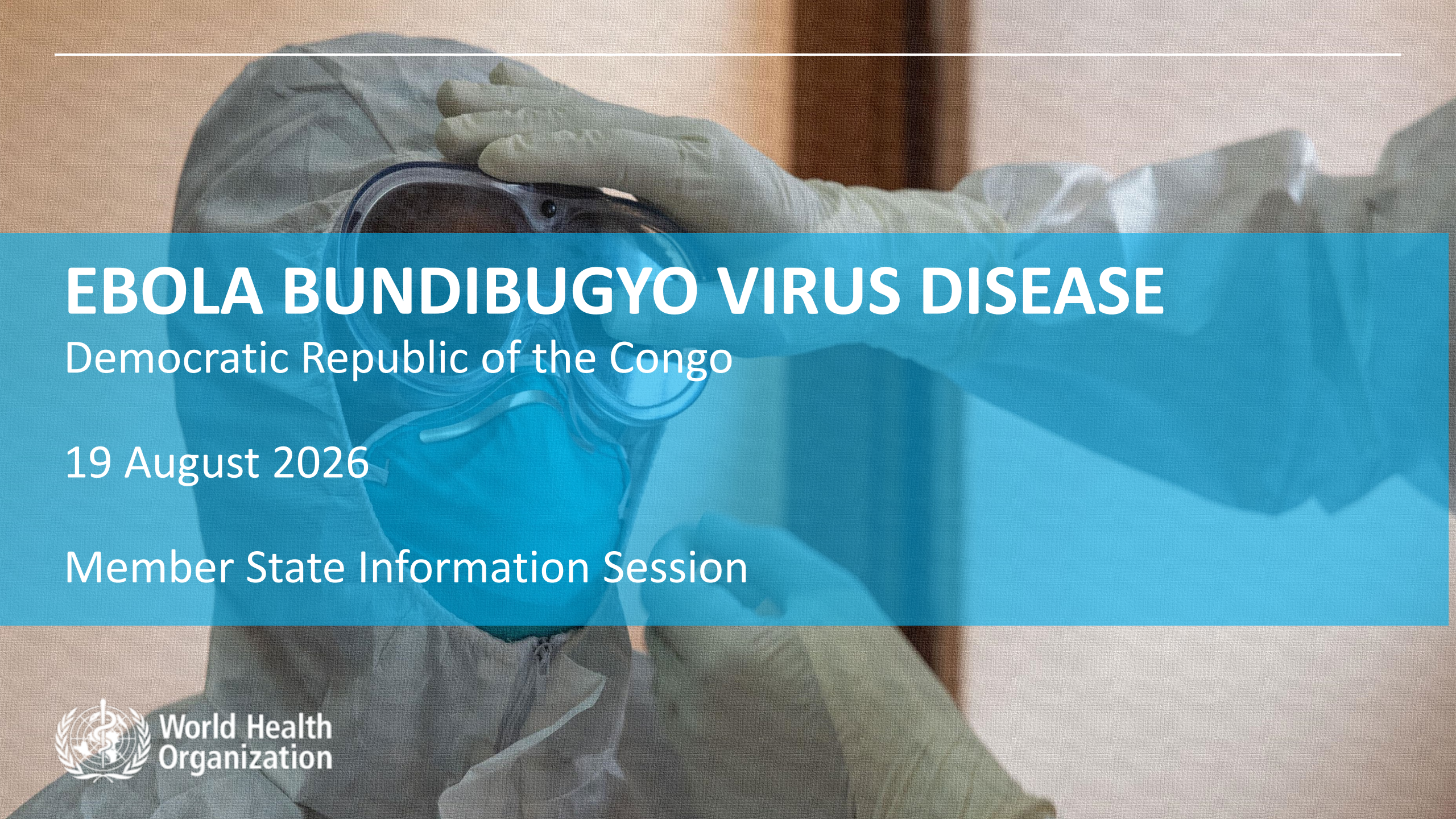


EBOLA BUNDIBUGYO VIRUS DISEASE

Democratic Republic of the Congo

19 August 2026

Member State Information Session

World Health Organization

Epidemiological overview

A total of 3,802 cases and 1,707 deaths had been reported in the last briefing on 4 August – **an increase of 1,219 cases and 671 deaths in 2 weeks**

Democratic Republic of the Congo: Key figures as of 2026-08-16

Time period	Confirmed cases	Confirmed deaths	Recoveries	Health Zones affected	Health worker infections
Total to date	5,021	2,378	1,061	55	141
New - last 24h	76	53	21	0	0
New - last 7d	640	367	192	2	0
New - last 21d	1,759	941	478	7	18

Exportation of cases to other countries

Country	Confirmed cases	Confirmed deaths	Recoveries	Health worker infections
France	1	0	1	1
Uganda	15	2	18	4

*5 additional local cases were reported in Uganda with an epidemiological link to the imported cases
Uganda has reported an additional one probable case

Data Source MOH DRC

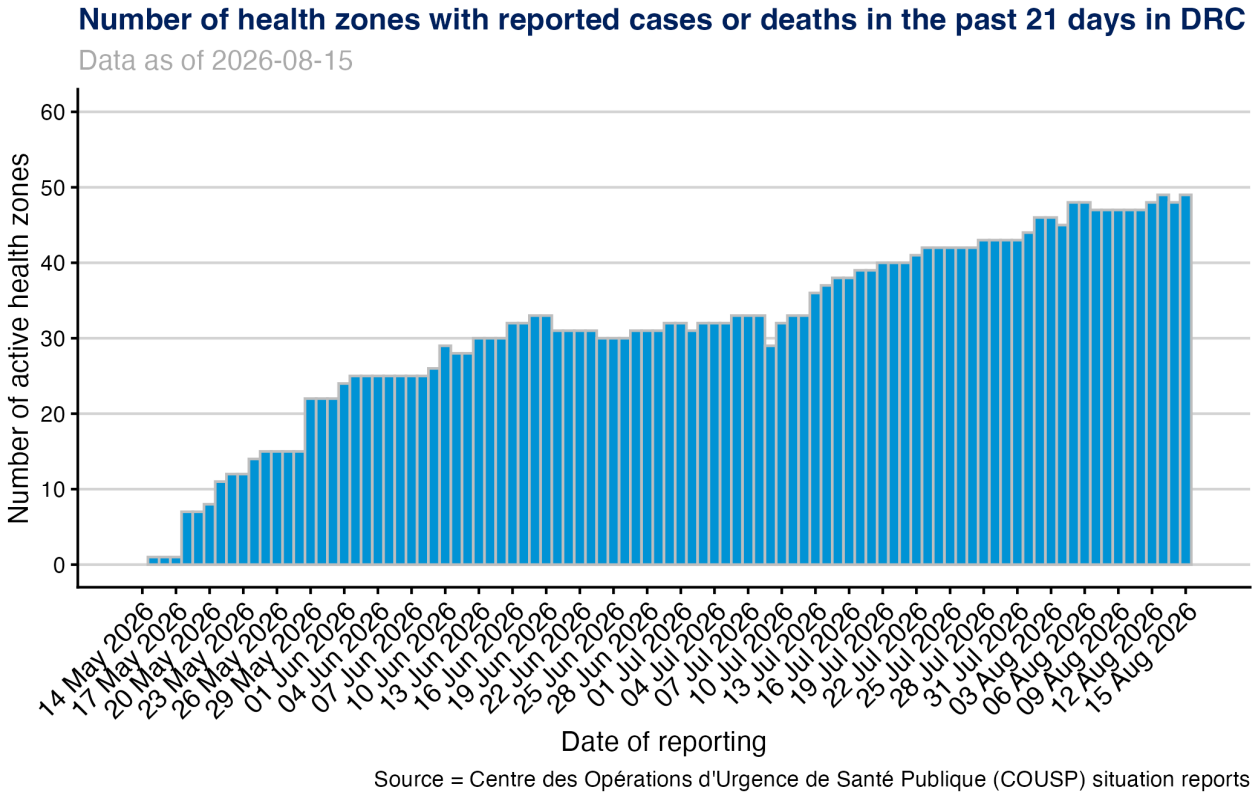
* Suspected deaths have been temporarily excluded from the count pending the results of ongoing investigations which will determine whether they can be classified as probable cases or definitively discarded.

Data Source MOH DRC, MOH Uganda, MOH France

Within country spread: number of active health zones over time

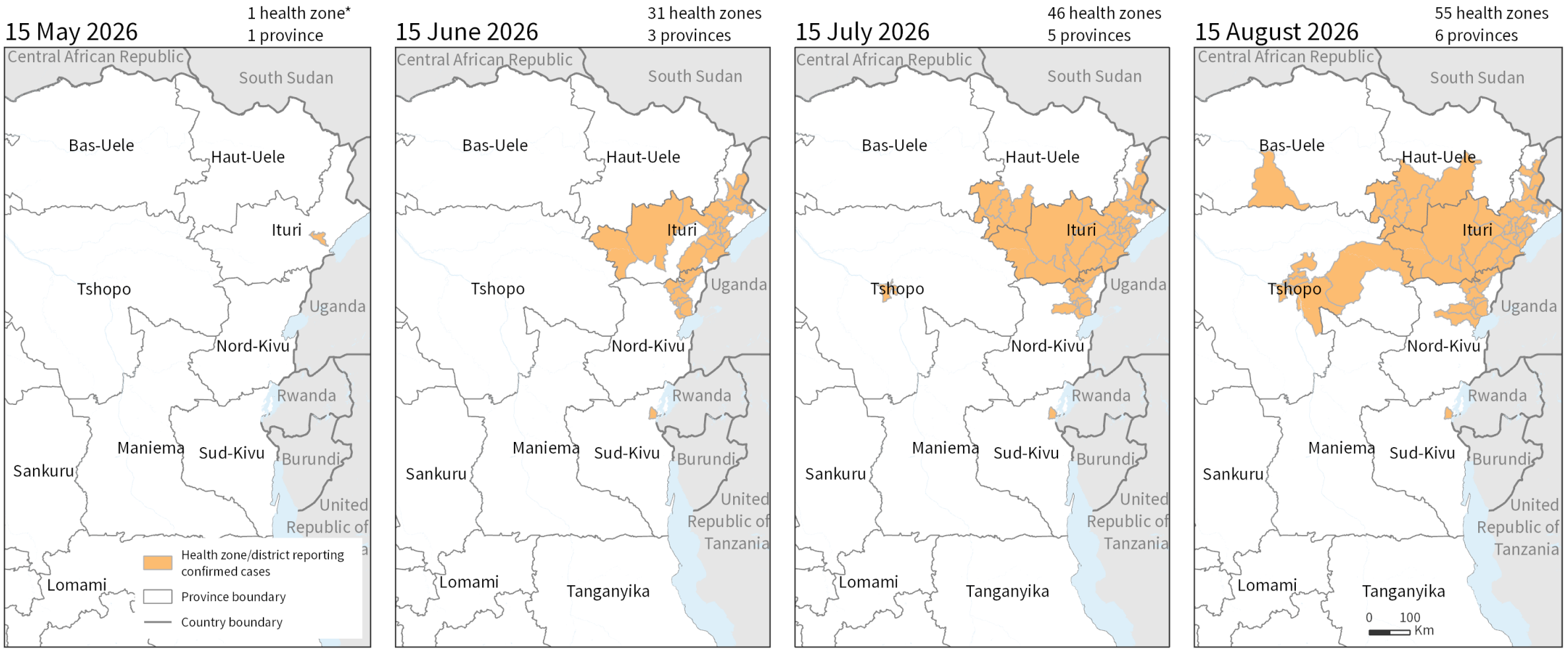
- **49 active health zones**, as of 15 August 2026
- A total of 55 health zones have reported cases - only **6 health zones have sustainably contained the outbreak** to date
- **84% of cases** coming from **Ituri,** where 28 out of 36 (78%) of health zones are affected

Province	Confirmed cases (% total)	Confirmed deaths	Number of health zones affected
Ituri	4309 (84%)	1915	28/36 (78%)
Nord-Kivu	633 (12%)	431	12/34 (35%)
Haut-Uélé	145 (3%)	65	6/13 (46%)
Tshopo	14 (<1%)	7	7/23 (30%)
Sud-Kivu	3 (<1%)	1	1/34 (3%)
Bas-Uélé	1 (<1%)	1	1/11 (9%)



Source = Centre des Opérations d'Urgence de Santé Publique (COUSP) situation reports

Health zones or districts reporting confirmed Ebola Bundibugyo virus disease cases in the Democratic Republic of the Congo



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.

* On 15 May 2026 (date of the BVD outbreak declaration), 13 confirmed cases were reported in Rwampara health zone. Suspected and probable cases were reported in Bunia and Monbwalu health zones.

** The health zone of Goma in Nord-Kivu province is not visually distinguishable on the map due to its small geographic size and the scale of the map. Goma began reporting cases on 18 May 2026.

Data Source: World Health Organization, Ministries of Health Democratic Republic of the Congo and Uganda, GRID3
Map Production: WHO Health Emergencies Programme

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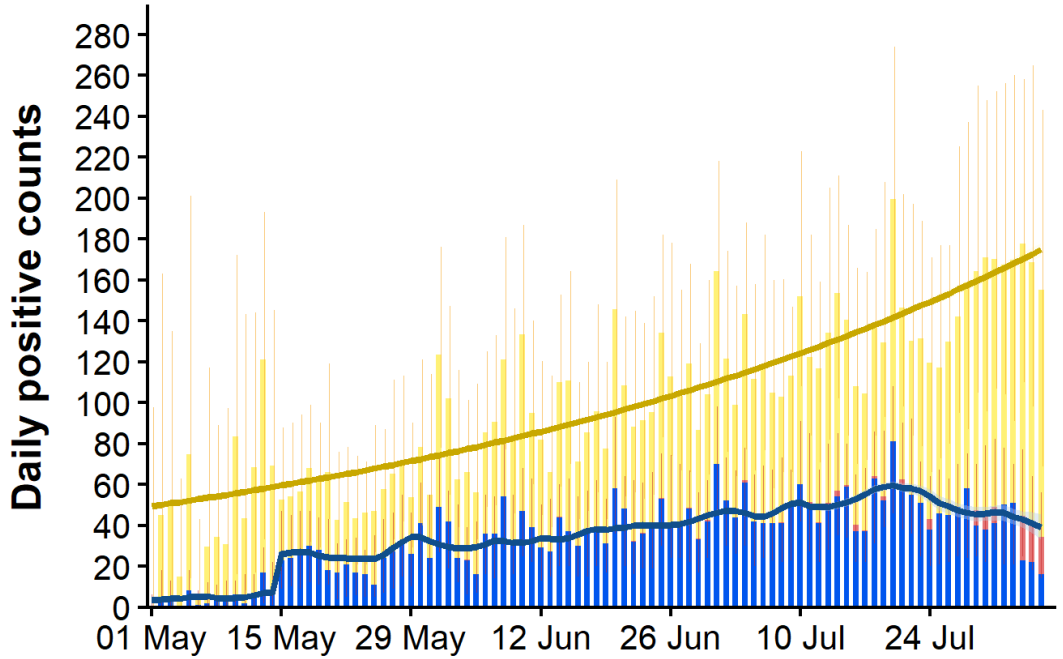
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Growth rate: Rt using reported cases

- Low estimated case ascertainment is a challenge for estimating growth rate
- Using cases, the estimated doubling time is 52 days
- Estimates account for some sources of under-ascertainment, but results are still uncertain given not enough data to account for how many deaths in the community are never recorded and the CFR inside and outside of ETCs

Under the most plausible assumptions, the outbreak is **3-4 times larger** than what is currently being observed – verified by a range of methods and data sources

Quantity	Estimate
Rt	1.24 (95%CI 1.05-1.44)
Doubling time	52 days

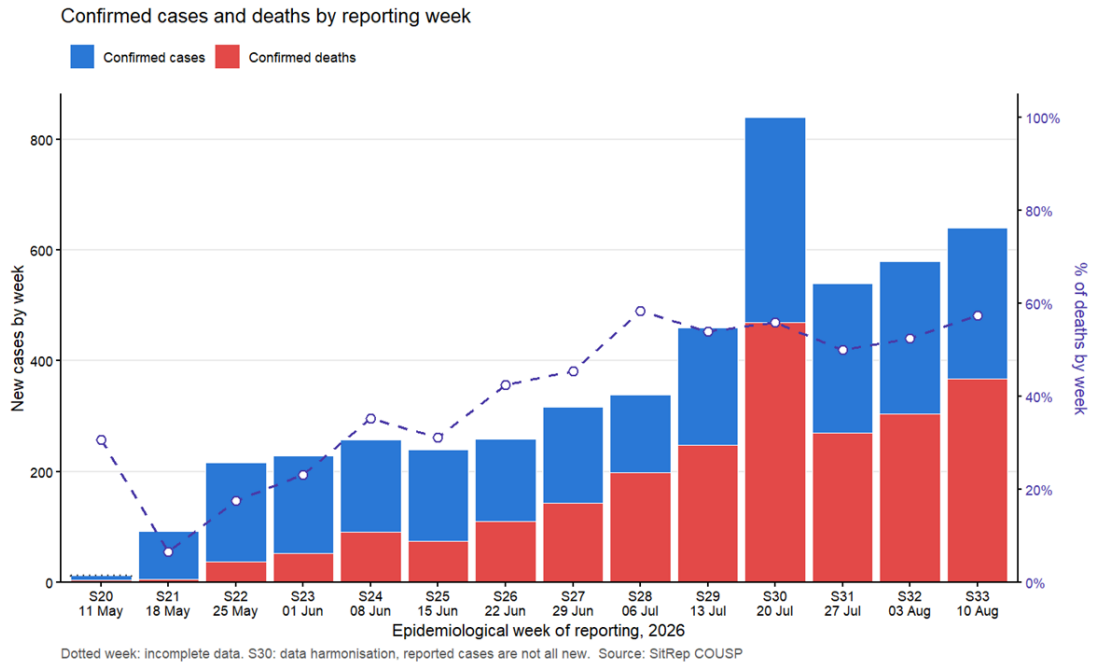


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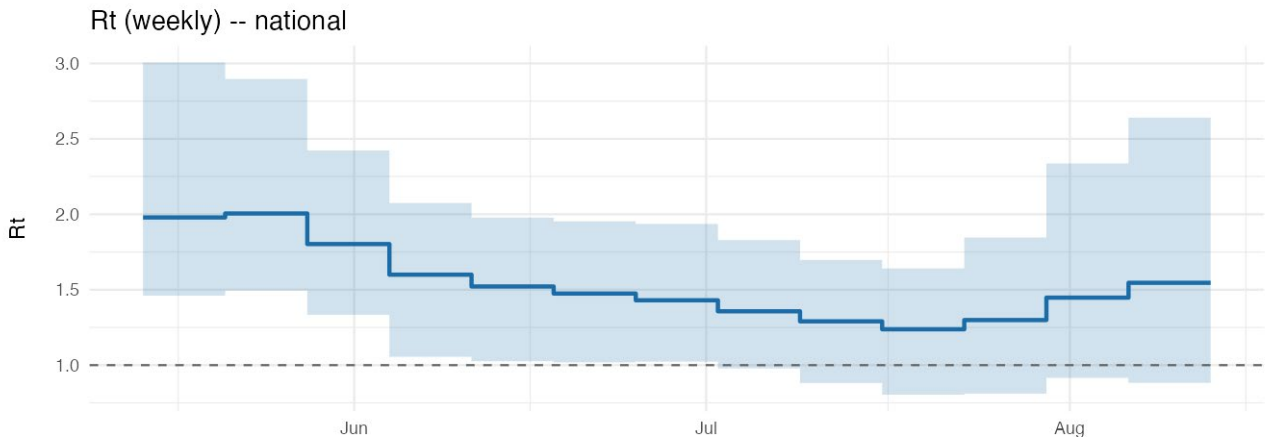
Source: WHO and Imperial College London, in collaboration with DRC MoH, INSP, INRB and Africa CDC

Growth rate: Rt using reported deaths

- Deaths are currently a better indicator of growth of the epidemic due to the saturation in case detection and the higher ascertainment of deaths
- Estimated doubling time **using deaths is 21 days** compared with **52 days using cases**



Quantity	Estimate
Rt	1.55 (95%CI 0.89 - 2.64)
Doubling time	21 days

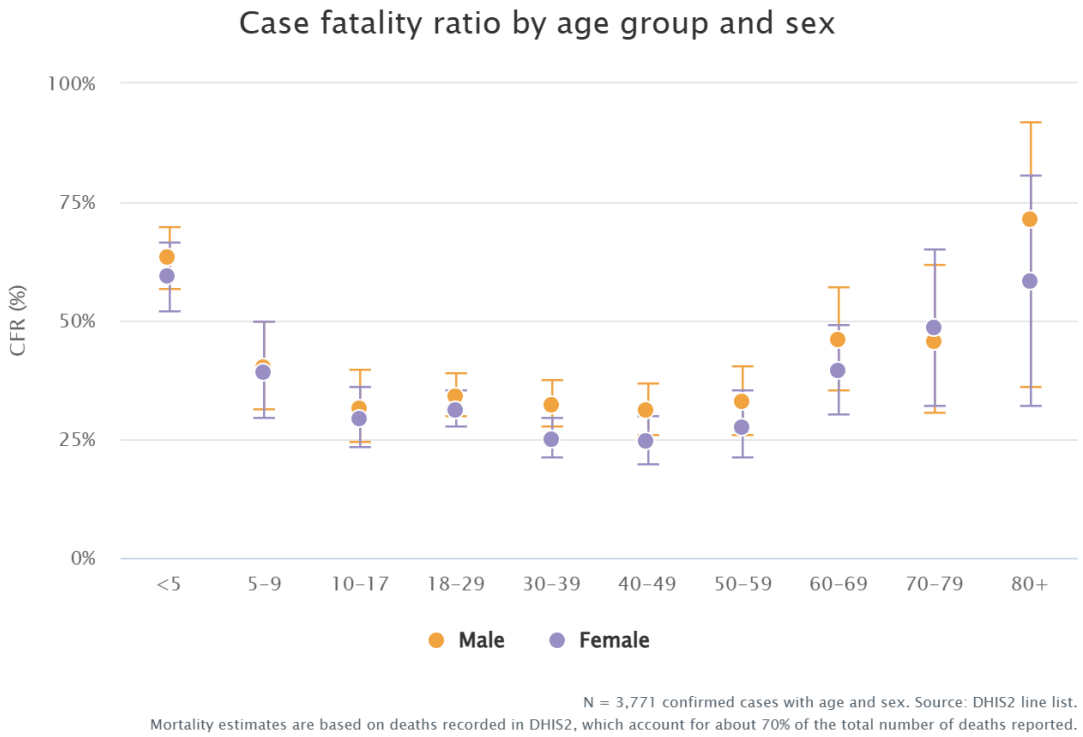


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Source: WHO and Imperial College London, in collaboration with DRC MoH, INSP, INRB and Africa CDC

Severity

- Case fatality ratio (CFR) varies by age group
- No evidence of differences in severity between male and females
- According to DHIS2 data, crude CFR remains approximately stable at ~40% since the start of June, however the line list only includes 70% of reported deaths (not ETC)
- Estimates from one CTE suggests **overall CFR of ~50%,** reducing to **~35% for those with length of stay > 2 days,** however this varies by CTE
- In one CTE, mean time from symptom onset to admission for those who die is 5.3 days while this is 4.5 days in those who recover

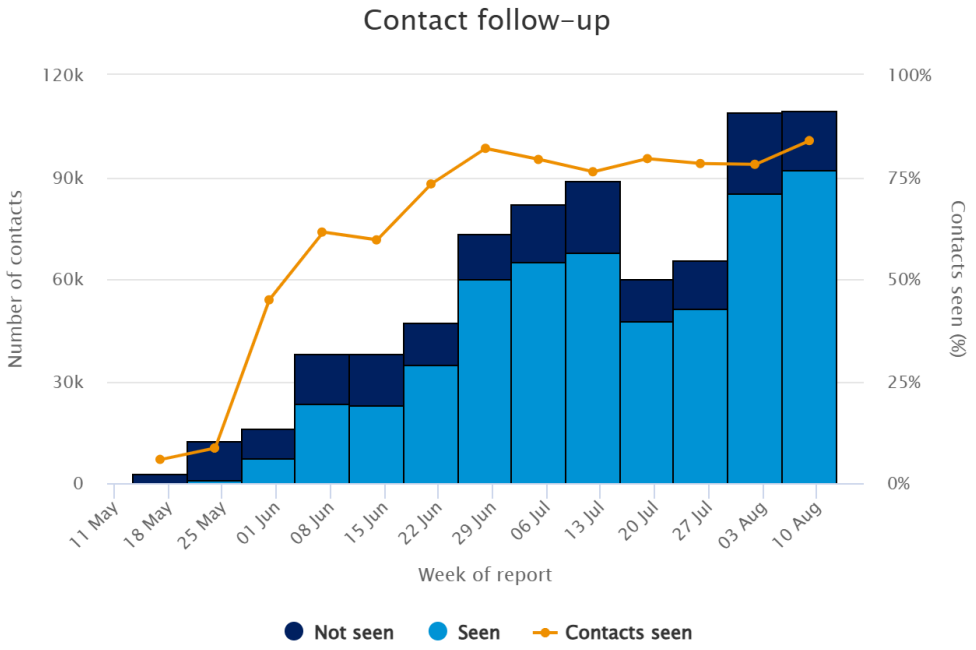


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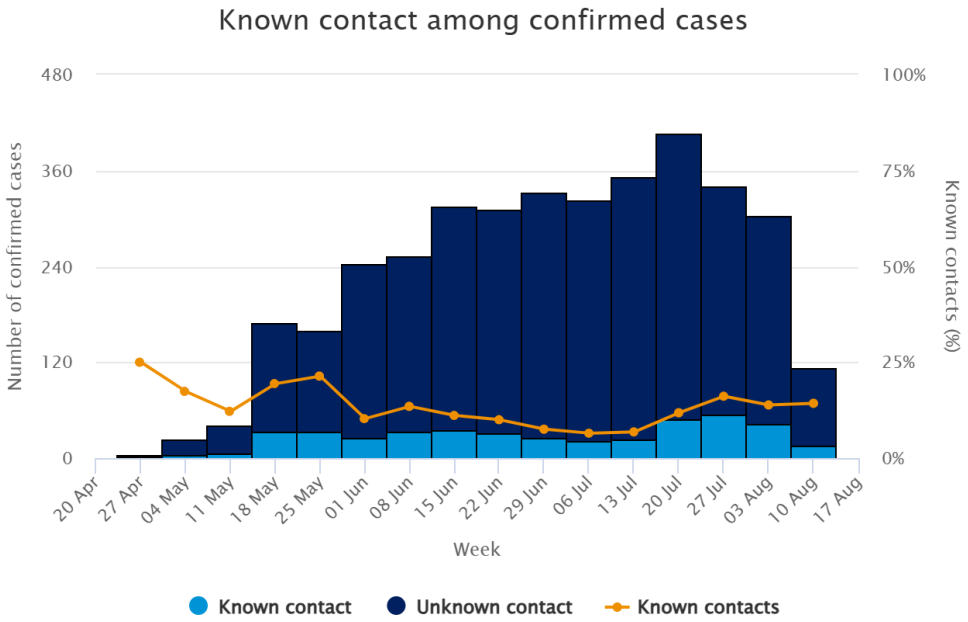
Challenges to contact tracing

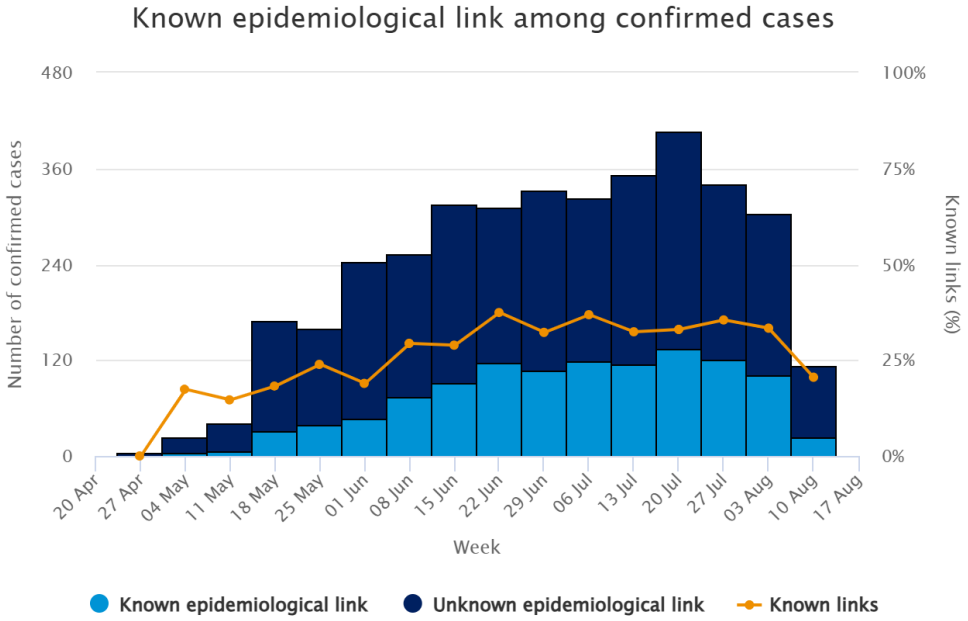
- Contact tracing follow-up has hovered around 80% (somewhat short of 95% target), however this only represents **known** contacts (**average 13 per case**)

- Only **~20% of cases come from contact lists** (and **~40% are epi linked** after investigation) indicates that **case investigation and contact listing are sub-optimal**



Source: COUSP situation report.

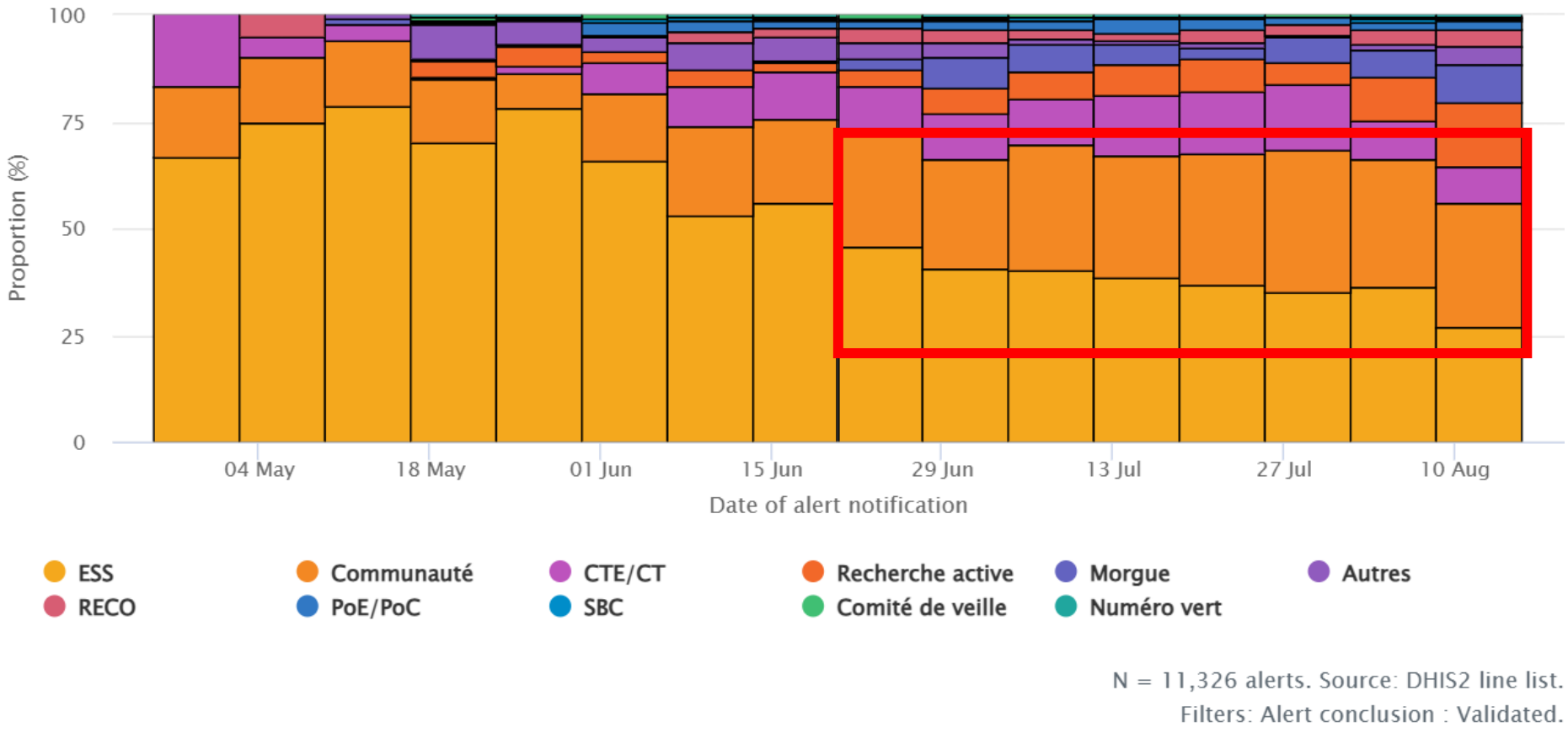




N = 3,686 confirmed cases. Source: DHIS2 line list.

Source of alerts for suspected cases

Proportion of suspected cases coming from the community and community-based surveillance is increasing



N = 11,326 alerts. Source: DHIS2 line list.
Filters: Alert conclusion : Validated.

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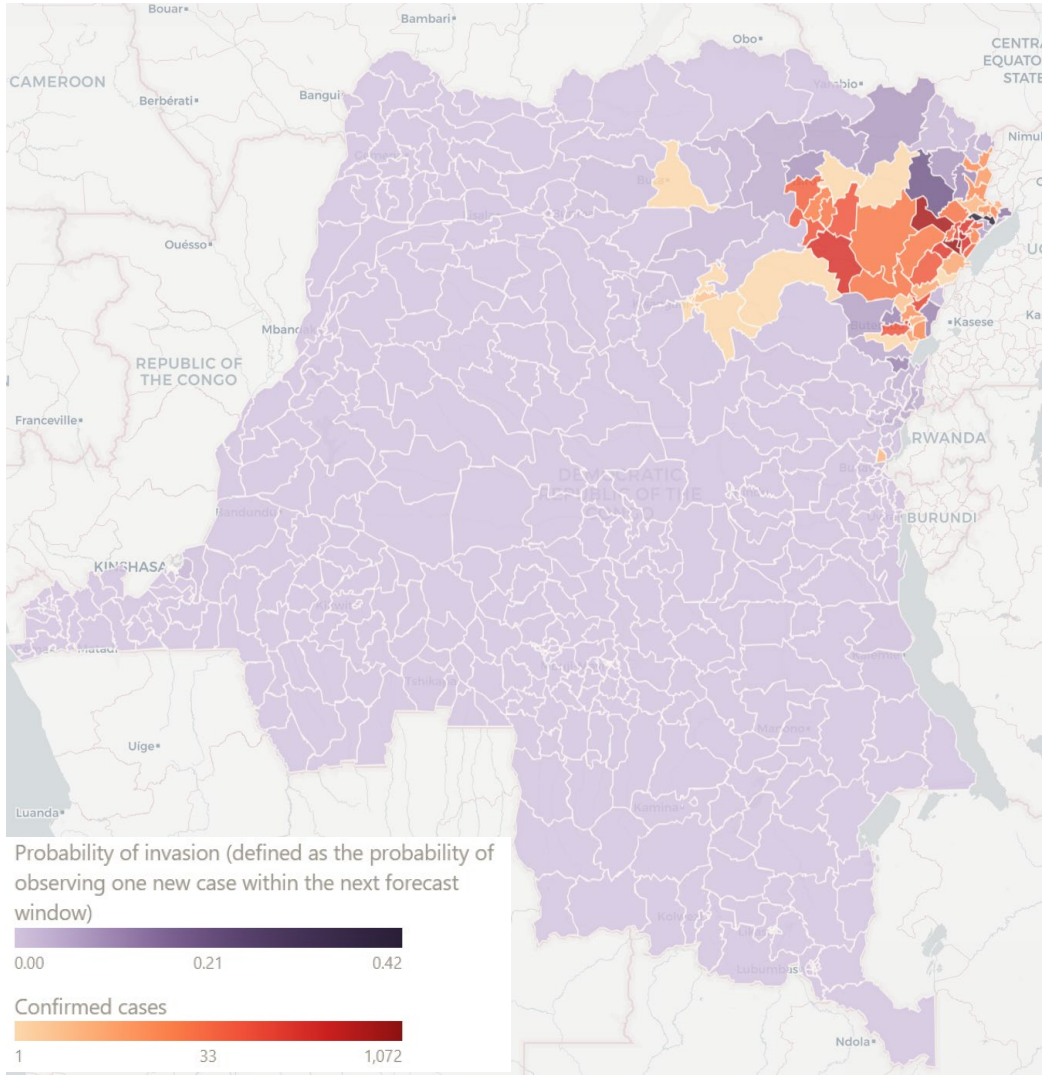
ESS: healthcare center, CTE/CT: Ebola treatment and transit center, RECO: community health worker, SBC: community based surveillance

Within country geographical spread: areas **at risk** of further spread

4 of the 15 health zones at highest risk of importation border surrounding countries: **Uganda** (blue), **South Sudan** (orange), **Rwanda** (purple)

Forecasting horizon window August 18th to August 24th

Province	Health zone	Invasion probability	95% CrI
Ituri	Rethy	0.546	0.449 - 0.640
Haut-Uele	Watsa	0.248	0.185 - 0.317
Ituri	Nyarambe	0.171	0.128 - 0.219
Nord-Kivu	Kayna	0.146	0.114 - 0.180
Nord-Kivu	Mutwanga	0.143	0.110 - 0.178
Nord-Kivu	Biena	0.140	0.108 - 0.175
Ituri	Biringi	0.132	0.098 - 0.169
Bas-Uele	Viadana	0.111	0.077 - 0.150
Haut-Uele	Dungu	0.101	0.072 - 0.133
Haut-Uele	Makoro	0.100	0.074 - 0.131
Ituri	Linga	0.095	0.073 - 0.118
Ituri	Jiba	0.089	0.069 - 0.111
Nord-Kivu	Manguredjipa	0.086	0.065 - 0.109
Ituri	Angumu	0.083	0.062 - 0.108
Nord-Kivu	Karisimbi	0.081	0.062 - 0.102



Source: INRB, link [DRC Ebola Bundibugyo - Epidemic Intelligence Dashboard]

Number of State Parties with BVD: modelled estimates of relative importation risk (as of 23 July 2026)

- Risk of exportation outside Africa is very low
- **If an exportation occurs**, country most at risk is **South Sudan with 80.1% probability** of introduction (79.6% Juba), followed by United Arab Emirates (3%) and Kenya (2.8%)
- **Caveat**: the estimates are as of 23 July and do not account for the newly affected province (Bas-Uele) on the border with Central African Republic

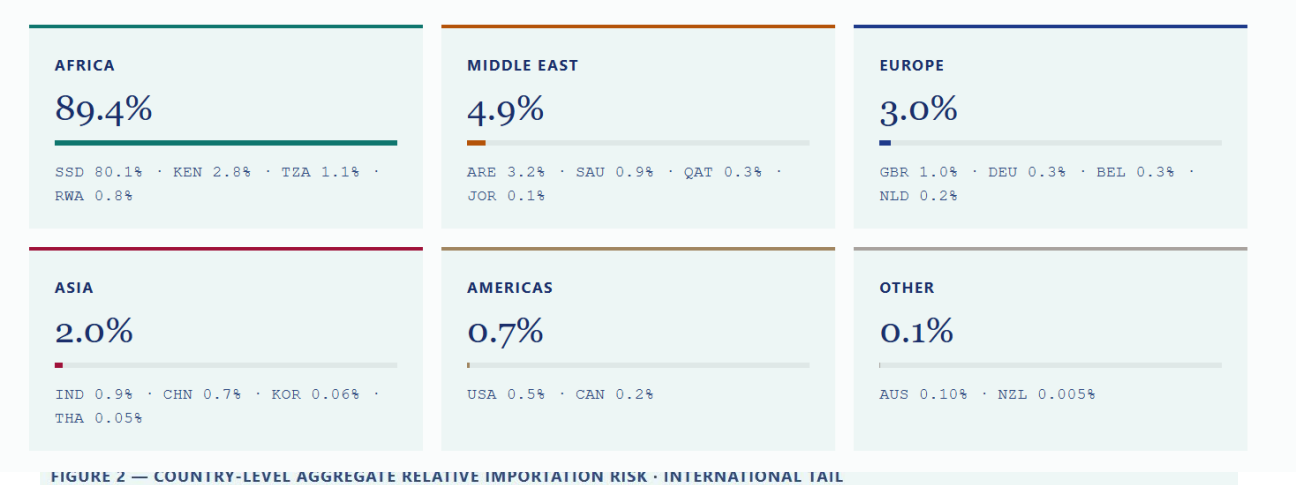
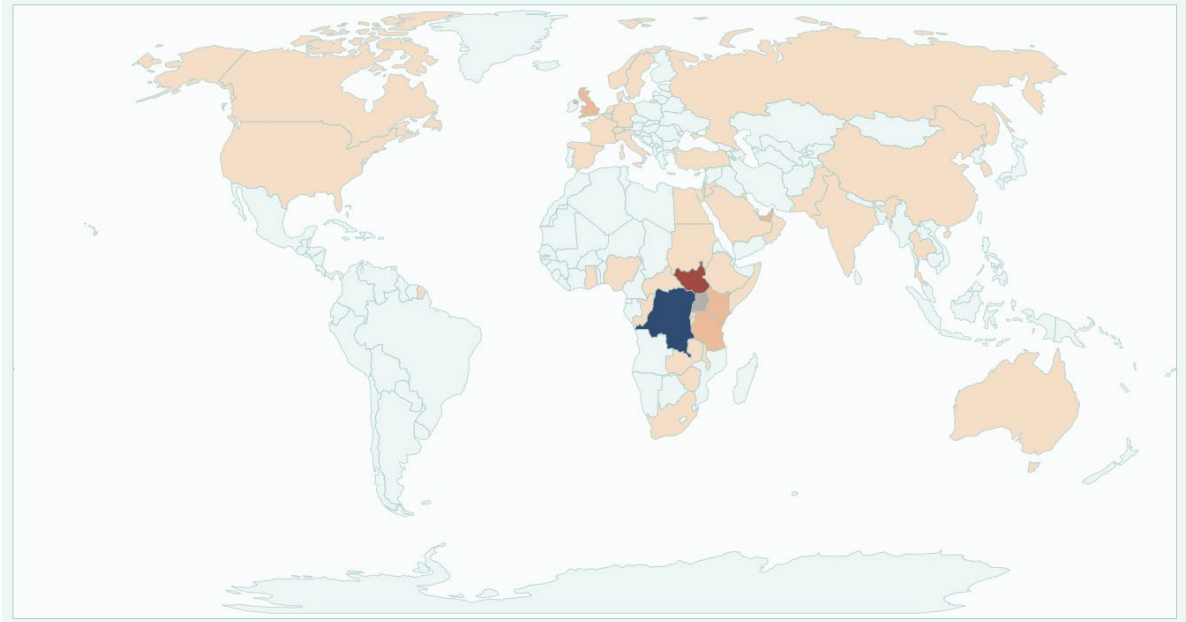


FIGURE 2 — COUNTRY-LEVEL AGGREGATE RELATIVE IMPORTATION RISK · INTERNATIONAL TAIL



Source: Epistorm, North Eastern University
Ebola BVD — DRC · International Dissemination · Update (Jul 23)

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WHO Risk Assessment

15 May - V1

Overall risk and confidence (based on information available at time of assessment)

Overall risk		
National	Regional	Global
High	High	Low

Confidence in available information		
National	Regional	Global
Moderate	Moderate	Moderate

20 May - V2

Overall risk and confidence (based on information available at time of assessment)

Overall risk		
National	Regional	Global
Very High	High	Low

Confidence in available information		
National	Regional	Global
Moderate	Moderate	Moderate

5 June – V3

Overall risk and confidence (based on information available at time of assessment)

Overall risk				
Democratic Republic of the Congo	Uganda	Countries with land borders adjoining countries with documented BDBV detection	Rest of the African Region	Global
Very High	High	High	Low	Low

Confidence in available information				
Democratic Republic of the Congo	Uganda	Countries with land borders adjoining countries with documented BDBV detection	Rest of the African Region	Global
Moderate	Moderate	Moderate	Moderate	High

14 August – V4

Overall risk and confidence (based on information available at time of assessment)

Overall risk			
Democratic Republic of the Congo	Countries sharing land borders with the Democratic Republic of the Congo	Rest of the African Region	Global
Very High	High	Low	Low

Confidence in available information			
Democratic Republic of the Congo	Countries sharing land borders with the Democratic Republic of the Congo	Rest of the African Region	Global
Moderate	Moderate	Moderate	High

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PSEAH / PRSEAH

Safeguarding BVD Response and Readiness:

Operational Framework, Progress, Challenges, Gaps and Priority Needs

COLLECTIVE / IASC/ INTER-AGENCY PSEA OUTCOMES

Common standards & coordination • Community empowerment on rights, reporting/CBCMs • Inter-agency referral & victim support services• Collective risk mitigation • Leadership & accountability

AGENCY-SPECIFIC PSEAH RESPONSIBILITIES

Workforce safeguarding • Code of Conduct • Safe recruitment/deployment • Partner due diligence • Organizational accountability

Government leadership and national PSEAH frameworks and systems underpin sustainable accountability

PSEAH Governance, Coordination & Accountability

Two connected levels translate system-wide standards into country-level operational safeguarding

LEVEL 1 | GLOBAL / SYSTEM-WIDE

IASC PSEA Technical Advisory Group (TAG)

- System-wide technical guidance and strategic support on PSEA
- Supports integration of PSEA into the Ebola/BVD system-wide scale-up and common operational approaches
- BVD enabling actions: PSEA Addendum • Inter-Agency Checklist • briefing/mobilization of PSEA Coordinators and WHO focal points

System-wide guidance, strategy development, capacity, tools & technical support

LEVEL 2 | COUNTRY

HC/RC-led Inter-Agency PSEA Network + Government framework & Response Structures

- Coordinates collective PSEA action & clarifies WHO/partner roles and accountability
- Promotes common prevention, safe/accessible reporting mechanisms, community engagement, Implementing partner due diligence and victim support & accountability
- Coordinates joint PSEA risk assessments and translation into joint plan of action
- WHO participates as Agency PSEA focal point, and contributes to the collective actions. In DRC, WHO supported the IA PSEA network leadership, & remained principal actor for safeguarding BVD operations

- Leads national outbreak preparedness, readiness and response
- Integrates PSEAH into national/subnational coordination, plans and operational arrangements
- Builds sustainable government and local safeguarding capacity, including focal points, community mechanisms, victim support services, policy alignment, partner due diligence

SHARED OPERATIONAL OBJECTIVE

Safe & accountable BVD operations • protected communities & responders • accessible reporting and referral • effective accountability • community trust

Current and planned measures: system-wide to country action

SYSTEM-WIDE / INTER-AGENCY

PSEA integrated into the IASC Ebola system-wide scale-up

- **PSEA Addendum** developed for infectious-disease scale-up
- Inter-Agency **PSEA Checklist** developed for response and readiness
- Inter-Agency **PSEA Coordinators and WHO PSEAH focal points briefed** and mobilized
- **PSEA Adviser** designated in the Office of the Senior Ebola Emergency Coordinator

COUNTRY OPERATIONALIZATION

- PSEAH safeguarding mainstreamed across response and readiness
- Complementary leadership and coordination through national and inter-agency PSEA networks
- Government and inter-agency PSEA plans aligned and risk-informed
- Government and agency focal points support collective action – e.g 36 PSEA focal points across 18 health zones in Ituri
- CBCMs, reporting/referral pathways and survivor support being strengthened
- Community awareness on rights, expected conduct and complaint channels
- Partner and focal-point capacity, monitoring and accountability strengthened

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Selected country focus: DRC and Uganda response; DRC, Uganda, South Sudan and CAR readiness

Results to date and operational risk picture

SEA Risk Assessment: common risk factors requiring mitigation

Provides a strategic risk lens; joint country assessments localize risks and translate findings into action.

PSEA risk assessments undertaken/initiated in DRC, South Sudan and Uganda. DRC, South Sudan and CAR were among the 15 highest-risk humanitarian contexts for SEA prior to the BVD response; outbreak-related risks require continued local assessment and mitigation.

1 Situational context & Vulnerability

- Conflict/insecurity & displacement
- Poverty and livelihood dependency
- Gender inequality, high GBV risks and other power imbalances
- Heightened vulnerability among women, girls, youth, displaced people and persons with disabilities
- Limited access

2 Operational context

- Outbreak expansion, rapid scale-up, multiple partners, workforce turnover
- Uneven PSEA knowledge / focal-point coverage
- Responder–community power imbalance
- Recruitment, onboarding and partner safeguards may lag expansion
- Community Interventions & Volunteers
- Variable partner capacity

3 Enabling Environment

- PSEAH related policies and frameworks
- Limited awareness of rights / channels
- CBCMs absent, inaccessible or under-used
- Fear, stigma and low trust suppress reporting
- Language and geographic barriers affect access

4 Protective environment

- Policies and national frameworks
- PSEA coordination capacity
- Gaps in CBCM/reporting & referral capacities
- Limited victim support services
- Weak accountability mechanisms
- PSEAH coverage may lag operational expansion
- Limited PSEA capacity in some intervention areas

DRC EVIDENCE

325 participants / 19 focus groups (59% women): 37% had no PSEA information; 33% were unaware of the toll-free number; among those familiar with complaint procedures, 80% reported not using them. Community-proposed mitigation measures informed awareness planning.

Joint PSEA risk assessment findings inform inter-agency, national and agency-specific mitigation plans integrated into BVD operations and monitoring

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PSEAH Safeguarding: results to date

GLOBAL / IASC SYSTEM-WIDE

Enabling framework

- PSEA integrated into **Ebola system-wide scale-up**
- **PSEA Addendum** for infectious-disease scale-up
- Inter-Agency **Ebola PSEA Checklist** developed
- IA **PSEA Coordinators & WHO focal points** briefed / mobilized
- **PSEA capacity deployed** to support Senior Ebola Emergency Coordinator
- **Common tools/guidance** adapted for response & readiness

COUNTRY / COLLECTIVE PSEA

Operationalization through PSEA networks

- **Inter-agency plans** aligned with Government plans
- **Joint SEA risk assessments** & mitigation measures
- **Partner** mapping, capacity assessment & strengthening
- **Community PSEA messages** and outreach
- **CBCMs established/reactivated** — including 12 in DRC
- Reporting/referral pathways strengthened

NATIONAL GOVERNMENT

Leadership & sustainable systems

- National PSEA policies/frameworks established or adapted (DRC is establishing PSEAH national framework – All of Government Approach)
- PSEAH integrated into outbreak preparedness & response
- Government focal-point capacity strengthened
- National/subnational coordination strengthened
- Reporting/referral mechanisms linked to national systems
- DRC: 36 PSEA focal points across 18 health zones

WHO / AGENCY-SPECIFIC

Workforce safeguarding & Code of Conduct • PSEAH induction / briefings • Internal reporting channels • Safe recruitment/deployment • Partner due diligence

RESULT: PSEAH progressively embedded across BVD response & readiness — from system-wide standards to country coordination, organizational safeguards and sustainable national capacity

Where further scale-up is needed

1

GEOGRAPHICAL COVERAGE

Extend CBCMs and PSEAH capacity to all affected health zones/areas and strengthen PSEA preparedness in priority countries and areas

2

TECHNICAL CAPACITY

Deploy local-language capacity and experienced senior technical oversight; expand focal-point coverage.

3

SAFE REPORTING

Reactivate and sustain accessible reporting mechanisms

Increase awareness, trust and practical use of confidential complaint channels.

4

SURVIVOR SUPPORT

Resource survivor-centred referral pathways and quality care for GBV/SEA survivors.

5

ACCOUNTABILITY

Strengthen inter-agency coordination, Government focal-point continuity and partner compliance with safeguarding standards.

Critical enabler: adequate and predictable human and financial resources for PSEAH response and readiness.

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Concrete next steps

1

Update and operationalize risk assessments

Update PSEAH risk assessments, review mitigation measures and monitor emerging risks and trends.

2

Close capacity gaps

Update and disseminate focal-point contacts and close focal-point and technical capacity gaps across intervention areas.

3

Strengthen reporting & referral

Strengthen and publicize CBCMs/reporting channels and reinforce survivor-centred referral pathways and services.

4

Embed in readiness

Integrate PSEAH risk mitigation into BVD preparedness and readiness, prioritizing government and inter-agency collective action in South Sudan, Uganda and CAR.

5

Strengthen collective accountability

Strengthen community awareness of rights, partner accountability and local PSEA capacity, including Government capacity; monitor compliance with PSEAH standards/Codes of Conduct and clarify roles.

6

Resource the scale-up

Track PSEAH indicators routinely, sustain community feedback, and mobilize resources for priority safeguarding gaps.

Goal: move from reactive safeguarding to PSEAH embedded from the outset and systematically in outbreak preparedness, readiness and response across all areas.

Risk Communication and Community Engagement (RCCE)

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Community context - population and vulnerability factors

POPULATION

- 7 million people
- ~1 million internally displaced persons
- High ethnic diversity (Hema, Lendu, Alur, Lugbara, Nande).
- Swahili and Lingala widely spoken. Local languages important in rural areas
- Dense and connected urban centres

INSECURITY

- Ongoing intercommunal violence in Djuju
- ADF attacks in Beni, Irumu and Mambasa (>950 deaths in 2025)
- Health facilities frequently targeted
- Food insecurity widespread
- Armed group presence and roadblocks limit access
- Coordination challenges in non- gov controlled areas

MOBILITY & ECONOMY

- Artisanal gold mining drives population movement
- Major mining hubs attract transient populations
- Strong cross-border mobility with Uganda
- Informal border crossings common
- High movement to and from South Sudan

FUNERAL PRACTICES

- Funerals involve large social gatherings
- Body preparation and transport increase transmission risk
- Traditional burial practices may involve direct contact with deceased
- Safe and dignified approaches required

VULNERABLE GROUPS

- Women at higher risk due to care giving roles
- IDPs face overcrowding and poor living conditions
- Limited ability to implement prevention measures
- Communities affected by conflict are particularly vulnerable

Conflict, displacement, mobility, and traditional funeral practices increase transmission risk and complicate outbreak response in Ituri and N.E DRC

World Health Organization

Contextual Note on the Ebola Bundibugyo Outbreak in Ituri (May, 2026)
ACAPS Briefing Note – DRC: Ebola outbreak (22 May 2026)

Focus on RCCE - Scaling up strategy

STRATEGIC FOCUS: TARGETED & DIFFERENTIATED APPROACH

High Transmission Areas
Hyperlocal and deep engagement via community structures and trusted local leadership.

Newly Affected Areas
Immediate, intense engagement and rapid activation of community networks for early detection.

Areas at Risk of Spread
Proactive preparedness and prevention for early action before transmission is established.

Contextualised Operations
Strengthening community capacity for SDB, safe care, surveillance, IPC, and essential services.

CORE PLATFORM STRENGTHS

Deployed Workforce	27 Staff	Strategically deployed workforce supported by local daily worker teams.
Analytics Capacity	Strategic	Embedded social scientists driving evidence-based vs. reactive strategy.
Community Networks	Established	Deep operational footprint across local leadership & civil society.
Multi-Pillar Integration	Operational	Direct alignment with SDB, Safe Care, Surveillance, and IPC priorities.

KEY GAPS & STRATEGIC SCALE-UP PRIORITIES

1. **Systematic Local Intelligence & Harm Reduction** Anticipate spread, identify trusted local voices, and deploy harm-reduction approaches.
2. **Direct Hyper-Local Resourcing** Channel resources directly to CSOs, local NGOs, cultural, and church groups at community level.
3. **Strategic Workforce Positioning & Alignment** Scale and strategically position workforce, aligned and coordinated with partners for joint scale-up. Delineate roles between WHO and UNICEF
4. **Anticipatory vs. Reactive Capacity** Shift from ad-hoc reactive engagement to systematic, anticipatory community capacity.

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RCCE pillar achievements in the DRC (04 – 16 August 2026)

937,872	505,627+	6,009
People Reached	Households Visited	RECO deployed

Geographic expansion: RCCE activities active across **Ituri, Nord-Kivu, Sud-Kivu, Tshopo, Haut-Uélé**
Daily alerts consistently above **200+**, with strong radio coverage (118 stations engaged)

Household outreach: Significant increase in coverage, with **Beni, Katwa, Goma, Rwampara** driving the highest volumes
Daily household visits peaked on **14 August (39,400 households)**

Relay training & capacity: RECO mobilisation strengthened: **2,000–3,000 active daily**
Large-scale training events: **900 RECOs trained in Kisangani (6 Aug)**

Media & mass sensitisation: 118 radio stations aired 3,100+ spots and 42 programmes in July (~5M reach); ≥32 stations were documented on 16 Aug alone, with 12 programmes and 39 spot broadcasts. Over **3,100 radio spots** and **42 programmes** aired in July. Multi-zone radio mobilisation (up to **32 stations** on 16 Aug)

Support to other pillars: RCCE enabled **SDB acceptance increases (50% → 82%)**
Improved early alerts, contact listing, and ambulance referrals. Rapid resolution of **infodemic items** (**33 resolved in 48h**)

Community feedback resolved: Strong engagement: **369,000+ people sensitised (4–9 Aug)**
Multiple refusals reversed through targeted counselling and survivor testimony

DRC: challenges and actions taken (04 – 16 August 2026)

CHALLENGE AREA	WHAT WE OBSERVED	ACTIONS TAKEN
Security & staff safety	Insecurity and threats to teams persisted daily, including serious incident in Bunia, Lita, Pawa.	RCCE maintained inter-pillar coordination with surveillance, case management, IPC, SDB, PoE, psychosocial care and logistics so that access and security concerns were relayed and addressed quickly, in line with the response's humanisation approach.
Workforce & payment	RECO/CHW payment delays and low motivation recurred across all thirteen daily reports (4–16 Aug), alongside shortages of transport, airtime and outreach materials, risking continuity of household visits and alert reporting.	Priority recommendation issued to train, deploy and adequately support RECOs/CHWs across hotspot health zones; workforce, mobility and supply needs flagged to senior management.
Data quality & reporting	Reporting inconsistencies persisted (e.g. Butembo: 6,321 vs 2,685 in the sex breakdown); cumulative Beni figures and multi-zone HUB aggregates had to be excluded from daily totals to avoid double-counting.	Recommendation issued to clean and harmonise reporting templates, separate daily from cumulative data, disaggregate alerts by status, and record resolution timeframes before submission.
Safe and dignified burials	Families continued to request participation in SDB processes; rumours persisted that SDB teams remove organs or bury pregnant women without removing the foetus.	11 SDBs conducted with RCCE support; acceptance rose from 50% to 82% during the week. Customary and APA leaders committed to supervising and adapting burial rites; a committee of elders was created in Lita and 23 chiefs signed a declaration of support.
ETC & referral delays	Delays in ambulance transfer, SDB deployment and laboratory results continued to undermine trust in ETC referral; daily reports flagged limited CT/ETC capacity and nutrition gaps at Pawa and Nizi.	16 ambulance referrals accepted in Ituri, up from 9 in the previous period — including 8 self-initiated requests and 2 who overcame family resistance. Priority recommendation issued to reduce ETC transfer, SDB deployment and laboratory result feedback delays.
Infodemic & denial	Denial, financial-motive rumours and ETC/vaccine distrust recurred in all thirteen daily reports; the poison narrative persisted in Nizi and Isiro, with rumours of organ removal, fake medicines and alcohol- or palm-flower cures.	Sensitisation on the origin of EVD, transmission and the purpose of ETC and SDB continued; 7/7 survivor testimonials reached 3,846 people, helping reduce stigma and increase acceptance of early ETC care.
Refusals & access	103–747 alerts were logged per day (4,960 over 4–16 Aug, incl. ≥174 deaths); refusals and resistance to referral recurred, with 571 reluctance cases logged by the Nord-Kivu HUB on 16 Aug.	Educational talks, home visits and mediation with families and trusted figures helped resolve refusals; at least 201 feedback/infodemic items were resolved within 48 hours over 4–16 Aug.

Data for action - Community rapid assessments



- Qualitative methods to understand community perceptions, experiences and capacities
- Led by INSP, joined WHO/UNICEF/IFRC rapid assessment protocol

First round – completed – tracking ongoing
- Priorities: alerts, contact tracing, care, SDB and clinical trials
- 2 HZ and 6 AS + 2 IDP camps
- Findings shared with 108 multi-stakeholders
- 6 co-developed recommendations with community representatives, ongoing tracking of implementation

Second round – ongoing
- Priorities: community deaths and risks of secondary transmission
- 3 AS + 1 IDP camp

Readiness in South Sudan
- Protocol adapted to context
- Engagement with NPHI and University of Juba

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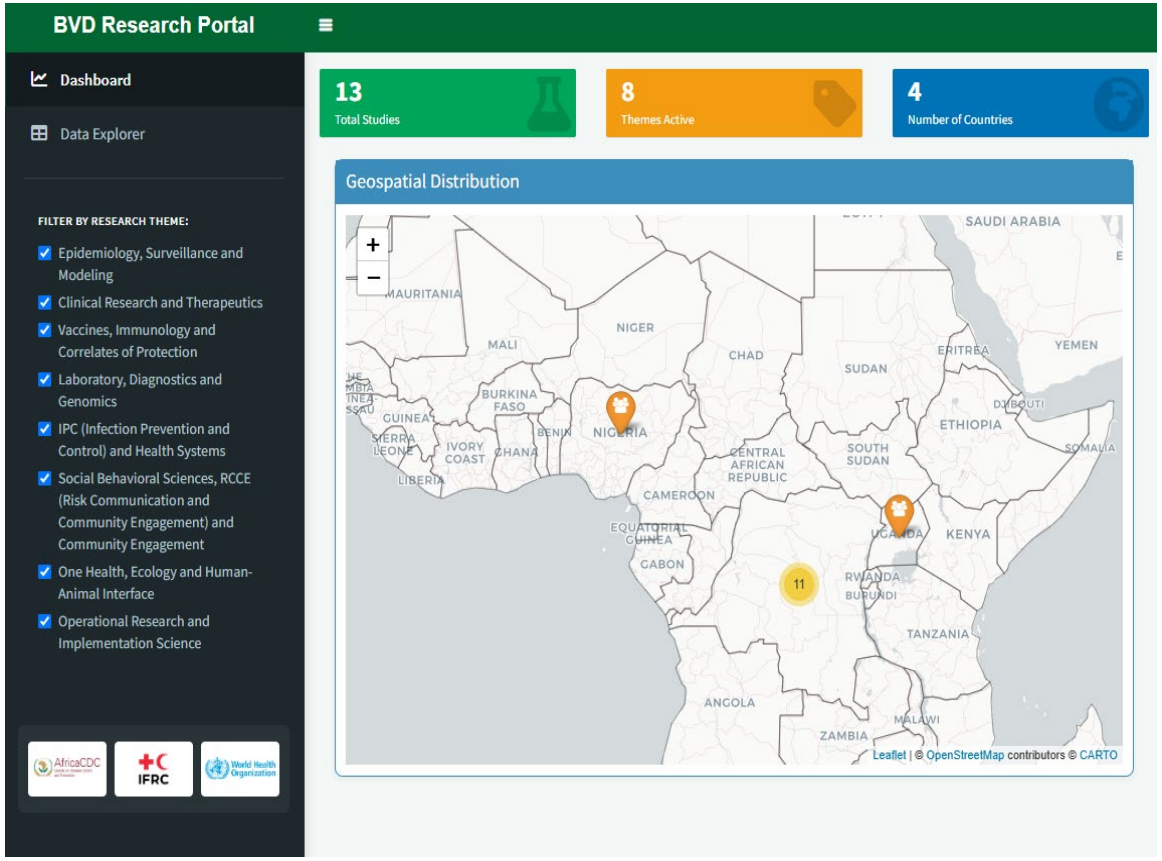
Entretien de planification du groupe de discussion avec les chauffeurs de taxi moto dans l'AS Aero Ituri, Juin 2026

Data for action – Social listening



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Data for action– coordination of social-behavioural data



- Working with Africa CDC and partners to **coordinate social behavioral research and access** to findings
  - Data collection tool developed and shared
  - Dashboard launched – 13 studies from three countries currently mapped - looking to rapidly expand mapped data
- Working with partners to **define community research priorities** through the CORC mechanism and support ongoing and planned clinical trials
- Working with partners- UNICEF and IFRC to ensure **partner studies and data sets** are available to decision makers at all levels

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[Dashboard]

[Ebola Community Evidence Tracker]

Priorities

- **Scale up and equip national RCCE workforce** – Training, appropriate and reliable payments, supportive supervision, safety and security

- **Move to RCCE systems response –** Decentralization of RCCE capacity to HZ, mapping HR, coordination, mapping of community capacities, activation of community networks, feedback mechanisms established, RECO trained and activated, strengthen M&E; **strong partner coordination**

- **Scale-up community-led solutions** - Advocacy, capacity building and resource mobilization to scale-up community-led solutions (empower community leaders, support other pillars, integrate community)

- **Strengthening of community data for action and feedback mechanism –** Expansion of rapid community assessments, training of call center staff, consolidating feedback mechanisms

- **Strengthening M&E –** Additional support to RCCE M&E for stronger and adequate data

- **Ensure readiness of high-risk countries –** Mapping of capacities, surge, activation of local networks, community data

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Thank you

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