RESEARCH SNAPSHOT

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Rapid evidence for community-centred Ebola response

This operational study demonstrates that community evidence can be produced rapidly within ongoing response. Once deployed, a pre-standing protocol delivered results within 4 weeks, including co-developed recommendations and community feedback.

A rapid assessment protocol speeds up community evidence to inform response

During the 2025 Ebola outbreak in Kasai, the Democratic Republic of the Congo (DRC), national teams adapted a pre-standing, interagency rapid assessment protocol for community protection to rapidly generate community evidence and co-develop recommendations with response actors and communities. This work demonstrates the value of investing in community evidence systems as a core function of outbreak preparedness.

Focus Group discussion with market women, Mweka health zone, DRC. Credit: Eric Tshiongo

Background

Effective outbreak control depends on how communities perceive risk, maintain social cohesion, access care, and engage with response interventions. Yet most health emergency systems lack mechanisms to generate timely evidence on these factors. On 4 September 2025, an Ebola outbreak was declared in Kasai province, DRC - a region with no Ebola transmission since 2007. Community evidence was needed to inform the public health response.

How the research was conducted

A rapid assessment for community protection was implemented across four affected health zones in Kasai province (26-30 November 2025). Using rapid qualitative methods, national field teams conducted 38 focus groups and 40 key informant interviews involving 270 community members. Priority recommendations were co-developed with response teams and validated with 165 community members.

Key findings

• Knowledge of Ebola was high, yet rumours and misconceptions about its origin and transmission persisted (e.g. sorcery, political motives, spiritual attacks).

• Ebola information was perceived as trustworthy, supporting uptake of protective measures. Traditional chiefs, religious leaders, teachers and health workers were central to communication and engagement.

• Stigma towards survivors and affected families remained widespread, affecting reintegration.

• Communities initiated self-protection strategies: restricting movements and public gatherings, while initiating prayers and cleansing rituals.

• Free healthcare and the availability of ambulance transport improved timely care-seeking.

• Vaccine demand was strong, despite concerns about side effects (e.g. infertility, death) and misinformation.

• Over time, reported adherence to protective measures declined, related, in part, to economic pressures (e.g. livelihoods, food insecurity).

Implications for humanitarian practitioners and policymakers

Community-centred response requires sustained engagement with affected populations and the active involvement of local trusted actors in response planning and coordination. Clear, consistent information and accessible services support uptake of public health measures. Addressing stigma, social exclusion, and wider economic impacts is critical for equitable response and recovery.

This operational study demonstrates that community evidence can be produced rapidly within ongoing response. Once deployed, a pre-standing protocol delivered results within 4 weeks, including co-developed recommendations and community feedback.

Ten recommendations were co-developed including: implementing integrated, community-based survivor support to address stigma; ensuring continuous, supporting community networks and actors in strengthening social cohesion, and strengthening their role in public health planning and response; and taking multi-sectoral approaches to reduce care barriers.

While the research cycle was rapid, administrative (e.g., contracting) and logistical (e.g., field access) bottlenecks delayed initial deployment. This highlights the need to invest in community evidence systems and capacity as a core function of health emergency preparedness.

Recommendations for future research

Future research should examine how nationally led, co-developed approaches to community evidence generation can be adapted and scaled across diverse outbreak settings and inter-outbreak periods, with a focus on what enables evidence use within health emergency preparedness and response architecture from the earliest stages of an emergency.

About the study team

This rapid assessment was nationally led and embedded within the Ebola response coordination system in DRC. Principal investigators in DRC were Professor Bien-Aimé Mandja (University of Kinshasa), Dr Pierette Mubadi (National Public Health Institute) and Deogracias Kakule (World Health Organization). Local teams from the communication task force in Bulape, coordinated through the research pillar of the response, implemented the study. At global level, it was led by Dr. Nina Gobat from the Community Protection and Resilience Unit, WHO's Health Emergencies program.

Keywords

Community Protection, rapid qualitative methods, Ebola, interagency reference protocol, health emergencies, social and behavioural science, community evidence

Articles and further reading

Elrha study page: https://www.elrha.org/projects/communities-at-the-center-of-mpox-and-ebola-emergency-responses-driving-local-level-impact-through-social-and-behavioural-science

World Health Organization, International Federation of Red Cross and Red Crescent Societies, United Nations Children's Fund. Rapid assessment for community protection in health emergencies. Geneva; 2026. https://iris.who.int/handle/10665/385098

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http://www.elrha.org/programme/research-for-health-in-humanitarian-crises/