

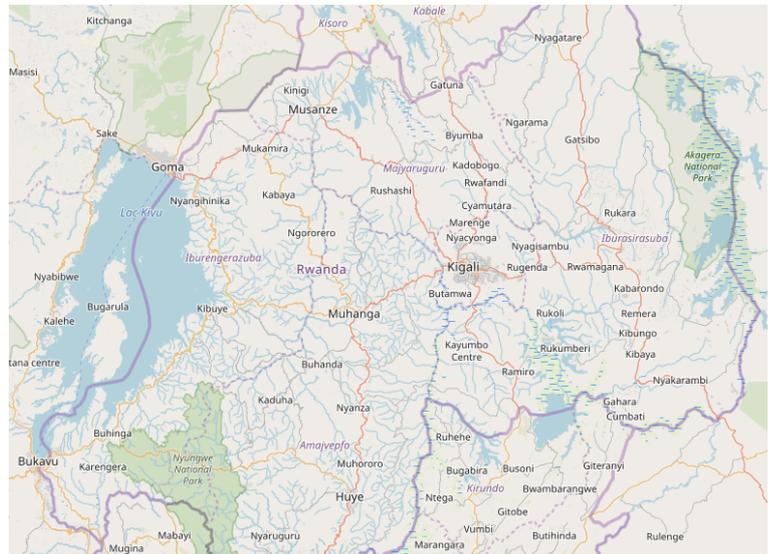
Brief: Rwanda – DRC cross border dynamics, April 2019

This brief summarises key considerations concerning cross-border dynamics between Rwanda and the Democratic Republic of Congo (DRC) in the context of the outbreak of Ebola in North Kivu and Ituri provinces. It is the second in a series of four briefs focusing on the at risk border areas between DRC and the four high priority neighbouring countries (including Uganda, South Sudan and Burundi).¹ As of April 2019, there had been no case of Ebola imported from the DRC into Rwanda, although alerts had been triggered on the roads leading from North Kivu towards neighbouring Rwanda and at least one high-risk contact was described as being a Rwandan national. Cross-border movement has been identified as a significant risk to transmission. This brief provides details about cross-border relations, the political and economic dynamics likely to influence these, and specific areas and actors most at risk.

The brief is based on a rapid review of existing published and grey literature, previous ethnographic research in Rwanda and DRC, and informal discussions with colleagues from the Rwanda Ministry of Health, UNHCR, UNICEF, WHO, DFID, IOM, USAID, CDC and others. The brief was developed by Hugh Lamarque (The University of Edinburgh's Social and Political Science Department - Centre for African Studies) with support from Ingrid Gercama, Emelie Yonally and Juliet Bedford (Anthrologica). Additional review and inputs were provided by Patricia Stys (London School of Economics), Jean-Benoît Falisse (University of Edinburgh), Benjamin Chemouni (University of Cambridge), David Peyton (Northwestern University), Papy Muzuri (London School of Economics) and colleagues from DFID (Rwanda Country Office) and UNICEF (Rwanda Country Office and East and Southern Africa Regional Office). The brief is the responsibility of the Social Science in Humanitarian Action Platform (SSHAP).

Key considerations and recommendations

- **Border region and physical terrain** – The DRC-Rwanda border is relatively short and contains a number of natural barriers to the large-scale movement of people and goods. Its total length of 217km includes 89km through the waters of Lake Kivu and approximately 60km of difficult-to-traverse, mountainous terrain in its northernmost section. These characteristics have produced bottlenecks for the passage of people and goods. Two large, trans-frontier conurbations – Goma/Rubavu and Bukavu/Rusizi – sit to the north and south of Lake Kivu. Both are inhabited by over one million people, with the bulk of the urban population on the Congolese side of the border. Considering the high degree of cross-border interaction that occurs in these cities, they are being treated as high priority sites for Ebola-related prevention and readiness interventions in the borderland. Rwandan territory is the most densely populated in continental Africa, at approximately 470 people per square kilometer.² This plus the country's high quality transport infrastructure, could both contribute to the rapid spread of infection. The Rwandan government has identified 15 high priority districts concentrated along its western and northern borders, at Rusizi, Nyamasheke, Karongi, Rutsiro, Rubavu, Nyabihu, Musanze, Burera, Gicumbi, Nyagatare, Bugasera, Nyanza, as well as Kigali City's three districts of Kicukiro, Gasabo, and Nyaurengenge.³ Kigali is considered at risk due to the high quality transport infrastructure that links it to the border areas and the possibility that people with EVD symptoms from other areas may travel to the capital to seek medical care. The city is approximately 3.5 hours drive from Rubavu and 6 hours from Rusizi, and has an international airport. (It should be noted that the names of many Rwandan towns have recently been changed. The former Gisenyi is now officially called Rubavu, a name it shares with the district at large. Despite this, the urban centre closest to the border belongs to a smaller administrative sector that has kept the name Gisenyi, and residents still refer to the town as such. Similarly, Cyangugu has recently been renamed Rusizi, but many still refer to the border town by its former name).
- **Cross-border asymmetry** – There are stark contrasts between the border districts in Rwanda and DRC in terms of their economic and political characteristics. In general, the Congolese side displays weak, locally contested state authority, insecurity, negotiable and inconsistent economic regulation, and greater opportunities for employment. The Rwanda side of the border is characterized by strong, centralised political authority, physical security, heavy regulation (both social and economic) and a relative lack of employment prospects.⁴ In this context, the complexity of implementing cross-border control mechanisms related to Ebola should not be underestimated. Practical responses must be catered carefully to and for each side, and take into account the borderland dynamics that drive high rates of cross-border mobility, particularly among informal traders.
- **Historical conflict and impact on trust** – Interstate conflict between 1996 and 2003 saw North Kivu and South Kivu violently contested between the military influences of Rwanda (aligned with Uganda) and DRC.⁵ Historical enmity between the states continues to be reproduced in local accounts, and national identities on both sides of the border have become entrenched by cycles of conflict that persist to the present day.⁶ Violence in the region has a strong ethnic dimension, both between ethnic Hutu and Tutsi following the 1994 Rwandan genocide, and between Banyarwanda (predominantly Hutu) in Goma and their economic



rivals among local Congolese ethnic groups, particularly the Nande to the north around Beni and Butembo.⁷ Violence in the borderland has involved a large number of armed non-state actors, and both Congolese and Rwandan government authorities have been accused of sponsoring militias against the interests of the other. This has resulted in a lack of trust and institutional coordination between state authorities on either side of the border, and a level of hostility based on ethnicity and national identity throughout the borderland population more widely.

- **Violence and security forces** – Preparedness interventions to prevent the spread of Ebola, including cross-border monitoring and surveillance, need to be understood against a backdrop of pre-existing suspicions, political and economic exploitation, smuggling, and the ongoing security concerns of both the Rwandan and Congolese states. The dominating state presence at border crossings is from the security rather than the health sector, and the issues of greatest concern tend to be the smuggling of drugs and small arms. This is particularly the case when supply chains are seen to have linkages to Rwandan opposition groups in DRC, most notably the *Forces Combattantes Abacunguzi* (FOCA) and the *Conseil National pour le Renouveau et la Démocratie* (CNRD-UBWIYUNGE), offshoots of the *Forces Démocratiques de Libération du Rwanda* (FDLR), a group originally comprised of members of militias involved in perpetrating the Rwandan Genocide. Both the 3rd Division of the Rwandan Defence Force (RDF) and the Rwandan Special Forces have headquarters in the western province close to Rubavu and the DRC border, and are actively involved in counter-insurgency operations.
- **Cross-border surveillance** – Ebola control interventions along the border are likely to find themselves enmeshed with the security agendas of the Congolese and Rwandan states. On one hand, powerful means of surveillance (patrols, community surveillance, checkpoints etc.) are already in place and could be operationalised for contact tracing and active case detection if necessary. This is particularly true in Rwanda, where local communities are closely monitored and coordinated by central authorities through a sophisticated system of administrative decentralisation.⁸ However, the key border-crossings are sensitive sites managed by the armed forces who may be reluctant to share information particularly if it is seen to pertain to national security. The Rwandan government is extremely autonomous and potentially capable of implementing its own Ebola prevention measures through the Ministry of Health (MoH), Ministry of Local Government (MINALOC), Rwanda Health Communication Centre (RHCC), and the Rwanda Biomedical Centre (RBC). These groups are supported by the Rwanda Defense Force (RDF) and the Rwanda National Police (RNP). An Ebola Taskforce was established at the national level following the announcement of the 2018 outbreak in DRC. It includes twenty-three agencies, and is co-chaired by the Minister of Health and the WHO.⁹
- **Trade routes and markets** – DRC is Rwanda's largest trading partner, and in 2017 cross-border trade between the two countries generated approximately US\$100 million.¹⁰ Market prices fluctuate in relation to the changing security environment, and there are strong links between traders, political actors, and the military. Recent reports suggest that up to 90,000 people cross the border each day.¹¹ The majority are traders who cross free of charge at official checkpoints between border cities (most notably at the *Petit Barrière* connecting Goma and Gisenyi, where border officials estimated that 50,000 people cross daily). Much of the cross-border trade in the region constitutes a 'survival economy' for those involved in it, and any disruption of trade routes is likely to be met with a popular backlash.¹²
- **Government and border closure** – One of the more unpredictable elements of the borderland dynamic is whether Rwandan authorities have the political will and capacity to entirely close the border in the event of a large-scale outbreak of Ebola on the immediate Congolese side. There is very little precedent for this – even during periods of heightened tension between the two states closing the border has proved difficult. Congolese authorities temporarily closed the border in 2012 at the height of the M23 (*Mouvement du 23 Mars*; March 23 Movement) militia crisis, but were quickly forced to reopen it due to popular protest.¹³ In September 2013, Rwandan authorities partially closed the border between Goma and Rubavu following a mortar attack on the Rwandan border town, but reopened it almost immediately. Contingency planning to mitigate the potentially destabilising effect of such a closure is required, particularly with regard to the supply of foodstuffs to Goma and Bukavu (which rely heavily on local Rwandan imports), the disruption to the 'survival economy' for tens of thousands of residents, and the potential to force informal traders to less regulated crossing points outside the major cities on the border.
- **Engaging local traders** – Because much of the trade at this border is informal, it is important to engage cross-border traders' cooperatives (including the disabled traders' associations in Goma and Bukavu), organised trading networks associated with particular commodities (*associations de petits commerçants transfrontaliers*), and organisations responsible for boat traffic on Lake Kivu. The response should work directly with associations of business owners (such as the *Fédération des Entreprises du Congo* (FEC), a national association with branches throughout the DRC but which are involved in cross-border trade). Women make up the majority of cross-border traders, and women's trade cooperatives are an extremely valuable point of access for both disseminating and gathering information. Throughout the borderland, markets are important sites for meeting and reinforcing connections as well as for trade, community engagement and the introduction of routine protection mechanisms such as hand-washing stations.
- **Local associations** – Decades of limited state authority in both North and South Kivu have resulted in a mode of governance that is relatively divorced from central authorities in Kinshasa.¹⁴ State actors in Goma and Bukavu represent only one political power base among many, and are treated with a degree of suspicion by the broader population.¹⁵ Demonstrating accountability to the needs of the community and acting on community feedback will help guard against campaign fatigue and reduce skepticism associated with outside actors. On the Rwanda side of the border, however, associations will likely be effectively accessed through the state, and in particular through government authorities at the district level. Linking up with local associations is important due to their extensive geographic reach and social embeddedness, and the fact that they tend to be trusted by their members. Such associations include transport associations (bus, truckers, taxis, or motorbike taxis), trade associations, money exchange associations at the border, and traditional healer associations. Many of these groups have sophisticated internal hierarchies that allow points of contact for external actors, either through elected regional heads or spokespersons.¹⁶ Establishing mechanisms for sustained dialogue is key, as is emphasising flexibility based on local feedback.
- **Community engagement and government approval** – Community engagement needs to take place not only at the border itself, but also within the wider borderland community that is located further from the immediate border posts. On the Rwandan side, community engagement measures continue to be implemented by the Government of Rwanda with the support of partners including UNICEF and ICRC (International Committee of the Red Cross) and radio is used by the majority of local residents to receive key information. The country's sophisticated system of administrative decentralisation means that channels are already in

place through which information can be readily disseminated to the population at large.¹⁷ Such interactions require the approval of central authorities at MINALOC, the RNP and the President's Office, and positive coordination is key to ensuring consistent messaging and a cohesive response.

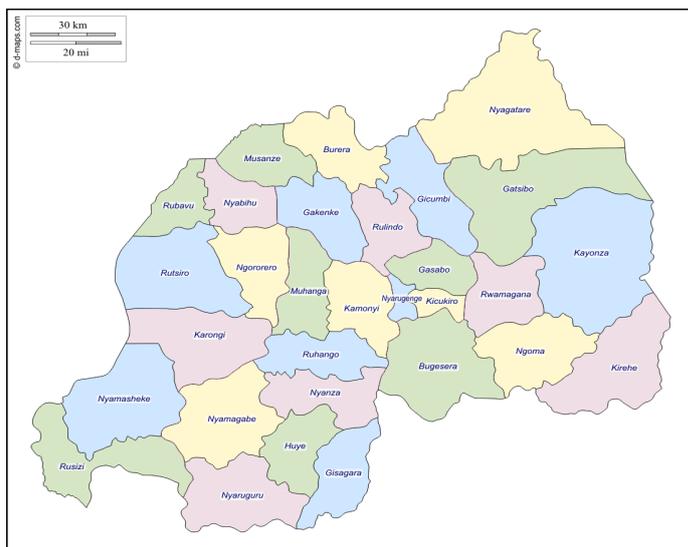
- **Language** – Congolese Swahili, which draws on French for technical vocabulary, is the language of trade between Rwandans and Congolese and is used widely throughout eastern DRC.¹⁸ Kinyarwanda is the lingua franca of those born on the Rwandan side of the border. In eastern DRC Kinyarwanda is spoken in areas with substantial Rwandan populations, such as Rutshuru, Nyiragongo, and Masisi, and in parts of South Kivu with Hutu, Tutsi, and Banyamulenge communities. Outside of these areas it is not widely understood and can carry negative associations related to the historical conflict. As a result, Rwandan communities sometimes refrain from using Kinyarwanda, preferring a combination of French and Swahili. Lingala is not spoken as widely as Swahili among Congolese in North and South Kivu, and again is perceived to carry negative associations in areas where it is regarded as the language of the armed forces. Preparedness, readiness and response activities must pay close attention to the nuances of language, and seek local feedback about the most effective way to convey information about Ebola in different parts of the borderland.¹⁹
- **Refugees** – Rwanda is host to over 75,000 Congolese refugees, with most living in one of five camps at Kibiza, Gihembe, Nyabiheke, Kigeme, and Mugombwa.²⁰ UNHCR operates refugee transit centres in Goma in DRC, and at the north and south ends of Lake Kivu on the Rwandan side of the border. At the time of writing, refugees are screened for Ebola (as well as other communicable diseases) at entry and exit from the transit centres. They are then referred on to the larger camps around Rwanda where screening also takes place on entry. The transit centres maintain contact with the Rwandan Ebola Rapid Response Team, a group of medical professionals from the Rwandan MoH (Ministry of Health) and major Rwandan hospitals who are responsible for responding to Ebola alerts and who coordinate with the National Ebola Task Team. In addition to preparedness and prevention efforts associated with the main refugee settlements, the response must also work through the key agencies that serve as meeting points for refugees and that provide support to undocumented refugees when they first arrive in country, such as the church, Refugee Law Project, InterAid and HIAS (Hebrew Immigrant Aid Society). Urban refugees do not always settle in formal camps but assimilate into host communities, drawing on social networks of family, friends and local leaders for assistance. The UNHCR DRC Regional Refugee Response Plan (2018) reports that there are up to 9,000 unregistered asylum seekers in Rwanda.²¹
- **Returnees and repatriation** – The refugee situation is complicated by the ongoing repatriation of Rwandan populations living in DRC. Many so-called Rwandan 'refugees' have been in the DRC for the majority, or all of their lives, and assume the title refugee only because of the discrimination they face from their host communities. In 2017, an enhanced return cash package and sensitisation of Rwandan refugees in DRC led to over 18,000 people being repatriated, and voluntary repatriation to Rwanda continued in 2018, albeit at much lower rates than the previous year.²² Despite repatriation, large movements of Congolese refugees across the border may trigger significant security concerns in north-western Rwanda, where authorities have been engaged in counter-insurgency operations for over two decades.

Administrative structures

- **Local administration** – Administrative decentralisation in Rwanda extends down to the local level, where every 100-150 Rwandan households, the *umudugudu* (plural *imidugudu*), elects a leader who chairs a Community Policing Committee (CPC) of five members. These groups meet regularly to discuss incidents of note within the neighbourhood, and could serve as a powerful means of gathering and disseminating information regarding Ebola preparedness and prevention. Each *umudugudu* generally hosts at least one community health worker, who would act as a valuable point of contact for the response. It is routine procedure that every morning, reports from *imidugudu* are passed up to cell (*akagari*) authorities (approximately 50-100 neighbourhoods) and then onwards to the sector (*umurenge*), district (*akarere*) and national level, where a meeting of the Joint Operations Centre (JOC) is convened daily in Kigali to discuss serious incidents that have occurred throughout the country over the previous 24 hours. Oversight of medical services has also been decentralised to the district level and is managed from district headquarters across the country. In principle, this infrastructure could be adapted to perform contact tracing, surveillance and active case detection should there be an outbreak of Ebola in Rwanda. The access that external Ebola response partners would have to these networks may be limited, however, and dependent on good relations with the Rwandan central government and its security forces. In general, the Rwandan Defence Force is suspicious of outside interventions, an attitude that can be traced to international inaction during the 1994 Genocide against the Tutsi. The security services are likely to act independently of international actors where they can, and in its preparedness and prevention efforts, the response would benefit from an early and sustained dialogue with these national authorities to avoid misunderstandings and duplicated efforts, and to improve coordination and collaboration.
- **Ebola response structure** – At the time of writing, six technical working groups (risk communication and community engagement (RCCE); surveillance, points of entry and laboratories; logistics; vaccines; infection prevention control case management; and leadership and coordination) reported every week to the Emergency Operations Centre (EOC) meeting. The RCCE working group has taken extensive measures to disseminate information regarding Ebola and prevention strategies to the Rwandan population, particularly residents of the 15 priority high-risk districts. Supported by response partners including UNICEF, these efforts have involved outreach through radio, television, digital billboards, town hall meetings and call-in sessions with representatives of the Rwandan MoH. Recently an informational song was composed to be broadcast nationwide. Regular retreats are being run in order to train healthcare workers, and preemptive vaccination of frontline health workers started on 15 April 2019.²³ A knowledge, attitudes and practices (KAP) survey on Ebola conducted in high-risk areas of Rwanda in October 2018 highlighted the ongoing need to increase community awareness, preparedness and prevention.²⁴ For many communities in Rwanda's high-risk zones, the Ebola outbreak continues to feel distant and far removed from their daily lives, and anecdotally many of the procedures being put in place were being treated as a 'nuisance'. These attitudes may change, however, should the outbreak come closer to the border on the DRC side, and if there was an imported case or a reported case of transmission within Rwanda.

Border Crossings, trade and surveillance

- North of Goma and Rubavu** – In its Ebola prevention strategies and to disseminate information encouraging community preparedness, the Rwandan Ministry of Health is supported by the Rwandan Defence Forces and Rwanda National Police. The overlap between health authorities and the state security apparatus is likely to be greatest along the 60km stretch of border to the north of Goma and Rubavu. This border separates the Rwandan Volcanoes National Park from the Virunga National park in DRC, and is made up of mountainous, forested and difficult to traverse terrain. Historically, it has been the site of smuggling (of minerals, wildlife, charcoal, timber, small arms, and narcotics) from DRC through Rwanda, as well as insecurity relating to militia violence in DRC.²⁵ As a result, the area maintains a heavy Rwandan military presence involved in border patrols and surveillance. In recent years there have been a number of high-profile border incidents involving the security forces, most recently in 2017 when eight people were reported to be killed attempting to cross the border illegally through the Cyanzarwe valley north of Goma.^{26,27} One of the chief concerns cited by a number of colleagues involved in the Ebola response was whether heightened monitoring in the larger cities would push informal traders into this area, where surveillance and contact tracing activities may be more difficult. Although possible, this seems unlikely to occur on a large scale due to the difficult terrain and the concerted efforts of the Rwandan state to control the border. At the time of writing, informal trading north of Goma and Rubavu predominantly takes place at semi-formalised border crossings such as the Gabiro *makabur* graveyard crossing (approximately 10km north of Goma). These crossings already see a heavy military presence on the Rwandan side. Crossing elsewhere is associated with illegal smuggling. The routes are constantly shifting in response to government crackdowns and the actual numbers of people crossing the border are low due to the difficulty and danger associated with doing so. Although screening is in operation at all of the official border posts, it is unclear how rigorously prevention and monitoring measures (e.g., hand-washing and temperature monitoring) are being enforced at present.
- In Goma and Rubavu** – Although the cities of Goma and Rubavu are heavily interconnected and characterised by large movements of people between them, the operational environment of the two cities is very different. The checkpoints connecting them are some of the most at-risk areas for the transmission of Ebola into Rwanda from DRC. This is due to the large and fluid population of Goma, its domestic links to areas affected by the current outbreak in North Kivu, and the high degree of international labour migration between the city and its Rwandan counterpart. The cities are connected by two principal checkpoints, the *Grand Barrière*, recently converted into a large One Stop Border Post (OSBP) close to the lakefront, and the *Petit Barrière* about 2km north. The *Grand Barrière* caters primarily to vehicles, including freight trailers moving in and out of DRC. Foot traffic is relatively low compared to the *Petit Barrière*, where estimates (provided by border officials and district officials in Rubavu) run as high as 50,000 people crossing per day. Rubavu is well connected to other areas of Rwanda by paved roads, and is approximately three and a half hours drive from the capital, Kigali. Buses depart Rubavu for Kigali approximately every 30 minutes throughout the day. For residents registered in Goma, Rubavu (Gisenyi sector), and the three sectors immediately surrounding it on the Rwandan side (Nyamyumba, Rugerero, and Rubavu sector), passage across the border is free. In effect, this results in a secondary border, approximately 15km from the state boundary, after which vehicles registered on the other side are required to pay road tax, and residents are required to purchase a *laissez passer* (literally 'allow to pass') document to cross. These permits are often prohibitively expensive for those involved in small-scale cross-border trade. As a result, cross-border movement is generally restricted to populations living in close proximity to the border itself, and drops off sharply at approximately 15km distance beyond it.
- Trade regulations and crossing borders** – At the time of writing, screening using handheld temperature monitors was in effect at both main crossings, where hand washing stations were also in place. The consistent use of both remains difficult to gauge, but with no cases yet confirmed in Goma, these measures were seen by some traders and local residents as an unnecessary inconvenience and their use was relatively relaxed. Border opening times vary between the different checkpoints. The *Grand Barrière* is open daily between 0600 and 2200, whilst the *Petit Barrière* is open from 0600 to 1800. The most common reason for crossing is small-scale trade, particularly the resale of foodstuffs bought in Rwanda and moved on foot to Congolese markets.²⁸ Goma's markets (Virunga and Birere) are larger and less regulated than those of its Rwandan neighbours (Murigare, Mudugudu and Yakabungo). Small-scale trade in both directions across the border is dominated by women who represent up to 80% of traders in agricultural produce.^{29,30} According to a detailed report by International Alert, the average age of these women traders is 27.6 years, approximately 10% are younger than 18 years, and the majority (78%) belong to a 4-9 person household, often made up of dependents who are supported by their labour.³¹ The women are referred to colloquially as *chora chora*, although formally this term refers only to those involved in illegal smuggling. Other common reasons to cross the border include access to financial services, churches, and education institutions (notably with Rwandans attending the many private higher education institutions in Goma). It is common for family members to live across the border, and people often maintain homes on both sides. Because of the insecurities associated with the border areas, some Congolese (particularly businessmen and traders) choose to spend the day in DRC and the night in Rwanda. Competition between Rwandan and Congolese traders has given rise to harassment and at times violent abuse.³² National prejudices and targeted violence against cross-border traders tends to spike during crisis events between DRC and Rwanda, notably the CNDP (*Congrès National pour la Défense du Peuple*, National Committee for the Defense of the People) militia crisis in 2008 and the M23 militia crisis in 2012/13.



Administrative Map of Rwanda by District. Source: D-maps.com

- **Lake Kivu and the islands** – Lake Kivu is 89km long, and the DRC-Rwanda border runs its entire length from north to south. The lake serves as a natural barrier to cross-border mobility and due to strict migration and customs regulations, fishing and passenger boats do not cross the lake between the two countries (other than in very exceptional circumstances e.g., resulting from extreme weather or an accident). Smuggling does take place across the lake, but the waters are patrolled by Rwandan military gunboats and the Rwanda police navy, and the passage across is both difficult and dangerous. The Rwandan navy is also active in patrolling the waters around its island territories, particularly Iwawa, an island detention and re-education centre. Official shipping routes maintain one or other side of the border and operate from north to south. On the Rwandan side, a bi-weekly passenger ferry connects Rubavu and Cyangugu via Kibuye, a town approximately half way between the two. Smaller, private boats service the same routes although they are not numerous and carry fewer passengers (approximately 10-15 per boat). In DRC, regular ferries run between Goma and Bukavu, some via the Congolese island of Idjwi. These craft include large ferries capable of holding 200-300 passengers at a time. It has been reported that the ferries are owned by a small group of Congolese businessmen in Goma, who may be of use as local brokers in disseminating information about the outbreak and related prevention measures. Screening of passengers should be prioritised due to the large urban populations that the ferries connect over a geographically wide area.
- **Bukavu, Rusizi and south of Lake Kivu** – Bukavu and Rusizi are at somewhat lower risk of Ebola transmission due to their geographical distance from the current outbreak in North Kivu. As cities, they operate with a similar logic to Goma and Rubavu in terms of their asymmetrical living environments and high degree of local cross-border trade. Approximately one third of DRC-Rwanda trade passes between them (accounting for US\$30 million going through the Rusizi crossing in 2017).³³ Rusizi has a population of approximately 60,000 and is divided into three sectors: Gihundwe, Kamembe, and Mururu.³⁴ The population is predominantly Banyarwanda (ethnic Hutu and Tutsi), speaking Kinyarwanda as a first language and Congolese Swahili as a trading language. Bukavu is much larger than its Rwandan counterpart, with a population estimated at slightly over one million inhabitants in 2014.³⁵ Its population is approximately two thirds Bashi and one third Balega, with a range of smaller minorities including Babembe, Bafulero, Batembo, Bandande, and Banyamulenge (approximately 3% combined). The number of people crossing the border each day ranges from thousands to tens of thousands. As with Goma and Rubavu, the majority of traders on both sides of the Bukavu–Rusizi border are women dealing in foodstuffs. For the most part they are resellers, moving between the two markets in Rusizi to the larger Bukavu markets of Nyawera, Kadutu, *La Botte*, and *La Brasserie*. The River Rusizi forms a natural barrier at the border and access is restricted by a number of bridges that provide practical points for Ebola related screening activities. Most cross-border traders make use of the Rusizi One crossing, close to the lakefront. Rusizi One consists of two bridges over the Rusizi river: an older wooden bridge and a newly finished larger metal bridge beside it. The border post opens daily from 0600 to 2200. Residents of Bukavu city and the Rwandan sectors of Mururu, Kamembe, and Gihundwe can obtain a *jeton* (day pass) to cross free of charge. A second post, Rusizi Two, is located 25km from Rusizi in Mururu sector and connects with Bukavu's Nyalukemba quartier. It opens daily from 0600 to 1800. The two borders serve different purposes. Rusizi One is the crossing point for most small-scale traders, some cars and small trucks. Rusizi Two has a much larger bridge dating back to the colonial period. This is used by larger vehicles, often transporting goods to and from Kenyan and Tanzanian ports.
- **Rwanda-Uganda border crossings** – The Cyanika (Rwanda)-Kyanika (Uganda) crossing point along Rwanda's northern border with Uganda has been categorised as high risk by the National Ebola Taskforce of Rwanda and the Uganda Ministry of Health, and the Gatuna (Rwanda)-Katuna (Uganda) crossing point as high risk on the Rwandan side and moderate risk on the Ugandan side.³⁶ The Cyanika-Kyanika crossing is located only 11km from the DRC-Uganda border crossing of Bunagana, and geographically it makes sense for people moving out of Ebola affected areas in the Grand Nord region to enter Rwanda via this route. Buses from eastern DRC often enter Kabale in Uganda where companies provide direct connections on to Rwanda. Screening and hand washing stations have been established at the border post, and at the time of writing, the Rwandan government continued to disseminate information throughout the surrounding district of Bureru. The second crossing, at Gatuna-Katuna is located significantly further east away from the current Ebola outbreak. However, the border post is a hub for long distance trucking and bus travel along the Northern Corridor trading route to Kampala (Uganda) and Nairobi (Kenya), and transmission at this site could result in rapid spread of the disease over significant distances. The surrounding Rwandan district of Gicumbi has been declared high risk by the Rwandan authorities, and Ebola screening is in place at the border crossing. Nevertheless, it was reported at the time of writing, that the system was not yet systematically checking all travellers and it was suggested that there was a level of complacency amongst traders and local communities based on the perception that Ebola remained a distant threat to the area.

Healthcare

- **Cross-border healthcare seeking** – The healthcare sector in Rwanda, with universal health insurance and near universal childhood vaccination rates, is significantly stronger than on the DRC side of the border. In the event of a dangerous epidemic, many Congolese may attempt to cross the border into Rwanda to seek healthcare. There are a number of large hospitals in Goma, most notably l'Hôpital Provincial de Référence de Goma, CBCA Ndosho, CIMAK, Belle Vue, Charité Maternelle and the Heal Africa Hospital. All of these, but particularly the Heal Africa Hospital, are considered prohibitively expensive by the bulk of the urban population. The Panzi Hospital outside Bukavu, although a large medical facility, has historically catered towards the treatment of victims of gender-based violence, and again is widely perceived to be too expensive for most residents of the city. Private facilities are common in both DRC and Rwanda and often provide routine care in line with government services (e.g. participating in national immunisation campaigns). These facilities are generally well-regulated in Rwanda, while wholly unregulated healthcare providers, including traditional healers and herbalists, operate on the Congolese side of the border. The use of traditional medicine in private homes is widespread in rural areas throughout the borderland, including on the Rwandan side.³⁷
- **Ebola treatment centres** – An Ebola Treatment Centre (ETC) has been established in Rubavu, and at the time of writing, a second was under construction in Rusizi, south of Lake Kivu. The Rubavu District Hospital is well managed and is the designated unit to lead on rapid reaction to Ebola alerts in the borderland. According to the Ebola Rapid Reaction Unit, all government medical facilities in Rwanda have held trainings in Ebola management and are preparing appropriate emergency room and mortuary facilities to handle Ebola cases if necessary.
- **Health workforce** – Despite these measures, however, Rwanda has a shortage of healthcare professionals (including health

workers and midwives), with 1.3 medical doctors per 1,000 people.³⁸ This limits the country's overall capacity to respond to an epidemic. The government is committed to strengthening its quality of service through a bottom up approach, and in the current administrative system, each village elects three volunteers to act as Community Health Workers for the general population (one man and one woman for general diseases, and another woman for maternal and antenatal care). These volunteers act as 'the first line of defence' and are trained to address 80% of the burden of disease through home-based care. The MoH has trained over 20,000 Community Health Workers to monitor health at the village level and to refer patients to the nearest health centre as required. At a health centre, cases can either be treated directly or referred onwards for more specialised care in the next tier of health facilities or a Referral Hospital.³⁹

- **Presentation at health centres and levels of trust** – In response to the knowledge, attitudes, and practice (KAP) survey conducted in October 2018, the majority of respondents (93%) confirmed that they would go to a health centre as their primary point of contact with the health system if they thought they may have Ebola (with over 85% saying they would do so within a day or two).⁴⁰ The majority of Rwandans have a good level of knowledge about HIV due to years of information campaigns and because they remember the devastation wrought by the high incidence of HIV in the 1990s. It has been suggested that because the authorities associated with combatting the HIV epidemic (and improving healthcare in Rwanda generally) are now providing information on Ebola (e.g. the MoH and MINALOC), the information is taken seriously, and there is little challenge to the government's Ebola preparedness and prevention agenda.

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Contact

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