Ebola Response in the Democratic Republic of Congo: A Bridge to Peace?

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Ebola Virus Disease (EVD) is raging once again in Africa, this time in the eastern part of the Democratic Republic of Congo (DRC). With more than 2200 cases, it has become the 2nd deadliest Ebola epidemic in history[i]. The highly contagious and deadly virus (death rate is currently at 60%) remains active in North Kivu and Ituri provinces. It also acts as a looming threat over the region, with one case confirmed in neighbouring Uganda. A vaccine has been rolled out, but community acceptance remains challenging. Reports of violence against health facilities and workers and issues of community resistance are omnipresent in the conflict-ridden provinces. Amidst this epidemic, daily life goes on, and communities mobilise with the spirit of endurance so characteristic of recent Congolese history. This article contextualizes the latest EVD outbreak in the DRC. First, it highlights how this specific conflict ecosystem has changed the impact of the disease. It raises challenges linked to public health failure, regional exclusion, and active conflict to show how this outbreak fits into a complex health-security nexus. The article proceeds to propose the revival of the forsaken concept *of Health as a Bridge to Peace* (HBP) as a meaningful starting point to address the political and social dimensions of complex disease outbreaks in conflict zones. By mainstreaming community and political reconciliation as the main priority of the response, an HBP approach could help avoid the outbreak spiraling further out of control. Acknowledging the inherent limitations of the framework, the paper proposes it as an alternative to currently failing biomedical disease security models. In short, the time has come to move towards a more politically conscious tackling of disease transmission in volatile contexts.

Public Health Conundrum

Long-term insecurity and an eroded public health system have created a 'perfect' ecosystem for Ebola transmission in the East of the DRC. One of the main requirements of Ebola containment is case finding. Responders need to find the sick, investigate who they have been in contact with and monitor the evolution of their symptoms. Isolating patients and ensuring safe burials is also key to containing the disease spread. Yet current insecurity is severely hindering adequate contact tracing and treatment[ii]. In the East of the DRC, communities are scattered across vast and insecure topographies, often isolated with poor roads or fluvial routes. Cholera and waterborne diseases are still endemic as a consequence of poor sanitation, neglect, and high levels of violence[iii][iv]. This prevalence of infectious diseases, combined with rampant insecurity, creates a perfect storm for hidden chains of transmissions. In this context, reaching and involving communities cannot be done without factoring in these holistic public health needs. Ebola containment cannot be done in a vacuum and needs to be embedded within a general public health plan. What differentiates this outbreak from previous ones is that it also requires a concrete peace and stabilisation component. At the international level, most Ebola-related policy has been formulated on the back of the more permissive and stable West African context. It is the first time an Ebola outbreak response is undertaken amidst active conflict. It also affects a community with a deep-rooted sense of regional exclusion and humanitarian distrust. The current DRC outbreak, therefore, represents a crucial test to the international and regional communities' responses to a complex high-threat disease emerging amidst active shifting political conflict.

Dusting out an Old Concept for Containment and Reconciliation

Health as a Bridge to Peace (HBP) emerged in the 1980s as a multifaceted concept. It was adopted and

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subsequently abandoned by the World Health Organisation[v]. At its core was the idea that health interventions could assist in stability and reconciliation. Successful examples have given weight to the approach. These included humanitarian cease-fires in Afghanistan or Days of Tranquility to allow for mass immunization (some of them in the DRC in 1999-2000)[vi]. These efforts were rooted in the concept's main premise according to which a superior and common health goal was to overstep warring parties' ambitions. Their joint efforts towards a given health intervention (in this case EVD) would in turn help reconcile communities. Alas, building credible evidence in support of health interventions as stabilizing and reconciliation factors in conflict-ridden regions has proven challenging[vii]. The lack of empirical data, a coherent analytical framework and political buy-in quickly resigned HBP to the dustbin [viii]. Instrumental uses of health goals for security purposes have also often proven detrimental to the sanctity of human life and humanitarian goals[ix]. Here a manipulation of health work to tackle governance shortfall could seem ludicrous at best and catastrophic at worst. Yet the concept's premise offers an interesting starting point to engage with the current Ebola outbreak in the DRC. Peace-through-health mechanisms could create further opportunities for health workers and decision makers to tackle the promotion of peace and security at the community level while further engaging local power brokers in this specific higher common health goal.

Regional Exclusion and Community Mistrust

This outbreak cannot be understood without factoring in the heterogeneity of the Congolese state structure and its complex regional interactions. Much academic and journalistic attention to the DRC has revolved around sexual violence and conflict minerals. Notwithstanding the general lack of Congolese voices in the literature, very little is known of local governance mechanisms[x]. The legacy of what Congolese scholar Nzongola-Ntalaja has coined "the colonial trinity: State, Catholic Church and large companies" is still present in everyday politics[xi]. The country's fragilised democratic system, infrastructural void and high levels of corruption have made the effective delivery of public services highly challenging[xii] [xiii]. Pressure from intrusive armed groups from neighbouring countries combined with an expanded aid economy has eroded state sovereignty in the eastern provinces[xiv]. While these provinces are often considered out of the central government's control, strong informal governance mechanisms persist. With intermittent state support, civil-society and faith-based organisations have filled the gap by supporting health structures in the East[xv]. If this situation has hampered local capacity, it also means local health know-how needs to be enabled and supported. Regional health providers need to be protected and put at the very centre of decision-making. The Congolese Ministry of Health (MoH) is said to have demonstrated strong leadership from the onset of the outbreak. However, Congolese involvement needs to go beyond MoH and crucial community engagement and into regional political security engagement.

Regional exclusion could also be felt in the constitutional decision during the recent presidential elections to exclude the city of Beni from the electoral process. This decision was substantiated by the presence of the Ebola virus in the city. The conflation of the political process and the presence of EVD fueled mistrust around the veracity of the virus itself. EVD was seen as a pretext to further exclude areas that have historically been opposition hotbeds. This further exacerbated pressures on the response. The long-lasting regional Internet and cellular data shutdown by the central government amidst the election also perturbed the response and further exasperated local communities. Protesters attacked dozens of clinics in the outbreak hotspots of Beni and Butembo. In this context, health facilities are often seen as proxies for the central government. Community upheavals and fomented armed attacks have seen health facilities burnt to the ground, their staff forced to abandon them and their remains looted[xvi]. Electoral violence also displaced some communities across frontier areas of Uganda. This, in turn, jeopardized case finding and treatment efforts. It has become clear that tackling this sense of regional exclusion and exasperation needs to be central to all relief efforts to protect responders and contain the spread of the disease.

Adopting an HPB framework at the centre of the response could potentially be beneficial to address issues of trust at the community level. Current challenges in reaching and treating patients call for a consciously peace-focused response. This EVD outbreak arose amidst a population accustomed to a humanitarian presence. Constant insecurity and the lack of political solutions has exacerbated popular discontent and fomented a generalised sense of cynicism towards all relief efforts. With decades of heavy humanitarian presence having failed to significantly decrease daily insecurity in the East, community mistrust comes as no surprise. Such deeply embedded exasperation towards government and humanitarian actors, while justified, also compromises the substantial

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resources being rolled out as part of the response. Neglecting to acknowledge and address this community fatigue could, in fact, lead to a situation where long-term control is no longer possible. Building any community public health trust in the eastern part of the DRC would be hard to achieve without embedding a conscious peace narrative addressing rampant frustration and suspicion.

Active Conflict

Along with Katanga and Ituri, the provinces of South and North Kivu have been at the centre of the conflict in the DRC for over two decades. Since the end of the Second Congo War (1998–2003), political tensions over land and power drove violent local conflicts [xvii]. Regionally-fuelled insurgencies led to a deep, protracted humanitarian crisis. While foreign mining companies have continued to operate in the region, neighbouring powers and various armed groups have had a vested interest in destabilizing these mineral-rich provinces[xviii]. Military fragmentation and shifting alliances have led to continual frontline relocations and population displacements[xix][xx]. Since the spring of 2013, MONUSCO (The United Nations Organization Stabilization Mission in the Democratic Republic of the Congo) has had a Security Council offensive mandate to neutralize armed groups. However, shortcomings in the peace-building process and poor results of demobilization campaigns have further exacerbated popular discontent[xxi]. Despite a succession of peace agreements, a severe security crisis continues. These tensions have largely been associated with the paradoxical military command of local and neighbouring political actors[xxii]. Many of these feuds are fuelled by a continuation of long-standing organised local power-driven group activities[xxiii]. In this context, local militiamen have been attacking Ebola treatment centres since January. Armed rebels have assaulted responders, burial teams and killed WHO Epidemiologist Richard Mouuzoko[xxiv]. Yet such attacks cannot be purely seen as violence against the healthcare response and are part of wider systemic, political violence.

Amidst the active conflict, adopting a systematic peace and reconciliation approach, as opposed to a traditional disease security standpoint, could be key to effectively tackling the outbreak. There will be no magic bullet solution to curving deep-seated systemic issues underpinning this outbreak. However, a peace-focused response goes beyond crucial community engagement. It would involve national and regional security actors to address the very governance challenges underpinning the epidemic. Since February 2019, calls were made on the World Health Organization to declare the outbreak a Public Health Emergency of International Concern (PHEIC)[xxv]. Such a designation would mark a global health governance shift to treating the current EDV outbreak as a security threat[xxvi]. However, the inherent limitations and dangers of this approach in such a complex conflict setting are clear. Whilst such a declaration might enhance external donor support, it also runs the serious risk of securitizing an already hostile environment. The outpour of resources, humanitarian and military actors in the region would exacerbate some of the security challenges already at play. The hazardousness of the virus and the region's extreme volatility do require the robust deployment of resources. But they also call for careful regional political expertise for containment and reconciliation.

A Bridge for Peace?

In his 2018 General Assembly address, the World Health Organisation (WHO)'s Director General Tedros Adhanom stated that 'Health as a bridge to peace' was central to all WHO work[xxvii]. However, current biomedical approaches adopted by the international community in the DRC could benefit from focusing on more political and peace-conscious. Can the Ebola response really be a bridge for peace in the DRC? Perhaps not. However, adopting a peace-focused and politically-aware approach could help curtail the disease's spread. Despite its inherent limitations, the HPB framework could act as a starting point to tackle security challenges on a community level. Lofty frameworks often tend to fall short in the face of fast-paced field imperatives. Yet addressing community resistance through a peace-focused holistic containment effort could help with local buy-in, cooperation, and communication. Further inclusion of regional and national actors in containment efforts would help protect response measures and further stabilise the region. The current Ebola outbreak might, therefore, stand as an opportunity to build an evidence base around health as a pacifying factor in conflict-ridden areas.

Notes

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[i] World Health Organisation, Ebola situation reports: Democratic Republic of the Congo, June 4th https://www.who.int/ebola/situation-reports/drc-2018/en/ [accessed June 4th 2019]

[ii] . The more straightforward containment of last year's Ebola outbreak in the central Congolese province of Equateur proves that it is possible to effectively tackle an outbreak early amidst the difficult Congolese public health context. The 2018 Equateur outbreak was handled in 3 months (with only 54 cases)[ii]. This containment effort alongside the 8 previous Congolese Ebola outbreaks proved that it is possible to tackle the virus quickly and effectively in the DRC.

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[v] The HBP concept was piloted in the 1990s. It was never formally abandoned, but slowly made a disappearance from WHO practice and publications.

[vi] World Health Organisation, Health as a Bridge for Peace – Humanitarian cease-fires Project (HCFP) https://www.who.int/hac/techguidance/hbp/cease_fires/en/ [accessed 27th June 2019]

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[xiv] Ibid.

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[xxi] Ibid.

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