority populations. Regular, clear, accessible information supports trust in sources of risk communication, helping slow the spread of rumours and disinformation.

HEALTH-SEEKING PRACTICES

Population preference for private health services and self-medication

People may seek care in both public and private health sectors, particularly if care in one setting fails to improve their health. That said, there is a general preference among the public in Kampala for private over public health services, as private services are usually much easier to access due to closer proximity, quick attention and financial flexibility.[10] Government health facilities, which also charge user fees, have long wait times and may lack medicine stocks (or be expected to).

Some studies suggest many in Kampala may seek care from qualified health services (public or private) within 24 hours of the onset of malaria symptoms[11] (the symptoms of which are very similar to early symptoms of Ebola[12]), particularly for children.[13] However, low cost self/at-home treatment is also highly popular and common,[14–16] and patients often go to health facilities only when self-treatment fails, and/or symptoms worsen. Many in Kampala will simply purchase Panadol from drug shops due to its low cost.

Additional important considerations related to health seeking include:

- **Distance from a health facility** (public or private) is likely to mediate whether external care is sought or if self/home-treatment is pursued, especially if the distance is greater than 3km.[17] Distance may be more of a concern for lower income residents and in more rural parts of Greater

Kampala, such as Wakiso[18] or Mukuno Districts. Village Health Teams (VHTs) and mobile services could be strategically used to cover these areas.

- **High levels of care-seeking for children** exist. One study in Wakiso District showed nearly 70% of caretakers of children with suspected malaria sought care the day symptoms appeared.[13] Data from the 2016 Uganda Demographic Health Survey suggested that around 60% of all children under the age of five with fever were taken for care or advice at a private health facility. This again underlines the importance of the response engaging with the private health sector.[19]

Enhancing SVD awareness and capacity across health services

There can be improved engagement between the public sector health system and private facilities and services,[10,19] as private clinic providers and pharmacists or drug shops are often less engaged in outbreak response during emergencies. However, private providers, which also include faith and traditional healers, may be consulted by people seeking treatment or advice for symptoms that could indicate SVD. It is therefore critical that response actors continue to engage with these providers. Engagement should also include support staff such as administrators, cleaners, security guards and food handlers.

'Traditional healers' include a variety of providers in Uganda, but the most relevant are herbalists (singular - *omusawo omuganda*). Spiritual healers are usually seen for cases of ancestor appeasement or worship. However, there have been reports that some healers in rural parts of Mukono District may be misleading local people into believing prayer and monetary offerings will protect them from the disease.[20] Baganda herbalists are popular sources of care, and they see a large number of people, especially for treatment of febrile illness or cough. It is critical they be similarly engaged for information and training.

- **Furnishing private providers with RCCE material and training**. Scale up access for private RCCE material in relevant languages and formats, PPE and hotline information to refer suspected SVD cases.
- **Training of traditional healers.** UNICEF and other partners have been effective in briefing traditional healers on the SVD outbreak and how to refer suspected cases to responders. Such training should be scaled up and reinforced, with further messaging to traditional healers via their professional associations, and established, experienced healers in the country.
- **Engaging religious leaders and places of faith.** These may also be visited by people experiencing symptoms, underscoring the need to engage with religious leaders and others based in faith centres for training in RCCE, recognition of SVD and safe referral. Furthermore, faith leaders can also play especially important roles communicating with congregants about SVD, supporting survivors and contacts facing psychosocial impacts, and supporting safe and dignified burials.

RISK AND VULNERABILITY

This section considers two aspects of risk and vulnerability: risk or vulnerability to Ebola, and vulnerability to the effects of public health measures like school closures, restricted movement or lockdown. In urban Uganda, several groups are at higher risk of SVD, with evidence from the Gulu outbreak (2000-2001) pointing to high transmission in urban informal settlements and other areas with high population density.[21] Informal settlement residents and other urban populations also experience vulnerabilities to SVD related to high mobility, use of congested public transport, limited economic opportunity, living in multi-generational or multi-family households, and inadequate access to appropriate communication channels, water and sanitation.[21–25] Beyond direct risks of SVD infection, 'hand-to-mouth' workers often suffer the most from public health measures like lockdowns due to their already precarious livelihoods, characterised by low daily incomes. Gender, disability, age, social status or other social characteristics **compound challenges for certain people or groups**. Groups who may be most vulnerable to SVD and/or response and who require specific attention with regard to RCCE include women, older people, health workers, children, rural-urban migrants/travellers, bar workers, sex workers, and *boda boda* and *takisi* drivers.

WOMEN

As caretakers for the sick, they are at **risk of contracting the disease** from ill or deceased family members or friends in their care at home, in hospitals and in their communities. Pregnant women are also more likely than other women to die from the disease. Women are also likely to be more vulnerable to:

- **Response impacts**. This especially includes any that may curtail informal livelihood strategies in which women frequently engage, such as street- and market-based trading (including salons or fast food-related businesses) or domestic work.[26]
- **Secondary health impacts.** Women are particularly affected if health facilities are shut, if critical services, such as maternal health services, become unavailable, or if they are afraid to attend clinics.[27]
- **Sexual exploitation and abuse.** Adolescent girls and young women may be exposed to unique risks of sexual exploitation and abuse by police, relatives, and humanitarian and development workers during the emergency response.[27] Experiences of violence, including teenage pregnancies and forced marriages, were increasingly recorded during the COVID-19 lockdown.[28]
- **Inadequate information.** Women, especially those from vulnerable socioeconomic groups, may face more barriers than men accessing the internet and other sources of health information in a language and format they understand, leading to greater risk of infection.[29]
- **Misinformation.** There is also evidence that women in Uganda have been more hesitant to take COVID-19 vaccines or other 'new' vaccines, in part reportedly due to rumours around infertility.[30] This may influence their willingness to take up vaccines for SVD if they become available.[31]

OLDER PEOPLE

Older people are also often caretakers in their families and neighbourhoods leaving them vulnerable to the risk of contracting the disease from ill people under their care including adult children, and other relatives and friends in their neighbourhoods.

- **Informal caregiving roles.** The particular roles older people play in communities may mediate their risk of contracting Ebola compared with younger adults, as they may be less likely to perform at-risk care and burial practices. However, those with fostering or non-formal caring roles may be at increased risk of infection.
- **Care for orphaned grandchildren.** Many older people are likely to step in to take charge of grandchildren orphaned by SVD. While this may not present high infection risk (due to contact-tracing efforts following the death of parents), grandparents (or other elderly relatives) may struggle to adequately provide for their new charges as many may have limited financial and other resources.
- **Food and financial insecurity**. Older people, in particular those living alone, may rely on food and financial remittances from their children or extended family. This support may be disrupted by the economic downturn faced by affected districts, or by restrictions on movements of people and goods.

HEALTH WORKERS

Health workers in both public and private health service settings are highly vulnerable to Ebola risks. These risks include:

- **SVD infection at health facilities**. Nineteen health workers have already contracted SVD and/or died in the current outbreak as of 20 November 2022. Patients with SVD may arrive to facilities where health workers – and other support staff like lab technicians, security, administrators/ receptionists and cleaners – lack adequate PPE[32] or information about how to protect themselves.
- **Ebola infection in mobile services and activities**. Community health workers, Village Health Teams (VHTs) and para-social workers are often women. They, and others involved in door-to-

door health services and outbreak response activities such as contact tracing, may also be vulnerable to infection.[33]

- **Overwork, burnout and attrition**. Health workers, particularly in the public sector, may also be vulnerable to mental health impacts of overwork, pressure to contain the outbreak, concern over risky conditions, and inadequate pay should the outbreak continue to spread. In addition to mental health impacts, this may lead to attrition, with knock-on effects for effective response, and for health services more broadly.
- **Stigma**. Health workers in all sectors may also face stigma and isolation in the community where they live if people fear they carry the virus.

RURAL-URBAN MIGRANTS AND TRAVELLERS

Significant rural-urban travel and exchange occurs between Kampala and surrounding rural areas, which is important for livelihoods, trade and sustaining social networks. Demand in Kampala for agricultural products from places like Mubende, for instance, drives frequent mobility and exchange.[34]

- **Rural-urban travel**. People travelling between rural SVD-affected districts and Kampala, as well as those involved in their transportation or who are otherwise around them (co-travellers, business contacts, family members, friends, neighbours etc.) may be at heightened risk of exposure and transmission of SVD to others.
- **Health seeking**. People from rural areas may travel to Kampala to seek medical attention for what may turn out to be SVD. Similarly, people from rural areas working in the city may leave to seek medical attention in rural areas due to limited ability (financial or otherwise) to access care within Greater Kampala, or a desire to return home if sick.
- **Kawempe, Rubaga and Nakawa Divisions**. Kawempe is of particular concern due to its linkages via highway to Mubende. Rubaga and Nakawa Divisions are highly populated and see a lot of trade, as well as significant numbers of rural-urban travellers using often-crowded public transportation and workers who split their time between the city and their homes outside of metropolitan Kampala.

Information and engagement around SVD could be **stepped up in rest stops and in both directions along key highways** going into/out of Kampala (e.g., Kampala-Fort Portal Road, Kampala-Masaka Road and Kampala-Mukono-Jinja Highway).

INFORMAL SETTLEMENT RESIDENTS

Informal settlement residents face inadequate access to safe water, sanitation, and other infrastructure; poor housing quality, and insecure residential status. Overcrowding is also common, and these combined conditions pose a critical risk for SVD spread. Informal settlement residents can also be highly mobile as limited economic opportunities force slum residents to migrate to other cities. This migration can prove difficult for SVD screening measures and contact tracing. Furthermore, residents in these areas may harbour particular mistrust for local authorities such as the Kampala Capital City Authority, which promotes unpopular 'slum upgrading' and informal sector regulation schemes that have affected informal settlement residents.

Informal settlement residents are also likely to be more immediately concerned with securing food and shelter than with SVD prevention. For these populations, it may be more appropriate to emphasise harm reduction approaches focused on how they can continue working safely (e.g., as transport workers or street or market vendors) rather than restrictions that affect their ability to work. If restrictions are necessary, it will be critical to establish accessible social safety mechanisms and emergency assistance programmes to support them meeting their basic needs.

BARS AND BAR WORKERS

Bars are often social and economic cornerstones of urban communities, particularly in informal settlements.[35] Bars are spaces where people gather, gain information about current events, and sometimes sleep overnight. Greater Kampala has very high rates of alcohol use,[36] and in its informal

settlements, the bar is like a 'living room'. Bars are often a first point of contact for people who have come from rural areas, looking to find a place to stay or a meal or drink. Bars are also densely packed, with people cycling in and out throughout the day and night. Bar workers may be particularly vulnerable to the economic impacts of a lockdown or curfew. They may also be vulnerable to exposure to SVD in crowded establishments with poor sanitation, although it is unclear if symptomatic individuals would enter these spaces.

SEX WORKERS

Sex workers' specific vulnerabilities in Kampala are dependent on the type and location of sex work (e.g., bar-based, street-based, lodge-based). Sex work is criminalised under the Ugandan Penal Code, and sex workers in Kampala are already highly vulnerable due to low access to health services[37] and high rates of physical and sexual violence from clients and police.[38]

- **Essential income.** Sex workers are typically unable to stop working, as their income usually supports themselves, children, and family members in rural areas, indicating high vulnerability to the effects of a lockdown.
- **Need for information and engagement of trusted information sources**. Sex workers are eager for information about SVD and how to protect themselves, e.g. through the use of temperature guns or other measures to screen clients, or by 'saying no' to clients with fever. Specific guidance can be co-adapted with local organisations (see list at end). *Ssengas* or older trusted sex workers should be trained in SVD prevention and case identification, for example, through training conducted by sex worker-led organisations in Kampala.
- **High-risk sex workers.** Low-income, transgender and male sex workers constitute some of the most marginalised groups in Kampala. They are particularly concentrated in informal settlements like Kataba and Kikkubamutwe in Kabalagala (Makindye Division), Kakima, Kifumbira (Kamokya Central Division) but also in Kawempe Division (i.e. Bwaise). Those living or working in lodges or brothels often work in close quarters and would be vulnerable to SVD.
- **Police and client violence**. Those engaged in street-based sex work are at particular risk of client and police violence, which increased during the COVID-19 lockdown.
- **Risk of post-survival transmission of Ebola virus.** Ebloa may be transmitted by survivors through sexual intercourse;[39] this may also put sex workers at risk of contracting the virus from clients who had previously survived the disease.

BODA BODA DRIVERS

Boda boda drivers are a highly mobile group that provide the most popular form of public transportation in Kampala. They often carry people to and from hospital or health facilities and/or from taxi parks, and therefore they may come into contact with travellers from high-risk districts or symptomatic or asymptomatic travellers. However, they may not be able to identify the symptoms of SVD. *Boda boda* drivers are very well organised, with most working from 'stages', which have an elected chairman and treasurer, among other positions. They are a vital source of information, which – along with misinformation – spreads rapidly through *boda boda* driver networks.

TAKISI (*MATATU*) DRIVERS

Takisi, taxi, or minibus (*matatu*) drivers and conductors travel popular routes throughout Kampala and connect central Kampala with neighbouring Wakiso and Mukono Districts. This form of public transportation is very popular. Takisis ferry people into Kampala for work during the day and take them home at night. Drivers and conductors are both highly vulnerable given the numerous passengers they come into contact with daily. If appropriately trained and equipped, takisi conductors and drivers could reach a large number of people with critical risk communication. Conversely, they may spread misinformation if not well informed. Takisi conductors and drivers can also be embedded in other response activities (e.g., surveillance and community engagement, including community dialogues).

CITY JAILS AND PRISONERS

Conditions in city jails and prisons are conducive to an SVD outbreak and spread. City jails are usually full or over capacity and therefore overcrowded. Police cells and prisons have limited access to clean water and sanitation. Kampala's vulnerable residents, including low-income (hand-to-mouth) workers in informal settlements and those in illegal occupations (e.g. sex workers) spend time in and out of these facilities, placing them at greater risk. Police station staff (Officers-in-Charge) should be provided with information on the identification of Ebola symptoms and should be encouraged to have a plan of action in case someone is arrested and is symptomatic. This screening could be integrated into their normal initial processing procedures before an individual is put in a police station cell. Similarly, Luzira and Kigo prisons in Greater Kampala are at risk from officers or visitors going between the prisons and the city.

URBAN REFUGEES

In 2021, Kampala was home to over 120,000 refugees.[40] While refugees are spread across Greater Kampala, some groups are concentrated in particular areas. The largest refugee population is from Somalia and resides in Kisenyi, Rubaga Division. Other populations include people from Ethiopia and Eritrea, mainly living in Mengo and Kabusu; from the DRC, living in Katwe, Nsambya and Makindye; from Ethiopia, Eritrea and South Sudan, living in Kansanga, Kabalagala and Seeta, and from Burundi, living in Namungoona and Nabulagala.

- **Refugee youth** in urban Kampala often face precarity, as they disproportionately experience language barriers and poverty and live in contexts with overburdened health systems. Daily priorities of food, shelter and safety need to first be addressed before youth can be engaged in health promotion.[41]
- **Risk of gender-based violence (GBV).** Female refugees in Kampala report high lifetime experiences of physical and/or sexual violence, post-traumatic stress disorder (PTSD), and symptoms of depression.[42] Experiences of GBV increased during lockdown, driven by increased stress and lack of confidence among men due to their loss of livelihoods, a rise in substance use, and social isolation.[28]
- **Recent arrivals or undocumented refugees** may face greater challenges than their longer-established counterparts. Those without identity cards, for instance, may struggle to access health services, while those arriving from SVD-affected or high-risk rural districts like Kyegegwa, Kikuube or Kamwenge where there are refugee settlements, may face stigma if people perceive them to be carriers of the disease.

CHILDREN

No instances of Ebola transmission have been associated with school attendance in Uganda or elsewhere. Nevertheless, school environments may present infection risks. Six pupils from three different schools in Rubaga Division have been infected (all six were children of the same family and related to the initial Kampala case), and their schools have been closed and staff and other children have faced stigma locally.[43] A greater risk than infection may be the loss of schooling in the event of a broader lockdown. Authorities have already decided to end the school year two weeks early.[43]

- **Loss of schooling** may be especially damaging as schools had already been closed for nearly two years to prevent COVID-19 transmission and only reopened in January 2022.
- **Pregnancy and child labour risks.** The prolonged school closures associated with COVID-19 led to increased child labour[44] and resulted in nearly 20,000 additional pregnancies among school-going girls and young women ages 10-24.[45] These and other effects of school closure are likely to recur if Ugandan schools are closed due to SVD.
- **Schools for risk communication.** If kept open, schools may be able to play an important role in communication and engagement about Ebola with students and their families and communities, including by providing critical information, supporting community-based surveillance and linking to health and other services.

SOCIAL INFRASTRUCTURES AND INFLUENCERS

Urban areas have vast assets and strengths, including, for example, 'social infrastructures' (Box 1) that can be used by the response.[23] Engaging social networks present in Greater Kampala, including in informal settlements, may contribute to success of the response by improving buy-in of different population groups. In informal settlements, for example, social networks and infrastructures have developed out of necessity in the absence of formal government service provision or social protection.[46] In West Africa, effective outbreak response in urban areas depended on leveraging social networks and community governance structures, through participation of community leaders and community members who helped with contact tracing, raising community awareness, improving hygiene, disease surveillance, and provision of food and water support for individuals in quarantine.[23,46]

Box 1. Leveraging urban 'social infrastructures' for RCCE in Greater Kampala

'Social infrastructures' are an under-recognised and under-utilised resource in Kampala's dense urban spaces, especially urban informal settlements. The term includes the range of services, facilities, organisations, individuals, and businesses that contribute towards quality of life in a community. Evidence from the West African epidemic showed that engaging social networks present in Greater Kampala, including in informal settlements, may contribute to success of the response through **improving buy-in from different population groups**.

Community champions and 'influencers'

Encouraging leaders to act as positive role models by consistently and publicly following and supporting preventive measures is key. Communication strategies for Ebola prevention must also consider the political climate. While it is necessary to engage local leaders (LC I and II chairpersons) in order to work legitimately in informal settlements and other parts of Kampala, grassroots leadership structures are likely the best channels for effective communication. It is important to engage with and support a range of actors, including training them on appropriate health practices and providing them with funds to carry out critical activities. These positions should be consistently funded, and job descriptions should explicitly set out the responsibilities related to spreading Ebola prevention messages.

Category	Key Influencers
Market vendors	Market vendors associations (e.g., those based on locations such as Kampala, Nakawa, etc.)
Large business operators	Factory owners, large transporters, industrial park owners, etc. Large corporations such as Coca-Cola and associations such as the Chamber of Commerce and Industry may also be able to support RCCE activities among their staff or members, and/or through marketing channels.
Small business operators	Operators of salons, takeaways/food vendors, bar owners etc.
Cultural leaders	The Kabaka (Buganda king) and his cabinet of advisors, and spokesperson, which are important for reaching Baganda residents of Kampala. They can spread the word via their own TV station, CBS. Also consider 'popular' media personalities like the hosts of popular entertainment programmes.
Religious leaders	Born Again church leaders and the Inter Religious Council. They can encourage leaders (Bishops, Pastors, Imams) to share information during services. They may also play important roles supporting congregants who may become infected with SVD, or who are contact traced. Religious leaders can also play key roles in safe and dignified burials.
Professional associations	Healers (National Council of Traditional Healers and Herbalists Associations), drug sellers and pharmacists (Pharmaceutical Society of Uganda), private health providers (Uganda National Association of Private Hospitals (UNAPH)), and other key medical associations such as the Uganda Medical Association, and trade unions.
Migrant worker leaders	Migrant Workers' Voice Association. In addition to advocating for migrant worker rights, they may be able to share critical information with migrant worker communities in Kampala.
Refugee leaders	These are often more informal leaders, based in specific communities where refugees live in Kampala (e.g., Ethiopian or South Sudanese communities in Kabalagala). Reach out to longer-

	term refugees who know people and who are frequently approached by others in the community for advice, as they have informal or semi-formal authority. For example, the Association of the Somali Community in Uganda has been instrumental in engaging its members in the Kisenyi area of Kampala.
Sex worker-led organisations	Alliance of Women Advocating for Change (AWAC) is the leading sex worker-led organisation in Uganda and has a vast network of smaller CBOs. They are extremely experienced in community engagement, including with sex workers but also other residents of Kampala's informal settlements.
Political and elected leaders	Local Councillors I and II at the local levels, though involvement of informal security personnel like Crime Preventers should be avoided. Presidential appointees such as Resident District Commissioners may also be engaged.
Transport workers	*Boda boda* stage leaders in key areas, including in Kawempe and Rubaga Divisions; taxi drivers.
Other CSOs	Rotary, Lions Clubs and others that engage in community service activities.

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