

EVALUATION FINALE

# Tushinde Ebola Pamoja – Let's Beat Ebola Together

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## Executive Summary

“Tushinde Ébola Pamoja (TEP)” (Let’s Beat Ebola Together) was a project funded by the Canadian Government and implemented by Search for Common Ground (Search) over the course of 12 months. The project aimed to help contain the spread of the EVD epidemic and reduce violent resistance and community distrust of the EVD response in North Kivu. Search proposed to support the response against the EVD epidemic by implementing an intervention that fostered stabilisation and peacebuilding. Search mobilised influential stakeholders at the national, provincial, and local level to strengthen their positive influence on communities within the context of the response to the EVD pandemic.

This study aims to evaluate independently the results achieved by the project “Tushinde Ébola Pamoja” (Let’s Beat Ebola Together), focusing on the impact, efficiency, and sustainability of the interventions implemented as compared to the objectives set.

More specifically, it aims to:

- Objective 1: Assess project results.
- Objective 2: Assess gender integration during the project implementation.
- Objective 3: Assess project sustainability.
- Objective 4: Identify lessons learned (best practices) and recommendations.

This study was implemented in the province of North Kivu in the zones targeted by the project: Beni, Oicha, Mangina, Butembo, Lubero, and Kayna, as well as in Goma and Kinshasa for stakeholders at the provincial and national level.

The study included key informant interviews with influential actors (politico-administrative authorities, media actors, civil society representatives, and youth and women leaders). It also included focus group discussions with community members and household surveys in the project target locations. The evaluator used a survey and key informant interview and focus group discussion guides to collect quantitative and qualitative data around the following themes: community member trust in the EVD response teams; youth, women, state authority and community leader engagement; inter-group relationships; relationships between community actors and response teams; community member access to dialogue spaces with state actors; opportunities for collaboration between community members and state actors, and gender integration.

A total of 80 women and 80 men participated in the focus group discussion and 412 respondents, including 235 men and 117 women participated in the quantitative survey in the project target zones.

## Key findings

### Objective 1: Assessing Project Results

The study population is *aware of the negative socio-economic consequences of the EVD* in their communities. In addition to Ebola, they consider malaria (91%) and typhoid (72%) as the most recurrent and dangerous diseases in their communities before coronavirus (15%) and diabetes (15%).

Regarding the *population's confidence in the EVD response teams*, the responses show an increase in confidence from 27% to 70%. The integration of influential community leaders and the use of local expertise in the various pillars of the response to the EVD have increased the confidence of the local population. The measures taken by the Congolese government to stop the spread of the EVD were considered effective (91%). On the other hand, those related to the Coronavirus were only approved by 75%.

Regarding the *involvement of young people in the response to the EVD*, quantitative data show that 84% of respondents said that they were significantly involved in dialogue activities with state and response actors, and in community outreach activities. 55% of respondents stated that the high number of deaths and infections were triggers for youth engagement as well as the change in response strategy from non-militarization to community outreach.

Regarding *women's engagement*, 86% of community members report that women were significantly engaged in the response to the EVD in community engagement activities through community discussion and solidarity groups but less so in community dialogues and outreach. The commitment and determination of women is justified by the fact that they have been the most affected by this epidemic. The results of the baseline study show an average of 40% of youth and women who were significantly engaged in the response to the EVD.

Regarding the *assessment of response staff on community resistance to acknowledging the EVD, its risks, and the importance to responding to it*, 81% of health care providers and non-providers working in the response, compared to 65% in the baseline study, agreed that people's resistance to the EVD has been decreased thanks to the combined efforts of influential community leaders and state and response actors through community dialogues and sensitization of specific groups. These activities have dispelled people's reluctance to use the response services and the contradictory messages that led to confusion among the population and resistance to the response teams.

The dialogue, forum and community outreach activities *have improved relations between the community and medical actors*. Quantitative data show an improvement of 60% to 80% of respondents who positively valued the relationship between targeted community members and health care providers.

The quantitative data show *access to quality information*. 67% in the final evaluation believe they receive reliable information. This is justified by the fact that involving media actors in the response activities, training them on CREC, equipping them, motivating them, and involving them in the response has enabled them to organize and disseminate verified information on the response and prevention of the EVD.

The majority of respondents believe that *members of their communities are able to fight rumors about the response to the EVD* because of the reliable information they receive from the media, particularly radio (94%), which was cited by respondents as their main source of information. The percentage increased from 40% to 67% in the study areas as a result of mass awareness efforts through radio broadcasts.

The majority of respondents (91%) thought that *non-medical state actors were positively engaged in the response to the EVD*, whereas the average was 74% at the baseline. The change in strategy in PRS 4.1, the project's approach

to working with influencers and supporting them to implement dialogue and outreach activities, has enabled them to effectively exercise their mandates and thus improved non-medical actor engagement in the response.

As in the baseline study report, quantitative data also show that 75% of respondents to the baseline study versus 88% in the final evaluation believe that ***local leaders (neighborhood chiefs, religious leaders, community relays, pressure group leaders, citizen movements, and women's and youth associations) are actively engaged in the response to the EVD***. Thus, the percentage increased from 66% to 88% of respondents who reported that local leaders were positively engaged in the response to VEM in the study areas.

Qualitative data show that the leaders with whom community members collaborated the most were neighborhood leaders, while leaders of pressure groups and youth associations collaborated with international NGOs (Search, FHI 360, IRC,) and the mayors of the cities of Butembo and Beni and the Bougmetre.) The latter facilitated the implementation of vaccination activities, decontamination, dignified and safe burials, and contributed to reducing the mistrust of community members towards the response teams.

60% of respondents believe that the communication strategy adopted by the response actors has fostered trust between social groups, compared to 12% in the baseline study.

Quantitative data show that awareness of positive models existing in the study areas increased from 75% at baseline to 82% of respondents at the final evaluation who think that community members had access to positive models for the response to the EVD. These are: (i) The systematic organization of door-to-door visits by young people; (ii) The securing of vaccination rings by young people under the direction of neighborhood leaders; (iii) The organization and holding of radio broadcasts and interactive programs by young people, traditional community leaders under the facilitation of a journalist.

## Objective 2: Assessing Gender Integration

In the context of the Ebola epidemic, interviews with project staff and the review of the quarterly report and project proposal show a practical and strategic gap between facilitators and influencers. There were more male influencers than female influencers, and more female facilitators than male.

The project monitoring and evaluation data shows 14,067 people of whom 7,294 were women and 6,773 men actively participated in the project activities. 40 facilitators (17 men and 23 women) trained by Search implemented the focus groups in Beni and Butembo; 29 men and 11 women were actively engaged in the dialogues, reconciliation, and community forums.

These differences can be explained by the configuration of the Ebola response, public administration, and social norms enacted by Congolese culture, which places men first in decision-making bodies. State authorities (neighborhood chiefs), leaders of pressure groups and citizen movements and civil societies, and chain managers were all men.

To address this problem, the project selected more women facilitators and encouraged the participation of women and girls in project activities to reduce practical and strategic gender gaps in the context of Ebola.

## Objective 3: Assessing Project Sustainability

The project has identified conditions for its effects to continue beyond the close of project activities. These are: (i) functional community radio to continue to disseminate prevention messages against Ebola and hygiene promotion; (ii) functional local associations capable of self-financing to continue the care of Ebola survivors; (iii) operational state institutions to continue to organize community dialogues with associations and youth groups.

The project results have been sufficiently appropriated by male and female participants, influencers and facilitators who continue to hold forums, discussion groups, and solidarity activities without financial support from the project in order to consolidate social cohesion and provide emotional support to Ebola survivors. However, the project has not developed a transition strategy document describing the project's exit from its areas of intervention and how its gains will be sustained.

The TEP project has generated partnerships and commitments that are critical to ensuring the continuity of results over the long term. These include collaborative partnerships and sustainable engagements with community radio stations, local associations and state institutions, advocacy groups, and the social movement.

The value-added for investments in social cohesion and peace in the context of positively transforming relational capacities among communities themselves and between communities and state medical and non-medical actors around the EVD are acceptance of Ebola services, culture of dialogue and mediation.

## **Objective 4: Identifying Lessons Learned and Best Practices**

Influencers (including youth and women) raised community awareness of the health risks of Ebola and enabled communities to respond with their own strategies.

The fact that the project worked through influencers and facilitators who are able to bring people together and promote the participation of the most resistant community members reduced violent resistance to the response to the EVD.

The project has adapted its strategy in line with the strategic response plan (SRP4) to improve coordination, collaboration, and communication by using community-based approaches and implementing community feedback forums and interactive radio programs.

## Recommendations

Considering the above findings and conclusions, the following recommendations were made:

- Ensure strict application of the principle of gender mainstreaming during the process of identification and selection of project actors for effective participation of women leaders in the activities of community dialogues and rapprochements.
- Continue to value the leadership of women actively engaged in the fight against EVD through associations and community self-help groups in the fight against EVD in the activities of community forums, reconciliations, dialogues, and discussion groups.
- Strengthen partnership aspects including behavior change communication with local associations and youth and women's groups to counter rumors and prevent violent tensions in communities affected by EVD.
- Put in place mechanisms to manage and capitalize on feedback from listeners of radio broadcasts to improve activity implementation, promote access to quality services for vulnerable populations, and strengthen the accountability mechanism to populations affected by the Ebola epidemic.
- Continue to provide technical and financial support to community radios in rural areas to improve access to reliable and verified information for vulnerable populations in order to increase their confidence in the Ebola response actors.
- Implement specific communication approaches focused on specific groups (youth, women) with specific problems to increase the confidence of the population of Beni towards the actors of the response against the EVD.
- Encourage the use of social networks and instant messaging in urban areas to improve access to quality information in a timely manner especially to youth and women in communities affected by the health crisis.
- Expand community solidarity activities in the Kayna and Lubero health zones to strengthen the resilience of individuals in households and communities in order to reduce the humanitarian costs caused by Ebola.
- Continue to technically and financially support psychosocial care structures for women and youth survivors of the EVD, particularly disproportionately affected women to restore confidence and self-esteem.
- Determine and/or adjust realistic and achievable targets over the duration of project implementation to achieve the expected results and goal set by the project.
- Develop the exit strategies document to define the sustainability mechanism of the project actions in the targeted communities.

### **Conduct advocacy with the Congolese government to:**

- Put in place measures to minimize the negative effects of the EVD on progress towards gender equality in the community.
- Create a synergy of coordinated and harmonized actions through local, provincial, and national gender mechanisms as part of the MSP's response plan against the EVD.
- Ensure gender equality in the identification and selection process of facilitators so that women and men are adequately empowered to fight the EVD.

- Provide small grants to local associations especially those of youth and women to carry out social sensitization and mobilization activities at the community level in favor of populations affected by the health crisis in order to strengthen the commitment of affected communities.

# 1. Introduction

Since August 1, 2018, the Democratic Republic of Congo (DRC) has been battling the worst Ebola outbreak ever recorded in the country and the second largest in the world after the 2014 West Africa outbreak. According to WHO, 3,470 cases, 2,287 deaths, and 1,171 survivors have been recorded from August 1, 2018, to June 25, 2020. There are many reasons why this outbreak has grown unexpectedly large, including problems created by armed conflict in the DRC, community resistance, and rumors and other misinformation that aimed to discredit response strategies.

The violence associated with armed conflict, division in the Congolese political class, and skepticism about the intentions of humanitarian organizations created an environment of widespread distrust and suspicion with the proliferation of community and online misinformation in the midst of the Ebola Virus Disease (EVD) outbreak in the DRC compounding the situation. According to WHO, in the face of rumors and misinformation, some families chose to care for sick relatives at home, increasing the risk of transmission to caregivers, family, and children.

A study conducted on institutional trust and misinformation in crisis-affected areas showed that the EVD epidemic is occurring in an active conflict zone where low institutional trust is linked to a long-term decline in security and political confidence. It was identified in this study that low levels of trust in government institutions and belief in misinformation about EVD were prevalent in crisis-affected areas.

In an atmosphere where rumors and misinformation are prevalent, people may be reluctant to accept unfamiliar infection prevention and control practices, such as burials, or decontamination activities. Community awareness of Ebola containment measures remains one of the key challenges in the Ebola response. Increased political tensions and unrest have made it difficult for health workers to reach communities.

It is in this context that Search for Common Ground (Search) DRC, with funding from the Canadian Stabilization and Peace Operations Program (PSOPS), proposed to contribute to the reduction of violent resistance and community mistrust to the response in North Kivu through a 12-month project called "Tushinde Ebola Pamoja (Let's beat Ebola together)".

## 1.1. Project Background

The “Tushinde Ebola Pamoja” (Let's beat Ebola together) project aimed to help contain the spread of the EVD epidemic and reduce violent resistance and community distrust of the EVD response in North Kivu. To achieve this overall goal, Search has two specific objectives:

- To positively transform relational capacities among communities themselves and between communities and medical and non-medical state actors around EVD; and
- Improve community communication practices, especially women's networks to counter rumors and misinformation related to the EVD response.

Search involves influential actors at national, provincial and local levels to strengthen their positive influence on their communities in the response to EVD. In addition, to build trust and create a participatory and inclusive response, Search engages diverse groups such as traditional leaders, political actors, religious leaders, leaders of armed groups, and leaders of youth and women's organizations. The project is articulated around the following:

***Intermediate results:***

- Intermediate Outcome 1100: Relationships between communities themselves and between communities and medical and non-medical state actors around EVD are positively transformed and promote social cohesion
- Immediate outcome 1110: Key non-medical actors at national and local levels are positively mobilized around the EVD response
- Immediate Outcome 1120: Local communities (and specifically women, women's organizations and networks, and youth) and state actors at the local and national level have access to spaces for dialogues and opportunities for meaningful collaboration in the response to the VEM.
- Intermediate Outcome 1200: Communities have access to reliable information on the response to EVD and are able to counter rumors
- Immediate Outcome 1210: Communication around the EVD response promotes positive role models, women's and girls' human rights, gender equality, and women's and girls' empowerment and fosters trust between groups

To achieve these results, Search implemented the following ***activities***:

- Activity 1111a. Mapping of key actors (political, religious, customary, armed groups, etc.).
- Activity 1111b. Retreat of key actors "Trust Camps."
- Activity 1111c. Peace Retreat.
- Activity 1111d. Training (capacity building) of members of leaders' platforms (10 per platform) in conflict transformation 2 (Beni and Butembo).
- Activity 1121a. Peace Forums.
- Activity 1121b: Reconciliation activities based on plans from the forums.
- Activity 1121c: Establishment of a mechanism for ongoing dialogue on interventions around EVD.
- Activity 1121d: Provincial workshops.
- Activity 1210a: Media campaign.
- Activity 1210b: Production and dissemination of the Mopila soap opera
- Activity 1210c: Training of partner radio station managers
- Activity 1210d: Establishment and holding of CDG meetings
- Activity 1210e: Establishment/reinvigoration of Community Participatory Theater (CPT) troupes

## **1.2. Evaluation Objective**

The overall objective of this study is to assess the results achieved by the "Tushinde Ebola Pamoja (Let's Beat Ebola Together)" project, with a particular focus on the impact, effectiveness, and sustainability of the actions taken in relation to the project objectives. It provides key information related to changes and other progress achieved throughout the implementation of the project.

Specifically, it includes:

- Objective 1: Assessing project results
- Objective 2: Assessing gender integration
- Objective 3: Assessing project sustainability
- Objective 4: Identifying lessons learned, best practices, and recommendations from project implementation.

## 1.3 Evaluation Guidelines

The study collected information on the following indicators and evaluation questions related to its specific objectives:

### **Objective 1: Assessing Project Results (*indicator list*)**

- 1.1. Percent of community members who trust the EVD response team.
- 1.2. Percent of community members who report that youth, women are meaningfully engaged in the response to EVD.
- 1.3. Percent of medical and non-medical personnel working in the response who agree or strongly agree that the population's resistance to the EVD has been reduced.
- 1.4. Percent of respondents who report that the relationship between their community and medical actors around the EVD is positive.
- 1.5. Percent of respondents who say that communities have access to reliable information on the EVD response.
- 1.6. Percent of respondents who say that communities are able to counter rumors about the response to EVD.
- 1.7. Percent of the population reporting that non-medical state actors are positively engaged in the response to EVD.
- 1.8. Percent of population who report that local leaders are positively engaged in the response to EVD.
- 1.9. Percent of community members who report that communities have opportunities to collaborate with state actors in the response to the EVD.
- 1.10. Percent of community members who report that opportunities to collaborate with state actors help reduce mistrust of the EVD response.
- 1.11. Percent of the population reporting that communication around the response to EVD promotes trust between groups.
- 1.12. Percent of population reporting having access to positive role models for the EVD response.
- 1.13. Percent of population reporting that communication about the response has promoted women's and girls' human rights and gender equality.

### **Objective 2: Assessing gender integration**

Gender mainstreaming throughout the implementation of the project has aimed to achieve gender equity. It does not exclude gender-specific activities and affirmative action where women and men are in a particularly disadvantaged position. Gender-specific interventions have been targeted exclusively at women, men or both to enable them to participate in and benefit equally from development efforts.

- 2.1. Does the project identify the practical and strategic gender gaps in the context that are related to the problem?
- 2.2. Has the project achieved verifiable results in reducing practical and strategic gender gaps in the context related to the problem?
- 2.3. Is information on project populations systematically disaggregated by sex or gender?

### **Objective 3: Assessing project sustainability**

Sustainability, or viability, refers to whether the effects of the program will continue after it has ended. It is an analysis of the likelihood that the positive effects of the action will continue after the external assistance has ended. Sustainability determines whether the positive results of the project (in terms of its specific objective) are likely to continue once external funding has ended. Financial viability, but also the opportunity to replicate or scale up the program.

- 3.1. Are there conditions for the effects to continue beyond the end of the project activities?
  - 3.1.1. Have the results of the project been sufficiently appropriated by the male and female beneficiaries?

**3.1.2.** What has the project done to support community structures or groups so that they can continue to meet the needs of the communities and maintain the impact of the projects? Is this sufficient?

**3.1.3.** Has the project developed an exit or transition strategy?

**3.1.4.** Has the project generated partnerships and commitments that are essential to ensure the continuity of results over the long term?

**3.2.** is there added value for investments in social cohesion and peace in positively transforming relational capacities among communities themselves and between communities and state medical and non-medical actors around the EVD?

**Objective 4: Identifying lessons learned, best practices, and recommendations**

**4.1.** What lessons were learned throughout the implementation? What worked well and what did not?

**4.2.** What recommendations should Search consider for future projects?

## 2. Evaluation Methodology

A mixed methodology approach was used to collect data. The study took place in the epidemic-affected health zones of Beni, Oicha, Mangina, Butembo, Lubero and Kayna from 17 to 21 February 2021. Interviews with former response teams were conducted in Goma and by Skype with the general coordination in Kinshasa. Quantitative data were collected from smartphones using the Kobo Collect application.

### 2.1 Qualitative Data

#### 2.1.1 Key Informant Interviews

Thirty-eight semi-structured interviews were conducted with the various state and non-state, medical and non-medical actors targeted by the study. An individual interview guide was used to collect the data. Table 1 summarizes the categories of key informants interviewed.

Table 1: Distribution of sample size of Key Informant Interview (KIIs)

Health Zones	Political Actors	EVD Actors	Media Actors	Health Workers	Women Leaders	Youth Representatives	Civil society representatives	Total Number
Beni	1	1	2	3	0	0	0	7
Butembo	1	0	2	2	0	1	1	7
Kayna	1	0	1	1	0	0	1	4
Lubero	0	0	1	2	0	0	1	4
Mangina	1	1	2	2	0	1	1	8
Oicha	1	0	1	1	1	0	0	4
Goma		3						3
Kinshasa		1						1
<b>Number of KIIs</b>	<b>5</b>	<b>6</b>	<b>9</b>	<b>11</b>	<b>1</b>	<b>2</b>	<b>4</b>	<b>38</b>

#### 2.1.2 Focus Group Discussions

24 separate focus groups were held with community members, including adult women, adult men, young girls, and young boys. Each group was composed of eight people, both women and men. One focus group was held with each target group per study area. The table below presents the FGD distribution.

Table 2. Distribution of FGD

Health Zones	Number FGD	Number of participants	Number total of participants
Beni	4	8	32
Butembo	4	8	32
Kayna	4	8	32
Lubero	4	8	32
Mangina	4	8	32
Oicha	4	8	32
<b>Total Number of participants</b>			<b>182</b>

## 2.2 Quantitative Data

### 2.2.1. Study population

The study population included the populations of six TEP intervention zones. These areas included Beni, Butembo, Kayna, Lubero, Mangina and Oicha. Criteria such as population density, accessibility, and areas that have been affected by Ebola helped us select the people involved in the sample.

### 2.2.2. Sample Methods

Stratified sampling, combined with simple random sampling, was used in this study. Drawing of primary units: random selection of health areas based on the list of health areas with population and number of people to be surveyed. Stratification was done at the health area level, where the health area will be considered as a stratum.

### 2.2.3. Distribution of sample size

The sample size was determined by the formula  $n = Z^2 \cdot p \cdot q / d^2$

n = sample size

Z = value for a 95% confidence level

p = the proportion having the characteristic under study = 50%.

q = 1 - p

d = the desired degree of precision (here = 0.05).

The value of p considered was fixed at 0.5 and "q" at 1- p i.e. 0.5. We used this proportion with a margin of error  $\alpha = 0.05$  at the 95% confidence interval.

$$n = \frac{(1,96)^2 \times 0,5 \times 0,5}{(0,05)^2} = 384$$

Because of the imponderables (non-respondents and errors that can occur when filling out the questionnaire), we took a sample size of 412. Table 3 presents the distribution of households surveyed by health zone and by gender.

Table 3: Distribution of sample size

Health Zone	Sex		Sampling
	Male	Female	
Beni	90	81	171
Butembo	73	46	119
Kayna	13	13	26
Lubero	24	13	37
Mangina	18	15	33
Oicha	17	9	26
<b>Total</b>	<b>235</b>	<b>177</b>	<b>412</b>

Details on the sampling method and process can be found in Appendix 2 of this report.

## 2.3 Data Analysis

The collected data were analyzed using SPSS software and formatting was done with Microsoft Excel. Data cleaning and quality control were performed by the principal investigator. The information collected was synthesized using the statistical methods indicated (frequency). Cross-tabulation and comparison of different groupings for important parameters. However, the qualitative data (focus group and individual interview) were analyzed using the RITA method.

### Recording Method (RITA)

Using this method, the evaluation team first identified key evaluation strengths that are directly related to the evaluation objectives. The evaluation team then used a combination of inductive and deductive approaches to develop a set of themes that were based on the following elements. Focus: deductive themes based on past theory and inductive themes based on experiences conducting interviews and reviewing audio.

All themes will be organized and defined in a thematic codebook. This codebook turned into a form of coding that allowed the evaluation team to indicate the presence, prevalence, and timing of each code while listening to the audio recordings of the KIIs and FGDs. The investigators also recorded key quotes and additional notes on the coding form. This coding form was tested and refined by analyzing at least the first two KIIs and FGDs. Once the coding form is finalized, all KII and FGD audio files will be analyzed using this tool.

Once all audio files were coded, all coding forms completed, they were examined to identify trends and patterns in the data. For example, the frequency of specific themes among the KIIs and FGDs as well as any trends in the context in which the themes were discussed. Investigators also noted any trends in code prevalence by analyzing attributes of the data collection event, such as the site, security situation, and presence of PET project activities.

Table 4: Socio-demographic characteristics

Socio-demographic characteristics	Male		Female		Total	
	#	%	#	%	#	%
<b>Group Age</b>						

18-24 years	33	19%	44	19%	77	19%
25-34 years	46	26%	90	39%	136	33%
35-49 years	64	36%	69	29%	133	32%
50-64 years	31	17%	29	12%	60	15%
65 years and above	3	2%	3	1%	6	1%
<b>Marital Status</b>						
Single	63	27%	45	25%	108	26%
Divorced	3	1%	0	0%	3	1%
Married	137	58%	112	63%	249	61%
Separated	6	3%	4	2%	10	2%
Widowed	26	11%	16	9%	42	10%
<b>Education</b>						
Secondary school not completed	42	24%	57	24%	99	24%
University not completed	16	9%	11	5%	27	7%
Primary school completed	27	15%	22	9%	49	12%
Secondary school completed	50	28%	75	32%	125	30%
University completed	16	9%	9	4%	25	6%
Primary school not completed	12	7%	32	14%	44	11%
Never attended school	14	8%	29	12%	43	10%
<b>Occupation</b>						
Farmer	65	37%	87	37%	152	37%
Craftsman	10	6%	13	6%	23	6%
Shopkeeper	15	8%	38	15%	53	13%
Student / Pupil	17	10%	18	8%	35	8%
Teacher	18	10%	16	7%	34	8%
Civil servant	20	11%	14	6%	34	8%
No occupation	19	11%	46	20%	65	16%

Other (Describe)	13	7%	3	1%	16	4%
<b>Social Roles</b>						
No special role	166	71%	96	55%	262	64%
Administrative authority	2	1%	12	7%	14	3%
Female leaders	33	14%	0	0%	33	8%
Male leader	2	1%	20	11%	22	5%
Community leader	15	6%	29	16%	44	11%
Other (Describe)	17	7%	20	11%	37	9%

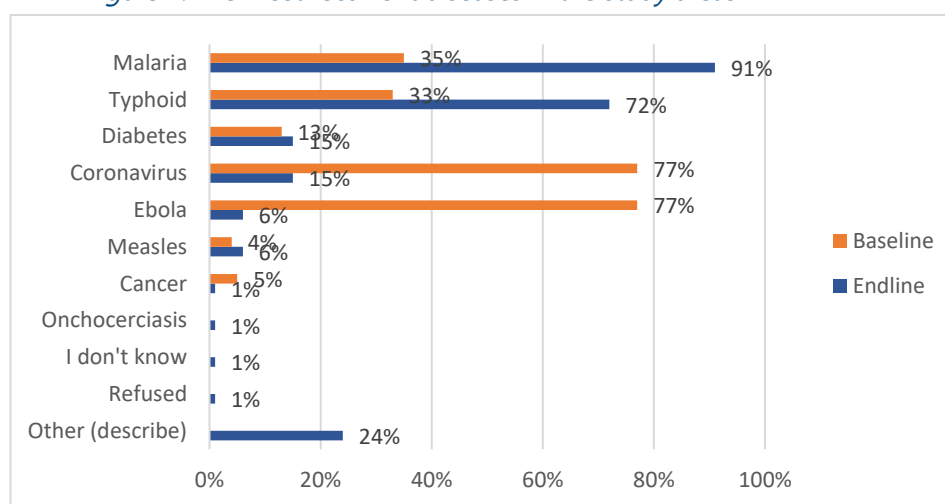
### 3. Results

#### 3.1 Objective 1. Assessing the Project Performance

##### 3.1.1 Most recurrent diseases

The quantitative data reveal that malaria (91%) was the most cited by respondents, followed by typhoid (72%), coronavirus and diabetes (15%), and Ebola (6%) (Figure 1). Respondents to the baseline survey questionnaire focused 76.5% of their responses on Ebola. The resurgence of Ebola in Butembo and Biena has once again drawn the attention of the population to this disease.

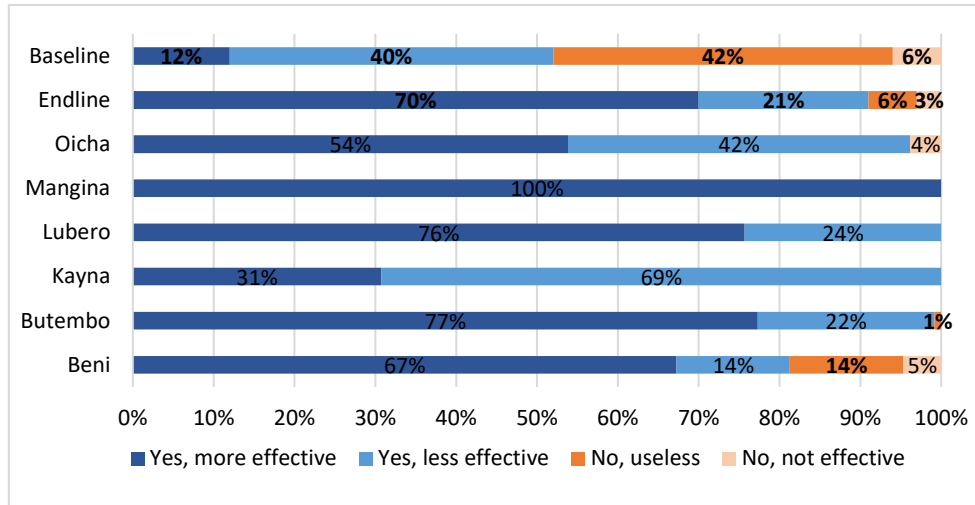
Figure 1: The most recurrent diseases in the study areas



##### 3.1.2 Assessing the MoH measures against Ebola

The preventive measures against Ebola as enacted by the MSP are not only known but also considered effective by 91% of respondents (Figure 2). These results demonstrate the increase in awareness resulting from the effectiveness of the risk communication sessions and the prevention measures against EVD in the project's target areas.

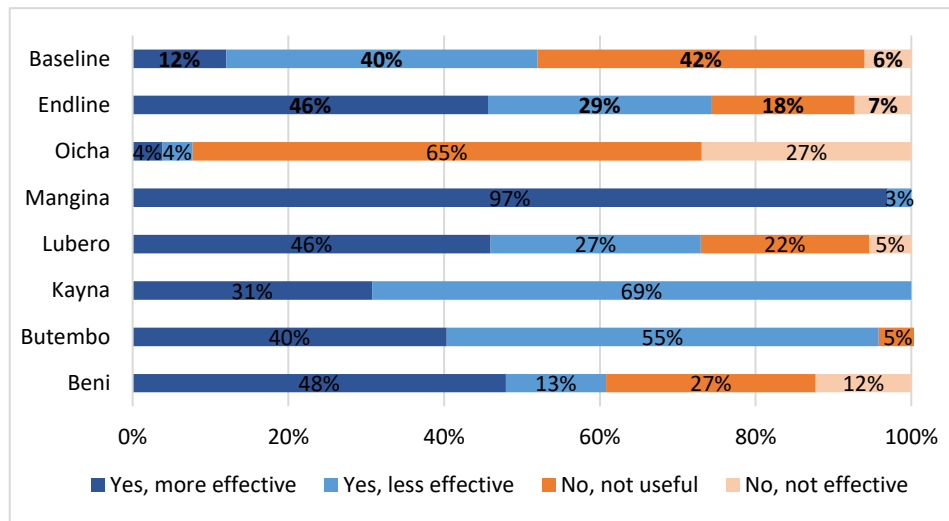
Figure 2: Assessment of Ebola Protective Measures



### 3.1.3 Assessing the MoH the measures against Coronavirus

The quantitative data from the study show that 75% of respondents believe that the barrier measures are effective in combating the spread of this coronavirus pandemic. These results are gains in the response to EVD in the study areas given that Ebola and Covid-19 are infectious diseases. The study population's experience with EVD explains these results, except for Oicha where barrier measures are less common (Figure 3).

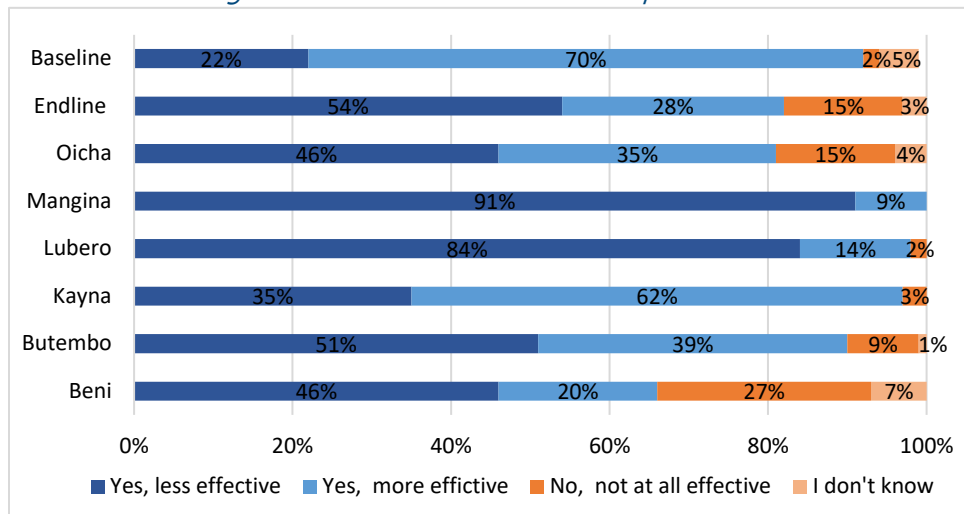
Figure 3: Assessment of Coronavirus Protective Measures



### 3.1.4 Rating the Ebola Response Team

A total of 82% of respondents rated the Ebola response teams as effective (Figure 4). According to one influencer, the effectiveness of the response was seen when it began to address the needs of the community in terms of medical and psychological care for survivors and community members, recruitment of Kinande-speaking caretakers and caregivers at Katwa CT. This has improved communication between health care staff and patients.

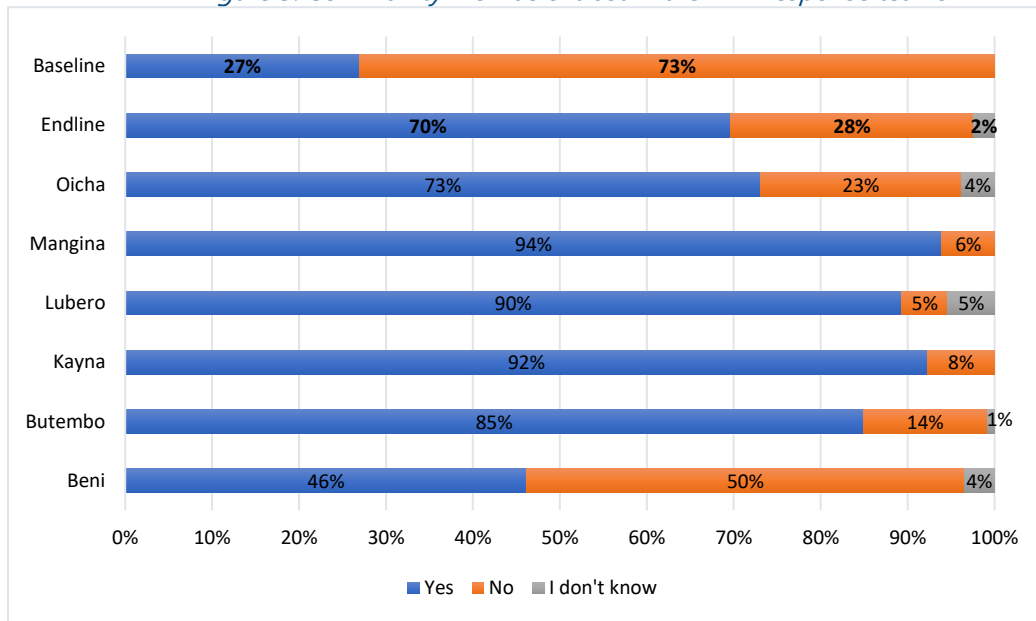
Figure 4: Assessment of the Ebola response team



### 3.1.5 Trust in the response teams

The population's confidence in the response teams has improved to 70% from 27% at Baseline (Figure 5). Participants in the FGDs cited the following reasons: (i) sensitization and communication took precedence over poor communication and rumors; (ii) the integration of all segments of the population into the response teams; (iii) the participation of young people and women in the DHS and community-based surveillance teams; (iv) visits to the ETCs and TCs by civil society and the local population; (v) the transfer of competencies from the response sub-coordinations to the central offices of the health zones; (vi) the commitment of the media to disseminate prevention messages.

Figure 5. Community members' trust in the EVD response teams



"At the beginning it was very difficult because the community considered the response to Ebola as a business. Confidence came after several deaths were recorded, but for the health care workers, confidence was still there because they themselves were really victims. That's why the community understood the existence of the disease. " **[KII, Chef Quartier Kanzulinzuli, Beni]**

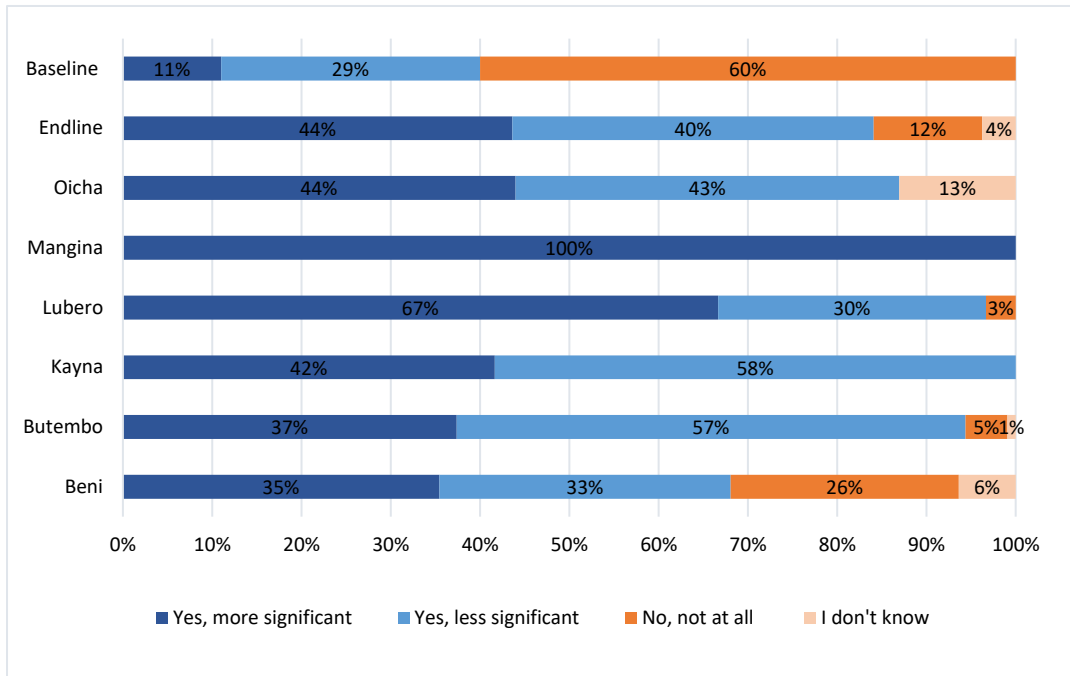
The level of confidence of the population in the response teams in Beni (46%) remains low. According to the Coordinator of the response in Beni, this is due to the fact that the response against Ebola is not the priority of the population but security is, because the massacres in the territory of Beni have caused and continue to cause more deaths than Ebola. The population does not understand that large resources can be mobilized to eradicate Ebola than to restore peace and security in their entities.

"From my side, the trust at the very beginning was doubtful, and a very small trust. But when the response communication team started involving us in the dialogues, the trust came little by little. " **[FGD Adult Male, Participant, Kayna]**

### 3.1.6 Analysis of youth engagement in the response

Youth engagement in the response to EVD varied from one area to another depending on the social, economic, political and security context as well as the evolution and management of the epidemic. A total of 84% of youth surveyed said they were actively engaged in the Ebola response, compared to 40% in the baseline study (Figure 6). This change is justified by the project's strategy of working with influential people such as leaders of advocacy groups (Youth Parliamentarians, Veranda Mutsanga, Young Patriots, etc.).

Figure 6. Analysis of youth engagement in the response



In addition, there is a strong involvement of young people in Mangina (100%) and Lubero (97%) in risk communication and community involvement, surveillance, ICP, DHS, vaccination, and community-based surveillance by detecting visitors in their environment. Awareness-raising sessions through local associations and the media were the basis for this change in attitudes.

"Given that Mangina had recorded many deaths, the youth were quickly involved in the response against Ebola in order to bring a solution to the problem, they were also in different pillars of the response such as surveillance, PCI and communication. We have seen the youth motorcycle associations sensitizing the local population about the EVD everywhere with banners. " **[KII, CTE Manager, Mangina]**.

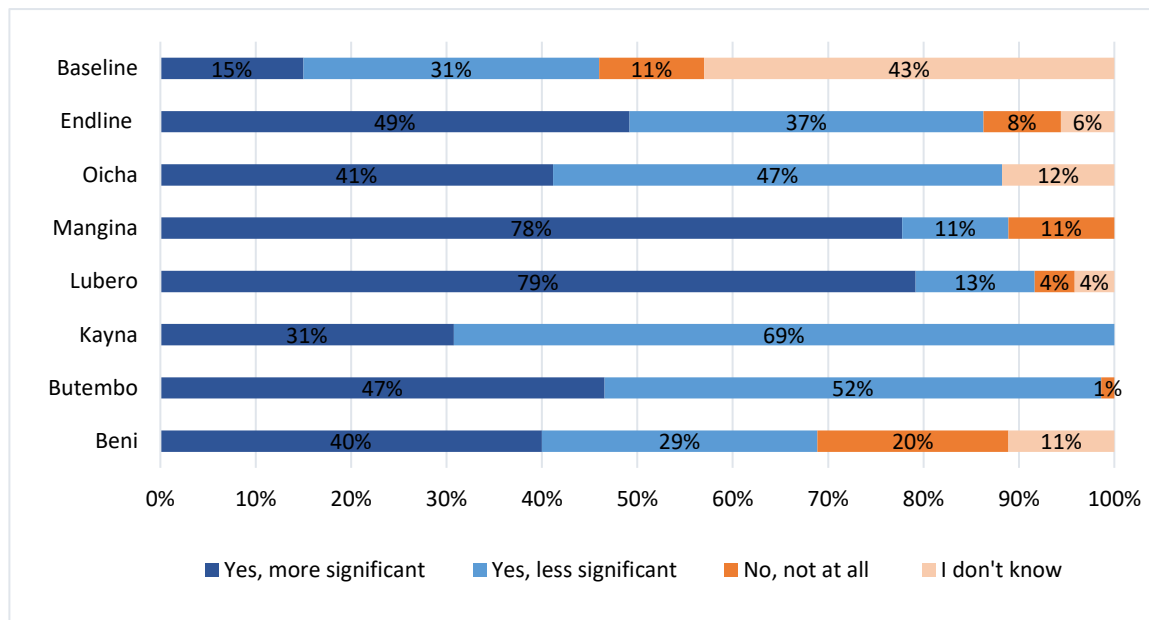
The baseline study shows the situation where youth (40%) are significantly engaged in Beni (12%) and Butembo (12%).

### 3.1.7 Analysis of women engagement in the response

Women were significantly engaged (86%) in door-to-door sensitization on Ebola prevention measures, caregiving, psychosocial support for affected families, patient care, infection prevention and control at checkpoints and entry points, Vaccination around confirmed cases, active contact tracing and contact tracing, provision of handwashing stations with water, training of community members on DBS and hygiene, and care of patients' children at ETCs (Figure 7).

According to the Lubero Zone Chief Medical Officer, the position of women and the role they play when someone is sick in the community has earned them respect and more attention than men.

Figure 7. Analysis of women’ engagement in the response



"For me, women's participation in the Ebola response was really important especially in door-to-door sensitization and Community Based Surveillance but also in identifying contact cases for vaccination. "[FGD, FA, Participant, Beni]

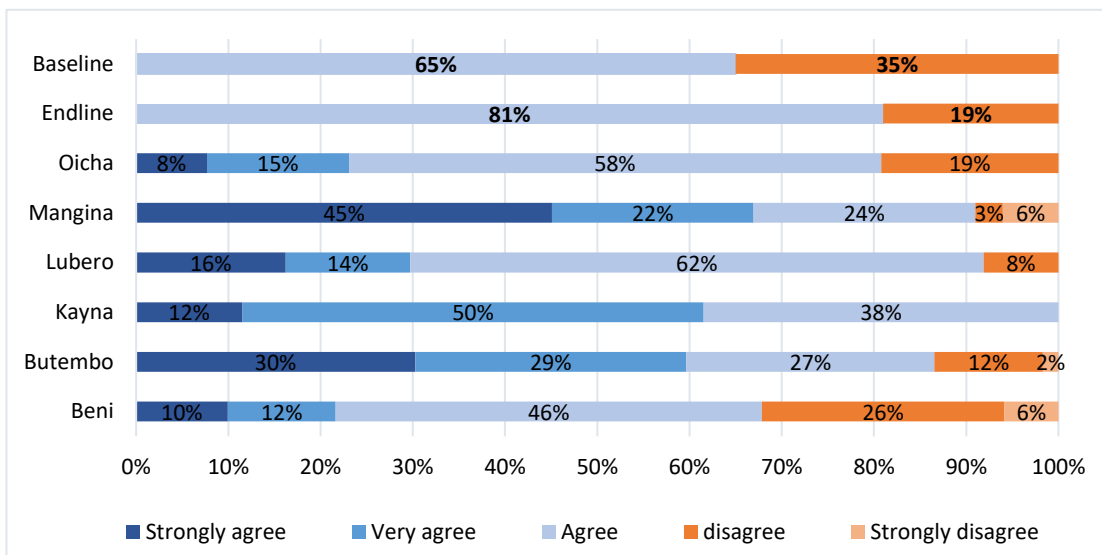
"At the beginning the involvement of women was not easy. Over time, they have integrated communication, contact tracing and community-based surveillance. [FGD, FA, Participant, Kayna]

The baseline survey data shows that 46% of respondents felt that women's involvement was significant. The percentage of women's engagement was 18% for Beni, 14% and 0% for Butembo and Lubero; and less significant in Beni (38%), Butembo (26%) and Lubero (40%).

### 3.1.8 Response staff’s assessment of community resistance

Health care providers' assessment of community resistance has evolved over time in the study areas. 81% of respondents felt that community resistance to acknowledging the EVD, its risks, and the importance of responding to it was significantly reduced before the official declaration of the end of the epidemic in June 2020, with 68% in Beni, 80%, Butembo 86%, Kayna, 92%, Lubero 92%, Mangina 91% and Oicha 81%. Baseline value was only 65% for this indicator (Figure 8). These results can be explained by the community's awareness of the existence and seriousness of the EVD, the involvement of young people in the various pillars of the response; positive responses to rumors through interactive radio broadcasts and community feedback meetings; the recruitment of local staff by NGOs; training of leaders on the EVD; the establishment and support of CACs; and community dialogues. In addition to all these reasons, there is also the joint verification of rumors by journalists and members of the Kayna civil society coordination office.

Figure 8. Response staff’s assessment of community resistance



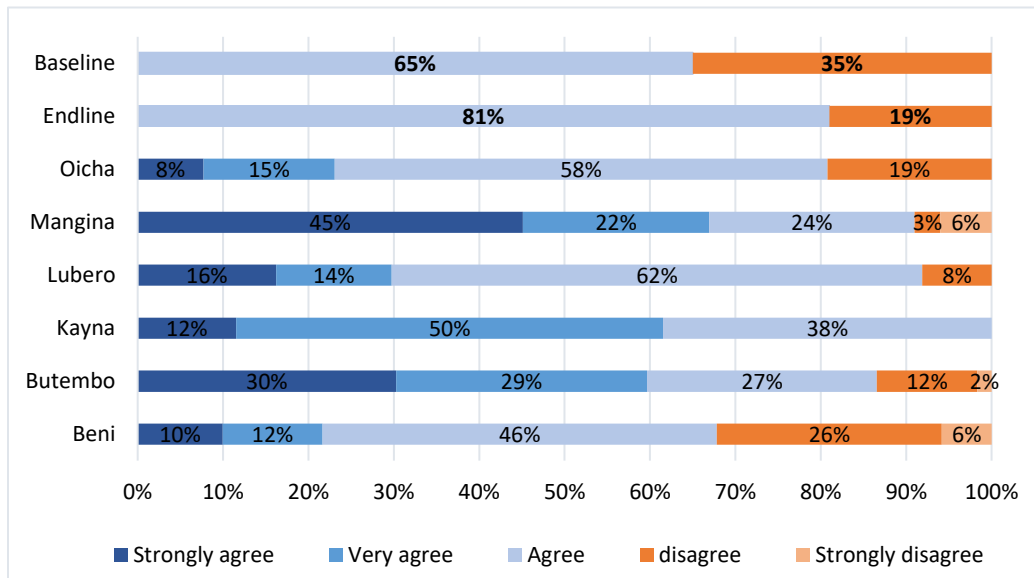
"There is an adage that says, 'consequences are better than advice'. The community understood that as they continue to think that Ebola is a witchcraft, a machination of medical staff in collaboration with the response teams; members of their communities continue to die; hence the need to reduce resistance and have guidance from the response teams. The strategy of bringing together and listening to the groups separately; girls, boys, women, men has allowed us to gather the opinions of each group and to know the motivations of the resistance and thus to have the involvement of the groups to put an end to the resistance. "

**[KII, IT, Male, CS Vulinde, Butembo]**

### 3.1.9 Relationship between the community and medical actors

The quantitative data from both the final evaluation (80%) and the baseline study (63%) show that the respondents positively appreciate the relations between the members of the targeted communities and the health care providers, but with a significant increase at the end of the project. According to the FGD participants, this is justified by the fact that nurses’ welcome patients well at the TCs and ETCs; the alert system is still functional even after the transitional period (Figure 9).

Figure 9. Relationship between the community and medical actors



"When the epidemic ended, we kept good relations with the medical staff because nowadays when a family member falls ill, we are no longer afraid to refer him or bring him to the hospital because we are no longer afraid of the disease, especially since lately we have noticed that the molecule we have started to use to treat Ebola patients is really efficient than the one we used to use before. **[FGD, Homme Adulte, Butembo]**

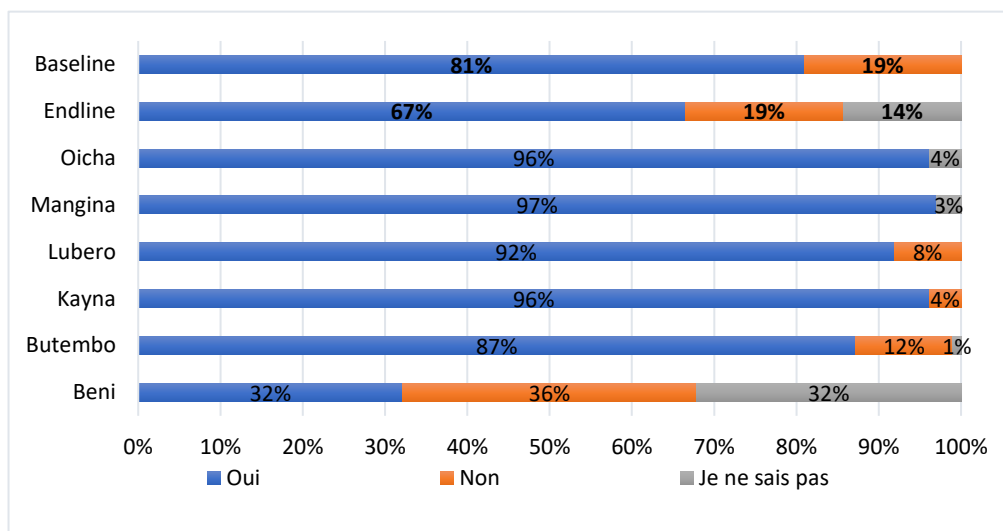
"Before the end of the epidemic, relations were already good between all actors and the community. There were no more uprisings against the response teams, the population itself started to alert for possible suspected cases in the community. And this contributed positively to the eradication of the disease" **[FGD, Femme Adulte, Kayna]**

At the level of the health zones targeted by this study, there has been a significant improvement as a result of the change in strategy made by the general coordination of the response. Thus, improvements in relations were recorded in Butembo (100%), Kayna (100%), Lubero (100%), Mangina (97%) and Oicha (96%) except in Beni (53%). According to a participant in the Beni FGD, a kind of mistrust that translates into disinterest is still perceptible between the various members of the community and the health care providers.

### 3.1.10 Access to EVD reliable information

The quantitative data in general show that respondents believe they are receiving reliable information. In total, 67% of respondents stated that the information they received was reliable: Beni 32%, Butembo 87%, Kayna and Oicha 96%, Lubero 92%, Mangina 97% (Figure 10), a decrease as compared to the baseline, when 81% of respondents already thought they had access to reliable information. These results are justified by the early participation of journalists in coordination meetings, surveillance meetings and meetings of those cured of Ebola, which allowed them to obtain verified and reliable information on the epidemic situation.

Figure 10. Access to EVD reliable information



Practically here at home it was from the radio, we have three (3) RTP (Radiotélévision Pambazuko, ESPOIR and La Radio Communautaire Mangina RCM) they really helped us in the sensitization against this disease through the recorded programs and even live, through the sms to react.” **[KII, Pdt Jeunes, Homme, Mangina]**

The information received by the population through local media contributed to improve the referral of patients to CTs and CTEs, hygiene practices and to cut the chain of transmission of EVD in the study areas.

"The meeting of the surveillance and coordination of each day, the local radio stations, the exchange of information and sensitization at the community level, led us to cut the chain of transmission and to put out of harm's way cette maladie d'Ebola dans notre aire de santé de Mangina.” **[KII, IT, Homme, CS Mangina, Mangina]**

### 3.1.11 Sources of information and Community Capacity to stop Ebola’ rumors

A total of 94% of respondents cited radio as one of the main sources of information (Figure 11). Interpersonal communication (chat, conversation) and social networks are also important sources of information. Note that this percentage (94%) was mentioned by respondents in the baseline study report.

Figure 11. Main sources of information

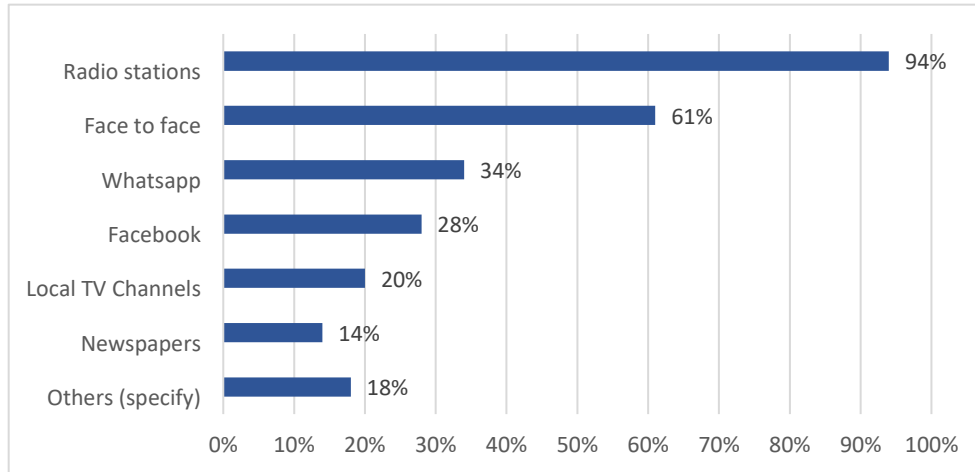


Figure 12. Community Capacity to stop Ebola’ rumors

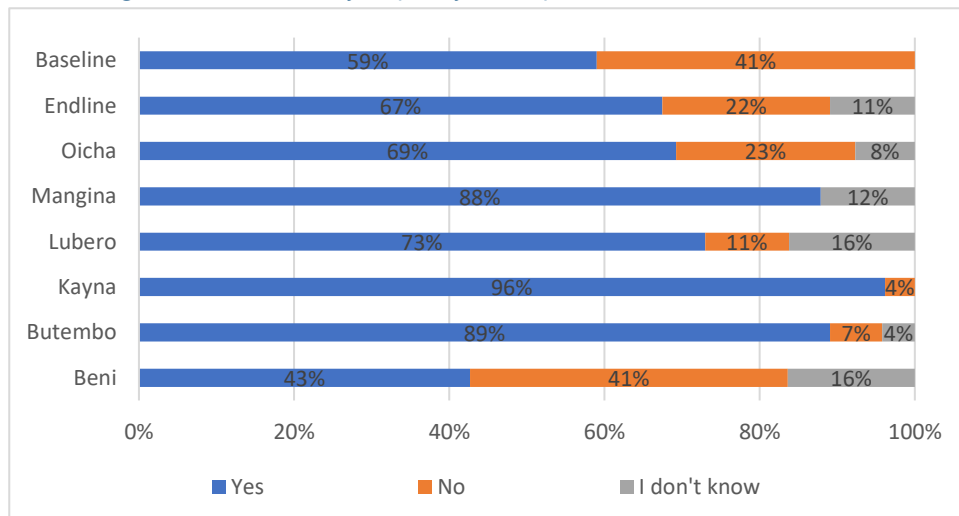


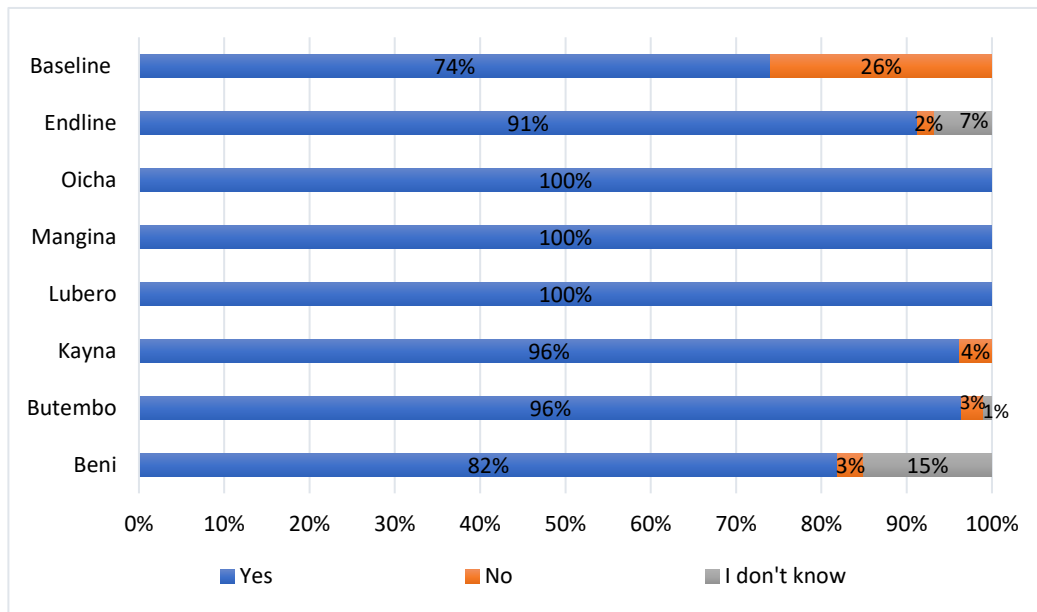
Figure 12 shows a slight improvement (67%) in the ability of communities to counter rumors compared to the baseline study where 59% of respondents felt that communities were not able to counter rumors around the EVD response (Figure 12).

"The community was able to counter rumors when they first became aware that the disease existed and sought information from local leaders and journalists about a situation before sharing it. "[FGD, Adult Male, Butembo].

### 3.1.12 Analysis of Government actors engaged in the Ebola Response

The engagement of state actors was generally positive. A total of 91% of respondents reported that non-medical state actors were positively engaged in the response to VEM (Figure 13) compared to 74% in the baseline study. These results are justified by the deployment of INRB laboratories in Butembo, Beni, and Goma, which have improved case diagnosis and facilitated patient management.

Figure 13. Analysis of Government actors engaged in the Ebola Response



"The commitment of state authorities is evidenced by the speed with which they facilitated the implementation of all the mechanisms in the context of Ebola: the surveillance and communication system to mobilize the population and obtain the commitment of communities." **[KII, Professor Muyembe, Ebola Response Coordinator, Male, Kinshasa]**

Field visits by the provincial governor and provincial and national parliamentarians to sensitize the community on the importance of immunization, medical management, and prevention and control of EVD have contributed to a reduction in the frequency of confirmed cases, a reduction in violence against the response teams, and an increase in the participation of the population in active case finding and reporting.

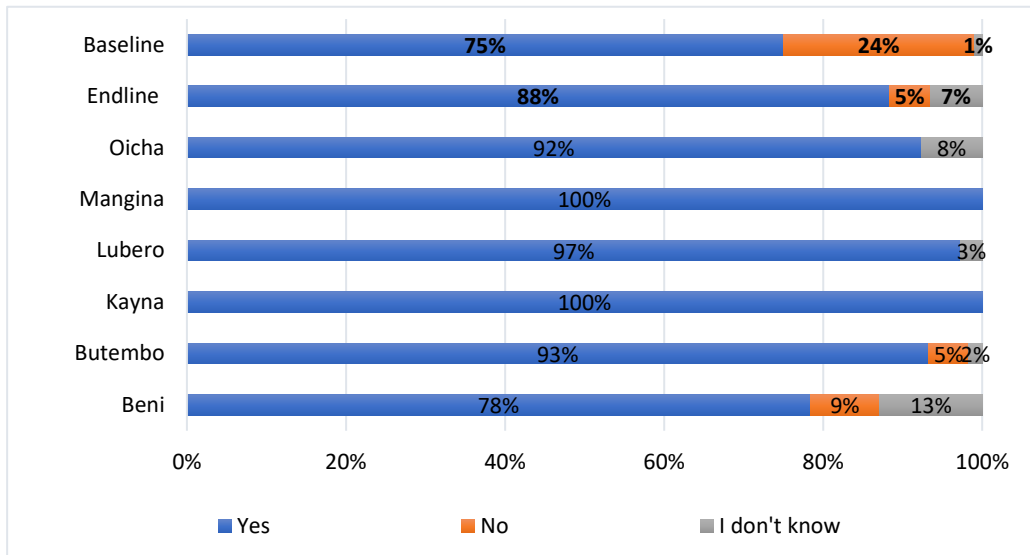
"The state actors sensitized young people, mothers and other segments of the population who were showing resistance to the agents of the response against EVD. They insisted on raising the population's awareness by showing them the consequences of community resistance." **[FGD, Adult Male, Butembo]**

According to the communication officer of the mayor of Beni, the mayor has shared information on the EVD with local officials on a weekly during the security council meetings. These are also reflected in the CAC meetings.

### 3.1.13 Analysis of community leaders engaged in the Ebola Response

According to the Response Coordinator, Butembo Sub-Coordination, local leaders have sensitized the population on the EVD, detecting the chain of hidden deaths. They have facilitated the access of response teams in insecure areas by providing information and tracing a contact. 88% of respondents thought that the engagement of local leaders in the response to EVD was positive (Figure 14) compared to 75% in the baseline study.

Figure 14. Analysis of community leaders engaged in the Ebola Response



"Local leaders were positively engaged/involved in the Ebola response especially in the beginning when people were dying. Most of the agents who came from the response did not speak Swahili, but local leaders were trained in advance to pass on information to the community." **KII, Chef de Quartier, Male, Butembo**

According to the President of the Civil Society of Butembo and Beni, state actors participated in breaking down resistance in the most resistant health areas by often bringing together specific groups to raise awareness. These actors helped to break down rumors in the community by giving true information about Ebola; organizing community dialogues; setting up entry points and checkpoints; organizing radio broadcasts and interactive, community feedback meetings where the mayors of the city, the mayors, the heads of neighborhoods, cells, and avenues; chiefs of chieftainships, groups, and villages.

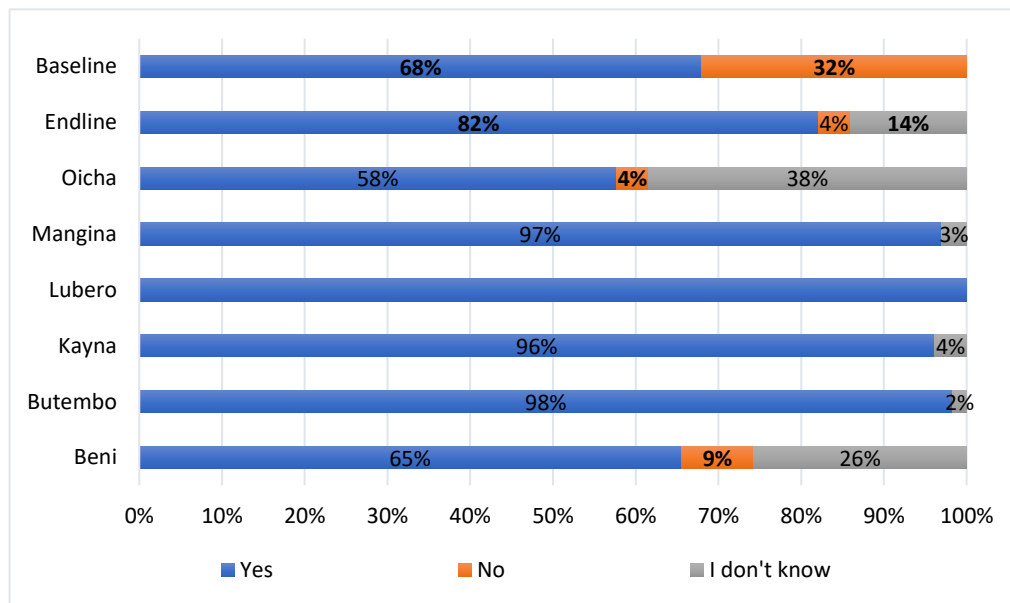
"Present in almost all the pillars, the leaders were positively involved in community mobilization and sensitization, especially in the vaccination pillar, where they played the role of convincing the population to be vaccinated and to accept DHS." **KII, Chef Quartier Kanzuli Nzuli, Male, Beni**

### 3.1.14 Access to community dialogue spaces

The spaces for dialogue mentioned during the focus groups were the extended security council, community feedback meetings, civil society coordination meetings, the peace nucleus, community forums and peace forums. These forums have allowed community members and authorities to act together to break down mistrust, prejudices, negative perceptions, and stereotypes about the EVD. In addition to these frameworks, the CACs were set up by the Ministry of Public Health with the support of the Congolese government's technical and financial partners in the health areas affected by Ebola. They served as forums for discussing, planning, implementing, and evaluating community response plans. The CACs brought together grassroots leaders, community relays, journalists, presidents of youth and women's associations, etc. The topics discussed were systematic surveillance of visitors in households to avoid the spread of EVD, community sensitization on vaccination against EVD, measles and barrier measures against COVID-19.

Quantitative data generally show that 82% of respondents feel that members of their communities have access to spaces for dialogue compared to 68% at baseline. This improvement is the result of the strategy to involve the community more in the response to the EVD by valuing local skills in finding effective and concrete solutions to community health problems.

Figure 15. Access to Community dialogue spaces



"Ebola is a community problem, to address it, we had to trust the equipment found on the ground, give them more consideration, respect, trust and accountability if it works it's us [and if it doesn't and so we have to do everything to advance the response. " **[KII, Dr. John Kombe, Risposte Coordinator, Beni]**

### 3.1.15 Opportunities of collaboration between community members and local authorities/officials

The dialogue spaces and key events (presentation of the healed, handing over of water works, follow-up visits by national ministers, the provincial governor and national and provincial deputies and the representative of the secretary of the United Nations) were opportunities for collaboration between community members and state actors where the population expressed their indignation, needs and other expectations. The data shows that 82% of respondents report having collaborated with state and non-state actors. The presence of committed grassroots leaders was an opportunity for collaboration between members of the population and state and response authorities (Figure 16).

Figure 16. Opportunities of collaboration between community members and local authorities/officials

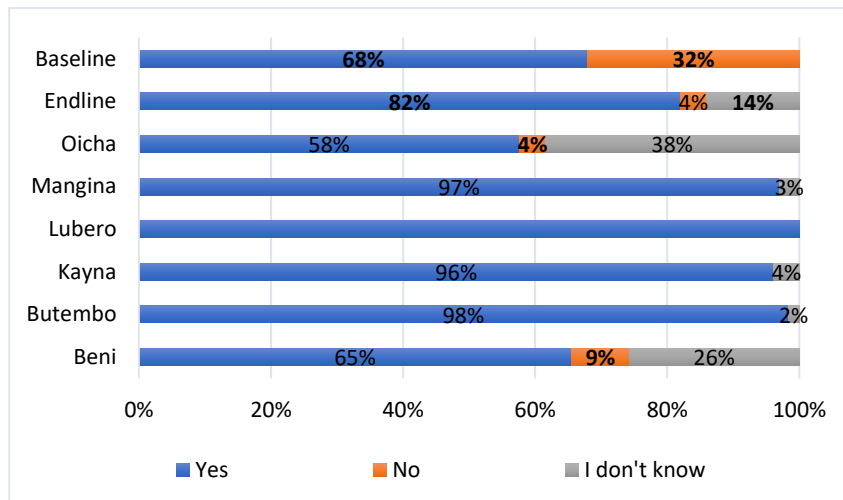
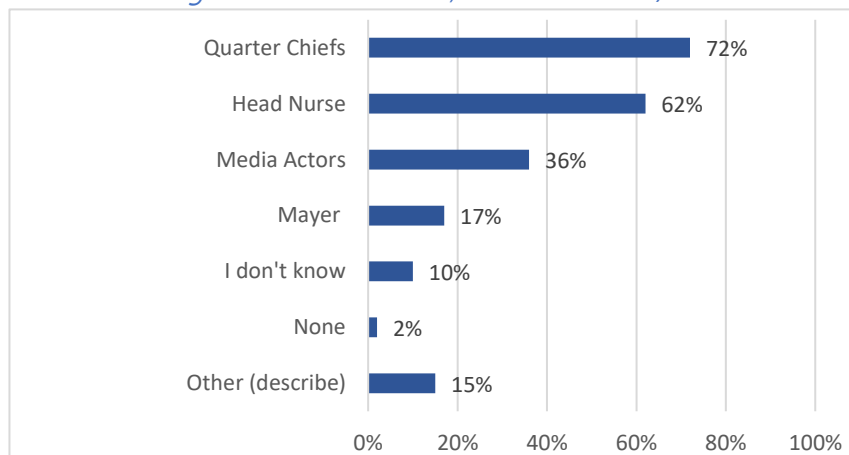


Figure 17. Local leaders, local authorities /officials

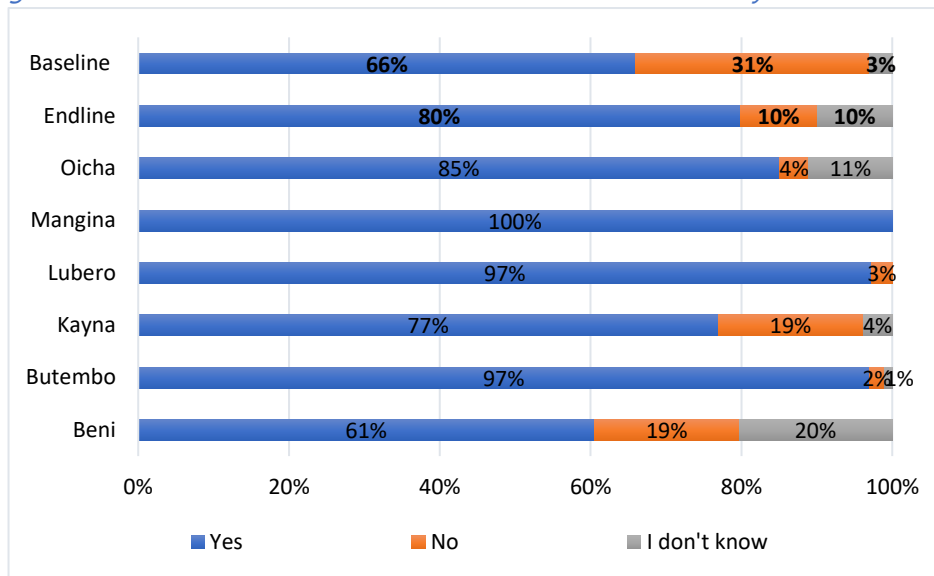


Neighborhood leaders were closer to the population and regularly collected their grievances, indignities, and proposals, and shared them with state and non-state authorities (Figure 17). These opportunities for collaboration increased trust and helped reduce community resistance.

### 3.1.16 Contribution of the collaboration to reduce community resistance

The response actors have put communities at the center of their interventions (surveillance, vaccination, DHS, etc.). Quantitative data show that 80% of respondents believe that collaboration with response actors has contributed to reducing mistrust in the response to Ebola (Figure 18), compared with 66% at the baseline.

Figure 18. Contribution of the collaboration to reduce community resistance



According to FHI 360's community engagement officer, the political and administrative authorities, in collaboration with international NGOs and WHO, were involved in the selection of certain local skills and this restored the population's confidence in the response teams. This is the case of the mobile and community DHS teams in Butembo where young responders have been trained to carry out DHS in their communities. This has significantly reduced resistance in inaccessible areas.

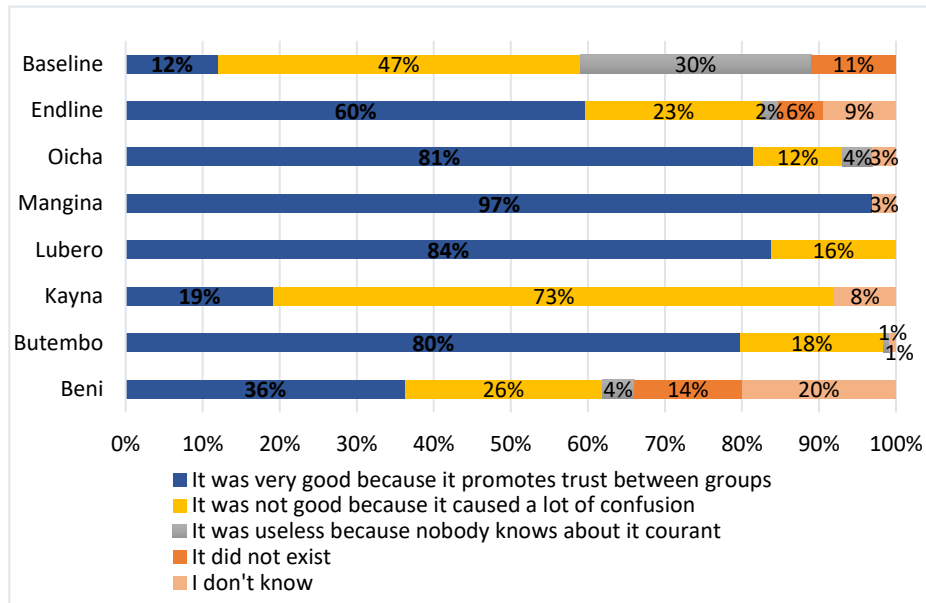
"The approach we used was to hold meetings with the mayor of the commune. Sensitizing and understanding the families that were affected helped us a lot and then involving them in sensitizing the rest of the community; this reduced resistance in Mangina center. The problem was in Aloya which had a particular context of the presence of negative forces and had many demands. Subsequently, by responding to these demands and to certain requests from the community through certain humanitarian actors, the resistance was reduced." **[KII, Coordinator, Mangina Sub-Coordination]**

### 3.1.17 Communication around the response to EVD and trust between groups

The different groups discussed are members of the response teams, community members, security forces, medical staff, and local community leaders. According to the quantitative data, 60% of respondents thought that communication (leveraging indigenous people helped a lot) around the response was very good because it fostered trust between the above-mentioned groups, with Beni 36%, Butembo 80%, Kayna 19%, Lubero 84%, Mangina 97%, Oicha 81% (Figure 19). These results can be explained by the

awareness of the high number of deaths due to Ebola coupled with the sensitization actions by people recovered from Ebola, the role played by media actors supported by the United Nations agencies and international organizations.

Figure 19. Communication around the response to EVD and trust between groups



"...Yes, because the state authorities involved the different groups and the recruitment took into account the representativeness of all groups. " **[KII, President of the Urban Youth Council, Butembo]**

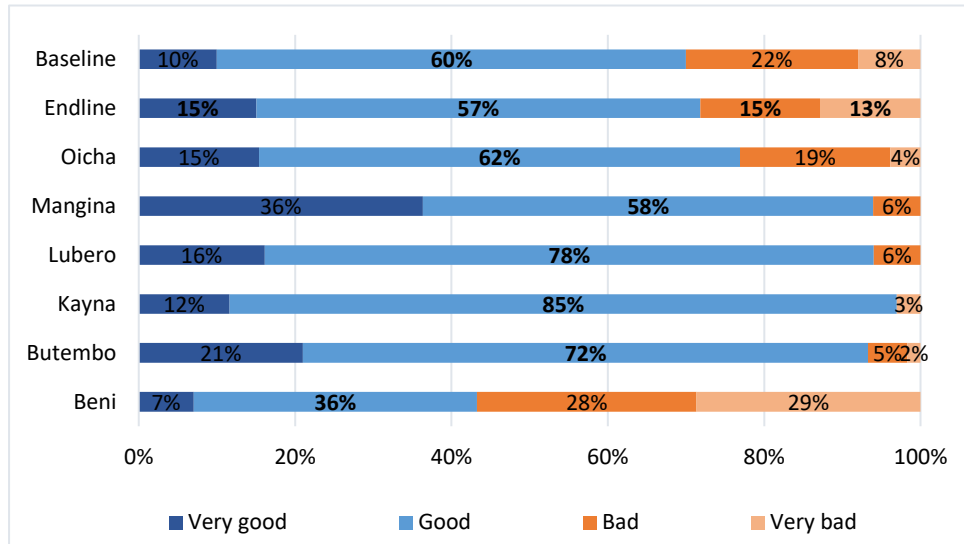
"In Vusigha, for example, which is a cell in my health area, in order to convince a suspect to go to the CTE OR CT, the cell leader had to engage the police. The local chiefs were very helpful in transferring patients to the health facilities. " **[KII, IT, Male, Butembo]**

The baseline survey data shows that 60% of respondents either "disagree" or "strongly disagree" with the statement "the way authorities have conducted communication around the EVD response has fostered trust between groups. This means that 40% of respondents agree with this statement. In Beni, this rate was 33.0% and it is 48.9% and 35.0% in Butembo and Lubero respectively.

### 3.1.18 Relationships between different groups around Ebola

Quantitative data show that respondents have positive assessments of the relationships between different groups around the EVD. 72% of respondents have positive assessments of the relationships between different groups around the EVD compared to 70% at Baseline (Figure 20).

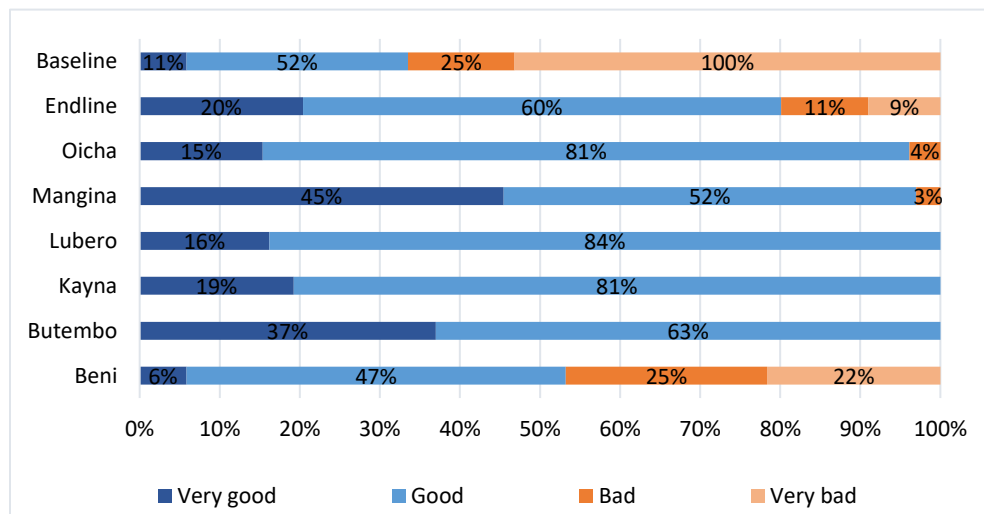
Figure 20. Relationships between different groups around Ebola



### 3.1.19 Relationship between the community and healthcare providers

The quantitative data from both the final evaluation (80%) and the baseline study (63%) show that the respondents positively appreciate the relations between the members of the targeted communities and the health care providers. According to the FGD participants, this is justified by the fact that nurses welcome patients well at the TCs and ETCs; the alert system is still functional even after the transitional period (Figure 21).

Figure 21. Relationship between the community and healthcare providers



"When the epidemic ended, we kept good relations with the medical staff because nowadays when a family member falls ill, we are no longer afraid to refer him or bring him to the hospital because we are no longer afraid of the disease, especially since lately we have noticed that the molecule we have started to use to treat Ebola patients is really efficient than the one we used to use before." **[FGD, Adult Male, Butembo]**

"Before the end of the epidemic, relations were already good between all actors and the community. There were no more uprisings against the response teams, the population itself started to alert for possible suspected cases in the community. And this contributed positively to the eradication of the disease." **[FGD, Adult Female, Kayna]**

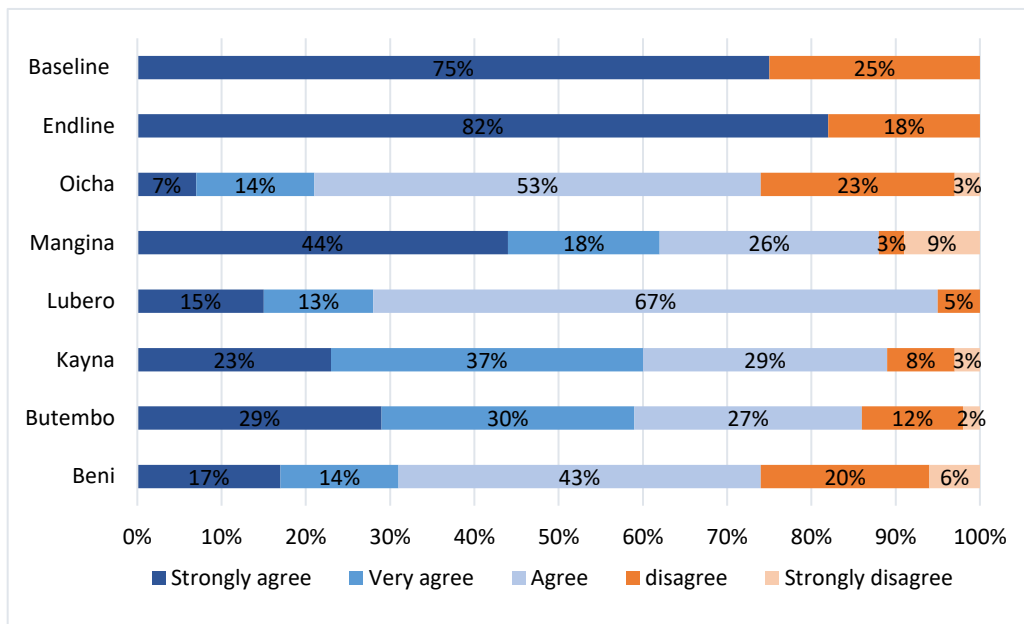
At the level of the health zones targeted by this study, there has been a significant improvement because of the change in strategy made by the general coordination of the response.

Thus, improvements in relations were recorded in Butembo (100%), Kayna (100%), Lubero (100%), Mangina (97%) and Oicha (96%) except in Beni (53%). According to a participant at the Beni FGD, a kind of mistrust that translates into disinterest is still perceptible between the various members of the community and the health care providers.

### 3.1.20 Access to positive behaviors

A total of 82% of respondents report having access to positive role models for the EVD response (Figure 22). The baseline survey data show that 75% of respondents do not believe that people in communities have had access to positive role models for the response to EVD. This improvement is justified by community actions, namely: (i) The systematic organization of door-to-door visits by young people and community relays under the leadership of the village or neighborhood chief to identify visitors, their origin, health status and reason for their stay in order to alert any suspicious case or contact in the village or neighborhood; (ii) The securing of vaccination rings by young people under the direction of the heads of neighborhoods or villages to avoid and block the road against any act of sabotage or attack against the response personnel; (iii) The organization and holding of radio broadcasts and interactive programs by young people, traditional community leaders under the facilitation of a journalist and with the accompaniment of an expert from one of the pillars of the response concerned by the theme of the day.

Figure 22. Access to positive behaviors



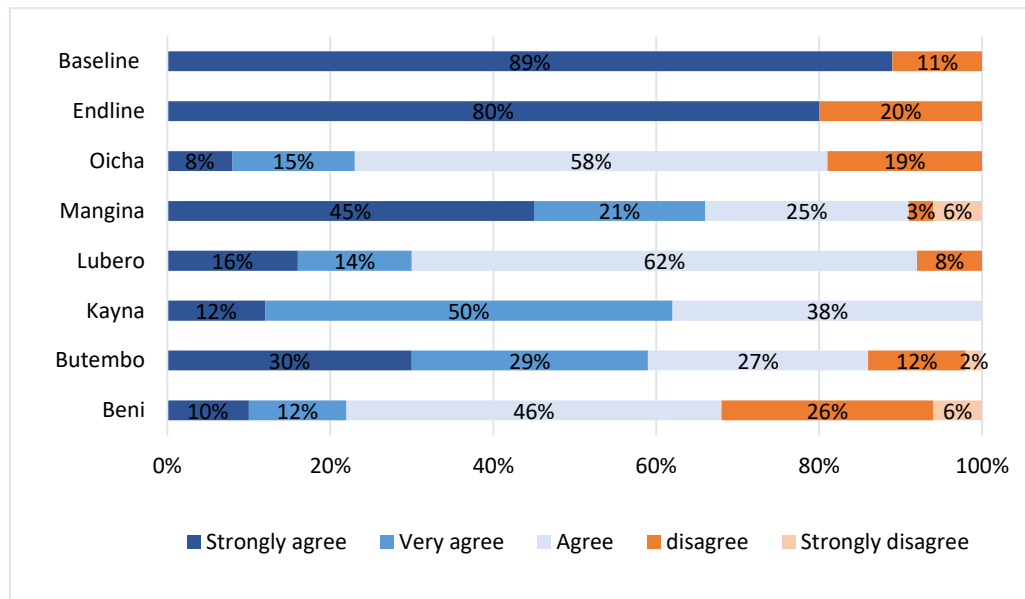
"Vigilance for suspicious signs, application of barrier measures and flexibility to adhere to care, regular hand washing, avoidance of handling dead bodies, culture of the morgue instilled in the mindset of community members." **[FGD, Adult Women, Mangina]**

According to the head of the Matembe district in Butembo, the population was associated with the Ebola response actors in the identification of members (youth) of the community and mobile EDS teams, in the decision to reduce the number of staff and the deactivation of the pillar teams (EDS, Surveillance, CREC, etc.) of the response. These representatives of the population were also consulted in the decision to build a TC or CTE in their respective entities.

### 3.1.21 Women and girls rights and gender equality in communication

The fundamental rights (freedom of expression, right to employment, etc.) of women and gender equality (recruitment of women and men in the CREC sub-committee, immunization, medical and psychosocial PEC, monitoring and PCI, DHS, etc.) The quantitative data show that 80% of respondents believe that the fundamental rights of women and girls as well as gender equality in communication were respected (Figure 23) compared to 89% recorded at baseline. These overall positive scores can be explained by the strategy of ensuring social inclusion in all pillars of the response, as women and youth were more resistant to the response teams, and their inclusion was one of the effective solutions for reducing community resistance.

Figure 23. Women and girls Rights and gender equality in Communication



"The approach was good especially since it allowed women to work on the same level as men to end the Ebola epidemic" [FGD, Adult Male, Butembo].

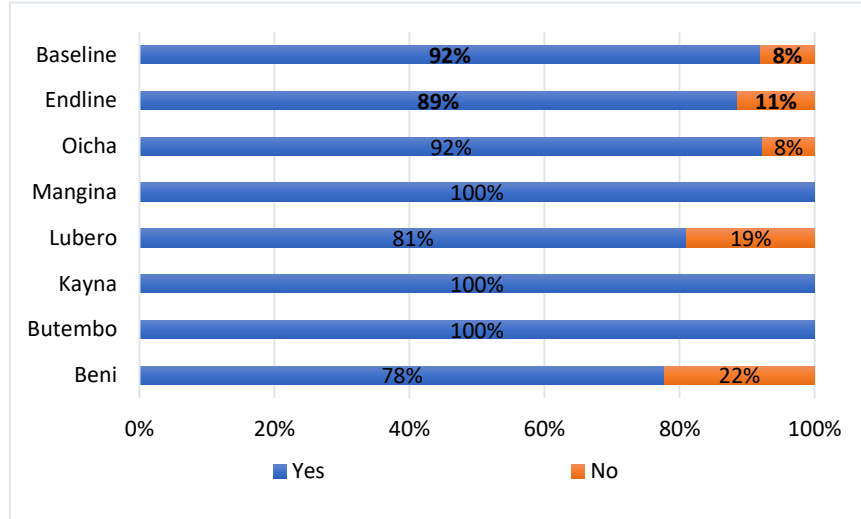
According to a focus group participant from Kayna, free health care applied to all patients, regardless of gender or social background, to ensure that patients had access to quality and timely care.

"On the communication level, the fundamental rights of women and girls and gender equality were respected. And women and men have the same opportunities to access information. Moreover, the number of women was higher than that of men during the mobilization." [FGD, Adult Male, Kayna]

### 3.1.22 Listening habits

The quantitative data collected shows that 89% of respondents listen to the radio often compared to 11% who do not (Figure 24). The baseline study also shows that 89% of respondents listen to the radio regularly. This is because radio is the main source of information.

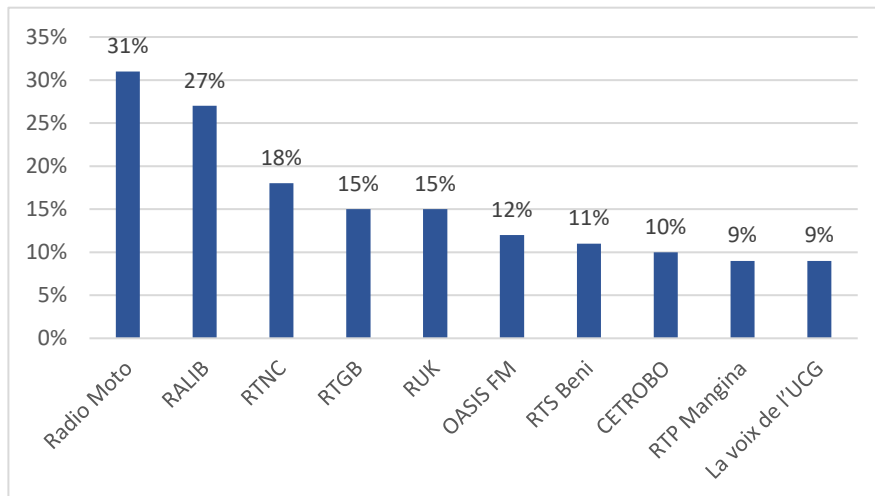
Figure 24. Habitude d’écouter la radio



### 3.1.23 Listeners’ preference

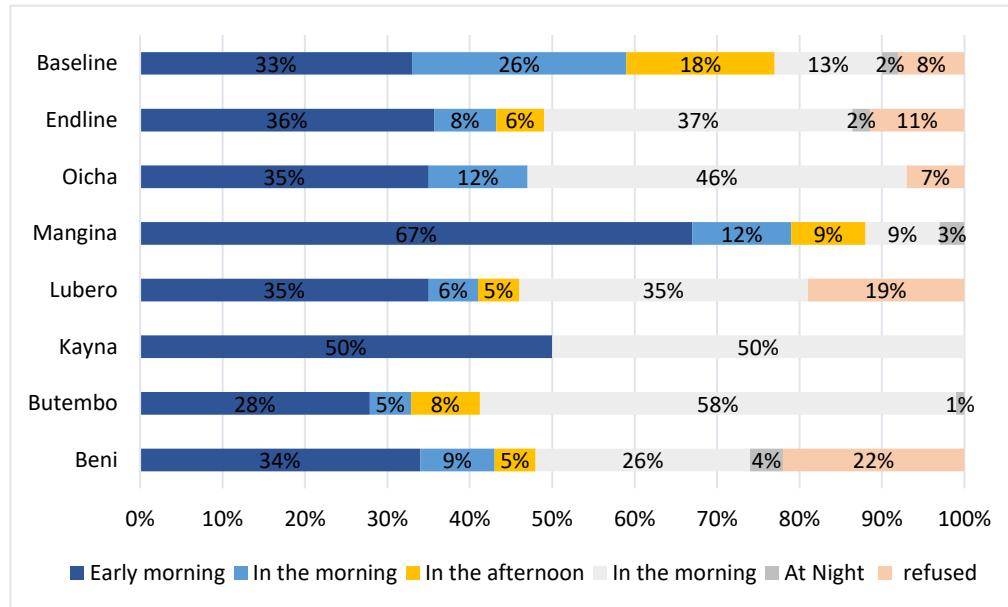
According to the respondents, the most listened to radios are Radio Moto, RALIB, RTNC, RTGB, RUK and OASIS FM (Figure 25). According to the journalist from Radio Moto, proximity, the emanation of the people, the local language and trust make community radio stations the most listened to, and they have contributed effectively to reducing violent resistance in Butembo.

Figure 25. Most listened radio stations



Regarding the time of listening, the respondents listen to the radio most often in the evening (37%), early morning (36%), during the morning (8%), during the afternoon (6%), during the afternoon (2%), (Figure 25) (Figure 26). The data from the baseline study show that, respondents listen to the radio most, in the evening (37.7%), early morning (28.4%) and during the morning (19.6%) (Figure 26).

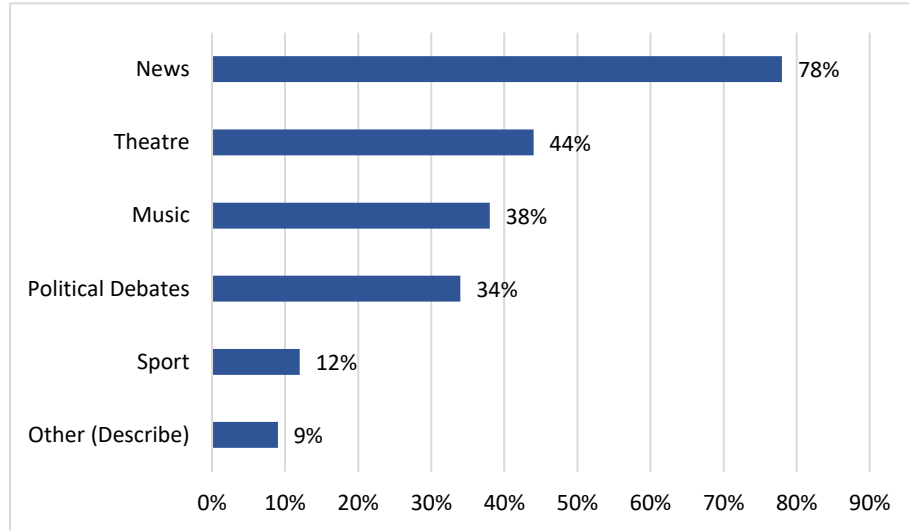
Figure 26. Preferred moments to listened to the radio program



According to the journalist of RUK FM radio, morning and evening are times to go to work and return home respectively. These are key times to receive news or watch programs because the family members are all together to share.

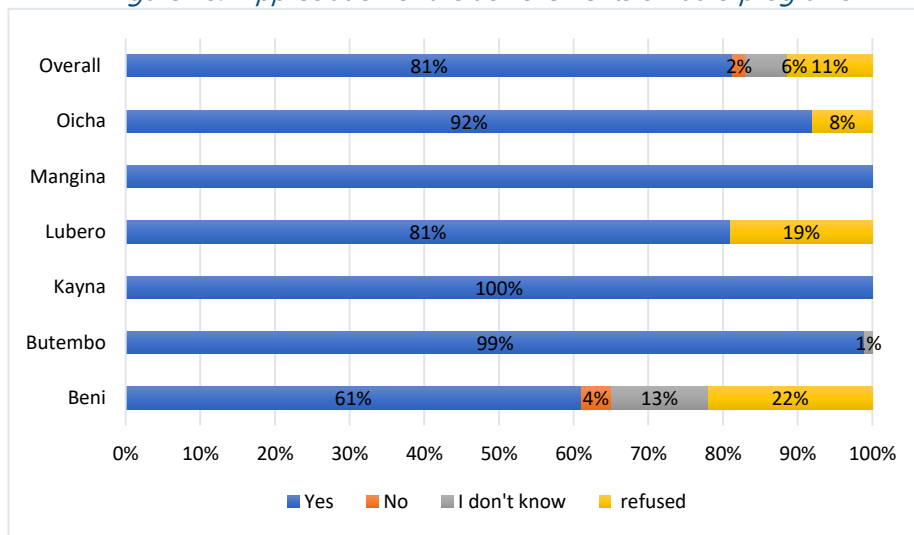
In terms of programming, quantitative data show that respondents cited news (78%), theater (44%), music (38%), political debates (34%) and sports (12%) most often (Figure 26). According to a participant at the Mangina FGD, reliable information helped them to fight rumors and keep up with the epidemic. The baseline study shows that most respondents are in favor of listening to awareness programs about EVD.

Figure 27. Most listened radio programs



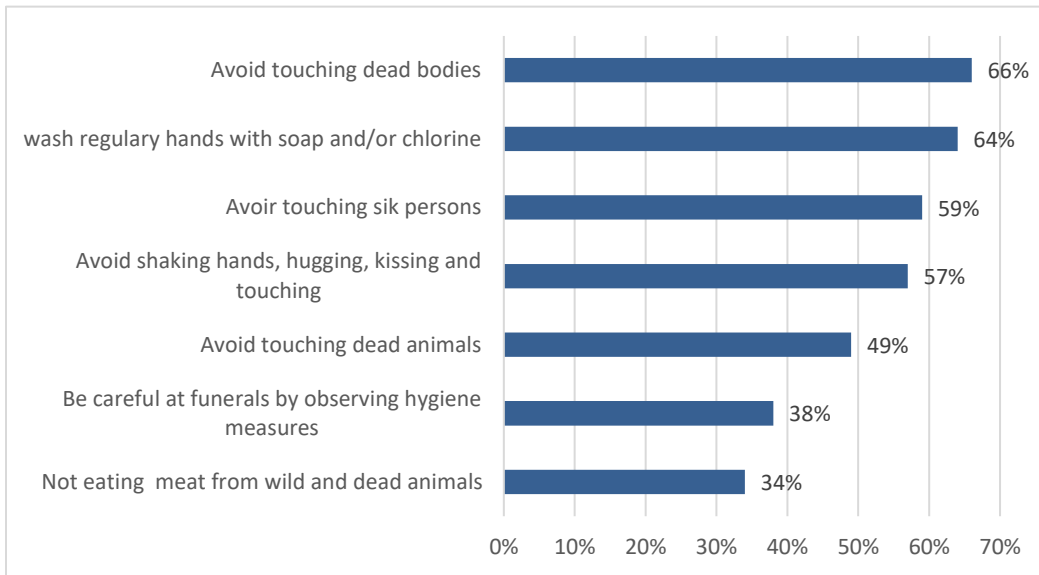
In relation to the awareness programs on Ebola prevention and control organized by journalists, 81% of respondents said they learned something (Figure 28). Figure 29 shows the Ebola prevention measures that respondents learned during the awareness sessions.

Figure 28. Appreciation of the achievements of radio programs



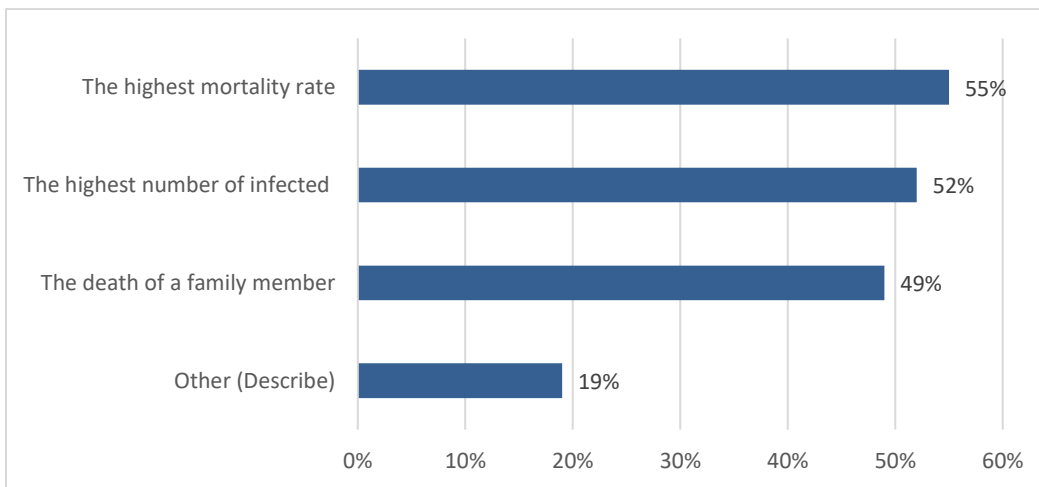
The quantitative data show the preventive measures learned, including washing hands with soap (64%), touching sick people (57%), handling corpses (49%), and eating wild meats (34%) (Figure 29).

Figure 29. Ebola protective measures



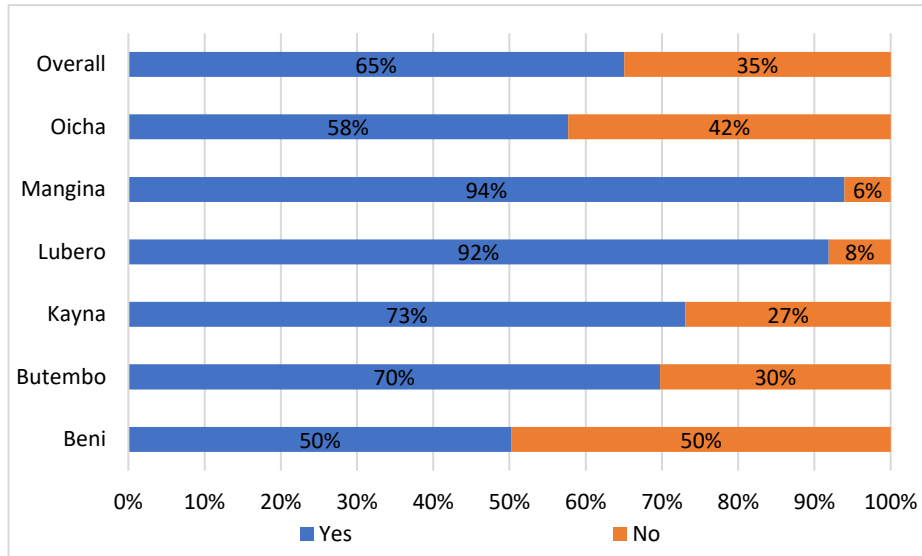
According to the interviewees, the most cited triggers that caused people to change their behavior to prevent and fight Ebola over the past eight months were the high number of deaths (55%), the increase in cases of infection (52%), and the death of a family member (49%) (Figure 30). These elements corroborate with the information provided in the FGD.

Figure 30. Triggers for behavior change



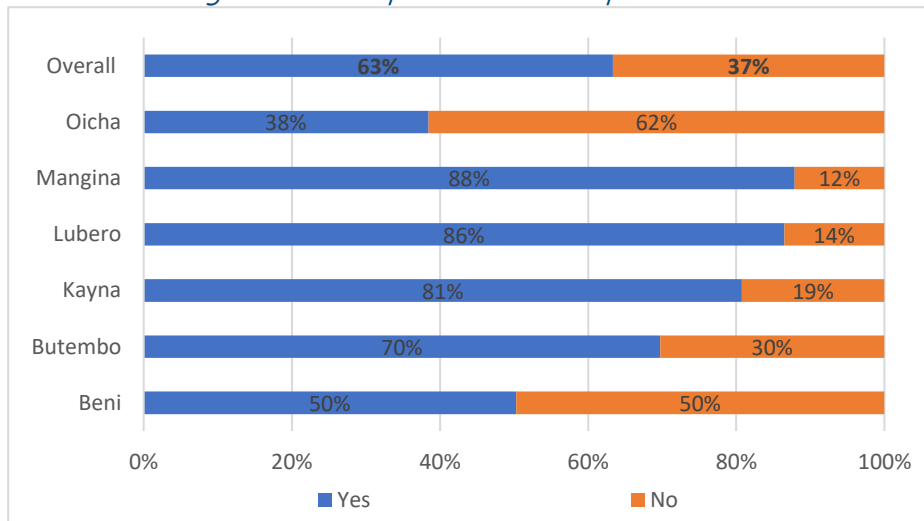
In terms of collaboration between community members and other actors in the response, 65% of respondents said that they had collaborated with Search, Internews, UNICEF, WHO and other communication/community engagement officers in forum activities, awareness-raising, community mobilization and training (Figure 31).

Figure 31. Collaboration with other non-governmental actors



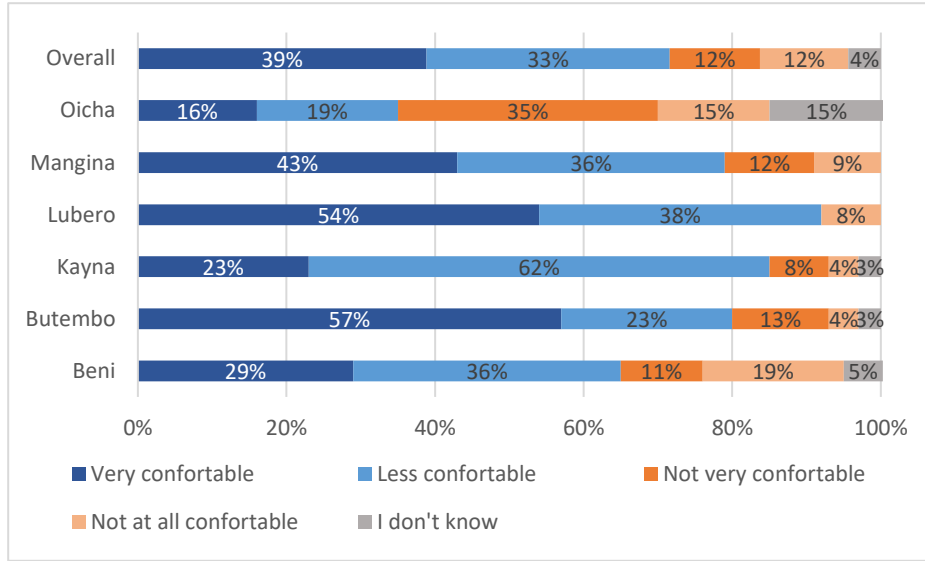
With respect to participation in response initiatives, 63% of respondents reported participation in initiatives such as setting up discussion forums, community outreach committees, trauma debriefing of Ebola survivors, mediation, and waiver (Figure 32).

Figure 32. Participation in Ebola response initiatives



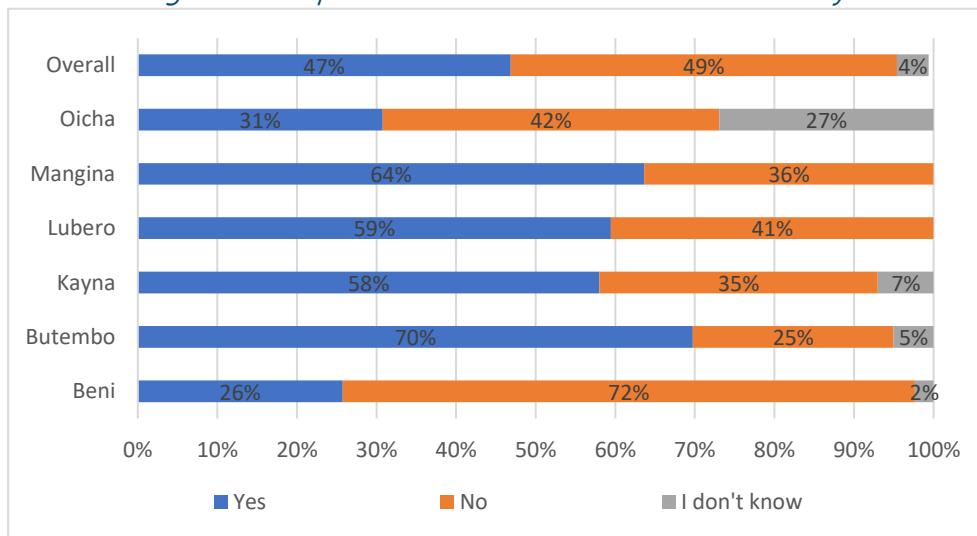
In terms of respondents' participation in peacebuilding discussions, in total, 39% of respondents feel very comfortable participating in public discussions about community life and peacebuilding, 12% not very comfortable, 33% somewhat comfortable, and 12% of respondents say they do not feel comfortable at all (Figure 33).

Figure 33. respondents feeling in peacebuilding discussions



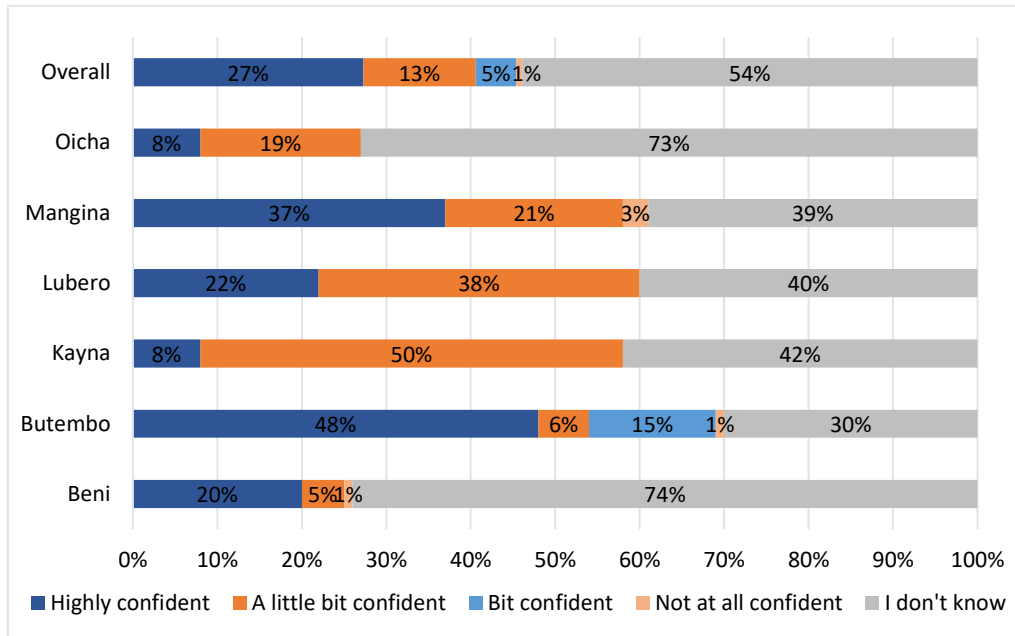
Regarding the consideration "community leaders," 47% of respondents think they are leaders versus 49% who do not think so and 4% are undecided (Figure 34). The majority of those who consider themselves leaders have played the role of influencer or facilitator in their entities through sensitization, action research and community-based monitoring, either by mentoring young people or women, or in advocacy activities with the authorities or with the leaders of pressure groups.

Figure 34. Respondents consider of themself as community leaders



Regarding self-confidence, 27% of respondents are very confident to be leaders, 5% not very confident, 13% somewhat confident (Figure 35).

Figure 35. A leader's sense of trust in his or her community



## Table of indicators

**Table 5: Project indicators**

Indicators	Baseline	Endline	Target
% of community members who trust the EVD response team	27%	70%	80%
% of community members who report that youth are meaningfully engaged in the response to EVD	40%	84%	85%
% of community members who report that women are meaningfully engaged in the response to EVD	46%	86%	85%
% of medical and non-medical personnel working in the response who agree or strongly agree that people's resistance to EVD has been reduced	65%	81%	80%
% of respondents who report that relationships between different groups around the EVD are positive	70%	72%	80%
% of respondents who report that relationships between their community and non-medical state actors around the EVD are positive	60%	80%	70%
% of respondents who report that relations between their community and medical actors around the EVD are positive	63%	80%	75%
% of respondents who report that communities have access to reliable information about the response to EVD	81%	67%	70%
% of respondents who report that communities are able to counter rumors about the response to EVD	59%	67%	65%
% of population reporting that non-medical state actors are positively engaged in the response to EVD	74%	91%	75%
% of population reporting that local leaders are positively engaged in the response to EVD	75%	88%	80%
% of community members who report that communities have access to spaces for dialogue with state actors in the response to EVD	68%	82%	85%
% of community members who report that communities have opportunities to collaborate with state actors in the response to the EVD	68%	84%	85%
% of community members who report that opportunities for collaboration with state actors help reduce mistrust of the EVD response	66%	80%	95%
% of population reporting that communication around the response to EVD promotes trust between groups	12%	60%	70%

% of population who report having access to positive role models for the response to EVD	75%	82%	80%
% of population reporting that communication about the response promotes women's and girls' human rights and gender equality	89%	80%	80%

## Objective 2: Assessing Gender Integration

Gender analysis explores the relationships of men and women in society and the inequalities in those relationships. The analysis therefore focuses on the power relations through which gender stereotypes and inequalities are perpetrated. In the context of development programs, its aim is to reveal the connections between gender relations and the problem to be solved.

It is clear that the EVD outbreak generally exposes already entrenched disparities and inequalities in the populations of the study areas, particularly gender inequalities: access to employment, decision making, freedom of expression, right to education, etc. The 2018 Ebola outbreak in the study areas has exacerbated women's socioeconomic vulnerabilities, although apart from a few isolated evidence-based studies, evidence for this is generally case-by-case. The burden of the disease on women is illustrated by the fact that at the time of the outbreak, 65% of those infected were women who had lost husbands, sons, and daughters. They are often the ones who take care of their relatives and provide for the family. They work in the fields, in the market and make up the majority of nurses. As the most exposed, women were the most affected, directly or indirectly, by the disease.

Monitoring and evaluation data show that 1,467 people, including 7,294 women and 6,773 men, actively participated in the forums, discussion groups, dialogues and community solidarity activities in the project intervention zones. Influential men and women played a role in community mobilization, sensitization and awareness raising of the most resistant youth. 40 facilitators (17 men and 23 women) trained by Search implemented the focus groups in Beni and Butembo, while 29 men and 11 women were actively engaged in the dialogues, rapprochements, and community forums.

This discrepancy is linked to the selection of influential actors (neighborhood leaders, civil society presidents, radio station managers, leaders of community groups and movements) who are mostly men in the community. The configuration of the response has greatly influenced the involvement of men and women in the implementation of the project. For example, women were more involved in stigma activities through community discussion groups because they were more affected by Ebola than men. They facilitated the focus groups while men were more involved in community dialogue and reconciliation activities in conflict transformation, mediation and community dialogue and played a key role in conflict prevention and resolution at the community level in a win-win approach at the community level in a sustainable manner. These differences in terms of participation and commitment can also be explained by the community dynamics in the project's intervention zones, which are influenced by the culture in which men hold more decision-making positions and women more executive functions. For example, among the six sub-coordination of the Ebola response, there was one female sub-coordination president out of six. The TEP Project, through the community facilitators, has contributed to the socio-psychological recovery of survivors by reducing the negative effects of the Ebola epidemic, which are

the cause of discrimination and psychological trauma. Women and men accompanied Ebola survivors through community solidarity activities (income-generating activities) to mitigate and uplift 396 Ebola survivors (257 women and 139 men) through economic activities that enabled survivors' households to ensure food security, schooling, and health care for their children.

## Objective 3: Assessing the Project Sustainability

The project outcomes have been sufficiently appropriated by male and female participants in that community influencers and facilitators are conducting focus group and dialogue and outreach activities respectively at no cost. Ebola survivors are actively and regularly participating in de-traumatization sessions and income-generating activities. Young men and women members of advocacy groups participate in community dialogue sessions with local authorities; listeners provide feedback from *Mopila* episodes. Search partner radios share *Mopila* episodes with other non-partner radios in the study areas.

To support community structures or groups to continue to respond to community needs and maintain project impact, the TEP project has informed, consulted, involved, collaborated with, and strengthened the capacity of these community radios, administrative entities, advocacy groups, civil society, and local associations on the holistic response to EVD at the community level in order to promote social cohesion among social groups, state and non-state institutions, and community members themselves.

With respect to the exit or transition strategy, no document has been developed that defines the exit strategy for the TEP project. Nevertheless, the involvement of state authorities, local associations, male and female influencers, and facilitators, and committed journalists will ensure the sustainability of the project's actions in the face of future epidemics in the study areas. The continuity of regular consultative meetings of the mayor and lobby groups, community discussion group meetings, provision of agricultural inputs (vegetable seeds) to survivors, and technical support.

The TEP project has generated important partnerships and commitments from the Beni mayor's office with pressure groups that have increased community access to dialogue spaces and improved relations between communities and state actors by significantly reducing violent resistance; partnerships and commitments needed from 40 associations, 20 of which are in Butembo and 20 in Beni, that support Ebola survivors through solidarity activities.

Tolerance and the culture of mediation and acceptance of response services are added values of the TEP project in terms of investments in social cohesion and peace for positive communities themselves and between communities and state medical and non-medical actors around the EVD. At the community level, there is tolerance among young people whenever there is a disagreement between pressure groups and state institutions. This is justified by the cessation of protests in the study areas by youth members of pressure groups. The culture of mediation has been established at the community, household, and individual levels where disputes are settled amicably.

## Objective 4: Identifying lessons learned and best practices

The first lesson learned from the “Tushinde Ebola Pamoja” project is that community engagement and ownership strengthen the response to EVD. This project benefits when communities are consulted on their needs, involved in planning, and given the lead role in implementation. Infectious diseases such as Ebola and COVID-19 spread at the community level, and preventing their transmission requires community action.

Key actors (including youth and women) have raised awareness of the health risks of Ebola and have enabled communities to respond with their own strategies. Ebola-affected communities responded by rapidly changing their attitudes, building confidence in the response effort, and strengthening the resilience of their communities.

The second lesson of the project is to work through influencers and facilitators who are able to bring people together and promote participation. A leader has the legitimacy to convince people to work together. In the study areas, many of these leaders are chiefs of neighborhoods, villages and groups, pressure groups and community movements. They oversee a consensus-based decision-making model that allows people to have a say in community problems and actions.

The third lesson learned is to adapt the strategy in line with the strategic response plan (SRP4) to improve coordination, collaboration, and communication by using community-based approaches and implementing community feedback forums and interactive radio programs

The influencers and facilitators supported by the project found entry points into communities and served as a reliable source of information on how to prevent Ebola transmission. Through their intervention, the response teams gained access to communities that had previously been hostile to their presence. Influencers and facilitators also strengthened social cohesion and changed attitudes, ending people's willingness to cooperate with the response teams.

Influencers and facilitators remain an indisputable social and political force in the study areas. The project recognized their investment in the well-being of their communities and gave them a role in pacifying and preventing the Ebola epidemic. This was achieved while strengthening other stakeholders.

## Conclusions

According to anthropologist Brooke Grundfest Schoepf, "epidemics are social processes influenced by history, politics, economics, culture, social organization, and dynamics." Like other social processes, then, the Ebola epidemic is a vehicle for increasing already existing gender inequalities in the study areas.

Social expectations of women's role in caring for the sick, whether in the home or in the health care setting, as well as their traditional role in funeral rites, put them at greater risk than men for contracting the virus.

The engagement of community leaders and the mobilization of civil society as well as state and non-state actors through community dialogues has contributed to a significant reduction in the violent resistance of community members affected by Ebola.

Community facilitators have contributed enormously to the recovery of women and girls at very high risk of death, loss of income, loss of family ties, loss of social mobility, delay in formal education and professional development through de-traumatization, reconciliation, and community solidarity activities.

The participation of women influencers in spaces of dialogue and community rapprochement in the prevention of conflicts and the resolution of conflicts remains respectively weak and reduced. The project's monitoring and evaluation data show that women represent 27% of the influential people involved in the prevention and peaceful resolution of conflicts.

The project's failure to take advantage of new technologies (instant messaging and social networks) has contributed to limiting the access of populations affected by the Ebola epidemic to quality and timely information in urban areas, such as the cities of Beni and Butembo.

## Recommendations

Regarding the above findings and conclusions, the following recommendations were made:

- Ensure strict application of the principle of gender mainstreaming during the process of identification and selection of project actors for effective participation of women leaders in the activities of community dialogues and rapprochements.
- Continue to value the leadership of women actively engaged in the fight against EVD through associations and community self-help groups in the fight against EVD in the activities of community forums, reconciliations, dialogues, and discussion groups.
- Strengthen partnership aspects including behavior change communication with local associations and youth and women's groups to counter rumors and prevent violent tensions in communities affected by EVD.
- Put in place mechanisms to manage and capitalize on feedback from listeners of radio broadcasts to improve activity implementation, promote access to quality services for vulnerable populations, and strengthen the accountability mechanism to populations affected by the Ebola epidemic.
- Continue to provide technical and financial support to community radios in rural areas to improve access to reliable and verified information for vulnerable populations in order to increase their confidence in the Ebola response actors.
- Implement specific communication approaches focused on specific groups (youth, women) with specific problems to increase the confidence of the population of Beni towards the actors of the response against the EVD.
- Encourage the use of social networks and instant messaging in urban areas to improve access to quality information in a timely manner especially to youth and women in communities affected by the health crisis.
- Expand community solidarity activities in the Kayna and Lubero health zones to strengthen the resilience of individuals in households and communities in order to reduce the humanitarian costs caused by Ebola.
- Continue to technically and financially support psychosocial care structures for women and youth survivors of the EVD, particularly disproportionately affected women to restore confidence and self-esteem.
- Determine and/or adjust realistic and achievable targets over the duration of project implementation to achieve the expected results and goal set by the project.
- Develop the exit strategies document to define the sustainability mechanism of the project actions in the targeted communities.

### **Conduct advocacy with the Congolese government to:**

- Put in place measures to minimize the negative effects of EVD on progress towards gender equality in the community.

- Create a synergy of coordinated and harmonized actions through local, provincial, and national gender mechanisms as part of the MSP's response plan against EVD.
- Ensure gender equality in the identification and selection process of facilitators so that women and men are adequately empowered to fight EVD.
- Provide small grants to local associations especially those of youth and women to carry out social sensitization and mobilization activities at the community level in favor of populations affected by the health crisis in order to strengthen the commitment of affected communities.