Mistrust, Misinformation and Community Engagement

Reflections on lessons from the Democratic Republic of the Congo and Yemen

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Breaking the cycle of violence

This is the third briefing in a series released by the Oxford Research Group's (ORG) Strategic Peacebuilding Programme. These briefings examine lessons that can be drawn from the response to Ebola in the Democratic Republic of the Congo (DRC), and how they can be applied in the response to COVID-19 in Yemen.

The other briefings, focused on respectively Background Information, Aid, Community, and Security can be found here. For readers new to this topic, we suggest reading the background briefing before the others, as this will provide background information on the disease outbreaks and conflicts in both the DRC and Yemen, as well as the international responses in both countries.

A brief note on methodology: the sections focused on the DRC were written by the ORG team based on desk-based research conducted in the summer and autumn, 2020. This was supplemented with a closed-door roundtable with international experts in August and interviews with experts and practitioners with experience of working in the DRC, including Congolese nationals, throughout Autumns 2020. The sections focused on Yemen were written by local experts; each writer has a different methodology. These briefings are meant to offer a local perspective on the early impact of COVID-19 in the country, and how lessons from the DRC can best be applied. These briefings are of limited scope; their purpose is to inspire future research more than to present final conclusions.

Breaking free from the traditional top-down approach to humanitarian and disease response by engaging communities in meaningful discussions and decision-making is essential when responding to crises. When done right, such a process ensures that community needs, concerns and interests are not just taken into consideration, but stand at the very core of responses, creating more effective projects.[1] This is especially true in fragile, conflict-afflicted contexts, such as those found in the DRC and Yemen, where meaningful community engagement is essential to building trust in the international community's response and – where appropriate – the governing authorities.

This briefing examines the mistrust, misinformation and community engagement during the Ebola and COVID-19 outbreaks in the DRC and Yemen, respectively. First, it explores the international response to community engagement during the 2018-2020 Ebola outbreak in the DRC community response plans. It then goes on to identify the key challenges and lessons learned concerning misinformation, response staff and local institutions associated with the Ebola response. It will then explore similar trends within the Yemeni context where it identifies key challenges in relation to stigma, wider community outreach and the roles played by local community actors. Finally, it lays out the key findings from both the DRC and Yemen context.

Democratic Republic of the Congo (DRC)

It is widely recognised that trust in the enforcement of health policies by the community is central to a health system's legitimacy. With a trust-building approach, the conditions for populations' acceptance - and compliance with - preventive or curative interventions could be enhanced.[2] The Ebola virus disease (EVD) outbreak in North Kivu and Ituri occurred in an area of notable insecurity with frequent, systematic armed attacks; here, low institutional trust was linked to a long-term decline in security and confidence in political institutions.[3] This mistrust spanned the DRC's state institutions, including public healthcare. Without such trust, EVD response measures, which were coordinated by the country's Ministry of Health (MoH), became particularly challenging to implement, lacking the required level of public cooperation to report suspect cases, public confidence in responders and treatment facilities, and the ability to ensure response teams' freedom of movement.[4]

In the Eastern DRC, the lack of trust was manifested in the prevalence of misinformation regarding Ebola in general and the response itself. Misinformation that often circulated included: Ebola doesn't exist; Ebola is fabricated for financial gain; and Ebola is fabricated to destabilise the region.[5] One study found that at least 45.9% of survey respondents in North Kivu believed at least one of these statements.[6] It is of course important to note here that there is some truth to several of the statements above; extensive illicit use of funds, corruption, and profiteering occurred in the context of the international response to EVD, to the extent that it gained its own name: 'Ebola Business'. At the same time, Ebola did, to some extent, repress the DRC and the region more widely; the Beni and Butembo provinces, for instance, lost their democratic right to vote in December 2018 in the context of the epidemic. Nevertheless, these statements were also used to form the core of misinformation and were often greatly exaggerated or mis-applied – often deliberately for political purposes.

Widespread misinformation at the community level has been identified by a wide range of experts and practitioners – including many of those interviewed for this briefing series – as a significant obstacle to effectively controlling the 10th outbreak of EVD in North Kivu and Ituri.[7] The prevalence of misinformation and mistrust was compounded by a lack of meaningful community engagement from a wide variety of actors involved in the international EVD response from its very outset. According to the World Health Organization (WHO), in the context of an EVD outbreak, risk communication refers to "real time exchange of information, opinion and advice between frontline responders and people who are faced with the threat of EVD."[8] Community engagement refers to mutual partnerships between EVD response teams and individuals or communities in affected areas, whereby community stakeholders have ownership in controlling the spread of the outbreak.[9] This report finds that neither community engagement, nor effective inclusion of community stakeholders were prioritised in the North Kivu and Ituri EVD responses. This heightened the division between communities and responders, creating the conditions for a self-reifying cycle of exclusion, misinformation and, eventually, resistance. More attacks were witnessed on EVD responders in this case than any other EVD outbreak. As of 5 August 2019, sixty-two attacks had been targeted against Ebola response efforts – causing the temporary suspension of EVD response activities, prolonging the epidemic.[10] This is in addition to attacks on local communities, where EVD responders were simply in the wrong place at the wrong time.

The next section will identify the systematic negligence of the affected communities from the outset by response leadership, and the strategic shift toward a more community-centred approach that arose following the failure to control the outbreak. It will analyse the consequences of excluding local actors and institutions that were crucial to ending this EVD outbreak, drawing lessons from examples of positive engagement. Finally, we delineate the recommended forms of mapping and identify the local individuals needed for successful community engagement.

Hyperlocal[11] actors and institutions: A Strategic Shift

The failings of the response were exemplified by the strategic response plans (SRPs) authored by the centralised response leadership: the DRC MoH and the WHO. The SRPs detail the strategy for each pillar of the response and enabled the deployment of the resources required to support the Congolese Government and its partners.[12] Despite the work done to develop the two SRPs for the period August 2018 to January 2019, with SRP-3 the third iteration covering the period February to July 2019, their implementation failed to respond effectively to the outbreak. Possible reason for the unfulfilling of the three SRPs' planned impact can be found in analysis of their fundamental strategy, which exemplifies the disconnect between the response and the affected communities.[13] This shows a sustained inability or unwillingness to shift the burden of change from the community to the response itself, making it the communities' responsibility to buy-in and accept ownership. Community resistance and associated misinformation, here, was attributed to the wider climate.

In reality, experts across our interviews and roundtable – the majority of whom were part of organising and implementing the international response – emphasised that the design of the response from its outset exacerbated the lack of institutional trust and made community engagement difficult, if not impossible. Communities resented their lack of inclusion in the EVD response and the disparity between the international resources for the EVD epidemic compared to other crises. The vast funds that were poured into addressing a health crisis with international/regional ramifications stood in stark contrast to the inadequate action taken to tackle the highly visible, non-EVD health crises and violence they face every day.[14] This perceived double standard led to increased local communities' suspicion of response actors' motivations, fuelling the various forms of misinformation that were perpetuating the risk of EVD transmission.[15]

The continued and deepening failure of the EVD response to contain the outbreak during the period covered by SRP-3 led to an overhaul of the design and leadership of the response in May 2019. This bolstered the work of NGOs and other UN agencies. The UN's Inter-Agency Standing Committee stated: *"We can only tackle Ebola if there is trust and confidence by the communities in the response. Community engagement needs to be strengthened: the response must be patient and community-orientated."*[16]

This was reflected in the framing of SRP-4, covering the period July to December 2019. It was aimed at "strengthening the resilience of the population, fostering community ownership and involvement by the community in the response." There is a clear discursive shift compared to the three previous SRPs, with the responsibility of encouraging and achieving local ownership placed upon responders rather than the community's themselves. On the ground, NGOs were better integrated into the response.[17] Many of these[18] NGOs had previous experience addressing the core humanitarian needs of populations across the affected provinces, with interviewees noting their legitimacy and trust amongst communities. **Box A** details an exemplary case study of this by Medicine San Frontier and the Alliance for International Medical Action (ALIMA).

BOX A / CASE STUDY

MSF and ALIMA – humanitarian INGOs with long-term operating experience in Eastern DRC – initiated a decentralisation of care. They created temporary transit centres aimed at bringing Ebola-related health services closer to communities, with the added provision of free care for all health conditions. This helped to quell communities' anger who felt that their wider health needs had been neglected for many years. Moreover, bringing the centre into the community led to an increase in local ownership, with rising attendance rates attributed to the local populations' sense of responsibility for and appropriation of the structure.

Adopting a community-centred approach from the outset of outbreak response must be a non-negotiable priority. Failure to do so will limit – or curtail – the success of the response. This is especially true when the response takes place in a conflict zone that is already beset by a climate of mistrust and misinformation. The consequence of this is a decline in long-term trust in governmental and international institutions. This undermines both current and future outbreak responses.

The conflict in the North Kivu and Ituri provinces is characterised by complex localised violence and political instability. These factors demand a hyperlocalised, conflict-sensitive response. Belief in EVD-related misinformation was uneven across localities and so countering such misinformation requires different approaches and resources in different areas.[19] Interviewees emphasised the inclusion of hyperlocal actors and institutions at the district, village and even street level as critical and necessary for effective community engagement across this fragmented region.[20] Additionally, simply including hyperlocal actors is not enough as the local experience is not uniform. At the very least, there must be gender diversity as well, with women deliberately invited to the table. As the briefing on women's experience argues, the importance of gender diversity seems to have been accepted by most international organisations in rhetoric. However, this has not been reflected in practice, as women remain excluded from decision making.[21]

A Congolese Kinshasa-based charity worker interviewed for this briefing emphasised the need for 'genuine dialogue and collaboration.'[22] Genuine dialogue demands an interdependent relationship between active listening and communication, in which communities are consulted in advance of response activities and are able to give feedback that is readily adapted into response interventions. Collaboration in the North Kivu and Ituri contexts required that responders entrust and empower existing local actors and institutions to lead on key community engagement activities, as the below cases demonstrate.

Response staff

In September 2018, a survey in North Kivu from the Harvard Humanitarian Initiative concluded that the more local an institution, the more favourably it was seen by respondents.[23] This sentiment reflected community feedback data in which people frequently asked 'why don't we see our people' or 'our doctors' as part of the response teams, stating that their inclusion would foster greater trust and confidence in interventions.[24] The centralised leadership by the MoH and WHO meant the widespread deployment of Congolese and international responders to North Kivu and Ituri provinces. However, most Congolese came from the capital, Kinshasa, where the MoH department headquarters is based. Local populations perceptions of responders as 'foreign outsiders' persisted for both international and MoH staff alike.[25] Relatedly, locals lacked faith in such

responders' duty of care towards them. Such fears were not necessarily unfounded, with one international aid official noting:

> ***In a marginalised area, Eastern DRC, there is little push or incentive within the Kinshasa-based Ministry of Health and its staff to protect people.***[26]

Relatedly, there was a perception that appointments to leadership roles in the response were politicised, prioritising the advancement of individuals aligned with the national government over the health of the affected communities.[27]

Local mistrust of government and international staff was exacerbated by culturally insensitive practices and their inability to speak the local languages.[28] The language barriers did little to quell concerns from locals that they would be misdiagnosed with EVD and sent to Ebola treatment centres. These centres were seen by locals as 'death camps.[29]

Despite the above weaknesses, the response evolved over time. One of these was the utilisation of local healthcare workers in the EVD response. This enhanced community trust in the response; for instance, their employment in ETCs reduced fears of misdiagnosis due to language barriers.[30] One Congolese interviewee operating for an international development charity in North Kivu acknowledged how locally-sensitive behaviours made a tremendous difference in convincing people that the response was helpful. Acknowledging and incorporating locally-sensitive behaviours into the response, he emphasised, was vital at all levels, from ensuring burials are completed in a culturally appropriate manner to ensuring that culturally appropriate food is served in hospitals.[31] One survey found local health professionals to be the most trusted source of information regarding EVD, despite the fact that respondents ranked them fifth in terms of who/where they actually receive information from.[32] This suggests that their role in community engagement, both in treatment centres and within their localities more generally, was under-utilised by the response. The inclusion, training and capacity-building of local healthcare workers helps to increase the potential of the local health system to support the response and continue activities over the long term.[33]

During disease outbreaks, it is crucial to ensure that 'relai communautaire' (local healthcare communicators) are at the centre of the communication. To do this, the international community must ensure that they have adequate training and resources. Unfortunately, this was not the case during the response.[34] Moreover, there was no system put in place to retrain and reinforce the relai communautaire based on their feedback. In the absence of guidance in their primary local language, each communicator developed their own explanations. These varied between individuals and can lead to inaccuracies, inconsistencies, and cause general confusion for populations. Coordination between responding organisations can help to avoid the proliferation of competing messages from similar actors and reduce unnecessary duplication. An example of this is the Risk Communication and Community Engagement (RCCE) Partners group (the DRC MoH, WHO and UNICEF) in North Kivu and Ituri.[35] Relai Communautaire delivered new instructions yet lacked the relevant information to answer questions, resulting in a breakdown in trust with community members.[36]

Resentment toward the employment of 'outsiders' in the response extended to ancillary staff. Mercy Corps, a humanitarian NGO, sought to address this when expanding their work to cover non-Ebola basic services. Mercy Corps ensured that local workers were employed on construction sites, allowing communities to elect committees responsible for construction and repair work.[37] This is a positive case study of including the local community in both the discussion, design and administration of response activities. Their economic participation as ancillary staff helps to further reduce a community's fears arising from any sense of exclusion.

Existing local institutions

Community resilience to future outbreaks can only be built by reinforcing existing structures. In the politically and socially fragmented localities of Eastern DRC, engagement with religious actors – including leaders, institutions and faith-based organisations (FBOs) – offers an essential gateway to the community. Religious actors are trusted messengers that are well positioned to encourage community cooperation and compliance with public health measures.[38] It is estimated that 60 % of educational facilities are managed by faith groups, with 40 % of the health system managed by Catholic health structures ('Bureau Diocésain des auvres Médicales').[39] During the EVD outbreak, building on other basic forms of assistance provided by religious institutions, faith groups provided hygiene facilities such as handwashing kits, supported monitoring of case contacts through food distribution and psychological assistance, and established reception areas where people could be referred onto ETCs.[40] Further to this, religious institutions sensitised local populations to the threat of EVD by disseminating self-developed guidance. Utilising their broad networks, religious institutions were able to affect broad behavioural change amongst local populations. An official from a faith-based international non-governmental organisation (INGO) stated:

> ***The Catholic Church has over 47 diocese and over 2000 parishes in areas with poor or no infrastructure. [My organisation] gets the information from those structures and is in contact with health centres in those areas.***[41]

Many religious leaders preached by example, with 70 leaders coordinating independently to counter misinformation around EVD vaccinations by being publicly vaccinated themselves. The Catholic bishops' 'Ebola Free Families Campaign' mobilised grassroots women's and youth groups to meet in neighbours' homes to discuss and educate around misinformation, misunderstandings, and the stigmatisation of survivors. Muslim and Protestant leaders undertook similar activities. [42]

Despite this evident willingness, proactivity and established capacity of religious leaders to engage in broad community engagement activities - in addition to surveillance and safe and dignified burial practices - interviews conducted for this briefing revealed that the response failed to consult religious actors at its outset and throughout.[43] This limited the potential of community engagement. Moreover, some religious leaders were directly opposed to supporting the Ebola response, with an INGO staff member operating on the ground noting:

> ***Some religious leaders opposed the response and disseminated the image that Ebola didn't exist. Many Churches actually rejected handwashing stations.***[44]

The resistance shown by certain religious actors could have been partially mitigated had the international response facilitated coordination between local religious leadership and international responders. Instead, faith leaders were not invited to strategy meetings during the outbreak.[45] This lack of engagement occurred despite the recurrent lip service paid to faith-based organisations as one of the major actors in the response. Numerous Congolese and international interviewees noted this trend, affirming that plenty of talk and goodwill from EVD response actors was not followed by funding for faith-based operations.[46] Where faith leaders were engaged by international responders, some Congolese faith actors averred such engagement to be mere instrumentalisation as opposed to seeking genuine partnership, with international agencies accused of looking to 'win hearts and minds' or gain access.[47] Religious leaders in North Kivu expressed frustration that they were only involved "when problems arise" rather than being integrated into the design and implementation of the response.[48]

An SRP-4 innovation included "[r]egular communication and community engagement training for stakeholders and community leaders on the response, so that they are able to answer questions on the multiple aspects of the response and humanitarian issues, and for building trust with communities."[49] An example of this is the training of priests in how to sensitise behavioural change amongst local populations, who were then encouraged to pass this training on to parishes and community groups.[50] Equipping local leaders with the basic information and tools to adapt to their own community's setting increases the resonance and legitimacy of community engagement messaging.

Another key local institution was traditional healthcare. Traditional practitioners constitute a sizeable and culturally significant provider of local communities' informal healthcare across North Kivu and Ituri provinces. The EVD response failed to address how these practitioners would be included in the implementation of EVD-related activities. A clear example of this was that, although traditional practitioners were often the first stop for people showing symptoms of Ebola, they were not systematically provided with personal protective equipment (PPE).[51] Interviews revealed that traditional practitioners perceived their exclusion as a threat to their business and because of this they "went more clandestine"[52], as the traditional practitioners continued their operations but kept it in low profile from the surveillance teams. This increased challenges for surveillance teams, with street chiefs describing how medical care was being "driven underground".[53]

Following the strategic shift in May 2019, the negative impact of traditional practitioners on transmission was reduced by their increased integration into the response. This, however, doesn't discount the fatal impact of their original exclusion. SRP-4 sought to reduce the clandestine nature of practitioners' operations, delineating a flat monetary rate to be paid to each health facility (public, private or traditional) for each validated and confirmed case notified to the surveillance team.[54] Traditional practitioners were belatedly provided infection prevention and control (IPC) training, building the capacity of the local health system to support this and future outbreak responses. However, Cellule d'Analyse en Sciences Sociales (CASS) surveys taken at the end of the EVD response found that traditional practitioners remained insufficiently trained and were not included in the same level of training as other health care workers.[55]

Local media channels

Media constituted a key area of contention in the EVD response, operating as a channel for both positive community engagement and the spread of misinformation. As a public health official attested:

> ***"We saw the power of WhatsApp and technology – how quickly rumours spread. It's hard to stay on top of that. The response must look at all potential channels when communicating with a community."[56]***

Reaching local populations through the new media they consume is a necessary counterweight to the masses of misinformation promulgated on social media platforms. Achievements in this area came from bottom-up approaches, which required the engagement of credible local leaders. In North Kivu, the Bishop of Butembo-Beni said in an interview that the vaccine does not kill, condemning the politicians that spread false information against the Ebola campaign and imploring the local population to not trust them. This interview gained large traction on WhatsApp, in addition to various local media sources.[57] Community members were active in circulating announcements and situation reports from WHO and other agencies via WhatsApp, demonstrating a determination to keep apprised of response activities.[58]

Local media is a crucial channel to convey the official messaging and advice of the response. Lessons from the EVD outbreak in West Africa exemplified how radio can be used to explain the disease, the response structure and interventions, the symptoms and what to do if/when they arise, in addition to instigating a radio Q&A dialogue through which to respond to key questions and hear from communities.[59] Risk communication must concurrently promote two broad messages: firstly, an awareness of the seriousness of the disease to encourage the adoption of preventative behaviours, and secondly, to communicate the necessity of seeking formal EVD treatment when displaying symptoms. Without sufficient emphasis of the latter, sensitisation to EVD's risks can lead to fear and an overabundance of caution, especially in a climate of mistrust toward health authorities, which increases the risk of community transmission. This is consistent with the finding that, across EVD outbreaks, individuals' increased EVD risk perception was associated with reduced odds of care seeking and vaccine acceptance.[60] In North Kivu and Ituri provinces, comprehensive risk communication was enhanced through local media sources increasing the visibility of treated EVD survivors and their stories. Local radio stations, a communication channel with the widest reach in Eastern DRC,[61] disseminated 'Ebola broadcasts' that included interviews with EVD survivors who presented a positive view of EVD response teams. Similarly, these gained great traction and were widely circulated on WhatsApp.[62] An International Rescue Committee (IRC) report found that the increasingly strategic use of EVD survivors in community engagement helped to reduce the fear of the ETCs as "places where people are left to die", as well as reducing the stigma and reintegration challenges faced by survivors.[63]

Youth

The impact of new technologies is directly related to the growing role of the DRC's youth populations in local communities. When this is acknowledged, young people can play an important role in spreading information. When ignored, it can have the opposite effect; a Congolese responder interviewee explained how anti-response terminology, messages and even songs were created and dispersed by young people - some of whom highly influential in their communities - reaching and convincing many older community leaders.[64]

The capacity and willingness of Congolese youth to lead on certain aspects of community engagement was undervalued and ignored. During November and December 2018, large local youth associations in the Grand Nord hosted public forums on EVD with substantial crowds. Here, the youth leaders' support or scepticism toward the response was highly influential at the community level.[65] Local individuals both supporting and opposing the response have called for more facilitated discussion forums in which local communities can ask questions and receive further detailed information about treatment and laboratory procedures.[66] Roundtable discussions conducted for this briefing revealed how dialogue with previously resistant and violent youth groups was successful in bringing certain groups involved in the response as stakeholders.[67]

Mapping hyperlocal power dynamics

The EVD outbreak in North Kivu and Ituri demonstrated the importance of identifying the right individuals and groups to empower and entrust to lead activities in their community. The first step would be a mapping exercise of the main referral pathways that includes actors and services which, unfortunately, was not conducted during the response. The urgent nature of the emergency given with as one of the reasons for this oversight.[68] However, international actors together with the MoH, are accused as having perceived North Kivu as "one monolithic entity from the start" rather than acknowledging the multiple levels of locality and different groups within each.[69]

It is vital to triangulate information to ensure that those who appear to be community leaders are also perceived as such by the community they claim to represent. Commenting on the outbreak, an anthropologist advised caution when seeking to engage "locally trusted leaders," affirming that "the effort to discern the wishes of the community should not confuse the general will of the population for the wishes of a few local intermediaries."[70] This is demonstrated with the case of the powerful business class of Nande traders in Butembo city, North Kivu, who are said to have presented themselves and been accepted by responder 'outsiders' as entrepreneurial and practical problem-solvers. This was the case in spite of research that documents how this group has repeatedly used violence to sabotage or hijack development projects to preserve their trade monopolies and political power at the expense of other ethnic groups.[71] The potential for the EVD response to be appropriated in the escalation of ethnic tensions and the spread of misinformation should be taken into consideration by the response when identifying leaders for community engagement.

One public health interviewee attested that "a questioning eye" is needed to determine whether individuals that claimed to be local leaders actuality had the ear and trust of the community.[72] A Congolese responder emphasised that assessments of power dynamics at the community level can be performed within just three hour visits or even over the phone. They recognised the presence of inter-communal division, affirming that their organisational approach is to work across opposing groups or individuals.[73] Response teams must listen to members of the local community when identifying trusted leaders.

There is a clear need to perform recurrent and evolving contextual analyses, beginning at the response outset prior to the design and adaptation of activities. Such analyses are not the exclusive right of the responders and must be locally-driven. This outbreak saw the facilitation of workshops between over 120 local faith-based organisations (FBO) and faith leaders. Diverse inclusion enabled Ecumenical and inter-faith exchange. These were convened by international FBOs and INGOs. Participants reflected on good practices and challenges in their work.[74] Broad consensus emerged around the recommendation for the wider response to establish inter-faith working groups, including sub-groups on health and other issues.[75] Facilitating locally-driven analysis and reflection helped lay the foundations for building and integrating the capacity of existing local institutions, whilst improving clarity as to which institutions should be best engaged in community programmes.

At the hyperlocal level, community members demonstrated their own initiative in wanting to perform locally driven analyses of response partners. They repeatedly called for stronger mechanisms to report perceived corruption, in addition to the establishment of a dedicated hotline to enable community members to make real-time reports of insecurity or suspicious activities.[76] By creating and maintaining such mechanisms, the response will increase responders' real and perceived accountability to affected populations, whilst garnering a clearer understanding of the potential partners they engage with and rely on. Communities called for further clarity in the decision-making processes involving local authorities, doctors and health workers.[77] Building community trust requires greater transparency concerning the flow of response money, who is involved in the response and why they are involved.

Republic of Yemen

Creating an effective disease response plan to a large-scale disease outbreak, which generates a positive outcome for the public, is a challenging task for any government. It is exceptionally challenging in a country such as Yemen, where ongoing conflict among competing power holders has created a complex environment. Both the Internationally Recognised Government (IRG) and the Houthi de-facto authorities lack the required minimum level of trust from the Yemeni population in the areas they control.[78] This absence of trust stems from the authorities' inability to provide basic services. This is exacerbated by a sense that the IRG is out of touch as the president and the majority of the cabinet members reside outside the country, while the Houthis are prioritising political and military gains over the wellbeing of the public. The above, alongside the fragmented authority structures, resulted in conflicting information, spread of misinformation, and exacerbated the lack of trust. Despite this lack of trust at the top governance level, local leaders emerged as more trustworthy actors across the country. Local communities continue to seek guidance from their heads of neighbourhoods, Sheikhs, religious leaders, and civil society leaders. Mapping and engaging trusted community leaders in the response plan and equipping them with the required knowledge is therefore necessary to provide communities with guidance and improve their acceptance and compliance of the response guidelines.

This section argues that, although there was an attempt at community engagement, it is vital that these efforts are expanded to combat the proliferation of misinformation and gain the buy-in of the communities. It is also essential to ensure that local civil society organisations supporting the response are consulted at an early stage of the planning process. This section will address issues related to information sharing, misinformation and stigma during the first wave of COVID-19 in Yemen. It will then explore challenges faced by medical staff and the roles played by youth, community members and Yemenis in the diaspora in the COVID-19 response.

COVID-19 Information Sharing

The first alleged case of COVID-19 in Yemen was originally announced by Houthi's Saba News Agency in Sana'a on 2 April 2020.[79] It was, however, retracted within two hours by the same institution, claiming it was a suspected case rather than a confirmed one. Yemen analysts perceived the retraction as a move by the de-facto authority to withhold information and continue to politicise humanitarian and public health issues such as the diversion of humanitarian aid to support their fighters. Unlike in the DRC, where the MoH was leading the response, Houthis were deliberately concealing COVID-19 related information in the areas they control. In the following weeks, while the Houthis continued to deny the presence of cases in their areas and refused to report accurate numbers, there was a notable increase in the number of deaths within communities.[80] Adding to the overwhelming loss families experienced and the higher number of dead bodies, burials took place at night for the suspected COVID-19 cases, defying the rules for traditional daytime burial ceremonies. The burials for those suspected fatalities of COVID were initially carried out by the Houthi's themselves and not by the families; in fact, some families were even not allowed to take part in the burial of their deceased family member. The Houthis then forced the family members to self-quarantine (inside their homes) and not to share news, information or raise questions about the death, nor about their strict and harsh procedures. Moreover, Houthis deployed some armed men to guard the doors and gates of the houses of these families to prevent any visits from people to express sympathy and condolences to the family. Further to this, cemetery workers were also warned not to share any information about causes of death and were allegedly told to say that the bodies were unidentified casualties from the ongoing conflict.[81]

In addition to the deliberate lack of transparency and clear guidance from the de-facto authorities, the situation was exacerbated by WHO temporarily halting its staff activities in Houthi controlled areas. Here, WHO had been pressuring the Houthis into being more transparent regarding their reporting of COVID-19 cases. This worsened the fears over COVID-19 in an already exhausted population.[82] As a result, it became more challenging for local initiatives to work on awareness campaigns within communities, especially given the already hostile environment caused by the Houthis crackdown on civil society organisations (CSOs) since the beginning of the conflict in 2014.[83]

In IRG areas, on the other hand, the first case was announced on the 10 April 2020 in Hadhramaut governorate. To contain this outbreak, the Supreme National Emergency Committee was established to coordinate the IRG's COVID-19 response and coordinate with partners. These included the UN, MSF, and the King Salman Humanitarian Aid and Relief Centre. The committee developed official social media accounts on Facebook and Twitter to share information with the public and act as the trusted authority reporting on COVID-19 cases in Yemen. Although these channels were useful to those seeking accurate information, they did not stop the spread of disinformation both on social media and within the communities where the lack of trust of authorities has allowed misinformation to prevail as it did in the DRC.

It must be noted that rivalry and competition emerged between IRG and the Southern Transitional Council (STC) regarding who should receive the COVID-19-related equipment for treatment or prevention. For instance, during March and April, STC hindered the opening of a special COVID-19 medical facility that was to be supported by the WHO and INGOs. They did so because they objected the IRG MoH's administration of the centres.[84]

Misinformation

The perception of COVID-19 as a hoax – amongst other conspiracy theories – has permeated through Yemen, as it has across populations across the globe. In Houthi controlled areas, the denial of COVID-19 cases and proliferation of misinformation was similar to the ones associated with Ebola in the DRC such as: COVID-19 doesn't exist and COVID-19 was fabricated for financial gain.[85] These were spread alongside rumours that Houthis were giving lethal injections (so-called "Injection of Mercy") in hospitals to COVID-19 cases.[86] This was one of the reasons why people avoided seeking help and accessing health services/facilities.[87]

Rumours circulated in IRG territories concerning COVID-19 isolation units, related to the fear of death associated with those facilities. Populations believed that this was largely due to the low capacity of the facilities and lack of care from the medical teams.[88] This has hindered some patients from seeking medical help at the early stages of being infected by the disease as health facilities reported that most cases arrive to the hospital when it is almost too late.[89]

Moreover, international news and information also influenced the response in Yemen. For example, research for this project indicated that when President Trump was discussing hydroxychloroquine, an anti-malaria drug, and its potential use against COVID-19, messages started circulating on WhatsApp on whether this will be the cure. These messages were countered by awareness messages encouraging people to take the preventive measures and only use prescribed medication if needed.[90] In turn, fears were raised that malaria patients, who need the medicine, may not be able to access the drug in the Yemeni market.[91] "Some people I know started ordering medication from Sana'a because it was no longer available in Aden I myself bought a bunch of them that I still have at home to this point" said a professional working in the medical response field in Aden.[92]

Factoring this international influence in the communication plan of the response is essential to combating misinformation. Doctors and social media influencers tried to combat the spread of this misinformation through explaining the unsubstantiated President Trump's comments and the importance of following the WHO's and doctors' guidelines to ensure a safe recovery. It is, however, hard to assess the impact of such efforts as there is currently surveying and assessment of counter-misinformation campaigns.

Due to the polarised and politicised character of news and information in Yemen, reliable sources were harder to identify when the spread of COVID-19 first started.[93] According to the second round of UNICEF-Yemen regular rapid assessment, the top three sources for information were television, WhatsApp and social media.[94] Although local and international non-for-profit organisations and UN agencies used these platforms to raise awareness among the population, WhatsApp was widely used as a tool to spread rumours and misinformation, which was hard to detect due to the fast spread nature of these messages.[95] This was made worse, for instance, in areas of Yemen combating the spread of multiple infectious diseases, including Aden, where communities were unsure on how to differentiate between the symptoms and would circulate misinformation and confusion among their social network.[96] Local medical professionals and community volunteers played a positive role in their attempts to clarify the differences and used leaflets and brochures to address misinformation and the fears of social stigma within the community.[97] However, there was a critical moment when COVID fatalities stood at over 80 per day in Aden, this occurred amidst people's uncertainty whether the cause of the deaths was from COVID-19 or other pandemics caused by the flash floods and heavy torrential rains that hit Aden in April.[98] The circulation of misinformation grew exponentially when a number of doctors had differing views on the nature and real causes of the high fatality rate. The failure of official channels to respond decisively provoked a number of doctors to make efforts to inform people, through different and often conflicting interpretations, concerning the "real cause of deaths in Aden". This resulted in panic among people and made the situation increasingly confused.[99]

Stigma

According to the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) weekly (26th September), stigma continues to be identified as one of the reasons behind people's delay in seeking medical assistance.[100] While stigmatisation of survivors in the DRC is what was posed as one of the key challenges to survivors and responders helping them reintegrate within community, in Yemen misinformation regarding the symptoms of Coronavirus and how it spreads has led to a stigmatisation of people taking protective measures, survivors and those who are suspected of contracting the virus. On social media platforms, such as Facebook and Twitter, people wearing masks and taking other protective measures shared their experiences of being ridiculed amidst growing fear of being stigmatised.[101]

In an interview with a male law student in Hadhramaut governorate, he reported that he was mocked as a result of wearing a mask in public spaces.[102] He also expressed that his tribe, after they suffered a COVID-19 related death, were stigmatised within the community and sarcastically labelled 'disease spreaders.'[103] Although stigmatisation of entire groups is not the norm, such behaviour was discouraging people from taking preventative measures in the area.

Although only 19 % of respondents to round two of UNCIEF's Rapid Assessment of Knowledge, Attitudes and Practices related to COVID-19 said that the disease is creating stigma, it is important to note that a large percentage of the sample is based in areas where less cases are being reported. Therefore, it is worth documenting that social pressure to preserve norms and the fear of stigma

drives families' decisions in relation to social events, mainly the loss of a family member. While some families chose to take the cautious approach through receiving condolences via text, calls and on social media platforms, the fear of social stigma drove other families to hold regular social rituals and plan sizeable social gatherings to mourn their losses.[104] One Sana'a-based female artist and activist interviewed for this research argued;

> ***"Although my family is educated and aware of the potential consequences of spreading the virus they acted irresponsibly and held a large funeral and reception in fear of social stigma."***

Medical response staff

Unlike the 10th EVD outbreak in the DRC, the majority of response staff in Yemen are locals. This is also the case for COVID responses across the world because of travel restrictions. Consequently, communication and language was not a problem for response staff in Yemen; however, the limited availability of PPE equipment during the early stages of the response in some areas, such as Aden, meant doctors avoided dealing with patients suffering from respiratory diseases before the arrival of the appropriate PPE equipment and doctors confirmed information about COVID-19 cases from global health institutions, such as WHO.[105] These fears of COVID-19 amongst health professionals were worsened by the high rate of COVID-19 associated deaths among doctors, nurses and other medical support professionals.[106] Interviewees suggested that although doctors should not be blamed for taking such decisions this created a level of mistrust as communities felt left out by the frontline workers.[107] The combination of misinformation and fear related to COVID-19 patients' need for artificial ventilation support has led to increased instances of aggressive behaviour shown to some medical staff by patients' companions, for the latter's anger and anxiety as to whether their relatives are receiving appropriate treatment.[108]

Effective youth, community, diaspora and private sector engagement

Youth initiatives, youth-led CSOs and the private sector were generally excluded from the IRG and UN-led response plan.[109] Despite this, Yemeni youth and the private sector have been playing a significant role in a number of different COVID-19 related activities and programmes.

One of these activities has been the mobilisation of communities and leadership of locally funded disinfection campaigns in their districts. Further to this, there were other proactive initiatives such as social media influencers using their platforms to spread awareness and debunk, to an extent, locally spread misinformation. Similarly, Facebook pages were established to spread information and host medical professionals to address people's questions.[110] Similar to the DRC attempts to address misinformation and raise awareness through new media, responders in Yemen created animated stories and music videos for social media platform and WhatsApp to raise awareness amongst both younger and older community members. Mazen Al-Sakaqaf, one of Yemen's most popular youtubers, used segments of his weekly show to raise awareness about COVID-19 and debunk the misinformation being spread through WhatsApp.[111] Another youtuber, Abdulrhaman Al-Jameeily, took to Twitter, Facebook and Instagram, sharing a short video called 'not an indictment'. The video addressed social stigma associated with people who contracted the virus and those who also chose the protection measures such as wearing masks.[112]

According to OCHA weekly (26 September 2020) COVID-19 preparedness and response snapshot, in Yemen Religious Leaders raised awareness in 5000 mosques across the country reaching 3.6 million people. This positive role, comparable the DRC context where traditional and religious messages

also get much traction, was praised by the experts who were interviewed for this research as it allows for community engagement and discussion in positive manner as those leaders lead by example. However, they also noted that there were occasions where mosques operated, defying lockdown rules, and some prayers were performed as a number of religious leaders believed that COVID-19 was unreal and an attempt to discourage people from religious practices. Additionally, those addicted to chewing Qat (young people and adults) defied the lockdown. STC tried to prevent selling Qat in Aden and Lahj to stop people from gathering in crowds inside Qat markets, but they failed. This "resistance" is not simply a consequence of misinformation spreading about COVID-19, as seen by the reality that some Qat consumers were going to the crowded markets wearing masks and gloves. Rather, it is more related to the social and cultural dynamics of the community.

For the diaspora, Yemeni doctors living abroad have formed multiple support groups to lift part of the pressure that their colleagues are facing locally, including advice, consultations, and medical equipment. These efforts have been even more vital due to the COVID-19 response being implemented with either limited or, in some cases, no PPE and the high-risk level experienced by families of medical staff due to exposure in health facilities and living in crowded and multigenerational households. Compounding these safety and operational concerns, Yemeni medical staff and professionals have not received their salaries for months, as the country-wide salary crisis continues. Initiatives such as 'I am with you' and 'I am a doctor I can' established groups on Telegram and WhatsApp where Yemeni doctors both inside and outside the country responded to patients' questions, reviewed medical reports and provided distant advice and consultation.

A Yemeni senior doctor based in Germany interviewed is a member of one of the online clinics initiatives and who worked with a group of local and diaspora initiatives to raise more than 13,000 Euros through Facebook crowdfunding, which was then used to send PPE equipment to the National Epidemiological Supply Programme, the authority in charge of disseminating supplies across the country.[113] The senior doctor stated that:

> ***"We established this initiative to help our colleagues in Yemen, and to help reduce in person visitation to health facilities for those who live in crowded cities and offer Yemenis living in remote locations with limited access to health facilities the opportunity to seek consultation at zero cost."***[114]

The PPE purchasing led by the crowdfunding initiative was coordinated with the WHO officials and local authorities in Aden.[115] Despite this assistance, a senior member of the "I am a doctor I can" initiatives - who established a field hospital in Aden - asserted that the initiative struggled due to a lack of coordination and cooperation with local officials and UN agencies.[116]

The private sector in Yemen remains one of the vital operating sectors in the country, providing job opportunities and sustaining the production of essential products and services. However, the sector faces many challenges including state fragmentation, supply chain disruption, physical damage to the infrastructure, double taxation, customs, lack of electricity and exchange rate instability. Despite this all, the sector continues operations, specifically those in the food and health sectors. In early 2019, the sector came together to formulate the Yemeni Private Sector Cluster, a high-level platform consisting of private sector representative bodies from all over the country.[117] The platform's purpose is to coordinate and support the efforts of the private sector in humanitarian and development work and to have an effective role in the recovery and reconstruction of Yemen.

With this platform, the sector was amongst the first responders to mitigate the impact of COVID19 in the country, providing emergency support to health facilities and isolation units. Led by the Hayel

Saeed Anaam Group, the sector launched the largest international initiative to combat the spread of the virus.[118] This initiative supported the efforts of the UN, international agencies, and local authorities by bringing into the country vital health supplies worth $4 million. These included 426 ventilation machines, medicine, 34,000 testing kits and over a million units of PPE equipment. These items were distributed all over the country through the World Health Organization. Furthermore, the business diaspora contributed by launching several initiatives like the food, medicine and shelter banks which supported affected households and stranded Yemenis in neighbouring countries with cash relief.

The need for a localised approach

In Yemen, the top-down centralised approach of the COVID-19 response by both the IRG Ministry of Health (MoH) officials and UN agencies have neglected the need for wider-consultations with community leaders and local organisations. This continuous error, witnessed in humanitarian and development programmes, leads to interventions based on assumptions about the communities rather than up-to-date facts. To mitigate these, detailed needs assessments and mapping exercises can assist in ensuring any response is designed and implemented with a community-based approach.[119]

Communities and local responders need to be consulted and local organisations/institutions should push against the UN top-down approach in their response. During an interview, the Director of the Small And Micro Enterprise Promotion Service (SMEPS) stated that some institutions/organisations such as SMEPS do challenge the top-down approach, "however pushing back can be an exhausting and time-consuming process."[120] Nonetheless, such an approach from SMEPS and its parent organization, the SFD, has helped to create trust between the agency, its partners, stakeholders and communities.[121] This supports transparency and accountability towards communities and donors, creating lasting impact within the served communities.

For example, COVID-19 awareness and hygiene promotion by SMEPS and the Social Fund for Development in Yemen (SFD) started before a first case was reported in Yemen. This was because both organisations had several ongoing projects being implemented in over 1,000 rural communities. There was a small window of opportunity to help rural communities receive the needed messaging through effective channels before a spread was reported.[122] Therefore, the awareness campaign was based on rural door to door campaigns which took into consideration the vast constraints facing rural communities such as lack of electricity, televisions, and mobile phones, to access information. During this rural awareness campaign, both SMEPS and SFD, utilized communities themselves to 'pay it forward' through passing the right information. Even though there was no trust in information at the national level, community leaders and youth advocates implementing these projects at sub-district and district levels gained the trust of communities, being members and part of the communities themselves; many of who work under the Tamkeen program of the SFD.[123] This programme has supported the formulation of 7,000 village cooperative councils all over the country with the mandate of empowering communities to implement their own projects. Youth advocates and field leaders were trained by health workers on preventive measures of COVID-19 and were supported to reach households with the needed messaging. Awareness materials were designed to have very simple language and OHS messaging, as well as COVID-19 preventive measures. These materials targeted community midwives, farmers, fishers and livestock breeding communities. The material took into consideration the fact that these are the main economic sectors of work in rural populations. While conducting these awareness campaigns, SMEPS collected data from rural communities which showed that 80% of responders preferred community health workers/ individuals as their source of information because it was easier for them to access and

understand the information. By the time the first case was reported in the country, thousands of rural households had received awareness on COVID-19 precaution and preventive measures.[124]

Beyond understanding the needs, the identification of beneficiaries and processes used are crucial to community consultations to reduce duplications and for beneficiaries not to be selected through biases of community leaders.[125] A positive example of this is the tri-cluster, consisting of Shelter, Protection and COVID-conscious camp management, which aims to implement and sustain a community-managed strategy in internal displaced people (IDP) camps across the country.[126] Working with community networks on site is a step in the right direction that should be replicated by other clusters.

The RCCE intervention took an innovative and multi-dimensional approach which included:

1. Building the capacity of frontline staff and community mobilisers to engage further with communities.
2. Producing and distributing awareness raising materials, including music videos developed in local dialects and aired on radio/social media, as well as children's colouring books.
3. Engaging with mosques and religious leaders to increase awareness and community by-in of COVID-19 material and activities.
4. Educating children in Houthi controlled areas on COVID-19 measures through music and instructions among other activities. However, as this was mostly implemented in northern dialects, it excluded audiences from the central and southern parts of the country.
5. Producing and distributing communication support material.

Based in Aden, the Head of National Centre for Awareness and Health and Population Communication argued that the Centre's communication with RCCE officials in Sana'a and the response in the south operated with minimum support, this suggests that there was minimal communication between the Centre and RCCE officials.[127]

It is important to note here, just as it was in the DRC section, that future community engagement campaigns and activities should be inclusive of dialects of the targeted communities. Furthermore, it is essential that outreach be further extended to suburbs and rural areas, where much of the population resides. These efforts, alongside others outlined in this sub-section, could assist in reducing the misinformation consumed by local populations.

What needs to be done?

As we have seen in Yemen, information about COVID-19 varied depending on the authority controlling the area. As the majority of cases are being reported in the areas controlled by the IRG, the situation allowed authorities and community initiatives to address issues such as misinformation more appropriately. Although traditional and social media were both used to raise awareness across the country, the materials were not always sensitive and inclusive to differing local dialects across the country. Furthermore, rural areas were somewhat excluded since the population lacks access to the internet and most civil society awareness campaigns were focused on the urban areas. These issues must be addressed by the government and UN agencies both at the planning and implementation stages of the RCCE process to improve responses to any future disease outbreaks.

Similar to the DRC, the engagement of religious leaders in the Yemeni context was essential to raising awareness among the population during the peak of the pandemic. This effort needs to be expanded to increase awareness of outreach to the population and to avoid mix messaging.

Additionally, community engagement led by local youth initiatives played a positive role and their efforts need to be recognised, supported, funded, and incorporated into the planning of future outbreaks.

Furthermore, the role of diaspora doctors was also vital in supporting their colleagues and providing advice to vulnerable communities. Supporting doctors' initiatives would also contribute positively to shaping a healthier community response, at a time where Yemen has lost many health workers due to COVID-19-relatedsymptoms.

There must be effective engagement of the private sector in emergency, development, and peacebuilding efforts.

Supporting and empowering rural communities to be aware and support awareness raising, not only for COVID-19 but for other epidemics also, can help them be more resilient to shocks.

Findings and Conclusion

Trust is central to the legitimacy of health systems. The lack of trust in both the DRC and Yemen has led to constant misinformation. While the MoH was leading the response in the DRC, Yemen was torn with two authorities (IRG and Houthis) leading the response. This presented challenges in coordination and in ensuring accurate reporting of the total cases of those infected in the country. Both countries experienced the spread of both deliberate and non-deliberate misinformation on COVID-19 and Ebola for political gains. In Yemen this has caused a spread of a different type of misinformation based on the authority controlling the area. This challenge has to be met through more locally tailored community messaging in Yemen.

In the DRC the strategic shift towards engaging local communities in the response was vital in improving the outreach and in showing how community and religious leaders were able to lead by example. While this was also the case in Yemen, both contexts require a meaningful inclusion of community engagement planning and a shifting of either the top-down approach or the community engagement and risk communication that is led by the governments their international partners.

Additionally, it is vital for responders to take a conflict sensitive approach and ensure that the language used by the medical professionals and within awareness campaigns is accessible to the local communities. This is especially necessary in countries where the conflict is multi-layered and the social fabric is highly fragmented. Here, paying attention not only to the language, but also to the local dialects becomes all the more important. Finally, ensuring that the different awareness raising materials are accessible for vulnerable people, such as people with disabilities, is usually left out from rapid responses and requires attention from both strategic and community level communicators.

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