Ebola response and violence in the Beni and Butembo regions of the Democratic Republic of Congo

A learning paper on the 2018–2020 Kivu Ebola epidemic

RESEARCH SUMMARY: November 2020

Summary

International Alert, along with consortium partners Mercy Corps, Oxfam, CARE International and the Collectif des radios et télévisions communautaires du Nord-Kivu (CORACOM), implemented the project, 'Lutter Contre Ebola via des Communautés Redynamisées' (LEVER) between November 2019 and October 2020, in technical partnership with Viamo and Domagi, and with funding from USAID/OFDA.

As part of this project, a study was commissioned to identify lessons from the Ebola response in the Beni and Butembo regions of the Democratic Republic of Congo. The study found that a series of social factors and shortcomings in community engagement, combined with pre-existing structural factors, have undermined the effectiveness of the Ebola response, limited the take-up of public health measures and, in some cases, led to violent incidents perpetrated against Ebola response workers.

This paper summarises the report's findings and recommendations, and it identifies key lessons to be learned for future responses to epidemics.

Background

The Kivu Ebola epidemic officially began on 1 August 2018, when four cases of the Ebola virus disease (EVD) were confirmed in the eastern region of Kivu in the Democratic Republic of Congo (DRC). By 21 January 2020, 3,416 cases had been reported and 2,238 people had died of the disease. The number of confirmed cases started to decrease on 15 September 2019 and the outbreak officially ended on 25 June 2020.

During this period, the epidemic reached the South Kivu, North Kivu and Ituri provinces of DRC, an area already affected by insecurity and with a public health system hardly coping with the effects of a chronic humanitarian crisis. A series of social, cultural and political factors prevented the epidemic from being effectively controlled and managed by the DRC government, the World Health Organization (WHO), and local and international partners.

Among the issues faced was that from the onset, the Ebola response was affected by violence: Ebola response workers not only had to deal with ongoing conflict dynamics, but also acts of violence targeted directly at them.[1]

The learning paper, written by independent consultant Patient Keedja and finalised in July 2020, looks at the relationship between the Ebola response and violence in the areas of Beni and Butembo. The paper looks at how the Ebola response interacted with existing conflict dynamics which led, in some cases, to violent incidents.

Findings

The study explored the questions below. Here, we provide findings for each of these questions, followed by a summary of the main factors that played a role in fuelling violence in North Kivu and Ituri in the context of the Ebola response.

- What are the knowledge gaps of communities on EVD and methods for its control and prevention? How can these lead to health risks and fuel conflicts among local communities?

The study found that communities, at the time of the study in July 2020, had good knowledge on EVD and methods for its control and prevention. This had not been sufficient to limit the spread of EVD however. Looking at data from previous studies, the study concluded that knowledge gaps had been identified between June and August 2019, but that there had been a good progression in the level of knowledge of communities on EVD and methods for its control and prevention by July 2020. This lag can explain some of the limits of the response. The study also found that beyond knowledge gaps, limited implementation of the known methods for the control and prevention of EVD could have led to health risks among local communities. The study concluded that the limited take-up and implementation of these methods were mostly linked to sociological factors, rather than knowledge gaps. Beliefs and perceptions around the existence of EVD, rather than knowledge gaps could have fuelled conflicts however (see next questions).

- What are the perceptions/opinions of the communities on EVD and approaches for its control and prevention? How can these perceptions become health risks and fuel conflicts among local communities?

The study found that 24% of respondents did not believe EVD existed or had existed. More than half of these thought the existence of EVD was a rumour, which was reinforced by actual rumours, that were strongly believed by some of the respondents: for instance that EVD had been invented by people for making profit from the most vulnerable. Other studies concluded similarly. Rumours around EVD included hidden agendas by a powerful elite, organ trafficking, regional destabilisation, genocide against the Nande. Perceptions that EVD does not exist can represent significant health risks. The perception that EVD has been invented by a specific group of people against others can generate conflict.

- What are the behaviours/practices that have been the basis of the refusal and trivialisation of the danger of EVD? What behaviours/practices have contributed to the acceptance of EVD response interventions by communities? What influenced this change in behaviour/practices from trivialising EVD to acceptance of response interventions?

[1] The WHO reported that 11 response workers have been killed in more than 400 attacks since the outbreak began in August 2018.

The study found that 43% of respondents were hostile to vaccination. 77% of respondents were unwilling to get treated at the Ebola treatment centres because they thought most people who went there did not come out alive, and for the same reason, 50% of respondents said they would not report suspected cases and direct them to a treatment centre. The study suggests that behaviours that did not take sufficiently into account misinformation and mistrust limited the take up of measures to prevent and limit the spread of EVD, rather than it being about its trivialisation. The behaviours/practices that did contribute to the acceptance of EVD response interventions by communities on the other hand were community responses, community dialogue, valuing local labour force, and implementing accountability mechanisms, which all contribute to increased trust and limit rumours.

- What acts of violence have communities perpetrated against response teams? What are the reasons that motivated the violent acts of the communities on the response teams? What was the impact on the response of the violent acts that the communities perpetrated against the response teams?

The study found that acts of violence were perpetrated against response teams. The reasons that motivated these acts of violence included the lack of respect of funeral rites, beliefs that the response teams were agents acting against the interest of communities or of a specific group – this was linked in some cases to the politicisation of the response, or the belief that EVD was a profit-making system. Incidents of violence contributed to the militarisation of the response, which in turn contributed further to the believe that violence was justified.

- What lessons have been learned from communities and response teams, such as around EVD response interventions? How can these lessons be used in future response interventions to EVD and other similar disasters in a peaceful manner? How can these learnings serve as lessons in conflict sensitivity in future response interventions?

The lessons that have been identified by the report are taken up in the recommendations below.
In summary, the study found that the following factors played a role in fuelling violence within the context of the Ebola response:

- **Insecurity due to military operations against armed groups:** Military operations by the Congolese army (FARDC) against armed groups[2] have been ongoing during the last five years. These military operations have not been effective in preventing massacres of civilian populations, which have been recurrent since 2014, including during the Ebola epidemic, leading to the displacement of thousands of civilians. This has affected the confidence of the population in the political regime in Kinshasa and their willingness to bring the conflict to an end. Lack of trust in the government has, in turn, fuelled suspicion that the government and local authorities were somehow benefiting from the epidemic, with survey respondents and key informants repeatedly using the phrase “Ebola business”. This significantly undermined the take-up of public health messages and measures.

- **The electoral political context:** The Beni, Butembo and Lubero areas have long resisted the power of outgoing President Joseph Kabila. During the period preceding the 2018 presidential and legislative elections, communities and civil society remained supportive of the opposition. Because of the epidemic, however, the elections in Beni and Butembo were delayed until 31 March 2019. This was perceived as a direct attack

[2] For example, the Democratic Forces for the Liberation of Rwanda (FDLR), Nduma Defense of Congo (NDC), Alliance of Patriots for a Free and Sovereign Congo (APCLS), Nyatura, Mai-Mai Mazembe and Mai-Mai Corps du Christ.

on democratic principles and processes. It also contributed to suspicion of the government, further fuelled the “Ebola business” rumours, and was seen by the Nande populations as a plot by the government directed against them.

- **Cultural beliefs and behaviours:** The practice of ancestral burial and burial rites is widespread in Beni and Butembo. This practice has been shown to fuel massive explosions of new cases of EVD in that area, as was the case in other parts of DRC and Africa during previous epidemics. This was further exacerbated by how close-knit communities and family networks are in the area, with a culture that advocates compassionate care for the sick and ceremonial care for their bodies if they die. The relationship between communities and Ebola response workers, who often did not come from the area, was partly defined within the frame of this culture war, where ancestral burials and caring for the sick was now forbidden.

- **Confidence in traditional healers:** Traditional medicine has a long history in DRC, especially among the Nande people. Even before the outbreaks, insufficient access to public health training made traditional medicine and self-medication through pharmacies the most widely used healthcare option by a significant part of the population, especially the economically vulnerable. In parallel, a perception that Ebola treatment centres and other care facilities were places of contagion and death led to people continuing to seek advice and medicine from traditional healers. Despite the fact that many waves of new cases have been found to be related to contact with a traditional healer or herbalist, or participation in their funerals, the trust in traditional medicine and suspicions of the Ebola treatment centres undermined the effectiveness of the response.

- **Community resistance and mistrust of response teams:** At the start of the epidemic, the response was mainly carried out by qualified people with previous experience of treating Ebola outbreaks, coming from abroad or Congolese not living in the areas affected by the epidemic. EVD was also perceived as an unknown, foreign, new disease, introduced into the community to exterminate the Nande people and enrich humanitarian and government actors. This led to a large number of people in the communities refusing to believe that Ebola was real. One justification reported by the study was that people and their ancestors lived in the same ecological environment for centuries, hunting the same wild animals in the same forests, and had never known a disease like Ebola. As a result, there was resistance and mistrust of Ebola response teams, which significantly undermined the effectiveness of the response.

- **Community participation of trusted expertise:** At the onset of the epidemic, emergency response relied on qualified people with previous experience of treating Ebola outbreaks, rather than on local capacity. However, there were infrastructures and actors who work in the health sector, control diseases, vaccinate populations, raise awareness of health problems and, most importantly, have credibility locally and the trust of community members. The side-lining of those who already had the public's trust led to incredibly limited community ownership of the response actions. Local civil society leaders, customary and administrative authorities, religious leaders, local youth and others also spoke out about not being sufficiently involved in the response and that the local workforce did not have a prominent place in local interventions early in the response.

Overall, the association of EVD with foreign assistance, combined with rumours of plots targeting the Nande, suspicion of the government, the perception of an attack on traditional and ancestral local culture, and lack of trust in Ebola response workers and Ebola response centres, supported by narratives of hidden interests in the “Ebola business” rumours, all

contributed to a lack of trust in and resistance to the Ebola response, which within the context of ongoing armed conflict, led in some cases, to incidents of violence.

Conclusion and recommendations

The study identifies key factors that limited the effectiveness of the Ebola response. These included negative perceptions by communities because of:

- the spread of rumours and misinformation linked to the politicisation of the response;
- information and knowledge gaps due to the lack of clear communication on the epidemic; and
- practices that were seen as hostile by communities.

These factors constituted serious obstacles to the response and were the basis of violence within the communities.

The fact that communities felt they were not sufficiently involved in response interventions exacerbated communities' mistrust of Ebola response teams, which significantly hampered efforts to reduce the transmission of a disease, that part of the population didn't believe existed. Gaining the trust of the community requires greater transparency regarding the flow of money (locally, nationally and internationally) and who is involved in the response and why. Communities are also calling for further clarification of decision-making procedures involving local authorities, doctors and health workers.

More communities, especially community and opinion leaders, will need to be engaged so that they in turn can engage local populations by liaising between the response team and the people. Dignified and safe burial practices have divided the community response team, but community dialogue could allow the health workers and community members to find common ground. The response should remain participatory, inclusive, transparent and sensitive to gender and conflict.

To conclude, the study looked at the practices that should be followed and provided the following recommendations:

- increased information sharing on the Ebola response, including through communication by trusted influencers;
- increased community engagement and participation by Ebola response actors, supported by local leaders and influential stakeholders, through community dialogue processes, townhall meetings and existing civil society structures;
- systematic use of community dialogue to discuss funeral rituals and come to a viable compromise that will not alienate community members;
- the set-up and use of effective feedback and complaint mechanisms;
- increased capacity building and coaching to be more inclusive of local capacity and infrastructure;
- increased reliance on basic hygiene measures that communities are familiar with and emphasis on prevention;
- increased transparency in the identification of response teams and in the origin and allocation of funds;
- response strategies that take into account the social, cultural, political and security context of intervention areas, based on regular analysis of the socio-security context;
- offering free medical support and compensation for the material that is incinerated to prevent the spread of the virus; and
- support to survivors to reduce stigma and facilitate their reintegration within their communities.