

Lessons Learned on Ebola-Related Behaviors

Applying a behavioral lens to the 2026 Bundibugyo Ebola outbreak using evidence from previous Barrier Analysis studies on Ebola-related behaviors in West Africa

The current moment

On 17 May 2026, the World Health Organization declared the Bundibugyo Ebola outbreak in the Democratic Republic of the Congo and Uganda a Public Health Emergency of International Concern. As of mid-May, Africa CDC and WHO reported approximately at least 10 confirmed cases, 336 suspected cases, and 88 deaths across Ituri Province DRC, and two additional confirmed cases and one death in Uganda raising fears of urban and cross-border transmission. The outbreak began around the health zones of Mongbwalu and Rwampara — which are densely connected, highly mobile, and unstable due to ongoing armed conflict. The index case may have been a nurse who presented at a Bunia health facility in late April.

Critically, there is no licensed vaccine and no approved therapeutic for the Bundibugyo strain. Containment will depend on what controlled past outbreaks before vaccines existed: communities adopting protective behaviors quickly, completely, and at scale.

Why a behavioral lens, and why now

In every Ebola outbreak studied, awareness has not been the binding constraint on behavior change. Many people knew Ebola was serious and knew the symptoms, and they often knew what they were being told to do. Yet many did not call the burial team promptly, did not refrain from washing or touching the body, did not seek care for fever within 24 hours, did not report suspected cases, and did not maintain handwashing. Knowledge alone rarely changes behavior.

This is the central message of the 2016 Ebola Barrier Analysis Compendium (produced by Curamericas Global, now [Impact Global Health Alliance](#)), which synthesized studies conducted in Liberia and Sierra Leone by Mercy Corps, Catholic Relief Services, and Samaritan's Purse during the 2014–16 West African epidemic. [Barrier Analysis \(BA\)](#) compares “Doers” of a behavior with “Non-Doers” and reveals the perceptual, social, and structural factors that actually distinguish them — not assumed barriers, but evidence-based ones.

These findings have wider relevance. While cultural specifics differ between West and East Africa, the categories of determinants that drove Ebola behaviors — perceived self-efficacy, perceived social norms, perceived consequences (including stigma), access, and cues for action — proved decisive across multiple behaviors studied and are highly likely to operate again in DRC, Uganda, and any country these outbreaks reach. This brief consolidates those lessons for the 2026 response.

Key lessons by behavior

1. Early reporting of suspected cases

In Mercy Corps' Montserrado County study, four determinants distinguished Doers from Non-Doers.

- **Access to a community leader** was decisive: Non-Doers were six times more likely to say lack of access was a barrier.
- **Phone access** mattered: Non-Doers were about three times more likely to cite lack of a functional phone, network, or charging point.
- **Stigma** was a powerful brake: Non-Doers were roughly seven times more likely to say friends and neighbors would disapprove of reporting.
- Doers were also motivated by **preventive altruism** — they reported to protect family and community, not primarily themselves. Messages that lead with collective benefit outperformed messages that emphasized individual survival.

2. Calling the burial team within 30 minutes

In CRS's Sierra Leone study, Doers were 8.2 times more likely than Non-Doers to identify "**preventing transmission of Ebola**" as a benefit — and 4.3 times more likely to identify **household quarantine and movement restrictions as a disadvantage**. **Stigma** was pivotal again: Non-Doers were 5.6 times more likely to say community stigma made it difficult. **Access barriers** were structural — no phone credit (minutes), no phone, family resistance, and the need to inform mosque members first. The decision was rarely individual: families navigated it together, often under emotional shock.

3. Not touching the body while waiting for the burial team

This is where culture and social norms most visibly collided with public health. Doers were 25 times more likely than Non-Doers to say most **people they knew approved of the behavior** — by far the largest effect in the entire Compendium. Specific influencers mattered: approval by aunts and uncles (Estimated Relative Risk [ERR] of 7.8) and neighbors (ERR 2.8); disapproval by brothers and sisters was a strong barrier. Fines and community bylaws were helpful (ERR 2.8). Notably, Doers were 7.3 times more likely to say there were no cultural taboos against the behavior — suggesting that "culture" is rarely as monolithic as outsiders assume, and that framing practices as universal cultural norms can entrench them.

4. Care seeking for fever within 24 hours

Doers were 7.7 times more likely to say most people **approved** of seeking care; husband or wife **disapproval** was a key barrier (ERR 7.3). **Fear of catching Ebola at the hospital** made the behavior 3.5 times harder. **Free treatment** (ERR 3.5) and encouragement from doctors and nurses (ERR 5.1) made it easier. One counter-intuitive finding was identified, as well: more Non-Doers (than Doers) said they would receive the right treatment at a hospital — but knowing this apparently did not lead them to go. Confidence in the service is not the same as the social permission to use it.

5. Survivor reintegration into work and school

Mercy Corps found that a **medical clearance certificate** was the single largest enabler of reintegration after recovering from Ebola (ERR 5.79): employers and administrators who saw a certificate were almost six times more likely to rehire a person who had Ebola. **Empathy** after hearing a survivor's story was nearly as strong (ERR 5.61). **Stigma** — fear that customers, friends, and colleagues would withdraw — was the dominant disadvantage. The implication for 2026: every survivor will need verifiable, formal proof of Ebola-free status, including those who were never seen in a treatment unit.

6. Handwashing with soap

In Samaritan's Purse's River Gee study and the wider Compendium review of 17 handwashing BA studies across 11 countries, the most consistently significant determinants were **perceived self-efficacy** (75% of studies), **perceived social norms** (69%), and **perceived positive and negative consequences of the behavior** (56%). **Perceived divine will** mattered in roughly a quarter of studies in that caregivers who believed getting diarrhea was God's will were less likely to wash hands. Doers more accurately understood the **severity** of diarrhea and that their own actions could prevent it (i.e., **perceived self-efficacy**).

Cross-cutting lessons for the 2026 response

A small number of determinants appeared repeatedly across behaviors and contexts in the earlier outbreak. Social and behavior change strategies in DRC, Uganda, and surrounding countries should address each explicitly:

- **Self-efficacy and access are inseparable.** Ebola-prevention behaviors often are not adopted when phones don't work, treatment isn't free, community leaders are unreachable, or the steps to act are unclear. Map functional phones, identify emergency contact persons, ensure no-cost referral pathways, and make every recommended action as operationally simple as possible.
- **Stigma is often a primary, not secondary, barrier.** It consistently hindered case reporting, burial team calls, care seeking, and survivor return. It must be addressed in messaging, in structured community dialogue (such as Sierra Leone's Palava huts), and through visible normalization by trusted local voices — not undervalued or treated as an afterthought.
- **Social norms drive behavior more than facts do.** Perceived approval produced a 25-fold effect — far larger than any knowledge-based determinant measured in the studies. Identify *which influencers (people)* matter most for each behavior — spouses, aunts and uncles, neighbors, religious leaders, employers? — and design messaging around those specific influencers, not "the community" abstractly.
- **Mention collective benefit.** Doers sometimes acted to protect family and community. (This was the case for early case reporting and calling the burial team, for example.) Messaging built on preventive altruism sometimes out-performed messaging built on individual survival.
- **Crisis can disrupt memory.** Non-Doers consistently struggled to remember new behaviors at the moment they were needed. Reminders — posters, stickers, hotline numbers in visible places, trained neighbors who can prompt others — matter more than how often the message was broadcast beforehand.
- **Policy tools work when paired with community legitimacy.** Fines, bylaws, and free treatment lowered barriers in Sierra Leone, but only because community leaders helped frame them as *community-owned* rather than externally imposed.
- **Survivors need an institutional path back.** Without certification and visible reintegration support, survivors face the exclusion documented in Liberia — which in turn deters future case reporting.

Application to the 2026 response

The 2026 outbreak is occurring in a region whose population is mobile, urban-connected, and operating amid armed conflict — a context that compounds every behavioral challenge described above. With no vaccine for the Bundibugyo strain, behavior is the primary line of defense. Four immediate priorities follow: **First**, build response messaging around the determinants that proved decisive — social norms, stigma, access, and collective benefit — rather than around symptom recognition alone. **Second**, invest in trusted local intermediaries (e.g., Care Group Volunteers, CHWs, community-elected neighbors) over mass-media saturation. **Third**, commission rapid Barrier Analysis studies on priority behaviors in the affected health zones rather than assume the West African findings transfer wholesale; these can be run concurrently while the other lessons above are applied. **Fourth**, plan now for survivor certification and reintegration so that the cost of being identified as a case does not deter reporting later in the outbreak.

There are lesson plans on Ebola for use with the Care Group Approach (or that can be modified for use by CHWs and others with groups of people or individuals) that can be accessed [here](#). Note that these lessons were created before the Barrier Analysis studies, but they still focus on some of the key barriers (e.g. stigma, social norms against behaviors) and enablers of the behaviors discussed above.

The 2014–16 epidemic in West Africa came under control when responders shifted from raising awareness to changing behaviors — and from telling communities what to do to working with them to understand why they were not doing it. That shift, taken earlier in 2026, will save lives.

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Primary source: Davis T and Srinivasan A (eds.) 2016. [Ebola Barrier Analysis Compendium: Summary of Barrier Analysis Studies on Ebola-related Behaviors](#). Curamericas Global. Outbreak figures drawn from WHO, Africa CDC, and CDC situation reports, 15–18 May 2026.