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From Biolegitimacy to Antihumanitarianism: Understanding People's Resistance to Ebola Responses in the Democratic Republic of the Congo

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FROM BIOLEGITIMACY TO ANTIHUMANITARIANISM: UNDERSTANDING PEOPLE'S RESISTANCE TO EBOLA RESPONSES IN THE DEMOCRATIC REPUBLIC OF THE CONGO

Aymar Nyenyezi Bisoka, Koen Vlassenroot, and Lucien Ramazani[1]

INTRODUCTION

The tenth outbreak of Ebola hemorrhagic fever in the Democratic Republic of the Congo (DRC) officially started in August 2018 in the eastern province of North Kivu, leading the World Health Organization (WHO), on July 17, 2019, to recognize it as a "public health emergency of international concern."[2] At its formal conclusion on June 26, 2020, the pandemic had resulted in 3,470 reported cases, including 2,287 deaths.[3] Despite its devastating impact, local populations seemed to be skeptical about the existence of the new pandemic. Consequently, the outbreak saw substantial and often fierce local resistance to the medical response, including armed attacks on Ebola treatment centers (ETCs) and violence toward health centers, health workers, and caregivers, all of which seriously disrupted the response and restricted access to affected communities in several places. Inspired by the belief that Ebola was invented by *Wazungu* (NGOs or politicians), these attacks and other forms of resistance were carried out by various actors, including armed groups, customary chiefs, state agents, health-care workers, and patients and their families.

Guiding this resistance was the widespread belief that the disease was invented by outside actors to: a) exterminate the population; b) test new vaccines by multinationals; or c) capture funding from donors to the benefit of international organizations, NGOs, and the central government in Kinshasa. The influx of millions in donor funding and "NGOs' jeeps" in a war-torn environment added to the suspicion by local communities that the aid related to the Ebola response was a matter of business for multinationals and NGOs and not of caring for the sick.

Starting from an analysis of these popular beliefs, discourses, criticisms, and reactions to the Ebola response following the 2018 outbreak in North Kivu, this research brief argues that the widespread resistance against what was considered yet another humanitarian intervention should be seen as symptomatic of structural and cyclical problems that go much deeper than the response to Ebola and its failures have revealed. The reactions against Ebola responses in North Kivu are part of a historical popular resistance against humanitarianism at large. They are expressions of a multilayered reaction against international donors, humanitarians, and Congolese authorities and their ineffectiveness in providing security and creating lasting peace in areas hit by conflict. In such areas, people prioritize security above health provisions and feel abandoned by those they expect to care about them. As one respondent told us, "we die more from war than from Ebola and no one cares about it."[4] The local population experienced the Ebola health crisis as an opportunity not to aim for better health care but to demand protection and peace. These observations tell us that, rather than accepting the health-care priorities of humanitarian interventions, people living in North Kivu saw the pandemic as a moment of struggle and resistance and mobilized to express their demands to a wide range of public authorities.

Our findings reveal that there is an underlying rationality explaining the attacks against ETCs, health workers, and humanitarians providing assistance, which often goes unnoticed yet should inform the management of disasters, including the different humanitarian responses to health crises in conflict-affected areas. Beyond local discourse on the origins and objectives of the response, local populations have taken advantage of the attention paid to this pandemic to demand an improvement of their overall living conditions. The Ebola health crisis was used as a space for protest and to express frustration with the setting of priorities as part of humanitarian responses. Echoing the idea of biolegitimacy (Fassin 2005), international interventions have been criticized for being selective and arbitrary in deciding which emergencies needed immediate action and which lives were worth saving. It is this selectivity and its arbitrariness that have led the population to be suspicious about the merits of the Ebola response. People in Ebola-affected areas understood that such pandemics mobilize international institutions more than the other crises to which they had been subject the most, such as armed conflict, malaria, and other epidemics linked to hygiene and sanitation problems. In response, they have used the way their bodies are treated as a political vehicle to claim the right to a decent and peaceful existence that is guided by responsible public authorities.

Based on extensive field research conducted by a team of ten researchers,[5] carried out in May and December 2020 in Ebola-affected areas in North Kivu, this research brief documents and analyzes

the resistance of a variety of actors against the Ebola response and connects it to larger popular sentiments and positionings toward humanitarianism. This brief first investigates the Ebola response, both in terms of patient care and prevention, and pays particular attention to the security logics of the response, which are the basis of local mistrust and resistance. Then, the research brief looks into the different acts of resistance, their actors, and their discourses, in order to understand the logics underlying the antihumanitarianism that it suggests and that has been recorded in the region for several years. Finally, we present a genealogical and political economy perspective on Ebola to understand the contemporary and historical factors underlying the issues related to the public's response.

CONTEXTUALIZING RESISTANCE AGAINST THE EBOLA RESPONSE

The public announcement of the new outbreak of Ebola hemorrhagic fever in the DRC took many by surprise. Health workers were thrown into total confusion, and the population immediately started panicking. Some inhabitants of the affected rural town of Mangina moved to the city of Beni under the pretext of fleeing the pandemic. This led the Ministry of Public Health in Kinshasa to send a team of national experts to Beni with the mission to interrupt the chain of disease transmission into other communities and avoid its subsequent spread to other provinces and even neighboring countries. The international community did not remain indifferent to the outbreak either and mobilized assistance to stop the further transmission of the virus. However, for local populations, this international reaction was considered part of the Congolese authorities' larger strategy to "eliminate the people living in the affected area." These sentiments would trigger a fierce popular reaction against the Ebola response. This resistance during the 2018–2020 pandemic was also conditioned, both in meaning and format, by two specific contextual elements: the country's long history of violence and conflict, and the neglect of the ruling regime in seriously dealing with the unstable security conditions.

The tenth Ebola epidemic started in August 2018 in the rural commune of Mangina, in the territory of Beni (North Kivu). It very quickly spread to the city of Beni, located thirty kilometers east of Mangina, followed by the city of Butembo, and to the territory of Lubero. These areas are predominantly inhabited by people living off of agriculture, commerce, fishing, and animal husbandry. They are also marked by a recent history of armed violence. In the early 1990s, growing regime decline and democratization triggered a first round of political violence and armed mobilization, soon to be followed by the arrival of large numbers of Rwandan Hutu refugees resulting from the Rwandan genocide in 1994. Among these refugees were also members of the security forces of the ousted Rwandan Hutu regime, who started targeting the new Rwandan regime from Congolese soil and contributed to the militarization of this refugee crisis. Little by little, conflicts developed between the local Nande populations and the Rwandan Hutu rebels, who were held responsible for the rising insecurity in the area and the growing prevalence of sexual violence and looting.

Faced with the inability of the Mobutu regime to put an end to these conflicts, Congolese populations, including the Nande, set up self-defense groups. In 1997, when the Kabila-led Alliance of Democratic Forces for the Liberation of Congo-Zaire (AFDL) rebellion, which had started in South Kivu in October 1996, spread further north, the area experienced a relative, yet short-lived, calm. However, the start of the Second Congo War in August 1998 triggered the next proliferation of armed groups which, until today, have remained a major cause of instability.

The already precarious security conditions took a crucial turn in 2013, when the Allied Democratic Forces-National Army for the Liberation of Uganda (ADF-NALU) moved westward and intensified its attacks against the local population. This force was a merger of different rebel groups with origins in neighboring Uganda and mainly operated in the Rwenzori Mountains before moving to the Beni area. In early 2014, the Congolese army launched a military operation against the rebel group, which responded with a number of retaliatory attacks. At the end of 2014, the ADF-NALU was held responsible for several massacres in and around Beni. Numerous attacks followed and continued to be reported, allegedly carried out by the rebel force. That said, the ADF-NALU is not the only armed group operating in the area, pointing to a very complex and fragmented security landscape.

The constant attacks against the local population triggered growing popular frustration and anger. Civilians raised their voices and regularly organized marches to demand greater protections. These protests increasingly targeted the Congolese government, which was held responsible for failing to provide the necessary security. This explains why mistrust against the then-ruling Kabila regime in Beni, Lubero, and Butembo had mounted over the years, despite the fact that these territories had been massively supportive of Kabila during the 2006 and 2011 presidential elections.

It is in this context that Ebola first appeared in Mangina, located thirty kilometers from the scene of the massacres that have

taken place in the territory of Beni. From its onset, this proximity inspired people to understand the pandemic as a deliberate strategy to target the local population. As one priest told us:

> For me, this Ebola issue was imbued with *Kabilie* [referring to President Kabila's politics], which wanted to destabilize and neutralize the Banande/Bayira by means of two pillars of a citizen's life: security and health. The *Kabilie* has worsened the security context and has created the Ebola disease. All this to annihilate the Banande people.[6]

The formal announcement of the presence of Ebola in the area and its consequent impact, indeed, could not be disconnected from the country's tense political context. In his attempts to run for a third presidential term, Kabila sought to change the constitution and postpone the elections. Eventually, these elections were held in December 2018, despite being originally scheduled for 2016. Around April of the same year, the first Ebola patients were dying in the health zone of Mabalako at the Mangina Reference Hospital. At that time, health staff were on strike and requesting the payment of their back wages. None of them took the time to analyze the reasons for why people were dying in increasing numbers. It was only two months later that they realized there was a problem of excess mortality due to an unknown disease and alerted Congolese authorities.

On August 1, 2018, Minister of Public Health Oly Ilunga officially declared the presence of the Ebola virus in Mangina. Three months later, the electoral process began. For people living in the eastern parts of the country, who were tired of war and multiple massacres, these elections were a moment of hope for political change. Many rallied around the opposition candidate Martin Madidi Fayulu and his political coalition, Lamuka. The Independent National Electoral Commission (CENI) accelerated the training of its electoral agents and put everything in place for the elections. Meanwhile, the Ebola pandemic continued to spread and cause an increased number of deaths in the Beni territory, alongside continuing massacres attributed to the ADF-NALU rebel group.

These elements served as a legitimization of the eventual official postponement of the elections in the territory of Beni and in the cities of Beni and Butembo in North Kivu, as well as in the Yumbi territory in the western Mai-Ndombe province, which was announced on December 26, 2018. As formally declared by the national president of CENI, security conditions, including the murderous incidents that occurred in Yumbi on the night of December 14, and the presence of the Ebola virus in the Beni and Butembo cities and territories, left no other option for the CENI than to postpone the electoral process.

To no one's surprise, this news was received by the population in Beni and Butembo with anger. On December 27 and 28, mass protests against CENI's decision were held in both cities. Patient care facilities were destroyed by outraged protesters, and stones were thrown in the main roads of both towns. Patients in the Ebola transit centers and ETCs were in complete disarray.[7] On the originally scheduled election day, December 30, 2018, the population of Beni mobilized to go vote symbolically despite the postponement. As one resident confirmed:

> We are mobilized as a family; we will all go to vote this morning. The precarious conditions in the area, Ebola… We understand that this is a way for the government to want to deprive us of the presidential elections.[8]

For the population, if Kabila had allowed the massacres to continue in these areas for so many years and if he had prevented the population from voting for fear of losing, then he was also capable of spreading Ebola in these areas to finish the job. As a staff member from a national NGO in Goma told us:

> For other interventions or vaccinations that we had known at the time, it was our local doctors who intervened. But strangely enough, we have seen foreign people arrive speaking a non-local language. This situation has further frustrated the population. No collaboration between stakeholders and the population happened.[9]

MOUNTING RESISTANCE AGAINST EBOLA

Local resistance to the Ebola response took multiple forms, including armed attacks against ETCs and violence against health centers, health workers, those responsible for safe and dignified burials, and the response teams, all of whom paid the price of an intervention in a context where the local population doubted the existence of the pandemic. These targeted attacks severely disrupted the response and restricted access to affected communities in several locations.

Local resistance focused on three aspects in particular. First, in terms of prevention and diagnosis, at the start of the response, communities in affected areas were reluctant to observe hygiene rules, especially at points of entry as well as in health facilities. This refusal was based on the belief that the response teams were adding the virus to the water used by local communities. As the local population argued, washing your hands was tantamount to contaminating yourself. A similar rejection developed concerning the obligation

to have one's body temperature taken at points of entry and health checkpoints. It was said that the flash thermometers were being used by President Kabila to get reelected. A connection was made between voter identification and the voting machines that would be deployed, which were themselves subject to a heated debate. The flash thermometers, it was believed, in reality were being used to count voters. A health-care worker explained what was behind this popular belief:

> The population here thinks that the government, in collaboration with the health ministry and with MONUSCO, want to exterminate the Nande people because they have long been reluctant to this government.

Similarly, there was a widespread and categorical refusal by most of the targeted communities to be vaccinated. Only direct and indirect contacts of those infected were eligible for this vaccine. Some of these contacts, however, opposed vaccination outright. It was said that the vaccine was meant to eliminate populations in the affected regions and originated from Rwanda, considered the most prominent enemy of the Congolese people.

Second, in terms of care, some patients with symptoms of Ebola refused to board ambulances taking them to transit centers. This resistance was based on the idea that these ambulances were already infected and entering them would be synonymous with contracting the virus. The fact that many did not come back from these centers alive was considered further evidence of this claim. Sick people and their family members saw not being taken to the transit center at all or taking a motorcycle instead of an ambulance as the only wise choices. Also, the surge in deaths early in the health response campaign created fear within local communities. People felt that anyone admitted to the Ebola transit and treatment centers was doomed to die and so resisted being taken there. This trend has been observed in all health zones affected by the Ebola virus in North Kivu. In most cases, transport to a treatment center took so long that most patients felt exhausted even before being examined, which added to the hesitance to seek assistance. In addition, family members of confirmed cases were largely opposed to the decontamination of their plots and houses. They believed that this was a way to infect their home with the virus so that there would be more cases. This suspicion helps to explain several attacks against response teams that were reported. Similarly, the safe and dignified burial teams were targeted because people did not understand why these teams would bury the dead without the participation of family members. A rumor circulating throughout the region was that agents of these teams mutilated the body before burying it, giving rise to the fear that these teams would confuse the remains of the deceased.

Third, numerous direct attacks were reported against the transit and treatment centers, including stones being thrown at response agents and the burning of response team vehicles. The health zones most affected by these acts of resistance were those of Mabalako, Beni, Butembo, Katwa, Alimbongo, and Kayna for greater North Kivu, and the localities of Komanda, Tchomia, and Mambasa for Ituri province. Such resistance was perpetrated by a diversity of actors, including politicians, doctors, civil authorities, armed groups, citizens' movements, young people and adolescents, women, etc. These acts did not take place without consequences. During the first seven months of the Ebola crisis alone, 198 health workers were attacked, 7 died, and 58 were injured. Armed groups' presence also prevented international organizations and health teams from intervening and tracing the contacts of infected people. Attacks by armed groups against the screening and vaccination efforts of the United Nations Organization Stabilization Mission in the DRC (MONUSCO) even led to this mission's suspension in November 2018.

Whenever the response teams met with community members to talk about the Ebola virus, they were faced with negative, and at times very aggressive, reactions, ranging from a total refusal to listen to reluctance or resistance. Also, there was widespread popular rejection of preventive health interventions and the quarantine of infected people. Response teams were accused of entering the community using approaches that did not facilitate community engagement, complicating the task of these teams to inform and mobilize the population about the importance of each response component. Communities always found a rationale to justify their suspicions of actors on the ground and the nonexistence of the Ebola virus. According to the population, as no similar responses were developed during previous disease outbreaks and pandemics, such as measles and yellow fever, Ebola must have been *un montage* (an invention). Popular songs with the lyrics "Ebola *montage*" or "Ebola cop" expressed local resistance against these health responses, which were considered part of a conspiracy against the population.

FROM BIOSECURITY TO BIOLEGITIMACY

Such resistance to the Ebola response is not at all unique, nor is it limited to the eastern DRC. During the Ebola crisis in West Africa, for instance, opposition to health responses, both passive and active,

was also prevalent. In terms of passive resistance, populations often continued their daily lives without taking into account biosecurity measures and the various restrictions they entailed (Woldemariam and Di Giacomo 2016). As more active forms of resistance, people tore up informative signs on Ebola; planted roadblocks to prevent response teams from accessing affected sites; killed health workers carrying out prevention and awareness-raising missions; and hid the sick from response teams (Desclaux and Anoko 2017).

Explanations for this resistance often start from two different views. One is a culturalist interpretation, which considers the resistance against Ebola responses as a manifestation of a backward worldview, which should be reversed by means of sensitization campaigns in order to comply with top-down responses (Thomas and André 1975; Otu et al. 2017). The other is a socioanthropological perspective according to which the Ebola response should consider and adapt to local realities in order to be effective and sustainable (Desclaux and Sow 2016; Mbaye et al. 2017). Both views, however, reflect the belief that the resistance against Ebola responses conceals something exotic, particularly African, and apolitical, which the first interpretation wants to see erased and the second to be integrated into existing policies. In both cases, there is always something irrational or peculiar in local populations' rejection of the existence of Ebola and resistance against response strategies.

The 2018–2020 Ebola pandemic in the DRC reveals, though, that such reactions toward health responses should be historicized and contextualized, as well as considered as a form of political activism against selective and ineffective local and international humanitarianism. The more than a hundred respondents we interviewed in the Congolese province of North Kivu articulated a number of arguments explaining their critical stance toward health and humanitarian interventions:

- Respondents wondered why international and national assistance dealing with the effects of the pandemic was mobilized and organized so quickly and so massively, only to cure a limited number of cases compared to the numbers of victims of armed conflict, to which the outside world has largely seemed indifferent.
- Some interviewees argued that the response teams came from elsewhere and that the millions of dollars at stake created a clientelist system centered around work and rental contracts, various kinds of markets, etc., turning the Ebola virus response into a real business at the local level.
- Further downstream, conflicts emerged not only between NGOs, the health system, national research centers, and the Ministry of Public Health, but also at the level of multinational companies in relation to vaccine issues. Worse even, those involved in the health system at the local level complained that the design of the response did not reinforce its capacity to face possible future pandemics. All of this strengthened the belief that the disease was not only a kind of business but also an external invention.
- The Ebola pandemic also further deteriorated the relationship between the population in Ebola-affected areas and the ruling political regime. Its inaction in the face of the massacres to which the population is regularly subjected to, in contrast to its pandemic response, was taken very badly. The fact that on the eve of the elections it was decided by the regime that a large part of North Kivu province would be prevented from voting reinforced local suspicion around the idea of Ebola being a political invention.
- People noticed that the health care provided varied according to whether the patient was a white person, a foreign health worker, a local health worker, or just an ordinary Congolese citizen. The lower on this scale a patient was, the less access they had to quality care.
- The separation of patients from their families also heightened suspicion of an existing Ebola plot. Even if, at some point, families agreed to be kept away from isolated patients, they would never accept that their loved ones might be buried in their absence and often without their consent.

These interview outcomes offer a number of important lessons about the management of pandemics in rural areas and humanitarianism more generally. The questions posed by the population are situated at different levels and address all actors involved in the Ebola response. The inability of the response strategy to acknowledge and adapt to the local context (including lack of knowledge of local languages, the exclusion of family members at the funerals of Ebola victims, the ignorance of death rituals, the hypersecurity and militarization of response interventions, conflicts of interest in the face of a team composed mainly of foreigners, etc.) has only reinforced the local population's will to resist. Similarly, civilians targeted the Congolese state for allowing the massacring of a whole section of the population and for not providing much-wanted and needed improvement of security conditions in the area. Popular

demands thus did not only address the health interventions as such but expressed deeper political demands coinciding with the existence of a pandemic and the deployed intervention dealing with it.

Such political demands were in line with the idea of biolegitimacy (Fassin 2005) insofar as, by trying to move beyond culturalist approaches to ethnomedicine or the anthropology of disease, they allow us to understand the political dimensions that often underlie public health issues. Resistance against the Ebola response became not only an expression of refusal "in the face of the impersonal and dehumanizing patterns of health interventions," but also an expression of political demands for the improvement of existing living conditions more broadly (Gasquet-Blanchard 2014, 58). The populations of North Kivu saw that the Ebola virus mobilized international institutions to a significantly greater degree than the phenomena that killed them on a much larger scale, such as armed conflict, malaria, and other pandemics linked to problems with hygiene and sanitation, issues that the Congolese state has long failed to address. People in North Kivu thus used the way their bodies were treated to claim the larger right to a decent existence (Bibeau 1993). The "body usually denied and ignored is exposed as a political vector"; as such, although ill, the local population was finally recognized in the context of this health crisis. This echoes Fassin and Memmi (2004, cited in Gasquet-Blanchard 2014, 58), who argue that the organic attack is subversively reconfigured to claim social rights.

CONCLUSION: "WE WANT PEACE AND NOT HUMANITARIANS"

The resistance against the Ebola response during the 2018–2020 pandemic in North Kivu has shown how such acts cannot be detached from their larger meaning and local context. To declare Ebola a health disaster was, without saying so explicitly, to reveal Ebola's connections with politics and highlight how all other disasters were ignored and trivialized and met with an indifferent international community. These other disasters and living conditions had already constituted the backdrop to the local population's lives for several years. The care and prevention advocated by the response to Ebola was directed at those whose lives had to be saved, which was in sharp contrast to the lack of protection provided to those that had to live through atrocities on a daily basis and for whom staying alive often was nothing short of a miracle.

In such a context, how does one explain how ending the spread of a virus suddenly became a wider emergency? It was at this level that the provision of health care forged a close link with politics, as it was considered a form of "support" (Worms 2012). For the local population, the Ebola response was considered proof that what was happening in Beni (and elsewhere in the area) was not going unnoticed. Acting against anything that represented this response was an attempt to grasp the meaning of what qualifies as a disaster. If the number of victims was the sole consideration, then Ebola was not the only, and perhaps not even the worst, health crisis affecting local populations. If it was only Ebola's capacity as an internationally shared "inconvenience" that mattered, then it was the consequences the pandemic could produce for the wider region that mobilized humanitarian workers. For all people living in the affected area, the unpredictability of Ebola and its capacity for harm did not produce a rupture, a discontinuity in their usual way of life. Material and security conditions mattered as much as the biological conditions of life.

The resistance against the Ebola response reminds us that while it is fashionable to worry about a life threatened as quickly as possible, this concern should apply to all lives in danger, no matter the cause—not only due to Ebola, but also as a result of rape and killings. The local population's acts of resistance called for the recognition of all life and all human existence, which indeed goes beyond the biological or the medical and cannot be reduced to solely these dimensions.

This explains why the Ebola response was experienced as just another provocation. The different forms of resistance in the towns of Beni, Butembo, and Goma demonstrated that such responses cannot be based on a presupposed form of humanitarianism that puts sole emphasis on health issues. The clear message of this resistance was that one needs health care as much as protection—having secured access to food, freedom of movement, and so on. The health emergency that Ebola represented was meaningless to most people in the affected area when they were constantly left to their own devices in the face of other crises. The urgency of the health crisis seemed to serve as a pretext for a hidden agenda, with health workers seen as collaborators of what was perceived as a "mafia" that unscrupulously put the health needs of a population seriously affected by war and violence at the forefront in order to serve its own selfish interests. The myth of this intervention was that health comes first and that it is more important than issues of security, water, food, or freedom, thus reducing life to its biological dimension. This is what the millions of dollars of support in the Ebola-affected areas in North Kivu suggested and what has triggered different forms and acts of resistance. The key message of those involved in this resistance was that if we want to save lives, then we should pay close attention to everything that puts lives in danger.

ENDNOTES

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4 Interview with a civil society member, Mangina, September 2020.

5 Research and fieldwork were facilitated by the Study Group on Conflicts and Human Security (GEC-SH) and carried out by Francine Mudunga, Plamédie Neema Bikungu, Lucien Ramazani, Ernest Katembo Ngetha, Sylvie Nabintu, Arsène Mweze, Irène Bahati, Godefroi Rucinga, Romuald Adili, and David Karubara.

6 Interview, Framicabet, DRC, April 26, 2020.

7 Ebola transit centers offered care to patients awaiting their test results and possible referral to ETC.

8 "RDC: élections législatives à Beni, Butembo et Yumbi," RFI, March 31, 2019, https://www.rfi.fr/fr/afrique/20190331-rdc-elections-legislatives-beni-butembo-yumbi-fayulu-ebola.

9 Interview with a humanitarian staff member, Goma, March 2020.

10 Interview, Kayna, March 2020.

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