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When communities resist: The critical role of risk communication and community engagement in the 2026 Ebola outbreak response

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Abstract

The ongoing Ebola outbreak in the Democratic Republic of Congo (DRC) and Uganda has highlighted a persistent but often underappreciated challenge in outbreak response: disease control cannot succeed without community trust. Reports of attacks on Ebola treatment centres, hostility toward health workers and burial teams, and the escape of suspected patients from treatment facilities demonstrate how fear and mistrust can undermine outbreak control efforts. Drawing on lessons from previous Ebola outbreaks, this commentary argues that Risk Communication and Community Engagement (RCCE) should be recognised as a core public health intervention rather than a supporting activity. Sustained investment in trust-building, community participation, social science expertise, and community feedback systems is essential for effective outbreak preparedness and response. In Ebola response, trust is not merely a communication objective; it is a lifesaving intervention.

Keywords: Ebola 2026 outbreak, risk communication and community engagement, Community Trust, health communication

Citation

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Commentary

A public health emergency and a crisis of trust

According to media reports, residents in Rwampara, Ituri Province, DRC, burned an Ebola treatment centre following tensions surrounding the handling of a suspected Ebola death[1]. Days later, another treatment facility in nearby Mongbwalu was attacked and set ablaze, leading to the escape of several suspected Ebola patients[2]. These incidents directly undermine outbreak control by disrupting case management, delaying diagnosis, weakening contact tracing, and discouraging care-seeking behaviour. They also highlight a familiar but often underappreciated challenge in Ebola response: disease control cannot succeed without community trust. Since the declaration of the Bundibugyo Ebola outbreak, response efforts have focused on surveillance, case detection, contact tracing, clinical management, infection prevention and control, and preparedness activities across affected and neighbouring countries[3]. As of 3rd June 2026, the Ebola outbreak had resulted in 344 confirmed cases and 60 confirmed deaths in DRC and 15 confirmed cases and one death in Uganda[4]. Yet alongside the epidemiological emergency, another crisis has emerged—one of fear, mistrust, and resistance. The events in Ituri underscore a critical lesson from previous Ebola outbreaks: epidemics are not only biological emergencies, but also social emergencies shaped by trust, perceptions, culture, and community engagement. In this context, Risk Communication and Community Engagement (RCCE) is as essential as prevention, surveillance, laboratory testing, and clinical care.

Ebola outbreaks are social events as much as biological events

Ebola virus disease is transmitted through direct contact with the blood or other body fluids of infected individuals, contaminated materials, or infected animals. Consequently, transmission frequently occurs within families, households, caregiving networks, health facilities, and during social gatherings where close contact with infected persons or their body fluids occurs. As a result, outbreak control measures inevitably intersect with deeply held social norms, cultural practices, religious beliefs, and community structures. Community cooperation, therefore, becomes one of the most important determinants of outbreak success because response measures such as isolation, quarantine, contact tracing, vaccination, and safe and dignified burials often require individuals and families to alter traditions or cultural norms during periods of fear, grief, and uncertainty. Lessons from previous Ebola outbreaks have repeatedly shown that communities are more likely to comply with response measures when they trust the institutions delivering them, understand the rationale behind interventions, and feel included in decision-making processes[5]. Recent evidence from Uganda's 2022–2023 Sudan Ebola outbreak reinforces this point, identifying delayed consultation with communities, poor communication, misinformation, limited support for community-level actors, and institutional coordination challenges as major barriers to effective community engagement during outbreak response[6]. Conversely, when communities perceive response activities as coercive, externally imposed, politically motivated, or culturally insensitive, resistance can emerge.

What resistance means for outbreak control

Resistance to Ebola response activities is often described as a communication challenge. It is also an epidemiological challenge. Without RCCE, how can a treatment centre treat patients who never present for care? How can contact tracers monitor contacts they cannot identify? How can vaccines protect people who refuse vaccination? How can surveillance systems detect cases that communities choose to conceal? The reports of community resistance from Ituri Province illustrate these stark realities. Attacks on treatment facilities have resulted in patients escaping isolation centres, including suspected and confirmed Ebola cases, while community resistance to burial protocols has contributed to tensions between response teams and affected families.

Research from previous Ebola outbreaks has shown that violence against health workers and treatment facilities can significantly disrupt case management, surveillance, vaccination, case isolation, and contact tracing activities, thereby increasing opportunities for continued transmission [7]. Resistance, therefore, should not be viewed as a secondary issue to be addressed after surveillance and clinical response systems are established. It is a central determinant of whether those systems can function effectively at all.

Why risk communication and community engagement must be elevated from a supporting activity to a core response pillar

The World Health Organization defines RCCE as the systematic approach of engaging communities and communicating risks to enable informed decision-making, build trust, address concerns, and promote protective behaviours during public health emergencies[8]. While the RCCE is formally recognized as a core outbreak response pillar, it is frequently operationalised as a supporting activity, with delayed funding, limited staffing, and insufficient integration into early response decision-making. Risk communication and community engagement (RCCE) is often treated as a supporting component rather than a core public health intervention.

During public health emergencies, significant investments are often made in laboratories, surveillance systems, treatment centres, emergency operations centres, and logistics. While these investments are essential, their effectiveness ultimately depends on public cooperation. The current outbreak demonstrates that technical interventions

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alone cannot control Ebola when trust is weak.

Despite growing evidence of its importance, RCCE continues to receive comparatively limited attention and investment in many outbreak responses, which reflects structural rather than intentional challenges. Emergency financing mechanisms and donor funding structures often prioritise rapidly deployable biomedical interventions and operational activities with immediate, measurable outputs, while community engagement may be perceived as less urgent or more difficult to quantify. In addition, compressed response timelines, shortages of trained RCCE personnel, and limited institutional capacity can delay meaningful engagement with affected communities to build trust until resistance to response measures has already emerged. These systemic constraints underscore the need to embed RCCE within preparedness planning, workforce development, and sustainable financing mechanisms rather than treating it as an ad hoc activity during emergencies.

Risk communication and community engagement should therefore be recognized as a core outbreak control strategy rather than a complementary activity. Just as countries invest in laboratory networks and surveillance systems before outbreaks occur, they should invest in systems that build community trust, strengthen local engagement structures, and support meaningful two-way communication. The objective of RCCE should not simply be to disseminate information. It should be to create dialogue, understand community concerns, address misinformation, build trust, and ensure that affected populations participate actively in response efforts. Community engagement should be treated as a preparedness activity rather than an emergency activity. Relationships established before an outbreak are often more valuable than communication campaigns launched during one.

Lessons from previous Ebola outbreaks

The importance of community engagement is not a new lesson. During the 2014–2016 West African Ebola epidemic, early response efforts were often criticised for relying heavily on top-down messaging and insufficient community involvement. Over time, response strategies evolved to include local leaders, religious authorities, community volunteers, and survivor networks, contributing to improved acceptance of public health measures[9]. Successful interventions increasingly relied on dialogue with communities, adaptation of safe burial practices, engagement of trusted local leaders, and efforts to understand the social realities influencing behaviour. These experiences suggest that effective Ebola response requires more than medical expertise. It also requires social science expertise, cultural understanding, and community partnership.

A new agenda for community-centred Ebola response

The current outbreak should serve as a catalyst for strengthening community-centred approaches to outbreak preparedness and response. First, RCCE should be funded and implemented as a core response pillar from the earliest stages of an outbreak. Second, governments and partners should invest in community engagement structures before emergencies occur. Trust cannot be built only after an outbreak has begun. Community engagement should be viewed as a continuous process rather than an activity activated during emergencies. Previous outbreak experience does not guarantee community acceptance during future outbreaks. Communities evolve, leadership structures change, new misinformation emerges, and public perceptions shift over time. As a result, every outbreak response should prioritise rebuilding trust, re-establishing dialogue, and understanding current community concerns rather than assuming that knowledge and acceptance from previous outbreaks remain intact. Third, community health workers, Village Health Teams, religious leaders, traditional leaders, women's groups, youth representatives, and survivor networks should be integrated into surveillance, preparedness, and response activities. These actors often serve as the most trusted interface between health systems and affected populations. Fourth, social scientists, anthropologists, behavioural scientists, and communication specialists should be embedded within outbreak response structures alongside epidemiologists and clinicians. Fifth, response agencies should strengthen systems for rumour tracking, misinformation monitoring, and community feedback collection to enable rapid identification and resolution of emerging concerns. Finally, trust and community acceptance should be monitored as outbreak indicators alongside epidemiological indicators. Measuring community perceptions may provide critical insights into the effectiveness and sustainability of response efforts.

Conclusion

Trust is a public health intervention

The current outbreak suggests that community resistance is not merely a communication challenge but an indicator of deeper shortcomings in how communities are engaged, consulted, and supported during public health emergencies. While healthcare workers, laboratories, treatment centers, surveillance systems, and emergency response teams remain indispensable tools for controlling Ebola, none can achieve their full potential without community trust. As governments and partners respond to the current epidemic, RCCE should no longer be viewed as a supporting pillar of outbreak response. It must be recognized, funded, measured, and implemented as a core public health intervention. Yesterday's outbreak is not today's; consequently, previous outbreak contexts cannot predict current community responses. Response efforts cannot assume that past community education translates into active compliance during a current crisis. The current evidence proves that

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communities do not simply apply old knowledge to new outbreaks. Risk Communication and Community Engagement interventions must be iteratively re-engaged and sustained in vulnerable regions. Because prior knowledge rapidly becomes obsolete, establishing new mechanisms for re-engagement and trust-building remains essential. In Ebola response, trust is not merely a communication objective. It is a lifesaving intervention.

What is already known about this topic

- Ebola outbreak control depends not only on surveillance, laboratory diagnosis, and clinical care but also on effective Risk Communication and Community Engagement (RCCE).

What This Study Adds

- Using the 2026 Bundibugyo Ebola outbreak in the Democratic Republic of the Congo and Uganda, this commentary argues that community resistance is an epidemiological challenge, not merely a communication issue.
- It calls for integration of RCCE as a core outbreak preparedness and response pillar, acknowledging that community engagement and trust are essential for acceptance of measures such as contact tracing, vaccination, isolation, and safe burials, while mistrust and misinformation can undermine response efforts.

Conflict of Interest

The authors of this work declare no competing interests.

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Authors' contributions

Joseph Magoola conceived the commentary, conducted the literature review, and drafted the manuscript. Rachel Chelimo, Edgar Ampaire, and Derrick Kimuli critically reviewed and revised the manuscript. All authors reviewed and approved the final manuscript.

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