SBC in intercommunal conflict-affected Lubunga Health district (DR Congo):
Interventions-challenges and lessons learned
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Presentation plan

1. Health district context
2. SBC Planning process: Mapping-Conflict analysis-Strategy
3. Challenges
4. Lessons learned

Lubunga Health district context

Lubunga health district is an urban-rural area in the province of Tshopo in the DRC.

- **Covering area** : 740 km².
- **Population** : 188.878 habitants
- **Major activities**: Farming and fishing
- **Major religion**: Christian
- **Cvdpv2 cases** reported in 2021
- **3,072 zero-dose children and 4,390 under-vaccinated children**
- Existence of land dispute between the Mbole and Lengola ethnic groups, which has turned into an ethnic/community conflict resulted in 850 death and more over 76,000 IDP's.

SBC Planning process

1. **Mapping of insecures health areas** in collaboration with sub-district team originally from villages and locations in conflict

2. **Conflict analysis dynamics, Identification of influencers and opportunities present in the insecure areas** through interviews with key informants, in particular the Community organizer of the Health district, Community health workers, Head of health facilities, Leader of health committees and leaders of ethnic groups in conflict.

3. **Co-creation of SBC strategies** with Head of health facilities and Leader of health committees from health areas in conflict, members of the health district management team and leaders of ethnic groups in conflict.

1. Insecrures areas mapping

- 5/18 health areas are insecures and affected by conflicts: insécures :Osio 16, Osio 21, Ngenengene, Yalisombo, Batiamendje in rural area.
- More than 50.732 people are affected by the conflict

2. Conflict analysis: a. Conflict Cause -Trigger and consequences

1

Cause of conflict

Land disputes between the Mbole and Lengola peoples are the main cause of the clashes

2

Trigger

CAP Congo company evicted Mbole farmers from fields in the 200-hectare concession purchased from the provincial authority in collusion with the traditional Lengola chief

3

Escalation

Seeking revenge, the Mbole chiefs also took steps to sell to the same CAP Congo company part of the land where the Lengola farmers were located

4

Consequences

800 people dead and entire villages burnt down

b. Conflict stakeholders

Protagonists

Lengola (Kifyagiyo) and **Mbole** (Jo Fils) people

Allies

Anamongo people support Mbole and **Kumu/Rega people** support Lengola

Neutral

Lokele people

Other actors

Provincial **government** and **CAP Congo** cie

c. Trusted and credible actors

Religious leaders

whose ethnic groups are not parties or allies in the conflict

Health professional

whose ethnic groups are not parties or allies in the conflict

Political leaders

at national and provincial level (deputies, ministers and senators) from both sides

Humanitarian Organisation

Agences UN (UNICEF) and International NGO

d. Conflict impact on Immunization programme

Population movement

+- 76 400 IDPs in Kisangani (Konga-Konga site), Lubunga HD (Sainte Marthe site and camp Lukusa), Kipokoso Church and surrounding area with host families

Access issue

To the people who fled into the forests to protect themselves from attack

Service reduced

Insufficient and decrease supervision and vaccination sessions

Community disengagement

Non-native community leaders forced to flee has resulted in unfunctional community structures

Low vaccinal coverage during 2024 August SIA

Rejection of HD results (All localities failed following LQAS results)

e. Existing opportunity to leverage

1 Health facility continue to operate

Not targeted by the parties to the conflict
Health facilities continue to operate with their local staff

2 Health business meeting

Health areas chiefs, including those from rural areas still in conflict, take part in monitoring meetings at health-area level

3 Community gathering

Weekly markets (Tuesday and Thursday) and Sunday worship services continue to operate in the affected health areas.

4 Radio and mobile coverage

16 of 18 Health areas partially covered by radios broadcasting from a neighboring health zone

5 Protagonist support

Support for health activities by leaders in conflict

6 IDPs camps

IDPs grouped together in 2 main sites

3. Tailored SBC Strategy in support to Polio campaign

1 Local recruitment and capacity building

- Selection and distribution of actors by village according to ethnic group to facilitate acceptance
- Integration of certain militias into the teams to mobilize and manage vaccine hesitancy
- Training of selected and new player

2 Partnership and collaboration with Emerging local leaders

- Close collaboration with local leaders in conflicts areas
- Access negotiation and engagement of local leaders in refusals resolution

3 Community engagement

Mobilization of farmers community health workers and community cell members to engage with individuals and families

4 Radio and digital (SMS) campaign in local language

Mobilize influential leaders for radio awareness programs (radio programme, spots, etc.)

5 Fixed and Mobile vaccination team

Weekly markets, churches and mosques, farmers' camps, IDPS camps

6 Influencers advocacy

To gain Political, traditional and religious leaders from both parties’ support to the campaign

Challenges and mitigation measures

	Challenges	Mitigation measures
1.	Lack of reliable data to measure progress in SBC/vaccination	Explore the possibility of online mini-surveys through Rapid-pro or household surveys by CHW
2.	Weak management of disinformation/infox/rumors (social networks)/feedback management Lack of specific social listening analysis in the conflict zone to respond to rumors	Work with local volunteers to organize “On ground” social listening and strengthen online social listening in the conflict zone.
3.	Difficulty in mobilizing communities during the interphase due to the non-functionality of traditional community structures.	Partnership and capacity building of existing/active community networks for community mobilization (Revitalize community structures)

Lessons learned

1. Consultation and co-decision on the activities to be carried out with local players + militias facilitated acceptance of the activities and the vaccination of children.

2. Weak social analysis to identify problems specific to localities in conflict and guide/adapt SBC planning and messages

3. The non-functioning of basic community structures (CACs) encourages misinformation and the spread of rumours against vaccination/polio.

4. Recruiting some community mobilizers among combatants promotes acceptance and reduces mistrust of vaccination

THANK YOU