

COVID-19 INFORMATION ECOSYSTEM ASSESSMENT IN THE EASTERN DRC:

*INFORMATION NEEDS DURING
THE PANDEMIC IN THE PROVINCES
OF NORTH KIVU, SOUTH KIVU,
TANGANYIKA, AND ITURI*

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ACRONYMS AND ABBREVIATIONS	3	7. INFORMATION ACCESS: COMMUNITY INFORMATION SOURCES	21
PROJECT SUMMARY	4	7.1 The Radio as Information Channel for IDPs.....	21
A Brief Overview of the COVID-19 Context.....	4	7.2 Places of Worship.....	22
Main Findings.....	6	7.3 Community Health Workers as Information Sources	22
Recommandations.....	8	7.4 Face-to-Face Interactions with Friends, Family, and Acquaintances.....	22
1. MÉTHODOLOGY.....	9	7.5 Other Information Sources.....	22
2. COVID-19 RESPONSE PLAN AND ORGANIZATION AND CHALLENGES OF IMPLEMENTATION.....	13	8. MEDIA SOURCES OF INFORMATION.....	24
3. COLLABORATION AND COORDINATION PROBLEMS WITH THE COVID-19 RESPON.....	14	9. MAIN DETERMINANTS AND BARRIERS TO ACCESS TO INFORMATION.....	25
4. RISK COMMUNICATION AND COMMUNITY ENGAGEMENT IN THE CONTEXT OF THE COVID-19 RESPONSE: STAKEHOLDERS, STRATEGIES, CHALLENGES, AND EFFORTS TO CURB MISINFORMATION	15	10. RUMORS, SUSPICIONS AND MISINFORMATION REGARDING THE PANDEMIC.....	27
4.1 Challenges and Shortcomings in Community Engagement and COVID-19 Communication.....	15	10.1 Language issues.....	27
4.2 Mechanisms for Rumor Monitoring and Community Feedback.....	16	10.2 Discern fact from fiction.....	28
5. DEMAND FOR INFORMATION AT THE COMMUNITY LEVEL: PRIORITIES AND NEEDS.....	17	11. TRUST IN DIFFERENT PANDEMIC INFORMATION PROVIDERS.....	30
6. MEDIA ASSESSMENT OF INFORMATION DEMANDS IN LOCAL COMMUNITIES, INCLUSIVITY, AND BROADCASTING CHALLENGES	19	12. DETERMINANTS OF TRUST IN INFORMATION.....	33
		13. FORMAT OF INFORMATION	34
		14. TRANSMISSION OF INFORMATION.....	35
		14.1 Interactions between information providers.....	36
		15. INFLUENCE OF INFORMATION ABOUT THE PANDEMIC AND IMPACT ON ATTITUDES AND PRACTICES.....	37



ACRONYMS AND ABBREVIATIONS

■ **AFEM**

Women's Media Association

■ **ANR**

National Intelligence Agency

■ **BAVE**

Baptism, Vaccination, Civil Status Registration

■ **CAC**

Community Outreach Unit

■ **CBO**

Community-Based Organization

■ **CCC**

Church of Christ in the Congo

■ **CODESA**

Health Area Development Committee

■ **CORACON**

North Kivu Community Radio Collective

■ **CPN**

Prenatal visit

■ **CPS**

Postnatal visit

■ **DPS**

Provincial Health Districts

■ **DRC**

Danish Refugee Council

■ **DRC**

Democratic Republic of the Congo

■ **GIZ**

German Society for International Cooperation

■ **HZ**

Health Zone

■ **ICRC**

International Committee of the Red Cross

■ **IDPs**

Internally Displaced People

■ **IMC**

International Medical Corps

■ **IOM**

International Organization for Migration

■ **IPC**

Infection Prevention and Control

■ **MSF**

Médecins Sans Frontières (Doctors Without Borders)

■ **NGO**

Non-Governmental Organization

■ **OXFAM**

Oxford Committee for Famine Relief

■ **PWD**

Person with Disability

■ **RCCE**

Risk Communication and Community Engagement

■ **REMED**

Media Development Network

■ **RTCT**

Taina Community Broadcaster

■ **RTNC**

Congolese National Broadcaster

■ **SANRU**

Primary Health Care in Rural and Urban Areas

■ **TWB**

Translator Without Borders

■ **UCOFEM**

Congolese Union of Women in Media

■ **UNICEF**

United Nations Children's Fund

■ **UNPC**

National Press Union of the Congo

■ **WHO**

World Health Organization

PROJECT SUMMARY

This report presents the results of the Information Ecosystem Assessment (IEA) undertaken as part of the Rooted in Trust (RiT) project funded by the USAID Bureau for Humanitarian Assistance (BHA). The study was conducted in four provinces of the Democratic Republic of the Congo (DRC): North Kivu, South Kivu, Tanganyika, and Ituri. These provinces were chosen because they are disproportionately affected by chronic humanitarian and health crises marked by protracted conflict, displacement, and disease (Ebola and COVID-19). The study focused on internally displaced people (IDPs), minority groups (including Burundian refugees and communities such as the Twa and Banyamulenge) and small-scale cross-border traders in the four provinces. These vulnerable populations are often marginalized and thus acutely impacted by diverse socioeconomic shocks related to complex crises.

RiT seeks to mitigate the physical, social, and economic impact of disasters by helping to establish more reactive and sustainable community-run information systems. Thanks to improved access to reliable and precise information, individuals and households can make better informed decisions regarding their health, reducing the risk of adverse behavior during disasters like the COVID-19 pandemic.

The IEA is a key project component which aims to provide a more nuanced, evidence-based understanding of the relationship between information supply, demand, and adoption in the areas of intervention.

BRIEF OVERVIEW OF THE DRC'S COVID-19 RESPONSE

Each province (Ituri, North Kivu, South Kivu, and Tanganyika) designed its own response plan to address the pandemic based on the national plan developed by the Ministry of Health in Kinshasa. These plans were inconsistently implemented due to insufficient financial resources, poor coordination ef-

forts, limited local ownership and uptake, lack of engagement from administrative authorities, and community mistrust.

In all four provinces, healthcare workers used existing communication channels to disseminate information about COVID-19. These included the media, text messaging and the UNICEF U-Report, posters displayed in healthcare facilities, and information-sharing during community events and in places of worship. Media actors who spoke with RiT reported attempting to work in partnership with other stakeholders and experiencing difficulties accessing information. They noted that collaborating with the government and humanitarian actors and

obtaining information from them were constant challenges they struggled to overcome.

Although response stakeholders (INGOs and NGOs, government health services, communication task forces, civil society, media, etc.) tried to coordinate their activities, local level community structures were largely excluded from these initiatives. For example, local community health workers or health promoters, community outreach units, and the Health Area Development Committees (CODESA) were not major components of the response plans.





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Additional problems included training and communication delays, stalled deployment of laboratory services to detect cases, vaccine shortages, and poor vaccine-related information campaigns (especially in Tanganyika). Particularly in Ituri, and more generally in all four provinces where the study was conducted, health authorities reported limited community support for healthcare personnel involved in the COVID-19 response; logistical delays that hindered the procurement of medical supplies; and failure to recognize the importance of using local labor and local languages in communicating health information and implementing response activities. Language was also identified as a weakness of response plans in the other provinces. In North Kivu, for example, these problems were exacerbated by communities' negative experiences with the Ebola response and vaccination campaigns, as detailed in the study by Translators Without Borders¹.

Pervasive issues hindering other humanitarian interventions in the eastern DRC's numerous crises reemerged in the context of the COVID-19 response. Conflict and insecurity prevented physical access to numerous communities. In other cases, community members felt that the recruitment of local facilitators was biased. General mistrust and the inadequate use of local languages in the response fueled rumors and misinformation. Countermeasures to correct such misperceptions were ineffective. Furthermore, the pandemic response failed to account for the specific needs of people living with disabilities, who cannot access audio and/or visual communications and thus risk missing crucial information.

Overall, the response to the COVID-19 pandemic was characterized by confusion, logistical constraints, and communication problems in regions where mistrust of healthcare workers and weariness from years of epidemic responses (Ebola, cholera) and violent conflict were deeply entrenched.

1. TWB, (2022), language data for the democratic Republic of Congo, Retrieved August 02, 2022 <https://translatorswithoutborders.org/language-data-for-the-democratic-republic-of-congo-drc>

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MAIN FINDINGS

- Communities consulted in the study demonstrated some knowledge of COVID-19. However, IDPs, people with disabilities, and small-scale cross-border traders needed more information about treatment; symptoms specific to COVID-19 versus other illnesses; vaccines (effectiveness; possible side effects; ages for men, women, and children to be vaccinated); and the COVID-19 test, which was introduced at the borders and required of travelers in all four provinces.
- Information priorities highlighted by participants included local news regarding general security, political developments within the country, and food aid at IDP sites.
- Radio is the most widely used information channel by IDPs, people with disabilities, and small-scale cross-border traders. Study participants also often cited community health workers or promoters, places of worship, community events, humanitarian organizations, and local organizations as sources of information.
- The trustworthiness of information is determined by a combination of how frequently it is shared in the community, the use of local languages, and the level of detail included in its content.
- Trustworthiness of information is also affected by perceptions of the credibility of its source. People who are close to the community, know the local languages, and verify information before disseminating it are seen as the most reliable. This includes religious leaders, local community health workers, relatives, and friends. People also trust community radio stations, local organizations, and humanitarian aid organizations as sources of accurate information.
- Several obstacles prevented surveyed communities from accessing relevant and precise information about the pandemic. These included poverty; daily survival concerns (food and safety), especially for women; the language and format of the information (especially for people with disabilities); mistrust of the media, government, and humanitarian actors; instability;

and the lack of mechanisms through which information could be verified and the spread of rumors managed.

- Most information on COVID-19 was disseminated in French and Swahili. Even though each province adapted messages into local languages, these efforts excluded some important minority languages. One-third of surveyed IDPs reported not having received information in their preferred language, which hindered comprehension and negatively impacted credibility.
- Information on COVID-19 positively influenced community awareness, attitudes, and behavior by promoting certain hygiene practices, such as regular handwashing. Misinformation also had negative impacts. Some people began viewing healthcare centers and services with suspicion and started avoiding routine vaccinations and prenatal and postnatal visits, which led to the resurgence of some epidemics (including measles in Tanganyika).
- The COVID-19 response was implemented by multiple stakeholders who struggled to collaborate and coordinate. Their efforts were further undermined by inadequate financial resources; poor organization; some partners' noncompliance with zonal divisions; delays in the logistical deployment of materials and laboratory services to detect cases; and vaccine availability (in Tanganyika and Ituri).
- The system of risk communication faced various challenges, especially in terms of the initial language of communication (mainly French), which limited information access for individuals unable to read or write; low engagement with community dynamics; poor collaboration and communication between health authorities and the media; lack of training of local stakeholders in disseminating information; compromised recruitment of stakeholders for the awareness-raising campaign; and use of a workforce not from the community by some humanitarian aid organizations. Security issues aggravated this situation, preventing access to several areas in the four provinces. Effective risk communication was

also hampered by inadequate media coverage in Ituri and Tanganyika; disinformation and skepticism of some influential community leaders (religious leaders, politicians, and healthcare providers); and a weak monitoring and response system to counter COVID-19 rumors.

The Pandemic Amidst Popular Concerns and Priorities

For most people, the struggle of daily survival and information crucial to it – such as developments related to security, food access, income-generating opportunities, and general healthcare – took precedence over COVID-19 concerns. IDPs who participated in the study were surprised that the government and humanitarian actors alike prioritized responding to the pandemic over resolving ongoing violent conflict, addressing safety concerns, or improving their living conditions. COVID-19 information was not a priority for IDPs in the four provinces. On the contrary, they reported needing more information on how to access humanitarian aid. IDPs wanted to know when humanitarian aid would arrive, who would provide it, and what type of aid it would be. Those surveyed said that their lives were more threatened by hunger and physical insecurity (clear and present danger) than by the pandemic.

Understanding of the Pandemic

Only 1.8% of surveyed IDPs reported being completely informed about COVID-19 prevention; 33% felt they had sufficient information on preventive measures; and 24.9% said they received some information on the signs and symptoms of COVID-19. However, 40.7% considered their knowledge of the pandemic to be very limited, and 55.4% felt they had no information whatsoever on COVID-19 treatment.

IDPs wanted more information on treatment (18%); signs and symptoms of the virus (16%); COVID-19 prevention (16%); and how to access information on the pandemic in general (12%).





Language

One of the main obstacles to accessing information about COVID-19 was the language in which information was communicated. Nearly one-third of study participants in Ituri, South Kivu, and Tanganyika reported not having received information in their preferred language. In North Kivu, this figure increased to 46% of participants. It was more often the case when information was provided in French, Swahili, or Lingala. This not only impaired comprehension, but also impacted trust: 57% of participants viewed language as an important or key determinant of the trustworthiness of information.

Trust in Sources of Information

Religious leaders and personal networks (friends and family) were identified as credible sources of information. Of the individuals surveyed, 53.1% claimed to have a lot of or complete trust in religious leaders, 42.5% in friends and family, and 38.1% in community leaders. Community health workers and promoters, community radio stations, humanitarian aid organizations, and local organizations also benefitted from the absolute trust of many respondents (37%, 31.9%, 30%, and 24.4%, respectively). Only 9.6% of IDPs reported having absolute confidence in professional medical staff.

Mistrust of Non-Local and Government Sources of Information

The media and government did not inspire confidence. Nearly 40 percent of survey respondents did not trust international media; the same percentage did not trust government media. National government authorities, national media, and provincial government authorities did not garner much trust either (36.3%, 35%, and 30.3%, respectively).

Most Frequently Used Information Sources

According to IDPs, their main sources of information are the radio (35% said they used it “very often”), places of worship



(22.5%), community health centers (Reco) (18.9%), and word-of-mouth from friends and family (16.8%). Information shared by word-of-mouth generally came from radio broadcasts whose content had been verified using other sources, such as community and religious leaders’ announcements.

The Most Rarely Used Information Source: The Internet

WhatsApp (5.2%), online media (3.9%), and social media (3.9%) were less popular information sources. The fact that Internet access in rural areas of the DRC is limited and very expensive accounts for these results.

Effects of Misinformation and Rumors Surrounding COVID-19

During focus group discussions (FGDs), most IDPs, especially women, conveyed that they were afraid to use health-care facilities for their children’s routine vaccinations and for prenatal and postnatal care. This mistrust of healthcare services and providers was rooted in rumors positing the COVID-19 vaccine as a conspiracy to sterilize the population through alleged vaccination against the virus. Difficulty distinguishing rumors from reliable information reinforced these suspicions and fears.



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RECOMMENDATIONS

General Recommendations:

- Adapt messages to the context of each province to reach populations in areas with no media coverage. Engage local experts known by the community in risk communication strategies because their trustworthiness extends to that of the information they convey.
- Before disseminating information, assess which languages the target population speaks and incorporate their language preferences in communication strategies.
- Provide an initial professional translation of the information into local languages to lower the risk of messages being distorted and transformed into misinformation or rumors.
- During content production, keep people with disabilities in mind and choose adaptive formats. Identify what these formats are in different communities.
- Adapt COVID-19 messages to address people's other priorities in terms of information, such as poverty alleviation, armed conflict resolution, and humanitarian assistance for IDPs and victims of other diseases endemic to the region, especially Ebola.
- When working with marginalized groups, such as the Twa, engage their community representatives to provide information in their preferred language and format.
- Work with individuals trusted by the community, including community health workers and promoters, community outreach workers, religious leaders, etc. Strengthen their capacities in information dissemination and risk communication.
- Use individuals who have recovered after contracting the virus as resources to share their experiences with their fellow community members. It has been observed that their testimony largely contributes to increased awareness, especially in areas with fewer identified cases and less organized care management.
- Encourage interactive programs and activities to collect community feedback and provide timely answers to participants' questions.

For Humanitarian Actors:

- Leverage diverse information channels by connecting media outlets to other means of communication and information dissemination (churches, health authorities, civil society associations, NGOs, town criers, etc.).
- Consider an advanced stationary approach², an expedient mobile radio system that can be installed in a village or market to broadcast messages.
- Study and analyze popular perceptions and incorporate the results into the design and implementation of the response.
- Conduct rapid preliminary surveys of target populations' current knowledge of pandemic-related topics and use the findings to develop effective, relevant risk communication strategies.
- Align and associate COVID-19 messaging with other community priorities and needs.
- Strengthen the capacities of information providers, especially community outreach and health workers, religious leaders, and the media.
- Increase support for local media actors.

For the Government:

- Reinforce collaboration between healthcare providers and the media to improve information access for media actors and dissemination efforts for medical professionals.
- Provide small transmitters to distant villages to facilitate information diffusion and access.
- Focus not only on training of journalists, but also on advocating for improved working conditions for media actors, including contracts and salaries.
- Support community radio, especially rural stations, by supplying them with equipment and powerful transmitters to increase coverage in rural areas.
- Provide technical and material support to revitalize fundamental community structures to improve information dissemination at the local level.

For the Media:

- Strengthen the capacities of journalists; encourage practical training.
- Organize town forums that enable communities to voice their preoccupations and concerns.
- Increase the number of radio ads and programs that raise awareness about the pandemic.
- Support and broaden local communication efforts so that vulnerable groups (IDPs and marginalized Twa communities) can access health information. In Tanganyika, it was observed that despite resistance and mistrust of the healthcare system, some informed members of the Twa community began approaching healthcare professionals for information on COVID-19.
- For online media: promote field missions to engage and connect with the community and assess their information needs and priorities. Incorporate these insights into content development. ▶



2. This approach was used in the markets in Goma by UCOFEM, one of the partner organizations implementing the RIT 2.0 project.

METHODOLOGY

This IEA employed a mixed methods (qualitative and quantitative) research design to identify the information needs and preferred information channels of internally displaced persons (IDPs), minority groups (including Burundian refugees), and small-scale cross-border traders in the eastern DRC's Ituri, North Kivu, South Kivu, and Tanganyika provinces. These research sites were chosen because they are disproportionately impacted by chronic humanitarian and health

crises, including violent conflict and frequent disease outbreaks (Ebola and COVID-19). The study focused on often marginalized minority groups as they are under-represented, vulnerable communities living in precarious, unstable conditions, and thus at heightened risk during disasters.

Not all targeted populations were surveyed in each province; the table below specifies which groups participated in the study in each

province. Participant selection was led by partner organizations implementing the RiT 2.0 project³. In this research, they were collaborators who collaborated in the design of research tools, facilitated primary data collection, and contributed to the dissemination of findings to stakeholders, including participating communities.

³ Implementation partners for the RiT 2.0 project who participated in primary data collection in the various provinces were UCOFEM in North Kivu, Pole Institute in Ituri, and AFEM in South Kivu and Tanganyika.

TABLE 1 : STUDY AREAS AND TARGET GROUP DIVISIONS

PROVINCES	SPECIFIC HEALTH ZONES	TARGETS
ITURI	*Salama Site, *ISP, *Kigonze High School	IDP community
NORD-KIVU	*Munigi and *Kahembe	IDP community
	Goma	Small-scale cross-border traders
	*Butembo	IDP community
	*Beni	IDP community
TANGANYIKA	*Kalemie ville	IDP community and Twa minority groups
	*Kalemie territoire	IDP community
	*Moba	IDP community
SOUTH KIVU	Bukavu	Small-scale cross-border traders
	*Kamanyola	IDP community, Banyamulenge minority groups, and small-scale cross-border traders
	*Fizi (Lusenda)	IDP community and Burundian refugees



METHODOLOGY

The **qualitative component** of the study comprised focus group discussions (FGDs) with small-scale cross-border traders and semi-structured interviews. Across the four provinces, 36 interviews were conducted with key informants,

experts on the research topics. Forty interviews had been scheduled but some participants were not available for interviews. Among those who participated were members of humanitarian and health organizations, government authori-

ties, media professionals, local community representatives, leaders of associations for people with disabilities, and religious leaders.

TABLE 2 : DETAILS OF KIIS

PROVINCES	KII NUMBER	INFORMANT TYPE AND POSITION	SEX
SOUTH KIVU	9	MSF Communications Officer	Female
		Director, Friends of Children Journalist Network	Male
		Vice President, Civil Society Coordinating Office	Female
		Editor, Radio Maendeleo	Male
		Program Director, Radio Flash FM Kamanyola	Male
		Coordinator, Kamanyola Guidance Center for the Social Promotion of Persons with Disabilities	Male
		Program Director, Kamanyola Community Radio	Male
		Supervisor, Health Information, Communication, and DPS Research	Male
		Pastor, CEPAC Kamanyola Protestant Church	Male
NORTH KIVU	10	Division Head, Communication and Media	Male
		Supervisor, RCCE	Male
		President, Organizations for Persons with Disabilities	Female
		President, Congolese Civil Society	Male
		Protestant Reverend	Male
		President, National Press Union of the Congo (UNPC North Kivu)	Female
		Director, Reporter.net (online media)	Male

METHODOLOGY

<i>NORTH KIVU</i>	10	Field Agent, Ebola and COVID-19 project, Mercy Corps	Female
		Program Director, Taina Community Radio (RTCT)	Male
		Officer in Charge of Strategic Planning Research, MONUSCO Grand-Nord	Male
<i>ITURI</i>	8	Division Head, Communication and Media	
		Supervisor, RCCE	Male
		Field Agent, COVID-19 project, CARITAS development	Male
		Deputy Supervisor, CBO	Male
		President, Religious Denominations of Ituri	Male
		Communications Officer, Federation of Associations for Persons with Disabilities	Male
		Director, Bunia infos24	Male
		Director, Ituri Kwetu.net	Male
<i>TANGANYIKA</i>	9	Supervisor, Health Information, Communication, and DPS Research	Male
		Division Head, Tanganyika Communication and Media	Male
		President, Tanganyika Network for Women in Media	Female
		President, Religious Denominations of Tanganyika	Male
		President, Tanganyika Organizations for Persons with Disabilities (PWD)	Male
		President, Tanganyika Civil Society New Dynamic	Male
		Program Director, RTNC Tanganyika	Male
		Director, Journalist and Reporters Network (RJR)	Male
		Department Head, Communication for Development (C4D), UNICEF Tanganyika	Male



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In addition, eight FGDs were held, two per province. Each FGD was composed of 10 participants, equally divided between men and women, totaling 80 people (40 men and 40 women).

The **quantitative component** focused on IDPs and comprised a survey (structured questions) of 384 IDPs. An indicative sample was identified for each province, with 96 people surveyed per province (50-50 distribution between men and women). For each province, several health zones were selected for quantitative and qualitative data collection. Surveys were conducted in health zones marked with an asterisk in Table 1.

The research team used SPSS and Excel to clean, code, and analyze the data.

An additional **linguistic research component** was undertaken in Tanganyika consisting of FGDs and semi-structured interviews that focused on the language and communication aspects of disseminating information about COVID-19. CLEAR Global/Translators without Borders consulted 175 community members across eight research sites. The age of participants ranged from 18 to 68 years. Population subgroups sampled in this part of the study were IDPs and marginalized Twa minority groups. To permit comparative analyses, participants also included community members, youth, fishermen, and motorcycle taxi drivers in the city of Kalemie. Twenty-four interviews were conducted with religious, political, and traditional community leaders, physicians and medical personnel in different health zones and provincial health districts (DPS), journalists, and humanitarian staff. ▶

In March of 2020, the DRC recorded its first case of COVID-19, in Kinshasa. A national plan was developed to coordinate the response. The national plan was then disaggregated into provincial response plans. Each province was responsible for adapting the national plan to its context and local realities.

Each province's response plan included eight components: coordination, epidemiological monitoring, risk communication and community engagement (RCCE), infection prevention and control (IPC), medical and psychosocial care management, laboratories, and logistics. The pandemic response plan was implemented at three levels: the macro or national level, the intermediate or provincial level, and the operational or zonal level. A coordination committee was established at each level (national, provincial, local). After the plan was adapted at the provincial level, each component had to develop a work plan to identify outstanding needs, stakeholders, and implementation partners.

In the provinces, response coordination took place at two levels. Strategic response coordination was led by the political-administrative authority under the state Ministry of Health; provincial health districts were charged with sub-coordination. In addition to the national plan, specific programs were piloted based on need, like the distance learning program initiated by the government and its partners. According to UNICEF Tanganyika, the primary purpose of this program was to broadcast the curriculum via media outlets. To this end, UNICEF distributed receivers to households and IDP sites in rural areas, but demand exceeded supply.

The humanitarian response to COVID-19 faced similar challenges in all four provinces. Insufficient financial resources prevented effective implementation of the plans, and study participants stressed a lack of coordination, which was also related to competition for funding. Technical services

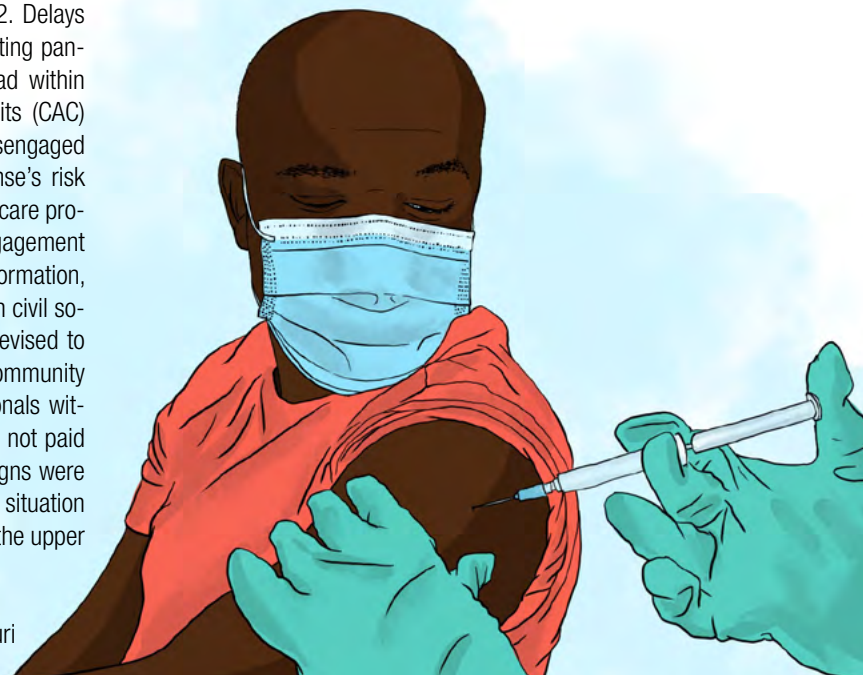
were poorly monitored, and the response was plagued with inconsistencies. As a member of the provincial health district noted, *"When funds are available, partners carry out activities without informing or involving the DPS [provincial health district]"* (Interview with the Tanganyika DPS Communication and Research Department, Kalemie, 28 June 2022).

This situation was more common in Ituri and Tanganyika, where some partners did not respect zoning divisions and excluded health zones, which are the implementing bodies for health-related activities at the community level. This lack of coordination led to delays in implementation and poor community ownership and engagement.

Other shortcomings were reported in Tanganyika, which did not have a laboratory for case detection until 2022. Delays in training of individuals responsible for communicating pandemic-related information allowed rumors to spread within communities. Members of community outreach units (CAC) and health workers and promoters gradually disengaged from the response, further undermining the response's risk communication strategy. Eventually, provincial healthcare professionals went on strike, compounding the disengagement of community outreach and health workers. Misinformation, suspicion, and rumors continued to spread, and even civil society actors believed that the COVID-19 test was devised to generate profit rather than combat the pandemic. Community outreach and health workers and medical professionals withdrew from their responsibilities because they were not paid for their work. COVID-19 awareness-raising campaigns were simply underfinanced. In some areas, however, the situation inflamed suspicions of misappropriation of funds by the upper echelons of the response.

In addition to funding issues, health authorities in Ituri faced other complications. Delivery of medical sup-

plies to the province, especially vaccines, was delayed, and vaccines expired before they could be used. Such was the case, for example, for vaccine doses that arrived on site a few days before their date of expiry. Furthermore, linguistic considerations were ignored in risk communication strategies and awareness-raising activities were conducted only in French and Swahili. Implementing partners engaged in the response also failed to engage local labor, depriving communities of potential jobs and reinforcing suspicion and mistrust. The response plan was further weakened by its focus on people of higher socioeconomic status rather than on the general population (Interview with a key stakeholder in an organization for people with disabilities, Bunia, June 2022). ▶



COLLABORATION AND COORDINATION PROBLEMS IN THE COVID-19 RESPONSE



From the onset of the pandemic, humanitarian aid organizations rallied to support the response in collaboration with the government. These included UN agencies and international, national, and local organizations. Multiple organizations participated in the response plan across the four provinces, depending on their geographic coverage and area of intervention. Some programs were implemented regionally. These organizations collaborated with local government structures, religious institutions, civil society organizations, and government ministries to carry out activities.

Stakeholders interacted through multi-sectoral response coordination working groups at the provincial and operational levels. Stakeholder meetings were held regularly at the beginning of the pandemic. The different clusters brought together national, local, and humanitarian partners. These meetings encouraged interaction and provided a channel for sharing information, materials, and directives on preventive measures, and for harmonizing messages about COVID-19.

Media actors interviewed by RiT positively assessed their overall level of collaboration with partners and other response actors. They reported that some UN agencies and NGOs had established partnerships that predated the pandemic. These included technical support, capacity-building for journalists, and financial backing for the production of demos and other COVID-19-related communication products (Interview with a media actor, Kamanyola, 24 May 2022).

Despite media actors' favorable evaluation of their partnerships, collaboration between the media and humanitarian stakeholders remained strained. The project team found that media actors struggled to obtain information from humanitarian aid organizations. These difficulties were compounded by strict regulations that further hampered collaboration during the pandemic. The media had similar issues collaborating with government services. One journalist explained: *"The government does not communicate easily. When they want to speak with you, they call you, but when you need information from them, they play games"* (Interview with a media actor, Goma, 16 May 2022). ▸

RISK COMMUNICATION AND COMMUNITY ENGAGEMENT IN THE COVID-19 RESPONSE: STAKEHOLDERS, STRATEGIES, CHALLENGES, AND EFFORTS TO CURB MISINFORMATION

The Risk Communication and Community Engagement (RCCE) component of the response is organized through sub-coordination at the provincial level and through community facilitators who work with various stakeholders at the zonal level.

In all four provinces, healthcare workers leveraged standard communication channels used by the community to disseminate information about COVID-19. For example, the Ituri DPS has 36 community outreach units across health zones, including community participation structures and outreach workers in the health areas. The community communication strategy put in place by the outreach units (CACs) was adapted to each context and included awareness-raising campaigns, home visits, educational town hall sessions, and training

for community leaders. In addition, the U-Report messaging system developed by UNICEF was employed to collect community feedback. For undereducated populations, community outreach and health workers and promoters used in-person, oral messaging in the local language.

In terms of the magnitude of stakeholders and partners involved in these efforts, provinces were prioritized based on the epidemiological context and rate of spread. Consequently, more response actors were engaged in risk communication in North and South Kivu than in Tanganyika and Ituri. Mechanisms of risk communication also involved religious institutions, civil society organizations, and other government ministries, such as the Communication and Media Department of Provincial Health Districts, as well as media outlets.

CHALLENGES AND SHORTCOMINGS IN COMMUNITY ENGAGEMENT AND COVID-19 COMMUNICATION

The risk communication strategy was not adapted to local realities, which undermined its effectiveness at best and exacerbated the problems it was meant to resolve at worst. For example, an NGO working with governments to provide healthcare in resource-poor communities organized an online training session for local outreach workers to equip them to deliver information regarding COVID-19. This approach was not adapted to the context of Tanganyika, where community outreach and health workers live in villages without smartphones and where Internet coverage is limited and unaffordable.

Community health workers and promoters and members of (CACs) were undercompensated or not compensated at all for their work and therefore underperformed or disengaged completely from their risk communication tasks. In addition, some healthcare professionals remained skeptical of the dangers posed by the pandemic. Health authorities in Tanganyika, for example, did not adequately explain or promote the vaccination campaign, which also received scant media coverage. Recruitment processes for local outreach workers and the limited training they received amplified these problems. In Ituri and Tanganyika, civil society actors reported that some humanitarian aid organizations regularly employed facilitators from outside the area of intervention. They had limited understanding of the local context and did not speak the local languages. Members of local communities thus viewed them as strangers, with skepticism and distrust.

Due to insecurity and safety concerns, some vulnerable communities were inaccessible. The use of radio for risk communication ignored the fact that large parts of Ituri and



RISK COMMUNICATION AND COMMUNITY ENGAGEMENT IN THE COVID-19 RESPONSE: STAKEHOLDERS, STRATEGIES, CHALLENGES, AND EFFORTS TO CURB MISINFORMATION

...

Tanganyika do not have radio coverage. Moreover, risk communication was not adapted to the special needs of some people with disabilities, such as those with hearing and/or vision impairments.

In some provinces, political leaders and government authorities themselves undermined the risk communication strategy by voicing their misgivings and disseminating erroneous information. For example, in Tanganyika, the provincial authority denied the pandemic's existence, reinforcing popular mistrust of and public resistance to the COVID-19 response.

MECHANISMS FOR MONITORING RUMORS AND COMMUNITY FEEDBACK

Information feedback mechanisms were first developed by the RCCE component through sub-committees (radio, religious denominations, interpersonal communication via the CACs and community health workers and promoters, etc.). They collected feedback from the community regarding their knowledge of the disease, symptoms, prevention, and vaccination. As part of the vaccination component, another mechanism was put in place to provide feedback through reporting forms for immunization side effects.

Some humanitarian organizations involved in the COVID-19 response set up digital tools (applications) to collect perceptions, misinformation, and rumors on social media. By tracking social media, RiT was able to monitor online rumors thanks to specialized software, the "Talkworker". RiT's implementation partners also organized community forums and round tables in the provinces to gauge misperceptions and disinformation.

During the Ebola outbreak in Beni, North Kivu, some organizations reported having used Viamo and Dimagi via a mes-

saging system sent to users. Poor Internet coverage limited the practicality of this approach. In rural areas, suggestion boxes were used. Toll-free numbers were also available to respond to concerns by direct call, and radio stations offered interactive programs that allowed listeners to call in and ask questions.

Language was an issue during the processing of feedback received in local languages. Humanitarian aid workers had difficulties translating and transcribing information because they lacked personnel familiar with the languages, terminology, idioms, and local context (Feedback collected during a town hall, Kalemie, 30 May 2022). ▶



DEMAND FOR INFORMATION AT THE COMMUNITY LEVEL: PRIORITIES AND NEEDS

In all four provinces, IDPs spoke of physical, economic, and social insecurity. During focus group discussions, they said they felt abandoned by political and administrative authorities as they struggled to meet their basic needs without government assistance. Women stressed water shortages, issues accessing health care, and the need for more food aid. IDPs also expressed a desire to return to their villages of origin and wanted more information about them (FGDs with IDPs, Kamanyola, 19 May 2022; FGDs with IDPs, Kyomba, 24 June 2022; FGDs with IDPs, Kigonze, 4 June 2022).

Unsurprisingly, IDPs identified a gap between the COVID-19 information they received and the information they wanted to receive. Only 18% of survey respondents wanted information on treatments and treatment sites; 16% wanted to know more about the signs and symptoms of the virus; 16% wanted to know more about prevention; and 12% wanted to know more about how to access pandemic-related information generally. Equally unsurprisingly, only 1.8% of surveyed IDPs reported feeling completely informed about COVID-19 prevention, whereas 33% expressed feeling sufficiently informed regarding preventive measures, and 24.9% felt sufficiently informed about the signs and symptoms of the virus. Over half of participants (55.4%) felt they had no information about COVID-19 treatment.

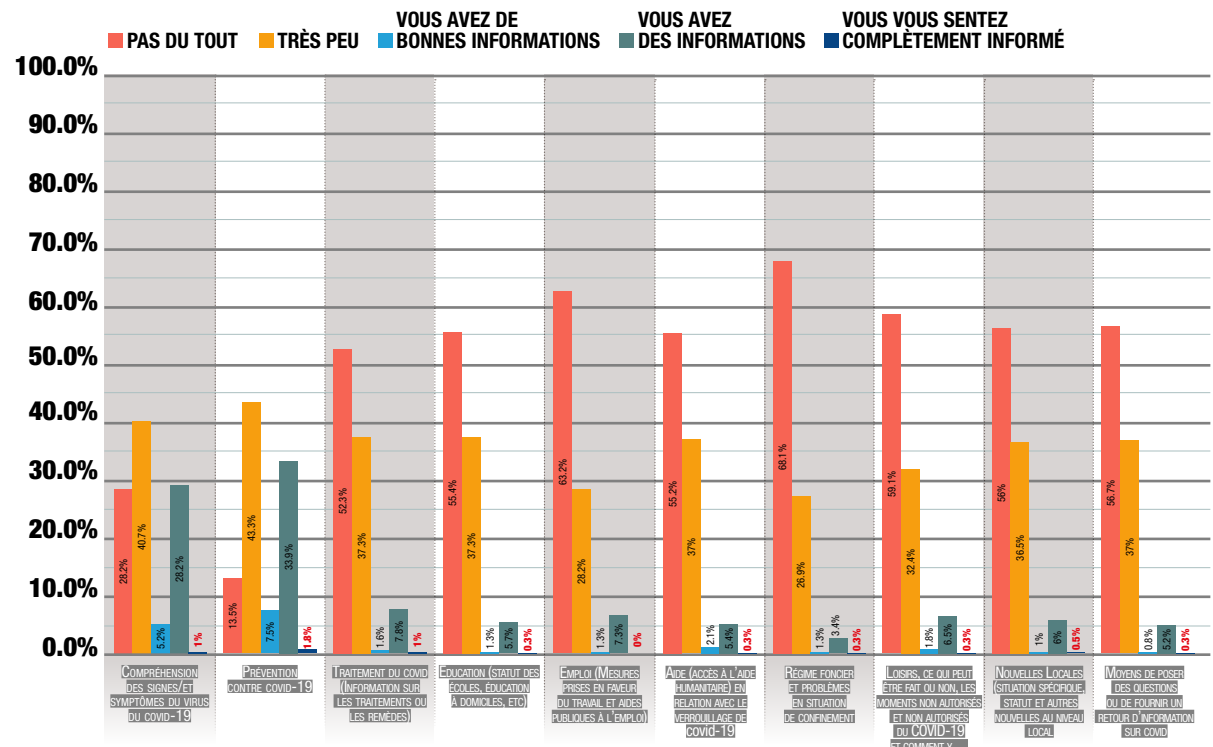
During focus group discussions, IDPs in North Kivu and Ituri emphasized the need to better understand the state of siege under which both provinces had been operating since May 2021, including its purpose and results to date (FGDs with IDPs, Munigi, 13 May 2022; FGDs with IDPs, Kigonzi, 4 June 2022). IDPs in Ituri and Tanganyika also emphasized security and conveyed that it should be prioritized by the government over the dissemination of information about the pandemic. Persistent tensions between the Bantu and Twa (Tanganyika) and the Hema and Lendu (Ituri) were pressing concerns.

One FGD participant explained: “The government has failed to end the war. They talk about COVID-19. They say that it kills people, but not as much as the CODECO do here. Instead of giving us the COVID-19 vaccine, it would be better if they ended the war here first” (FGD with IDPs, Kigonze, 4 June 2022).

IDPs in Ituri were surprised that humanitarian workers and the government focused more on COVID-19 than on conflict and security concerns. “Every time there is a war in the east that kills a single ethnic group, what is the government thinking? Since we’re asking white people for money to fight against

COVID-19, why not also ask them for money to disarm those who are waging war? We’ve been eating the same food for three years. If only we could return to our villages! Schooling has become a problem at the site because parents don’t have the money to pay tuition fees” (FGD with IDPs, Kigonze, Bunia HZ, 4 June 2022). Internally displaced youth in all four provinces were equally concerned with issues of security, governance, and politics. As one participant said during a focus group discussion, “If you don’t deal with politics, it will deal with you” (FGD with displaced youth, Kokolo, Nyemba HZ, 24 May 2022).

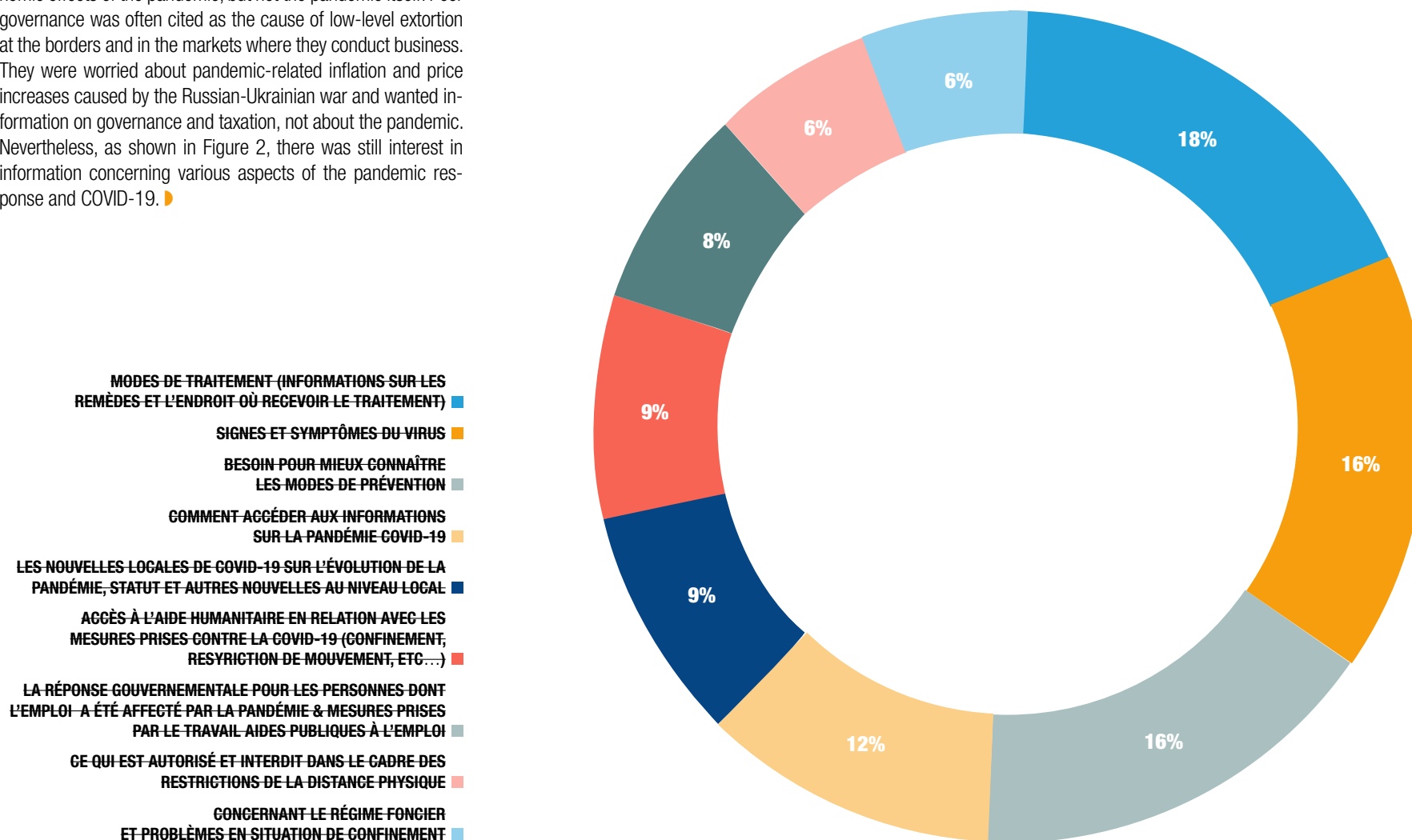
FIGURE 1. COMMUNITY SELF-ASSESSMENT OF RECEIVED INFORMATION ON COVID-19



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FGDs with small-scale cross-border traders in North and South Kivu also showed that prevailing concerns were more urgent than COVID-19. They discussed poor governance and the economic effects of the pandemic, but not the pandemic itself. Poor governance was often cited as the cause of low-level extortion at the borders and in the markets where they conduct business. They were worried about pandemic-related inflation and price increases caused by the Russian-Ukrainian war and wanted information on governance and taxation, not about the pandemic. Nevertheless, as shown in Figure 2, there was still interest in information concerning various aspects of the pandemic response and COVID-19. ▶

FIGURE 2. COMMUNITY INFORMATION NEEDS REGARDING COVID-19



THE MEDIA'S ASSESSMENT OF LOCAL COMMUNITIES' INFORMATION NEEDS, INCLUSIVITY, AND DISSEMINATION CHALLENGES

Internews asked different media outlets and actors how they ensure that the information they provide is locally relevant. Traditional media outlets, community radio stations (South Kivu), and online media outlets (Ituri) said they collected feedback using phone messaging (short message services), interactive programs via hotlines and call-ins, and comment sections on news stories published online and on social media (WhatsApp groups, Facebook, etc.). Online media outlets also monitored the number of people who viewed an online article and directed readers' queries to its authors.

Media outlets in South Kivu reported identifying hot topics in the community by asking questions and gathering community reactions, complaints, and impressions concerning various subjects. In Tanganyika this was accomplished using postcards: *"The mechanism consisted of leaving postcards with households in the morning and collecting them in the evening to tally them. This enabled the media to know what types of information the community wanted to prioritize"* (Interview with a media actor, Kalemie, June 2022).

Some media outlets also reported setting up listening clubs in local languages to reach vulnerable and marginalized groups. Listening clubs were frequently employed by radio stations in North Kivu, South Kivu, and Tanganyika. They served as a bridge between the community and the radio station. In Tanganyika,

4. The listening club approach consists of facilitating a group discussion among members of a radio audience. The discussions were based on themes addressed in aired programs, while participants also proposed other subjects of interest.
5. The advanced stationary approach is an innovative development of the traditional town crier method of disseminating information. Here, information is translated into the local language, transferred to a USB key, and broadcasted from a speaker attached to a bicycle. The awareness-raising campaigner cycles from village to village very early in the morning when families are going to the fields to ensure they hear the broadcasted news. This approach was used in areas with poor media coverage.

listening clubs were complemented by what is known as the advanced stationary approach⁵ (an innovation on the commonly used town crier method), traditional town criers, and educational discussions with journalists.

In North Kivu, media strategies aimed at marginalized groups focused on local languages – rarely used in broadcasting – to increase inclusivity. One media actor noted, *"On our program schedule, we tried to create cultural programs where each community could express itself in its mother tongue. We had Kinyarwanda, Kinyanga, and Kinande so that those who didn't understand in Swahili could catch up [on missed content] in their native language"* (Interview with a key media actor, Goma, May 2022).

Religious denominations have audiences across the four provinces and functioned as additional channels through which to reach vulnerable groups. In Tanganyika, for example, faith-based organizations, with an emphasis on children, leveraged the Baptism, Vaccination, and Birth Registration (BAVE) to disseminate important information to their communities. This approach involves multiple stakeholders who encourage congregations to register children at birth, baptize them in the church, and vaccinate them at health centers. These messages were paired with information on COVID-19 when disseminated (Interview with a religious leader, Kalemie, June 2022).

According to humanitarian actors consulted by Internews, vulnerable groups were also reached by civil society organizations and community-based organizations (CBOs) comprised of customary government representatives and community leaders. Some humanitarian workers felt that media outlets, community outreach units, and community health workers and promoters complemented one another in disseminating information, each covering areas the others could not.

In South Kivu, for example, CBOs helped NGOs reach people living with disabilities: *"Among our CBOs, we have people living with disabilities, like the deaf or deaf-mute. We had a sign language translator. During outreach activities, there was also a translator who accompanied us to translate for this vulnerable group who don't understand the common languages"* (Interview with a humanitarian stakeholder, Bukavu, May 2022).

According to health authorities, community health workers and promoters bridge the gap between healthcare services and communities. Community health workers can reach vulnerable groups, including those which speak minority languages. During the COVID-19 pandemic, however, there was an observed decrease in the engagement of community outreach, and health workers and communities themselves were not heavily involved in the process of message transmission, from training to dissemination.

In Ituri and Tanganyika, community outreach and health workers reported that humanitarians, as part of the response, brought in people who were not familiar with the context or local language and were not known or trusted by the community. This resulted in ongoing resistance to and mistrust of COVID-19 response teams. In Tanganyika, some civil society actors reported that those recruited for COVID-19 training had been poorly selected, and that trusted community actors were not engaged in the response.

The dissemination of pandemic-related information was further hampered by poor Internet access, persistent language barriers, insecurity and conflict, and insufficient financial resources. Very few IDPs, and few Congolese in general, have regular access to the Internet, electricity, or smartphones. Moreover, Internet penetration is low and prohibitively expensive for most people. One online media actor commented: *"If we have to reach marginalized*



THE MEDIA'S ASSESSMENT OF LOCAL COMMUNITIES' INFORMATION NEEDS, INCLUSIVITY, AND DISSEMINATION CHALLENGES

...
people, we need a lot of resources" (Interview with an online media actor, Bunia, June 2022). Online media content is also largely produced in French, a language that not everyone speaks, reads, or writes. Other media outlets that produce written content also primarily publish in French and Swahili. This presents an obstacle to reaching some vulnerable communities, such as IDP and minority groups, whose educational levels are often relatively lower than those of the general population. As the quantitative data show, 43% of respondents reported not having received infor-

mation in their preferred language since it was only available in French. Respondents who did not have access to information in their preferred language asserted that information was generally provided in Swahili (20%) or Lingala (6%).

In all four provinces, protracted violent conflict impeded physical access to some areas and prevented humanitarian aid workers from reaching certain populations. IDPs living in conflict zones were less likely to receive timely information. Another challenge

was the lack of funding for dissemination campaigns. As health actors who spoke to Internews highlighted, *"For most activities, the BCZ of Nyangezi (where the village of Kamanyola is located) waited for a partner to arrive and provide the necessary financial resources to carry out the activity"* (Interview with a government [health] actor, Bukavu, May 2022). The dearth of funds made it difficult to supply information products and broadcasts. In some parts of Ituri and Tanganyika, where media coverage is non-existent, people had practically no access to information. ▶



INFORMATION ACCESS: COMMUNITIES' SOURCES OF INFORMATION

Information that circulated among the general population, and within IDP communities in particular, originated from various sources and traveled through diverse channels.

Thirty-five percent of people reported using the radio very often to receive information; 22.5% said they relied on their place of worship; 18.9% on community health workers and promoters (Reco); and 16.8% on friends, family, and acquaintances, who shared information in person.

Very few IDPs (5.7%) reported having regularly ('very often') accessed information through community events, and even fewer reported using television (5.2%), WhatsApp (5.2%), online media (3.9%), social media (3.9%), YouTube (2.3%), or newspapers (1.8%). Those who reported using the Internet to access information resided in IDP sites near urban areas, such as Kigonze, located on the outskirts of the city of Bunia, and Kanyarucinya in Nyiragongo, close to the city of Goma. Other IDPs with access to the Internet were those who lived with host families in the cities of Beni, Butembo, Kalemie, and Kamanyola.

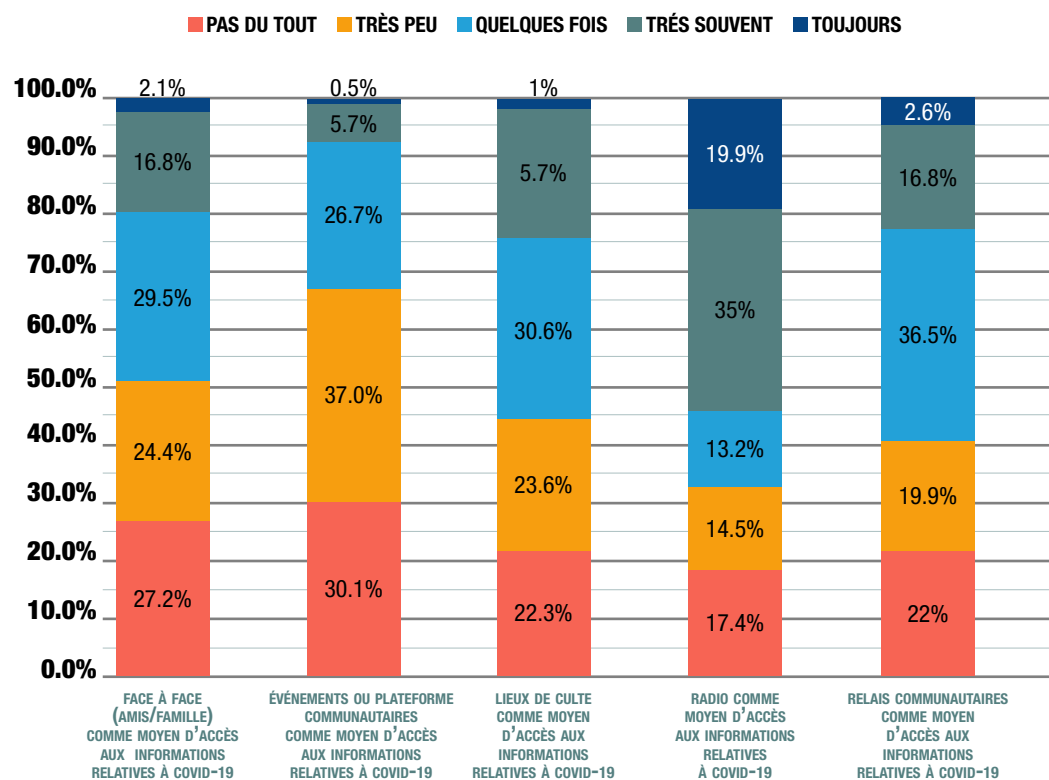
Very few IDPs reported using television or newspapers to access information, in part due to their low incomes and in part because of their low literacy levels. IDPs are less likely to have access to electricity and television sets, which are expensive and cannot be carried when moving from place to place. The cost of telephones and television sets is also prohibitive for small-scale cross-border traders: *"Many of us want to watch the news on television, but with the power cuts in the city of Bukavu... Many people aren't able to have a telephone with WhatsApp because of poverty, and many others haven't gone to school"* (FGD with small-scale cross-border traders, Bukavu, 18 May 2022).

RADIO AS AN INFORMATION CHANNEL FOR IDPS

Radio is the main consistent source of information for IDPs. Thirty-five percent of surveyed IDPs reported that the radio was very often their preferred channel for accessing information, while almost 20% stated that they always used the radio to access pandemic-related information. Frequency of use, however, varied by site. IDPs in South Kivu, North Kivu, and Ituri had the

most exposure to radio broadcasts thanks to their proximity to urban centers and cities. Kamanyola community radio – Flash FM radio of Kamanyola in South Kivu – even accommodated IDPs and developed programs specifically for them, such as "Sautiya Muhamiyaji". In North Kivu, Radio Moto of Beni and other stations like Pole FM and Taina Community Radio (RTCT) broadcasted in the city of Goma. In Ituri, IDPs could listen to Radio Candip, located a few feet from the Kigonze IDP site.

FIGURE 3. COVID-19-RELATED COMMUNITY INFORMATION SOURCES





One radio often served several listeners at the same time, and the broadcasted information was then relayed to several households in the IDP site. Others gathered in the evening to listen to the radio and share the news with community members at the site. During focus group discussions, participants relayed that despite the constraints, particularly poverty, that prevented most households from owning a radio, many IDPs considered it a regular, reliable, and trustworthy source of information on a diverse range of topics. For these reasons, radio is ranked first in terms of information providers. Small-scale cross-border traders in South Kivu also preferred the radio as a channel for accessing information because they felt that journalists verified information before broadcasting it to the public.

PLACES OF WORSHIP

Among surveyed IDPs, 22.5% reported that they received information about COVID-19 'very often' at church, and 1% said that they 'always' received information about the disease at church. Religious leaders discussed preventive measures, such as handwashing, mask-wearing, social distancing, etc. Those interviewed by Internews stated that their churches were important channels for spreading messages because most of the population in eastern DRC is Christian. The non-Christian minority practices other religions and attends other faith-based institutions. *"We make up the population. If the community is not part of the Catholic Church, they belong to the Muslim community. If they are not there, they are in the ECC or Pentecostal churches. We are the community. We are represented all over. Even in the most remote villages, there are churches. You can't go to a village and not find a church or mosque"* (Interview with a religious leader, Kalemie, June 2022).

Almost forty percent of survey participants also reported that religious leaders were highly trusted as sources of information

on COVID-19, and about fourteen percent had absolute confidence in them.

COMMUNITY OUTREACH AND HEALTH WORKERS AS SOURCES OF INFORMATION

Eighteen percent of surveyed IDPs and small-scale cross-border traders cited community outreach and health workers and promoters as important sources of information, often providing exclusively health-related information.

"The real information comes from community health workers because they sit down and study it before they share the information. Afterwards, they ask the experts questions, and finally, they share this information through official announcements" (FGD with small-scale cross-border traders, Goma, May 2022).

Among IDPs, 37% placed a large amount of trust in community health workers, and 9.5% placed absolute trust in them as an information source due to their proximity, integration into the community, command of the local language, and the training they received from medical professionals before distributing information. During focus group discussions in Ituri, IDPs named community health workers and promoters as the channel through which they received information in the language they understood best. They also noted that community health promoters are healthcare workers who are recognized as trained and well-known members of the community. This fact ensures the community's trust in the information they relay (FGD, Kigonze, 4 June 2022).

Similarly, in Tanganyika, community health workers and promoters were often the only source of information available to IDPs. In addition to the benefit of receiving information in a language they understood from someone they trusted, participants said they preferred this type of interpersonal commu-

nication in awareness-raising campaigns because of the high level of detail offered in explanations and the opportunity to ask questions. As one participant in a focus group discussion told us: *"Out of all these communication methods, the only effective one is the one that goes from mouth to mouth, ear to ear, door to door, because with a face-to-face interaction, I can ask questions, which isn't the case with TV or radio. When there is a team of healthcare workers, we can ask questions without any problem and then we understand easily"* (FGD with IDPs, Kokolo, 28 June 2022).

FACE-TO-FACE INTERACTIONS WITH FRIENDS, FAMILY, AND ACQUAINTANCES

About 17% of IDPs and small-scale cross-border traders stated that they received their information very often from friends and family. Some relied on family and friends because they had limited access to other sources, whilst others stressed that they trusted their peers. Study participants also discussed sharing information with friends and relatives. *"If a family member gives you information by word-of-mouth, and then you experience it, I don't think that you can have any doubt"* (FGD with small-scale cross-border traders, Bukavu, 18 May 2022). The degree of social relations, physical proximity, and regular interactions between members of the same community were factors that encouraged this practice.

OTHER INFORMATION SOURCES

Other sources of information mentioned by IDPs during focus group discussions were humanitarian aid organizations and health agencies. Beyond COVID-19-related topics, humanitarian actors disseminated information on general health and hygiene practices. They organized training sessions and workshops for IDPs and community leaders to share information. During focus group discussions, IDPs and small-scale cross-border traders reported that in most cases, humanitarian aid workers collaborated with other stakeholders, namely





healthcare providers, community health workers and promoters, and community leaders, to deliver messages to the community. Humanitarian aid workers relied on community leaders and outreach workers to transmit the health information they provided, as well as information from health agencies and the government.

Health agencies and healthcare facilities were other sources of information for IDPs. Health agencies organized pandemic awareness-raising campaigns, including vaccination drives, in the health zones using several channels: town criers, the media, community health workers and promoters, community outreach workers, posters, leaflets, etc. During focus group discussions, several women noted receiving information on COVID-19 during visits related to prenatal care and children's pre-school medical screenings (CPN and CPS). Similarly, displaced women in Kigonze (Ituri) said they accessed health information through the healthcare center installed at the IDP site (FGD with IDPs, Kigonze, June 04, 2022).

In FGDs, small-scale cross-border traders discussed using **social media** to access information. This practice is more widespread among youths. Many displaced youth, however, hail from the country's interior regions, marked by low Internet and mobile network penetration. This is particularly the case for displaced Twa youth from Tanganyika who live in areas with little or no mobile network coverage. Others simply cannot afford mobile telephones. In large cities like Goma and Bukavu, participants mentioned posters and banners that serve as sources of information for small-scale cross-border traders. For example, at the so-called 'small' border post between the DRC and Rwanda, a large digital screen has been installed to disseminate information on COVID-19 prevention measures (Report of Restitution of the Results of the IEA to the Stakeholders in Goma, October 2022).

Displaced Banyamulenge in South Kivu said they receive information by **telephone**. *"It is through our phones that we often have direct information, because those who want to help us, or inform us, often do so by phone"* (FGD with displaced Banyamulenge, Kamanyola, 19 May 2022). Displaced Twa in Tanganyika also rely on their telephones and received SMS alerts about COVID-19 from mobile telecommunications companies like Vodacom. According to them, the content of these alerts is mainly related to protective measures against contracting COVID-19. The importance these communities confer on the telephone as a source of information is explained by the fact that both groups live in marginalization and in conflict with other communities, translating into heightened distrust of people from other communities. Those who favored the telephone also stressed that its portability and the immediacy of received information made it a valuable resource (FGD with IDPs, Kamanyola, 19 May 2022; FGD with IDPs, Kyomba, 24 May 2022).

Most small-scale cross-border traders belong to **professional associations or trade unions**. In North Kivu and South Kivu, these associations are classified according to the type of products sold by traders. For example, there are associations for women who sell milk, those that deal in meat, and those who sell vegetables, tomatoes, etc. Several small-scale cross-border traders stated that they accessed information through their respective associations. These associations mainly provide economic and social information, but in the event of a disease outbreak, they can provide health-related information, which they did during COVID-19. Many of these traders cite the heads of their trade associations as sources of information they consider reliable (FGD with small-scale cross-border traders, Goma/Kahembe, 12 May 2022). ▶

THE MEDIA'S SOURCES OF INFORMATION

Most members of media outlets who spoke with Internews reported receiving information from three sources: official government sources, community leaders and civil society, and social media and community platforms. **Official sources** comprise political-administrative authorities and government ministries, including health. They are the “authoritative voice” and a source of reference for clarifying information before it is released.

The media also uses **civil society and community leaders** as sources of information and means of triangulating it. An interviewed media representative noted that civil society actors in North Kivu in particular do a good job of documenting the information they collect. Civic sources of information also include women’s and youths’ associations and other social groups that share information and comment on news.

Some media actors said they used **social media networks** to gather information, but stressed that information sourced this way needed to be verified. This channel was discussed more by online media outlets and actors than by others.

For their reporting on COVID-19, media actors described using the official websites of UN agencies, international NGOs, the ICRC, and government and health departments at the national, provincial, and local levels. Media outlet representatives who spoke with Internews recounted the obstacles they encountered in accessing some sources of information about the pandemic. They said certain health agencies refused to provide accurate and relevant information without financial compensation. A media actor from Tanganyika pointed out, “*health professionals tell you they are busy and if you find them, they tell you that information is paid for, you make money and you need the data, so, share the envelope with us too*” (Interview with a media actor, Kalemie, 28 June 2022).

Another media actor in North Kivu discussed how slowly information concerning the COVID-19 vaccine circulated, fueling the fabrication of rumors throughout the community. “*When the vaccine arrived, we called the DPS communication unit and in return, they told us to wait. While we waited, rumors spread*” (Interview with a media actor, Goma, 4 May 2022).

Misunderstanding and mistrust between some media actors

and some health authorities seem to be mutual. Health officials who spoke with Internews said the media is primarily interested in making money by disseminating information. They said they suspect the media of taking advantage of the financial support they receive from their partners. This distrust has affected collaboration between the media and health workers, hindering effective dissemination of information during the pandemic while inflaming rumors. ▶



Access to information about the pandemic is hindered for IDPs and small-scale cross-border traders in the four targeted provinces for a multitude of mutually reinforcing reasons. These include poverty, certain forms of disability, insecurity and conflict, the language and format of information, the underdevelopment of the media sector, mistrust between media and state actors, and weak mechanisms for responding to rumors.

Limited sources of income prevent households from buying electronic devices, Internet, and electricity which would facilitate access to information. This reality also forces IDPs and small-scale cross-border traders to prioritize survival – obtaining food, shelter, and safety – over information about a misunderstood pandemic. In Tanganyika, several IDPs noted that food aid is not provided on a regular basis, which exacerbates their economic insecurity and means that most of their time is spent struggling to secure basic needs. A displaced woman explained, *“You wake up; you go directly to fetch the firewood; you leave there, then you go to the market; you won’t have time to follow the news”* (FGD with IDPs, Kyomba site, 24 May 2022).

In South and North Kivu, small-scale cross-border traders prioritized finding goods in Rwanda and selling them in local markets – survival – and have little or no time to listen to the news on the radio. **This situation is even more acute among women. In addition to day-to-day cross-border business activities, they are responsible for cooking, cleaning, and childcare.** One of these women clarified, *“When we mothers go home, during the 8 p.m. news we are still preparing food”* (FGD with small-scale cross-border traders, Ruzizi I, Bukavu, 23 May 2022). Furthermore, in Tanganyika, media actors noted that in some households, women are not allowed to touch the radio. It is considered the property of men and boys, while women and their daughters are rele-

gated to the kitchen. As a result, women are more exposed to unreliable sources of information.

Language is also a barrier to accessing information – for women in particular. They often have a lower level of education and rarely speak French. Among the women surveyed, 43% preferred to receive written or oral information in a language other than Swahili, Lingala, or French (they ask for Kibembe, Kholoholo, Kinyamulenge, or Kilendu), compared to 29% of men. Data from focus group discussions and interviews confirmed this finding. As one key informant explained, *“we have the national languages, Swahili, Tshiluba, Kikongo and Lingala [...] These four languages are not to the advantage of women living with disabilities, or even women in general, I can say, which makes access to information very difficult for rural women”* (Interview with a civil society representative, Beni, 6 May 2022).

In Ituri and North Kivu, IDPs feel abandoned by the government and therefore distrust it and the information it disseminates. These feelings are reinforced by the fact that most media outlets prefer to broadcast information in French, Swahili, or Lingala. **If information is not disseminated in the mother tongue, comprehension and interpretation become problematic.** This is evident in Ituri, where most IDPs in the Kigonze site speak Kilendu and prefer to receive information in this language. This is also the case for marginalized communities such as the Twa. Many Twa study participants relayed that they feared reprisals for speaking their language and were afraid to ask questions during public outreach activities. A participant from the Twa community explained during a focus group discussion, *“We prefer to speak in our own language, Twa, because no one can listen and because in our language we feel better and we understand each other well; and we are not afraid to speak because it is our language”* (FGD with Twa women, Kiomba site, Kalemie, 23 June 2022).

The issue of language has hardly been addressed by humanitarian organizations which, for the most part, do not translate documents into local languages. Such efforts require additional human and financial resources. Some organizations leverage local expertise to translate educational tools, using a pilot to test them and adjust the translation if necessary before wider dissemination. More often, community outreach workers receive written educational materials in French and, when using these materials, translate them orally into local languages. As one humanitarian actor in North Kivu pointed out, this approach incurs some risk: *“The fear we have is that if someone reads in French and translates into the local language, they risk altering the message. We prefer that the person goes to the field with the right tool”* (Interview with humanitarian worker, Beni, 29 May 2022).

Language poses additional challenges for people living with disabilities. The blind cannot grasp written and visual information unless in braille, and the deaf cannot assimilate information in audio format (radio broadcasts, town criers, etc.). A leader of a disabled people’s association explained: *“We have several difficulties. Imagine a hearing and speech impaired person. Even if he has a radio, even if he turns it on, what will he hear? For television, it is true, he can see, but there is no sign language interpreter. And not all deaf people are trained in sign language. There is also the blind. He has a radio, but can he cycle through the channels [frequencies]?”* (Interview, head of a PWD organization, Goma, 6 May 2022). The national pandemic response plan does not include provisions and accommodations for people with disabilities, who have been regularly neglected in national policies and media outputs.

Pervasive insecurity and sporadic violent conflict in many regions compound these challenges. They cripple income-generating activities; hinder schooling; render many



MAIN DETERMINANTS OF – AND BARRIERS TO – INFORMATION ACCESS

... areas inaccessible to health workers, humanitarians, and journalists; and further reduce daily life to the requirements of mere survival (FGD with IDPs, website from Kanyaruchinya, Nyiragongo, 16 May 2022). **Media access to and coverage of insecure areas also has a significant impact on the provision of accurate and relevant information and on access to that information.** Lack of electricity in rural and conflict-affected areas, the poor quality of community radio transmitters, and insufficient radio coverage are additional barriers to accessing information. According to media actors, Ituri has sparse radio coverage, while in Tanganyika most radio stations are concentrated in the town of Kalemie. Their depen-

dence on external financial support influences the frequency of broadcasts and therefore the availability of information in these areas as well. This is the case, for example, of some RTNC listener clubs, notably Bonga na RTNC and Kama-ti Mama, whose frequency was reduced to a monthly basis when the partners reduced their funding.

The mistrust between media, health, and state actors – identified in the previous section in relation to the difficulties faced by the media in obtaining pandemic-related information – has negatively impacted overall access to information and reduced the effectiveness of the pandemic response. Collabo-

ration between the media and health authorities involved in the COVID-19 response was weak. *“There was a lot of withholding of information,”* noted a media actor in South Kivu (Interview with key media actor, Bukavu, 23 May 2022). Health authorities were often unavailable to respond to journalists or to community concerns. At the same time, access to official sources to verify and triangulate information remained limited. The situation was similar in Tanganyika. According to media actors, health experts preferred to focus on other health emergencies rather than answer questions about COVID-19, creating an information gap and encouraging speculation. This dynamic led to a proliferation of rumors and misinformation and has fueled their spread. ▶



RUMOR, SUSPICION, AND MISINFORMATION SURROUNDING THE PANDEMIC

Constraints on providing information about the pandemic, local difficulties in accessing that information, and the exigencies of daily survival coincided with the uneven and problematic implementation of the COVID-19 response. This dynamic exacerbated the spread of rumors and misinformation. These misconceptions ranged from downplaying the severity of the pandemic and likening it to the common flu, to believing that COVID-19 was a global conspiracy to exterminate Congolese and Africans in general, to suspicions of apocalypse from certain religious organizations.

Views discounting the seriousness of the pandemic overlapped with suspicions that the government and the international community were manipulating the situation to profit from the population's payments for tests and fines for disregarding prevention protocols. A small-scale cross-border trader elaborated: *"I tested positive when I wanted to cross the border into Rwanda. I was isolated and after a few minutes I was retested and immediately released and told it was over and I could go. Since that day, I understood that it was not serious and that it was just to eat money"* (FGD with IDPs from Munigi, Kanyarucinya site, Nyiragongo HZ, 13 May 2022). In South Kivu and North Kivu, small-scale traders associated the COVID-19 response, particularly the compulsory, paid test at the borders, with a COOP. COOP is a concept that denotes a scam by powerful stakeholders to enrich themselves while further impoverishing local communities; the concept was developed locally during the Ebola response.

Other cross-border traders emphasized the coercion and intimidation employed by law enforcement to enforce pandemic prevention measures, notably curfews, mandatory mask-wearing, and compulsory border testing. Those who failed to comply with these measures were fined, arrested, and in the worst cases, subjected to torture and death. Isolation and quarantine

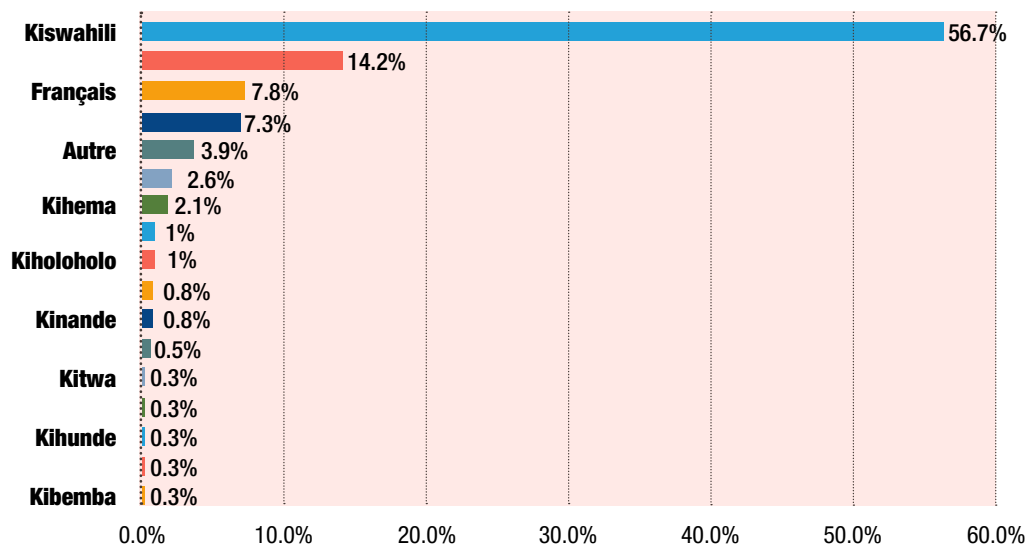
were often interpreted as government strategies to force public opinion to acknowledge the existence of the disease. Isolation and quarantine protocols, however, also fueled popular fears of extermination – that *"those who entered would not leave alive"* (FGD with IDPs, Kigonze, Bunia HZ, 4 June 2022). Similarly, because of ongoing violent inter-community conflict in Ituri, some IDPs believed vaccination against COVID-19 was a conspiracy to exterminate them, orchestrated by hostile communities (FGD with IDPs, Kigonze, Bunia HZ, 4 June 2022).

THE ISSUE OF LANGUAGE

Some study participants identified the lack of information

about the pandemic in local languages as a potential source of misinformation and rumors. Poor comprehension of information received in an unfamiliar language can lead to the circulation of messages whose meanings have been inadvertently altered. In the words of a civil society representative, *"When you do outreach, you pass on information and if the person is not able to understand it or they don't speak the language you are speaking, that person is likely to misinform, to distort the information, because the person has not mastered everything that was important"* (Interview with member of civil society, Goma, 5 May 2022).

FIGURE 4 LANGUAGE PREFERENCES FOR RECEIVING WRITTEN INFORMATION





In the four provinces covered by the study, most information is provided in Swahili and French. Of surveyed IDPs, 56.7% preferred to receive written and oral information, and even sign language, in Swahili; only 7.8% preferred French for written information. In Ituri, 61% of IDPs speak Kilendu; 57% preferred to receive written information in Kilendu and 60% preferred oral information and sign language in Kilendu. Similarly, in South Kivu, most surveyed IDPs speak Kinyamulenge (44%) and Kibembe (18%), compared to 33% who cited Swahili as their main language. However, the preference for written and spoken information in Swahili was higher (50%) than for Kinyamulenge (28%) and Kibembe (10%).

Linguistic preferences are directly related to IDPs' areas of origin, explaining partiality for Kikumu and Kinyabwisha in North Kivu and Lingala in Ituri. The linguistic variations across these provinces are bewildering. Among other languages, North Kivu features Kinande, Kihunde, and Kinyarwanda. In South Kivu, Kibembe, Kimashi, Kifulero, Kirega, and Kinyamulenge are spoken. Ituri is dominated by Kilendu, Kihema, and Lingala; and Tanganyika by Kitwa, Kihoholo, and Kihemba. Language is thus an important factor in accessing information not only for IDPs but also for those without formal education. A leader of a civil society organization in North Kivu recounted: *"All the press releases that were broadcast on the radio were in French and Swahili, so someone from the back [from rural areas], he never speaks Swahili; he can't even speak Swahili"* (Interview with head of civil society organization, Goma, 5 May 2022).

Notably, even though Swahili is the lingua franca of the eastern DRC, its many dialects are not mutually intelligible. Additionally, study participants stressed that information should be conveyed in *"easy Swahili,"* meaning it

is presented using plain language and local terminology mixed with French concepts. One focus group participant explained: *"Easy Swahili can make it easy for people who have not studied and those who are used to French to understand"* (FGD with small-scale cross-border traders, Goma, 15 May 2022). Most IDPs in North and South Kivu conveyed that when information is presented in Swahili Saffi (formal Swahili which borrows concepts and words from English), understanding is complicated by the use of terms in English.

The provincial response plan did not take into account linguistic needs, thus neglecting language policies and their impact on access to information, understanding, transformation of messages, misinformation, and rumors. A humanitarian worker explained: *"We had difficulty in translating the message into Twa due to the lack of translators able to do so"* (Interview with a humanitarian actor [UNICEF], Kalemie, 28 June 2022). While most IDPs requested that information be provided in their native language, some actors involved in the response in North Kivu feared this would reinforce perceptions of linguistic exclusion, given the province's ethnic and linguistic diversity and history of intercommunal conflicts. According to these actors, using mainly Swahili and French was a strategic choice. A government spokesperson clarified: *"If all languages were to be taken into account, there are more than 70 dialects and this would risk creating other rumors, even discrimination of languages that are not used"* (Interview with DPS, Goma, May 2022).

As a result of this approach, almost half of study participants in North Kivu relayed that they had not received information about the pandemic in their preferred language; this was the case for around a third of respondents in Ituri, Tanganyika, and South Kivu. An incomplete or non-existent

understanding of information increases the likelihood of its transformation and the spread of misinformation and rumor. The fact that broadcasters use different languages to strategically target specific audiences, making messages inaccessible to others, can fuel suspicion and the very perceptions of language exclusion that the response was intended to mitigate. Some media actors in South Kivu, for example, conveyed that if the messages were intended for decision-makers, they were transmitted in French, and when they were intended for the general public, Swahili was used (Interview with a humanitarian actor, Bukavu, 13 July 2022).

Language barriers to accessing information compounded the general lack of information at the beginning of the pandemic. The response was sorely underfunded and medical experts expected compensation for media interviews, which journalists could not afford. This situation fueled speculation, misinformation, and rumors. They spread through communities via various channels that connected them as social networks. They were passed on by word of mouth at community events and in public places such as markets. In North Kivu, some small-scale traders also reported heated discussions of theories and suspicions surrounding the pandemic on public transport, while using motorcycle taxis and buses.

DISCERNING FACT FROM FICTION

Circulating rumors also influenced decisions to accept or reject COVID-19 vaccines. Displaced and marginalized communities struggled to determine whether the information shared about the pandemic, prevention, and vaccination was credible. Difficulties in discerning fact from fiction are related to the information gap identified in this study, where most IDPs have some level of knowledge about the pandemic but express concerns about being insufficiently



RUMOR, SUSPICION, AND MISINFORMATION SURROUNDING THE PANDEMIC

... informed on topics like symptoms, treatment, and vaccination. Using a quantitative approach, this study assessed IDPs' ability to identify rumors versus hard facts about COVID-19. The results show that approximately 55% of IDPs surveyed were able to identify at least two pieces of misinformation regarding COVID-19, while 45% were unable to distinguish between misinformation and facts. There was no significant difference between men (43%) and women (47%).

Notably, the study revealed that participants' level of knowledge concerning COVID-19 is high, which is most likely a result of the awareness-raising campaigns carried out by response actors. In the four provinces, stakehol-

ders and community members noted that it was through their exposure to outreach activities, including those of the RiT2.0 project, that they were able to access accurate information and have their concerns about COVID-19 and vaccination addressed. Awareness-raising campaigns leveraged public meetings and round tables organized by implementing organizations in Goma (North Kivu), Bukavu (South Kivu), Kalemie (Tanganyika), Bunia (Ituri), and in some IDP sites like Kigonze, in Ituri. These activities provided an opportunity for community members to ask questions and receive clear answers from health experts. Dispelling rumors and fears in this manner influenced some participants' decisions concerning vaccination. According to a faith-based actor in Tanganyika, "Several of our collea-

gues who refused COVID-19 got vaccinated and took their dose after receiving clear and precise information about the COVID-19 vaccine during a roundtable organized by REFEMET [a network of media women in Tanganyika working in collaboration with the Association des Femmes des Médias du Sud-Kivu, a direct partner of Internews within the framework of the RiT2.0 project]" (Interview with a key media actor, Kalemie, 28 June 2022).

Despite these successes, most interviewed IDPs indicated that they did not know how to corroborate information on COVID-19. Some civil society actors regretted that no unambiguous, established mechanisms for verifying information had been put in place. During the pandemic, many people in the cities of Bukavu and Goma turned to the diaspora to verify information on COVID-19 and the vaccine (FGD with small-scale cross-border traders, Goma/Kahembe, 12 May 2022). Most sought advice from their relatives in the West before deciding to be vaccinated. Due to the crisis of confidence characterizing the relationship between the population and the government, some community members relied on information from the international media, but this was only possible if their literacy levels spanned understanding of foreign languages. Displaced people and small-scale cross-border traders in Kamanyola, South Kivu, relied on information from neighboring Rwanda and Burundi. This preference was motivated by their desire to resume cross-border activities after months of restrictions and the requirement to take a COVID-19 test at the border.

To access information, IDPs and the general population relied on a range of sources. However, the credibility, adoption, and application of that information – as well as the importance afforded it – depended on the trustworthiness of its sources. ▶



TRUST IN DIFFERENT PROVIDERS OF PANDEMIC-RELATED INFORMATION

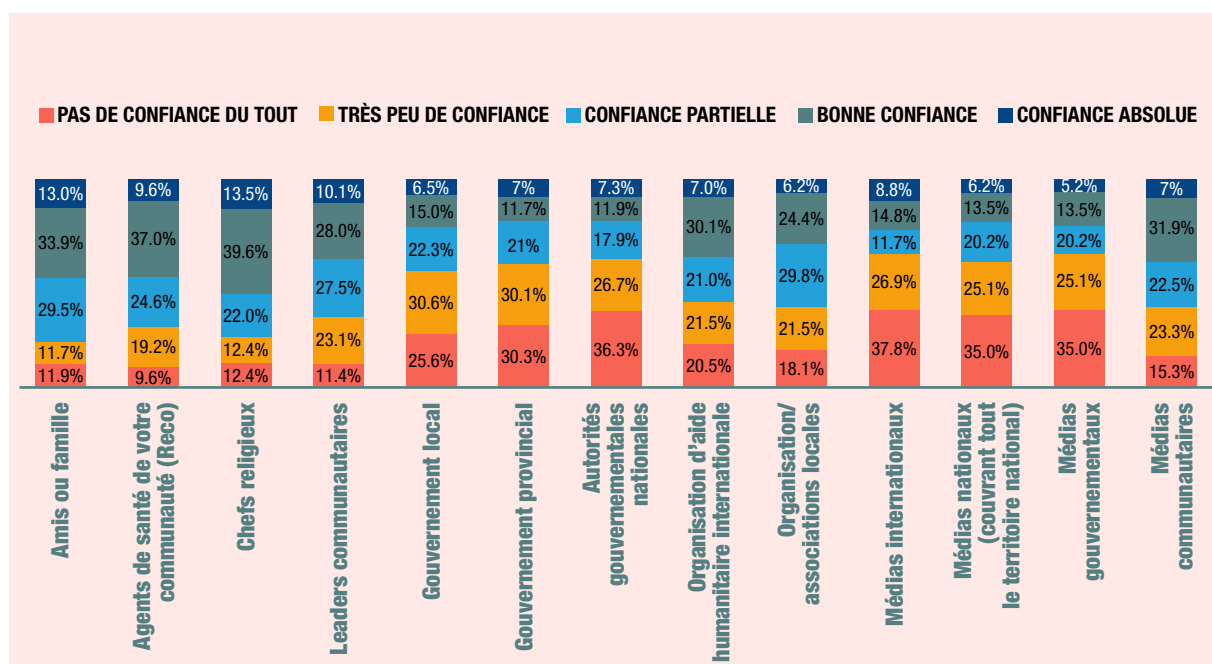
Difficulties verifying information about COVID-19 reinforced the importance of sources, whose perceived trustworthiness is an indicator of the credibility of the information they share. This study included a quantitative assessment to determine which sources of information IDPs deem trustworthy across the four RiT2.0 project areas.

As shown in Figure 4, IDPs maintain a high level of skepticism. Absolute trust in information sources is low: 13.5% of surveyed IDPs have ‘absolute trust’ in their religious leaders; 13% in their parents and friends; and 10.1% in their community lea-

ders. Slightly less than 10% of IDPs have ‘absolute confidence’ in community health workers and promoters. A considerable amount of trust is placed in religious leaders (39.6%), community health workers and promoters (37%), community radio stations (31.9%), humanitarian organizations (30%), friends and family (29.5%), community leaders (28%), and local organizations (24.4%). Over a third of surveyed IDPs reported that they have no trust in international media (37.8%), government media (37.6%), national government authorities (36.3%), or national media (35%). Similarly, 30.3% of survey participants stated that they do not trust the provincial government at all.

Trust in **church leaders** is based on their status in society, their integral presence in the community, and the moral and spiritual guidance they provide to their followers. Notwithstanding the level of trust afforded to religious leaders, some IDPs believe that a healthy dose of skepticism ought to be maintained; even information disseminated by churches should be verified. A displaced person from the Banyamulenge community in South Kivu elaborated: “*Even as a pastor, we can’t fully believe him. We are going to sound out the information... we are waiting for confirmation from the others... I cannot have total confidence in him if I have not received confirmation on the radio, and then we will know that there has been verification of information before it is released*” (FGD with IDPs from the Banyamulenge community, South Kivu, Kamanyola, May 2022).

FIGURE 5. LEVEL OF TRUST IN SOURCES OF INFORMATION ABOUT COVID-19



A media representative in Tanganyika echoed these reservations about religious leaders, noting that beyond the churches’ significant contribution to disseminating information on COVID-19 throughout their communities, some paradoxically undermined the response by spreading rumors about the pandemic and vaccination. “*Some pastors were spreading the misinformation about COVID-19 calling it a sign of the end of time and the vaccine that is coming is 666 or the mark of the beast*” (Interview with media representative, Kalemie, 28 June 2022).

“*I will trust what community health workers say because they are the ones who deal with treatment information*” (FDG with IDPs, Kigonze site, Bunia, 4 June 2022).

Besides churches, many IDPs conveyed having great confidence in **community outreach and health workers** and promoters. Like religious leaders, they are well integrated in their communities, but they also master the languages of IDPs, interact with them personally by going door-to-door, and are specialized

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in health issues. In Ituri, Tanganyika, and North Kivu, the fact that community health workers and promoters hail from the same communities as IDPs and speak their languages during outreach and awareness-raising sessions increases the trust vested in them. Small-scale cross-border traders from North and South Kivu added that the collaboration between community health workers and promoters and medical professionals made the information they shares more credible. In Tanganyika, however, some health zones reported a disengagement of community health workers during the pandemic, which affected the dissemination of information about COVID-19 and its assimilation. This disengagement was the result of the lack of financial motivation for community health workers and the meager funding of the COVID-19 outreach campaign.

Displaced people also trust information from **community media outlets**. Study results reveal similarities between the four provinces. In North Kivu, IDPs and small-scale cross-border traders agreed on the reliability of information broadcasted by community radio stations. They believed broadcasts are the products of journalists' data collection in the field, verification of sources, triangulation of information, data analysis, and finally dissemination of the results via radio. According to study participants, reports of journalists on the ground lend credibility to the information they provide: *"There are fake media (...) called sidewalk radio [information heard in the street and broadcast by word of mouth]. But there are radio stations that are very popular because they send reporters into the field to see the reality, then they broadcast verified information. These include Radio Okapi and Radio Maendeleo"* (FGD with small-scale cross-border traders, South Kivu, Bukavu, 18 May 2022).

Other IDPs believed that even information broadcasted over the radio should not be accepted with blind confidence. These participants noted that the process of news produc-

tion can include censorship as well as bias, diminishing the veracity and objectivity of broadcasted information. In Ituri, trust in radio news is evident, but it varies according to listeners' appraisal of different radio stations: *"It's not what a radio station broadcasts that I can believe"* (FGD with IDPs, Kigonze site, Bunia, 4 June 2022). Each radio station has its own audience, and trust in its programs depends on listeners' assessment of the relevance and reliability of the information it broadcasts. The independence and ownership of the media outlet also influence trust in the information it provides. For example, in Tanganyika and Ituri, several media outlets are popularly associated with political figures. Media representatives we met noted that these media prioritize information related to the political activities of their sponsors, which affects the outlets' credibility and independence, and by extension their reliability.

In North Kivu, small-scale cross-border traders stressed the importance of receiving news in a timely manner. They expressed limited trust in information broadcast by **national radio** stations. According to them, the news is broadcast too long after the events it reports have occurred: *"something that may be happening now, they will broadcast tomorrow instead of airing it on the 6 p.m. or 8 p.m. news... that information will no longer make sense"* (FGD with small-scale cross-border traders, North Kivu, Goma, 12 May 2022). Others believed that news broadcast by national radio stations is biased, championing government actions whilst providing minimal coverage of community and local news. Similarly, but perhaps for different reasons, international and government media suffer from a lack of trust among IDPs, particularly because of the language in which they publicize information. International media mainly use French and English, languages in which IDPs are rarely proficient (Interview with a key civil society actor, Goma, 5 May 2022).

Trust in **humanitarian organizations** is based on their strong historical presence and the humanitarian assistance they provide to vulnerable communities, even in conflict-affected areas that are difficult to access. For example, these organizations assume some of the government's responsibilities to meet the needs of IDPs – shelter, food, medical assistance, and psychosocial care – which are considered lifesaving interventions.

Other reliable sources of information for IDPs and small-scale cross-border traders are **relatives and leaders of their community networks**, social structures that often replace governance functions when the state is weak or absent. Thus, important sources of credible information include friends, relatives, and community leaders such as those in charge of IDP sites, heads of local associations of small traders, and directors of civil society organizations and associations for people living with disabilities. Trusted relatives and friends included those living in close physical proximity and those who resided much further away or are part of **the diaspora**. External information from the Congolese diaspora on the pandemic and the vaccines was considered reliable. Most people confided in their friends and family in the West and, believing they had clear and precise information, followed their recommendations regarding the existence of the disease, the effectiveness of preventive measures, the recognition of symptoms, and whether or not to be vaccinated. Reminiscent of community leaders, their credibility derives from their cultural role in Congolese society (FGD with small-scale cross-border traders, North Kivu, Goma, 12 May 2022).

Across the four provinces included in the study, IDPs reported having limited trust in **government authorities**. Levels of perceived trustworthiness decreased from the bottom to the top of the administrative ladder, with national authorities being the least trusted, followed by provincial and then local authorities. Displaced people believe that the national government

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TRUST IN DIFFERENT PROVIDERS OF PANDEMIC-RELATED INFORMATION

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is responsible for their vulnerability and the precariousness of their livelihoods because it has failed to end violence and armed conflict. They expressed feeling neglected and denounced the promises of national authorities to improve their living conditions as unrealistic.

Media and humanitarian workers, on the other hand, propound a mantra that is potentially partly based on self-preservation: they claim that government authorities are accurate, timely, and trustworthy sources of information. For the media, government sources are traditionally considered the “authoritative mouthpiece” – an official source which provides clear, verified, and final versions of events or pieces of information. Many media outlets are also supported or funded by the state. For humanitarians, the state is an important partner without whose authorization they cannot pursue development programs or intervene in complex emergencies. Conversely, during the pandemic, some media actors questioned official government sources and instead relied on information provided by international health agencies, including the WHO. These actors regarded resorting to government information as second best. A media actor in South Kivu noted: *“We trust them because we don’t have another authorized service to provide us with this information”* (Interview with a key media actor, Bukavu, 24 May 2022). During this period, certain information provided by the government on official sites lacked regular updates, thus media actors had to rely on international organizations and their data.

This crisis of confidence is related to the cacophony and contradictions that have characterized the COVID-19 response in general and government communication on the pandemic in particular. Examples include irregularly updated and poorly explained statistics on the evolution of the pandemic, as well as published figures that were contradictory and demonstrated a lack of harmonization between the national and provincial levels. ▶



DETERMINANTS OF THE TRUSTWORTHINESS OF INFORMATION

While different providers of pandemic-related information are accorded varying levels of trust, the characteristics of the information they provide also affect its credibility.

In addition to its source, trust in information depends on several factors. Survey results show that 43% of IDPs trust information provided in their **mother tongue**, and 13% consider this to be the most important factor in determining credibility. This is particularly the case in South Kivu and Ituri, where respectively 82% and 62% of participants consider language to be an important or key feature of trust in information. **The extent of dissemination** is another factor: 32.6% trust information that is widely circulated in the community, and 10.9% consider it a necessary condition for trusting information. **The proximity of the information provider** to the recipient – as family, friend, community member – is cited as necessary for trustworthiness by 32% of respondents. Twenty-seven percent of surveyed IDPs stated that **triangulation of information**, i.e., receiving the same information from different, unconnected sources, is imperative for the information to be accepted as true. Among study participants, 22% trust **information with a high level of detail**. On the other hand, 32.6% of IDPs have very little confidence in ‘official information’, communications from public institutions and public authorities shared by local leaders. Forty-nine percent do not believe information presented in written form or published in newspapers at all, while 43% do not believe information if it comes from foreign sources.

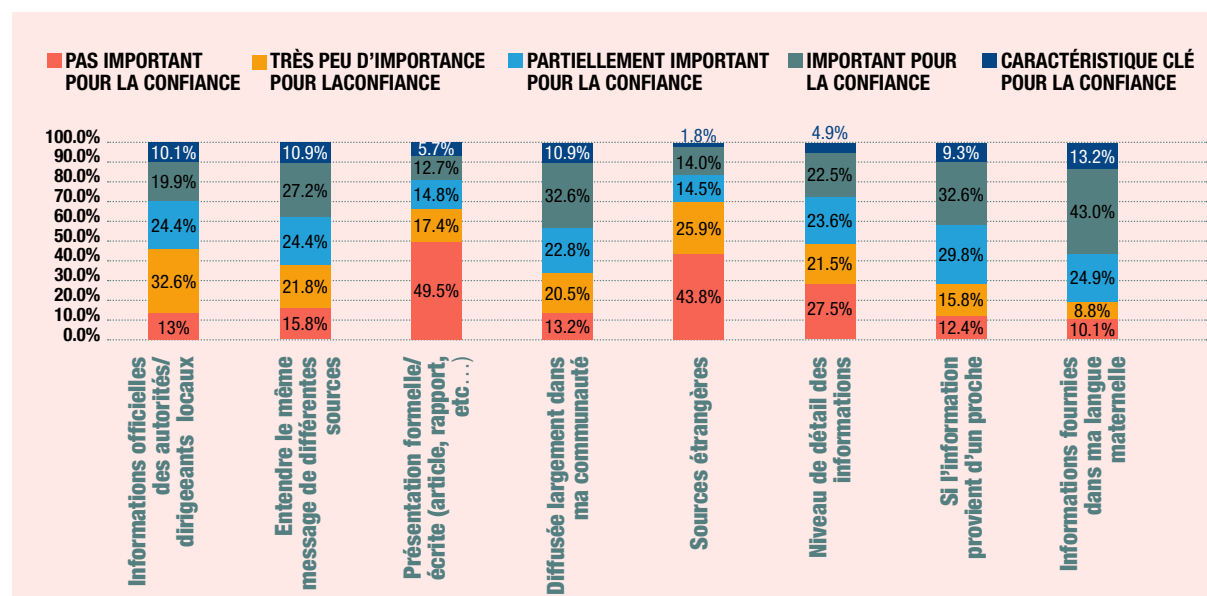
From these findings, we can infer that for IDPs to trust information, it must be communicated in their native language; come from different, disconnected sources; and be shared multiple times in the community. For example, in South Kivu, displaced Banyamulenge believe that in order to accept information as true, it is not sufficient that it is communicated by a community or religious leader; for the information to be

regarded as true, it must also be confirmed by the radio. According to these participants, truthful information is that which has been shared several times and by diverse sources in the community. Most individuals consulted for this study in North Kivu stressed that they only trust information disseminated in the language they understand best.

The way information is communicated also has an impact on the trust accorded it. In Tanganyika, participants focused on the tone and style of communication. A calm and thoughtful tone inspires trust in media communications. On the other hand, face-to-face outreach is deemed most credible when delivered in a softened, respectful tone akin to pleading – an emotional

appeal that target audiences find convincing. In the media, messages of paramount importance, often repeated, must be presented with emphasis and rigor to authenticate their gravity and their veracity. The importance of tone was also mentioned by key informants. A health worker explained during an interview: *“I have seen someone who says hard words in a gentle tone and people will tolerate that as opposed to someone who tells you good things in a mocking or authoritative tone which people won’t tolerate. That is to say, the way you communicate, the tone and the attitude of the communicator, are also important in communication, because before someone understands you, you have to give the other person a taste”* (Interview, health personnel, Kalunga, 20 June 2022). ▶

FIGURE 6. DETERMINANTS OF THE TRUSTWORTHINESS OF INFORMATION



FORMAT OF INFORMATION

Given the complex dynamics engaged in assessing the reliability of information, it is prudent for providers to leverage several formats in their dissemination strategies, appealing to as wide an audience as possible. Furthermore, formats are most effective when they incorporate feedback mechanisms and include community participation.

In Tanganyika, media actors use radio spots to broadcast interactive programs where listeners can call in and contribute to discussions and debates. In South Kivu, they use audiovisual programs and reports, press releases, online articles, documentaries, commercials, educational flashes, and duplexes⁶.

In North Kivu, the media are trying to adapt their programming in response to community feedback. For example, they use comedy spots and quizzes (games with questions that reward winning listeners with small gifts). A media actor explained: *“We have a comedian who takes all the news of the week broadcasts it in a comical way, because people are interested in comedy now”* (Interview with a media actor, Goma, 4 May 022). This format is similar in Ituri where some media convey messages through radio sketches.

The communities' preferred media formats are short. In Tanganyika, radio spots, short radio sketches, and vox pop are preferred, because they elicit viewpoints and perspectives without commentary from journalists. When people hear a well-known person in their village speaking on the radio, it builds confidence in the information being communicated as well as in the source. In addition, live interactive broadcasts give listeners the opportunity to engage in debates while news providers gather their feedback. News bulletins are also popu-

⁶ An educational flash is a short pedagogic message while a duplex is a sound bite of information dubbed in another language.

lar, especially in the evening around 6 p.m., when most people are free from their daily tasks.

Some IDPs in North Kivu noted the value of information in the form of posters and pamphlets; they believe those who produce them are held directly responsible if they are misleading or inaccurate. Focus group discussions demonstrated that this format is also popular because it is portable and stands the test of time. An IDP elaborated: *“Posters, written diaries and bulletins are important because you can walk around with them many years later and people will read them to understand what happened a long time ago”* (FGD with IDPs, Munigi, Kanyarucinya site, Nyiragongo Health Zone, 13 May 2022).

Notwithstanding the reliability accorded to information in written format, it remains inaccessible to people who are illiterate and to people with certain disabilities. Written materials produced for profit are likewise difficult to access; many are unable to buy a newspaper. The literacy rate in the DRC is 71%, and 29% of people over the age of 15 are still illiterate (UNESCO, 2022). The written format presents additional difficulties when the language used is not adapted to the area of distribution.

For IDPs in Ituri, information providers favor audio formats in local languages – word of mouth, town criers, and radio broadcasts. The same holds true in South Kivu, where information is provided in audio format in Kinyamulenge for IDPs from the Banyamulenge community living with host families in the town of Kamanyola, and in Kibembe and Kirundi for IDPs of Lusenda in the territory of Fizi.

In Ituri, some IDPs emphasized the importance of combining audio, video, and image formats to make messages easier to understand. One IDP explained: *“Video projection is good because everyone can see and understand. We need more*



posters with pictures to complement the information we received on the radio that we did not fully understand” (FGD with IDPs, Kigonze site, Bunia, 4 June 2022). Another participant added, *“When someone comes himself to give information, it’s good, it makes it easier to understand the things we heard on the radio”* (FGD with IDPs, Kigonze site, Bunia, 4 June 2022).

Of all these formats – written, audio, visual – the ones preferred by IDPs in each province are those that are accessible to them despite their economic precariousness, their level of literacy, and the presence of forms of disability within their community (Interview with a key actor in PWD organizations, Tanganyika, Kalemie, 28 June 2022). ▶

Regardless of source and format, focus group discussions revealed that most information is spread primarily by word of mouth. The source of circulated information is principally radio broadcasts. Information shared orally can also originate from what is heard at places of worship, markets, sites of mourning, training workshops, and awareness-raising sessions.

During focus group discussions, IDPs in North Kivu listed some radio stations they consider to be the most influential: Taina Community Radio and Television (RTCT), Okapi, and Pole FM, among others. In South Kivu, small-scale cross-border traders noted Radio Maendeleo, which covers much of the province; Radio Neno la uzima and Radio Maria, which primarily cater to Christian communities; Mama Radio, a station dedicated to women; and Radio Sven, Star, and Jambo Fm, which are favored by youth because their programs include a wide range of music. For both official and unofficial releases, RTNC is in high demand. In Tanganyika, IDPs identified RTNC, Ndega FM, and Afia FM. Displaced people in Ituri stressed the veracity of CANDIP radio. These are the preferred sources of information that are deemed credible; the information they provide is then widely disseminated by word of mouth.

Online stations are important to smartphone users, including La Prunelle, Le Labor, and La Libre Grand-lacs in South Kivu. In most cases, these media outlets are concentrated in Bukavu and reach the city's outskirts. Their audience, however, is limited to people of a certain socio-economic status given the cost of electronics and the Internet. Consequently, the audience for online media is very limited. Displaced people do not use this channel for three reasons: most do not have smartphones, mobile data is expensive, and French is the dominant language. These reasons render online media outlets inaccessible to most IDPs.

Displaced people rely instead on interpersonal communication (word of mouth) with friends, relatives, and close ones. In contrast, civil society actors, public authorities, and community leaders claim to use social media networks to share as much information as possible. According to them, online media offers additional channels through which to reach young people and social groups that do not regularly use radio and television.

Information sharing practices vary. Some community leaders stated they share information as they receive it, without altering the content, whether the information is true or not. They share all information because they feel they are helping to inform the public, even if they are simultaneously exposing them to rumors.

Social media platforms make it easier for online media actors to indirectly relay information to the community level. *“When there is news, we share the link in many WhatsApp groups, which makes it possible to reach specific groups... someone can receive the information in the WhatsApp group and will forward it on to someone who is not in constant contact with us”* (Interview with online media manager, Goma, 10 May 10 2022). This approach is akin to advertising and is limited to relatively affluent people in urban centers.

In many regions, the actors who disseminate information are not affiliated with the media: community and religious leaders, civil society representatives, humanitarian organizations, health personnel, political and administrative authorities, community outreach units, and community health workers and promoters. Although present in all provinces, these stakeholders do not have the same level of influence. Influence in the community depends on a few factors. The information provider's relationship with and integration into the community that comprises their audience is important. The community's



... assessment of the relevance and significance of the information provided is another factor. Characteristics of the targeted audience and the security context also affect a stakeholder's level of influence. These actors use a variety of channels to disseminate information: community meetings, round tables, public speaking forums, and training and feedback workshops – all targeting community leaders and their constituencies.

Some humanitarian workers noted that the dissemination of information in the community is a multi-step process. First, the Ministry of Health verifies the information, then the personnel involved in the dissemination undergo training, then the community structures that will receive the information are identified (such as community outreach units, for example). According to a stakeholder interviewed in North Kivu, “*dissemination of the message can also be done through the organization of community events such as round tables, where the community can express themselves and ask questions on a subject, or the distribution leaflets, posters, and the display of posters and image boxes in health facilities*” (Interview with a humanitarian actor, Beni, 28 May 2022).

COLLABORATION AND COMPETITION: INTERACTIONS BETWEEN INFORMATION PROVIDERS

This study found that information providers in the four provinces interact with one another and with external partners. This collaboration is mainly observed in the sharing and verification of information. In terms of structural coordination, small community radio stations are connected to larger stations in a network, allowing them to relay national and international news. Furthermore, most media actors belong to the same associations, unions, and regulatory frameworks. They collaborate even more closely and frequently when they work on similar topics, like sport or child protection. Among these associative platforms are the National Union of the Congo Press (UNPC), represented in

all provinces; the Congolese Union of Media Women (UCOFEM); and the Association of Media Women (AFEM).

Another level of collaboration occurs when media outlets have the same partner organizations. This support can be regular, as with community radio stations for example, or it can take the form of agreements established between media outlets and their partners who finance programming linked to their

projects. Collaboration, in an indirect manner, also includes community leaders and communities, civil society organizations, citizens' movements, lobby groups, and women's and youth's associations. They are crucial in terms of verifying and disseminating information at the local level.

Collaboration does not preclude competition, as providers jockey to be the first to deliver information. ▶



Several IDPs in the four provinces highlighted the contrast between their lived realities and the information they received on COVID-19 prevention. They said that the preventive measures they were told about could not be implemented because of their living conditions.

Some people said they did not have the means to purchase masks, hand sanitizer, or soap. Others said the emphasis on social distancing ignored the realities of their living conditions. Most people have large households and live in overcrowded shelters. They felt that these conditions made them more vulnerable to COVID-19, as focus group discussion participants explained:

“IDPs are most at risk of COVID-19 because of poor living conditions, no water, no protective equipment, no means to get tested, and no means to access healthcare” (FGD with IDPs, Munigi, Kanyarucinya site, Nyiragongo Health Zone, 13 May 2022).

“A house of 3.4 meters where eight people live, and they say you need social distancing of at least one meter! There is no way we can observe this measure at night” (FGD with IDPs, Kigonze site, Bunia Health Zone, 4 June, 2022).

Small-scale cross-border traders in South Kivu questioned the compulsory COVID-19 test, which cost US\$5 and was valid for 14 days. These traders condemned it as a predatory practice and demanded to know how the money collected from tests at the borders was used. Some called the measure a scam, questioning its contribution to strengthening the pandemic response.

Displaced people and small-scale cross-border traders said that information on COVID-19 prevention was important, but that it needed to be context-specific so that they could implement preventive measures effectively and realistically.

IDPs in Tanganyika concluded that *“empty bellies don’t have ears”* (FGD with IDPs, Kokolo site, Kalemie, 23 May 2022). Their most urgent preoccupation is securing food; pandemic-related concerns are not amongst the top priorities. They discussed the dependence on food aid provided by humanitarian organizations, which is sometimes insufficient vis-à-vis their needs.

Nonetheless, study participants noted that information about COVID-19 has generated both positive and negative changes in attitudes and practices at the local level and among IDPs. In Ituri and North Kivu, for example, IDPs reported that during the pandemic, preventive measures played a role in controlling diarrheal diseases. Respondents recounted that outbreaks of these diseases decreased or even stopped altogether during period when protective measures were in place. Other IDPs believed that information about COVID-19 and prevention measures forced government actors to recognize their dire financial situation and the precariousness of their livelihoods.

Regarding the use of health services, misinformation led some IDPs, particularly women, to fear using them for their children’s routine vaccinations, prenatal consultations (ANC), and postnatal visits (CPS) (FGD with small-scale cross-border traders in South Kivu, Bukavu, May 2022). This distrust stemmed from rumors that COVID-19 vaccines rendered the vaccinated sterile to decrease the global population. The situation was

similar in Tanganyika, where several stakeholders believe there is a correlation between the resurgence of the measles epidemic and the mistrust of routine immunization caused by rumors surrounding COVID-19 vaccination. Tanganyika was affected by measles in the second quarter of 2022.

In South Kivu, small-scale traders described both positive and negative changes at the DRC-Rwanda borders. In terms of health, hygiene measures have improved, particularly with the installation of handwashing stations. However, the lockdown and mandatory testing have had disastrous effects on their businesses and incomes (FGD with small-scale cross-border traders, Bukavu, 18 May 2022).

The information campaign around COVID-19 has had a strong impact on IDPs whose morale has been weakened by the trauma of violent conflict and pervasive economic insecurity. Most IDPs in the four study areas agreed on the adverse effects of the information campaign and prevention measures. They cited exposure to danger; exacerbation of conflict, hatred, division; and the erosion of trust in information providers found to have spread misinformation and rumors. In North Kivu, most concluded that misinformation always carries negative consequences. The government’s broken promises also have detrimental impacts, as they result in the deterioration of trust in the state. Displaced people see the state as a deceitful parent that does not respect its commitments and neglects its responsibilities. These perceptions were reinforced by the government’s unfulfilled vow to improve the living conditions of those displaced by the Nyiragongo volcanic eruption in May 2021 (FGD with IDPs, Munigi, Kanyaruchinya site, 13 May 2022). ▶



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