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KEY FINDINGS

58% of women and girls
Reported that at least one form of violence against women and girls in their household had started or increased since the Ebola outbreak began.

64% of women and girls
Whose households had experienced at least one Ebola response measure reported new or increased violence.

90% of women and girls
Who reported new or increased violence and whose household experienced a response measure attributed the violence to Ebola-related stress and fear.

RECOMMENDATIONS

Make the **safety of women and girls a measure** of an effective Ebola response. Work with local women's organizations to spot rising risks early and act.

Keep services for women and girls open, accessible and funded at scale throughout the outbreak, and establish new services in Ebola hotspots.

Build VAWG surveillance at **scale in partnership with women-led organizations** in future public health emergency preparedness and response.

WHY A SURVEILLANCE SYSTEM ON VIOLENCE AGAINST WOMEN AND GIRLS?

A 2026 systematic review published in *BMJ Global Health* by UNICEF and Washington University found that infectious disease outbreaks can increase risks of violence against women and girls (VAWG) through economic stress, movement restrictions, disruptions to essential services, fear of infection, and pre-existing inequalities and mistrust. At the same time, measures needed to control an outbreak can unintentionally make it more difficult for women and girls experiencing violence to reach support.

During the current Ebola outbreak in the Democratic Republic of the Congo, UNICEF and partners are piloting a real-time surveillance mechanism for VAWG in five affected health zones in Ituri Province, with the aim of identifying how the outbreak and the response affect VAWG and informing the response itself, while generating learning on what it would take to replicate the approach in safely and ethically in other infectious disease outbreaks. To our knowledge, this is the first system of its kind implemented during an active outbreak, and will contribute to much-needed evidence beyond the COVID-19 pandemic.

The approach brings together UNICEF, Washington University in St. Louis and SOFEPADI, a Congolese women-led organization and gender-based violence (GBV) service provider.

HOW DOES THE SURVEILLANCE MECHANISM WORK?

Designed to be safely implemented in an active outbreak, the surveillance uses a mixed-channel, quantitative and qualitative approach to detect changes in violence and risks affecting women and girls during an outbreak. Rather than relying on one survey or one source of information, it brings together signals collected

through different channels and uses them to identify patterns that may require further investigation or action. Each of the five health zones targeted in the current surveillance serves as a sentinel site[1].

The surveillance draws on:

- **Surveys**: Trained female SOFEPADI enumerators use a short, structured questionnaire with women reached through household visits and at selected churches and water points. Within each sentinel site (health zone), each enumerator was assigned one sampling axis covering three health areas (*aires de santé*). Each health area was divided into blocks, from which households were randomly selected. Household identification began from a randomly selected household and proceeded using a sampling interval. One church and one water point were selected per sampling axis, based on comparable conditions, including distance to health-care facilities, accessibility and patterns of use. Questions cover changes in physical, sexual, emotional or psychological violence and controlling behaviour, as well as reported exposure to Ebola response measures, possible reasons for changes in violence, help-seeking and barriers to support.
- **U-Report[2]**: UNICEF's digital platform provides an additional channel for capturing broader community perceptions of risks facing women and girls and barriers to accessing GBV services.
- **Qualitative engagement with stakeholders:** Consultations with child protection and GBV service providers, women-led organizations, health workers, and other response stakeholders. These generate systems-level insights on service availability, referral pathways, and observed changes in violence and disclosure patterns during the Ebola response.
- **Community feedback and operational insights**: Focus group discussions with women and adolescent girls, information from community feedback mechanisms and other response channels complement the direct engagement with women and girls, helping response teams understand emerging concerns and how outbreak operations may need to adapt.

SAFETY, ETHICS AND LIMITATIONS

Consistent with the Inter-Agency Standing Committee GBV Guidelines, GBV prevention, risk mitigation and survivor-centred services should be in place from the outset of an emergency, regardless of the presence or absence of concrete evidence. Accordingly, UNICEF continues to prioritize and support the provision of quality GBV services for women and girls, with surveillance used to inform and adapt the response, not as a prerequisite for action.

Safety and referrals are built into the approach. Data collection is carried out all-female and locally recruited staff embedded within SOFEPADI[3], which is also a GBV service provider in Ituri. This means that women requiring assistance can be safely connected with specialized support. The system was

[1] Heath zones covered by the surveillance: Bunia, Rwampara, Mongwalu, Tchomia, Komanda
[2] U-Report is a free, anonymous, and safe platform by UNICEF that allows young people to share their views, access trusted information, and drive positive change in their communities.
[3] SOFEPADI, a Congolese women-led organization that has been active in Ituri for more than 26 years, manages safe spaces that provide women and girls with a confidential and protective environment where they can seek specialized and quality multi-sectorial support services.

designed around survivor-centred and safety principles. The study protocol has received IRB approval – an institutional review board.

The individual surveys are voluntary, with sensitive questions asked only where privacy can be ensured. The protocol provides for verbal informed consent, no collection of direct personal identifiers, secure data collection and information about available support and referral.

These data are early-warning signals, not prevalence estimates. The individual surveys use an operational sentinel sample. The surveillance is intended to identify patterns of risk early enough for programmes to investigate and respond, not to identify individual cases or count every incident of violence.

KEY FINDINGS

The findings below are based on the following main sources:

- Results from interviews with 1,062 women and older adolescent girls aged 15 and above, conducted by trained SOFEPADI staff between 28 August and 15 October 2026.
- U-Report poll launched in September 2026 to capture community perceptions of how Ebola is affecting the safety of women and girls, reaching around 11,500 young people in Ituri and other affected areas.

Links between Ebola and increased violence.

Nearly 58 per cent of women interviewed reported that at least one form of violence against women or girls in their household had started or increased since the outbreak began.

Moreover, UNICEF launched the U-Report poll in September 2026 to capture community perceptions of how Ebola is affecting the safety of women and girls, reaching around 11,500 young people in Ituri and other affected provinces. Nearly 50 per cent of female respondents mentioned increased risks of violence for women and girls, and 29 per cent of respondents ranked physical and sexual violence as the greatest concerns.

An association between response measures and reported new or increased violence.

Sixty-four per cent of women whose households had experienced at least one Ebola response measure reported new or increased violence, compared with 45 per cent of women whose households had not. The findings show an association, but do not establish that response measures caused the increase. By Ebola response measure, we mean such actions as isolation, quarantine or contact tracing.

Women connect increased violence to Ebola-related pressures.

Among women who reported new or increased violence and whose household had experienced a response measure, 90 per cent attributed the violence to Ebola-related stress and fear. Loss of income or food, stigma, and isolation or quarantine were also frequently cited, helping identify potential pathways through which the outbreak and response environment may compound existing risks. Women in households that had experienced a response measure were more likely than other women to link the violence to stress and fear, stigma, and isolation or quarantine.

Women face barriers to support, while existing services for survivors are coming under greater pressure.

Surveillance of service use also points to increased demand on existing GBV services, reinforcing the importance of maintaining and adapting essential services as part of the outbreak response. Among women who sought specialized GBV support but could not get it: 49 per cent said Ebola response restrictions had prevented them from accessing services; 37 per cent cited shame, fear of the perpetrator or lack of trust; 24 per cent feared contracting Ebola at a health facility; 12 per cent of respondents did not know where to go; 10 per cent said the service was closed or not working; and 6 per cent cited insecurity or armed conflict.

According to the UNICEF U-Report poll launched in September 2026, 35 per cent of young people said few people are aware of the GBV response services available. The main barriers women and girls named to reaching services were fear (29 per cent), distance (26 per cent), lack of trust in services (12 per cent) and lack of information (9 per cent).

Where services for women and girls exist – such as the ones supported by SOFEPADI in collaboration with UNICEF – they are under pressure. Attendance at the eight safe spaces – locations survivors of violence can access services – supported by SOFEPADI rose by 200 per cent between July and September 2026, with 3,548 visits over the three months, compared with 1,183 visits in the first quarter of the year. Visit figures count each attendance at one of the services offered through the safe spaces, which provide a confidential and protective environment where they can seek support, access psychosocial assistance and be safely referred to medical, legal and other specialized services. The figures do not equate to the number of survivors assisted.

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