Democratic Republic of Congo
Assessment Report for Post-Ebola planning

March 11-24, 2020

EXECUTIVE SUMMARY

The world's second-deadliest Ebola outbreak and the tenth epidemic in the Democratic Republic of the Congo (DRC), which occurred in the East of the country, was finally declared over on the 25th of June 2020, after almost two years of combined efforts of the DRC authorities, civil society and the international community. In total, 3.470 people were affected by Ebola (3.317 confirmed and 153 probable), of which 2.287 people sadly lost their lives and 1.171 people survived. Previous outbreaks and the ongoing COVID-19 pandemic have shown the impact health epidemics can have on people's lives. To understand how this outbreak had impacted people living in North-Kivu, IRC conducted an assessment in March 2020.

The following report is based on focus group discussions and key informant interviews from ten communities in Beni and Butembo, North Kivu. The purpose of this assessment was to collect data from communities, to listen to their perspectives on how the Ebola Virus Disease affected their lives. The report explains the methodology, and findings across multiple program sectors as well as recommendations. Some key findings include:

- The Ebola Virus Disease (EVD) disrupted people's well-being, including fear, stress and panic. People also reported they had experienced a lack of understanding and acceptance of the disease, due to how it was introduced, and had experienced fear to seek health care.

- Security was one of the major concerns for the people interviewed, both related to the EVD response period as the future. Attacks against health workers and health facilities created fear, with community health workers reporting being threatened and attacked. People also expressed their concerns about what would happen after the EVD response would stop, with fears that there would be an increase in criminality and banditry due to the high unemployment that would follow.

- The EVD had also socio-economic effects. Men and women reported that there had been changes in the relationships within families and communities, decision-making within households, and more conflicts and disagreements. Livelihoods were also disrupted as access to fields and markets became more difficult, and the labor market was affected due to people who were recruited for the EVD response. Women were exposed to higher threats of sexual exploitation and domestic violence, and children's access to health and education were affected as well.

- People felt left out of the response initially, as there was little implication of local actors, and communication from response actors created confusion. In future responses, communities recommend ensuring that various local actors participate in activities and that communications approaches and messages are adapted to their realities.

- Communities are concerned about stigma and the isolation which they would experience, and the return of the disease.

- Fourteen percent of the people perceived changes in their needs compared to before the EVD outbreak, with an increase in needs for WASH and health. When asked what the most pressing needs were in March 2020, WASH, health, income-generating activities and security were most often cited by groups and individual men and women.

- When asked what the international community can do to help the recovery of the communities affected by EVD, the most common responses were related to income-generating activities, hygiene awareness and promotion through different channels.

I. INTRODUCTION

In August 2018, the government of the Democratic Republic of Congo (DRC) declared an outbreak of the Ebola Virus Disease (EVD) in North Kivu province. The IRC responded by strengthening Infection Prevention and Control (IPC), including triage, referrals, surveillance, training and supplies. At the time of this assessment in March 2020, the IRC worked in 85 Health Facilities (in French: formations sanitaires - FOSAs). In addition to IPC, the IRC supported communities through child protection, as well as women's protection and empowerment activities. Through risk communication and community engagement activities, the IRC remained close to the communities to understand their needs and adapt the interventions through the community feedback received.

To plan for the transition out of the EVD response as cases declined, the IRC commissioned an internal assessment. The purpose was to speak with communities and gather data about the effects of the EVD response, as well as current priorities both within the context of EVD and the ongoing humanitarian crisis in the province. This report presents the assessment's findings and recommendations, based on communities' voices and perspectives.

1.1. Methodology

As the purpose was to collect data on community-level priorities, this assessment did not require a household-level survey. Traditionally, a household survey is used to collect individual experiences in relation to a crisis, such as number of times individuals eat within a day, specific hygiene practices, etc. Instead, data on community priorities could be obtained through Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs). As surveys were designed questions were streamlined based on available secondary data, such as IRC assessments[1] and other external assessments.[2] The purpose was to avoid duplicating questions if the information existed in reports.

Though some questions were quantitative, much of the data was qualitative, to gather more specific detail and perspectives. The team felt that there was a risk of over-prescribing the assessment to the point where respondents might just say "yes" to everything, or that it would not give them the opportunity to explain how their communities were affected by EVD. To analyze the qualitative data, responses were assigned codes based on themes that emerged from the data (e.g. inductive, or grounded analysis). The counts within the data (e.g. N=x) are based on the number of mentions. For example, if KIIs were asked "how has EVD affected women in your community?" and one KII lists three things, while another KII lists five things, it would be the number of times that something was mentioned. If both of those KIIs said something about women being mocked or humiliated, then that data would be coded together, and that would be N=2 for 'women are stigmatized'. In addition, quotes are inserted in this report where relevant, keeping in mind that they have been translated from the local language to French (data was interpreted by assessors and entered in French), and then translated to English.

FGDs were approximately 10 people per group, separately male and female. After discussing with the response team, KIIs were determined to be focal points within the community, such as village chiefs, teachers, religious leaders, and vendors. To represent the needs of women and children, KIIs were from women's associations, as well as community child-focused organizations: child parliaments (Parlement d'enfants); RECOPE (Reseau Communautaire pour le Protection de l'Enfant) or child protection network; and a ministry organization, DIVAS (Division d'Affaires Provinciales de Nord Kivu). Health KIIs included IPC nurse or doctors at the health facilities, health development committees from the Ministry (CODESAS), community health workers, and traditional healers. All participants received informed consent and all were above the age of 18, as this assessment did not require interviewing children.

The aim was to learn from communities about the positive and negative effects of EVD on their communities, and their perspective on community needs, rather than their own households. To obtain diverse perspectives, the teams elected the abovementioned KIIs based on experience in the communities. These people were deemed as suitable to speak on behalf of the needs and changes in each community (e.g. teachers can speak to their observations on children's needs).

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[1] International Rescue Committee. 4 February 2020. "Not all that bleeds is Ebola: how the DRC outbreak impacts reproductive health". And IRC March 2019: "Everything on her shoulders: Rapid assessment on gender and violence against women and girls in the Ebola outbreak in Beni, DRC."
[2] Mercy Corps. 12 August 2019. "The Ebola Effect: Economic Impact of a Public Health Care Crisis".
World Vision. February 2020. "Fear and Isolation: the impact of Ebola and war on child protection in the Democratic Republic of Congo."
Translators Without Borders. December 2019. "We need to talk: Effective Ebola risk communication requires respect and transparency and remains as vital as ever".

Data was collected between March 11-24, using mobile devices and the platform, KoboCollect. A total of 111 KIIs were interviewed, but eight were removed because they were duplicates (e.g. two village chiefs in one location), which could bias perspectives. Of the 103 KIIs, 38 were female (37%) and 65 were male. There were 20 FGDs (10 male, 10 female), with participants in each FGD, ranging from 7-16. The IRC aims for 8-10 participants per group to enable active participation from each participant. In this context, despite efforts to maintain a maximum of 10 participants, the average was 12. A total of 237 people participated in FGDs, including 128 women and 109 men. This means that between KIIs and FGDs, 340 people were interviewed, with a 49/51 per cent ratio between women and men (166 women and 174 men) respectively.

1.2.   Locations

The assessment team coordinated with the health team to determine appropriate locations for this assessment. During the whole period of the EVD outbreak (August 2018 – June 2020), IRC supported 123 Health facilities in total, but as mentioned before at the time of the evaluation, 85 FOSAs were being supported. Thirty were removed as potential assessment locations, because the IRC was phasing out these FOSAs based on a positive IPC score (meaning that there were reduced EVD cases and less of a need for support, compared to other FOSAs). To further reduce from the remaining 53 FOSAs, for security reasons, time limitations, and logistics, the team selected FOSAs near the IRC's offices in Béni and Butembo. This left 32 remaining FOSAs. To select the final 10 (with a few backups, in case of security challenges), the team chose FOSAs where the IRC was more directly engaged with the community (rather than a referral hospital or HGR). The goal was to be as 'close' to the community as possible to gain relevant perspectives. Seven out of the ten final locations were in Béni: Butsili, Emmanuel D'Alzon, Kasabinyole, Kasanga, Mapendo, Mulamo and Paida; and the remaining three in Butembo were Makasi, Malende, and Vuteste. Together, the ten locations had 22 confirmed Ebola cases between 2018 and 2020.

1.3.   Limitations

The volume of qualitative data and coding meant that it was challenging to disaggregate and associate the KII sex or type to each finding. However, throughout the coding process, if there was an anomaly or particularly noteworthy quote or data, a note would be assigned to mention the KII source and sex. There were few differing opinions throughout the data coding and analysis process that required a need to compare against men and women, or KII type. The team also streamlined some FGD questions (e.g. asked women questions about women's needs, and men about men's needs, rather than ask both), due to the volume of questions and time allocated to collect data. Another limitation was the delay it took to get authorization from the Ebola coordination to conduct the survey on the ground, which shortened the time available to conduct the interviews and Focus groups.

Assessors were a mix of IRC staff as well as recruited locally. Health staff were involved to clarify technical terms in their interviews with health KIIs. To reduce bias, these staff worked in different IRC FOSAs in Mabalako, rather than in the ten assessed locations. In addition, other IRC staff did not work directly within a program, but were community engagement and accountability focal points. As they are accustomed to gathering feedback across all sectors, these staff were seen as a step removed from bias. Assessors hired locally were teamed up with the IRC staff as a support to collecting data (as some assessors had varying experience), and to keep the IRC as unbiased as possible during data collection.

II. THE CONTEXT IN NORTH-KIVU AND ITURI PREVIOUS TO THE OUTBREAK

The DRC has been confronted for over two decades with a humanitarian crisis and large-scale displacements, due to armed conflicts and structural governance issues. Since 2017, the situation has been deteriorating steadily, and in 2020 the DRC was the third major humanitarian crisis worldwide, with 15.9 million people in need of humanitarian assistance. The Eastern areas of the country are marked today by a protracted displacement crisis, a major protection crisis, and several epidemics (cholera, measles), which have resulted in high humanitarian needs in the North-Kivu and Ituri provinces.

> **Key figures DRC Humanitarian Needs Overview 2020**
>
> · 15.9 million people in need
> · 8.1 million people targeted for assistance
> · 8.59 million children in need
> · 15.57 million people in food crisis (IPC 3 and 4)
> · 5.51 million IDPs

Before the Ebola outbreak began in 2018, the Humanitarian Needs Overview estimated that 1.2 million people were in need of humanitarian assistance in the two provinces, with more than 1.3 million people living in displacement. Since the 1st of August 2018, the situation in the two provinces has continued to deteriorate. This is partly due to the political crisis that destabilized the country since 2015, as well as an intensification of interethnic conflicts and attacks from non-state armed groups, including against health actors and facilities.

> **Priority sectors identified in 2018's North-Kivu and Ituri Humanitarian Response Plan in terms of people in need:**
>
> 1. Protection: 1,23 M
> 2. WASH: 1,22 M
> 3. Health: 0,68 M
> 4. Food Security: 0,64 M
> 5. Shelter and NFIs: 0,57 M
> 6. Education: 0,48 M
> 7. Nutrition: 0,14 M

The World Health Organization reported that more than 420 attacks against health facilities and health workers had been recorded between the 1st of August 2018 and the 27th of February 2020, including 11 deaths and 86 injuries. This was a significant increase compared to previous years, as between the 1st of August 2016 and the 30th of July 2018 2 attacks had been recorded[3].

In areas which had been historically less affected by conflicts, such as the city of Butembo, more insecurity and criminality[4] was reported over the period of the Ebola outbreak, and overall needs for basic services have remained high throughout.

Figure 1 Kivu Security Tracker data for Butembo area - August 2017 to February 2020

As a result of the intensified conflicts, the number of displaced persons in the two provinces has continued to increase, while the humanitarian needs have been largely unattended due to systematic underfunding since several years, with funding gaps close to 50% since 2017, and by mid-2020 the HRP for this year only funded up to 14%.

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[3] Surveillance system for attacks on Health Care (SSA) – World Health Organization
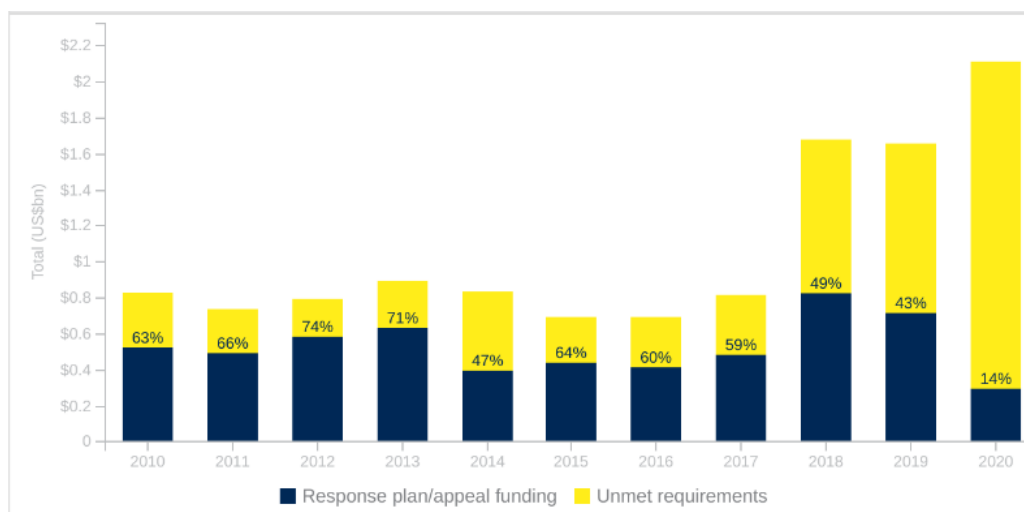[4] INSO MVE report 2019 ; INSO alerts ; Kivu Security Tracker data.

Figure 2 FTS UNOCHA: Trends in response plan/appeal requirements 2010- June 2020 for DRC

In the first months of the EVD response, humanitarian organizations had also raised concerns about the impact the response was having on the humanitarian operations, and the lack of humanitarian funding which was necessary to address the most urgent humanitarian needs.

From 1.2 million people estimated to be in need of humanitarian assistance in the first months of 2018 in Ituri and North-Kivu, the number increased to 4.3 million people in 2020 for both provinces[5]. The sharp increase in humanitarian needs cannot be attributed solely to the EVD response, as some of the areas which have been confronted with an intensification of conflicts and have been affected by disasters were not affected by the EVD outbreak, but an analysis by OCHA between September 2018 and October 2019 indicated that the vulnerability of people living in the 17 health zones which had been doubled affected by EVD and a humanitarian situation had increased according to several indicators, except in one area[6].

III. GENERAL FINDINGS IN MARCH 2020

When asked how EVD has disrupted communities, the top ten reasons given by KIIs were categorized as follows:

1. Fear, stress, and panic in the community (e.g. of unknown, visiting the sick). This was mentioned by 21 people and confirms previous findings of research conducted during and after the West-African Ebola outbreak in 2014-2016 and social sciences research conducted during the North-Kivu outbreak[7].

2. Lack of understanding and acceptance (e.g. didn't know how to behave, did not understand the origin of the disease). 17 people reported this to be one of the main disruptions and specified that "*Ebola was badly introduced by the response teams*" and that "*people did not understand this disease because it killed like the massacres*". Several researches conducted showed how the lack of appropriate communications and effective engagement with the communities resulted in a lack of understanding and acceptance[8], which eventually fueled strong mistrust including violent acts against the response.

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[5] Humanitarian Response Plans for North-Kivu and Ituri 2018, 2019 and the HRP pour le Nord-Kivu et ex-province Orientale 2020, Humanitarian Needs Overview 2020.
[6] Indicators analyzed in the Humanitarian Response Plan for North-Kivu and the ex-Provincial looked at the number of IDPs and returnees; number of protection incidents; morbidity of epidemics such as cholera, measles and Yellow Fever; IPC phase per health zone and malnutrition.
[7] A. O'Leary, M. F. Jalloh and Y. Neria. "Fear and culture: contextualising mental health impact of the 2014-2016 Ebola epidemic in West-Africa".
[8] P. Vinck PhD et al. 27 March 2019. "Institutional trust and misinformation in the response to the 2018–19 Ebola outbreak in North Kivu, DR Congo: a population-based survey"; Translators without borders, December 2019. "We need to talk. Effective Ebola risk communication requires respect and transparency and remains as vital as ever". TWB March 2019. "Missing the mark? A rapid language needs assessment in Goma, DRC".

3. Fear of seeking treatment (e.g. lack of trust in health center, lack of trust in vaccine). 16 people reported that the EVD had made them afraid of seeking treatment, and according to some it was what made people not get vaccinations. The epidemic was perceived as a business, imposed by people who spoke foreign languages. Research from the Social Sciences Analysis Cell in September 2019 in Beni territory had indeed concluded that fear was one of the main barriers for people to seek treatment, which impacted the delays in visiting the health facilities. A previous program assessment of IRC on sexual and reproductive health in the Ebola outbreak showed also that women had delayed visiting health centers due to fear, which added life-threatening delays for some[9].

4. Lack of social cohesion, and more precisely changed friendships, lack of engagement in the community and less solidarity was reported by 15 people. The EVD "*Lowered the rate of love and solidarity in the community*", created distance within the communities and it "*cut relationships between friends and relatives*".

5. Conflict or disagreements, between families, between nurses and families that lost members, was also reported by 12 people.

6. Coping with death and trauma was mentioned by 10 people. "*Everyone expected death*" and demoralized communities were named specifically. In the West-African outbreak, research had shown that people suffered from Post-Traumatic Stress Disorder due to the EVD, including health workers and survivors, and this has been also reflected in research conducted in the North-Kivu outbreak.[10]

7. Ten people reported their daily activities had been disrupted and they perceived changed customs.

8. There were also six mentions of perceived political reasons and/or disrupted elections. Legislative and provincial elections which were supposed to be held in December 2018 were reported in Beni and Butembo to March 2020, as the authorities had decided that the Ebola would bring risks to holding the elections, but the population perceived it differently. According to one KII, there was a political perception as the government hid behind the outbreak to keep the population away from the election. In community feedback reports from the SCAC and in IRC community feedback reports, mentions of political causes for the Ebola outbreak were common throughout 2018 and 2019.

9. Six people also perceived a disruption in the economy, as "*work in the fields was no longer done as before*". Research from Mercy Corps showed indeed that an Ebola outbreak can have a serious impact on the overall economy.[11]

10. Some services in health centers were perceived as disrupted according to five people. This was also a finding of the IRC's report on sexual and reproductive health in the Ebola outbreak in North-Kivu, which indicated that maternal health services and prenatal services had been disrupted.

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[9] International Rescue Committee. 4 February 2020. "Not all that bleeds is Ebola: how the DRC outbreak impacts reproductive health".
[10] L. Paladino, R.P. Sharpe, S.C. Galwankar, June 2017. "Reflections on the Ebola Public Health Emergency of International Concern, Part 2: The Unseen Epidemic of Posttraumatic Stress among Health-Care Personnel and Survivors of the 2014-2016 Ebola outbreak."; Shultz JM, Baingana F, Neria Y. 2015. The 2014 Ebola outbreak and mental health: Current status and recommended response; World Vision. February 2020. "Fear and Isolation: the impact of Ebola and war on child protection in the Democratic Republic of Congo.";
[11] Mercy Corps. 12 August 2019. "The Ebola Effect: Economic Impact of a Public Health Care Crisis"

COMMUNITY ACCEPTANCE AND COMMUNICATION

KIIs mentioned a "*lack of understanding and acceptance*" of the response. When FGDs were asked if cholera and EVD messaging was clear and understandable, almost half (N=9 for cholera and N=8 for EVD) said they did not understand the messages. When asked why, they suggested in both cases to use local grassroots community networks and authorities as "*in the beginning, there was poor communication from sensitizers and the local population wasn't properly engaged*". More specifically, for EVD, FGDs suggested to "*de-politicize health*", noting that "messaging came at the same time as the electoral campaign" (N=3); and that the "*response team [should] not be accompanied by armed forces*" (N=1).

These findings confirm the tendency of mistrust of communities and the communication challenges that marked the EVD response, and which resulted in an important impediment to contain the outbreak. When asked what could have been improved in the response (not specific to IRC but the overall EVD and humanitarian response) KIIs mentioned as the top three answers:

1) More local recruitments (considering local customs, giving preference to local doctors and nurses in the community) (N=13)
2) The use of local languages (N=7)
3) Involving the local population, e.g. local leaders, community health workers, community relays ("RECO"), local associations (N=4).

Other suggestions were related to the quality of services, as some suggested to recruit specialists instead of amateurs (N=2), improving the constructions and placement of the isolation units and Ebola Treatment Centers (ETC) (N=2), improving the training of local nurses and doctors (N=1), improving the welcoming of patients in the centers (N=1), improving the training of people carrying out community awareness (N=1) as well as ensuring that trainings were "sincere" (N=1) and avoiding duplication of assistance (traditional healer – N=1).

Many additional comments were focused on the lack of inclusion. KIIs recommended studying the communities well before intervening (N=2), involving religious leaders (N=1), ensuring the inclusion of marginalized groups such as people with physical disabilities, elderly and widows (N=1), ensuring all layers of communities and local leaders were informed (N=1), engaging also non-medical staff in IPC such as traditional healers (N=1) and not only giving confidence to religious leaders (N=1).

Some comments were related to survivors and stigmatization. One KII recommended to avoid discrimination against the population (N=1), one community child based organization recommend avoiding exposing EVD survivors to the media as it traumatized them (N=1) and one person recommended to ensure food and non-food items assistance for the survivors who left the centers (N=1). On the response, there was one suggestion to improve the rapidity of the interventions so there would have been fewer deaths (N=1) and another person recommended ensuring security for health staff (N=1).

These overall suggestions are strongly in line with the feedback which was collected throughout the response by the Social Sciences Analysis cell between September 2018 and February 2020 and the LEVER Consortium reports in the most recent months.

The above is to get a sense of what people had to encounter and how it altered the social fabric.
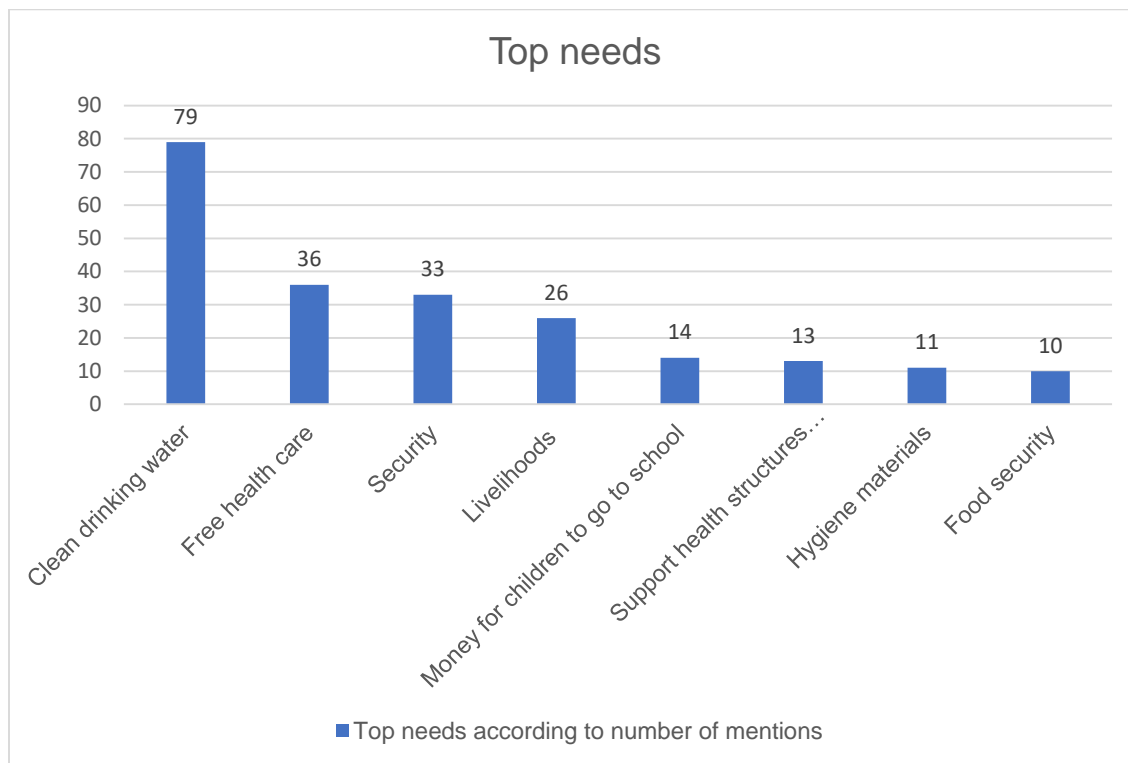
"In the beginning, there was poor communication from sensitizers and the local population wasn't properly engaged"

"Response team [should] not be accompanied by armed forces"

IV. NEEDS

When asked to suggest the overall top three needs in the community, 79 people mentioned clean drinking, water, 36 free health care and 33 security. Other top needs were related to livelihoods, education, quality of health care, hygiene materials and food security.

Top needs

Values shown on bars: Clean drinking water 79, Free health care 36, Security 33, Livelihoods 26, Money for children to go to school 14, Support health structures… 13, Hygiene materials 11, Food security 10

■ Top needs according to number of mentions

When KIIs were asked on the top five needs for women and men accordingly, they mentioned:

For women	
1.	Income generating activities (sewing, hairdressing, upholstery, making mats, livestock, agriculture) (N=39)
2.	Potable water (N=25)
3.	Security (N=12)
4.	Free health care (N=11)
5.	Psychosocial support (N=8)

For men	
1.	Jobs (N=67)
2.	Security (N=18)
3.	Free health care (N=16)
4.	Potable water (N=12)
5.	Access to fields (N=8)

FGDs specified needs for women and girls. Overwhelmingly, this was related to income-generating activities, such as training on manual labor, sewing, livestock, and hairdressing (N=17). Remaining answers included female hygiene kits (N=3), followed by N=1 for reinforcing gender awareness in the community, inform women and provide access to treatment, psychosocial support, and support young mothers with literacy and skills.

For children, FGDs said that the main needs for children were:

1. Education (N=14)
2. Free health care (N=10)
3. Nutrition (N=8)
4. Recreational areas for them to play (N=7)
5. Support to deal with trauma (N=4)

Other needs which were mentioned were water and latrines in schools (N=2); vocational training for youth (N=2), and N=1 for clothing, school fees, children's safe spaces, and comedy theatre to help them de-stress. KIIs said that the three main needs were free access to school (N=21), games to de-stress to support their psychological development (N=14), safe spaces for children (N-11).

Fourteen KIIs said that these needs are different as a result of EVD. When asked why, reasons included: the need for additional supplies to reinforce hand washing; displacement out of fear of EVD, funds to go to health centers "*before Ebola, people auto-medicated. Now they go to the health center*"; rehabilitating water sources supports hygiene; need for clean water has increased – people are using more; orphans because of EVD; and insecurity that follows unemployment, since many people were employed because of the EVD response.

4.1. Primary health care

FGDs specified their key needs within health, with the top four are free health care, good infrastructure/equipment, potable water sources, and quality health care.

Health needs

	Free health care	Good infrastructure/equipment	Potable water sources	Quality health care
■	12	10	7	4
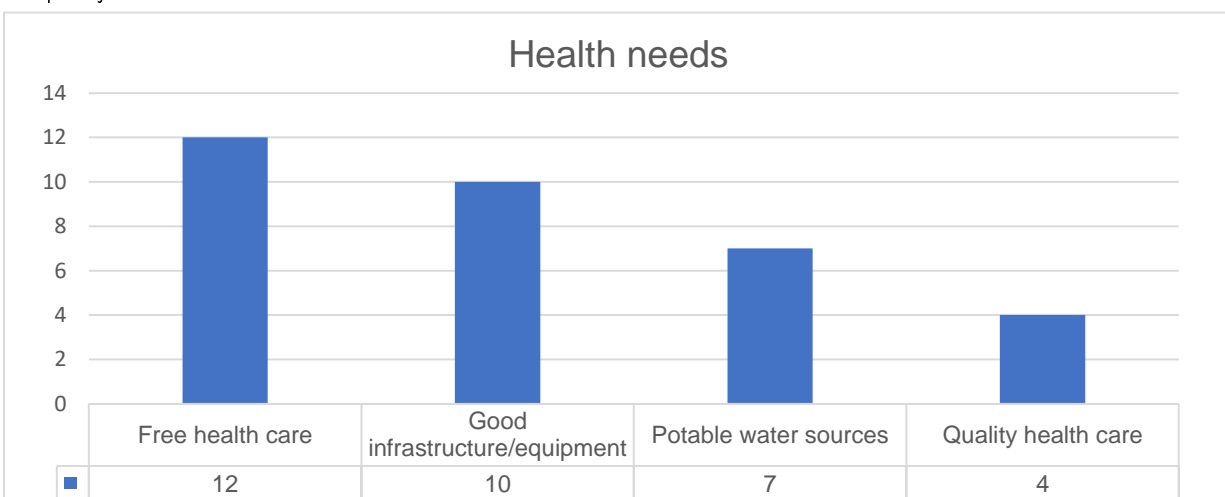
FGDs said that in the context of EVD, if they sought health care, they would first: self-medicate (N=8), seek '*modern medicine*' (N=5), traditional healer (N=4), religious figure (N=1), and other options included pharmacy to self-medicate (N=5), and one group said "*we hide in our houses because of the poor awareness and high mortality rate*". Similarly, when asked who they would trust to help them if they were ill or knew someone needed help, FGDs said a health center (N=12), pharmacy (N=4), traditional healer (N=2), and community health worker (N=1). When asked to specify 'other', one female FGD said: "*private dispensary, because we're afraid to be referred to the ETC*".

KIIs noted the biggest risks to the health system with the withdrawal of the EVD response, specifically for health actors. These include threat or conflict from the population (N=16), further exposure or risk to disease (N=10), loss of incentives means that people will abandon their work (N=7), and lack of medicine and proper supplies (N=6). In regards to increased risks of conflict, two quotes illustrate perceptions against health workers: "*Health care providers will be suspected by the community if free health care is cut*" and "*They will be prosecuted, thinking that they have made money*".

More specifically, Community Health Workers (CHWs) were asked how EVD affected them. Out of ten respondents, six said that they had conflict with our families and neighbors. "*We were threatened in our neighborhoods*"; "*Some of us were killed, and our houses destroyed*"; "*we were beaten*". The remaining three responses (one person did not respond) were difficulty to help the population understand EVD, fear of death, and discouraged. Two CODESAS representatives participated, and both mentioned that they are accused by the community of having money, more specifically "*the community doesn't trust CODESAS, they think we are paying people to say that there is an EVD case where there is not*".

"Some of us were killed, and our houses destroyed"

All health KIIs (N=36, including doctors, nurses, traditional healers, CODESAS, and CHWs, were asked how the FOSAs were affected:

Diminished cases of EVD *(the only positive response)*	5
Staff were threatened	5
Destroyed materials	4
Burned health buildings	4
Withdrawal of some health care staff "Staff fled and left the ill in the health structures"	6
Staff were beaten by bandits	2
Lack of confidence "Nursing staff were considered accomplices to the deaths"	2
We (staff) were afraid of EVD	1
People did not come to the health centers because they were scared	1
The work was difficult	1
Patients fled	1
Neighbors to the health center "condemned the health center because of reported cases"	1
Conflict with neighbors who were not employed by the response	1

Female workers seem to be particularly vulnerable to threats and attacks. Four FGDs said that female response workers have faced threats, including public threats to female CHWs and local associations: "*even women who worked in CODESAS moved back to their homes because bandits were revolting against health workers*".

4.2. Environmental Health (WASH)

All FGDs reported some difficulty accessing potable water, including paying for water (16/20 FGDs); long distances (N=10); water point is not secure (N=12); risks of attacks when fetching water (N=9), unsafe to drink (N=3); insufficient amount (N=2), and not accessible to everyone (N=1).

Payment in Congolese Francs for 20L of water ranged from 50 CDF ($0.03) to 1500 CDF ($0.84). The higher payments were in Makasi.

Only one FGD (male) said that they have a safe place to bathe. All FGDs said that they do not have access to safe and clean latrines.

While FGDs were not asked specifically about WASH needs (they were asked about health), when asked about other needs in the community, three said a water pipeline (notably in Makasi and Vuteste), waste management (N=2), and N=1 for household latrines, public latrines, rehabilitate water sources, rainwater management, and hygiene kits.

4.3. Protection and rule of law (PRoL)

The main change in protection risk due to EVD that KIIs identified was attacks and intimidation toward health workers (N=10).

KIIs and FGDs were asked about specific barriers to services, including groups of people, as well as the types of barriers. In terms of who created barriers, FGDs listed youth groups, religious leaders, "*pressure groups*", gangs, and "*young taxi men that harassed the response team*" all created barriers for children to access health services. Female and male FGDs said that barriers for women were that both their husbands and neighbors prevented/discouraged/intimidated women from accessing health services. Eight FGDs said that the main barrier for children to access services was that their parents were intimidating them or went to the pharmacy instead to self-medicate.

KIIs also noted additional groups that affect power dynamics in the community, as a result of EVD:

Intimidation from armed groups (e.g. Mai-Mai groups)	14
"Pressure groups"	12
Religious belief systems	7
Some isolated youth harass people	7
Some husbands forbid to work in the health centers	1
Some husbands forbid family members to seek health care	1
"Politicians that said EVD is a political issue to manipulate people"	1
"Some traditional healers and nurses impede people to access health care"	1

Specific types of barriers were intimidation (N=6), stigmatizing those who have been to the ETC (N=3), and N=1 for violence, threats, circulating negative messages, and saying the opposite of the messages shared about EVD.

When asked about services they do not trust in the community, five FGDs said health centers "*they have always been a target since Ebola…since bandits come to them*", and "*they require you to present your voting ID, which causes insecurity*", and N=1 for public spaces, church entrances, markets, and "*water points are in the same location as the military*".

The top five ways that decision-making in the household was affected by EVD:

Conflict between whether children to seek treatment or receive vaccination (e.g. "women tend to prefer child gets health care"; "some children died because a parent refused")	17
Seeking health care (treatment, vaccine) (e.g. if one accepts the vaccine, and the other does not)	14
The extent to which each parent both understands and reinforces good hygiene practice	13
Spouses separated (e.g. if one of them had EVD)	9
When women got a job with the response team, it wasn't accepted by men ("it changed the decisions in the family"; "insubordination of women")	6

Stigma

Previous research conducted in the West-African Ebola outbreak indicated that survivors and affected communities were confronted with stigmatization, which could have an impact on mental health and social cohesion.

Within this assessment, in terms of stigma against men, the top five ways that men were stigmatized according to KIIs: people feared that recovered patients would re-contaminate (N=14); isolated or separation within the spouse (N=10); people don't go near them or visit them (N=9); public humiliation (mocked, accused of sorcery) (N=9), and recovered EVD patients were accepted in the community, but with doubt (N=5).

In terms of ways that women were stigmatized in the community, they were "*not easily accepted*" (N=14); separation from their husbands (e.g. "considered naïve for accepting to go to the ETC") (N=13); public mockery and contempt (N=9); people avoiding them (N=9). Two anecdotes (N=1) were that widows are neglected, and "*women have become solitary as a result of Ebola, because it humiliates them*".

The FGDs had varying opinions on stigma. Five said there was no stigma, four said that they were afraid that other women would infect them, and two said that stigma occurred in the beginning, but now women who had EVD are integrated into the community. In terms of ways to reduce stigma, FGDs suggested awareness in churches, through youth groups, radio, interviews and in conversations (N=7). Remaining answers (all N=1) suggested promoting family acceptance, continue psychosocial support, and create EVD survivor groups. The male FGDs suggested organizing debates between community leaders and young people, put religious leaders at the helm of awareness campaigns, and acknowledge that midwives and community leaders convinced people to intermingle again.

In terms of ways that children were stigmatized, KIIs said that friends wouldn't play with them (N=11), they were mocked by neighbors (N=8), treated with doubt in the community and isolated (both N=5), people did not get close to them or were afraid (N=4), orphans were neglected (N=2), and N=1 for orphans were stigmatized at school, chased, "*despised by others*", and nobody helped them.

4.4. Women's Protection and Empowerment

KIIs identified the top four new threats to women since EVD:

1. Sexual exploitation/transactional sex to get a job in the response "*some organizations recruited women in exchange for sex*" (N=9). While mentioned by only one KII, to support the point about transactional recruitment, one female FGD said that women give half their salary to the person who gave her the job.
2. Domestic violence related to women supporting their families to seek health care, while their husbands forbid it (N=8).
3. Domestic violence because they worked in the response "*women…who worked without consent from their husbands*" (N=7).
4. Separation or divorce "*forced*" – because she received treatment for EVD (N=4).

Additional negative consequences to women as a result of EVD included trauma from death and becoming widows (N=25); separation/divorce/broken engagements (N=11); stigmatized/isolated (N=7); and rejected from the household or conflict in the family (N=7). While these were the top four, anecdotal but noteworthy examples: "*they receive sexual threats before entering a health service*" and "*many [women] experienced sexual harassment and are pregnant by response doctors*" (N=2). Within the family, one KII said that there is a "*crisis of confidence between women who work in the response and their spouses*".

FGDs supported these effects, with one female FGD saying that there were "*issues in households because it's not accepted that men bring children to the ETC*". They listed other negative effects of EVD as being "*afraid to bring sick people to the ETC because the sick person had to stay alone without their family*". They also mentioned less solidarity in the family and community, and confirmed what KIIs said about family conflicts because women worked in the response. The two positive effects that FGDs expressed were that women were reinforcing good hygiene practices within the household, and that the EVD response provided an opportunity for them to work.

KIIs explained harmful coping strategies were self-medicating at home and not seeking treatment (N=7); resisting response workers, such as mocking them and "*singing while men throw stones*" (N=6); transactional sex in exchange for work (N=4); drink alcohol so as not to catch EVD (N=3). Other examples (all N=1) getting married in exchange for work, ignoring hygiene measures, and tattooing themselves so as not to get EVD.

When asked about the perceptions of women's concerns of EVD and its effects, KIIs said the key concerns were the return of EVD (N=25); being rejected or abandoned by their husband if they survived EVD (including accused of infidelity) (N=14).

Services available to women and girls included: health centers, women's associations, safe space, psychologist, church, children's safe space, Parlement des enfants, and "sages" or wise people in the community. The only location where there was no mention of services was in Paida.

KIIs said that the role of women has changed since EVD because women are reinforcing good hygiene measures (N=17); reduced ability to earn money from their small business and loss of food product (N=9); staying home and not meeting in groups (N=5); left their work or activities to work on the EVD response (N=2); monitoring children more closely to reduce the spread of EVD (N=2); and one female vendor said: "the character of women has changed, especially in terms of pride".

4.5. Sexual and Reproductive Health

Concerns about the effects of EVD (KIIs) include:

1. Long-term effects of the vaccine (e.g. being sterile, birth defects) (N=10).
2. Their partner is having an affair and unprotected sex (N=4).
3. Fear of losing their baby due to EVD (N=3).
4. Being pregnant with bleeding and elevated temperature – thus suspected of having EVD (N=2).
5. Not being able to breastfeed their children, mother to baby transmission, and both unintended pregnancies and sexually transmitted infections due to sexual violence (all N=1).

A few KIIs provided anecdotal harmful coping strategies that women were using (both N=1): were giving birth at home and no longer using condoms.

Among the list of needs for women, seven KIIs said "free maternal health care" and three said that equipment to support the maternity ward.

Seven out of ten female FGDs said that they have difficulties accessing maternal health services, such as prenatal consultation. When asked for more specificity, two FGDs said that there was not enough information about services or the type of medicine they would receive, and two cited poor quality of materials and services. The remaining comments (all N=1) noted the lack of transport, lack of finances, no local services available, and "*we're afraid of being infected because we are not vaccinated*".

4.6. Child Protection

According to KIIs, the role of children has changed since EVD in terms of respecting hygiene rules, they became awareness-raising actors in the community, they help their parents to clean the house, don't go long distances, "*no longer eat just anything*", ask their parents' permission before doing anything, and one negative change is that they have "*become delinquents who throw rocks at response vehicles*".

FGDs reported new threats to children in the community since EVD, including:

1. Lack of access to school (displacement, illness, parents don't want them to risk contamination) (N=4).
2. Lack of access to health care (N=3).
3. Discrimination (if they were vaccinated, directly affected by EVD, lost their parents) (N=3).
4. Threatened by their parents if they were vaccinated at school without parents' permission (N=1).
5. Trauma (from death, as well as "messaging about Ebola from the response teams") (N=1).

KIIs said that the main threats to children at the community level were:

1. Limited movement (N=20).
2. Refusal to send children to seek health care (N=16).
3. Economic exploitation – e.g. now selling bananas (N=6).
4. Intimidation and conflict with parents who are stressed or drunk (N=4).
5. Trauma (N=4).
6. Physical violence (N=3).
7. Negligence (N=3).
8. Separation from parents, parents' fear of contamination, stigma if they are suspected to have EVD (N=2) and N=1 for sexual violence, keeping children from school, and abandoning children due to poverty.

KIIs said that at the individual level, the main threats to children are stigma (N=12), isolation (N=10); N=4 for aggression, orphans abandoned or not taken under care, violence; exploitation – heavy work (N=3), presence of armed groups (N=2), and N=1 for kidnapping, sexual violence, sexual exploitation "*maison des tolerances*", rumors that the EVD response "*kills children*", and "*pressure groups*" that recruit children to throw stones at trucks from response teams.

In terms of changes observed in children, the only positive thing FGDs noted was practicing good hygiene (N=12). The remaining changes were negative, including that they no longer play in groups (N=3), trauma (N=2), lack of freedom of movement (N=2), and N=1 for isolation, orphaned, fear of EVD, "*vaccine was seen as something that caused death*"; and "*stress caused from the rapid removal of sick people from their family, particularly for breastfeeding mothers*". KIIs said that they observed two negative coping mechanisms: children resisted parents, and joined the "pressure groups".

There was limited data in terms of observations of unaccompanied and separated children. The range of children was unreliable. Most KIIs said between 2-10 children in their respective communities, but two answers included "2000" and "1236". Of those who responded, N=18 said that it was boys and girls equally, and N=11 said that it was children aged 6=11, followed by children aged 0-5 (N=7).

KIIs said that the main services available for children in communities was RECOPE, Parlement des enfants, youth associations, and women's associations.

When asked for any additional observations about children, KIIs said that there is a need to support malnourished children (N=8), support orphans (N=2), and that there is "*a presence of girl mothers*" (N=1).

4.7. Education

Two KIIs in Mulamo and Mapendo said that schools were shut down in their communities. In Mapendo, it was for two weeks, and Mulamo, for seven months. Four KIIs said that teachers had to miss school due to EVD, ranging from two days to one year.

Thirty-eight KIIs said that they observed changes in teachers' behavior, such as enforcing handwashing (N=17), maintaining distance within the classroom (N=10), and that teachers' behavior is reserved (N=2). Six KIIs said that teachers left their position to work in the EVD response.

When asked about how EVD affected the quality of education in their community, KIIs reported both positive and negative effects: reinforced handwashing (N=4), parents were fearful and prevented their children from going to school (N=4), dealing with both children and families' trauma of losing loved ones to EVD (N=3), and teachers left to work in the response (N=3).

4.8.Economic Recovery and Development

The main livelihoods for men are agriculture, small business, masonry, carpentry, livestock, mechanic, mining, and daily labor. For women, their sources of income are more diverse: agriculture, small business, braiding hair, sewing, sugar cane, livestock, sales (manioc, bananas, charcoal, fish, drinks, bread), as well as daily labor. In terms of key changes to livelihoods, the top two (both N=3) were that people stopped working in the fields, and they work in the emergency response. Other reasons specific to women included turning to sex work, women not getting together for their collective work, and switching to sell products that they can easily sell, so as not to hold on to their product or risk spoilage for food.

Seven FGDs said that they cannot safely access markets right now, and five of those were female. When asked why not, they live in an insecure area (N=4), there are no markets nearby (N=3), and N=1 each for banditry, and the bad condition of the roads.

Thirteen FGDs noted the following changes in the markets: handwashing stations at the entrance of the markets (N=3), more fear to touch money and that markets were a hub to spread EVD (N=2), poverty from EVD meant less ability to purchase items (N=1), and one FGD said that the cost of building materials increased (wood beams, flooring, etc.) because of the demand for construction of ETCs and triage.

In terms of ERD-related needs, the top four specified by FGDs were 'local' seeds (N=13), tools (N=6), livestock (N=5), and security to access the fields (N=4). The latter is an intersection with protection, because the sense of insecurity affects people's ability to continue with agriculture practices as a form of both food security, as well as gaining income.

For NFIs, FGDs requested to replace NFIs, specifically to replace burned mattresses (N=6); sheets and blankets, or cash to replace these items (N=3).

Eight vendors (KIIs) participated in the assessment, and had been vendors ranging from 1-12 years. All said that people pay for things using cash, and two said via mobile transfer. None said that people use vouchers. The three main mobile money transfer companies were Airtel Money, PEPELE, and M-PESA. One said that they observed a reduction in the market because people were afraid to take public transport. Another vendor said that the only practice that they changed was disinfecting money.

V. PATH TO RECOVERY

5.1.   Concerns about the future after Ebola

KIIs noted the biggest risks to the health system with the withdrawal of the EVD response, specifically for health actors. These include threat or conflict from the population (N=16), further exposure or risk to disease (N=10), loss of incentives means that people will abandon their work (N=7), and lack of medicine and proper supplies (N=6).

When asked what would be potential negative effects of withdrawing from the EVD response in terms of protection risks, the top three were hatred "*haine*" and risk of threat or attack towards those who worked in the response (N=16), theft (N=12), and unemployment will push people toward banditry (N=10).

FGDs described their concerns about community safety, including risk of robbery or violence because people are unemployed (N=5), return of the disease (N=2) and operation "Toyebi Ndako" which means "*we know you are home*" – a threat to those in the community who worked in the response. These two FGDs came from Malende and Makasi, so this operation may be specific to these locations. In terms of other concerns about the effects of EVD, one notable concern was the violation of culture due to safe burial practices (N=5), such as burying people in bags "*culture is violated and ancestors are angry*".

Specifically for children, KIIs said that children's concerns about EVD were fear of death, contamination, the vaccine, becoming orphans, trauma, death of their friends, separation from their parents, lack of control, schools will remain closed, abandoned by their parents if they are infected, and exposure to violence from pressure groups.

5.2. Suggestions from communities

Overall recommendations

The 20 FGDs (N=10 female and 10 male) were asked for recommendations to help men and women recover from future outbreaks. Female FGDs suggested:

1. Skill-building centers for social reintegration (N=4);
2. Continue with hygiene promotion (N=2);
3. Awareness raising activities (N=1 for radio broadcasts and door-to-door messages);
4. Social cohesion activities to "reinforce collaboration between husbands and wives on hygiene measures" (N=1).

Male FGDs suggested:

1. Hygiene awareness (N=5);
2. Door-to-door awareness (N=3);
3. Rehabilitating water points (N=1);
4. Creating jobs (N=1)

In addition, providing families with a thermoflash and to avoid politicizing health care were mentioned once each.

On stigma

When asked how to reduce this stigma, KIIs the top three suggestions were 1) community awareness sessions (e.g. that people recovering from EVD have rights, that everyone can live together, and to surround recovered people with support) (N=32); 2) create income-generating opportunities to support their ability to reinsert themselves in the community and show their value (N=12); 3) provide psychosocial support (N=9). Additional suggestions were radio awareness, accompaniment from response teams to the women's homes; collaborate with local women's associations, create a safe space for women; regular follow up with the patient; create work opportunities to unite people who have recovered from EVD and those who have not had EVD; and *"tell them that they are just like everyone else – it is not their fault"*. To reduce stigma against children, KIIs suggested awareness sessions in communities, schools and church (N=30), provide psychosocial support (N=9), space for children to play together (N=8), promote social reintegration (N=7), space for children to receive psychological support (N=5), pay for their school fees (N=3), and N=1 for accompanying the child to school, if possible, community dialogue, theatrical presentation to promote awareness, school feeding so that children can eat together.

"Tell them that they are just like everyone else – it is not their fault"

On children's recovery

Similar to the question above, KIIs (N=103) were asked for suggestions that humanitarian organizations should consider to help children recover from and prevent future outbreaks. The top five responses were:

1. A space for children to play together (N=27);

2. Reinforcing hygiene measures through families, communities, churches and schools (N=27);

3. Psychosocial support (N=11);

4. Fees for children to return to school (N=10);

5. Continue free health care for children (N=5).

KIIs suggested the following ways to support education: train or reinforce teacher training for better quality (N=9), continue hygiene promotion at school (N=9), provide free access to school (N=7), build or rehabilitate schools (N=5), properly pay teachers (N=5), clean water and latrines in schools (N=5).

On feedback and communication

To submit a complaint or request for more information about a service, FGDs said they would most likely use a help desk at a health service (N=5); poster for information (N=4); community awareness session (N=4). "Other" options included a suggestion box (N=3); Radio (N=3); telephone number/hotline (N=2); focal point within that specific service (N=2); and N=1 each for: community health worker; in an appropriate room/area; and to the head of the district on a weekly basis. FGDs said that they prefer to communicate once a week (N=8); once a month (N=7); daily (N=4); and every 2-3 days (N=1). All 20 FGDs said they prefer to receive communication in Swahili, followed by Nande; French; Lingala; and 'other' was Kipiri.

Preferred languages
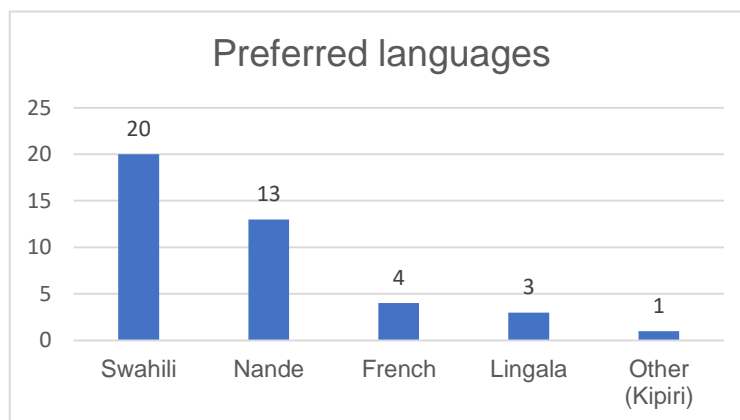
On the overall response

FGDs were asked for their suggestions to improve the humanitarian response: train providers to properly welcome patients (N=3), hire local teams and be transparent about recruitment (N=3), advocate for peace and security in North Kivu (N=2), involve the population from the start (N=2), study local culture and customs before the intervention to reduce resistance (N=2) and N=1 for free health care, improve health worker salaries, provide messages in local languages, community messages go through community workers, do not use armed forces in this response, police presence frightened the community, and involve youth in response teams to "*empower them for the next time this happens*".

RECOMMENDATIONS

The following recommendations are based on the abovementioned data. They do not include anecdotal observations or secondary data not mentioned in this report.

Health
→ Continue addressing that people avoid health care because they do not want to be referred to the ETC. This is linked with protection issues as well, since, though it seems to have diminished to some extent, people are still stigmatized within the community and home.
→ Work with local networks to speak with families about the consequences of not seeking treatment for children.
→ Review psychosocial support to health care workers, as they observed that their peers have faced threat and abuse or experienced it themselves.
→ Based on the finding that people would like free health care, consider additional health issues in communities and integrate into the EVD response, such as subsidizing primary health care, depending on specific health concerns.
→ To support the finding that people seek health care from traditional healers, collaborate with and integrate healers into health care training. This will strengthen linkages between response actors, local actors, and communities.
→ To reduce mistrust and stigma against health workers (particularly females, as noted in the findings), train CHWs on IPC measures, as they are more integrated in communities, to build trust within communities to support IPC.
→ To address the findings that cholera and EVD messages were not clear, review messaging to craft simple, precise and relevant points to communities. Involve communities in the design of these messages to ensure relevance, and that the messages address their concerns and needs.

Environmental Health
→ Review opportunities to provide free access to water, as the top need identified by KIIs.
→ Address the dearth in safe places to bathe as well as access to safe and clean latrines, as reported by the FGDs.
→ Where appropriate, draw on key figures in the community to enhance hygiene awareness campaigns, such as religious leaders, youth leaders, and midwives.

Protection and Rule of Law
→ Continue with awareness campaigns as 13 FGDs stated that this was the main way to address stigma. Three specific ideas included putting religious leaders at the helm of the awareness campaigns; to follow the example of midwives and community leaders assuring the population that it was okay to intermingle; and a suggestion to organize debates between community leaders and youth.

→ Provide psychosocial support, including 1:1 sessions, as well as support groups, as suggested by three FGDs.

→ Pay attention to those who have lost their family unit as a result of EVD, such as widows and orphans, as some respondents noted that these people are neglected.

→ Though no organization was specifically named as inadvertently encouraging transactional recruitment (e.g. women exchanging sex for a job as a response worker), organizations should review the recruitment and onboarding practices to ensure women are safe, aware of their rights, and feel supported to address any reporting channels if sexual harassment and exploitation occur. Review ways to prevent this from occurring while training new staff and refreshing current staff and partners with safeguarding messages, protocols, and consequences, while at the humanitarian coordination level the PSEA responses should be strengthened.

Women's Protection and Empowerment
→ Discreetly and safely speak with female staff and CHWs to support any challenges they are having, such as being asked to pay a portion of their salary to those who recruited her; or if she has faced particular threats within her home and the community because of her work in the response.

→ Work with response teams and community mobilizers to continue dispelling rumors to reduce negative effects of EVD, such as women being accused of infidelity if they had EVD.

→ Work with both men and women to discuss decision-making in the household, particularly around the decision for a woman to work in the response, as well as the decision at a family level to send a child for health care.

→ Review opportunities to provide skills training for income-generating purposes, as this was identified as the key need for women and girls.

→ Deliver messages to communities to prevent GBV, including domestic violence, as well as preventing sexual exploitation and abuse – to address stigma that women faced in the EVD responses. Create these messages with community leaders and local organizations.

Sexual and Reproductive Health
→ Address the FGD perceptions that there was not enough information about services or the type of medicine they would receive, as well as concerns about being infected by EVD because they were not vaccinated. This is also a chance to reinforce messages about their concerns about EVD in terms of sterilization, birth defects, and mother to baby transmission.

→ Train health care workers and midwives on triage, to address pregnant women's fears that if they were bleeding they would automatically be sent to the ETC.

Child Protection
→ Address rumors with families if children are vaccinated at school, so that parents are not preventing their children to go to school out of fear of the vaccine.

→ Work with child-focused community actors, such as RECOPE and child parliaments, to learn more about why children join pressure groups and how to address the violence.

→ Adapt messages to children, parents, and communities to reduce fear and stigma against children.

→ Following one suggestion from a Child Parliament actor, do not expose EVD survivors to the media, as it further traumatizes them. Maintain confidentiality and respect of EVD survivors.

→ Provide psychosocial support to children, as they have faced fear, death, trauma, and stigma.

→ Provide focused support to orphans, who were neglected in communities as a result of EVD.

Education
→ Consider sensitization and training to encourage teachers that left their jobs to support the response, to return to their positions.

→ Continue awareness campaigns with families to reduce the fear of sending children back to school.

Economic Recovery and Development

→ Consider livelihoods programs as a transition plan, since workers who left their roles to join the emergency response will be out of work. This is also a security concern, as identified both by KIIs and FGDs that unemployment will bring theft and banditry.

→ Advocate for safe access to fields and improving the roads, as these are both hindering people from tending to and accessing their crops, which is a food security risk.

Feedback Mechanisms

→ To accommodate feedback and requests for information, consider installing a help desk at the health centers so people can request information.

→ Address KIIs recommendations to improve the response by involving communities – local leaders, religious leaders, community members prior to implementation.

CONCLUSION

With an estimated funding of more than 800 million USD[12] over 22 months, significant resources were injected into halting the spread of the Ebola virus in Eastern DRC. The operational challenges due to the insecurity, the lack of effective community engagement and the logistical challenges made the EVD response more complex. Despite these challenges, the end of the outbreak in the East was reached and officially declared over on the 25th of June 2020 by the DRC authorities.

There have been positive elements of this outbreak, such as the use of the vaccines and treatments, the investments in the health facilities and the trainings to health providers. KIIs and FGDs also reported some positive changes in terms of improved hygiene practices, and it impacted positively on the role of some community members such as women, children and teachers who were identified as having a key role in reinforcing good hygiene measures and raised awareness. Some women also reported the opportunity to work as a positive consequence of the EVD response, although this also created according to the women interviewed more conflicts and domestic violence.

Negative consequences were related to psychosocial aspects (fear of seeking treatment, fear of attacks against health facilities and CHWs, stigmatization), more difficult access to quality health (a reduction in services available) and education, changed social dynamics (power dynamics and relationships), and economic burdens as more money was needed to cover health costs and for education.

People reported fear and stress about what will happen once the EVD response stops, and specifically in terms of unemployment, stigma and criminality. The fear of stigma was also very present, as well as specific concerns about the possible resurgence of the disease and the isolation that both men and women could experience due to the disease.

The road to recovery and preventing a new major outbreak will take more than only structural interventions in WASH and health, as communities perceived livelihoods, security and education/awareness raising as areas for which they need support. With the complex emergency situation ongoing in many areas of the two affected provinces, the threat of multiple epidemics, it is crucial that the humanitarian response takes into account the exacerbated vulnerability and needs of the population further than purely the health needs. In that sense, it is imperative that the most pressing needs of the population continue to be addressed in an adequate way, based on what communities report as their priorities and their engagement, and go beyond purely medical interventions.

For any questions, please contact the Response Director, Borry.Jatta@rescue.org.

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[12] Kaiser Family Foundation. Dec 19, 2019. Data Note: Donor Funding for the Current Ebola Response in the DRC; WHO. Updated 4 June 2020. Ebola response funding.