Working with local leaders and communities to stop the spread of the virus - providing chlorinated water for handwashing outside a church in Mangina. Photo: John Wessels/Oxfam

CRUCIAL COURSE CORRECTIONS FOR THE EBOLA RESPONSE IN BENI, DRC

The DRC government, the UN, national and international NGOs, health workers, local leaders and community members have prevented Ebola getting out of control in Beni, North Kivu, despite the complex context. However, major challenges remain. In the last week of September, almost all response activities were stopped after an armed group attacked Beni, and civil society called for a general strike or *'ville mort'* in the town. The virus continues to emerge in new areas, including insecure ones, and amongst people who were not previously known to have been in contact with victims. So-called "community resistance" is cited as a daily challenge. Looking ahead to the next phase of the response, now is a critical moment to recalibrate and put more emphasis on building trust and engagement with communities, alongside the essential medical response. A stronger and more independent role for NGOs would also better support scale-up and reinforce quality.

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THE RESPONSE

Two months since the outbreak was declared in North Kivu on 1 August, there have been 161 cases (confirmed and probable) of Ebola, with 106 deaths (as of 1 October). The number of new cases is now fewer than 10 per week, mostly from known transmission chains. Around 11,500 people have been vaccinated, and nearly 2,000 contacts are visited daily.[1]

However, the virus is still appearing in new areas, some of them very challenging contexts. There have been seven confirmed cases in Butembo – a large, complex city and key transport hub – since the beginning of September. People avoiding treatment in Beni have carried the virus to the outlying village of Kyavisimi, where access has been restricted by an armed group. In mid-September, there was a confirmed case in the Masereka Health Zone, south of Butembo, another insecure area. Worryingly, there have been two recent cases in Tchomia in Ituri province on Lake Albert, on the border with Uganda, very far from the epicentre of the crisis. The risk for Uganda is increasing.

The weak capacity of the health system in DRC, where nurses have little training and even less equipment, remains a major risk factor. Nineteen health workers have contracted the virus (nearly 13 percent of total cases),[2] increasing the risk of transmission via health centres. Efforts to ensure that health posts and centres are secure have been slow, and by mid-September some health workers in Beni were still unvaccinated.[3]

Referrals to treatment centres can be slow: in mid-September, a woman spent five days in Beni General Hospital showing symptoms before being referred, and a baby who died later in September spent five days at a health centre before referral. In Beni, eight of the 16 deaths at the treatment centre occurred within 24 hours of admission, implying poor diagnostics in health centres and/or people not coming forward when showing symptoms. Although data indicates increased attendance at health centres as medical care has been made free, community members tell Oxfam that some people prefer to go to traditional practitioners because they are afraid of being forced into treatment centres.

Importantly, the brutal attack in Beni on 22 September, when around 21 people were killed, led to anger in the community about the lack of security that they have lived with for so long. Community leaders declared a ‘ville mort’, and this, together with further attacks on Beni and in the nearby town of Oicha the same week, and low-level insecurity due to linked protests, brought the response to a halt for almost a week. While treatment centres continued to operate, all other activities – vaccinations, contact following etc – ceased for several days, which is likely to have a clear impact on the trajectory of the outbreak.[4]

CENTRALITY OF COMMUNITY ENGAGEMENT

Almost every day, so-called community ‘resistance’ to the response is cited as a key ‘obstacle’, with reports of this becoming more and more violent. Even before the attack on 22 September, ‘resistance’ was delaying all aspects of the response – vaccinations, safe burials, contact tracing – and reducing its effectiveness. Sometimes roads are blocked or stones are thrown, and burial teams and vaccinators have been injured and health centres destroyed. This also deters

people from getting too involved in changing their neighbours' attitudes – they ask what they should do if they become targets and how the response team will keep them safe.

Pre-existing trust deficit

From a community perspective, 'resistance' is due mostly to a deep and longstanding lack of trust in the authorities, which can readily be understood when considering the context.

Beni territory has suffered violent activity from armed groups for years. There are frequent attacks on Beni town; the 22 September was just the deadliest of many recent incidents. Since 2013, over 1,000 people have been brutally murdered and many more abducted. Most of these incidents are attributed to the Allied Democratic Forces (ADF), the most violent group in the region, but the situation is highly complex, with many interlinked groups. Incidents may be the work of other groups, and according to the Congo Research Group potentially even elements of the national army itself.[5] What is clear is that these incidents create real fear, distrust and anger in relation to authorities; people are angry that they are not being protected.

The lack of a concerted and consistent government response to insecurity, and the fraught electoral context, mean that many people are highly sceptical about government intentions. With rumours rife in communities about the origins of Ebola, the combination of distrust in the responses to Ebola and to insecurity,[6] led to civil society[7] in Beni calling for the Ebola response to temporarily halt, and for the UN and international NGOs to leave.[8]

Communities ask why there is such a huge response to Ebola, but not to the insecurity that surrounds them daily. Oxfam teams have been told "We would rather die from Ebola – but the government has to stop these attacks" because security has more of a direct impact on their lives. The international response to Ebola is not speaking to their needs. Further, to them, this epidemic looks like cholera or malaria, but people are not allowed to care for their sick or bury their dead as they should. The heavy government and medical response is feeding some perceptions that Ebola is a '*plot to exterminate the Nande people'*.

The response, led by the government and the UN, is naturally working through government political and administrative structures. This approach does not adequately take into account the fact that many people distrust the state, and for years have at best experienced only neglect and at worst the abuse of power by local authorities.[9]

(Re)building trust in the response

Mistakes within the response have further alienated people. In the early stages, rumours and suspicion were spread as a result of people being forced into ambulances and treatment centres, or bodies being buried without respect of customs. Too often, communication is top-down, didactic, not contextualized, in technical language and in French, rather than the Swahili dialect understood by most people. This does not foster trust and confidence in the response; rather, it contributes to a distance between communities and response teams, and in particular it alienates women.

Community engagement must be a two-way information flow, with community needs fed back to the appropriate response team, acted upon and followed up – otherwise hard-won trust will be lost again. For example, the recent Knowledge, Attitudes and Practice survey conducted by UNICEF shows that many more people are now aware that handwashing is key to preventing Ebola. However, people frequently express frustration that they are told to wash their hands while the means of doing so is difficult. This is the case in the Ndindi area of Beni, where people consistently say that there are not enough water facilities and that they struggle to pay for water, particularly those whose fields are inaccessible due to insecurity. Closing the feedback loop is a real challenge, but it is crucial.

Even where working with communities has been properly attempted – delivered by trusted partners, in the right language, listening and responsive – a lack of coordination risks once more undermining community good will and trust. Community leaders in one area told Oxfam that they were overwhelmed by demands from the response team (including Oxfam), who they saw as confused and uncoordinated, and that there has not been enough investment in ensuring that responders are properly equipped and trained to do what is being asked of them. They also expressed frustration at delays when they alert the system to new suspected cases or deaths, or report individuals in need of further support, and the response is slow and the alert line is on occasion answered in Lingala, the language of Western DRC and the army.

Building trust means that the whole system needs to work effectively, and that attention is consistently given to detail, with clear and coordinated messages from all actors. It means listening to community concerns and supporting them with the information and skills needed to answer questions that arise. This is even more the case in a complex insecure context and the attack on 22 September has brought this into sharp relief. In some places, Oxfam was starting to see successes with a more sensitive community engagement strategy; while it remains to be seen how easily this trust can be rebuilt, community leaders have told us that in that they will ensure our security in focus areas.

Contingency planning for security incidents is required at coordination level to avoid and reduce the impact of such events. The emphasis needs to be on working with communities to improve acceptance, rather than a response that involves calling in the police or local authorities, or using armed escorts to continue vaccinations. Securitised and top down approaches only risk exacerbating issues and further distancing responders from those they are trying to help.

A detailed and integrated community engagement plan takes time and intensive resources. With pressure to cover disparate and emerging hotspots, it is hard to balance speed and scale with the quality so essential to changing community dynamics. A poor, reduced or delayed response can further fuel negative perceptions and lead to a lack of confidence in the response.

Another way of building trust with communities is to consider the longer-term aspects. Communities expect that once Ebola has gone, the international focus will shift elsewhere. Starting now to build sustainable structures, contribute to better water, sanitation and health facilities and promote a stronger health system will support community acceptance, meet very real needs and help avoid and minimize the virus spreading in the future.

Language and perception

Finally, international actors should consider very carefully the language used around communities and 'community resistance'. A typical example of attitudes comes from the 17 September epidemiological update,[10] which refers to '*efforts en cours pour vaincre les résistances communautaires*' ('ongoing efforts to defeat community resistance'). Militarized language is frequently used about those who do not immediately cooperate, reinforcing perspectives of communities as being ignorant and at fault and justifying the top-down response by 'experts'.[11] While anthropologists are involved in the response, their observations are not hardwired into operations. A tendency to emphasize 'culture' over 'context' also risks further portraying communities as 'backwards'.[12]

WOMEN AND YOUTH HAVE A KEY ROLE

Women repeatedly ask why they are most often victims of Ebola. Although the statistical difference is not enormous (56 percent of cases are women),[13] the perception in communities remains that women are most vulnerable. Women aged 15–34 are the most affected. The number of older women (over the age of 60) dying is disproportional to the numbers of older women within the population, which is most likely due to their role in caring for sick people and preparing bodies for burial.

Women often ask very practical questions: '*Should I send my child to school?', 'Is the short-sleeved school uniform a risk to my child?', 'Can you get Ebola through handling money?', 'Should I pass my child around the church when she is baptized?'*. When working with women, it should be ensured that they have clear and prioritized information so that they can answer these questions themselves.

Breastfeeding women are often among the most anxious contacts as they cannot be vaccinated and do not understand why. Despite some suspicion of the vaccine (*'It is to spread Ebola'*) most understand that it is critical for saving lives, and feel that those who make decisions have decided not to save them.[14] Sex is also a major concern for women, who believe it to be unsafe but usually have little choice; they say that their unwillingness is leading to tensions with their husbands.[15]

These genuine concerns need to be addressed, and information provided sensitively. In this context, it should be noted that the response team itself is majority male; the proportion is higher than in usual humanitarian responses in DRC, as the government and doctors are playing such a key role.

In terms of youth, young men play an important role either in supporting the response or making it more difficult - and played a large role in Beni's rejection of the Ebola response in late September. Young people make up a large part of the population (almost 50 percent of DRC's population is under the age of 15) and are largely unemployed or under-employed, and highly politicized. Outsiders talking at them is an approach that does not work and that contributes to suspicion.[16] One young man explained that he had instigated violence because he felt that outsiders were manipulating the community. With more understanding of Ebola, however, he committed to talking to his peers about it.

Developing a distinct and adapted youth engagement strategy is important: this

involves taking time to find the right methods and people, treating young people as equals and key partners, building on their ability to talk to their peers and working on tensions between 'youth groups' and humanitarian organizations.

AN INDEPENDENT NGO VOICE

The response to date has lacked the traditionally strong NGO contribution that is expected in humanitarian contexts, and certainly in Eastern DRC. While MSF and ALIMA have a strong role in running treatment centres, the technical and operational expertise of other NGOs is not being tapped into, and this is having an impact on the scale and quality of the response.

In part, this may be because the relatively few international NGOs working on the response, have struggled to access funding.[17] To date, approximately 71 percent of funding for the response has gone to UN agencies and 25 percent has gone directly to the government through the World Bank.[18] This funding has not been swiftly made available to all implementing partners; several international NGOs were operating on their own unrestricted funding for weeks, as a number of contracts between UN agencies and INGOs were signed only in the second half of September.

Coordination structures are government-heavy, with a focus on information sharing rather than strategy development. With UN agencies acting as both donors and co-coordinators, it is difficult for NGOs to bring alternative voices to the table or influence strategy. This is particularly wasteful as NGOs have years of operational experience in the area, as well as from the Ebola response in West Africa. Along with technical expertise, NGOs understand how difficult it is to get interventions right – an area where UN agencies usually have less hands-on experience. For example, while the medical expertise of WHO is highly appreciated within the medicalized aspects of the response, the agency has far less experience working with communities or in an insecure environment.

A strong NGO voice could also strengthen the independence and neutrality of the response. The UN works closely with the DRC government, which is important, but as outlined above this may present challenges in building trust and therefore the effectiveness of the response for some communities. Creating a secure space for NGO voices to be heard, relaying NGO concerns to the government and protecting NGOs from too much pressure from the government are essential roles for the UN.

UN investment in local NGOs is important and is welcomed. However, as international NGOs are struggling to challenge agencies, power dynamics mean that this is even more difficult for local organizations. To end Ebola in North Kivu, listening and responding to the concerns of implementing organizations will be critical, and a safe and equitable space is needed that takes account of the unseen power dynamics between UN agencies and all NGOs.

NGOs should be respected partners in the response. Oxfam's experience is that generally UN agencies are open to NGOs shaping the response, but that this is not always a reflex or a natural starting point. And too often, in coordination meetings and in communications, the role that NGOs play and the expertise that they contribute is lost under UN agency headlines.[19] There have been a few recent initiatives – the establishment of a regular NGO meeting with senior UN

staff, and a WHO external relations officer in Beni – which are very welcome. Oxfam urges that more should be done to promote the principles of partnership across the response, including ensuring that strategies that NGOs are expected to implement are not developed without NGO participation.

Oxfam also urges that NGO perspectives are included as the response moves into a new phase. So far, and within the recent response review, this has not been done in a thorough, well-planned or systematic way, and has not properly reflected or acknowledged NGOs' role in the response. The UN should include key implementing partners in analysis and forward planning, particularly working with technical capacity in Beni. The funding plan should also be reviewed, to encourage UN agencies to fulfil their coordinator role more strongly and to convene space for strategic discussion that includes a range of voices, rather than focusing on their perspective as a donor.

RECOMMENDATIONS

As the response plan is reviewed, and in the light of the community response to the recent attacks in Beni, Oxfam recommends that:

- **Community engagement is significantly strengthened to build trust and address the suspicion**, which is hampering the response. This means an acute consideration of context and localized stakeholder mapping to identify who is best placed to engage with different groups within the community. It means finding a delicate balance between working with and through existing community leadership structures and at the same time strengthening the involvement of vulnerable groups through dialogue and feedback. Crucially, it means adapting the response to address issues raised by communities and developing an accountable, transparent and timely referral system across all sectors. Community engagement requires substantial resources to build the capacity of communities and to ensure continuous interaction and follow-up. Trust needs to be built at different levels and expectations managed around what is feasible in a short timeframe. There is a need for greater focus in developing safe programming and identifying protection concerns. And more needs to be done to ensure that communities gain something from the response and that there is some preparedness left behind; this includes building sustainable structures, contributing to better water, sanitation and health facilities, and promoting a stronger health system.
- **More imaginative and adapted strategies are developed to reach women and youth**. Separate strategies are required to address their specific needs and challenges. Again, this takes time and resources and requires thinking beyond government structures and people with visible power. It also requires an appropriate balance of female and male staff at senior, coordination and field levels. It should involve working with community-based groups as well as from the top down and convening spaces to bring different stakeholders together. Expertise from sectors such as preventing sexual and gender-based violence should also be drawn on, working with men to change their practices in order to protect women, for example.
- **Donors and UN agencies should do more to promote the principles of partnership**, building on work initiated by the new UN Response Lead in Beni and the relative added value of different organizations. Donors should fund NGOs directly to support a greater diversity of expertise in the response and

should allow for all support costs to be met in full. At the same time, the UN should strengthen its coordination role across all actors in each sector, developing common strategies that systematically include NGO technical and operational expertise. The UN should also proactively take up advocacy issues raised by NGOs with the government. A proactive and NGO-accessible OCHA could strongly support this, and UN agencies should undertake to systematically credit their partners for the work they are doing.

NOTES

[1] WHO (25 September 2018) EVD in the DRC: External Sitrep number 8. http://apps.who.int/iris/bitstream/handle/10665/274863/SITREP_EVD_DRC_20180925-eng.pdf?ua=1

[2] WHO and DRC Ministry of Health (24 September 2018) Mise a Jour de la Situation Epidemiologique

[3] The split between private and government-run health facilities also complicates follow-up.

[4] Contact following had improved prior to this incident, but dropped significantly in Beni and Tchomia for several days due to security concerns, and achieving 100% remains extremely challenging everywhere, as people move both for their livelihoods and because they do not want to be sent to a treatment centre.

[5] Congo Research Group (2017). *Mass Killings in Beni Territory: Political Violence, Cover Ups, and Cooptation: Investigative Report No 2*. http://congoresearchgroup.org/wp-content/uploads/2017/09/CRG-Beni-2017-report-updated.pdf

[6] The Ebola response is UN and Government led. The response to insecurity is Government led, actively supported by the UN through the Force Intervention Brigade (FIB) of the UN peacekeeping mission, MONUSCO.

[7] Civil society in DRC is a specific entity, elected by other civil society organisations. It has a specific place within Congolese society and does not directly correlate to "civil society organisations", although the representative is elected by them.

[8] While the demand that the response stop was rescinded the next day, demonstrations linked to the "ville mort" meant it was not possible for activities to resume and community leaders advised against it.

[9] Participants in Oxfam's protection programme in Beni and Lubero territories have consistently identified local authorities as authors of abuse. Protection trends across North Kivu and the rest of the country indicate that over 50 percent of abuses are committed by state security agents.

[10] WHO and DRC Ministry of Health (17 September 2018) Mise a Jour de la Situation Epidemiologique, https://reliefweb.int/sites/reliefweb.int/files/resources/Point%20epidemiologique_20180918_Final.pdf

[11] See also *Social Science in Humanitarian Action*, 5 September 2018. *Key considerations: changing behaviours & care-seeking practices in the Grand Nord, North Kivu, DRC*. https://reliefweb.int/sites/reliefweb.int/files/resources/SSHAP changing behaviours and care seeking practices.pdf

[12] *Anthrologica*'s regular short and clear briefs are an exception to this.

[13] WHO and DRC Ministry of Health (24 September 2018) Mise a Jour de la Situation Epidemiologique,

[14] There are no current publicly available figures on the number of breastfeeding women and their children who have died.

[15] There is also confusion with HIV messaging, where fidelity is likewise critical but condom usage is helpful.

[16] See, for example, *Anthrologica* (forthcoming).

[17] INGOs working on the response besides MSF and the International Federation of the Red Cross include Alima, Care, IRC, Save the Children, DRC, Mercy Corps, Medair, World Vision, Oxfam and IMC.

[18] OCHA Financial Tracking Service, accessed 21 September, https://fts.unocha.org/countries/52/flows/2018?f%5B0%5D=destinationEmergencyIdName%3A%22707%3ADR%20Congo%20-%20Ebola%20Outbreak%202018%22

[19] See, for example, UNICEF, 17 September 2018. https://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF DRC Ebola Humanitarian Situation Report No. 8 - 17 September 2018....pdf

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