

**INTERDISCIPLINARY CONSORTIUM FOR
EPIDEMICS RESEARCH AND RESPONSE (ICER)**

**ICER REGIONAL OPEN EMERGENCY
SCIENTIFIC DIALOGUE REPORT**

**Priority Actions to Halt the Growth of the Current
Bundibugyo Ebolavirus Outbreak in the Democratic Republic of the Congo**

27 August 2026

Virtual Dialogue - Zoom

Duration: 3 hours 50 minutes 49 seconds

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Contents

1.0 Executive Summary	3
2.0 Webinar Profile.....	4
3.0 Purpose and Objectives	4
4.0 Participation and Geographic Reach.....	5
5.0 Thematic Proceedings and Key Findings	5
5.1 Epidemiology and Social Anthropology.....	5
5.2 Diagnostics, Therapeutics and Candidate Vaccine	6
5.3 Optimisation, Prevention and Protocols	6
5.4 Opportunities for Cross-Border Collaboration.....	7
5.5 Community Engagement and Participation	7
5.6 Resource Mobilisation and Allocation	8
6.0 Consolidated Priority Recommendations.....	9
7.0 Agreed Follow-up Actions.....	10
8.0 Conclusion	10
Annex 1. Registration and Participation Summary.....	11

1.0 Executive Summary

Interdisciplinary Consortium for Epidemics Research and Response (ICER) convened a Regional Open Emergency Scientific Dialogue on 27th August 2026 to identify practical actions for containing the ongoing Bundibugyo ebolavirus (BDBV) outbreak in Democratic Republic of the Congo (DRC) and strengthening regional preparedness. The dialogue brought together public-health leaders, clinicians, epidemiologists, laboratory scientists, social scientists, researchers, outbreak responders, community-engagement specialists and regional partners.

The webinar attracted 492 participants from at least 23 countries, including 359 from Uganda and 84 from the DRC. The webinar record indicates that more than 170 participants logged onto the live dialogue. The registration form also captured 167 substantive participant responses on actions needed to control the outbreak, providing a useful indication of stakeholder priorities.

The technical discussion is organized in this report under six thematic areas: (1) Epidemiology and Social Anthropology; (2) Diagnostics, Therapeutics and Candidate Vaccine; (3) Optimization, Prevention and Protocols; (4) Opportunities for Cross-Border Collaboration; (5) Community Engagement and Participation; and (6) Resource Mobilization and Allocation. Across these themes, the central operational priority was to shorten the pathway from alert to investigation, sampling, confirmation, isolation and treatment, while strengthening community trust, frontline capacity and coordinated regional action.

2.0 Webinar Profile

Item	Details
Event	ICER Regional Open Emergency Scientific Dialogue
Date	27 August 2026
Platform	Zoom
Duration	3 hours 50 minutes 49 seconds
Live attendance	More than 170 participants logged on
Approved registrations	492
Geographical reach	At least 23 countries/territories represented in the registration export
Primary focus	DRC outbreak response and regional preparedness
Convening institution	Interdisciplinary Consortium for Epidemics Research and Response (ICER)

3.0 Purpose and Objectives

The dialogue was convened as an open scientific platform to review the evolving outbreak, identify critical operational and evidence gaps, and define actions that can strengthen outbreak control in DRC while improving preparedness in neighboring countries.

- i. Review the epidemiological situation and factors sustaining transmission.
- ii. Identify practical gaps in surveillance, diagnostics, clinical care, therapeutics and vaccine research.
- iii. Examine how prevention, infection prevention and control (IPC), referral and response protocols can be optimized.
- iv. Define opportunities for stronger cross-border surveillance, information sharing, research and response.
- v. Strengthen community engagement, trust and participation in outbreak control.
- vi. Identify resource requirements and priorities for timely, equitable and accountable allocation.

4.0 Participation and Geographic Reach

The webinar attracted 492 participants. Uganda accounted for 359 participants and the DRC for 84, with additional participation registered from Rwanda, Nigeria, Kenya, South Africa, the United Kingdom, Burundi, Ethiopia, Ireland, the United States, Tanzania, Zimbabwe and other countries. This breadth reflects the regional and international relevance of the outbreak and the value of maintaining a multidisciplinary response platform.

Participants represented universities and research institutions, ministries and public health agencies, hospitals and clinical services, non-governmental and humanitarian organizations, and regional or international public-health partners.

5.0 Thematic Proceedings and Key Findings

5.1 Epidemiology and Social Anthropology

The epidemiological discussion focused on delayed case detection, community deaths, population movement, insecurity, incomplete contact tracing and uneven access to response services as important factors that can sustain transmission. Participants emphasized active case finding, rapid investigation of alerts, complete contact identification and follow-up, timely referral, and stronger community-based surveillance, particularly in hard-to-reach and high-risk settings.

Social anthropology was treated as an operational component of outbreak control rather than an adjunct activity. Participants stressed that care-seeking behaviour, perceptions of Ebola, stigma, rumours, resistance, burial practices, trust in institutions and household decision-making can directly affect surveillance and treatment outcomes. Experienced anthropologists and behavioral or social scientists should therefore work alongside epidemiological and clinical teams, with social evidence feeding directly into response decisions.

Priority actions under this theme include:

- Shorten the interval between alert, investigation, contact tracing, sampling, confirmation and referral.
- Strengthen event-based and community-based surveillance and analyze community deaths as a marker of delayed detection or access barriers.
- Deploy context-aware social scientists within response teams to identify behavioral and social drivers of transmission.

- Use rapid social and epidemiological intelligence jointly to adapt response strategies in insecure or low-trust settings.

5.2 Diagnostics, Therapeutics and Candidate Vaccine

Participants identified diagnostic turnaround time as a critical determinant of outbreak control. Reliable molecular testing should be brought closer to affected populations where feasible, while maintaining biosafety, quality assurance and appropriate specimen-management standards. Health facilities also require consistent triage, routine screening and clear referral pathways so that suspected cases are recognized and managed promptly.

The dialogue reviewed therapeutics and candidate vaccine work and called for stronger clinical evidence generated through appropriately designed studies. Therapeutic and vaccine research should proceed without weakening proven supportive care, early treatment and patient monitoring. The reported high case fatality was highlighted as a reason to examine delays in presentation, clinical pathways, treatment access and other operational determinants of survival.

- Expand reliable decentralized molecular diagnostic capacity with quality assurance and biosafety safeguards.
- Strengthen specimen referral, laboratory-result communication and linkage of confirmed cases to care.
- Advance well-designed therapeutic and vaccine studies with appropriate ethical and regulatory oversight.
- Ensure research activities are integrated with, and do not displace, high-quality supportive clinical care.

5.3 Optimization, Prevention and Protocols

The discussion emphasized optimization of the complete response cascade rather than isolated technical interventions. Surveillance, triage, IPC, laboratory testing, isolation, referral, clinical management, contact tracing and safe burial procedures need to operate as one coordinated system with clearly defined responsibilities and rapid escalation when performance deteriorates.

Prevention priorities included consistent IPC in health facilities and communities, hand hygiene, appropriate use of personal protective equipment, safe waste management, early isolation of suspected cases and risk-based screening at points

of entry. The registration responses similarly showed repeated concern with surveillance, IPC, community sensitization, contact tracing, isolation, vaccination and border measures.

- Review and harmonize operational protocols for alerts, case investigation, triage, IPC, specimen handling, referral, isolation and contact follow-up.
- Use simple performance indicators to track delays at each step of the response cascade and correct bottlenecks rapidly.
- Maintain regular refresher training and supportive supervision for surveillance focal persons and frontline health workers.
- Adapt protocols to insecurity, remote communities and other settings where standard response pathways may be disrupted.

5.4 Opportunities for Cross-Border Collaboration

The outbreak was recognized as a regional public-health risk requiring coordinated preparedness beyond national borders. Participants called for stronger routine information sharing, joint surveillance, coordinated points-of-entry preparedness, interoperable alert and referral mechanisms, and technical collaboration between the DRC, neighboring countries and regional institutions.

The dialogue proposed moving from ad hoc support towards pooled regional capabilities, including joint technical teams, embedded training, shared expertise and a standby epidemic-response mechanism. Cross-border collaboration should also extend to laboratory networks, research protocols, data and analytic capacity, risk communication and preparedness exercises.

- Establish or strengthen rapid cross-border alert and information-sharing channels.
- Coordinate surveillance and preparedness at major formal and informal movement corridors.
- Develop joint training, simulation exercises and deployable technical teams.
- Explore a standing regional capability pool that can be activated rapidly during epidemic emergencies.

5.5 Community Engagement and Participation

Community engagement emerged as a core condition for successful outbreak control. Participants recommended working through trusted local actors, including

religious and cultural leaders, youth networks, transport operators, traditional healers, community health workers and other locally legitimate structures. Messages and interventions should be practical, locally intelligible and responsive to community concerns.

The dialogue supported institutionalizing rapid community-feedback mechanisms so that rumours, fears, resistance, misinformation and operational barriers are captured systematically and acted upon. Engagement should be two-way: communities should not only receive information but should also influence how surveillance, referral, isolation, burial and prevention measures are implemented.

- Map and engage trusted community structures early in the response.
- Establish rapid feedback loops linking community concerns to incident-management decisions.
- Use local languages and context-specific communication approaches, including channels accessible to mobile and hard-to-reach populations.
- Track trust, misinformation, refusal, delayed care-seeking and other social indicators alongside epidemiological indicators.

5.6 Resource Mobilization and Allocation

Participants stressed that the response requires resources proportionate to the scale and regional significance of the threat. Financing should prioritize functions that directly reduce transmission and mortality: surveillance and contact tracing, diagnostics, treatment capacity, IPC supplies, frontline workforce support, community engagement, transport and logistics, data systems, and priority clinical or vaccine research.

Resource mobilization should be accompanied by transparent prioritization and allocation. Funding gaps at community and frontline levels can undermine otherwise strong technical plans; therefore, resources should be directed to the points where delays and operational bottlenecks are greatest. Regional and international partners can add value by financing shared capabilities that individual institutions or countries may not sustain alone.

- Develop a costed, time-bound action plan linked to the agreed outbreak-control priorities.
- Prioritize frontline surveillance, diagnostics, treatment, IPC, community engagement and logistics before lower-impact expenditure.

- Mobilize flexible emergency financing that can respond to changing epidemiological and operational needs.
- Track commitments, disbursement, utilization and implementation outputs to support accountability and rapid reallocation where necessary.

6.0 Consolidated Priority Recommendations

- i. Accelerate the full alert-to-care pathway: alert, investigation, sampling, confirmation, isolation, referral and treatment.
- ii. Expand active case finding, contact tracing and community-based surveillance in high-risk and hard-to-reach areas.
- iii. Integrate experienced anthropologists and behavioral or social scientists into outbreak response teams.
- iv. Strengthen decentralized diagnostics while maintaining biosafety, quality assurance and reliable linkage to clinical care.
- v. Advance therapeutic and candidate vaccine studies while maintaining high-quality supportive care and ethical oversight.
- vi. Harmonize and routinely test surveillance, triage, IPC, referral, isolation and contact-management protocols.
- vii. Institutionalize rapid community-feedback systems and work through trusted local actors.
- viii. Strengthen cross-border surveillance, information sharing, points-of-entry preparedness and joint technical response capacity.
- ix. Mobilize and allocate resources according to epidemiological risk, operational bottlenecks and frontline needs.
- x. Translate the dialogue into an ICER position statement and a costed strategic action plan with responsible institutions, timelines and monitoring indicators.

7.0 Agreed Follow-up Actions

Action	Lead/Partner	Timing
Prepare and circulate a draft position statement arising from the dialogue.	ICER leadership/Secretariat	Within 3 days
Develop a strategic action plan setting out immediate outbreak-control priorities.	ICER	Immediate
Advance the cluster-randomized vaccine trial protocol and therapeutic trial activities.	Africa CDC/research partners	Urgent
Continue scaling the village/community health approach, surveillance, contact tracing and case management.	WHO, national authorities and partners	Ongoing
Link modelling expertise with proposed outbreak analytics and preparedness work.	ICER scientific network	Follow-up
Explore institutionalization of rapid community feedback in response decision-making.	ICER and relevant partners	Follow-up
Explore establishment of a standby regional epidemic-response team/capability pool.	ICER and regional partners	Strategic follow-up

8.0 Conclusion

The dialogue reinforced that BDBV outbreak control requires a combined biomedical, epidemiological, social and operational response. Faster detection and diagnosis must be matched by accessible clinical care, effective IPC, trusted community participation, coordinated cross-border preparedness and adequate financing. The next step is implementation: recommendations should be converted into defined activities, responsible institutions, timelines, budgets and measurable indicators, with regular review of progress.

Annex 1. Registration and Participation Summary

The webinar recorded 492 participants. The largest recorded country groups were Uganda (359) and the DRC (84). The webinar attracted participants from at least 23 countries or territories. A total of 167 participants provided responses to the optional question on actions needed to control the outbreak.

Country/Region code	Registrations
UG	359
CD	84
RW	7
NG	6
KE	6
ZA	4
GB	3
BI	3
ET	2
IE	2
US	2
TZ	2