AfricaCDC
Centres for Disease Control and Prevention

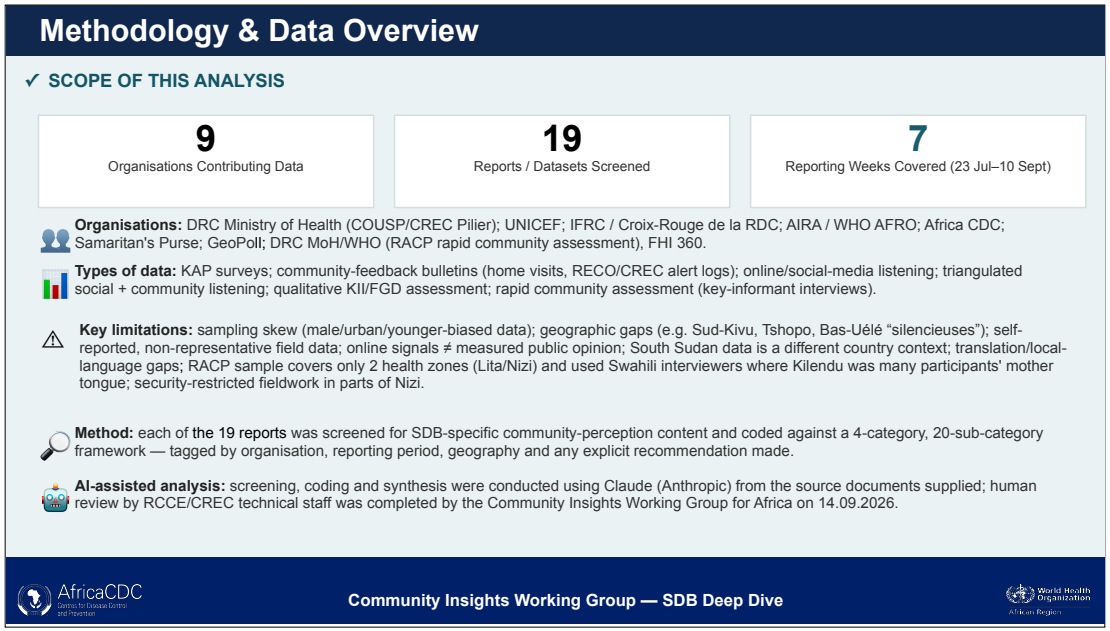
World Health Organization
African Region

SDB Community Perceptions

Analysis Framework Summary

Reporting Period Covered (23 Jul–10 Sept 2026)

This presentation summarises the SDB Community Perceptions Analysis Framework: a synthesis of community perceptions, beliefs, attitudes and sentiment specifically relating to Safe and Dignified Burials (Enterrement Digne et Sécurisé, EDS), drawn from reports shared by 9 organisations working on the 17th Ebola/BVD outbreak response in the Democratic Republic of the Congo (primarily Ituri, Nord-Kivu, Sud-Kivu and Haut-Uélé provinces), with one contributing report (Samaritan's Purse) covering Ebola/BVD preparedness in neighbouring South Sudan.



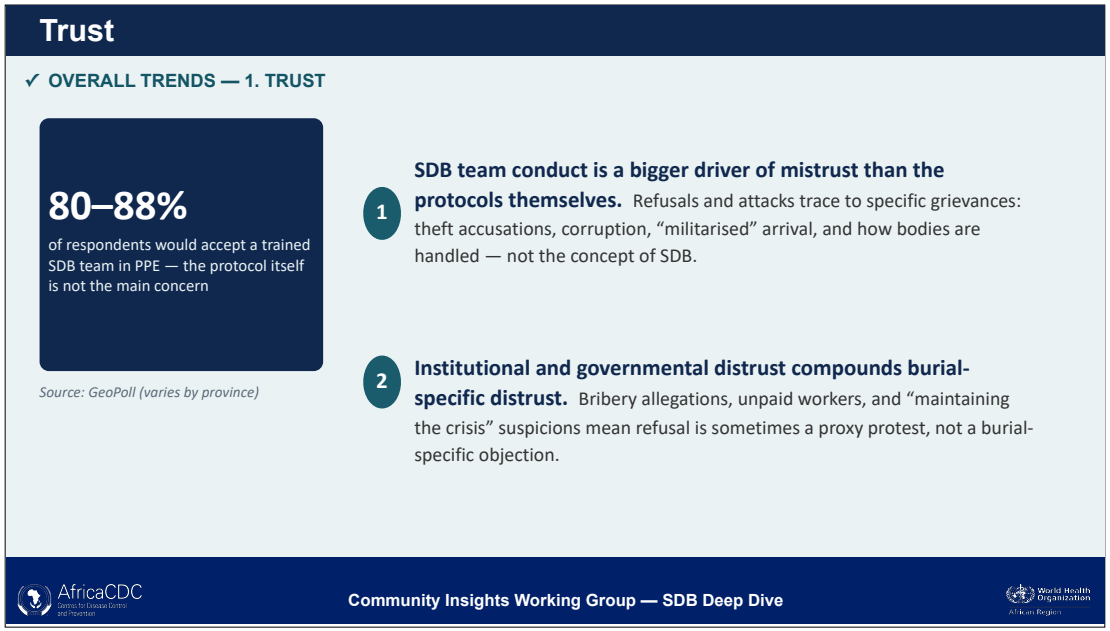
Since the beginning of June 2026 the Community Insights Working Group for Africa have been collating, analysing and sharing joint community insights reports shared by RCCE and operational social science partners working on the outbreak on a weekly basis. This deep dive on community perceptions of Safe and Dignified Burials (SDB) has been taken from data shared by partners who collected data between 23rd July – 10th September.

Using Claude AI, the data shared by all partners over these reporting weeks was scanned for content relevant to SDBs. Based on this, nine organisations' data included findings relevant to SDBs: the Croix-Rouge de la RDC; GeoPoll; UNICEF; AIRA (African Infodemic Response Alliance), operated under WHO AFRO; the COUSP/CREC Pilier (the national-level RCCE pillar of the Ministère de la Santé Publique's incident management system); Africa CDC; and Samaritan's Purse; FHI 360 and DRC MoH/WHO, whose rapid community-death assessment (RACP) covered Lita and Nizi health zones in Ituri (10–18 Aug 2026).

TYPES OF DATA: Structured KAP or perception surveys with quantitative SDB indicators (GeoPoll national KAP survey; UNICEF Ituri perception survey, n=2,814). Recurring community-feedback bulletins built from home visits, causeries éducatives and RECO/CREC alert logs, coded against a standardised feedback taxonomy (IFRC/Croix-Rouge de la RDC CRRDC bulletin; DRC Ministry of Health daily CREC pillar sitreps). Online social- and media-listening bulletins (Facebook, X, TikTok, Instagram, YouTube, news) with thematic clustering (AIRA/WHO AFRO infodemic insights decks). Triangulated social and community listening products combining online monitoring with field feedback networks (UNICEF écoute sociale reports). Incident/rumour-management logs specific to SDB refusals, resistance or security incidents (DRC Ministry of Health CREC sitreps; Africa CDC BIIM behavioural/infodemic deep dive). Qualitative key-informant-interview/focus-group assessment reports (Samaritan's Purse Rapid Qualitative RCCE Assessment, South Sudan). Rapid qualitative community-death assessment based on key-informant interviews, commissioned jointly by DRC MoH and WHO (RACP, Ituri, Aug 2026).

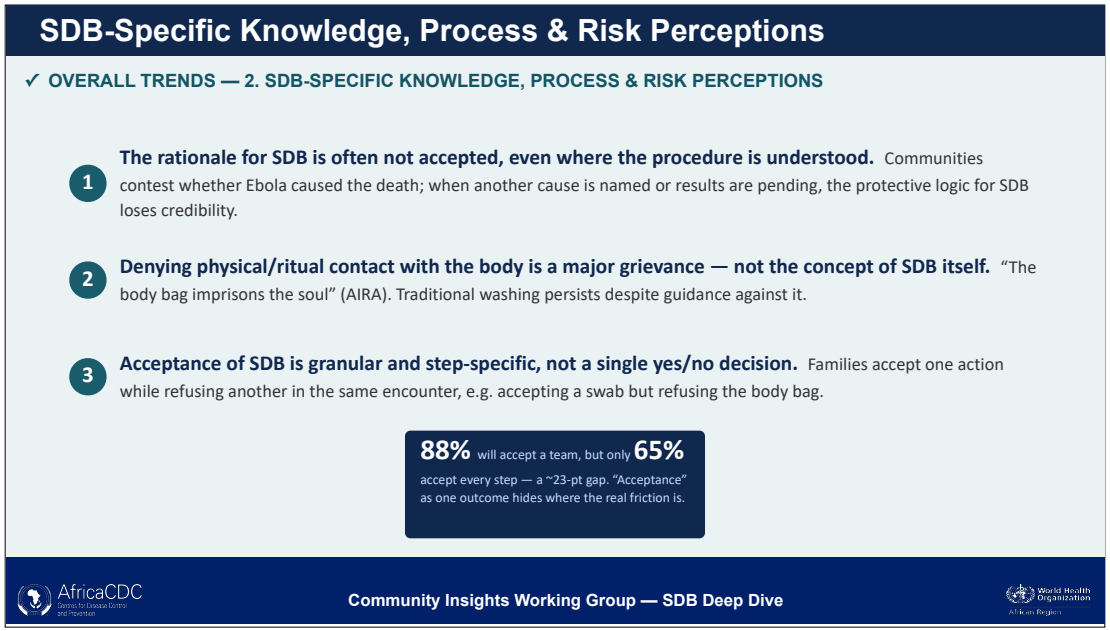
LIMITATIONS: Sampling skew — GeoPoll's mobile-web sample skews male, urban and younger (mean age 31); UNICEF's survey covers ages 18–65 only across 6 cluster-sampled health zones; Samaritan's Purse's 33 KIIs and 6 FGDs are a small, non-random qualitative sample. Geographic gaps — DRC Ministry of Health's own 28–30 Aug analysis meeting names Sud-Kivu, Tshopo and Bas-Uélé as "silencieuses" (no active community-feedback signal) despite being affected provinces; the Samaritan's Purse report covers South Sudan, a different country/outbreak-preparedness context, and should not be merged into DRC-specific trend statements. Self-reported and non-representative field feedback — IFRC/Croix-Rouge and DRC Ministry of Health community-feedback logs are convenience samples from home visits and causeries, not randomised surveys, and cannot be read as prevalence estimates. Online signals are indicative, not measures of public opinion — AIRA states explicitly that its qualitative/media signals "do not measure public opinion or belief in claims" and that some are screenshots not representative of all conversations. Translation and language-access limitations — sources are primarily French (DRC) and English (South Sudan, GeoPoll); AIRA also monitors Swahili-language content; nuance in Lingala, Swahili or other local languages may be lost in translated verbatims. Small, geographically narrow qualitative sample — the RACP rapid community-death assessment covers only two health zones (Lita and Nizi, 123 key informants) and is not representative of Ituri as a whole; most interviews were conducted in Swahili while Kilendu was the mother tongue of many participants, and interviewers' Kilendu proficiency was limited, which the report itself flags as likely to have reduced the depth of testimony on emotional experience. Security-restricted fieldwork — periodically unstable security conditions in parts of Nizi Health Zone restricted access to some sites and prevented fieldwork there, so the RACP sample may under-represent households in those areas.

METHOD: Each of the 19 included reports was screened using Claude AI specifically for passages relating to community perceptions of Safe and Dignified Burial, and relevant content was coded against the category/sub-category framework (Trust; SDB-Specific Knowledge, Process & Risk Perceptions; Access & Implementation; Social, Cultural & Ethical Dimensions). This analysis, including the document screening, thematic coding, cross-organisation synthesis and trend identification, should be treated as a first-pass analytical aid: human review and validation by the Community Insights working group partners and RCCE pillar members familiar with the underlying reports is recommended before this framework is used to guide operational decisions.



The Geopoll survey highlighted that 80-88% of respondents (depending on province) would accept a trained burial team in PPE, highlighting that the protocol itself is not the main concern within communities. Attacks on burial teams and SDB refusals are attributed to accumulated distrust ("fossé de confiance," IFRC) rooted in specific, repeated grievances: teams accused of theft ("The burial teams steal the clothes and money of the dead"), corruption (belief that families are charged for services meant to be free), a "militarised" arrival (when uniformed personnel arrive before the family are prepared), and concern over how the bodies of the deceased are treated by SDB teams are the main factors linked to mistrust towards SDB teams. The RACP rapid community-death assessment (Lita/Nizi) reinforces this: households reported support during the waiting period from church, neighbours and camp committees — explicitly "not the response team" — and described recurring grief where SDB teams appeared rushed, performed no prayer or rite, and gave the family no role in the burial.

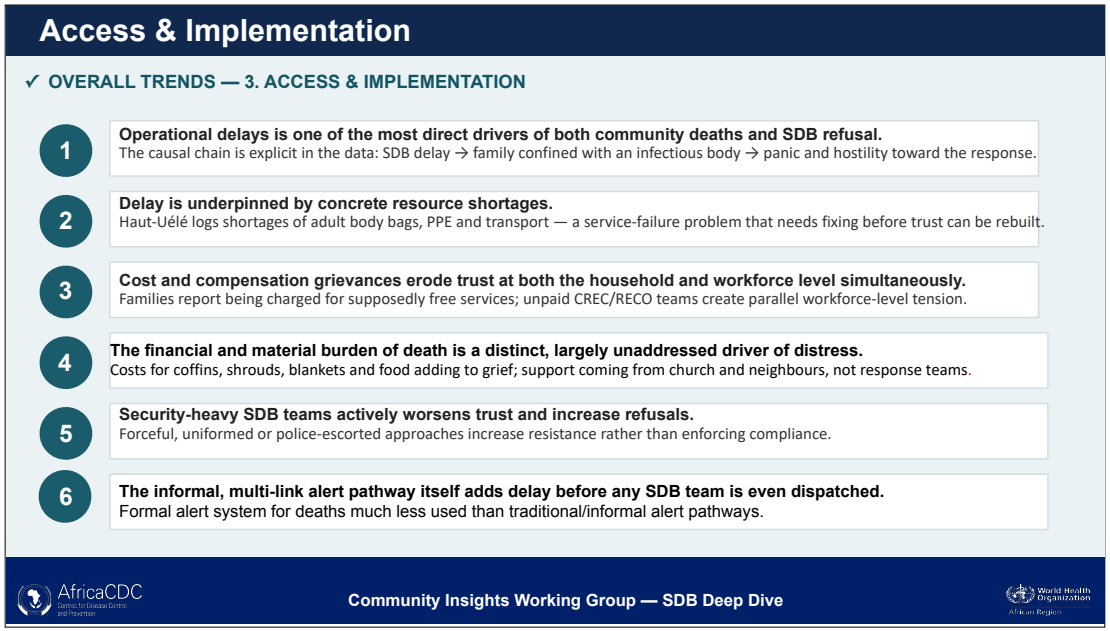
Independent of SDB conduct itself, communities question the legitimacy of the whole response: bribery allegations against local leaders, non-payment of workers, suspicion the government is "maintaining the crisis for financial interests" (with explicit Uganda comparisons), and lab-result inconsistencies that undermine confidence in the diagnostic chain feeding into SDB. This suggests refusal is sometimes a proxy protest against the response's perceived integrity, not a burial-specific objection.



Communities question why burial must happen "under the doctors' conditions" (Katwa) and, more fundamentally, contest whether Ebola caused the death at all — when a death is attributed to another illness or an accident, or lab results are pending, the protective logic for SDB loses credibility (Africa CDC). Low personal risk perception reinforces this — communities perceive the outbreak as less dangerous than other threats they face daily (AIRA).

UNICEF and Geopoll's surveys indicate approx. 64-65% of respondents would accept an SDB (all protocols) for an Ebola death. GeoPoll's data shows the two lowest-accepted of four tested SDB practices are the ones involving physical contact (limiting family washing/touching the body; placing the body in a sealed body bag). Qualitatively, the insights highlight the perception that burying someone in a body bag is synonymous with a lack of respect and consideration (the "body bag imprisons the soul" (AIRA)). The data also highlights the persistence of traditional washing despite guidance against this (DRC MoH). RACP highlights that practices considered essential to a dignified burial — dressing, singing, a wake, a communal meal, undoing the hair, separating pregnant women from the foœtus, and exposure of the body — were consistently reported as missed once SDB teams arrived; not touching the body was described by some as "profoundly painful and unnatural."

Multiple sources independently document families accepting one action while refusing another in the same encounter, e.g. accepting a swab but refusing the body bag (Africa CDC, Niania). The GeoPoll survey highlights the gap: 88% accept a burial team, but only 65% accept all four SDB steps as a package. Treating "acceptance" as one outcome likely understates where the real friction points are. RACP's findings recommend treating bereaved families/communities as situated "somewhere on this spectrum" of ritual compliance, rather than simply "compliant or not."



Haut-Uélé's MoH data shows only 63% of deaths received an EDS as of 11 July; Nizi has only 3 SDB teams for the whole zone, producing 3–5 day recovery delays with at least one body unburied 5 days; a 72-hour delay in Niania/Bafwambaya triggered a specific complaint. Families are understandably extremely frustrated with these delays — a household self-buried after waiting until noon for SDB teams to arrive. The causal chain is explicit in data: SDB delay → family confined with an infectious body → panic and hostility toward the response. RACP findings highlight that “the SDB team dragged a lot [...] the body stayed two days in the house until it swelled and split” (farmer, Nizi); one household's home was sealed for 21 days pending response. RACP records a 0–3 day waiting window before SDB team arrival.

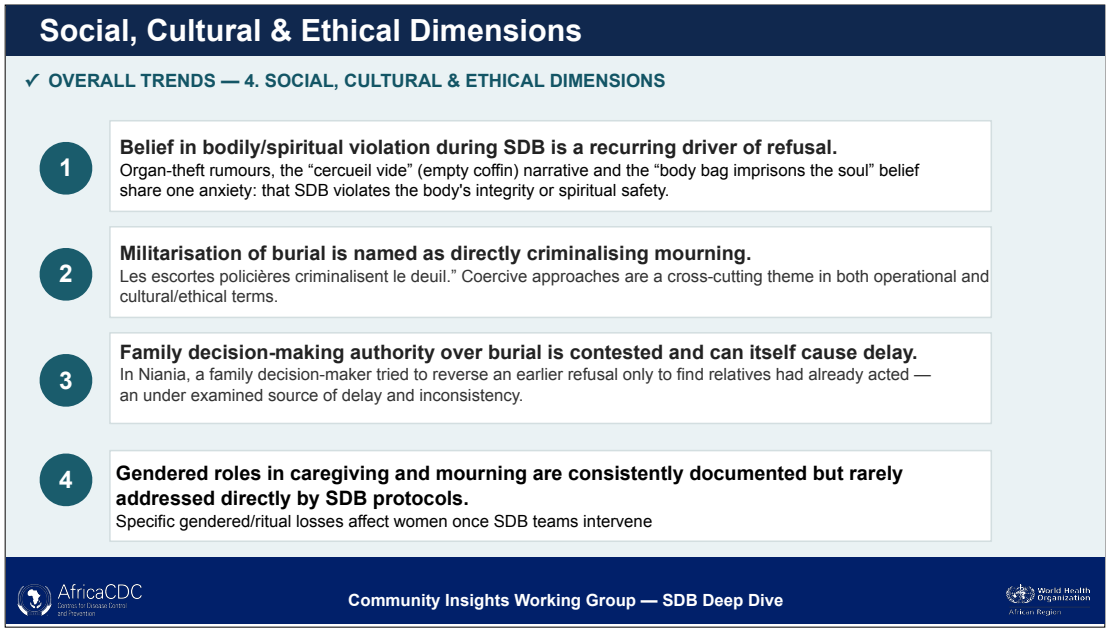
Nizi's 3-team coverage and Haut-Uélé's logged shortage of adult body bags, PPE, and transport show that some delay is a service failure problem which needs to be addressed before trust can be (re)built. RACP's findings highlight how pre-positioning protective equipment at the health centre for the ECUMER youth burial teams is described as a precondition for community acceptance, alongside deploying an ambulance to Mandro and repairing the Ngezi bridge.

Families report allegations of being charged for supposedly free services, including providing coffins and grave-digging; separately, unpaid CREC/RECO teams and local providers create workforce-level tension that risks further destabilising delivery of SDB services. These are two distinct financial grievances, but both point toward the same underlying need for financial transparency and accountability. RACP's key recommendations include paying RECOs directly (phone credit, transport costs), since they are often the first point of direct contact with a household after a death.

The financial and material burden of death is a distinct, largely unaddressed driver of distress. RACP documents households — including displaced families with no income — expected to cover coffins, shrouds, blankets and food, incurring debt for coffin planks borrowed from mutual-aid committees, and losing burned mattresses and bedding to decontamination, alongside anxiety, sadness and fear during the waiting period. Support during this period came from church, neighbours and camp committees — explicitly not the response team.

Forceful, uniformed, or police-escorted approaches increase resistance rather than enforcing compliance.

The informal, multi-link alert pathway itself adds delay before any SDB team is even dispatched. RACP documents 4 parallel death-alert routes — traditional/cultural (village/group chiefs), health (RECO/IT), informal networks (neighbours/family), and a formal system that is “much less used” — noting that each additional link in this chain keeps the body in the community for longer, raising transmission risk before the SDB team is even alerted.

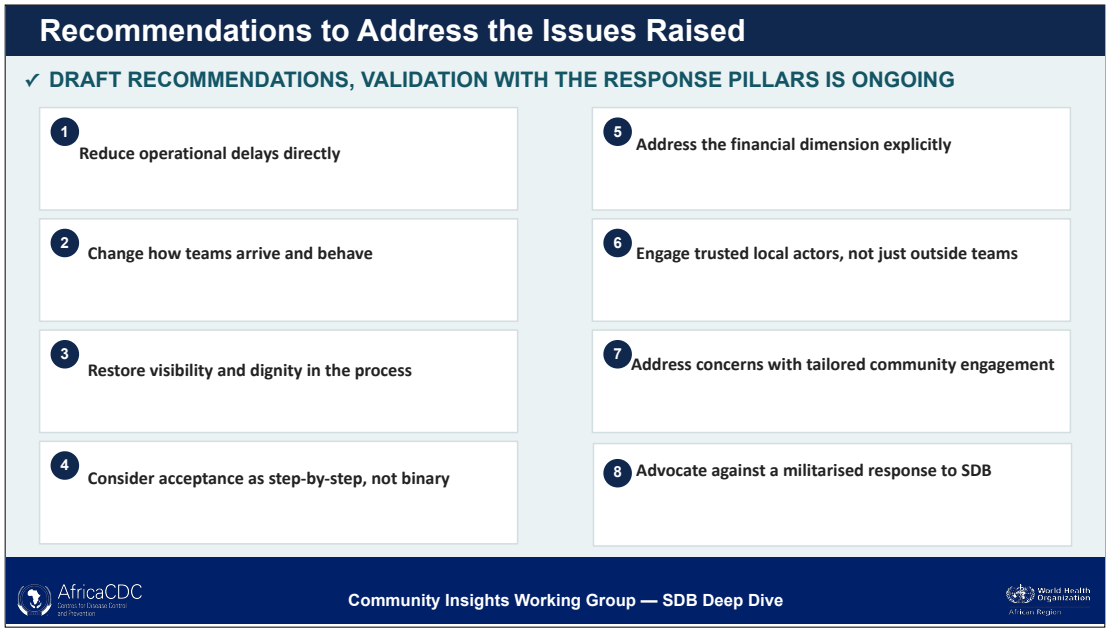


Organ-theft rumours (implicating both traditional healers and health workers in different zones), the “cercueil vide” (empty coffin) narrative, and the “body bag imprisons the soul” belief are distinct concerns with a shared underlying anxiety — that SDB violates the integrity or spiritual safety of the body. RACP findings highlight the cultural importance of “sacred water” used to wash the body (also used for drinking and for cooking for funeral hosts), and body-preparation rites including “cassage/ redressement des articulations (kuvunjavunja)” — cracking/straightening of the joints — and massage with palm oil, petroleum jelly or plant-based solutions.

Police/security escorts during ordinary burials are experienced as treating grief itself as a security threat (“les escortes policières criminalisent le deuil”). Coercive approaches are a cross-cutting theme showing up in both operational and cultural/ethical terms.

Africa CDC's Niania case shows a family decision-maker attempting to reverse an earlier refusal only to find relatives had already acted — intra-family authority disputes over who controls burial decisions are an under examined but real source of delay and inconsistency. RACP's four parallel death-alert pathways (traditional/cultural, health, informal networks, formal system) similarly show authority over the death-to-burial process distributed across multiple, sometimes competing actors before an SDB team is even involved.

Gendered roles in caregiving and mourning are consistently documented but rarely addressed directly by SDB protocols. RACP found home care during illness is most often provided by women, and reported specific gendered/ritual losses once SDB intervenes: the undoing of women's braids, and the separation of pregnant women from the foœtus.



This slide reproduces, in full, the “Summary of recommendations to address these issues” block at the end of Section 4 (Overall Trends) of the SDB Community Perceptions Analysis Framework.

Highlight that there is a health-zone specific breakdown of key findings and recommendations which may provide a more tailored response to community perceptions being heard in these areas available in the full analytical framework: SDB_Community_Perceptions_Analysis_Framework_11092026.docx - Google Docs.

Recommendations to Address the Issues Raised

✓ **ACTIONS TAKEN**

IFRC/DRC Red Cross

Reinforced SDB protocols with mandatory and systematic community engagement processes. Ensured community perspectives and family preferences are integrated into all SDB decisions. Strengthened trust, acceptance, and accountability through proactive community engagement. Red Cross

Alignment of protocols across partners

Red Cross, FHI360 and WHO are collaborating to discuss the strategic interface between RCCE and SDB and aligned their protocols

Example of draft recommendations per heath zones- to be discussed and monitored across pillars

Health Zone / Area	Province	Key Findings	Recommended Actions
Bunia	Ituri	Central hub of EDS activity and of the "cercueil vide"/organ-theft rumour origin (adolescent verbatim); gloves abandoned at Nyamurongo cemetery feed contamination fears; siren use during EDS interventions provokes negative community reaction.	Stop siren use during EDS interventions; enforce a glove/waste-disposal checklist at cemetery sites; implement IFRC's "visual transparency" protocol (2 family observers at 2m) to counter the organ-theft rumour.
Komanda (Village Mungamba)	Ituri	Highest documented violence-with-resistance incident in the MoH data: EDS team attacked, vehicle damaged, escorted out by FARDC (6 bodies registered).	Prioritise recruitment of local "Relais Communautaires EDS" (IFRC model) before further deployments; hold the advocacy meeting with local authorities proposed in the MoH sitrep.
Kilo	Ituri	Structural, not episodic, resistance — families refuse to hand over bodies to official teams ("laissez-nous enterrer nos morts," cumulative frequency 34); risk of concealment of illness and death.	→ UNICEF recommendation: direct dialogue with family heads and religious leaders on the exact EDS process before any new alert, rather than after refusal has occurred.
Nyankunde	Ituri	Most severe facility-level security incident reviewed: the CTE itself was attacked (15–16 July); 8/11 health areas in the zone affected.	→ UNICEF recommendation: continue the 32 community dialogues already held (1,500+ leaders reached) and measure their effect on the refusal rate over time.
Nizi	Ituri	Capacity-constrained SDB response (3 teams for the whole zone, 3–5-day recovery delays, teams stoned) combined with severe CTE-avoidance sentiment ("a place of death") and an emerging "secret funerals" trust-breach narrative (Sept). RACP's findings document a case where an SDB team "dragged a lot," leaving a body in the house for two days "until it swelled and split"; another household's home sealed for 21 days pending response; and recurring grief described as SDB teams giving "no role for the family in the burial" and using the black body bag.	→ AIRA recommendation: guarantee and systematically communicate documented family notification for every EDS performed; increase SDB team coverage. → RACP recommendation: pre-position protective equipment at the health centre for ECUMER youth burial teams (a precondition for community acceptance); pay RECOs directly for their role as first point of contact after a death; involve religious leaders in team preparations and a brief religious service before burial.
Mangala	Ituri	A single, specific monetisation complaint (100,000 FC charged for burial) reported as sufficient to stall EDS uptake in this zone.	Investigate and publicly refute the specific payment allegation; enforce and communicate real free-of-charge burial services..
Rwampara	Ituri	Generally responsive to sensitisation (documented "EDS réalisé" outcomes after family conscientisation), but a serious adjacent infection-control breach — dogs entering the CTE high-risk zone at night — threatens to undermine trust gained.	Urgent CTE perimeter security (flagged as a 72-hour fix in the MoH analysis meeting); continue the family-preparation approach that has shown results here.

These recommendations are examples formulated from the individual partners' reports, on which the attached report is based. They are subject to further discussion with the response pillars and field actors/stakeholders before any validation and implementation takes place.

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