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Evidence Review

CULTURALLY GROUNDED EBOLA RESPONSE

Integrated literature review for the response to Bundibugyo Virus Disease in the DRC and Uganda

2026

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KEY MESSAGES

This review synthesises the social science evidence that underpins a culturally grounded response to Bundibugyo virus disease (BVD) in the Democratic Republic of the Congo (DRC) and Uganda. It is the evidence companion to the Field Guide, which contains the operational tools.

1) Ebola infection occurs through contact with infectious body fluids, but exposure occurs through caregiving, burial, work, health care seeking, mobility, worship, schooling, and material conditions. Biomedical, social epidemiological, and One Health inquiries are part of a biosocial logic.

2) Culture is both a resource and a constraint in Ebola Response. Communities hold multiple explanatory models simultaneously. Some Indigenous epidemic-control practices align with biomedical control while others don't (Hewlett & Amola, 2003).

3) Trust is not just a communication concern. It is shaped by state presence, service delivery, prior epidemics, alignment of leadership words and actions, and governance. Low institutional trust is directly associated with reduced adoption of preventive behaviour (Vinck et al., 2019, Natifu & Bwambale, 2025).

4) Response practices may generate mistrust. Militarised operations, coercive enforcement, and non-negotiated burials drive concealment rather than cooperation (Sweet et al., 2024; Mayhew et al., 2021). This dynamic has been documented in Ituri, where over 60 security incidents against the response were recorded within six weeks of the outbreak's escalation (Mercy Corps, cited in Physicians for Human Rights, 2026).

5) Feasibility comes before compliance. A technically correct measure may fail if people lack water, soap, food, transport, income, privacy, childcare, or access to communication needed to follow a specific requirement. Feasibility barriers are outbreak-control problems, not just community-relations problems (Schmidt-Sane et al., 2020).

6) Stigma is an epidemic concern. It suppresses symptom reporting, delays care-seeking, and worsens workforce shortages (Paterson et al., 2025).

7) Social evidence only works when it has recognised operational authority. The recurring failure across Ebola responses is not the absence of social data but the absence of a mechanism that converts it into authoritative changes in practice.

8) By late July 2026, the Ebola outbreak in the DRC had become one of the largest. It occurred during an active conflict, a mass displacement crisis, and a collapsing protection system. It confirms that Ebola control in this setting cannot be separated from conflict, displacement, and gender-based violence response.

This document was developed by Warren Parker and Barbra Natifu of AS-SBC. With thanks to Lilian Kamanzi Mugisha and Leonard Bufumbo for comments. This resource is based on lessons learned across epidemic and pandemic responses. The main approach is to integrate biomedical and social understandings of epidemic epidemiology and to recognise biomedical and sociocultural response systems in an integrated way. The document draws on various literature to inform this analysis, including lessons from previous Ebola epidemic responses and emerging lessons from the 2026 epidemic.

1. PURPOSE, AUDIENCE, AND RELATIONSHIP TO THE FIELD GUIDE

This document has three functions.

It is written for people who will benefit from lessons learned from Ebola Virus Disease (EVD) responses: national and subnational response leads, Risk Communication and Community Engagement (RCCE) and social science teams, Ministry of Health and Ministry of Education planners, One Health actors, humanitarian and civil society partners, academic and operational researchers, donors, and those designing training or conducting after-action reviews.

Teams working in the field during an active outbreak should use the Field Guide. This volume supports understanding of the decisions behind it. It does not replace the technical guidance from the Ministry of Health, WHO, or Africa Centres for Disease Control and Prevention (Africa CDC). It sits alongside response plans, Standard Operating Procedures, clinical and Infection Prevention and Control (IPC) guidance, surveillance protocols, and safe and dignified burial procedures. It addresses the social, political, economic, and practical conditions that determine whether those measures are trusted, feasible, equitable, and effective.

The document does not attribute difficulties to any institution, sector, community, or country. Community concerns, rumours, refusals, delays, and hostility are treated as operational indicators of trust, fear, feasibility, and unmet need. Technical and logistical constraints are treated as response conditions requiring coordination, rather than as individual failures.

2. APPROACH AND EVIDENCE BASE

2.1 What was reviewed

This review draws on four kinds of literature. Peer-reviewed social science and medical anthropology of filovirus outbreaks in Central, East, and West Africa; operational and grey literature from the Social Science in Humanitarian Action Platform (SSHAP), UNICEF, Institute of Development Studies (IDS), Anthrologica, and Médecins Sans Frontières (MSF); current situation reporting from WHO, WHO Regional Office for Africa (WHO AFRO), and national ministries on the 2026 BVD outbreak; and national policy instruments issued during the current response, including Uganda's Ministry of Health Standard Operating Procedures (SOPs) and Ministry of Education and Sports Circulars.

Sources were selected for relevance to the specific decisions the response must make on how illness is interpreted, where people seek care, how the dead are handled, who holds legitimate authority, how movement and livelihoods interact with control measures, and how response practice produces or erodes trust. It is a synthesis rather than a systematic review.

2.2 The evidence and its relevance

The most important limitation is that the evidence base is not about Bundibugyo virus. It is about the Ebola response. Table 1 outlines evidence sources, what they support and limitations for lessons learned.

Table 1: Evidence sources, support learning, and limitations

Evidence source	What it supports	Limits for lessons learned
Uganda 2000–01, Gulu (Hewlett & Amola, 2003)	Explanatory models; culture as resource; indigenous containment practices	Sudan virus, single ethnic setting (Acholi), 25 years old. The analytic claim is relevant; the ethnographic detail is dated.
West Africa 2014–16 (Lee-Kwan et al., 2017; Abramowitz et al., 2015; James et al., 2019)	Burial acceptance and refusal; urban community response; survivor stigma	Very different state, epidemic scale, and response architecture. Mechanisms are robust; specific adaptations need local testing.
DRC 2018–20, North Kivu / Ituri (Vinck et al., 2019; Mayhew et al., 2021; Sweet et al., 2024; Pham et al., 2020; Sikakulya et al., 2021; Natifu & Bwambale, 2025)	Trust and misinformation; trust and leadership words and actions, militarisation; local authority; gendered exposure; burial adaptation	The closest example. Same provinces, overlapping conflict dynamics, some of the same institutions. Strongest lessons, but conflict actors and vaccine availability differ.
Uganda 2022 Sudan virus (Paterson et al., 2025; Rutakumwa et al., 2025)	Stigma as an outbreak-control variable; survivor reintegration; person-centred care	Recent and institutionally continuous with the current Ugandan response. Strong lessons.
Borderland preparedness (Schmidt-Sane et al., 2020)	Livelihoods, trust, and the limits of movement restriction on the DRC–Uganda border	Directly relevant geography. Predates the current outbreak.
2026 Bundibugyo virus disease outbreak reporting (WHO, 2026a–e; WHO AFRO, 2026; Africa CDC, 2026; Villa et al., 2026; Nsawotebba et al., 2026; MSF, 2026; Sullivan, 2026)	Current context, index case pathway, Ituri social and linguistic complexity	No longer early or partial: by 1 August 2026 this is a five-province, 49-health-zone, largest-ever DRC outbreak with over three months of situation reporting. Still largely descriptive rather than analytic.
2026 real-time monitoring and grey literature (Physicians for Human Rights / Mercy Corps, 2026; Panzi Hospital, cited in Health Policy Watch,	Security incidents against the response; sexual and gender-based violence in the outbreak zone; humanitarian funding gaps; rapid social and behavioural synthesis specific to Ituri 2026	New since the original review. Valuable and current, but situational documentation rather than peer-reviewed analysis; figures should be treated as a snapshot, not a stable baseline.

Evidence source	What it supports	Limits for lessons learned
2026; UNFPA, 2026; SSHAP, 2026b)		

2.3 The limitations of countermeasures

Much of the 2018–2020 DRC literature focuses on vaccines and therapeutics. There is currently no licensed vaccine or approved therapeutic for Bundibugyo virus disease (BVD), although several candidate treatments and vaccines are under evaluation. In July 2026, the first human trial of a Bundibugyo-specific vaccine began, with other candidates also entering early-stage trials (Health Canada, 2026; University of Oxford, 2026a, 2026b; CEPI, 2026; IAVI, 2026; WHO, 2026d).

Access during the present outbreak is nevertheless likely to remain limited to research or exceptional-use arrangements. The operational response therefore continues to depend primarily on early detection, supportive care, infection prevention and control (IPC), trusted care-seeking, safe caregiving, dignified burial, and survivor support. These are precisely the domains where social evidence is vital. This also raises an important research question: how are trust, participation, and rumours shaped around the first human trials of an unlicensed Bundibugyo-specific vaccine while the disease remains active in the region? See Section 8 (MSF, 2026).

Another consideration is clinical non-specificity. Early BVD symptoms, including vomiting, diarrhoea, epigastric pain, generalised weakness, and hiccups, are indistinguishable from those of malaria, typhoid, gastroenteritis, and sepsis (Nsawotebba et al., 2026). People do not present as "Ebola cases" to clinicians or to themselves. Detection therefore depends partly on where people seek care and whom they consult before diagnosis is possible, making care pathways a social as well as a laboratory question.

3. CONCEPTUAL FRAMEWORK: THE BIOSOCIAL MODEL

Like all epidemics, Ebola transmission can be understood through a **biosocial epidemiological** lens. Pathogens move between people within social systems. Consequently, biological processes of infection and transmission are inseparable from the social, economic, political, and cultural conditions that shape who is exposed, when, and under what circumstances (Farmer, 1996; Krieger, 2001).

The Bundibugyo virus is transmitted through contact with infectious body fluids, but contact is not random. It is produced by relationships and obligations: who nurses the sick, who washes the dead, who travels to trade, who shares a room, and who is believed when they say they are unwell. Exposure is therefore socially structured, and any measure that ignores this structure operates on an incomplete model of transmission.

In practice, biomedical and social epidemiology work together.

Table 2: Biomedical and social epidemiology questions

Biomedical epidemiology question	Paired social epidemiology question
Where are cases occurring?	Why are people moving, caring, delaying, hiding, or seeking care in the ways they are?
Who are the contacts?	What relationships, obligations, institutions, or services connect these people to one another?

Biomedical epidemiology question	Paired social epidemiology question
Which behaviour increases risk?	Why is that behaviour occurring — economically, structurally, culturally? What circumstances make it likely? Is any control measure itself increasing risk, for example through stigma?
Which measure reduces transmission?	What support makes that measure feasible for the people expected to follow it?

This framing also helps explain the One Health concept. Human, animal, and environmental health are connected, but those connections are also shaped by how people live and work. WHO identifies fruit bats as the suspected natural reservoir of Bundibugyo virus, with initial human infection thought to occur through contact with infected wildlife before person-to-person transmission takes over (WHO, 2026c).

This makes the animal–human interface important for preparedness. But activities such as hunting, farming, mining, forest use, food markets, animal handling, water collection, settlement, displacement, conflict, and cross-border trade are all shaped by livelihoods and wider social conditions. The key question is therefore not only where exposure may occur, but why it occurs and what protection is realistic without undermining people's livelihoods (Sikakulya et al., 2020).

Once sustained human-to-human transmission is established, the main priorities become trusted care-seeking, safe caregiving, infection prevention and control (IPC), dignified burial, survivor support, and measures people can realistically follow.

Response measures themselves can affect transmission. They can reduce transmission, but poorly designed measures can also drive illness, movement, or care-seeking out of sight. Second, the social effects of response measures should be monitored as carefully as their technical effects.

4. THE 2026 OUTBREAK

4.1 Early outbreak pattern

The 2026 Bundibugyo virus disease (BVD) outbreak was officially declared by the governments of the Democratic Republic of the Congo and Uganda on 15 May 2026. On 17 May, the WHO declared the outbreak a Public Health Emergency of International Concern (PHEIC). The following day, Africa Centres for Disease Control and Prevention (Africa CDC) declared it a Public Health Emergency of Continental Security (PHECS), reflecting the outbreak's cross-border character and the need for coordinated continental action.

The outbreak has since become the largest Ebola outbreak ever recorded in DRC. As of 30 July 2026, DRC had reported 3,605 confirmed cases and 1,587 deaths (a crude case fatality ratio of 44%), surpassing the 2018–2020 outbreak's 3,317 confirmed cases. During epidemiological week 30 alone, 567 new cases and 296 deaths were recorded (WHO, 2026c). There were also two cases medically evacuated to and treated in Germany, 20 in Uganda, and one in France (WHO, 2026c).

There have been 151 confirmed cases among health workers, with 44 deaths—a health-worker-specific case fatality ratio of 29% (WHO, 2026c).

The two national epidemics have since diverged in both status and scale. DRC's transmission has expanded from Ituri alone to five provinces — Ituri, North Kivu, South Kivu, Haut-Uélé, and Tshopo — and 49 health

zones, up from 35 a month earlier. Ituri remains by far the most affected province, accounting for 88% of confirmed cases and 82.6% of deaths nationally, concentrated in the Bunia–Rwampara–Mongbwalu corridor (WHO, 2026c).

Uganda's outbreak, by contrast, was declared over on 28 July 2026, with a final total of 20 confirmed cases, one probable case, and three deaths. A regional preparedness and prioritisation framework (the WHO/Africa CDC Continental Preparedness and Response Plan, June–November 2026), launched jointly on 5 June 2026, guides readiness and response activities across the African region while allowing for this divergence (Africa CDC, 2026; WHO, 2026a). A single uniform response model remains inappropriate.

4.2 Ituri and eastern DRC: social context as epidemiology

Ituri and neighbouring areas are home to many ethnic, linguistic, religious, political, and livelihood groups. They are also affected by displacement, insecurity, armed conflict, mining, cross-border trade, and repeated humanitarian and epidemic responses (Villa et al., 2026). These conditions can shape how people understand and respond to Ebola measures, including whether they trust them, negotiate them, adapt them, or avoid them.

Insecurity is an important part of this context. Armed groups, including the Allied Democratic Forces (ADF), Cooperative for the Development of Congo (CODECO), and the Rwanda-backed March 23 Movement (M23), operate in areas affected by mining and conflict. Fighting can restrict humanitarian access and make surveillance, contact tracing, referral, and follow-up more difficult.

Mercy Corps recorded more than 60 security incidents affecting the Ebola response in Ituri, North Kivu, and South Kivu between 15 May and 30 June 2026. These included attacks on staff, facilities, vehicles, and equipment, as well as threats, intimidation, and abductions. At least 11 Ebola facilities or treatment centres were damaged, and humanitarian workers and government officials were injured (Physicians for Human Rights, 2026).

Other incidents were reported in July. These included a group entering Nyakunde Hospital and contact-tracing teams being driven away from Kpangba displacement camp after disagreement over whether two deaths were caused by Ebola (TIME, 2026; U.S. News, 2026). Similar tensions were seen during the 2018–20 outbreak. In May 2026, the WHO Director-General also referred to the earlier experience of deep mistrust and insecurity, and to the importance of rebuilding trust through listening (WHO, 2026e).

Social context is therefore important for understanding both exposure and response. People move between homes, mines, markets, farms, health facilities, places of worship, and border areas. Their choices are also shaped by access to transport, money, food, water, phones, and services, and by whom they trust. These factors can influence whether people report symptoms, accept referral, remain in care, identify contacts, take part in follow-up, or request support for safe burial.

Some people may first manage illness within households, workplaces, faith networks, or other local groups before contacting formal services. This may reflect fear, stigma, cost, distance, uncertainty about symptoms, past experience of emergency responses, or the need to keep households and livelihoods functioning. Contact tracing therefore works best when it is combined with social inquiry into why people delay, move, hide illness, or seek care elsewhere.

Displacement adds further difficulties. The Eastern DRC hosts an estimated 3.4 million internally displaced people, and the outbreak and its wider effects are estimated to affect 7.7 million people (Refugees International, 2026; UNFPA, 2026). Around Bunia, some families are living in very crowded conditions with

serious shortages of water and soap, making basic prevention measures harder to follow (Refugees International, 2026).

Language is another practical issue. Swahili is widely used in towns and mining areas. Lingala is used in administration and broadcasting, and French is not understood by everyone. Local languages, including Hema, Lendu, and Nyali, also vary across communities (Villa et al., 2026). An estimated 35,000 Mbuti people live in forest areas of Ituri and may face particular barriers linked to discrimination, displacement, and low trust in formal authorities. The Social Science in Humanitarian Action Platform (SSHAP) recommends working through trusted intermediaries rather than assuming that standard community engagement approaches will reach them (SSHAP, 2026b). Risk communication and community engagement (RCCE) materials therefore need to be reviewed, translated, and tested for local use early in the response, not as a later step.

4.3 Uganda: borders, private providers, and institutions

The Ugandan epidemic is an example of preparedness. Cross-border trade, trucking routes, informal crossings, kinship networks, and health-seeking pathways create conditions in which a suspected or confirmed case may pass through many settings before detection. The case reported in late June involved a truck driver on the DRC–Uganda route who developed symptoms before entering Uganda and who was isolated shortly after arrival (WHO, 2026).

The index case in Uganda involved a patient seeking care in DRC, then at a private clinic in Hoima district where no blood work was performed, then self-referring to a private hospital in Kampala, where he died before BVD was confirmed (Nsawotebba et al., 2026). Detection happened in the private sector, not at a designated outbreak facility. Private clinics, pharmacies, and informal providers are frequently the first point of care for acute febrile and gastrointestinal illness, particularly in urban and peri-urban settings, because they are closer, faster, more familiar, or perceived as more accessible. Excluding them from alert systems, specimen referral pathways, training, IPC support, and result feedback creates a structural blind spot in surveillance.

Uganda’s Ministry of Health declared the outbreak over on 28 July 2026. The declaration followed 42 days without a new confirmed locally transmitted case. The Ministry emphasised identifying the outbreak's source, fully reconstructing transmission chains, epidemiologically linking all confirmed cases, and successfully conducting 21-day follow-up of every identified contact (Uganda Ministry of Health, 2026a, 2026b).

WHO commended Uganda's specialised treatment facilities, trained emergency medical teams, and available medical supplies as important factors (Uganda Ministry of Health, 2026a). As part of the closure, Uganda signed a memorandum of understanding with DRC for a joint cross-border Ebola response and established two mobile laboratories and an 80-bed Ebola treatment unit on the DRC side of the border in Aru and Kasenyi (Uganda Media Centre, 2026). Following the discharge of an imported case on 16 July, enhanced surveillance continued for a further 42 days to ensure that no transmission chain had been missed. Uganda's health minister was explicit that the country remained at risk of imported cases and re-introduction of BVD while transmission continued in DRC (WHO, 2026c).

Schools, similarly, are not only potential settings for transmission. They are trusted institutions and communication networks through which fear spreads quickly when information is unclear. Uganda's Ministry of Education and Sports Circular required school-based response teams, sensitisation, immediate reporting, handwashing facilities, temperature screening, cleaning, ventilation, and isolation areas. Whether those requirements are feasible—for example, who resupplies the soap, how fever is triaged against a high

background of malaria, who contacts parents, and how a monitored child avoids being labelled—is a separate question from whether they are mandated. Where school surveillance is framed as policing rather than care, it creates the possibility of concealment.

5. THEMATIC SYNTHESIS OF THE EVIDENCE

Eight themes recur across the literature. Each is presented as what the evidence shows, how far it can be relied on, and the guidance implication. The corresponding operational tools are in the Field Guide, with references at the end.

5.1 Explanatory models and culture as a resource

Hewlett and Amola's study of the 2000–01 Gulu outbreak found that Acholi communities used several explanatory models simultaneously — biomedical, epidemic-spirit (gemo), and sorcery-related — and that some indigenous epidemic-control measures, including household isolation, marking of affected houses, and restriction of movement and burial contact, aligned closely with biomedical containment. Others required adaptation (Hewlett & Amola, 2003). Of relevance is the analytic point that people hold multiple models at once, and that, on the basis of these views, they act pragmatically. Local practice contains both protective and risky elements.

The implication is that social inquiry must precede messaging. Rapid social inquiry should begin at the start of the response, not when resistance emerges, and should be led or co-led by social scientists, anthropologists, community researchers, and local health workers. It must be repeated as the outbreak evolves and should establish community priorities, not merely community beliefs. This is necessary because a population facing conflict, displacement, and food insecurity may rationally rank Ebola below other risks, and a response that does not recognise this will misread its own reception.

Operational tools: Field Guide 4.1 (Rapid social inquiry).

5.2 Trust, history, and politicisation

Vinck and colleagues' population-based survey in North Kivu during the 2018–19 outbreak found that low institutional trust and belief in misinformation were associated with a lower likelihood of adopting preventive behaviours, including vaccine acceptance and use of formal healthcare (Vinck et al., 2019). This provides a strong quantitative link between a social condition and epidemiologically relevant behaviour, and the evidence comes from one of the provinces affected by the current outbreak.

Trust, in this sense, is not simply a communication variable. It is shaped by histories of state presence, service delivery, livelihood insecurity, border governance, and prior encounters with health authorities. Sweet and colleagues show that, in conflict-affected settings, outbreaks and response measures can become politically charged. They also caution that frameworks which locate the problem primarily in supposedly resistant or misinformed communities can obscure how the conduct of the response itself may contribute to mistrust and hostility (Sweet et al., 2024). In the 2026 response, community feedback has already identified concerns about delays in safe and dignified burial, transport of suspected cases, quality of care at treatment centres, resource distribution, and rumours linked to self-medication.

The security incidents described in Section 4.2 suggest that politicisation, mistrust, insecurity, and response conduct are again interacting in the affected provinces (Physicians for Human Rights, 2026; TIME, 2026; U.S. News, 2026).

The implication for guidance is that trust should be treated as an operational condition to be monitored and, where necessary, repaired—not as a message to be delivered. Where hostility escalates, including violence against facilities or responders, refusal to release bodies, or organised rejection of response teams, the response should include social diagnosis: what grievance is driving the reaction, who has legitimate authority to address it, and what would need to change for engagement to resume. Security escalation alone is unlikely to restore the conditions needed for outbreak control.

Operational tools: Field Guide 3.2, 4.2, 4.13.

5.3 The "community" problem: engagement, authority, and militarisation

Mayhew and colleagues found that the 2018–20 DRC response often gave limited space for local actors and institutions to shape decisions, even though local involvement was widely recognised as important. They argue that social science should do more than explain communities to responders. It should also examine how response practices themselves may contribute to mistrust and shape relations of power (Mayhew et al., 2021).

A wider literature also cautions against treating "community" as a single, unified group. Communities include different interests, hierarchies, identities, and forms of authority, and these differences can affect who is heard, who is excluded, and who bears the costs of response measures (Leach et al., 2010; Abramowitz et al., 2015). In Ituri, this means paying attention to ethnicity, gender, displacement status, age, economic position, and indigeneity (Villa et al., 2026). A current rapid social synthesis also highlights the situation of the estimated 35,000 Mbuti people in Ituri, who face discrimination and displacement and may have low trust in formal authorities. Reaching them may require working through trusted intermediaries rather than relying on standard community-engagement approaches (SSHAP, 2026b). Sweet and colleagues similarly caution that security-heavy or militarised health operations can undermine trust and encourage concealment rather than cooperation (Sweet et al., 2024).

In practice, it is often more useful to think in terms of the smaller social settings through which care, exposure, communication, and accountability take place. These may include households, burial groups, markets, transport networks, mining teams, schools, faith groups, women's and youth groups, survivor networks, displaced households, and cross-border livelihood groups. They are often the settings where illness is first interpreted, where alerts are raised or delayed, and where response measures become workable or difficult.

Trusted people within these settings can be linked to district, health-zone, or border coordination structures so that concerns can be raised, adaptations proposed, responses received, and feedback shared back with communities.

Engagement, in this sense, is more than consultation or message delivery. It means creating ways for affected groups and local actors to influence how the response is designed and adapted.

Operational tools: Field Guide 4.2 (Community governance; decision forum composition).

5.4 Communication, rumour, and participatory design

Misinformation and disinformation are prominent in the 2026 DRC outbreak (ABC News, 2026). Treating misinformation as a failure of communities to engage with accurate information is an incorrect diagnosis. It is more useful to understand misinformation and disinformation as linked to weak trust, poor communication

infrastructure, inadequate framing and translation, limited local authority, and response practices that people find confusing, coercive, or inconsistent with what they can see.

A rumour that aid workers brought Ebola to make money is false, but it may also express a community interpretation of aid economies, inequality, or exclusion (Vinck et al., 2019; Mayhew et al., 2021). Correcting the claim may therefore be necessary but is rarely sufficient.

Participatory communication research offers a different starting point. Approaches such as community dialogue, Action Media, and community conversations begin with audiences working together with researchers and facilitators. Dialogue, reflection, and possible actions are developed with communities and grounded in the ways people make sense of their circumstances (Parker & Becker-Benton, 2016). This differs from directive, individually oriented biomedical messaging in which experts define the problem and required behaviour in advance, leaving less space for collective interpretation, negotiation, locally generated insights, and agreed pathways for action.

Several practical implications follow. Identify who is trusted by different groups, rather than only which channel reaches the largest audience. Engage communities in making sense of the problem, identifying relevant actions, and deciding how these should communicate them. Translate biomedical concepts into locally meaningful explanations rather than simply translating technical messages into local languages. Treat rumour tracking as social diagnosis with an operational output, not only as a misinformation-correction process.

Operational tools: Field Guide 3.4, 4.3 (Communication and listening systems).

5.5 Care pathways and the limits of “report early”

Care-seeking is socially organised. People may delay, conceal illness, move across districts or borders, or use informal providers because of fear, cost, mistrust, stigma, family obligations, or lack of respectful and accessible care. The movement of patients from DRC into Uganda during the current outbreak illustrates some of these pathways (Nsawotebba et al., 2026).

Private facilities, pharmacies, and informal providers should therefore be integrated into surveillance through alert pathways, specimen referral, training, IPC support, and result feedback. Otherwise, the system may have a blind spot precisely where people first seek care. Traditional healers, spiritual healers, herbalists, and religious healing actors should also be recognised as possible first points of care, trusted interpreters of illness, and referral partners. Engagement should focus on symptom recognition, safe referral, non-contact support, and privacy. Criminalisation may drive these care pathways out of sight, making them harder to engage and safer practice harder to support.

The instruction to “report early” is therefore not simply a communication issue. Early reporting has to be safe, affordable, trusted, and practical before it can reasonably be expected.

Operational tools: Field Guide 4.4 (Care pathways; care pathway map).

5.6 Death, burial, and dignity

Burial is both a high-risk transmission event and a morally, religiously, and socially essential process. Unsafe burial can amplify transmission, while highly medicalised or poorly negotiated burial practices can contribute to mistrust, concealment, and unsafe private burial (Ripoll et al., 2018). The evidence on what makes safe burial acceptable is relatively specific and actionable.

Focus group research in Sierra Leone found that key barriers to acceptance stemmed from burial practices rather than beliefs about the disease alone. Families were not permitted to witness burials, did not know what happened to bodies at the cemetery, and perceived that bodies were handled disrespectfully. These conditions fuelled rumours of dismemberment and organ harvesting. Factors supporting acceptance included community participation in grave-digging, the presence of religious leaders, and timely notification of families so they could attend the burial (Lee-Kwan et al., 2017).

In North Kivu during 2018–20, communities adapted burial practices once they understood the transmission risk. Families selected perfume for burial teams to spray on the body, provided clothing for the deceased, and viewed the body safely through a transparent body bag. Local community members were also recruited and trained as liaisons with burial teams. Their role was not to make the body medically safe, but to bridge families and burial crews, explain procedures, and relay family wishes. This approach was associated with reduced rumour and resistance (Sikakulya et al., 2021).

The evidence suggests that avoiding physical contact with the body was not necessarily the main obstacle. A central concern was the loss of families' ability to know what had happened, see and accompany the deceased, verify identity and burial, and mourn in socially meaningful ways. Where the response provided safe alternatives for these functions, technical requirements became more acceptable. Innovation here was social rather than technological. Transparent body bags, safe viewing, family accompaniment, burial documentation cards, named grave locations, trained religious representatives, and negotiated symbolic substitutes for washing or dressing all helped address family and community concerns.

Operational tools: Field Guide 4.5 (Burial adaptations; pre-burial checklist).

5.7 Survivors, stigma, and the health workforce

Stigma is not only a post-epidemic concern. It can shape the epidemic itself. Research across the DRC, Sierra Leone, Guinea, Liberia, and Uganda documents stigma against Ebola survivors, expressed through hostility, avoidance, and structural disadvantage that can persist during and beyond the outbreak (James et al., 2019; Paterson et al., 2025). In Uganda's 2022 Sudan virus outbreak, stigma was linked to delayed care-seeking, reduced symptom reporting, and workforce pressures, alongside mistrust of authorities, limited knowledge of the disease, and conspicuous survivor follow-up (Paterson et al., 2025).

Stigma is therefore an outbreak-control concern with possible implications for transmission. Survivor support should form part of the response from the outset, rather than being left to post-epidemic recovery. Qualitative work with Ugandan survivors emphasises holistic, person-centred care that takes account of the sociocultural, economic, and political context of the outbreak (Rutakumwa et al., 2025). Survivors who receive psychosocial support and advocacy can also become important community voices for trust and reduced stigma (Paterson et al., 2025). Continuous community engagement has been associated with improved adherence and survivorship outcomes (Soke et al., 2024).

The same logic applies to the workforce. Health workers, community health workers, volunteers, and burial teams face multiple pressures, including infection risk, limited personal protective equipment (PPE), illness and deaths among colleagues, long working hours, threats to personal security, and weakened social support. Burnout, anxiety, depression, and post-traumatic stress can affect quality of care, increase errors, and contribute to staff attrition at a time when the workforce is most needed (Katz, 2015). Burial team members may also face particular stigma within their own communities. Health worker welfare is therefore part of response effectiveness: supported workers are better placed to provide compassionate isolation, dignified

burial, and respectful care, while visible mistreatment of health workers can undermine community confidence in the response (Paterson et al., 2025; Soke et al., 2024).

The2026 outbreak has added further evidence of these pressures. As of 30 July 2026, 151 health workers had been confirmed infected in DRC, with 44 deaths. This occurred in the context of sustained occupational exposure, uneven IPC implementation, and exposure in both facilities and communities (WHO, 2026c). Security incidents described in Section 4.2 have also affected health workers and response teams, including staff leaving remote health zones, teams being driven from displacement camps, and attacks on facilities (Physicians for Human Rights, 2026; TIME, 2026).

The arrival of vaccine trials has introduced an additional workforce issue. SSHAP has identified healthcare-worker concerns about vaccine side effects and confidence in candidate BDBV vaccines as an area requiring attention during the current epidemic (SSHAP, 2026b). Health workers may be both highly exposed to infection and important sources of information for communities, while some may also become trial participants. Their views on experimental vaccines therefore warrant specific study rather than being treated simply as part of general community vaccine confidence work.

Operational tools: Field Guide 4.6, 4.11.

5.8 Equity, gender, and response harms

Redondo and colleagues, reviewing Uganda's Ebola and COVID-19 preparedness and response plans, identified repeated missed opportunities to address systemic inequity. They argue that social determinants, health equity, and resilience should be built into outbreak planning rather than added afterwards (Redondo et al., 2025).

Gender analysis provides an important example. During the 2018–20 DRC outbreak, women accounted for 57 per cent of confirmed cases. This pattern has been linked to caregiving roles, trading activity, and constrained agency in health decisions—in other words, to the social organisation of exposure (Pham et al., 2020). Gender-sensitive communication, livelihood support, and attention to caregiving roles are therefore important parts of outbreak response.

Outbreak conditions and some response measures may also increase vulnerability to gender-based violence (GBV). Quarantine, economic stress, displacement, and disruption of social and health services have been associated with increased GBV in previous emergencies (Lokuge et al., 2020). GBV risks should therefore be monitored and referral and support services maintained throughout the response.

The scale of violence in areas affected by the 2026 outbreak is severe. Panzi Hospital in South Kivu recorded an 85% increase in newly reported survivors of sexual violence during the first six months of 2026 compared with the same period in 2025. Between January and June, 646 newly reported survivors were admitted, including 119 women and girls who became pregnant following rape, 84 of whom were under 18. Panzi's psychiatric team also reported 91 suicides during the first five months of 2026, already three-quarters of the total recorded during 2025 (cited in Health Policy Watch, 2026).

Human Rights Watch and the Congolese women's rights organisation SOFEPADI documented sexual violence by several non-state armed groups and members of the Congolese army across provinces affected by both conflict and the Ebola outbreak (cited in Health Policy Watch, 2026). At the same time, clinics faced serious shortages of post-rape care, including HIV post-exposure prophylaxis (PEP) and emergency contraception where relevant, as well as other sexual and reproductive health services (Health Policy Watch, 2026).

These figures illustrate a serious protection crisis in the outbreak zone. Conflict, displacement, insecurity, and service disruption are major concerns co-occurring during the outbreak.

Movement restrictions present another potential source of response harm. Families, ethnic groups, trading networks, and care-seeking pathways extend across the DRC–Uganda border, with communities on both sides connected through kinship, trade, water access, and health services (Villa et al., 2026).

Research in the Uganda–DRC borderlands found that these social and economic connections make movement difficult to restrict without affecting livelihoods and access to essential services (Schmidt-Sane et al., 2020). Restrictions should therefore be assessed not only as epidemiological measures, but also in terms of their effects on household survival, informal economies, kinship, care-seeking, and trust in authorities. WHO advised against travel and trade restrictions during the current outbreak (WHO, 2026).

Equity, in this sense, is more than identifying vulnerable groups. It means asking who is most exposed, who has the least ability to follow a measure, who bears its costs, who may be stigmatised by it, and who was excluded from deciding it.

Operational tools: Field Guide 4.7, 4.12 (Equity screen).

6. CROSS-CUTTING FRAMEWORKS

Three frameworks relate to the evidence above: The listening loop, the four-decision typology, and the failure mode analysis.

6.1 The listening loop

Hear – Classify – Respond – Adapt – Report back. The loop requires all four steps. The recurring challenge documented across Ebola responses is collecting community feedback without changing response practice, which teaches communities that feedback is extractive and accelerates the loss of trust it was meant to repair. Reporting back what changed is a critical step that makes the next round of listening possible. Closing the loop also requires designated technical capacity at national and subnational levels. Relevant biomedical, social science, anthropological, One Health, protection, and operational specialists should be assigned to review recurring community questions, identify knowledge gaps, and provide timely responses through trusted channels. The quality and timeliness of these responses should be monitored as indicators of accountability and trust-building.

6.2 The four-decision typology

Community feedback should be reviewed for patterns across places, groups, institutions, and time. When the same issue recurs across communities or days, it must prompt one of four decisions: clarify, support, adapt, or review.

Table 3: Decisions, application, requirements

Decision	When it applies	What it requires
Clarify	The issue is misunderstanding, uncertainty, rumour, or an information gap.	Trusted channels, local languages, and a communicator with authority in that setting.
Support	The measure is right but people cannot follow it: food, water, water sanitation and hygiene (WASH)	Material provision, not messaging.

Decision	When it applies	What it requires
	supplies, transport, childcare, income, communication access.	
Adapt	The measure is technically correct but socially or operationally unworkable as implemented.	Negotiation with technical leads, local authorities, religious or traditional leaders, and affected households.
Review	The measure appears to be causing harm, undermining trust, increasing avoidance, worsening inequity, or failing repeatedly despite clarification and support.	Escalation to incident management or the equivalent coordination structure.

This typology only functions if the RCCE lead sits in operational coordination with the authority to escalate. Without that authority, RCCE becomes a parallel communications track and the loop cannot close.

6.3 The failure-mode analysis

Failure modes in the Field Guide are classified by severity, which determines the urgency of response. This is whether it is a trigger, an amplifier, or a transmission accelerator.

Table 4: Decisions, applications, requirements

Class	Definition	Example
Trigger	A practice that initiates a failure.	Using local leaders as messengers for decisions taken elsewhere.
Amplifier	A practice that increases the scale of an existing problem.	Keeping RCCE data in a separate track rather than feeding it into operational adaptation.
Transmission accelerator	A practice that measurably increases transmission risk. Requires the most urgent response.	Instructing people to report early without making early reporting safe, affordable, trusted, and practical. Treating burial as body management rather than a social and religious process.

The distinction matters because it converts “this is bad practice” into “this is an outbreak-control problem of a specific severity,” which is the register in which incident management makes decisions.

7. GUIDANCE FOR PREPAREDNESS BETWEEN OUTBREAKS

Most of the factors that determine whether a response is trusted cannot be built during a response. BVD-specific preparedness is less developed than for other Ebola species. Early symptoms are non-specific, diagnostic readiness is uneven, and although there are vaccine and therapeutic trials, nothing is licensed or approved.

Uganda's closure of its outbreak on 28 July 2026 provides a useful, current illustration of how preparedness capacities can support rapid detection, reconstruction of transmission chains, contact follow-up, treatment readiness, and cross-border coordination. It does not, by itself, establish the independent effect of each capacity on the duration of the outbreak. Uganda's account of closure nevertheless highlights private-sector alert integration, contact-mapping discipline, and a formal cross-border coordination instrument with DRC, each of which appears as a preparedness domain in Table 5 below.

Table 5: Preparedness, what must exist, and the evidence that guides it

Preparedness domain	What must exist before an outbreak	Evidence
Language and translation	An audit of which RCCE materials exist in which languages, including village-level languages and not only administrative ones; tested translations; a roster of interpreters.	Villa et al., 2026
Private and informal providers	Private clinics, pharmacies, and informal providers inside alert pathways, specimen referral, training, IPC support, and result feedback.	Nsawotebba et al., 2026
Traditional and faith healers	Referral relationships, symptom recognition, and non-contact support agreed in advance, without criminalisation.	Hewlett & Amola, 2003; Ripoll et al., 2018
Community governance	Trusted actors mapped within small units; a standing forum linked to district and health-zone coordination.	Mayhew et al., 2021; Abramowitz et al., 2015
Burial capacity	Trained community burial liaisons; religious representatives trained in safe burial; dignity-preserving materials procured.	Sikakulya et al., 2021; Lee-Kwan et al., 2017
Listening systems	A rumour and concern log, a classification protocol, and an agreed escalation route into incident management.	Vinck et al., 2019; Mayhew et al., 2021
WASH	Functional water, soap, and waste management at schools, markets, points of entry, health facilities, and for burial teams, with named responsibility for maintenance and resupply.	Cross-cutting
Health worker and PPE readiness	Pre-negotiated PPE stockpiles, payment systems, and security protocols for facilities and outreach teams in conflict-affected areas.	Katz, 2015; Physicians for Human Rights, 2026
Cross-border coordination	Joint district-to-health-zone relationships; understanding of kinship, trade, water, and health-seeking networks across the border; a standing bilateral instrument, not an ad hoc one.	Schmidt-Sane et al., 2020; Villa et al., 2026; Uganda Media Centre, 2026
Survivor and workforce support	Survivor networks and psychosocial support structures established, not improvised; welfare planning that includes CHWs, volunteers, and burial teams.	Paterson et al., 2025; Katz, 2015
Equity baseline	Who is most exposed, least able to comply, most likely to bear the cost of restriction, and least represented in decisions — known in advance; GBV and PEP-kit supply chains that do not depend on a single donor.	Redondo et al., 2025; Pham et al., 2020; Health Policy Watch, 2026

Water, sanitation and hygiene (WASH) deserves emphasis because it is routinely treated as a support function. It is a protection requirement. If people cannot wash their hands, isolate safely, care safely, or bury with dignity, transmission risk rises, and trust erodes. Where WASH infrastructure is absent or unreliable — as it may be in displacement settings where families share tents— interim provision must precede any expectation of compliance with measures that depend on water, soap, chlorine, or safe sanitation.

8. EVIDENCE GAPS AND A RESEARCH AGENDA

- **BVD-specific social science is beginning to generate real-time data, but there is still limited analysis.** Security-incident tracking (Mercy Corps/PHR), GBV surveillance (Panzi Hospital), and a rapid social and behavioural synthesis (SSHAP, 2026b) are being produced during the outbreak itself. This narrows the evidence gap, but the findings have not yet been peer-reviewed, theorised, or tested against earlier literature in ways that support broader transferability.
- **The introduction of vaccine and therapeutic trials creates a new set of social research questions.** These include how trust, participation, and rumours develop around the first human trials of a Bundibugyo-specific vaccine. SSHAP's rapid synthesis already identifies healthcare-worker vaccine hesitancy as an emerging concern (SSHAP, 2026b). There is not yet comparable evidence on how affected communities understand experimental vaccines developed and tested outside the outbreak zone.
- **Ituri's ethnic and political heterogeneity remains under-described for response purposes.** Existing analysis is rightly cautious about treating "community" as a single category, and the current outbreak's rapid synthesis has begun to disaggregate populations, including specific attention to the Mbuti Indigenous population. However, systematic analysis by ethnicity, displacement status, gender, age, and economic position at health-zone level is not yet available in a form that can readily guide response (SSHAP, 2026b).
- **Care-seeking pathways through private and informal providers are known largely through individual cases and operational observation rather than systematic study.** A pathway study across affected districts could be directly useful, and Uganda's now-closed outbreak offers a tractable setting for retrospective analysis.
- **Burial adaptations have been documented in earlier outbreaks but not systematically evaluated in the current one.** North Kivu innovations were reported to reduce rumour and resistance. Prospective documentation of burial practices and adaptations during the current outbreak could strengthen this evidence.
- **Sexual and gender-based violence in the outbreak zone is being measured, but its relationship to the Ebola response remains unclear.** Panzi Hospital data document a sharp rise in GBV in the same provinces and months as the outbreak, but attribute this primarily to the wider conflict rather than to Ebola-response-specific factors such as quarantine, displacement into camps, or disrupted services (Health Policy Watch, 2026). Understanding these pathways remains relevant.
- **Evidence on how RCCE authority operates within incident management remains limited.** The argument that RCCE should be able to trigger operational adaptation is well supported as a diagnosis of past failures, but there is much less evidence documenting when this has worked in practice. Research on RCCE processes, authority, and decision pathways could contribute both to the current response and to future preparedness.

9. REFERENCES

ABC News. (2026). DRC minister says people should not panic amid Ebola outbreak. https://abcnews.com/Health/drc-minister-people-panic-ebola-outbreak/story?id=133432404

Abramowitz, S. A., McLean, K. E., McKune, S. L., Bardosh, K. L., Fallah, M., Monger, J., et al. (2015). Community-centered responses to Ebola in urban Liberia: The view from below. PLOS Neglected Tropical Diseases, 9(4), e0003706. https://doi.org/10.1371/journal.pntd.0003706

Africa CDC. (2026a, June 5). Africa CDC and WHO launch joint continental Ebola response plan. https://africacdc.org

Africa CDC. (2026b, August 2). Bundibugyo Virus Disease Outbreak, Situation Report, Issue No. 77. https://africacdc.org/download/bundibugyo-virus-disease-outbreak-situation-report-issue-no-77-august-2-2026/

CEPI. (2026, June 1). CEPI fast-tracks three Bundibugyo ebolavirus vaccine candidates. https://cepi.net/cepi-fast-tracks-three-bundibugyo-ebolavirus-vaccine-candidates

Farmer, P. (1996). Social inequalities and emerging infectious diseases. Emerging Infectious Diseases, 2(4), 259–269.

Health Canada. (2026, July 30). Health Canada authorizes vaccine clinical trial for Ebola disease caused by the Bundibugyo virus. Government of Canada. https://www.canada.ca/en/health-canada/news/2026/08/health-canada-authorizes-vaccine-clinical-trial-for-ebola-disease-caused-by-the-bundibugyo-virus.html

Health Policy Watch. (2026, July 30). Sexual violence surges in eastern DRC as conflict and Ebola overwhelm health system. https://healthpolicy-watch.news/sexual-violence-surges-eastern-drc-conflict-ebola/

Hewlett, B. S., & Amola, R. P. (2003). Cultural contexts of Ebola in northern Uganda. Emerging Infectious Diseases, 9(10), 1242–1248. https://doi.org/10.3201/eid0910.020493

IAVI. (2026, June 1). IAVI to advance vaccine candidate for Bundibugyo virus, receives funding from CEPI. https://www.iavi.org/press-release/iavi-vaccine-candidate-bundibugyo-virus-cepi-funding/

James, P. B., Wardle, J., Steel, A., & Adams, J. (2019). Post-Ebola psychosocial experiences and coping mechanisms among Ebola survivors: A systematic review. Tropical Medicine & International Health, 24(6), 671–691. https://doi.org/10.1111/tmi.13226

Katz, C. L. (2015). Mental health in emergency response: Lessons from Ebola. Lancet Psychiatry, 2(11), 955–956. https://doi.org/10.1016/S2215-0366(15)00451-4

Krieger, N. (2001). A glossary for social epidemiology. Journal of Epidemiology and Community Health, 55(10), 693–700. https://doi.org/10.1136/jech.55.10.693

Leach, M., Scoones, I., & Stirling, A. (Eds.). (2010). Dynamic sustainabilities: Technology, environment, social justice. Earthscan. https://www.routledge.com/Dynamic-Sustainabilities-Technology-Environment-Social-Justice/Leach-Scoones-Stirling/p/book/9781849710930

Lee-Kwan, S. H., DeLuca, N., Bunnell, R., Clayton, H. B., Turay, A. S., & Mansaray, Y. (2017). Facilitators and barriers to community acceptance of safe, dignified medical burials in the context of an Ebola epidemic, Sierra Leone, 2014. Journal of Health Communication, 22(sup1), 24–30. https://doi.org/10.1080/10810730.2016.1209601

Lokuge, K., Thurber, K., Marquez, C., Dhingra, N., Nyirenda, D., Sreenivasan, N., et al. (2020). The syndemic of COVID-19 and gender-based violence in humanitarian settings: Leveraging lessons from Ebola in the Democratic Republic of Congo. BMC Medicine. https://pubmed.ncbi.nlm.nih.gov/33208316/

Mayhew, S. H., Kyamusugulwa, P. M., Bindu, K. K., Richards, P., Kiyungu, C., & Balabanova, D. (2021). Responding to the 2018–2020 Ebola virus outbreak in the Democratic Republic of the Congo: Rethinking humanitarian

approaches. Risk Management and Healthcare Policy, 14, 1731–1747. https://pubmed.ncbi.nlm.nih.gov/33953623/

MSF. (2026). The Bundibugyo virus challenge: Why is this Ebola disease outbreak different. https://www.msf.org/bundibugyo-virus-challenge-why-ebola-disease-outbreak-different

Natifu, B., & Bwambale, A.M (2025). Preaching Water and Drinking Wine: Transformational Leadership and Reputational Trust as Key Drivers to Sustainable Uptake of COVID-19 Social and Behaviour Change Messages in Uganda. In Strategic Public Relations in Emerging Economies: Public and Private Sector Perspectives (pp. 83-105). Cham: Springer Nature Switzerland. https://doi.org/10.1007/978-3-031-85344-9_4

NICD (National Institute for Communicable Diseases). (2026). Bundibugyo virus disease updates. https://www.nicd.ac.za/bundibugyo-virus-disease-updates/

Nsawotebba, A., Ssewanyana, I., Ayitewala, A., Wayengera, M., Kanyerezi, S., et al. (2026). Clinical profile and genomic characterization of the 2026 Bundibugyo virus index case in Uganda. Nature Medicine. https://doi.org/10.1038/s41591-026-04510-7

Parker, W. M., & Becker-Benton, A. (2016). Experiences in conducting participatory communication research for HIV prevention globally: Translating critical dialog into action through Action Media. Frontiers in Public Health, 4, 128. https://doi.org/10.3389/fpubh.2016.00128

Paterson, J., et al. (2025). Ebola stigma and its impact on outbreak control: Lessons from key informant interviews in central Uganda. Tropical Medicine & International Health. https://doi.org/10.1111/tmi.70014

Pham, P. N., Vinck, P., & Nilles, E. J. (2020). Protective behaviors associated with gender during the 2018–2020 Ebola outbreak in eastern Democratic Republic of the Congo. JAMA Network Open / Harvard Humanitarian Initiative. https://doi.org/10.1001/jamanetworkopen.2021.47462

Physicians for Human Rights. (2026, July). Ebola death toll reaches 1,000 in DRC, as conflict and aid cuts compound a spiralling health and humanitarian crisis. https://phr.org/news/overwhelmed-and-under-resourced-congolese-health-workers-tell-of-mounting-obstacles-to-containing-the-outbreak/

Redondo, G., Murray, L., Bromhead, C., & Makumbi, I. (2025). Is equity meaningfully incorporated into pandemic preparedness and response? A scoping review and critical analysis of Ebola and COVID-19 outbreak responses in Uganda 2019–2023. Critical Public Health, 35(1). https://doi.org/10.1080/09581596.2025.2574954

Refugees International. (2026, June 12). Addressing the Ebola crisis amid the humanitarian emergency in eastern DRC. https://www.refugeesinternational.org/reports-briefs/addressing-the-ebola-crisis-amid-the-humanitarian-emergency-in-eastern-drc/

Ripoll, S., Gercama, I., Jones, T., & Wilkinson, A. (2018). Social science in epidemics: Ebola virus disease lessons learned. SSHAP Lessons Learned Issue 2. UNICEF, IDS & Anthrologica. https://www.preventionweb.net/publication/social-science-epidemics-ebola-virus-disease-lessons-learned

Rutakumwa, R., Ninsiima, S., Settuba, E., Kyohangirwe, L., Mpango, R. S., Tusiime, C., et al. (2025). A qualitative study of Ebola survivors' psychological experiences of evacuation, treatment, and community reintegration: Lessons in holistic person-centred care from the 2022 outbreak in Uganda. PLOS Mental Health. https://doi.org/10.1371/journal.pmen.0000316

Schmidt-Sane, M. M., Nielsen, J. O., Chikombero, M., Lubowa, D., Lwanga, M., Gamusi, J., Kabanda, R., & Kaawa-Mafigiri, D. (2020). Challenges to Ebola preparedness during an ongoing outbreak: An analysis of borderland livelihoods and trust in Uganda. PLOS ONE, 15(3), e0230683. https://doi.org/10.1371/journal.pone.0230683

Sikakulya, F. K., Mulisya, O., Munyambalu, D. K., & Bunduki, G. K. (2020). Ebola in the eastern Democratic Republic of Congo: One Health approach to infectious disease control. One Health, 9, 100117. https://doi.org/10.1016/j.onehlt.2019.100117

Sikakulya, F. K., Ilumbulumbu, M. K., Djuma, S. F., Bunduki, G. K., Sivulyamwenge, A. K., & Jones, M. K. (2021). Safe and dignified burial of a deceased from a highly contagious infectious disease ebolavirus: Socio-cultural and anthropological implications in the eastern DR Congo. One Health, 13, 100309. https://doi.org/10.1016/j.onehlt.2021.100309

Social Science in Humanitarian Action Platform (SSHAP). (2026b, June 10). Recommendations: Rapid synthesis of social and behavioural science learnings on Ebola for the Bundibugyo virus outbreak (2026), Ituri, DRC. https://www.socialscienceinaction.org/resources/recommendations-rapid-synthesis-of-social-and-behavioural-science-learnings-on-ebola-for-the-bundibugyo-virus-outbreak-2026-ituri-drc/

Soke, G. N., Fonjungo, P., Mbuyi, G., Luce, R., Klena, J., Choi, M., et al. (2024). Continuous community engagement is needed to improve adherence to Ebola response activities and survivorship during Ebola outbreaks. Global Health: Science and Practice, 12(4). https://doi.org/10.9745/GHSP-D-23-00006

Sullivan, N. J. (2026). Bundibugyo virus disease in 2026 — Clinical and public health responses. New England Journal of Medicine, 395(3), 278–289. https://doi.org/10.1056/NEJMra2607216

Sweet, R., et al. (2024). Public health intervention amidst conflict: Violence, politics, and knowledge frames in the 2018–20 Ebola epidemic in Democratic Republic of the Congo. Social Science & Medicine, 350, 116854. https://doi.org/10.1016/j.socscimed.2024.116854

TIME. (2026, July 22). Angry mobs are attacking health workers in Congo. It will only make the Ebola outbreak worse. https://time.com/article/2026/07/22/angry-mobs-are-attacking-health-workers-in-congo-it-will-only-make-the-ebola-outbreak-worse/

Uganda Media Centre. (2026, July 28). Uganda declares the end of the 2026 Ebola disease outbreak. https://mediacentre.go.ug/press-room/uganda-declares-the-end-of-the-2026-ebola-disease-outbreak-s9m4

Uganda Ministry of Education and Sports. (2026). Circular No. 3/2026: Guidance on the Ebola virus disease outbreak and prevention measures in educational institutions.

Uganda Ministry of Health. (2026a, July 28). Uganda is officially Ebola free [press statement]. https://health.go.ug/uganda-is-officially-ebola-free/

Uganda Ministry of Health. (2026b). Standard operating procedures (SOPs) during response to the Ebola virus disease outbreak. https://health.go.ug/download/ebola-sops-may-2026/

UNFPA. (2026). Ebola outbreak — Democratic Republic of the Congo appeal (June–November 2026).

University of Oxford. (2026a, July 13). World's first Phase I Bundibugyo ebolavirus vaccine trial launched by Oxford Vaccine Group. https://www.ox.ac.uk/news/2026-07-13-worlds-first-phase-i-bundibugyo-ebolavirus-vaccine-trial-launched-by

University of Oxford. (2026b, July 24). First volunteer vaccinated in the world's first Bundibugyo ebolavirus vaccine trial. https://www.ox.ac.uk/news/2026-07-24-first-volunteer-vaccinated-in-the-worlds-first-bundibugyo-ebolavirus-vaccine-trial

U.S. News & World Report / Reuters. (2026, June 14). Health workers struggle to contain Ebola in Congo camps as distrust grows. https://www.usnews.com/news/world/articles/2026-06-14/health-workers-struggle-to-contain-ebola-in-congo-camps-as-distrust-grows

Villa, J., Wilkinson, A., Bedford, J., Schmidt-Sane, M., & Duclos, D. (2026). Ituri Ebola outbreak 2026 (DRC): Summary overview of context. Social Science in Humanitarian Action Platform. https://www.socialscienceinaction.org/resources/ituri-ebola-outbreak-2026-drc-summary-overview-of-context/

Vinck, P., Pham, P. N., Bindu, K. K., Bedford, J., & Nilles, E. J. (2019). Institutional trust and misinformation in the response to the 2018–19 Ebola outbreak in North Kivu, DR Congo: A population-based survey. Lancet Infectious Diseases, 19(5), 529–536. https://doi.org/10.1016/S1473-3099(19)30063-5

World Health Organization. (2026a, May 17). Epidemic of Ebola disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a public health emergency of international concern. https://www.who.int/news/item/17-05-2026-epidemic-of-ebola-disease-in-the-democratic-republic-of-the-congo-and-uganda-determined-a-public-health-emergency-of-international-concern

World Health Organization. (2026b). Disease Outbreak News: Bundibugyo virus disease — Democratic Republic of the Congo and Uganda [earlier editions, May–July 2026]. https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON605

World Health Organization. (2026c, August 1). Disease Outbreak News: Ebola disease caused by Bundibugyo virus — Democratic Republic of the Congo. https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON614

World Health Organization. (2026d, May 28). Experts convened by WHO advise on candidate treatments and vaccines for Ebola disease caused by Bundibugyo virus. https://www.who.int/news/item/28-05-2026-experts-convened-by-who-advise-on-candidate-treatments-and-vaccines-for-ebola-disease-caused-by-bundibugyo-virus

World Health Organization. (2026e, May 28). Message by the WHO Director-General to the people of the Democratic Republic of the Congo. https://www.who.int/news/item/28-05-2026-message-by-the-who-director-general-to-the-people-of-the-democratic-republic-of-the-congo

WHO Africa Region. (2026). BVD outbreak, DRC and Uganda: Weekly external situation report 07, data as of 28 June 2026. WHO.