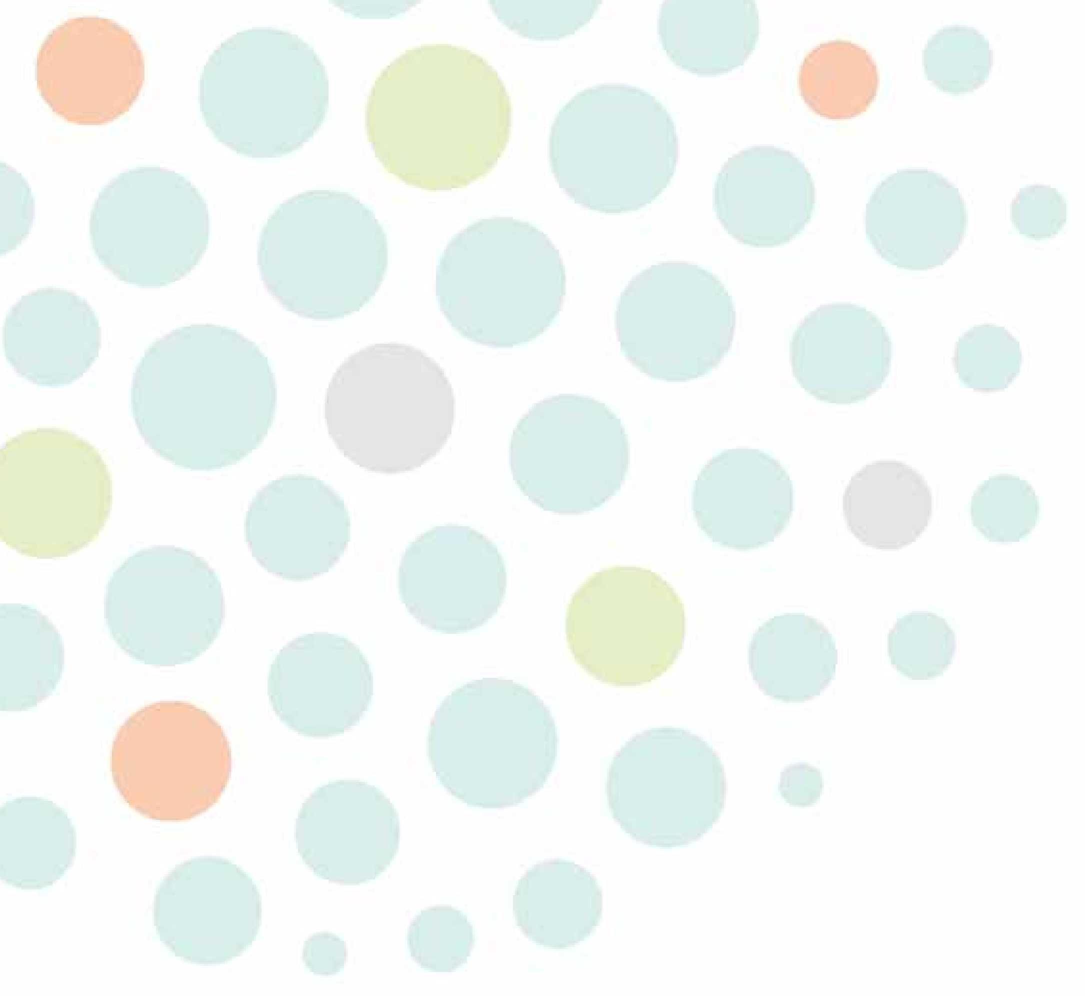

SUMMARY REPORT

Social and Behavioural Sciences Research for Ebola Roundtable

26 May 2026

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Social and Behavioural Sciences Research for Ebola Roundtable

26 May 2026

11:00-13:00 CEST

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Agenda

TIME	AGENDA ITEM	SPEAKER
11.00-11.20	**1. Welcome and background to meeting**	
	1.1 Welcome remarks	Prof Clare Chandler, FCDO Prof Alice Norton, GloPID-R Secretariat Dr Vincent Ronin, ANRS-MIE and Filovirus CORC
	1.2 What are the SBS asks for the response?	Dr Robert Kabanda (Uganda), Prof Don Jethor (DRC)
	1.3 Work already ongoing 1.4 Meeting purpose and objectives	Oluwatoyosi Olawande (Africa CDC) Dr Nina Gobat (WHO)
11.20-11.50	**2. What are the key social and behavioural research questions for this outbreak?**	
	2.1 Adding questions into buckets	Dr Dijana Spasenoska (GloPID-R) Dr Nina Gobat (Chair)
12.00-12.20	**3. Which are the most immediate and which are medium term research questions, and how can these be answered?**	
	4.1 Classification of questions as immediate/longer term research 4.2 Identification of activities needed, reviews, fieldwork, consultation, other	Prof Clare Chandler, (FCDO)
12.20-12.50	**4. Mechanisms for uptake of social and behavioural research**	
	5.1 Options for sharing plans, ongoing work, Outputs- tracking dissemination outputs – tracking dissemination 5.2 Next steps	Oluwatoyosi Olawande (Africa CDC)
12.50-13.00	**5. Summary and actions**	

Welcome and background

Welcome remarks

- Clare Chandler, UK FCDO, gave an overview of the actions taken by GloPID-R in response to outbreaks, including actions to date on BDBV, such as the launch of the Pandemic PACT

outbreak page, an emergency member's meeting convened to share plans and coordinate plans, and the identified need with WHO and FCDO for the consultation on SBS.

- Alice Norton, Scientific Director of GloPID-R, presented on the research funding mapping, showing that 51 grant awards, with at least $43.3 million committed by 13 funders, have been allocated to (mostly interdisciplinary) studies with a SBS component on Ebolaviruses, but none specific to BDBV. This is in comparison to a total investment of at least $490 million across 375 grants related to all aspects of Ebolavirus research. A rapid mapping of systematic reviews resulted in the identification of 148 systematic reviews identified from Ovid Medline, Ovid Embase & Scopus, with 44 having a component on social and behavioural studies.
- Vincent Ronin presented on behalf of the Filoviruses CORC. The CORC has 600 experts, and around 100 of those research the social sciences. SBS matter in the current BDBV outbreak, as it is not only a biomedical crisis, but involves social, cultural, and political dimensions. For example, community trust directly affects early case detection, contact tracing, medical management, adherence to IPC measures and survivor follow ups, funeral rites and cultural norms affect transmission dynamics, and armed conflict, insecurity and population displacement in Eastern DRC limit access to health care. Community engagement and participatory approaches integrated into surveillance, diagnostics, clinical care and clinical trials is important and SBS priorities are important to guide the roadmap development.

Opening remarks by the meeting Chairs Dr. Oluwatoyosi Olawande (Africa CDC) and Dr. Nina Gobat (WHO)

- The chairs thanked GloPID-R for hosting the meeting to define critical evidence gaps in support of a community-centred, evidence-informed response to the BDBV public health emergency.
- They emphsised how BDBV outbreak dynamics in Eastern DRC and Uganda make clear the importance of understanding this event through a social and human lens and the criticial role of evidence to drive response decision making.
- Effective outbreak response requires strong collaboration, timely communication, clear coordination, community partnership, and evidence-driven public health action. Coordination supports Member State prioritized interventions that protect communities, avoid duplication of efforts, generate actionable evidence, and mobilize resources efficiently.
- Essential to align actions with Member State priorities to strengthen sustainable and functional evidence system during and beyond this emergency.
- Research in this emergency should drive impactful public health action and strengthen trust and resilience within affected communities. Key principles include a people-centered approach, equity and gender responsiveness, timeliness, safeguarding, collaborative, open access, and a commitment to quality.

Meeting purpose and objectives

- To convene those with expertise and experience in SBS in VHFs to define urgent and critical evidence gaps, share perspectives and plans for SBS work on Bundibugyo Virus.
- To collate and group priority research questions, formulated for inclusion in the CORC roadmap.
- To articulate ways of working that will enable collective learning across SBS activity and inform responses.

What are the asks for the response?

Prof Don Jethro Mavungu presented a model developed for SBS for mpox and COVID, which is now being used for the Ebola outbreak in the DRC. The model considers the population of Ituri and three types of breakdown which prevent effective action: structural; cognitive; and contextual breakdowns.

- Structural breakdowns prevent messages from reaching parts of the population, for instance physical and geographical access barriers, including war, the existence of areas not covered by even local media, as well as vulnerable groups which are excluded from information such as certain ethnic groups or other communities.
- Cognitive barriers include cognitive resistance to certain ideas and alternative beliefs, especially when messages are not adapted to the local context – messages therefore require cultural translation to ensure seriousness of the risk is conveyed. The capacity to understand and action instructions is also important and influenced by educational and linguistic barriers.
- Finally, a proportion of the population with operational understanding cannot then convert to action due to contextual breakdown, which leads to a gap between intention and action – factors contributing to this include economic constraints and the stigmatisation of actions such as not performing burial rites. Overall barriers in this model can therefore be thought of as social stigmatisation and perceived vulnerability, which are particularly pertinent here as Ebola is believed by some to be a spiritual disease which can be protected against with prayer.
- With the current outbreak in mind, including discontent over the weekend over funeral rites not being performed for a religious leader who died of Ebola, actionable levers for improving preventative practices include contextualising messages to address uncertainties and specific fears and improve cultural legitimacy, using mediators close to communities such as trusted messengers and community health workers, and education and engagement to improve understanding of health messaging.

Dr Richard Kabanda from the Ministry of Health Uganda shared some of the in-country experiences. Three challenging areas identified include the one directional information sharing where information comes from authorities only, and the need to have bi-directional exchange of information. Second, communities that experience outbreaks frequently are showing signs of fatigue and resistance. Third, recently there has been an increase in distrust in the information shared from the authorities. This also compounds the stigma that survivors are experiencing.

Which are the most immediate and which are medium term research questions, and how can these be answered?

The discussion started with noting the distinction between research priorities with different purposes and timelines for informing response actions. Priority research is needed to address urgent and immediate response challenges. This research is explicitly designed with a line of sight to operational goals and by what decision-makers need to know to act in as close to real time as possible. Equally important is longer term research driven by a deeper purpose: to understand the lived experience of communities affected by the event and the wider influence of structural factors. While this research may not have immediate operational application, it generates rich contextual understanding that shapes longer-term policy and practice. Rapid syntheses of this evidence base have already been drawn upon to inform emergency response operations, highlighting the critical importance of maintaining an evidence pipeline to ground truth evidence surfacing from operational data and rapid methods as the response progresses.

Participants were asked to use the whiteboard to share research priorities, and to vote on the priorities they deem to be important in the medium or long-term. For a full list of ideas please see Appendix 1 (Whiteboard feedback) and Appendix 2 (Chat discussion summary). It was agreed that findings from some research questions would be urgently needed to inform the immediate response, and other research questions would inform the response in the medium and longer term. It was also agreed that research questions may be answered with fieldwork, co-design, desk reviews and/or expert consultations. There was insufficient time within the meeting to achieve these classifications for all proposed research questions. The below is a summary of the research questions proposed in the meeting:

Informing Public Health & Social Measures

- What are local priorities (e.g. maintaining livelihoods, care, food security, spiritual needs) and how can these inform disease containment approaches (eg. safe burial practices, quarantine measures)
- What feasible and effective measures can be taken to infection prevention and control in different local settings, such as personal protection, alternatives to physical contact, approaches to routine gathering (such as markets, religious events, traditional festivals)?
- What drives sharing, or reluctance to share, information about contacts for tracing? Which institutions and authorities are trusted, and distrusted?
- How will PHSMs need to be tailored to the differences in contact patterns in different types of settlements (e.g. villages, refugee camps, IDP camps, urban areas)?
- What roles are, and could, different formal and informal health providers play in response (e.g. medicine sellers, traditional healers)?

Evaluating & Adapting the Response

- How is the response and its expectations from people being experienced by – and in between – different groups (incl. marginalized and vulnerable groups, displaced and host communities) and what changes have/could improve outcomes?
- What factors are impacting the reach of accurate information on Ebola and the response to different groups (incl. considerations for local languages, interventions to address misinformation and improve digital information resilience)?
- How is the response affecting local economies?
- What factors are impacting care seeking (incl. cross-border movement, displaced individuals, armed conflict affected communities, perceptions and availability of care)?
- What are the drivers and potential mitigations of any exploitation and sexual abuse in the response?

Mitigating impacts of Bundibugyo

- What are community priorities and options beyond the outbreak and how do these affect protection efforts?
- How have other health services been disrupted, maintained and perceived (e.g. RI, SRH, MNCH) in the context of (free) Ebola care?
- What are the socio-economic impacts of the outbreak (for individuals, families of those who have Ebola, wider social and economic systems including across borders)?
- What are the effects of the outbreak on stigma, dignity, discrimination and human rights and what has improved this (including role of survivors in the response)?
- What mechanisms are needed to ensure community feedback uptake in real time in response?
- What are the various perceptions of response measures (e.g. protective, coercive, unfair, discriminatory)?

Informing ethical countermeasures roll-out

- What are the drivers of acceptance, social dynamics and perception of new vaccines or treatments?
- What can be learned from the roll-out of previous vaccines (including for Ebola and with different platforms and schedules)?
- How can community engagement be effective for new vaccine and treatment roll-out, including with local authorities? In what ways can different local groups (e.g. militia groups, religious groups) be engaged in roll out of medical countermeasures, and what are the consequences?
- How well do medical countermeasures reach different groups?
- What are peoples' perceptions of different diagnostic tests and their accuracy, in context?

Understanding transmission contexts & dynamics

- What are health workers' concerns regarding their own risks, their mental health and what are their knowledge and material needs?
- What are local approaches to isolation and quarantine and reasons why it may be difficult?
- What has led to the delay to recognition of the Bundibugyo outbreak?
- How is Ebola prioritised in the context of multi-crisis (e.g. violence, food insecurity, displacement)?
- How are specific social and political dynamics (eg of cross-border communities, displaced and host groups) impacting and being impacted by Ebola spread?
- How do people recognise, describe and act on early symptoms and 'danger' signs and what informs these responses?
- How do people seek to protect themselves, how does this vary (eg by gender, socioeconomic status and information sources)?
- What are the patterns of determinants and modes of transmission between different groups (incl age, sex/gender, occupation, geography, pregnancy status etc)?
- What are people's contact patterns including social networks, and how diverse are these across affected populations?

Understanding Emergence & Natural History

- What is the diversity of early Ebola signs and progression for individuals and carers?
- In what ways does the natural history of the disease intersect with individuals' livelihoods and access to food?
- How did the emergence of Bundibugyo in this case relate to social, political and ecological drivers (eg. extractive economies and changes in the environment)?
- What is the short and long-term disease course across different sub-groups?
- What memories, experiences and narratives of previous outbreaks of unidentified diseases impact how the emergence and natural history of this Bundibugyo outbreak has unfolded?

Informing Ethical Clinical Trial Design

- What will shape clinical research acceptance and perception of trials of new vaccines and/or therapeutics?
- What experiences and perceptions do individuals, families, leaders and groups have of trial participation?
- How can the development of scientific protocols take into account local realities and participant experiences?
- How can equity and fairness be ensured in vaccine trial participation?
- Inclusion/exclusion of pregnant and breastfeeding women in clinical trials and community perspectives on this?

Improving detection and reporting

- How were initial cases understood and managed, and what informed this?
- What drives willingness, perceptions, and decisions to support contact tracing?
- How have previous outbreak experiences informed community surveillance efforts?
- What might the roles of different groups (including survivors) be for supporting testing of contacts, contact tracing, identification of potential cases, testing and care seeking?

Other

- How have the aid cuts and withdrawal from key global health partners affected the response to this outbreak?

Participants highlighted a common challenge in the lack of reflexivity in how the response itself is delivered, and the need to actively ensure that, at a minimum, it does no harm to the communities it seeks to serve. They further reflected on the challenges of conducting rapid, high-quality, field-based research in a high-security-risk context. Communities affected by this outbreak are already under enormous pressure; any ethically research must weigh burden against benefit. There is a need to build evidence on how existing ethics and methods standards are being built into practice, the practical practice challenges and ethics dilemmas arising, to strengthen research quality and use for BVD and beyond.   Finally, it was noted that important considerations around gender, equity, and ethics were critical, particularly in the current outbreak context.

Mechanisms for uptake of social and behavioural research

Options for sharing plans, ongoing work, outputs

Oluwatoyosi Olawande summarized some of the mechanisms suggested in the whiteboard, including working with community leaders and trusted insiders.

Oluwatoyosi Olawande presented the Ebola community evidence tracker, a structured framework for recording information on study structure and progress for studies on community evidence. The form would be linked to the joint IMST dashboard, so what is happening in SBS research and who is working with which communities can be visualised. A participant noted the importance of adding the aim of the study into the fields collected by the research tracker to avoid duplication.

Summary and actions

Alice Norton thanked participants and noted that the Filovirus CORC roadmap is currently out for consultation. The GloPID-R Secretariat will collate inputs from the meeting and send out findings to participants.

Nina Gobat welcomed the inclusion of SBS in the CORC scientific meeting held on Friday 22 May and the continued discussions at the round table event today. She emphasized the need for close engagement and collaboration, including across disciplines, and the importance of a joint approach.

Oluwatosi Olawande reflected that the meeting was rich but not exhaustive and that the discussion will be continued, perhaps through another meeting.

Clare Chandler thanked cochairs and participants for sharing their expertise.

ANNEX I: List of participants

Name	Organisation
Alice Norton	GloPID-R
Almudena Mari Saez	IRD
Alun Davies	The Global Health Network
Annie Wilkinson	Institute of Development Studies
Bien-Aimé Mandja	Université de Bandundu, DRC
Charles Orora	Harvey & Keene
Chioma Dan-Nwafor	Africa CDC
Christoph Vogel	UN
Clare Chandler	FCDO UK
Deogratias Kakule Siku	WHO
Diane Duclos	LSHTM
Dijana Spasenoska	GloPID-R
Don Jethro Mavungu Landu	L'Universite Moderne de Kinkole
Dr Manar Keshk	Africa CDC
Elliot Rakotomanana	Institut Pasteur de Madagascar
Elysee Nouvet	Western University
Emmanuel Lampaert	CHESD
Eva Niederberger	WHO
Gloria Rukomeza	University of Oxford
Habtamu Wondiye	Africa CDC
Hayley MacGregor	Institute of Development Studies
Helen smith	Anthrologica
Holly Sadler	GloPID-R
Ilaria Michelis	MSF
Inyambo Mumbula	University of Zambia
Isabel Foster	CEPI
Jade Siu	FCDO UK
Jean Claude Rukundo	Africa CDC
Jean Corneille Lembebu	Center of Tropical disease and global health/Université Catholique de Bukavu
Jennifer Palmer	London School of Hygiene & Tropical Medicine
Jules Villa	Sciences Po
Kai Hopkins	Elrha
Kalidou SOW	Africa CDC
Katherine Littler	WHO
Kennedy Muhindo Wema	Bernhard Nocht Institute for Tropical Medicine
Lio Kariko	Africa CDC
Lucien de Corte	EDCTP3
Luisa Enria	LSHTM
Margaux Chavardès	GloPID-R
Meddy Rutayisire	Ministry of Health, Uganda
Megan Erwin	FCDO UK
Nadine Beckmann	LSHTM
Nambusi Kyegombe	LSHTM/MUL
Natsuko Imai-Eaton	Wellcome Trust
Nel Druce	FCDO UK

Nicolas Pulik	University of Oxford
Nina Gobat	WHO
Nora Sylvana Efire Emagha	Africa CDC
Oladunni Opeyemi	Adeleke University
Olive Leonard	UKHSA
Oluwatoyosi Olawande	Africa CDC
Pacifique Ndishimye	AIMS RIC & Stansile
Paidamo Magaya	Africa CDC
Patrick LaRochelle	
Patrick Vinck	Harvard University and Kobo Inc.
Phuong Pham	Harvard Humanitarian Intiative
Polydor Ngoy Mutombo	Africa CDC
Raïssa Litete	Africa CDC
Rose Burns	LSHTM
Sonia Whitehead	
Sophie Allain Ioos	WHO
Stella Neema	Makerere university
Sung Joon Park	Bernhard Nocht Institute for Tropical Medicine
Supriya Bezbaruah	WHO
Takudzwa Marembo	Africa CDC
Tamara Giles-Vernick	Institut Pasteur
Vincent RONIN	ANRS-MIE
Waly Diouf	Cheikh Anta Diop University
Yang Zhao	LSHTM
Yuval Bitan	WHO
Zewdie Birhanu	Jimma University

GloPID-R SBS Ebola round table

26 May 2026
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Appendix 1 – Whiteboard transcript

The following feedback is reproduced as written from the Zoom Whiteboard session and organized based on number of votes received during the prioritization session (questions with similar number of votes are not ordered).

Public Health & Social measures

- Tensions around safe burials - how can communities be involved in decisions around burials [5 votes]
- Which institutions and people are trusted or distrusted? What past experiences shape this trust? [5 votes]
  - Action: co-designing
- Care centres- opportunities for meaningful continued family contact, community care opportunities [4 votes]
- Consideration of key communication channels and trusted channels [2 votes]
- Local approaches to quarantine + identifying reasons why quarantine might be difficult (e.g. farming and other livelihood dynamics) [2 votes]
- How do social networks and contact patterns (including in care and death) differ in different settlements (e.g. villages, IDP camps, urban areas) [2 votes]
  - Action: fieldwork
- What rumours are circulating about the disease, testing, treatment units, burials, government motives, vaccines, aid money or outsiders? Which channels spread or correct information: radio, WhatsApp, churches, mosques, village meetings, markets, boda-boda stages, health workers? [2 votes]
- Role and possibilities of the church and other religious institutions in the response [1 vote]
- Evaluation, adaptation, co-development of guidance [1 vote]
  - Action: rapid study
- Local priorities in containment approaches (e.g. maintaining livelihoods, care, spiritual needs) [1 vote]
  - Action: fieldwork
- Perceptions of vulnerability in the absence of specific treatment/ vaccines [1 vote]
- How does everyday insecurity affect acceptance of the fact that one has the condition? How, in this context, can we encourage such acceptance? [1 vote]
- Contact patterns: research into social networks, movement and extended household dynamics (e.g. food sharing across different houses etc)-participatory mapping? [1 vote]
- Communication about targeted Ebola therapeutics that does not decrease faith in the value of supportive care (arguably the best therapy at this point)
- What rumors / misinformation are circulating? [1 vote]
- How can we include informal health providers in the response (medicine sellers, traditional healers) given they will be a first point of contact for many BVD cases. [1 vote]
- How might affected populations be part of producing, vetting, and sharing images, messages, and dialogues to build trust that Ebola is real (and thus public health measures make sense)? [1 vote]
- The flow of information online in the digital spaces - such as whose information (in which languages) is more trusted? [1 vote]

- To produce a translation that is tailored to the cultural context of the messages by involving local stakeholders in the process [1 vote]
- Risk perception, perception of the measures being implemented, and early identification of vulnerabilities
- Experiences of care, safety and relative risk
- Knowledge and experience of IPC in home and workplaces
- Trust in and experience of authorities
- Understanding local funeral rites
- Information environment
- Understanding the evident mistrust of external and government messaging and intervention is a critical issue. This includes analysis of the political-economic situation in addition to the information ecosystem.
    - Action: rapid study
- Isolation. and treatment unit care experience
- Community consultation and active involvement
- What are the best ways for community leaders/authorities to have/use the community research? How can it ben taken up best?
- Address questions of local risk concerning care, burials (and attendant tensions), but also food insecurity. These are gendered issues, since women are primary carers
- Community perceptions of care in light of lack of treatment: transparently share around the role of different types of treatment and the role of caregivers for those with BVD.
- Active engagement of academia. Taking gown to town.
- Consideration of the response team and health system capacities
- Local approaches to PPE (use of local materials, water/sanitation conditions)
- Which cultural concepts can be leveraged to support response activities? (rather than viewing 'culture' as a barrier)
- With regard to SDB, it would be worthwhile to conduct a brief study into the reasons why communities are reluctant to participate, and to discuss the practical arrangements they would like to see and expect (colours of funeral equipment, burial procedures and conditions, gender considerations, the involvement of family members, etc.), as well as rituals of healing in response to situations that create tension between social norms and biosafety standards
- Conduct a critical study of the practices inherent to the response mechanism (including communication, medical care, management of EDS, epidemiological surveillance, contact tracing, and the application of barrier measures) in order to analyze their impact on the acceptability and appropriation of control strategies by the populations.
- The objective is to critically examine the interventions of the various response actors to determine the extent to which the organization of the mechanism itself can generate factors promoting resistance behaviors within communities.
- I think that safe and dignified burials should be key. Does the population perceive this as dignified?

Evaluating & Adapting the Response

- What is the involvement and participation of local communities, including marginalised and vulnerable groups in the response (shaping the response) [3 votes]
- Explore health worker decision making when there is uncertainty (with this strain) [2 votes]

- To assess the uptake of preventive behaviours and the contextual barriers preventing such uptake. [2 votes]
- Assess the level of exposure to information about Ebola and identify the various structural barriers [1 vote]
- Effects of response on local economies (Ebola business and generating mistrust) [1 vote]
- Mobility issues in care seeking (where do people go to get care?) Also an issue related to transmission [1 vote]
- How movements and networks of displaced individuals affect effectiveness of interventions
    - Action: Primary quantitative and qualitative data collection
- Mobility patterns of different groups and granular data on the impact of armed conflict on different communities [1 vote]
- Are there response discourses which are flattening or obscuring important social or practical concerns on the ground (e.g. discourses around 'resistance', or even 'trust' when [sometimes] the real issues are feasibility) and how can more nuanced understandings be developed among response actors [1 vote]
- To assess the public's practical understanding and the cognitive barriers that limit this understanding [1 vote]
- What are possibilities for ongoing consultations with community leaders and population itself in affected areas, in light of the challenges outlined in DRC roadmap of these? Consultation and fieldwork [1 vote]
- Care-seeking behaviours; perceptions of success
- Violence, coercion and SRHR concerns in PH measures
- IDP camp experiences
- Community engagement
- Impact of low-cost, at-scale to address mis/dis-information that can be implemented during the onset of the emergency
- Action: First reviews, then potential primary quantitative + qualitative data collection (e.g. A/B testing)
- Interdisciplinary modelling which can integrate SBS considerations into scenarios
- Impact of intensive intervention that increases digital/information resilience among communities to better prepare for future emergencies to reduce impacts mis/dis information
- Action: First reviews, then potential primary quantitative + qualitative data collection (e.g. A/B testing)
- What forms of RCCE is most effective to change transmission-relevant behaviour?
- Community responses to medical countermeasures development
- Consideration of the internal conflicts and neighbouring countries' interconnectivities
- What are the effectiveness ways to communicate messages to communities, especially considering the rise of gen- AI and changing political/social circumstances of the 'trusted' voices in the communities
- Understanding sexual abuse and exploitation as resources and staff are mobilised in the region.
- How do the displaced and host communities interact during emergencies and how do these interactions amplify/reduce the impacts of interventions?
- What is the role of local businesses during emergencies, such as their usual role as lenders in some contexts, and how do these roles affect effectiveness of interventions?
- A rapid study to document and evaluate communication and community engagement practices. Objective: to assess the impact of these practices and identify ways to improve and refocus them

- Just to highlight the importance of local languages and the contexts in which they should be used. In English, addressing which contexts are important for ensuring that communication (hopefully two-way) takes place in local languages, and not just in Swahili or Lingala
- What aspects of the care and communication of healthcare providers and other members of the response are acceptable, and which are not? How is the quality of care being provided being perceived?
- What are the main barriers to care?
- Do people generally avoid healthcare centres and healthcare professionals in the affected regions? To what extent is distrust and/or avoidance and using alternative healthcare seeking methods unique to Ebola?

Mitigating Impacts of BVD

- What are community priorities beyond the outbreak, and how do they affect the capacity of affected and at-risk communities to protect themselves? [4 votes]
- Wider health service disruptions: consider which essential health services (such as SRH, maternal and newborn and child health) are being reduced, delayed or interrupted (staff, commodities and resources redirected into BVD response). [3 votes]
- Socioeconomic support and its relevance to families of and those who have ebola. [2 votes]
- Lessons from previous outbreak on impact mitigations [1 vote]
- Social, economic and psychological impacts of disease and/or control measures on individuals, families, carers and society
- Stigma, discrimination and human rights
- How can survivors be integrated in a meaningful way into response? Can they be organized into associations that can both contribute to response and to helping survivors get back on their feet following illness and to counter stigma?
- Psychological impact on Safe and Dignified Burial on families.
- Perceptions of dignity and quality of care and participation for families
- How can cultural and religious context be used to the advantage of the response; rather than just a barrier.
- What are the roles of religious organizations in mitigating the impact of
- Community perception of the frontline workers especially different from a tribe
- Continuous health education and peer led health education.
- Impact of response measures on cross-border communities, schools, markets etc., including long and short term effects. Consider quarantine requirements in the context of mobility needs of communities affected by armed conflict: what support is needed for people to feel safe (enough) and able to engage in key interventions that aim to break the transmission chain? [1 vote]
- How are people coping and what support system help them?

Medical Countermeasures Roll-out

- Clinical research acceptance, especially perceptions of the anticipated new vaccine trials [4 votes]
- Social dynamics relevant for clinical research on vaccines and therapeutics: eg. participant experiences and expectations, reasons for joining/ anxieties around participation, local dynamics that may influence uptake of specific treatments and vaccines or deployment strategies [3 votes]

- What makes people willing or unwilling to name contacts? What fears are attached to being listed as a contact? How do households manage quarantine practically, socially and economically? [3 votes]
- Systematic review of the acceptability of the Ervebo vaccine in previous outbreaks (in DRC and elsewhere) [1 vote]
- How to engage with the different public authorities when rolling out resources associated with trials - including the militia groups. How to avoid ebola 'economies' emerging. [1 vote]
- Use cases, feasibility and person-centred approaches
- Equity of access
- Public and HCW engagement on target product profiles
- Equity and fairness in vaccine trial participation
- Consideration of the acceptability of different vaccine platforms
- Care centres: identify meaningful ways for continued family contact, community care opportunities, anxieties around transmission in areas where centres are being established (In recent LSHTM study, found partners working in the east on cholera noted a need to extend response into private clinics, as public CTCs were highly disliked because of low care standards)

Transmission Contexts & Dynamics

- What are the concerns of health care workers in relation to their own risks as well as knowledge needs. What mental health challenges are they facing? [6 votes]
- Identify local approaches to isolation and quarantine that could be adapted or leveraged + socioeconomic reasons why staying in quarantine may be difficult (e.g. farming responsibilities that could be addressed through neighbourhood farming groups etc) - include social and political dynamics that shape this for Congolese refugee communities in Uganda [3 votes]
- Community priorities vs disease burden and cross cutting emergencies [2 votes]
    - Action: Fieldwork review from past outbreaks
- How do communities prioritise ebola vs violence, food insecurity, or displacement? [2 votes]
- Impact of response measures on cross-border communities, schools, markets etc., including long and short term effects. Consider quarantine requirements in the context of mobility needs of communities affected by armed conflict: what support is needed for people to feel safe (enough) and able to engage in key interventions that aim to break the transmission chain? [1 vote]
- How do people describe early symptoms , severty and 'danger' signs? and where do they first seek help/what causes delays in presentation? [1 vote]
    - Action: Fieldwork
- How do cross-border mobility and livelihood networks affect transmission? [1 vote]
- What are the main occupational, psychosocial, and safety challenges experienced by healthcare workers involved in the Bundibugyo outbreak response during the early outbreak phase?
- Formal and informal authority influence on care pathways
- Cross-border dynamics (land and lake borders)
    - Action: Reviews
- Ability to adhere to control measures
- Need to breakdown caring practices: household, churches, neighbourhood.
- Cross border collaboration
    - Action: Reviews
- What are Health zone and community specific context and dynamic?

- How does the authority collaborate effectivelly with the community to influence care seeking and pathways?
- Information sharing/Communication
- Understanding of Contact, keep in mind the possibility of asymptomatic people and not everyone showing same symptoms. How people are experiencing contact and transmission?
- How does cross-border mobility, particularly informal border crossing, influence access to information, early detection, referral and care, and psychosocial, social, and economic support among mobile and border communities affected by Ebola?
- What are the local names community members used in describing the symptoms.
- Which care providers to people trust?
- Transmission dynamics (data on cases disaggregated by age, sex/gender, occupation, geography, pregnancy status etc)
- How are community experiences with Ebola case management and free Ebola health care shaping trust, expectations, and decision-making around seeking care for non-Ebola illnesses, and how is this affecting the use and delivery of routine services such as SRH care?
- Mining sector
- What is the consensus of evidence about EVD determinants and modes of transmission?
- What do the communities know about EVD? What sources of information on EVD exist in the community?
- What are the factors contributing to the stigma and discrimination of affected individuals?
- What are communities' perceptions about EVD and its preventive measures, with particular attention to gender differences?
- What practices, including health-seeking behaviors, are communities carrying out to protect themselves from EVD, with particular attention to gender differences?
- How much transmission is happening in treatment facilities. From past outbreaks, the perception that people will get Ebola if they go to treatment facilities was a factor that kept people away from care. What are perceptions of quality of care and IPC in facilities, also based on past experience
- Contact patterns: research into social networks, movement and extended household dynamics (e.g. food sharing across different houses etc)-- participatory mapping or other social contact mapping that can offer more granular understanding to support modelling
- Community of practice/stakeholder dynamics surrounding effective and ethical contact tracing - which actors are involved, how are they connected and supported, innovations that emerge and can be shared, how contact tracing is perceived by contacts in socio-political context?
- Why transmission circulated for weeks before detection
- How people interpret early Ebola symptoms when malaria, influenza-like illness, typhoid, and arboviruses are also circulating.
- Whether stigma, fear of isolation, burial restrictions, treatment costs, or distrust drive concealment of illness.
- The role of informal drug sellers, traditional healers, mining-clinic networks, churches, and family caregiving before patients reach Ebola treatment centers.
- Gendered decision-making dynamics around who decides when and where someone seeks care.
- What proportion of community members report stigmatizing attitudes toward suspected, infected, or recovered Bundibugyo virus disease patients during the early phase of the outbreak, and which factors are associated with these attitudes?
- How mobility between mining sites and towns shapes delayed diagnosis.

Emergence & Natural History

- Livelihoods and access to food. It is one of the areas with highest food insecurity. [1 vote]
- Socio-ecological analyses of emergence drivers
- Short- and long-term disease course across sub-groups
- Broader epidemiological context: plague, mpox
- Do communities have memories and experiences of other outbreaks of unidentified / undetected (i.e. formally) diseases - what happened, how were they controlled and responded to locally?
- Extractive economies and changes in the environment contributing to adaptations of livelihood. And link with diseases appearance.
- Care and burial practices; health system realities

Ethical Clinical Trials

- Legacies of previous experiments and external projects [1 vote]
- Experiences and perceptions of trial participation [1 vote]
- Vaccine candidate will need trial. How is that understood / perceived.
- Trial design cannot be separated from both the needs and behaviours of populations - not just technical question. Key to understand this in designing trials - including questions around ring design
- Adapt CE for experimental vaccine and treatment roll-out (but work with COUSP and local authorities for approval to conduct any activities esp. on vaccination)-- leverage existing SBS knowledge around vaccine confidence and experience from previous Ebola vaccine trials (possibly also recent successful mpox vaccination campaigns in same areas)
- Navigating the inclusion/exclusion of pregnant and breastfeeding women in clinical trials and community perspectives on this.
- Research on experimental research (on vaccines and therapeutics): participant experiences and expectations, local engagement with clinical research, support development of scientific protocols that take into account local realities and participant experiences (ideally facilitate prospective participant engagement in protocol design), reasons for joining/ anxieties around participation, local dynamics that may influence uptake of specific treatments and vaccines or deployment strategies (e.g. mobility posing challenges to two dose vaccine candidates etc)

Detection & Surveillance

- What makes people willing or unwilling to name contacts? What fears are attached to being listed as a contact? How do households manage quarantine practically, socially and economically? [2 votes]
- Do communities have memories and experiences of other outbreaks of unidentified / undetected (i.e. formally) diseases - what happened, how were they controlled and responded to locally? [2 votes]
- Why were initial cases not identified as ebola? [1 vote]
- Local health seeking practices and disease models - are there explanatory models or models of severity which influence care seeking and detection opportunities? [1 vote]
- How do communities perceive surveillance (and community based surveillance) and contact tracing? [1 vote]

- Reporting consequences for patients and HCWs
- Relationships with surveillance authorities
- Action: co-designing, review and fieldwork
- Need for disaggregated data and understanding of transmission dynamics (data on cases disaggregated by age, sex/gender, occupation, geography, pregnancy status etc)
- How to avoid undue militarisation of responses in this region, given the contextual realities and the presence of several militias and different defence forces. Would militarisation further reduce public trust, for instance.
- How to set up systems of community/grass roots surveillance that will help rapidly identify the next outbreak whether of Ebola or other disease (in a way that will complement not undercut government surveillance systems)
- (more of an intervention than a research question, but formative research can help) Possible to work with survivors of current epidemic to participate in community surveillance and communication in local languages around identifying contacts, encouraging those exposed to be tested? (more of an intervention than a research question, but formative research can help) Possible to work with survivors of current epidemic to participate in community surveillance and communication in local languages around identifying contacts, encouraging those exposed to be tested?

Other

- What process / mechanisms / channels are effective to ensure that community feedback change operations in (near) real time?
- Who is trusted, for what, and by whom?
- Engagement with rebel groups to facilitate surveillance and cooperating and to avoid actions of rebel groups that will disrupt response?
- What self-protection measures and actions have been initiated by the communities - who is leading these efforts, who is included?
- What are the impact of the experiences of the past series of outbreaks especially Mpox and last 16th Ebola.
- Improving evaluation of trust building efforts
- Which response measures are perceived as protective, coercive, unfair or discriminatory? How can isolation, quarantine, burial, movement control and data collection be implemented with consent, dignity and support?
- Not sure how to articulate but it seems that certain guideline based interventions lead to a lot of fear and then hinder the response. If loosening certain protocols will decrease tension with families and communities without significantly increasing risk to responders. Should this be considered. Can these risks/benefits be quantified?
- Impact of aid cuts and withdrawal within key global health players on preparedness and response
- In Uganda: engage Congolese refugee communities directly, through refugee-led organisations
- How to make the findings digestible in a way that directly meets stakeholder needs (and is determined by them)
- Strengthening the capacity for data collection (and often crucially the analysis capacity) of these organisations that are already in communities with a purpose to serve or provide things for key populations can help to make data collection less extractive for communities.’

Appendix 2 – Meeting chat summary

Discussion points raised in the meeting chat are reproduced here as written. Bold writing indicates sections lifted as research questions. Related discussion in reply to specific comments are grouped into indented paragraphs.

1. 'One of the most urgent unanswered questions **is why transmission circulated for weeks before detection**. Reports indicate a major delay between symptom onset and outbreak confirmation, with patients moving through multiple informal and formal health systems before diagnosis. Key evidence gaps include:
   - **How people interpret early Ebola symptoms when malaria, influenza-like illness, typhoid, and arboviruses are also circulating.**
   - **Whether stigma, fear of isolation, burial restrictions, treatment costs, or distrust drive concealment of illness.**
   - **The role of informal drug sellers, traditional healers, mining-clinic networks, churches, and family caregiving before patients reach Ebola treatment centers.**
   - **Gendered decision-making dynamics around who decides when and where someone seeks care.**
   - **How mobility between mining sites and towns shapes delayed diagnosis.**

   And from here the link with models of care/response: decentralised see home based'

2. '[In response to Meddy Rutayisire, MoH – Uganda] Thanks, this is interesting. Any idea about more entrenched resistance to be linked back to Robert Koch sleeping sickness experimentations under colonial rule? This was something that came up 2018-2020 during the Kivu outbreak (re larger Yira community and elders with memories)?'

3. 'A suggestion for the CORC: it's great to have identified SBS priorities, and as a WG member I think the CORC can offer a great opportunity to systematically integrate social sciences in all pillars. As therapeutics and vaccine development protocols are being put together, it would also be useful to have social scientists involved directly in those processes, as many of the social science priorities you have outlined will matter for the effectiveness of different protocol designs'

4. **'Je pense que l'EDS devrait être clef. Est-ce que la population perçois cela comme digne ?' [English translation: I agree. I think that safe and dignified burials should be key. Does the population perceive this as dignified?]**
   5. 'Jusque à ce stade, c'est le facteur central de tensions.' [English translation: Up to this point, this has been the central factor driving the tensions]
   6. **'Aussi je pense une question sur la perception des communautés par rapport aux frontline workers. Spécialement de tribu différente (in the DRC)' [English translation: I also think there should be a question about how communities perceive frontline workers, especially when they come from different tribes (in the DRC).]**

7. ‘Dear all my name is Sung Joon Park. I am leading the research group medical anthropology at the BNITM, also member in one of the working groups of CORC. Sorry, I am about to board my plane. Just wanted to led you know that Nene Morisho and myself are going to explore how we can extend the activities of the Pole Institut to explore the drivers of mistrust and also address them. Pole is since a while doing community building projects around Bunia. Want to see how the existing network can be used for community preparedness. It will be a anthropological approach which hopefully can complement ongoing SBS activities. We would be very happy and grateful for any support. Sorry have to board… would be grateful if you could keep us in the loop’

8. ‘There are some excellent suggestions regarding having social scientists involved in ALL the key stages of both the operational response and the research design and decision-making processes. I would add, having ethicists to hand to be able to consider some of the trade-offs/ ethical challenges would also be helpful. I think we could work with Glopid-r funders to make this happen.’
   9. ‘There used to be a Unicef-affiliated think-tank called CASS for these kinds of things in 2018-2020…’

10. ‘Research Questions
    - **What is the consensus of evidence about EVD determinants and modes of transmission?**
    - **What do the communities know about EVD? What sources of information on EVD exist in the community?**
    - **What are the factors contributing to the stigma and discrimination of affected individuals?**
    - **What are communities’ perceptions about EVD and its preventive measures, with particular attention to gender differences?**
    - **What practices, including health-seeking behaviors, are communities carrying out to protect themselves from EVD, with particular attention to gender differences?’**

11. ‘Je suis Dr Waly DIOUF, de l’Université de Dakar. Nous sommes partenaires dans la mise en place d’un essai sur la PEP et nous sommes intéressés par la recherche ethnographique pour définir et implémenter une stratégie de communication et d’engagement communautaire. L’essai PEP est une activité complémentaire aux interventions de réponse à l’épidémie.’ [English translation: I am Dr. Waly DIOUF from the University of Dakar. We are partners in the implementation of a PEP trial, and we are interested in ethnographic research to help define and implement a communication and community engagement strategy. The PEP trial is a complementary activity to the epidemic response interventions.]

12. ‘Immédiatement :
    1- La population est en colère en se basant par exemple le décès du leader religieuse, hopital incendié, fuite… è L’engagement communautaire est plus qu’important, il est important de le restaurer ou de mettre en place rapidement à travers une étude rapide.

- Voir la situation sur terrain (contexte)
- Identifier pourquoi les gens sont en colère ?
- Identifier les différents leaders traditionnels et leur niveau d'influence ?
- Revoir les messages et les discuter avec ces leaders traditionneles et les adapter si necssaire

2- La question de gestion des décès à travers l'enterrement digne et sécurisé. La leçon d'Ebole 2014-2016 est importante, les volontaires jouent un rôle important dans la pratique de l'enterrement digne et sécurisé et les pratiques doivent être alignés avec les pratiques locales pour éviter le refus. Une étude rapide est importante pour comprendre les rites funéraires locales si ça n'existe pas encore.

3 - La perception des risques/des me…'

[English translation:

1. The population is angry, as illustrated for example by the death of the religious leader, the burning of the hospital, and people fleeing the area. Community engagement is therefore more than important; it is essential to restore it or rapidly establish it through a rapid assessment study.

- **Assess the field situation and context**
- **Identify why people are angry**
- **Identify the different traditional leaders and their level of influence**
- **Review the communication messages with these traditional leaders and adapt them if necessary**

2. The issue of death management through dignified and safe burials. The lessons learned from the 2014–2016 Ebola outbreak are important. Volunteers played a key role in implementing dignified and safe burial practices, and these practices must be aligned with local customs in order to avoid rejection. **A rapid study is important to better understand local funeral rites if such information is not already available.**

3. **Risk perception, perception of the measures being implemented, and early identification of vulnerabilities. All of this helps improve the effectiveness of the response strategy and its implementation.]**

13. 'That is a really salient reflection, thank you. This question of why there is mistrust and how to now try to build trust seems critical. Deogratias' point about the quality of care that is provided and perceptions of what one would get access to in a biomedical treatment facility I think is one important factor.'

14. 'It would be useful to distinguish between (1) **research needs that are more about known issue: e.g. we know that ongoing monitoring of trust, rumors, protective behavior adoption, vaccine acceptance** ... (2) **What are real gaps in understanding - e.g. transborder livelihood networks, role of (ethnic) coopératives, effective modalities for RCCE**. For (1) it is about setting up the right participatory / community centered infrastructure - technically and financially challenging, but easy to solve. (2) Is more ambitious...'

15. 'For immediate concern part of the question is "can we do anything about it" - is there a clear pathway to influencing the response?'

16. 'In 2018 we had the survey infrastructure and did rapid surveys. It can be done in a more participatory manner and be followed with dialogue. However, link with response remains uncertain.'

17. 'This is a heavily surveyed population. But there is generally a strong desire to be heard and express opinions. Local universities and researchers typically are rather trusted.'

18. 'Quality and trust building and understanding of research'

19. 'In addition to using the pre-existing guidance. we may need to use groups like this as a sounding board to discuss issues around 'quality' when there may be a dearth of pre-existing evidence as to what that is'

20. 'From past outbreaks a common complaint is that people are just told what to do instead of building understanding if what is happening etc. Separately, trusted actors vary a lot by communities.'

21. 'An operational example. During the Rwanda Marburg outbreak (coinciding with mpox as well), Rapid Qualitative Assessments were conducted collaborating with the Rwanda NGO forum which enabled access to key vulnerable communities. From my perspective, **strengthening the capacity for data collection (and often crucially the analysis caapcity) of these organisations that are already in communities with a purpose to serve or provide things for key populations can help to make data collection less extractive for communities.'**

22. 'Is there also uptake of existing research/feedback/social listening with the community leaders/others? Or is this outside this conversation?'

23. 'So this links to trust/how to uptake the reserach, think this is so so important **- how to make the findings digestible in a way that directly meets stakeholder needs (and is determined by them)** Seen this in other responses'

24. 'Co-design of communications and engagement would be great, beyond consultation'
    25. 'Ideally co-design yes, but in past outbreaks these are heavily centralized processes requiring multiple layers of approval as opposed to more localized efforts.'
    26. 'This is an important point, but are there pathways for integrating local representation into the response?'

27. ‘On this digestible very short bulletins framed to stakeholder needs showcasing community voice/collating feedback has worked well (not using research terms, and being v topical to the issues being faced)’

28. ‘Hi all, not a social scientist but I’ved lived in Ituri for 11 years. In my opinion the most trusted institution in Ituri is the church—protestant or catholic depending on the community. Trust building that will facilitate the Ebola response and research will likely be most effective if there is some sort of partnership and facilitation by the church. I think the church is probably the most effective megaphone for health education with many local Christian radio stations, etc.’

29. ‘For doing research with Congolese refugees in Uganda: A structural need is to engage refugee communities and recruit and pay refugee researchers specifically (not automatically hiring Ugandan researchers because of perceptions that it is easier because of visa issues)’

30. ‘Feedback to participating communities in research and assessments / surveys - also critical for trust building - research efforts (immediate, mid- and long-term) also needs to clearly articulate pathways to uptake’

31. ‘Trusted community agent as sources of information. Use photovoice approach’

32. ‘Use channels that are well used eg WhatsApp’

33. **‘Research questions: What proportion of community members report stigmatizing attitudes toward suspected, infected, or recovered Bundibugyo virus disease patients during the early phase of the outbreak, and which factors are associated with these attitudes? What are the main occupational, psychosocial, and safety challenges experienced by healthcare workers involved in the Bundibugyo outbreak response during the early outbreak phase?’**

34. ‘In the DRC, Close collaboration with Religious leaders… and since it a high risk please note the army is also key.’

Appendix 3 – Resources shared by participants at registration and during the meeting

3.1 Resources shared by participants prior to the meeting

Name	Institution	Email	Materials
Alun Davies	The Global Health Network	alun.davies@ndm.ox.ac.uk	There is a range of resources for community engagement on https://mesh.tghn.org
Christoph Vogel	UN	christoph.vogel@un.org	Research on the 2018-20 outbreak
Clare Chandler	Foreign Commonwealth and Development Office, UK	Clare.chandler@fcdo.gov.uk	https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Firis.who.int%2Fserver%2Fapi%2Fcore%2Fbitstreams%2F4fbcdf7c-cdc
Elysee Nouvet	Western University	enouvet@uwo.ca	https://uwo.ca/fhs/pret/en/index.html https://www.sciencedirect.com/science/article/pii/S2666991926000229
Emmanuel Lampaert	CHESD	emmanuellampaert@hotmail.com	See Pubmed arricle on decentralised models of care
Eva Niederberger	World Health Organization	niederbergere@who.int	https://iris.who.int/items/72a013b2-c4f9-4138-8aad-cc511a8db9ee https://iris.who.int/items/ba72ac56-fe70-4e5b-89fb-4533a6d3d098
Habtamu Wondiye	Africa CDC	Bekeleh@africacdc.org	The draft protocol prepared to conduct the social and behavioural research for the Bundibugyo outbreak in affected MS.
Kai Hopkins	Elrha	k.hopkins@elrha.org	Yes, plenty of previous SBS work on Ebola, mpox and other infectious diseases, available on the elrha website: https://www.elrha
Katherine Littler	WHO	littlerk@who.int	Yes - https://iris.who.int/server/api/core/bitstreams/f1fd9770-ac6c-47ef-9662-d205d58193af/content
Patrick Vinck	Harvard University and Kobo Inc.	patrick.vinck@kobotoolbox.org	www.kobotoolbox.org
Cathy Tabaro	Africa CDC	tabaroc@africacdc.org	The protocol was shared
Frank Mugisha	Africa CDC	mugishaf@africacdc.org	Will share insights into behavioral science
Jules Villa	Pasteur Institute	jules.villa@pasteur.fr	The contextual brief on Ituri by regional experts will be out by Tuesday morning, will share the link during the meeting
Pippa Ranger	Foreign Commonwealth and Development Office, UK	pippa.ranger@fcdo.gov.uk	Yes - we will have an SBS brief ready in advance
Umberto Pellecchia	Medecins Sans Frontieres, Brussels	umberto.pellecchia@brussels.msf.org	https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0143036

3.2 Resources shared during the meeting

- To know more about the ANRS MIE CORC on Filovirus: https://anrs.fr/en/partnerships/fighting-epidemics-anrs-mie-leads-who-filovirus-corc/
- The CORC Filovirus roadmap is available via https://anrs.fr/wp-content/uploads/2026/04/rd-roadmap-final-draft-team-corc-filovirus-vdef.pdf
- A collective of researchers wrote a contextual brief on Ituri - here's the English version https://hal.science/hal-05632368 , version française: https://hal.science/hal-05632431
- Just wanted to make everyone on the call aware of the recently published: Guidance on evidence for community protection in public health emergencies. We have a SSHAP review in progress on social science lessons from past Ebola outbreaks. This is now FCDO funded under the new Multi-Hazard Research Network. We will get it out in the SSHAP website ASAP. We have collected all our relevant SSHAP resources on the SSHAP website. https://www.socialscienceinaction.org/resources/social-science-lessons-learned-ebola-epidemics/
- 11 researchers based in the region participated in the writing of this note https://hal.science/hal-05632368 There are 15 universities in Bunia, and 34 in Ituri.
- One approach for involving people directly in research: https://www.socialscienceinaction.org/resources/citizen-ethnography-in-outbreak-response-guidance-for-establishing-networks-of-researchers/
- At the Global Health Network (TGHN), we are setting up an Ebola/Bundibugyo knowledge hub to share relevant tools, resources and learning materials for evidence generation and capacity strengthening. We also plan to develop a community of practice where researchers and response teams can connect and collaborate. TGHN is accessed by 1.3 million users globally, many of them in Africa, so we hope this can be a useful and trusted space for regional knowledge sharing: https://globalhealthoutbreaks.tghn.org/ebola/
- Through the Sonar-Global Association (which builds on a past EC project to create a global network of social scientists for preparedness and response to epidemics) and a current EC project Sonar-Cities (which focuses on urban populations experiencing vulnerabilities in epidemics and disasters), we do have a network of social scientists ready to contribute expertise, training, development of trainings. We have experience in mpox, COVID, other epidemics and are very happy to collaborate with other networks and responders. Please also see recent brief in French and English, led by Jules Villa: En français : https://hal.science/hal-05632431 En anglais : https://hal.science/hal-05632368