

Attacks on Health Care During the 10th Ebola Response in the Democratic Republic of the Congo



Threats and assaults



Arson attacks



Abductions



Killings



Sexual violence

This document summarises reported incidents of violence against health care providers in the context of the 10th Ebola outbreak in the Eastern part of the Democratic Republic of the Congo (DRC). The pandemic officially lasted from the 1st of August 2018 to the 25th of June 2020.

Key figures

483 total recorded attacks.

49 arson attacks on health facilities.

27 health workers were abducted.

25 health workers died in violent attacks.

277 health workers reported threats.

At least **50** women linked to the Ebola response experienced sexual exploitation and abuse during recruitment processes. [Export data](#)

3481 [Ebola cases](#) were recorded in 29 health sectors in North and South Kivu and Ituri provinces.

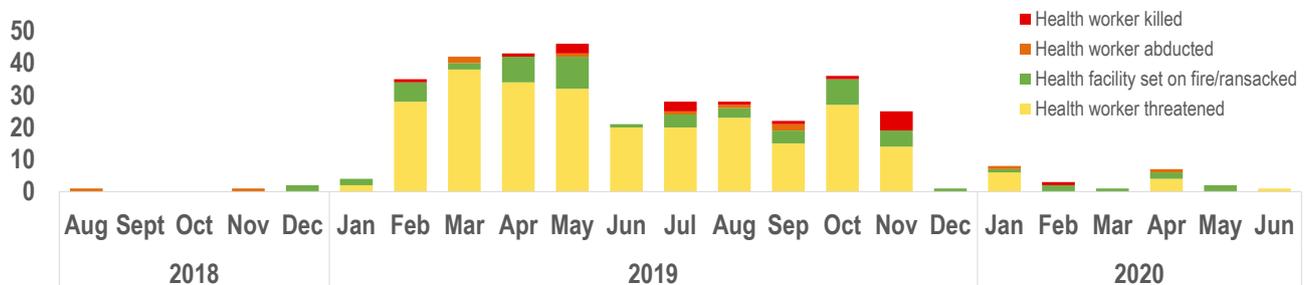
2299 [people died](#) of Ebola during 10th Ebola outbreak in the DRC.

The report compiles known information on 483 attacks on health care reported during the 10th Ebola outbreak with a view to support policy responses that better protect health workers and health providers during future outbreaks.

The reported information focuses on the context and contributing factors leading to violence against health care. The data presented in this brief is neither complete nor comprehensive and may differ from other sources.

The second-largest Ebola outbreak in history was characterised by a noticeable rise in violence against health care in particular between February and November 2019. It occurred against a backdrop of weak state control in the provinces of Ituri, South and North Kivu all affected by protracted conflict and insecurity. The area is characterised by a near-constant state of political crisis, high levels of institutionalized corruption. The health response was also impeded by widespread mistrust of health providers by local communities.

Reported violence or threats of violence against health care, August 2018-June 2020



The Ebola response was primarily managed by public health actors not all of whom were experienced in tackling the outbreak of infectious diseases in an active conflict zone which presents unique operational and organisational challenges. While the majority of attacks on health care have occurred in the context of the Ebola response and in Ebola-affected areas, many also occur in the context of on-going violence and insecurity that affect civilian populations in the DRC. These attacks can affect both the Ebola response as well as the wider provision of vital health services in the area.

Contributing factors to violence against health care

Multiple factors are likely to have contributed to the high levels of violence against health care providers during the 10th Ebola response. Perpetrators rarely explain their motives, and explanation of causes remains circumstantial and based on context. The main aspects considered here are: [Community trust](#), [corrupt practices](#), and [protracted conflict](#).

Key facts

- The number of reported attacks on health care was highest between February to May 2019 but remained elevated through November 2019.
- The high numbers between February and May 2019 coincided with intensified Ebola intervention efforts following the rise in reported Ebola cases in Katwa and Butembo, North Kivu.
- There is evidence that [social media](#) was at times used to stir up distrust and possibly to incite violence against health care. It is unclear to what extent the COVID-19 pandemic impacted on the final weeks of the 10th Ebola Response.

Widespread community distrust

Community resentment and resistance to the Ebola effort put health workers at risk. Threats and assault of health workers peaked during the height of the Ebola response.

- Rumours regarding the origins of Ebola and the motivations of responders were widespread. In some communities, people believed that the vaccination campaign was an experimental trial that caused harm or Ebola itself. Fears of forced vaccinations, quarantine, hysterectomies, and abortions made individuals highly distrustful of health workers.
- The outbreak coincided with the DRC's presidential electoral cycle, leading to the politicization of the disease - politicians, and drug companies were blamed for the pandemic, and health workers were viewed with suspicion.
- The influx of foreigners – from UN agencies, international NGOs, media outlets, and private sector companies increased fears and suspicions among local communities that those involved in the Ebola Response were working on a foreign agenda.
- Misappropriation and abuse of power only further exacerbated misperceptions.

Key facts

- Health workers were sometimes targeted directly, most likely in relation to their work.
- Some health workers may have been threatened as a result of patron-client expectations.
- Many health workers reported having been threatened or assaulted by community members.
- National health staff workers were most at risk -of the 277 health workers who were threatened, only 17 were international staff members.
- In April 2020, local residents attacked an Ebola response team and their vehicles in the Butanuka area, North Kivu. The medical team was in the area to disinfect the house of a new Ebola case reported.

Impact of rumours and distrust

- Rumours and distrust led many people to avoid going to government-operated health facilities altogether, preferring to use private dispensaries or pharmacies. Some also relied on traditional medications and other home-made solutions.
- Fear of forced vaccines and quarantine and stigmatisation meant that many people avoided health structures for a variety of illnesses and sexual and reproductive health services. During the response, over **130,000 suspected measles cases** were reported in 2019 and some 6,000 people died of measles in 2019 alone as vaccination coverage remains very low and health system was under strain from the Ebola response.

Recommendations for NGOs working on communication with affected populations

Community engagement is central to preventing mistrust, which can degenerate into threats and violence against health providers.

- Involve local communities to strengthen feedback loops from communities in order to adapt communication to address possible concerns and distrust vis-à-vis the health response.
- Identify the opinion leaders within communities who may encourage threats and violence against health responses and target these opinion leaders specifically or seek ways to counter their information.
- Consider the role of social media in spreading such information that may be important for some community groups, less so for others and of little importance to others.
- Adapt the language and messaging to the target communities by using local languages as well as the most appropriate forms from pictograms, radio, mass media, social media, or direct communication depending on the social group within the local community.

Training for health workers

- Support health workers in developing effective communication strategies with communities related to the necessary health measures and compassionate communication with concerned and bereaved family members.

See these [recommendations](#) for more details.

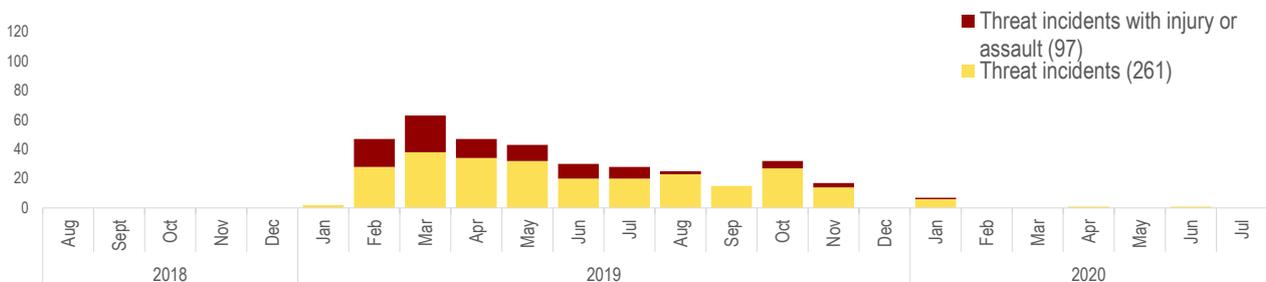
Threats and Assaults

Threats and assaults were rarely reported prior to the middle of the 10th Ebola response.

Key facts

- Reports of community members threatening staff members during health activities were frequent and included assaults that caused injuries. In many of these incidents, staff members were targeted directly and likely in relation to the work they were carrying out.
- Widespread community distrust and resistance to external help hampered efforts to contain the spread of Ebola and measles outbreaks.

Reported threat incidents, August 2018-July 2020



The Ebola response occurred in an area where fraud and corrupt practices are common

Blindness to a system of illicit practices based on wide-spread patron-client communal networks that allow for economic and sexual exploitation to flourish. A complex system of expected kickbacks in relation to recruitment and supplier subcontracting put health workers at risk during the Ebola response.

- The influx of Ebola responders and associated cash flows allowed for an abuse of power by intermediaries and managers and exposed health workers involved in the Ebola Response to corrupt practices ranging from intimidation to exploitation and revenge.
- Abuse of power by those in control of recruitment and subcontracting places those of lower socio-economic status at risk of exploitation. Some female health workers experienced sexual violence and abuse during the recruitment or work process.
- Some staff from outside the affected area experienced harassment and resentment from locals who had missed out on lucrative contracts.
- Some violence or threats of violence may have been intended to intimidate health workers, particularly those who did not live up to expectations of a kick-back system.

Ebola response teams used security escorts from both the DRC Armed Forces (FARDC) and armed groups.

These are reported to have also been procured at very high costs. Significant tensions about such lucrative contracts developed between some actors in the response and parties to the conflict. Anecdotal evidence suggests that armed groups put pressure on health responders to use paid security escorts, and that refusal was linked to subsequent security incidents.

Dr Richard Valery Mouzoko Kiboung, an epidemiologist was killed on the 19th of April 2019 during a militia attack in Butembo while chairing a meeting with members of the Ebola response team. According to various sources, this assassination targeted the Ebola response due to the perception that certain individuals were an obstacle to the circulation of resources.

In July 2019, unidentified attackers killed two Congolese Ebola health workers in Mukulia village, North Kivu. The staff members had been receiving threats since last December, and one had already been previously attacked.



Sexual Violence and Abuse

Very few cases of sexual exploitation and abuse (SEA) were formally reported during the Ebola response. However, anecdotal evidence highlighted sexual violence and abuse against female health workers during the 10th Ebola response. Moreover, an investigation by the [New Humanitarian and the Reuters Foundation](#) identified 50 women who accused aid workers in the Ebola response of sexual exploitation and abuse.

The number of jobs created through the Ebola response fostered a culture of abuse of power in some instances. According to field-based NGOs: Recruitment of female Ebola workers involved in some cases demands for sexual favours in return for positions (transactional sex).

- There are several allegations of sexual harassment in the Ebola workplace.
- There are reports of 'Ebola babies' after women, and young girls were impregnated and abandoned by male Ebola response workers.
- Perpetrators are typically individuals with direct contact to those seeking work in the Ebola response.

These reports could not be independently verified. Most reports were provided by NGO workers who met the survivors. The investigation by the New Humanitarian and Reuters Foundation is based on interviews with survivors and others who could confirm key aspects, such as drivers or health workers.

Several individuals reported abuse in the recruitment process or work context

"You must always have sexual relations with agents working on the Ebola-response, even if you have a diploma. It's very remarkable amongst women.

Even for men, they will expect them to give half their salary to the one who got you the job in the first place."

[Anonymous informant]

"I've had a patient come to me to ask for an assisted abortion.

She was pregnant owing to sex she was forced to have with an Ebola responder in order to get her job."

[Health care worker]

Key concerns

- **Lack of reporting:** Reporting of sexual exploitation and abuse has been rare due to shame or stigma, a sense of responsibility on the part of the survivor as well as the use of bribe payments to buy silence. Many survivors also do not trust the available reporting mechanisms.
- **Insufficient awareness:** Understanding of what constitutes sexual exploitation was not widespread and victims often felt implicated, making them reluctant to report.
- **Little accountability:** Perpetrators cannot easily be held accountable.

Recommendations

Sexual exploitation and abuse should be addressed through the following measures:

- **Prevention:** Better integration of a code of conduct into the whole health response framework;
- **Reporting:** Via aid agencies and trusted local women may be a way forward;
- **Sanctions:** Sanctions for perpetrators should be implemented.

All response activities relating to sexual violence and abuse should be survivor centred. This means that the survivor has control over all decisions relating to the incident. The only exception to this approach would be if the survivor's wishes place the survivor or others at risk of harm.

Report Abuse

Insecurity Insight is currently developing a new online reporting platform to facilitate the reporting of sexual exploitation and abuse in public health responses within the DRC. This online platform provides survivors, who have experienced sexual exploitation and abuse whilst working in a public health response, a safe and secure way to report and share their experience.

Insecurity Insight is also developing a reporting tool for trusted supporters of survivors of sexual exploitation and abuse to report an incident on behalf of a survivor. Please visit our [website](#) for future developments.

The Ebola outbreak occurred in provinces plagued by protracted conflict

Some of the violence against health care workers was without a doubt triggered by the outbreak of the Ebola disease and some aspects of the implementation of the health response.

The safety of health workers was further impacted by insufficient consideration of how to respond to outbreaks of infectious disease in the context of an on-going humanitarian crisis due to a protracted conflict (such as the one in the DRC).

- Violence by armed groups against civilians has plagued the area for decades, and such attacks continued during the Ebola response, affecting several health workers and health facilities.
- The location of infections determined where the health response had to take place, exposing frontline health workers to security risks in particular when humanitarian principles of independence, neutrality, and impartiality were not respected (by conflict parties).
- Sustained conflict has resulted in a normalisation of violence in everyday life and specifically gender-based violence.

In the DRC violence against health care is often closely linked to attacks on civilians:

- The Anglican Mission Hospital in Boga town, Ituri, was looted, and a doctor and lab technician were abducted during a wider early morning assault on the town on the 23rd of August 2019. More than 200 youth, children, and women were also abducted, shops were looted, and cows were stolen. In April, **ADF claimed responsibility** for an attack on behalf of ISIS.

Key facts

- At least 47 health workers were abducted, killed, or injured by non-state armed groups.
- 17 of the 47 health workers who were abducted, killed, or injured worked for an international aid agency.
- Health facilities were attacked by non-state armed groups over 40 times.
- At least two health workers suffered during indiscriminate violence against civilians.
- Known perpetrators included ADF forces and Mai Mai militia, communal militia groups, the Veranda Mutsanga vigilante group, and local community members.

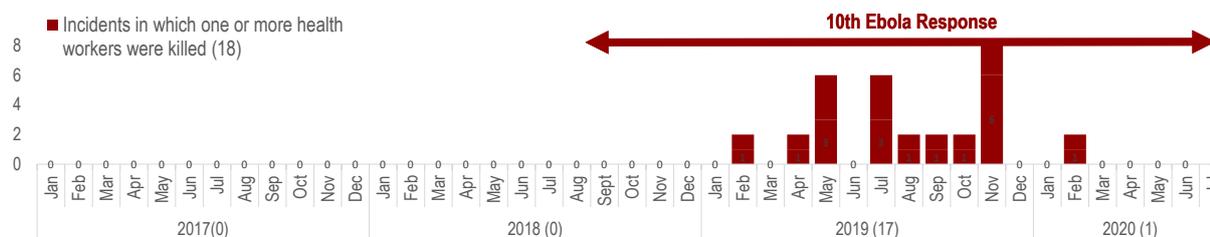
Health Worker Killings

The murder of health workers increased during the Ebola response, and some may have been linked to complex client patron relationships. However, violent murder was not uncommon in the area before the disease outbreak.

Key facts

- At least 25 health workers have died in violent attacks between August 2018 and June 2020.
- 13 of the 25 health workers who were killed worked for an international aid agency.
- Over half of reported health worker killings took place in Beni and Lubero territories, North Kivu.
- Perpetrators of these attacks include suspected members of armed groups, civilians, and other health workers, but the precise circumstances are not known. Many attackers used machetes, sticks, and stones in these attacks.

Reported health worker killings, January 2017-July 2020



Recommendations

- Each abduction and killing is different and requires a unique response. Responding to an abduction or the killing of a staff member is complex and often requires professional support. See these [recommendations](#) for more details.



Health Worker Abductions

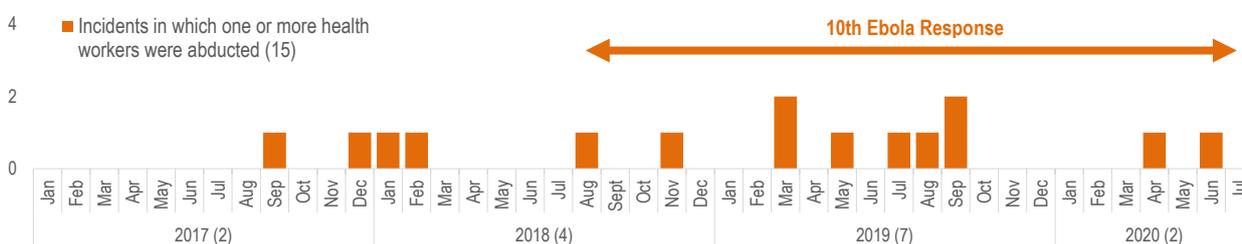
The number of reported abductions of health workers increased during the Ebola response. However, kidnappings did not peak in the middle of the Ebola response in the same way as other violence against health care.

Kidnappings of health workers are an endemic problem in the Eastern DRC and are not directly related to the Ebola response. While many kidnappings may not have been directly related to the Ebola response, in one kidnapping, the perpetrators identified collaboration with the Ebola response as a contributing factor.

Key facts

- At least 27 health workers were abducted by non-state armed groups while travelling to and from intervention sites, at health facilities, or during wider assaults on civilians.
- Eight of the 27 health workers kidnapped worked for an international aid agency.
- Over half of reported kidnappings took place in North Kivu.
- Approximately half of the 27 abducted were released within 72 hours. At least two health workers were killed or tortured while in captivity. In February 2019, a health worker in Vuhovi village was kidnapped and killed by attackers armed with bows and arrows. It is unclear if he was targeted because he was a health worker or for other reasons. The status of at least 11 health workers remains unknown.

Reported health worker abductions, January 2017-July 2020



Attacks on Health Facilities

The number of reported attacks on health facilities in the form of arson attacks and ransacking peaked in the middle of the Ebola response. However, attacks on health facilities were a common security threat for health facilities in unstable areas prior to the disease outbreak. These incidents decrease access to health care for civilian populations.

Key facts

- At least 56 arson and ransacking attacks on health facilities were reported. Attacks have caused staff member fatalities and injuries and often lead to reduced services that have an impact on access to health care.
- In some instances, such attacks caused the displacement of confirmed Ebola patients – sometimes to areas inaccessible to responders due to security constraints – allowing the disease to spread further.
- Attacks occurred in areas where armed groups operate, and where community distrust of efforts was high. Known perpetrators included communal militia groups, including the Veranda Mutsanga vigilante group, ADF forces, and Mai Mai militia.
- The precise motives of the perpetrators remains unclear. However, **social media** may have been used to build up distrust and possibly to incite violence. On 16 April 2020, riots organised by Veranda Mutsanga ensued in Beni, North Kivu, during which three ETC's were ransacked, vandalised, and looted.

Reported attacks on health facilities, January 2017-July 2020



Recommendations for providers of health facilities

- Develop a security plan based on context-specific risk assessments. Depending on the context, consider measures to prepare for **arson attacks** or **mob violence**.

Final observations

Community distrust was widespread, and resistance to public health measures put health workers at risk.

Pandemics create disbelief, distrust, and resistance in all societies. During a pandemic, frustrations, concerns, and fears among affected communities are often directed against frontline health workers. The root causes of such violence are frequently linked to wider underlying societal problems.

Improved communication that explains the disease, as well as the public health response is needed. Understanding of how the response may be perceived in relation to other concerns related to unpopular governments or societal inequalities is key.

Patron-client relationships affected the response and put workers at risk from exploitation, extortion, revenge, and silencing.

Violence and abuse of health workers were, in some cases, linked to many of the underlying expectations for kickbacks. The aid sector's inability to prevent such corrupt practices from infiltrating aid flow mechanisms meant that the resources for the responses created new opportunities for corrupt 'Ebola business' practices.

Improved control mechanisms are needed in order to prevent aid resources from being siphoned off. Enforcement of a code of conduct for all those working within the response effort is key. Better reporting and whistle-blowing mechanisms are needed, including sexual exploitation and abuse reporting.

Protracted conflict violence against health responders was widespread before the response and the abduction and killing of health workers continued throughout the Ebola response.

Under international humanitarian law (IHL), those providing health care in armed conflict are protected. The reality, however, is different. International aid agencies tend to use an acceptance-based security strategy where access in conflict-affected areas is negotiated with local actors based on the agency's assurance of independence, neutrality, and impartiality. Such an approach is challenging when the government may be perceived as a party in the wider conflict, yet is the lead agency in the health response.

Few international donors providing financial resources for health responses collaborate with local health providers on acceptance-based security plans.

Improved guidance on how Ministries of Health and local health providers can negotiate independent, neutral, and impartial health access during a pandemic is needed. Improved guidance on how local health providers can adapt acceptance-based aid access practices developed by international aid providers for their own use in protracted conflicts is key.

Context analysis is not a standard component in public health measures but is nevertheless essential for effective public health responses in societies weakened by distrust, conflict, and corruption.

The experience from the 10th Ebola response in the DRC raises important questions in the context of the Grand Bargain that seeks to put more means into the hands of people in need to improve humanitarian action in particular by supporting and funding more local responders. Most response workers are local citizens who are affected by a wide range of challenges.

There is a need for the international aid sector to support local health responses in order to also support the development of appropriate policies to protect health workers. In many cases, local health workers are neither entitled to the duty of care provided to local aid agency staff, nor are they seen as beneficiaries whose well-being is measured as part of donor reporting. There is little information on what duty of care policies, if any, apply to local health providers.

The context of armed conflict and violence against civilians needs to be better understood in order to support locally-led public health responses in developing security risk management solutions to operate effectively in such challenging environments.

Reporting attacks on health care

Attacks on health care have received increasing attention over the last several years. In particular, when public health programmes are rolled out in unstable and conflict-affected areas, health workers cannot rely on such protection. The UN Security Council [Resolution 2286](#) of 2016 condemned attacks against medical facilities and personnel in conflict situations. [Attacks on Health Care Monthly News Brief](#) by Insecurity Insight gives an overview of safety, security and access incidents that affect health workers, infrastructure and services. The [annual report](#) of the [Safeguarding Health in Conflict Coalition](#) (SHCC) has highlighted the growing concern of attacks on health care, and the World Health Organisation [Surveillance System on Attacks on Health Care](#) (SSA) documents attacks in 16 countries and territories.

Definition: Attack on health care

Defined as any act of verbal or physical violence, obstruction, or threat of violence that interferes with the availability, access, and delivery of curative and/or preventive health services, perpetrated by state and non-state actors, patients or relatives of patients, private individuals and criminals. See [here](#) for further information.

Research and data limitations

The brief was compiled using an event-based approach to documenting attacks on health care. Event descriptions from multiple sources were cross-checked and consolidated into a single dataset of recorded incidents that were coded using standard definitions. The incidents reported are not a complete nor a representative list of all events that affected the provision of health care in the DRC and have not been independently verified.

The figures presented in this report can be cited as the total number of incidents of attacks on health care during the 10th Ebola response identified by Insecurity Insight. This [datasheet](#) is available on HDX.

The data summarised in this document have been systematically compiled from two categories of sources: (a) verified security incidents submitted to Insecurity Insight by Aid in Danger partner agencies and confirmed incidents published on the publicly available WHO Surveillance System for Attacks on Health Care (SSA) dashboard; and (b) open-source information, as published in the Attacks on Health Care Monthly News Brief and the monitoring reports other sources.

The dataset suffers from limitations inherent in the information provided by the sources used. These publicly available sources adopt use different methodologies and certain biases within individual sources influence the data. Some sources used also varied their activities throughout the monitoring period. Notably, the WHO SSA began monitoring attacks on health care in January 2019. While the WHO reported 241 events in the DRC throughout 2019, only 12 events were reported in 2020 (as of 12 October).

Not all contributors provided access to their original sources and many details were lost in the process, affecting the ability to provide more accurate and consistent classification. The WHO SSA does not report information on perpetrators or location of events.

Mobile guide

Recommendations of how to how organisations can implement security risk management measures to protect health care responders and communities during a public health emergency or infectious disease outbreak are available as a [mobile guide](#).

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