

Community Responses to the Ebola Response: Beni, North Kivu

This report focuses on factors that hindered safe and effective Ebola response strategies, as identified through rapid data collected with community members in ‘resistance’ hotspots of Beni, North Kivu, in September-October 2018.

BACKGROUND AND CONTEXT

Background

Since July 2013, a series of massacres have occurred in the Beni territory of North Kivu province, Democratic Republic of Congo, an area heavily affected by the current Ebola outbreak. More than 1,000 civilians have been killed and tens of thousands have been displaced (Congo Research Network, 2016, 2017). The kidnappings and mass killings transformed Beni from an area of relative calm to a violent hotspot. What has been historically troubling about these armed attacks is the lack of knowledge surrounding them. With the constant shifting of political alliances, the emergence of new armed groups and political scapegoating, the identity and motives of perpetrators remain highly ambiguous and contested. In the face of this complexity, civilians are left with the constant fear of being killed, kidnapped, or conscripted. In addition, tensions between the government and ethnic groups in the region have further intensified people’s mistrust in state institutions and activities.

Current context

Since the country’s health minister declared the presence of the Ebola Virus Disease (EVD) in North Kivu on 1 August 2018, the Ministry of Health, WHO, UNICEF, MSF, and many other local and international partners have worked tirelessly to respond to the outbreak. This is the first time in history that Ebola has affected an active conflict zone, making it one of the most challenging outbreaks to contain.

Throughout the outbreak, the security situation in Beni territory has remained highly volatile with a numerous armed attacks. On 6 August 2018, six people were killed at Matiba (east of Beni-Oicha road) and 14 people were killed at Tubameme near Mayangose the next day. After a lull in reported Ebola cases in early September, there was a surge in the number of cases directly correlating with the surge in violence in Beni. The WHO regional emergency director for Africa, Dr. Ibrahima-Soce Fall stated,

‘The fighting and armed attacks around Beni killed a lot of civilians, and there were demonstrations in the city. For three to four days, the Ebola operation was stopped. There was no possibility to identify cases or contacts, to vaccinate. If we have any disruption, that will lead to another cycle of infection transmission.’
(Vox, Oct. 15 2018).

Rebel attacks on 17 November 2018 just a few metres from the Ebola Operations Centre in Beni caused further disruption and temporarily suspended response activities. The first week of December saw another increase in cases re-emerging in health zones that had previously been declared Ebola-free, including in Komanda, Maseraka and Mabalako. The deadliest attack on UN forces in recent history followed on the 6 December 2018 with a significant assault on a MONUSCO base near Beni in which 14 soldiers were killed and over 40 wounded. This was attributed to the rebel group the Allied Defense Forces (ADF). The WHO continues to place emphasis on the impact the volatile security situation is having on the outbreak and response (WHO, Ebola Situation Report, 30 January 2019).

‘Community resistance’

The cities of Beni and Butembo have seen a series of incidents that the government and some responders have termed ‘community resistance’. A Ministry of Health report from 4 September 2018 stated, *‘Some families have long hidden sick people, refused that health care providers bring the sick to the Ebola Treatment Center (ETC), and refused to be vaccinated’*. In the upward epidemiological surge of December 2018, many new cases were not from existing contact tracing lists, high risk contacts were actively fleeing follow-up, and there were high numbers of community deaths when people had not presented at an ETC (WHO, 2018). This *‘lack of collaboration with the health authorities’* was deemed as *‘resistance’* by the Ministry of Health. Neighbourhoods including Ndindi (west of Beni city), Rwangoma and Butanuka (both east of Beni city) experienced a series of attacks against health service providers. In the same report of September 2018, the Ministry of Health also stated, *‘Several violent incidents against medical staff and care facilities were also reported. In order to ease tensions, a community dialogue was launched between the response coordination and Ndindi community leaders ...’*.

‘Resistance’ was used as an umbrella term for reluctance or refusal to cooperate with Ebola response efforts, including contact tracing, case management and safe and dignified burial activities; in addition to acts of active and violent hostility towards Ebola response teams. Efforts to unpack these concepts have been made, e.g. by the Risk Communications and Community Engagement Pillar (RCCE pillar, 2018) and the WHO situation report of 5 December 2018 broadens the concept to emphasise sporadic but ongoing incidents of *‘community reluctance, refusal or resistance’* (WHO, 2018). However, the reasons behind these phenomena, their root causes, have not been clearly, nor widely, understood.

Insight has been provided by social science activities in North Kivu to date. Community feedback data gathered by the IFRC, UNICEF and Oxfam, in Beni, Butembo, Bunia and Mabalako in October 2018 (compiled by SSHAP, 2018a) revealed the large number of unanswered questions and concerns articulated by the community. Key topics included: response processes (e.g. *‘why are there so many staff for the response to Ebola and not for other diseases or for the conflict?’*); vaccines (e.g. *‘why not give the vaccine to everyone?’*); diagnosis and treatment (e.g. *‘why collect samples from sick people after their death?’*); Ebola vs. other diseases/problems (e.g. *‘are the symptoms for Ebola the same as for malaria?’*); and Ebola outcomes (e.g. *‘how many survivors have there been since the beginning of the epidemic?’*). The persistence of these concerns can be linked to the phenomena of *‘community reluctance, refusal or resistance’*.

Despite the inferences that can be drawn from the rich information that has been generated to date, the concept of ‘community resistance’ and its various causes must be further deconstructed at the community level.

Data collection

To contribute to a more nuanced understanding of the root causes of ‘community resistance’, the CI-Bethesda Counseling Center conducted a rapid survey-based assessment in areas where ‘resistance’ had been reported, including Ndindi, Butanuka, and Rwangoma. A cross-sectional survey with open-ended questions was conducted with 56 community members across the three sites between 11 September and 15 October 2018. These sites had active cases of Ebola during the period of the study. The main objectives were: 1) to better understand the concept of ‘community resistance’ by identifying the underlying factors and causes affecting safe and effective response strategies; and 2) to understand the recommendations of these communities to improve the safety and efficacy of the response. Incidents of violence and hostile engagements were deemed the most alarming and disruptive form of ‘resistance’, and so were the main focus of study.

By eliciting local perceptions, the overall aim was to improve coordination efforts between response teams and Ebola-affected communities by providing recommendations to national and international response teams and health service providers interested in addressing prevailing community concerns.

REASONS FOR ‘HOSTILE ENGAGEMENTS’

The reasons most frequently cited by community respondents for why they had been involved in ‘hostile engagements’ with Ebola response teams were categorised into sub-themes. These were then re-grouped into five overarching and inter-related themes: 1) difficulty separating the persisting conflict from Ebola; 2) perceived true purpose and intentions of the outbreak and response; 3) pre-existing views of ‘humanitarians’ and ‘foreigners’; 4) disappointment with Ebola response activities; and 5) the spread of misinformation and rumours. These factors fed into overall mistrust of the Ebola response and Ebola responders.

In the North Kivu context, trust and therefore mistrust works on multiple levels: mistrust of government officials (police, military); mistrust of armed groups; mistrust of NGO workers; mistrust of health professionals and so on. Research shows that ‘trust’ is built around the perception of six elements: competence, objectivity, fairness, consistency, sincerity and concern (WHO, 2017). The five themes outlined below under-cut each of these elements to some degree and mistrust has become a central mediating factor. As Dr Peter Salaama, Director of the WHO Health Emergency Programme has identified, there is a ‘*cycle of violence and mistrust*’ in North Kivu in which violence and mistrust are mutually reinforcing (CSIS, November, 2018).

Reasons for hostile engagements with response teams	
Overarching and inter-related themes - Ndindi, Butanuka, and Rwangoma	
Difficulty separating the persisting conflict from Ebola	Mistrust in the Ebola response and responders
Perceived true purpose and intentions	
Pre-existing views of ‘humanitarians’ and ‘foreigners’	
Disappointment with Ebola response activities	
Misinformation	

1. Difficulty separating the persisting conflict from Ebola

Respondents were honest and open about the hostility they both felt and enacted towards Ebola responders. As one interlocuter reported,

‘It is good that you are not the Ebola response team. That has saved you. If you had been one of them, we would have chased you out of our community right away’.

It was difficult for the majority of respondents to separate the Ebola epidemic from the perpetual insecurity they continue to endure, a fact exacerbated by the fact that both phenomena are experienced simultaneously. In a context in which the local population lives in a constant state of fear, suspicion, and general mistrust, certain Ebola response strategies and actions were described as playing on existing fears. The majority of respondents reported that when anybody had the slightest fever (due to a common cold, malaria, or other infection), they are immediately ‘*taken by force*’ without explanation, and this was associated as ‘*kidnapping*’.

‘Every single fever and diarrhoea today is called Ebola! People are feeling afraid of going to a local clinic lest they are taken by force in the ambulance to the ETC. The Ebola response has to stop taking people to the ETC by force’.

Some community members reported their perception that Ebola responders may be directly connected to armed groups, leading them to feel fear and anger, which would often manifest in a violent response. Other analysis from September concluded that, ‘*Ebola is perceived [by the population] as the latest weapon of war that is being used to target the people of Beni and Lubero. There is a growing perception that the same actors behind the kidnapping and killings are now behind the Ebola outbreak ...*’ (SSHAP, 2018b). In the current study, one respondent explained that Ebola was simply part of a change in strategy as, ‘*they have realized that with the massacres only, they will not succeed*’.

Respondents explained that families were not always informed that fever is an Ebola symptom, nor that a person with a fever needs to be monitored. Similarly, the importance of isolating suspected cases was not well understood. In a context where every action is shrouded in mystery, such actions contributed to the misperceptions described.

The Mayor of Beni, Bwanakawa Masumbuko Nyonyi announced that the response team can call or request support from the Forces Armées de la République Democratique du Congo (FARDC) and the Police Nationale Congolaise (PNC) during Ebola testing and/or during safe and dignified burial processes (MOH, October 2018). The association of these forces with Ebola and the Ebola response teams further contributed to the parallels community members drew between the outbreak and threats from the ongoing conflict.

2. Perceived true purpose and intentions

The majority of respondents confirmed they had heard of the Ebola virus. The biological basis of the virus and various preventative measures appeared to have been accepted, and communities were observed to have changed certain habits (e.g., not shaking hands, washing hands frequently etc.) One of the main drivers of the hostility therefore was not the existence of the Ebola virus, but rather the perceived purpose of the Ebola virus and by extension, the intentions of Ebola responders. A large group of respondents reported that the widespread belief that Ebola was in Beni to ‘exterminate’ the Nande people.

The Ebola virus and the response were therefore perceived as a ‘danger’ which led communities to take defensive action in order to protect themselves, and translated into an unwillingness to follow the guidance of the response (which they mistrusted) but to seek care at tradi-modern healers rather than present at an ETC.

In relation to the trial vaccine, it was commonly reported that the vaccine contained products that may be harmful to one’s health (e.g. in-line with the narrative focusing on ‘extermination’), and should therefore be avoided.

‘My sister was taken by Ebola people. She was not even in a critical condition. Two days later I had a call my sister has died. I heard that while she was in the ambulance, they vaccinated her. That vaccine is killing people’.

The fact that bodies were not always been made visible to families, ‘dead bodies are disappearing without explanation’, fueled suspicions around the manifestation of Ebola and the intention or practices of responders.

3. Pre-existing views of ‘humanitarians’ and ‘foreigners’

In general, the image of ‘foreign’ people has developed complexity from colonial times to contemporary society. This view suggests that foreigners (wazungu, white) continue to neglect the people of the DRC and only want resources from the region. Respondents suggested that ‘foreigners come to envy us’ (e.g., the country’s natural resources) and several respondents highlighted that ‘the killings are imposed by foreigners ...’. Another commonly reported belief was that foreign Ebola response teams were active to make themselves rich for as one respondent concluded, ‘For every single death, there is a gain that enters in their pockets’.

Many respondents explained that their hesitancy or opposition to Ebola response teams was because of their prevailing view of humanitarian, NGO and UN agency workers, developed over the years of prolonged insecurity. This included the perceived failure of such stakeholders to protect the people, and the notion that they had little concern for the wellbeing of the population. Against the backdrop of on-going suffering and insecurity, respondents frequently, ‘why this, why now?’ Such suspicion and resentment was reported to fuel frustrations and contribute to hostile interactions. It was notable that because communities have become so sensitised to seeing humanitarian workers in their villages (e.g., with vehicles, uniforms and logos), when the Ebola response team arrived looking similar, respondents projected their pre-existing views of NGO/UN workers.

It is important to recognise that the notion of being ‘foreign’ does not always mean ‘white people’, but is also an expression used to describe people from neighboring countries (such as Uganda, Rwanda and Burundi) and even people from Kinshasa who are also viewed as ‘outsiders’. There is a growing belief across Beni’s communities that it is ‘those outsiders’ who are the ones causing and perpetuating the harm. Because of this, people in Beni are suspicious of everyone who does not speak the local language (including people who speak French) and of people who ‘look different’ (e.g., not local).

These underlying factors led to respondents disbelief that foreign or outside response teams actually wanted Ebola to be eradicated, and their guidance was something to be treated with caution, not always to be listened to or acted upon. As one respondent emphasised,

‘When they come to our community with their vehicles, we hide. Nobody wants to listen to them’

4. Disappointment with response activities

Many respondents confirmed that their self-described negativity was rooted in their perception that the Ebola response teams failed to do anything to address their primary concern – the conflict. After questioning the Bethesda study team, one respondent in Butanuka concluded,

‘Ebola has been at the center of all the attention for the whole world today. Yet people are still being killed in Beni on the silence of the international community’

Given the direct associations drawn between the security forces and the response teams, particularly when the response teams are escorted into communities by military and police personnel, it was suggested that people’s sense of being neglected by the FARDC and the PNC over many years of insecurity spilled over into pre-emptive disappointment with response teams.

Beyond this, however, further disappointments were also reported that were specifically related to experiences of Ebola-related activities. Particular concerns were raised that patient care in ETCs was not good enough.

‘At the beginning of the outbreak we started hearing that a lot of money was given to provide food for have contracted Ebola at the hospital. It was very revolting when we started hearing that sick people were not eating well. Or they were not having good varieties of food at the ETC’

For communities in Beni and Butembo, how well one is treated is often measured by the quality of the food they are given to eat, and so this aspect of care is of central importance in terms of public perception.

Similarly, when families did report a death in the community, burial teams were not always able to respond in a timely fashion and cases were reported where the burial team did not arrive at all. The WHO situation report of 30th January 2019 reported that as of 27th January 2019, the Red Cross and Civil Protection burial team had successfully responded to 82% of burial alerts. This is commendable considering the plethora of challenges response teams face, yet data collected as part of this study implied that the few instances when burials were not successfully managed fuelled disengagement and hostility.

In contrast, a number of respondents voiced appreciation that care was even being made available and as one respondent confirmed for example, *‘they [Ebola responders] came here to help us treat the [Ebola] virus. We are suffering from ignorance’*. The appreciation mentioned by communities was also reflected in the community feedback data collected by the Red Cross.

5. Misinformation

Misinformation was described by one of the study’s data collectors as *‘circulating from mouth to ear at the same speed as the virus’*. Indeed, community participants explained that they had not developed their ideas *‘from nothingness’* but had based their thinking on ‘information’ they heard. Unfortunately, a number of influential individuals contributed to the spread of misinformation in the early phases of the outbreak and response both during meetings and through social media. This message from the national deputy Crispin Mbindule Mitondo was published in several social networks (excerpt from SSHAP, 2018b),

‘... As long as we are not informed of its origin [alluding to the Ebola virus], we will believe that it was made in the laboratory to exterminate the people of Beni.’

‘... if you ask me. I would not be sure how this disease actually started. I think that this disease is another (killing force) that has been sent again. And this is why I challenge the Minister (of Health or Defense) to prove me wrong. Show me, where did this outbreak really come from? Scientifically, I do not believe that it is possible to have first killings of people in Beni, and today this disease without them being connected. Study the course of events for yourself! ...’

During data collection, excerpts from this message, and in particular the two terms *‘exterminate’* and *‘connected’* were often heard, suggesting that accurate information had yet to reach community members included in the survey. It was worrisome that one female respondent suggested, *‘That’s what is told in families even in churches, people talk about it everywhere. They want to exterminate us and take our land’*. It was difficult for respondents to distinguish between

misinformation and other messages heard through radio, social media, church and from their neighbours. Many linked different types of information to the hostilities that had been directed towards response teams.

Juxtaposed to the circulation of misinformation, were notable examples of ‘good news stories’ in which positive experiences were being recounted. For example, the experience of a survivor, their treatment and recovery, was aired on Radio Television Rwanzururu and was re-circulating on Whatsapp and the radio during the time of data collection, ‘A few days later, the six of us who touched the body fell sick and were taken to ETC for treatment by the Ebola medical team. At ETC we were very well taken care of and we recovered. Today the six of us are back to our home healed!’ Such communication was well received by respondents.

COMMUNITY SUGGESTIONS TO IMPROVE ENGAGEMENT

Community suggestions for strategies to improve their engagement with response teams were thematically grouped and are presented below. These are well aligned with the underlying reasons for hostility discussed above.

Community suggestions to improve engagements with response teams
Key themes - Ndindi, Butanuka, and Rwangoma
Response teams should mobilise as much as possible to stop the killings and violence in the region
Involve people in the burial of their family members
Vaccinate all authorities publically
Improve the care of patients in the hospital
Improve collaboration with local leaders
Raise awareness through the churches

1. Mobilise as much as possible to stop the killings and violence in the region

The dominant priority was to end conflict in the region, which respondents saw as inextricably linked with the Ebola outbreak. Respondents emphasised that additional resources (which were highly visible) and focused attention on the Ebola response should be redirected towards overcoming or at least mitigating the violence conflict. As one respondent concluded,

‘We want the same attention that has been given to the Ebola outbreak. People have been killed since 2014 and there has not been any action to stop these killings’.

A display of support from Ebola responders that the violence must end, and the positioning of response teams as being neutral and not engaging or perpetuating the conflict in any way was deemed necessary to reduce incidents of ‘resistance’.

2. Involve people in the burial of their family members

Another suggestion frequently made by respondents was to ensure that family members were included in burial procedures, not only to help families from a psychosocial level, but to communicate openness and transparency, and to improve community-level understanding about how and why such burials are performed.

‘We don’t see the bodies. And this makes us wonder what they are doing to them. Rumors we are hearing say that certain organs are being removed to be sent outside of Congo’.

Family member attendance is already part of the safe and dignified burial protocol, but either this element has not always been facilitated, or familial involvement does not always guarantee greater understanding.

3. Vaccinate all authorities publicly

Again, in terms of transparency, improving understanding and increasing acceptance, respondents suggested that all local authority figures should be publically vaccinated to demonstrate that it was safe and show its effectiveness.

'We need the public vaccination of all the authorities starting with the Ministry of Health, the governor, and their families'.

One positive example that was cited by respondents was the public vaccination in Butembo of the governor of North Kivu and nine of his deputies from the province.

4. Improve patient care in the hospital

Respondents knew that care for people with Ebola was available, but they suggested that improving the overall care of patients could help encourage utilisation. As mentioned, food is central to local perceptions of quality care.

Appropriate and acceptable food must be incorporated into care offered at the ETCs and its availability emphasised in community engagement activities.

'We were told there is food for sick people so we don't need to bring any for our family members, yet we have heard that sick people in Mabalako are not eating well. What are they doing with the money given to provide food for the sick people?'

5. Improve collaboration with local leaders

The culture of Beni is predominantly a collective and community culture. In this context, community leaders are very important and a resource to build on, particularly when those leaders are trusted by their communities and/or can exert great influence over their constituents. Many respondents emphasised that response teams should work more explicitly with and through their local leaders. Given the complicated recent history of Beni, leaders with less political connections were seen to offer more confidence. Pastors, bishops, household elders well respected by the community, as well as the chiefs and customary chiefs (*Kyahanda*) were identified as key influencers. Respondents anticipated that if response team were closely associated with such individuals, then instances of reluctance, refusal and resistance would reduce.

'People don't trust the government based on all the perpetual killings happening in the region and the current dictatorship. The Ebola response team should go back to the local community leaders because people don't trust the Ebola response team'.

6. Raise awareness in churches

The church was described by respondents as an important institution that people continued to visit even in the most difficult times. Religious groups were understood to offer respondents spiritual but also psychological and social support and to strengthen collective resilience. Raising awareness of Ebola and of the 'true intentions' of Ebola responders in places of worship was seen as ideal to many respondents. They suggested that the response teams should 'make good use' of religious institutions and religious leaders in order to reach a large section of the population in a place they perceive as 'secure'.

KEY CONSIDERATIONS

The report has highlighted how the complex context in eastern Congo not only forms the backdrop to the outbreak but also influences all response strategies. Ebola response teams must keep this in mind and adapt strategies accordingly. These key considerations are therefore designed to complement the recommendations made by community members outlined above.

- **Embed trust in every activity** – This must be approached systematically. To build trust others must perceive you as competent, objective, fair, consistent, sincere and concerned in every action you take (WHO, 2017). Although anthropologists, psychosocial and community engagement personnel are key personnel to provide technical guidance, building, maintaining and embedding trust is the responsibility of everyone working within the Ebola response, at every level and within every discipline.
- **Recognising priorities and political neutrality** – In line with other studies, this survey highlighted that the priority of community members was to stop the killings and insecurity. Although stopping the massacres is not the main mission of the Ebola response in the Beni area, its importance should not be neglected. Whilst conflict

resolution may be ongoing, it remains essential to publically separate the response from the conflict. It is imperative that the political neutrality of the Ebola response is consistently emphasised across all levels. Given already tense relations and mistrust between the government and the local population, Ebola response strategies employed in conjunction with the government may be perceived as a political tool and/or military strategy. NGOs and other actors that have been in DRC for some time, are already interwoven into the politics. It is encouraging that more recent findings from an analysis of media and messages circulating on Whatsapp suggests that Ebola narratives are moving away from political concerns, partly due to efforts to frame the virus as a medical concern rather than a political tool (SSHAP, 2018d). Nevertheless, ongoing violence and the aftermath of the December elections have the potential to provoke popular unrest, and to breed further mistrust. The response should learn from peace-building initiatives and technical experts should be engaged to guide policy and action decisions. All responders should be taught negotiation skills and supported to adopt compassionate communication that portrays their competency, sincerity and concern (critical to trust building).

- **Clear and consistent explanation of response strategies** - There is an exigent need to explain all response strategies to community members and ensure that family members understand isolation, contact tracing, vaccination and safe and dignified burial measures. Response teams need to explain that there are critical strategies that help control the spread of the virus and that only by quickly presenting for treatment at ETCs do people have a good chance of survival and recovery.
- **Transparency** – More recent data from an analysis of media and messages circulating on Whatsapp in the wider Beni and Lubero territories (SSHAP, 2018d) and community feedback data from the IFRC suggests that community concerns are shifting towards what happens at treatment facilities. As noted above, respondents highlighted that transparency not only communicates a sense of openness and honesty, but also helps to increase understanding about the purpose of response activities and the true intentions of responders. Providing community tours to ETCs, supporting family visits and facilitating the treatment of patients in the ALIMA cubes are all excellent strategies to increase acceptance and positive engagements. In addition, media and Whatsapp platforms may help in counter unhelpful narratives related to the Ebola response, and local radio stations have started '*Ebola broadcasts*' to dispel misinformation about Ebola and interview survivors on their experiences of treatment and care.
- **Psychosocial approach** – From a psychological perspective, the conflict has affected the entire population of Beni, both children and adults, and its recent historical trajectory continues to influence contemporary society. In describing the psychosocial effects of violence amongst the wider population in North Kivu, it has been correctly reported that '*violence has, to some degree, become normalised and is a common recourse action when frustrations become too great*' (SSHAP, 2018c). Responders need to counteract violent hostilities by embedding psychosocial principles including hope, safety, calm, social connectedness and self- and community efficacy across every intervention (Hobfall et al., 2007). All sectors should closely align with Mental Health and Psychosocial Support (MHPSS) initiatives and expertise.
- **Mechanisms for tracking and responding to ongoing community feedback** – The situation in North Kivu changes constantly, and the data collected at any one time (including this survey) should be seen as a snapshot. Ongoing engagement is critical, particularly considering the speed and breadth of misinformation spread. The International Federation of the Red Cross (IFRC) are collecting common questions and concerns through their Red Cross volunteers which serves as an ongoing source of insight. The Social Science in Humanitarian Action Platform (SSHAP) is regularly compiling social science and behavioural data related to the outbreak of Ebola in North Kivu and Ituri provinces which summarises community feedback and community suggestions (e.g., SSHAP, 2018a). Whatsapp, social media and other messaging threads also continue to be monitored and analysed to make operational recommendations (e.g. SSHAP, 2018b; SSHAP, 2018d). Such initiatives should be capitalised upon in order to learn, reflect and adapt strategies accordingly.

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