



“Everything on her shoulders”

Rapid assessment on gender and violence against women and girls in the Ebola outbreak in Beni, DRC

March 2019

Pre-existing gender norms expose women and girls to specific and increased risks during disease outbreaks. During the current outbreak of Ebola Virus Disease (EVD) in North Kivu, in the Democratic Republic of Congo (DRC), health actors have seen a similar pattern to that seen in West Africa in 2014, with infections rates for women and girls fluctuating between 57-62%.¹

“It’s as if this illness were woman’s fault.

She is stigmatized in her community. Some members of her family are angry at her and put everything on her shoulders.”

-FGD, women 26-40 years old

Following the EVD outbreak in West Africa, humanitarian actors and academics recognized the gendered impacts of the disease and the response on women and girls, as well as the long-term recovery implications for women and girls.²

The EVD outbreak in North Kivu was declared on Aug. 1, 2018, in the midst of an already complex and chronically insecure environment. Today there are an estimated 120 armed groups active in North Kivu and South Kivu, according to the Congo Research Group and Human Rights Watch.³ Since 2014, civilians in Beni in North Kivu have experienced repeated attacks, with more than 1,000 people killed as a result.⁴ The killing and other violence perpetrated by armed groups has displaced large numbers of the population. As cited by UN OCHA, between January and October 2018, around 50,000 people had been displaced in Beni, doubling the number of displaced persons in Beni Territory.⁵

The ongoing insecurity, combined with weak pre-existing services, have made it extremely challenging to contain the current EVD outbreak. By February 3, a total of 785 cases and 484 deaths were recorded as a result of EVD, across 18 health zones in the provinces of North Kivu and Ituri.⁶

In December 2018, the International Rescue Committee (IRC) completed an assessment in Beni, DRC, with the aim of examining the effects of the EVD outbreak and response on women and girls, and specifically how the outbreak has impacted women and girls’ experience of violence, also considering the pre-existing context of insecurity in which they live. The ultimate

¹ WHO situation report, December 2018; WHO situation report, February 2019; WHO final data set for West Africa, May 2016.

² Bennett, Belinda, and Sara E. Davies, *International Affairs* 92: 5 (2016) 1041-1060, “A gendered human rights analysis of Ebola and Zika: Locating gender in global health emergencies.”

³ Kivu Security Tracker, Congo Research Group and Human Rights Watch, December 2017: <https://kivusecurity.nyc3.digitaloceanspaces.com/reports/5/Landscape%20of%20Armed%20Groups%20Essay%20KST.pdf>

⁴ Human Rights Watch, 3 October 2018: <https://www.hrw.org/news/2018/10/03/dr-congo-uptake-killing-ebola-zone>

⁵ OCHA Information Bulletin, 18 November 2018:

https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/bulletin_mensuel_ocha_novembre_2018.pdf

⁶ WHO EVD DRC External Situation Report 27, 5 February 2019.

goal of this assessment was to inform how humanitarian actors take gender into account in the response and ensure the protection of women and girls. The IRC focused its assessment in four health areas – Butsili, Kanzulinzuli, Kasanga and Mabolio – due to the high number of EVD cases documented there since the beginning of the outbreak.

Assessment aims

The IRC set out to answer the following questions within this assessment:

- How has the experience of women and girls changed since the EVD outbreak? Specifically, how have these shifts impacted roles, responsibilities, decision-making, and access to services? How do these shifts impact women and girls' risk of contracting EVD?
- What is women and girls' current experience of violence? How have the risks and experience of violence changed since the EVD outbreak?
- How are women and girls accessing EVD response and prevention services and support? What barriers do they face? How have they been engaged to inform the response?
- Where do women and girls access services and support, both as related to EVD and as related to gender-based violence (GBV)?

It is critical to note that in exploring these questions the IRC used qualitative methods, and the findings do not speak to scale or prevalence. Respondents shared their perception of trends and concerns they have in the current context. No women reported individual cases of sexual exploitation to the IRC during the assessment, and neither the assessment nor this report seek to quantify any of the issues highlighted here. A more robust understanding of the specific issues for women and girls would require deeper examination by the humanitarian community in DRC.

Key findings

Key findings in the assessment, also reviewed in the discussion at the end of this report, include:

Women and girls carry primary responsibility for caring for the sick and for managing household prevention. This means that women and girls, and particularly adolescent girls, must increase the number of times they travel long distances by foot each day to fetch water. This results in elevated risks of sexual violence and harassment.

Community members perceive an increase in violence against women and girls during the current crisis, with the highest risks being viewed as sexual violence and domestic violence.

Community members report commercial sexual exploitation of women and girls to meet basic personal and household needs; and report concerns regarding sexual exploitation and abuse.⁷

⁷ The IRC uses the phrase 'commercial sexual exploitation' to describe any actual or attempted abuse of a position of vulnerability, differential power or trust for sexual purposes, including, but not limited to profiting monetarily from the sexual exploitation of another. This encompasses sexual exploitation and abuse as it is understood in the humanitarian sector, but extends beyond this as well.

Some women and girls in need of EVD-related services face barriers including lack of information, misinformation, and lack of financial means.

Some women and girls who experience violence do not feel confident in or able to safely access confidential, quality GBV response services.

Assessment methodology

The assessment was conducted using focus group discussions (FGD) and key informant interviews (KII).⁸ The IRC hired 11 data collectors, including seven women and four men, and provided a one-day training on data collection, assessment tools and ethics. The IRC and the data collectors tested the tools in the field before moving to the formal data collection phase.

The assessment included 34 FGDs, including 20 with adult women, 11 with adult men, two with adolescent girls (16-18 years old) and one with adolescent boys (16-18 years old). Each group was made up of 15 to 20 participants. FGD participants were chosen using snowball methodology.⁹ This allowed for greater trust and openness during discussions. This was particularly important due to tensions in Beni and lack of trust between certain community members.

The IRC carried out 24 key informant interviews (16 female; eight male). The IRC worked with community-based focal points to identify key informants who play a leadership, educative, or social support role in their local community; based on this, the key informants included community leaders, health workers, religious leaders, and community workers/volunteers.



Table 1, below, provides an overview of the number of times the IRC was able to complete each tool to collect assessment data. The specific locations are not provided here in order to protect the confidentiality and safety of respondents.

Table 1: Assessment tool completion overview

Tool	Number completed
Female FGD	20
Male FGD	11
Adolescent girls FGD	2
Adolescent boys FGD	1
KII – Females	16
KII – Males	8

All participants gave their consent to participate in the assessment. For the adolescent participants, the IRC also received consent from their caregivers. Before every FGD or

⁸ Data collection tools available upon request.

⁹ The snowball methodology started in each case in areas with relatively high EVD caseloads. Each initial individual (e.g., the “snowflake”) was asked to select three other respondents, and these subsequent respondents were asked to invite four or five additional participants.

interview, the participants received information regarding the objectives of the assessment, as well as their right to participate or not, to refuse to answer if they do not feel comfortable, and to stop at any time of the FGD or the interview.

All discussions and interviews were facilitated by same-sex data collectors, who were all trained on ethical data collection, including safety and confidentiality. All data collectors signed confidentiality commitments and received guidance on how to handle GBV disclosure during discussions. Data collectors were also trained on the GBV referral pathways in the area, and how to provide referrals. The IRC designated a psychosocial officer as focal point to support any GBV survivors who came forward during the assessment.

Limitations

The IRC faced the following principal limitations in the assessment:

1. Insecurity in Beni during the data collection meant suspension of the assessment for one day. The team was able to resume data collection the following day; however, as a result of continued insecurity and resulting access challenges, the team was able to complete just 34 out of the originally planned 36 FGDs.
2. The assessment tools were translated into Swahili. Despite this, some words were not locally understood. This resulted in enumerators fluent in both French and Swahili needing to rephrase, and translate back to French in some cases to ensure local understanding of the question. While a full review of the tool and discussion of key definitions was included in the enumerator training, some irregularities during survey administration may have occurred as a result.
3. The snowball methodology relied upon one FGD participant identifying others, which results in participants selecting people they know and trust. As noted above, this was intentional as an approach, in order to reinforce a sense of trust in the group. However, it may also have meant that FGDs were largely made up of participants with similar backgrounds and less diversity of experiences or views.
4. This assessment did not specifically interview children as this would have required additional training and specialized skill sets. Adult FGD participants and key informants provided information regarding children's experience within the response. Adolescents 16 years old and above did participate in the assessment after consent from their parent or caregiver, allowing the IRC to gather more direct information regarding their experience. The IRC is also planning to conduct a specific child protection assessment, and seeking to address similar questions as they relate to the experience of girls and boys in the current EVD outbreak and response.

As noted above, the IRC data collection reported here is qualitative and does not reflect scale or prevalence of any findings. Further, this report reflects respondents' perception of trends and concerns they have in the current context. No women reported individual cases of sexual exploitation to the IRC during the assessment.

Findings

The following section will describe and discuss assessment findings in three key areas: 1) roles and behaviors since the EVD outbreak; 2) violence against women and girls; and 3) access to EVD-related and GBV-related services.

“Women and girls are marginalized when they are menstruating. People say they are infected with EVD... Some husbands send their wives away because they are afraid of contamination.”

-FGD, women 26-40 years old

Roles and behaviors since the EVD outbreak

The IRC asked key informants and FGD participants about the roles and responsibilities of men and women in the community, and how those have changed since the EVD outbreak.

Nineteen of the 34 FGDs stated that men are responsible for financially supporting the family's basic needs and/or working outside the household, including in the fields.

When asked who is responsible for household work, all FGDs noted women and girls; two FGDs also included men as responsible, and two FGDs included boys within those listed as responsible.

Twenty-six of the 34 FGDs said that the amount of time required for household work has changed since the EVD outbreak. Of the eight out of 34 FGDs responding “no” to this question, six FGDs noted that these household chores already require between six hours and the entire day, into the night. When discussing community-level changes since the EVD outbreak, three FGDs said that women's overall workload has increased.

Eight FGDs noted that the changes in women and girls' household work are related to their increased role in ensuring best hygiene practices within the home and family. Five FGDs made the same reflection related to men's role; one female FGD specified that men are responsible for hygiene by giving instructions for women to carry out.

Four FGDs specifically highlighted increased hand-washing as a change as a result of the EVD response. As one adolescent girl explained, “People are washing their hands many times. This means we need to draw water many times. Before Ebola we used to go to water points twice a day because the distance is long. And since the Ebola outbreak was declared we can go up to five times a day. It is very tiring.”

When asked about household decision-making, 13 FGDs said that men are the first and/or final decision-makers in the household; and six FGDs said that women have no decision-making role or that women's decision-making role is to listen to their husbands. Eleven FGDs said that men make decisions about household hygiene and are responsible for following the advice of medical personnel to prevent EVD. Fourteen FGDs said that women make decisions about or reinforce good practice as it relates to household hygiene.

The majority of FGDs (20) said that women and girls are the primary caretakers for the sick and the elderly. Five FGDs said that women and men are responsible; six FGDs said that the whole family or other community members (doctors, church leaders, or non-governmental organizations) are responsible. Two FGDs said that men care for the sick and elderly.

When asked about community-level discussion and decision-making, three FGDs reflected a greater role for women in debate and leadership on hygiene; and reflected this as positively impacting both women and men.

Twelve of the 34 FGDs noted that women are working outside of the home in some capacity, including agriculture and other income-generating activities. Six FGDs specifically noted that women play a role in community sensitization and education, particularly related to hygiene.

Five FGDs said that men's sexual behavior has changed, with increased fidelity and abstinence being adopted as measures to prevent EVD. Two FGDs said the same with regards to women. Eight FGDs said that adolescent girls engage in fewer sexual relations; and eight FGDs said the same with regards to adolescent boys.

Only two FGDs included women specifically in naming those responsible for caring for children who have been separated from their families or have lost their parents/caregivers as a result of EVD. More often, respondents named extended family (12) and EVD response providers and/or humanitarian actors (19) as those providing care for separated, unaccompanied or orphaned children.

Violence against women and girls

When asked about the types of violence that women and girls experience before and during the EVD outbreak, a majority of FGDs highlighted sexual violence. In key informant interviews, 21 out of 24 respondents shared their perception of an increase in violence against women and girls since the beginning of the EVD outbreak. They named the top three risks to women and girls as sexual violence (19), domestic violence (18) and "aggression outside their communities" (18). Graphic 1 on page 7 illustrates FGD perceptions of the types of violence that women and girls face, both before and during EVD. Table 2, on page 7, highlights key informant responses to the question on the most significant safety concerns of violence for women and girls.

During the IRC assessment, participants raised commercial sexual exploitation, and sexual exploitation and abuse of women and girls as concerns.¹⁰ The IRC did not explicitly ask a question regarding these types of violence. When speaking to commercial sexual exploitation (4 FGD), it was not always clear that this represented a change since the EVD outbreak; these responses may also refer to the prior context. When speaking to SEA (5 FGD, 3 KII), FGD participants were responding to a question regarding barriers to accessing EVD-related services; KIIs were responding to a question regarding types of violence women and girls experience both before and during the EVD outbreak.

When asked what women and girls do to meet basic needs, 23 out of 24 key informants interviewed said that women and girls move outside their communities to earn income. Fifteen of 24 key informants also said here that women and girls face commercial sexual exploitation, or the exchange of sex for money, to help meet basic personal and household needs. Nineteen of 24 key informants said that women and girls do housework; lesser numbers said that they collect wood (10) and beg (8).

¹⁰ FGD participants and KIIs spoke to general trends. They did not report specific incidents.

Graphic 1¹¹

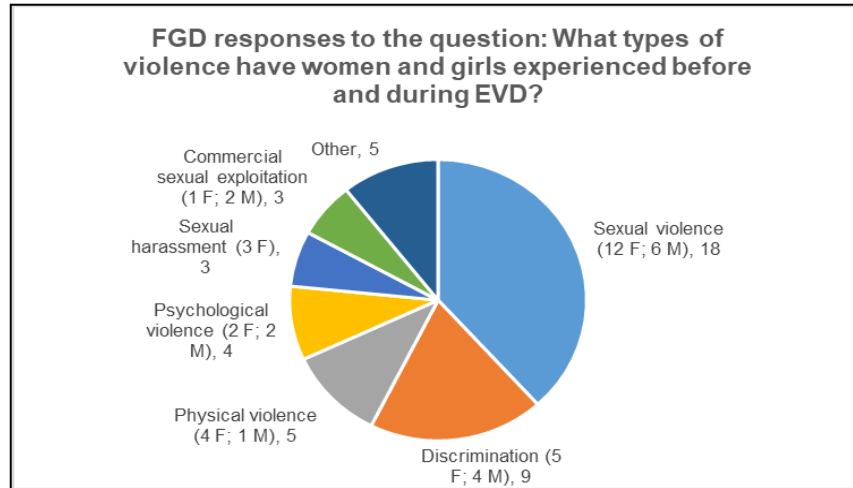
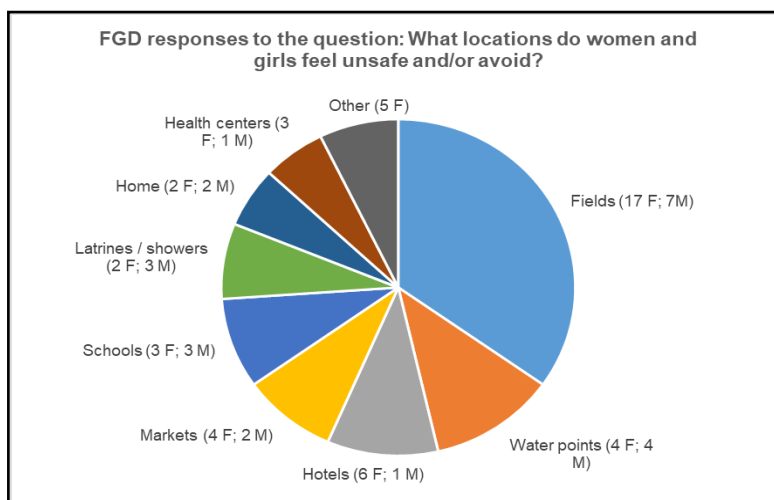


Table 2: Safety concerns for women and girls according to KII

Concern	Yes, an issue of concern.		No, not an issue of concern.	
	Male KII (n=8)	Female KII (n=16)	Male KII (n=8)	Female KII (n=16)
Lack of safe places in the community	4	8	4	8
Sexual violence	6	13	2	3
Domestic violence	5	13	3	3
Risk of aggression/violence outside of the community	4	14	4	2
Risk of aggression/violence in public spaces (e.g., markets, latrines, etc.)	3	5	6	9
Lack of access to services and resources	2	7	6	11
Arranged marriage	4	6	4	10
Human trafficking	0	2	8	14



Graphic 2

¹¹ The IRC's data cannot provide detail on the extent to which trends have changed since the beginning of the EVD outbreak.

When asked about locations that present safety and security concerns for women and girls, both FGDs and key informants highlighted risks when moving outside the immediate community, and particularly when working in the fields. Graphic 2 on page 7 highlights places that FGDs said are unsafe for women and girls, and includes a gender breakdown of the responding FGDs.

Access to EVD-related services

When asked whether EVD-related services are available to the entire community, 14 FGDs said yes, seven FGDs said there were some limitations or barriers, and 13 FGDs said no. FGD participants listed those without financial means or unemployed (11), pregnant and lactating women (6), and women and girls more broadly (3) as not able to access some EVD-related services.

FGD participants most often cited lack of information (13) or misinformation about EVD (10) as barriers to women and girls accessing EVD-related services. Other key barriers included lack of financial means (9), being pregnant or breastfeeding (9), or lacking permission from husbands or parents (9).

As noted above in the section on violence against women and girls, a few FGDs (5) also raised concerns about sexual exploitation and abuse when asked what barriers women and girls face in accessing EVD-related services. At the same time, when the IRC asked key informants which EVD-related services women and girls *do* feel safe accessing, 13 said health services. Similarly, 13 key informants said that there is a psychosocial response available for women and girls affected by EVD.

The 24 key informants interviewed said that most often a woman impacted by EVD will reach out to a family member (18) for support. Others stated that she will seek help from a friend (7), a health center or health worker (4), a community leader (4) or an NGO working on EVD response (4).

“It’s difficult to name dangerous places for girls, because every place is dangerous.

Girls are pretty much raped everywhere.”

-FGD, girls 16-18 years old

Access to GBV response services

A majority of key informants the IRC spoke with stated that psychosocial support services and referral mechanisms exist for survivors of GBV and women impacted by EVD (15). However, when asked to indicate what types of services are available, only five informants stated there are mental health services, less than half stated that GBV case management services are available (11), and none of the key informants said that survivors have access to formal group-based psychosocial support.

Nine out of 24 key informants said that health services are accessible to women and girls who experience violence. When asked why women and girls are unable to access GBV response services, most key informants said lack of confidentiality of the services and fear of being identified as a survivor (20). Seventeen key informants cited the same reason for women and girls being unable to access psychosocial support services.

Eighteen FGDs said that there are focal points or other trusted individuals that women and girls can trust if they experience violence. Seemingly contradicting this, in 18 FGDs, participants

also said that women and girls cannot trust these individuals or seek their support safely. The reasons most often cited for this were lack of confidentiality (16), fear of reject, blame, or humiliation (3), and lack of information (3). When asked where survivors of GBV do seek help, 29 FGDs said hospitals or health centers; nine said non-governmental organizations; eight said authorities, police or legal actors; seven said the church; and seven said psychosocial assistants or centers.

Nineteen FGDs said that family attitude towards survivors of GBV are mostly negative, explaining that if a survivor comes forward her family will blame, stigmatize, or send her away. Ten FGDs also said families also take the survivor to seek health services; in two cases the FGD reflected both of these actions simultaneously – blame the survivor but also take her to seek health services.

Discussion

The data collected and outlined in this report points to important risks and challenges for women and girls in this particular response to EVD. The IRC also recognizes that many of these findings echo retrospective studies done regarding the 2014 EVD epidemic in West Africa, making them part of a larger trend seen for women and girls during disease outbreak.¹² Critically, humanitarian actors waited until the spread of the virus had slowed in West Africa before focusing on women and girls. By then, there had already been increases in sexual violence and severe consequences for many women and girls.¹³ The onus is on the humanitarian community to ensure that this pattern does not keep repeating. With that in mind, critical findings for discussion here include:

Women and adolescent girls are primary caretakers for the sick and are responsible for hygiene practice in the home. As documented in West Africa, gender norms dictate that women and adolescent girls are also typically not in a position to refuse sex or negotiate condom use with their male partners. In all EVD outbreaks, these factors can put women and girls at high risk of exposure to bodily fluids that transmit the disease.

At the same time, pre-existing gender norms mean that EVD-related changes in daily tasks – the need to collect increased amounts of water and firewood, and the need to provide for the family when a head-of-household falls ill, for example – put women and girls at increased risk of violence, exploitation and abuse.

Water collection falls largely to adolescent girls and during the EVD outbreak has required more time on roads and at water points, exposing girls to elevated risks of sexual violence and other forms of gender-based violence. Similarly, locations required for other household and income-generating tasks (markets, fields, etc.) are considered by the community as unsafe for women and girls. “Some girls are even sent to water points when it is totally dark,” said one adolescent girl. “It is very scary.”

¹² Are We There Yet? Progress and challenges in ensuring life-saving services and reducing risks to violence for women and girls in emergencies, September 2015, pages 17-19.

<https://www.rescue.org/sites/default/files/document/664/ircarewethereyetwebfinalukspell.pdf>

¹³ D.A. Schwartz et al. (eds.) *Pregnant in the Time of Ebola*. (2019) Adhiambo Onyango, M., & Resnick, K., & Davis, A., & Ramesh Shah, R. “Gender-based violence among adolescent girls and young women: A neglected consequence of the West African Ebola outbreak,” pages 121-132.

Despite acknowledgement of these risks across FGDs, women and girls remain largely responsible for household tasks. This echoes findings in West Africa in 2015, where that primary household responsibilities were recognized as a risk factor for exploitation and sexual violence.¹⁴

Within this IRC assessment, focus groups and key informant interviews also drew attention to risks of commercial sexual exploitation (e.g., the exchange of cash for sex) and sexual exploitation and abuse in the response itself. The fact that FGD participants and key informants – both female and male – volunteered concerns about various types of sexual exploitation is telling, as this is often a taboo topic and is challenging to address in research.

The lack of effective prevention and response to sexual exploitation and abuse by humanitarian actors remains a gap in humanitarian action, despite global commitments, policies and program guidance. Implementation of community based complaints mechanisms; ensuring access to quality GBV response services, including for survivors of SEA; and resourcing adequate investigation capacity to hold perpetrators to account are all often missing in the first phase of humanitarian response. This delay in action allows the concerns of the local community, as captured in this report, to go unaddressed.

Recommendations

Pre-existing gender norms and gender inequality translated into increased risks of both infection and of violence for women and girls during disease outbreak. Where women and girls have been invisible in previous international responses to EVD epidemic and other outbreaks, the humanitarian community in eastern DRC documented specific issues for women and girls in the current response to EVD¹⁵ and took initial steps to build a more protective response by deploying experts to scale GBV programming. Despite this progress, it is imperative that the humanitarian community continue to gather learning and improve how it listens to and reaches women and girls with information, services and support related to EVD prevention and response. Similarly, the humanitarian community must recognize and act rapidly to meet the need for stronger GBV services and outreach during all emergencies, including outbreak response.

The IRC is making the following recommendations based on the findings of this report, and will be working with partners and stakeholders across the EVD response in DRC and at the global level to support collaborative, responsive action:

1. Strengthen women and girls' meaningful participation in decision-making processes during humanitarian action to address EVD.

Humanitarian programming should meet the specific needs of women and girls and be informed by an understanding of the gendered inequalities and harmful norms which act as barriers to their equal access to humanitarian services. To ensure humanitarian response is responsive to local gender inequalities, women and girls should be meaningfully engaged from the beginning of a humanitarian crisis in needs assessments, the design and monitoring of

¹⁴ D.A. Schwartz et al. (eds.) *Pregnant in the Time of Ebola*. (2019) Adhiambo Onyango, M., & Resnick, K., & Davis, A., & Ramesh Shah, R. "Gender-based violence among adolescent girls and young women: A neglected consequence of the West African Ebola outbreak," pages 121-132.

¹⁵ Oxfam, Crucial course corrections for the Ebola response in Beni, DRC, 3 October 2018.

humanitarian response. Ensuring that women and girls' feedback and guidance ensures globally recommended actions to promote GBV risk mitigation, including prevention of sexual exploitation and abuse, is informed by the local realities of women and girls' lives.

2. Develop communication and prevention strategies that are informed by and specific to women and girls.

Women and adolescent girls' increased domestic responsibilities, more limited freedom of movement, and different ways of accessing information require that humanitarian actors target women and girls with a specific communication and prevention strategy. Given women and girls' key role in caring for the sick and household hygiene practices, targeted prevention efforts to reach women and girls at home and at water points are critical to ending the spread of EVD.

3. Prioritize and resource protection and specialized psychosocial support services for GBV survivors early in outbreak response.

Communities report perceived increase in violence against women and girls during the current EVD outbreak in DRC. Increased prevalence of GBV in humanitarian crisis is frequently reported by women and girls and has recently been documented in ground breaking prevalence research.¹⁶ Learning from Sierra Leone and Liberia also demonstrates that a gap in GBV response services during disease outbreak is connected to increases in GBV, in particular the rising rate of sexual violence against adolescent girls and resulting increase in teenage pregnancy. Access to community based psychosocial support through local women's groups and women-led community based organizations has successfully brought GBV response services within reach of women and girls in rural DRC and ensures prevention and response efforts addressing GBV are community owned and led by women and girls. This must be reinforced and resourced in the current environment.

Further, the humanitarian community must invest in laying better groundwork – tools, guidance and funding – to ensure that protection response and specialized GBV response services are put in place concurrently with other outbreak response in future.

4. Develop action plans to integrate the specific needs of women and adolescent girls in each response.

In accordance with the IASC Gender Equality Policy and Accountability Framework and the IASC GBV Guidelines,¹⁷ each sector across the humanitarian response should integrate within their humanitarian response plans key actions to address the specific needs of women and adolescent girls in each crisis. Informed by local assessments led by women and girls, action planning should ensure equitable and safe access to humanitarian services and adjust activities in light of local barriers to access. In the current context in DRC, attention to these global standards should be built into the strategies of the commissions, to ensure that EVD response actors are safely and appropriately meeting the needs of women and girls.

¹⁶ No Safe Place: A Lifetime of Violence for Conflict-Affected Women and Girls in South Sudan (2017), The IRC, Global Women's Institute, et al <https://gbvresponders.org/wp-content/uploads/2017/11/What-Works-South-Sudan-Full-Report.pdf>

¹⁷ See: <https://interagencystandingcommittee.org/gender-and-humanitarian-action/documents-public/iasc-policy-gender-equality-and-empowerment-women> and <http://gbvguidelines.org/>.

5. Continue existing momentum and efforts within DRC and at the global level to protect against sexual exploitation and abuse in humanitarian settings.

The humanitarian community in DRC, and specifically in Beni, has taken important steps toward the prevention of SEA. The IRC applauds the launch of a PSEA initiative specifically for Beni in August 2018, which was followed by action planning, training, and the establishment of a reporting hotline. Similarly, the Ministry of Health has established a free hotline for reporting concerns about SEA, continues to remind the population that all EVD-related services are entirely free, and has established professional response recruitment criteria to prevent sexual exploitation linked to employment in the response.

While these measures are extremely positive, the humanitarian community must further strengthen its prevention and response efforts. This requires continued priority and resourcing of PSEA efforts, zero tolerance for perpetrators of SEA, ensuring equal access to all humanitarian goods and services for women and girls, and the establishment of safe, confidential, accountable support services when they experience sexual harassment, exploitation and abuse.