Almost six months after the declaration of the Ebola epidemic in northeastern Democratic Republic of Congo (DRC), response teams on the ground, including Médecins Sans Frontières (MSF), are still struggling to gain control of the outbreak. So far, 619 people have been infected with the virus and 361 have died in what is the second-largest Ebola outbreak ever recorded since the virus was discovered in the country in 1976.

Unrest diminishes access to healthcare

As the number of new confirmed Ebola cases keeps growing, a heightened climate of unrest linked to the recent presidential elections has further restricted the population's access to health care in and around the city of Beni. Several health centres in the city were damaged during protests. This is making the prompt identification of new Ebola cases more challenging, as remaining health centres become overloaded.

"In this situation people might have no other choice than to seek medical help in health facilities that do not have adequate triage or infection prevention and control measures in place, which makes the risk of contamination higher," says Laurence Sailly, MSF emergency coordinator in Beni. "We are talking about a population that has endured many years of conflict. On top of that, they are now faced with the deadliest Ebola outbreak DRC has ever seen. The unrest of these past few weeks adds even more to their plight by limiting their chances of finding adequate medical care."

MSF expands Ebola outbreak response

Since the outbreak was declared on 1 August 2018, MSF has been steadily scaling up patient care activities to respond to the needs of people affected by the epidemic.

Summary

Democratic Republic of Congo (DRC) declared their tenth outbreak of Ebola in 40 years on 1 August 2018. The outbreak is centred in the northeast of the country, in North Kivu and Ituri provinces, with cases also now appearing in South Kivu. With the number of cases having surpassed 3,000, it is now by far the country's largest-ever Ebola outbreak. It is also the second-biggest Ebola epidemic ever recorded, behind the West Africa outbreak of 2014-2016.

During the first eight months of the epidemic, until March 2019, more than 1,000 cases of Ebola were reported in the affected region. However, between April and June 2019, this number doubled, with a further 1,000 new cases reported in just those three months. Between early June and the beginning of August, the number of new cases notified per week was high, and averaged between 75 and 100 each week; since August, this rate has been slowly declining, with just 70 cases identified throughout all of October.

Latest figures - information as of 22 November 2019; figures provided by DRC Ministry of Health via WHO.

While there are positive signs that the number of cases is slowly reducing, the outbreak remains a serious public health concern, and it is unclear when it may end.
Although the proportion of new Ebola cases previously identified and monitored as contacts has increased in the last three months, the rate is still hovering at around one-third. However, 40 per cent of new Ebola cases were never registered as contacts, showing that identifying and following up contacts of people diagnosed with Ebola remains difficult. Reasons include the movement of people (such as in the case of motorbike taxi drivers), to downright fear in some communities which hinders engagement.

New Ebola patients are confirmed and isolated with an average delay of five days after showing symptoms, during which time they are both infectious to others and miss the benefit of receiving early treatments with a higher chance of survival.

On 11 June 2019, Uganda announced that three people had been positively diagnosed with Ebola, the first cross-border cases since the outbreak began. After several weeks with no recorded cases, the Ugandan government announced a new case on 29 August; the patient, a young girl, sadly died.

On 14 July 2019, the first case of Ebola was confirmed in Goma, the capital of North Kivu, and a city of one million people. The patient, who had travelled from Butembo to Goma, was admitted to the MSF-supported Ebola Treatment Centre in Goma. After confirmation of lab results, the Ministry of Health decided to transfer the patient to Butembo on 15 July, where the patient died the following day. On 30 July, a second person in Goma was diagnosed with Ebola; they died the next day and two more cases were announced.

No new cases have since been recorded in either Uganda or in Goma.

In reaction to the first case found in Goma, on 17 July 2019, the World Health Organization (WHO) announced that the current Ebola outbreak in DR Congo represents a public health emergency of international concern (PHEIC).

In mid-August, the epidemic spread to neighbouring South Kivu province - becoming the third province in DRC to record cases in this outbreak - when a number of people became sick in Mwenga, 100 kilometres from Bukavu, the capital of the province.

Given the ongoing challenges in responding to the outbreak, MSF believes that Ebola-related activities should be integrated into the existing healthcare system, in order to improve proximity of the services to the community and ensure that it remains functional during the outbreak.

**Background of the epidemic**

Retrospective investigations point to a possible start of the outbreak back in May 2018 – around the same time as the Equateur outbreak earlier in the year - although the outbreak wasn’t declared until August. There is no connection or link between the two outbreaks.

The delay in the alert and subsequent response can be attributed to several factors, including a breakdown of the surveillance system due to the security context (there are limitations on movement, and access is difficult), and a strike by the health workers of the area which began in May, due to non-payment of salaries.
A person died at home after presenting symptoms of haemorrhagic fever. Family members of that person developed the same symptoms and also died. A joint Ministry of Health/World Health Organization (WHO) investigation on site found six more suspect cases, of which four tested positive. This result led to the declaration of the outbreak.

The national laboratory (INRB) confirmed on 7 August 2018 that the current outbreak is of the Zaire Ebola virus, the most deadly strain and the same one that affected West Africa during the 2014-2016 outbreak. Zaire Ebola was also the virus found in the outbreak in Equateur province, in western DRC earlier in 2018, although a different strain than the one affecting the current outbreak.

First declared in Mangina, a small town of 40,000 people in northern North Kivu province, the epicentre of the outbreak appeared to progressively move towards the south, first to the larger city of Beni, with approximately 400,000 people and the administrative centre of the region. As population movements are very common, the epidemic continued south to the bigger city of Butembo, a trading hub. Nearby Katwa became a new hotspot near the end of 2018 and cases had been found further south, in the Kanya area. Meanwhile, sporadic cases also appeared in neighbouring Ituri province to the north.

Overall, the geographic spread of the epidemic appears to be unpredictable, with scattered small clusters potentially occurring anywhere in the region. This pattern, along with the lack of visibility on the epidemiological situation, and the risk of flareups in former hotspots, is both extremely worrying and makes ending the outbreak even more challenging.
Area

Located in northeastern DRC, North Kivu province is a densely-populated area with approximately 7 million people, of whom more than 1 million are in Goma, the capital, and about 800,000 in Butembo. Despite the rough topography and the bad roads in the region, the population is very mobile.

North Kivu shares a border with Uganda to the east (Beni and Butembo are approximately 100 kilometres from the border). This area sees a lot of trade, but also trafficking, including ‘illegal’ crossings. Some communities live on both sides of the border, meaning that it is quite common for people to cross the border to visit relatives or trade goods at the market on the other side.

The province is also well-known for being an area of conflict for over 25 years, with more than 100 armed groups estimated to be active. Criminal activity, such as kidnappings, are relatively common and skirmishes between armed groups occur regularly across the whole area.

Widespread violence has caused population displacement and made some areas in the region quite difficult to access. While most of the urban areas are relatively less exposed to the conflict, attacks and explosions have nonetheless taken place in Beni, an administrative centre of the region, sometimes imposing limitations on our ability to run our operations.

Cases have also been confirmed in North Kivu’s neighbouring provinces, Ituri to the north and, more recently, South Kivu.
Existing MSF presence in the area

MSF has had projects in North Kivu since 2006. Today, we have regular projects along the Goma-Beni axe as follows:

- Bambu-Kiribizi: Two teams support local emergency room and paediatric and malnutrition in-patient departments, plus care and treatment of sexual and gender-based violence.
- Rutshuru hospital: MSF withdrew from the hospital at the end of 2017. However, in light of the volatile conditions in the region, we have returned to support emergency room, emergency surgery and paediatric nutrition programmes.
• Goma: HIV programme supporting four medical centres (including access to antiretroviral treatment).

![Image](https://www.msf.org/drc-ebola-outbreak-crisis-update)

**Current situation**

Across a total of 47 health zones across Ituri and North Kivu provinces, 28 have reported cases of Ebola. Of these 28, nine are considered active transmission zones, meaning that they had notified new confirmed cases in the last month (21 days being the maximum incubation period for the Ebola virus). Of these nine, most are located in Biakato (Ituri), Mangina and Beni (North Kivu), which are the current hotspots - Beni, a previous hotspot, experienced a resurgence of cases in late October. South Kivu has recently recorded cases in Mwenga health zone, becoming the third province in DRC to be affected in the current outbreak.

The first case of Ebola in Goma, a city of 1 million people, was reported on 14 July; while a few more cases were found, the city has not recorded any new cases in more than 42 days (twice the maximum incubation period for the disease).

WHO has declared the outbreak to be a Public Health Emergency of International Concern (PHEIC).

We have new tools and improvements in the medical management of this epidemic, compared to previous Ebola epidemics, such as new developmental treatments; a vaccine that has given indications of being effective; Ebola treatment centres are more open and accessible for the families of patients; and provision of a higher level of supportive care.

Despite this, there is a 67 per cent case fatality rate in the current outbreak. More than a year into the epidemic, the situation in the Ebola-affected areas of DRC has not improved and the number of Ebola cases continues to increase: over 3,000 cases and more than 2,000 deaths have been reported to date.
Many people continue to die in the community – either at home or in general healthcare facilities – and nearly half of new confirmed cases cannot be traced to an existing contact with Ebola.

COMMUNITY MISTRUST ANDAttacks on Responders

The response has been marked by community mistrust towards the response; attacks on our Ebola Treatment Centres (ETCs) in Katwa and Butembo in February 2019 led us to withdraw from running these centres.

The mistrust and violent attacks against the Ebola response show no signs of abating; as recently as early November, a radio journalist, Papy Mumbere Mahamba, was killed in Lwemba, Ituri province, reportedly for his involvement in the response. Also in Lwemba, violence was reported and around 30 houses and a part of the health centre were burnt down in mid-September, following the death of a local health worker from Ebola. In late June, angry crowds hurled rocks at a driver working with an Ebola response team in Beni and set his vehicle on fire.

High levels of insecurity continue to hamper the efforts to control the epidemic and have a negative impact on its evolution: the violence further discourages people from seeking care in Ebola treatment centres, resulting in an increased likelihood of the virus spreading across the healthcare system.

The unrest, such as fighting between the army and armed groups in early May, and the killings of a WHO doctor in April in Butembo, and a health worker in Vusahiro in late May, have at times brought many outbreak response activities to a standstill. A new offensive of the national security forces against armed groups started at the end of October 2019 in the area around Beni, with our teams on alert.

EBOLA IN UGANDA

On 11 June, the Ugandan Ministry of Health and WHO confirmed three people from the same family had tested positive for Ebola in the Kasese district, western Uganda, which borders DRC. The family had travelled over the border into Uganda from DRC. They are the first cross-border cases in the current outbreak.

Two of the people sadly died, while the third person and two other members of the family, showing symptoms consistent with the disease, were repatriated to DRC.

After several weeks with no recorded cases, the Ugandan Ministry of Health announced on 29 August that a new case had been recorded in the country. A young girl, who had travelled from DRC with family, was diagnosed with Ebola and admitted to a treatment centre but unfortunately died the following day. Uganda has not recorded any further cases.

RELATED

Ebola and Marburg

Ebola and Marburg haemorrhagic fevers are rare but deadly. Outbreaks can kill 25 to 90 per cent of those infected, spreading fear and panic. No cure exists and treatment is mainly symptomatic.

https://www.msf.org/drc-ebola-outbreak-crisis-update
The response to the current outbreak

The DRC Ministry of Health (MoH) is leading the outbreak response, with support from WHO.

We believe **it will not be possible to end this outbreak if there is no trust built between the response and the affected people.** Response authorities and workers must listen to the needs of communities, restore people's choice when it comes to managing their health, and involve the community in every aspect of the Ebola response.

MSF believes that **Ebola-related activities should be integrated into the existing health care system** to improve the proximity of services to the community and ensure the system remains functional during the outbreak. We aim to do this with our own Ebola-related activities wherever possible. This would help identify earlier on suspected cases and could encourage people to seek help more promptly at healthcare posts, clinics and hospitals that they know and trust.

**MSF RESPONSE**

MSF has been involved in the outbreak response, working with the Ministry of Health, since the declaration of the epidemic on 1 August 2018.

As of October 2019, we have more than 820 staff working in DRC responding to the Ebola outbreak.

We are supporting the Ebola response through patient care in four Ebola Treatment Centres in Bunia, Beni, Goma, and Biakato Mines in collaboration with the Ministry of Health.

We continue to provide care to suspect cases, and also manage decentralised isolation and Transit Centres for suspected Ebola patients. MSF is supporting existing health structures including treating common illnesses, and improving water and sanitation, building transit units within existing facilities, and implementing and strengthening triage and infection prevention and control activities (IPC).

In addition, our teams are reinforcing health promotion and community engagement in the areas where we are working. We are also working towards strengthening the disease surveillance system in our regular project areas, including in Goma.
A contaminated health centre can contribute to disease transmission.

MSF

Interview with Ebola Watsan, Thomas Compigne

MSF is currently running the following activities in the affected North-Kivu and Ituri provinces:

**Goma – North Kivu province**

- MSF has been providing medical care to suspected and confirmed cases in the 10-bed ETC in Munigi, on the outskirts of Goma. More than 840 patients have been admitted since February 2019.
- Vaccinating participants who have consented to take part in a clinical trial of a second investigative vaccine, Ad26.ZEBOV/MVA-BN-Filo from Johnson&Johnson.
- We are supporting emergency preparedness by reinforcing the surveillance system and ensuring there is adequate capacity to isolate suspected cases.
- MSF is undertaking health promotion and community engagement activities in Goma and the surrounds.
- Providing free primary healthcare for non-Ebola needs, including treating malaria, diarrhoea and respiratory and urinary tract infections.

**Beni and surrounds – North Kivu province**

- Managing an ETC in Beni and managing and triaging suspect cases in three health centres.
- Providing infection prevention and control, across Lubero and Beni.
- We are providing medical care to suspect cases in isolation awaiting test results.
- MSF teams are engaging in community and health promotion activities.
- Supporting access to free non-Ebola healthcare in multiple hospitals and health centres across Lubero and Beni.
Since the outbreak was declared on 1 August 2018, MSF has been steadily scaling up patient care activities to Raising awareness among communities about measures to control the spread of Ebola remains one of the family visits easier, re-establishing some of the human contact that is so hard to maintain in Ebola treatment.

**Bukavu - South Kivu province**

- Managing the 34-bed Bunia ETC: 24 beds for suspect patients and 10 beds for confirmed.
- Undertaking infection prevention and control measures, including in Komanda, Bunia and Rwamara.
- Providing support to six health centres and facilities across Bunia, including Bunia general hospital.
- Undertaking health promotion and community engagement activities in the communities.

**Biakato – Ituri province**

- Managing, in collaboration with MoH, a 20-bed ETC that had been upgraded from a transit unit.
- MSF teams are undertaking infection prevention and control, and water and sanitation activities (including providing access to clean water).
- Providing free healthcare across four primary healthcare centres and mobile clinics, and secondary healthcare for paediatrics.

**Mayuano/Somé - Ituri province**

- Managing a 12-bed transit centre in Mauvano, and a 3-bed isolation unit in Somé for suspect cases which have been integrated into healthcare facilities.
- Providing basic healthcare across four health centres.
- Providing infection prevention and control measures in healthcare facilities.
- Undertaking community involvement and engagement in activities.

**Mambasa - Ituri province**

- Managing basic healthcare centres and transit units in Binase and Salama.
- Managing the surveillance system in the Binase health zone.
- Implementing infection prevention and control in the community and infection prevention support at 12 health centres.

**Bukavu - South Kivu province**

- Managing transit centre in Bukavu, with a current capacity of 8 beds, and with possibility to transform into an ETC.
- Implementing infection prevention and control measures in five health facilities.
Unlike the 2014-2016 West Africa Outbreak, there now exists two vaccines against Ebola which are in clinical study phases and are not licenced. One, the rVSV-ZEBOV vaccine produced by Merck, has been used in a ‘ring’ vaccination strategy since the start of this year. Using this strategy - where the contacts of people diagnosed with Ebola are vaccinated (first-degree contacts), and their contacts (second-degree contacts) in turn are vaccinated - over 250,000 people have been vaccinated up to mid-November 2019.

In mid-November 2019, MSF teams started vaccinating people who had given their consent to participate in a clinical trial of a second investigational vaccine, Ad26.ZEBOV/MVA-BN-Filo, produced by Johnson&Johnson, following an announcement by the Ministry of Health in September.

While vaccination is a good measure designed to prevent the further spread of the disease, use of the vaccines in DRC during the outbreak is not without its challenges:

- The rVSV-ZEBOV vaccine requires to be transported in temperatures of around -60C to areas which are remote and often lack adequate roads and infrastructure.
- The new investigational Johnson&Johnson vaccine needs to be given in two doses, 56 days apart - requiring people to be followed up in a context notoriously difficult for follow-up.
- Identifying contacts and their contacts has been extremely challenging, with three-quarters of contacts not able to be traced or followed up to be vaccinated during this outbreak.
- WHO's approach to managing supplies and eligibility for the vaccine has been opaque, with even some frontline health workers - those who should be the first to get the vaccine - going unvaccinated.

We have urged for a change in vaccination strategy - given the above challenges - to go for a more expanded, geographically targeted approach, rather than the unreliable ring vaccination strategy.

"In this situation people might have an urge that is almost to seek medical help in health facilities that do not have adequate triage of infection prevention and control measures in place, which makes the risk of contamination higher. This is why we consider to urgently MSF emergency coordinator in Beni. We are talking about a population that has endured many years of conflict. On top of that, they are now faced with the deadliest Ebola outbreak DRC has ever seen. The unrest of these past few weeks adds even more to their plight by limiting their chances of finding adequate medical care.

MSF maintains complete independence from all political, religious or military powers and observes neutral, humanitarian principles of impartiality, neutrality and independence of the organization. The activities of MSF in DRC have been opaque, with even some authorities involved in the response.

"We designed the Katwa treatment centre with the aim of offering greater capacity for patient care,” Massart says. “Large windows allow our patients to see the faces of the doctors and nurses treating them and make family visits easier, re-establishing some of the human contact that is so hard to maintain in Ebola treatment centres."

"We urge for an increase in patient capacity at our facilities, but without losing the respect and care for our patients,” Wright says. “We also urge for adaptation of the vaccination strategy to the specific contexts in which it is being applied. Our priority is to increase our efforts to engage the community as active participants in the fight against the outbreak. This trust is key to get the outbreak under control”, says Roberto Wright, MSF anthropologist in Katwa. "With Ebola, treatment centres alone are not enough. Connecting with the communities and building mutual trust is key to get the outbreak under control.”

"With Ebola, treatment centres alone are not enough. Connecting with the communities and building mutual trust is key to get the outbreak under control."

MSF expands Ebola outbreak response

https://www.msf.org/drc-ebola-outbreak-crisis-update
Since the outbreak was declared on 1 August 2018, MSF has been steadily scaling up patient care activities to raise awareness among communities about measures to control the spread of Ebola remains one of the family visits easier, re-establishing some of the human contact that is so hard to maintain in Ebola treatment centres.” says. “Large windows allow our patients to see the faces of the doctors and make contamination higher,” says Laurence Sailly, MSF emergency coordinator in Beni. “We are talking about a second-largest Ebola outbreak ever recorded since the virus was discovered in the country in 1976.

Unrest diminishes access to healthcare

As the number of new confirmed Ebola cases keeps growing, a heightened climate of unrest linked to the recent presidential elections has further restricted the populations access to health care in and around the city of Beni. Several health centres in the city were damaged during protests. This is making the prompt identification of new Ebola cases more challenging, as remaining health centres become have overloaded.

In this situation people might have no other choice than to seek medical help in health facilities that do not have adequate triage or infection prevention and control measures in place, which makes the risk of contamination higher and adds to already limited MSF emergency coordinator in Beni. We are talking about a population that has endured many years of conflict. On top of that, they are now faced with the deadliest Ebola outbreak DRC has ever seen. The unrest of these past few weeks adds even more to people's plight by limiting their chances of finding adequate medical care.

“Visiting communities to explain our activities before we actually launch them can go a long way in terms of connecting with the communities and building mutual trust is key to get the MSF maintains complete independence from all political, religious or military powers and observes impartiality in its actions, based on an assessment of medical needs. The independence of the association is witnessed against the background of the outbreak under control”.

“With Ebola, treatment centres alone are not enough. Connecting with the communities and building mutual trust is key to get the outbreak under control”.

With Ebola, treatment centres alone are not enough. Connecting with the communities and building mutual trust is key to get the outbreak under control.”

MSF expands Ebola outbreak response.

https://www.msf.org/drc-ebola-outbreak-crisis-update
On 1 August 2018, Democratic Republic of Congo (DRC) declared an outbreak of Ebola in the country's northeast. With the number of cases passing 3000, it is now by far the country's largest-ever Ebola outbreak. It is a...
Since the outbreak was declared on 1 August 2018, MSF has been steadily scaling up patient care activities to raise awareness among communities about measures to control the spread of Ebola remains one of the centres. “We designed the Katwa treatment centre with the aim of offering greater capacity for patient care,” Massart says. “Large windows allow our patients and nurses treating them and make family visits easier, re-establishing some of the human contact that is so hard to maintain in Ebola treatment centres.”

Unrest diminishes access to healthcare
As the number of new confirmed Ebola cases keeps growing, a heightened climate of unrest linked to the recent presidential elections has further restricted the population’s access to health care in and around the city of Beni. Several health centres in the city were damaged during protests. This is making the prompt identification of new Ebola cases more challenging, as remaining health centres become overloaded.

“The unrest of these past few weeks adds even more to people’s plight by limiting their chances of finding adequate medical care,” says Roberto Wright, MSF anthropologist in Katwa. “We are also addressing the need to gain the trust of the affected communities.”

Unrest diminishes access to healthcare

The unrest of these past few weeks adds even more to people’s plight by limiting their chances of finding adequate medical care.

The need for Ebola treatment centres alone are not enough. Connecting with the communities and building mutual trust is key to get the outbreak under control.

“We designed the Katwa treatment centre with the aim of offering greater capacity for patient care,” Massart says. “Large windows allow our patients and nurses treating them and make family visits easier, re-establishing some of the human contact that is so hard to maintain in Ebola treatment centres.”

MSF expands Ebola outbreak response
Ebola patient care increases amid growing tensions in North Kivu

On 1 August 2018, Democratic Republic of Congo (DRC) declared an outbreak of Ebola in the country’s northeast. With the number of cases passing 3,000, it is now by far the country’s largest-ever Ebola outbreak. It is a...
Unrest diminishes access to healthcare

As the number of new confirmed Ebola cases keeps growing, a heightened climate of unrest linked to the recent presidential elections has further restricted the population’s access to health care in and around the city of Beni. Several health centres in the city were damaged during protests. This is making the prompt identification of new Ebola cases more challenging, as remaining health centres become more overloaded with the population that has endured many years of conflict. On top of that, they are now faced with the deadliest Ebola outbreak DRC has ever seen. The unrest of these past few weeks adds even more to people’s plight by limiting their chances of finding adequate medical care.

“Visiting communities to explain our activities before we actually launch them can go a long way in terms of improving mutual understanding and facilitating better collaboration in the long run.”

Likewise, our transit centres are not only there to identify Ebola patients and refer them for treatment, but also to ensure adequate care for other health issues, which is a clear need for these people, Wright says.

The need to increase community trust

Unrest diminishes access to healthcare and makes it more challenging for MSF to increase community trust, which is key to get the outbreak under control, says Roberto Wright, MSF anthropologist in Katwa. “We need to increase community trust in order to engage the community as active participants in the fight against the outbreak. This involves listening to their broader needs. For instance, at the end of December, we distributed trauma kits to the city of Beni. Several health centres in the city were damaged during protests. This is making the prompt identification of new Ebola cases more challenging, as remaining health centres become more overloaded with the population that has endured many years of conflict. On top of that, they are now faced with the deadliest Ebola outbreak DRC has ever seen. The unrest of these past few weeks adds even more to people’s plight by limiting their chances of finding adequate medical care.”

“Large windows allow our patients to see the faces of the doctors and nurses treating them and make family visits easier, re-establishing some of the human contact that is so hard to maintain in Ebola treatment centres.”

MSF expands Ebola outbreak response

As the number of new confirmed Ebola cases keeps growing, a heightened climate of unrest linked to the recent presidential elections has further restricted the population’s access to health care in and around the city of Beni. Several health centres in the city were damaged during protests. This is making the prompt identification of new Ebola cases more challenging, as remaining health centres become more overloaded with the population that has endured many years of conflict. On top of that, they are now faced with the deadliest Ebola outbreak DRC has ever seen. The unrest of these past few weeks adds even more to people’s plight by limiting their chances of finding adequate medical care.

“Visiting communities to explain our activities before we actually launch them can go a long way in terms of improving mutual understanding and facilitating better collaboration in the long run.”

Likewise, our transit centres are not only there to identify Ebola patients and refer them for treatment, but also to ensure adequate care for other health issues, which is a clear need for these people, Wright says.

The need to increase community trust

Unrest diminishes access to healthcare and makes it more challenging for MSF to increase community trust, which is key to get the outbreak under control, says Roberto Wright, MSF anthropologist in Katwa. “We need to increase community trust in order to engage the community as active participants in the fight against the outbreak. This involves listening to their broader needs. For instance, at the end of December, we distributed trauma kits to the city of Beni. Several health centres in the city were damaged during protests. This is making the prompt identification of new Ebola cases more challenging, as remaining health centres become more overloaded with the population that has endured many years of conflict. On top of that, they are now faced with the deadliest Ebola outbreak DRC has ever seen. The unrest of these past few weeks adds even more to people’s plight by limiting their chances of finding adequate medical care.”

“Large windows allow our patients to see the faces of the doctors and nurses treating them and make family visits easier, re-establishing some of the human contact that is so hard to maintain in Ebola treatment centres.”

MSF expands Ebola outbreak response

As the number of new confirmed Ebola cases keeps growing, a heightened climate of unrest linked to the recent presidential elections has further restricted the population’s access to health care in and around the city of Beni. Several health centres in the city were damaged during protests. This is making the prompt identification of new Ebola cases more challenging, as remaining health centres become more overloaded with the population that has endured many years of conflict. On top of that, they are now faced with the deadliest Ebola outbreak DRC has ever seen. The unrest of these past few weeks adds even more to people’s plight by limiting their chances of finding adequate medical care.

“Visiting communities to explain our activities before we actually launch them can go a long way in terms of improving mutual understanding and facilitating better collaboration in the long run.”

Likewise, our transit centres are not only there to identify Ebola patients and refer them for treatment, but also to ensure adequate care for other health issues, which is a clear need for these people, Wright says.

The need to increase community trust

Unrest diminishes access to healthcare and makes it more challenging for MSF to increase community trust, which is key to get the outbreak under control, says Roberto Wright, MSF anthropologist in Katwa. “We need to increase community trust in order to engage the community as active participants in the fight against the outbreak. This involves listening to their broader needs. For instance, at the end of December, we distributed trauma kits to the city of Beni. Several health centres in the city were damaged during protests. This is making the prompt identification of new Ebola cases more challenging, as remaining health centres become more overloaded with the population that has endured many years of conflict. On top of that, they are now faced with the deadliest Ebola outbreak DRC has ever seen. The unrest of these past few weeks adds even more to people’s plight by limiting their chances of finding adequate medical care.”

“Large windows allow our patients to see the faces of the doctors and nurses treating them and make family visits easier, re-establishing some of the human contact that is so hard to maintain in Ebola treatment centres.”

MSF expands Ebola outbreak response

As the number of new confirmed Ebola cases keeps growing, a heightened climate of unrest linked to the recent presidential elections has further restricted the population’s access to health care in and around the city of Beni. Several health centres in the city were damaged during protests. This is making the prompt identification of new Ebola cases more challenging, as remaining health centres become more overloaded with the population that has endured many years of conflict. On top of that, they are now faced with the deadliest Ebola outbreak DRC has ever seen. The unrest of these past few weeks adds even more to people’s plight by limiting their chances of finding adequate medical care.