



Ebola in the DRC - an extraordinarily complex crisisⁱ

On July 17, the Ebola outbreak ravaging through North Kivu and Ituri, provinces of the Democratic Republic of the Congo (DRC), was declared a Public Health Emergency of International Concern by the World Health Organization (WHO). Over the past ten years, there were only four other such decisions. The death toll is nearing 2,000, and the disease has spread to Goma – a city on the Rwandan border, home to more than a million people. To understand how the situation escalated, we must recognize the multifaceted nature of this crisis.

A cocktail of horrors

To fully grasp the complexity of the response, one needs to realize that Ebola is just one of the many disasters currently wreaking havoc in DRC. Among those are not only major political instability and violent conflicts, but also other epidemics and widespread food insecurity. One disaster amplifies the other, bringing about a humanitarian nightmare eventually leading to mass population displacements.

The North Kivu and Ituri provinces suffered conflicts long before the Ebola outbreak. Militia with varying motives are wound up in a continuous struggle for power and seek to gain control over territories (see Figure 1).

“Armed clashes resulted in the killing of at least 46 civilians and 101 combatants and the displacement of thousands of civilians between January and March 2019. The Group recorded at least 30 incidents between armed groups in dozens of small and remote villages in the area.”¹

Insecurity is partly due to ethnic tensions, exemplified by a series of mass killings that swept through Ituri, leaving hundreds dead in June.² To make things worse, some rebel groups from neighboring countries Burundi and Rwanda, like the Hutu génocidaires of the FDLR, are entangled in the ongoing rivalries. The radical Islamist group ADF, who regularly attack civilians, also recruits children for combat, and is feared for sexual violence.

“United Nations peacekeepers heard or saw many women and children among the attackers. All ADF combatants were armed, and they screamed before the attack. Some attackers shouted ‘surrender United Nations, surrender Malawi’. Some attackers wore uniforms similar to those of FARDC, while others were in civilian clothing. They used several types of weapons, including AK-pattern assault rifles, machine guns and mortars. The attack lasted for at least five hours and continued into the night, when some isolated United Nations peacekeepers were tracked down by remaining ADF combatants. The United Nations peacekeepers estimated that they were attacked by at least 200 ADF combatants.”³

ⁱ This case is part of a series of humanitarian operations vignettes by the INSEAD Humanitarian Research Group called *Behind the Scenes of Humanitarian Operations*. It was written in August 2019 by Alex Fleuren and Luk Van Wassenhove. For more information go to <https://www.insead.edu/centres/humanitarian-research-group>.

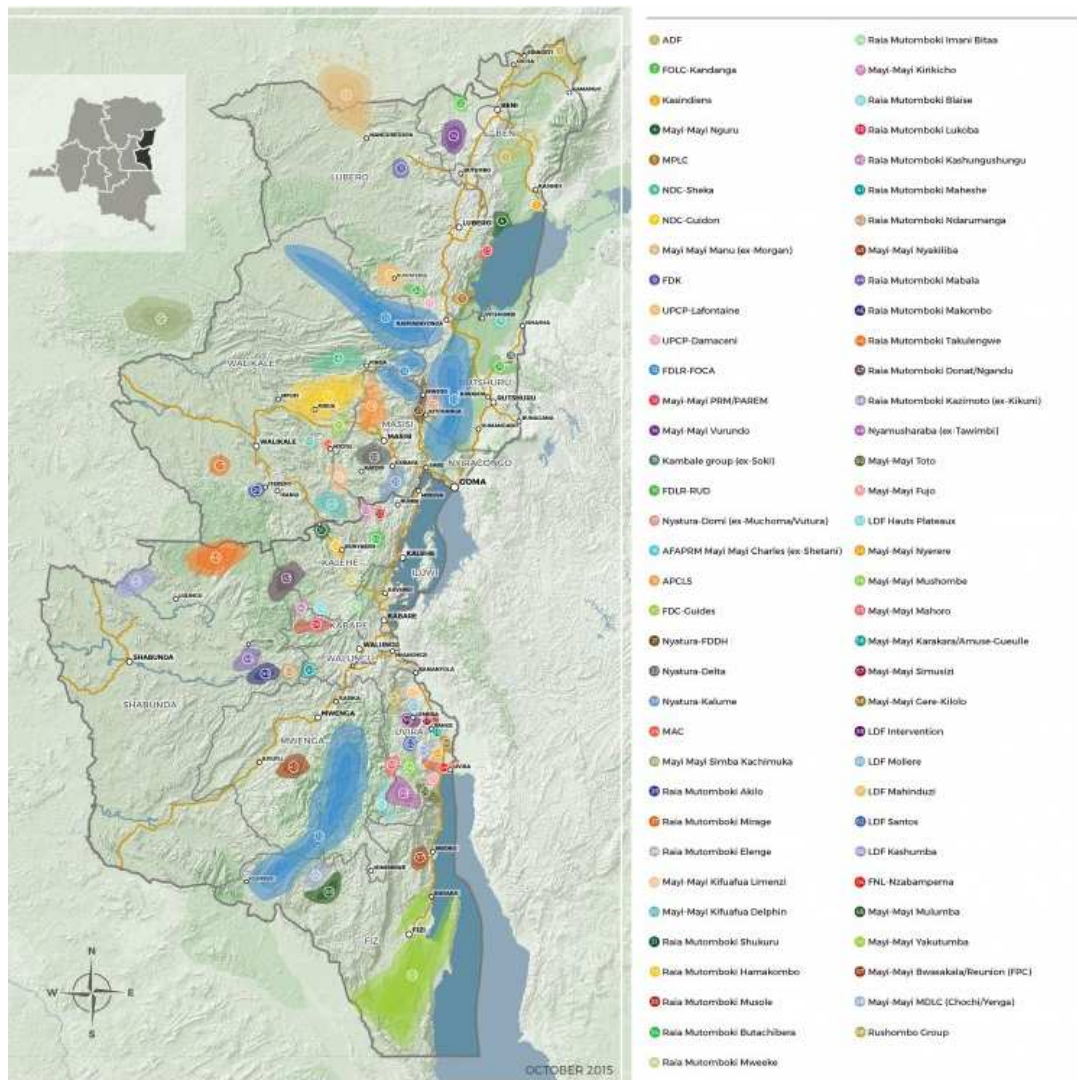


FIGURE 1. ARMED GROUPS AND THEIR TERRITORIES IN NORTH AND SOUTH KIVU IN 2015.⁴

Ebola is not the only epidemic affecting the people of North-Kivu and Ituri. While resources are focused on trying to control the Ebola epidemic, even more people are dying from measles, cholera, and malaria in this part of the country, and they barely receive support.⁵ To cap it all, over 4.5 million people in the area struggle with critical food insecurity.

All these issues are closely interconnected in these so-called complex crises. As a result of conflicts in the area, mainly the genocides in Ituri and the ADF attacks in North-Kivu, many people are forced to flee their homes. The estimated number of displaced people from these provinces is nearing half a million. These people – now mostly living together in sites scattered across the provinces - are in urgent need of humanitarian assistance as many are dying from preventable diseases like malaria, measles, and diarrhea. Fear of further spread of Ebola through injections has prevented the response from vaccinating people against measles. Generally, the conditions in these sites are terrible, given the lack of food, shelter, and hygiene, not to mention overcrowding, hostile coexistence and resulting sexual violence.



“Support we’ve received so far to respond to outbreaks of cholera and measles has been very limited. But you cannot just say ‘you can have money for Ebola but we cannot help with other diseases’.” [Ibrahima Soce Fall, assistant director-general for emergency response at the World Health Organization] said. “In the end more people will die of those other diseases.”⁶

The Ebola response is hampered by ongoing security issues. Following an attack on Beni, killing 21 people, a *ville morte* was organized in the city. This period of mourning and striking held up the health care workers trying to reach Ebola patient contacts and limited the ability to investigate suspected cases.

It is imperative to find solutions to these issues if we want the Ebola epidemic to stop. However, in the web of problems that torment northeast DRC, each reinforcing the others, it is difficult to identify root causes. Still, efforts are being made to alleviate the burden of the countless problems the Congolese have to face. First, in combatting multiple epidemics, Médecins Sans Frontières proposes an integrated Ebola response. This entails an assimilation of Ebola-related care into local health facilities, and upgrading these facilities with respect to primary healthcare, triage, isolation, and sanitation. This way, healthcare unrelated to Ebola is improved and becomes more accessible to the community. Most local health facilities have been weakened by reallocation of staff to the Ebola response. Second, the WHO is adapting to insecurity problems by adjusting their vaccination strategy. Since it is often very difficult to identify and vaccinate contacts of cases in conflict areas, WHO invites contacts to a secure location and vaccinates them there, or they vaccinate the entire village with security forces present.

Bridging the gap between the response and the community

Distrust of health workers in the response is prevalent, and there are many rumors surrounding Ebola. Imagine living in a village in North-Kivu, being visited by strangers wearing ‘space suits’, who take away a family member to a place you are not allowed to visit and where the person will probably die. If that is not enough reason for distrust, remember the region has long supported the political opposition, resulting in suspicion towards any government interference.⁷ The exclusion of two cities in North-Kivu from presidential elections, with the Ebola outbreak cited as its reason, made this even worse. As a result of this distrust, belief in misinformation is widespread, with a significant amount of people thinking Ebola is not real, decreasing the likelihood of adopting preventive behaviors, such as acceptance of vaccines.⁸ Rumors are amplified through social media, where false information spreads faster than the epidemic. One user denied the existence of Ebola and called it a government lie.⁹ Distrust leads to community resistance to the response, including threats to healthcare workers and vandalization of healthcare and screening facilities. Distrust and misinformation also lead infected people to avoid Ebola clinics, and roughly a third of the Ebola deaths diagnosed post-mortem.

To overcome these community resistance problems the response must engage with the locals, fighting with rather than against them, but this is easier said than done. What could

help is an ‘integrated response’, demystifying the Ebola treatment and putting the focus on the patient. Adapting the response to the needs of the patient creates an environment that stimulates mutual trust and acceptance to Ebola care. The WHO is also trying to transfer ownership of the response to the community. Their method includes training local healthcare providers to carry out vaccinations and creating awareness about the disease. The latter has become an increasingly important part of the response over the past year with countless examples of efforts, such as guided visits of Ebola treatment centers for students, mobilization of local leaders to support the response, and monitoring of rumors on social media.

Ebola is highly contagious

It may sound like stating the obvious, but Ebola is highly contagious in the DRC. Human-to-human transmission can occur when body fluids of an infected person are in contact with broken skin or mucous membranes of a healthy person, possibly via some item, like clothing, bed linen, or medical waste. Those at greater risk of contracting the disease are close contacts of an infected person, health workers, and people attending burial ceremonies. Infections of the latter group have proven problematic throughout the response. Given that the body is most contagious when someone has died from Ebola, it is crucial to protect the mourners at a burial. However, many Congolese have cultural and religious practices surrounding death. For instance, in Islam it is obligatory to ritually wash a Muslim’s corpse before burying it, a tremendous risk if done without proper protection. Large efforts have been made to educate communities on the importance of safe burials. Establishing good relations with the community can help in getting consent from families to let Red Cross teams perform safe and dignified burials (SDBs) with protective suits, goggles, and gloves to prevent transmission, along with a decontaminated body bag and coffin. By welcoming family members and religious leaders, the cultural and religious aspects of the grieving process can be respected. The acceptance of the community is a requirement for safe burials as there are numerous examples of community resistance incidents during attempts at safe burials.¹⁰

“As of 15 July 2019, there have been a total of 8566 SDB alerts notified through the Red Cross SDB database, of which 6875 (80%) were responded to successfully by Red Cross and Civil Protection SDB teams and community harm reduction burial teams.”¹¹

Health workers clearly carry a heightened risk of contracting Ebola. In total, 150 health workers were infected since the onset of the epidemic, 5 percent of the total number of cases. Unfortunately, there have been occurrences where health workers were threatened to burn down their facilities, resulting in reluctance to wear protective equipment and initiate infection control procedures.¹² Uninfected people in Ebola clinics, e.g. people under surveillance or people who show Ebola-like symptoms, can get the disease if proper infection prevention procedures are not followed. These nosocomial infections constitute a significant share of the transmissions with 273 such infections documented. The WHO is working hard to train health workers in infection prevention and control.



There is enough of nothing

Resources are scarce. There are only 245,000 non-diluted doses left of the currently used vaccine.¹³

With an estimated combined population of over ten million people, this is not nearly enough for mass vaccinations in North-Kivu and Ituri. Only people exposed to the highest risk of contracting Ebola can be vaccinated. To add to this, the in-country vaccine stock is usually extremely low, often below 1,000 dosages.¹⁴ The Ebola vaccine also requires a highly sensitive cold chain to ensure its maximum potential. It must be stored in freezers that can reach temperatures of minus 80 degrees Celsius, which requires constant power supply, in a country with one of the lowest electrification rates in the world. Second, there is a funding gap which has hampered the response in recent months. Delays in payment of frontline workers have caused them to go on strike. In June, the WHO flagged a critical funding gap of 54 million US dollars which could cause a devastating setback to the response. If things were to spiral out of control, like in the 2014 Ebola outbreak, the cost of the crisis could run up to tens of billions of dollars.¹⁵ In July, the WHO declared the outbreak a Public Health Emergency of International Concern. Soon after, the World Bank committed \$300 million, and USAID and the EU contributed \$38 and \$30 million, respectively. Still, more funding will be needed to fully control the outbreak.

“Just when you thought things could not get worse ... it starts to rain. In the rainy season, heavy storms have caused the collapse of Ebola screening facilities. Furthermore, the number of cases of Malaria peaks at this time of the year. All of this not to mention complications due to the state of the roads during heavy rainfalls.”

How to tackle such complex crises? There is no single explanation for the enduring spread and survival of the disease. A vast network of complications – be it ongoing insecurity, other epidemics, community resistance, or lack of resources – are at play and it must be acknowledged that an all-round collective response to the crisis is imperative.

¹ Final report of the Group of Experts on the Democratic Republic of the Congo, p. 13. United Nations Security Council. https://reliefweb.int/sites/reliefweb.int/files/resources/S_2019_469_E.pdf.

² *Hunger, measles, cholera, and conflict: Ebola not the only killer ravaging Congo*. The New Humanitarian. <https://www.thenewhumanitarian.org/news/2019/07/03/hunger-measles-cholera-and-conflict-ebola-not-only-killer-ravaging-congo>.

³ Final report of the Group of Experts on the Democratic Republic of the Congo, p. 10. United Nations Security Council. https://reliefweb.int/sites/reliefweb.int/files/resources/S_2019_469_E.pdf.

⁴ *Mapping of Armed Groups in Eastern Congo (October 2015)*. Congo Research Group. <http://congoresearchgroup.org/mapping-of-armed-groups-in-eastern-congo-october-2015/>.

⁵ *Congo sees rise in deaths from malaria, measles, and cholera as Ebola outbreak swallows up resources*. British Medical Journal. <https://www.bmj.com/content/366/bmj.l4522.full>.

⁶ *Congo sees rise in deaths from malaria, measles, and cholera as Ebola outbreak swallows up resources*. British Medical Journal. <https://www.bmj.com/content/366/bmj.l4522.full>.

⁷ *DRC Ebola outbreak response struggling one year on*. MSF. <https://www.msf.org/drc-ebola-outbreak-response-struggling-one-year>.



⁸ *Institutional trust and misinformation in the response to the 2018–19 Ebola outbreak in North Kivu, DR Congo: a population-based survey*. P. Vink et al. (2019). *The Lancet*.

<https://www.thelancet.com/action/showPdf?pii=S1473-3099%2819%2930063-5>.

⁹ *Ebola responders in Congo confront fake news and social media chatter*. *The New Humanitarian*.

<https://www.thenewhumanitarian.org/news/2019/05/02/ebola-responders-congo-confront-fake-news-and-social-media-chatter>.

¹⁰ Ebola Virus Disease DRC External Situation Report 19, WHO,

http://apps.who.int/iris/bitstream/handle/10665/276811/SITREP_EVD_DRC_20181212-eng.pdf?ua=1.

¹¹ Ebola Virus Disease DRC External Situation Report 51, WHO,

https://apps.who.int/iris/bitstream/handle/10665/326015/SITREP_EVD_DRC_20190721-eng.pdf?ua=1.

¹² Ebola Virus Disease DRC External Situation Report 42, WHO,

https://apps.who.int/iris/bitstream/handle/10665/324843/SITREP_EVD_DRC_20190521-eng.pdf?ua=1.

¹³ *J&J Ebola Shot Languishes, Making Merck Vaccine Only Option*. Bloomberg.

<https://www.bloomberg.com/news/articles/2019-07-21/johnson-johnson-shot-languishes-amid-deadly-ebola-outbreak>.

¹⁴ *Not contained, new cases: three questions on vaccines and the Ebola outbreak in DRC*. MSF.

<https://www.msf.org/not-contained-new-cases-three-questions-vaccines-and-ebola-outbreak-drc-democratic-republic-congo>.

¹⁵ *The Economic and Social Burden of the 2014 Ebola Outbreak in West Africa*. Huber C., Finelli L. and Stevens W. (2018). *The Journal of Infectious Diseases*. https://academic.oup.com/jid/article-abstract/218/suppl_5/S698/5129071.