Impact Global Health Alliance
Transforming global health outcomes, one community at a time.

Lessons Learned on Ebola-Related Behaviors

Plain Language Edition — using past Barrier Analysis studies on Ebola behaviors in West Africa to help guide the 2026 Bundibugyo Ebola outbreak response

The current outbreak

On 17 May 2026, the World Health Organization (WHO) called the Bundibugyo Ebola outbreak in the Democratic Republic of the Congo (DRC) and Uganda a Public Health Emergency of International Concern.

By mid-May, Africa CDC and WHO reported at least 10 confirmed cases, 336 suspected cases, and 88 deaths in Ituri Province, DRC. Uganda had two more confirmed cases and one death. There is now fear that Ebola will spread in cities and across borders.

The outbreak started in the health zones of Mongbwalu and Rwampara. These areas are crowded. People move in and out often. There is also armed conflict in the area. The first case may have been a nurse who came to a health facility in Bunia in late April.

There is no approved vaccine and no approved treatment for the Bundibugyo strain. So we must stop the outbreak the way past outbreaks were stopped before vaccines existed. Communities must adopt protective behaviors quickly, fully, and at a large scale.

Why focus on behavior, and why now?

In every Ebola outbreak that has been studied, awareness was not the main problem. Most people knew Ebola was serious. They knew the symptoms. They knew what they were told to do. But many people still did not:

- call the burial team quickly,
- stop washing or touching the body,
- seek care for fever within 24 hours,
- report suspected cases, or
- keep washing their hands.

Knowledge alone rarely changes behavior.

This is the main message of the 2016 Ebola Barrier Analysis Compendium. This is a collection of studies. It was produced by Curamericas Global (now Impact Global Health Alliance). The Compendium brings together studies done in Liberia and Sierra Leone during the 2014–16 West African epidemic. The studies were done by Mercy Corps, Catholic Relief Services, and Samaritan's Purse.

Barrier Analysis (BA) compares people who do a behavior ("Doers") with people who do not ("Non-Doers"). It shows the real reasons people act differently. These reasons can include what people believe, who influences them, what they have access to, and what is hard for them. These are evidence-based reasons, not guesses.

When this brief says someone was "7 times more likely" to do or say something, that number comes from BA results. Researchers call this number an Estimated Relative Risk, or ERR. A higher number means a stronger effect.

These findings are useful beyond West Africa. The cultural details in East Africa are different. But the types of factors that drive Ebola behaviors are similar. They include:

- self-efficacy (a person's belief that he or she can do the behavior),
- social norms (what a person thinks others approve or disapprove of),
- positive and negative consequences (including stigma),
- access (having the things one needs to do the behavior), and
- cues for action (reminders).

These factors made a real difference for many behaviors studied. They are likely to matter again in DRC, Uganda, and other countries the outbreak may reach. This brief brings together those lessons for the 2026 response.

Key lessons by behavior

1. Reporting suspected cases early

In Mercy Corps' Montserrado County (Liberia) study, four things were different between Doers and Non-Doers:

- **Access to a community leader was very important.** Non-Doers were six times more likely than Doers to say they could not reach their community leader.
- **Phone access mattered.** Non-Doers were about three times more likely to say they did not have a working phone, network coverage, or a way to charge their phone.
- **Stigma was a strong barrier.** Non-Doers were about seven times more likely to say their friends and neighbors would disapprove of reporting.
- **Doers were also motivated by helping others.** They reported cases to protect their family and community — not just themselves. Messages that focused on protecting others worked better than messages about saving oneself.

2. Calling the burial team within 30 minutes

In Catholic Relief Services' (CRS) Sierra Leone study:

- Doers were 8.2 times more likely than Non-Doers to say "preventing Ebola from spreading" was a benefit of calling the burial team.
- But Doers were also 4.3 times more likely to say household quarantine and movement restrictions were a downside.
- Non-Doers were 5.6 times more likely to say community stigma made it hard to call.
- Practical barriers included no phone credit (minutes), no phone, family pushback, and a need to inform mosque members first.

The decision was rarely just one person's. Families decided together, often while in shock.

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

This is where culture and social norms most clearly clashed with public health.

- Doers were 25 times more likely than Non-Doers to say most people they knew approved of the behavior. This is the largest effect in the whole Compendium.
- Approval by aunts and uncles mattered (ERR 7.8). Approval by neighbors also helped (ERR 2.8). Disapproval by brothers and sisters was a strong barrier.
- Fines and community bylaws helped (ERR 2.8).
- Doers were 7.3 times more likely to say there were no cultural taboos against the behavior. This means "culture" is not the same for everyone in a community. Calling a practice "cultural" when only some people do it can make the practice stronger.

4. Seeking care for fever within 24 hours

- Doers were 7.7 times more likely to say most people approved of seeking care.
- Disapproval from a husband or wife was a big barrier (ERR 7.3).
- Fear of catching Ebola at the hospital made care seeking 3.5 times harder.
- Free treatment helped (ERR 3.5). Encouragement from doctors and nurses helped a lot (ERR 5.1).
- One surprising finding: more Non-Doers than Doers said hospitals would give them the right treatment. So they knew this. But they still did not go. Trust in the service is not the same as the social permission to use it.

5. Helping Ebola survivors return to work and school

Mercy Corps found that an official medical clearance certificate was the most important enabler. Employers and school administrators who saw a certificate were almost six times more likely (ERR 5.79) to take a survivor back. Hearing a survivor's story also helped — empathy after hearing the story had nearly the same effect (ERR 5.61). The main barrier was stigma: fear that customers, friends, and colleagues would pull away.

What this means for 2026: every survivor will need official proof of being Ebola-free, including those who were never treated in a health facility.

6. Handwashing with soap

Samaritan's Purse studied this in River Gee, Liberia. The Compendium also reviewed 17 BA studies on handwashing from 11 countries. The factors that mattered most often were:

- self-efficacy (in 75% of studies),
- social norms (in 69% of studies),
- positive and negative consequences (in 56% of studies), and
- perceived divine will (in about 25% of studies — people who believed diarrhea was God's will were less likely to wash hands).

Doers understood better that diarrhea is serious and that their own actions can prevent it (in other words, they had higher self-efficacy).

Cross-cutting lessons for the 2026 response

A small number of factors came up again and again across behaviors and contexts in the earlier outbreak. Social and behavior change (SBC) plans in DRC, Uganda, and nearby countries should address each one clearly:

- **Self-efficacy and access go together.** People often do not adopt Ebola-prevention behaviors when their phone does not work, treatment is not free, community leaders are hard to reach, or they do not know what steps to take. Map which homes have working phones. Pick emergency contact persons. Make sure care is free. Make every recommended action as simple as possible.
- **Stigma is often a main barrier, not a small one.** It consistently blocked case reporting, calling burial teams, seeking care, and survivor return. Address stigma in your messages. Use community discussions (such as Sierra Leone's Palava huts). Have trusted local people show that the behavior is normal. Do not treat stigma as a small problem.
- **Social norms drive behavior more than facts do.** Perceived approval had a 25-fold effect — much larger than any knowledge-based factor in the studies. Find out who matters most for each behavior (spouses, aunts and uncles, neighbors, religious leaders, or employers). Then design messages for those specific people. Do not design messages for "the community" in general.
- **Mention collective benefit.** Doers sometimes acted to protect their family and community. This was true for early case reporting and calling the burial team. Messages about protecting others sometimes worked better than messages about saving oneself.
- **Crisis can disrupt memory.** Non-Doers often forgot new behaviors at the moment they were needed. Reminders matter — posters, stickers, hotline numbers in visible places, and trained neighbors who can prompt others. These matter more than how often a message was broadcast before the crisis.
- **Policy tools work when communities support them.** In Sierra Leone, fines, bylaws, and free treatment lowered barriers. But this only worked because community leaders helped people see the rules as their own — not as something forced on them from outside.
- **Survivors need an official path back.** Without a certificate and visible support, survivors face the rejection seen in Liberia. This in turn makes others afraid to report cases.

Applying this to the 2026 response

The 2026 outbreak is happening where many people move around, cities are connected, and armed conflict continues. This makes every behavioral problem above harder. With no vaccine for Bundibugyo, behavior is the main line of defense.

Four immediate priorities:

1. Build messages around the factors that proved important: social norms, stigma, access, and collective benefit. Do not focus only on teaching people to recognize symptoms.
2. Invest in trusted local people (Care Group Volunteers, CHWs, community-chosen neighbors) instead of mass-media saturation.

3. Do rapid Barrier Analysis studies on priority behaviors in the affected health zones. Do not assume the West African findings will transfer fully. These studies can be done at the same time as the other lessons are being applied.
4. Plan now for survivor certification and reintegration. If we do not, the cost of being known as a case may make people afraid to report later in the outbreak.

The 2014–16 West African epidemic came under control when responders changed two things. First, they shifted from raising awareness to changing behaviors. Second, they shifted from telling communities what to do, to working with them to understand why they were not doing it. Taking that shift earlier in 2026 will save lives.

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