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COVID-19 Risk Communication and Community Engagement (RCCE) Assessment

Uganda 2020

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BIO

U-Learn (Uganda Learning, Evidence, Accountability and Research Network) is designed to promote improved outcomes for refugees and host communities in Uganda. In collaboration with government and a wide range of implementers and stakeholders, U-Learn focuses on facilitating learning, conducting assessments, and amplifying refugee voice and choice in the protracted refugee crisis.

U-Learn is a consortium funded by UKAID under the BRAER (Building Resilience and an Effective Emergency Response) programme and delivered by The Response Innovation Lab (hosted by Save the Children), in consortium with IMPACT Initiatives and the International Rescue Committee.

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Executive Summary

Rationale

This assessment aims to strengthen the evidence base surrounding risk communication and community engagement (RCCE) approaches in Uganda, in particular in refugee communities during the COVID-19 response, to inform the successful delivery of RCCE. Specifically, the research intends to strengthen the evidence base on whether and how different communities access information about COVID-19, if the modalities through which the information is delivered are appropriate and in line with different community preferences, how this information is interpreted by them and how it shapes the risk perception of COVID-19 across communities of the study. In addition, this assessment aims to build evidence and provide a basis for government and humanitarian actors to explore why risk communication in communities is not always translating into behavior change, and how the current communication strategies could be adapted to enhance the uptake of preventive measures to limit the transmission of COVID-19.

Methodology

A secondary data review was conducted to supplement the findings from primary data collection. The assessment team gathered quantitative data through a total of 1533 remote individual level surveys via phone calls while field teams travelled to various locations in the south-west and West Nile regions to conduct 66 focus group discussions (FGDs) with refugees, host community and general population members[1]. The field teams also conducted 51 key informant interviews (KIIs) with community leaders, local government members and health workers; some of these were done in-person and some remotely via the phone[2]. After a preliminary data analysis, field teams returned to the field to provide validation workshops to some of the communities that had been visited during data collection to jointly discuss and analyse the preliminary findings.

Due to remote data collection and non-random sampling, findings presented are **indicative** and not statistically representative.

[1] The difference between host communities and the general population is that although both populations consist of Ugandan citizens, only those in host communities live in proximity to refugees.

[2] The numbers of completed interviews stated here include those completed for the Social Network Analysis

Key findings

Information flows

Availability and barriers

- Information about COVID-19 is generally available, often on a daily basis. Received information is most frequently reported as focusing on the symptoms of COVID-19, the nature of the disease, its transmission, social distancing, and risks and complications of the disease.
- Respondents report lacking information on infection rates and death tolls that is specific to their district or to Uganda.
- Thirty-one percent (31%) of respondents report experiencing barriers to information. The lack of access to a radio, living remotely or having a disability are the most common barriers mentioned.

Channels and sources

- The most reported commonly used and preferred information channel for refugees and host communities is the radio. Alternatively, refugees also rely on mobile loudspeakers or "boda talk" while host communities also reportedly access information via television.
- Refugees most frequently indicate receiving information from non-governmental organizations (NGOs) and United Nations (UN) agencies while host communities rely on presidential addresses as their most common information source.

Misinformation and trust

- Around half of the respondents (52%) report having heard conflicting[3] information about COVID-19. This proportion is as high as 80% in high-risk districts[4]. The most common source of misinformation surrounding COVID-19 is indicated coming from friends or family.
- Community members indicate they can trust information about the disease as accurate when it is shared by multiple sources.

Risk perception

- Almost all respondents (96%) report perceiving COVID-19 as a threat. Notably, the majority of respondents (81%) report considering the restrictions put in place by the authorities as a source of risk. FGDs participants most often relate perceiving COVID-19 as an economic or social threat rather than a health threat, indicating that the threat emanates from the preventive measures and restrictions put in place by authorities to limit the spread of the disease, rather than from the disease itself.
- Despite some community members report perceiving COVID-19 as a threat due to the rising death tolls reported on a global level, others feel that COVID-19 is not a threat

[3] Conflicting information was defined, for the purposes of this assessment, as different or non-coherent information related to the same topic and coming from two or more different information sources.
[4] Kampala, Amuru and Tororo; level of risk determined by the number of COVID-19 cases in August.

to them because they lack evidence of infections and deaths in their immediate surroundings.

- Community members commonly report feeling safe to socialize with people from their own communities since they have not heard of any cases in their immediate surroundings, but would refer any person newly arriving in their area for testing or isolation. This suggests that those who perceive a health risk, consider it low/absent within their own communities and rather sensed risk coming from outside them.
- Findings suggest that the authority figures could play a role in contributing to building the risk perception of communities. When enforcing adherence to preventive measures, authorities are also implicitly communicating to the communities that the health risk is present; the opposite happens when authorities do not exert their enforcement power.

Behaviour change

- Despite widely available information about COVID-19 and a high reported threat perception, findings indicate that such perceptions have generally not been sufficient in promoting behaviour change.
- Whilst respondents interviewed by phone report a high-level of compliance with preventive measures (e.g. wearing masks, washing hands and socially distancing), this is contradicted[5] by qualitative and observational findings which show that these reported behaviours are not taking place consistently:
    - Despite nearly all (98%) respondents reporting access to a mask, and 86% that they wear a mask, observations from the field show that individuals may report wearing a mask even if not doing so consistently or properly (e.g. not entirely covering both nose and mouth).
    - Most respondents (92%) report regular handwashing with soap and water and relatively few respondents (23%) report having difficulty implementing this measure. However, FGD participants in several communities commonly mentioned a lack of soap is hindering the implementation of recommended preventive measures.
    - A lower proportion of respondents (61%) report respecting social distancing guidelines and almost half of the respondents (44%) indicate having difficulty implementing the social distancing measure.

AAP mechanisms

- A majority (86%) of respondents to the quantitative survey report using feedback mechanisms, however, FGD participants criticize the lack of feedback channels available to them.
- FGD participants and KIs suggested expanding the use of suggestion boxes and community meetings to strengthen AAP mechanisms.

[5] The contradiction between quantitative data from the phone survey and both qualitative and observational data could partially due to the incentive for respondents to report social desirable answers (e.g. adopting the required preventive measures), even if they are not always or properly doing so.

Opportunity for improvement

Suggestions to improve the response from key informants, including community leaders, focus on:

- Continued and increased use of **local languages** in risk communication.
- Increased **provision of materials** such as masks and soap to comply with preventive measures.
- Continuous sensitization of the communities on COVID-19.

Contents

List of Acronyms

AAP	Accountability to affected populations
AO	Assessment officer
CBO	Community based organizations
CEFORD	Community empowerment for rural development
DHE	District health educator
DHO	District health officer
FGD	Focus group discussion
FO	Field officer
GTS	Ground Truth Solutions
IEC	Information education communication
IMPACT	IMPACT Initiatives
IRC	International Rescue Committee
KAP	Knowledge, attitude and practices
KI	Kei informant
KII	Key informant interview
LC	Local council
MTI	Medical Teams International
MSNA	Multi-sector needs assessment
MoH	Ministry of Health
NGOs	Non-governmental organisations
OPM	Office of the Prime Minister
PWD	Persons with disability
RCCE	Risk communication and community engagement
RCSMCE	Risk communication, social mobilization and community engagement
RDC	Resident district commissioner
REACH	REACH Initiative
RWC	Refugee welfare committee
SNA	Social network analysis
SOPs	Standard operation procedures
U-Learn	Uganda Learning Evidence Accountability and Research Network
UNHCR	United Nations High Commissioner for Refugees
VHTs	Village health teams
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

1.0 Introduction

1.1 Background

The COVID-19 disease, which originated in Wuhan, China in December 2019, was declared a pandemic by the World Health Organization (WHO) on 11th March 2020. To date, the 11th of November 2020, there have been a total of 7,771 recovered cases, and 562 currently active cases in Uganda[6].

Beginning on 18th March, 2020, the Government of Uganda took several measures to curb the spread of the disease, such as closing borders, enforcing isolation and social distancing policies affecting particular gatherings of people, places of worship, schools, and public transport[7]. On 20th September, the Government of Uganda announced changes to the current restrictions, including the opening of Entebbe International Airport

[6] Ugandan government COVID-19 response info hub; November 2020
[7] Ugandan ministry of health website, November 2020

and all land borders on 1st October, allowing schools to re-open on 15th October for the candidate classes, permitting places of worship to gather with groups of 70 persons or less, and allowing open-air sport activities to resume without spectators. Movements to and from border districts were restored.

Despite great efforts from the Government of Uganda and partners involved in the pandemic response in communicating the importance of adopting behaviour to reduce the spread of COVID-19, public adherence was observed to be relatively low by field teams. Recent knowledge, attitude and practices (KAP) studies and other assessments have identified information gaps, misinformation, and rumours as drivers of this low adherence[8]. For example, the Uganda Learning Evidence Accountability and Research Network (U-Learn) publishes a monthly rumour tracking bulletin with support from Ground Truth Solutions (GTS). This bulletin was conceptualized by the consortium to support the ongoing COVID-19 response in the country and has recently identified "downplaying COVID-19" and rumours surrounding "cures for COVID-19" as the top two rumours circulating amongst communities in Uganda (please see the section on "conflicting information 3.2.7" for more information on this)[9].

Many KAP studies also note that some individuals who do have access to accurate information about COVID-19 still do not fully adhere to the restrictions or preventive behaviours, despite trusting the information at hand[10]. Therefore, increased access to information may not fully close the adherence gap. While there have been past KAP studies and assessments related to this topic, particularly around the Ebola response in Uganda, studies have been ad-hoc, smaller-scale, and generally only focused on a particular region or geographic area, limiting a nation-wide perspective and understanding.

COVID-19 has affected all communities in Uganda including refugees and Ugandans communities living in both refugee-hosting districts and the other districts. Some of these community types, including refugees, may be more vulnerable to the direct and secondary impacts of the disease, which is why this assessment was planned with all community types in mind but with a focus on refugees.

Background on Uganda's Refugee Response

Uganda is currently hosting the largest number of refugees in the region with over 1.4 million refugees and asylum seekers[11]. Nearly 800,000 refugees have fled to Uganda from South Sudan, over 400,000 from the Democratic Republic of the Congo (DRC), 48,000

[8] Danish Refugee Councils (DRC) "Multi-sector Needs Assessment: COVID-19 Situation in Uganda" (May 2020); GTS "Insights from refugee community leaders – Uganda" (different bulletin from 2020); Population Council and MoH Kenya "COVID-19 KAP (March 2020)

[9] Ground Truth Solutions COVID-19 rumour tracking bulletin, October 2020

[10] Danish Refugee Councils (DRC) "Multi-sector Needs Assessment: COVID-19 Situation in Uganda" (May 2020); GTS "Insights from refugee community leaders – Uganda" (different bulletin from 2020); Population Council and MoH Kenya "COVID-19 KAP (March 2020)

[11] UNHCR Uganda comprehensive refugee response portal; November 2020

from Burundi and the rest from Rwanda, Somalia, and other African countries. The influx of refugees, especially from DRC and South Sudan, is expected to continue, as there is no political solution in sight to the on-going crises. Additionally, there is little prospect of the refugees from other countries returning soon. Most refugees have arrived in Uganda within the last few years, but for some it has been decades. Since refugees in Uganda have different backgrounds, come from a variety of different places, and have been displaced for varying periods of time, their past experiences and current needs may differ[12].

In Uganda, the refugee response is led by the Office of the Prime Minister (OPM), and is supported by the United Nations High Commissioner for Refugees (UNHCR). They are guided by the 2006 Refugee Act and the 2010 Refugee Regulations, which grant refugees the right to work, freedom of movement, and the establishment of refugee settlements rather than refugee camps[13]. Nearly all refugees (95%) in Uganda live in established refugee settlements in rural areas across the country, while the others live with the host community, mostly in urban centres. Uganda maintains progressive policies towards refugees, allowing freedom of movement and freedom to work, amongst others.

As COVID-19 swept across the world, the World Health Organization (WHO) and the Ugandan Ministry of Health (MoH) kick-started an eight-pillar response plan spearheaded by a national task force for public health emergency coordination and response in Uganda. A key pillar of the response plan was the Risk Communication, Social Mobilization and Community Engagement (RCSM-CE) subcommittee[14]. Through messages on transmission, signs and symptoms, prevention and reporting mechanisms, the subcommittee has focused on raising awareness and promoting preventive behavioural practices. The Ugandan government has further refined and dispatched purpose-built guidelines for community engagement that enable health educators to conduct awareness raising campaigns at district and village levels, within the framework of government restrictions. Humanitarian and government actors provide multi-sectoral support during the COVID-19 response, through awareness and information campaigns on the disease, within the most affected communities with a focus on the high-risk districts, but also throughout the territory where responding organizations were already implementing projects[15]. Effective RCCE (including two-way AAP) is a key operational approach in the response to influence communities' risk perceptions, health behaviours and practices in such a way that they contribute to reduce the risk of an untenable spread of the COVID-19 disease.

[12] REACH Initiative. Uganda Joint Multi-Sector Needs Assessment: Identifying humanitarian needs among refugee and host community populations in Uganda. August 2018.
[13] Government of Uganda. The Refugees Act 2006. 22 June 2009.
[14] For ease of understanding we will use RCCE (Risk communication and community engagement) instead of RCSM-CE throughout this report also because the RCSM-CE acronym only refers to the particular committee formed within the Ugandan government and not to the concept in general.
[15] Those districts at the border of Uganda with official/unofficial entry points.

1.2 Rationale

In order to rapidly and effectively provide the general public with accurate information about COVID-19, response actors first require a solid understanding of community beliefs, levels and methods of community participation, the community's access to information, as well as the most trusted and commonly used information channels. Beyond that, response actors need information in order to adapt strategies to combat the tendency of individuals to lower their perceptions of risk over time, which is a trend that is common even when accurate information about COVID-19 is readily available. It is crucial to inform this response and assess whether community engagement is being conducted in an appropriate and inclusive manner. This involves assessing whether actors are disseminating the information that people really need, and whether the information and communication messages are being disseminated through effective channels and are both well-understood and well-interpreted, in a way that leads to a healthy assessment of risks.

Although some evidence has been generated on this topic, there is a lack of a comprehensive study producing broad findings that could feed into a national-level risk communications strategy[16].

In addition, despite the fact that refugee communities have particular vulnerabilities, at the time of the design of the study no other assessments had been published with a focus on refugee communities, including all the different settlements. This study's focus is on refugee communities, while also assessing host and Ugandan population communities living in no-hosting districts in order to ensure representation of other groups.

A comprehensive study in this area will afford government and humanitarian actors an improved understanding of key communication channels, information flows, risk perceptions and behaviour change, in particular in refugee communities, are based on evidence encompassing the different target groups. Consequently, the communications modalities in place could be adapted or their use confirmed and reinforced according to the communities' preference. Furthermore, the findings of this study are intended to provide a basis from which government and humanitarian actors can explore *why* risk communication in communities is not translating into behaviour change, and *how* the strategy can be adapted.

Additionally, to date, little is also known on the role that local social networks that underlie community communication channels can have in influencing community behaviour, risk awareness, and risk perception. The networks of community influencers may be of pivotal importance for effective risk communication and community engagement activities on a community level.

[16] Ugandan national health sector development plan 2019/20

This assessment aims to answer these questions, complementing already ongoing KAP assessments including the rumour tracking bulletins and AAP assessments which U-Learn has launched with GTS as well as another COVID-19 MSNA conducted by the DRC[17].

2.0 Methodology

2.1 General objective

The main objective of this assessment is to inform the broader humanitarian and government response in Uganda by creating a solid evidence-base around risk communication and community engagement approaches, with a focus on COVID-19. This assessment attempts to complement recent and ongoing rapid KAP studies, which have consistently identified a disconnection between communities' relatively high understanding of COVID-19 and related behaviours, and relatively low uptake of these preventive behaviours[1819]. In particular, this assessment aims to provide evidence to explain the *why* behind this disconnection to inform adjustments to national RCCE strategies. Further, this assessment aims to understand what the local social networks underlying community communication channels are and what might be their role in influencing the uptake of these preventive measure and consequential behaviour change of the communities.

2.2 Research questions

1. Through which communication channels and at what frequency do communities receive information related to COVID-19?
    a. Are there instances of conflicting sources of information around COVID-19?
    b. If so, how do community members reconcile such conflicting information?
    c. Are there differences across different sub-groups within a community (by age, gender, status (refugee/host), marginalized groups)?
    d. Are there specific access barriers different sub-groups within a community face in accessing communication channels established for COVID-19?
2. What are the communication channels most accessible, preferred and trusted across different population groups for general and COVID-19 related communication?

[17] Danish Refugee Councils (DRC) "Multi-sector Needs Assessment: COVID-19 Situation in Uganda" (May 2020); GTS "Insights from refugee community leaders – Uganda" (different bulletin from 2020); Population Council and MoH Kenya "COVID-19 KAP (March 2020)

[18] UNICEF- Uganda Terms of Reference for Knowledge, Attitude and Practice (KAP) Study on COVID-19 (Two-Phased KAP Study On COVID-19)

[19] Danish Refugee Council (DRC), "Multisector Needs Assessment: COVID-19 situation in Uganda," May, 2020

   a. Are there differences across different sub-groups within a community (by age, gender, status (refugee/host), marginalized groups)?
   b. Do these communication channels overlap with those employed by the key COVID-19 responders?
   c. What roles do local social networks play in the proliferation and circulation of COVID-19 related information and misinformation?
   d. Are there specific access barriers different sub-groups within a community face in accessing communication channels?
3. How do individuals and communities interpret available information about COVID-19 in order to assess the risks related to COVID-19, and relatedly to determine the relative benefits and detriments of pro-health behaviour change?
   a. Are some approaches to packaging the same information (e.g. different channels, different messaging, etc.) more effective than others in communicating the risks associated with COVID-19 and the benefit of behaviour change? Which are those and why?
   b. What role does trust, social networks, economic considerations, and other external factors play in attenuating or amplifying individuals' perceptions of risks related to COVID-19?
4. Which AAP mechanisms are currently in place to support COVID-19 risk communications?
   a. How do communities engage with these mechanisms in the context of COVID-19?
   b. To what extent do these mechanisms allow for a two-way exchange of information and feedback?
5. What perceptions do affected communities have about the response of government and humanitarian actors to COVID-19?

2.3 Area of study and population of interest

This assessment sought to answer the research questions across different community environments to test whether information landscapes and prevailing informational needs differed across different population cohorts.

A particular focus was put on **the refugee population,** with **1053 quantitative surveys** completed in this community group. This focus was decided on because the U-Learn consortium itself is a refugee-focused project and because refugees in Uganda are often categorized as one of the most vulnerable population groups. With the aim to produce research findings tailored to inform the ongoing refugee response, the research was designed to produce findings at the settlement level; all 13 refugee settlements across Uganda were assessed.

Since the COVID-19 pandemic also affects other parts of the population, the assessment covered other population groups, in addition to refugees. In place of a gross nation-wide assessment, the assessment singled out different types of assessment areas across Uganda (detailed below) with specific characteristics that had an influence on the existing

information ecosystem and the access to reliable information on COVID-19 more specifically.

In addition to the refugee population, **Ugandan host communities** were included in this assessment, with **225 quantitative surveys** completed in this community group. With an ongoing refugee response and a continued presence of humanitarian actors within their community areas, hosts may benefit from a dual access to information through humanitarian partners operating in the refugee-hosting districts and through information channels more common amongst the Ugandan population, and thus possibly resulting in stronger awareness or better behavior change outcomes.

The desire to cover all 12 refugee settlements as well as some host communities resulted in two assessment regions. For purposes of this assessment the following locations were considered as part of the south-west region:

- Isingiro district (hosting Oruchinga and Nakivale refugee settlements)
- Kamwenge district (hosting Rwamwanja refugee settlement)
- Kyegegwa district (hosting Kyaka refugee settlement)
- Kikuube (hosting Kyangwali refugee settlement)

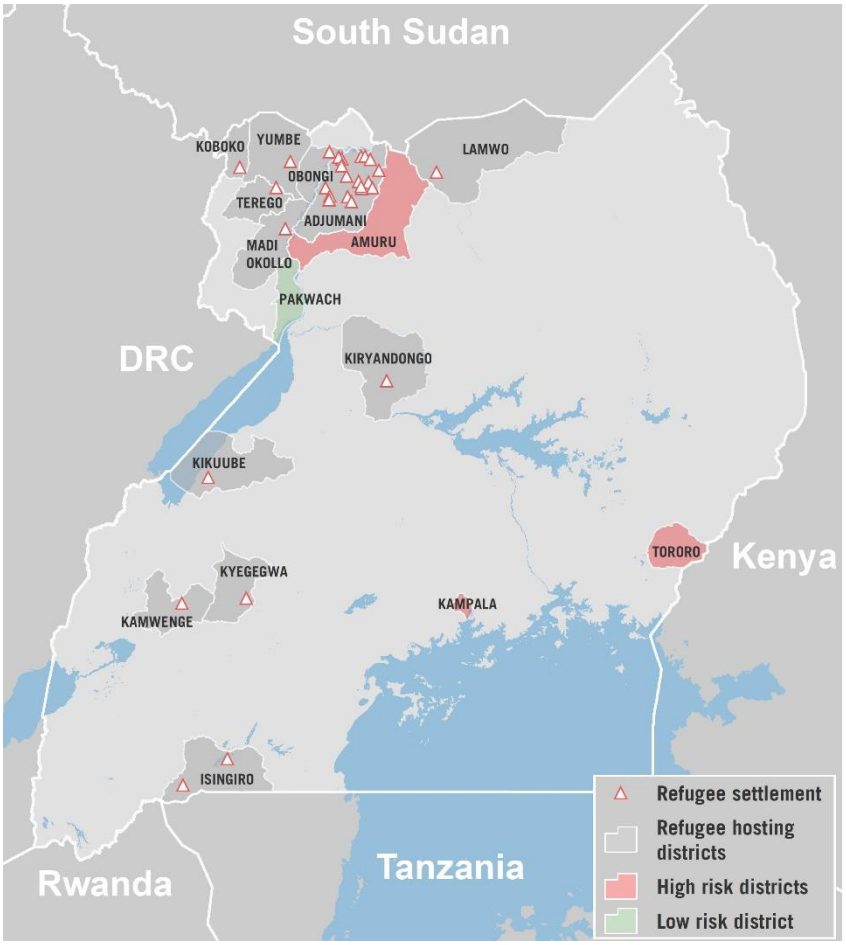
In addition, the following locations were considered to be part of the West Nile region (see Figure 1):

- Yumbe district (hosting Bidibidi refugee settlement)
- Koboko district (hosting Lobule refugee settlement)
- Adjumani district (hosting Pagirinya, Nyumanzi, Ayilo, Boroli, Mungula, Maaji, Olua, Baratuku, Agojo, Alere, Mireyi, Elema and Oliji refugee settlements)
- Madi Okollo district (formerly Arua and hosting Rhino camp[20])
- Terego district (also formerly Arua and hosting Imvepi refugee settlement)

Thirdly, **the general population** living in three "high-risk" districts (Kampala, Amuru, Tororo), which faced high COVID-19 infection rates as of August 2020 and faced increased exposure risks through their geographic location at border crossings or important traffic hubs, were included, with **180 interviews** completed in this community group. Risk communications and community engagement efforts to fight the pandemic may be proliferating in these areas and show different results as compared to less affected parts of the country. Lastly, one "low-risk" district (Pakwach) was included to draw a comparison with the aforementioned groups on peculiar aspects related to the risk perception building process of individuals and communities and how this was influenced by external factors. Sixty (60) interviews were completed in this community group. For the purposes of this assessment, the level of risk for each district in Uganda was determined using the number of confirmed COVID-19 cases in the district during the month of August 2020.

[20] Rhino refugee camp and Imvepi refugee settlement were formerly part of Arua district, but have now been assigned to new districts due to restructuring of the district boundaries.

Figure 1: Map of Uganda showing assessment locations



2.4 Primary data collection

U-Learn used a mixed-methods approach to achieve the study objectives and answer the research questions outlined above. As part of this assessment, a total of **1,533 remote individual surveys** were conducted from the 11th of September 2020 to the 7th of October 2020. In addition, **66 FGDs** with community members disaggregated by gender and age, and **51 KIIs** with government officials, health service providers, community based organization (CBO) representatives, community leaders and NGOs were conducted from the 10th of September to the 16th of October 2020[21].

Due to COVID-19 related uncertainties around field access and in-person data collection, a combination of remote and in person-data collection was carried out. Remote data collection was adopted for **quantitative individual level surveys** in refugee settlements, host communities and for the general population. To conduct remote individual interviews, U-Learn set up a call centre in Kampala managed by two field officers with the support of a field manager, assessment officer (AO) and database officer.

[21] The numbers of completed interviews stated here include those completed for the Social Network Analysis

In-person data collection was adopted for the **qualitative data collection** including both FGDs and KIIs. Qualitative data was collected in Terego district (only in the Imvepi refugee settlement), Isingiro district (only in the Oruchinga refugee settlement), Kamwenge (in the Rwamwanja refugee settlement and in the host community), Kyegegwa district (in the Kyaka refugee settlement and the host community), Koboko (in the Lobule refugee settlement and in the host community), Yumbe (in the Bidibidi refugee settlement and in the host community), and Pakwach districts.

All field activities were implemented in strict adherence with the MoH guidelines and standard operation procedures (SOPs) developed by IMPACT to reduce the risk related to COVID-19 and were led by four field officers.

2.4.1 Quantitative data collection

U-Learn conducted a large-scale individual-level remote survey across the targeted assessment areas (13 refugee settlements, 12 host community districts, 3 general population high-risk districts, 1 general population low-risk district) (see table 1 below).

For the refugee settlement hosting districts, the initial pool of respondents was identified through contact lists of past survey respondents that were randomly selected through previous IMPACT/REACH assessments. For some of the settlements and host population communities, the contact list had to be expanded; this was done using the snowball technique[22].

In areas outside the refugee settlement hosting districts, i.e. in high-risk and low risk districts without refugee populations, U-Learn relied on contacts shared by partners working in these districts. By using the list of contacts from past projects and partners' databases, the remote data collection did not allow for probability sampling across the different areas under scope. Therefore, the results should be interpreted as **indicative** only rather than statistically representative of the population sub-groups (refugee population, host population, population in high-risk areas, and population in the low risk district) and specific locations.

Table 1: List of locations by population and sample size

Target[23]	Location	Population	Number of completed interviews
Refugee settlements	Adjumani	214,477	83
	Bidibidi	232,722	81
	Imvepi	66,11	79
	Kiryandongo	67,712	80
	Kyaka II	123,378	79
	Kyangwali	123,039	81
	Lobule	5,511	75
	Nakivale	132,811	79

[22] According to research-methodology.net, the snowball sampling technique is a purposeful sampling technique which is applied when samples with defined characteristics are not easily accessible and involves primary data sources nominating further potential data sources.
[23] UNHCR and the Office of the Prime Minister, "Uganda – Refugee Statistics August 2020,"

	Oruchinga	7,911	79
	Palabek	53,806	87
	Palorinya	122,811	81
	Rhino	120,164	80
	Rwamwanja	72,666	89
Host community	Hosting districts[24]	4,347,800	225
General population[25]	Amuru	197,900	72
	Tororo	537,400	62
	Kampala	1,993,900	60
	Pakwach	142,500	61

The quantitative data collection was conducted through standardized mobile data collection questionnaires using tablets or smartphones. All the data was uploaded daily to a KoBo server to allow remote data quality monitoring by the U-Learn database officer.

The data was collected from the call centre set up in Kampala with a data collection team of 20 enumerators for the host community and 20 enumerators for the refugee communities, supervised by two field officers. The enumerators were trained on the data collection tool and on how to conduct remote interviews. During the data collection, both in the field and at the call centre, the COVID-19 SOPs were adopted to reduce the risk of transmission (e.g. handwashing facilities, distribution of individual hand-sanitizer, distribution and wearing of masks, maintenance of distance between enumerators, FGDs participants and during KIIs, ventilation of the room).

2.4.2 Quantitative data processing and analysis

Data was collected using the KoBo toolbox[26] and reviewed for inconsistencies and outliers on a daily basis by a U-Learn database officer who recorded these in a cleaning log. This log was then used by field officers, supervising the data collection at the call centre, to follow up with the enumerator teams to correct any issues and improve data collection on a daily basis. Finally, the data was cleaned and analysed using R and was validated in-country and by IMPACT's technical backstopping team in Geneva to ensure validity.

2.4.3 Qualitative data collection

54 FGDs with 6-12 participants each and **36 individual KIIs** were conducted in selected refugee and host communities and in the district of Pakwach (see table 2 below). Only locations where the risk was considered relatively low were selected for field data collection. Both the FGDs and the KIIs were carried out following strict safety procedures, allowing distance among participants and ensuring that facemasks were worn throughout interviews.

The FGD participants were divided by gender and age to appreciate the point of view of the different population groups. The discussions aimed to understand how the community

[24] Using UBOS data, the population sizes for the host community was combined and the sample was taken at the national level/across all host community districts (Adjumani, Arua, Isingiro, Kamwenge, Kikuube, Kiryandongo, Koboko, Kyegegwa, Lamwo, Madi Okollo, Obongi, Yumbe).
[25] Uganda Bureau of Statistics (UBOS) population projections.
[26] KoBo Toolbox is a suite of tools for field data collection for use in challenging environments.

members receive and interpret the communication related to COVID-19 and how have they changed their risk perception and behaviour because of it. Additionally, the discussions focused on understanding the opinions of the participants regarding the available Information Education Communication (IEC) material developed by the MoH and distributed by the MoH and humanitarian response partners.

Table 2: List of target locations and completed FGDs and KIIs in each

District	Target/settlement	# FGDs	#KIIs
Arua	Imvepi	6	7
Koboko	Lobule	6	4
Yumbe	Host community	6	3
Pakwach	General population	6	8
Isingiro	Oruchinga	6	4
Isingiro	Host community	6	5
Kamwenge	Rwamwanja	6	2
Kamwenge	Host community	6	3
Kyegegwa	Kyaka II	6	0
Total		**54**	**36**

In parallel, the 36 semi-structured KIIs were conducted with representatives of local government, OPM, district health officers, NGO workers, health and education providers, village health team (VHT) members, community leaders and persons with disabilities (PWD) representatives. The aim of these interviews was to better understand how the communication around COVID-19 was delivered to the communities and understand the key informants' perception on uptake and behaviour change, as well as to gather insights on the opportunities of improvement for the risk communication strategies implemented. The KIs were purposively sampled for their knowledge and involvement in the risk communication activities implemented at local level.

Both the FGDs and the KIIs were carried out following a strict safety procedure, allowing distance among participants and ensuring that facemasks were worn during the discussions.

2.4.4 Social network analysis (SNA)

Rationale

The social network analysis (SNA) aims to understand how local social networks underlying community communication channels might influence community behaviour, risk awareness, and risk perception[27]. Networks of community influencers, be they community members, local or religious leaders or local organizations and institutions, may have an important impact on community information ecosystems and could thus be of pivotal importance for effective risk communication and community engagement activities on community level.

[27] International Rescue Committee (IRC), "Social Network Analysis Handbook: Connecting the dots in humanitarian programs," July, 2016

A social network is made up of different actors, such as community members, but also local institutions, organizations or other stakeholders that play a role in influencing community life. The premise of the SNA approach is that these actors are connected by some type of relationship, which can be mapped and analysed in order to expose a more general structure of the social network and patterns of influence between these actors.

In the context of this assessment, SNA was used to identify local social networks that underlie community communication channels. The assumption was that these networks might influence community information ecosystems and have better outcomes in influencing the communities' behaviour and perception around COVID-19.

Methodology

As part of the assessment, three SNA case studies were conducted in two refugee communities (Bidibidi and Imvepi settlements) and in one host community (Kyegegwa). For every case study, four FGDs were implemented with community members, disaggregated by gender and age. During the FGDs, participants identified the key actors that influence behaviour and risk perception of community members. In a second step, semi-structured interviews were carried out with the identified key actors and with humanitarian and government partners involved in the COVID-19 response. An average of four KIIs were realized per case study (see table 3 below).

Table 3: Table of SNA data collection

Location	Community	SNA Case Study	FGDs	KIIs
Bidibidi Refugee Settlement	Refugees	1	4	7
Imvepi Refugee Settlement	Refugees	1	4	2
Kyegegwa District	Host Community	1	4	4

2.4.5 Qualitative data processing and analysis

Qualitative data was collected by trained field officers and then reviewed on a daily basis by the U-Learn AOs. With support from GTS, the data was analysed using MAXQDA and was validated in-country and by a technical backstopping team in Geneva to ensure validity[28].

2.4.6 Validation Workshop

After the preliminary results had been compiled, validation workshops were carried out from 19th October to 28th October 2020 with both refugee and host communities in the south-west and West Nile regions. The main objectives of the validation workshops were to inform the communities of the key preliminary findings, gather insight on the communities' perspectives on these findings and to integrate any further information collected in order to provide context to the quantitative and qualitative findings.

The validation process consisted of 44 FGDs conducted with different community members in some of the same districts in which the first round of data was collected.

[28] MAXQDA is a world-leading software for qualitative and mixed methods research.

Specifically, the validation workshops were completed in the following districts: Isingiro (Oruchinga and Nakivale refugee settlements), Kikuube (Kyangwali refugee settlement, Kikuube host community), Kiryandongo (refugee settlement and host community), Adjumani (host community and Pagirinya/ Nyumanzi/ Boroli/ Baratuku refugee settlements), Madi-Okollo (Madi-Okollo host community, Rhino Camp settlement) and Yumbe (Bidibidi refugee settlement).

2.5 Limitations

Remote data collection by its nature did not allow for a probabilistic sample representative of the whole population; this is in part because of the lack of a comprehensive database of all target population phone numbers that would allow for each individual to have an equal chance of being selected for an interview. People with no access to phone numbers or living in a remote area with low network coverage are inherently excluded from the sample. Additionally, studies have shown that men and women have unequal access to phones in Uganda. The gender gap in Sub-Saharan Africa is one of the largest in the world, and according to a Global Systems Mobile Communications Association (GMSA) study, in the refugee settlement of Bidibidi, only 36% of women own a phone versus the 67% of men[29].

The average rate of response to the quantitative survey was 35% in the refugee settlements, 39% in the host districts and 50% in the high and low risk districts meaning that the reported findings do not accurately reflect the population sizes in relation to each other. Thus, although this report includes indicative findings for each population group and location independently, it is not advised to read these findings as comparable across population groups and locations as some groups and locations may be over- or under-represented.

Furthermore, qualitative data was collected using snowball sampling, usually by contacting one mobilizer in a community and relying on them to gather a predetermined number of individuals with certain qualities (e.g. sex, age, disability). Mobilizers may have unknown ulterior motives or may have subconsciously selected individuals who are more available due to unemployment or eagerness to air their concerns. It was also noted that some FGD participants with a disability such as deafness, only took part in the discussions with great difficulty as there were no sign language interpreters on the field teams and that the participation of people with difficulty walking has been limited due to mobility constraint.

Finally, since qualitative data was collected in person and because this was not done in high-risk areas as a precaution against COVID-19, the qualitative data collected may under-represent the populations in these high-risk areas. This may also mean that the

[29] Bridging the mobile gender gap for refugees – GSMA (March 2019)

level of analysis for these districts is less in-depth since qualitative data is often used to help explain why the quantitative data shows certain trends.

3.0 Findings

3.1 Demographics

This section presents demographic information related to the population groups assessed as part of the sample at the national level, unless noted otherwise. Due to the limitations described above, the findings should be interpreted as indicative only, and are not representative of the different populations groups.

The assessed population was comprised of 63% males and 37% females. The percentage of female respondents was higher in high-risk districts (mostly driven by Kampala, where 55% of the respondents were female) and lower in Pakwach. The higher proportion of male respondents overall could partially be explained by the gender gap in phone ownership as discussed in the limitations section above and especially relevant to the rural areas and refugee communities.

The average age was 36 years old with no under 18-year-olds interviewed. Little variation was found across assessed population groups, except for the respondents from the high-risk districts, where the average age was 46 years old. Across all groups, the average size of the household was seven members and **76% of the households were reportedly male-headed**. This stands in contrast with past assessments in refugee areas, many of which found that a majority of refugee households in Uganda are headed by women[30]. Again, this difference might be explained by the lower proportion of females owning a phone (especially in the refugee settlements). Past assessments also found that demographic characteristics of refugee households drove a generally higher vulnerability level, caused in part by a higher percentage of female-headed households,[31] a relatively high dependency ratio, and a generally younger population (56% below the age of 15) amongst refugees as compared to host community members. Thus, the study sample under-represents the group of female headed households.

Regarding the education level of the respondents, **8% reported having completed secondary school, 26% reported having completed primary school, and 10% reported that they did not have any formal education**. Overall, the differences across groups were limited. It should be noted that the few people interviewed with higher education levels were generally Ugandans living in Kampala (21% of respondents started but did not finish a university education, and 24% reported having completed a professional degree).

[30] WFP and REACH Uganda, "Vulnerability and Essential Needs Assessment: Volume 1," October, 2020.
[31] World Bank Group, "Informing the Refugee Policy in Uganda: Results from the Uganda Refugee and Host Communities 2018 Household Survey," October 2019.

The most frequently reported main income generating activity was agricultural work, with almost half of the respondents (46%) reporting to work in the agricultural sector. The only exception were respondents from Kampala, of whom only 13% reported to be involved in agricultural work while the majority (47%) reported to be small business owners or shop keepers. Twenty percent (20%) of all respondents reported not engaging in any income generating activity; of this group, refugees accounted for the largest proportion with 27%. Fourteen percent (14%) of respondents reported having their own small business or shop. With regard to this, differences can be appreciated across groups with 47% of respondents from Kampala running a small business or shop versus only 11% of refugees, 23% of respondents from host communities and around 13% of Ugandans from non-refugee and non-host districts. Ten percent (10%) of the respondents declared to be involved in casual labour. This percentage is greater for refugees and for respondents living in Kampala (10% and 13% respectively) as compared to other targeted groups. In terms of pre-existing health conditions, overall 16% of the respondents reported having a chronic illness. The variation across groups was limited.

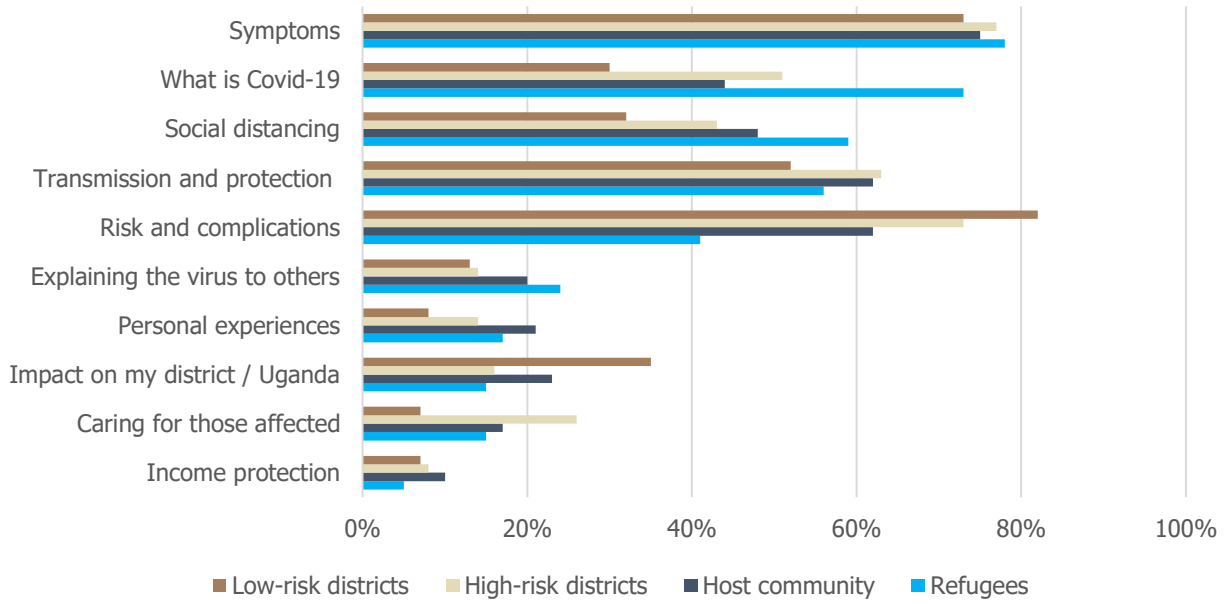
3.2 Information Channels and COVID-19 Awareness

3.2.1 Information awareness

Refugees and Ugandan respondents unanimously stated that they have received information on COVID-19 over the last six months, with 99% answering positively. People across all response groups said they have received information on COVID-19 symptoms, explanation of the disease, transmission and protection, social distancing guidance, and risks and complications associated with the disease (see figure 2 below). However, few respondents reported receiving information on the impact of COVID-19 on their specific district nor on Uganda (including the number of cases, deaths, and recoveries), on the personal experiences of those affected by the disease, or on how to protect ones' income during the pandemic. Despite some differences across target groups, there is a clear overall trend showing that **people received more information about COVID-19 symptoms, definition of COVID-19 and risk and complications as compared to information about income protection, impact of COVID-19 and personal experiences of COVID-19 cases**.

These findings are in line with the information shared by KIs, who most frequently reported informing their target audience about COVID-19 prevention measures, transmission, symptoms and reporting mechanisms.

Figure 2: Most commonly reported information topics, by proportion of respondents and community group



3.2.2 Frequency of information sharing

The majority of respondents (71%) said they had received COVID-19 related official communication (from government, district officials, VHTs, NGOs/INGOs) daily during the two months prior to data collection. However, interviewed refugees reported receiving information less frequently (63% said they had received daily information) compared to surveyed Ugandans (85%). Fewer refugees from Adjumani (52%), Bidibidi (52%), and Palorinya (54%) reported receiving information about COVID-19 on a daily basis as compared to refugees from Nakivale (72%), Oruchinga (74%), and Rwamwanja (73%).

3.2.3 Information gaps

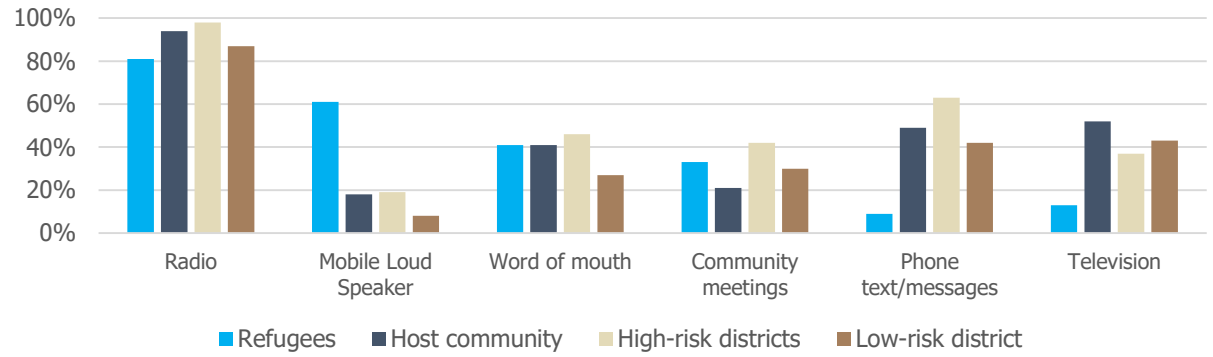
Data from the validation workshops, which were held after the first round of data collection had been completed, show that participants still felt they required additional information on COVID-19 cases, origins, testing, quarantine criteria, caring for someone infected with the disease, protecting their incomes and businesses, and accessing psychological support.

3.2.4 Communication modalities

When asked about the most common channels through which to receive COVID-19 related information, respondents commonly mentioned radio both as the most common (85%) and preferred (71%) communication channel. Findings suggest that radio might be deemed slightly more important by Ugandans living in high-risk districts (96%) and host community members (94%) than by refugees (81%) (see figures 3 and 4 below).

When looking at the refugee group, the preference for radio was lower in Nakivale (59%) and Kyangwali (52%) compared to other refugee settlements. Female participants were also slightly less likely to report receiving information via radio (79%) as compared to male participants (89%).

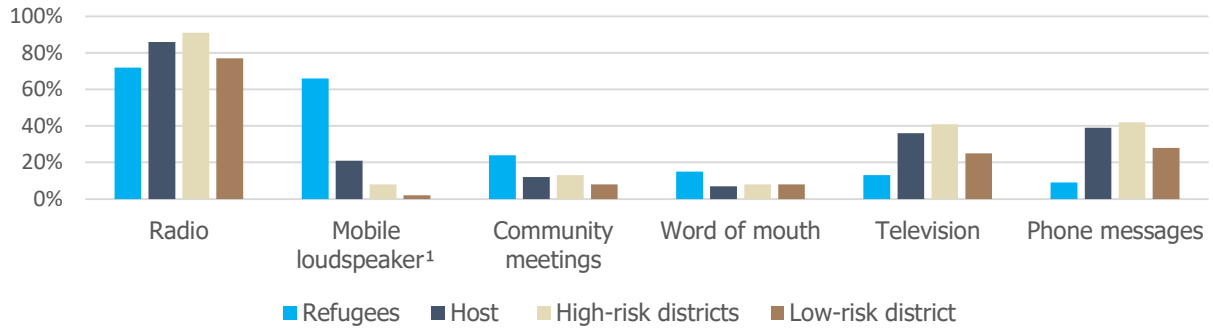
Figure 3: Most common reported communication modalities, by proportion of respondents and community groups



Furthermore, the apparent trust in and use of radios as an information source was further reflected during the FGDs with refugee, when participants frequently mentioned radio to be the most trusted information channel. According to FGD participants, radio was reported as among the most accessible sources of information for many participants across all assessed locations.

Participants trust radios because they could hear the number of registered cases/deaths announced and it made them believe that COVID 19 is real". (FGD with male host community members of mixed ages in the south-west region)

Figure 4: Top-three reported preferred communication modalities, by proportion of respondents and community groups



This preference for information sharing via radio is unsurprising considering radio is the most common communication hardware owned by households in Uganda, according to

the 2017/18 National IT survey, where 65.3% of households were reported to own radios (see figure 5 below)[32].

Figure 5: Table of most common IT assets owned by households in Uganda, 2017/2018 National IT survey

	Radio	Tv	Pay Tv	Working Laptop	Working tablet (or similar handheld device)	Working Desktop Computer	Digital Tv set-top box
All households	65.3%	21.8%	17.3%	1.8%	1.5%	1.3%	0.3%
Urban	67.5%	33.3%	28.3%	3.9%	3.1%	2.7%	0.6%
Rural	63.8%	14.0%	9.8%	0.4%	0.4%	0.4%	0.0%

Mobile loudspeakers as a communication channel are mentioned by refugees (61%) more frequently than Ugandans, although less so in Palorinya (19%), Nakivale (25%), Kyaka II (28%), Oruchinga (29%), and Rwamwanja (30%) refugee settlements. FGD participants argued for the use of mobile loudspeakers as a way of reaching many people fast, but mentioned the downside that they do not always sufficiently reach the deaf or those living in remote areas or off of main roads. In contrast, Ugandans living in both hosting districts and non-hosting districts most frequently mentioned television and phone texts/messages as preferred information channels.

"The information that we got from Ministry of Health was put on the USB flash drive and our partners would use the public address system to do road runs within the settlement catchment area so that the people would listen to the messages while in their own homes, that would help them cope with the situation at hand". (OPM representative, West Nile region).

Asked how they share information with their communities, KIs mentioned door-to-door sensitisation and organising meetings to inform their target audience, often by or with the help of VHTs. In addition, radios, megaphones and posters/flyers were frequently named as key information methods. Although survey respondents also named radios and megaphones as key information channels, only 16% of respondents reported printed material as COVID-19 information channels. KIs in refugee communities in particular reported the frequent use of megaphones or "boda boda talk" to share information which involves pre-recorded messages being communicated through speakers or megaphones strapped to a vehicle such as a motorcycle or car[33].

[32] The Collaboration on International ICT Policy for East and Southern Africa, National Information Technology Survey 2017/18 Report, March 2018.

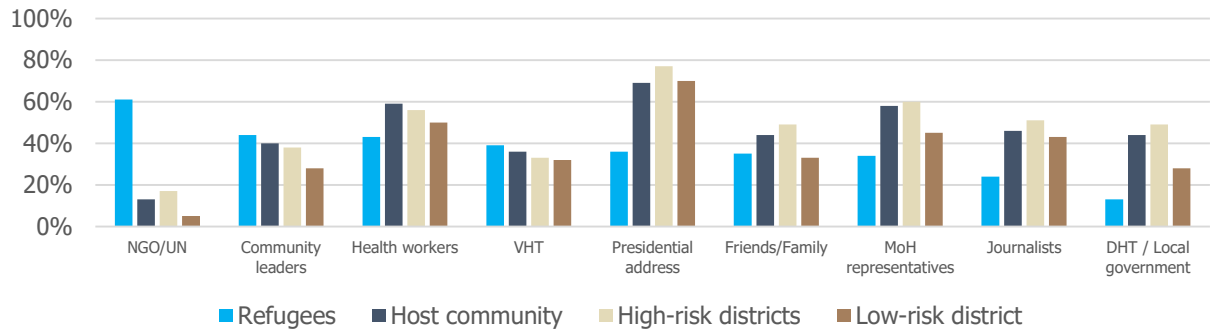
[33] "Boda boda talk" is sometimes used to refer to the method of using mobile loudspeakers strapped either to a car or a motorcycle, often called "boda bodas" in Uganda.

Finally, interviewed KIs most frequently named radio, TV and newspaper and meetings as popular ways they themselves obtain COVID-19 related information.

3.2.5 Information sources

The most common sources of COVID-19 related information mentioned by survey participants include the presidential address, health workers, and NGOs/international organisations. However, this seems to vary slightly by population group, as Ugandan national respondents mainly mentioned the presidential address and MoH initiatives as primary information sources, while refugee respondents, on the other hand, more commonly mention NGOs/UN agencies, community leaders, health workers, and VHTs (see figure 6 below). This aligns with the fact that there might be more NGOs and UN agencies present in refugee settlements as part of the humanitarian response as compared to other non-refugee hosting areas.

Figure 6: Most common reported sources of COVID-19 information, by proportion of respondents and community groups

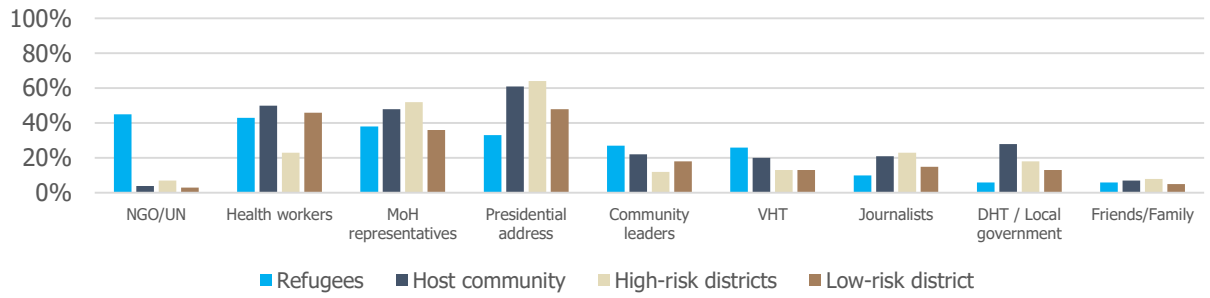


In terms of KIs' information sources, most mentioned NGOs and the MoH as current and trusted: "The information I deliver is from Ministry of Health, which provides rightful information which is approved by the scientists" (health expert, south-west region). This was particularly the case for KIs located in refugee and host communities in both the south-west and West Nile regions. Most of them also said that they considered themselves to be well equipped to inform their communities most often because they felt the information they had, came from trusted sources in the health system or government. In particular, KIs frequently reported informing their communities about COVID-19 prevention measures, mode of transmission, symptoms, and reporting mechanisms.

Community members across groups reported health workers, the presidential address and the MoH as the most trusted information sources regarding COVID-19 (see figure 7 below). The main difference between refugee and Ugandan respondents was that refugees most frequently mentioned NGOs a trustworthy information source. This was further reflected in KIIs with community leaders which GTS conducted earlier this year;

community leaders identified NGOs (50%), community groups (41%), and UN agencies (25%) as the most trusted information sources amongst refugee communities[34].

Figure 7: Top-three reported trusted information sources, by proportion of respondents and community groups



This is in line with data from FGDs with refugees, which suggests that health workers/health centres and NGOs/UN agencies are the most trusted sources by community members. Elderly participants and those in the south-west region in particular tended to mention NGOs and UN agencies as a trusted information source. In contrast, participants in Imvepi and Pakwach did not commonly mention NGOs and UN agencies as a trusted source of information.

During the phone interviews, both refugees and Ugandan citizens rarely reported friends and family, religious leaders and schoolteachers among their trusted information sources. Data from the validation workshops confirmed that friends and family were often perceived to be sources of misinformation or rumours.

To explore the role of the different actors in shaping the information channels facilitating the circulation of information on COVID-19 and potentially influencing the community members to adopt the preventive behaviors, three SNA case studies were conducted in two refugee communities and one host community. The three case studies showed similarities in the dynamic of the community social networks and confirmed the information collected through the individual surveys, the FGDs and KIIs. Several interconnected actors delivered the information to the communities, mostly NGOs, health works, community-based organizations such the VHTs, RWCs/LCs, government representative (e.g. MoH, OPM and police), media (e.g. radio and internet), but also other community members (e.g. friends and family members). Most of these actors enjoyed the trust and favour of the community members, though to different extents, and had different power to influence them and encourage the adoption of the preventive measures. Those actors closer to the community members, the ones that have long-lasting relationships with them, and the ones perceived as knowledgeable on the topic seemed to be the ones more likely to be influential.

[34] Ground Truth Solutions, "COVID-19 insight from refugee leaders and humanitarian staff Uganda", September 2020.

However, findings suggested that people are generally already receiving accurate and rapid information about the pandemic often through local and well-integrated actors, yet the uptake of measures (e.g. behavior change) falls behind. Therefore, leveraging these particular actors and channels to accurately and rapidly inform the general public about the pandemic could be an effective way of delivering risk communication messages, which in turn might generate behaviour changes to counter the impact and spread of the disease, further increasing the level of community participation and engagement during and after a pandemic. Please see the text box below for the full case study conducted in the Imvepi refugee settlement and see Annexes 1 and 2 for the remaining case studies.

Case study[35]: Social network analysis in the Imvepi refugee settlement:

The participants from Zone 2 of the Imvepi refugee settlement identified the OPM, the police, NGOs, RWCs, VHTs and religious leaders as part of the network informing their community around COVID-19 and influencing the members in adopting the preventive measures recommended by the MoH and government.

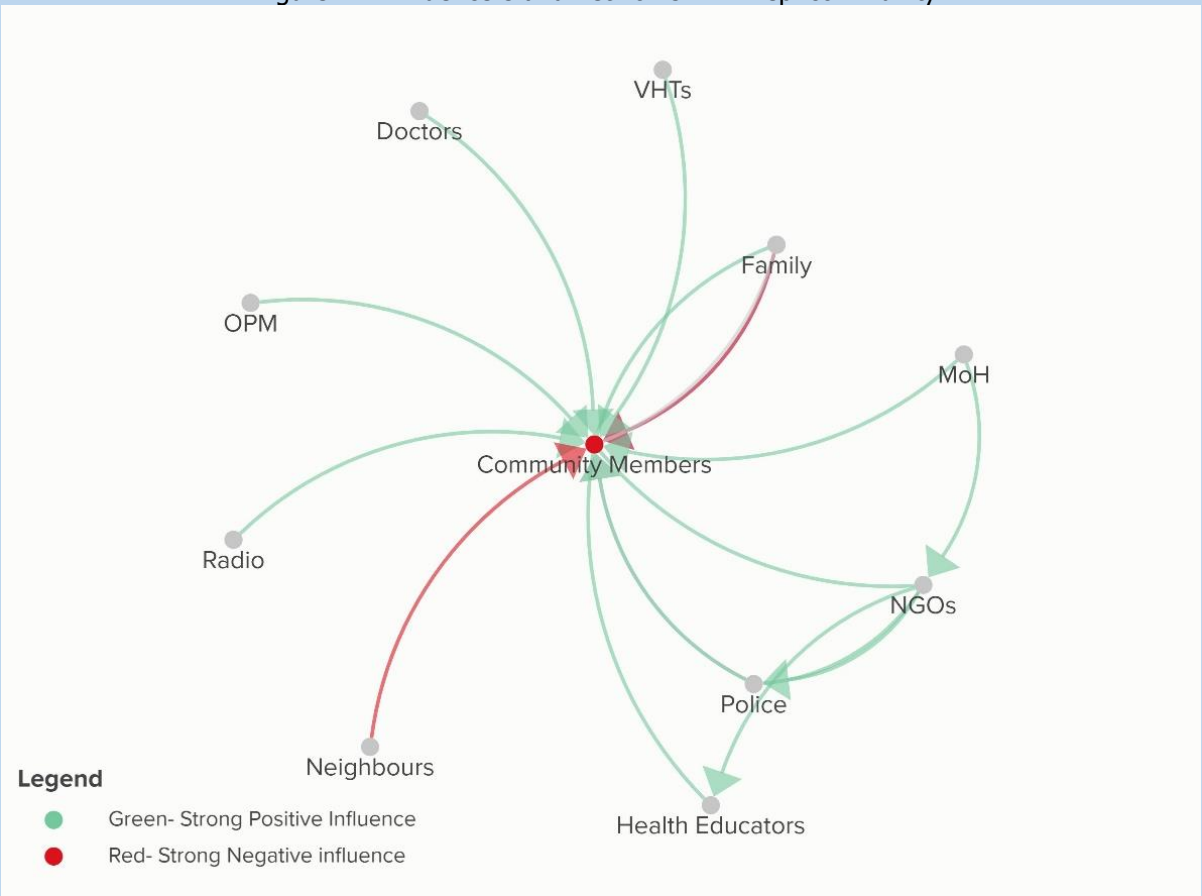
Among these actors, the participants reported to trust the VHTs and hygiene promoters, RWCs, pastors, police, OPM and NGOs (among these the Catholic Agency for Overseas Development (CAFOD) and the Danish Refugee Council (DRC)) the most. **The main reason reported by the participants to trust these actors was that they are on the ground, interact with them regularly and translate COVID-19 information into languages they understand** (see figure 11 below).

VHTs, RWCs, community development workers, the police, OPM and NGOs are reported to have a strong influencing power to incentivise the community members to adopt the preventive measures for COVID-19. These actors are recognized for being closest to the community due to their strong presence there. **Despite NGOs having an overall positive influence over the communities, according to the participants, the strength of this influence depends on their presence in the community and the presence of previous relationships with the community members.**

A distinction must be made on the nature of the influencing capacities of these actors. Some of them have either a coercive power or condition the provision of services on the adoption of the preventive measures ("*IRC has a strong positive influence because when you go to the health facility they chase you or do not allow you to enter the health facility if you go without a mask*"). Others are considered influential because they are engaged in informing and sensitizing the communities, or because they have a historical presence on the ground and have gained the trust of the communities. In sum, being a close and known presence seemed to be highly valued by participants and relevant to having a genuine long-lasting impact on behavior change.

[35] Social network analysis case studies on the Bidbidi refugee settlement and the host community in Kyegegwa can be found in the Annex.

Figure 11: Influencers and networks in Imvepi community.



Actors implementing risk communication activities should be aware of the negative influence of informal information flowing within the communities facilitated by community members themselves. Participants recognized that some members of the community (e.g. neighbours and friends) have a negative influence because of the misinformation and rumours about COVID-19 they potentially disseminate within the community.

Overall, this case study indicates that actors who have established a long-term presence in the communities and simultaneously are seen as authorities have the strongest positive influence on community members. Closeness alone, as exemplified by the relationship community members reported to have with their own family and friends, does not necessarily result in a positive influence.

3.2.6 Information format

During the FGDs, participants were shown different types of information education communication (IEC) material published by the MoH and were asked to comment on their clarity, effectiveness and were asked to rank them according to the respondents' preference. According to the data collected, interviewed participants felt that using images and posters was one of the most effective ways of sharing information around

COVID-19 within their communities. A preference for posters with images rather than writing was also stated, as many pointed out that not everyone is literate or will be able to read posters in other languages. When asked which mediums would be most effective in risk communication, FGD participants pointed to community radio and audio, followed by megaphones, door-to-door sensitisation, and community leaders. Asked whether audio only, image only, or a combination of audio and image would be preferable ways of receiving information, the majority of FGD participants voted in favour of the combination of both audio and image.

To improve on the existing methodology, KIs suggested making widespread use of local languages in all sensitization efforts, where it has not yet been done. This was also in line with suggestions made by FGD participants interviewed in refugee but also in host and general population communities.

3.2.7 Conflicting information

Conflicting information was defined to participants as different or not coherent information related to the same topic and coming from two or more different information sources. Around half of the respondents (52%) reported having heard conflicting information around COVID-19. This proportion is as high as 80% in high-risk districts[36]. Host community members reported higher instances of conflicting information (66%) than refugee communities (44%). However, there are regional differences among refugee settlements, as over half of respondents from Oruchinga (69%), Kyaka II (67%), and Rwamwanja (56%) reported having received conflicting information on COVID-19. Respondents most commonly reported conflicting information comes from friends/family (77% of the 52% of respondents who reported having received conflicting information), community leaders (16%), and NGOs/international organisations (11%).

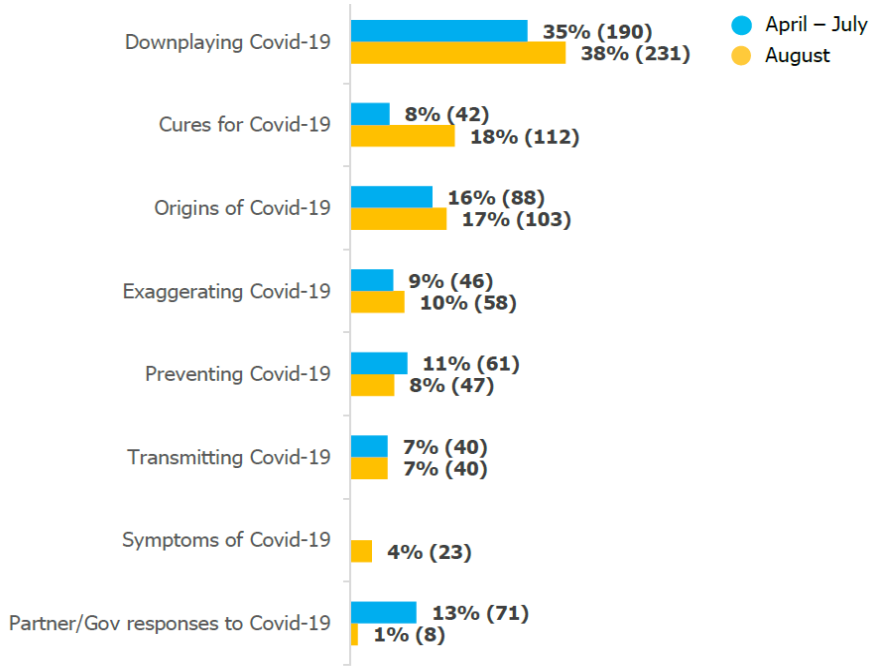
Linked to misinformation, there is also growing evidence of rumours surrounding COVID-19. During the FGDs with refugee communities, rumours were almost exclusively mentioned in the south-west region locations, and were more commonly reported by elderly people. Misinformation around the prevention and treatment of COVID-19 surfaced most heavily, with examples of home remedies, the belief that alcohol could act as a prevention and/or cure, that a vaccine has been found[37], or that praying is an effective remedy against the disease. Down-playing the disease also came up regularly, with some respondents believing it only affects white people, others labelling the disease as a political ploy, mentioning that it is not real as there is no hard evidence, and that it is just like the common flu. Lastly, rumours which exaggerated COVID-19 surfaced, where participants shared the belief that the disease signals the end of times or that it is a curse.

[36] Amuru, Tororo, and Kampala.
[37] At the time of writing, a vaccine for COVID-19 had not yet been found.

"Boiling salt with tea leaves and drinking them before 2:00pm will cure one of COVID-19" (FGD with elderly female refugees in south-west region).

The rumours mentioned in FGDs with refugee communities are in line with rumours recorded as part of the interagency effort to track rumours surfacing across various settlement in Uganda (see figure 9 below)[38].

Figure 7: Overview of rumour tracking bulletin trend data from April-August 2020



The source of misinformation was identified primarily as coming from people's social circles, followed by community leaders, although this varies from settlement to settlement and across the different population groups. When looking specifically at the refugee population, differences in terms of sources of misinformation can be appreciated across settlements (see figures 10 and 11 below).

While friends and family were identified as the most common source of conflicting information across the board (see figure 11 below), regional differences in terms of other conflicting information sources between refugee respondents in the south-west and West Nile regions (see figure 10 below). Of the 52% of respondents who reported having received conflicting information, the belief that the MoH was sharing conflicting information was reported highest in Adjumani (48%), Imvepi (43%) and Rhino (42%). NGOs were perceived as sharing conflicting information predominantly in Imvepi (43%), Palabek (32%), and Adjumani (30%). Interestingly, the MoH was relatively commonly reported as a source of conflicting information in the West Nile region (see Figure 10),

[38] Interagency COVID-19 rumour tracking bulletin, October 2020

particularly when compared to responses from the south-west areas. A possible explanation might be that the respondents considered that MoH share truthful information which was in contrast with the information shared by other sources (friends and family). However, the data does not offer a clear explanation as to why this might be the case.

Figure 8: Reported sources of conflicting information, by proportion of refugee respondents and regions

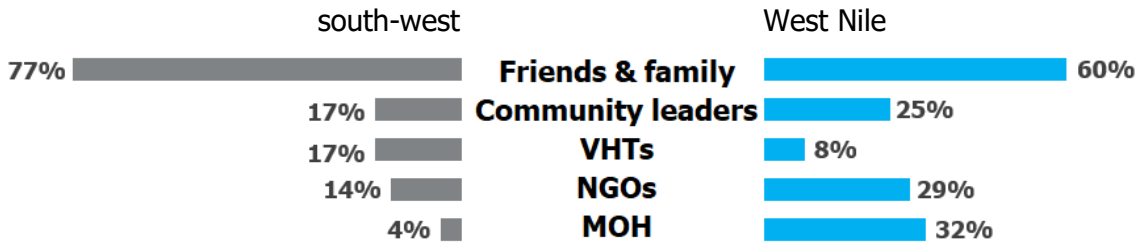


Figure 9: Reported friends and family as a source of conflicting information, by proportion of refugee respondents and settlement

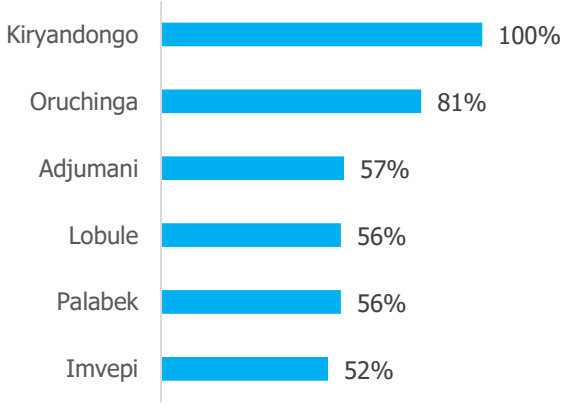
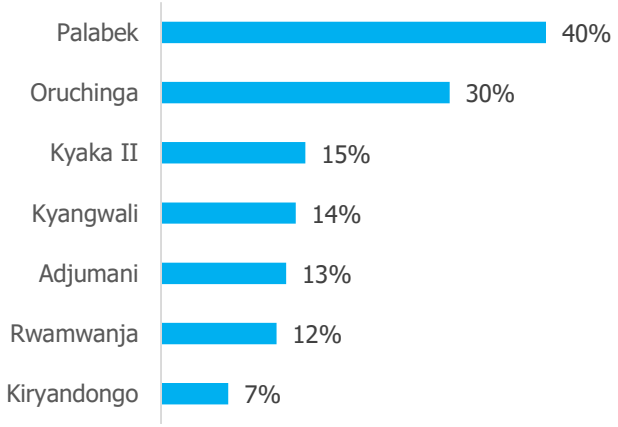


Figure 10: Reported community leaders as a source of conflicting information, by proportion of refugee respondents and settlement



Reported confusion around information received most commonly centered around information explaining what the disease is (58% of the 52% of respondents reporting having received conflicting information) and symptoms of the disease (55%). A majority of respondents (82%) from Lobule settlement reported that information received on COVID-19 symptoms was most contradictory, followed by 77% respondents from Kyangwali, 68% from Kyaka II, and 65% from Adjumani.

3.2.8 Identifying trustworthy sources

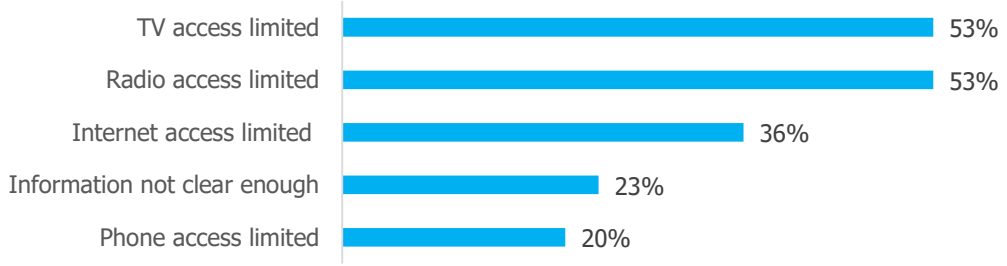
FGD findings show that the most common reason given for participants trusting certain information sources or channels was perceiving them to be official or legitimate. Female participants were found more likely to give this reason than male participants. Confirmation from health workers, the government, and scientists were similarly often identified as key drivers in trusting information around COVID-19. Male participants more frequently cited confirmation by government as a reason for trusting information around the disease. Only participants from the south-west region mentioned confirmation by scientists as leading them to trust information on COVID-19.

According to FGD participants, having experienced and seen preventative measures against COVID-19 being enforced and observed reportedly helped participants believe that information about the disease which has been shared is true (see risk perception section below for more details). Multiple information sources sharing the same information about the disease was also noted as a reason for trusting that information shared is accurate.

3.2.9 Barriers to information

Overall, just under a third of respondents (31%) reported experiencing any barriers to accessing information on COVID-19, with minimal differences according to gender, location, nationality status, age, etc. Respondents in Nakivale (42%), Kyaka II (41%), and Palorinya (41%) however more often reported information barriers. Not having reliable access to a television, radio, or the internet were cited as key barriers people face in accessing COVID-19 related information. Some regional differences were found, as 61% of respondents from the south-west reported limited access to televisions, compared to respondents in the West Nile at 37%.

Figure 11: Reported barriers to information, by proportion of respondents



Refugee communities spoken to during FGDs mentioned information access issues, which tended to be regionally specific. Barriers mentioned in the West Nile region mostly concerned access issues – people not having access to radios, phones, or living in remote areas, and were mainly brought up during discussions held in Yumbe. Barriers mentioned in the West Nile region centre around specific groups being seen as more vulnerable and therefore described as less likely to receive sufficient information– including people with disabilities, children, older people, or those who are illiterate. Illiteracy also played a role along gender lines as data from the individual survey showed that females more than males had difficulties accessing information due to the inability to read (9% women and 5% men) or the lack of information materials in their local language (12% women and 6% men). In particular, people with disabilities were most commonly mentioned in the discussions as not receiving accurate or timely information around COVID-19. Those who cannot hear or cannot move were mentioned as particularly vulnerable.

"When they use megaphones to convey the information the deaf people won't understand it. People who have language barriers have to find someone to translate for them." (FGD with elderly female refugees in the West Nile region)

KIs also identified people with disabilities and the elderly as hard to reach in this regard, explaining that these groups are mostly unable to travel to where information is being published or cannot access the information mediums (radio, megaphones, etc.). For example, one Refugee Welfare Counsellor (RWC) in the West Nile region stated that people with disabilities "*cannot go [when the village chairperson calls for meeting] so they stay at home and will not get the right information*."

Additionally, people without access to radios and phones were noted in the FGDs as being unable to access timely and relevant information about COVID-19. Those living in remote parts of refugee settlements, older persons, children, and those who are illiterate, or face language barriers were also commonly identified by FGD participants as harder to reach.

3.2.10 Communities' suggestions to reduce barriers to information

FGD participants suggested that targeted messaging for specific groups such as people with disabilities, older persons, and children would be helpful to overcome information access barriers. Having messages translated into relevant languages was also emphasised as necessary during the discussions. Unsurprisingly, these recommendations predominantly come from the West Nile region where more participant reported vulnerable groups experiencing barriers to access information. Female refugees of mixed ages in the West Nile region suggested: "*Getting someone in the village who can inform those with disabilities those who are visually impaired so that they can get the information on time.*"

The need for continuous sensitisation efforts was also suggested by participants to ensure equal access to information on COVID-19 for all community members, and door-to-door sensitisation was specifically mentioned as necessary. Male refugees of mixed ages in

Rwamwanja said that "Door-to-door sensitisation would be the best option for everyone to receive accurate information." Although this was a popular suggestion, some KIs did point out that this must be done with care in order to comply with preventive measures and avoid unnecessary risk of spreading COVID-19 to particularly vulnerable households.

Another suggestion brought up during FGDs was that the government or aid agencies should provide radios to all households in order to increase access to information and awareness around the disease. Several participants claimed that the government had promised them that this would be done and that this promise should be fulfilled.

Installing and using speakers, especially in remote areas, was suggested for sharing accurate information on the disease. In some areas, this would reportedly require the construction of new roads to enable access to hard-to-reach areas, as reported by this participant in the south-west region: "*Roads should be constructed in areas that are hard to reach so the officials sensitising about COVID-19 could be able to get there*" (FGD with elderly female host community members in the south-west region). Finally, increased numbers of health workers, village chairpersons, health centres, and government officials being trained to share information with communities was also suggested in FGDs.

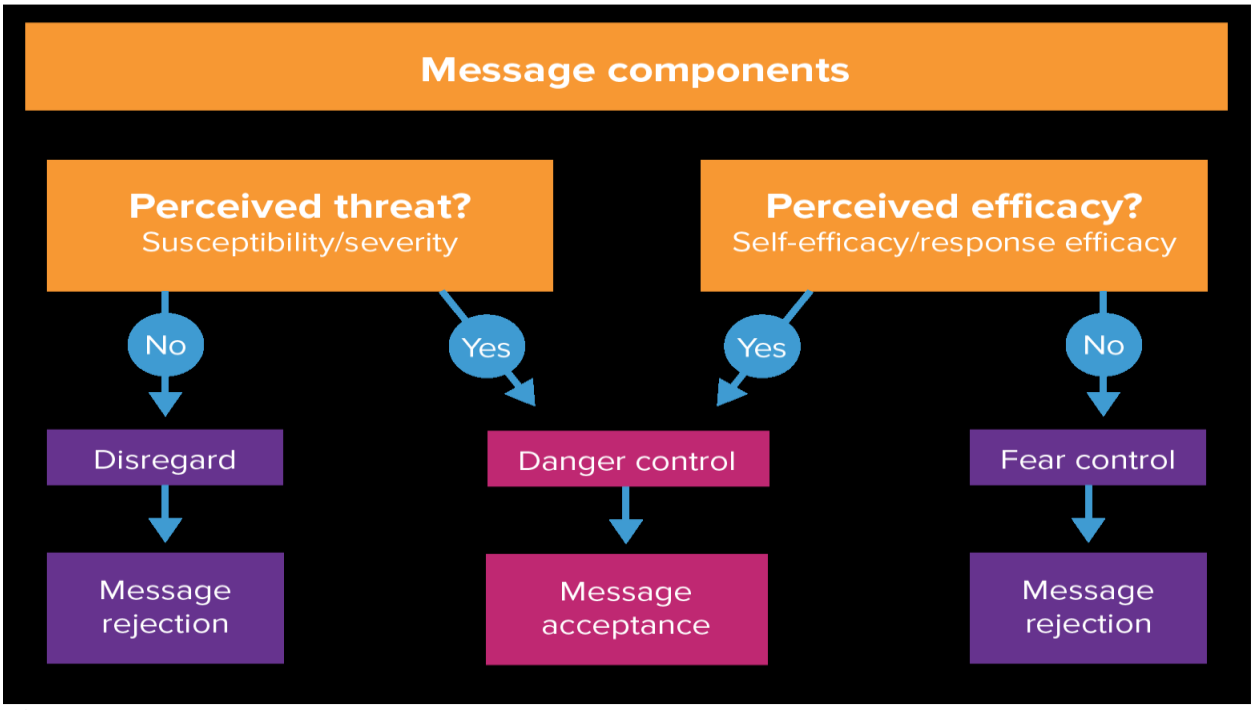
Interviewed KIs, particularly those in the refugee communities in the south-west region, suggested that to overcome these information barriers, targeted home visits should be used to share information. Informants in host communities more commonly asked that communities be provided with radios to close information gaps. In the West Nile region, suggestions to overcome information barriers included translation of information, use of radios and megaphones to increase reach, continuous sensitisation and the use of focal points to gain better access to specific communities. A representative of people with disabilities in the south-west region suggested that, *"If possible, organisations should do some outreaches in small groups or door-to-door among persons with disabilities so they too can get information".*

3.3 Behaviour Change

3.3.1 Threat perception

One objective of risk communication and community engagement (RCCE) is to change behaviour. Behaviour change in turn is the result of a combination of *risk perception*, e.g. whether or not a risk is perceived at all and if so, how serious that risk may be, and *self-efficacy* or the belief that one's own actions can be effective in avoiding the perceived threat[39]. In other words, according to the extended parallel process model on risk communication, an individual must believe both that a threat is real and that they are able to do something to avoid this threat in order for behaviour change to occur (see figure 14 below). If the threat is perceived but people do not believe they have the power to influence that threat, the result is fear without behaviour change. If the threat is not perceived despite given self-efficacy, the threat is disregarded and behaviour change, again, does not take place. Thus, in assessing whether communities in Uganda are likely to change their behaviour and adopt the three recommended preventive measures for COVID-19, it is useful to understand whether COVID-19 is perceived as a risk.

Figure 12: The extended parallel process model



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In this assessment, nearly all (96%) respondents to the quantitative survey reported that they consider COVID-19 to be a threat. This proportion remains stable when disaggregated by gender, location or community type. Moreover, the high percentage of

[39] According to the Extended Parallel Process Model outlined in the global readiness for major disease outbreak response "READY" initiative lectures on RCCE

[40] Global readiness for major disease outbreak response lecture series, session 1: introduction to risk communication and community engagement (RCCE) during COVID-19

risk perception related to COVID-19 was confirmed by the majority of the FGD participants and KIs. Eighty-six (86%) percent of respondents stated that COVID-19 is a threat to them because they could die, while the most frequently reported reasons for perceiving COVID-19 as a threat in FGDs and KIIs included the foreseen impact of restrictions implemented by authorities to prevent the spread of COVID-19 and the continuing news of rising infection rates and death tolls from within Uganda and around the world. Of the 4% of respondents to the quantitative survey that stated that COVID-19 is not a threat to them, 69% reported this low risk classification was due to the lack of infections amongst the people around them. **This was confirmed in FGDs and KIIs where those participants who reported not feeling at risk from COVID-19, stated that the threat felt distant or abstract.**

"It is a risk because it can kill, it started in China and we would hear that thousands of people have died." (FGD with refugee women of mixed ages in the West Nile region)

This is further demonstrated by FGD participants and KIs who reported that community members duly report any person newly arriving in their area for testing or isolation but also argue that they feel safe to socialize with people from their own communities since they have not heard of any cases in their immediate surroundings. Such behaviour shows that communities in Uganda may classify COVID-19 as a serious threat but not one that is immediately affecting their own communities. Participants in the validation workshop confirmed that they lack regular updates on infection rates in their own communities, making it hard for them to believe that the threat is immediate. The lack of perception of an immediate health threat emanating from COVID-19 may also be linked to unmet needs in other sectors. For example, the MSNA compiled by REACH in 2018 found that the majority of host community (93%) and refugee households (89%) across the country were in need in the environment and energy sector and similarly, 66% of host community and 67% of refugee households were in need in the protection sector[41]. These unmet needs, in comparison to COVID-19, may be more immediate and thus, result in a lower threat perception related to COVID-19 for households in Uganda.

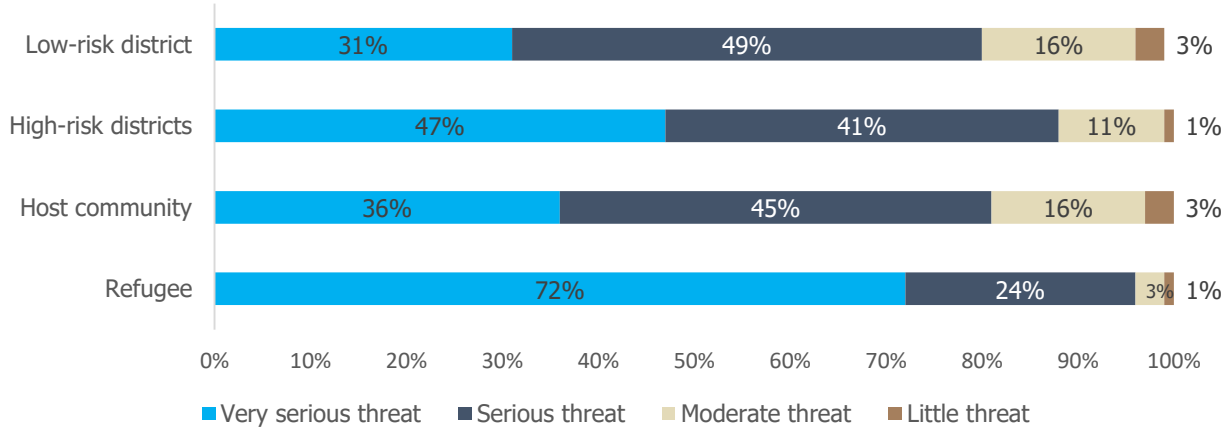
"Participants said that, there is no registered case in the district so there is no need to start social distancing." (FGD with male host community members of mixed ages in the south-west region)

Although it is encouraging that overwhelming majorities of respondents reported that they perceive COVID-19 to be a threat to them, the level of seriousness of the threat may also affect whether behaviour change will take place. When asked how much of a threat COVID-19 is to them, 62% of all respondents classified COVID-19 as a very serious threat. However, some differences across groups can be appreciated. It is clear that the perceived threat level is lower amongst host community members where only 36% reported it as a serious threat (see figure 15 below). This proportion is even lower in low

[41] REACH MSNA Uganda, 2018

risk communities (31%) and stands at 47% in high-risk communities. Finally, 72% of refugees reported COVID-19 as a serious threat. This may indicate that many but not all community members view COVID-19 as a threat so serious that they are convinced they should do something to protect themselves from it, whether they can or not.

Figure 13: Reported perceived extent of COVID-19 threat, by proportion of respondents considering COVID-19 a threat (96%) per threat level (very serious, serious, moderate or little threat) and group



Moreover, the reasons to consider COVID-19 as a threat given by respondents do not all indicate that behaviour change is likely to take place. Although many respondents to the quantitative survey (86%) reported that the primary reason to consider COVID-19 as a threat was that people are afraid of death, FGD participants reported threat perception was more often linked to the perceived negative impact of the preventive measures taken by the government.

"(…) all community would say it is a big threat because schools and markets, where they transact business, was closed and this means a big threat to them." (FGD with young male refugees in south-west region)

Considering this, it is likely that people who regard COVID-19 as a threat to them because of the restrictions put in place may not see the disease itself as a risk (to their health). Instead, the more urgent threat to them may be caused by the COVID-19 preventive measures put in place by authorities. Results from the validation workshop support this as FGD participants who were asked directly whether COVID-19 is more of a health threat or an economic and/or social threat, commonly responded that the economic and social threat posed by COVID-19 was greater than the health threat. Supporting this, in interviews conducted earlier this year, GTS found that refugee community leaders pointed to poverty as the main cause of deteriorating social relations within families, communities and between Ugandan nationals and refugees living alongside. These community leaders stated that since COVID-19 was putting economic pressure on these communities, the

pandemic was thus causing this deterioration at least in part[42]. The overwhelming majority of FGD participants in refugee and host communities as well as amongst the assessed general population agreed that although COVID-19 is seen as a threat, it is primarily an economic one. These findings are strengthened by the 81% of respondents to the phone survey who felt that there were some risks linked to COVID-19 restrictions. FGD participants in refugee and host communities in West Nile and the south-west regions of the country agree that restrictions put in place to halt the spread of COVID-19 have impacted their economic welfare either by hindering their market access, impacting their ability to run a business or through the increase in prices for transportation.

In April 2020, coincidentally aligned with the outbreak of the pandemic, WFP had to reduce the food rations in the refugee settlements due to a shortfall in funding. Refugee communities interpreted this cut in the amount of food rations as a consequence of the pandemic despite communication and sensitization explaining the unrelated cause: "We as refugees, we depend on food rations and small-scale farming. COVID-19 has significantly affected us. The ration has greatly reduced from 12kgs to 8kgs so we no longer have what to sell. The poverty level has very much increased" (FGD participant in Rhino Camp settlement). This reported increase in poverty aligns with the WFP bulletin on the impact of the COVID-19 outbreak on East African supply chains, trade and food security which states that an estimated 34 to 43 million people were likely to be food insecure in the region between May and July as compared to only 20 million in the period between March and April 2020[43].

"There was economic decline as well as markets and businesses were closed which showed how serious the disease was." (FGD with elderly male refugees in the south-west region)

In addition, during the validation workshop, FGD participants in most locations added that teenage pregnancy and domestic violence had increased as negative social consequences arising from the prolonged closure of schools: *"(…) the restrictions were necessary to prevent exponential transmission of the disease, however, closing schools affected our progression to another level; teenage pregnancies were also rampant (…)"* (FGD participant in the West Nile region). This risk was also mentioned during FGDs and KIIs mainly in the West Nile region of the country. An MSNA published by the Danish refugee Council (DRC) earlier this year stated that: "(…) *only 8% of respondents reported witnessing or hearing of conflict related to COVID-19 [but] 40% of that conflict was categorized as domestic violence*." The report also goes on to say that this violence mostly arose as a result of stress and loss of income which, as mentioned above, are widely perceived to be exacerbated by the COVID-19 pandemic[44].

[42] Ground truth Solutions (GTS) key informant interviews with 101 South Sudanese and Congolese refugee community leaders, September 2020
[43] WFP bulletin on the Impact of COVID-19 outbreak on supply chains, regional trade, markets and food security in East Africa, 8th May 2020
[44] DRC MSNA: COVID-19 situation in Uganda, May 2020

Refugee community leaders interviewed by GTS earlier this year also noted this threat and suggested that aid agencies provide counselling services for gender based violence (GBV) survivors, provide support to the community leaders themselves to increase their capacity to provide counselling, and point to a lack of resources as the root cause further indicating that the provision of more general livelihoods support to refugees would help fight domestic violence and GBV[45].

In sum, although high proportions of respondents reported viewing COVID-19 as a threat, the reasons for this may be partially linked to the preventive measures put in place rather than the disease itself. This is an important distinction given that the desired behaviour changes in this case (e.g. wearing masks, social distancing and washing hands) may not be seen as solutions to the economic or social threat posed by the preventive measures.

3.3.2 Self-efficacy

In addition to threat perception, the above outline theory for behaviour change identifies self-efficacy as a key determinant of behaviour change. In the case of COVID-19 the actions proposed are the wearing of a mask, the frequent washing of hands and distancing oneself socially. The assessment investigated declared behaviour changes of community members and their difficulties in adopting these recommended behaviours. The resulting data gives some indication as to whether is it feasible to implement the recommended behaviours in the assessed communities.

Masks

Nearly all respondents to the quantitative survey (98%) reported having access to masks, and of those, 86% reported wearing a mask; however, U-Learn field teams in Kampala and across Uganda observed minimal compliance with mask wearing and social distancing, suggesting that these figures should be caveated as they might be over-reported. The availability of masks and reports of their use were relatively similar in host, refugee and low and high-risk communities although the reported availability of masks was on average higher (98%) than the average self-reported usage of the same (86%). Moreover, mask usage was reported by a larger proportion of refugee respondents in the south-west region (91%) as compared to those in the West Nile region (77%).

However, 53% of all respondents also reported that wearing a mask may be a difficult thing to do in their communities. FGD participants confirm that many community members reported having difficulty breathing when wearing a mask or find the masks uncomfortable. Some FGD participants, especially those in refugee communities in the south-west region, also reported that the regular application of masks was made difficult by a shortage in supply. In particular, participants in Imvepi, Kamwenge, Kyaka II, and Rwamwanja reported that a majority of people in their settlements did not have access

[45] Ground truth Solutions (GTS) key informant interviews with 101 South Sudanese and Congolese refugee community leaders, September 2020

to masks, which is contrary to the reports from respondents to the phone survey. However, among those who have been provided facemasks, many stated that the quantity was insufficient for their household, reportedly requiring them to wash their masks daily or share a mask with other individuals. FGD participants in the validation workshop confirmed that masks were provided to some individuals in the majority of the assessed communities, but that not every household member always received their own mask.

Other frequently mentioned concerns surrounding wearing facemasks amongst FGD participants include the barrier it poses to effective communication, the cost of buying masks, poor quality of masks, lack of knowledge surrounding how to properly use masks, and the belief that masks pose health risks.

"The mask distribution was not done properly and only ca. 1% of people were given masks. So very few people are using masks regularly"[46]. (Validation workshop FGD with male refugees of mixed ages in the south-west region)

These findings indicate that, although some respondents report that masks are generally accepted amongst all targeted groups in Uganda, there is also evidence to suggest that COVID-19 is not a strong enough motivation to encourage the widespread use of masks amongst a majority of community members. In addition to this, there may be a gap in the provision of free masks to all household members and a general shortage of masks available to all community members. This aligns with suggestions made by FGD participants who advocated for the provision of more masks and for continued sensitization to promote the correct usage of masks in their communities.

Finally, further research may be needed to understand the contradiction between seemingly widespread awareness of the necessity to wear masks and the observed low compliance. It is also important to note that any other assessments reporting high compliance with preventive measures should be taken with a grain of salt given this clear contradiction.

Handwashing

Compared to mask usage, a similar proportion of respondents (92%) reported washing hands with soap and fewer respondents (23%) reported having difficulty implementing this measure in order to protect themselves from COVID-19. Moreover, the proportion of respondents reporting regular handwashing remained stable across most targeted groups and dipped only slightly (to 80%) in low risk communities (see figure 16 below). However, some FGD participants highlighted possible areas for improvement including the provision of additional soap. Data from UNHCR suggests that monthly soap rations were doubled since the start of the pandemic which is confirmed by data from KIIs: *"We have also increased the pieces of soaps given to the refugees during this pandemic period to ensure*

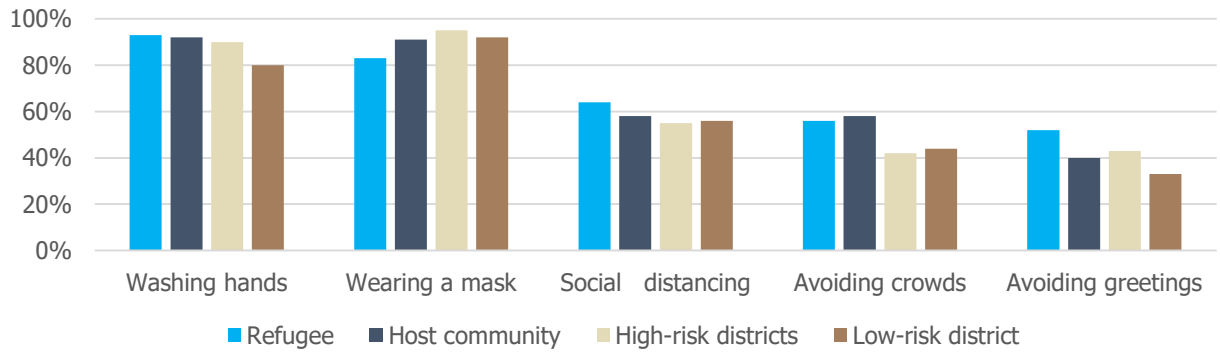
[46] Although the respondent mentions a percentage here, this is most likely based off of their own subjective perspective rather than an academically sound statistic.

regular hand washing is being practiced otherwise mere words wouldn't work" (DRC Employee, West Nile region). Nevertheless, FGD participants reported theft of blocks of soap or simply stated that the provided amount was not sufficient to last one month.

"People cannot afford soap and therefore will not practice hand washing with just water." (FGD with elderly female refugees in the south-west region)

In addition to a lack of sufficient soap, FGD participants, particularly those in the West Nile region, criticized that handwashing facilities were insufficient, mentioning in particular too small jerry cans and occasional interruptions in water supply. Such concerns may not be entirely unfounded as an MSNA conducted by REACH in 2018 found that 39% of the host communities and 41% of refugee communities in Uganda were categorised as in need in the WASH sector. More specifically, 58% of host community and 50% of refugee households reported using 15 litres or less per person per day, and 28% of host community and 23% of refugee households reported using 10 litres or less, indicating an existing gap in the availability of water amongst both host and refugee communities in Uganda[47]. KIs, particularly those working in the health sector, echoed the need for more handwashing facilities and, like FGD participants, suggested that the government and NGOs provide more materials to bridge this gap.

Figure 16: Reported adoption of preventive measures, by proportion of respondents and groups



Social distancing

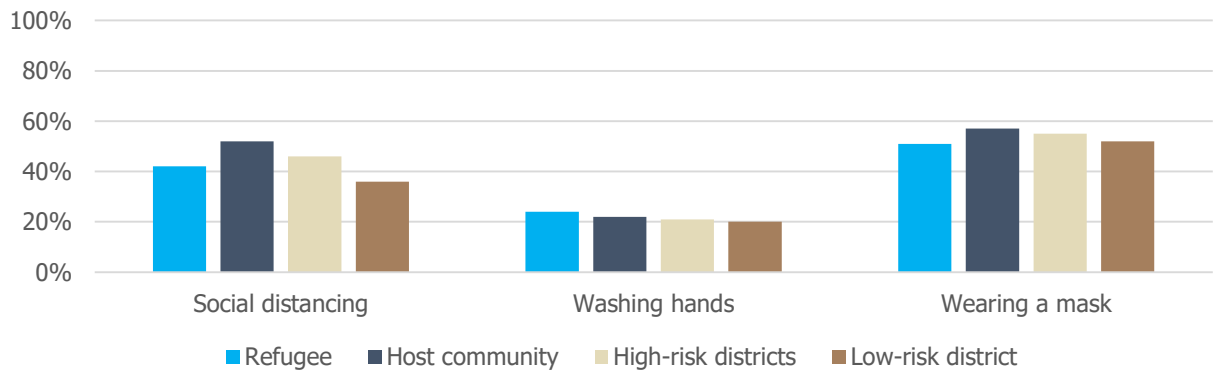
In comparison to wearing face masks and washing hands, relatively few respondents (61%) reported having adopted the 1-meter social distancing guidelines to protect themselves from COVID-19. Self-reported social distancing among refugees was more common in the West Nile (68%) than in the south-west region (58%). In comparison to the refugee population, host and low risk communities the proportion of respondents reporting social distancing was lowest in high-risk communities and particularly in Kampala where only 45% of respondents reported adhering to social distancing (see figure 16 above). This data may be unsurprising given the population density in the city

[47] REACH MSNA Uganda, 2018

and is supported by a brief developed by the Social Science in Humanitarian Action Platform (SSHAP) which highlights that "*the population density in Eastern and Southern African regions is highly and often densely populated, with many living in overcrowded informal settlements in urban areas. In such settings, avoiding crowded areas or proximity to others is highly challenging*"[48].

This is further highlighted by the 46% of respondents in high-risk communities who stated that adopting social distancing in their areas may be difficult (see figure 17 below). FGD participants also highlighted the lack of space outside the home in community areas as a limitation to successful social distancing: *"The shade in health centres is very small and one cannot really sit under the sun"* (FGD with female refugees of mixed ages in the West Nile region).

Figure 14: Reported preventive measures difficult to adopt, by proportion of respondents and groups



Further deterrents from social distancing are social and cultural factors or stem from a lack of belief in COVID-19 as a real threat. FGD participants, particularly in the West Nile region, reported that this preventive measure is seen as interfering with their norms, which often involve communal eating, gathering and celebrating. One FGD participant in Yumbe explained: "*It has reduced social relation in the community because we used to share but now no one wants to even share food with the neighbours*" (Participant in an FGD with females of mixed ages in the West Nile region).

The tension between social and cultural norms and COVID-19 preventive measures is also reflected in the relatively low proportion of interviewees reporting avoiding handshaking as a greeting (49%) and avoiding visiting crowded places (54%) throughout the country, although the proportion tends to be slightly higher in refugee communities (see figure 17 above). In addition, both KII and FGD participants reported that it is difficult to persuade youth and particularly children to adhere to social distancing due to a lack of understanding amongst children. Youth, particularly in the south-west region

[48] Social Science Humanitarian Action Platform (SSHAP) brief on compliance with physical distancing measures for COVID-19 and implications for RCCE in Eastern and Southern Africa, April 2020

reported to not believe that COVID-19 is a threat to them and consequently do not adhere to social distancing guidelines: "*Social distance is not practiced because they are from the same area and so they are safe. Others say, they have not heard of any registered case in their area so there is no need to practice social distancing*" (DHO in the south-west region).

In sum, despite some gaps in supply, wearing masks and washing hands are generally reported to be accepted and reportedly used most people in the assessed communities, while field observations and qualitative findings simultaneously seemed to contradict these reported figures. Social distancing is reportedly less common, primarily because it clashes with social and cultural norms and is hard to do in some, densely populated areas. Nevertheless, these findings indicate that communities in Uganda are able to implement all three COVID-19 preventive measures to some degree even if many community members may not always do so for various reasons.

3.3.3 Uptake of recommended behaviours

Considering the data on threat perception and self-efficacy, it is not entirely clear whether or not behaviour change will take place in all communities. Although the majority of respondents nationally reported that COVID-19 is perceived as a threat in their communities, the threat, although linked to COVID-19, may emanate more directly from the travel restrictions, school closures and other government regulations rather than from the disease itself. This is confirmed by data from KIs who reported that communities in Uganda understand the information that is given to them about COVID-19 well but that this information does not always result in the adoption of preventive measures: "*Yes the majority have understood but many are thinking that the disease is not serious, I don't know whether it is because they have not been seeing deaths around here or people only put on masks when they are reaching a specific place, like the banks and the hospitals, but on the streets they are not*" (Mission Health III in the West Nile region).

As hinted at by this KI in the West Nile region, the seeming contradiction between self-reported adherence to preventive measures and observed disregard of the same may be linked to a respect of authority figures and the necessity to access certain services and communal areas. This was touched upon in several FGDs where participants reported that authority figures are a catalyst for behaviour change amongst members of their communities. During one FGD with elderly female refugees in the West Nile region for example, a participant stated that: "*Some community members wear masks when accessing public offices only or when they have met any of the government authorities like police.*" Moreover, the inability to access services if not compliant with preventive measures also represents a form of oversight or exertion of authority over communities as one KI in the south-west region stated: "*At the MTI health center, no one is allowed in without a mask which has made people take the disease even more seriously*" (RWC in the south-west region).

The data also suggests that economic factors may represent deterrents from behaviour change. During FGDs, for example, poverty and the need to earn a living to survive was highlighted as the primary barrier for people respecting social distancing in settlements. As one participant put it: "*Sometimes it is just hard to stay at home yet one has to get food for the family so we end up going to the market places and it is really hard to practice social distance from these places*" (FGD with elderly male refugees in West Nile region). The need for less crowded distributions by aid organisations and for the separation of distributions between refugees in urban areas and settlements was identified as essential. Moreover, reports from community leaders of the inability of some community members to purchase a mask further points to economic hurdles preventing the uptake of recommended preventive measures[49]. Similarly, both FGD participants during this assessment and community leaders interviewed by GTS mentioned that it was common practice for community members to share boda bodas[50] to save money and that it would be a high an economic burden to expect people to refrain from this money-saving practice[51].

"Wrong mind set by community members on the reason behind wearing a mask. Some people put on mask not to prevent COVID-19 but for fear of government authorities like police." (FGD with elderly male host community members in the south-west region)

Moreover, responses from the validation workshop FGDs highlighted that some communities may be experiencing prevention fatigue, e.g. that community members did adhere to the recommended preventive measures when these were first introduced but have since then given up on wearing masks and/or washing their hands regularly and/or socially distancing themselves. One FGD participant explained that: "*They were practicing the preventive measures at the beginning but now people are not because we are tired, and many have relaxed a lot are not practicing the preventive measures*." (Validation workshop FGD with male refugees of mixed ages in the West Nile region). These findings indicate that any observed behaviour change may not be linked to COVID-19 as a health risk. Rather, community members may be adopting the desired behaviour only when forced to do so and instead are primarily concerned with the economic impact of the restrictions put in place to stem the spread of COVID-19.

3.4 Feedback and Accountability to Affected Populations (AAP)

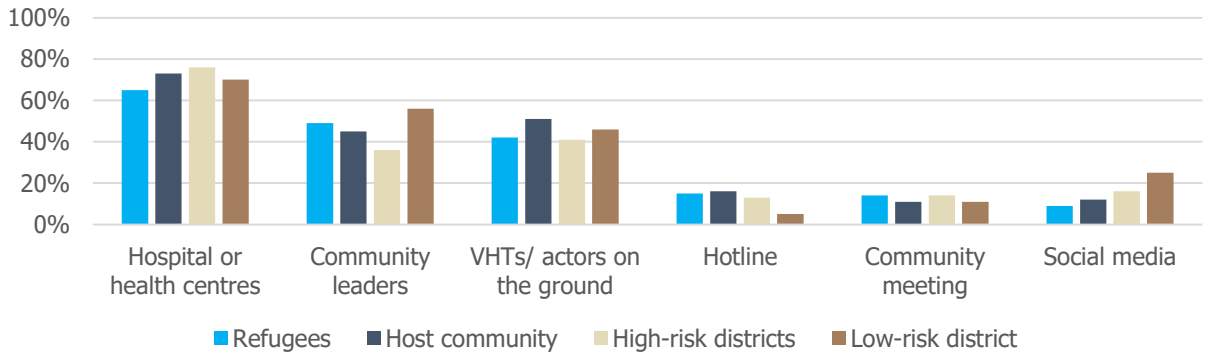
Establishing an effective two-way communication (e.g. clearly defining the channels through which communities can address their doubts, concerns and difficulties related to

[49] Ground truth Solutions (GTS) key informant interviews with 101 South Sudanese and Congolese refugee community leaders, September 2020
[50] Boda bodas are motorcycles or bicycles used as public transport in the East African region
[51] Ground truth Solutions (GTS) key informant interviews with 101 South Sudanese and Congolese refugee community leaders, September 2020

the information on COVID-19 or on the adoption of the recommended preventative measures) is a key pillar of an effective risk communication and community engagement strategy. When asked about feedback mechanisms available to them, 86% of respondents in the quantitative survey reported to use feedback channels. Moreover, almost all refugee, host, low- and high-risk community respondents reported having knowledge of one or more information channels though which they might be able to obtain more information on COVID-19 (see figure 18 below). In contrast, FGD participants tended to be negative about their ability to provide feedback to aid and health providers on the COVID-19 response. Participants' inability to give feedback or lack of knowledge surrounding feedback mechanisms as well as the lack of feedback given to them by partners, were the most commonly voiced concerns.

"They don't feel able to provide feedback because participants don't know when and where to deliver their feedback." (FGD with elderly female host community members in the south-west region)

Figure 18: Reported knowledge of information channels to clarify questions/concerns in regard to COVID-19, by proportion of respondents and groups



KIs on the other hand, were more positive, almost always reporting having received feedback and being open to it, most often through face-to-face meetings, over the phone, through community leaders or VHTs. Moreover, KIs reported most often receiving feedback related to tracking and tracing possible COVID-19 cases. In particular, KIs felt that local reporting systems to catch any potential cases early, were functioning well. Nevertheless, functioning track and trace mechanisms are only one of the purposes for which AAP mechanisms are conceived and the lower proportion of KIs reporting the use of these mechanisms for other purposes suggests that the mechanisms themselves may be underutilized.

"I informed the community on signs and symptoms of COVID-19 and District Task Force would receive many calls if they have seen some one showing signs and also when they receive a new person from other districts or even from other countries like Rwanda." (Communications officer, south-west region)

This aligns somewhat with those FGD participants who did report being able to give feedback and most often mentioned VHTs, community leaders and NGOs as feedback channels. Respondents to the quantitative survey that knew about and used feedback mechanisms, most often reported using health centres (71%) community leaders (57%) and volunteers, VHTs, partners or local authorities involved in the COVID-19 response (51%) to give feedback. The channels reportedly used the least included suggestion or complaint boxes (1%), WhatsApp groups (3%), phone numbers or e-mails (9%) and help desks (7%). Surprisingly, considering the reported low usage of suggestion boxes, FGD participants suggested that NGOs and the government should hold community meetings, particularly in the West Nile region, or set up suggestion boxes, particularly in the south-west region, to improve the availability of feedback channels. Finally, although 92% of the respondents who submitted feedback reported having received a response to their submitted feedback, a relatively small proportion of interviewees in Bidibidi (16%), Oruchinga (15%) and Kyangwali (14%) reported having received a follow-up on their feedback.

4.0 Conclusion

This assessment aimed to identify how the information related to COVID-19 was delivered to different communities in Uganda and how this information is shaping the communities' risk perception and influencing the uptake of behaviours for the prevention of COVID-19. Findings indicate that communication channels in Ugandan communities are successful in disseminating the information about COVID-19. Despite some information barriers related to lacking infrastructure or the characteristics of the information recipient, a majority of respondents as well as FGD and KII participants have confirmed that their communities are regularly, and often daily, informed about COVID-19 by trusted sources and through the appropriate channels. To further improve on this, participants suggest focusing on improving targeted information channels for disabled and particularly immobile people.

Additionally, misinformation about COVID-19 is also reported to be prevalent, mainly in the south-west region and often coming from friends and family. According to reports from both KIs and FGD participants, the spread of misinformation can be addressed through continued sensitization while a strengthening of the communication infrastructure may further this aim and strengthen the response where needed.

Notably, the findings do not indicate that demographic or social factors play a considerable role in the perception of risk and the uptake of the recommended preventive behaviours. Instead, findings suggest that the level of trust recipients generally have in the information source, the relevance the recipients feel the information has to their own surroundings, and the information format are likely to influence how the information is received and thus, how the communicated threat is perceived.

Regarding behaviour change, findings suggest that despite some gaps in resource supply, most communities are able to implement the suggested preventive measures (e.g. wearing a mask, washing hands and socially distancing) to some extent. Although supplementary distributions of masks and soap may further increase the proportion of community members successfully adhering to preventive measures, this alone may not achieve the desired results. More specifically, findings suggest that, even in areas where there are enough masks and handwashing is made possible through the supply of sufficient soap, community members may not take up on the recommended behaviours.

Findings suggest that behaviour change is far less prevalent than information about COVID-19 is available, and is not entirely dependent on the feasibility of adopting preventive measures. Rather, although an overwhelming majority of the respondents from the quantitative survey and from the FGDs report to perceive COVID-19 as a threat, the threat is mainly reported to be a secondary economic threat instead of a direct health risk. One factor indicating the lack of perceived health risk is the fact that some community members only comply with preventive measures when pressured to do so by authorities. Further, the relatively high number of community members who reportedly complied with the recommended behaviours at first but have since then stopped indicate that the health threat is not perceived to be immediate. This, in combination with reports of economic distress, indicate a higher economic threat perception as compared to a health risk, which may in part explain the limited behavior change.

To rectify this and motivate communities to adopt preventive measures, it may therefore be useful to demonstrate the health threat more clearly to communities and community members who either do not feel threatened or feel that the economic risk associated with compliance with the preventative measures outweighs the risk of not adhering to them.

An additional consideration which may require further research is that boosting the economic stability of some households in Uganda may be the key to enabling these households to uptake the recommended behaviour. Particularly households facing economically unacceptable consequences if and when restrictions are adhered to and the recommended behaviour is followed, may need to be supported financially. Alternatively, it may be important to monitor such households in terms of their economic stability to assess whether or not increased sensitization surrounding the health risk alone will be sufficient to affect behaviour.

So far, Uganda has managed to contain the spread of the disease through early preventive actions (i.e. full country lockdown and closure of the national borders in March 2020, relaxation of the restrictions in June 2020 while maintaining a curfew and opening of borders in October 2020)[52] and a communications strategy designed to inform the population and advocate for the adoption of the preventive measures. Other

[52] https://covid19.gou.go.ug/timeline.html

characteristics of the country might have facilitated the containment of the case transmissions (e.g. demographic advantage due to a relatively young population, overall low population density with the exception of Kampala among others). This has resulted in a comparatively low caseload, standing at 14574 cumulative cases on 8 November 2020 (7771 of which were recovered, 562 were active and 133 dead)[53]. Uganda's success in dealing with the COVID-19 outbreak and controlling the spread of the disease so far may have resulted in an unintended consequential difficulty in communicating the severity of the health risk, which the findings suggest is an essential determinant of behaviour change. This finding should be taken into consideration by government and aid actors in future risk communication and community engagement intervention planning.

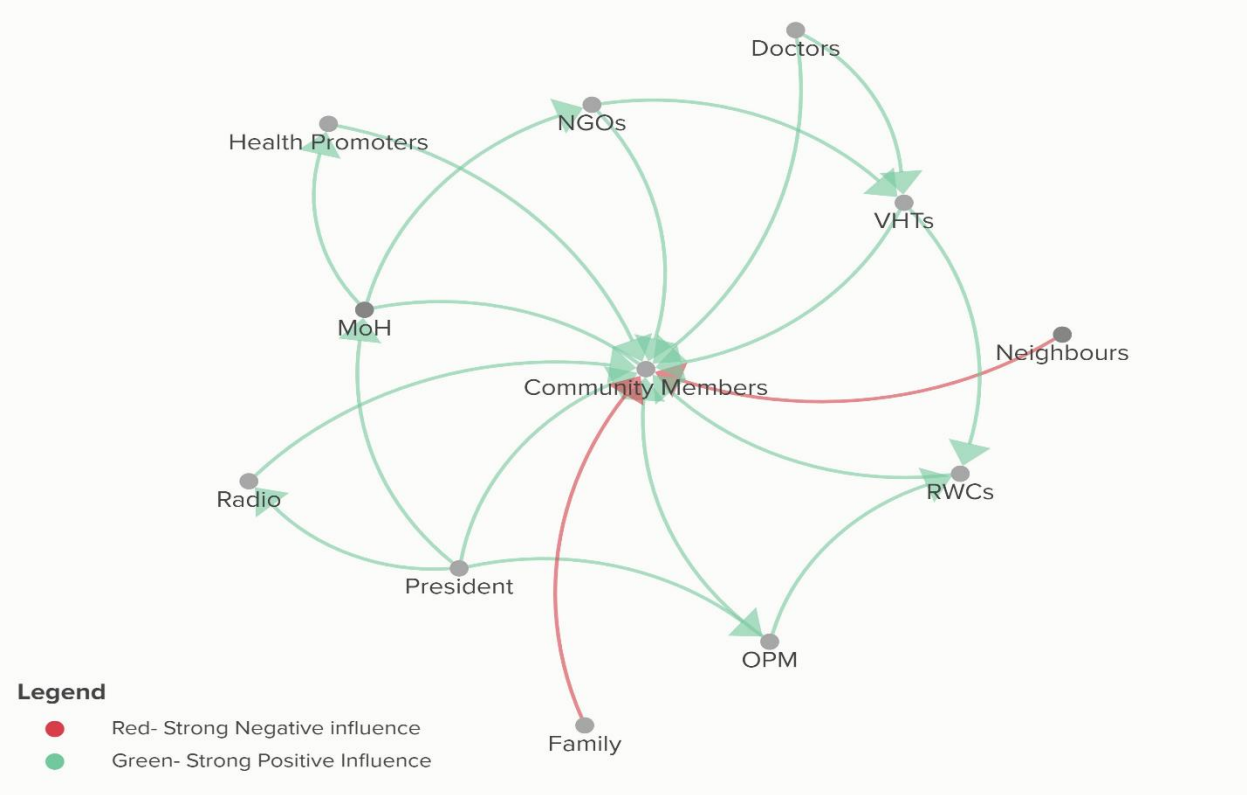
[53] https://covid19.gou.go.ug/index.html

5.0 Annexes

Annex 1 - Case study 2: Social network analysis in the Bidibidi refugee settlement:

The community members interviewed in Zone 1, Bidibidi, Yumbe district identified the media such as radio, non-government organizations (NGOs), government officials such as the OPM, health workers such as Village Health Teams (VHTs), the Refugee Welfare Committee (RWCs) leaders, religious leaders and friends and family as the actors informing the community around COVID-19. The community members recognized these actors are closer to them and have a greater potential to influence their beliefs and behaviours in relation with COVID-19. In relation, participants reported the highest level of trust from radio on information on COVID-19, followed by health workers and OPM, as well as in NGOs such as International Rescue Committee (IRC), Water Mission, World Vision and Community Empowerment for Rural Development (CEFORD), arguing that these organizations were sensitizing participants about COVID-19 on ground.

Figure 19: Influencers and networks in Bidibidi community



The participants interviewed reported that NGOs had a positive strong influence on them. An example here reported was partners such as IRC who were the lead health

implementing partners and also trained Village Health Teams who disseminated COVID-19 information to the participants. Equally, doctors were also reported to have a positive strong influence as these too worked with the Village Health Teams as well as closely with the lead health implementing partner- IRC on educating the communities on the risk of COVID-19. Last but not least, the presidential address being the country authority through media like radio was identified as a strong positive influence, and so was the community led structures – the RWC who are the focal points in terms of community communication and engagement.

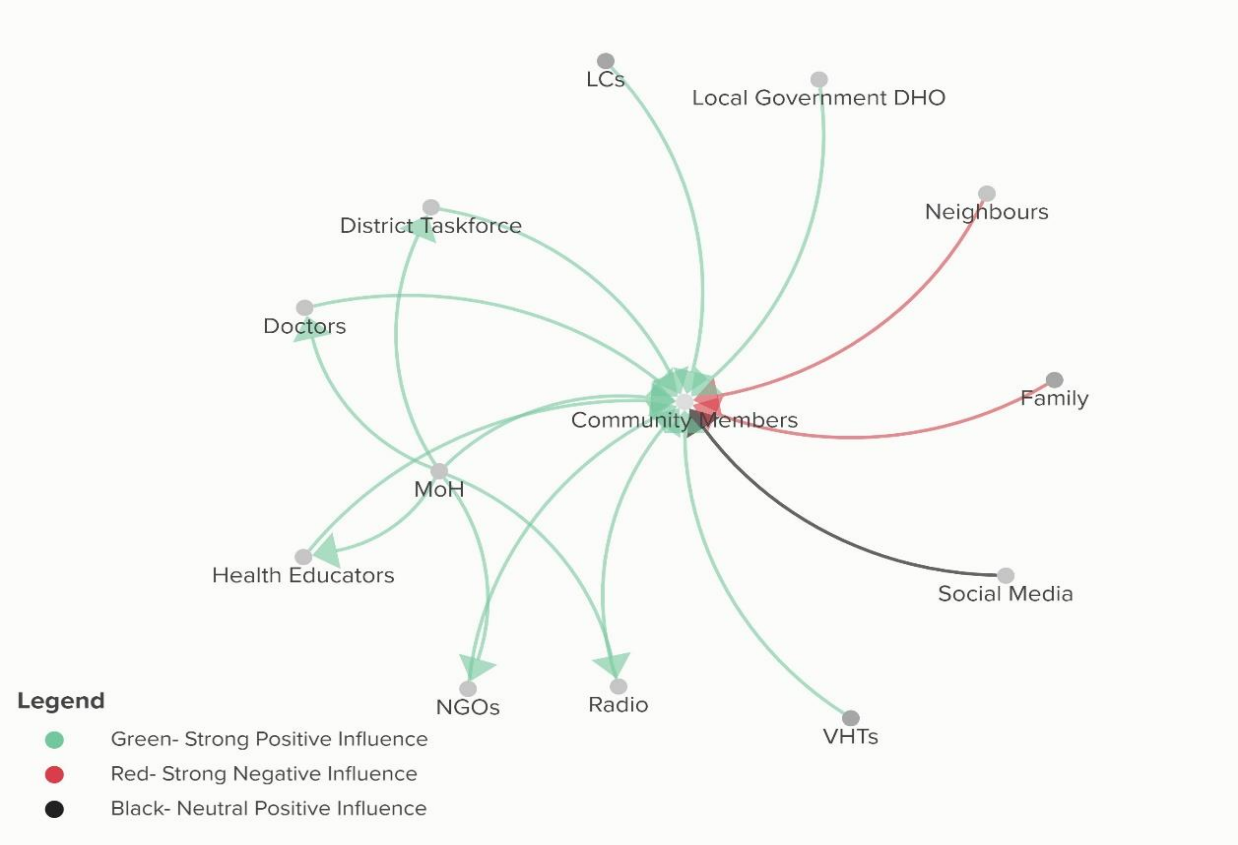
Regarding the interconnection of the different influencers (or node of the networks), KIs reported other NGOs, Government entities, Health promoters and VHTs as people informing the community and that in order to ensure communication consistency on COVID-19 information, these stakeholders engaged in community dialogue as well as meetings before they went out into the communities.

From this case study, we see that the influencers identified by FGD participants have a positive influence. Friends and family have a controversial role in influencing the community members in adopting the recommended behaviour. In some cases, they are playing a positive role, but may also be unknowingly furthering the spread of false information while having a low capacity to clarify COVID-19 information, leaving family members doubtful. Participants also further point out that when NGOs stop the sensitization activities, then they lose the communities' trust and capacity to positively influence them.

Annex 2 - Case study 3: Social network analysis in the Kyegegwa district:

The participants from the host community of Bukere zone in Kyegegwa district, identified the NGO- Medical Teams International (MTI), doctors, the District Health Officer (DHO), Local Council (LC) chairmen, VHTs and Health Educators as those shaping the communication around COVID-19 in the community. Participants reported a high level of trust amongst the local government officials- DHO, LCs, Doctors and the Uganda Red Cross. Participants reported to trust them because they carry out door to door sensitization for the community members. They further added that doctors had treated other diseases such as malaria in their community which increased the trust in the information they provided and through this, they were able to address doubts about COVID-19.

Figure 20: Influencers and networks in Kyegegwa community



In the same vein, other local government officials such as the Resident District Commissioner (RDC), parish chiefs and women councilors were identified as a positive influence in behaviour change. This is because they chaired and passed information through the District Taskforce set up by the MoH on COVID-19 and had sessions (radio talk shows) at Kyegegwa community radio which most community members had access to. On the other hand, even though social media as well as the internet were mentioned as trusted mediums for generating information on COVID-19, their influence was identified as neutral by the participants as not many community members had access to the internet. Furthermore, similar to the findings from the other SNA case studies, neighbours and friends who brought rumours that were reported by participants as negatively influencing the community members on not adopting preventive measures on COVID-19.

From this case study, examining the communication flows within this community showed that the local government actors as well as community leaders were identified as positive influencers as they were constantly engaging with the communities and the information brought forth would reportedly be commonly trusted as well as followed by community members.

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