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# Putting Communities and Trust at the Centre of Outbreak Control

## Information Dynamics, Risk Communication and Community Engagement in the Ebola Bundibugyo Virus Disease Response

ROIX-ROUGE
E LA RÉPUBLIQUE
CRATIQUE DU CONGO
TO CICR BUTEMBO
EBOLA/ FICR BUTEMBO

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# Summary


## Overview

The Bundibugyo virus disease (BVD) outbreak in eastern DRC is at a critical juncture. As of late June, the outbreak is still growing and has spread across a large and widening number of health zones. Transmission is currently outpacing control efforts, and the caseload is stretching the response faster than capacity can be built to meet it. The response itself has scaled substantially: contact tracing has improved sharply, decentralised diagnostics are now operational across multiple sites, and community outreach continues to expand. That scaling is significant but not yet sufficient, and it has not yet turned the trajectory of the outbreak.

The outbreak – and key aspects of the response – are being shaped as much by harmful information dynamics as by the epidemiology of the disease itself. Meanwhile, with no licensed vaccines or therapeutics currently available for the Bundibugyo strain, the response depends primarily on community-based measures, making trust central to outbreak control.

This paper draws on the IFRC 2026 *World Disasters Report* and wider literature on harmful information to assess the current outbreak and sets out robust recommendations for the response across four possible future trajectories.

## Harmful information dynamics in the outbreak and response

Harmful information as well as the health and safety of information environments can shape an outbreak and its response through six elements that operate as a cycle of amplification, with consequences feeding back into context.

- **Context:** long-running armed conflict, M23 control of parts of North and South Kivu, fragmented armed group ecosystem, historical marginalisation, eroded institutional trust, concurrent cholera outbreak, supply pressures driven by the Middle East crisis.
- **Causes:** armed groups with political incentives, local political actors, and cultural and family authorities all operating as competing authority systems rather than separate sources of harmful information.
- **Content:** five distinct narratives in active circulation (see box below).
- **Channels:** WhatsApp, community radio, markets, churches, family networks, the operational footprint of the response itself.
- **Consequences:** physical (attacks on facilities and volunteer teams), psychological (fear suppressing care-seeking, survivor stigma), operational (detection gap, contact tracing gaps, IPC weaknesses, patient walk-outs from treatment centres), societal (cultural rupture, institutional trust erosion, militarisation of health responses).
- **Cycle of amplification:** consequences feed back into context, compounding the trust deficit and making narratives harder to dislodge. Trust is event-driven and reversible; a single visible incident can undo weeks of engagement work.

| Narratives in circulation | |
|---|---|
| **Denial of the disease** (outbreak dismissed as invented or exaggerated to serve financial interests) | **Cultural rights claims** (body removal as denial of mourning rights) |
| **Hostile intervention reframe** (response as a cover for military presence and resource extraction; global north protection grievance) | **Political failure and manipulation framing** (response as evidence of state negligence, international mobilisation as cover for political consolidation) |
| **Alternative causation** (typhoid framing, plant and-potion vaccine alternatives, bioweapon framing, arsenic poisoning theory) | |

## Emerging impacts of harmful information on the response

### Detection and tracing

Decentralised testing is operational at multiple sites, and mobile laboratories have been deployed. Confirmation remains slower than is ideal, particularly for safe and dignified burial. The numbers of families demanding laboratory confirmation before agreeing to safe and dignified burials pose operational challenges: it is encouraging because it shows communities are engaging with rather than rejecting biomedical evidence, but the demands indicate underlying scepticism as the precondition for communities. Contact tracing performance is an important proxy measure of trust and is steadily increasing but not yet at target levels.

### Response capacity

Health workers and volunteers face dual risks of physical contagion and stigmatisation. Where narratives frame the response as covert hostility, the workforce becomes a target for wider anger. Community engagement is the primary mechanism for addressing trust dynamics but works only where the response has institutional capacity to listen and act. Funding pressures often fall hardest on the patient, long-term community engagement work that responses rely upon.

### Treatment and care

Treatment uptake depends on whether centres are seen as places of care or as places where people go to die. The Village d'Accompagnant model used in 2018–2020 led to a measurable improvement in acceptance where adopted. Patient retention during treatment is shaped by the same perceptions: unplanned patient departures from Ituri health facilities during the most recent reporting period signal the extent of ongoing challenges. Survivors are frequently underutilised but have proved vital in an effective response. Burial dynamics are perhaps the most contested element of this response, in common with other Ebola disease responses.

## Four possible trajectories from here

The trajectory of the outbreak depends on two uncertainties: community trust (low to high) and the security and conflict environment (stable to escalating). These generate four trajectories that should be read as directions of travel rather than exclusive end-states.

| Trajectory | Conditions | Where we are relative to this trajectory |
|---|---|---|
| **1. Effective containment** | High trust, stable security | Closer than a month ago. Substantial gains in contact follow-up, decentralised capacity and community reach. But follow-up remains below the 90% target, feedback systems are not yet consistently visible in operational decisions and burial protocol negotiation is uneven. |
| **2. Constrained response** | High trust, escalating security | Least likely at this point. Information dynamics frame the response as part of external intervention, so security escalation almost inevitably challenges both trust and access. Lesson: investment in local relationships builds resilience if conditions get harder. |
| **3. Persistent trust gap** | Low trust, stable security | A clear forward risk. Cases continue rising, new health zones have reported confirmed cases, unplanned patient departures from health facilities suggest pockets of fragile trust. Risk that operational improvements appear to be working while the outbreak spreads geographically. |
| **4. Compounded crisis** | Low trust, escalating security | Some way away at present, but enabling conditions exist. M23 controls territory in parts of North and South Kivu, attacks continue, the funding environment is constrained. 2018–2020 is the closest historical reference, but features of the current situation could make this trajectory more severe. |

The signs to watch are community feedback, especially around testing, treatment and burial, harmful narrative entrenchment, continued geographic spread and changes in the security and conflict picture.

## Priority recommendations

The paper sets out 14 recommendations structured in 4 parts. The most critical for action are summarised below.

## Immediate operational priorities

- **Set up transparent two-way communication and community feedback.** Community feedback institutionalised as a core input into decision-making, with weekly adaptation.

- **Recruit, support and protect locally embedded volunteers.** IHR Emergency Committee protection package visibly operational. Recruitment and service delivery visibly fair and equitable.

- **Build surveillance from the community level.** Communities as a primary source of outbreak intelligence, not only as recipients of information. Surveillance systems should be informed by, and responsive to, community reporting and feedback.

- **Redesign burial operations around community involvement.** Burial teams should include trusted individuals with roles in funeral practices, supported by appropriate IPC training and protection. Protocols should be locally negotiated to ensure safety while respecting cultural and social obligations.

- **Resource psychosocial support and survivor engagement.** Survivors emerging now. Survivor leadership in planning, management and engagement activities builds trust where institutional channels have struggled.

- **Address the social and economic needs of affected families.** Food support, transport, cash assistance for those isolating, MHPSS, child protection. Where compliance imposes costs households cannot absorb, cooperation with detection, isolation and burial measures will decline.

## Cross-cutting response capabilities

- **Differentiate engagement strategy by the political, security and social context of each health zone.** Communities are not homogeneous; a singular approach across zones will entrench rather than resolve trust issues.

- **Communicate transparently and in dialogue with communities.** Local actors as co-designers, co-implementers and accountability actors, not message relays. Community engagement is not only communication; it is how the response behaves.

- **Deal with gender and disability as cross-cutting vulnerabilities.** Sex-disaggregated data, women in named strategic roles, disability inclusion in how the response delivers information and services.

- **Treat cross-border coordination as a trust and security function, not just surveillance.** Without understanding and monitoring the information environment on both sides of the border, the response risks missing key drivers of behaviour and transmission.

## System-wide leadership

- **Anticipatory function and adaptive programming architecture.** Community intelligence used in contingency planning and operational decisions. Funding mechanism should enable adaptation, including flexibility for reallocating resources in response to community intelligence and evolving operational needs.

- **Social and behavioural science capacity embedded alongside medical and logistical capacity.** Senior level, dedicated resources and clear pathways

into incident command. Evidence base includes anthropological studies, behavioural data, social/community listening, perception surveys.

- **Accountability to affected populations institutionalised.** Named senior accountability-holder, defined routes into incident command, published commitments, minimum accountability standards audited regularly.

- **Operations anchored in humanitarian neutrality and independence.** Critical conditions that determine community access. Where the response is perceived as aligned with military or political actors, perceptions of hostility can intensify and undermine trust.

## Trajectory-specific actions

- **If Trajectory 2 is emerging:** Increase IPC capacity in areas that can still be reached; pre-position supplies through alternative routes; work with trusted community actors to maintain access rather than relying on military escorts; build community-based reporting in areas that cannot be reached; prioritise the safety of volunteers.

- **If Trajectory 3 is emerging:** carry out rapid qualitative assessments in areas where communities are disengaged; step up identification and support for survivors; shift from general messaging to communication led by survivors; avoid expanding into new areas until trust improves in current locations.

- **If Trajectory 4 is emerging:** scale up international support urgently; focus on protecting the existing volunteer network; preserve remaining trust in affected communities; if movement restrictions are introduced, ensure support for affected people (food, water, communication, financial and psychosocial support).

# 1 Introduction and focus of this paper

On 17 May 2026, WHO declared the Bundibugyo virus disease (BVD) outbreak in Ituri Province, Democratic Republic of Congo (DRC), a Public Health Emergency of International Concern (PHEIC).[1]

The outbreak is occurring amid an ongoing complex emergency driven by conflict and violence.[2] Armed conflict, the extensive militarisation of eastern DRC, political instability around proposed constitutional changes and high levels of sexual violence compound longstanding humanitarian pressures in the region.

Almost 2 million people were already in acute need before the outbreak began. Ituri's artisanal mining economy depends heavily on purchased fuel, and supply and price disruptions resulting from the Strait of Hormuz crisis have been placing further pressure on communities already stretched to their limits. DRC is also experiencing a severe cholera outbreak, while continuing to face a chronic burden of malaria and measles. This has further strained health system capacity in the affected regions,[3] and is feeding wider grievances related to the selective nature of international attention.

No licensed vaccines or therapeutics exist for the Bundibugyo strain of Ebola, although investigations are active and new experimental candidates are emerging. When these become available, deployment will depend on the wider conditions in affected health facilities.

In the last few weeks, contact tracing has improved sharply, decentralised laboratory capacity has been deployed, treatment centres have scaled and cross-border coordination has strengthened. While the response is scaling, however, this is from a low base. Performance remains below what is needed to interrupt transmission, the outbreak continues to expand faster than the response can contain it, and cases and deaths continue to rise. (See Box 1 for the status of the outbreak at the time of writing.)

Given the constraints faced, the current response relies on community-based case finding, contact tracing, infection prevention, safe and dignified burial, and supportive care. All these interventions depend critically on communication, engagement and trust. The same will apply to any future therapeutics or trials.[4,5]

WHO has been explicit on this point, noting that the conditions of the outbreak "underscore the need for response efforts to be led by local leaders and anchored in communities."[6] Communities are not just stakeholders in outbreak control but primary actors, and must be involved as central partners in design and delivery.

However, the information and trust dynamics on which the response depends are deeply complex and contested. The International Health Regulations (IHR) Emergency Committee has acknowledged that the response is being undertaken in "one of the most challenging operational environments possible."[7] WHO received the initial alert on 5 May, accompanied by a warning to WHO's Director-General that the disease could have been circulating unreported for months. This gap between transmission, reporting and detection is itself a signal of pre-existing trust deficits and challenges in community engagement. The past few weeks have also seen attacks on medical facilities[8] and on volunteer teams,[9] disputes around burial protocols at cemeteries, constrained access for response teams in zones of active conflict and challenges related to coordination across territories controlled by the state and non-state armed groups.

Box 1

# Snapshot of the current context

Figures and operational details are changing rapidly. For the latest updates, see the WHO's weekly Situation Reports and Disease Outbreak News.

**DRC cases, deaths and recoveries:** As of 28 June 2026, 1,307 confirmed cases and 377 confirmed deaths have been reported in DRC across 35 affected health zones spanning 3 provinces (Ituri 23, North Kivu 11, South Kivu 1). The reported case fatality rate of 28.8% is likely an underestimate given the high number of deaths that remain under investigation. A total of 195 patients have now recovered in DRC.

**Geographic distribution:** 91.6% of confirmed cases and 84.4% of national fatalities are concentrated in Ituri, with Bunia, Rwampara, Mongbwalu and Nyankunde health zones the most affected. The case fatality rate in North Kivu stands at 54.2%, with deaths concentrated in the densely populated urban centres of Katwa, Butembo and Beni. These patterns should be interpreted in the context of expanded surveillance: part of the recent rise in confirmed cases reflects the scale-up of testing and the clearing of a backlog of previously collected samples.

**Operational status:** 9,968 contacts were under follow-up across the three affected DRC provinces at the time of update, with 8,105 (81.3%) having been seen in the previous 24 hours. Follow-up rates vary by province (Ituri 82.9%, North Kivu 75.6%). National bed occupancy in treatment facilities stands at 96.2%, with Ituri facilities at 91.7%.

The Ituri Health Cluster Infection Prevention and Control (IPC) Readiness Assessment in May 2026 scored Mongbwalu General Referral Hospital at only 34% and other assessed facilities below 7%.[10] A broader system-wide assessment of 21 June 2026, conducted across 236 facilities in 28 health zones, found overall IPC performance to be at 44%, with two-thirds of facilities still classified as "insufficient."[11]

In Ituri, 1,350 trained community mobilisers (RECOs) have conducted 43,899 household visits reaching 153,512 people with Ebola prevention messages. In North Kivu, Red Cross volunteers and other community actors reached 52,105 people with Ebola prevention messages and covered 16,332 households. In South Kivu, 879 frontline workers have conducted 35,500 household visits reaching 175,800 people including 99,447 women[12]. WHO notes that although contact follow-up and alert investigation have improved, performance remains insufficient to rapidly interrupt transmission.

**Cross-border and regional:** Uganda has reported 20 confirmed cases (2 deaths) and 1 probable case that has resulted in death, with exposure risks concentrated in healthcare settings. Uganda's most recent case, on 21 June, was a truck driver operating along the DRC-Uganda route. 15 Ugandan patients have recovered. Ten neighbouring countries have stepped up border readiness and alerts. On 24 June, French authorities confirmed a case in a physician returning from a five-week deployment in Ituri; the patient self-reported symptoms on arrival at Charles de Gaulle, was isolated and PCR-confirmed positive for Bundibugyo virus. This brings to three the number of countries with confirmed BVD cases from this outbreak.[13, 14, 15, 16, 17, 18]

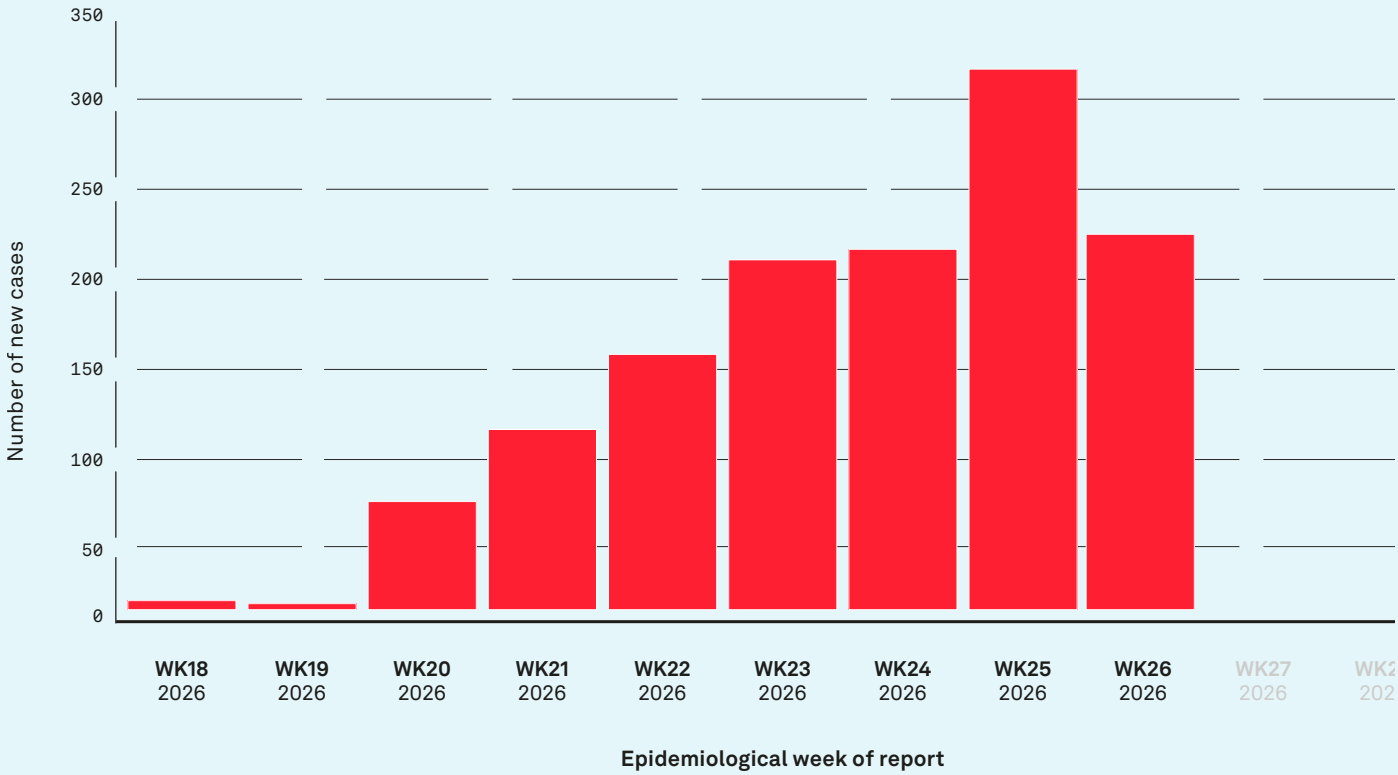
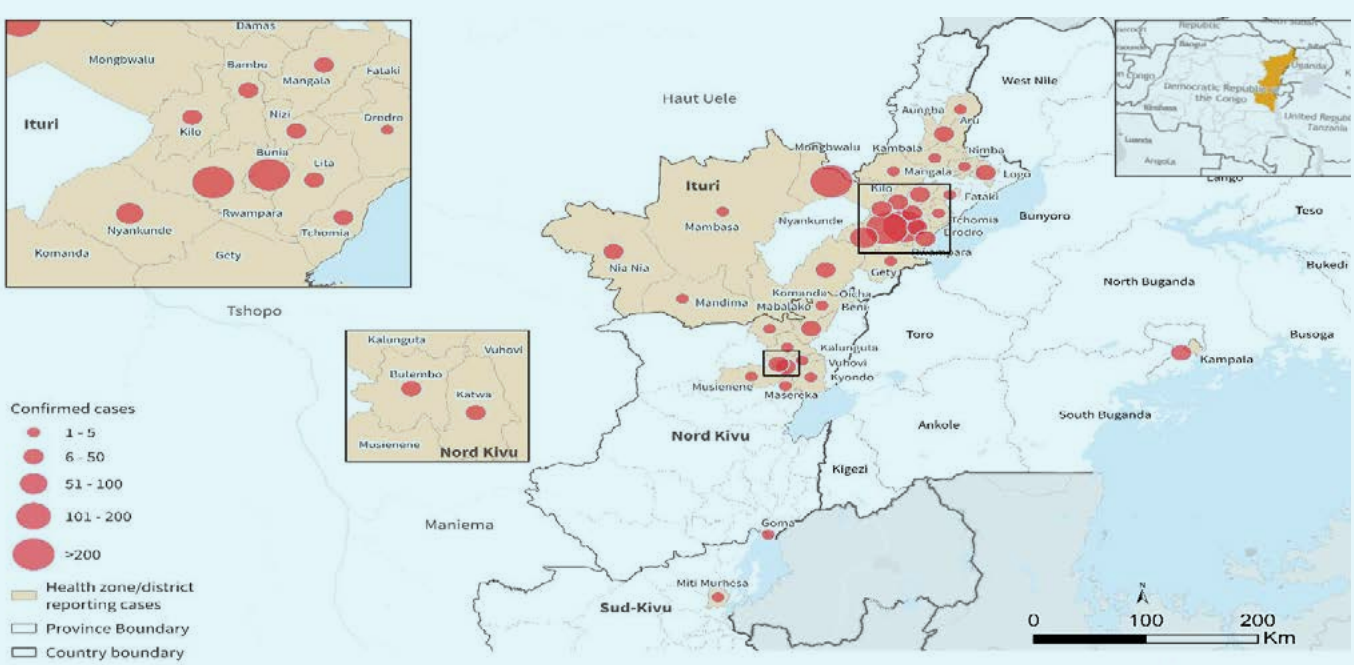



Fig 1

## Weekly trends of confirmed cases of BVD in DRC Congo by epidemiological week of report, epidemiological weeks 14–26, 2026




The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization, Ministry of Health Democratic Republic of the Congo, AFRO GIS CENTRE, GRID3
Map Production: HIS/EPR WHO AFRO, WHO Health Emergencies Programme.
Map date : 29 June 2026

World Health Organization

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Fig 2

## Geographical distribution of confirmed cases of BVD in DRC and Uganda, as of 28 June 2026

Information and trust are not separate from the epidemic; they are an integral part of how it unfolds. The response trajectory is already being shaped as much by harmful information dynamics as by the epidemiology of the disease itself, as the next section sets out in detail.

The 2026 IFRC *World Disasters Report* (WDR) frames harmful information as a humanitarian crisis in its own right: one that undermines access to aid, erodes trust and destabilises social cohesion.[19] The WDR documents such patterns across epidemics, conflicts and climate emergencies worldwide, and makes the case that the response to harmful information is now as important to humanitarian outcomes as the response to the underlying crisis itself.

This crisis intelligence paper applies insights from the 2026 WDR and the wider literature on disinformation and epidemics to the current Ebola outbreak.[20,21] It shows how pre-existing and emerging narratives in affected communities and regions are already shaping the trajectory of the outbreak, and how harmful information dynamics are affecting key aspects of the response, across detection, response capacity and care.

The paper sets out four scenarios, or trajectories, for how the outbreak might unfold, and synthesises existing evidence into operational and strategic lessons that are robust across all four.

The paper is structured in three parts.

- **Section 2** describes the information dynamics playing out in the outbreak, the emerging impacts of these on the response and the cycle of amplification that compounds them.
- **Section 3** identifies the critical uncertainties this analysis surfaces and describes four trajectories the outbreak could follow.
- **Section 4** sets out recommendations for responding organisations that hold across all trajectories , supported by lessons and evidence from prior crises.

# 2 Harmful information dynamics in the outbreak and the response

The information dynamics shaping the current outbreak have deep historical, political and economic roots, and are being reshaped in real time by current events, competing political authorities and the international response itself. Harmful information does not arise in isolation: it is produced by specific actors with particular motivations, travels through specific channels and has consequences that feed back into the conditions that produced it. Not all narratives have equal weight: some circulate widely without changing behaviour, whereas others shape behaviour even where they are less visible.

The rest of this section traces these dynamics through the six-element framework illustrated in Figure 3, which covers Context, Causes, Content, Channels, Consequences and the Cycle of amplification.

- **Context** is the political, economic and security setting in which a narrative can take root.

- **Causes** are the actors operating in that context and their motivations to create and spread harmful narratives.
- **Content** is the harmful information itself.
- **Channels** refer to how and where the information travels.
- **Consequences** are the physical, psychological, operational and societal impacts of harmful information.
- **Consequences** feed back into context through **cycles of amplification**. Information that takes root through such cycles becomes harder and harder to dislodge.

**Harmful information dynamics: context, causes, content, channels, consequences and the cycle of amplification**

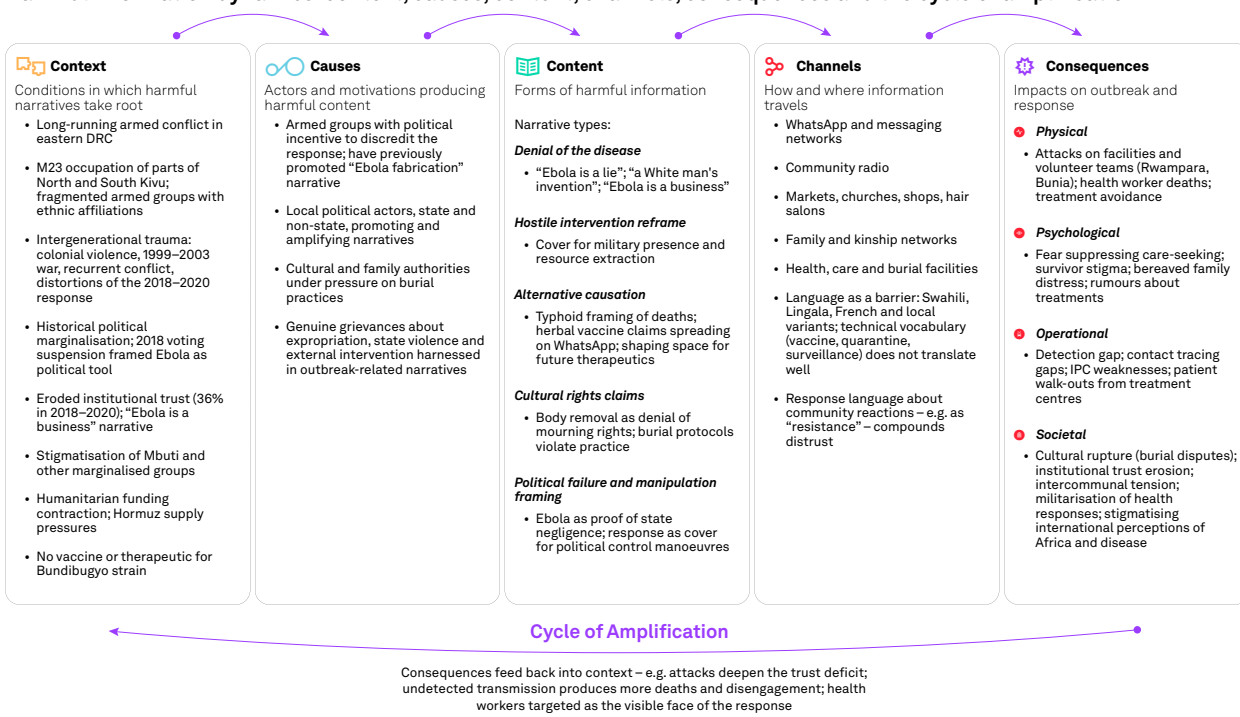


Fig 3

## The dynamics of harmful information in the DRC BVD outbreak[22]

**Context:** The health and safety of the information environment is shaped by the conditions in which the outbreak is unfolding: long-running armed conflict in eastern DRC, M23 control of parts of North and South Kivu, a fragmented ecosystem of other armed groups with different affiliations and control, historical political marginalisation, stigmatisation of specific indigenous groups and eroded institutional trust (recorded at 36% during the 2018–2020 outbreak). This situation has been worsened by the recent contraction in humanitarian funding, and by supply and economic pressures arising as a result of the Middle East crisis.

Ituri itself has around 7 million people, 13% of whom are internally displaced. Bunia, the provincial capital, has been a humanitarian hub since the second Congo war in 1998–2003. The province has at least 18 ethnic groups; the long-running Hema–Lendu conflict, rooted in contested claims to indigeneity and reinforced by colonial divide-and-rule policies, plays out within a broader conflict landscape that includes multiple armed factions linked to specific ethnic groups, including CODECO (Coopérative pour le développement du Congo) and FRPI (Front for Patriotic Resistance in Ituri) (associated with Lendu communities), Zaire (associated with Hema communities) and ADF (Allied Democratic Forces) (affiliated with the Islamic State in Central Africa).

The province recorded over 100 attacks on health workers in 2025, before the outbreak began. The Mbuti indigenous community in the forest regions, of around 35,000 people, faces longstanding discrimination and has particularly low trust in government and local authorities. Questions of who holds influence, whom communities trust, who is perceived as legitimate and who is excluded or stigmatised vary substantially across locations and population groups. In previous Ebola disease responses, these same conditions generated distrust and rumours.

The atmosphere of mistrust has both historical roots and modern underpinnings, to include both colonial and postcolonial violence and the present-day failure of humanitarian actors and peacekeepers to provide safety in periods of chronic insecurity between emergencies. There are perceptions of a gap between the resource influx during an Ebola outbreak and the absence of attention at other times, all in a political-military context where authority is contested. When elections were postponed in opposition strongholds in 2018–2019 during the outbreak, Ebola came to be seen as a political tool to suppress opposition. Intergenerational trauma resulting from colonial violence, recurrent armed conflict and the 2018–20 response affects both communities and responders, deepening psychosocial challenges. These tensions and grievances underpin many of the narratives now circulating about the current outbreak.[23, 24, 25]

**Causes:** Genuine and longstanding grievances about expropriation, state-sponsored violence and external intervention are harnessed in narratives about the outbreak and the response.[26] In eastern DRC there are specific social actors and dynamics that generate harmful information. Armed groups – which include AFC/M23, CODECO, FRPI and ADF affiliates – have a political incentive to discredit humanitarian responses and have in the past promoted the "Ebola fabrication" narrative.[27,28] Local political actors, both state and non-state, promote and amplify similar narratives for their own purposes. Cultural and family authorities face pressure on sensitive issues, most notably in burial practices, where public health protocols conflict with social and religious obligations.

These actors are not separate sources of harmful information so much as competing authority systems. Trust is relational and competitive: communities are choosing between multiple authority systems (state, customary, religious, armed group), not deciding whether to trust "the response" in the abstract.[29]

**Content** relates to the harmful information itself: the specific narratives circulating in the current outbreak. A number of distinct narratives can be discerned in the current crisis.

The first are denials of the disease. Framings such as "Ebola is a lie" and "Ebola is a White man's invention" circulated during the 2018–2020 outbreak. The "Ebola is a business" framing emerged specifically from that response, which created opportunities for inflated rentals, lucrative security contracts and political side payments and kickbacks. UNICEF U-Report polling across DRC found 17% of respondents saying that people in their community do not believe Ebola is real[30] while the June 2026 Ground Truth Solutions (GTS) survey in Ituri found this at 60%[31], suggesting the denial narrative is present nationally but concentrated in affected areas. Among those Ituri respondents who reported community disbelief, 34% attribute it to the view that the disease has been fabricated by authorities for financial reasons.

The second type are reframing of health and aid interventions as covert hostility – that is, the use of Ebola as cover for military presence and resource extraction in eastern DRC. The contrast between the international mobilisation around Ebola outbreaks and the comparatively muted response to cholera and other more common causes of mortality, such as malaria and polio, feeds a wider grievance in affected communities – namely, that the response reflects concern about risks to the global north rather than genuine concern for the people of DRC themselves.

The third type are alternative causes, such as the typhoid framing of Ebola Bundibugyo deaths, which has led to tensions and attacks on health facilities in the past week. A variant of this is now spreading on WhatsApp – that specific plants and potions can serve as a vaccine for Bundibugyo. A bioweapon framing and an arsenic poisoning theory have also emerged on social media in recent weeks. This narrative risks shaping the response to any future genuine treatments. Conspiratorial suspicions around vaccines have been a marked feature of Covid-era responses. This differs from the situation in previous Ebola outbreaks, where acceptance among those reached has generally been high, though implementation challenges around trial design and rollout have created friction.

The fourth type are cultural rights claims against response protocols, with body removal as denial of mourning rights being the most extensively evidenced example.[32, 33, 34]

The fifth narrative type reframes the response as a political failure. With constitutional reform debates under way, the outbreak is being held up as evidence that the government cannot protect people, and that the international response is being used as political cover. This is amplified through opposition channels and on social media.[35] 22% of Ituri respondents who identified community disbelief in Ebola attribute it to the view that the disease has been fabricated to exert control over the population.

**Channels** through which harmful narratives move are familiar from prior responses: WhatsApp; community radio; markets, churches, shops and salons; family networks; and health, care and burial facilities themselves. In the current response, 178 radio stations across Ituri and Goma have been engaged in messaging, and community outreach has reached more than 1.7 million people. The reach is significant, and UNICEF U-Report polling suggests that radio is the leading trusted information source among DRC respondents. However, the same channels can carry harmful and false narratives as well as response messaging, and contested events quickly become pervasive stories across them.[36,37]

UNICEF U-Report polling, conducted with self-selected respondents in DRC and Uganda, suggests significant knowledge gaps. In DRC, more than half of respondents indicated gaps in knowledge of symptoms, transmission and prevention.

Language is also a complicating factor. The technical vocabulary of outbreak response (vaccine, disinfect, decontaminate, quarantine, surveillance) does not translate cleanly into the languages used in Ituri. Swahili is the lingua franca, Lingala the language of army and administration and French the language of elites, with substantial local variation in villages and around mining sites. In the 2018–2020 response, "quarantine" in French was found to carry connotations of rights infringement. The framing of community behaviour as "resistance" compounds the problem.

**Consequences** of harmful information in this outbreak fall into four categories:

- **physical** attacks on facilities, healthcare worker deaths, treatment avoidance;
- **psychological** fear suppressing care-seeking, survivor stigma, bereaved family distress, rumours about treatments, trauma from prior outbreaks and responses;

- **operational** detection gap, contact tracing gaps, IPC capacity gaps, patient walk-outs from treatment centres (see Box 3);
- **societal** cultural rupture, institutional trust erosion, intercommunal tensions, militarisation of health responses, reinforcement of stigmatising perceptions of Africa and disease internationally.

The impacts of the information dynamics can already be seen across the response, from detection and tracing, to response capacity, to treatment and care. Box 3 shows how these consequences are already visible. The pattern across all three areas is consistent: where harmful information dynamics take root and generate denial, fear and distrust, clinical and operational interventions become harder to deliver.

Box 2

## Emerging impacts of harmful information dynamics on the response

These consequences are already visible in three operational areas of the current response: detection and tracing, response capacity, and treatment and care.

**Detection and tracing:** The Bundibugyo strain is not detected by GeneXpert, the rapid test most widely deployed in past Ebola responses. The response has since invested heavily in decentralising diagnostics, and turnaround times are down. There is still no rapid point-of-care test for Bundibugyo, however, and confirmation remains slow enough to matter for treatment decisions and for the timing of safe and dignified burial. Diagnostic delays feed the information environment in specific ways. Communities draw their own conclusions about why testing takes so long: that samples are being taken and not returned, that the testing is foreign-controlled, that the slow process suggests the disease was never what was claimed. The response's explanation of the gap has to compete with these differing interpretations.

Whether patients go to be tested depends on how families respond to the early signs of illness, and whether they interpret it as Bundibugyo, or as other similarly presenting diseases such as malaria or typhoid. Families may also have practical reasons not to go for testing: cost, distance, the slow speed of formal care and prior poor experiences at facilities. The narratives circulating in the outbreak reinforce some of these decisions for some households.

In some cases, families have demanded laboratory confirmation before allowing safe and dignified burial. While it is encouraging that communities are taking biomedical evidence seriously rather than rejecting it, such demands are operationally hard to meet, and the slow pace of response can create further distrust. Where the demand cannot be met, the response can end up confirming the rumours it was trying to dispel.

Contact tracing performance varies by province, and the variation tracks where the response has been able to invest in community presence and decentralised coordination. The contact tracing figures represent an important proxy measure of trust. People name contacts when they trust the protocols and feel confident the names will not expose them or anyone close to them. Where confidentiality is in doubt, the data is incomplete, so tracing is partly an indicator of the disease and partly an indicator of the trust environment around it. The case of the 2018–2020 outbreak in eastern DRC illustrates how this can deteriorate: targeted violence against response teams during that outbreak increased the effective reproduction number for

weeks after each incident, with a larger effect than that of generalised insecurity. The response then used security escorts and restricted movement, which compounded the trust problem in the communities where transmission was highest.[38, 39, 40,41,42,43]

**Response capacity:** Health workers and volunteers face the dual risk of physical contagion and stigmatisation in their own communities once they take on response roles. Where harmful narratives frame the response as covert hostility or as cover for political consolidation, the workforce becomes the most available and obvious target for wider anger. Healthcare worker infections directly reduce capacity in a context where trained workers are already scarce, and the health worker and volunteer base narrows as a result, weakening the response further.[44,45]

Community engagement is the primary mechanism for addressing trust dynamics, but this works only where the response has the institutional capacity and continuity to listen and act on what it hears. The militarisation of the 2018–2020 response, which included armed escorts for community response teams, deepened mistrust rather than securing operations. The funding environment compounds these constraints: a humanitarian response plan that was 78% unfunded before the outbreak, high partner turnover and supply pressure resulting from the Middle East crisis all place additional pressure on the patient, long-term community engagement work that the response relies upon.[46, 47, 48, 49, 50, 51, 52]

**Treatment and care:** Treatment uptake depends on whether centres are seen as places of care or as places where people go to get sick and possibly die. The Ground Truth Solutions survey found that 51% of people feel safe at health centres, but of those that didn't feel safe, 78% named fear of getting sick as the main reason why[53].

In the 2018–2020 outbreak, many communities had similar views. The Village d'Accompagnant model, which allowed family members to stay close to patients, directly addressed this perception, and higher community acceptance and earlier presentation were reported where it was adopted.

Patient retention is shaped by the same dynamics: when treatment is not trusted, patients leave. The WHO SitRep 6 recorded six unplanned patient departures in Ituri during a recent reporting period.

Survivors often face stigma and challenges. UNICEF U-Report polling suggests that 29% of respondents in DRC would not accept survivors back into the community. However, this can be countered to good effect. In prior responses, survivors who were visible, supported and brought into engagement work countered denial narratives in ways messaging alone could not. How survivors are received in the early weeks shapes treatment-seeking for the remainder of the outbreak.[54, 55, 56]

Burial dynamics are the most contested element of the response, with hostility often concentrating in the wider neighbourhood rather than among immediate relatives. Burial in the affected communities is a social and religious act as much as a public health one. At cemeteries, volunteers have been detained and forced to alter protocols after the coffin has been placed, reflecting the spiritual and social weight of the final stages of burial in the affected communities.

The **cycle of amplification** turns the information dynamic from a linear chain into a self-reinforcing loop. The process is well documented from prior responses, and early indicators are visible in the current outbreak.

The cycle is not a slow drift but a series of connected inflection points, because trust is event-driven and reversible. Each consequence feeds back into context. An attack on the response, for example, simultaneously constrains operations, deepens the trust deficit, generates new narratives and drives

the case load higher.[57,58] A single visible incident can undo weeks of engagement work, and recovery of trust often depends on rapid and focused responses.

What communities see of the operational response – security escorts, burial team protocols, isolation arrangements – tends to outweigh what they hear in messaging. The way the response handles a moment of stress is often more significant than the way it explains itself.

Box 3 shows how these elements interact in practice through the lens of one of the harmful narrative cycles already taking hold in the current outbreak.

Box 3

## Example of a harmful narrative cycle in the current outbreak

**Context:** There is deep mistrust of external actors and interventions. This has historical roots in colonial-era violence, the legacies and distortions of the 2018–2020 Ebola response and the 2018–2019 voting suspension in opposition strongholds.

**Causes, content and channels:** Ebola is viewed as something invented by outsiders to justify their presence. This is the basis for a specific Ebola denial narrative that is circulating on WhatsApp and through family and market networks – that the symptoms are really of typhoid or malaria, and the official story is a fabrication.

**Consequences:** A family member falls ill with fever and vomiting. The wider family interprets the symptoms as malaria or typhoid and keeps the patient at home. Going to the health facility would signal acceptance of the official story, and also carries the risk of the patient being held there.

The case is not detected and contacts are not traced. Family members provide care without protection and one of them becomes infected. If the patient dies, the body is washed and prepared for burial in line with cultural and social obligations. Some of those handling the body are infected.

By the time the response detects this, the transmission chain is several generations into the community. The narrative will have produced a cluster of undetected cases.

**Cycle of amplification:** When the response arrives, the visible interventions (burial teams arriving, isolation requests, security escorts) risk confirming the perceptions of outsider presence, and the harmful narrative becomes more entrenched.

Without active intervention, the cycle continues. The dynamics described in this section will not stabilise on their own but will deepen, making the operating environment harder to navigate.

Two uncertainties are critical as the response considers what might come next. The first is how trust in the response develops in the coming weeks – that is, whether feedback systems begin to function and community engagement begins to work, or whether the cycle of amplification continues. The

second is how the security and conflict environment evolves – whether armed group territorial movements stabilise or escalate, whether response teams continue to be targeted and whether cross-border coordination holds.

Section 3 sets out four trajectories that combine these two uncertainties and anticipate where the outbreak could go from here.

3

# Critical uncertainties and possible trajectories

What direction will the outbreak take from here? The analysis so far points to two uncertainties that will determine the future trajectory:

1. community trust, on a low-to-high spectrum, which drives whether communities engage with detection, contact tracing, safe burial and feedback processes;
2. security and conflict dynamics, on a stable-to-escalating spectrum, which drive whether the response can physically reach communities and operate safely at scale.

Together, these two axes generate four possible trajectories, set out in Figure 4.

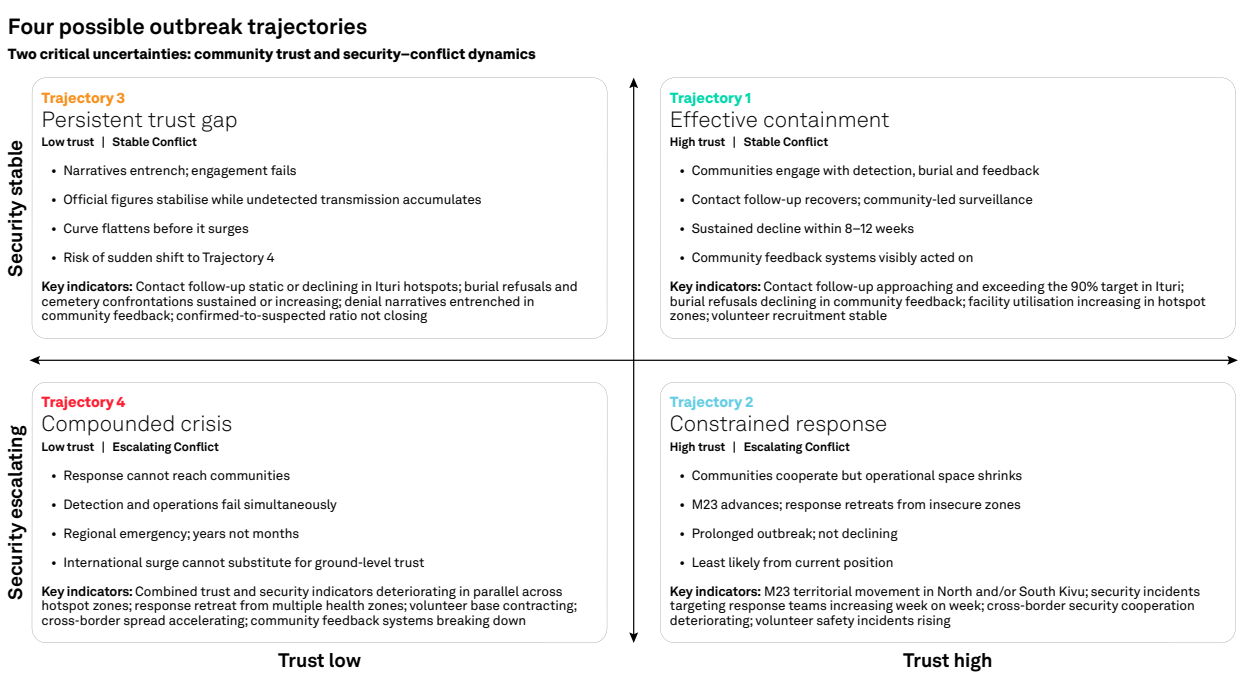


Figure 4 **Four trajectories the outbreak could follow, based on two critical uncertainties – community trust and the security–conflict trajectory**

The trajectories should be read as directions of travel rather than exclusive end-states. The response is currently moving along both axes at once, and the current position has elements of all four. The critical question is which direction it might tilt towards, and what would tip it that way.

Wider factors will influence all of these future trajectories: the pace at which rapid diagnostics for Bundibugyo virus become available; whether and when experimental vaccines or therapeutics are evaluated under clinical trials; who is eligible to receive them; and how those decisions are communicated to communities. Other relevant factors include the direction of regional UN peacekeeping efforts; cross-border movements into Uganda and onward to Kenya, Burundi, Rwanda and South Sudan; and the state of humanitarian funding against the agreed response budget. While all four trajectories begin in the current phase before medical countermeasures are available, the rollout of any future vaccines and therapeutics will continue to rely on community trust and enabling security conditions. Table 1 sets out the trajectories in more detail.

Table 1

## Four trajectories for the outbreak and response

| | Trajectory 1: **Effective containment** | Trajectory 2: **Constrained response** | Trajectory 3: **Persistent trust gap** | Trajectory 4: **Compounded crisis** |
|---|---|---|---|---|
| **Trust axis** | Improving; communities engage with detection, burial and feedback | High; communities cooperate but operational space shrinks | Low and static; narratives entrench, engagement fails | Low and deteriorating; active non-engagement and conflict |
| **Security axis** | Stable; no M23 escalation, security corridors holding | Escalating; M23 advances, response retreats from insecure zones | Stable; community-driven incidents at low frequency | Escalating; response cannot reach communities |
| **Detection** | Contact follow-up in Ituri hotspot zones increases to levels that close the detection gap; suspected-to-confirmed gap closes; community-led surveillance established | Holds where access permits; coverage falls in inaccessible zones | Official figures stabilise while undetected transmission accumulates; Ituri follow-up stalls below the 90% target | Detection and operations fail simultaneously; caseload invisible to response |
| **Response capacity** | Volunteer presence scales across affected health zones; feedback loops operational and visibly acted on | Volunteer safety becomes the operational limit; expansion pauses | Extractive engagement deepens mistrust; capacity stagnates; funding cuts hit community engagement first | Volunteer base protected not grown; international surge cannot substitute for ground-level trust |

| | Trajectory 1: **Effective containment** | Trajectory 2: **Constrained response** | Trajectory 3: **Persistent trust gap** | Trajectory 4: **Compounded crisis** |
|---|---|---|---|---|
| **Medical measures** | Vaccines and trials deployable when available; community trust enables rollout | Cannot reach worst-hit areas; cold chain and follow-up break down | Communities distrust products; eligibility decisions confirm existing suspicions | Cannot be deployed at scale; deployment worsens trust and security problems |
| **Trajectory** | Sustained decline beginning within months | Prolonged outbreak; not declining | Curve flattens before it surges; undetected transmission accumulates | Regional emergency; lasts years not months |
| **Historical precedent** | October 2019–January 2020 stabilisation in eastern DRC | Elements of West Africa outbreak, particularly Sierra Leone from late 2014 (partial precedent only – trust–security divergence likely harder to sustain in eastern DRC) | March 2019 North Kivu pattern | 2018–2020 dynamic at larger scale with lower case fatality rate |
| **Key risk** | Trust stalls if feedback systems not visibly acted on within weeks | Border surveillance degrades as security management absorbs capacity | Undetected transmission invisible until it surges | Funding fatigue, responder fatigue, governance turnover compound over time; recovery progressively harder |
| **What must change from now** | Community feedback systems operational and visibly acted on; burial protocols locally negotiated; contact follow-up in Ituri hotspot zones increases substantially | Security corridor design must prioritise trusted actors; cross-border preparedness to be stepped up immediately | Shift from broadcast risk communication to survivor testimony; joint case review with local clinicians and burial protocols negotiated zone by zone | Emergency international scale-up triggered; community trust held not grown; adherence support if movement restrictions imposed |

## Trajectory 1: Effective containment

The current position is closer to Trajectory 1 than it was a month ago. Contact follow-up in Ituri has improved from 30% in late May to 82.9% by end-June. Community outreach has scaled to reach more than 1.7 million people, decentralised diagnostic capacity is now operational across multiple sites and the international response has mobilised politically and financially.

However, contact follow-up remains below the 90% threshold consistent with effective transmission interruption. Feedback system information is not yet consistently visible in operational decisions, and burial protocol negotiation is uneven across the hotspot zones.

The closest historical reference is the October 2019–January 2020 stabilisation in eastern DRC, when the response had its best period of the 2018–2020 outbreak. This worked thanks to a combination of interventions: systematic community feedback mechanisms that were visibly acted on, burial protocols negotiated locally rather than imposed, survivor networks actively involved in community engagement and a security landscape that had stabilised enough to allow consistent access.[59,60] International engagement during that period was intensive and coordinated across humanitarian, political, military and community actors.

## Trajectory 2: Constrained response

Trajectory 2 is the least likely from the current position. It would require community trust to hold or strengthen as security conditions deteriorate, a situation which the information dynamics in eastern DRC make difficult. The narratives frame the response itself as part of external intervention, so security escalation almost inevitably challenges both trust and operational access at the same time.

Elements of the West Africa epidemic, particularly Sierra Leone from late 2014, offer a partial precedent. In several chiefdoms, community cooperation held and even strengthened as operational constraints tightened, because the response had invested sufficiently in local relationships that trust survived the pressure.

The key difference in eastern DRC is that the information dynamics specifically frame the response as part of the external interventions, meaning security escalation almost inevitably challenges both trust and operational access. This makes the trust–security divergence that Trajectory 2 sets out harder to sustain here than it was in West Africa.

The key lesson for the current response is that investment in local relationships builds resilience that pays off if the operating environment gets harder.

## Trajectory 3: Persistent trust gap

The risk posed by this trajectory is that operational improvements appear to be working while the outbreak continues to spread geographically. The number of cases rises sharply, and new health zones report confirmed cases. Growing incidence of unplanned patient departures from health facilities indicate that trust in treatment faces pockets of fragility. Contact tracing has improved but uneven progress across provinces leaves coverage below the level needed to interrupt transmission in the hotspots.

The March 2019 North Kivu pattern is the closest historical reference: official figures stabilised, cautious optimism set in and undetected transmission accumulated in communities where engagement had failed. The curve flattened and then surged. The signs to watch are community feedback (especially around testing, treatment and burial), harmful narrative entrenchment and continued spread to new zones.

## Trajectory 4: Compounded crisis

The current position is some distance from Trajectory 4, but conditions exist that could tip the response into it. M23 holds territory in parts of North and South Kivu, attacks on response teams continue in some zones, the funding environment is constrained and the cycle of harmful narrative amplification operates across all the elements of the response.

The compounding dynamics accumulate over time in ways that are difficult to reverse. Funding fatigue sets in among donors as the outbreak drags on without visible progress. Responder fatigue affects the quality and continuity of engagement. Governance turnover disrupts institutional relationships that have taken months to build. The longer this scenario persists, the harder recovery becomes, and the less relevant the interventions designed for the outbreak's early phase will be.

The 2018–2020 outbreak is the historical reference[61,62] but the current situation has features that make Trajectory 4 potentially more severe: Bundibugyo's geographic spread across three provinces from the outset, the absence of any licensed vaccine or therapeutic, a more contracted funding environment and a regional security situation that is more complex than it was in 2018.

## Monitoring: Anticipating which trajectory is emerging

The two axes generate distinct streams of indicators that responders should track separately and analyse together.

**Community trust indicators** (tracked weekly from SitReps, community feedback systems and volunteer reports):

- facility utilisation in Mongbwalu, Rwampara and Bunia (rising suggests trust improving);
- contact tracing completion (rising above 80% or approaching 90% target in Ituri);
- confirmed-to-suspected ratio in affected zones (recent falls in the number of suspected cases reflect lab backlog clearance rather than improved community detection; the ratio should stabilise and then close if there is a genuine signal);
- community deaths as proportion of the total (declining suggests trust improving);
- burial refusals and conflicts in community feedback (declining suggests trust is improving);
- narratives in community feedback (entrenched or shifting);
- volunteer recruitment and retention.

**Conflict and security indicators** (tracked weekly from security incident reports, OCHA bulletins and field reporting):

- number of security incidents targeting BVD response teams or infrastructure per week (attacks, threats, intimidation);

- number of weekly incidents of hostility, threats or violence directed at frontline healthcare workers and primary care facilities, regardless of whether they are formally part of the BVD response;
- M23 territorial movement in North and South Kivu;
- Armed Forces of the Democratic Republic of the Congo (FARDC) engagement in response areas (presence or escalation);
- cross-border security cooperation status;
- intercommunal tension reports.

Section 4 sets out the recommendations that can be justified across all four trajectories, with additional actions tied to specific trajectories when their indicators are confirmed.

# 4 Recommendations

These recommendations integrate the operational specifics of the current outbreak and the IHR Emergency Committee's temporary recommendations of 22 May 2026 with evidence from prior Ebola disease responses, drawing on SSHAP, ALNAP, IFRC and UNICEF social and community listening, social media monitoring, Ground Truth Solutions community perception surveys and wider peer-reviewed literature. They should be seen as levers to help move the outbreak towards containment and away from the worst-case trajectories.

They are structured in four parts:

1. immediate operational priorities applicable across all four trajectories;
2. cross-cutting response capabilities that need to be in place from the early weeks;
3. system-wide leadership recommendations on the architecture the response needs to function; and
4. trajectory-specific recommendations.

## Immediate Operational Priorities

### Activate transparent two-way communication and community feedback systems with systematic follow-up in each affected health zone

- The four most-affected zones in Ituri (Mongbwalu, Rwampara, Bunia and Nyankunde) need two-way feedback channels as a foundational element of the response. Each concern communities raise needs to be tracked through to a response that is communicated back in terms they can verify. Communications should be transparent about what the response knows, what it does not yet know and how decisions are being made under conditions of incomplete information.

- Community feedback should be institutionalised as a core input into decision-making, with weekly adaptation of response strategies based on community concerns, perceptions and behavioural barriers. This is not an optional function; it is the mechanism by which the response stays aligned with the communities it serves. DRC Red Cross volunteers are already operating in Bunia, Rwampara and Mongbwalu, and their work should be matched by institutional commitment to act on what is heard.

- The sustainability of community engagement is especially important, as the budget for this is often among the first to be cut when funding tightens, while the capabilities are some of the hardest to rebuild. Top-down monitoring fails in low-trust contexts, and community-led reporting closes the detection gap. Past responses have shown that feedback collection without follow-up becomes extractive and deepens mistrust: communities see their concerns documented but not acted on and conclude that engagement is performative. Every concern raised needs to be heard, escalated and acted on where action is appropriate, and the response needs to be communicated back to the originating community.[63]

## Recruit, support and protect locally embedded volunteers

Locally recruited workers are simultaneously the most trusted by communities and the most exposed to risks. As already noted, health workers and volunteers face two connected risks: physical contamination and stigmatisation in their own communities. In Sierra Leone in 2014, for their own safety, Red Cross burial volunteers required housing separate from their neighbourhoods. Frontline workers also carry psychosocial costs that responses have consistently neglected.

- The IHR Emergency Committee's package for health worker protection (personal protective equipment (PPE), IPC training, hazard pay and timely salary payments, psychosocial support, investigation of every occupational exposure) should be visibly operational. Recruitment and service delivery should also be visibly fair and equitable across affected communities, because communities assess trust based not only on engagement but also on whether they see services being delivered fairly.

- Healthcare worker engagement on medical countermeasures, when they are available, needs dedicated attention and resources. Evidence from the 2018–2020 DRC vaccine trials shows that healthcare worker hesitancy, often driven by side-effect concerns, directly influenced patient willingness to accept vaccination.[64, 65]

## Build surveillance and case detection from the community level

- Community-based surveillance teams should be established in each affected health zone, with decentralised care arrangements in the remote areas where the journey to a central facility is itself a transmission risk and a reason for delayed presentation. Reliance on Bunia, Rwampara, Mongbwalu and Nyankunde as the main treatment locations builds in a delay for outlying communities that the response should plan for.

- Communities should not only receive information but also serve as a primary source of outbreak intelligence, giving the response granular visibility into what is happening in homes, markets and burial sites before it surfaces in case data. The key feature is community ownership of these systems: where communities own the surveillance, reporting increases and the system is perceived as their own rather than as external monitoring imposed on them. Surveillance that depends on external monitoring alone fails where trust is low.[66]

- Local watch groups have played a role in helping communities monitor the epidemic in prior outbreaks. Community-based surveillance worked in the 2018–2020 response where it was phased and properly supervised, carried a lighter reporting burden than in facility-based systems and was integrated with primary healthcare services rather than running as a parallel Ebola-only function.[67] Evidence from Sierra Leone in 2014–2016 showed similar dynamics: community-based prevention and care reduced transmission where the systems were properly resourced and locally embedded.[68]

## Redesign burial operations around community involvement in each health zone

- Burial teams should include people already involved in funeral ceremonies, and use negotiated protocols that allow family access from a safe distance, locally agreed burial locations and the placing of personal effects in the grave rather than their burning.[69] Engagement with religious and traditional leaders should happen before body removal and before cultural practices are contested publicly. The solutions developed in Liberia (MSF produced plexiglass-windowed morgues and viewing areas) and in DRC in 2018–2020 (Red Cross teams developed body bags with transparent panels at the head) both emerged from community feedback that body removal was distancing families from their final obligations. Burial teams composed of strangers in full PPE were among the most contested elements of the response.

- In many communities in Ituri, burial is a multi-stage process in which the handling, positioning and sealing of the body carry obligations to the dead that families will not readily cede to strangers. Field reporting from the current outbreak suggests a specific pattern at cemeteries: volunteers are detained by family members and gravediggers, and forced to alter burial protocols after the coffin has been placed. Burial procedures that feel disrespectful are not recovered through messaging; communities read into what the response does at the moments of greatest spiritual weight.

- Engagement and negotiation also need to extend to the wider community, not just the immediate relatives: increasing volunteer safety and burial acceptance both depend on getting the neighbourhood on side as well as families. A 2018–2019 safe and dignified burials intervention evaluation shows that timely safe burials reduced incidence by between 7% and 40% in the study zones, and, once the share of burials conducted under the protocol passed 40%, transmission fell below the level at which the epidemic could sustain itself.[70]

## Resource psychosocial support and survivor engagement from the outset

- Community and faith leaders should be trained as the first line of psychosocial support from the early weeks, and be given dedicated budget and reporting lines. Psychosocial support has been consistently under-resourced across previous Ebola responses, arriving late and treated as secondary to clinical and logistical functions. Where it has worked, it has been because trained community and faith leaders reached survivors, bereaved families and health workers in ways that external provision could not.

- The two previous Bundibugyo outbreaks had case fatality rates of 30% and 50%, which indicates 50–70% of confirmed cases will recover. The first survivors are emerging now. How they are received in the coming weeks will shape treatment-seeking for the rest of the outbreak. Survivors are one of the few groups with direct and personal evidence that recovery is possible, and can counter denial narratives in ways messaging cannot. Survivor leadership in planning, management and

engagement activities builds trust where institutional channels have struggled to. In prior Ebola outbreaks in the region, survivors reported rejection, loss of employment and sustained distress; where stigma was severe, people suppressed symptoms and delayed care to avoid being identified. Recent U-Report data from DRC shows 29% of respondents would not accept survivors back into their community, suggesting reintegration messaging through trusted community and faith leaders should be active from the point survivors begin emerging.[71]

- The Village d'Accompagnant model from the 2018–2020 response, which allowed family members to stay close to patients in treatment centres, directly addressed the perception that the centres were places of isolation and death. Facilities that adopted it reported higher community acceptance and earlier presentation. Open door days and public ceremonies celebrating recovered patients were used in 2018–2020 to counter the same narrative.

### Address the social and economic needs of affected families

Families affected by BVD face economic and social pressures alongside health risks. Lost income from quarantine, transport costs to facilities, food insecurity for households separated by treatment, protection needs for children separated from parents in treatment or burial and ongoing mental health and psychosocial support requirements all shape whether households can comply with isolation, contact tracing and burial protocols.

- Where compliance with response measures imposes costs that affected households cannot bear, the response loses the cooperation it needs. Food assistance, transport contributions, cash payments for those isolating, mental health and psychosocial support services (MHPSS) and protection for children separated from parents should be integrated into the response architecture rather than treated as separate humanitarian needs. The wrap-around approach from the 2018–2020 response, which integrated primary healthcare; water, sanitation and hygiene (WASH); nutrition; and MHPSS rather than running clinical management in isolation, generated greater community buy-in for detection and contact tracing.

## Cross-Cutting Response Capabilities

### Differentiate engagement strategy by the political, security and social context of different health zones

- Mongbwalu, Rwampara, Bunia and Nyankunde have distinct histories, security dynamics and relationships to external actors, and need distinct engagement strategies. Community engagement strategies should be localised and socially segmented, in recognition that behavioural barriers, trust dynamics and decision-making structures differ across health zones and population groups.

- The starting point in each zone should be rapid power mapping that covers state actors, armed groups with territorial control, customary authorities, religious institutions and the informal power structures that frequently hold real influence without formal roles. These include traditional healers; boda boda associations for motorcycle taxi drivers, who are important both as cross-border movers and as everyday couriers of information; market vendor associations; mining leaders, who hold capital and political connections and are entry points in mining-dependent zones like Mongbwalu; and the artisanal mining networks themselves.

— Communities are not homogeneous, and consultations limited to community leaders and chiefs will miss the people whose endorsement matters most: traditional healers, faith leaders of different denominations, women's representatives, youth and leaders of marginalised ethnic groups.[72,73] Access and trust in eastern DRC are rarely held by a single authority, and a singular approach across the affected zones will entrench rather than resolve trust issues already apparent in the outbreak.

## Communicate transparently and in two-way fashion

Communications work needs to use trusted messengers, address specific rumours, run in both directions and have language and translation capacity in place across Swahili, Lingala, French and local variants. Communications should be framed as dialogue rather than transmission, with explicit space for community-defined priorities to shape the response. The communications should also be transparent about what is known and what is not, because negative framings fuel fear and deter care-seeking.[74,75] Faith leaders are among the most-cited trusted messengers across previous responses.[76] UNICEF U-Report polling identifies radio, community leaders and health workers as priority channels in DRC, and Ministry of Health, health workers and SMS/digital channels in Uganda.

Communications work needs to operate in terms of enabling factors and barriers rather than using divisive terms such as "resistance." It should also use locally adapted terminology rather than relying on the literal translation of technical vocabulary.

In Beni during the 2018–2020 response, systematic mapping of the gap between response vocabulary and community language was used to revise communications materials and retrain community health workers in real time. Terms like "decontaminate," "surveillance" and "quarantine" were found to carry meanings that undermined rather than supported the response; standardised locally adapted translations were then shared.[77]

Communications legitimacy also depends on what the response delivers alongside messaging. Community engagement is not only communication; it is how the response behaves. Local actors should be engaged as co-designers, co-implementers and accountability actors within response structures, not as message relays.

## Deal with gender and disability as cross-cutting vulnerabilities

The response should track sex-disaggregated data from the outset across cases, contacts, volunteer recruitment, burial team composition, feedback channels and engagement consultations. Efforts should be made to ensure women play named roles from the early weeks in feedback channels, burial negotiation panels, survivor leadership, advisory bodies and strategic planning forums. Sexual and reproductive health services and protection from secondary risks should be maintained throughout.

Women and girls accounted for around 60% of reported cases in the 2019 DRC outbreak, because Ebola transmission follows caregiving, domestic labour, frontline health work and burial practices.[78,79] In artisanal mining areas, transactional sex creates an additional exposure pathway through close contact with potentially symptomatic clients.

Recent demographic data from the current outbreak shows transmission concentrated among adults aged 20–49, with the highest case numbers reported among women aged 20–29 and men aged 30–39. This is consistent with the caregiving and mining/mobility patterns seen in previous outbreaks. The pattern warrants close monitoring as it may indicate transmission moving from occupational and mobility settings into household and community contexts.

Women and girls face secondary risks following Ebola epidemics, including sexual and reproductive health issues,[80] pregnancy and disrupted education.[81] Evidence from Sierra Leone shows women's family planning decisions during an outbreak follow a mix of outbreak-specific reasoning – avoiding health facilities where Ebola transmission is feared – and longstanding wider factors that include cost, side effects, gender norms and return to school. Interventions addressing only the outbreak-specific elements will miss other critical dimensions.[82]

In previous Ebola responses, operational strategy has been shaped disproportionately by men, while women's groups, female community leaders, caregivers and frontline workers have been engaged later, more peripherally, or as implementation partners rather than strategic actors. Gendered representation needs to be built into incident command, advisory structures, community engagement leadership, burial negotiation panels, survivor leadership and planning forums from the early weeks.[83]

- Disability inclusion is part of the same vulnerability picture. People with disabilities face additional barriers to information, services and protection, and risk being missed in surveillance and engagement consultations. Sensory and communication disabilities affect access to health messaging and informed consent; mobility disabilities affect access to facilities; and caregivers of people with disabilities face heightened exposure risk.

### Treat cross-border and regional coordination as a trust and security function as well as a surveillance function

- Cross-border surveillance and care pathways should be designed on the assumption that movement will happen, not on the assumption that it can be prevented. Coordination with Uganda, South Sudan, Burundi, Rwanda and Kenya needs to be treated as a function of trust and security architecture rather than only as surveillance machinery. People move across the DRC–Uganda border continuously and informally, and those who cross while symptomatic make a calculation about where they are more likely to receive care or avoid adverse consequences.

The information environment on both sides of the border shapes these calculations and is itself part of cross-border coordination. Systematic monitoring of community perceptions, narratives and feedback in both DRC and Uganda is needed to interpret cross-border case patterns and to align messaging with the realities communities face on each side.

The 2018–2020 use of national armed forces as escorts deepened the trust deficit rather than securing the operation, and messaging that simply tells people not to cross borders has historically pushed movement onto undetectable routes. Coordination should focus on building trust on both sides of the border, supporting care pathways for people who cross and avoiding measures that drive movement underground.

## System-Wide Leadership Recommendations

### Build an anticipatory function and adaptive programming architecture across both country responses

- The community dynamics of this outbreak will shift as the response changes community perceptions, as political events alter the context and as misinformation evolves in response to official communication. Intervention designs need to be revised in light of what community intelligence is showing, in order to be fit for purpose.

- A structured anticipatory function should run across the response, with the authority and channels to push community intelligence into contingency planning and operational decisions. Communities should be treated as a primary source of outbreak intelligence, not only as recipients of information. Ensuring and sustaining this adaptive capacity is a critical senior leadership responsibility.

- In many cases, epidemiological models used to forecast previous outbreaks failed to predict case surges because they had not incorporated social variables: deteriorating trust and escalating attacks on response teams were driving transmission but the models missed them.[84] The Red Cross community feedback system in the 2018–2020 response demonstrated what is possible: behavioural data compilations produced in near real time fed directly into operational strategy, enabling rapid adaptation of burial operations as community dynamics shift.[85]

- For the response to adapt as community intelligence shifts, the funding architecture has to support such adaptation through flexibility in grant agreements, centrally managed reserves and, in particular, the protection of community engagement, volunteer pay, logistics and transportation against funding pressure.

## Deploy social and behavioural science and community engagement capacity at the same time as medical and logistical capacity

- Social and behavioural science should be commissioned at senior level, and have dedicated resources and clear pathways into incident command, so that evidence on context, behaviour, perceptions and acceptance can feed into every pillar of the response: clinical care pathways, surveillance design, contact tracing, burial protocols, vaccination and trial design, IPC, security planning, survivor support and operational decision-making.

- The evidence base that the response should draw on is broad. It includes anthropological studies of affected communities, behavioural data compilations from previous outbreaks, social and community listening insights from humanitarian agencies, infodemic management reports, community perception surveys and ongoing community feedback. These sources have to be commissioned, resourced and integrated into operational decision-making.

- The consistent finding across retrospective analyses of Ebola responses is that community engagement arrives late and under-resourced, and is treated as secondary until the response runs into resistance it cannot navigate. The same assessments show that social and behavioural science capacity often gets folded into engagement efforts. This narrows both what it is asked to do and the value it can generate.[86, 87] It also means responses gather community evidence without being able to use it to shape wider clinical, logistical and security decisions.

## Institutionalise accountability to affected populations across the entire response

The current outbreak's information dynamics – deep institutional distrust, a history of communities seeing concerns noted but not acted on and a cycle of amplification that turns extractive engagement into deeper mistrust – make accountability to affected populations a central operational necessity.

While RCCE handles the operational interface with communities – feedback, messaging, sensitisation, liaison, negotiations – accountability to affected populations is the strategic and institutional

commitment to ensuring the response is answerable to the people it is trying to serve. This requires a named senior accountability-holder, defined routes into incident command, published commitments that can be audited and regular decision points at which community feedback can change strategy.

Minimum accountability standards, such as those set out in the Sphere standards and the IFRC Code of Conduct, should be in place and audited regularly.

### Anchor operations in humanitarian neutrality and independence

Humanitarian neutrality and independence should be seen as operational conditions that determine community access. In the 2018–2020 response, organisations that guarded their neutrality carefully did so at some cost to coordination but maintained community access that more integrated actors lost. The separation between medical and security functions is the clearest operational expression of this: once the response is perceived as aligned with military or political actors, the hostile intervention narrative described earlier is reaffirmed.

Principled humanitarian engagement requires working with actors who have political affiliations – mining leaders, customary authorities, armed group-adjacent figures. Rather than avoiding these actors, the response needs to be explicit about engaging with community and power structures to reach people in independent and impartial ways but not aligning with political or military agendas. This distinction has to be held publicly and operationally, including when access negotiations make compromise tempting. Senior leadership in particular has to hold this line.

## Trajectory-Specific Recommendations

These apply when monitoring indicators confirm which trajectory is emerging, alongside the universal recommendations.

### Trajectory 2: Constrained response

- Increase IPC capacity in areas that can still be reached
- Pre-position supplies through alternative routes
- Work with trusted community actors to maintain access rather than relying on military escorts
- Build community-based reporting in areas that cannot be reached; prioritise the safety of volunteers.

### Trajectory 3: Persistent trust gap

- Carry out rapid qualitative assessments in areas where communities are disengaged.
- Step up identification and support for survivors
- Shift from general messaging to communication led by survivors
- Avoid expanding into new areas until trust improves in current locations.

## Trajectory 4: Compounded crisis

- All Trajectory 2 and 3 additions apply.
- Scale up international support urgently.
- Focus on protecting the existing volunteer network.
- Preserve remaining trust in affected communities
- If movement restrictions are introduced, ensure support for affected people (food, water, communication, financial and psychosocial support).

# Endnotes


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