Community Structures Strengthen Response During an Ebola Outbreak: A case Study of the Jinja Outbreak in December 2022

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Uganda's fifth ebolavirus disease (EVD) outbreak highlighted areas of concern and left about 142 people infected by 12th November 2022. Community engagement proved to be a pivotal pillar for all standard interventions. Village task force teams (VHTs) were an excellent resource for strengthening case management and enabling swift laboratory services.

Despite the swift response, the community engagement sub-pillar had been unsupported three weeks into the Jinja response; this limited access to the community caused several spill-over effects. First, there needed to be more community-based alerts and contact tracing, which could not happen mainly because of the broken link between the district response task force and the village task forces.

Consequently, community members were hesitant to receive the widely shared mass communication because they needed help relating with the experts hosted. Some community members even perceived these experts as government adversaries with a hidden agenda. Suspected virus victims sought the care of traditional herbalists, potentially risking widespread transmission of this highly infectious disease.

The Infectious disease Institute (IDI), which has grown its capacity and experience in implementing national-level projects to prevent, detect, and respond to outbreak and epidemic threats, was contacted to bridge this gap. With funding from the US Centres for Disease Control and Prevention (CDC), IDI collaborated with the Ministry of Health to support district efforts to map and mobilize available community task forces members at the Village, Parish, and sub-county levels, to strengthen community response structures. IDI also prioritized the village-level dissemination of available risk communication materials during field engagements.

The team mapped a village task force of seven to include the Local Council 1 (LC) chairperson, 2 VHTs, a youth leader, a persons-with-disabilities (PWDs) representative, a religious leader, and a women leader. The five sub-counties targeted had 210 villages clustered into 26 parishes. The parish targeted three members; the LC2 chairperson, parish chief, and health assistant, and the sub-county taskforce comprised eight members; LC3 chairperson, Health Centre (HC)III in-charge, Gombolola Internal Security Officer (GISO), health inspector, chairperson PWD, Area Police Officer In-charge, Community Development Officer (CDO), Health Information Assistant. In total, the team identified and mobilized 1470, 78, and 49 individuals to their sub-county headquarters for an engagement at village, parish, and sub-county levels, respectively.

These engagements were brief, about 2 hours, and conducted in small groups to allow those available to conclude and leave, a lesson learned from previous limitations of gathering large numbers of community members in one location for a long time. In addition, the orientation of individuals on the updated EVD Case definition, linkage mechanisms, and alert guidelines took place. Finally, the team put additional effort into defining roles and responsibilities along the community structure with unidirectional information flow from the district task force through the Sub- County and Parish taskforces to the Villages and back up the chain.

An IDI staff member assisting a participant in interpreting the job aid during a village-level training in the Busede sub-county on 7th December 2022.

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A trained health assistant facilitating one of the community training sessions in the Busede sub-county on 7th December 2022.

By the end of the activity, 1264 of 1470 (86%) village task force members were competent in supporting the response, 102 (131%) of the 78 engaged at the Parish level, and 24 of 40 (60%) at the sub-county level. In addition, in the event of a future outbreak, all these individuals are recorded in a database to enable recall.

For example, in Jinja, the task forces have strengthened community-based surveillance. The VHTs moved house-to-house daily in their respective villages. They collected data and sent it to the parish VHT coordinators, who then passed on the information to the sub-county supervisor and the health assistant.

The health assistants then sent the data from the respective sub-counties to the supervisor (Subcounty Task Force), which then was sent to the coordination Centre (CBDS sub-pillar head) daily.

As a result, after the training in one week, CBDS increased the proportion of households visited from 1.9% to 19%.

The graph above shows a gradual rise in the proportion of households visited from 1.9 to 19% in one week.
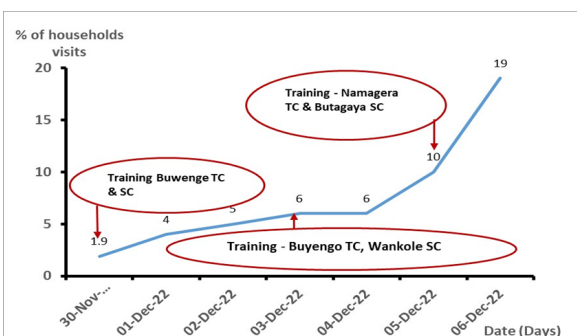
The model made entering to hard-to-reach and hostile communities easier. For example, in Kayarwe B, a contact and son to case C161, who presented with signs and symptoms, escaped and went into hiding for three days.

Despite the support of the district leadership, efforts to find him were unsuccessful. However, with the community counsellor and chairperson's engagement, the response team was able to see him the following day. Lastly, the model has been a route to understanding the non-biomedical orientation of the communities.

CLOCKWISE: 1. The Jinja assistant Resident District Commissioner thanking IDI for extending its support to the village.
2. A Task force member facilitating a session.
3. One of the participants registering for the activity.
4 A participant using one of the job aids provided with support from UNICEF and disseminated by IDI during a training session in Buwenge Sub-County Jinja district on 8th December 2022

CLOCKWISE: In 1 and 2, IDI staff supporting Engagements in Buwenge Town Council, while in 3 & 4, Technical leads from the Ministry of Health and Jinja District Heath Team, respectively, support the same activity on 5th Dec 2022.

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