

Ebola Knowledge, Attitudes, and Practices Survey in Ugandan Refugee Sites

June 2026 | Uganda

Context

Uganda continues to host more than 2 million refugees and asylum seekers¹, primarily from South Sudan, the Democratic Republic of the Congo (DRC), and Sudan. Ongoing conflict, insecurity, and humanitarian crises in neighbouring countries continue to drive displacement into Uganda, placing sustained pressure on health services and public infrastructure in refugee-hosting districts and settlements. These population movements occur in a context of heightened regional public health risk linked to the ongoing Ebola disease outbreak caused by the Bundibugyo virus. The current Ebola outbreak was declared by the Government of the DRC on 15 May 2026² and has since expanded rapidly across eastern provinces, particularly Ituri, North Kivu, South Kivu, and now recently Haut-Uele and Tshopo. As of 18 July 2026, the DRC had reported 2,344 confirmed cases and 930 deaths across 46 affected health zones³, and continues to grow within a complex humanitarian environment characterized by insecurity, displacement, population mobility, and limited access to basic services, all of which increase transmission risks and complicate response efforts.

Uganda has reported a smaller but epidemiologically linked outbreak resulting from cross-border transmission from the DRC. As of 20 July 2026, Uganda had recorded 20 confirmed cases, including two deaths, and one suspected death, with cases concentrated in Kampala and Wakiso districts⁴. While no new cases have been reported since 21 June 2026, the risk of further spread remains due to continued population movements and epidemiological links with affected areas of eastern DRC. Refugee populations may face heightened vulnerability to Ebola transmission due to frequent population movements, crowded living conditions, barriers to accessing information and services, and continued epidemiological links between Uganda and affected areas of eastern DRC⁵. At the same time, many settlements host populations with strong social, familial, and economic connections to South Sudan, creating potential pathways for cross-border disease spread should transmission occur within refugee communities.

In response to these vulnerabilities and to better understand the preparedness of refugee populations for the ongoing Ebola outbreak, REACH/IMPACT conducted a Knowledge, Attitudes and Practices (KAP) assessment among refugees living in settlements across Kampala City, Northern Region (Adjumani, Bidibidi, Imvepi, Lobule, Palabek, Palorinya and Rhino), and Southwest Region (Kiryandongo, Kyaka II, Kyangwali, Nakivale Oruchinga and Rwamwanja) settlements of Uganda. The assessment aimed to examine community awareness of Ebola disease, perceptions of transmission risks, trust in health information sources, care-seeking behaviours, and adoption of preventive measures to inform preparedness and risk communication efforts. The findings presented in this report are intended to support government and humanitarian actors in strengthening community engagement, targeting public health interventions, and reducing the risk of Ebola transmission among refugee and host populations, while contributing to broader regional preparedness efforts along population movement corridors linking Uganda, the DRC, and South Sudan.

Key Messages

- Risk perception remains moderate despite high outbreak risk, particularly among some refugee groups: While general awareness of Ebola is high, only 57% of respondents perceived themselves to be at risk. This suggests that awareness of Ebola does not necessarily translate into a sense of personal vulnerability. Risk Communication and Community Engagement (RCCE) efforts should prioritize communication that localizes risk and helps communities understand how ongoing cross-border mobility and everyday activities may expose them to infection.
- Trusted community and health-system actors should remain the centre of Ebola communication: Health workers, health facilities, community health volunteers (CHVs), radio, and community leaders were consistently identified as both the most commonly used and most trusted information sources across refugee settlements. Even in Kampala, where refugees access social media and digital platforms more frequently, trust remained concentrated in interpersonal and health-system channels. RCCE interventions should therefore prioritize health workers, CHVs, and community leaders as primary messengers.
- Knowledge of handwashing is strong, but critical gaps remain around reporting, and safe burial practices: Respondents overwhelmingly identified handwashing as a preventive measure, but significantly fewer recognized avoiding contact with deceased Ebola cases, safe burial practices, or reporting mechanisms such as alert hotlines. Knowledge of what to do following a suspected Ebola death was also more limited than knowledge of transmission and prevention. RCCE activities should expand beyond basic awareness messaging and focus on promoting reporting pathways, and safe disposal of suspected deaths.
- Communication strategies should be tailored by language and refugee population profile: The assessment identified clear differences between regions and language groups. Arabic-speaking respondents in Northern settlements consistently reported lower perceived risk, while Congolese and Kiswahili-speaking populations in the Southwest demonstrated higher awareness and concern. These findings suggest that a one-size-fits-all communication strategy may be insufficient. RCCE actors should investigate whether the existing Juba Arabic language communication is sufficiently available, understood, locally relevant and linked to concrete exposure scenarios and adapt communication materials to the linguistic and cultural context of different refugee populations.

Methodology and Limitations

This assessment employed a quantitative cross-sectional Knowledge, Attitudes and Practices (KAP) survey to assess Ebola-related knowledge, perceptions, and behaviours among refugee populations residing in Uganda's 13 refugee settlements and refugee-hosting areas of Kampala. Data were collected remotely through structured telephone interviews using a questionnaire adapted from the CDC and RTI International Ebola KAP toolkit. The survey covered key themes including Ebola awareness, transmission and prevention, risk perceptions, health-seeking behaviours, trusted information sources, and perceptions of the Ebola response.

A probability-based stratified sampling approach was used. Refugee settlements and Kampala were defined as sampling strata, and households were randomly selected from a UNHCR refugee registry containing telephone contact information. The assessment originally targeted 1,300 households, with sample sizes calculated at a 95% confidence level and 10% margin of error. Interviews were conducted with one adult respondent per selected household by trained enumerators based in Kampala.

Survey submissions were monitored daily to ensure adherence to sampling targets and data quality standards. Following data cleaning and validation, descriptive and bivariate analyses were conducted in R, and survey weights were applied to account for differences in settlement population sizes and achieved sample distributions across strata. Limitations include:

- **Coverage bias:** The assessment relied on telephone interviews using contact information from the UNHCR refugee registry. Households without access to a functioning phone, those with outdated contact details, or those living in areas with poor network coverage may be underrepresented.
- **Sampling frame limitations:** The representativeness of the sample depends on the completeness and accuracy of the UNHCR refugee registry. Any omissions or inaccuracies in the registry may have affected the probability of selection for some households.
- **Self-reported data:** Findings are based on respondents' self-reported knowledge, perceptions, and behaviours and may therefore be affected by recall bias or social desirability bias, particularly for questions related to preventive practices and intended response behaviors. To minimize these biases, enumerators received standardized training on neutral interviewing techniques, respondents were assured of the confidentiality of their responses and interviews were conducted in a manner intended to encourage honest and accurate reporting.
- **Rapidly evolving context:** As the assessment was conducted during an active Ebola outbreak, community knowledge, perceptions, and behaviours may change over time as the epidemiological situation and response activities evolve. Findings should therefore be interpreted as a snapshot of conditions at the time of data collection.

Survey Results

Data collection was conducted between 25 and 30 June 2026 using telephone interviews with refugee households selected from the UNHCR refugee registry. A total of 695 interviews were completed across the three assessment regions, including the Northern, Southwest, and Kampala regions. While the assessment was initially designed to achieve a larger sample distributed across all refugee settlements and Kampala, implementation was affected by substantial non-response rates (69.2%) as calculated by the number of successful interviews over the number of contacts attempted from the sampling frame. Out of all calls made, the primary reasons were related to no successful connection when called (49.7%), followed by connection but no answer (6.4%), and no service found (4.3%). Additionally other reasons (8.1%) were cited including phone numbers had been re-allocated to host community members who didn't meet our eligibility criteria, additional disconnections, lines were busy, multiple non-pickups, language issues, or a handful of true refusals (5). A significant number of non-responses were recorded in the first two days of data collection, and this was significant in Kampala. However, the reasons for these non-responses were not formally recorded and are therefore unknown.

As a result of these challenges, the achieved sample sizes in several individual settlements were insufficient to support the originally planned settlement-level analysis. To preserve statistical robustness and ensure reliable interpretation of findings, the analysis was aggregated to the regional level, producing indicative findings for the Kampala City, Northern and Southwest settlements rather than for individual settlements. This approach allowed for meaningful comparisons across the major refugee-hosting regions while maintaining an adequate sample size within each analytical stratum. Interviews remained reasonably well spread across different sites for Northern and Southwest regions. Nevertheless, the completed interviews provide valuable insights into Ebola-related knowledge, attitudes, perceptions, and practices among refugees living in Kampala and other high-risk refugee-hosting areas.

Table 1: Summary of Data Collection Completion

Region	Settlement / Site	Results				
		Target	Completed	% Complete	Attempts	% Non-Response
Central	Kampala	100	50	50%	180	72.2%
Northern	Adjumani	102	53	52%	117	54.7%
	Bidi Bidi	101	32	32%	107	70.1%
	Imvepi	99	30	30%	117	74.4%
	Lobule	97	52	54%	179	70.9%
	Palabek	99	34	34%	258	86.8%
	Palorinya	100	46	46%	149	69.1%
	Rhino	101	41	50%	83	50.6%
South West	Kiryandongo	100	82	82%	236	65.3%
	Kyaka II	100	59	59%	227	74.0%
	Kyangwali	100	62	62%	173	64.2%
	Nakivale	99	74	75%	199	62.8%
	Oruchinga	3	3	100%	17	82.4%
	Rwamwanja	99	68	69%	186	63.4%
	TOTAL	1300	686	52.8%	2228	69.2%



Demographics and Mobility

Assessed respondents were generally evenly distributed by sex and had a mean age of 51.9 years, reflecting an established refugee population rather than a recently displaced population. The assessed refugee population was primarily composed of refugees from South Sudan (58.0%) and the Democratic Republic of Congo (DRC) (33.0%), reflecting the major refugee populations hosted in Uganda. Smaller proportions originated from Burundi (2.5%), Somalia (3.0%), Eritrea (1.3%), Sudan (1.2%), and other countries.

Kampala region

The Kampala stratum exclusively covered Kampala district, with all interviews conducted among refugees residing in Kampala urban settlement, making it the only urban survey site included in the assessment. Unlike the Northern and Southwest strata, which comprised multiple refugee settlements, the Kampala stratum represents the experiences of urban refugees living in and around Uganda's capital city. The Kampala region displayed the greatest diversity in countries of origin. While South Sudanese (38.2%) and Congolese (33.0%) refugees formed the largest groups, notable proportions of respondents also originated from Somalia (18.2%) and Eritrea (14.5%).

English was the dominant language preference (69.1%), and respondents were more likely than those in other strata to identify as Muslim (30.9%) or Evangelical (25.5%). Respondents in the Kampala region reported relatively higher levels of educational attainment, with nearly half (49.1%) having completed secondary education and some (10.9%) having attended university. Livelihoods were more urban in nature than in other strata, with 18.2% reporting regular employment and 21.8% operating their own businesses. Nevertheless, more than one-third (38.2%) reported having no income-generating activity.

Northern region

The Northern stratum covered seven refugee settlements across the West Nile and Acholi sub-regions: Adjumani, Bidi Bidi, Imvepi, Lobule, Palabek, Palorinya, and Rhino Camp. Located largely along the South Sudan border, the stratum was characterized by a highly homogenous refugee population, with nearly all respondents (95.6%) originating from South Sudan. Women accounted for half (50.4%) of respondents and the mean age was 49.6 years. Reflecting this population profile, respondents most commonly preferred receiving Ebola-related information in English (41.7%) and Arabic (36.1%), while the majority identified as Protestant (42.6%) or Catholic (36.3%).

Educational attainment was generally lower than in the Kampala region, with more than one-third (35.5%) of respondents reporting primary education and 15.4% reporting no formal education. Livelihoods were predominantly rural and agriculture-based, with nearly half (44.5%) relying on own production activities as their primary source of income. Smaller proportions reported self-employment (12.4%), casual labour (11.4%), or regular employment (7.0%), highlighting the strong dependence on farming and other subsistence activities across the Northern settlements.

South West region

The Southwest stratum covered six refugee-hosting districts and settlements: Kiryandongo, Kyaka II, Kyangwali, Rwamwanja, Nakivale, and Oruchinga. The population was predominantly composed of refugees from the Democratic Republic of Congo (69.5%), while approximately one-fifth (19.2%) originated from South Sudan. Respondents in this stratum were older on average than those in other regions, with a mean age of 55.1 years, and women accounted for 44.9% of respondents. Reflecting the large Congolese refugee population, Kiswahili (51.0%) was the predominant preferred language for receiving Ebola-related information, followed by Kinyabwisha (19.2%) and English (20.5%). The religious profile was similar to that observed in the Northern region, with respondents primarily identifying as Protestant (43.2%) or Catholic (36.3%).

Educational attainment was mostly at the secondary level (42.1%), while some respondents reported no formal education (12.8%) and smaller proportions reported university (8.5%) or technical/vocational (4.6%) education. Livelihoods were more diverse than in the Northern region, with respondents most commonly relying on casual labour (27.1%), self-employment or small businesses (24.4%), and own production activities (17.7%). Compared with other strata, the Southwest region had the highest proportion of respondents engaged in casual employment and self-employment, reflecting the combination of agricultural, trading, and informal economic opportunities

available across the refugee settlements and surrounding host communities.

Respondents were also asked if they consented to additional questions on their mobility between Uganda and countries of origin, which the majority of respondents agreed to answer (92.3%). However, only a small minority (5.6%) reported any movements within the last one month. Of those who reported any movement, the primary reasons given included visiting family or friends (56.3%), temporary returns to areas of origin (25.0%), business or trade (17.0%), agricultural activities (9.8%), and other reasons.

Table 2 : Participant Characteristics (%)

Question	Value	Central	Northern	South West	Overall (%)
Respondent Sex	Male	49.1	49.6	55.1	51.9
	Female	50.9	50.4	44.9	48.1
Respondent Age (years)	Mean	49.1	49.6	55.1	51.9
Education Level	None	12.7	15.4	12.8	14.1
	Primary	25.5	35.5	12.8	33.0
	Secondary	49.1	37.7	42.1	40.5
	Technical	1.8	4.3	4.6	4.2
	University	10.9	7.1	8.5	8.0
Income Activity	None	38.2	22.8	22.7	24.1
	Regular Employment	18.2	7.0	4.9	7.0
	Casual Employment	14.6	11.4	27.1	18.4
	Own Business, Self-Employed	21.8	12.4	24.4	18.3
	Own Production	3.6	44.5	17.7	29.6
	Remittances	1.8	0.7	0.6	0.8
	Other	1.8	1.2	2.3	1.7
Religion	Catholic	16.4	36.3	36.3	28.8
	Evangelical	25.5	13.2	13.2	17.7
	Muslim	30.9	7.7	9.5	10.4
	Non-religious	0.0	0.0	0.2	0.1
	Protestant	27.3	42.6	43.2	41.6
	Other	0.0	0.3	3.0	1.4
Country of Origin	Burundi	1.8	0.8	4.7	2.5
	DRC	33.0	2.4	69.5	33.0
	Eritrea	14.5	0.0	0.2	1.3
	Somalia	18.2	0.0	3.4	3.0
	South Sudan	38.2	95.6	19.2	58.0
	Sudan	0.0	1.3	1.4	1.2
	Other	3.6	0.0	1.6	0.9
Language	Acholi	0.0	6.6	2.9	4.4
	Arabic	1.8	36.1	2.1	18.6
	English	69.1	41.7	20.5	35.0
	Kakwa	0.0	4.0	0.0	2.0
	Kinyabwisha	3.6	0.0	19.2	8.5
	Kiswahili	18.2	1.3	51.0	24.0
	Kuku	0.0	4.1	0.2	2.1
	Other	7.3	6.2	4.1	5.4
Consent - Movement Questions		100.00	88.7	95.7	92.3
In the past month, have you travelled to your country of origin from Uganda, or returned to Uganda from your country of origin, for any reason?		3.6	8.7	2.7	5.6

Perceived Severity

Overall, perceptions of Ebola severity and risk were moderate across the assessed refugee populations. Respondents were first asked whether they believed they could get infected or become sick with Ebola Virus Disease (EVD), if so, to rate their level of risk from very low to very high. They were also asked if they thought most people in their community believed the Ebola outbreak was real. Over half of respondents (56.8%) believed that they could be personally at risk if an Ebola outbreak occurred in their community, while a similar proportion (49.3%) felt that people in their community believed the Ebola outbreak is real.

Several characteristics were associated with any perceived risk such as education level, livelihood activities, gender, and language. Educational attainment was associated with perceived risk ($p=0.033$), with respondents with secondary education (68.2%), technical education (74.1%), and university education (75.0%) were more likely to report personal risk than those with no formal education (55.0%) or only primary education (59.3%). Men were significantly more likely than women to report personal risk during an outbreak (68.0% versus 60.1%; $p=0.048$). The higher reported perceived risk from men may be partially explained by their engagement in certain livelihood activities which were strongly associated with perceived risk ($p<0.001$). Respondents engaged in casual labour (79.5%) and business activities (71.2%) were among the most likely to perceive themselves at risk, whereas respondents with no livelihood activity (57.0%) or those relying on own production (57.2%) reported comparatively lower concern. Respondents without income-generating activities reported lower perceived risk (57.0%) than those involved in labour markets and business activities, while respondents with lower educational attainment were generally less likely to perceive personal risk than those with secondary, technical, or university education ($p=0.033$).

Language was significantly associated with perceived risk ($p<0.001$), with Arabic-speaking respondents substantially less likely to perceive themselves at risk (38.5%) than English (67.0%), Kiswahili (67.6%), or speakers of other languages (69.4%). Among those who perceived risk, Arabic speakers were also much more likely to rate that risk as low (43.3%) or very low (23.3%) and much less likely to report very high risk (10.0%) than other language groups.

Regional differences in perceived personal risk were statistically significant ($p=0.002$), as were differences in risk severity ($p<0.001$). Respondents were less likely to perceive themselves at risk in the Southwest (67.4%) and Kampala region (60%) compared to Northern (50.3%) region. However of reported perceived severity, a higher proportion of respondents reported perceived high and very high severity in Southwest (23.4% and 27.5%) and Northern (17.4% and 26.5%) regions compared to Kampala (20.0 and 13.3%) with more moderate severity of perceived risk.

Kampala

In the Kampala region, perceptions of Ebola risk were characterized by relatively high awareness but more moderate assessments of severity. This pattern may be linked to the profile of Kampala's refugee population, where characteristics associated with greater risk awareness were relatively common. Across the assessment, perceived risk was higher among respondents in Kampala with secondary (68.2%), technical (74.1%), or university education (75.0%), as well as among those engaged in casual labour (79.5%) or business activities (71.2%), suggesting that the comparatively educated and economically active urban refugee population may have contributed to the relatively high recognition of Ebola risk observed in the region.

At the same time, Kampala hosts a more diverse refugee population than the settlement-based strata, including many refugees from countries with less direct experience of Ebola outbreaks. This may help explain why awareness of risk did not translate into the higher severity perceptions observed elsewhere, particularly in the Southwest, where over half of respondents rated their risk as high or very high (50.9%). Taken together, the findings suggest that respondents in Kampala generally recognized Ebola as a credible health threat but tended to view their personal vulnerability as moderate rather than severe.

Northern region

In the Northern settlements, perceptions of Ebola risk were comparatively lower and less consistent than in the other regions. This pattern may be partly explained by the characteristics of the Northern refugee population. Language was one of the strongest predictors of risk perception, and Arabic-speaking

respondents were considerably less likely to perceive themselves at risk (38.5%) than English (67.0%), Kiswahili (67.6%), or other language speakers (69.4%) in Northern region. Among those perceiving risk, Arabic speakers were also more likely to rate it as low or very low (66.6%) and less likely to report very high risk (10.0%). The prominence of South Sudanese refugees in the Northern settlements may suggest the lower overall risk perceptions are associated with this population group and explain the association with Arabic language. Another possible explanation is that populations may not have access to Ebola related information in Arabic, therefore speakers of other languages would have greater access to information and therefore a greater perceived risk.

South West region

The Southwest region exhibited the highest perceived Ebola severity of all three strata. This heightened concern is consistent with the profile of the Southwest refugee population, which includes characteristics associated with greater perceived risk across the assessment. Kiswahili-speaking respondents, who make up a substantial proportion of the region's predominantly Congolese refugee population, were significantly more likely to perceive themselves to be at risk of Ebola. This is likely attributable to their greater proximity to the ongoing outbreak and stronger awareness of cross-border transmission risks.

Figure 1: Do you think you can get infected or become sick with EVD?

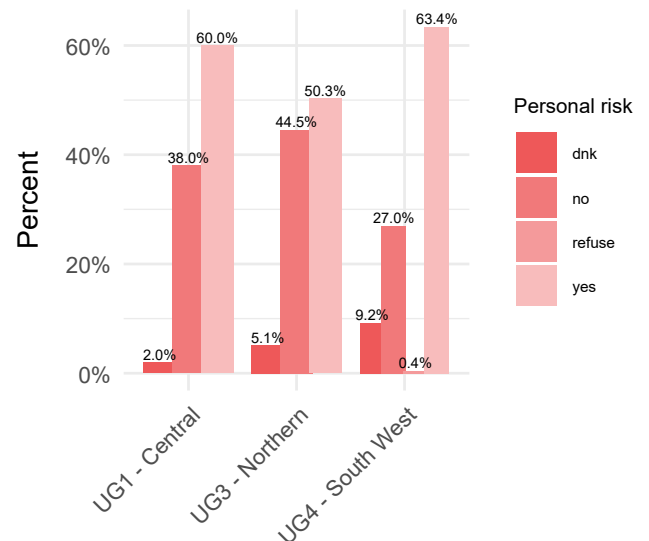
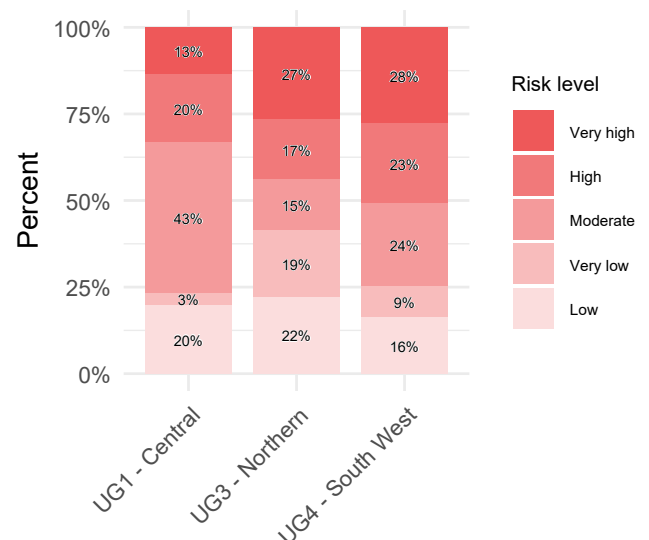


Figure 2: How high would you say your risk is for getting sick?



Livelihood patterns may also help explain the elevated perceptions of Ebola severity observed in the Southwest. Respondents engaged in casual labour (79.5%) and business activities (71.2%) were among those most likely to perceive themselves at risk, while those with no income-generating activity (57.0%) reported lower levels of concern. Taken together, the prominence of Kiswahili-speaking Congolese refugees, alongside relatively high participation in labour markets and self-employment, may help explain why respondents in the Southwest reported the highest levels of perceived Ebola severity and personal vulnerability.

Health Information Sources

Respondents were asked "What is your source of information on health and diseases?" and could select multiple responses. Across all strata, health information was obtained through a combination of formal health channels, community networks, and mass media. The most reported sources were radio (60%) and health workers (59%), followed by community health volunteers (CHVs) (41%). Smaller proportions of respondents reported obtaining health information from health facilities (11%), Facebook (10%), posters or leaflets (9%), WhatsApp (9%), and family and friends (7%), Traditional healers (5.1%), places of prayer (5%), and word of mouth (2%) were among the least commonly cited sources of health information.

Important regional differences were observed in information-seeking behaviour. In the Northern region, respondents most commonly obtained health information from health workers (69.4%), radio (61.9%), CHVs (42.9%), community leaders (21.1%), and health facilities (15.2%), suggesting a strong reliance on health-system and community-based communication channels. The Southwest showed a similar pattern, with radio (58.0%), health workers (50.0%), and CHVs (40.8%) among the most frequently reported sources. In contrast, respondents in Kampala were more likely to obtain health information from television (51.7%), Facebook (31.0%), WhatsApp (20.7%), Instagram (17.2%), and Twitter (10.3%), reflecting greater access to digital and mass-media platforms in the urban environment.

Respondents were also asked a series of questions on "How much do you trust [source] for health information?" to assess trust in different communication channels. Across all strata, formal health sources were consistently the most trusted. Health workers were the most trusted source overall, with the majority (78.1%) of respondents reporting that they trusted them "a lot", followed by health facilities (72.9%), radio (59.9%), Community Health Workers (CHWs) (58.5%), community leaders (57.9%), and religious leaders (56.0%). In contrast, social media was among the least trusted sources, with only 19.5% reporting high trust and 23.1% reporting no trust at all. Trust in traditional healers was also low; only 10.5% of respondents trusted them "a lot", while a majority (54.1%) reported not trusting them at all. Trust in health workers was strongly associated with recognizing Ebola as a real disease, with respondents who trusted health workers "a lot" more likely to recognize Ebola as real (62.1%) than those reporting only moderate trust (41.4%; $p=0.001$). Similar associations were observed for CHVs, community leaders, health facilities, schools, family members, friends, radio, television, and SMS communications (all $p<0.001$).

Regional differences in trust broadly mirrored patterns of information use. Respondents in the Northern region reported the highest levels of trust in health workers (86.2% trusted them "a lot"), health facilities (85.7%), CHVs (68.0%), and radio (69.5%). The Southwest also reported high levels of trust in health workers (72.0%), health facilities (62.7%), and community leaders (50.7%). Although respondents in Kampala (Kampala) accessed a wider range of information channels, trust remained concentrated in health workers (61.8%) and community leaders (58.2%), rather than digital sources. Together, these findings suggest that while urban refugees access a more diverse information environment, trusted interpersonal and health-system channels—particularly health workers, health facilities, CHVs, and community leaders—remain the most influential sources of health information across refugee populations.

Figure 3: What is your source of information on health and diseases?

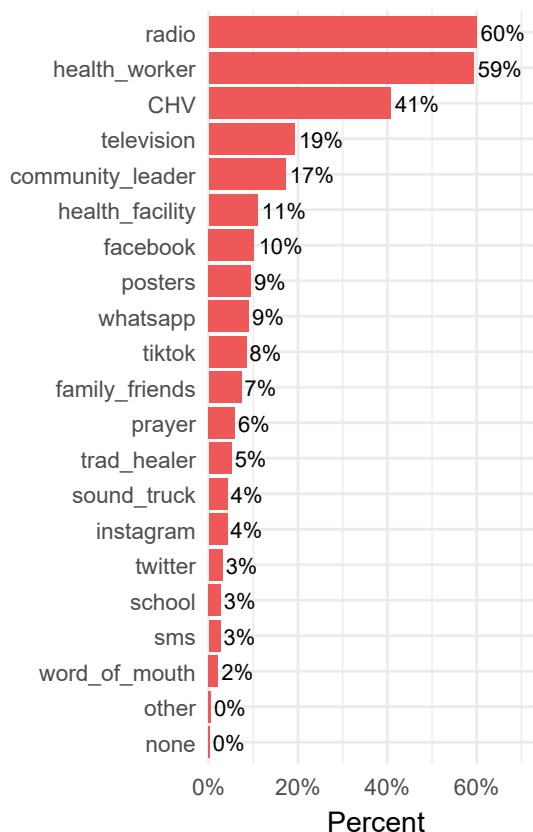


Figure 4: From what source did you last see, hear or read about EVD?

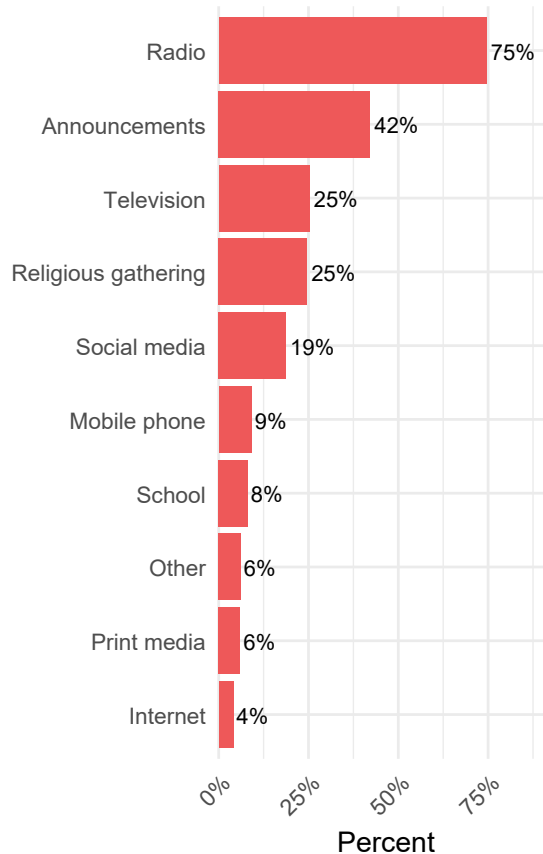
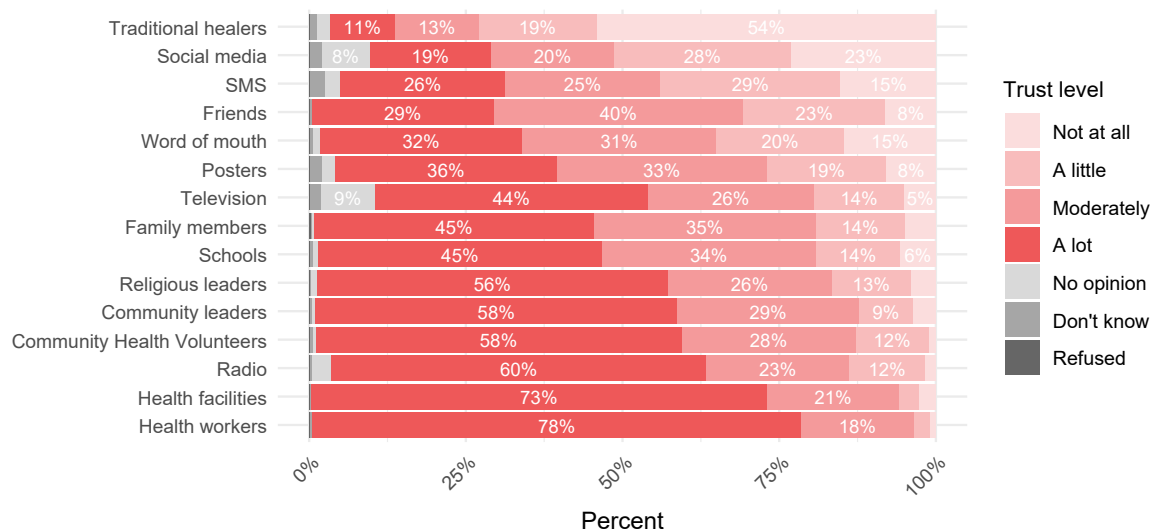


Figure 5: How much do you trust [source] for health information?



South West region

The Southwest region demonstrated a communication profile that was closely aligned with community and health-system channels. Respondents most commonly obtained health information from radio (58.0%), health workers (50.0%), and CHVs (40.8%), while digital and social media sources were used less frequently than in Kampala. This pattern is consistent with the demographic profile of the region, which is predominantly composed of refugees from the Democratic Republic of the Congo (69.5%) and where Kiswahili is the most commonly preferred language for receiving Ebola information (51.0%). These characteristics suggest that information is largely disseminated through established community networks and humanitarian health structures operating within the settlements.

Trust in formal health and community sources was also high in the Southwest, particularly for health workers (72.0%), health facilities (62.7%), CHVs (52.0%), and community leaders (50.7%). The prominence of Kiswahili-speaking Congolese refugees may help explain both the strong reliance on these channels and the comparatively high levels of Ebola awareness and concern observed elsewhere in the assessment, given the greater historical exposure of this population to Ebola-related messaging. Taken together, the findings suggest that community-based communication networks remain highly influential for refugees in the Southwest and are well positioned to support Ebola risk communication and community engagement efforts.

Knowledge on Ebola Sources, Transmission Risk, and Prevention

Respondents were asked a series of questions to assess their knowledge of Ebola transmission, prevention measures, symptoms, and appropriate response behaviours. Overall, knowledge of Ebola was generally high. Most respondents correctly identified contact with the body fluids of a person with Ebola (62.4%), shaking hands with infected individuals (53.6%), and contact with the body fluids of someone who had died from Ebola (43.8%) as routes of transmission. Respondents also commonly identified lack of information (56.8%), touching infected animals (55.2%), and caring for people with Ebola (50.0%) as important drivers of disease spread. However, some misconceptions remained. A small proportion believed Ebola could spread through the air (5.6%), while 5.0% were unable to identify any mode of transmission.

Several characteristics were associated with stronger Ebola knowledge. Awareness that Ebola is a real disease varied significantly by educational attainment ($p=0.026$) and religion ($p=0.043$). Respondents with no formal education were most likely to recognize Ebola as a real disease (73.6%), compared with those with primary education (51.1%), while Muslim respondents reported greater awareness (71.0%) than Catholics (54.4%), Evangelicals (53.7%), and Protestants (59.9%). Knowledge was also associated with trust in health information sources. Respondents who

Kampala

In Kampala, respondents reported a more diverse health information environment than in the settlement-based strata. Health workers remained an important source of information, but respondents were also substantially more likely to obtain health information through television (51.7%), Facebook (31.0%), WhatsApp (20.7%), Instagram (17.2%), and Twitter (10.3%) than respondents in the Northern or Southwest regions. This pattern is consistent with the profile of Kampala's refugee population, which is comparatively more educated, more urban, and includes a higher proportion of respondents with secondary (49.1%) and university education (10.9%) than other strata. The predominance of English speakers (69.1%) may also facilitate access to a wider range of formal, digital, and mass-media information sources.

Despite this broader information environment, trust remained concentrated in traditional and formal health sources. Health workers (61.8% trusted "a lot"), community leaders (58.2%), and health facilities (50.9%) were trusted more than social media and other digital platforms. Taken together, these findings suggest that while urban refugees in Kampala access information through a wider range of channels, they continue to rely primarily on trusted health and community actors when assessing the credibility of health information.

Northern region

In the Northern settlements, health information was obtained primarily through health workers (69.4%), radio (61.9%), CHVs (42.9%), community leaders (21.1%), and health facilities (15.2%), indicating a strong reliance on health-system and community-based communication channels. This pattern is consistent with the region's predominantly South Sudanese refugee population (95.6%), many of whom reside in settlement settings where community structures and humanitarian services play a key role in information dissemination. The region also had the highest proportion of respondents preferring to receive Ebola information in Arabic (36.1%), alongside a large proportion preferring English (41.7%), suggesting that language is likely an important factor shaping how health messages are delivered and received.

Trust in information sources was also highest in the Northern region. Large majorities reported trusting health workers (86.2%), health facilities (85.7%), CHVs (68.0%), radio (69.5%), religious leaders (67.0%), and community leaders (64.1%) "a lot". Given the lower perceived Ebola risk observed among Arabic speakers elsewhere in the assessment, these findings suggest that lower risk perceptions in parts of the Northern population may reflect differences in access to or interpretation of health messages rather than an absence of trusted communication channels. Strengthening health communication through trusted Arabic-language channels may therefore help improve awareness among groups reporting lower perceptions of risk.

reported trusting health workers “a lot” were more likely to recognize Ebola as a real disease (62.1%) than those reporting moderate (41.4%) or low trust (41.7%; $p=0.001$). Similar associations were observed for trust in CHVs (66.1%; $p<0.001$), community leaders (67.0%; $p<0.001$), radio (64.8%; $p=0.001$), television (66.1%; $p<0.001$), social media (82.4%; $p<0.001$), health facilities (64.0%; $p<0.001$), family members (70.8%; $p<0.001$), and schools (69.7%; $p<0.001$).

Knowledge of Ebola prevention was particularly strong. Nearly all respondents identified regular handwashing with soap as a preventive measure (91.8%), and handwashing was also the most commonly reported action taken to avoid infection (91.4%). Awareness of other preventive measures was lower. Fewer respondents identified avoiding contact with the body of someone who died from Ebola (39.9%), avoiding funerals of Ebola victims (24.5%), wearing gloves when caring for sick individuals (16.6%), or vaccination (6.9%) as ways to prevent infection. These findings suggest that prevention knowledge remains heavily centred on hand hygiene, while awareness of vaccination and other important preventive behaviours is comparatively limited.

Knowledge of Ebola symptoms and appropriate health-seeking behaviour was also relatively strong. The most commonly recognized symptoms were bleeding (67.6%), fever (64.3%), headaches (62.7%), and vomiting (46.9%). When asked what they would do if they developed Ebola symptoms, respondents most frequently reported that they would seek care at a public health facility (61.2%), inform authorities (46.1%), call the alert hotline (31.4%), or notify response teams (29.6%). Knowledge of appropriate actions following a suspected Ebola death was more moderate. Approximately half of respondents reported that they would avoid touching the body (51.3%) or inform authorities (51.3%), while fewer said they would notify a community leader (39.8%), call the alert hotline (37.2%), or notify a health facility (31.7%). Although unsafe responses were uncommon, these findings suggest that knowledge of case reporting and safe management of suspected Ebola deaths remains less widespread than knowledge of transmission and prevention. Together, the results highlight the continued importance of trusted health and community communication channels in reinforcing key messages on Ebola prevention, reporting, and response.

Regional differences in Ebola knowledge were evident across several indicators, although overall awareness remained relatively high in all strata. Respondents in the Kampala region generally demonstrated stronger knowledge of Ebola prevention and response measures, particularly with regard to recognizing symptoms and identifying appropriate actions if they developed Ebola, including seeking care at a public health facility and informing authorities. This pattern likely reflects the region's comparatively higher levels of education and broader access to mass media and digital information channels. In contrast, respondents in the Northern and Southwest regions, while relying more heavily on health workers, CHVs, and radio for information, demonstrated

stronger recognition of some transmission routes and prevention practices that are commonly emphasized through community-based risk communication.

Perceptions of Ebola as a real disease varied across regions, although approximately half of respondents in all regions believed that the ongoing Ebola outbreak was real. Respondents in the Kampala City were most likely to perceive the outbreak as real (60%), followed by those in the Northern (50%) and Southwest (47%) settlements, while between 12% and 21% of respondents remained unsure. Among respondents who believed the outbreak was real, the overwhelming majority correctly attributed Ebola to contact with infected animals, ranging from 63% in the Kampala City to 68% in the Northern region settlements. However, a notable minority attributed the outbreak to alternative explanations, including it being an imported disease (9–14%), foreigners (4–6%), politicians (2% in the Northern region), or profiteering motives (2% in the Northern and Southwest regions). Uncertainty regarding the causes of Ebola was particularly evident in the Kampala City, where nearly one-quarter (23%) of respondents stated they did not know the cause of the outbreak, compared with 13% in the Southwest and 6% in the Northern region. These findings suggest that while outright misinformation was relatively uncommon, important gaps remain in understanding the origins and causes of Ebola, highlighting the need for RCCE activities to continue reinforcing basic information on Ebola transmission and zoonotic origins while actively addressing misconceptions.

Notable differences were also observed in awareness that Ebola is a real disease and in perceptions of community awareness. Respondents in the Kampala City were most likely to believe that Ebola is real (60.0%), compared with those in the Northern (49.7%) and Southwest (46.9%) settlements. Similarly, respondents in the Northern region were more likely to report that most people in their community believed there was an Ebola outbreak (64.9%) than respondents in the Southwest (45.8%). Knowledge of preventive behaviours such as vaccination was highest in the Kampala City (22.0%) and lower in the Northern (4.7%) and Southwest (10.0%) region settlements. These findings suggest that while settlement populations may benefit from strong community-based communication networks, respondents in Kampala City generally had broader exposure to Ebola-related information, particularly through formal education, media, and health information channels.

Kampala

Kampala City demonstrated comparatively strong Ebola knowledge across several indicators, particularly regarding prevention and appropriate response behaviours. Respondents in Kampala were more likely than those in the Northern and Southwest regions to identify vaccination as a protective measure (22.0%, compared with 4.7% and 10.0%, respectively) and were also more likely to report having received an Ebola vaccine (24.0%, compared with 3.2% in the

Figure 6: Do you think the EVD epidemic in your community is real?

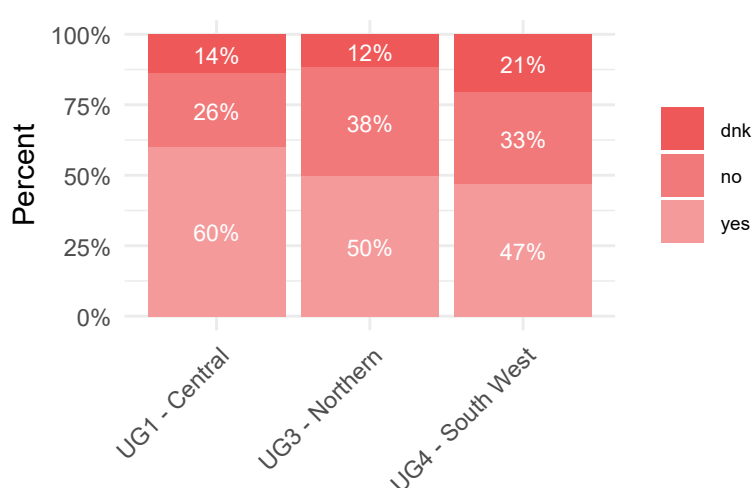
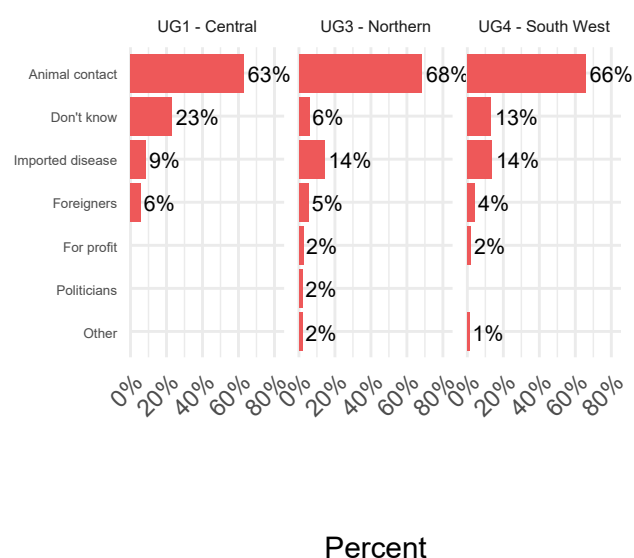


Figure 7: If you think the EVD outbreak is real, what do you think is the cause of the epidemic?



Northern region and 10.1% in the Southwest). Respondents in the Kampala region were also more likely to recognize that Ebola is a real disease (60.0%) than respondents in the Northern (49.7%) and Southwest (46.9%) regions. These patterns are consistent with the region's comparatively educated and urban refugee population, which has greater access to television, social media, formal education, and health information channels.

The broader information environment in Kampala may help explain why respondents demonstrated stronger knowledge of preventive measures and response pathways despite reporting lower perceptions of Ebola severity than in the Southwest. The predominance of English speakers (69.1%) and relatively high levels of secondary (49.1%) and university education (10.9%) likely facilitate access to a wider range of Ebola information sources, including television, schools, health facilities, and digital platforms. Taken together, these findings suggest that respondents in Kampala benefited from greater exposure to Ebola-related information and prevention messaging, contributing to comparatively strong knowledge of Ebola transmission, prevention, and response.

Northern region

The Northern region demonstrated generally good Ebola knowledge, particularly on commonly promoted transmission routes and preventive behaviours, but several indicators suggest lower overall awareness than observed in Kampala. Respondents in the Northern settlements were less likely to recognize Ebola as a real disease (49.7%) than respondents in the Kampala region (60.0%), and were more likely to report uncertainty regarding transmission, symptoms, and risk.

These patterns may partly reflect the demographic profile of the Northern population, which is predominantly South Sudanese (95.6%) and includes a large proportion of respondents preferring to receive information in Arabic (36.1%). Elsewhere in the assessment, Arabic speakers were less likely to perceive Ebola risk than speakers of English or Kiswahili, suggesting that differences in language and exposure to Ebola-related messaging may also influence knowledge levels.

South West region

The Southwest region demonstrated strong Ebola knowledge in several areas, particularly those related to transmission, symptoms, and practical prevention measures. This pattern is consistent with the demographic profile of the region, which is predominantly composed of refugees from the Democratic Republic of the Congo (69.5%) and where Kiswahili is the preferred language for receiving Ebola information for over half of respondents (51.0%). Given the greater historical exposure of Congolese refugee populations to Ebola outbreaks and Ebola-related risk communication campaigns, respondents in the Southwest may be more familiar with Ebola transmission pathways, symptoms, and protective behaviours than populations with less direct exposure to the disease.

However, as in other regions, knowledge of less frequently promoted prevention measures, including vaccination and safe management of suspected Ebola deaths, remained lower than knowledge of handwashing and basic transmission routes. These findings suggest that existing communication networks provide a strong foundation for Ebola preparedness efforts, while highlighting opportunities to reinforce more specialized prevention and response messages.

Knowledge on Practices and Prevention Measures

Respondents were asked a series of questions to assess the practices and preventive measures they had taken to avoid Ebola virus disease (EVD) and the actions they would take if they or a community member developed symptoms or died from EVD. Overall, respondents demonstrated strong knowledge of key preventive practices and appropriate care-seeking behaviours, although some gaps remained regarding less frequently promoted prevention measures.

Handwashing with soap was by far the most reported preventive practice, with 91.0% of respondents indicating that they washed their

Figure 8: Could you describe the signs that a person may have EVD?

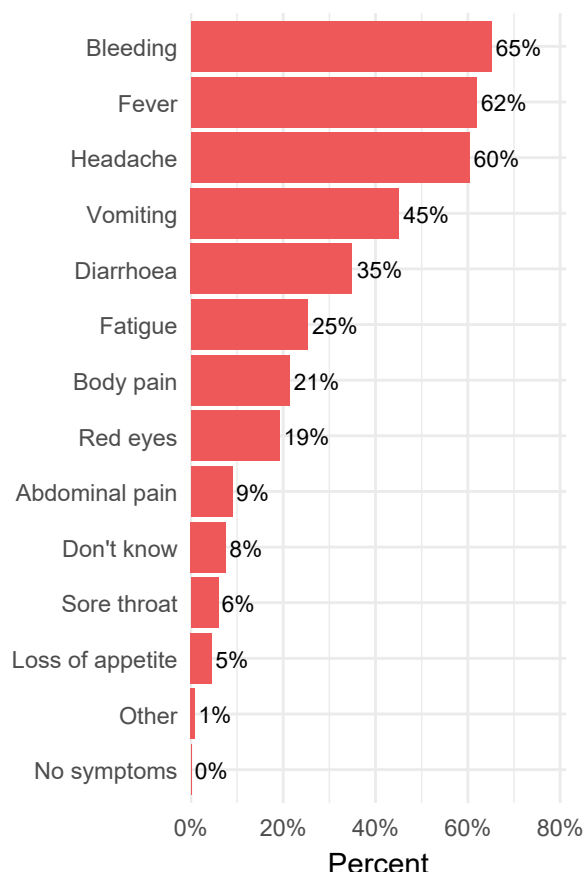
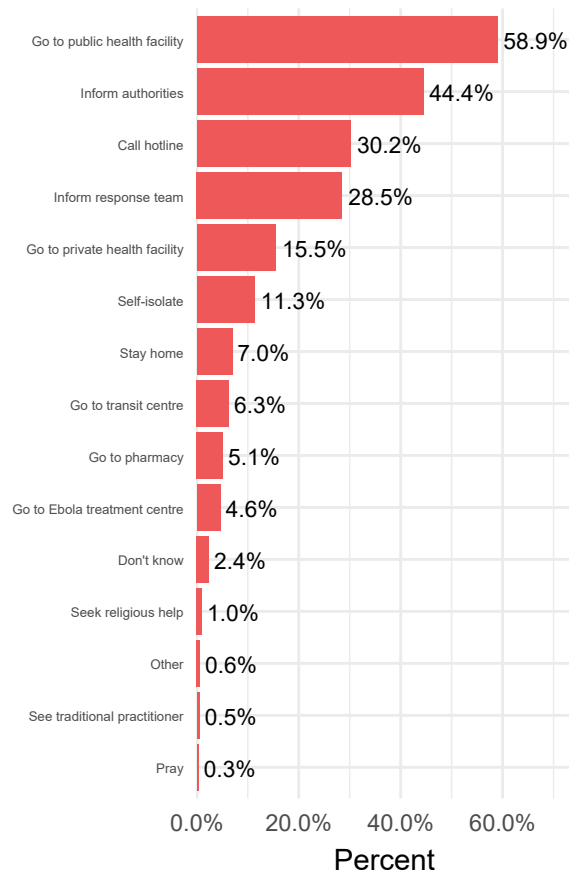


Figure 9: What would you do if you had EVD symptoms?



hands regularly to avoid EVD infection. Approximately one-third reported avoiding contact with the body of someone who had died from EVD (32.0%), while 18.0% stated that they would not attend the funeral of someone who had died from EVD. Smaller proportions reported wearing gloves when caring for a sick person (12.0%), having received the Ebola vaccine (8.0%), or worn gloves when cleaning bodily fluids (7.0%). Very few respondents reported taking no preventive action (4.0%), avoiding health facilities (2.0%), avoiding traditional healers (1.0%), or accepting household disinfection if required (3.0%).

When asked how they would respond if they developed Ebola symptoms, most respondents reported appropriate care-seeking behaviours. The majority indicated that they would go to a public health facility (61.0%), inform the authorities (46.0%), call the Ebola alert hotline (31.0%), or inform the response team (30.0%). Some respondents also reported that they would self-isolate (12.0%) while awaiting further assistance. Less appropriate responses, such as staying at home (7.0%), seeking care at a pharmacy (5.0%), or consulting a traditional practitioner (1.0%), were reported by relatively few respondents.

Similarly, respondents demonstrated good knowledge of the appropriate actions to take if a community member died from Ebola or an unknown cause. Around half reported that they would avoid touching the body (51.0%) and inform the authorities (51.0%), while 40.0% would notify a community leader, 37.0% would call the Ebola alert hotline, and 32.0% would notify a health facility. Harmful practices were rarely reported, with only 1.0% indicating that they would organise a secret funeral, and almost no respondents stating that they would tell no one or avoid raising the alarm. These findings suggest generally appropriate intended response behaviours in the event of a suspected Ebola-related death.

Response Satisfaction

Respondents were asked whether they had seen anyone from the Ebola response team in their community during the current outbreak. Overall, fewer than one-third of respondents reported having seen a member of the response team (29.7%), while most reported that they had not (67.1%) and a small proportion were unsure (3.2%). Visibility of response teams varied significantly across regions ($p < 0.001$), with respondents in the Southwest (33.8%) more likely to report having seen a response team member than those in the Kampala (28.0%) or Northern (26.2%) regions.

Respondents who had seen a response team member were then asked whether they were satisfied with the way response teams worked with community members. Among these respondents, satisfaction was generally high, 84.4% reporting that they were satisfied compared with (12.8%) who were dissatisfied and (2.8%) who were unsure. Satisfaction varied significantly by region ($p < 0.001$), income activity ($p = 0.0008$), and language group ($p = 0.0075$). Respondents engaged in own production, casual labour, government employment, and recipients of remittances reported particularly high levels of satisfaction, while Arabic speakers were more likely to express satisfaction than Kiswahili speakers. No statistically significant differences were observed by gender, age, education level, or religion.

Regional differences were evident in both response visibility and satisfaction. Respondents in the Southwest were most likely to report having seen a response team member (33.8%), followed by those in the Kampala region (28.0%) and the Northern region (26.2%). However, among respondents who had seen response teams, satisfaction was

Figure 12: Have you seen anyone from the response team in your community during the current outbreak?

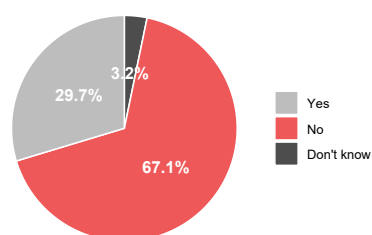


Figure 13: Are you satisfied with the way the response teams work with community members?

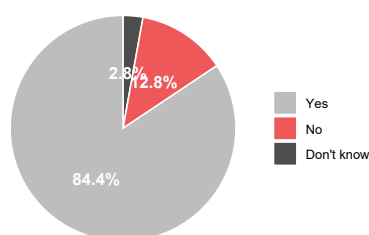


Figure 10: Could you describe the signs that a person may have EVD?

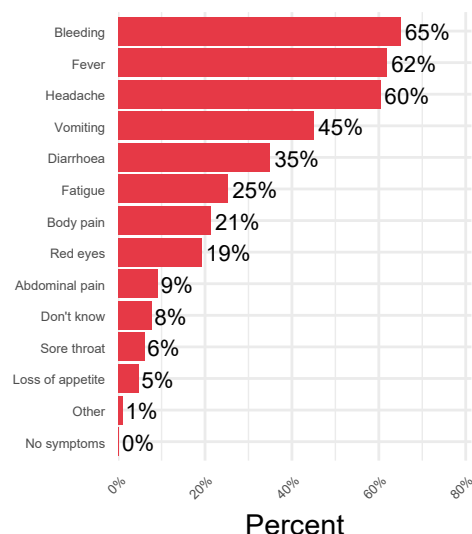


Figure 11: What would you do if you had EVD symptoms?

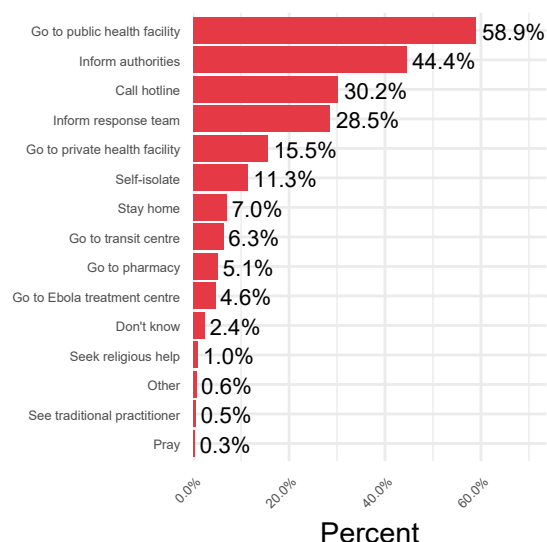
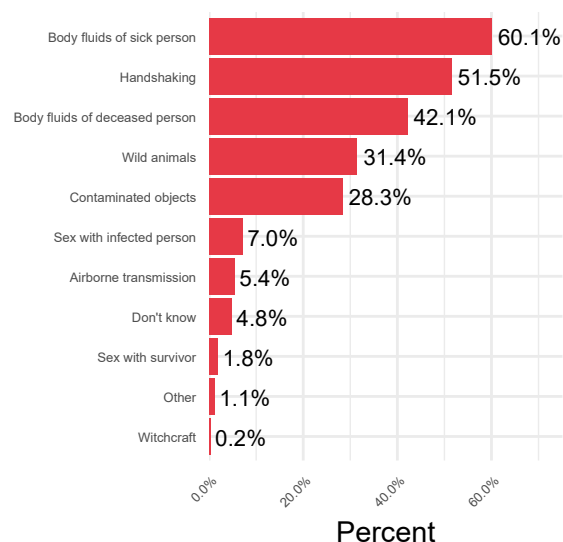


Figure 12: In your opinion, how can EVD be transmitted from person to person?



highest in the Northern region (89.3%), compared with the Kampala region (85.7%) and the Southwest (79.9%). These findings suggest that while response activities were most visible in the Southwest, respondents in the Northern settlements expressed the greatest confidence in the way response teams engaged with communities.

Conclusion

Overall, the assessment found that knowledge was strong for key Ebola prevention and response that have been widely promoted, particularly common symptoms, transmission pathways, handwashing, and appropriate care-seeking behaviours. However, important knowledge gaps remained in other areas, highlighting the need for continued and targeted RCCE efforts.

Respondents also largely relied on and trusted formal health and community-based information channels, including health workers, community health volunteers (CHVs), health facilities, community leaders, and radio. These findings suggest that existing RCCE structures provide a strong foundation for Ebola preparedness and response efforts within refugee-hosting areas.

Despite relatively high levels of awareness, the findings highlight important gaps that may undermine effective prevention and response. Perceived personal risk remained moderate across all regions, with lower levels of concern among women, respondents with lower educational attainment, Arabic-speaking populations, and households with limited livelihood engagement. In addition, knowledge was heavily concentrated on handwashing, while awareness of vaccination, alert hotlines, safe management of suspected Ebola deaths, and other prevention measures was comparatively limited. The assessment also identified persistent uncertainty regarding the causes of Ebola and whether the outbreak was real among some respondents, indicating a continued need for targeted risk communication and myth-busting activities.

The findings underscore the importance of maintaining and strengthening community engagement efforts that are tailored to different refugee populations and linguistic groups. RCCE strategies should prioritize trusted interpersonal communication channels, reinforce messages on personal vulnerability, case reporting, vaccination, and safe burial practices, and ensure that information is available in locally relevant languages and formats. By addressing remaining knowledge gaps and strengthening risk perception among lower-awareness groups, response actors can improve preparedness and reduce the risk of Ebola transmission among refugee communities in Uganda.

Table 3: What steps have you taken to avoid being infected with EVD?

Response	%
I wash my hands regularly with soap	91%
I avoid touching the body of someone who has died from EVD	32%
I would not attend the funeral of someone who has died from EVD	18%
I wear gloves when caring for or touching a sick person	12%
I have received the EVD vaccine	8%
I wear gloves when cleaning vomit or other bodily fluids	7%
Nothing – No action needed	4%
I would accept the disinfection of my house if needed	3%
I avoid going to clinics, health centers, or hospitals	2%
I avoid consulting traditional healers	1%
I use a condom when having sex with someone infected with EVD	0%
I use a condom when having sex with an EVD survivor	0%
Other (specify)	10%
I don't know	2%
Refuse to answer	0%

Table 4: What would you do if you had EVD symptoms?

What steps have you taken to avoid being infected with EVD?	%
Go to a public health centre	61%
Inform the authorities	46%
Call the alert hotline	31%
Inform the response team	30%
Go to a private health facility	16%
Self-isolate	12%
Stay at home	7%
Go to a transit centre	7%
Go to an ETC/CTE (Ebola Treatment Centre)	5%
Go to a pharmacy	5%
Consult a traditional practitioner	1%
Seek support from a religious leader	1%
Continue normal activities	0%
Pray	0%
Other (specify)	1%

Notes de bas de page

1. UNHCR Operational Data Portal. Uganda. Last Updated 30 June 2026.
2. The Ministry of Public Health, Hygiene and Social Welfare, DRC, officially declares the 17th Ebola Disease outbreak. <https://administration.sante.gouv.cd/wp-content/uploads/2026/05/Declaration-de-la-17e-Epidemie-de-la-maladie-a-virus-Ebola-dans-les-zones-de-sante-de-Rwampara-Mongwalu-et-Bunia-dans-la-province-dlturi.pdf>
3. Sitrep Ebola. 17e Épidémie de la Maladie à Virus EBOLA/RDC. SitRep No 065/MVB 18/07/2026. https://insp.cd/sitrep-n065-mvb_18-07-2026/
4. Ebola Updates. The Republic of Uganda Ministry of Health. As of Monday 20 July 2026. <https://evd-daily.health.go.ug/>
5. Uganda-DRC Cross-Border Dynamics. Social Science in Humanitarian Action Platform (SSHAP). 2018. <https://www.socialscienceinaction.org/resources/uganda-drc-cross-border-dynamics/>