2020

When global health emergency meets chronic emergency: parsing out (inter)national and local optics in the democratic republic of the Congo's tenth ebola virus disease outbreak

Samuel O'Keefe
Vassar College

Vassar College

When Global Health Emergency Meets Chronic Emergency:
Parsing Out (Inter)National and Local Optics in the Democratic Republic of the Congo's Tenth
Ebola Virus Disease Outbreak

A Thesis submitted in partial satisfaction of the requirements for the degree Bachelor of Arts in
International Studies

by

Samuel O'Keefe

Thesis Advisers:
Professor Toivo Asheeke
Professor Elizabeth Bradley

May 2020

Table of Contents

Abbreviations

ALIMA - Alliance for International Medical Action
ADF - Allied Democratic Forces
CFR - Case Fatality Ratio
CFS - Congo Free State
CRA - Congo Reform Association
DRC - Democratic Republic of the Congo
EBV - Ebolavirus
ETC - Ebola Treatment Centre
EVD - Ebola Virus Disease
FARDC - Forces armées de la République démocratique du Congo
GHE - Global Health Emergency (same as PHEIC)
HCW - Healthcare worker
HIV/AIDS - Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
ICG - International Coordinating Group
IHR - International Health Regulations
IRC - International Rescue Committee
MoH - Ministry of Health
MONUSCO - Mission de l'Organisation des Nations unies pour la stabilisation en République démocratique du Congo
MRU - Mano River Union
MSF - Médecins Sans Frontières (Doctors Without Borders)
NGO - Non-governmental Organization (INGO - International)
NSAG - Non-state armed group
PEPFAR - President's Emergency Plan for AIDS Relief
PHEIC - Public Health Emergency of International Concern (same as GHE)
UN - United Nations
USAID - United States Agency of International Development
WHO - World Health Organization

Introduction—Emergency as a Disjuncture Between Discourse and Reality

As a mode of discourse that calls for a particular, routine procedure in response to a perceived health threat, the concept of emergency appears frequently in global health parlance as a method of distilling order from intrinsically complex environments. According to the World Health Organization (WHO), an "emergency" describes a "state" which "requires threshold values to be recognized", and which "demands to 'be declared' or imposed by someone in authority, who, at a certain moment, will also lift it" ("Definitions: Emergencies."). For the WHO, an emergency seems dependent on numerical figures that render certain conditions in affected countries acute enough to constitute a temporary event, discernible against a messy reality, that merits attention and intervention. In the WHO's emergency classification system, a Grade 3 emergency, the most severe, refers to "a single or multiple country event with substantial public health consequences that requires a substantial World Customs Organization response and/or substantial international WHO response" ("Emergencies"). This conception suggests a degree of arbitrariness and subjectivity behind the WHO's ranking system, which appears shared with the concept of the Public Health Emergency of International Concern (PHEIC), the organization's highest-level emergency at an international scale: "an extraordinary event…that is serious, unusual or unexpected, carries implications for public health beyond the affected State's national border, and may require immediate international action" ("IHR…(PHEIC)"). Formally declared by the WHO six times in the past decade, the PHEIC has from its beginning been shaped by decisionist processes that are politically subjective: what diseases deserve research and emergency preparations priority, and to what extent are wealthier nations obligated to poorer ones in PHEIC situations (Lakoff 2016)?

Despite the equivocal and still unresolved nature of these questions, the PHEIC has provided a welcomed sense of predictability and control in an era permeated by great uncertainty surrounding the emergence of new and known infectious diseases. The declaration of a PHEIC in 2016 in response to Zika virus in the Americas, which until its appearance was largely unknown to scientific communities, represented the process of "assimilating [it]...into a more general form, making it comprehensible and potentially manageable" (Lakoff 2). This example shows how the notion of emergency, borne out of the language of dread inhering within global health security, has become, rather than a description of reality, a discursive tool of typically wealthier, and mostly Western nations to gain control over a threat: Lakoff (2016) describes the technical and administrative measures encompassed by a Global Health Emergency (GHE) response as those which "function to constitute a given situation as an emergency, one that requires an urgent and rapid collective response" (6). This process of transforming a reality into an emergency is significant, as it signifies a potential disjuncture between the response mobilized and reality, an incongruence between the procedures that *ought* to work and the situation that *is,* between the perspectives of those who envision PHEIC procedures as a quick fix and those on-the-ground facing inherently complex issues.

Illustrative of this disconnect was the 2014-16 Ebola Virus Disease (EVD) outbreak in the Mano River Union (MRU) countries of Guinea, Liberia and Sierra Leone, better understood when placed into the historical context of the virus since its relatively recent discovery. First recognized by the Western scientific community in 1976 near a river in the DRC after which it was named, EVD is a virulent hemorrhagic fever with a case fatality ratio (CFR) of 50-90%[1]

---

[1] By comparison, the figure for the SARS outbreak in mainland China in 2002-2003 was 9.6% (WHO 2004, cited in Hewlett and Hewlett 2008), while the worldwide average mortality rate of Covid-19 as of April 2020 is about 3.4% (Adhanom-Ghebreyesus 2020).

existing in several species or subtypes. The novelty and danger associated with this disease

spurred a "Super-Ebola" simulation exercise in Honolulu in 1989 aimed at assessing the world's

capacity to respond to a global pandemic of Ebola, which jumpstarted the formation of the

GOARN and establishment of a governance framework for GHEs[2] (Lakoff 145). Yet Lakoff

(2016) argues that the general lack of large-scale Ebola outbreak until that which occurred in

West Africa shifted the international community's impression of the virus from one of

catastrophic potential to a manageable one namely affecting marginalized, rural communities,

which helps explain the world's slow reaction to the outbreak in West Africa in the mid-2010s[3].

Thus when WHO finally sounded the alarm through declaring the outbreak a PHEIC, it

confronted the consequences of its global health governance paradigm in poorer countries, where

the prioritization of disease surveillance system development had made minimal improvements

in underdeveloped healthcare systems (Walsh and Johnson 2018). The activated GHE response

machinery would be disadvantaged from the start, having failed to account for a non-robust

health infrastructure as well as local distrust of health authorities and the state.

　　With a death toll of 11,325 and a CFR of around 39%, the Ebola outbreak in West Africa

would bring a renewed attention to the imperative of community engagement from the outset of

---

[2] As Heymann et al. (2019) explain, the widespread availability of portable satellite telephones and video link-ups by 1995 allowed the transfer of images from journalists and camera crews arriving in Kikwit soon after the Ebola epidemic was announced; these technological capacities contrasted with those that existed during the previous major outbreaks on scientific record that occurred in the late 1970s, where representatives of the news media were absent. Subsequent representations of Ebola in Western media gave it connotations combining fear and exoticism: microbiologist Richard Preston's book *The Hot Zone: The Terrifying Story of the True Origins of the Ebola Virus* (1995), journalist Laurie Garrett's *The Coming Plague* (1994), and the film *Outbreak* (1995) starring Dustin Hoffman have all served to highly dramatize the virus through depicting first encounters with it (Hewlett and Hewlett 2008).

[3] Previous, isolated outbreaks were mostly successfully contained via the WHO's general approach: (1) isolation of infected cases (2) health education to inform the public about symptoms and modes of transmission (3) limitation of dangerous activities, such as unsafe burials of the deceased, and (4) contact tracing to identify and follow those who have had contact with the infected for 21 days, the virus' incubation period (Hewlett and Hewlett 2008).

an emergency response to address local mistrust[4] (CDC, 2019). As Abramowitz (2017) writes, the response was beset by strategic mistakes made early on that perpetuated its "structural disconnect" with social mobilization, leading to tensions between response agendas and protocols on one side, and the overlooked priorities and practices of affected communities on the other. African burial practices, which consist of touching the deceased and which were militaristically repressed due to the heightened contagiousness of dead Ebola victims, were presented as bizarre and backward in some Western media reports, while pathological accounts of "community resistance" were equally produced (Pellecchia et al. 2015); these perspectives homogenized complex communities while also presenting locals' efforts to conceal sick cases, and at times perpetrate attacks against elements of the response apparatus, as irrational and indicative of Africans' proclivity toward violence (Fairhead 2016). Important work by anthropologists helped counter the reductive and stigmatizing narratives these terms perpetuated through researching the ways in which individuals' lived experiences with the state can be implicated in different patterns of social "resistance" seen in this outbreak (Wilkinson and Fairhead 2016). Critical information gleaned from what went awry in gaining individuals' trust informed recommendations to prioritize community engagement from the start of a response through ensuring that listening, empathy, and the facilitation when possible of local ownership not be dispensed for rapid, urgent containment efforts that privilege security over public health and basic rights (Walsh and Johnson 2018).

Yet in reform efforts after the outbreak, all fingers pointed to the WHO's strategic failure after the major epidemic, advising that "WHO must substantially strengthen and modernize its

---

[4] This notion of mistrust had surfaced in previous Ebola outbreaks in Gabon and the Republic of Congo, leading to some violent attacks against HCWs; here, Western medical anthropologists recruited by the WHO ultimately proved effective in engaging with communities through understanding their perspectives and also identifying ways to reconcile and combine Western and non-Western medical paradigms (Formenty et al. 2003; Epelboin et al. 2007).

emergency management capacity": notably, the organization's approach to emergencies would be rationalized "through one set of emergency management processes and performance metrics that will be standard across the organization" ("Ensuring…Emergencies", cited in Lakoff (2016)). In other words, the same emergency response machinery that had been profoundly misaligned with local conditions in the MRU countries and hindered the response would undergo a uniformization and centralization, one which would have implications for the next Ebola "emergency" (Lakoff 2016).

The top-down, security-driven emergency paradigm would quickly witness the consequences of its disjuncture with reality in the eastern provinces of North and South Kivu and Ituri in the Democratic Republic of Congo (DRC), where an 18-month Ebola outbreak has encountered significant levels of local distrust. Declared as a Grade 3 emergency on August 1, 2018 and formally defined as a PHEIC nearly a year later on July 17, 2019, this ongoing Ebola outbreak as of April 19, 2020 has caused 2,242 deaths and had a CFR of 66%. Negative reactions from local community members to the presence of Ebola and the *riposte* have manifested since the beginning of the declaration in ways that parallel those seen in West Africa: the hiding of sick loved ones, avoidance of the Ebola Treatment Center (ETC) and response workers, and verbal threats and deadly physical attacks against ETCs, healthcare workers (HCWs), and humanitarian convoys. These forms of "resistance" have been conveyed in media and scholarly discourse with a pathologizing hue reminiscent of that seen in West Africa: framed as "misinformation", "rumours", "falsehoods"[5], and "conspiracies"[6], locals' interpretations of the

---

[5] https://www.thenewhumanitarian.org/news-feature/2020/1/15/Ebola-Congo-social-media-whatsapp-misinformation
[6] https://www.nytimes.com/2019/05/19/world/africa/ebola-outbreak-congo.html

events transpiring around them have been presented as products of their "ignorance"[7], and their problematic "beliefs"[8] and lack of education, thus emphasizing their irrationality. Yet as Alcayna-Stevens (2020) notes, these stigmatizing tones have shifted to a more investigative journalistic approach, examining the many alternative explanations for Ebola and the response provided by civilians that underpin their distrust; recurrent narratives present Ebola as a business to enrich the government, local elites, and foreign workers, and as a political tool of the government to exterminate populations in the affected provinces and/or to gain legitimacy.

These various forms of "resistance" toward the *riposte*, when placed back into their proper historical and sociopolitical contexts, reveal the fundamental disconnect between the constructed emergency response and lived realities of emergency of the populations affected. As a region profoundly shaped by the legacies of imperial, colonial and postcolonial violence that turned it into a warlord regime with an absence of state authority, it would become embroiled in the Congo Wars from 1996-2003 during which time it is estimated 3.4 million died of physical violence, yet mostly from disease, starvation, and mass displacement; the resulting humanitarian crisis has persisted along with silence from the international community. As a region where various non-state armed groups (NSAGs) have been known to routinely attack civilians, a widespread atmosphere of insecurity has shaped a securitized approach toward stabilizing it: a dominant state-building paradigm has manifested in the deployment of a United Nations (UN) peacekeeping operation that has bolstered Congolese armed force presence in the region and failed to protect civilians from violence perpetrated by the latter, fostering mistrust in state forces

---

[7]https://www.express.co.uk/news/world/1010639/ebola-latest-virus-supervirus-epidemic-ignorance-escalating-militia-violence-congo-cdc
[8] Vinck et al. (2019)

as well as foreign personnel. In this way, the Ebola response, also known as the *riposte*[9], led by

the Congolese government and as well as the WHO, a UN-body, has reproduced a structure in

which both national and international lenses are difficult to disentangle, hence the fusion of both

entities in the title of this thesis[10]. In the Eastern Congo, the existence of these forces, along with

a small handful of independent humanitarian non-governmental organizations (NGOs) in the

eastern region, symptomatic of chronic detachment of the national government, and world, to

reality in the region, have normalized a state of emergency for civilians, generating a landscape

of fear and distrust surfaced by Ebola.

Main Argument

The main argument is that the tenth Ebola outbreak in the DRC and the ensuing

(inter)national response have witnessed a convergence of two conceptions of emergency: one

created from a discursive tool that reflects Western notions of bio(in)security, and the other lived

as experiences of chronic crisis and its concomitant physical and economic insecurities. The

imposition of this temporary response and its treatment of Ebola as a disease posing "substantial

public health consequences", requiring "substantial" international action, and eventually, as an

"exceptional event" worthy of "international concern" implies in the eyes of those populations

most affected the insubstantial, and non-exceptional nature of other disease threats and sources

of insecurity that have killed far greater numbers of people than Ebola[11]. This message

transmitted to locals, without engagement of their perspectives from the start of the outbreak, has

---

[9] This word, originating in French, translates to "counter-attack", which as will be demonstrated has framed a response that in many ways has taken a militaristic approach.

[10] (Inter)National

[11] Endemic malaria, diarrheal diseases, lower respiratory infections, and neonatal disorders are all among the top ten causes of death in the DRC as of 2018, a list on which Ebola does not figure.

entrenched a disconnect between them and the response and considerably eroded distrust, a

significant factor that has hampered anti-Ebola efforts, and led to considerable and at times

deadly consequences for civilians and response workers.

Objective

While this thesis makes reference to other disease outbreaks, it seeks to work against

what Crystal Biruk (2014) describes as a reification of a global health that looks quite different in

separate locales, a common pitfall of reading across places. As many have noted, several

characteristics of the tenth Ebola outbreak compared with that of West Africa pose puzzling

questions: how can one make sense of the fact that the DRC outbreak, evolving in a much

smaller, isolated region of one country rather than the three MRU countries in West Africa, has

proven so intractable? Why, armed with a long list of lessons learned from the West Africa

outbreak concerning community engagement and other areas of health emergency response, a

more robust and updated scientific knowledge base on Ebola, and a demonstrably efficacious

vaccine, has the *riposte* seen such high levels of local "resistance", lasted 18 months, and

sustained a CFR 1.7 times higher than that seen in West Africa? While pondering these questions

may be useful in some respects, they also imply a commensurability between the conditions and

realities in both outbreak locations[12]. While some lessons learned in West Africa have been

neglected, others have been applied with varying levels of success: why? What are the precise

---

[12] Who is to say, for example, that certain types of strategies that worked in Sierra Leone, such as that of enlisting customary authorities as local intermediaries, would necessarily work in the Congolese provinces impacted by Ebola? As Joe Trapido (2019) has noted, in the DRC entrenched social hierarchies within communities have eroded trust of locals in their local leaders, and socioeconomic conditions have encouraged many local elites to profit from the outbreak through deliberately spreading misinformation.

conditions and histories in the Eastern DRC that have complicated the application of these lessons?[13]

While not taking an anthropological approach to examining the tenth Ebola outbreak, this thesis seeks to embody a spirit outlined by Biruk (2014) who calls for a more "particular" anthropology of global health, one attuned to Ebola *in a particular time and place*. By focusing predominantly on the case of the Congo, its history and its contemporary socio political realities, this project will devote itself to better understanding the specificity of the locale where the DRC's tenth EVD outbreak has unraveled, and seek to illuminate with the resources available the voices of ordinary people, civilians, not holding positions of power, who are oftentimes the most marginalized and underrepresented[14]. How does the relationship between this particular citizenry and their particular government impact a global health emergency?

---

[13] This thesis also seeks to work against analyses of the intractability of the Ebola outbreak that emphasize the role of armed group violence which tends to obscure the complex sociopolitical realities facing civilians in the region affected. Articles published such as that of Laurie Garrett which link the spread of Ebola in the eastern DRC to a fight over "conflict minerals" (https://foreignpolicy.com/2019/04/17/your-cell-phone-is-spreading-ebola/) perpetuates long-disproven tropes that link minerals and cell phones with ongoing violence in the Congo (Vogel et al. 2019). The outbreak's development in what many term an active conflict zone has made many scratch heads as to why disease containment in this particular locale has proven so challenging when in previous civil war contexts, such as the Biafran Civil War in Nigeria, and the Sri Lankan civil war, the delivery of medical supplies to those in need of it was largely successful. The discrepancy between the eastern DRC and these historical cases suggests the incommensurability between these locales, and the need to engage with the complexities of local power structures and distrust.

[14] By centering many parts of this thesis on populations most affected by this Ebola outbreak, many of whom are impoverished and historically marginalized, the author is conscious of how his analysis may identify with what Biruk (2014) terms the "global health slot". Derived from Trouillot's notion of the "savage-slot", this concept conveys a trend in the social sciences, and particularly anthropology, which when approaching global health topics tends to focus on the subject living in pain, poverty, or other oppressive conditions. While the author has attempted to work against this type of pathologizing scholarly approach through illuminating acts of African resistance throughout colonial and postcolonial rule and the voices of the people in the affected provinces, he recognizes how he inevitably does reinforce a kind of medicalized savage slot; the subjects and their testimonies that appear in this work, "are always already illuminated against the objects they move through, negotiate, come up against, and are narrated by (here, global health and its anthropologists)" (Biruk 2014). The author has thus sought to remain aware of his positionality in researching and writing about this topic, and hopes to, despite his complicity in this reality, highlight the injustices this emergency response has obscured and contribute constructive analyses and recommendations to improve responses for populations most affected by this outbreak.

The Chapters

The thesis will rely on various primary and secondary sources. Interviews were conducted with practitioners in the global health delivery and humanitarian sectors who were either on-the-ground in the DRC or who had previous field experience, and also with scholars in the fields of political science, Africana studies, and anthropology. In addition to interviewees, Social Science in Humanitarian Action Platform (SSHAP) reports, comprehensive compilations of surveys conducted by NGOs throughout the outbreak of community perceptions of the response, have provided the most raw data accessible to examine alternative explanations. Secondary sources have been pulled from the fields of history, global health, anthropology, Africana studies, political science, and humanitarianism and have provided contextual background and theoretical insights.

The first chapter is a context chapter that seeks to chart the history and more contemporary approaches to global health grounded in security. It seeks to help readers grasp the optics of global health security and its impact on approaches to health in Africa, which reflect colonial legacies and have led to cycles of panic and neglect in the continent that have hindered WHO's commitment to health equity in developing countries in Africa and elsewhere.

The second chapter is an historical context chapter on the Congo, aiming to provide a glimpse through an alternate lens, that of the Congolese, through tracing Congolese responses to Belgian colonial medicine as well as examining the history of violence and emergency in the eastern region of the country. The epidemic of trypanosomiasis (sleeping sickness), will be the main focus of the historical analysis of Belgian colonial medicine and convey the ambivalence that defines African engagement with colonial medicine, which would have legacies in Ebola responses after the DRC's independence. In this way the significance of African "resistance"

throughout imperial and colonial rule in the Congo will be highlighted and nuanced, which combined with an overview of the history leading to chronic, silenced crisis in the Eastern DRC will provide an important backdrop to the "resistance" seen in the Ebola *riposte*.

The third chapter seeks to unpack this "resistance" observed amongst communities affected by Ebola in the Eastern provinces of North and South Kivu and Ituri and convey how they reflect frictions between the optics studied in the first two chapters: a Western, biosecurity one and lived experiences of chronic insecurity. To examine "resistance", the stigmatizing connotations and inadequacies of the term will first be discussed while offering alternatives. Individuals' various responses to the presence of Ebola and the *riposte* will be examined according to the recurrent narratives that likely underpin them, thus illuminating socio-political realities in the affected provinces and communities.

The final chapter will reflect on the lessons that have been learned from the consequences of this convergence of different conceptions of crisis in the Eastern DRC upon the arrival of Ebola and its ensuing response; in particular, efforts will be made to tease out sentiments of fear and blame which health crises produce, and which are often expressed in ways that reflect and reinforce the power structures and inequalities that epidemics and international responses surface. This chapter will furthermore discuss how a politicized, securitized response to Ebola in the DRC has brought to the fore inconsistent definitions of peace and state authority between the Congolese state and independent humanitarian NGOs, and the implications of these tensions between Médecin Sans Frontières (MSF's) commitment to neutrality and emergency-based aid and the state's desires to affirm statehood and strengthen national health policy. The humanization of the Ebola response will be discussed through highlighting the innovations

developed by the Alliance for International Medical Action (ALIMA), while recommendations

for future Ebola outbreaks in the Eastern DRC will be made.

Chapter 1: Disease and (In)Security: Examining the securitization of global health and Ebola in African 'spaces of exception'

Securitization and Aid in a Time of Crisis

One could argue that in various ways, the Western imagination has evolved today to become hyper-aware of the precariousness of the world, prone to dangerous, isolated, and unpredictable situations of 'exception'. Caduff (2015) encapsulates this constant state of fragility he sees pervading contemporary discourse and conversations and governing our interactions and decisions in what he terms a "culture of danger", which has effectively supplanted more positive affirmations and predictions of the world's safety and stability. As human beings, our frameworks for interpreting the world are shaped by those memories that retain shock-inducing images and connotations often defying our imaginations: the September 11 suicide terrorist attacks and the 2004 Boxing Day tsunami in South and Southeast Asia, to name a couple. Consequently, in a world where no one is immune from the threat of terrorism, environmental catastrophe, nuclear Armageddon, as well as crippling economic collapse, individuals, many in the Western world, bear a perceptual set that primes them to look for, anticipate, and respond to emergencies on various scales. This generalized anxiety could reflect in the increased militarization of national and international politics, as well as in what Duffield (2013) and other scholars view as the securitization of the international development and humanitarian fields.

This heightened securitization in the West is underpinned by implicit logics that see many of the world's dangers ("emergencies") emanating from non-Western, mostly developing countries, a phenomenon revealed through the design and disbursal of international aid. The triumph of liberalism and market economies over communism at the end of the Cold War ushered in a new era in which international aid, primarily from developed to developing nations,

became instrumentalized to spread Western ideals of peace and democracy, and serve as an antidote to the dangerous instability associated with the Third World (Nascimento 2015). This formal end to communism also reinvigorated the West with a sense of control in a new unipolar world, in which the "Third World" became seen as a threat, and thus an entity to dominate through the avenue, or guise, of development and humanitarian aid. Consequently, the notions of "crisis" and "emergency", often invoked in reference to wars, natural disasters, and other extreme circumstances disproportionately enveloping the developing world, have prompted action on the part of the international community to allay the suffering produced, while also westernizing the places of intervention (economically, socially, etc.).

This seemingly humanitarian impulse seems difficult to detach from the "dangers of underdevelopment" intimated through a more politicized Western aid discourse (Enria 2017). Coinciding with the fall of communism in 1989 was a general shift observed from a humanitarian model predicated on impartiality and neutrality to one rooted in an ethos of liberal development, market economy, and participatory democracy (Nascimento 2015). In a time of great American and Western hubris, the Global South bears connotations as a source of volatility, a breeding ground for conflict, unrest, and danger that must be fixed through liberal interventionism by the West, thus collapsing aid and security. And the potential for the dangers of the developing world to affect the West was further entrenched in national policy following 9/11, when the notion of the "failed state", (in that case, Afghanistan), became a fundamental threat to Western security; the 2002 national security strategy states that "America is now threatened less by conquering states than we are by failing ones", thus synonymous with the unstable "Third World" countries (Bush 2002).

The Securitization of Global Health

Global health provides a useful example to study how the "Global South", or the developing world, remains discursively and imaginatively constructed as an emerging threat to the well-being of the Western-dominated world order. When examining global health as a discipline and field today, to note is the concept's evolution from that of "international health" which characterized health interventions throughout the late 19th and most of the 20th centuries. This linguistic shift generally signifies a larger philosophical one, from health work abroad focused on developing countries and predominantly concerned with addressing infectious and tropical diseases, water and sanitation, and maternal and child health, to a partnership between developed and developing countries collaborating to address health issues that are transnational in nature (Koplan et al. 2009). Theoretically, a more charity-based, biomedicine model that locates and contains health issues in the developing world has given way to an inherently multidisciplinary approach to achieving health equity in all nations for all people.

Yet despite this renewed identity of global health as an apolitical quest to achieve good health and health equity for all, some interventions in the field of global health today seem to preserve rather than dismantle the negative connotations of the developing world with disease-related dangers. The evolution and fortification of a more politicized humanitarian and development paradigm retains parallels with the field of global health, whose highly politicized nature seems continually reproduced through the securitization of the global health agenda. The connection between global health and security seems to have been forged beginning in the 1990s, when the WHO embraced "global health" in the political climate of newly victorious capitalism and liberal democracy and a Western need to protect this political and cultural hegemony. As the WHO came to strengthen its financial position through appealing to external

donors and forming global partnerships, so too did it come to bend its position to assume the role of protector of the West from certain diseases that were becoming increasingly threatening to the Occident; Ebola, West Nile Virus, and TB were all on the list of those diseases representing "palpable disease threats" associated with the 'Third World' (Brown et al. 2009).

And in the past two decades, this link between global health and security has been significantly shaped by the ongoing War on Terror. This U.S.-declared military and ideological war in reaction to 9/11 implicated disease in a new, complex terrorist threat, a response to the release of anthrax spores soon after the terrorist attacks. The emergence of this relatively unprecedented idea that diseases can become weaponized led biological terrorism to become a security issue managed by the Department of Homeland Security, who classified diseases into three degrees of danger posed by "potential bio warfare agents"; category A, in which Ebola and anthrax have been placed, represents the highest risk category for diseases that requires special action for health preparedness. This recognition at the policy level of the mass harm and havoc that could be wreaked with the appropriate knowledge, skills and resources has precipitated and preserved a robust biodefense protocol in the U.S., where substantial government funds are continually allocated to the construction and maintenance of biosafety laboratories, and research on vaccines and therapies to neutralize bioterrorist agents (Hewlett and Hewlett, 159)[15].

The connection between global health and security has been reified by the fear of possible pandemics of lesser known diseases, prompting security concerns at political and individual levels. A relatively recent development in the history of global health is the revision of the International Health Regulations (IHR) in 2005, and formally adopted in 2007 by 196

---

[15] To note here as well is the role that pharmaceutical developments at the time played in the mounting bioterrorism threat, as research such as that of Finkel et al. (2001) demonstrated how knowledge used to develop these drugs and vaccines can be used to develop biological weapons (Frischknecht 2003).

countries, including all 194 Member States of the WHO, who agreed to work together for global health security. These current regulations have evolved to encompass not only known but also unknown diseases and thus all potential threats to international health (Hanrieder and Kreuder-Sonnen 2014). These revisions, which require all Member States to report disease outbreaks and other health events to the WHO, have also been seen as marking a shift of public health authority to the supranational level.

This new authority governing the regulation of unknown or lesser known diseases can be seen in what Wenham (2019) explains as the framing of health threats as security threats, which can be seen in the WHO's naming of "Disease X" as a priority research need, due to its potential to be caused by a pathogen that could lead to a serious, international pandemic. Ebola, for example, was a known but minimally researched disease with no vaccines or therapies at the time of the West Africa outbreak that became the largest outbreak of the disease on record and that reached African countries outside West Africa, France, and the U.S.; consequently, the virus was declared by the UN Security Council in 2014 a "threat to peace and security", typifying the link between health and security (of the West) (Enria 2017). This declaration, indicative of the ways in which health crises can be viewed through security optics, is to be distinguished from the public health concerns driving the WHO's declaration of a PHEIC during the outbreak, a decision that, as will be discussed, is not uninfluenced by Western security concerns.

Global Health and the Pathologization of Africa

Western conceptions of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) in Africa serve as a point of entry into understanding the ways in which Africans have been associated with a disease-laden continent, evocative of colonial "civilizing"

ventures in Africa. In George W. Bush's 2003 State of the Union address, the then U.S. president

announced his proposal of the Emergency Plan for AIDS Relief (PEPFAR), and his demanding

of Congress to pledge $15 billion to this project, the highest amount of money ever committed

by one nation to tackle a single disease. The president's decision to create a governing apparatus

for PEPFAR apart from United States Agency of International Development (USAID) and the

Global Health Bureau, under the State Department, devoted exclusively to HIV/AIDS in Africa,

constituted a response that seemingly placed Africa at the center of the security threat posed by

HIV/AIDS at the time; in 2000, the UN Security Council passed an unprecedented resolution

related to a health issue, Resolution 1308, which "declared HIV to be a threat to security and

stability around the world" (Bradley and Taylor 2020). While the existence of an HIV/AIDS

epidemic in Africa contributing to staggeringly high rates of the disease was undoubted—over

50% of HIV/AIDS cases in the world at the time were in the continent—the urgency that

President Bush conveyed to address what he saw as a "severe and urgent crisis abroad"

reinforced connotations of the place as one of emergency and tragedy, home to a people in need

of rescue. The moral and ideological underpinnings of PEPFAR evoked a discourse reminiscent

of colonial "civilizing" ventures in the African continent that bolstered the superiority of the

West and the primitiveness of the African. The president, himself an evangelical Christian,

portrayed the new Emergency Plan as "a work of mercy beyond all current international efforts

to help the people of Africa", combining a sense of American exceptionalism with religious

undertones that drove the project.

     In historicizing 19th-century Western medicine which has given way to the economic and

moral hegemony of biomedicine in today's world, Comaroff (1993) discusses the healing

mission of the British evangelists in South Africa, whose rhetoric was to exploit the image of

Africa as savage and suffering. These white missionaries' depictions of the African led them to pose and ponder the deep moral ramifications of "[neglecting] to heal her wounds" and "[refusing] to disperse her darkness'' which "[justified] 'humane imperialism', making it a heroic response rather than one of economic or political self-interest" (Comaroff 313). One could ask how legacies of this racist, self-aggrandizing rhetoric, rooted in healing metaphors which laid the groundwork for a colonial public health serving to discipline black populations, are visible in Bush's very own rhetoric surrounding American actions to address HIV/AIDS in Africa. His determination to "provide humane care for millions of people suffering from AIDS and for children orphaned by AIDS", invoked next to his affirmations that allaying this suffering "aligned with American [imperial] values", served to bolster the heroic narrative of the U.S. PEPFAR provides a contemporary example of the continuity of colonial ideology's embeddedness in representations of disease in Africa, which rely upon conscious and unconscious constructions of the Africans' primitiveness[16].

While sowing a more pronounced sense of panic amongst American and Western populations than did HIV/AIDS, Ebola, notably because of its arrival in the West, elicited responses that reinforced an Otherization of Africans living in environments 'prone to disease crises'. One comment made by an American parent in response to a school letter notifying parents and guardians about two students arriving from Rwanda provides a salient example of this Otherization process: his combative statement, that "anybody from that area should just stay

---

[16] Colonial images of the primitive African body persist and serve to normalize the concepts of disease and emergency in the continent, while also Othering it. Achille Mbembe (2001) contends: "speaking rationally about Africa is not something that has ever come naturally" (1); the continent is an entity with its "peculiar feature that of shared roots with absolute brutality, sexual licence, and death" (1-2). The image of irrationality projected onto the continent, which in turn defies order, logic, sense, and even humanity, has proven an enduring strategy of the West in constructing its own self-image and rationalizing its own dominance. External discourse on HIV/AIDS in sub Saharan Africa serves as one example of the ways in which African physical and cultural traits were used to uphold an othering process that has been perpetuated through external discourse produced in reference to other "African" diseases, such as Ebola.

there until all this stuff is resolved. There's nobody affected here; let's just keep it that way," creates an Us versus Them dichotomy (Monson 12). The parent's use of the term "that area" plays into the Africa-as-a-country trope, and in doing so also suggests that over "there", in Africa, is where deadly diseases naturally generate, and should remain (Monson 12); his request to maintain the status quo, of preserving disease, danger, and death far away from "here", implies that such realities are to be kept out of the U.S. and the West, where they are not *supposed* to occur. This parent's comment joins a large group of commentary from mainstream media, forums and fringe publications, and everyday communication in the U.S. and the West that, in response to the possibility for a dangerous and diseased reality associated with the Othered Africa arriving in their "territory", fueled a panic that propagated during this outbreak.

The shock elicited from the West at the presentation of Ebola cases in the U.S. helps us to better understand what Adia Benton (2014) terms a "racial immuno-logic" that emerged from the West Africa outbreak, a term that helps one better understand the urgency the outbreak developed upon the arrival of cases in the West. A brief examination of the stories of three professionals comprising the Ebola response proves telling; one of these doctors was a Sierra Leonean national who contracted Ebola, prompting Sierra Leone's government to organize a medical evacuation plan for the doctor to Germany later denied by the WHO; around the same time, two Dutch nationals, suspected of having been exposed to Ebola-infected individuals, were able to flee to the Dutch embassy in Ghana, and then sought immediate evacuation to the Netherlands. These two stories read together illustrate Benton's concept of 'racial *immuno*-logic' at play during the outbreak, signifying that "wealthy whites are not supposed to die or fall ill when they are helping 'others'; they are believed to be immune to the tragedies that befall black Africans." Benton's subsequent analysis of a tweet in which a senior fellow in global health at

the Council on Foreign Relations denounced the infection control situation in ETCs after three American missionary workers contracted Ebola reveals its implications: the infection of white Americans, rather than the infection and death of thousands of black Africans preceding them, are what matter. And while the senior fellow dismisses the significance of black African deaths in her critique of infection prevention, she also fails to implicate the larger structural issues at play in the epidemic: the lack of preparedness of the three countries' healthcare systems which reflect legacies of colonialism, structural adjustment programs of the West, and donor biases in Western countries.

The WHO and Reinforced Cycles of Panic and Neglect Following Ebola in West Africa

The WHO has consistently been guided by its overarching objective: "the attainment by all peoples of the highest possible level of health", one it seeks to achieve through a broad approach to health promotion, which includes projects in the following areas: environmental hygiene, strengthening of health and epidemiological services, and advance work on eradicating epidemic, endemic, and other diseases (WHO Const. Art. 1). Yet since its beginning, the organization has faced considerable financial obstacles in working towards these more systemic goals. In the mid-to-late 1980s, a shift occurred from WHO's reliance on its "regular budget" (collected from Member States' contributions based on their population sizes and gross national products) to "extra budgetary funding" from multilateral agencies and rich, donor nations. Consequently, the WHO found itself at the mercy of the donors keeping its operations afloat, having to appeal to their demands and thus erect "vertical" health programmes completely independent of its other, neglected programs focused on building healthcare infrastructures (Brown et al. 2006). This period saw the ascendancy of the World Bank into the field of global health (which was then in common parlance referred to as "international health"), whose budget

exceeded that of the WHO. Yet despite its economic prowess, the World Bank pragmatically saw the WHO as the best-poised technically to have the reins in matters of health and medicine.

Subsequently, the 1990s saw the WHO assume the task of proving itself as a leader in the new "global health" field, which necessitated a financial repositioning of the organization, and an evolution in its particular role that consisted of tackling specific diseases at the expense of promoting longer-term health needs in developing countries. To obtain such a recognition at a global scale, the WHO in ways was forced to sacrifice its global, regional and country programs and supplant them with more focused global health initiatives that helped facilitate the construction of new global partnerships; the newly-elected Director-General of WHO Gro Harlem Brundtland's efforts were in many cases successful in creating long-lasting projects that would have considerable, long-term impacts on health in developing countries (Brown et al. 2006). Yet it is important to consider how the WHO's heightening acclaim at the international stage was also set against the backdrop of the panic-inducing HIV/AIDS pandemic. This new decade ushered in new anxieties about 'emerging' and 're-emerging' infectious diseases, and their potential to cause pandemics. Regardless of its commitment to effect longer-term health improvements in poorer countries, the WHO increasingly assumed the role of emergency responder by drawing on outbreak reports, and developing proposals for the extension of the IHR to cover all potential future 'public health emergencies of international concern', the first time this notion was invoked (Hanrieder and Kreuder-Sonnen 2014). Thus despite this decade that earned the WHO more legitimacy in the new field of global health, the pressure placed onto the organization in the face of increasing global disease threats contributed to an erosion of the WHO's longer-term sustainable health development goals through the formation of financial partnerships that did not facilitate, as will be shown, its sustainable financial security.

The WHO's successful response to the SARS outbreak early in the new millennium would provide the impetus for the formal institutionalization of its emergency powers through the creation of the PHEIC, a process that would in ways exacerbate the budget restraints that have always limited the WHO's capacities to fulfill its overarching objectives. Nowhere is the WHO designated as a primary responder in health emergencies; regarding health emergencies, the WHO's enumerated functions clarify its role in emergency preparedness, collaboration and coordination in emergencies, and provision of assistance and necessary aid in health emergency situations upon request of governments (WHO Const. Ch. II, Art. 2); additionally, authority is conferred to the Executive Board "to take emergency measures *within the functions* and financial resources of the Organization" (WHO Const. Ch. VI, Art. 28, emphasis added). Yet the exceptional public health measures the WHO took during the 2003 outbreak, which included publicly shaming states for having not complied with certain regulations, and implementing travel warnings for the most affected countries, facilitated its effectiveness in containing a dangerous, unexpected disease outbreak, and led WHO's Member-States to agree upon a codification of WHO's emergency powers in the revised IHR in 2005 (Hanrieder and Kreuder-Sonnen 2014). Under the revision, the UN-specialized WHO was endowed with the authority to declare a PHEIC. Up until Ebola emerged in West Africa, the WHO had used this capacity to declare two PHEICs: the 2009 H1N1 influenza epidemic, and global polio setbacks in 2014, to which it responded efficiently and further affirmed itself as a health emergency response leader. Yet with this increased discretion and recognition, WHO found itself overextended in its commitments, as well as financially restrained in an increasingly crowded global health arena, alongside public-private partnerships and non-state actors (Reddy et al. 2018).

And faced with the Ebola epidemic in West Africa beginning in 2014, the WHO would confront the consequences of its precarious financial status as well as its entrenchment as an emergency aid organization at the expense of its long-term, regional development goals. Lacking any medicines, vaccines or diagnostics with which to combat Ebola, the WHO, whose core budget depends on annual assessments of member states and donor-controlled trust funds for donor-selected conditions, was criticized by those who fund the organization and who ironically did not furnish it adequate funds to respond to the epidemic (Turshen and Gezmu 247). The WHO received paltry amounts of funding from the U.S. and other large donors for its Ebola response activities, after experiencing significant cuts to its budget in years preceding the outbreak[17] (Turshen and Gezmu 2017). The Ebola outbreak, in which greater funding was allocated to private, voluntary partners rather than WHO provides one example of how the WHO's more decentralized, regional approach to giving more autonomy to local governments to build robust, sustainable health systems continues to be marginalized.

What has been prioritized is donor-driven aid via NGOs from some of the most financially powerful global health leaders, including the Gates Foundation, Global Fund for AIDS, TB, and Malaria, and UNAIDS; these and other members of the "H8" along with their narrowly-defined disease priorities in Africa have contributed to "stove-piped health sectors" ill-equipped for responding to Ebola, as well as more generalized health issues in the affected countries (International Coordinating Group [ICG], 2015, in Turshen and Gezmu, 2017). Simultaneously, critical reports of WHO published by the ICG (2015) and Moon et al. (2015) in

---

[17] To better understand WHO's acute financing challenges, it is helpful to put its budget into perspective: the WHO's budget for the biennium 2018-19 was around $4.421 billion USD, while the annual healthcare and social services budget of Quebec, one province within Canada, is approximately $33 billion USD (Reddy et al. 2018). Scholars point out the irony in the fact that the WHO, charged with helping facilitate the "attainment by all peoples of the highest possible level of health", is obligated to function on a budget equal in value to that of the University hospital in Geneva, and less than that of many major hospitals in the U.S. (Kickbusch 2015; Gostin 2015).

response to the WHO's perceived shortcomings in responding to Ebola in West Africa have called for an expansion of the WHO's technical guidance and rapid early response capacities, and shrinking of its wide-ranging health activities (Turshen and Gezmu, 2017). Further preserved as an emergency aid organization, the WHO has become subsumed in cycles of development aid and emergency-induced panic that are continually reproduced in the neoliberal structuring of the global health arena[18].

And this structuring has had deadly implications for much of the continent; governments and philanthropists' financial power has come to dictate whose lives matter, and the health conditions they implicitly believe to constitute "emergencies". Indeed, as Maxmen (2019) notes in her analysis of the current Ebola outbreak in the DRC, "donors must be convinced of the value of their investments", which in the DRC has forced the WHO to leverage the PHEIC as a way to garner more financial support to respond to the outbreak. What Turshen and Gezmu (2017) see as "the international community's neglect of Third World public health" has reinforced global health inequalities, and seems to reveal an amnesia reminiscent of that described by Nascimento (2015) in reference to the humanitarian paradigm of the neoliberal era: a system "that simultaneously denies its own role in sustaining or addressing complex emergencies", a phenomenon which in global health has had significant ramifications for the rights and dignity of populations affected by epidemics (257).

---

[18] Lakoff (2016) conveys well how the entrenchment as an emergency aid organization has ultimately resulted in an erosion of WHO's power; despite the WHO's catapulting into the global health governance arena as a looked-to guardian of health since its formation, and now in the era of emergencies, its authority remains rather illusory; in speaking about the IHR which served to embolden WHO's emergency guidelines and operations, Lakoff (2016) writes "although the regulations served as the ligature for the strategy WHO called 'global public health security in the 21st century,' their actual operation rested on a twentieth-century paradigm of international health in which nation-states remained the site of authority and responsibility while WHO played a role of administrative coordination and technical norm-making" (3).

Securitization of Health in 'States of Exception'—Ebola as a Case Study

The securitization of the international response to Ebola in West Africa presents an important case study of the dangerous implications for democracy of the increasingly reified link between health and security. Bolten and Goguen (2017) apply Agamben's (2005) 'state of exception', a concept in which state-level strategies demonstrate the potential to transform democracies into totalitarian states, to understand realities faced by communities during the PHEIC response. There, a village chief in Sierra Leone instituted an 'iustitium', defined as "the suspension of law in response to a mortal threat to governance (such as invasion or civil war)," prompted by news of a nearby Ebola case. The authors contrast this chief's rapid quarantining policy to comply with national and international Ebola containment measures, with that of a neighboring village, whose chief decided to shelter an Ebola-infected individual and conceal the case. This latter community leader acted on a fear that his reporting the case would lead to the government seizing control of his village through the National Ebola Response Centre, which represented a hybrid "medical/security apparatus" that would "[usurp] any control that the chief or residents had over their activities" (Bolten and Goguen 2017). This response of the village chief and of the villagers of Mabele, who "in a crisis turned inward in order to evade 'capture,' both physically and in terms of the balance of power, by outsiders" anecdotally illustrates the local levels of fear and "resistance" to a coercive Ebola response that threatened people's individual and collective autonomies. The response's unique constellation of WHO responders, humanitarian actors and foreign and state military personnel, adopting policies of containment, isolation, quarantine and overall force, constituted a highly securitized response that infringed upon the very securities of those whom the response was supposedly seeking to protect from the disease.

Indeed, the national and international repression by military forces of these types of resistance in West Africa reveal the intimate relation between humanitarian and military intervention to safeguard public health. This outbreak saw an unprecedented convergence between peace-keeping style practices and health crisis response with the establishment of the United Nations Mission for Emergency Ebola Response, the first-ever UN emergency health mission, a product of decisions made by the UN Security Council. The wider application of security paradigms to managing public health crises led to a widespread militarization of outbreak containment in West Africa, visible in various elements of control: the establishment of military and police checkpoints throughout the three countries, enforced quarantines, and punitive measures for all those not adhering to control protocols. In these situations of high security, humanitarian and military actors are expected rather than unusual bedfellows: Fassin and Pandolfi (2010) discuss how "the two sides come together...in a reciprocal and asymmetrical dependency", a rapprochement which facilitates acceptance of militaries allied with humanitarians, and the protection of humanitarians in dangerous contexts (Benton 35). The highly securitized response to Ebola seen in West Africa, in which domestic militaries largely assumed the disciplining role under the auspices of foreign militaries, seems to have been informed by many of the security concerns associated with certain diseases, including Ebola, and its ability to become weaponized; consequently, during the outbreak the militarized state of Sierra Leone led one journalist, Bankolay Turay, and others to compare the "'invisible war' waged against Ebola to the country's civil war" (Benton 38). This civilian framing of Ebola as an "invisible enemy" helps one better comprehend the degree of extreme measures taken by domestic militaries to purportedly safeguard public health. As Benton (2017) explains, acts of violence and suppression occurred with some frequency among vulnerable and marginalized

communities: one example is in the West Point area of Monrovia, Liberia, where police and military opened fire and used tear gas against area residents who had become irate over an enforced quarantine and other measures taken without their consent (40).

Despite the positive impact domestic military forces can have in a response, the West Africa outbreak showcases how viewing Ebola through an emergency lens can lead to the transgression of ethical laws and principles for the safeguarding of "public health". Under International Human Rights Law, the Siracusa Principles state that "public health may be invoked as a ground for limiting certain rights in order to allow a state to take measures dealing with a serious threat to the health of the population or individual members of the population" (UN, 1985, cited in Cailin and Poncin 2015). Public health ethics also outline how collective actions such as quarantine, isolation and other public health measures can outweigh individual autonomy in public health emergencies, so long as such actions are grounded in public necessity, non-discrimination, scientific rationale, demonstrated effectiveness, reciprocity, justice and fairness (Cailin and Poncin 2015). Yet in West Africa, the quarantining techniques violated principles of non-discrimination, in that they sought to control the movement of those suspected of concealing their symptoms. Additionally, forcible quarantines in West Africa, lacking scientific evidence, led to severe stigma as well as temporary losses of livelihoods and personal possessions that only exacerbated poor families' and individuals' socioeconomic and health statuses (Cailin and Poncin 2015). And "resistance" to such coercive quarantines by vulnerable, marginalized communities in West Point, Liberia and Womey, Guinea, among other places, elicited repressive and violent retaliation from military and police personnel. One could argue that this marginalization and disproportionate disciplining of certain communities placed them into the latter category of Enria's dichotomy of "Ebola heroes and dangerous bodies": in contrast

to the "active citizens that accepted biomedical expertise and took charge of sensitization drives", those resisting were viewed as "holding up progress...putting their society at risk'' (1614). This simultaneous elevation of those complying with the response and problematization of those deemed recalcitrant was concomitant with a stigmatization and rejection of traditional medicine and cultural practices, such as burial rites; consequently, existing social tensions and inequalities in communities were exacerbated.

Importantly, these overt acts of "resistance" were removed from their specific historical and socio-political contexts rather than signaling the need to critically engage with local people's perspectives; this reality demonstrates how events framed as emergencies tend to necessitate rapid responses that privilege certain "expert" voices, such as epidemiological ones in public health crises, over others, thus eclipsing local voices. As Benton (2017) writes, "an effort to demilitarize and downplay the coercive effects of public health requires dialogue and deep understanding of local political and social conflicts" (41). If anything has been learned from West Africa, it is that of the importance of seeking to understand the complexity of lived experience on-the-ground in outbreak environments, so as to avoid sacrificing the knowledge integral to achieving trust and responding to any disease outbreak. This thesis seeks to examine the extent to which these lessons have been learnt and applied in the current Ebola outbreak in the DRC, an analysis that subsequently requires an overview of the complex historical and socio-political terrain of the outbreak's environment.

Chapter 2: The View from the "Other": Tracing the History of Responses to Medical Intervention in the Congo and Chronic Emergency in the Eastern Provinces

Understanding Resistance to Address Silences in the Congo

Any attempt to examine and understand local perceptions of the national and international response to Ebola in the eastern DRC should begin with efforts to grasp the complex historical context of the country from its imperial inception, and the precise socio-political responses its Western-ruled origins engendered. Of particular interest in this thesis are the ways in which the introduction and oftentimes imposition of European medical models were interwoven with colonial conquest, eliciting simultaneous forms of "resistance" and engagement with Western medicine. The Congo provides a unique case to study these linkages between medicine and colonialism, which would characterize other colonized countries in Africa and elsewhere and have complex legacies on local reactions to international health responses.

The complexities of this medical history should be placed against the backdrop of two major realities that characterized the Congo under Belgian imperial and colonial rule: 1) continual exploitation, violence, and physical and cultural oppression of the Congolese at the hands of Belgian colonizers, and 2) the emergence of different forms of Congolese resistance to the conditions forced upon them. Shedding light on these two components of Congolese history that this thesis seeks to tell corresponds to the importance of working against the silencing mechanisms that international forces and representations have on the atrocities perpetrated by Belgium, and that have removed agency from colonized peoples. Attention toward this second component can also help avoid what Depelchin (2005) views as a disproportionate focus on "facts of resistance" rather than "how the resisters defined and understood in their flesh, so to speak, what they were resisting", a trend in scholarly discourse which reflects legacies of

profoundly unequal access to the power to tell stories between those from colonizing and colonized societies (5).

Furthermore, in studying any sort of contact between peoples bearing different histories, origins, and experiences, attention must be given to culture, whose definition will be taken from that used by Hewlett and Hewlett (2008): "knowledge and behaviors transmitted and acquired through social learning" (14). Culture, as they explain, governs how humans think and feel, and in the case of medicine, critically informs their perceptions of the type of medical care they receive and feel is appropriate (Hewlett and Hewlett 15). And importantly, past events experienced individually and collectively, such as the terrors and upheavals of colonialism, can have profound effects on how societies view and interpret the actions of others, which can become embedded in culture and passed onto future generations. Hence the importance of an historical analysis of the events transpiring in the Congo under Belgian imperial and colonial rule, neocolonialism, and continual external aggression which will help one begin to grasp the histories that prompted a multiplicity of responses, some resistant, some more receptive, advancing colonial encounters as dynamic rather than static processes.

Imperial Violence and Primary Resistance in the Congo Free State

At the onset of Belgian imperial rule, over 250 ethnic groups inhabiting the region that is now the Congo would be brought together as an arbitrarily defined geographical entity, subjected to the strategic use of terror and violence by the imperialists. In King Leopold II's Congo "Free" State, which in reality operated as a "private enterprise" sustained through the plunder of the Congo's natural resources, notably rubber, a "draconian system of forced labor" was elaborated and implemented by colonial officers (Stearns 7). In what many term an unknown holocaust, the

King defaulted to the systematic use of torture, murder and other inhumane methods to eliminate any and all resistance posed by the Congolese, fitting Depelchin's (2000) definition of conquering: "silencing those who might resist and/or might speak credibly about being conquered" (210). And outside the Congo, silencing of the truth was pursued through a media campaign furthered by the King and his entourage that gave the Belgian presence in the Congo a strong, humanitarian veneer, "disguising…[it] as a humanitarian venture for scientific research and economic development in Central Africa" (Stearns 7).

The extreme brutality of the Congo Free State (CFS) would lead to different forms of resistance, to be distinguished by their ideological stances on colonial domination. One group of Europeans and Africans, and African Americans attempted to lift the systemic silencing of the CFS terror through organizing the first-ever transatlantic human rights campaign, the Congo Reform Association (CRA)[19]. Yet Nzongola-Ntalaja (2002), while appreciative of several European and African men's successful efforts to end the brutality of the Leopoldian Congo, clarifies how they "did not represent a radical departure from humanitarianism as a social practice," targeting the "symptoms" of the Congo problem rather than the "root causes": the ideology of imperial domination[20] (26). Their "heroism" as Hochschild (1998) describes it, is to be contrasted with primary modes of resistance as Nzongola-Ntalaja (2002) describes: "armed struggle waged by an African people or state against the imposition of colonial rule" (42). This struggle would be taken on by Congolese professional warriors defending their territorial and

---

[19] These men, who combined their skills in photography and journalism into a political movement would document the abuses of the CFS, and would also have a legacy on humanitarianism visible in the presence of NGOs around the world that preserve a concern for human rights abuses globally.

[20] Indeed despite their important work in generating an adequate, global outcry to end the brutality of methods used by the Belgian imperialists, images produced by the movement in ways also objectified the Congolese and violated their agency. As Hunt (2016) writes, "The Congo atrocity photographs...reify maimed, black bodies, producing a traumatic form with an 'insistent grammar of sight'", thus reducing the Congolese to the level of victims, and like the imperial and soon-to-arrive colonial system, effacing their humanity, a mechanism of objectification that would resurface in future, internationalized Ebola outbreaks (28).

trading rights in the Congo and defectors from the colonial army (42). Within the Force

Publique, a maintained hierarchy of Africans with Whites at the top, regular abuse of African

subordinates, and inadequate pay and food engendered contempt that sparked multi-ethnic

revolts which in turn reified a sense of Congolese solidarity against the racist system (45).

The Ambivalence of African Responses to Belgian Colonial Medicine: Sleeping Sickness as a Case Study

Unraveling around the same time as these active forms of defiance was a more

ambivalent response from the Congolese to one important element having a complex yet

nonetheless participatory role in colonial conquest: the Belgian medical service. Here, studying

colonized people's responses to medical interventions in cross-cultural contexts in the Belgian

Congo presents ideal opportunities to interrogate the ways in which the Belgian colonial medical

service elicited 1) "resistance" of the Congolese, which at times blurred the lines between

Congolese healing responses and insurgencies, and 2) engagement of the Congolese with

Western medicine. To parse out these responses, the author will rely heavily on the

comprehensive history, complete with illuminating primary sources, of the Belgian sleeping

sickness campaign provided by Lyons (1992), as well as her scholarly approach which

emphasizes the importance of placing medicine *within* history to obtain a more nuanced and

accurate understanding of the responses it prompted. By focusing on the Belgian medical

response to the epidemic of trypanosomiasis (AKA sleeping sickness), this analysis will also

follow Lyons' (1992) assertion of the importance of analyzing both disease and medicine

together, in order to grasp the ways in which this specific disease acquired particular meanings

and responses to be distinguished from those of other diseases. This section will also make use of

Hunt's (2016) analysis of Congolese therapeutic responses to Belgian colonialism and disease

campaigns as embodied by the subversive character of a woman healer, and the ensuing difficulties in disentangling Belgian medical and security concerns during the colonial era.

The Congolese' own perceptions of the impacts of Belgian colonial rule in some respects necessarily involved the European power's role in wreaking more harm and havoc on Congolese lives through the propagation of sleeping sickness. The Belgian colonialists actually contributed to the spread of this disease through continually forcing Congolese to collect rubber from *Landolphia* vines, in areas infested with the primary vectors of the illness, tsetse flies (Headrick 2014). This reality became especially prevalent during WWI, when a large increase in European demands for rubber led to increased pressures on territorial governments to increase rubber collection in their districts; in July of 1915, the vice governor of Province Orientale, Malfeyt, instructed all his administrators that "the moment is...favorable to bring back the natives to the rubber harvest"[21] (Lyons 34). Consequently, these demands and the harsh punishments inflicted on the Congolese for not satisfying rubber quotas induced many Africans to flee across colonial frontiers, as well as travel long distances into areas where they would come into closer contact with tsetse flies. Commissioner of Uele district in April 1917 would assert that the collection of rubber had become likely the principal cause of the propagation of sleeping sickness; and a senior administrator with years of experience in the north would explain in reference to the "blacks in the centre of Africa" that "we did not even protect them from the scourges that we have propagated in the necessity of occupying the country" (Lyons 36).

Faced with a colonial regime that was harmful and deadly due to oppressive conditions as well as disease, the people of the northern Congo would have trouble dissociating the prevalence of deadly sleeping sickness from the overall political and military conquest of their lives:

---

[21] "Le moment est...favorable pour ramener les indigènes à la récolte de la gomme"

It is not surprising that by the early 20th century, many African peoples perceived the increased incidence of disease as a kind of biological warfare which was part of the overall upheaval and chaos brought about by European military conquest and the roughshod tactics which accompanied early implementation of colonial authority" (Lyons 3).

One Congolese woman Maria N'koi, a famed healer, spoke out against the Europeans who caused and spread the sleeping sickness. Apparently overheard linking the risk of black extinction with the necessity to expel whites, she responded to colonial interrogators after her arrest, "why would I make war with the whites?" (Hunt 82). This linking of extermination, yet more largely intentional war and violence, with disease interestingly echoes anxieties of the West about bioterrorist threats posed by diseases endemic to colonized regions whose propagation was facilitated by colonizers themselves. Consequently, the Congolese' perceptions of the intimate relation between colonial subjugation and disease would foreshadow local responses to disease epidemics and international responses later in the 20th century and into the 21st century in Central Africa.

Research conducted by the Liverpool School would advance an inaccurate aetiology of sleeping sickness that would inform the stringent and in many ways dehumanizing containment measures of the Belgian colonial campaign against the disease. Invited by King Leopold II of Belgium, scientists from the Liverpool School in England studied sleeping sickness in the Congo beginning in 1903, performing physical examinations, autopsies, and other procedures involving African bodies, while completely neglecting the ecology of the disease. Their assumptions of sleeping sickness being a contagious and infectious illness led them to conclude that because "parasites were found sporadically in blood and spinal fluid...it was important to watch cases of trypanosomiasis very carefully in order to exclude secondary infections" (Lyons 92-3). Their additional finding that "there was a low percentage of *T. gambiense* infection among the natives

of the lower Congo region" seemed to be explained by a Liverpool team member John Todd's linking of the spread of sleeping sickness to the movement of Africans from west to east in the Congo territory[22]. Operating under the assumption of the superiority of the European medical ethos over African knowledge or capacities to combat the disease[23], the Belgians would elaborate a strategy of isolation of infected individuals as well as suspected cases through the use of the *cordon sanitaire*. On 7 December 1905, the Liverpool researchers would issue their "First comprehensive Sleeping Sickness Instructions" systematizing the isolation strategy: infected individuals and also suspects had to be moved to *lazarets*, isolation centres; and if natives had to cross a river to get to the lazaret, "they were placed in movable cages surrounded on all sides by fine wire net" (Lyons 108). Conditions inside these isolation centres were generally deplorable, and frightening for internees: in June 1910, the lazaret director Dr. Bottalico shared that "We have had no meat or fish, as what should go to the patients has been taken for the labourers and soldiers...people who are here...often stay months and receive no salt or oil and are forced to roam about haggling" (Lyons 114). By 1910, the mortality rate at Ibembo lazaret had reached 33%, and because of the associations made between the centers and death, as well as patients' separation from their families, the lazarets became known as 'death camps'[24] (Lyons 120).

Yet Africans did not unanimously accept these dehumanizing conditions, as well as the imposition of forced physical examinations and vaccines that conflicted with local disease aetiologies and medical paradigms; rather, for some who survived, their active observations led

---

[22] This geographical lens through which the researchers viewed the disease supported the Europeans' perception of the disease as an "alien invader", an "enemy" that had to be prevented from encroaching on uninfected regions; this analysis informed the intense campaign against the disease that was conceived of as a "lutte" or battle, a marrying of public health with security that would have apparent legacies in the Congo (Lyons 56).

[23] A medical administrator in 1943 asserted that "we know how primitive and futile was the knowledge of the natives in matters of hygiene" (Lyons 103).

[24] Despite the expressed opinions of some doctors at the time against the coercive isolation of infected or suspected Africans, as well as the forced administration of the atoxyl medication, which was shown to cause blindness in some, these protocols would dominate the Belgian medical approach.

them to forge several forms of overt and passive resistance that were successful in triggering

reforms in the Belgian colonial services in 1910. While in response to the horrid state of the

lazarets, riots at Ibembo and elsewhere should also be read as a consequence of the incongruence

between European and African conceptions of quarantine: while the African model followed the

principle of removing an individual from harmful influences in their social sphere, the Belgian,

and more largely, European model was based on protecting the group from the individual (Lyons

190). In response to physical examinations, which for most Congolese represented a foreign and

invasive procedure which they opposed for many years, individuals would hide from authorities,

often with the help of their local chiefs. The needle, also an invasive technique, had horrific

connotations for Africans that led them to flee from doctors, and that also inspired rumours that

doctors were using needles to deliberately infect people and spread diseases (Lyons 189). These

various forms of "resistance" engendered tangible reforms that in ways improved natives'

experiences with the Belgian medical system. In response to such pressures from Africans, the

lazarets became more open, "village-lazerets", to which only the patients in the most advanced

stages of the disease would go. Less "prison-like", these new centers could welcome patients'

immediate families, while patients with less advanced symptoms could be treated at injection

clinics located closer to their homes (Lyons 126).

However, these reforms would also coincide with the shift to a colonial-ruled Congo, a

transition in which the new colonial administration would affirm its legitimacy and control of

African peoples through methods in which medicine and security reinforced each other. Indeed,

reforming the medical services seemed to provide a convenient way for the Belgian colonists to

not only quell African insurrections, yet also separate itself from the unconscionable horrors of

the CFS by appearing more "humane" as they continued conquering the native peoples. The

imposition of medical passports as well as surveillance and screening stations for sleeping sickness became measures of control of the new colonial administration: on 30 April 1910, all Africans had to carry medical passports, while at the stations Africans were examined and also issued passports to further control movements. In addition, increasing surveys of sleeping sickness in the north were completed by European doctors, who, when accompanied by administrative representatives, led natives to equate the public health campaign to other facets of state control, such as taxing (Lyons 132). The natives' conflation of medical and state hegemony brings back the enigmatic figure of the healer Maria N'koi, whose speaking out against sleeping sickness, and assertions that Belgium's archenemies, a set of ancestral spirits, would "help her charms drive the Belgians out of their colony", inspired a tax rebellion and armed insurrections; her consequent arrest and relegation by the Belgian colonial state, as Hunt (2016) argues, demonstrates her to have been emblematic of the ways in which "healing" from disease and insurgencies against elements of colonial rule became intertwined. While she herself represented a security threat, so too did many of the African natives whose supposed recalcitrance precipitated an increasingly highly securitized Belgian medical operation, in which doctors going into villages in the 1920s and 30s were accompanied by armed soldiers of the Force Publique.

In this way, the more negative responses and forms of "resistance" to Belgian medical services must be contextualized within a system in which medicine and colonial power were intimately linked. As Lyons (1992) writes, "healing conferred authority, and medicine throughout history has been related to power", a power that in colonial situations infringed upon fundamental notions of cultural, and consequently, national, autonomy of the colonized (197). Through an analysis of the reactions of Algerian colonized peoples to Western medicine introduced by the French colonizers, Fanon (1965) propounds that what he frequently observed

as a rejection of Western medicine from the colonized constituted an effort on the part of this group to defend its individual and collective identities. In his view, the colonized individual views any form of acceptance of Western medicine as a validation of the "Western technique", engendering a sense of alienation from their own culture, and thus from their own self (236). Medicine was one among many elements of colonial rule with which colonized peoples' ambivalent engagements distanciated them from their own bodies, violating their agencies. In this way, their forms of "resistance" signify not necessarily an outright rejection of Western biomedicine, but rather their efforts to survive and preserve their basic human rights, asserting their agency, identity, and more fundamentally, their humanity.

Africans' more positive responses to the Belgian medical services aimed at addressing sleeping sickness and other medical issues, reveal how the particularities of the sleeping sickness campaign produced considerable barriers to effective medical intervention. Evidence shows that receptivity of natives to the sleeping sickness campaign could be explained by the fact that they witnessed favourable results of treating a chief, whom they respected and trusted. Natives could have also sought out the lazarets for their family members when the latter were in advanced stages of the disease, viewing running away or abandonment of the victims as the only possible responses. Yet as a general trend, most Africans avoided the lazarets and the hospitals, while colonized subjects in the Congo were generally open to other forms of medical care, such as the removal of visible, painful hernias, and also later in the colonial era, injections for yaws, which led to its eradication. Indeed, some historians do argue that biomedicine and public health were important and positive legacies left in the wake of Belgian colonial rule, an opinion which deserves exploration. Despite the predominance of a vertical health approach as well as a medical campaign that in many ways buttressed state power and policed African bodies, Belgian

colonialism would lead to the creation of rural primary health clinics and health services. These positive contributions of colonialism to medicine should not be discounted, as well as the positive ways that Africans themselves interpreted and engaged with some elements of these developments. The sleeping sickness campaign and its mostly negative features and responses illustrates the consequences of power and politics being inextricable from the declaration and response to epidemics, in contexts that reflect historically unequal relationships.

Legacies of Colonial Medicine in Ebola Responses in the Congo

While the Belgians argued that the success of their medical service was "best exemplified" by their capacities to contain sleeping sickness, it seems that improved overall health in the colonies beginning around 1930 could have and should have been attributed to the development of a more generalized, and cost-effective, health delivery model that Lyons (1992) refers to as 'horizontal'; this approach was characterized by an increased prevalence of primary health clinics permitting treatment of a broader range of health issues including infant and child care, nutrition, public health and sanitation, endemic and epidemic diseases, and vaccination campaigns, such as for smallpox; ordinances such as those of 27 May and 10 June 1925 calling for African *infirmiers* and medical assistants and African auxiliaries in medical services, and those of 1930 recruiting Africans as sanitary guards to assist with hygiene measures in urban centers, seemed to lay the groundwork for a more robust medical service comprised of Africans (226); this equipping of Africans themselves with the skills to contribute to improvements in hygiene could be a factor in the improved overall health trends observed beginning in the 1930s, correlating with the decline of sleeping sickness.

Points made in an address given in 1929 by Dr. A. Wauters, a member of the National Committee of Kivu and Secretary of the Colonial Commission of the Belgian Workers Party,

also suggest that other related social factors could undergird such improvements; faced with the consistent reality of population decline in the Congo, Belgian social policies at the time called for not only the setting up of Health and Sanitary Commissions, but also improved nutrition and maternal and child health in wage labourers and women and children: "taking into consideration local difficulties in regard to supplies, [regulations for employers] lay down the quantity of fats, hydrates, carbon, etc., which rations must contain, and even mention the requisite number of calories," while various Infant Welfare and Maternity Centres, and schools for native midwives were successfully organized (59). The partitioning of each of the four provinces into economic zones which granted the Congolese concessions for various undertakings, including agricultural ones that allowed natives to remain in their natural environments and pursue jobs with which they were accustomed, could also have facilitated more Congolese economic self-sufficiency, and a decline in the social and economic reshuffling that had defined Belgian colonial rule for so long and contributed to displacement and famine. "Spreading professional instruction as much as possible" was an additional cited priority of Wauters, who also lauded the education of over 1 million students in schools throughout the Congo (59); hence, improved basic health services and social conditions in the Congo, rather than the narrow focus on single epidemic diseases such as sleeping sickness, seem more compelling factors in the decline of the disease and general, positive trends seen in health beginning in the 1930s.

Yet as these underlying factors suggest, the variation in health status of natives became a mirror for that of social conditions in the Colony, which by 1960 had resulted in an uneven distribution of improved health, that was also exacerbated by the colonial power's fixation on addressing several endemic and epidemic diseases. Notably, disparities manifested in health standards and living conditions between urban and rural areas of the Congo, with poorer natives

in the rural regions lacking hygienic controls of food supplies and clean drinking water (U.S. Dept. of Health, Edu, and Welfare III). By 1960, health services, channeled through hospitals and dispensaries, and aimed at the main endemic diseases—malaria, sleeping sickness, leprosy, and tuberculosis—provided only one bed per every 16,000 inhabitants throughout the Congo. Simultaneously, by the time of 1960, no Africans had been officially trained as physicians, while the practicing European ones were stretched to meet the needs of a large population. Thus, these conditions characterizing the colonial epoch and bearing a legacy on the post-independence era set an important backdrop for the 1976 Ebola outbreak. With "health standards and living conditions [varying] markedly...among peoples in different stages of cultural progress" in the Congo, many in the rural provinces, areas with a dearth of "modern" medical services, would witness consecutive Ebola outbreaks; these epidemics would elicit local cultural responses that would in different ways conflict with international health responses reminiscent of colonial public health responses to epidemic diseases (U.S. Dept. of Health, Edu, and Welfare III).

The Congolese response to contain the first Ebola outbreak in Yambuku, Zaire (now DRC) in 1976 provides a useful example of how the knowledge, skills and resilience to respond to disease outbreaks remained immanent within local cultures and belief systems. As Hewlett and Hewlett (2008) explain, the outbreak, which had an 88% CFR and saw 318 deaths, was relatively short-lived and contained by the local population before the arrival of international teams. Many inhabitants of Yambuku explained that the Ebola outbreak originated from ancestral spirits disgruntled over a "human transgression" which led them to send magical poison darts, *ndoki*, to cause illness; the invocation of this term, *ndoki*, which as analyzed by Likaka (2009) was historically assigned by many Congolese to a colonial station chief whom they saw as using harmful stereotypes that denied them justice during colonialism, could suggest a fear or

mistrust of white foreigners in the "human transgression" referenced in the Ebola story (93).

With no foreign presence in Yambuku during the outbreak, villagers turned to local strategies

that helped halt the spread of the disease: following the orders of healers and chiefs, they erected

bamboo poles with special, protective objects, while maintaining dutiful knowledge of who

entered and exited their community (Hewlett and Hewlett 104). Yambuku residents also

abstained from traditional burial practices that involved touching loved ones (105). After this

outbreak, a subsequent one in Kikwit, DRC in 1995 would be shaped by a local response

indicative of a more pronounced resurgence of colonial and postcolonial memories influenced by

international presence.

Indeed, the origin stories for and local reactions to this Ebola outbreak, bearing a similar

death toll and CFR as the one in Yambuku, revealed and reinforced the accumulated beliefs and

meanings surrounding foreign medical personnel held by recently colonized, African

populations. While local perceptions and responses to the outbreak received scant media

attention, several sources do discuss local explanations for the outbreak suggestive of the deep-

rooted mistrust of internationally-linked personnel[25] (Hewlett and Hewlett 105). One origin story

---

[25] What did receive substantial Western media attention was the sensationalized suffering caused by Ebola, which transmitted inaccurate portrayals of the outbreak. Heymann et al. (1999) note how representatives of the news media arrived unannounced, breaching ethical standards such as patient consent to be filmed, and demonstrating gross cultural insensitivity by filming family members caring for the sick and burying the dead. The authors also note how this presence of Western media personnel greatly disrupted the work of response teams, rendering necessary resources such as response vehicles more scarce for response crew.

The sensational dimension to this media frenzy which certainly contributed to the fear-inducing, exotic connotations of Ebola seen in Western films and books emerging around the same time also, as Heymann et al. (1999) argue, played a critical role in facilitating a rapid, timely mobilization of national and international experts and resources to adequately contain the outbreak. This role of the media in eliciting international attention and concern seems to continue a trend begun in the Congo during the Free State years with the CRA; in Kikwit, as well as in imperial Congo, Congolese continue to be victimized, their suffering amplified for the gaze of the international community, and thus they remain to a certain extent objects for the West. This outbreak, which solidified an internationalization of Ebola, resurrects conversations about the ethics of the CRA, as both events importantly engendered concern from outsiders at the "suffering" of Congolese, while at the same time not advancing criticisms of larger systems (i e imperial/colonial ideology, and structural adjustment programs and neoliberal policies perpetuating the underdevelopment of the DRC's healthcare resources).

recounted that the Ebola outbreak was caused by the curse of Kungu Pemba, the chief of the village of Kipuka who was the first local leader in the region to resist the intrusion of the colonial state, and who punished foreigners and national elites when trespassing on his grave. A disease outbreak seemed to resurrect for villagers of Kikwit notions of resistance and the defense of local autonomy, identity, and independence, all of which Pemba embodied. Some villagers also believed that an American missionary working in a nearby hospital was at the origin of the Ebola transmission: vengeful following his capture by other missionaries for having transformed into a hippopotamus and terrorized locals, Dr. Fontaine then conspired with Mobutu, the country's Western-backed dictator, to obtain the Ebola virus in a European lab and then deliberately infect villagers of Kikwit, a village Mobutu disliked (Hewlett and Hewlett 108).

The responses elicited from local communities to Ebola outbreaks in the DRC seem to have given voice to these names, non-violent forms of expression and opposition to colonial rule that were passed down to generations, and embedded in colloquialisms and everyday conversations. Kungu Pemba's name encapsulated what he symbolized for locals: *kungu* coming from 'Kongo', the name of the precolonial state, and *pemba* referring to whiteness, *pembe*, of ancestral spirits, ideas emblematic of his comforting, guiding nature untouched by colonialism and corruption. Contrastingly, Dr. Fontaine's American, white, foreign identity led to depictions of him as a source of fear, violence, death, and evil, representing the antithesis of the ideals embodied by Kungu Pemba. Likaka (2009) analyzes the ways in which Congolese people's naming of representatives of colonialism constituted less overt forms of resistance to colonial rule through cementing negative associations with such figures and inscribed into Congolese collective memory. This naming strategy also gave voice to a profound fear of the Belgian colonizer that villagers sought to propagate throughout their communities: names such as

Chakundia, 'he who can eat me', and *Koma-Koma,* 'he who can strangle me', seem to bear a resemblance to the threatening images created of Dr. Fontaine[26] (Likaka 96). The ways in which colonial and postcolonial figures feature in the narratives produced by local populations illustrate what Hewlett and Hewlett (2008) see as the "unmistakable links...between the missions, whites, biomedical healthcare, and the postcolonial state", and the lack of sensitivity to such histories in international response teams (108). The consequent lack of trust in both international and state/national responders is not unique to the DRC; however, the eastern DRC's added dimension of being an active conflict zone and a location of intersecting humanitarian crises complicates the analysis, necessitating an understanding of how this ongoing violence can be situated in the region's complex socio-political history.

(Inter)National Neglect and Ethnic Conflict Preceding Large-Scale Violence in the East: 1965-96

At the onset of independence, Western-backed dictator Joseph-Désiré Mobutu would exacerbate the ethnic tensions created under Belgian colonial rule in the eastern DRC and fuel ongoing violence. Starting in the 1930s, the Belgian colonial administration would disrupt social relations through implementation of a contentious immigration policy that welcomed tens of thousands of people from Rwanda to plantations of the Kivus and mines of Katanga, conferring these new arrivals with greater political and economic power than that of indigenous Congolese (Autesserre 2010: 133-34). Mobutu's favoring of Banyarwanda (signifying those of Rwandan descent) and also Tutsi pastoralists who did not threaten his regime deepened political and social inequalities, as he gave more land to Banyarwanda and undermined indigenous Congolese

---

[26] One is also reminded of the reappearance of *ndoki* during the Yambuku outbreak, thus demonstrating the conservation of Congolese' particularly negative perceptions of Westerners and what they represent.

agricultural autonomy. Far from passive onlookers accepting these affronts to their land and political rights, indigenous citizens would form lobbies to curtail Banyarwanda power, and also contribute to ongoing, "low-level" violence in North Kivu between the two groups throughout the 1980s; simultaneously, similar tensions erupting into violence between indigenous groups and those of Rwandan descent occurred in South Kivu. This violence was sustained through ethnic conflict that was inextricably linked to conflict over land and political power.

The Kivus would experience continual violence and increasing rates of corruption and exploitation into the 1990s under Mobutu's policy of *géopolitique*, a strategy of maintaining control of the region that would quickly deteriorate, sowing a mistrust for a state difficult to disentangle from the West and neighboring countries. With the multiplicity of ethnic groups vying for political and economic power in the region, this strategy only heightened the competition for power, leading to the Masisi War in 1993 which in North Kivu led to 1,000 deaths and the displacement of 130,000. At the same time, foreign states would continue to exert control over the eastern region through competition for much coveted conflict minerals. What one understands from this important backdrop of violence and tension in the eastern regions preceding these wars is a reality that would have a legacy far outlasting them: "Mobutu's ruling strategies largely caused the disintegration of state authority in the eastern Congo and eroded existing forms of decentralized authority" (Autesserre 2010: 142). Any semblance of a democratic form of governance for the eastern DRC was supplanted by an institutionalized form of opportunistic pillage of the region's resources, and its descent into disorder (Turner 120).

The Congo Wars: The Myth of Liberation in the East and Congolese Resistance: 1996-2003

Consequently, the toppling of Mobutu during the "First War" in the eastern DRC in 1996 would symbolize an initially decisive victory for the Congolese yet would ultimately lead to a

continuation of civilians' social and economic plights and widespread human rights violations. In response to increased tensions and violence in the eastern regions due to the influx of Rwandan Hutu refugees which led to a proxy war for the Hutu/Tutsi conflict, Uganda and Rwanda invaded the Congo to depose the indifferent Mobutu, elevating the Congolese rebel Laurent Kabila, a way for their involvement in Congolese affairs to appear to have national ownership (Nzongola-Ntalaja 225). Many Congolese embraced this war as one of "Liberation", a culmination to their long struggle for true independence after the end of Belgian colonial rule[27]. Yet their celebration of a new leader who symbolized liberation at a seemingly new chapter in Congo's, and the East's history, quickly became disillusionment. Lacking any clear vision of what his political structure would resemble and how it would function, Kabila confirmed the negative views of other Congolese who struggled to overthrow Mobutu peacefully, as he replicated rather than eliminated many of Mobutu's autocratic "leadership" activities, and contributed no marked improvements to civilians' rights and qualities of life[28] (Stearns 90).

Subsequently, inhabitants of the eastern DRC would see their region become embroiled in a second war, whose roots, opportunistic, foreign pillage by foreign powers, would engender a humanitarian crisis met by silence and inaction of the international community. Deciding to capitalize on the vacuum of authority preserved by Kabila, Uganda and Rwanda, backed by the U.S., would create a façade of civil war to conduct an invasion in 1998 through the eastern DRC to secure its access to the region's natural resources, which would disproportionately affect unarmed civilians: according to the International Rescue Committee (IRC), by 2000, 1,700,000

---

[27] By 1996, 31 years of Mobutu's predatory state had led to undernourishment of 60% of Zaire/DRC's population, and decimated infrastructure and industry (Stearns 95).

[28] In addition, neighboring countries' military strategies during the rebellion to install Kabila led to alleged massacres of Hutu refugees in the eastern regions, believed to have constituted acts of genocide against the Hutus according to the UN that were never seriously examined (Turner 5).

individuals died in the east due to the war, due to direct violence but mostly to hunger, malnutrition, the disintegration of healthcare, and internal displacement (Turner 3); the IRC further estimated at least 3.3 million Congolese died between August 1998 and November 2002[29]. The Kivus were also disproportionately impacted by massacres and acts of violence against innocent women, men, and children. The resounding silence of the international community to the ongoing bloodshed and humanitarian crisis[30] must be situated within the reality of continual plunder of the Congo in the era of globalization: the movement of money and its investment in off-shore banks has created ripe opportunities for money launderers, arms merchants, warlords, and other opportunistic figures to pounce on the country's and region's resources, thus profiting from the almost anarchic conditions that prevail, and the perpetual crisis in which its people live.

Yet civilians in the eastern DRC would channel their resistance strategies to both external and internal aggressors which would have an enduring legacy on Congolese resilience and perceptions of authorities. Courageous members of civil society would transmit their messages through a nonviolent campaign despite being targeted through executions, disappearances, and other crimes. Added to this strategy would be the growth of civil society organizations as well as the formation of NSAGs as vectors of the fight for democracy, and more fundamentally, a basic improvement in the lives of Congolese people. In the east, people's lived experiences and collective memories associated with their circumstances would see them negate the myths of civil war and develop a nuanced understanding of the obstacles to their vision of the country:

---

[29] These figures could be higher, and make the Congo Wars collectively the deadliest conflict since WWII.
[30] The UN Security Council took two years, until June 2000, before making a formal request to Uganda and Rwanda to withdraw troops from the DRC (Nzongola-Ntalaja 232).

both foreign powers, and the Congolese state, cementing a distrust of the two that would

continue and worsen in the decades following the official "end" of the war period.

Keeping the Peace? Violence, the Failure to Protect, and Chronic "Emergency" in the Eastern DRC: 2003-Present

Three structural factors responsible for what some scholars call a "third war" in the

Congo, and "everyday emergency" by NGOs such as MSF[31], having direct implications for

civilians' lives and attitudes toward state and international actors, will be discussed: 1) violence

perpetrated by the Forces armées de la République démocratique du Congo (FARDC) and

NSAGs, 2) the shortcomings of international peacekeeping, and 3) implications for humanitarian

aid and healthcare provision in the eastern provinces.

Unarmed civilians in the eastern DRC have continued experiencing severe human rights

violations extending beyond the war period at the hands of various armed groups, abuses in

which FARDC officers[32] have often been complicit. While some NSAGs have helped civilians

forge paths toward reclaiming rights, many do not operate within the interest of civilians' well-

being, some controlling the wealth of the region's natural resources, and others employing

coercive means and violence against civilians[33] to further their political and ideological agendas.

Despite the victory in 2014 of the FARDC over M23, a rebel military group based in North Kivu

notorious for summary executions and rape, various armed groups continue to occupy the eastern

---

[31] MSF has published numerous reports over the year detailing the silencing surrounding lived
https://www.msf.org/everyday-emergency-silent-suffering-democratic-republic-congo

[32] Under the agreement of the Sun City Deal, signed in 2003 by Congolese armed groups, previous rebel groups from the war period were incorporated into the FARDC, whose purpose in the east was to co-opt armed rivals and maintain a cohesive military presence. Yet many of these national officers, coming from low socioeconomic backgrounds, would use their proximity to armed groups in the east to their advantage, defecting from their positions to these groups to negotiate better pay and positions, which oftentimes benefited local politicians (Stearns and Vogel 2015).

[33] While elaborating on the countless acts of violence in the eastern DRC is outside the scope of this project, a discussion of some more recent ones can offer a glimpse into the realities faced by civilians.

region and contribute to violence and mass displacement (Stearns and Vogel 2015). Between October 2014 and February 2016, the city of Beni in the northeast witnessed 500 civilian deaths, many from decapitation in front of loved ones, and the displacement of tens of thousands. While the UN Mission and the Congolese government locate the main responsibility for these criminal acts with the Allied Democratic Forces, research collected from local testimonies by the Congo Research Group (2016) demonstrates to the contrary the ways in which this explanation masks the complicity and even participation of the FARDC in the violence. Analyses also implicate MONUSCO in the attacks, who were reported to have prioritized supporting the authority of the state (the FARDC) over the protection of civilians, and produced a skewed narrative of the killings.

MONUC/MONUSCO's top-down, ideological approach and its intimate relationship with the FARDC has compromised its mission to curtail this violence and further fueled suspicion in the eastern Congolese population. From the outset, the failure of MONUSCO (formerly MONUC), consisting of the largest-ever UN peacekeeping mission deployed, to communicate its mandate to civilians would foster a climate of mistrust, exacerbated by language and cultural barriers between foreign peacekeepers and the local population (Reynaert 28). Additionally, Autesserre (2010), in her analysis of the UN peacebuilding mission during the years 2003-2006, argues that the failure to curb violence and achieve stability in the eastern regions can be attributed in part to a dominant, peacebuilding paradigm that located the causes of local conflict in insufficient state authority and Congolese' "propensity to violence", rather than complex social, political, economic, and historical contexts of the communities concerned. Equipped with no local conflict resolution capacities, MONUSCO has consequently permitted and in ways exacerbated fighting, massacres, and human rights violations, instilling a deep

mistrust of UN-affiliated forces in civilian populations that reverberates today in the opinions of local people; one farmer from Kididiwe interviewed by the Congo Research Group (2016) for their research on the Beni massacres noted "we have the impression that the FARDC and MONUSCO are more concerned with their own interests rather than protecting the local population"[34] (18). A cartoon by a Congolese cartoonist Kash Thembo, presented by Alcayna-Stevens (2020), captures the anger civilians feel at the inaction of UN peacekeepers in the face of attacks by the ADF, who remain protected by Congolese police and scratch their heads as to why the community is angry (Appendix A).

MONUSCO's negative political connotations with the FARDC, along with chronic neglect of the region, have combined to considerably hamper the deliverance of medical aid, primarily by humanitarian actors, to those who most in need it in the East. The continual renewing of MONUSCO's mandate, with recent ones such as United Nations Security Council Resolution 2098 and the new mandate in 2018, have preserved a deep entanglement of humanitarian, military, and political forces in the eastern Congo, leading to a lack of trust in UN medical resources. And independent humanitarian actors' commitments to neutrality are routinely compromised by the frequent presence of FARDC soldiers in healthcare settings; MONUSCO forces' failure to prosecute or hold accountable FARDC soldiers responsible for ongoing violence have hindered NGOs' access to those most in need, notably due to the mistrust fostered in locals (Ponthieu et al. 2014). This distrust has also resulted from civilians' understanding of NGO personnel's ideological proximity with military forces, who often necessarily accompany humanitarians for protection. These realities demonstrate how the UN is working in ways that undermine the work of the few NGOs in the eastern region struggling to

---

[34] "Nous avons l'impression que les FARDC et la MONUSCO songent plus à leurs propres intérêts qu'à protéger la population locale"

operate and tend to the intersecting humanitarian crises (refugee, medical, etc.) amidst minimal

funding and negative perceptions. Ebola has joined a list of other epidemic diseases that have

proven more deadly than the former: during the same period that Ebola has been present, over

13,400 cases of cholera have occurred, mainly concentrated in North and South Kivu, a

concurrent measles outbreak has killed over 6,000[35] in the country, worsened by low vaccination

coverage in vulnerable communities, malnutrition, and weak public health systems, and five

separate outbreaks of vaccine-derived polio have occurred ("Cholera...Week 27";

"Deaths...6000"; Mbaeyi et al. 2019). Public health in the DRC, and especially in the East where

healthcare remains limited, seems to represent its own state of emergency.

---

[35] An article posted by MSF in December 2019 noted that almost 10,000 measles cases were reported in one week in November, and 73% of the deaths of these cases are of children under 5 https://www.msf.org/efforts-tackle-deadly-drc-measles-epidemic-remain-insufficient

Chapter 3: Convergent Insecurities—Unpacking "Resistance" to the Ebola Riposte in the Eastern DRC

EVD in the Eastern DRC: Distinctive Challenges and the Structure of the *Riposte Ebola*

The tenth EVD outbreak in the DRC on-record seems to follow a trend of heightened Ebolavirus (EBV) spillovers in human populations in the Congo basin region in the past two decades, which has amounted to a fragmentary landscape of Ebola knowledge and preparedness levels. Significant rates of deforestation, and also greater contact between humans and natural reservoirs of the virus due to human activities integral to economic and physical survival, including hunting, agriculture, and gold-digging, have been used to explain the increased frequency of EBV spillovers since 1994 (Muyembe-Tamfum et al. 2012). Appendix B (CDC, 2017) reveals the outbreaks in the DRC on record through 2017. While outbreaks have expanded knowledge of the disease in the isolated regions where they have occurred, no national Ebola guidelines exist, while outbreak responses led predominantly by the state and foreign organizations such as the WHO have marginalized local agency and knowledge in responses. One Western aid worker from the American NGO Mercy Corps shared with the author the difficulties in providing sustainable Ebola preparedness training in the Congo as opposed to Guinea, a function of the Congo's high rates of displacement and mobility, and the largely *ad hoc* Ebola responses that perpetuate dependence of the DRC on foreign resources and expertise (Personal interview 1).

Occurring in a region that has seen ongoing armed conflict, prolonged, intersecting humanitarian "emergencies" and high rates of mobility across porous borders, the DRC's tenth outbreak has sustained a top-down, securitized response consistently framed by emergency. Appendix C (CDC, 2020), reveals the location of North Kivu province and the other provinces

and their respective health zones concerned by the current epidemic along the country's eastern border. Since it was declared on August 1, 2018, the outbreak has been classified as a Grade 3 emergency, triggering the highest level of mobilization from the WHO, as well as an activation of the UN's Humanitarian System-wide Scale-up ("Ebola...Concern"). This first-ever deployment of WHO personnel on-the-ground, FARDC soldiers from the Ministry of Health (MoH), and various humanitarian actors have led to a rapprochement between public health, humanitarian and security sectors that has evolved throughout the different iterations of emergency labeled by the response. On 17 July 2019, when the epidemic was declared a PHEIC, a decision influenced in part by the confirmation of a case of Ebola in Goma, a "gateway to the rest of DRC and the world" ("Emergency...Congo"). This emergency framing has been accompanied by a securitized, at times militarized approach taken in the *riposte*. A Western nurse working for MSF on-the-ground in the DRC expressed to me in a conversation their disapproval of the pervasive use of the word 'riposte' in reference to the Congo and West Africa cases, which for them has translated into militaristic tactics: forced removals of suspected cases from their homes, and also threats toward individuals who have not complied with safe burial practices through shooting into the air and chasing them (Personal interview 2).

Countering the 'Counter-Attack': Contextualizing Different Forms of "Resistance" to Healthcare Workers, ETCs, and Other Elements of the *Riposte*

As touched upon in the introduction, the word "resistance" has a tendency to advance skewed portrayals of individuals responding to the enforcement of certain public health measures, which has encouraged the author to use alternative terms. The politically charged nature of the term "resistance" can mask individuals' efforts to survive in the face of perceived threats to their lives. During the West Africa Ebola outbreak, media discourse on violence

perpetrated by young Sierra Leonean men against medical teams and government security forces linked these acts with "resistance", explained solely for its impact on disease containment efforts, rather than the harsh repression from armed forces and social and structural factors contributing to them[36] (McLean 2019). During the West Africa outbreak and also the current one in the DRC, the word "resistance" appears frequently in WHO and humanitarian situation reports without any formal definition of the term or methodological form of measuring it, which as Abramowitz (2017) notes, leaves the impression that affected communities are irrational and noncompliant. Furthermore, Calain and Poncin (2015) problematize the use of a single word to encompass all community responses, suggesting the importance of distinguishing between violent and non-violent community responses when examining the DRC case, while contextualizing both of them. Hence, in this analysis, the word "resistance" will be substituted with the term "reluctance" to be used in reference to community members' non-violent refusal to accept Ebola containment efforts; "reluctance" will be distinguished from violent forms of aggression against the Ebola response, which will be explicitly identified as overt, physical actions. For purposes of concision, the word "resistance" will at times be used in quotation marks, reminding the reader of the term's imperfections and inviting reflection on more fitting ones.

The goals of the following section are to situate both violent attacks and cases of reluctance toward the *riposte* in the explanatory models behind them, which help illuminate sentiments of mistrust that reflect socio-political histories and realities of the affected communities[37]. Surveys of residents in Beni and Butembo, North Kivu done by Vinck et al.

---

[36]

[37] Hewlett and Hewlett (2008) employ child-caregiver attachments as an analogy for the relations civilians feel with local governments, the state, and international actors; this comparison helps explain the challenges encountered by

(2019) in 2018 revealed only 31.5% of respondents to trust local authorities to represent their interests. While not representative of all of the eastern DRC, this one example suggests underlying apprehension and suspicion toward the intentions of different authorities that has generated "circulating narratives" and "alternative explanations". These terms, advanced by Alcayna-Stevens (2020), better convey the accumulated meanings from histories and experiences of exploitation and violence in local populations[38] that have been resurrected and reproduced through the current Ebola response. While reluctance, overt hostilities, and alternative explanations are not unanimous amongst heterogeneous communities, their recurrence deserves analysis for the ways in which they bring to light systemic issues facing them, such as the ongoing NSAG violence[39][40]. This discussion will bring to light certain patterns in the outbreak through examining several recurring narratives arising from affected communities that could be behind the reluctance and acts of physical violence of said communities.

"First the kidnappings...then the massacres...now Ebola": Ebola as Politics

---

Ebola responders who oftentimes lack the trust of local populations because of their neglecting to provide the latter sensitive, responsive, and consistent healthcare, and thus demonstrated concern for their well-being.

[38] As opposed to such terms as 'misinformation' and 'rumours' which imply ignorance and irrationality.

[39] Armed group presence in the region affected by Ebola has also considerably heightened the insecurity faced by response workers. As expressed to the author in an interview with a PhD student in political science with expertise in the Eastern Congo, intelligence on armed group motives is critically lacking in the response due to the constantly shifting alliances between groups and other factors. The identities of armed assailants in ETCs and other perpetrators of violent attacks often remain obscured and thus it remains difficult to know exactly whether armed groups share responsibility with civilians for such attacks (Personal interview 3). Nonetheless, a distinction should be made between the agendas of armed groups and those of civilians responsible for attacks: while the former may be motivated by economic opportunism or ideological reasons, the latter are encouraged by narratives on Ebola and the *riposte* that reveal important messages.

[40] In public health emergency discourse, any factor obstructing or complicating response efforts is generally referred to as a "disruptive event", recognized mostly for its epidemiological implications, and in many ways removed from the contexts in which it arose. In the high insecurity context of the eastern DRC, attention must be paid to the ways in which discourse on the outbreak conflates acts of so-called "resistance" to various elements of the Ebola response with other security incidents associated with armed groups, and also other acts of political resistance of communities.

One of the most common themes surfacing from the community feedback data from the beginning of the outbreak to the present is the belief of Ebola being instrumentalized as a political tool, both by the Congolese government and by the international community. For some of those living in North and South Kivu and Ituri provinces, the arrival of Ebola in a region that according to them has been the target of mass killings and relentless violence, is no coincidence. WhatsApp and local media messages circulating in the second month of the outbreak revealed beliefs among community members that Ebola represented another weapon deployed by the forces responsible for the continual mass killings and kidnappings in the eastern region (Sweet and Bedford 2019). Civilians' own awareness of the national army forces' complicity in the murders and crimes transpiring in their environments renders this interpretation of Ebola implicitly political, linking the emergence of the disease with the violence of the state, and in the process revealing questions about belonging and citizenship in a region long neglected by the national government.

In addition to implicating the civilians' own government, narratives arising from community surveys as recent as November of 2019 have viewed Ebola as a disease concocted by "whites", and deliberately introduced into populations in the eastern DRC to "eliminate Africans", a strategy undertaken in collusion with the Congolese state (Bardosh et al. Sep-Nov 2019). All of these stories that convey the political weaponization of Ebola seem redolent of colonized Congolese', including the woman healer Maria N'Koi's, own depictions of sleeping sickness as a form of biological warfare indissociable from the conquest of the Europeans, thus linking the deaths and suffering Ebola to both internal and external aggression (Hunt 2016; Lyons 1992).

Regarding the power of these narratives to provoke action, reports also highlighted the unscrupulous strategies of some local politicians to spread these narratives, exploiting their communities' own distrust of authorities to galvanize them against the Ebola response and incite violence, thus prolonging the Ebola outbreak for their own personal gain. Important to remember here is the pervasiveness of such realities as corruption, nepotism, and embezzlement in the DRC, especially in rural areas where local leaders must forego salaries for lengthy periods, thus encouraging them to capitalize on the access and benefits that their positions afford them in order to survive (Alcayna-Stevens 2018). These clarifications are not to excuse the immoral actions of local elites but rather to situate them within the socioeconomic context of the Ebola response.

The fact that these alternative explanations began to propagate throughout community circles, due to local political manipulation or not, at the same time that attacks by community members occurred against humanitarian convoys in the first couple of months of the outbreak, suggests the types of motivations that could be behind such actions. Furthermore, despite an observed decrease in the circulation of these political suspicions in media and elsewhere, controversy surrounding the exclusion of two communities affected by Ebola from voting in the national elections in December 2018 seemed to confirm some residents' beliefs in the political origins of Ebola, an event which could be connected with the series of violent attacks against several ETCs that occurred from late December 2018 through March of 2019.

This decision of the Congolese government to postpone elections in Beni town, Beni territory, and Butembo under the pretext of avoiding further spread of Ebola in these territories fueled anger and resentment in these regions, which are all opposition strongholds to the government in Kinshasa. The resulting animosity seems to have been directed toward public health officials who were implicitly linked with the MoH, and thus the government, which

manifested in the destruction of ETCs in Beni and Oicha and a spike in violence during the early weeks of January in 2019 (Wells et al., 2019). Nine additional attacks on ETCs through the end of March 2019 could also be attributed to political skepticism of the disease's presence, especially due to the use of Ebola as a campaign strategy for the legislative elections in March, thus sowing even more doubt as to the apolitical nature of the outbreak (Bardosh et al. Feb-May 2019).

"Ebola as business": an epidemic of predation and opportunity

Interwoven with the politicization of Ebola narratives is the perception of Ebola as a "business", relating the intentionality of the Congolese government as well as national and foreign aid workers, doctors and scientists who all have economic interests in introducing and sustaining the outbreak. Responding to the spike in presence of outsiders (Westerners, non-Congolese Africans, and those from Kinshasa) whose relations with the eastern Congo have historically been predicated on predation, some locals have implicated foreign personnel in the response who seem to be reaping the financial rewards from people's affliction with Ebola, and overall continued suffering. These sentiments reflect in WhatsApp messages sent during the first few months of 2019, whose senders demanded questions centering around "why do the healthcare people want to get rich off the blood of others while they know the truth about Ebola? (Bardosh et al. Jun-Aug 2019). Denouncing the rampant corruption that they see in multiple levels of authority, locals as part of an historical trend see the state and the international arenas as intimately linked; viewing Ebola as a scheme of the government to obtain more outside funding with a humanitarian façade, individuals also are reacting to what they see as a corrupt state whose sudden attention to the eastern regions, piqued by the Ebola epidemic, reflect intertwined political and economic motives lacking any sincere concern for its people. And in July 2019, the

resignation of the DRC's health minister Oly Ilunga, and his subsequent arrest in September

under allegations of mismanagement of some $4.3 million allocated for the Ebola response, only

cemented individuals' suspicions of the corruption intrinsic to the international-national response

apparatus. These feelings seem to have propelled verbal threats from local populations which

demonstrate resentment toward response teams for not hiring "their people", manifesting in

posters such as that hung up in Butembo (Appendix D) which reads:

> We inform all involved persons in the EBOLA infierno that we don't want them anymore
> in the following places…And everywhere where they are housed, we know. We give
> them 48 hours to decamp, or else they will come to know who we are. They just have to
> remember what happened to VUHOVI center. (ed: Local name of Katwa ETC) (Wells et
> al. 9).

This reference to the Katwa ETC, which was previously destroyed in an attack, suggests how

this anti-outsider sentiment could be transformed into subsequent physical acts of violence

toward response teams and ETCs.

Grasping the "Ebola as enterprise" belief of some locals requires understanding how this

health emergency response, and the concomitant, massive influx of aid workers and resources

into poor communities, serve as reminders of the deep structural inequalities between "locals"

and "foreigners", and the convergence of insecurities between these two groups. In vast areas of

rural DRC, systemic poverty remains firmly entrenched, with the average household living on

less than $1 per day; hunger and undernourishment have become quotidian realities for folks

whose livelihoods depend on agriculture and hunting, as crop harvests can easily fail, while wild

animals have greatly diminished over the years due to the intensification of the bushmeat trade

following the civil war years (Alcayna-Stevens 2018). Consequently, a sudden and exceptionally

large economic response in this socioeconomic context inevitably serves to reinforce economic

disparities between rural and semi-rural Congolese and national and international response

workers. In this outbreak, inequalities between civilian populations and responders, visible

through the appearance of aid workers such as in the clothes they wear and the vehicles they

drive in, as well as in the hotels and more affluent compounds they live in which separate them

from locals, contributes to the latter's resentment toward foreigners, who seem to be profiting

from the response. The PhD student whose research interests focus on the eastern DRC and who

has contributed to several of the SSHAP reports shared with the author that the physical

separation between response workers and locals, while necessary because of legitimate security

concerns that threaten the former's response capacities, and lives, inevitably fuels mistrust of

locals towards the anti-Ebola personnel who are protected from the dangers the former continue

to face (Personal interview 3).

The resulting distanciation felt between populations affected by the outbreak and those

part of the response have affected local perceptions and attitudes toward the Ebola control

measures, such as vaccines. Surveys reveal community members' questions: they struggle to

reconcile the expensive response vehicles rented by response teams with the lack of adequate

vaccines to dole out to affected populations, as well as why response teams were so often

accompanied by armed forces (Bardosh et al. Feb-May 2019). Duffield's (2012) theorization of

the bunkerization of aid helps convey how foreign aid workers' insulation from the quotidian

economic and physical insecurities faced by local populations fuel a schism felt between the

former and the latter. In an era where the aid industry continues to expand into increasingly

insecure environments, yet simultaneously recede from them through segregating itself from

populations it is serving, aid workers themselves have come to willingly or unwillingly operate

within a paradigm that relies upon risk and insecurity, rather than effectively reducing it; these

"postmodernist calls for resilience and the acceptance of risk as an opportunity for enterprise and

reinvention" seems to connect with local populations' perceptions of the ways in which the Ebola response represents a continual form of exploitation of the eastern Congo and people's suffering for outsiders' own benefits (Duffield 2012). The frictions between the (in)security of responders and the lived insecurity of local populations have likely contributed to mistrust, in an environment where local economic and social realities have been shaped by the response.

Lack of transparency surrounding the Ebola vaccine, eligibility for it, and the apparent benefits that accompany it has generated alternative explanations amongst community members about the economic motives that could be behind the Ebola response. Recurrent in surveys throughout the outbreak have been requests to expand the vaccination program and immunize all members of the population rather than what seems to be certain members of society. Community members claim that the ring vaccination strategy seems biased in favor of those involved in the response, and local political and economic elites who "profit" from the vaccine (Bardosh et al. Feb-May 2019). Survey responses as recent as November of 2019 reveal how getting vaccinated is perceived as giving into "Ebola business": "I have been told by my pastor that it is a sin to have the vaccine. I do not listen to the Ebola business, I listen to my pastor so I do not sin for taking a fake vaccine" (Bardosh et al. Sep-Nov 2019). Perceptions of injustice related to the vaccine also reflect in locals' questions as to the status vaccinated individuals seem to be granted: "Why do you only give food to vaccinated contacts?" (Bardosh et al. Sep-Nov 2019). In communities where hunger and undernourishment are common, benefits concomitant with vaccination such as the procurement of food could fuel skepticism in communities through seemingly devaluing the lives of those who are refused access to the vaccine, and also those who, as will be discussed in the next section, "resist" it.

Grasping the extent of economic insecurity in the provinces affected by the Ebola

outbreak helps understand how the arrival of the disease and the response it has triggered has

influenced a simultaneous resistance to and engagement with the *riposte* that nuances the solely

external source of aggression associated with it. The same Western nurse who expressed

criticism of the militaristic framing and execution of the response also shared with the author that

while "resistance" from communities is prevalent, it manifests alongside an impulse in some to

capitalize on the economic benefits that associating with the Ebola response could bring them,

and thus welcome a prolonging of the outbreak (Personal interview 2). While some of this

reaction is a product of local politicians' opportunism exhibited through their purposeful

spreading of circulating narratives to preserve the epidemic and get a piece of the cake, it also

must be read as a reflection of the economic insecurities that inhere within local realities in the

eastern DRC. Youths in Goma were apparently once reported expressing their hope that Ebola

would arrive in their city as it would open up new labor and employment opportunities in the

response[41] (Alcayna-Stevens 2020). And in this environment, where individuals vie for

employment, and thus economic well-being, the recruitment of hundreds of locals for contact

tracing has inexorably exacerbated tensions within communities. Indeed, in July of 2019, two

local Ebola responders were killed by their neighbours, due to the latter's allegedly envying the

former for having found employment in the response (Maxmen 2019). Yet envy also seems

accompanied by mistrust, as surveys demonstrate strong resentment toward local HCWs and

their alleged complicity in the "Ebola business", which allegedly encompasses the political

[41] Alcayna-Stevens (2020) demonstrates with her ethnographic research conducted in post-Ebola contexts in the western equatorial regions of the DRC after the seventh (2014) and ninth (2017) Ebola outbreaks, how people of all ages and professions sought to gain work from the epidemics. In underlining these more dynamic ways in which local communities interact with the presence of Ebola and the response helps, as the author explains, nuance understanding of the ways in which epidemics impact local social fabrics and politics, and depicts "Ebola Business" less as a modern imperial system in which local actors retain no power or ability to react to the circumstances they face.

agendas of exterminating the eastern Congolese populations[42] (World Vision 2019, cited in

Bardosh et al. Sep-Nov 2019). These aggravated social tensions have resulted from locals'

contributions to rather than resistance to anti-Ebola efforts, adding to the dynamic ways in which

local populations have responded to the changes brought about by the *riposte*. Seen by many

community members as an apparent site of capitalist production, the epidemic seems to, like

those that occurred in Equateur province studied by Alcayna-Stevens (2020), hold the potential

for "profit-making" and in turn deepening economic inequalities through enriching those already

in wealthy and privileged positions[43] (22).

Reluctance and "Dangerous Bodies": Oscillations Between Adaptation and Fear

According to some response workers and media depictions, from the economic

inequalities created and in many places exacerbated by the response in local communities, a

moral distinction has arisen between those who contribute to Ebola containment efforts and those

who "resist" them. In a high insecurity context like the DRC, a discourse of heroism and bravery

seen in the West Africa Ebola outbreak that lauded those response personnel for their work has

emerged in a more pronounced form to praise HCWs, yet also many of the unsung heroes of the

response including local HCW, as well as non-healthcare-related community members (Alcayna-

Stevens 2020); for example, a journalist and NGO practitioner working for ALIMA emphasized

to the author the integral roles that taxi drivers and janitors have played in surveillance for the

Ebola response (Personal interview 4). While their efforts should not go unnoticed, they also

---

[42] Locals not comprising the response have spoken out against what they see as the complicity of locals enlisted in the response, the "Ebola Business": "They have swallowed the money of the enemy who wants to exterminate us" and "A nurse who used to receive $100 a month now has $100 a day. Does this one really want the epidemic to end?" (World Vision 2019, cited in Bardosh et al. Sep-Nov 2019).

[43] In this way, "it is the labor of sick and suffering bodies which generates value" (Alcayna-Stevens 2020: 22). Community members in both Equateur province and in the Eastern DRC seem to make an implicit connection between their suffering and the profiting of international, national, and local response workers.

should not be analyzed without considering how their elevation, along with that of HCW, above others, could be giving rise to a similar dichotomy of "Ebola heroes" and "dangerous bodies" as adopted by Enria (2017) in her research in a Sierra Leonean village. What she found to be the intimacy and reinforcing natures of "engagement" and "containment" logics in the response paradigm in Sierra Leone seem to operate in the eastern DRC, where the response has shown high militarization produced by the police and armed forces who are oftentimes the same figures responsible for community engagement (Personal interview 2). Almost inevitably there emerges a contrast between those who dutifully adapt themselves to response measures and those who "resist" them (oftentimes out of rational fear and distrust), labeled as recalcitrant, rebellious, dangerous, and needing to be contained themselves[44].

The previous use of force by the army and police with civilian populations demonstrating reluctance to comply with containment measures, actually leading to some civilian deaths, provides an extreme example of a source of the fear instilled in community members by elements of the response which underpin reluctance. This fear seems to reflect in the acquired meanings of response protocols, such as the vaccine, in everyday language; research discussed by Alcayna-Stevens (2020) that was carried out by Translators Without Borders in Beni, one of the Ebola hotspots in North Kivu, revealed locals' understanding of the ring vaccination technique as a boxing ring; rather than associated with protection and good health, getting vaccinated thus has become in some people's eyes another arm of the response against the civilians that it is professed to protect (Bagnetto 2019). While certainly not generalizable to all of

---

[44] This article written by the Director-General of the WHO, Dr. Tedros Ghebreyesus, unintentionally advances this dichotomy. While rightfully recognizing the intrepid and committed HCWs from local communities who have put themselves on the frontlines, who despite security risks are "heroes" and "want to return to the field", those responsible for attacks are "culprits" from communities to which increased security presence is an immediate answer. His reasonable denouncement of an attack committed by Mai Mai militia seems to conflate armed group motivations with those of civilians. https://www.theguardian.com/global-development/2019/dec/10/ebola-responders-face-deadly-attacks-we-must-step-up-security-in-drc

the populations in the provinces affected, this mistrust and fear of the vaccination help trace a line of continuity from colonial times to the present. Indeed, survey responses as recent as November 2019 in which individuals affirm the "deadly" and "poisonous" nature of the vaccine seem to bear a resemblance to the widespread and long-lived "fear that the invasive needle actually caused the disease" observed amongst African populations during the Belgian sleeping sickness campaigns in the early 1900s (Bardosh et al. Sep-Nov 2019; Lyons 189). While the historical parallels know their limits, as explanations surrounding the needle today manifest in a reluctance to seek out the vaccine and medical care rather than the flights of people from the feared 'injection campaigns' seen in the 1910s, they are nonetheless important for understanding how the past has informed or diverged from the present.

In addition, a link between the vaccine, the perceived self-interest of the West, and the devaluing of the lives of Africans also surfaces from SSHAP reports which reveal some community members' dismay upon discovering the experimental nature of the vaccine. A community outreach worker from Beni in September 2019 expressed:

> We were told that the vaccine is still in the experimental phase, and I will never forget that word in my life. When I checked in the dictionary, I realised that I had become a guinea pig, and I immediately had doubts...I had become part of a test, and a test can fail (Novetta Nov. 2019, cited in Bardosh et al. Sep-Nov 2019).

This worker's comments touch upon a sensitive history in which African populations and those of African descent in the West have been used as test subjects for research purposes and exposed to potentially dangerous vaccines and pathogens[45]. This impression of locals of research and scientific results taking precedence for response workers over health improvements and saving

---

[45] The Tuskegee syphilis experiment conducted by the U.S. Public Health Service from 1932-72 in which Black males were purposefully infected with syphilis to study its effects left untreated comes to mind here. In addition, recent remarks amidst the Covid-19 outbreak made by two French doctors who suggested testing a vaccine for the coronavirus in Africa have sparked waves of criticism, and spurred the circulation of the message "Africa is not a laboratory" around social media and other media outlets.

lives has also appeared in other reactions, such as that of a prominent civil society organisation, La Lucha, which has claimed that the second vaccine is a conflict of interest as it indeed "favours research instead of saving lives"[46] (Novetta, November 2019, cited in Bardosh et al. Sep-Nov 2019).

Difficult to disentangle from this fear of the vaccine is that of the doctor and the ETC, which have been a defining feature of the outbreak, and which also share historical similarities with the colonial era. Additional research discussed by Alcayna-Stevens (2020) and conducted by Translators Without Borders in Beni revealed how the language of violence and combat inheres within representations of the doctor: those who have been cured of Ebola are referred to as "vainqueurs", or winners, thus implying that patients who leave the ETC have emerged victorious as they are presumed to have "had a fight with the doctor and won" (Bagnetto 2019); this interpretation of visits with the doctors as confrontations rather than as relations of healing and empathic care undoubtedly feed into a fear and avoidance of the ETC, which have remained rather constant since the beginning of the outbreak. Connotations of the ETC as a "death trap" recur in survey responses, which can largely be attributed to communities' observations that many of those entering ETCs never return. Survey responses indicate circulating fears of ETCs related to circulating narratives of dismemberment and injection of lethal substances as causes of death, and subsequent organ extraction all occurring in the treatment center upon a patient's

---

[46] These sentiments reveal a tension between natural science and social science research, and more largely, biomedical versus ecological approaches toward addressing epidemics raised by Adams (2013). Social scientists have critiqued so-called successful health interventions, noting that although they may be successful according to some metrics, they often produce unintended consequences that make their overall success ambiguous. Thus seems to be the case in the current outbreak, where trials have proven the efficacies of the Ebola vaccine yet have exacerbated distrust and perceived inequalities in societies, hampering the response. This reality demonstrates the inadequacies of scientific, biomedical approaches to complex, intersecting issues Ebola has revealed and against which it evolves. While the experimental vaccine was deployed in order to save lives under a "compassionate use" protocol, the lack of transparency surrounding vaccine eligibility has fueled a logic in the eyes of locals that suspects an unsettling trend also discussed by Adams (2013) in which experimental research has prioritized the production of statistics over the actual medical goal of protecting as many people as possible from getting infected with Ebola.

arrival (Bardosh et al. Nov 2018-Feb 2019; Bardosh et al. Sep-Nov 2019). Throughout the

course of the outbreak, a significant factor in the low survival ratios of patients admitted to

receive treatment has been the prevalence of late presentation at ETCs, reflecting a profound fear

of evidencing the infection of loved ones, which seems to feed a cycle of low survival ratios and

consequent fear of the ETCs; these delays in reporting the infection of oneself or of loved ones

seem to connect with African responses to the Belgian colonial campaign against sleeping

sickness, when as a general trend if Africans noticed a victim to be at an advanced stage of the

disease, they brought them to the lazaret (Lyons 195); the consequent association of the lazaret

as a conduit from life to "the cemetery" surely fueled African "resistance" to the practices of

isolation and hospitalisation observed until the 1930s (Lyons 191).

At the same time, studying aspects of the sleeping sickness campaigns may help

illuminate some of the factors underpinning reluctance observed in the eastern provinces today.

In regards to those Africans who cooperated with the sleeping sickness campaign and seemed

supportive of the lazaret in the early 1900s, Lyons (1992) offers the explanation that when

endorsed by respected authority figures, aspects of European medicine were more easily

assimilated by Africans (195). This historical analysis, when compared with the current outbreak

in the Congo and the distrust of the vaccine, the ETC, doctors, and other personnel involved in

the response, begs the question of how local authorities could be to blame for such suspicion.

Indeed, survey reports reveal church and political leaders to be deliberately spreading

misinformation about the ETCs, thus sculpting the optics through which civilians interpret the

response and its features (Bardosh et al. Sep-Nov 2019). Mistrust of the vaccines, ETCs and

medical professionals in some locals appears a consequence of beliefs informed by some local

leaders, as well as civilians' own experiences with foreigners, the police, and histories of

exploitation; here, local suspicion toward a national-international Ebola response should not be evaluated as evidence of cultural stasis from the colonial era, yet rather a response to the continuation of their socioeconomic plights and insecurity that has been largely facilitated and ignored by the international-national forces who are embodied by the response. Considering how some reluctance toward the Ebola vaccine contrasts with general acceptance and voiced desire for vaccines and medications for other diseases suggests the particular ways in which Ebola and the unprecedented mobilization of resources it has engendered in the eastern region response have become understood by civilians.

"You will leave when Ebola does…but we will still be here, slowly dying from the diseases that have always killed us": the Suspicion of Urgency in the Eastern DRC

During the sleeping sickness campaign, at the same time as significant reluctance toward the vaccine and other elements of trypanosomiasis occurred, Africans in fact sought out vaccines for other diseases, including yaws and syphilis (Lyons 191); this separation between the disease of focus for the Belgian campaign and other diseases and health challenges such as maternal health affecting Congolese' daily lives, seems to reverberate in the eastern Congo today: the fixation of the national and international teams on Ebola, as well as the specific form their response has taken, have associated Ebola with a particular set of experiences and have inspired many questions amongst civilians as to why Ebola has elicited such urgency alongside other diseases and issues that are resulting in far greater illness and deaths in the region.

One anecdote proves telling of this mismatch between the international community's priorities channeled through the *riposte* and those of populations in the Eastern DRC. Trish Newport, MSF Emergency Coordinator, received an enlightening answer from a Congolese staff

member in the DRC in response to her question as to why there was much anger directed at the

humanitarian response to Ebola. Her reply was as follows:

> My husband was killed in a massacre in Beni. At that time, all I wanted was some
> organisation to come and protect us from the killings, but no international
> organisation came. I have had three children die of malaria. No international
> organisation has ever come to work in this area to make sure we have healthcare
> or clean water. But now Ebola arrives and all the organisations come, because
> Ebola gives them money. If you cared about us, you would ask us what our
> priorities are. My priorities are security and making sure my children don't die
> from malaria or diarrhoea. My priority is not Ebola – that is your priority
> ("After...MSF").

This Congolese staff member's story is by no means unique to her, and presents common

grievances that are behind much of the distrust of communities and their observations of self-

interest in the *riposte*. Suspicion in these populations becomes inevitable in the face of the

international community's inactions in the face of security issues as well as diseases that have

consistently faced civilians and constituted a prolonged state of emergency that has failed to

sound a loud enough alarm. As of 2018, malaria constituted the number one cause of death in the

DRC, followed closely by lower respiratory infections, neonatal disorders, and TB

("Democratic...Health"). The DRC has also seen a concurrent measles epidemic, that by June

2019 was reported to have exceeded the death toll of the ongoing Ebola epidemic. As of April

2020, more than 342,000 people had been infected and 6,400 had died, compared to 3456

infections and 2266 deaths in the current Ebola outbreak to date ("Deaths...6000").

Overall, the sudden influx of personnel and aid into affected cities and villages, has been

seen as a development not propelled not by a "humanitarian" concern for the populations

affected by a deadly disease, but by an ingrained fear of Ebola spreading beyond the eastern

DRC, and notably to the West. A specific suspicion understood by the author in community

feedback, that the measles vaccine used by responders is not for measles but in actuality for

Ebola, provides an entry point into understanding some civilians' skepticism toward the entire response apparatus and the motives underpinning it (Bardosh et al. Sep-Nov 2019). Thinking about the low threshold of panic of the West when it comes to high-profile diseases such as Ebola discussed in the first chapter, and the ways in which the media's sensationalist depictions of the disease fuel this fear, community members are critiquing a response they see as motivated by the impulse to protect the West rather than improve the general health and well-being of populations affected. While this security-driven motivation for a global health intervention is not new, its imposition onto the eastern DRC has touched upon an especially raw feeling of neglect of locals, exacerbated by years of resounding silence and indifference of both the Congolese government and the international community, in the face of continual massacres, and deadly disease outbreaks.

"You will leave when Ebola does…but we will still be here, slowly dying from the diseases that have always killed us", a researcher has heard from the eastern Congo, a message that encapsulates the intersecting economic and political arguments that figure in alternative explanations, and that seem to retain veracity (Nguyen 2019). All of this analysis of the various types of reasoning underlying distrust of populations of the anti-Ebola efforts is certainly not to discount the significant fear and anxieties populations have of Ebola and the threat it poses to their lives, families, and livelihoods. Yet understanding how some are rationalizing the *riposte* helps glean important insight into how lived realities in the eastern Congo have been and continue to be shaped by particular histories of health and basic insecurity that are inevitably in contention with the insecurity paradigms of those responding to the outbreak. The optics through which some civilians have come to understand Ebola have been sculpted by the *riposte*, and begs the question of how, as the epidemic seems to be "ending", the inextricable link between the

disease and the specific, and now expected response it triggers, will have a legacy in future

outbreaks and the meanings with which Ebola has been imbued.

Chapter 4: Interrogating Urgency Amidst Chronic Neglect: Learning from Disjuncture Between Local and (Inter)National Perspectives and Recommendations for Future Ebola Outbreaks in the Eastern DRC

Teasing Out Fears and Blame in a Convergence of "Crises" in the Eastern DRC

As the Ebola workers in the eastern DRC continue navigating various forms of uncertainty, the prospects of an "end" to a declared health emergency require understanding how the West's sentiments of fear and insecurity have undergirded the temporary, *ad hoc* approach that has magnified the fear and insecurity of affected community members. As Nunes (2017) writes, paraphrasing Philip Alcabes (2009),

> The fears that surround health issues do not just relate to their specific physical or clinical dimensions...disease functions as a catalyst of other fears in society—the fear of strangers, of technological development, of racial difference, and so on" (7)

As a universal, evolutionarily adaptive emotion, fear, and the sense of risk that accompanies it, in this Ebola outbreak seem to have emerged on both sides of the epidemic response: on the one hand, an institutionalized fear of EVD in America and the West have combined with the DRC MoH's militaristic approach to Ebola containment to create a highly securitized, top-down response; this structure has according to the humanitarian worker with Mercy Corps engendered a heavy biosecurity context governed by a "no-touch" policy with locals; contact with those from affected populations is strictly limited by physical distancing rules and to mainly medical settings, which in turn considerably constrain response workers' abilities to connect and empathize with locals and learn about their communities and challenges (Personal interview 1). On the other hand, affected populations have "resisted" those elements of the response that inspire rational fear, notably white foreigners associated with colonial violence, military personnel that have been complicit in the routine massacres of civilians, and the perceived dangers of the ETC from which sick patients rarely return. Reproduced through both local and

(inter)national optics, these expressions of fear and uncertainty cannot be removed from the profoundly unequal power dynamics that the Ebola response has surfaced and reinforced.

These asymmetrical power relations that reflect legacies of colonialism, neocolonialism and continual external aggression, have demonstrated the capacities for (mostly Western) sentiments of fear and risk to dictate what problems actually merit attention and action in the eastern DRC, and thus whose lives matter[47]. Indeed, the sounding of the alarm in this region of the country through the declaration of the Ebola outbreak as a national and regional emergency and subsequently as a PHEIC transmitted a message of urgency that resonated with donor's and some global health professionals' fears of Ebola, and implicitly of diseases viewed as "inherently African", intrinsic to the African body, to the "Other". And as the WHO witnesses a gradual decline in Ebola cases and a considerably diminished threat posed by the outbreak, it faces a $20 million funding gap which threatens to financially impede it from continuing response operations through the end of the outbreak (Fall 2020). This familiar trend in which the global community's attention and action hinge upon the visible, tangible threat a supposed "crisis" poses to those outside the affected zone typifies the world's indifference to widespread suffering in the eastern provinces, which remain mired in residual violence from the civil wars and prolonged humanitarian crisis. Yet crisis is the precise lens through which donors and the international community view the current outbreak as well as that of West Africa: one which externalizes the threat posed by Ebola, and internalizes a sense of fragility and vulnerability of the self, i e the

---

[47] Roitman's (2012) analysis of the etymology and history of the term "crisis" proves useful; originating from the Ancient Greek word *krinô*, meaning to choose, separate, cut, to judge, the word "crisis" as it is known and used today connotes a sense of power, particularly to the party applying it, who deems it an apt term for the situation of concern. Remaining predominantly associated with the Hippocratic school, and thus immanent within a medical grammar, the term denoted a critical phase in which life or death was at stake due to a disease threat which justified an "irrevocable decision", a "decisive judgment", a definition which seems to hold relevance today.

West (Nunes 8-9). As a result, these optics have generated mutually reinforcing discourses of risk and securitization.

Structured to address a "discrete crisis event", the *riposte* has in many ways perpetuated a short-term, reactive response model in which Ebola has distracted from, and concealed, the larger politico-economic "crisis" that has arguably produced greater suffering and contributed to the epidemic (Nunes 2017). Fassin (2012) captures the humanitarian lens through which foreign, particularly Western countries respond to complex situations that transpire elsewhere:

> Our way of apprehending the world derives from a process of problematization through which we come to describe and interpret the world in a certain way, bringing problems into existence and giving them specific form, and by this process discarding other ways of describing and interpreting reality, of determining and constituting what makes a problem (3).

The transformation of Ebola into an emergency represents this form of problematization, which not only normalizes the ongoing crisis in the eastern DRC and the country more largely, but also conceals it[48]. Viewed as a health emergency rather than intimately tied to this ongoing "crisis", the Ebola outbreak itself has become implicated in an "alibi" for the larger global community: a strategy of manipulating humanitarian assistance *in place* of political engagement, or in support of military intervention, which often removes responsibility of larger power structures for the perpetuation of short-term, non-sustainable aid:

> At a deeper level, this alibi buttresses the idea that crisis contexts in the geographic periphery – Rakhine, Eastern DRC, Haiti – are 'shitholes' with humanitarian problems to be addressed via responses that are humanitarian in nature (Dubois 6).

---

[48] As Roitman (2012) argues, crisis in contemporary times represents "a discrepancy between the world and knowledge of the world", thus rendering "certain things visible and others invisible."

Dependent on an unwieldy global health governance structure that operates on this politics of fear and risk that perpetuates cycles of health emergencies and neglect, the WHO struggles to overcome this tension between brief disease containment work and longer-term health systems development and promotion in the DRC. Emphasizing the imperative to "transition the capacities built in this response toward building a stronger health system", one which can adequately respond to "malaria, measles, cholera, and now Covid-19", WHO Assistant Director-General Dr. Socé Fall struggles to reconcile his and other practitioners' visions of a more equitable, just reality with an outside world that has long tolerated, and silenced, widespread suffering in the eastern DRC (Fall 2020). These populations who have now become subsumed in an unprecedentedly large health emergency response have not been immune to Fassin's (2012) notion of "compassion fatigue": a "wearing down of moral sentiments until they turn into indifference or even aggressiveness toward victims of misfortune", a process which shifts blame onto those populations directly affected by the outbreak (3).

As previous Ebola outbreaks have demonstrated, the overuse of socio-cultural factors to explain epidemics engender strategic blame-the-victim dynamics which remove international and state responsibility for the structural problems that disease crises surface. Wilkinson and Leach (2015) discuss how deforestation and bushmeat hunting associated with African populations most affected by Ebola during the West African outbreak drew disproportionate attention in explanations for the outbreak. Farmer (2005) elaborates on the conflation of poverty and inequality, consequences of structural violence, and "otherness". This trend observed in scholarship as well as the media in response to a myriad number of different catastrophes transpiring in the "Third World", including epidemics, thus reinforces the connection between the Global South and disaster and tragedy, distancing the suffering from the West that in reality

is inherently linked with global structures of inequality[49]. Wilkinson and Leach (2015) argue that the Ebola outbreak in West Africa cannot be understood without establishing the context of a global economy and regional history that created favorable conditions for an epidemic: a neoliberalization of healthcare which has undermined the WHO's mission of promoting health as a "global public good" and horizontal health system strengthening, civil war in Liberia and Sierra Leone, pervasive corruption, and consequent mistrust in civilians of state and international actors. As Farmer concludes, and echoes Dubois, readers should heed the ways in which notions of culture furnish an "alibi" and distract from the roots of an epidemic (49).

The DRC outbreak has demonstrated how mechanisms of blame toward communities affected most by an epidemic can hinder trust not only of civilians toward response personnel but also in the opposite direction, a reality which serves to remove responsibility from response teams and also distract from larger issues. Community perspectives gleaned from WhatsApp messages, local media, and social media outlets reveal frustrations when response teams attribute the spread of the outbreak to a lack of community buy-in, a default toward problematizing locals that locals themselves claim reflects stigmatizing attitudes held by response workers (Sweet et al. 2019). A Nande youth group in Kinshasa, Cojeunak, a progressive group coordinated by youth themselves who have mobilized against armed group violence in the East and the complicity of Congolese police and armed forces have also spoken out about response teams' condescending demeanors. An open letter they composed to the Minister of Public Health criticized the "paternalistic" views of response teams:

> And even worse, there is current trend to attribute the failure of the response to the community. Worryingly, some members of the response go so far as to grow

---

[49] Roitman's (2012) discussion of how the identity and meaning of "crisis" become displaced for larger concepts that in turn justify it is pertinent: "Crisis is claimed, but it remains a latency; it is never itself explained because it allows for the further reduction of 'crisis' to other elements, such as capitalism, economy, politics, culture, subjectivity."

angry with the population and launch slurs against the community ravaged by violent armed conflict[50] (Dianzenza 2019).

These observed actions of response staff by community members suggest the insensitivities of some response workers to the particular lived experiences and conditions of civilians who are most affected by and vulnerable to Ebola, and a mistrust and violence directed in the opposite direction than is presented in media reports. These harsh, alleged criticisms emanating from response personnel prove all-the-more shocking and indicative of their ignorance, especially in the face of many communities who are committed to ending Ebola yet have consistently voiced their need of handwashing sinks, soap, clean water, disinfectants, and bathroom facilities (Bardosh et al. Sep-Nov 2019). The Nande youth's letter goes further to advocate a "stigma-free" approach to community mobilization, in which response workers see locals as rational actors, oftentimes sharing the same motivations as them, and thus listening critically to them to learn about their realities. This familiar situation in which critical engagement with local perspectives becomes displaced by a dynamics of blame that problematizes populations emphasizes the importance of how in an epidemic response environment trust must go in both directions.

Humanitarian Actors: Navigating the (Politicized) Militarized *Riposte* in the East

Western countries' desires for state-building in the DRC, which remain intimately linked with Western security concerns, rely upon a discourse of state fragility. The DRC in the West's eyes typifies a "fragile state", denoting generally "the lack of capacity and willingness to perform key government functions for all citizens", yet also a deviation from the Western ideals of statehood and governance that renders it a security threat (OECD 2014; Aembe and Dijkzeul

---

[50] "Et le pire dans tout cela est qu'aujourd'hui, on a tendance à remettre en cause une raison diplomatique, tout en donnant la responsabilité de la non-maîtrise de la maladie à virus Ebola à la communauté" http://www.adiac-congo.com/content/maladie-virus-ebola-les-jeunes-nande-de-kinshasa-ecrivent-au-ministre-de-la-sante-publique-0

2019). Consequently, state-building in the DRC has become an attractive, desirable project in the eyes of the West, manifesting in the aforementioned UN peacebuilding missions to the Congo that have discursively and ideologically linked the stabilization of the Congo to international security; preceding titles of these missions have included the United Nations Security and Stabilization and Support Strategy which became the International Security and Stabilization and Support Strategy "to reinforce political progress" (Barrera 2015). This paradigm of state-building in the Congo has been implemented to supposedly protect or help populations but also, and perhaps more so, to act as an ideological vehicle for Western ideals of peace and democracy, which are in many ways paradoxical to realities in the DRC. Some argue that because this paradigm is predicated on a dehistoricized narrative of the Congo as a "weak state" that needs to be strengthened, it fails to see how the Congolese state since its creation has been "patrimonial, clientelistic and predatory", and thus preserves "the patrimonial and predatory method of governance employed in the Congo since it was first created by King Leopold II" (IA 2012: 48, cited in Barrera 2015).

Unresolved tensions between this state-building paradigm, which fails to address the primary causes of ongoing violence and underdevelopment, and humanitarian NGOs' vertical, emergency-based intervention modalities have shaped the DRC's fragmentary health system, and hindered assertions of statehood. Underlying these frictions is a lack of concurrence between these two parties on definitions of peace and state authority in the region: while the latter envisions peace beyond the simple cessation of hostilities and state authority as more than the presence of the army and state agents, representatives of the state seem to find these factors as adequate to achieve such goals. While acknowledging the importance of promoting longer-term development of the health system, which has been funded and pursued to an extent by donors

and INGOs such as USAID, IRC, and Malteser, humanitarian actors tend to justify the continuance of their emergency-based vertical model because of the continuance of urgent and unmet civilian needs. While this bypassing of the state may contravene the principles of the 2005 Paris Declaration which sets the framework for a consensus model of 'country-led development', and thus undermines state actors' efforts to assert statehood, humanitarian actors continue with their work which in many ways is conducive to saving lives and improving community health (Aembe and Dijkzeul 2019). Humanitarian actors thus in some ways have inadvertently inserted themselves within what Kabamba (2012) views as "internal dynamics" in the DRC working to make the state, which he sees as the problem, as weak as possible, as opposed to the "external dynamics" supported by the UN and international community seeking to fortify it.

The Ebola outbreak provides a helpful platform to study the impacts of these tensions between humanitarian actors and the Congolese state (and by extension the international community), the latter which could be argued has taken the *riposte* as an opportunity to perform state legitimacy. MSF and other NGOs' in their commitment to delivering healthcare to those affected by Ebola have been considerably beset by the Congolese government's militaristic approach to health and enforcement of anti-Ebola efforts, which has only exacerbated civilians' distrust. Former response coordinator from the Congolese MoH Aruna Abedi was quoted saying "We tried community engagement. It doesn't work. We need to use force", while the declaration of the outbreak as an international health emergency in July 2019 provided the impetus for security forces to increase their involvement in the response in enforcing infection controls (Freudenthal). While maintaining strict policies against what they see as the "militarisation" of epidemic responses, and attempting to eschew visible interaction with military and police

personnel to maintain an appearance of neutrality for civilians[51], humanitarian actors have at times had to accept accompaniment by Congolese armed forces and police, and UN peacekeepers due to the high risk posed by armed groups, and at times, by civilians. These NGOs thus struggle to 1) avoid identity and ideological conflation with MONUSCO, a product in part of Western security concerns, and 2) reckon with the MoH's problematic employment of state agents responsible in part for the predatory method of DRC's governance, who comprise a response that reflects Western biosecurity concerns.

Humanitarian Neutrality? Community Perceptions of MSF Amidst Ebola

Throughout the Ebola outbreak, attacks against MSF centres and armed group presence have led to the decisions of MSF teams to pull out of communities because of the threat posed to patients, staff, and the organization's neutrality, which have undoubtedly had impacts on communities' perceptions[52]. While perhaps unintentionally, MSF in its decisions to stop and remove operations in certain villages has reinforced in the eyes of local communities an imaginary divide between exceptional and non-exceptional violence: abandoning their posts due to violent attacks in villages where civilians face violence regularly, MSF transmits the message to civilians that the violence their team and patients faced was exceptional, thus implying that the quotidian violence faced by civilians from military forces and armed groups is unexceptional. In the eyes of civilians, these mechanisms of differentiating violence seem significant: considering

---

[51] Humanitarian actors alone have also faced difficulties in engaging with communities and earning their trust due to their usually foreign appearance and inescapable association with a global community that has long been indifferent to ongoing massacres and deprivations of basic needs in such populations; though they tend to bear more positive connotations than UN-affiliated personnel.

[52] https://www.msf.org/medical-activities-suspended-after-ebola-treatment-centre-attack
https://www.msf.org/msf-withdraws-staff-security-ebola-affected-biakato-deteriorates
https://www.msf.org/dr-congo-msf-stops-ebola-and-medical-care-due-military-presence

that large portions of MSF's staff are foreigners, evacuations of staff could be viewed as a way in which NGOs privilege the lives of (often white) foreigners over those of Africans. One MSF nurse indicated to the author the negative influence of evacuations of the organization's staff on communities' perceptions, by revealing the positive impact on such impressions of MSF's decision to stay in communities despite security incidents (Personal interview 2). Overall, trust seems to vary according to whether or not humanitarian NGOs appear self-interested, which reflects in their decisions to stay or leave.

One is also encouraged to think about how this particular epidemic has forced MSF to confront tensions between its commitment to political neutrality and its critique of the larger, global health governance structures that have contributed to the epidemic. As discussed earlier in this chapter, MSF, one of the sole humanitarian actors present in the Eastern DRC, has published several reports over the years and recently, detailing the shocking conditions of the humanitarian crisis seen in the Eastern DRC, which have significantly contributed to the Ebola epidemic. Thus at the same time that they denounce the presence of armed groups in hospitals and medical settings and call for a neutral humanitarian aid that must be organized according to the real needs of the populations and not political motivation seen in state-building efforts, they have argued for lifting financial barriers to healthcare access in the region as well as improving vaccination coverage and the overall healthcare system to halt epidemics. In this way, MSF expresses its commitment to maintaining neutrality to get people the medical they need to survive, while also advancing a critique of the global neglect of this region which is symptomatic of the larger global health governance system[53]. As Nunes (2017) notes, MSF may need to contemplate how

---

[53] MSF has also taken political stances to advocate for health justice through for example its support of the Access Campaign, which contrasts with its insistence on being concerned primarily with getting immediate care to people who need it rather than with discussions about the IHR and international law (Nunes 13).

its reluctance to assume an overtly political role has rendered it complicit in the "short-termist"

approach prevalent in the global health agenda that can be implicated in the deplorable

conditions in the provinces affected by Ebola (14). This complicity could be seen in the

organization's privileging of its mission of tending to the urgent needs of civilians and saving

lives, and thus perpetuating its vertical, emergency intervention model, over supporting the

Congolese state in its construction of a more comprehensive and sustainable healthcare system.

As one public health official stated, "INGOs represent donors, and sometimes they trade on the

fragility of the state and deploy in the sector of service provision with their own terms of

reference"; he contrasted these INGOs with "respectful" ones who "align with state policy by

integrating national health policy" (Aembe and Dijkzeul 2019). While MSF's position in this

distinction is unclear, Ebola has encouraged deeper engagement with such questions.

Indeed, the Ebola outbreak could perhaps be read differently: not only as a situation that

has revealed the problematic predatory and violent tendencies of the Congolese state, yet one

that has surfaced the longstanding and unresolved tensions between INGOs and the state and the

consequences of the disjuncture between their conceptions of peace and state authority in the

Congo. As one MSF nurse shared with the author, the NGO has dedicated significant time and

efforts to convincing populations that they are not associated with the armed forces,

peacebuilding and political agendas (Personal interview 2); while understandably critical of how

the state's militarized approach to the response has eroded trust and compromised the Ebola

riposte, this nurse's sentiments could be indicative of attitudes held by MSF and other INGOs in

the humanitarian sector, who have consistently refused to collaborate with the state in order to

save lives (156). Perhaps one could think about how MSF's decision to stop medical services in

the name of impartiality and neutrality represents an assertion of its immunity from the situation

unraveling in the Congo, and its occupying of a "higher ground" from the Congolese armed forces, and implicitly, the state whose agency and efforts to construct a more robust, public healthcare sector it indirectly works to undermine.

Cultural Sensitivity or Human Sensitivity? Addressing Disjuncture Between Civilians and Response Personnel through Humanizing the Ebola Response in the DRC

Nonetheless, despite these factors significantly complicating humanitarian actors' reputations and abilities to gain trust in communities, certain NGOs such as MSF and ALIMA have shown the possibility of rebuilding trust and thus improving the response through developing several innovations informed by civilians' concerns that have been integrated into the larger response. In this way, these organizations have proven how viewing and treating community members' fears, apprehensions, and reluctance as rational rather than problematizing them through culturalist framings has helped cultivate more sustainable rapport with civilians. While cultural competence in this particular response has been a critical component of earning communities' trust, such as through the implementation of safe and dignified burials (SDB), the particular histories and lived experiences of insecurity of affected populations in the eastern DRC reveal how some aspects of the Ebola response structure and protocols touch upon sensitivities that are inherently human. Innovations have brought to light legitimate fears held by civilians that tend to be overshadowed and invalidated in a response dominated by Western fears linked to Western biosecurity risks, and helped address disjuncture between healthcare delivery and affected civilians.

An ALIMA employee working in Senegal at the time of interviewing emphasized how several innovations have been instrumental in humanizing the Ebola response, particularly in the areas of accessing treatment (Personal interview 4). The design and implementation of peripheral

transit centres has been a way to integrate the Ebola response into existing healthcare structures: patients entering health centers at the village and city levels can be screened for a range of diseases including Ebola, thus de-isolating Ebola from other lethal diseases endemic in the region such as malaria that have been of longer-term and greater concern for local populations. Because of the proximity and familiarity of health centers for some locals, the peripheral transit center has the potential to decrease the prevalence of late arrivals at ETCs through earlier detection of Ebola; in turn, infected individuals' trust can be established earlier in a place with which they are more accustomed, thus increasing the chances for earlier treatment and survival. This method of decentralizing the Ebola response has also been accompanied by the "transparent cubicle" innovation, which has helped allay civilians' fears of the ETC; rendering the insides of the ETC isolation ward visible to those outside the centre came from ALIMA's recognition of how locals' apprehensions, present in this outbreak as well as in West Africa, represented a rational, human reaction to the act of severing loved ones from their sick kin having entered the ETC. Phasing out this structure's opaque walls, which fueled suspicions of HCWs' nefarious actions that were responsible for the deaths of patients, has helped increase trust from communities[54]. This change represents a positive step toward engendering a cycle of trust in ETCs, earlier presentation at them, and survival, thus helping decrease the spread of the disease. An MSF nurse working on-the-ground also stressed the positive impact that other strategies have had in promoting greater transparency: holding "Journées des portes ouvertes"[55] at ETCs to allow community members to come and visit the ETC and meet response staff, while also

---

[54] One may also note striking historical parallels between these "innovations" and those reforms prompted by African "resistance" to the sleeping sickness campaign; in the Belgian colonial era, the system of lazarets, which similar to ETCs were labeled as "death camps", became more decentralized, in closer proximity to villagers, while they were also less "prison-like": these new centers could welcome patients' immediate families, while patients with less advanced symptoms could be treated at injection clinics located closer to their homes, which arguable could be described as analogous to the peripheral transit centers discussed above (Lyons 126).
[55] Open houses

injecting response personnel in front of communities to help decrease fear associated with the vaccine (Personal interview 2).

Other practices popularized by ALIMA have also helped render treatment and engagement with response personnel less foreign and frightening through bringing the response closer to the community. The ALIMA employee underscored the positive impact that an on-average 96% local staff has had in improving the sensitivities of the response team, decreasing language barriers as well as avoiding the immediate loss of trust in communities that the arrival of foreign response personnel can precipitate[56]. While not unique to this Ebola outbreak, the recruitment of survivors into the Ebola response has been instrumental in increasing trust in the eastern DRC: these individuals' built-up immunity to the virus has allowed them to administer treatment to children and participate in care-giving routines without wearing the protective suit which bears alien-like connotations as health workers remain unrecognizable while wearing them, and associations with the ETC. This enlistment of survivors has importantly helped empower Ebola survivors in communities and decrease the stigmatization often brought against them, thus helping to mitigate some of the adverse psychological and psychosocial effects suffered by survivors post-Ebola; in turn, Ebola has become less foreign and more normalized within places affected by it, as communities come to recognize how their own members have endured this traumatic experience, and how the disease constitutes an important part of their history from which they have emerged resilient.

"Endemic" Conflict and Endemic Ebola: Recommendations for Future Ebola Outbreaks in the Eastern DRC

---

[56] Recruiting predominantly from within the community also has the potential of decreasing suspicions of humanitarian organizations and foreign workers profiting from the response, especially since local staff are trusted more, while their employment can help contribute to village and city economies (Alcayna-Stevens 2018).

As a region whose instability shows no signs of abating anytime in the near future, where conflict has been described as "endemic" by one African scholar (Kabamba 2012), and where the risk of Ebola transmission remains high in a region where the disease has been referred to as "endemic", attention must be given towards preparing for the next outbreak. The following recommendations are presented by the author, based on the presentation and analysis of the response structure and the various forms of "resistance" that the response elicited from communities affected by the outbreak. Some recommendations are inspired by interviewees and borrowed from other scholars in regards to previous Ebola outbreaks, and are referenced.

- *Prioritize community engagement from the start.*
  - As the outbreak comes to an end, organizations and the WHO begin to reflect on a fundamental mistake made at the outset of the outbreak and that certainly set the tone for the response: the non-inclusion of local voices. The confirmation of an Ebola case sounded the alarm for the international community and the DRC government, who in delving into emergency response mode neglected to remember critical lessons learned from the West Africa outbreak about how important listening to local perspectives is in developing an action plan that is sensitive to communities' stated needs and priorities. Before the next outbreak occurs, considerable efforts should be made by NGOs and other researchers to communicate with populations affected by the outbreak and listen to what factors contributed to their mistrust. Regular public forums should be held that allow communities to surface their own ideas for community ownership of the response, how the response can better serve their priorities and needs, etc.
  - A huge improvement from the West Africa outbreak seen in this response was the production and integration of social science data thanks to operational briefs made available through the SSHAP platform, and these research and collection processes should be mobilized from the very beginning of the outbreak.
- *Facilitate a more robust, multi-sectoral response through promoting dialogues between humanitarian NGOs, DRC MoH, and civil society actors to develop a single, national action plan for Ebola before the next outbreak occurs.*
  - A Mercy Corps worker on-the-ground in the DRC shared with the author that NGOs operating in the same villages/cities/areas should better communicate and coordinate their activities in order to avoid duplicating efforts, or transmitting mixed messages to communities (Personal interview 1). And as discussed earlier in the chapter, tensions persist between state actors' desires for state authority and national health policy implementation and INGOs' vertical intervention

modalities that circumvent the state and undermine its authority. MSF was open in its disapproval of state strategies of using coercive tactics with populations to achieve compliance with anti-Ebola efforts. At the same time, neither the state nor humanitarian actors are best positioned to engage with communities to gain trust, but rather local structures such as religious associations and civil society organizations, who are well trusted by populations in the city of Goma and have provided health services in the past, as pointed out by David Peyton in an SSHAP brief (Mar 2019). Asad et al. (2014) suggest through their research on Partners in Health and Oxfam America how NGOs and their humanitarian projects are more likely to succeed when they adjust how they interact with the different types of states through engaging in processes of interest harmonization and negotiation.

○ Before the next Ebola outbreak occurs, dialogues should be pursued between humanitarian actors such as MSF, ALIMA and the IRC, the MoH, and local structures such as the Protestant umbrella organizations Eglise du Christ au Congo (ECC), Communauté Evangélique au Centre de l'Afrique (CECA),Communauté des Eglises Baptistes du Congo (CEBCE), and Baraza Intercommunautaire, an interethnic organization specializing in dispute resolution, and Société Civile du Nord Kivu, an umbrella civil society organization. Including members of these local structures, as well as local Congolese HCWs/staff from the provinces affected by Ebola who worked with the WHO and with foreign humanitarian NGOs will facilitate greater representation of local perspectives in larger forums with national and international actors.

○ These dialogues can consist of reflections on what went awry in this outbreak and how the response could be modified, especially to better earn communities' trust, and lead to a single, national action plan for Ebola. Fingers should not all be pointed immediately at the MoH but rather focus on what failed as a team and how a more collective mindset can be cultivated going into the future. These more collective values fostered by a unified plan can be attractive for both the state and INGOs: they would help facilitate a more efficient Ebola response in which the state leverages its civil society actors and also develops relationships with INGOs that do not circumvent or undermine its national policies and authority, while these organizations' strategies and visions are not rejected or eroded by militarization tactics. Conversations could include how to better differentiate tasks between NGOs, the state forces, and WHO: since MSF has a better reputation with civilians, especially after this outbreak, perhaps it should take on more community mobilization than the FARDC in order to not replicate the coercion from this outbreak. As a previous leader of MSF shared with the author, MSF and independent organizations must not cling to their autonomy and overly criticize other actors in a health emergency response, and better communicate and

collaborate in order to achieve a more robust, coordinated response (Personal interview 5).

- *In pre-departure training as well as during field deployment, for foreign healthcare staff, INGOs should place a greater emphasis on sensitivity to the cultural as well as the historical and sociopolitical contexts of the outbreak environments, ideally through dialogues between foreign staff and community members from Eastern DRC.*
    - The Mercy Corps worker also revealed to the author that sensitization on cultural, historical, and sociopolitical contexts of outbreak environments receive cursory treatment in training organized by NGOs for foreign response teams before arrival in the outbreak zone (Personal interview 1). Considering the stigmatizing and critical attitudes demonstrated by response workers in this outbreak, as well as the dehistoricizing culturalist framings of the outbreak in media and elsewhere, training should devote significant time to the history of the country and especially the regional dynamics of violence, providing critical context on the alternative explanations often produced by populations. Pre-departure reading on the history and discussions about these topics should occur. In line with Kabamba's (2012) critique of international workers arriving with the proper language and technical training but minimal-to-no historical awareness, readings could include works by Mudimbe (2008), Mamdani (1996), Mboloko (1995), and Ndaywel (1998). Similar training should continue during field deployment and consist of discussions on the readings mentioned as well as other forms of sensitization done by local staff and/or civil society actors.
- *Better define, measure and tabulate "community resistance" through funding the development of an actual methodology for studying the phenomenon and its impact on the response's progression beyond simple observational or anecdotal methods.*
    - In line with Abramowitz's (2017) observations of the lack of a proper methodology to examine "community resistance", a phrase pervasive in humanitarian situation reports during the West Africa outbreak, this recommendation calls for funding and work to transform this concept into an empirically valid measure of the response's success rather than a poorly defined term that perpetuates the idea that affected communities are intrinsically irrational and noncompliant. Anthropologists who were instrumental in gaining trust of local communities affected by Ebola in the DRC such as Julienne Anoko, and David Niabalamou, who also worked in the West Africa outbreak, could be contacted to pursue this methodological development.
- *Once in the Congo, INGOs should hold frequent trainings and debriefs focused on unpacking any "resistance" seen in communities and challenges in connecting with communities to combat stigma led by anthropologists and local civil society actors.*
    - In an emergency health response, various forms of "resistance" can become quickly problematized and time is not taken to reflect upon how histories and

lived experiences of affected communities underpin alternative explanations. NGOs as well as the FARDC and all response teams should dedicate weekly meetings to the topic of community trust and messages emanating from communities. In particular, training should be implemented regularly which bring to response workers' attention the types of actions, behaviors, and attitudes which could be stigmatizing and potentially worsen trust levels in communities.

- These trainings can be planned and led by anthropologists from the region or elsewhere in collaboration with a local civil society actor having strong rapport with the communities. Long-term funding should be established to pay for these individuals' work in organizing and leading meetings, and also for their engagement with locals to gain their perspectives.

- *Organize public forums between youth and elder populations to promote dialogues surrounding the presence of foreign response teams and surface disagreements.*
  - A report reflecting on the Ebola outbreak in Equateur province that directly preceded the current one written by Alcayna-Stevens (2018) emphasized how youth in the DR tend to be more welcoming toward foreigners as they see them as helpful, and way to find employment, as opposed to elders who often reject foreign presence. The author recommended better harnessing the motivations of youth (those under 25), who comprise over 60% of the DRC's population in subsequent Ebola responses. Youth should continue to be mobilized for Ebola awareness throughout the Eastern DRC, and encouraged to study and enter public health. More forums should be held between youth and elder populations in the region to facilitate dialogues between those who support foreign presence and those who do not, which could encourage elders to reflect more on the ways in which Ebola affects their and their families' health.

- *Provide more transparent information about vaccine funding, and funding for the response overall, in local Swahili and through public forums.*
  - Much of the "resistance" to and alternative explanations surrounding the vaccine came from a dearth of information as to why so few people could get vaccinated (WHO had short supply and it was difficult to procure new supplies, many were experimental). Sensitization on the Ebola vaccine should be pursued currently as the outbreak seems to be dying down and before the next one hits, and information about who is eligible and how ring vaccination works should be made more comprehensible. Information on who supplies the vaccine, how much it costs, and who profits from it should be made publicly available. Reports on the previous Ebola response and who funded what entities and how much should be written up and/or translated into local Swahili so that civilians can access these reports digitally or via printed copies available in communities.

- *In line with the recommendations of Alcayna-Stevens (2018) in reference to the DRC's 9th Ebola outbreak, efforts should be made to subsidize healthcare for especially*

vulnerable populations (women, ethnic minorities), and establish long-term funding to train these populations as midwives, nurses and doctors.

- ○ In the Eastern part of the country, conflict zones are common and produce many vulnerable populations, especially women, their children, and ethnic minorities who are targeted. While the Congolese state does in principle guarantee free healthcare in urgent cases, authorities in the East have proven incapable of holding to this commitment. The vast majority of the population lives on less than $2/day. A greater proportion of women than men in this Ebola outbreak died, likely due to roles of women as caregivers.
- ○ This effort would be pursued over a longer period of time, and have several positive effects. Since large segments of the population in the Eastern DRC are barred from accessing the few healthcare facilities that do exist because of no health insurance, subsidized healthcare can help accustom individuals to the healthcare system and build more trust in it. This acclimation to the process of seeking out care would likely help cultivate a sense of trust amongst the population that would help decrease the potential for a resurgence of Ebola to elicit distrust and skepticism. Training these populations could also help empower them and mitigate economic inequalities that response can bring through recruiting those civilians who are already trained as nurses and doctors or better financially positioned and visible to response teams.

- *Hold* regular *forums between community members, representing a diverse array of professions, socioeconomic levels, gender, and ethnicity, and response personnel to discuss the response,* not only after incidents occur.
  - ○ While public forums were established during the Ebola outbreak, this strategy should be continued and also made more regular. WHO situation reports seem to indicate that forums only took place on an *ad hoc* basis, after security incidents occurred, which had signaled the need to check in with communities. Instead, more regular public forums should be pursued between response personnel and communities, not only after violent episodes. More frequent conversations will make communities feel that their opinions and ideas matter and are wanted, and that their perspectives are not only appealed to after response workers' lives or missions become threatened by insecurity, etc. MSF has shown how more frequent communication with communities and sharing of responsibilities in the design and erecting of ETCs and other aspects of the response, and thus *trust* in locals has facilitated more community ownership and been productive for response efforts, and these types of endeavors should be prioritized.

- *Establish funding to invest in research into the resilience, and local empiricism demonstrated by local communities in this outbreak to identify innovations and agency.*
  - ○ As the first major Ebola epidemic where a vaccine and treatment were available and able to be administered to response workers and affected populations,

unprecedented biomedical solutions could very well have obscured the realities of an underdeveloped healthcare system and lack of resources, as well as local forms of adaptation/coping. As access to populations was significantly hindered, many communities were left to respond without support of international or national responders. As Richards (2016) discusses, community mobilization in the West African outbreak was often predicated on an assumption that local communities possessed no knowledge or capacities to respond to Ebola, thus perpetuating their dependence on foreign teams, and reducing their agency. He and Abramowitz et al. (2015) also reveal how local knowledge was mobilized from the "bottom-up" and was more successful in containing Ebola than international response teams.

- ○ The purpose of the research should not be to highlight local responses as necessarily ideal or desirable by communities, but rather as adaptations to a situation that saw the absence in many places of health, infrastructural and material supports (Abramowitz et al. 2015). Local perspectives can reveal the benefits as well as individual, social, and public health costs of local coping methods that were deployed.

Conclusion: Healing and Harming—Revisiting Colonial Legacies in the Eastern DRC and Recognizing "Patterns" Behind Mistrust in Epidemic

Security, Exception, and Health in the Congo: Revisiting Colonial Legacies

Returning to the enigmatic figure of Maria N'koi is helpful when seeking to historicize the links between security and "exception" in the Congolese socio-political landscape. She embodied what Hunt terms "therapeutic insurgency", which weds the notion of medicinal healing with that of armed insurrection, health with liberation from oppressive, dehumanizing structures and systems such as colonialism. While continuing to wield an ability to incite others to armed rebellion even after her arrest, she herself became a "security risk" to the power of colonial officials and the dominance of the Belgian colonial state: she maintained "powers, patients, followers and spirits" which seemed to transcend the control of colonial officials, and thus "ignited colonial emergency" (Hunt 71, 72, and 61). In this case, the construction of "emergency" denoted the volatile state of rebelliousness inspired by N'koi observed by colonial agents throughout the colony, prompting them to "[declare] a state of exception" and stabilize the colonial order through relegating the healer (Hunt 92-3). Here, the declaration of emergency, a prerogative of the entity in a position of power, was deployed in response to a danger embodied by an elusive, mystical, and potent healer who, in the eyes of colonial officials, was fundamentally a subaltern body seeking to liberate herself and her people from subjugation.

Among the many consequences of white, colonial domination that N'koi spoke out against was the disproportionate number of African deaths due to sleeping sickness: this disease constituted a prolonged epidemic in Belgian colonial Congo and showcased the power of colonial officials to subjectively define, and in ways create, security risks, and the ensuing

consequences. Nunes (2017) conveys the relationship between power and security through capturing the inventiveness of the latter:

> "...'security' is not a description of reality but a tool for shaping reality...The notion of securitization helps to explain the current tendency to use security to make sense of events...and the resulting ability to create or expand areas of exception where normal rules do not apply" (5).

Security thus becomes a way to alter the optics through which a certain situation like an epidemic is viewed, which in turn justifies a departure from normalcy to respond to it. In the early 1900s, the campaign to end sleeping sickness in the colonies was elaborated upon the predominant conception of disease as an "enemy agent", rendering the battle against it a "'struggle', which would require all the logistics and strategy of a military campaign" (Lyons 103). The consequences of this discursive framing of the response to the epidemic fell heavily on "African societies...who had to be controlled for their own protection" (Lyons 104). Yet this seemingly benevolent mission to "protect" the health of Africans cannot be removed from a context of Belgium's "civilizing" mission in the Congo, where the Belgian colonial medical service was deployed "as a form of 'constructive imperialism'", and where Belgians had an economic incentive to save African lives to preserve manual labour (Lyons 64). And despite the demonstrated aetiology of the disease, infection through contact with the disease's primary vectors, tsetse flies, the Belgians' campaign targeted man, and predominantly, Africans for "sterilisation" of the parasite, reinforcing associations between the disease, security, and the African, subaltern body. Consequently, "disease, like the recalcitrant Africans, would be forced into submission", justifying strict policing of Africans, restrictions of their social and economic activities and movements, and harsh conditions in the *cordons sanitaires* (Lyons 103).

While the Belgian sleeping sickness campaign's intensive focus on controlling African movements ultimately led to an effective containment of the disease, its biomedical ethos should

be analyzed for the ways in which it bolstered colonial state power and justified violence throughout the imperial and colonial eras. According to Lyons (1992), the sleeping sickness campaign initiated a "medicalisation of the Congolese", where the Belgians sought to instill in colonized Africans the idea that European doctors and their medications were the sole and unquestionable solutions to problems of ill health (102). Lauding and entrenching this biomedical model to treat a disease whose propagation originated at the nexus of social, economic and environmental factors, the Belgians further cemented an optics through which they came to diagnose the physical and psychological effects of colonialism detached from the colonial condition. In the 1930s, in a colonial research investigation into the depopulation trend observed in the Congo region of Tshuapa, Dr. Georges Schwers "[underlined] sterility as inherent in the 'race' and as resulting from 'primitive', 'primordial' shock" (Hunt 147).While with this notion of shock Schwers acknowledged how early colonial occupation served as a profound disturbance that weakened familial spirit and maternal instinct, he overall spoke in "an abstract, dehistoricized language, not in structural terms about harm" (Hunt 147). Schwers' language that described the trauma and weakness of the Africans in Tshuapa referred to a nonspecific previous time of shock, failing to mention and implicate imperial and colonial violence, and reducing the scope of his research field to the medicalized, human body (Hunt 156).

Overall, Schwers conveyed and preserved a pathologizing and dehistoricizing degeneration of the African body in Belgian and European medical circles that helped silence past colonial violence, a narrative that could help illuminate discourse on the Congolese state today. As Hunt (2016) writes, citing Daniel Picks, "joining ideas about a social body—a nation, a race—with fears about skin color, respectability, and birth rate, degenerationist language tends

to combine 'a technical diagnosis and a racial prophecy'" (147). Deployed as an intentional, destructive tool, this degenerationist language justified colonial conquest through affirming the inexorability of the African's decline, and even extinction, because of their inherent weakness faced with a superior (white) race. One could argue the same power structures that shaped this resulting lens through which colonial powers viewed and diagnosed their colonized subjects operates today in discourse pervading the international community that conveys the DRC as a "weak state". Described by such institutions like the World Bank as a "state...characterized as being in an 'advanced state of degradation', and as a "destabilizing factor for its nine neighboring countries", the Congo in mostly Western understandings continues to be presented through language and meanings that pathologize its conditions and existence, which threaten to infect nearby nations and the world, detached from the violence that has defined its history since its creation (World Bank 2013, p. 3, cited in Aembe and Dijkzeul 2019). And the consequences of these remnants of degenerationist discourse are far from benign: for the DRC, as a weak and fragile state, the only alternative in the West's eyes becomes strengthening and stabilizing it, through "extending the authority of a predatory state" and thus "replacing one group of perpetrators (foreign and Congolese rebel groups) with another (state authorities and state security forces)" (Autesserre 2012). And civilians, especially in the country's war-torn east where UN peacekeeping operations persist, who are currently affected by Ebola, are harmed the most from continual violence that in their eyes, and that in truth, reflect in several ways legacies of the violence and perturbations intrinsic to colonialism.

It is with this particular history of the Congo, which as illustrated very much lives in the present, that one must read the "resistance" of civilian populations in the eastern Congo in reaction to Ebola and the (inter)national response, and grasp the complex ways in which Western

biomedicine, security, and power intersect. Fanon's reminders of the anger and ambivalence produced by biomedicine in colonial and postcolonial contexts, seminal in the field of decolonial thinking, encourages one to combat depictions of acts of "resistance" amidst Ebola in the eastern DRC that center on individuals' "beliefs" and "ignorance", attributing these negative reactions of civilians to an African culture that is implicitly inferiorized to that of the West and biomedicine (Hunt 164). What should not be mistaken for a cultural incongruence between Congolese populations affected by Ebola and biomedical approaches to anti-Ebola measures is rather a friction between protected response workers' senses of health and physical insecurity and affected populations' lived experiences of chronic physical, health, and economic insecurity. What have converged are different optics through which Ebola and its presence are viewed: while on the response side those optics are sculpted to exceptionalize Ebola as a formidable biosecurity threat, those on the receiving end look through a lens in which Ebola simply adds a dimension of precariousness, that poses no "extraordinary" threat out of the overall insecurity that envelops their lives.

One cannot help but see parallels with the colonial state of emergency declared in response to N'koi: the state and international community, entities retaining greater power, and importantly, employing violence, continue exercising the paternalistic power to declare what is exceptional, what constitutes emergency, prompted by a risk that poses a threat to them that should in turn receive priority rather than the threats faced by affected communities that have been met with silence for years. The Mercy Corps worker who spoke with the author presented this trend as a symptom of the West's tendency to arbitrarily impose urgency on all that is Ebola; the resulting disconnect with reality reflects in decisions that, "nonsensically", created urgency in an outbreak with 10x fewer people touched by Ebola than in West Africa (Interview 1).

In the same way that Ebola should not be framed as a "substantial", "unexpected", "unusual" event, as its labels as a Class 3 emergency and PHEIC denote, the various forms of "resistance" to the *riposte* from local populations in the affected provinces, and importantly the messages they transmit, should equally not be viewed as anomalous, thus not meriting attention or recognition. Benton (2016) advocates an understanding of attacks on healthcare workers that is not "exceptional", but rather placed "within their broader social, political and cultural contexts"[57] (158). This enlarged perspective that helps combat a narrow analysis of events, analogous to how an ecological model resists a biomedical examination of public health issues, reveals the complex, profound nature of acts of "resistance", and alternative explanations produced by communities affected by Ebola that evidence their agency in conditions that have long silenced their voices, and their suffering, since imperial times. N'koi, a figure who inspired unrest, was outspoken about sleeping sickness as a colonial tool of extermination against African populations, a message that surely resonated with other Africans for whom disease became viewed as a form of biowarfare used by colonial agents. Observing how this same type of optic through which the presence of disease is viewed has recurred with Ebola demonstrates how violent realities have evolved yet in ways remained unchanged for many throughout history, and how some Congolese have offered an alternative biosecurity narrative to that of the West that views disease as an element difficult to dissociate from politics and history. While by no means representative of all individuals' opinions in regions affected by Ebola, and while sometimes mobilized to achieve unscrupulous political ends, alternative explanations like that of Ebola as a

---

[57] As one Nigerian national shared with the author, the political nature of interventions in health crises, in which humanitarian, neutral NGOs participate, is irrefutable, and also inevitable (Interview 6). In this way, these independent, impartial actors must not see themselves as immune from criticism against the political dimension of their actions, and the impossibility of compartmentalizing spaces occupied by humanitarian actors and the politicized milieux in which they operate.

tool of warfare and extermination join with others that nonetheless provide a powerful commentary on the consequences of global neglect and inaction.

From Ebola to Covid-19: Recognizing "Patterns" Behind Mistrust in Epidemics

As Ebola in the DRC, as well as other epidemics and pandemics such as Covid-19 have demonstrated, disease outbreaks can be mobilized as attempts to shape the optics through which those lacking power interpret their political and social realities. As previously discussed, local elites in the Kivus and Ituri Provinces have capitalized on the deep-seated mistrust of civilians in this region of the DRC through propounding Ebola bioweapon narratives to secure their own political support, prolonging the outbreak to enrich themselves. Other manipulative tactics such as framing Ebola as a hoax seen in the DRC's tenth outbreak and West Africa seem to parallel ones which have emerged during the Covid-19 pandemic. Prime Minister Hun Sen of Cambodia has previously denounced social media and news reports on coronavirus as "fake news", and used this anti-propaganda façade to jail opposition leaders as well as civilians who have expressed concerns about the disease[58]. In the UK and the US, various conspiracy theories have sprung out from right-wing extremist groups, making such claims that Covid-19 is linked with 5G technology[59], and that coronavirus was concocted in a Chinese lab and released as a bioweapon. The Chinese state has reciprocated this bioweapon trope and utilized its tight control of media to obscure its own alleged inaction in the face of mounting coronavirus cases, and use the epidemic as an opportunity for nationalist performance (Zhou et al. 2020). In response to the crisis of confidence in Xi Jinping's leadership, Chinese state media turned conspiratorial chatter found in the recesses of the internet into official state propaganda: rather than accept perceptions

---

[58] https://www.hrw.org/news/2020/03/24/cambodia-covid-19-clampdown-free-speech
[59] https://www.bbc.com/news/52168096

of himself as a leader who knowingly ignored a growing threat to his nation's people, Jinping and his communist state have deployed a narrative that depicts him as the defender of his people from the US and their bioweapon, coronavirus. This self-inflating tactic that makes use of conspiracies lauds the Chinese state for bringing order namely through strong leadership and scientific innovation, the latter of which in China is often seen as a panacea to complex social ills[60] (Zhou et al. 2020).

The aforementioned narratives can be aptly labeled conspiracy theories, whose intentions often aimed at distorting reality to achieve some political gain are to be distinguished from those alternative explanations produced by historically marginalized peoples amidst epidemics. Providing comfort to individuals who find an explanation for and source of this pathogen with catastrophic power that is both "motiveless and meaningless", conspiracy theories correspond to what Stuttaford describes as "a susceptibility to finding patterns where none exist." As inventions, these narratives are utilized as tools to seemingly create order from what is inherently disorder, and also distract from underlying structural issues that events such as epidemics and pandemics reveal in society, and the world. While many of the alternative explanations given by Congolese civilians during the most recent Ebola outbreak, other civilians during the West Africa outbreak, and others in disease outbreaks throughout human history are given the label of

---

[60] State media posts presenting the "construction miracle" of new hospitals in China as a patriotic engineering feat rather than evidence of an overburdened medical system provides an idea of this reality (DiResta 2020). Here one should recognize how in wealthier countries such as China, and Western ones such as the U.S. and U.K., bioweapon narratives can be deployed selectively in order to promote self-inflating tactics that also impose blame on poorer countries amidst health crises. While during Ebola and Covid-19, media reports have been known to link the devastation wreaked by such diseases in poorer countries such as in Africa with mismanagement of funds, poor hygiene, failing institutional structures and the dangers of misinformation, the severe consequences faced by wealthier countries are depicted as something beyond their control (a bioweapon attack as a case-in-point). If anything, the intractability and great damage caused by Covid-19 in low-, middle-, and high-income countries alike requires an interrogation of the responsibilities of leaders of various countries in the inequality and unpreparedness that the pandemic has revealed, all while acknowledging the vulnerability of poorer countries with under-developed health infrastructures.

"conspiracy theories", this thesis, and the work of other scholars such as Alcayna-Stevens (2020) demonstrate the inaccuracy of this term. The world's and societies' most vulnerable and marginalized, often disproportionately impacted by epidemics, have produced themselves narratives to explain epidemics and their ensuing responses in ways that in fact recognize and respond to the patterns of control, silencing, and oppression of their own bodies and voices.

The history of "resistance" to cholera outbreak responses provides a helpful illustration of the importance of situating negative and sometimes violent reactions of certain populations into the historical, sociopolitical patterns to which they are well-accustomed. During the second pandemic of cholera, a water-borne illness primarily affecting urban slums, that struck Russia in 1830, rumors arose from those cholera victims who were indiscriminately thrown together with those suffering from other ailments that doctors were intentionally seeking to exterminate the sick; doctors and government officials thus became the targets of repeated, violent cholera riots, transpiring in subsequent outbreaks such as the fifth in what is currently the Ukrainian city of Donetsk, creating reinforcing government repression and unrest that ultimately led to the Russian Revolution. After the disease broke out in Haiti in October 2010, rumors began to circulate, fueling riots, and positing UN peacekeeping troops as the source of the outbreak, which later turned out to be true (Kolbert). While these explanations for cholera may on-the-surface seem as fantastical as those conspiracy theories delineated above, they must not be removed from the historical, social, and political contexts of those who proposed and propagated them. Reactions of second-class citizens mistreated by doctors and government officials during the earlier cholera outbreaks deserve a reading as responses to the harsh treatment as well as adverse socioeconomic conditions that the epidemic had magnified and importantly brought to society's attention. In Haiti, seemingly far-fetched "rumors" that implicated a Western security force may make more

sense when placed into a history in which the Haitian people have been historically marginalized and harmed by the foreigner: forcibly removed from their homes in Africa by the white Europeans, enslaved by them, indebted to them, and perpetually intervened by them and the US.

Epidemics can generate an abundance of narratives to explain them, that oftentimes convey distrust and suspicion, deviate from the truth and produce behaviors and sometimes violence that can be counter-productive for public health measures; however sensitivity to the positionality of who is advancing such narratives, who is exhibiting such distrust, must be integrated into efforts to address them, providing a critically more complex understanding of the historical and sociopolitical landscapes against which epidemics and their responses emerge and evolve. Epidemics and their responses can give a voice and opportunity to a wide range of actors that occupy their own unique spaces within a larger, common one that can transcend communal, regional, and national borders. During epidemics those with specific political agendas can advance narratives that they strategically construct to resonate with marginalized peoples, and often to keep them in their inferior and subdued positions; yet epidemics showcase how these disadvantaged, oppressed peoples, oftentimes those who are disproportionately harmed by health cries, so too can speak up and transmit messages that resonate with each other. In epidemic and pandemic responses now and in the future, the first priority should be not rejecting both of them, but rather listening carefully to them and discerning between the two. This combination of listening and patience must comprise any attempt toward working with communities to heal what they define themselves as the wounds in their own lives and societies.

Appendices

Appendix A:
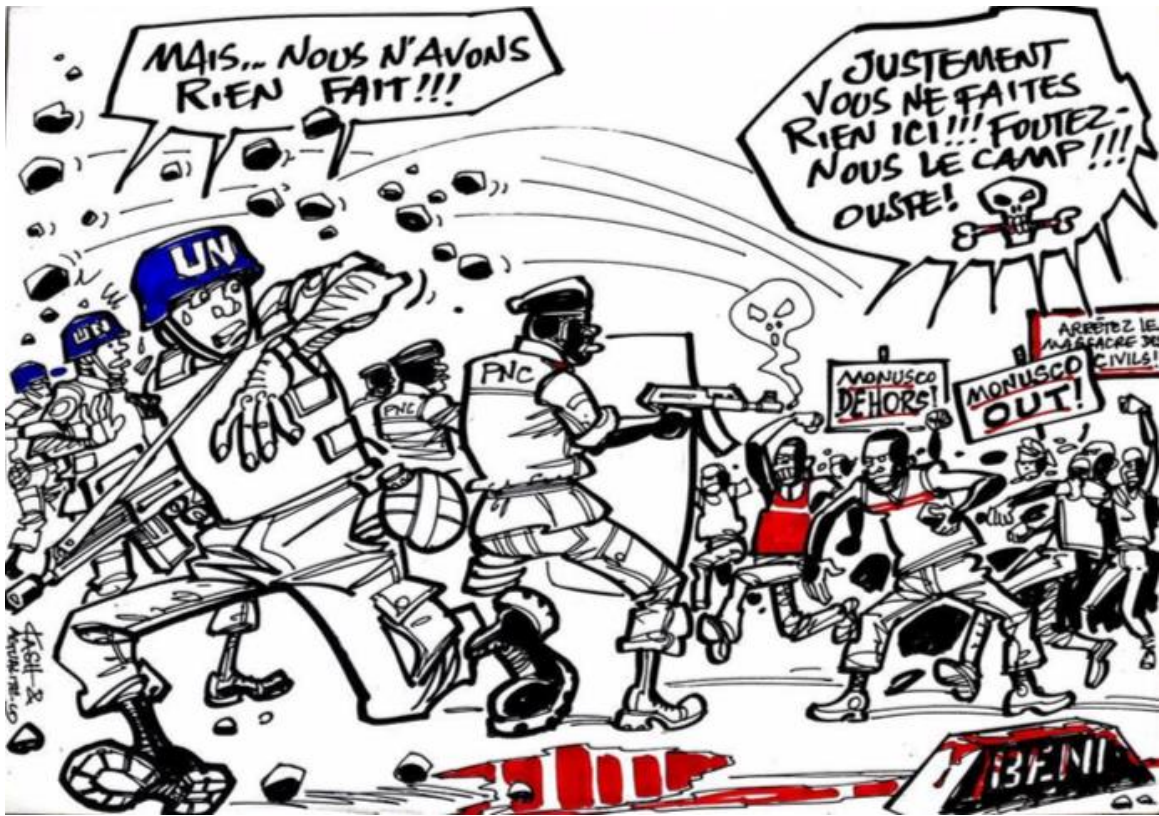
« En 20 ans, avec les drones, les lunettes à vison nocturne, les autos blindées, les avions, les milliards et tous le matos etc... comment les casques bleus n'arrivent pas à 'attraper la souris' ?????? » Kash Thembo, November 24, 2019 (Source: Alcayna-Stevens 2020)

Here, UN peacekeepers ask themselves why civilians are so upset, because they "didn't do anything". Civilians shrewdly respond, "exactly, you don't do anything here," as they chant in protest "out with MONUSCO".

Appendix B:
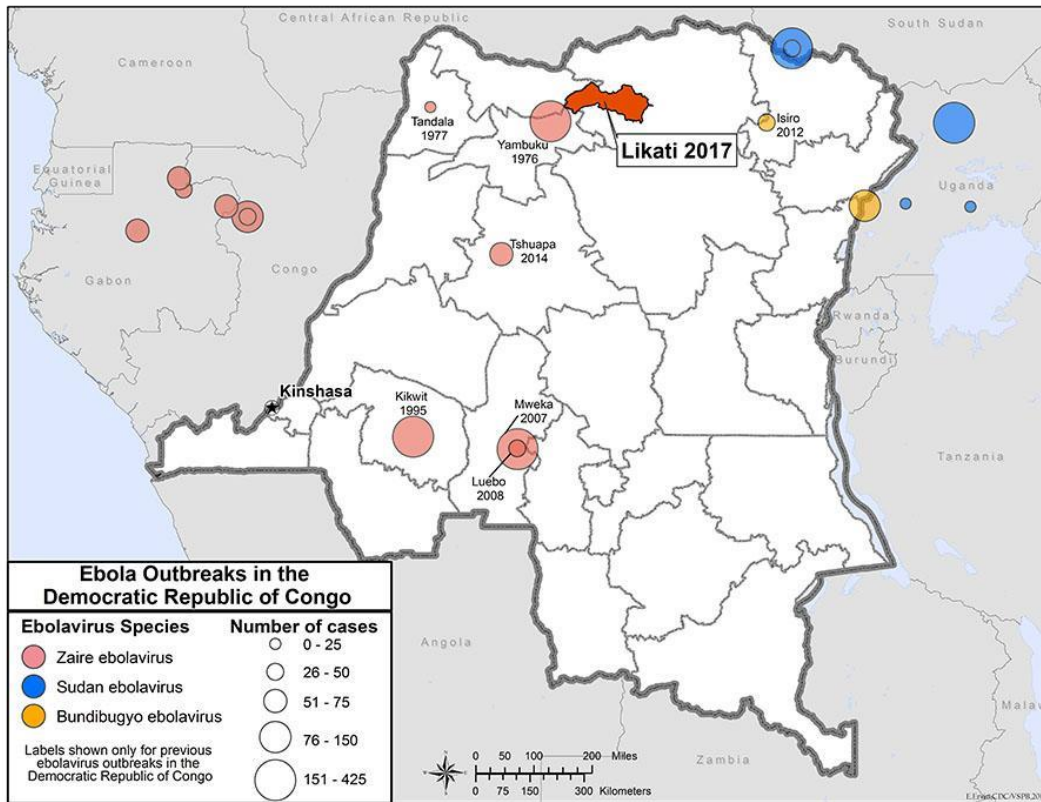
The map indicates outbreaks of Ebola in Yambuku in 1976, Tandala in 1977, Kikwit in 1995, Mweka in 2007, Luebo in 2008, Isiro in 2012, Tshuapa in 2014, and, at the time of the map's creation, in Likati in 2017. All outbreaks were of the Ebola Zaire subtype, except for the Isiro outbreak, with Ebola Bundibugyo. All outbreaks of Ebola Zaire were between 51-75 cases; the Isiro outbreak was from 26-50 cases (Source: CDC 2017).

Appendix C:
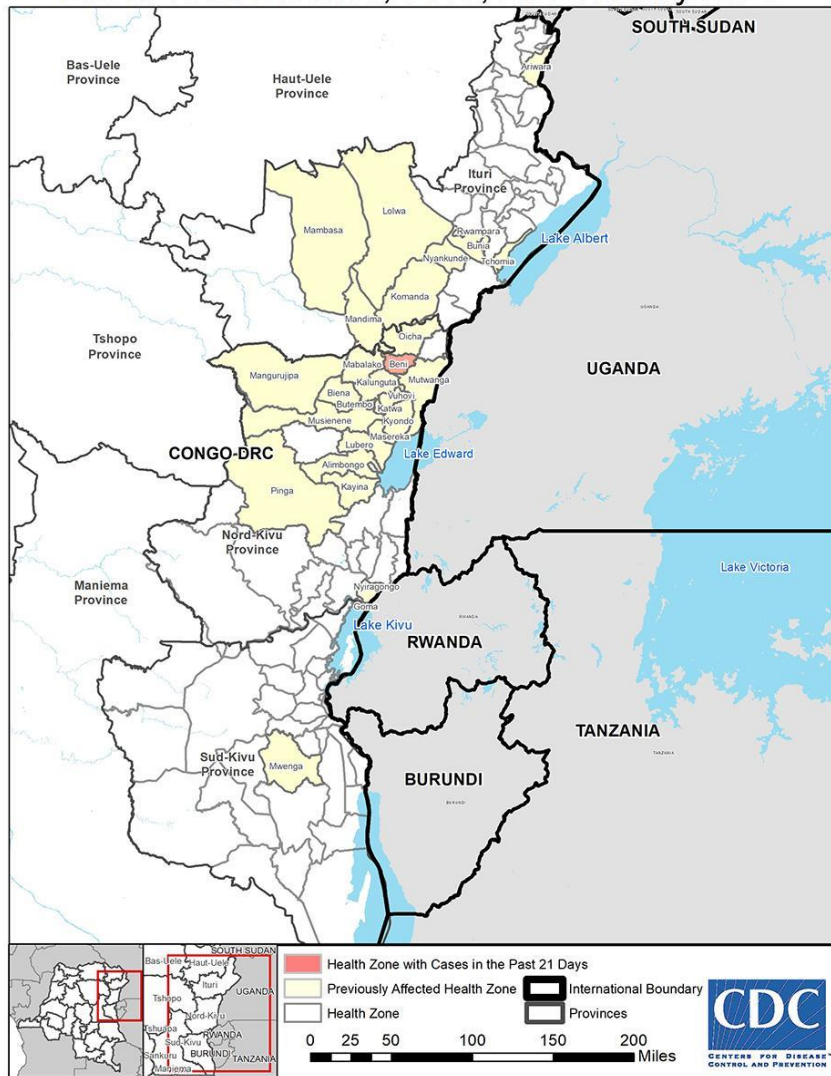
Map showing health zones previously affected by Ebola or affected by the disease at the time of the map's creation on February 20, 2020 (Source: DRC MoH, CDC, WHO).

Appendix D:
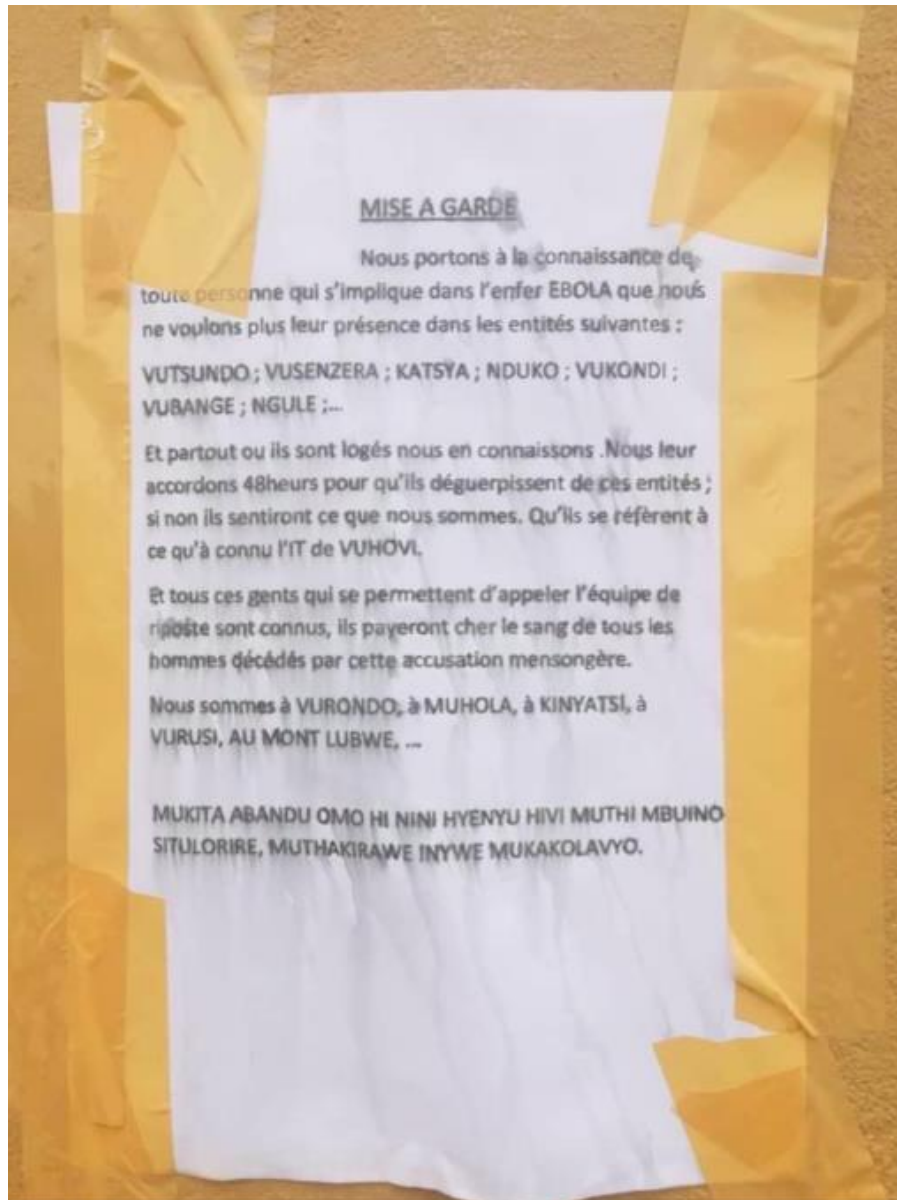
A poster distributed after the attack on the Katwa ETC on February 24, 2019
(Wells et al. 2019). Translation in text of thesis.

References

Primary Research

Personal interviews:

Personal interview 1: Mercy Corps practitioner in DRC (21 Jan. 2020). Telephone interview.

Personal interview 2: MSF nurse in DRC (11 Jan. 2020). Telephone interview.

Personal interview 3: PhD Candidate at Northwestern University (30 Nov. 2019). Telephone interview.

Personal interview 4: ALIMA employee in Senegal (9 Jan. 2020). Telephone interview.

Personal interview 5: Previous MSF leader (27 Jan. 2020). Telephone interview.

Personal interview 6: Nigerian national (10 Jan. 2020). In-person interview.

Survey Compilations:

Bardosh, Kevin, et al. *Social Science and Behavioural Data Compilation, DRC Ebola Outbreak, November 2018-February 2019*. Social Science in Humanitarian Action Platform, 2019.

---. *Social Science and Behavioural Data Compilation (No. 3), Ebola Outbreak Eastern DRC February-May 2019*. Social Science in Humanitarian Action Platform, 2019.

---. *Social Science and Behavioural Data Compilation (#4), Ebola Outbreak Eastern DRC, June-August 2019*. Social Science in Humanitarian Action Platform, 2019.

---. *Social Science and Behavioural Data Compilation (#5), Ebola Outbreak Eastern DRC, September-November 2019*. Social Science in Humanitarian Action Platform, 2020.

Peyton, David, et al. *Key Considerations: Ebola Preparedness and Readiness in Goma, DRC*. Social Science in Humanitarian Action Platform, 2019.

Sweet, Rachel, and Juliet Bedford. *WhatsApp and Local Media (Grand Nord) – 9-18 September 2018 Reluctance, Refusal, Resistance and the Politicisation of the Ebola Response*. Social Science in Humanitarian Action Platform, 2018.

Sweet, Rachel, et al. "Politics, Factions and Violence: Listening to Local Voices on Ebola Local Media Update #3 (February-April 2019)." Social Science in Humanitarian Action, 2019.

Secondary Sources

Abramowitz, Sharon. "Epidemics (Especially Ebola)." *Annual Review of Anthropology,* vol. 46, no. 1, 2017, pp. 421–445.

Abramowitz, Sharon, et al. "Community-Centered Responses to Ebola in Urban Liberia: The View from Below." *PLOS Neglected Tropical Diseases*, vol. 9, no. 4, Sept. 2015.

Adams, Vincanne. "Evidence-Based Global Public Health: Subjects, Profits, Erasures." *When People Come First: Critical Studies in Global Health*, Princeton University Press, 2013, pp. 54–90.

Adhanom-Ghebreyesus, Tedros. "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 - 3 March 2020." World Health Organization, World Health Organization, 3 Mar. 2020.

Aembe, B., & Dijkzeul, D. "Humanitarian governance and the consequences of the state-fragility discourse in the Democratic Republic of Congo's health sector. *Disasters*, 43(S2), 2019.

"After the Fire - How We Could Have Better Managed DRC Ebola Outbreak: MSF." Médecins Sans Frontières International, 23 Apr. 2020.

Agamben, Giorgio. *State of Exception*. Univ. of Chicago Press, 2003.

Alcabes, Philip. *Dread: How fear and fantasy have fueled epidemics from the black death to avian flu*. New York: Public Affairs, 2009.

Alcayna-Stevens, Lys. "'Ebola Business': Surfeit and Suffering in the Democratic Republic of the Congo." Paper presented at the ASW, Harvard, 24 Feb 2020, pp. 1–25.

---. "Planning for Post-Ebola: Lessons Learned from DR Congo's 9th Outbreak." UNICEF, 2018.

Asad, Asad L., and Tamara Kay. "Theorizing the Relationship between NGOs and the State in Medical Humanitarian Development Projects." *Social Science & Medicine*, vol. 120, 2014, pp. 325–333.

Autesserre, Séverine. "Dangerous Tales: Dominant Narratives on the Congo and Their
    Unintended Consequences." *African Affairs*, vol. 111, no. 443, Sept. 2012, pp. 202–222.

---. *The trouble with the Congo: local violence and the failure of international peacebuilding*.
    New York: Cambridge University Press, 2010.

Bagnetto, Laura Angela. "Stealing Tongues: Miscommunication in the Time of Ebola in DR
    Congo." RFI, RFI, 4 Nov. 2019.

Barrera, Alberto. "The Congo Trap: MONUSCO Islands of Stability in the Sea of Instability."
    Stability: International Journal of Security & Development, vol. 4, no. 1, Mar. 2015.

Benton, A. "Even war has rules:" On Medical Neutrality and Legitimate Non-Violence. *Culture,
    Medicine and Psychiatry*, 2016, 40(2): 151-58.

---. Race and the Immuno-logics of Emergency Response during the West African Ebola Crisis,
    Somatosphere, September 19, 2014.

---. "Whose Security? Militarization and Securitization During West Africa's Ebola Outbreak."
    The Politics of Fear: Médecins Sans Frontières and the West African Ebola Epidemic,
    Oxford University Press, 2017, pp. 25–50.

Biruk C. "Ebola and emergency anthropology: the view from the 'global health slot'.
    Somatosphere: Science, Medicine, and Anthropology. 2015.

Bolten C, Goguen A. "Ebola through a glass, darkly: ways of knowing the state and each other."
    Anthropological Quarterly (Spec. Issue: Producing Ebola), 2017, 90(2):429–56.

Bradley EH, Taylor LA. "Turning the Tide: The Application of Grand Strategy to Global
    Health." In: Eds., C Nichols, E Borgwardt, A Preston; *Rethinking American Grand
    Strategy*, Oxford Press, in press 2020.

Brown, Theodore M., et al. "The World Health Organization and the Transition From
    'International' to 'Global' Public Health." *American Journal of Public Health*, vol. 96,
    no. 1, 2006, pp. 62–72.

Bush, George. "U.S. National Security Strategy: Overview of America's International Strategy."
    U.S. Department of State, U.S. Department of State, 1 June 2002.

Caduff, Carlo. *Pandemic Perhaps - Dramatic Events in a Public Culture of Danger*. University
    Of California Press, 2015.

Calain, Philippe, and Marc Poncin. "Reaching out to Ebola Victims: Coercion, Persuasion or an Appeal for Self-Sacrifice?" Social Science & Medicine, vol. 147, 2015, pp. 126–133.

"Cholera Outbreaks in Central and West Africa : 2019 Regional Update - Week 27." Regional Cholera Platform in Africa, 12 Apr. 2019.

Comaroff, Jean. "The Diseased Heart of Africa: Medicine, Colonialism, and the Black Body." Knowledge, Power, and Practice: The Anthropology of Medicine and Everyday Life, University of California Press, 1993, pp. 305–329.

Congo Research Group. "Qui Sont Les Tueurs De Beni?" Center on International Cooperation, 2016.

Constitution of the World Health Organization, *Basic Documents*, Forty-fifth edition, Supplement, October 2006.

"Deaths from Democratic Republic of the Congo Measles Outbreak Top 6000." World Health Organization, World Health Organization, 7 Jan. 2020.

"Definitions: Emergencies." World Health Organization, World Health Organization, 17 Nov. 2014.

"Democratic Republic of Congo - CDC Center for Global Health." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 23 May 2019.

Depelchin, Jacques. *Silences in African History: between the Syndromes of Discovery and Abolition*. Mkuki Na Nyota Publishers, 2005.

Dianzenza, Lucien. "Maladie à Virus Ebola : Les Jeunes Nande De Kinshasa Écrivent Au Ministre De La Santé Publique." Agence D'Information D'Afrique Centrale, 1 Apr. 2019.

DiResta, Renée. "For China, the 'USA Virus' Is a Geopolitical Ploy." The Atlantic, 11 Apr. 2020.

DuBois, M. "The new humanitarian basics." Humanitarian Policy Group, 2018, 1–31.

Duffield, Mark. "Challenging Environments: Danger, Resilience and the Aid Industry." *Security Dialogue*, vol. 43, no. 5, Oct. 2012, pp. 475–492.

---. *Development, Security and Unending War: Governing the World of Peoples*. Polity, 2013.

"Ebola Outbreak in the Democratic Republic of the Congo Declared a Public Health Emergency of International Concern." World Health Organization, World Health Organization, 17 July 2019.

"Emergencies." World Health Organization, World Health Organization, 30 Aug. 2019.

"Emergency Committee on Ebola in the DR of Congo." World Health Organization, World Health Organization, 17 July 2019.

Enria, Luisa. "What Crisis Produces: Dangerous Bodies, Ebola Heroes and Resistance in Sierra Leone." (Bath Papers in International Development and Wellbeing; No. 53). Centre for Development Studies, University of Bath, 2017.

Ensuring WHO's Capacity to Prepare for and Respond to Future Large-Scale and Sustained Outbreaks and Emergencies. WHO, 2015, pp. 1–6.

Epelboin A, Formenty P, Anoko J, Allarangar Y. "Humanisation and informed consent for people and populations during responses to VHF in central Africa (2003–2008)." Presented at Human. Bord., Dec., Geneva, 2007.

Fairhead, James. "Understanding social resistance to Ebola response in the forest region of the Republic of Guinea: an anthropological perspective." Afr. Stud. Rev.59, 2016, pp. 7–31.

Fall, Ibrahima Socé. "Statement on the Meeting of the IHR Emergency Committee for Ebola Virus Disease in the Democratic Republic of the Congo." World Health Organization, World Health Organization, 6 Mar. 2020.

Fanon, Frantz. *A Dying Colonialism*. Grove Press, 1965.

Farmer, Paul. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. University of California Press, 2005.

Fassin, Didier. *Humanitarian reason: a moral history of the present times.* Berkeley: University of California Press, 2012.

Fassin, Didier, and Mariella Pandolfi. "Introduction: Military and Humanitarian Government in the Age of Intervention." *Contemporary States of Emergency: The Politics of Military and Humanitarian Interventions*, Zone Books, 2010.

Finkel E. "Engineered mouse virus spurs bioweapon fears." *Science*, 291, 585, 2001.

Formenty P, Libama F, Epelboin A, Allarangar Y, Leroy E, et al. "L'épidémie de fièvre hémorragique à virus Ebola en République du Congo, 2003: une nouvelle stratégie." Méd. Trop. 63, 2003, pp. 291–95.

Freudenthal, Emmanuel. "In Congo, a 'Militarised' Ebola Response Has Fuelled Community Resistance." *The New Humanitarian*, 2 Oct. 2019.

Frischknecht, Friedrich. "The History of Biological Warfare." EMBO Reports, vol. 4, no. S1, Sept. 2003.

Gostin LO. The future of the World Health Organization: lessons learned from Ebola. The Milbank Quarterly. 93(3), 2015, pp. 475–9.

Headrick DR. "Sleeping Sickness Epidemics and Colonial Responses in East and Central Africa, 1900–1940." PLoS Negl Trop Dis 8(4): e2772, 2014.

Hanrieder, Tine, and Christian Kreuder-Sonnen. "WHO Decides on the Exception? Securitization and Emergency Governance in Global Health." *Security Dialogue*, vol. 45, no. 4, Aug. 2014, pp. 331–348.

Hewlett, Barry S, and Bonnie L Hewlett. Ebola, Culture and Politics: The Anthropology of an Emerging Disease. Thomson Wadsworth, 2008.

Heymann, David L., et al. "Ebola Hemorrhagic Fever: Lessons from Kikwit, Democratic Republic of the Congo." *The Journal of Infectious Diseases*, vol. 179, no. s1, 1999.

Hochshild, Adam. *King Leopold's Ghost: a story of greed, terror, and heroism in colonial Africa*. S.l.: Mariner Books, 1998.

Hunt, Nancy Rose. *A Nervous State: Violence, Remedies, and Reverie in Colonial Congo*. Duke University Press, 2016.

ICG. "The Politics behind the Ebola Crisis." Africa Report no. 232, October 28. Brussels: International Crisis Group, 2015.

"IHR Procedures Concerning Public Health Emergencies of International Concern (PHEIC)." World Health Organization, World Health Organization, 4 Oct. 2017.

International Alert "Ending the deadlock: Towards a new vision of peace in eastern DRC." 2012.

Kabamba, Patience. "The Real Problems of the Congo: From Africanist Perspectives to African Perspectives," African Affairs 111.443 (2012): 202-22.

Kickbusch I, Reddy K. "Global health governance–the next political revolution. public health." 129(7), 2015, pp. 838–42.

Kolbert, Elizabeth. "Pandemics and the Shape of Human History." The New Yorker, 30 Mar. 2020.

Koplan, Jeffrey P, et al. "Towards a Common Definition of Global Health." The Lancet, vol. 373, no. 9679, 2009, pp. 1993–1995.

Lakoff, Andrew. *Unprepared: Global Health in a Time of Emergency*. University of California Press, 2017.

Letouzé, E., J. Profos, SL Cramer. "Fragile States 2014: Domestic revenue mobilisation in fragile states" OECD, 2013.

Likaka, Osumaka. *Naming Colonialism: History and Collective Memory in the Congo, 1870-1960*. University of Wisconsin Press, 2009.

Lyons, Maryinez. *The Colonial Disease: a Social History of Sleeping Sickness in Northern Zaire, 1900-1940.* Cambridge University Press, 2002.

Maxmen, Amy. "Exclusive: Behind the Front Lines of the Ebola Wars." Nature, vol. 573, no. 7773, 2019, pp. 178–183.

Mbaeyi C, Alleman MM, Ehrhardt D, et al. "Update on Vaccine-Derived Poliovirus Outbreaks — Democratic Republic of the Congo and Horn of Africa, 2017–2018." MMWR Morbidity and Mortality Weekly Report, 68, 2018, pp. 225–230.

Mbembe, Achille. *On the Postcolony*. University of California Press, 2001.

McLean, Kristen E. "Caregiving in Crisis: Fatherhood Refashioned by Sierra Leone's Ebola Epidemic." *Medical Anthropology Quarterly*, 2019.

Monson, Sarah. "Ebola as African: American Media Discourses of Panic and Otherization." *Africa Today*, vol. 63, no. 3, 2017.

Moon, Suerie et al. "Will Ebola Change the Game? Ten Essential Reforms before the Next Pandemic. The Report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola," Lancet 386, 10009 (November 28), 2015, 2204-2221.

Muyembe-Tamfum, J.j., et al. "Ebola Virus Outbreaks in Africa: Past and Present."
        Onderstepoort J Vet Res, vol. 79, no. 2, 2012.

Nascimento, Daniela. "One Step Forward, Two Steps Back? Humanitarian Challenges and
        Dilemmas in Crisis Settings." *The Journal of Humanitarian Assistance*, 18 Feb. 2015.

Nguyen, V.-K. "An Epidemic of Suspicion — Ebola and Violence in the DRC." *The New
        England Journal of Medicine*, 380(14), 2019, 1298–1299.

Nunes, João. "Doctors Against Borders: Médecins Sans Frontières and Global Health Security."
        The Politics of Fear: Médecins Sans Frontières and the West African Ebola Epidemic,
        Oxford University Press, 2017, pp. 3–24.

Nzongola-Ntalaja, Georges. *The Congo: From Leopold To Kabila: a people's history.* ZED
        Books LTD, 2002.

Pellecchia U, Crestani R, Decroo T, Van den Bergh R, Al-Kourdi Y. "Social consequences of
        Ebola containment measures in Liberia." PLOS ONE, 2015.

Pick, Daniel. *Faces of Degeneration: A European Disorder, c. 1848-c. 1918.* Cambridge:
        Cambridge University Press, 1989.

Ponthieu, Aurelie, et al. "Without Precedent or Prejudice? UNSC Resolution 2098 and Its
        Potential Implications for Humanitarian Space in Eastern Congo and Beyond." *The
        Journal of Humanitarian Assistance,* 21 Jan. 2014.

Reddy, S., Mazhar, S. & Lencucha, R. "The financial sustainability of the World Health
        Organization and the political economy of global health governance: a review of funding
        proposals." *Global Health* 14, 119, 2018.

Raeymaekers, Timothy. *Violent Capitalism And Hybrid Identity In The Eastern Congo: power to
        the margins*. Cambridge University Press, 2018.

Reynaert, Julie. *MONUC/MONUSCO and Civilian Protection in the Kivus*. International Peace
        Information Service, 2011.

Richards, Paul. *Ebola: How a People's Science Helped End an Epidemic*. Zed Books, 2016.

Roitman, Janet. "Crisis." Political Concepts: A Critical Lexicon, no. 1, 2012.

Stearns, Jason K. *Dancing in the Glory of Monsters: the Collapse of the Congo and the Great
        War of Africa*. PublicAffairs, 2011.

Stearns, Jason, and Christoph Vogel. "The Landscape of Armed Groups in the Eastern Congo."
     Center on International Cooperation, 2015.

Trapido, Joe. "Ebola: Public Trust, Intermediaries, and Rumour in the DR Congo." *The Lancet
     Infectious Diseases*, vol. 19, no. 5, 2019, pp. 457–458.

Turner, Thomas. *The Congo Wars: conflict, myth and reality.* London: Zed Books, 2010.

Turshen, Meredeth, and Tefera Gezmu. "The World Health Organization and the Ebola
     Epidemic." *Understanding West Africa's Ebola Epidemic: Towards a Political Economy,*
     Zed Books, 2017, pp. 244–262.

United Nations. Siracusa Principles. Human Rights Library. University of Minnesota, 1985.

U.S. Dep. of Health, Education, and Welfare. "Republic of the Congo (Formerly The Belgian
     Congo): a Study of Health Problems and Resources." 1960.

Vinck, Patrick, et al. "Institutional Trust and Misinformation in the Response to the 2018–19
     Ebola Outbreak in North Kivu, DR Congo: a Population-Based Survey." *The Lancet
     Infectious Diseases*, vol. 19, no. 5, 2019, pp. 529–536.

Vogel, Christophe, et al. "Cliches Can Kill in Congo." Foreign Policy, 30 Apr. 2019.

Walsh, Sinead, and Oliver Johnson. *Getting to Zero: a Doctor and a Diplomat on the Ebola
     Frontline.* Zed Books, Limited, 2018.

Wauters, A. "Belgian Policy in the Congo." *Journal of the Royal Institute of International
     Affairs*, vol. 9, no. 1, 1930, p. 51.

Wells, Chad R., et al. "The Exacerbation of Ebola Outbreaks by Conflict in the Democratic
     Republic of the Congo." Proceedings of the National Academy of Sciences, vol. 116, no.
     48, 2019, pp. 24366–24372.

Wenham, Clare. The over securitization of global health: changing the terms of debate,
     International Affairs, Volume 95, Issue 5, September 2019, pp. 1093–1110.

Wilkinson, Annie. M. Leach. "Briefing: Ebola–myths, realities, and structural violence", *African
     Affairs*, Volume 114, Issue 454, January 2015, pp. 136–148.

Wilkinson A, Fairhead J. "Comparison of social resistance to Ebola response in Sierra Leone and Guinea suggests explanations lie in political configurations not culture." *Critical Public Health* 27, 2016, pp. 1–14.

World Bank. "The World Bank Country Assistance Strategy for the Democratic Republic of Congo for the Period FY13–FY16", 2013, Washington, DC.

"Years of Ebola Virus Disease Outbreaks: 40 Years of Ebola Virus Disease around the World." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 15 Oct. 2019.

Zhou, Yu, A. Coplin, D. Estéban. "Mapping the Coronavirus outbreak: Virology, Society, and the Environment". Vassar College, Poughkeepsie, NY. 18 February 2020. Public lecture.