

Peace Operations at the Intersection of Health Emergencies and Violent Conflict

Lessons from the 2018–2020
DRC Ebola Crisis



Dirk Druet

AMERICAN ACADEMY OF ARTS & SCIENCES

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ISBN: 0-87724-150-3

This publication is available online at www.amacad.org/humanitarianhealth.

Suggested citation: Dirk Druet, *Peace Operations at the Intersection of Health Emergencies and Violent Conflict: Lessons from the 2018–2020 DRC Ebola Crisis* (Cambridge, Mass.: American Academy of Arts and Sciences, 2022).

Cover image: A United Nations peacekeeper has his shoes cleaned with a chlorine solution before leaving an Ebola treatment center in Mangina, North Kivu province, on September 1, 2019. UN Secretary-General António Guterres on September 1 vowed continued support for the Democratic Republic of the Congo, grappling with the double scourge of militia violence and an Ebola epidemic. Photo by Alexis Huguet/AFP via Getty Images.

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Acknowledgments

The American Academy's project on *Rethinking the Humanitarian Health Response to Violent Conflict* brings together legal and security experts, health professionals, leaders of humanitarian organizations, policy-makers, artists, and representatives of victimized communities to confront the current crisis in humanitarian protection and the provision of health services in areas plagued by violent conflict. The project is based on the premise that new approaches are best derived from a deeper, transdisciplinary understanding of the changing political, military, legal, and health dimensions that are dramatically redefining humanitarian challenges throughout the world. The initiative's overarching goals include questioning, where necessary, long-standing assumptions about how to meet the needs of populations and devising new strategies for the effective provision of humanitarian health responses. To ensure the relevance of its work in the face of the COVID-19 pandemic, the project adopted a pragmatic approach to the changing context for meeting humanitarian needs by examining underlying issues that undermine effective humanitarian responses, including a lack of global cooperation on pandemic preparedness and response.

This publication, *Peace Operations at the Intersection of Health Emergencies and Violent Conflict: Lessons from the 2018–2020 DRC Ebola Crisis*, by Dirk Druet (McGill University), reflects the project's examination of the intersection of pandemics and peace operations. The paper is based on extensive desk research as well as a series of interviews with key participants in the response to the Ebola crisis. We would like to express our gratitude to the participants in these interviews, as well as the group of scholars, representatives of international organizations, and humanitarian practitioners who joined us for a workshop on pandemics, peace operations, and public health responses in October 2021. We are deeply appreciative of their comments on the paper and of the broader set of ideas they shared on preparing integrated missions to operate in pandemic contexts in conflict. We also thank Emily K. M. Scott for serving as a rapporteur during this session.

As cochairs of the project, we thank our advisory group for their guidance on both the wider initiative and the specific research on peace operations. We also extend our thanks to many experts—at humanitarian organizations, at universities and think tanks, at the United Nations, and elsewhere—who have encouraged our work during a very challenging period for all researchers. In addition, we are grateful to the team at the American Academy of Arts and Sciences, including Kathryn Moffat,

Islam Qasem, Melissa Chan, Francesca Giovannini, Jen Smith, Kathleen Torgesen, Phyllis Bendell, Scott Raymond, Heather M. Struntz, and Peter Walton.

Finally, we express our gratitude to Louise Henry Bryson and John E. Bryson and to the Malcolm Weiner Foundation for their generous support for the *Rethinking the Humanitarian Health Response to Violent Conflict* project.

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I. Introduction

In many fragile and conflict settings around the world, humanitarian responses overlap with the work of international peace operations.¹ United Nations (UN) “mission settings” range from the UN special political mission in Afghanistan (UNAMA), to the long-standing military observer mission between Syria and Israel (UNDOF), to the large, well-equipped stabilization mission in Mali (MINUSMA). These missions are not neutral; they are mandated to help end a violent conflict, restore normal state functions, and protect civilians from physical violence. In these same settings, humanitarian organizations provide food, shelter, medical supplies, and other forms of immediate assistance. Each of these humanitarian organizations operates on principles of strict neutrality and independence grounded in the conviction that life-saving assistance and dignity are rights to be enjoyed by all and that affiliation with one or another side of the conflict risks politicizing the organization’s presence and impeding its safe access to people in need.

While these two types of crisis intervention are interdependent, they also exist in an uneasy relationship with each other. For humanitarian actors, a baseline of security is necessary for their work. Peace operations—along with national security forces and even some nonstate armed groups—can provide a degree of protection. However, the humanitarians’ principles require them to maintain a distance from political and military actors, invoking an ongoing debate over how close is too close. For international peace operations, whose mandates are negotiated by the UN Security Council, the life-saving assistance provided to populations by humanitarian actors is often seen as complementary to the pursuit of longer-term solutions such as negotiated political settlements or better governance. Yet humanitarian objectives do not necessarily contribute to these longer-term pursuits in a linear way. In some cases, immediate life-saving needs clash with the political interests of peace operations or may even exacerbate the conflict dynamics in the short term; for example, when humanitarian aid is used by armed groups to bolster their legitimacy in areas where it is distributed.

1. The author thanks Jennifer Welsh of McGill University and Kathryn Moffat of the American Academy of Arts and Sciences for their advice and support in preparing this paper, and Nathan Devereaux for his research assistance on this project.

The complex relationship between humanitarian responses and international peace operations was brought into sharp relief during the Ebola vector disease outbreak in the eastern Democratic Republic of the Congo (DRC) in 2018. The World Health Organization (WHO) described the situation as a “perfect storm” in which this highly infectious disease arose in an area of active conflict, in a country with weak governance and often predatory national armed forces, and in a dense, highly mobile population near two porous international borders.² The potential global threat posed by the outbreak prompted an enormous national and international health response aimed at stemming the wider spread of the disease while also treating those infected.

This perfect storm and the health response to it played out within the theater of the UN’s largest and ostensibly most robust peace operation, the UN Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO). MONUSCO was mandated to aggressively neutralize armed groups in the east of the country, first among them the notoriously violent, Ituri-based Allied Democratic Forces (ADF), while protecting civilians and supporting crucial national elections. The unique nature of the health emergency and the unique characteristics of the peace operation raised unprecedented questions for both humanitarian actors and MONUSCO about how the mission could, should, or should not work to support the Ebola response and/or pursue its mandates amid the health emergency.

Not all of these questions were new, however. Over the years, the overlap between peace operations and humanitarian action has invoked sharp debates over the appropriate boundaries of missions’ relationships to humanitarian actors, the application of humanitarian principles to these relationships, and the consonance and dissonance between peace operations’ political and security mandates and humanitarian objectives. In many mission settings, armed escorts provided by peacekeeping missions are considered by some agencies as critical for enabling humanitarian access across the country and panned by others as unnecessarily politicizing humanitarian aid.³ In 2010, a camp of the UN Stabilization Mission in Haiti (MINUSTAH) was found to be using highly dangerous sanitation practices

2. World Health Organization, “Ebola-Hit DRC Faces ‘Perfect Storm’ as Uptick in Violence Halts WHO Operation,” press release, September 25, 2018, <https://news.un.org/en/story/2018/09/1020392>.

3. Alexandra Lamarche, “Leaving the Embers Hot: Humanitarian Challenges in the Central African Republic,” Refugees International, February 24, 2019, <https://www.refugeesinternational.org/reports/2019/2/20/leaving-the-embers-hot-humanitarian-challenges-in-the-central-african-republic>.

in a fragile health environment, leading to the first outbreak of cholera in Haiti in over 150 years and killing at least nine thousand Haitians, according to official figures.⁴ The case raised significant, open questions about the effects peace operations can have on humanitarian settings and the roles and responsibilities of such operations vis-à-vis humanitarian actors.

At the time, the 2018 Ebola outbreak in the DRC was the only major epidemiological crisis to have taken place in an active conflict setting in recent history. This is no longer the case. The COVID-19 pandemic has brought the questions faced by MONUSCO and the humanitarian health community to the front steps of all peace operations in the world. As new vaccines and treatments roll out, many of the phenomena encountered in the DRC are likely to be reproduced in other places. Relatedly, the Ebola crisis in the DRC formed part of an ongoing global trend of increased politicization of humanitarian assistance and access and a correlated surge in attacks on health care facilities and personnel in these places.⁵ A WHO compilation of open sources found that, in 2014 and 2015, almost six hundred attacks on health care facilities in emergency settings were reported in nineteen countries, resulting in the deaths of 959 people and injuries to 1,561.⁶

To improve both mandate effectiveness and the safety of health, humanitarian, and peace and security actors, we must better understand the tensions that can arise when health emergencies develop in conflict settings and identify strategies to address them. This paper asks how peace operations should interact with international humanitarian responses during health emergencies in contexts of violent conflict. The answers should

4. “Leaked UN Report Faults Sanitation at Haiti Bases at Time of Cholera Outbreak,” *The Guardian*, April 5, 2016, <https://www.theguardian.com/world/2016/apr/05/leaked-un-report-sanitation-haiti-bases-cholera-outbreak>.

5. See, for example, Francis Kofi Abiew, “Humanitarian Action under Fire: Reflections on the Role of NGOs in Conflict and Post-Conflict Situations,” *International Peacekeeping* 19 (2) (2012): 203–216, <https://doi.org/10.1080/13533312.2012.665698>; and Milena Dieckhoff, “Reconsidering the Humanitarian Space: Complex Interdependence between Humanitarian and Peace Negotiations in Syria,” *Contemporary Security Policy* 41 (4) (2020): 564–586, <https://doi.org/10.1080/13523260.2020.1773025>.

6. See WHO, *Attacks on Health Care: Prevent, Protect, Provide—Report on Attacks on Health Care in Emergencies Based on Consolidated Secondary Data, 2014 and 2015* (Geneva: WHO, 2016), <https://www.who.int/hac/techguidance/attacksreport.pdf>. The WHO defines “attack against health care” as violence against people, infrastructure, vehicles, and other health-related entities. It divides these incidents into five categories of “object of attack,” namely 1) health care facilities, such as hospitals or clinics; 2) health care providers, such as nurses, vaccinators, or health care security personnel; 3) health care transport, such as ambulances or supply vehicles; 4) health care recipients, such as patients or their visitors; and 5) health care entities, both individual and institutional, such as health officials, ministries, or medical educational institutions.

inform not only how these missions provide support to international humanitarian and health responses but also how they adapt their operations to execute their own mandates under these conditions, including the ways in which the responses to an emergency can impact the effectiveness and legitimacy of the mission. The answers also hold important implications for humanitarian policy as international health systems continue to adapt their programs to the evolving COVID-19 pandemic.

The paper proceeds in four parts, bringing together several bodies of literature. The first section draws on the history of the public health system in the Congo to analyze the roots of the intersection between health and conflict in the east of the country and to help explain the responses by the population and armed actors to the health crisis in 2018–2020. The second section dissects the role played by the UN Mission in Liberia (UNMIL) during the 2014–2016 West African Ebola crisis, highlighting the ways in which the mission interacted with other parts of the national and international response and describing how the lessons learned by the international community in that crisis informed the subsequent policies and practices adopted in the DRC. The third section briefly examines the conflict dynamics in the eastern DRC at the time of the outbreak in 2018, the characteristics of the national and international health responses—known collectively as the *Riposte*—and where MONUSCO fit into the picture.⁷ To isolate and analyze the role of MONUSCO, the analysis is complemented with data from interviews conducted with current and former UN and humanitarian officials. The final section distills a series of conceptual, operational, and policy challenges for health, humanitarian, and peace and security communities as they continue to implement COVID-19 interventions around the world and look ahead to future health emergencies.

7. This section draws heavily on previous studies of the Ebola crisis, first among them a thoroughly researched 2021 analysis by the Congo Research Group entitled *Rebels, Doctors and Merchants of Violence: How the Fight against Ebola Became Part of the Conflict in Eastern DRC* (New York: New York University Center on International Cooperation, August 2021), <https://cic.nyu.edu/publications/ebola-drc-rebels-doctors-and-merchants-violence>.

II. The Makings of the Public Health System and the Root Causes of Conflict in the DRC

The origins of contemporary health governance in the Congo lie in the strategies adopted under the colonial rule of Belgian King Leopold II (1835–1908) for the exploitation of human beings for labor. This section traces the evolution of the public health system at key points in the DRC’s history and assesses the relationship between the system—and the massive international humanitarian assistance that enveloped it—to the conflict in the eastern DRC at the time of the onset of the 2018 Ebola outbreak. It describes how the extractive motives of the country’s early health system reproduced themselves in the first decades of the Congolese state and how this had the effect of empowering more localized, if not necessarily more effective or just, forms of service delivery. Following the country’s descent into the logic of violence that is dominant today, the historical roots of public health in the Congo offer critical insights into how power and knowledge in health are perceived and understood in different segments of the population.

a. The Colonial Origins of an Extractive Congolese Public Health System

With the arrival of colonial rule in the Congo came new diseases and new vectors of transmission. As local Congolese people were pressed into service by the Europeans—as long-haul porters, steamboat crew, or rubber pickers—previously isolated communities came into much more frequent contact with one another. Accelerated by malnutrition, wounds, and exhaustion among enslaved workers, new diseases spread rapidly, especially smallpox and “sleeping sickness” (trypanosomiasis). Five hundred thousand Congolese people were estimated to have died of sleeping sickness by

1901, shortly before rule of the Congo passed from Leopold to the government of Belgium in 1908.⁸

Under Leopold, the state initially provided few public services beyond the maintenance of public order, leaving the health and education systems almost entirely to missionaries.⁹ When the Belgian government took control of the country, it made greater efforts to develop medical services, which resulted in a gradual fall in mortality rates.¹⁰ Social historian Maryinez Lyons argues that the initiative was motivated primarily by a desire to counter international perceptions of colonial Congo as a bastion of cruelty while still maintaining the labor force.¹¹ In a 2021 historical analysis of the Congolese health system and its implications for the Ebola crisis, the Congo Research Group argues that, “under the Belgian colonial system, biomedical healthcare was not a right or a public good; instead, it was provided and mandated to keep workers on rubber plantations in working condition, to increase Congolese women’s fertility and child-bearing for the prosperity of these plantations, and to minimize the effects of infectious disease (including syphilis) on the Belgian colonists running plantations.”¹²

As Lyons describes, the Belgian administration’s response to sleeping sickness from 1900 to 1940 changed social and political dynamics in the Congo, thus helping to shape the future of the state. The colonial authorities’ approach to combatting the disease was based on the (partly correct) theory that its spread was made possible by the movement of people. Building on the recommendations of a study by the London and Liverpool Schools of Tropical Medicine, in 1905 the authorities established a system of “cordons sanitaire” known as “*lazarets*” or compulsory isolation camps.

8. Adam Hochschild, *King Leopold’s Ghost: A Story of Greed, Terror, and Heroism in Colonial Africa* (Boston: Houghton Mifflin, 1998), 230. Sleeping sickness is caused by a parasite first spread by the bite of the tsetse fly, which is concentrated at lower altitudes and near bodies of water and river systems. Once contracted by humans, it is highly contagious and causes fever, swelling of the lymph glands, a craving for meat, and sensitivity to cold, followed by the lethargy that gives the sickness its name.

9. Robert Benedetto, *Presbyterian Reformers in Central Africa: A Documentary Account of the American Presbyterian Congo Mission and the Human Rights Struggle in the Congo, 1890–1918* (Leiden: E.J. Brill, 1996), 38.

10. Martin Ewans, *European Atrocity, African Catastrophe: Leopold II, the Congo Free State and Its Aftermath* (London: Routledge Curzon, 2002), 241.

11. Maryinez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900–1940* (Cambridge: Cambridge University Press, 1992), 3, <https://doi.org/10.1017/CBO9780511583704>.

12. Congo Research Group, *Ebola in the DRC: The Perverse Effects of a Parallel Health System* (New York: New York University Center on International Cooperation, September 2020), 8, <https://cic.nyu.edu/publications/ebola-drc-perverse-effects-parallel-health-system>.

Canoes were taken from villages to prevent riverine travel, which also eliminated fishing. People found to be infected were forbidden to travel, sent to the *lazarets*, and given atoxyl injections that often appeared to make patients worse. People were regularly caged or chained if they tried to escape. By the 1930s, the sleeping sickness campaign formed the core of the colonial health program, examining approximately three million people annually and maintaining quarantine zones across the country. The system depended on a principle of “incessant surveillance” that encouraged all Europeans in the territory to regularly “palpate” Congolese people under their authority for early signs of the disease and dispatch them to medical services for further examination and potential isolation.¹³

As the sleeping sickness program expanded, individual health services provided by missionary orders were increasingly brought under the program, creating a nascent national health care system. While the *lazarets* became less cruel over time, the authorities continued to balance public health concerns against priorities for economic productivity.¹⁴ This balance shifted with the outbreak of World War I, when demand for rubber and other natural resources motivated an intensification of forced labor practices. Public health concerns were also invoked during this period to justify forced population movements, wherein small villages were collectivized into larger, more easily administered population centers in closer proximity to points of economic production.¹⁵

These practices help explain why the Congolese people were markedly hostile to the colonial public health system. Many associated the presence of Europeans with the outbreak of disease in a given locale, leading to the conclusion that colonists were undertaking “a kind of biological warfare.”¹⁶ Isolation was seen as a death sentence, and rumors that autopsies carried out by the Europeans involved cannibalism were widespread. Many Congolese thus strongly resisted surveillance, isolation, and treatment measures. Resistance to population relocations was so strong that the policy was abandoned in 1931.

13. Lyons, *The Colonial Disease*, 68–132.

14. *Ibid.*, 137.

15. Hochschild, *King Leopold's Ghost*, 278.

16. Lyons, *The Colonial Disease*, 216.

b. Centralizing and Hollowing Out the Postcolonial Health System

By the time of Congo's independence in June 1960, Belgium claimed that its health system, despite numerous injustices, was the best in Africa.¹⁷ This assessment was based on the number of available hospital beds and the success of the sleeping sickness program, which had established a large medical infrastructure that extended across the vast country and had benefited from a wave of Belgian investment in infrastructure after World War II.¹⁸

The Congo's first prime minister, Patrice Lumumba, struggled against entrenched interests in the resource extraction industries, leaving elements of the colonial labor and population management systems in place. The coup that installed Joseph-Désiré Mobutu (later known as Mobutu Sese Seko) as prime minister in November 1965 ushered in a new era of repression and mismanagement in the Congo—renamed Zaire by Mobutu—that would last over three decades. Public health, like other government services under Mobutu's reign, was heavily centralized and quickly hollowed out. "Support of schools and hospitals dwindled to almost nothing. . . . For years, garbage piled up in heaps, uncollected."¹⁹ An initial wave of foreign investment and international loans was largely used to enrich Mobutu and his patronage circle. By 1990 the government was spending 2.1 percent of the national budget on health and education combined, down from 17.2 percent in 1972.²⁰ As national debt rose, the gross domestic product shrank and inflation skyrocketed. In this context, "Most hospitals were closed, with private sources of health care available to only 50 percent of the population. In those hospitals which did operate . . . the practice of 'impounding the ill' in order to guarantee payment for services was common. The [Forces Armée Zaïroises] regularly 'patrolled' the hospitals to ensure that those indebted could not escape."²¹

As the national health care system was hollowed out and international assistance petered out amid corruption concerns, smaller administrative divisions benefited from the lack of centralized interference, especially in the east, where local and international nonstate actors began to play a

17. Ibid., 223.

18. Jeanne M. Haskin, *The Tragic State of the Congo: From Decolonization to Dictatorship* (New York: Algora, 2007).

19. Hochschild, *King Leopold's Ghost*, 303.

20. William Reno, "Sovereignty and Personal Rule in Zaire," *African Studies Quarterly* 1 (3) (1997): 43, <http://asq.africa.ufl.edu/files/Reno-Vol-1-Issue-3.pdf>.

21. Haskin, *The Tragic State of the Congo*, 69.

significant role in providing health services. Beginning in the 1970s, small universities, churches, and international nongovernmental organizations (NGOs) began providing a patchwork of piecemeal services. As the Zairian state abandoned the health system in the 1980s, many formerly public hospitals and clinics were forced to begin charging fees. “Following the withdrawal of the federal government from active management of health in the 1980s and 1990s,” J.M. Janzen writes, “the decentralized regional health zone became the effective framework for both public health services and the coordination of health care institutions.”²²

In 1997, a rebellion backed by Zaire’s neighbors brought Laurent-Désiré Kabila to power during the First Congo War. Spending on the health care system under Kabila was less than 1 percent of the national budget. Many of the country’s five hundred health zones dissipated as wars broke out, personnel fled, and buildings were destroyed. “Yet,” Janzen insists, “the survival of the Congolese health zones is a remarkable story.” By 2000, half of the clinics in the country were funded by faith-based organizations, and by 2012, the WHO estimated that nonstate actors accounted for over 99 percent of public health and health care services in the country.²³

In sum, at the time of the First Congo War and the DRC’s entry into its contemporary cycle of conflict, the country’s national public health system had been both centralized and hollowed out. From its origins as little more than a tool for the management of forced labor, it became another symbol of the predatory state and a source of mistrust and suspicion. At the same time, the failure of the central system increased the importance of local systems of health services delivery and peoples’ reliance on health mechanisms that were partially or wholly separate from the central Congolese state. This trend would have significant implications for local acceptance of national health programming during future public health emergencies, including the 2018–2020 Ebola crisis.

22. J. M. Janzen, *Health in a Fragile State: Science, Sorcery, and Spirit in the Lower Congo* (Madison: University of Wisconsin Press, 2019), 119.

23. *Ibid.*

III. Learning from UNMIL and the 2014–2016 West African Ebola Crisis

On August 8, 2014, the director-general of the WHO declared that an Ebola outbreak in West Africa that had begun the previous December in Guinea met the conditions to be classified as a “public health emergency of international concern.” The first cases in Liberia were reported in March 2014 but quickly subsided, leading to a short-lived sense of relief and safety. The virus returned in late May, escalated seriously in July, and peaked in September. By the time the emergency was declared over in 2016, 28,638 cases and 11,316 deaths had been recorded in West Africa. In Liberia, Ebola infected more than ten thousand people and claimed more than 4,700 lives, including two UNMIL staff members.²⁴

As one evaluation of the Ebola response in Sierra Leone noted, the outbreak constituted “an extraordinary situation that justified exceptional measures,” since “some predictive models warned of potentially millions of new cases.”²⁵ This section describes UNMIL’s place within this exceptional set of circumstances, from which many lessons would be drawn by the time of the outbreak in the DRC in 2018.

a. The Intersection of Ebola and Conflict Dynamics in Liberia

While widespread political violence had largely subsided in Liberia by the time of the Ebola crisis, the country remained deeply fragile, with an economy still heavily dependent on extractives and vulnerable to external shocks and waves of public resentment. Government structures were

24. UN Secretary-General, “Report of the Secretary-General on Lessons Learned Exercise on the Coordination Activities of the United Nations Mission for Ebola Emergency Response,” A/70/737, United Nations, March 4, 2016, <https://digitallibrary.un.org/record/823603>.

25. Pauline Oosterhoff, Esther Yei Mokuwa, and Annie Wilkinson, *Community-Based Ebola Care Centres: A Formative Evaluation* (Ebola Response Anthropology Platform, 2015), http://www.ebola-anthropology.net/case_studies/community-based-ebola-care-centres-a-formative-evaluation/.

heavily dependent on international financial and technical assistance, with elites lacking the political will to “abandon Liberia’s pre-war patterns,” according to one former senior UNMIL official.²⁶ “The very issues that have helped keep Liberia politically fragile help explain why Ebola spread as it did—and why it became so much more than a health crisis,” recalled Karin Landgren, UNMIL’s special representative of the secretary-general (SRSG).²⁷

In this context, Liberian President Ellen Johnson Sirleaf declared a state of emergency in August 2014, informing the population on national television that civil liberties might be curtailed to stop the virus. Schools and markets were closed, and a practice of establishing military blockades to quarantine affected communities—already in place in the western regions of Grand Cape Mount and Bomi—was officially sanctioned.²⁸ When the virus reached West Point later that month, the impoverished Monrovia slum was quarantined with barricades and barbed wire, causing food prices to skyrocket and confining seventy thousand residents to an area that had only four toilets.²⁹ An account of the event in *The New York Times* describes how, as the neighborhood was locked down, “angry young men hurled rocks and stormed barbed-wire barricades, trying to break out. Soldiers repelled the surging crowd with live rounds, driving back hundreds of young men” and wounding several.³⁰ As the Ebola outbreak reached crisis levels, discontent grew and violence flared around newly established Ebola treatment centers, especially when residents were prevented from taking care of the sick or collecting the dead. Days after the lockdown was imposed in West Point, a group of armed residents, reportedly shouting “there is no Ebola,” raided a health facility that was housing Ebola patients,

26. Internal memorandum by a former senior UNMIL official, July 2015, United Nations; on file with author.

27. Central European University, “Karin Landgren Shares the Lessons She Learned from Ebola,” press release, February 1, 2016, <https://dpp.ceu.edu/article/2016-02-01/karin-landgren-shares-lessons-she-learned-ebola>.

28. “Liberia Declares State of Emergency over Ebola Virus,” BBC News Online, August 7, 2014, <https://www.bbc.com/news/world-28684561>.

29. Per Liljas, “Liberia’s West Point Slum Reels from the Nightmare of Ebola,” *Time*, August 22, 2014, <https://time.com/3158244/liberia-west-point-slum-ebola-disease-quarantine/>.

30. Norimitsu Onishi, “Clashes Erupt as Liberia Sets an Ebola Quarantine,” *The New York Times*, August 14, 2014, <https://www.nytimes.com/2014/08/21/world/africa/ebola-outbreak-liberia-quarantine.html>.

releasing more than a dozen infected persons into the community and looting soiled bedsheets and other potentially infectious items.³¹

From the beginning of the response, government personnel and local staff from international agencies working to counteract Ebola were subject to stigma and resentment in communities suffering from a sudden economic downturn, fear of the pandemic, and human rights violations by security forces. Many religious leaders were initially unwilling to endorse a ban on traditional medical and burial practices that spread the infection. As a result, in some cases the government chose to impose these measures, including further forced quarantines. A WHO situation report from the period assessed that “six months into the outbreak, fear was proving to be the most difficult barrier to overcome. Fear caused contacts of cases to escape from the surveillance system, families to hide symptomatic loved ones or take them to traditional healers, and patients to flee treatment centres. Fear and stigma have threatened the security of national and international response teams. Health care staffs fear for their lives.”³² While rates of violence remained low compared to those that would be seen in the DRC in 2018–2020, the WHO nevertheless recorded five incidents in 2014 that rose to the level of an “attack on health care.”³³

b. UNMIL’s Role in the Response

The 2014–2016 Ebola outbreak in West Africa provided a first test of a UN peacekeeping mission’s capacities to work in support of a humanitarian response to a major health emergency. Although UN missions in the DRC, Liberia, and Sudan had operated during previous Ebola outbreaks,³⁴ “the scale of the [2014–2016] outbreak and the fact that it had spread into main centres of population,” an internal review of the UN’s response recalled, “made the latest outbreak much more deadly and threatening than in any

31. AFP, “Ebola Patients Flee as Armed Men Raid Liberia Clinic,” *The Telegraph*, August 17, 2014, <https://www.telegraph.co.uk/news/worldnews/africaandindianocean/liberia/11039693/Ebola-patients-flee-as-armed-men-raid-Liberia-clinic.html>.

32. Secretariat of the Presidential Advisory Council on Ebola of Liberia and the Office of the United Nations Resident Coordinator in Liberia, “Testimonies and Recommendations of Key People Involved in the Ebola Response in Liberia,” 2016; on file with author.

33. WHO, *Attacks on Health Care*.

34. For a full list of Ebola outbreaks, see Centers for Disease Control and Prevention, “History of Ebola Virus Disease (EVD) Outbreaks,” https://www.cdc.gov/vhf/ebola/history/chronology.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvhf%2Febola%2Foutbreaks%2Fhistory%2Fchronology.html, last reviewed January 12, 2022.

previous occurrence.”³⁵ At the time of the outbreak, the mission, which had been in the process of drawing down in advance of an eventual liquidation, had approximately 6,000 military personnel, 1,600 police, and 1,500 civilians deployed throughout the country.³⁶ Critically, the mission still had a uniformed and civilian presence in each of the country’s fifteen counties, where they maintained relationships with local administrators and civil society organizations.³⁷

In May 2015, Liberia’s outbreak was declared over. Two months later, UNMIL conducted an after-action review of its response to the crisis. The review found that several standing capacities of the mission were able to provide almost immediate support to the Ebola response as international humanitarian actors were still in the process of setting up their operations. For example, the mission’s use of quick impact projects (QIPs) was particularly successful in providing an initial surge of resources to county-level Ebola task forces and other government bodies to help them meet the growing demand for services.³⁸ These projects, which ranged in value from U.S.\$25,000 to \$50,000, required relatively little administration and provided immediate support for local awareness raising, contact tracing, construction of holding facilities, and the provision of basic protective clothing, equipment, and vehicles.³⁹ The mission’s public information capacities, including its spokesperson and UNMIL Radio, which broadcast messages in seventeen languages, were similarly useful in raising public awareness and distributing critical preventive information.⁴⁰

As the national and international response ramped up, the government of Liberia was both adamant that it should control the response efforts and overconfident of its capacity to do so after the outbreak initially, but only temporarily, dissipated. Another joint UN-government study of the response, based on testimony from UN and government officials, humanitarian actors, and civil society leaders, found that the outbreak hit Liberia at a low ebb in the relationship between the government, the national health system, and the population. Health workers had recently launched

35. UNMIL, “Ebola Virus Disease Outbreak 2014–2015: After-Action Review,” July 20, 2015; on file with author.

36. Figures as of February 5, 2014, as reported in UN Secretary-General, “Twenty-Seventh Progress Report of the Secretary-General on the United Nations Mission in Liberia,” S/2014/123, United Nations, February 18, 2014, <https://digitallibrary.un.org/record/766739>.

37. Internal memorandum by a former senior UNMIL official, July 2015.

38. UNMIL, “Ebola Virus Disease Outbreak 2014–2015.”

39. Internal memorandum by a former senior UNMIL official, July 2015.

40. UNMIL, “Ebola Virus Disease Outbreak 2014–2015.”

a national strike to protest poor pay and working conditions. The study noted that the Ebola outbreak “revealed a disconnect between the health structures at national, county and district levels. An inability to coordinate supply chains with warehousing and dispatch systems delayed the flow of resources and needed medical supplies to the counties.” Thus, once the virus resurged, “it quickly became apparent that the government was not able to cope with the scope and severity of the challenge it was facing.”⁴¹

UNMIL stepped into this coordination void, establishing a “discussion group” composed of key humanitarian actors, including Médecins Sans Frontières (MSF), the USAID Disaster Assistant Response Team, the WHO, and the International Committee of the Red Cross (ICRC), to act as an “information exchange and a platform to propose effective actions to assist the government and each other.” The SRSB, in turn, met with the Liberian president weekly to provide advice and support. UNMIL also began to play a key logistical role when, early on, humanitarian actors reported that the Liberian Ministry of Health and Social Welfare could not cope with the demands of accepting, managing, and distributing supplies. UNMIL deployed logistics officers to the ministry to assist in supply-chain processes. While helpful for the logistics of the response, this immediately created a dependency issue, whereby the mission effectively became responsible for the supply chain—UNMIL transported almost six million kilograms of cargo, deployed forklifts and trucks to government warehouses, and donated fifty vehicles to the government—undermining national ownership of the response and exposing a weakness in the country’s capacity to respond to future emergencies once UNMIL completed its drawdown.⁴²

In September, as the scale of the international response increased and more UN entities became involved, Liberia adopted the humanitarian cluster system under the leadership of a deputy special representative of the secretary-general/resident coordinator and established an interagency logistics team that included the World Food Programme, the ICRC, and the United Nations Children’s Fund (UNICEF). A joint lead role for UNMIL in the organization of humanitarian logistics was initially rejected by the UN emergency response coordinator and head of the Office for the Coordination of Humanitarian Affairs on the grounds that it violated humanitarian principles and risked politicizing the health response. However, this decision was reversed after the SRSB engaged personally. “Having uniformed peacekeeping personnel in a leading role for a humanitarian cluster was by global standards a first; however, humanitarian actors had no reservations

41. Secretariat of the Presidential Advisory Council on Ebola of Liberia and the Office of the United Nations Resident Coordinator in Liberia, “Testimonies and Recommendations.”

42. UNMIL, “Ebola Virus Disease Outbreak 2014–2015.”

in working hand-in-hand with UNMIL,” the mission reported.⁴³ This debate highlights an ongoing tension, also seen in the DRC’s Ebola crisis, between principle and pragmatism in urgent, high-risk humanitarian emergencies.

Amid reports of abuses by security forces in enforcing blockades and imposing public health measures such as in-home quarantines across West Africa,⁴⁴ UNMIL also played a leading role in monitoring and documenting respect for human rights by health authorities and security forces, adopting practices previously used in Haiti, Palestine, and Ukraine.⁴⁵ The mission established a weekly surveillance and reporting process, which it named “Ebola Rights Watch.” In the view of its authors, the weekly report, which was shared with the government and international partners, contributed to a considerable improvement in the use of force by security forces during the crisis after an initial series of high-profile violations.⁴⁶ UNMIL also invoked the UN Human Rights Due Diligence Policy on UN Support to Non-UN Forces to conduct an analysis of security services’ compliance with human rights standards during the Ebola state of emergency.⁴⁷ This process was used as an avenue to provide human rights training to a variety of security services, including the Liberian National Police, the Bureau of Immigration and Naturalization, and the armed forces.⁴⁸

43. Ibid.

44. See, for example, Patrick M. Eba, “Ebola and Human Rights in West Africa,” *The Lancet* 384 (December 13, 2014): 2091–2093, [https://doi.org/10.1016/S0140-6736\(14\)61412-4](https://doi.org/10.1016/S0140-6736(14)61412-4).

45. Office of the United Nations High Commissioner for Human Rights, “Human Rights Need Protection during Humanitarian Crises,” press release, May 20, 2016, <https://www.ohchr.org/en/stories/2016/05/human-rights-need-protection-during-humanitarian-crises>.

46. UNMIL, “Expanding the Human Rights Space, Building Protection Resilience,” Story of UNMIL, April 12, 2018, <https://unmil.unmissions.org/expanding-human-rights-space-building-protection-resilience>.

47. The UN’s Human Rights Due Diligence Policy on United Nations Support to Non-United Nations Forces of 2011 details the measures that UN actors must take when providing operational support to non-UN forces, such as national militaries or regional peace operations, to help ensure that the support is provided in a manner that is 1) consistent with the purposes and principles set out in the UN Charter and 2) compliant with, and promotes respect for, international humanitarian, human rights, and refugee law. It requires a risk assessment to evaluate the potential risks and benefits of providing or withholding support, engagement with the receiving entities about the UN’s legal obligations and core principles governing the provision of support, and the development of implementation frameworks for remedial or precautionary actions. See UN Secretary-General, “Identical Letters Dated 25 February 2013 from the Secretary-General Addressed to the President of the General Assembly and to the President of the Security Council,” A/67/775 and S/2013/110, United Nations, March 5, 2013, <https://digitallibrary.un.org/record/745567>.

48. Internal memorandum by a former senior UNMIL official, July 2015.

c. Engagement with UNMEER

The UN Mission for Ebola Emergency Response (UNMEER) was established by the secretary-general in September 2014 after the UN Security Council declared that the West African Ebola crisis constituted a threat to international peace and security and called on the secretary-general to help “accelerate” the response of all UN system entities and enhance liaison with governments of the region.⁴⁹ According to a note from the secretary-general to UN member states, the mission aimed to “harness the capabilities and competencies of all the relevant United Nations under a unified operational structure to reinforce unity of purpose, effective ground-level leadership and operational direction, in order to ensure a rapid, effective, efficient and coherent response to the crisis.”⁵⁰ The new mission built on a crisis management mechanism established in the UN Operations and Crisis Center (UNOCC) in New York under the leadership of UN Under-Secretary-General David Nabarro and his deputy, Assistant Secretary-General Anthony Banbury, whom the UN secretary-general had appointed UN System Senior Coordinator for Ebola Virus Disease on August 12, 2014.⁵¹ Banbury was appointed to lead UNMEER and relocated to Accra, Ghana, where UNMEER headquarters were established.

The decision to create UNMEER came as a surprise to UNMIL, which was not consulted on the proposal for the new mission. UN leadership in New York instructed UNMIL that it was expected to support UNMEER, while Banbury, according to an UNMIL after-action review, stated that the functional relationship between the two missions was to be one of “command and control,” creating considerable consternation within the mission. Nevertheless, UNMIL provided extensive operational support for the establishment of the new mission in Liberia, ranging from logistics and equipment to security and administration. The presence of UNMIL field offices provided considerable added value in enabling the delivery of immediate support and supplying bases of operations for UNMEER in the field. However, UNMEER perceived the notoriously complex and inflexible administrative processes for helicopters and similar assets to be “out

49. UN Security Council, UN Resolution 2177, S/RES/2177, September 18, 2021.

50. UN Secretary-General, “Identical Letters Dated 17 September 2014 from the Secretary-General Addressed to the President of the General Assembly and the President of the Security Council,” A/69/389 and S/2014/679, United Nations, September 18, 2014, <https://digitallibrary.un.org/record/779651>.

51. United Nations, “Report of the Secretary-General on Lessons Learned Exercise on the Coordination Activities of the United Nations Mission for Ebola Emergency Response.”

of alignment with the situation on the ground,” causing frequent friction between the Ebola mission and UNMIL’s mission support component.⁵²

d. Lessons Learned (or Not Learned) for Future Crises

In addition to the reflections on UNMIL’s specific roles during the 2014–2016 crisis, the collective international response generated several important lessons that strongly influenced the response to the 2018–2020 crisis in the DRC. First among them was the importance of marrying the centralized programming, operations, and financing that define large-scale humanitarian operations with flexible, localized interventions that respond to individual community contexts and needs. Critical to this approach was a mechanism for working through traditional and local social and political structures, with tailored strategies to reach individual communities.⁵³ A 2019 anthropological evaluation of community-based Ebola responses in Sierra Leone noted that community acceptance of public health measures such as prevention, burials, contact tracing, and quarantine were greatest where the people explaining those measures were introduced through existing community structures. Where these approaches were not adopted, mistrust, disputes, and violence over questions of land allocation for health facilities, the distribution of local jobs, and case management practices were common.⁵⁴

While the principle of localizing responses became a matter of consensus by the end of the crisis, officials had little to no understanding of how such a flexible approach should be systematized and planned for at a national or international level. In Sierra Leone, mechanisms for devising community-level strategies were coordinated through the District Ebola Response Committees that the government established with international financial support (the committees involved local health authorities but were outside the formal government system). In the short term, this approach raised concerns about reliance on traditional power structures that were perceived to create risks both of reinforcing patterns of inequality in local decision-making and of escalating local conflicts through the unequal distribution of jobs and other resources. In the longer term, the creation of parallel administrative structures prompted questions about the sustainability of such mechanisms and whether they undermined national

52. UNMIL, “Ebola Virus Disease Outbreak 2014–2015.”

53. Jeremy Konyndyk, *Struggling with Scale: Ebola’s Lessons for the Next Pandemic* (Washington, D.C.: Center for Global Development, 2019), <https://www.cgdev.org/publication/struggling-scale-ebolass-lessons-next-pandemic>.

54. Oosterhoff, Mokuwa, and Wilkinson, *Community-Based Ebola Care Centres*.

capacities.⁵⁵ Nevertheless, a report by the Center for Global Development argues that, in the face of future large-scale health crises, international responses will inevitably be forced to discard uniform, top-down “rigorous case finding, contact tracing, and infection control practices” and adopt “wider use of behavioural and community-driven methods” that engage “credible voices” and equip them “with the basic information and tools to adapt to their own community’s setting.”⁵⁶ As the West African Ebola response wrapped up, how to approach this principle during an externally driven emergency response remained ambiguous.

Tied to concerns about national capacity is what the Humanitarian Futures Programme (HFP) refers to as a “resurgence of sovereignty” among developing countries hosting humanitarian responses such as the one that unfolded in West Africa. Amid shifts in the global geopolitical, normative, and diplomatic environments, the HFP argues, host governments will be “more insistent on determining whether or not external assistance is required and, if so, what will be provided, by whom, when, where, and how.” Simultaneously, the HFP suggests that humanitarian crises have become more significant for domestic politics and governments’ political survival than in previous decades, making host states all the more sensitive to public perceptions of humanitarian responses and keen to be seen as playing the lead role—vis-à-vis external actors—in meeting peoples’ needs.⁵⁷

The clash between perceived operational expediency and principles of national ownership during health emergencies contributed to a shift in the humanitarian policy discourse in the wake of the West African Ebola response. Specifically, support has grown for the principle of “localization” in international humanitarian responses, commensurate with more general trends in this direction in the international aid world.⁵⁸ The embrace of this principle is also evident in the domain of peacekeeping, where both scholarship and mission strategies have sought to better understand and

55. Ibid.

56. Konyndyk, *Struggling with Scale*, quoted in Michael J. Snyder, “Ebola Response in DRC Undergoes ‘Important Shifts’ as Violence Intensifies,” International Peace Institute, May 22, 2019, <https://theglobalobservatory.org/2019/05/ebola-response-drc-important-shifts-violence-intensifies/>.

57. Randolph Kent, Justin Armstrong, and Alice Obrecht, *The Future of Non-Governmental Organizations in the Humanitarian Sector: Global Transformations and Their Consequences* (London: King’s College London, June 2016), <https://reliefweb.int/sites/reliefweb.int/files/resources/The-Future-of-Humanitarian-NGOs-HFP-Discussion-Paper-Aug2013-copy.pdf>.

58. For example, Séverine Autesserre, *Peaceland: Conflict Resolution and the Everyday Politics of International Intervention* (Cambridge: Cambridge University Press, 2014), <https://doi.org/10.1017/CBO9781107280366>.

incorporate local protection practices into missions' broader efforts to protect civilians.⁵⁹ However, localization can have many, sometimes contradictory, meanings. For example, some have called for a greater focus on local capacity building to prioritize the fostering of greater knowledge and expertise over the longer term, including by working more systematically through civil society groups.⁶⁰ Others advocate shifting power closer to affected communities, including through more direct funding or by empowering civilians to protect themselves rather than providing external protection.⁶¹ These varied strategies, and the dilemmas that arise from them, would quickly become apparent in the decision-making of humanitarians during the *Riposte* in the DRC.

59. Emily Paddon Rhoads and Rebecca Sutton, "The (Self) Protection of Civilians in South Sudan: Popular and Community Justice Practices," *African Affairs* 119 (476) (2020): 370–394, <https://doi.org/10.2139/ssrn.3666945>.

60. John Bryant, "Mapping Local Capacities and Support for More Effective Humanitarian Response," Policy Brief 75, Overseas Development Institute, November 2019, https://cdn.odi.org/media/documents/Mapping_local_capacities_and_support_for_more_effective_humanitarian_responses.pdf; and Michael N. Barnett, ed., *Paternalism beyond Borders* (Cambridge: Cambridge University Press, 2016), <https://doi.org/10.1017/9781316799956>.

61. Christian Els and Nils Carstensen, "Funding of Local and National Humanitarian Actors," Global to Local Protection, May 2015, https://www.local2global.info/wp-content/uploads/l2gp_local_funding_final_250515.pdf; Oliver Kaplan, *Resisting War: How Communities Protect Themselves* (Cambridge: Cambridge University Press, 2017), <https://doi.org/10.1017/9781316671887>; and Jana Krause, *Resilient Communities: Non-Violence and Civilian Agency in Communal War* (Cambridge: Cambridge University Press, 2018), <https://doi.org/10.1017/9781108675079>.

IV. The 2018–2020 DRC Ebola Crisis, the *Riposte*, and MONUSCO’s Role

On August 1, 2018, the Ministry of Health of the DRC reported an outbreak of Ebola virus disease—the country’s tenth—in North Kivu province, which was later expanded to Ituri and South Kivu provinces. By the time it was declared over by the WHO in June 2020, the outbreak had infected 3,470 people (probable and confirmed cases), killed 2,287, and become the world’s second most deadly Ebola epidemic after the 2014–2016 outbreak in West Africa.⁶²

A major international health response mobilized to help stem the spread of the virus in the DRC, heavily influenced by the experience in West Africa. Though the response was initially effective, a surge in violence in the Beni area hampered efforts, and by October 2018 only 20 percent of contacts had been traced.⁶³ Attacks resulted in localized lockdowns of health centers. Travel by workers to outbreak areas and the transportation of medical supplies was impeded when aid workers were unable to travel on roads that had suffered previous ambushes. This section describes how, amid these challenges, MONUSCO attempted to manage the crisis. It considers the state of the conflict at the time of the outbreak and MONUSCO’s role within it, how the mission and its partners applied the lessons from UNMIL and the West African epidemic, and how MONUSCO endeavored to implement its own mandate under these conditions. This analysis highlights questions and dilemmas that arose for peacekeeping and humanitarian officials at the time and offers insights relevant to those developing policies for peace operations during similar health emergencies.

62. WHO, “10th Ebola Outbreak in the Democratic Republic of the Congo Declared Over; Vigilance against Flare-Ups and Support for Survivors Must Continue,” press release, June 25, 2020, <https://www.who.int/news/item/25-06-2020-10th-ebola-outbreak-in-the-democratic-republic-of-the-congo-declared-over-vigilance-against-flare-ups-and-support-for-survivors-must-continue>.

63. C. R. Wells, Abhishek Pandey, Martial L. Ndeffo Mbah, et al., “The Exacerbation of Ebola Outbreaks by Conflict in the Democratic Republic of the Congo,” *Proceedings of the National Academy of Sciences of the United States of America* 116 (48) (2019): 24366–24372, <https://doi.org/10.1073/pnas.1913980116>.

a. Conflict Dynamics in the Eastern DRC on the Eve of the Ebola Crisis

After repeated delays of the DRC's presidential election, on December 31, 2016, leaders of the Majorité Présidentielle (Presidential Majority) and opposition parties in the DRC signed a "Comprehensive and Inclusive Political Agreement" wherein President Joseph Kabila committed not to seek a third term in office, a path for holding elections was identified, and transitional arrangements were established to permit the functioning of the government until the polls were held. The agreement called on MONUSCO to provide support to the national electoral commission in organizing elections, with a date for the presidential election set for December 2018.⁶⁴

The December 31, 2016, agreement put a shaky lid on a highly volatile political situation in the east of the country, where, at the time of the outbreak in the DRC, more than seventy armed groups were active.⁶⁵ Long-standing armed groups, such as the Forces Démocratiques de Libération du Rwanda (Democratic Forces for the Liberation of Rwanda, FDLR), though weakened, continued to influence the conflict through support to younger armed groups, such as the Nyatura in the Rutshuru territory of North Kivu. In Walikale and Lubero territories the Nduma Défense du Congo-Rénové (Nduma Defense of Congo-Renovated, NDC-R) was growing in influence. Because the Forces Armées de la République Démocratique du Congo (Armed Forces of the Democratic Republic of Congo, FARDC) had no significant presence in this area, much of the population there perceived the NDC-R to be providing security and defending local interests despite a record of illegal taxation and other violations. Additional Mai-Mai groups were active around Lake Edward and near the town of Lubero, where they frequently clashed with the FARDC.

Beni territory, where the Ebola outbreak began, has been the base of operations for the ADF since it migrated from Uganda in the 1990s. At the time of the outbreak, the group was estimated to number 400–500 combatants operating from small bases to the east of the town of Beni, where it continued to recruit youth from Uganda.⁶⁶ With obscure motives, and often working with other local armed groups, the ADF is notorious for its extreme brutality against civilians and since 2013 has been accused

64. UN, "UN Welcomes Signing of Political Agreement on Elections in DR Congo," press release, United Nations, December 31, 2016, <https://news.un.org/en/story/2016/12/548752-un-welcomes-signing-political-agreement-elections-dr-congo>.

65. Wells et al., "The Exacerbation of Ebola Outbreaks by Conflict in the Democratic Republic of the Congo."

66. *Ibid.*

of participating in a series of mass atrocities in Beni.⁶⁷ In January 2018, the FARDC launched “Usalama 2,” a major operation targeting the ADF and other groups in North Kivu. This led to a significant deterioration of the situation in Beni, with a major upsurge in attacks against civilians, the FARDC, and UN peacekeepers, though, as the UN Group of Experts on the Democratic Republic of the Congo pointed out, no armed group took responsibility for the attacks.⁶⁸

The 2018 Ebola crisis thus broke out amid a complex, tense, and fragile moment in the Congolese conflict. All aspects of the *Riposte*—including the infusion of money, the presence of Congolese officials from outside the region, and the steps taken to ensure security—profoundly affected, and would be affected by, these dynamics. However, little evidence suggests that the WHO, in preparing its response to the Ebola outbreak, took steps to understand and plan in relation to them.

b. The Outbreak of Ebola, the Entry of the *Riposte*, and the Spread of Mistrust

The DRC Ministry of Health notified the WHO of an outbreak of Ebola in North Kivu on August 1, 2018.⁶⁹ The announcement activated a large-scale, multisectoral response, formally led by the Ministry of Health and supported by the WHO and involving more than fifty international and national partners. Within weeks, the WHO, the ministry, MSF, the International Federation of the Red Cross/Red Crescent, and key international NGOs such as the International Medical Corps had collectively deployed

67. For a comprehensive description of the modus operandi of the ADF and the political and security dynamics surrounding the atrocities attributed to it, see Congo Research Group, *Mass Killings in Beni Territory: Political Violence, Cover-Ups, and Cooptation, Investigative Report No. 2* (New York: New York University Center on International Cooperation, September 2017), <https://www.congoresearchgroup.org/wp-content/uploads/2017/09/CRG-Beni-2017-report-updated.pdf>.

68. United Nations, UN Group of Experts Established Pursuant to Resolution 1533 (2004), “Letter Dated 18 December 2018 from the Group of Experts on the Democratic Republic of the Congo Addressed to the President of the Security Council,” S/2018/1133, December 18, 2018, <https://digitallibrary.un.org/record/1657735>.

69. Oly Ilunga Kalenga, Matshidiso Moeti, Annie Sparrow, et al., “The Ongoing Ebola Epidemic in the Democratic Republic of Congo, 2018–2019,” *The New England Journal of Medicine* 381 (14) (2019): 373–383, <https://doi.org/10.1056/NEJMsr1904253>.

more than five hundred personnel to what became known within the DRC as the *Riposte*.⁷⁰

The strategic approach of the international community's Ebola response—collectively, the activities of international agencies and NGOs that formed part of the *Riposte*—was heavily influenced by the WHO's new Health Emergencies Programme. The stated goal of this program, established in 2016 as a direct result of the criticisms of the WHO's response to the West African Ebola crisis of 2014–2015, was to deliver “more predictable, transparent and timely support to Member States.”⁷¹ In addition to internal reforms designed to detect and respond to disease incidents more quickly, the program pledged to embrace more nationally driven emergency responses, working through national systems wherever possible and striving to build local emergency response capacities before and during crises.⁷² The WHO and other key international agencies such as the UN Office for the Coordination of Humanitarian Affairs and, later, the Office of the UN Ebola Emergency Response Coordinator were more deferential to the Ministry of Health's leadership, agreeing to participate in a coordination mechanism the ministry set up in Goma and coordinating activities based on ministry data. Still, the sheer size of the international response and tensions within the agencies over questions of approach, principle, and resources soon necessitated an exclusively international coordination mechanism, which was initially operated by the WHO and also met in Goma.⁷³

This more nationally focused response created a dilemma for those NGOs and organizations, such as MSF and the ICRC, that most carefully guard their neutrality and independence and were thus deeply wary of any appearance of collaboration with the government, a party to the conflict. Still, in light of the lessons from West Africa, most agreed to the new

70. This paper adopts the conception of the *Riposte* defined by the Congo Research Group as the entirety of the political, institutional, infrastructural, and financial assemblage controlling the outbreak, including the Congolese Ministry of Health, the WHO, and a range of other medical and humanitarian actors, “and formally led by the Ministry of Health. . . . The notion of *Riposte* embodies both the self-conception of actors engaged in fighting the outbreak as well as the imagery and experience of Congolese with these actors.” See Congo Research Group, *Rebels, Doctors and Merchants of Violence*, 29.

71. WHO, *WHO Health Emergencies Programme in the African Region: Annual Report 2016* (Geneva: WHO, 2017), <https://www.afro.who.int/publications/who-health-emergencies-programme-african-region-annual-report-2016>.

72. Fiona Fleck, “WHO's New Emergencies Programme Bridges Two Worlds,” *Bulletin of the World Health Organization* 95 (1) (2017): 8–9, <https://dx.doi.org/10.2471%2FBLT.17.030117>.

73. Interview with former UN official involved in the Ebola response, October 8, 2021.

approach. A senior official with one of these organizations later said she regretted this decision to “play the game,” since the organization later concluded that its affiliation with the national response was putting its operation and personnel at risk.⁷⁴

Compared to the West African crisis, the *Riposte* had several important advantages in combating the virus. While institutionally weak, the Congolese health system had an established and tested response system, honed during the nine previous Ebola outbreaks in the country, to identify and contain outbreaks. This included a citizen alert system to report suspected cases and rapid reaction teams to investigate and track suspected cases and contacts. Critically, the response also had access to the rVSV-ZEBOV vaccine developed during the West African crisis. Though not yet licensed, it was authorized for emergency use, as were several new therapeutic treatments.⁷⁵

Initially, the public health response to the outbreak was relatively effective. Using the rVSV-ZEBOV vaccine, workers adopted a “ring vaccination” approach wherein an Ebola patient’s interpersonal contacts and, in turn, those contacts’ contacts would be targeted for vaccination.⁷⁶ When the virus was found to have spread to Ituri, authorities were successful in largely bringing transmission in the province under control by late August. Simultaneously, however, the virus spread to the commercial hub of Beni and then on to Butembo, raising concerns about possible spread over the border to Uganda.⁷⁷ This development added to the international community’s sense of urgency, contributing to support for a “no regrets” approach to managing the emergency, which was broadly seen as heavily empowering the WHO to direct actions with only limited consultation with other parts of the UN system.⁷⁸

The authorities in Beni and Butembo quickly encountered widespread community “resistance”—a term used as a catchall throughout the *Riposte* to describe “reluctance or refusal to cooperate with Ebola response efforts, including contact tracing, case management and safe and dignified burial

74. Interview with former senior NGO official, July 6, 2021.

75. Benedict Moran, “Fighting Ebola in Conflict in the DR Congo,” *The Lancet* 392 (October 13, 2018): 1295–1296, [https://doi.org/10.1016/S0140-6736\(18\)32512-1](https://doi.org/10.1016/S0140-6736(18)32512-1).

76. Wells et al., “The Exacerbation of Ebola Outbreaks by Conflict in the Democratic Republic of the Congo.”

77. Kalenga et al., “The Ongoing Ebola Epidemic in the Democratic Republic of Congo.”

78. Brian McCloskey and David L. Heymann, “SARS to Novel Coronavirus—Old Lessons and New Lessons,” *Epidemiology and Infection* 148 (22) (2020): 1–4, <https://doi.org/10.1017/s0950268820000254>.

activities; in addition to acts of active and violent hostility towards Ebola response teams.”⁷⁹ While complex and in some cases opaque, community distrust during the Ebola response appears to have been motivated by a combination of three broad factors, the first of which was widespread discomfort with the public health measures employed to stop the spread of the virus. These included the isolation of the sick in health centers and emotionally and culturally insensitive safe burial practices.

A second factor was a suspicion of the motives of national and international health workers, who appeared in the expensive Toyota Land Cruisers ubiquitous among international NGOs and hired large numbers of national staff, though often not from nearby locations or linguistic groups. Local people questioned why so many resources were being committed to Ebola when other diseases caused far more deaths (for example, the DRC was experiencing a large-scale measles epidemic at the time of the Ebola outbreak).⁸⁰ Some concluded that the health workers themselves, both national and international, had either brought the disease to the area or were propagating it to enrich themselves.⁸¹ A related conspiracy theory held that the government was spreading the disease to attract international aid dollars and create jobs and rents for its supporters. International health actors eventually took several steps to address these challenges—many of which had been identified during the West African epidemic—such as using motorcycles instead of large vehicles to reach communities and training community members to safely bury bodies.⁸²

Third, and most important for our study of MONUSCO’s role in the crisis, is what one study attempting to better understand the causes of “community resistance” identified as “difficulty separating the persisting conflict from Ebola.”⁸³ Many in the population associated the health response with the Congolese government as a whole and, by extension, with MONUSCO. This did not bode well for the legitimacy of the health response since, at best, the FARDC was widely seen as ineffective in protecting the population from armed groups and, at worst, was seen as a primary source of violence

79. Noé Kasali, *Community Responses to the Ebola Response: Beni, North Kivu* (Belfast: Congo Initiative—Bethesda Counselling Centre, ca. 2020), https://opendocs.ids.ac.uk/opendocs/bitstream/handle/20.500.12413/14353/Bethesda_Counselling_Centre_Report_FINAL_190206.pdf.

80. Malaria is the leading cause of premature death in the DRC, followed by neonatal disease, pneumonia, diarrhea, and tuberculosis. Kalenga et al., “The Ongoing Ebola Epidemic in the Democratic Republic of Congo, 2018–2019.”

81. Interview with former senior NGO official, July 6, 2021.

82. Moran, “Fighting Ebola in Conflict in the DR Congo.”

83. Kasali, *Community Responses to the Ebola Response*.

and corruption in many communities in the eastern DRC. MONUSCO was frequently accused of indifference in the face of attacks (whether by the FARDC or armed rebel groups) on civilians and, as it regularly took part in joint operations against armed groups, as complicit in the resulting reprisals inflicted on civilians by the ADF.⁸⁴

These suspicions soon found their way into the supercharged political environment leading up to the December 2018 election. For example, a national opposition deputy representing Butembo released a widely shared audio message on WhatsApp and later broadcast on the radio: “We want the Minister of Health to tell us the real origins of Ebola. As long as we’re not told its real origin, we’ll believe that it was manufactured in a laboratory in order to exterminate the population of Beni.”⁸⁵ Local politicians also claimed that the creation or propagation of the virus was a government strategy to avoid facing the opposition in the upcoming election, a suspicion reinforced when the government went ahead with the election but excluded Beni and Butembo, opposition strongholds, from the vote.

c. Violence, the Securitization of the *Riposte*, and MONUSCO's Role

In this volatile political context, violence became a regular feature of the epidemic almost immediately, with attacks and threats on health centers housing Ebola patients and health workers in the field an almost daily occurrence. On September 22, 2018, unidentified attackers killed twenty-one civilians in Beni and prompted five days of mourning that interrupted contact tracing and led the rate of Ebola cases to almost double.⁸⁶ In November, a group of armed men attacked two hotels housing workers with the World Food Programme and other UN programs involved in the *Riposte*.⁸⁷ Beyond acts of overt violence, hostility toward the *Riposte*, even from those working for it, was a fact of daily life. An NGO emergency coordinator based in Beni during the outbreak recalled regularly receiving threatening notes if payments to staff were late and regularly encountering

84. J. Stephen Morrison and Judd Devermont, “North Kivu’s Ebola Outbreak at Day 90: What Is to Be Done?” *CSIS Briefs*, November 2018, <https://www.csis.org/analysis/north-kivu-ebola-outbreak-day-90-what-be-done>.

85. Cited in Moran, “Fighting Ebola in Conflict in the DR Congo.”

86. Morrison and Devermont, “North Kivu’s Ebola Outbreak at Day 90.”

87. “Ebola en RDC: Le PAM poursuit son aide malgré les dernières attaques meurtrières à Beni,” *Radio Okapi*, November 21, 2021, <https://www.radiookapi.net/2018/11/21/actualite/sante/ebola-en-rdc-le-pam-poursuit-son-aide-malgre-les-dernieres-attaques>.

mobs threatening violence when she would arrive to provide health services in a new community.⁸⁸

Challenges in identifying and understanding the motives of the perpetrators of attacks on health facilities further fueled confusion among local civilians and security actors alike. Concerns grew of an alleged new alliance between the ADF and the Islamic State in Iraq and the Levant, though the UN Group of Experts on the DRC found no evidence of any cooperation between the groups.⁸⁹ While the United Nations assessed that the ADF did not appear to be systematically targeting the Ebola response,⁹⁰ the group continued its pattern of attacks on civilians in Beni, frequently limiting health workers' access to affected areas and thus interrupting contact-tracing efforts and enabling the virus to continue spreading.⁹¹

Other explanations posited by UN officials at the time include the possibility that local opposition political figures were encouraging or even organizing the attacks as a way of undermining central government officials and their local allies. More simply, the attacks might have been acts of frustration in response to the perceived instrumentalization of the virus as a justification to suspend voting in the presidential election in Beni and Butembo.⁹²

Perhaps the most important factor fueling violence against the *Riposte* was the perverse political economy created by the intervention in the Beni area and its link to security dynamics. Faced with an unprecedented security challenge and little in the way of conflict-sensitive operating procedures, the WHO reportedly engaged approximately 250 members of the Agence Nationale de Renseignements (National Intelligence Agency, ANR), a state security apparatus notorious for human rights violations, as “community liaisons” and followed their instructions on the most permissive locations

88. Interview with humanitarian official involved in the *Riposte*, October 8, 2021.

89. United Nations, UN Group of Experts Established Pursuant to Resolution 1533 (2004), “Letter Dated 6 June 2019 from the Group of Experts on the Democratic Republic of the Congo Addressed to the President of the Security Council,” S/2019/469, June 7, 2019, <https://digitallibrary.un.org/record/3808438>.

90. Interview with former senior UN official involved in the Ebola response, October 8, 2021.

91. See, for example, AFP, “Nine Killed in Eastern DR Congo Raid Blamed on ADF,” *Defense Post*, December 11, 2018, <https://www.thedefensepost.com/2018/12/11/dr-congo-adf-raid-oicha-beni-9-killed/>.

92. Nurith Aizenman, “An Urgent Mystery: Who’s Attacking Ebola Responders in Congo—And Why?” *All Things Considered*, June 4, 2019, <https://www.npr.org/sections/goatsandsoda/2019/06/04/726139304/an-urgent-mystery-whos-attacking-ebola-responders-in-congo-and-why>.

for Ebola response activities. In addition to alienating local communities, this arrangement incentivized the ANR to portray the situation as one of continuing danger, which in turn motivated stronger security measures. A senior UN official involved in the *Riposte* recalled, for example, that an alleged Mai Mai attack at the Bunia airport reported by the ANR turned out to be a small crew of MONUSCO workers cutting grass.⁹³ As a 2021 report of the Congo Research Group alleges, the WHO also paid armed groups, either directly or indirectly, to “ensure security,” again creating a perverse incentive for armed groups to attack the health centers to preserve a climate of insecurity and justify continued security payments.⁹⁴ A senior NGO official involved in the response suggested that the WHO naively thought it could “buy its way out of the situation,” resulting in a highly inefficient and ultimately counterproductive use of its ample budget on security.⁹⁵

The size and modalities of the Congolese response also fueled resentment and violence. During an earlier, unrelated 2018 Ebola outbreak around Mbandaka, the government had instituted an attractive financial incentive schedule to encourage health workers to deploy to Ebola-affected areas, paying them as much as U.S.\$200 per day, an enormous amount by local standards. As a result, government workers from around the DRC flocked to the reclusive Beni area to benefit from these payments. Many had little to do and even less reason to see the outbreak come to an end.⁹⁶

The pace and severity of attacks on health workers and facilities became a major obstacle to containing the virus. Security incidents and resulting suspensions of health activities correlated directly with drops in the rate of contact tracing, leading to an ongoing pattern of new Ebola patients being identified without epidemiological links to known cases. In attempting to measure the impacts of this violence on the spread of Ebola, a study of contact tracing between April 2018 and June 2019 found that “violence against health workers compromised the speed of isolation of patients once infections were identified—with the average time between symptom onset and isolation rising from 8.1 days to 10.0 days after a disruptive event—and impeded the speed of the vaccination campaign. Collectively . . . conflict events reversed what was otherwise a declining epidemic trajectory during the period.”⁹⁷

93. Interview with former senior UN official involved in the *Riposte*, October 15, 2021.

94. Congo Research Group, *Rebels, Doctors and Merchants of Violence*.

95. Interview with former senior NGO official, July 6, 2021.

96. Interview with former senior UN official involved in the *Riposte*, October 14, 2021.

97. Wells et al., “The Exacerbation of Ebola Outbreaks by Conflict in the Democratic Republic of the Congo.”

Security Council Resolution 2409 of March 27, 2018, authorized MONUSCO to field 16,675 military personnel and 1,441 police personnel, along with a considerable complement of civilian staff. Its top priorities, the resolution declared, were the protection of civilians and support for the implementation of the December 31, 2016, agreement and the electoral process, so that credible elections could be held and a political way forward for the country secured.

As the security situation escalated in late 2018, MONUSCO began to take a more explicit role in the response. On November 7, WHO Director-General Tedros Adhanom Ghebreyesus and Under-Secretary-General for Peacekeeping Operations Jean-Pierre Lacroix jointly visited Beni in a show of commitment to enhancing security for the Ebola response.⁹⁸ Lacroix was quoted in the media as saying, “we will do our best to contain the Ebola outbreak despite the security environment that is being degraded by armed groups. . . . We promise to neutralize and hunt down these rebels because we have a mandate to keep the peace. Peace is one of the major elements of the Ebola response.”⁹⁹ The following day a UN press release declared that MONUSCO “has contributed to a period of calm in and around the city of Beni, although some attacks have continued in surrounding villages.”¹⁰⁰

Throughout the Ebola crisis, active hostilities unfolded in close proximity to disease-affected areas. Although MONUSCO’s offensive operations against the ADF decreased during the Ebola crisis, periodic operations were still carried out, usually jointly with the FARDC. Whether causally linked or not, operations were followed by a significant spike in ADF attacks on civilians, military targets, and peacekeepers. A year later, in 2019, an offensive against the ADF launched unilaterally by the FARDC and against the advice of MONUSCO caused the rebel group to splinter across the territory and

98. Michael R. Snyder, “Ebola Outbreak in DRC Poses Conundrum for Peacekeepers, Public Health,” International Peace Institute, December 7, 2018, <https://theglobalobservatory.org/2018/12/ebola-outbreak-drc-poses-conundrum-peacekeepers-public-health/>.

99. Al-Hadji Kudra Maliro, “UN Vows to Tackle Congo Rebels, Contain Ebola,” AP News, November 7, 2018, <https://apnews.com/article/3933f652390f46509c156fa5ecfbd32e>.

100. MONUSCO, “New Measures and Strong Partnership Having Positive Impact on Ebola Response in the Democratic Republic of the Congo,” press release, November 8, 2018, <https://monusco.unmissions.org/en/new-measures-and-strong-partnership-having-positive-impact-ebola-response-democratic-republic-congo>.

sparked an intense series of attacks.¹⁰¹ The violence hit a breaking point for many in the population, resulting in violent protests against MONUSCO that culminated in the looting and torching of the MONUSCO office in Boikene, just north of Beni, destroying the office and forcing the staff to evacuate to the Beni airport.¹⁰²

The violence against the Ebola response opened a schism in the humanitarian community between those advocating for more armed security and those demanding less. On April 19, 2019, a Cameroonian epidemiologist deployed by the WHO was killed in an attack on Butembo University Hospital, where he was participating in a coordination meeting.¹⁰³ Following the incident, two hundred local doctors and more than one thousand nurses at hospitals and health centers in Butembo, who were responsible for initially evaluating potential Ebola patients and referring them to Ebola treatment centers, threatened to strike unless authorities prevented further attacks.¹⁰⁴ At the request of the WHO, MONUSCO began stationing troops to guard hotels where health staff were residing and medical facilities where Ebola patients were being treated, in some cases establishing temporary operation bases to allow health workers to remain onsite in rural areas for days or weeks.¹⁰⁵ The UN Department of Safety and Security (UNDSS), which dictates security measures for all UN civilian personnel, established a three-tiered security assessment of roads in the area. All “red

101. MONUSCO's Human Rights Office reports that, from January 1, 2019, to June 30, 2020, 793 civilians were killed, 176 were wounded, and 717 were abducted by ADF combatants in North Kivu and Ituri Provinces, while 59 children were recruited into armed groups and seven health centers were attacked and looted, causing massive displacement of persons. See UN Joint Human Rights Office OHCHR-MONUSCO, *Report on Violations of Human Rights and International Humanitarian Law by the Allied Democratic Forces Armed Group and by Members of the Defense and Security Forces in Beni Territory, North Kivu Province and Irumu and Mambasa Territories, Ituri Province, Between 1 January 2019 and 31 January 2020* (UN Joint Human Rights Office OHCHR-MONUSCO, July 2020), https://www.ohchr.org/sites/default/files/Documents/Countries/CD/ADF_EN.pdf.

102. Internal memorandum from a former senior MONUSCO official, February 5, 2021, United Nations; on file with author.

103. World Health Organization, “WHO Ebola Responder Killed in Attack on the Butembo Hospital,” press release, April 19, 2019, <https://www.who.int/news/item/19-04-2019-who-ebola-responder-killed-in-attack-on-the-butembo-hospital>.

104. Nurith Aizenman, “Why Health Workers in The Ebola Hot Zone Are Threatening to Strike,” *Goats and Soda*, April 25, 2019, National Public Radio, <https://www.npr.org/sections/goatsandsoda/2019/04/25/717079729/why-health-workers-in-the-ebola-hot-zone-are-threatening-to-strike>.

105. Internal memorandum by a former senior MONUSCO official, October 10, 2019, United Nations; on file with author.

coded” roads required an armed escort, often provided by MONUSCO. Even for “yellow coded” roads, however, as one UN staff member involved in the response recalled, WHO officials began to regularly request armed escorts—for example, on the road from Beni to Butembo—even though they were not formally required.¹⁰⁶

Much of MONUSCO’s security support for the health response came from its Force Intervention Brigade, which was already concentrated around Beni and was mandated to offensively “neutralize armed groups” that had been established in the wake of the 2012 M-23 rebellion and more recently had been focused on addressing the threat posed by the ADF.¹⁰⁷ The FIB deployed troops and vehicles to the response and was reinforced with a company normally based in Kinshasa, two police units, and individual police officers. Unsurprisingly, the security measures implemented as a result of the violence against health measures further amplified perceptions of links between the Ebola response and political motivations. Heavy security details for health workers arriving in affected localities compounded mistrust and fueled a reluctance to seek treatment.¹⁰⁸

As a consequence, when assailants set fire to two nearby Ebola treatment centers run by MSF in February 2009, resulting in the suspension of its activities and the evacuation of staff, the organization called for an “urgent change in strategy,” arguing that the response had become overly militarized.¹⁰⁹ In an interview with Reuters, acting MSF President Dr. Joanne Liu described the atmosphere as “toxic” and argued that Ebola could not be managed unless the community trusted the authorities and were treated humanely. “Using police to force people into complying with health measures is not only unethical,” she said; “it’s totally counterproductive. The communities are not the enemy.”¹¹⁰ Instead, the MSF argued, “we need to adapt our intervention to the needs and expectations of the population, to integrate Ebola activities in the local healthcare system, to engage effectively with the communities, and to further explore promising vaccinations to strengthen prevention. Choices must be given back to patients and their

106. Interview with former senior UN official involved in the Ebola response, October 8, 2021.

107. UN Resolution 2409, S/RES/2409, UN Security Council, March 27, 2018.

108. Wells et al., “The Exacerbation of Ebola Outbreaks by Conflict in the Democratic Republic of the Congo.”

109. Snyder, “Ebola Response in DRC Undergoes ‘Important Shifts’ as Violence Intensifies.”

110. Tom Miles, “Battle against Ebola Being Lost amid Militarized Response, MSF Says,” Reuters, March 7, 2009, <https://www.reuters.com/article/us-health-ebola-congo/battle-against-ebola-being-lost-amid-militarized-response-msf-says-idUSKCN1QO1F1>.

families on how to manage the disease—for example, by allowing people to seek healthcare in their local centres rather than in an Ebola Treatment Center (ETC). We owe this to our patients.”¹¹¹

Other aspects of MONUSCO's contributions to the *Riposte* were less controversial. In addition to its security activities, the mission provided a variety of logistical and substantive support. When the outbreak in North Kivu was announced, MONUSCO already had some experience in supporting a health response. Months earlier, when the ninth Ebola outbreak occurred in Equateur Province, much of the mission's logistical and substantive resources were dedicated to preparations for the election. Some of these resources were immediately redirected to aid the government-led response, supported by the WHO. By the end of May, the mission had deployed thirteen staff members to Mbandaka to assist with the establishment of an emergency hospital. The mission redeployed aircraft to transport cargo for the Ministry of Health and the WHO, as well as helicopters to access remote villages. The experience was generally seen as a success, and one senior mission staff member observed that this support was critical to helping the government rapidly resolve the outbreak.¹¹²

Given the worsening situation on the ground, in May 2019 the UN secretary-general appointed then MONUSCO DSRSG David Gressly as the UN's Emergency Ebola Response Coordinator. An official from UN headquarters was temporarily deployed to perform the DSRSG role during this period. The WHO, whose leadership of efforts on the ground had come into increasing question,¹¹³ described Gressly's role as “overseeing the coordination of international support for the Ebola response and working to ensure that an enabling environment—particularly security and political—is in place to allow the Ebola response to be even more effective. Mr. Gressly will work closely with WHO, which will continue to lead all health operations and technical support activities to the government response to the epidemic.”¹¹⁴ Upon taking charge of the Ebola response, Gressly endeavored to get MONUSCO to more directly engage local armed actors and their

111. Médecins Sans Frontiers, “MSF: Ebola Epidemic Not under Control, Urgent Change of Strategy Needed,” press release, April 12, 2019, <https://www.doctorswithoutborders.org/what-we-do/news-stories/news/msf-ebola-epidemic-not-under-control-urgent-change-strategy-needed>.

112. Internal memorandum from a former senior MONUSCO official, February 5, 2021.

113. Interview with former senior UN official involved in the *Riposte*, October 14, 2021.

114. World Health Organization, “United Nations Strengthens Ebola Response in the Democratic Republic of the Congo,” press release, May 29, 2019, <https://www.who.int/news/item/23-05-2019-united-nations-strengthens-ebola-response-in-democratic-republic-of-the-congo>.

political counterparts who were involved in influencing violence against health centers. “We have civil affairs officers who maintain close relationships with communities. We work with them all the time. That gives us a level of access to the population that WHO could never match,” he told National Public Radio at the time.¹¹⁵ One former senior UN official described Gressly’s appointment as intended to put an end to the “Ebola business”; that is, the insidious cycle of violence and “protection” that, according to some, had become the dominant logic of security in the Ebola response. MONUSCO provided administrative and security support for the setup and operations of Gressly’s small office, based in Goma.¹¹⁶

115. Aizenman, “An Urgent Mystery.”

116. Internal memorandum from a former senior MONUSCO official, February 5, 2021.

V. Reflections on the Role of Peace Operations in Responses to Health Emergencies

The mistrust, violence, and corruption that grew out of the 2018–2020 Ebola crisis, and its consequences for the effectiveness of the national and international health responses, point to several implications for the way that health emergencies can unfold in active conflict situations. The roles played, or not played, by MONUSCO during the *Riposte* in turn raise new questions and highlight possible lessons about how peace operations should respond to similar situations in the future. This section identifies some of the substantive and operational areas in which MONUSCO did play, or could have played, a role, and how its activities might have helped avoid some of the negative aspects of the response. Each subsection is followed by policy recommendations (aimed at the UN’s Departments of Peace Operations and Political and Peacebuilding Affairs, the WHO, international nongovernmental health and humanitarian actors, and the diplomatic community) for how future emergency health responses in active conflict situations can be better conceived, planned, and executed.

a. Conflict and Political Economy Analysis

Many of the security-related decisions taken by the WHO during the *Riposte* suggest a limited understanding of the eastern DRC’s conflict dynamics and political economies, including the relationship between state security services and various communities in the region, the roles played by state and nonstate armed actors, and the tense political and electoral context at the time of the outbreak. All three of these areas are central to the intelligence and political priorities of MONUSCO, making it well placed to advise the WHO on the likely consequences of its security strategies. Yet, according to a senior MONUSCO official involved in the *Riposte*, the WHO made no attempt to seek the mission’s analysis or advice, nor did it advise MONUSCO of the security strategies it intended to pursue.¹¹⁷ Indeed, the WHO’s en-

117. Interview with former senior UN official involved in the Ebola response, October 8, 2021.

agement of ANR officials became known to MONUSCO officials only after the fact.¹¹⁸ UNDSS did advise the WHO and other UN humanitarian actors on risk levels and travel precautions, but this was strictly limited to personnel's immediate exposure to the risk of violence, not the causal relationship between the *Riposte's* actions and that risk. Moreover, UNDSS was criticized for reportedly providing an outdated risk analysis and for failing to adequately adapt personnel deployments and risk management procedures to the needs created by the crisis.¹¹⁹

Policy recommendations: Given the WHO's lack of conflict, political, and security analysis capacities, a specific mechanism to systematically link the response to conflict-sensitive analysis and advice from other parts of the UN system operating inside the country should be required when the WHO takes a leading role in international health responses in situations of ongoing violent conflict or other complex political contexts. The UN Department of Peace Operations (DPO), Department of Political and Peacebuilding Affairs (DPPA), and the WHO should develop joint standard operating procedures dictating how missions will share political and security analysis with the WHO and other health actors, consult one another on program design and operational planning, and maintain joint crisis management arrangements. The WHO should also scale up investment in its internal capacity to plan health interventions in a conflict-sensitive manner.

b. Positioning MONUSCO vis-à-vis the *Riposte*

To this day, MONUSCO's role in—or in relation to—the *Riposte* remains ambiguous. Was the intent to continue, in line with its mandate, to promote peace and security in the eastern DRC, thereby creating a more permissive environment for the *Riposte* and public health efforts generally? Was it to enable a secure environment for the *Riposte* in a more proximate sense by providing armed escorts and area security for the deployment of health workers in conflict-affected areas? Was it to provide help in whatever way was deemed necessary by the WHO and/or the EERC in a “command

118. Congo Research Group, *Rebels, Doctors and Merchants of Violence*, 29. The report includes a response from the WHO stating that payments to state security forces were made under the framework of payment scales for services determined by the Congolese Ministry of Health and that it “is not aware of any payments to non-state armed groups.” *Ibid.*, 27.

119. Interview with humanitarian official involved in the *Riposte*, October 8, 2021; and interview with former senior UN official involved in the *Riposte*, October 14, 2021.

and control” relationship such as that described between UNMEER and UNMIL in West Africa? Lack of clarity around MONUSCO’s role, exacerbated by uncertainty about the roles being played by its national counterparts, especially the FARDC and the ANR, had clear consequences for the local population’s perceptions of different actors operating in the DRC. Local understandings of the Ebola crisis thus blurred with understandings of the causes and consequences of the ongoing conflict.

As research and policy around the role of peace operations during health emergencies has matured, some have called for missions and other security actors to develop a clearer distinction between functions that generally aim to provide a secure environment for health workers and functions that change the character of a health activity by providing direct, proximate security through, for example, vehicle escorts or by posting uniformed personnel at health facilities.¹²⁰ Through such an approach, a mission might establish a presence on the outskirts of a village receiving medical services, instead of establishing a cordon immediately around a health facility. It might clear a road of security threats in advance of a medical convoy rather than directly escort the convoy. This strategy would require an adjustment of UNDSS policy to adopt more flexible and perception-sensitive security procedures for personnel movement and closer day-to-day operational coordination between mission and humanitarian actors to plan movements. Overall, development of clear policy guidelines around engagement in less proximate forms of security provision by missions to facilitate emergency health activities could mitigate some of the challenges identified around MONUSCO’s support of the *Riposte*.

Policy recommendations: The United Nations should articulate a clear policy on the role of peace operations in public health emergencies that prioritizes modes of providing security without coming within close proximity of health activities. Missions and international health response teams should communicate this role systematically. UNDSS should review its repertoire of security measures for personnel movements to account for less proximate forms of security.

120. Interview with humanitarian official involved in the *Riposte*, November 11, 2021.

c. International Community Engagement and the Ebola “Panic”

From the start, the “no regrets” approach to the Ebola response adopted by the WHO and endorsed by international donors set the tone for an intervention that was poorly attuned to secondary and unintended consequences.¹²¹ In addition to facilitating increased mistrust of state institutions and international actors, widespread violence, and the exacerbation of political tensions in the east, the approach contributed to a widespread lack of transparency and accountability, as seen, for example, in the fact that more than fifty women were allegedly sexually exploited and abused by international aid workers with the *Riposte*.¹²² More generally, the political and economic effects of the *Riposte* on the drivers of conflict in the DRC—while difficult to quantify—seem likely to have significantly exacerbated key elements of the conflict and made a long-term solution to the conflict more difficult to reach. As one official noted, the “panic” within the international community over the risk that the outbreak would spread beyond the DRC’s borders also impacted the efficiency of the response. For example, so that it could play a leading role in coordinating the response efforts, the United States insisted that the headquarters for the response be located in Goma rather than in Beni, where most humanitarian emergency coordinators were located but where U.S. officials were not permitted to travel due to the ADF threat.¹²³

These findings highlight a tension between two principles. First, “in emergency response, it is generally better to over-react then scale back if necessary, rather than under-react and then act too late.”¹²⁴ Second, external actors should adopt a conflict-sensitive approach to international assistance. A better balancing of these principles would still have taken the Ebola crisis seriously but not to the extent that the conflict became an insignificant consideration. This might well have generated more accurate predictions of the short- and long-term consequences of some early

121. Philip Kleinfeld and Ben Parker, “Exclusive: UN Criticized for Holding Back Review of Troubled Congo Ebola Response,” *New Humanitarian*, December 4, 2020, <https://www.thenewhumanitarian.org/news/2020/12/4/congo-ebola-response-critical-UN-review-delay-corruption>.

122. Robert Flummerfelt and Nellie Peyton, “Investigation: More than 50 Women Accuse Aid Workers of Sex Abuse in Congo Ebola Crisis,” *New Humanitarian*, September 20, 2020, <https://www.thenewhumanitarian.org/2020/09/29/exclusive-more-50-women-accuse-aid-workers-sex-abuse-congo-ebola-crisis>.

123. Interview with former senior UN official involved in the *Riposte*, October 14, 2021.

124. McCloskey and Heymann, “SARS to Novel Coronavirus.”

actions by the health response on human rights and peace and security in the eastern DRC and, in turn, the effects of these trends on the vectors of transmission for the virus. In addition to shared analysis across the humanitarian and peace and security pillars of the UN system, a more coherent diplomatic response, integrated with the New York-based peace and security community and the Geneva-based health and humanitarian community, might have contributed to such an approach.

Policy recommendations: When health emergencies take place in situations of ongoing conflict, the international health response should be coordinated more closely with existing diplomatic processes of international engagement in the country, potentially including the Security Council and/or international contact groups and other diplomatic configurations. Further research could provide a more detailed mapping of the potential effects of health responses on conflict dynamics.

d. Logistical and Operational Support

In both the West African Ebola crisis of 2014–2016 and the two DRC crises of 2018 and 2018–2020, UNMIL and MONUSCO initially conceived of their role as primarily logistical. In that role, both missions brought considerable added value to the international response, especially in its early stages. The missions' unique logistical capacities and expertise and their access to supply chains position them well to play these roles in future health emergencies. Moreover, the missions' presence at the subnational level in many countries offers unique staging locations and secure start-up bases for international health responses. The interviews conducted for this paper suggest that, in the eyes of many humanitarians, the compromise of humanitarian principles that would be entailed by the involvement of mission capacity appears to be outweighed by the urgency of this support in the early phases of a response.

Policy recommendations: The WHO, DPO, and DPPA should develop joint contingency plans for emergency logistical cooperation during health emergencies, including the integration of missions into humanitarian coordination structures on an exceptional basis, detailed descriptions of the roles and responsibilities of the substantive components of the mission, and descriptions of measures to minimize the mission's visibility, especially in close proximity to humanitarian actors, and to communicate about its role.

e. Marrying Localized Approaches with Large-Scale International Responses

Tailored local approaches to engaging communities are critical to the success of international health responses. Yet the international community struggles to act on this principle, especially in the face of urgent health threats and panic. Peace operations may offer lessons and resources. Peacekeeping operations have long grappled with the challenge of how to tailor protection-of-civilians (PoC) activities to the characteristics and needs of individual communities, including ways to complement strategies that communities adopt to protect themselves from violence. To undertake this work, missions have developed a variety of tools, ranging from PoC risk assessments and operational planning structures, to community alert networks that link civilian populations to mission response teams, to community liaison assistants embedded with uniformed mission deployments in rural areas, where they establish extensive networks with local leaders and a nuanced understanding of their contexts. Both the policy lessons derived from how missions implement their PoC mandates and the resources they use for these purposes could benefit international health responses in conflict-affected areas.

Policy recommendations: The development of a policy on the roles of peace operations during health emergencies should include an exploration of the lessons mandated by PoC goals. DPO/DPPA/WHO contingency planning should investigate the inclusion of community liaison assistants and other mission “localization” tools to support health responses, at least in their early stages.

f. National Ownership and the Legacy of a Predatory State and Health System

In the fragile and conflict-affected states into which UN peace operations are deployed, public institutions often exist in a complex and sometimes conflictual relationship with local communities. The legacies of control and exploitation through public service delivery in the national health system, and the continuation of these dynamics in other public institutions, such as the national security forces, have created complex and nuanced relationships between communities and various parts of the state. By placing national institutions in leading and/or highly visible roles without understanding these dynamics, the international health response to the Ebola crisis in the DRC led to a situation in which the *Riposte* was implicated in conflict dynamics in the eastern DRC. While the principle of national

ownership remains valid under such conditions, it needs to be applied in a contextually informed and conflict-sensitive manner.

Policy recommendations: Humanitarian policies on national ownership in emergency health responses should be reviewed to incorporate unique sets of considerations and arrangements for conflict settings in which the government is a party to the conflict. These should include measures to analyze the potential political and economic consequences of health interventions and should allow for the weighing of the principle of national ownership with the principle of conflict sensitivity.

VI. Conclusion

While peacekeeping operations were not a primary actor in the *Riposte*, this analysis of MONUSCO's role during the 2018–2020 Ebola crisis in the DRC highlights how one peace operation, deeply embedded in Congo's conflict, interfaced with a heavily resourced emergency health response with few existing links to the situation in the country's east. This novel situation, in which an urgent public health emergency overlapped with an ongoing violent conflict, has forced the international peace and security and health and humanitarian communities to approach questions of principle and strategy in new ways. On the one hand, the experience of the *Riposte* is a lesson in the value of humanitarian principles and the consequences for both the safety of aid workers and the success of the intervention when a health response is politicized and/or securitized. On the other hand, the experience highlights the need for a much more thoughtful, humble, and communicative approach by future international health responses in conflict environments. This, in turn, demands more politically informed and localized approaches that engage with communities on their own terms. To achieve this, greater integration between peace operations and international health responses seems critical. The findings and policy recommendations in this paper aim to help international peace and security and health and humanitarian policy-makers achieve a better balance in this regard.

About the Author

Dirk Druet is a researcher, policy adviser, and strategist with over fifteen years of experience in the international peace and security pillar of the United Nations, including postings in New York, Afghanistan, and the Democratic Republic of the Congo (DRC). He is a Non-Resident Fellow at the Brian Urquhart Center for Peace Operations of the International Peace Institute and an Affiliate Researcher at McGill University's Centre for International Peace and Security Studies. Mr. Druet advises a variety of research and policy institutions, and in 2020 was a member of an independent team undertaking a strategic review of civilian protection in United Nations peacekeeping operations mandated by the Secretary-General.

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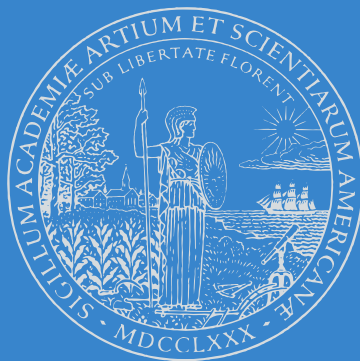
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