An Epidemic of Suspicion — Ebola and Violence in the DRC

Vinh-Kim Nguyen, M.D.

Until the 2014 Ebola epidemic in West Africa, Ebola outbreaks had been sporadic, small, and largely confined to isolated rural villages in Central Africa. But the 2014 epidemic broke all the rules and killed more than 15,000 people; since then, more outbreaks have been reaching larger urban centers, sometimes resulting in uncontrolled spread. The current epidemic in the Democratic Republic of Congo (DRC) has triggered a massive international response, which has been met by violence, culminating in attacks at the end of February that partially destroyed Ebola treatment units in the regional hub of Butembo and its township, Katwa. This area is the epicenter of the epidemic, which is likely to be fueled by any breakdown of isolation and treatment efforts.

Are these urban flares the new norm? What might the ebb and flow of intervention and violence bode for future epidemics? Insights from the front lines may offer some clues.

As a medical team leader for Médecins sans Frontières (MSF), I work halfway between Butembo and Goma, North Kivu's capital city and a transport hub. In late January, five Ebola cases were identified in Kayna and Kanyabayonga; MSF opened a center in Kayna to isolate patients with suspected cases and test them for Ebola virus disease (EVD). I soon suspected that most patients would turn out to have diseases other than EVD. The standard "isolate and test" model often leads to expectant management for such patients — the tendency is to "cover" patients with antimalarials and broad-spectrum antibiotics, wait for EVD test results, and then discharge patients without Ebola. We instead took a more active approach, treating severe cerebral malaria, typhoid, sepsis, and even cholera. I have witnessed how such active clinical management for all patients, along with MSF's long-term presence in North Kivu, has contributed to the community's acceptance of our Ebola unit. Having patients emerge from isolation in improved health is powerful evidence that we aim to make everyone better, not just to stop Ebola's spread.

Indeed, I've come to realize that the most important part of my job is building trust with the communities we serve. Greater trust means more patients presenting early, and early presentation strongly affects the prognosis for many conditions. Building trust starts with relationships with patients and families, which can be nurtured even if patients are in isolation.

I saw the impact that these relationships had on trust during the 2014–2015 Ebola epidemic in Guinea. Many attempts to engage with affected communities during Ebola epidemics have been tone-deaf: little effort has been made to understand the public's concerns or to find out what they understand from the messages being conveyed to them. Recognizing the need to listen to the community and be prepared to answer hard questions truthfully, we shifted from a health promotion strategy of delivering rote messages — about viral transmission from bats or the importance of hand washing — toward genuine community engagement. We recruited trusted community members and trained them in active listening and communication techniques, discussing how to address questions they would receive from the public. The questions the public asked us reflected their sense of anger and betrayal at "Ebola profiteers" and their worries that the focus on Ebola would be short term and would not address more common and equally deadly everyday health issues. We found that acknowledging and addressing issues of poverty and injustice, and using examples drawn from the questioners' experience, went a long way toward allaying the concerns underlying these questions.

Yet much of the fundamental work of engaging communities and building trust is still based on outdated health education models and is often led by specialists with little understanding of social science. Such practices continue despite clear epidemiologic evidence that current containment efforts are failing. In the wake of violent attacks on health workers and treatment units, there is growing recognition that more needs to be done to gain community acceptance.

Such attacks are often labeled "resistance," but they remain poorly understood. I have encountered two forms of resistance. The first is resistance by individuals and families to prevention activities aimed at them, such as isolating a sick family member, taking a

swab from a corpse, or vaccinating contacts of people with EVD. Fear drives such resistance, which is often linked to a sense of outrage and powerlessness and can lead to isolated violent incidents.

The second form of resistance involves orchestrated, armed attacks on symbols of the *Riposte* (the international response), such as triage points and treatment units. The attacks resonate with prevailing anger driven by the perception that the *Riposte*'s massive funding is not being adequately redistributed and is largely benefiting outsiders. The attacks' sophistication suggests that a shrewd political force may be behind them, capitalizing on popular anger over the epidemic in the service of larger political goals. Difficult questions are being raised not only about who might be behind the Katwa and Butembo attacks, but also about how the money for the *Riposte* is being spent and how its staff are being hired and paid.

In this setting, crucial outreach activities, such as identifying cases and ensuring safe and dignified burials, can be dangerous. Tense and occasionally violent standoffs between frightened residents and response teams are a routine occurrence. So in areas deemed insecure, outreach workers and vaccination teams are being accompanied by armed military escorts. Early in the epidemic, we witnessed armed agents forcibly bringing patients in for treatment. In a population already traumatized by violence and forceful responses to numerous crises, such tactics fuel distrust of responders, which prompts patients to flee and spawns violence.

The community outreach workers I supervise have reported that in areas where security forces accompany Ebola teams, there is substantial distrust and palpable fear, most notably of forced vaccination. In areas where the epidemic response has not involved security forces, the opposite is true: people ask to be vaccinated. The lesson is clear: guns and public health don't mix. Epidemics thrive on fear — when they are frightened, patients flee hospitals, sick people stay away to begin with, and affected communities distrust groups trying to respond to the epidemic.

As they see Land Rovers emblazoned with the logos of nongovernmental and international organizations cruising by, people in the DRC say, "Ebola is just a business." They note that no one seems to care about daily deaths from malaria and other infectious diseases, the lack of clean water, or surgeries that must be performed by candlelight because there's no power. "You will leave when Ebola does," I have heard, "but we will still be here, slowly dying from the diseases that have always killed us."

Clearly, we have learned a great deal since the 2014 Ebola epidemic. Treatment units are more humane, care is better, and more effort is being made to engage the affected communities. A vaccine appears to offer some protection, and we have rapid diagnostic kits and promising new treatments. Yet contacts are still becoming ill, and mortality remains stubbornly high; vaccine refusal is an ongoing problem, and patients continue to present late or not at all. Ebola is worsening despite medical progress because trust is breaking down. Medical innovations need social traction to deliver results. Paradoxically, the strength of the response only feeds the perception that we care about Africans only when they get diseases that can harm us, not when they are dying of diseases we can treat easily and cheaply.

Since 2014, anthropologists have pointed out that resistance to Ebola control efforts reveals ongoing, legitimate concerns about the conduct of interventions, respectful treatment of local populations, and resource distribution. Yet we have not learned how to alleviate distrust or establish mechanisms for recognizing and addressing underlying anxieties and actual injustices.

The mistrust of authority in the DRC also reflects a growing global mistrust of experts and science. Vaccine refusals are a growing problem worldwide, and they have already resulted in measles epidemics in the United States and France and in outbreaks elsewhere. Mistrust of public health authorities may thus be the new norm, and smoldering epidemics merely a symptom. State-of-the-art medical interventions won't be enough without serious efforts to rebuild trust, informed by social science rather than pious liturgies. Displays of armed force feed a vicious cycle of mistrust, infection, and violence. If we continue down that path, those seemingly fantastical dystopian outbreak movies, with their heavily armed global health forces and rebelling populations, may not be so far from reality in the near future.

The views expressed in this article are those of the author and do not necessarily reflect those of Médecins sans Frontières.

Disclosure forms provided by the author are available at NEJM.org.

From Médecins sans Frontières, Democratic Republic of Congo.

This article was published on March 6, 2019, at NEJM.org.

DOI: 10.1056/NEJMp1902682