POSITION PAPER FOR SOCIAL AND BEHAVIOR CHANGE IN THE 2026 EBOLA RESPONSE

STRATEGIC ACTION BLUEPRINT

Issued By: African Society for Social and Behavior Change (AS-SBC)

Target Region: Eastern Africa & Great Lakes Region (Uganda & DRC)

Date of Issue: May 2026

Classification: Public Health Policy / Emergency Response

POSITION PAPER FOR SOCIAL AND BEHAVIOR CHANGE IN THE 2026 EBOLA RESPONSE

ISSUED BY: AFRICAN SOCIETY FOR SOCIAL AND BEHAVIOR CHANGE (AS-SBC) | MAY 2026

PREAMBLE

The African Society for Social and Behavior Change (AS-SBC) is a professional association of Social and Behavior Change (SBC) practitioners, researchers, communication specialists, behavioural scientists, community engagement experts, programme designers, policymakers, and development partners working across the African continent. With membership spanning more than 30 countries and multiple national chapters, AS-SBC represents a substantial institutional footprint in public health SBC practice across Africa.

Our members have supported the containment of Ebola, COVID-19, Marburg virus disease, Mpox, yellow fever, Lassa fever, cholera, polio, malaria, and other public health threats, including the 2014–2016 West Africa Ebola epidemic, the 2018-2020 and earlier DRC outbreaks, and Uganda's 2022 Sudan Virus Disease (SUDV) outbreak in Mubende, Kassanda, and Kampala. Collectively, we bring decades of experience designing, implementing, evaluating, and strengthening evidence-based public health SBC interventions that place communities at the centre of outbreak, epidemic, and pandemic response.

This position paper reflects the collective voice of AS-SBC members regarding the critical role of Social and Behavior Change in the current Ebola response. It outlines the behavioural and social realities shaping the outbreak, presents key principles that should guide response efforts, and provides recommendations to governments, donors, international agencies, and implementing partners on how SBC can be effectively integrated, resourced, and coordinated.

> ***Core Affirmation:*** *AS-SBC recognises Risk Communication and Community Engagement (RCCE) as a critical pillar of public health emergency preparedness and response. We further affirm that Social and Behavior Change provides the behavioural science foundation that strengthens and complements RCCE efforts by helping responders understand the factors that influence behaviour, design interventions that address those factors, and sustain protective practices over time.*

As African practitioners working within the communities most affected by this outbreak, we issue this statement not as external observers but as professionals with lived experience, contextual knowledge, and deep understanding of the cultural, social, political, and communication environments in which this response is unfolding. We believe that ending this outbreak will require more than medical expertise. It will require trust, dialogue, empathy, partnership, and collective action. These are the domains in which Social and Behavior Change contributes its greatest value.

BACKGROUND

On 17 May 2026, the World Health Organization declared the Ebola outbreak caused by the Bundibugyo virus in Uganda and the Democratic Republic of Congo a Public Health Emergency of International Concern. In the DRC, this is the seventeenth recorded Ebola outbreak; in Uganda, it is the ninth. As of the date of this paper, the DRC has recorded the majority of confirmed and suspected cases, while Uganda has confirmed a smaller but significant cluster with cases extending into Kampala. Both countries are experiencing active transmission, and the audience for this paper is the response leadership and partners operating in both contexts.

The Bundibugyo virus disease (BVD) outbreak presents unique challenges. The Bundibugyo strain belongs to the Filovirus family and, unlike some previous Ebola strains, has no licensed vaccine or widely approved therapeutic. Candidate vaccines and treatments are under active investigation, and the paper uses the formulation “limited availability of licensed biomedical countermeasures” to remain accurate as the evidence base evolves. Beyond the absence of vaccines, this outbreak is unfolding in a context of multiple compounding challenges:

- **Armed conflict and population displacement** in eastern DRC, severely constraining health facility access and community movement.
- **Deep community distrust** of external health actors, rooted in past experience and compounded by misinformation disseminated by armed groups.
- **Overextended health infrastructure** unable to absorb the additional burden of isolation and treatment facilities.
- **Cross-border population mobility** between Uganda and DRC, with communities that live, work, and trade across the border, making purely national containment strategies insufficient.
- **Uganda’s precautionary temporary closure** of its border with DRC, which, while a legitimate public health measure, exacerbates the socioeconomic vulnerabilities of border communities.

Evidence from West Africa (2014-2016), eastern DRC (2018-2020), and Uganda’s own 2022 SUDV outbreak consistently demonstrates that mistrust, unsafe burial practices, delayed care-seeking, and resistance to response teams contributed substantially to transmission dynamics. Uganda’s 2022 experience offers important lessons in rapid community engagement, survivor involvement, and culturally grounded communication that should directly inform the current response.

Consequently, the trajectory of this outbreak will be shaped not only by clinical and epidemiological interventions but by the behaviours, decisions, relationships, and social dynamics that influence how communities perceive risk, seek care, cooperate with response measures, and support one another in treatment centres and laboratories, but also in households, places of worship, markets, schools, and social networks. Community trust, social norms, leadership structures, communication systems, and collective action often determine whether response efforts succeed or fail.

THE SOCIAL-BEHAVIORAL LANDSCAPE OF THIS OUTBREAK

The Bundibugyo strain presents a response environment shaped by several interlocking behavioural realities that must be understood before any effective SBC strategy can be designed. This section analyses those realities and the factors driving them.

2.1 Limited biomedical countermeasures amplify behavioural risk

With no licensed vaccine and no approved treatment for the Bundibugyo strain, the outbreak removes the safety net that shaped community and health worker behaviour in more recent responses. Fear is heightened, cooperation is harder to earn, and communities cannot be asked to comply with interventions that offer no guaranteed protective benefit beyond isolation and care. Importantly, this also raises the urgency of early presentation for supportive care—an outcome that can only be achieved through high levels of community trust built through participatory engagement and honest dialogue. This demands SBC approaches rooted in genuine dialogue, agency-building, and community ownership—not directive messaging. If and when investigational vaccines or therapeutics enter deployment, SBC will equally be required to address hesitancy, rumour, and misinformation that may compromise acceptance.

2.2 Impact of social-cultural norms and practices

When public health interventions clash with deeply held social, cultural, and religious practices—communal caregiving, the washing and touching of the deceased as expressions of love and mourning, vigils, prayers, and elaborate burial rituals—without sustained awareness and engagement, resistance follows. This resistance is not ignorance; it is a rational response to interventions that feel disrespectful or coercive. In some contexts, it has taken violent forms. Failure to engage social norm gatekeepers at cultural, political, social, and economic levels will deepen this resistance. Such engagement must in many cases precede biomedical interventions as an epidemic de-escalation measure.

2.3 Burial practices and cultural obligations carry extreme transmission risk

In the communities most affected by this outbreak, death is a communal event. Washing, touching, and mourning the body of the deceased are not peripheral customs; they are expressions of love, respect, and spiritual duty. Evidence from Sierra Leone, Liberia, eastern DRC, and Uganda demonstrates that burial-related transmission has been among the most significant drivers of spread when communities resist external protocols. Demanding that families surrender their dead without negotiation or cultural accommodation guarantees resistance. Safe and Dignified Burials, done well, acknowledge this reality and create a culturally grounded alternative—demonstrating through SBC practice that safety and dignity are compatible. Done badly, they become a source of community alienation that drives the outbreak further underground. Anthropological expertise must be integrated into safe burial programme design.

2.4 Delayed care-seeking is a primary driver of spread

The interval between symptom onset and arrival at an Ebola Treatment Unit is among the most consequential variables in outbreak trajectory. Fear of isolation, stigma attached to Ebola diagnosis, distrust of health facilities, misinformation about treatment unit conditions, and economic barriers—including transport costs,

fear of income loss, and livelihood disruption as well as psychosocial costs—all delay the moment people present for care. Every day of delay means more household and community contacts exposed. Reducing this interval requires SBC work, not clinical infrastructure alone.

2.5 Misinformation is a co-epidemic

The information environment in which this outbreak is spreading is characterized by active misinformation: claims that Ebola is fabricated by governments or international organisations, that treatment units are places of death rather than care, and that traditional remedies offer protection. With mobile phone penetration exceeding 70% in Uganda and significant access in DRC's urban centres, and with platforms including WhatsApp, TikTok, Facebook, and X amplifying misinformation algorithmically, false narratives reach communities faster than health messages. Critically, misinformation is not only a communication problem, it is a diagnostic signal. It indicates that existing communication is perceived as untrustworthy or insufficient. Monitoring and counter-response processes must therefore include a diagnostic function: identifying the underlying community concerns, grievances, and information needs that give rise to rumours in the first place. Addressing misinformation demands real-time monitoring, rapid-response communication, and deep community trust, none of which can be purchased with a budget line for leaflet production.

2.6 Gaps in community feedback, knowledge, and scientific communication

In every outbreak, communities sustain ongoing information and knowledge gaps that, if not systematically addressed, erode trust and fuel rumour. A cross-sectoral scientific communication team, one with the mandate, resources, and trusted authority to respond to community feedback, answer knowledge gaps, and counter misinformation in real time is an essential response structure. This team should operate with community feedback mechanisms as its primary inputs, and its outputs should be timely, accessible, and culturally credible.

2.7 Stigma threatens both individuals and the response system

Ebola-related stigma against survivors, their families, and affected communities drives concealment, discourages care-seeking, disrupts contact tracing, and creates lasting social fractures that outlast the outbreak itself. Long-term consequences for survivors include barriers to employment, education, marriage, and social inclusion. Survivor support must be built into the response system from day one, with SBC and biomedical responses operating together. Stigma is a behavioural and social phenomenon that SBC interventions are specifically equipped to address through community dialogue, survivor engagement, and norms-shifting communication that repositions Ebola survivors as community assets rather than dangers.

2.8 Community trust is non-negotiable and cannot be assumed

The communities most affected by this outbreak carry histories with disease, with international organisations, and with government health systems that shape how they receive and respond to information. Trust is the prerequisite for cooperation. It is not a soft concern but the hard substrate on which every other intervention depends. SBC includes a diagnostic process for identifying who the trusted communicators are—community leaders, religious leaders, women's groups, youth, and others—and which channels can be mobilised. Trust is built through sustained presence, honest communication, cultural respect, and the tangible demonstration that

the response serves community interests, not only institutional ones. Where trust concerns are raised and left unaddressed, trust declines further, creating negative feedback loops that accelerate transmission.

2.9 Leadership communication and public trust

For a response to succeed, leaders must model the desired behaviour. Failure to comply with the measures they publicly advocate—whether in use of protective equipment, avoidance of gatherings, or communication of honest and timely information—erodes public trust and undermines SBC messaging. Leadership communication must therefore be treated as a component of SBC programming, with consistent messaging, visible role modelling, and mechanisms for accountability.

RISK ASSESSMENT: BEYOND PUBLIC HEALTH TO SOCIOECONOMIC IMPACTS

A comprehensive risk assessment of this outbreak must move beyond immediate public health threats to include socioeconomic risks affecting the whole of society. Containment measures for zoonotic diseases such as Ebola carry socioeconomic implications that, if left unaddressed, generate resistance, negative publicity, and eroded trust in the response. A One Health approach to impact assessment is therefore critical, convening all affected sectors—such as health, agriculture, environment, wildlife, tourism, education, gender, and information and communication—to jointly assess the impact of control measures and their potential risks to society. This cross-sectoral collaboration minimises the emergence of socioeconomic harms arising from public health control measures, and positions the response as a whole-of-society effort rather than a biomedical intervention imposed on communities. Behavioural factors in this outbreak also extend to One Health dimensions: wildlife interaction patterns, animal handling practices, and zoonotic risk perception all influence transmission risk and warrant inclusion in SBC strategy. Cross-border population dynamics between Uganda and DRC represent a further dimension of risk that national-level response strategies alone cannot address.

WHAT EFFECTIVE SBC IN THIS RESPONSE REQUIRES

4.1 SBC must begin with listening, co-design, and community dialogue and not messaging

Effective SBC is not the broadcast of health messages. It begins with rigorous, real-time understanding of community knowledge, attitudes, practices, fears, and social norms, and recognises that communities are not homogenous. Different ethnic groups, languages, contexts, levels of exposure, genders, and age groups require tailored, contextually matched approaches. SBC ensures this variation is understood and addressed. Formative research including rapid community assessments, social listening, community dialogue, and participatory action approaches in which communities reflect on the problem and co-design solutions must be treated as a non-negotiable first step, not a luxury to be deferred when urgency mounts. These methods are not only diagnostic; they generate community-level insights into how meaning is made around an epidemic and how communities resolve their own circumstances. They operate at a fundamentally different level from biomedical communication, enabling humanistic and communal values to emerge, and supporting

conversations about how people can help and support each other, not only what individuals should do. SBC strategies designed without this foundation will miss the actual behavioural barriers driving the outbreak. We call on all actors in this response to resource formative research, social listening, and community feedback mechanisms as frontline activities from day one, and to integrate these into Incident Management Systems, RCCE pillars, and One Health structures. Failure to inform and engage communities on behavioural risks and desired preventive measures lowers risk perception and escalates infections.

4.2 Community engagement should move beyond approaches focused primarily on compliance

Communities are not passive recipients of Ebola response protocols. They are active agents whose cooperation, leadership, and creativity are essential to ending an outbreak. Approaches that treat communities as problems to be managed or populations to be made compliant will fail and, in failing, will waste the critical window of opportunity that the early weeks of response provide. Communities should not be blamed or regarded as ignorant if their responses do not align with expectations, this is the task of the communicators. Genuine community engagement means involving community leaders, women's groups, religious leaders, youth networks, community-based organisations, and survivors in the design and implementation of the response—not as messengers for predetermined protocols, but as co-designers of the strategies themselves. It means creating feedback mechanisms through which communities can raise concerns, report misinformation, and hold the response accountable. AS-SBC is cross-cutting in its mandate and can serve as a bridge between biomedical response structures and the communities they serve. We call on governments and implementing partners to structurally integrate community co-design into SBC programme architecture, with adequate time, resources, and genuine decision-making authority given to community structures.

4.3 Safe and dignified burials must be designed with communities, not for them

Safe and Dignified Burial is among the highest-impact SBC interventions in an Ebola response. But the 'dignified' element is not a modifier; it is a prerequisite for the 'safe' element to function. Burial protocols that ignore, override, or fail to adapt to local cultural, religious, and family practices will drive concealed deaths and unsafe home burials, dramatically increasing transmission. We call for safe and dignified burial strategies to be developed through direct dialogue with community and religious leaders in each affected locality, with SBC practitioners and anthropological expertise leading the cultural adaptation process. SBC should also actively share and document examples of how this has been done well across past outbreaks.

4.4 Misinformation must be addressed as a primary programme component

Misinformation in this outbreak is not background noise. It is an active driver of behaviours that spread the virus. Addressing it requires dedicated resources, real-time social media and community monitoring, rapid-response communication capacity, and close coordination between SBC teams, digital platforms, and community networks. The operational architecture for this must include: monitoring systems with defined escalation pathways and rapid response protocols; a diagnostic function to identify underlying community concerns; and a 'research panel' model using key informants with mobile phones in specific locations, an approach that does not require communication teams to enter high-incidence areas and can be formally resourced. Counter-narrative capacity alone is insufficient; the system must include diagnostic capacity to

understand what concerns and grievances give rise to misinformation in the first place. We call on donors and implementing partners to fund dedicated misinformation monitoring and response capacity as a core SBC programme component from the first days of the response, not an add-on, with the agility to respond within hours, not weeks.

4.5 Health worker communication capacity must be strengthened

Frontline health workers are the face of the response for most affected communities. Their ability to communicate with empathy, clarity, and cultural competence directly shapes whether people seek care, cooperate with contact tracing, and trust the response. However, health workers' primary mandate is the delivery of care; the pressure of complex community communication should not fall on them alone when skilled SBC practitioners and cadres within AS-SBC are available to fulfil this function. Critically, health workers must also be treated as an audience in their own right. What are their fears, information needs, and communication barriers? SBC support for health workers should include: communication skills and cultural competence training; stigma reduction; community trust-building; and psychosocial support for workers themselves. AS-SBC members can serve as mentors for local-level communicators and provide structured guidance for health workers operating in affected communities.

4.6 SBC must be coordinated across actors and co-led from within the region

A persistent failure in Ebola responses is the fragmentation of SBC efforts across dozens of organisations, resulting in contradictory messages, duplicated work, and community confusion. Coordination is not optional. A designated SBC coordination mechanism with clear technical leadership, shared monitoring systems, and rapid learning loops is essential, integrated with Incident Management Systems and RCCE coordination pillars. Critically, that coordination should include African SBC institutions as technical co-leads alongside international partners. African institutions bring trust, contextual knowledge, and speed of cultural navigation that are structural advantages, not supplementary qualities. They are also better positioned to ground the response in community insights into how meaning is made around an epidemic, correcting a persistent tendency to foreground biomedical and individualised communication at the expense of community-centred approaches. We propose the framing: "African institutions should be prioritised as technical co-leads alongside international partners" as the operational standard for this response.

SPECIFIC RECOMMENDATIONS

AS-SBC makes the following specific, operationally grounded recommendations to governments, donors, implementing partners, and international bodies coordinating the 2026 Ebola response.

Success Indicators Hierarchy

1. Reduced symptom-to-isolation intervals.
2. Improved community trust scores.
3. Increased reporting rates.
4. Reduced misinformation prevalence.
5. Improved contact tracing compliance.

Action Matrix by Stakeholder Category

Target Audience	Core Operational Requirements
Governments (Uganda & DRC)	• Formally recognise SBC as a strategic cross-cutting pillar within national frameworks, ensuring dedicated budget allocations, clear leadership structures, and Incident Management System inclusion. • Establish/strengthen district and national SBC coordination mechanisms with local civil society and AS-SBC country chapters. • Establish closed-loop community feedback systems capable of responding to concerns within clearly defined timelines. • Protect and engage Ebola survivors as community assets in communication strategy and long-term reintegration. • Convene a One Health cross-sectoral coordination mechanism to assess and mitigate socioeconomic impacts.
International Donors & Funders	• Allocate funding proportionate to behavioural drivers (at least 15–20% of total outbreak response budgets). • Direct a substantial proportion of funding directly to Africa-based organisations as primary technical partners with strategic authority. • Fund real-time social listening, formative research, and misinformation monitoring as frontline budget items from day one. • Support the medium-term development of an Africa-led, open-access SBC knowledge platform for continental learning.
WHO, UNICEF, Africa CDC	• Ensure country-level coordination mechanisms include African professional associations and civil society as technical co-leads. • Develop globally standardised but locally adaptable SBC frameworks for Ebola response in genuine regional partnership. • Invest in long-term capacity strengthening of national SBC workforces across DRC, Uganda, and neighbours for epidemic preparedness.
Implementing Partners	• Partner with African SBC institutions and CBOs from inception for practitioner placement, design, and quality assurance. • Adopt adaptive, agile programme management allowing strategies to evolve based on field data over rigid fixed campaigns. • Share SBC learning, failures, and field adjustments transparently and rapidly across response practitioner channels.

CONCLUSION

The success or failure of this response will not be determined solely in laboratories, treatment centres, surveillance units, or coordination meetings. It will be determined in homes, markets, schools, places of worship, and communities where people make decisions every day about whether to seek care, report

symptoms, cooperate with contact tracing, support survivors, and adopt behaviours that protect themselves and others.

AS-SBC therefore calls on governments, donors, international agencies, research institutions, and implementing partners to place SBC at the centre of the Ebola response, invest in existing African expertise and institutions, and prioritise active community engagement, co-design, adaptation, and continuous feedback over one-directional messaging. Communities are not the last mile of the response; they are the first line of defense. The lessons from every major Ebola outbreak are clear: investing in SBC is not a complementary activity, it is a core outbreak control strategy. Communities must be recognised not as beneficiaries of the response, but as essential partners in ending the outbreak.

Issued by: African Society for Social and Behavior Change (AS-SBC)
Date: May 2026

Contact: info@as-sbc.org
Document Reference: AS-SBC-EBO-2026-V1