



Field Guide

CULTURALLY GROUNDED EBOLA RESPONSE

For teams responding to Bundibugyo Virus Disease
in DRC and Uganda

2026

To learn more



info@as-sbc.org



as-sbc.org

Contents

1. WHAT THIS GUIDE IS FOR.....	2
HOW TO USE THIS GUIDE QUICKLY.....	2
2. THE 2026 OUTBREAK: CONTEXT AND IMPLICATIONS.....	2
3. SIX CORE PRINCIPLES	4
3.1 UNDERSTAND EBOLA/BVD AS A BIOSOCIAL EPIDEMIC	4
3.2 BUILD TRUST THROUGH WHAT THE RESPONSE DOES, NOT JUST WHAT IS SAID	4
3.3 GIVE COMMUNITIES THE POWER TO CHANGE DECISIONS	5
3.4 BUILD TRUSTWORTHY COMMUNICATION, NOT JUST RUMOUR CORRECTION	5
3.5 PROTECT DIGNITY AND TREAT LOCAL LEADERS AS DECISION-MAKERS	6
3.6 MAKE BVD RESPONSE MEASURES FEASIBLE TO FOLLOW	6
4. OPERATIONAL GUIDANCE: 13 AREAS	7
4.1 RAPID SOCIAL INQUIRY	7
4.2 COMMUNITY GOVERNANCE AND LOCAL AUTHORITY	7
4.3 COMMUNICATION AND LISTENING SYSTEMS.....	8
4.4 CARE PATHWAYS, ISOLATION, REFERRAL, AND TREATMENT-SEEKING	9
4.5 SAFE AND DIGNIFIED BURIAL AND MOURNING	10
4.6 SURVIVOR CARE, PSYCHOSOCIAL SUPPORT, AND REINTEGRATION.....	10
4.7 MOBILITY, BORDER MOVEMENT, AND LIVELIHOODS.....	11
4.8 SCHOOLS AND EDUCATIONAL INSTITUTIONS	11
4.9 FAITH INSTITUTIONS AND PUBLIC-FACING SERVICES	12
4.10 MARKETS, TRANSPORT, AND GATHERINGS.....	12
4.11 HEALTH WORKER WELFARE, PROTECTION, AND SUPPORT	13
4.12 EQUITY, STRUCTURAL VULNERABILITY, AND RESPONSE HARMS	13
4.13 MONITORING, ACCOUNTABILITY, AND ADAPTATION	14
5. DAILY RCCE-TO-OPERATIONS CHECKLIST	15
6. SELECTED SOURCES	16

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. WHAT THIS GUIDE IS FOR

This guide is for anyone responding to the Bundibugyo virus disease (BVD) outbreak in Democratic Republic of the Congo (DRC) and Uganda.

It does not replace Ministry of Health, World Health Organization (WHO), Africa Centres for Disease Control and Prevention (Africa CDC), or other technical guidance. It works alongside those documents, Standard Operating Procedures (SOPs), and protocols. It draws on lessons from previous Ebola epidemics and helps teams ask the human questions that determine whether a technical measure will work in practice: Will people trust it? Can they realistically follow it? Is it fair? Is it clearly explained?

Ebola transmission occurs through contact with infectious body fluids, but exposure is shaped by how people live: who cares for the sick, how families bury their dead, how people move, where they seek care, and whom they trust. This guide helps response teams consider the biomedical and social dimensions together, so that response measures work in real life, not only on paper.

It can be used for planning, training, coordination meetings, and adapting responses to specific districts, schools, health facilities, markets, and communities.

How to use this guide quickly

Use Section 3 to orient teams to the core approach. Use Section 4 to review the area most relevant to the day's work. Use the Section 5 checklist to make sure community feedback leads to operational decisions.

The epidemic in the DRC continues. Uganda is declared over, but risk of imported cases remains.

DRC and Uganda now require different operational approaches. Transmission continued in DRC and expanded beyond the early Ituri epicentre, amid insecurity and displacement. Uganda declared its outbreak over on 28 July 2026, but remained at risk of imported cases while transmission continued across the border. In Uganda, priorities include cross-border readiness, rapid detection, community surveillance, risk communication and communication engagement (RCCE) preparedness, and infection prevention and control (IPC) in public and private facilities. Adapt this guide to the local epidemic and institutional context rather than applying it as a fixed template.

This guide is for anyone responding to Bundibugyo virus disease (BVD) in DRC and Uganda, including teams supporting preparedness while transmission continues in the region.

2. THE 2026 OUTBREAK: CONTEXT AND IMPLICATIONS

The 2026 BVD outbreak was officially declared by the governments of the DRC 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.

By 30 July, DRC had reported 3,605 confirmed cases and 1,587 deaths. Across all affected countries, 3,626 confirmed cases and 1,589 deaths had been reported, including 20 confirmed cases and three deaths in Uganda and one imported case in France. At least 654 people had recovered. The outbreak had become the largest Ebola outbreak recorded in DRC, with transmission extending across five provinces and 49 health

zones. Ituri remained the main epicentre, accounting for most reported cases and deaths, particularly along the Bunia–Rwampara–Mongbwalu corridor.

The outbreak developed very differently in DRC and Uganda and therefore required distinct operational approaches. In DRC, transmission expanded in a setting already affected by armed conflict, displacement, mining and cross-border trade, uneven access to water and health services, linguistic diversity, and repeated humanitarian and epidemic interventions. These conditions shaped whether people sought care, reported illness and deaths, participated in contact follow-up, accepted burial procedures, or trusted response teams.

Uganda experienced a much smaller outbreak and declared it over on 28 July 2026, after 42 days without a new confirmed locally transmitted case. The country nevertheless remained at risk of imported cases while transmission continued in DRC. Uganda's experience highlighted the importance of preparedness, rapid case detection, transmission-chain reconstruction, contact follow-up, cross-border coordination, and the inclusion of private and informal providers in surveillance systems. The first case in the country moved through a private clinic in Hoima and a private hospital in Kampala before BVD was confirmed, demonstrating that private clinics, pharmacies, and other first points of care must be included in alert, referral, infection prevention and control, and result-feedback systems from the outset.

There is currently no licensed vaccine or approved therapeutic specifically for BVD. Candidate vaccines and treatments are undergoing clinical evaluation, but access during the present outbreak is 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, trusted care-seeking, safe caregiving, dignified burial, survivor support, and response measures that people can realistically follow.

A note on One Health

One Health treats human health, animal health, the environment, livelihoods, movement, and governance as connected systems. In preparedness, this means coordinating surveillance and risk assessment across land use, mining, farming, hunting, food and animal markets, water, settlement, and cross-border movement.

Fruit bats are suspected to be a natural reservoir of Bundibugyo virus, but the reservoir and specific spillover pathway for the current outbreak have not been established. Initial human infection is thought to occur through contact with infected wildlife, after which person-to-person transmission becomes the principal concern.

Once person-to-person transmission is established, One Health should not be used to blame hunting, bushmeat consumption, or cross-border livelihoods. The immediate priorities are trusted care-seeking, safe caregiving, IPC, dignified burial, survivor support, and material support that makes public health measures possible to follow.

Used well, One Health supports preparedness for ecological and livelihood risks while preventing communication from over-focusing on animal sources in ways that stigmatise communities or distract from stopping person-to-person spread.

Preparedness does not start after confirmation

BVD has caused previous outbreaks, but preparedness for Bundibugyo-specific diagnostics, vaccines, therapeutics, clinical protocols, community systems, and cross-border coordination remains limited. Preparedness is therefore a continuous preventive activity: maintain surveillance and laboratory readiness; train health workers; integrate private and informal providers into alert pathways; build trusted community networks; strengthen border coordination; and maintain One Health and RCCE systems before and between outbreaks, not only after cases are confirmed.

3. SIX CORE PRINCIPLES

These six principles guide every part of this document. They are useful for shaping how teams plan, communicate, and adapt throughout the response.

3.1 Understand Ebola/BVD as a biosocial epidemic

Ebola epidemics spread through infectious body fluids, but people are exposed to the virus through social life. This includes social activities such as caregiving, burial, work, movement, health-seeking, school attendance, worship, and family duties. Health workers are exposed through providing health care. For every medical question, there is a matching social question.

A biosocial approach recognises that biological transmission occurs within social systems that shape who is exposed, when, and under what circumstances.

Medical question	Social question
Where are cases occurring?	Why are people moving, caring, delaying, concealing, seeking care, or reacting to the response in these ways?
Who are the contacts?	What relationships, jobs, or services connect these people?
Which behaviour increases risk?	Why is this happening economically, structurally, or culturally? What circumstances make it likely? Could a control measure itself be increasing risk, for example through stigma?
Which measure reduces spread?	What support makes that measure feasible for the people expected to follow it?

3.2 Build trust through what the response does, not just what is said

- Trust is shaped by history, including past outbreaks, state presence, service delivery, livelihoods, border relations, aid delivery, and previous encounters with health authorities. This goes beyond the current epidemic response.
- Trust grows when people experience the response as respectful, honest, protective, and fair. It breaks down when words and actions do not align, or when people experience inequity, force, dishonesty, or disrespect.
- What is said should match what is done.
- To ensure effective communication and to build trust, dedicated multidisciplinary teams should be assigned at national and subnational levels to review recurring community questions and feedback, identify knowledge gaps, and provide timely technical and operational responses through trusted channels.

- Communities can be engaged constantly and still feel excluded from real decision-making. That does not build trust. Reasons for mistrust must constantly be interrogated.
- Low trust and belief in misinformation contribute to lack of adoption of protective behaviours and practices.
- The response itself can cause harm, including stigma, hidden movement, school exclusion, income loss, avoidance of clinics, unsafe private care, violence against responders, or mistrust of burial teams. The social and economic effects of the response must be tracked and considered holistically.

3.3 Give communities the power to change decisions

Risk communication and community engagement (RCCE) should be a full operational component of the response. Rumours, complaints, and refusals are data that inform understanding of trust, dignity, feasibility, and harm, and they should be treated as such.

The listening loop involves: Hearing → Classifying → Responding → Adapting → Reporting back.

The RCCE lead should sit in daily operations or incident management meetings with real authority to trigger one of four actions when the same concern keeps recurring:

- **Clarifying:** Is the issue a misunderstanding, uncertainty, a rumour, or a knowledge gap? Response should be initiated through trusted messengers, with relevant technical expertise and clear information.
- **Supporting:** Is the recommendation feasible? Are communities able to respond to the required guidance? If necessary, provide food, water, sanitation and hygiene (WASH) supplies, transport, childcare, income protection, access to communication, or other support that people need to follow the measure.
- **Adapting:** Is the measure technically correct but socially or operationally unworkable as designed? Negotiate a workable version.
- **Reviewing:** Is the measure causing harm, undermining trust, increasing avoidance, or repeatedly failing? Investigate the underlying cause and escalate the measure for reconsideration at the appropriate coordination level.

Collecting feedback without changing practice, or not explaining why a measure remains necessary, leads communities to believe that their input does not matter.

3.4 Build trustworthy communication, not just rumour correction

Misinformation spreads by word of mouth and through social media and other communication forums. Rumours may express fear, mistrust, grievance, or community interpretations of what people are seeing, as well as incorrect information. A rumour that “aid workers brought Ebola to make money” may reflect concerns about inequality or exclusion as well as a false claim.

- Find out who each group actually trusts and not just which channel reaches the most people.
- Use local communicators with genuine, trusted social standing. These may include health workers, religious and traditional leaders, teachers, women leaders, Ebola survivors, and representatives of market and transport associations.
- Engage communities in making sense of the problem, identifying relevant actions, and deciding how to communicate them. Follow participatory communication development approaches.
- Translate biomedical concepts into locally meaningful explanations, rather than simply translating technical messages into local languages.
- Track rumours as possible signals of fear, mistrust, grievance, or response harm, and avoid blaming people repeating them.

- Correct wrong information without shaming or humiliating anyone.
- Make sure communication teams can convert community concerns into real operational change.

Common mistake

Treating misinformation only as a social-media problem leads to more corrective messages, but that is rarely enough on its own. What is usually also needed is trusted relationships, communication that is audience tailored and designed with communities (not just for them), and a visible link between what is said and how the response is actually shaped.

3.5 Protect dignity and treat local leaders as decision-makers

- Isolation, referral, burial procedures, school monitoring, contact tracing, and movement rules can feel frightening and shameful. Ensure that dignity is upheld as a principle and applied wherever possible, especially for the sick, the deceased, survivors, returnees, learners, health workers, and families under monitoring.
- Never describe people or communities as “ignorant,” “resistant,” or “violent”. This language is disrespectful and blinds responders to the real reasons behind people's actions.
- A rumour, refusal, or hostile reaction may reflect fear, grief, prior harm, or response to a demand that people cannot realistically meet. Treat it as information to investigate, not proof that the community is the problem.
- Real community engagement means local health workers, faith leaders, women’s and men’s groups, youth groups, people with disabilities, displaced and refugee communities, teachers, transport workers, market leaders, survivors, traditional authorities, and other locally relevant actors help shape decisions. They should not be expected to just pass along decisions made elsewhere.
- Coercive approaches should be avoided wherever possible because they can contribute to concealment, reduced reporting, and loss of trust. Where safety risks require security involvement, this should be accompanied by urgent social diagnosis, community dialogue, and review of what caused trust to break down.

3.6 Make BVD response measures feasible to follow

A medically correct rule fails if people lack water, soap, food, transport, income, privacy, childcare, or trusted information. Feasibility is not a nice extra. It is a precondition for compliance.

- Response staff answer to many different authorities at once (e.g. WHO, Ministry of Health, national task forces, funders, communities), and these entities do not always agree. Some national measures (e.g. border rules, school monitoring) may need to be implemented even when social evidence suggests caution. In that case, focus on making the social effects visible and addressed.
- A technically correct measure can still weaken outbreak control if it causes concealment, informal movement, stigma, avoidance of health facilities, or hostility toward responders or burial teams. Treat these effects as outbreak-control problems, not merely communication problems.
- When refusal, rejection, or disagreement escalates into hostility, investigate the underlying causes alongside the necessary security response. Treat the incident as both a security concern and a signal that trust, grievance, or response practice may need attention.
- Where a restrictive measure cannot be avoided, push for the support that makes it easy to follow: food, water, communication, privacy, income protection, transport, psychosocial support, and a clear plan for when the measure will be lifted.

- Water, sanitation and hygiene (WASH) is not a side task. Without water and soap, people cannot wash their hands, isolate safely, care safely, or support dignified burial. They should have the means to apply whatever the rule says.

4. OPERATIONAL GUIDANCE: 13 AREAS

Each area below covers why it matters, questions to ask, what teams should do, and a common mistake to avoid. Mistakes are marked by how serious they are:

A **Trigger** starts a problem, an **Amplifier** makes an existing problem bigger, and a **Transmission accelerator** directly increases the risk of transmission. Transmission accelerators require the most urgent response.

Escalate immediately if:

The same concern appears in three or more communities; the same issue repeats for two or more days; families are hiding illness or deaths; burial teams are refused access; people are avoiding formal crossings or health facilities; health workers or responders are threatened; schools or institutions are excluding learners or returnees; or a response measure is causing visible harm.

4.1 Rapid social inquiry

Why it matters: Research in Uganda found that some locally used epidemic-control practices aligned with biomedical advice, while others required adaptation. Begin social inquiry during preparedness and from day one of a response. Do not wait for resistance to appear.

Ask:

- What do people call this illness, and what makes it recognisable or frightening?
- What explanations are people discussing? For example, animal, environmental, spiritual, social, or human causes?
- Who is seen as most at risk? How does Ebola compare to other risks people are already worried about (conflict, hunger, insecurity)?
- Where do people go first for care, and who cares for the sick at home?
- What happens when someone dies? Who normally prepares the body, and who has authority to negotiate changes to burial practice?
- What livelihoods (mining, farming, hunting, trade) might involve risk, and what protection is possible without destroying income?

Common mistake (Trigger / Amplifier)

Waiting until resistance appears before involving advisors or community members in the inquiry.

4.2 Community governance and local authority

Why it matters: Community engagement must mean shared authority, not only information, consultation, or message delivery. “Community” is not one group. In Ituri, engagement should be differentiated by ethnicity, language, gender, age, disability, indigeneity, displacement status, and economic position. Security-heavy operations can undermine trust and contribute to concealment rather than cooperation.

Do:

- Consider setting up a Community Decision Forum that can raise concerns, propose changes, receive real answers, and report back. Membership should reflect the setting and may include local health workers, religious and traditional leaders, women's and men's group leaders, youth, people with disabilities, displaced and refugee communities, Mbuti or other Indigenous representatives, school leaders, market and transport representatives, burial teams, survivors, local government, and local researchers.
- Map trusted people within the small groups through which care, protection, transmission, and accountability operate. These include households, burial teams, market stalls, transport and boda groups, mining teams, school classes, congregations, women's, men's and youth groups, survivor networks, displaced households, and cross-border livelihood groups. Link these groups to district or health-zone coordination before transmission peaks.
- When refusal, rejection, or disagreement escalates into hostility, investigate the underlying causes alongside the necessary security response. Ask: what grievance is driving this? Who has legitimate authority and community trust to address it? What would have to change for engagement to become possible again? Security-heavy operations can undermine trust and contribute to concealment, so security action should be accompanied by social diagnosis and community dialogue.

Common mistake (Trigger / Amplifier / Transmission accelerator)

Trigger: Using local leaders only to deliver decisions made elsewhere. **Amplifier:** assuming one single "community" exists. **Transmission accelerator:** treating hostility or rejection only as a security problem before investigating what is driving it.

4.3 Communication and listening systems

Why it matters: Low trust and belief in rumours are strongly linked to lower adoption of protective behaviour and formal healthcare. Rumours that aid workers "brought Ebola to make money" may reflect unequal aid economies and exclusion as well as false information. In Ituri, language is a major operational barrier: Swahili and Lingala are common in towns and administration, French is understood by only some people, and village-level languages such as Hema, Lendu, and Nyali are often absent from official materials. Mbuti communities and other marginalised groups may also require dedicated trusted intermediaries rather than standard engagement channels.

Urgent action on language

Almost no existing RCCE materials will be ready for community-level use in Ituri without review and translation. This is not a later-phase task. Audit which materials exist in which languages, identify gaps in village-level and marginalised-community languages. Test translations with affected groups, deploy appropriately skilled interpreters, and identify trusted intermediaries for Mbuti and other populations not reached through standard channels.

Do:

- Give the RCCE lead a seat in daily operations or incident management team (IMT) meetings, with authority to escalate recurring concerns and trigger Clarify, Support, Adapt, or Review decisions (see Section 3.3).
- Review feedback for patterns across places, groups, and time, and not just individual comments.

- Track what changed in the response because people were heard, not just how many rumours were “corrected.”

Common mistake (Trigger / Amplifier)

Treating rumour-tracking as only “correcting misinformation” rather than social diagnosis. Producing materials only in administrative languages, without testing whether affected communities actually understand them. Keeping RCCE data in a separate track instead of feeding it into decisions.

4.4 Care pathways, isolation, referral, and treatment-seeking

Why it matters: People may delay, hide illness, move between districts, or use different providers because of fear, cost, mistrust, stigma, family duty, or poor access to respectful care. Early BVD symptoms (vomiting, diarrhoea, stomach pain, weakness, hiccups) look like malaria, typhoid, or gastroenteritis, so people (and even clinician) may not recognise a case as Ebola at first.

Private clinics, pharmacies, drug shops, and traditional, spiritual, or faith healers are often first points of care and must be included in alert systems, specimen referral, training, IPC support, and result feedback.

Care pathway map. Ask at each step:

Step	Ask
Home care	Who is caring for the sick person? What resources do they have?
First advice	Who is consulted first—a healer, neighbour, pharmacist, local leader, or religious leader?
First care source	Private clinic, pharmacy, public facility, or traditional healer?
Transport	Is transport available? Who pays? Who transports the patient? How far is it?
Triage / isolation	Is triage or isolation perceived as safe? Can the family remain in contact?
Return or burial	What support exists for the family? What happens at death?

At every step, ask: where does the pathway break down, and what fear, cost, or delay is causing it?

Do:

- List every private clinic, pharmacy, and drug shop in the district, and check that each is actually connected to the alert pathway. Staff need to know whom to call, how to refer specimens, and how to return results.
- Agree to refer to traditional, spiritual, and faith healers rather than policing them. Focus on symptom recognition, safe, non-contact support, privacy, and a route for referral. Criminalisation may drive these care pathways out of sight, making safer practice harder to support.
- Before telling anyone to report early, check that reporting early is safe, affordable, and practical for them. If transport costs money, if isolation means lost income, or if a family cannot stay in contact with a relative in care, the instruction may be difficult or impossible to follow.

Common mistake (Transmission accelerator)

Telling people to “report early” without making early reporting safe, affordable, trusted, and genuinely practical.

4.5 Safe and dignified burial and mourning

Why it matters: Burial is a high-risk transmission event and also a morally, religiously, emotionally, and socially essential process. Forceful or secretive burial practices can produce fear, mistrust, concealment, and unsafe private burial. Evidence from Sierra Leone and North Kivu suggests that family observation and accompaniment, religious presence, transparent body bags or safe viewing, family-chosen clothing or perfume, and trained community burial liaisons can help address family concerns and make safe burial practices more acceptable.

The difficulty is often not simply the prohibition on touching the body, but the loss of families’ ability to see, accompany, identify, and mourn the deceased.

Practical adaptations that preserve dignity:

- Transparent body bags or safe-distance viewing, so families can confirm who has died.
- Family accompaniment of the ambulance or burial team where possible.
- A burial documentation card or grave marker, so families have proof and can find the grave.
- Trained community members serving as liaisons between families and burial crews. Their role is not to make the body medically safe, but to explain procedures, relay family wishes, and represent the family.
- Religious leaders present, and symbolic alternatives (prayer, blessing, placing a personal item) where touching or washing the body is unsafe.
- Clear waiting-time information so families are not left in distress.

Before every burial, ask:

- Who normally prepares the body, and who must be informed?
- What rituals are essential, and which of these can be done safely?
- Can the family view the body from a safe distance?
- How will the family receive proof of burial and follow-up support?

Common mistake (Transmission accelerator)

Treating burial only as a body-management procedure, rather than a religious, emotional, social, and public health process all at once.

4.6 Survivor care, psychosocial support, and reintegration

Why it matters: Stigma against survivors is well documented across DRC, Sierra Leone, Guinea, Liberia, and Uganda. It can discourage symptom reporting, delay care-seeking, and worsen workforce shortages, with plausible consequences for transmission control. Survivors who receive good psychosocial support and choose to become advocates can be powerful voices for trust and reduced stigma.

Do:

- Set up survivor support groups from the very start of the response, not after it ends.
- Give patients phone access to family members during treatment.
- Involve psychosocial support in case management from day one, not as an afterthought.
- Protect privacy in contact tracing and during a person's return home.
- Support survivors who want to become community advocates, with training and appropriate protection.
- Track economic losses among survivors as part of equity monitoring.

Common mistake (Amplifier)

Treating survivor care as something to deal with after the outbreak, rather than as part of outbreak control from the outset.

4.7 Mobility, border movement, and livelihoods

Why it matters: Families, ethnic groups, healing networks, and traders cross the DRC–Uganda border constantly. This movement sustains livelihoods, kinship, care, and access to services. Uganda's outbreak was declared over on 28 July 2026, but the country remained at risk of imported cases while transmission continued in DRC. Blanket restrictions may push movement underground rather than stop it.

Before restricting movement, ask:

Question	Why it matters
What specific risk does this measure address?	Avoids broad, symbolic restrictions.
Who is most affected and how?	Identifies who carries an unfair burden and the impact on their lives.
What essential movement must continue?	Protects food, water, care, trade, and health access.
What support makes compliance possible?	Prevents hidden movement and non-reporting.
How will it be explained, and to whom?	Reduces panic and rumour.
What will trigger lifting the measure?	Keeps the measure proportionate and accountable.

Common mistake (Amplifier / Transmission accelerator)

Treating all movement as dangerous, instead of asking what social, economic, and care needs that movement is meeting. Avoid designing border measures without accounting for cross-border kinship and livelihood networks.

4.8 Schools and educational institutions

Why it matters: Closing schools has real costs that affect learning, nutrition, and family stability. Keeping them open safely depends on having the resources to follow the rules, not just on issuing them. Uganda's

Ministry of Education called for school-based Ebola teams, regular sensitisation, and immediate reporting of suspected cases, with SOPs requiring handwashing facilities, temperature screening, and isolation areas.

Before treating a school as ready, check:

- Is there clean running water and soap at entrances, classrooms, dormitories, dining areas, and toilets?
- Are thermometers and disinfectant available, and actually used?
- Is there a designated isolation area, and who contacts parents when it's needed?
- How are sick children monitored without being publicly singled out or shamed?
- How are boarding students and children without nearby guardians supported?

Common mistake (Trigger / Amplifier)

Rolling out standard procedures at a school without first checking whether it actually has the water, supplies, and staffing to carry them out.

4.9 Faith institutions and public-facing services

Why it matters: Churches, mosques, banks, hotels, and workplaces are not just risk settings. They are trusted sources of care, information, and livelihood. Faith leaders provide pastoral care, burial guidance, and moral reassurance. If they are only asked to pass on messages, the response misses their deeper role in shaping trust and cooperation.

Work with leaders and managers in each setting to ask:

- Who has real authority? Religious leaders, managers, worker representatives, local councils?
- What are the actual risks: crowding, shared surfaces, overnight stays, food service, prayer or healing practices?
- What is feasible: handwashing stations, symptom reporting, safe spacing, staff protection from stigma or lost income?
- How will confidentiality be protected if a client, guest, or worker turns out to be a contact or case?
- How will concerns from these institutions be fed back into district coordination?

Common mistake (Amplifier)

Treating faith institutions, banks, hotels, and workplaces only as places to deliver messages or as risk settings, rather than as trusted social systems with their own authority.

4.10 Markets, transport, and gatherings

Why it matters: Markets sustain food access and livelihoods; transport enables both care-seeking and work. Restrictions designed without understanding this social role are usually ignored or resisted.

Ask:

- Who uses this space, and why? What makes it risky?
- What protective measure is actually feasible here, and what would make it impossible to follow?

- Who can legitimately encourage or enforce it, can market leaders be engaged for this?
- Could water utilities or soap manufacturers be engaged to provide free water and soap in high-risk markets?
- How will people report concerns, and how will the measure be revised if it fails?

Common mistake (Amplifier)

Issuing general restrictions on markets or transport without understanding the social and economic function of the space, or the practical barriers to following the rule.

4.11 Health worker welfare, protection, and support

Why it matters: Health workers, burial teams, community health workers, and volunteers face sustained occupational exposure, long hours, colleague deaths, security threats, and stigma. Their wellbeing and material protection directly shape the quality and credibility of care.

Do:

- Build psychosocial support into the plan from the start, not only after burnout becomes visible.
- Ensure timely payment, adequate PPE, effective IPC support, manageable working hours, and practical security arrangements. Material protection must accompany psychosocial support.
- Create peer support structures and regular debriefs, especially after deaths or security incidents.
- Address the stigma health workers face in their own communities, particularly burial team members.
- Include community health workers, traditional healers, and informal providers in welfare planning. They often carry heavy burdens without formal protection.

Common mistake (Amplifier)

Treating health worker psychological welfare as a personal matter rather than an operational one and leaving informal workers and volunteers out of welfare planning.

4.12 Equity, structural vulnerability, and response harms

Why it matters: Equity means understanding who is most exposed, who has the least power to comply, who bears the costs of response measures, and who is excluded from decisions. In the 2018–20 DRC outbreak, women made up 57% of confirmed cases, reflecting caregiving, trading roles, and constrained agency rather than differential biological risk. The current outbreak is also unfolding amid conflict, mass displacement, severe WASH shortages, and a major gender-based violence and protection crisis. These conditions must be monitored without assuming that the Ebola response caused every harm.

Equity screen: check each group's risks and the harms the response could cause them:

Group	Key exposure	Possible response harm
Women caregivers and traders	Caregiving exposure; income loss from market closures; GBV risk under quarantine	Isolation without childcare, income, or domestic support

Group	Key exposure	Possible response harm
Survivors	Stigma; psychological distress; livelihood loss	Conspicuous follow-up; being publicly marked by response teams
Health workers and burial teams	Infection risk; stigma; security threats	Burnout, attrition, community exclusion
Traditional healers	Contact with sick people; social authority; stigma	Exclusion from planning and referral systems; criminalisation; loss of trust
Displaced people and refugees	Limited access to services; crowding; WASH shortages; language barriers; mobility	Exclusion from surveillance or contact follow-up; restrictions without humanitarian exceptions; inaccessible or untranslated information
Children and orphans	Schooling disruption; loss of caregivers	Stigma from school monitoring; poor orphan-care pathways
Mbuti, people with disabilities, and other marginalised groups	Discrimination; inaccessible services and communication; low trust in formal authorities	Exclusion from decisions and standard engagement channels; inaccessible facilities or materials

Keep gender-based violence (GBV), sexual and reproductive health, child protection, disability inclusion, and psychosocial referral pathways open and actively monitored throughout the response.

Common mistake (Amplifier / Transmission accelerator)

Naming vulnerable groups without tracking who bears the cost of response measures, and who is excluded from decisions.

4.13 Monitoring, accountability, and adaptation

Why it matters: A grounded response tracks trust, rumours, feasibility, protection concerns, and response harms—not only case counts and supplies. Security incidents may arise from conflict, criminality, political contestation, fear, grievance, or response conduct. They should be investigated as both security events and potential signals that the social and political conditions of the response need attention.

Monitor, at minimum:

- Trust and legitimacy of response teams, facilities, and messaging
- Rumours, and what fear or grievance they point to
- Care-seeking patterns: reporting, delay, informal border crossing
- Burial acceptance and whether families feel treated with dignity
- Border and mobility effects, including informal or hidden movement
- School feasibility and stigma toward returning learners
- Health worker welfare: burnout, stigma, PPE, and payment
- Equity and response harms across the groups in Section 4.12
- Protection concerns: GBV, child protection, disability inclusion, displacement, and access to referral services

When the same concern is reported in three or more communities, or repeats over two or more days, escalate it and decide: Clarify, Support, Adapt, or Review (see Section 3.3).

Common mistake (Amplifier / Transmission accelerator)

Collecting social data but not changing response practice. Keeping this monitoring separate from operational decision-making and failing to escalate patterns that keep repeating.

Example: adaptation dashboard

Use a simple running log like this at district or coordination level. Update it regularly. It is a decision tool, not just a report.

What communities reported	Who reviewed it	What changed
Families don't know where bodies are buried after safe burial teams take them.	District coordinator, burial team lead, RCCE lead, religious/community representative	Burial documentation cards issued; safe viewing options reviewed; process explained to families before removal
Returnees from DRC report difficulty completing 21-day self-isolation.	District surveillance team, social protection focal point, local leaders, RCCE team	Household feasibility assessment added; food and income support referral created; privacy guidance issued to monitors

5. DAILY RCCE-TO-OPERATIONS CHECKLIST

For use in daily district, health-zone, point-of-entry, or hotspot coordination meetings. Its job is to make sure community feedback, feasibility barriers, and dignity concerns are treated as operational issues.

Step	Check
1. Data in	Rumour/concern log updated. Feedback reviewed by gender, age, language, ethnicity, displacement status, and location. Materials checked in relevant local languages.
2. Analysis	Issues classified: misinformation, feasibility barrier, dignity concern, trust concern, or response harm. Pattern check: same issue in 3+ communities, or repeated 2+ days → escalate.
3. Authority	RCCE lead present at the operations meeting. Community Decision Forum inputs reviewed. Trusted small-unit actors linked in (households, burial teams, market stalls, school classes, congregations).
4. Decision	Choose one: Clarify (fix a rumour/gap) · Support (fill a feasibility gap) · Adapt (renegotiate how a measure is implemented) · Review (escalate a harmful or failing measure).
5. Report back	Within 48 hours, tell communities: "We heard X; here is what changed / what support is available / why the measure remains necessary." Use trusted channels: leaders, radio, health facilities, schools, markets.
6. Cross-border check	Track hidden movement, informal crossings, and stigma toward returnees, travellers, and learners. Review weekly with neighbouring districts/health zones.

Reminder

This is not just a report. If the pattern check is positive, or support/adaptation/review is triggered, decide the action in the meeting, or escalate it to the right coordination level.

6. SELECTED SOURCES

This field guide draws on published evidence from Ebola outbreaks in DRC, Uganda, Sierra Leone, Guinea, and Liberia, and on 2026 reporting for the BVD outbreak. Full citations, evidence limitations, and the preparedness framework are provided in the companion Evidence Review.

- Farmer, P. (1996). Social inequalities and emerging infectious diseases. *Emerging Infectious Diseases*.
- Krieger, N. (2001). A glossary for social epidemiology. *Journal of Epidemiology and Community Health*.
- Hewlett & Amola (2003). Cultural contexts of Ebola in northern Uganda. *Emerging Infectious Diseases*.
- Lee-Kwan, DeLuca, Bunnell, Clayton, Turay & Mansaray (2017). Facilitators and barriers to community acceptance of safe, dignified burials, Sierra Leone. *Journal of Health Communication*.
- Mayhew, Kyamusugulwa, Bindu, Richards, Kiyungu & Balabanova (2021). Responding to the 2018–2020 Ebola outbreak in DRC. *Risk Management and Healthcare Policy*.
- Nsawotebba et al. (2026). Clinical profile and genomic characterization of the 2026 Bundibugyo virus index case in Uganda. *Nature Medicine*.
- Paterson et al. (2025). Ebola stigma and its impact on outbreak control, central Uganda. *Tropical Medicine & International Health*.
- Pham, Vinck & Nilles (2020). Protective behaviours associated with gender during the 2018–2020 Ebola outbreak, eastern DRC.
- Redondo, Murray, Bromhead & Makumbi (2025). Equity in pandemic preparedness and response: Ebola and COVID-19 in Uganda. *Critical Public Health*.
- Rutakumwa et al. (2025). Ebola survivors' psychological experiences of evacuation, treatment, and reintegration, Uganda 2022. *PLOS Mental Health*.
- Schmidt-Sane et al. (2020). Challenges to Ebola preparedness during an ongoing outbreak: Borderland livelihoods and trust in Uganda. *PLOS ONE*.
- Sikakulya, Ilumbulumbu, Djuma, Bunduki, Sivulyamwenge & Jones (2021). Safe and dignified burial in Eastern DR Congo. *One Health*.
- Sweet et al. (2024). Public health intervention amidst conflict: Violence, politics, and knowledge frames in the 2018–20 Ebola epidemic in DRC. *Social Science & Medicine*.
- Uganda Ministry of Education and Sports (2026). Circular No. 3/2026: Guidance on Ebola prevention in educational institutions.
- Uganda Ministry of Health (2026). SOPs during response to the Ebola Virus Disease outbreak.
- Villa, Wilkinson, Bedford, Schmidt-Sane & Duclos (2026). Ituri Ebola Outbreak 2026 (DRC): Summary overview of context. SSHAP.
- Vinck, Pham, Bindu, Bedford & Nilles (2019). Institutional trust and misinformation in the 2018–19 Ebola outbreak, North Kivu. *Lancet Infectious Diseases*.
- WHO Africa Region (2026). BVD outbreak: DRC, Uganda. Weekly external situation report 07.
- World Health Organization (2026). Disease Outbreak News: Bundibugyo virus disease — DRC and Uganda.