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THE RESPONSE TO THE EBOLA VIRUS DISEASE IN THE EASTERN OF DEMOCRATIC REPUBLIC OF CONGO

The twists and turns of an unexpected failure

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Executive summary

In 2018, the Democratic Republic of the Congo experienced its tenth episode of Ebola virus disease. This disease appeared in the east of the country, in the provinces of North Kivu and Ituri; and, it was one of the longest and most devastating in Africa. Announced in 2018, its end was officially declared in 2020 with a case fatality rate of around 70%.

Most cases of contagion or even death have been the result of the population denying the existence of the disease, mistrust of caregivers and of the care being administered. In general, the episode was characterized by resistance and violence. Beyond the trauma already endured, this resistance would was a reaction to the altogether original and strange methods adopted by the response team to break the chain of contamination and end the disease.

In order to find out what explains this resistance and how to make the process of response human, Pole Institute and its partner, Martin Luther University, initiated, under the funding of Elrha's "Research for Health in Humanitarian Crises" (R2HC) program, conducted a research entitled ""Humanizing the Design of the Ebola Response in DRC: Anthropological Research on Humane Designs of Ebola Treatment and Care to Build Trust for Better Health"

The results of this purely qualitative research derive from 76 semi-structured individual interviews with key informants and 28 focus group discussions. The duration of each interview or group discussion was about twenty to sixty minutes. In addition, twenty field notes were collected. Ethics approval was obtained from the Ethics Board of Oxford University and POLE Institute, in the Democratic Republic of Congo. Several interesting results were obtained, in particular:

1. Fear and mistrust are the main factors of the observed community resistance. In the context of the endless massacres in the region, the fear is underpinned by the belief that the disease is a creation of the regime of President Kabila in order to exterminate the Nande people who were strongly opposed to him; the mistrust, for its part, is justified by the fact that the response team did not take the time to understand local cultural practices. These include traditional bushmeat consumption, regular gatherings at family or village events, and traditional funeral practices.
2. The extent of the fear might vary from one area to another, but people generally believed that when the team brought a patient to treatment centers, they were killed. Indeed, many people thought that patients who entered treatment centers in relatively good health never came back alive.
3. The rejection of the response by the population was also largely due to a communication problem. Some of the response staff, especially those in charge of communication and outreach, were not even able to properly explain the symptoms of the disease. This inability sowed confusion among members of the community, leading some to question the diagnosis made by the doctors.
4. The rejection of the response is also part of the chaotic political and electoral context. The Ebola epidemic emerged in an electoral context where the population of Beni and Butembo, very opposed to the Kabila regime, were prevented from taking part in the presidential and legislative elections. This decision to prevent this part of the country affected by the Ebola virus from participating in the elections has helped fuel suspicion and ultimately animosity towards the response teams because of their links with the government.
5. The interventions of many organizations involved in the Ebola response were not conflict sensitive. Not only did they lack the capacity and skills to implement the "Do no Harm" principle, but they also did not involve peacebuilding organizations in the preparation of their interventions in order to introduce a conflict sensitive approach
6. Some areas that did not report conflict before the outbreak experienced violent conflict after Ebola cases were reported and response teams arrived. This shows that a huge public health problem like the Ebola epidemic experienced in eastern DRC can destabilize even regions

deemed to be stable and generate conflicts there. Whether they appear before or after the outbreak of the epidemic, these conflicts make surveillance, contact tracing and vaccination difficult.

7. As much as the response generated new conflicts and amplified old ones, these conflicts contributed so much to the spread of the disease. Ebola transmission rate was known to be higher following violent events. For example, as a result of the attack on the transit center of Beni in August 2018, the average reproduction rate was, twenty-one days later, between 1.12 and 1.23 in this district, while it was between 0.81 and 1.08 in all the other regions.
8. The inability of health workers to speak the local language created a psychological barrier in accepting treatment or even the disease. The people believed that this was a form of domination or a mockery towards them, and that the caregivers wanted to highlight the ascendancy that their language would have over that of the local population.
9. Pride and unwillingness to socialize on the part of the agents of the response is another significant pitfall. These agents accepted no blame, said they could not accept any guidance from local experts; they treated people without the intention of making an effort to communicate humanely with the patients; at the beginning almost all of them were new to the area and used only French, without an interpreter, to communicate with the local populations, most of whom were indigenous and poorly educated.
10. The collapse of the communication system and mistrust of medical staff contrasted with the noble ambition of the response mechanism, to save lives. The agents assigned to the response did not have time to contact the populations and explain to them why they were there and what their mission was. No explanation for the evolution of the vaccine stock, the slowness in the transmission of test results, all signs of an ineffective response and not very reassuring in the eyes of the population
11. Shenanigans and other small arrangements known locally as "Ebola business" were at the origin of the perceived resistance and the violence manifested. Much of the population believes Ebola was created as a cash-raising strategy "
12. Owing to opulence, some workers in the response had indulged in ostentatious behavior and debauchery. By behaving in this way, they made the population unfriendly and distant towards them.
13. The effect of the response system on the local labor market is negative and consists of a double frustration on the part of local bosses: by granting large salaries to local staff, the response system has robbed local businesses a cheaper and more experienced workforce; and, inspired unusual social demands on agents who remained loyal to local bosses.
14. The Ebola virus disease was a business opportunity that escaped local entrepreneurs and workers: a good part of these markets were taken by agencies and workers from distant cities of Goma, Bukavu or Kinshasa.

On the basis of these results, the following recommendations were made:

a. Ebola was just one of the emergencies in northeastern DRC:
   In the hope of gaining the trust of the community, the approach focusing only on a public health crisis like Ebola and ignoring other community issues is not effective. Efforts must be made to ensure that the medical response goes beyond the fight against the disease, the care provided must be comprehensive

b. Community engagement must be the cornerstone of any response, otherwise mistrust, anger, protest and violent conflict can undermine the response:
   The involvement of local leaders and actors who trust communities is crucial to ensure that communities adhere to protection measures and accept the response

c. Care should be decentralized:
Decentralization of care for suspected Ebola patients is not only an effective medical strategy to quickly identify and treat infected people, but is also proving to be an important tool in building community confidence.

d. Respect for patients is fundamental:
Even in situations requiring urgent actions and having major public health implications, Ebola patients (suspected and confirmed cases) should be treated and respected like any other patient, and not treated as biological threats.

e. e. staff recruitment and contract award:
e.1. the recruitment of staff who will work in the response should be done with the greatest transparency by proceeding through all the traditional stages of the selection process: for a country with a high unemployment rate, the transparency of such a process constitutes a guarantee confidence and reduce the tension that emerges in such circumstances. For some positions that do not require great skill and expertise, favor local or community recruitment.
e.2. With regard to the organization of markets for orders or vehicles for hire, it is recommended to take into account the contextual aspects. For orders of drugs or heavy and delicate equipment, proceed by calls for tenders at the national level; but for cars for rent, fuel, calls for tenders can be provincial or even local

1. Introduction

For several years, Ebola has struck the Democratic Republic of the Congo on a regular basis, and particularly certain areas in the east and west of the country. The consequences of this epidemic are numerous: loss of human life is numerous and the economic losses are incalculable, in a context where populations live in indescribable poverty. The persistence of this disease and the devastation it causes reflects the weakness of our health systems, unable to respond to epidemics of such magnitude. Since 2018, the provinces of North Kivu and Ituri have been facing the tenth episode of the Ebola virus which has already killed more than 2,280 people. Most of those infected and dead from this virus have been infected because of the denial of the existence of the disease and failure to comply with protective measures. Note, however, that the respect and application of protective measures against this disease depend largely on the confidence and above all on the perception that the population has of the disease, the response system and especially the quality of care they receive.

The city of Beni in the province of North Kivu and the surrounding areas which have been affected by the Ebola virus disease have also been the scene of several violent conflicts which have claimed many victims among the local populations. The Ebola virus therefore appeared in a social and political context already weakened by violent conflicts. In Beni, the response was made difficult by riots, the stoning of vehicles and even the murder of some response workers. Factors that fueled this social resistance included lack of confidence in the quality of care in treatment centers (CTEs), lack of confidence in the response team and mistrust of the strangers who came, according to the population, to benefit from the epidemic, and finally from the more economic dimension that this response had taken.

This report analyzes important elements that emerged from qualitative data collected over more than two months in areas affected by the virus. These include the perceptions of the population in relation to the care provided and the behavior of staff, and the business-like behavior of actors, well known under the generic term of "ebola business". Beforehand, the methodological approach of the study is presented in the next section

2. Methodological approach

2.1. Study area and methods

The main research setting was the city of Beni, in the province of North Kivu, which was one of the epicenters of the epidemic and serves as a base for many response organizations. In Beni, research was carried out at the Transit Center, at the Ebola Treatment Center) and at three Integrated Transit Centers (smaller decentralized transit centers accommodating up to 6 beds and located in an existing health center). We also conducted interviews and participant observations at various sites in Kayna and Mangina (also in North Kivu province) and Madima, in Ituri province.

2.2. Data gathering

We conducted 76 semi-structured individual interviews and 28 focus groups between July 2019 and October 2019, lasting approximately twenty minutes to an hour. The data was collected by a team of researchers that included six Congolese researchers and two German researchers, led by a German principal investigator and a Congolese researcher who reviewed the data as it was collected to ensure consistency in the process of collection within the team. We also performed participant observations in clinical settings, at stakeholder meetings, and at community meetings. 20 sets of field notes were collected.

Verbal informed consent was obtained from all participants. Verbal consent was chosen due to widespread illiteracy among community members and because the experiences of armed conflict, Ebola virus disease and political instability in the region created suspicion among some participants in the research. Participants were informed of the potential risks associated with participation and of their right to withdraw from the study at any time without any consequences for them personally. Specific consent was also requested for the recording of the data. When participants agreed to be recorded, the verbal consent process was also recorded. In other cases, a written consent note was collected.

2.3 Recruitment and study participants

The main participants in the research were (1) healthcare workers (2) survivors and family members of patients; (3) other members of the Community. A full list of participants is available in Table 1 (below). Health and medical staff were contacted through the facility's management team. Community members were approached by trusted community leaders and by local contacts of the Congolese research team. The survivors were approached by the association of the victors; a formal organization to support Ebola survivors.

Table 1. Research participants

Participants	Number
Armed groups	1
Authority	16
Community members	6
Dignitary	3
Victims families	5
Workers in the health sector	28
Journalists	2
Community relays	3
Leaders of churches	3
Workers for the responses	31
Survivors	13
Traditional healers	2
Young	5
Total	124

2.4. Data management and analysis

Interviews and focus groups were conducted in French or Swahili. This material was then transcribed, the data collected in Swahili being translated into French at the time of transcription. Brief handwritten notes were collected during field visits along with photographic data. More detailed field notes were written in French or dictated in English using a voice recorder, then transcribed into MS Word. In both cases, detailed field notes were produced as soon as possible after the fieldwork. The researchers used predefined topic guides to structure the interviews and focus groups, but iteratively probed and asked additional questions when new topics of interest emerged. The participant observation was guided by pre-defined research questions developed in our protocol. After transcription, the data set was uploaded to NVIVO12 and analyzed by topic. The initial themes were identified during a data analysis workshop involving the entire research team. The researchers theme-coded a selection of data individually before comparing them with others to refine the codes and create a set of shared themes. The remaining data was then analyzed by a subsection of the research team against these codes. Regular discussion of the data analysis by the whole team led to the addition of a few more codes during the research process.

2.5. Ethics approval

Ethics approval was obtained by the Research Ethics Board of the University of Oxford, UK and via Pole Institute, Democratic Republic of Congo. Pole Institute is mandated to conduct research on political, economic and cultural issues in the DRC, including health related issues through the Ministry of Justice and has obtained additional authorization from the DRC Ministry of Health to conduct this research.

3. Perception of the quality of care

3.1. Rumors and perceptions of the quality of care

At the start of the pandemic, rumors of all kinds were circulating about the quality of care provided to people infected with the virus. These rumors seriously eroded the perception that communities had of this pandemic. For example, it was common to hear that transferring someone to a CTE implied their immediate death (people knew that only 10% of patients who recover in a CTE, which was not true). Moreover, the families of the patients complained that they did not receive good medical follow-up. Therefore, very often a large part of the population thought that doctors did not want the disease to be eradicated so that they did not lose their jobs. This kind of rumors not only affected the confidence that the communities had in the response system, but also aroused a fear, a consequence of these rumors, of the latter towards, not necessarily of the disease, but rather towards the structures (CTE, CT, etc.) put in place to eradicate the virus. The combination of these two elements (rumor and fear) seriously affected the perceptions of communities towards the entire response system.

3.1.1. Lack of confidence: the basis of misperceptions about the response system

The city of Beni and many other villages around this city affected by the Ebola virus disease were, for a few years before the Ebola epidemic, faced with violent conflicts which caused the death of many

people. In such a context of insecurity, the populations did not trust the government security organs, NGOs and any initiative taken by the government. Therefore, this context did not facilitate community support for the Ebola response, in particular because of the bad information circulating about Ebola which was exploited by manipulators of all stripes. Violent incidents such as attacks by response teams have negatively affected the work of aid workers.

We have noticed a low level of trust in any government institution and a widespread belief in disinformation about Ebola virus disease. The provincial and national authorities, all close to the former regime of President Kabila, did not have the confidence of the populations. The latter had rather confidence in the community authorities close to them. It was in this context of great mistrust of the regime in place at the time that the response to Ebola took place, which was managed by WHO in partnership with the Ministry of Health. It was therefore not surprising to see that any initiative taken by the government was rejected by the population and that such a partnership could not facilitate a relationship of trust between the response teams and the communities.

The community's mistrust at the start of the Ebola epidemic of all UN agencies and humanitarian organizations involved in Ebla's responses was high. In fact, in the response to a major epidemic, there is a dilemma between the need to act quickly and decisively and the need to involve the affected community in participation and decision-making. For this 10th Ebola epidemic in DR Congo, the response teams decided to act quickly and ignore the community, and their lack of understanding or knowledge of local cultural practices by non-locals or non-nationals hampered the effectiveness of the response at the start of the epidemic.

Conspiracy theories circulated during the response. Some key informants with whom we conducted interviews completely rejected the existence of the disease, others believed that it was a creation of the whites in collusion with the power of Kinshasa to exterminate the Nande population who opposed the regime of Kabila, others finally thought that it was a fabrication of NGOs to be able to earn enough money; it was not uncommon to wait in the streets of Beni and Butembo for the concept of "No Ebola, No Job". In addition, the fact that food was given to the vaccinated people and the high salary paid to response agents led the population to believe that Ebola was an invention of those who benefited from the system.

Mistrust was the main factor behind the resistance and opposition of the population to the Ebola response team. It should also be noted that this opposition was justified by the behavior of the intervention team, which did not take the time to understand local cultural practices. These include traditional bush meat consumption, regular gatherings at family or village events and, especially with regard to the risks of Ebola transmission, traditional funeral practices. This mistrust was central to destroying any legitimacy the response team needed to do their job. Indeed, without confidence in the response team, it was difficult to control the disease and its eradication was delayed. It should also be noted that this climate of community mistrust in medical personnel and in the quality of care has generated conflicts, sometimes violent, in areas affected by the virus. This link between trust, perceptions and conflicts will be analyzed in subsection 3.

In a climate of generalized mistrust during a public health crisis like the one experienced in Beni, curative and preventive interventions are rejected by the population. For example, the vaccine and the quarantine of sick patients were often the subject of public criticism and rejection. This is all the more true since when the response team has changed its work strategy (making community sensitization by using known sensitizers in the community, decentralization of care to bring diseases closer to health structures and the health workers to whom they are accustomed), it began to gain the confidence of the population, and it was quickly found that it was becoming easier to convince the population about certain aspects of the disease such as for example the modes of its transmission, the protective measures, etc.

General mistrust of the Ebola response came to a head when armed groups began to attack ETCs, killing patients and health workers. Thus, for example, the city of Butembo saw these two CTEs attacked between 23 and 27 February 2019, causing the flight of patients and therefore contributing to the spread of the disease. People interviewed for our research mentioned that part of the population was happy because they felt that by attacking and driving out the NGOs involved in the response, they had driven the virus out of their community. This was obviously false, because the rate of contamination increased just after these attacks.

Let us end this section by emphasizing that the results of our research show that a good understanding of local perceptions on the measures taken to tackle a major health crisis, and of the local culture is important to effectively lead an effective response to a health crisis. major public health of the Ebola type, and above all to be reassured of its appropriation by the population and its relevance.

3.1.2. Fear: a consequence of chaotic communication

Fear was central to the community resistance observed during the response to the tenth Ebola outbreak in DR Congo. In interviews with patients and their family members, it was found that the reluctance to comply with the early isolation of the sick, the refusal of the family to take the sick person to the treatment center, vaccination and the rejection of other health measures proposed by the response team were more evident in people who have lost family members to Ebola virus disease. The fear and psychosis the community had of the response system also eroded confidence in the response team. Indeed, for the population, mortality was very high and contagiousness very high, while according to specialists, the mortality and contagion rate was far below that of diseases such as measles for example. The elements defining this fear could vary from one zone to another, but in general what emerged systematically in the discussions with the populations is the idea that, when the team brought a patient to the centers of treatment, we killed him. Indeed, many people thought that patients who entered treatment centers in relatively good health never came back alive. Such assertions were widely spread and were the basis for the rejection of the response system.

Moreover, the rejection of the response by the population was largely due to a communication problem. Most of the interviews we have done show that the behavior of the population, their perception of the quality of care, and the effectiveness of the response system as a whole have been largely influenced by the way in which communication around the disease has been made. Some of the response staff, especially those in charge of communication and outreach, were not even able to properly explain the symptoms of the disease. This inability sowed confusion among members of the community, leading some to question the diagnosis made by the doctors. So, for example, according to the communication made by the sensitizers of the response team, an Ebola patient must be bloody. Therefore, whenever a patient did not have bleeding symptoms, his relatives did not accept that he was infected with the virus and any attempt by the response team to quarantine him raised questions and the anger of the population.

Thus, the communication errors made by the response team did not build a relationship of trust with the communities. Not all important innovations, for example, were highlighted in the communication strategy to gain popular support. Some interesting practices such as making individual rooms available to patients, which has made it possible to reduce the nosocomial transition, i.e. we no longer put together, the existence of an effective vaccine, etc. have not been communicated to the population.

It should be noted, however, that at the time of data collection for this research, the majority of the population was already aware of the existence of the disease, and of the protective measures to be taken to avoid the virus. Some people we interviewed, for example, have a clear understanding of the disease and what to do to avoid infecting loved ones. A young student we met in Beni, for example, told

us very clearly what to do to put an end to the contamination of the population: identification and isolation of cases, control measures in hospitals, identification and follow-up of contacts and, above all, secure burials.

3.2. Trust, community perceptions of the Ebola response and local conflicts

The Ebola epidemic in North Kivu was declared barely 8 days after the end of the 2018 epidemic in Equateur province. The outbreak in Ecuador was successfully brought under control in 2.5 months with adequate contact tracing and the deployment of vaccine use.

The Mabalako health zone in North Kivu province was the initial epicenter of the Ebola epidemic. While Ebola was almost under control in the health zones of Mabalako (Beni) and Mandima (Ituri) at the end of August 2018, its incidence increased rapidly in the health zone of Beni between August and October 2019 This wave coincided with the intensification of the conflict in the region. More specifically, Beni experienced a deadly attack by the ADF on September 22, 2018, which resulted in a dead city of 5 days from September 24, characterized by movement restrictions. During this period, case isolation and vaccination were severely hampered.

It is also important to mention that the Ebola epidemic emerged in an electoral context where the population of Beni and Butembo was prevented from voting in the presidential elections while the legislative elections had been postponed. For the Beni region, the mistrust and anger of the population associated with the behavior of the response team and the decision of the governments to prohibit the populations of the affected provinces from participating in the presidential election have contributed to fueling the conflicts during the Ebola epidemic. We have seen, for example, that violence and tensions around the Ebola response increased just after the ban on elections in Beni and Butembo.

Therefore, animosity over the postponement of an election in the region was directed towards the response teams because of their ties to the government. For example, residents have linked teams from Medicines Sans Frontiers (MSF) to the DRC's Ministry of Health, eroding local cooperation and increasing violence.

Interviews we conducted with key informants revealed a relationship between lack of trust in the response system, the negative perceptions that this lack of trust engendered, and community conflicts.

In the areas most affected by the Ebola virus, the work of aid workers had become difficult even before the Ebola epidemic, as they could not access certain places under the control of armed groups. Unfortunately, during the Ebola response, not all of these areas were secure. Consequently, the context in which the teams of the operated were very risky due to the recurrent attacks by the armed groups. Threats against NGOs have become numerous and recurrent and the assassination of some intervention agents has ended up discouraging many NGOs from doing any work.

However, it is important to mention that the interventions of many organizations involved in the Ebola responses were not conflict sensitive as they did not have the capacity and skills to implement the “Do no Harm” principle and do not involve peacebuilding organizations in the preparation of their interventions that could help them introduce a conflict sensitive approach. Consequently, new conflicts were generated in the communities affected by Ebola and were not addressed accordingly either because all the attention of NGOs was directed towards the responses against Ebola while ignoring other problems or challenges in the communities. communities, or because organizations involved in peacebuilding activities did not have access to sufficient funds to manage the conflicts generated by the Ebola response.

Note that during the Ebola epidemic, we noticed that the number of violent conflicts was twice as high in the infected areas than in other areas. It is interesting to see that some areas that did not report conflict before the outbreak experienced violent conflict after Ebola cases were reported there and response teams got there (Mandima, Katwa, Mambasa, Masereka). This shows that a huge public health problem like the Ebola epidemic experienced in Beni can further destabilize already fragile regions and fuel conflicts. These conflicts made surveillance, contact tracing and vaccination difficult. It is well established that the identification of cases was even more difficult in areas too dangerous for health workers to enter or work.

For example, at the onset of the disease, civil unrest contributed to delaying reporting of the epidemic by 3 months. During the outbreak, several conflict events, including attacks on ETCs or healthcare workers and protests by healthcare workers, had a direct impact on the public health response.

Furthermore, it should be noted that as much as the response generated new conflicts and amplified old ones, these conflicts also played an important role in the spread of the disease. Ebola transmission rate was known to be higher following violent events. For example, there was an attack on in August 2018 in the city of Beni. And in 21 days, the average reproduction rate was between 1.12 and 1.23 in this district, and between 0.81 and 1.08 in all other cases. This suggests that violent events increased the rate of transmission in the weeks following a violent event. After the destruction of the Ebola health center in Katwa, for example, the Ebola response team needed a minimum of a month to fully resume its activities.

4. Local perceptions of the behavior of response agents

As part of the research on the humanization of the Ebola response, relevant elements emerged which, in a positive or negative way, influenced the attitude, judgment, but also the appreciation of populations affected by EVD., face to the teams involved in the response, and the response process as such. Indeed, the first teams to intervene in the response were mainly foreigners; this phenomenon immediately aroused the attention and observation of the local populations who were quick to judge the behavior of those who were now called to be their closest allies in the fight for eradication. EVD; this reality was therefore the subject of several perceptions, which the populations informed us in various exchanges during data collection. In the following lines, we analyze the main aspects around which these perceptions of the behavior of the agents of the response were centered.

4.1. The language spoken by the Agents Assigned to the Response (AAR)

At the start of the response process, a large majority of the agents, if not all, were foreigners. They did not speak the local language, nor could they understand it, which made the doctor - patient dialogue very difficult. Thus, the failure to take such evidence into account by the response was poorly perceived by the local populations, given that arrangements could be made, by introducing from the outset local agents even as translators, in order to allow fluid exchanges between the two parties.

The nursing staff had difficulty in communicating well with the patients, and the fact of not making any communication effort, or of not putting in place any palliative communication strategy, transmitted a kind of frustration to the populations, since they did not did not understand each other with the people in front of them. During an interview, a patient expresses himself: “They spoke only in French and Lingala only, it was a hobby for them; they couldn't even write our names well”. People therefore became skeptical, believing that it was a form of domination or mockery towards the patients, to want to highlight the fact that the doctor's language had ancestry over that of the local populations. The inability to speak the local language created a psychological barrier in accepting treatment or even illness. The

local populations seeing in front of them foreign faces and who did not even know how to pronounce their names, very quickly concluded that these people were not trustworthy, and therefore, all they could say n ' was nothing credible to them.

4.2. From the opulent character of AAR

In general, it is known that the populations of the Far North are discreet, do not make much noise, and most often avoid being noticed. The response team, mostly from Kinshasa, came from the west of the country, which is a rather hot area, with a culture far different from that of the populations of the east among whom it was called to work. As soon as she moved to the city, people quickly knew how to identify them in the midst of a group. Thus, not having had to anticipate this cultural affront, nor put in place any integration policy, she immediately made the local populations feel that she came from afar, and from her first impressions. it hinted at, the latter quickly positioned themselves as meticulous observers of their hosts.

Certain facts did not fail to attract the attention of the populations in particular. We can start from a few quotes that came up several times in the discussions with them: “They had a lot of phones, they wore badges, bought a lot of beers and therefore used a lot of money in the drinking establishments; During their interventions, it was enough for a single case to be announced to them, for them to unload in the neighborhood with 15 jeeps at the same time, one wondered, what were all these vehicles used for to rescue one person; they spoke in a strange language, shouted loudly and made a lot of noise; knowing where they were did not require any particular effort, they automatically stood out from the others; their influence in the community has perverted the mores of young girls and destroyed several homes; women began to dress in trousers, to meet the preferences of these foreigners and attract their attention; As soon as they got down to these retaliators, they suddenly had a lot of money; also, they were easily engaged in the response even without any experience; how could we believe in these teams? ”

By analyzing this brief description by the local populations, of the teams that came to intervene on the front line in the response, we immediately understand that their attitudes very easily aroused the questioning of the populations, who deduced that this mission had a lot of money. and that the agents of the response were more busy enjoying it than fighting the disease. This has contributed to the emergence of a hypothesis that has significantly contributed to destroying people's perceptions of the entire Ebola response process; they thought out loud, saying: “Ebola is a business here in Beni, and not a disease; the people attached to it came to make money by exterminating us; for us, this scourge does not exist, it is a disease that they invented to enrich themselves. They will never want to see it end, which is why, even the unaffected cases are always declared positive, they seek to inflate the number of patients to raise more money to spend excessively as they are doing in front of our eyes.

Thus, the outreach teams, when they visited the neighborhoods, were not well received; they had difficulty conveying the message, talking about the disease, the risks and dangers to be avoided, the protective and preventive measures to be adopted, etc. There was a strong resistance easily perceptible from the populations, they did not want to hear anything, did not accept sensitization or vaccines, and some became aggressive towards the teams in the field. To be able to bring his patient to a CTE, he had to manifest a very critical state of health, after self-medication and then the traditional practitioner had uttered their last word.

All this did not fail to have unfortunate consequences in the management of the crisis itself; this manifest lack of confidence of the populations towards the caregivers did not encourage the positive progression of the treatments, but rather caused situations of delays in the detection of the cases, and by ricochet, the increase of the rates of contagion within the families and the close relations patients

who camouflaged themselves, which had as consequences, enormous increases in mortality; leading to a lack of trust in caregivers.

4.3. Pride and refusal of integration

The populations felt that the opportunity was never lacking for the agents of the response to demonstrate their pride; "They didn't accept any reproach, said they couldn't accept any guidance from us; they came to educate us and treat us, with no obvious intention to make any communication efforts; they were whites, blacks, all foreigners and who used only French to communicate with the local populations, most of whom, natives, do not use French but rather their local languages. At all times we demanded the presence of the locals in the awareness teams, but they were content to make great strides in front of us and impose their language on us; and even when ours started to integrate the teams, they were treated with great contempt by their colleagues who did not consider them as equals; they would thunder at them in front of us, which made us very angry; they thought they were far superior to us, and for that it was almost impossible for us to get along; when someone died, they showed no compassion, it was felt that they had no feelings and that for them, they were rejoicing over the death of our people "; "The community was afraid of their way of behaving, so that someone could get sick and choose to hide rather than confront them."

From the above, it is visible that the response teams in their interventions were not sensitive to the trauma that the populations had previously experienced, with the horrors of the killings that had just passed through the area; their way of being and working with communities therefore created a kind of fear in them. Not being for the most part very educated and having in front of them people whom they considered enigmatic by their behavior from all points of view, the populations began to think that Ebola was a weapon coming to continue the massacres that the war had caused. start. It was inconceivable for them that people who came to fight a disease devastating a people, act as they did towards it. Rather than sympathizing and doing everything to create a climate of cohesion and understanding, they imposed themselves as masters, and established a divide between superior doctor and inferior population. One interviewee did not fail to mention: “when you arrive at a pygmy, to be able to eat his food, you have to behave like a pygmy, they have not been able to adapt to our environment, that's why they don't. had not succeeded in their mission”. We will understand here, that the behavior of the agents of the response had given rise to a lack of confidence in the populations in their regard, which generated in them negative perceptions which automatically became a brake as much to the appropriation as to the acceptance of the Ebola response process by them. The populations refused to welcome the agents of the response, they contested the disease, the vaccine, and even worse the care, and always ended with the conclusion according to which, all this was only theater, whose finality would one day be unveiled.

4.4. Communication and medical ethics

4.4.1. Communication

Good communication is an open door to good understanding, and poor communication or lack of communication is a source of misunderstanding. This introduces us to analyze and understand how the management of information by the response teams had created a lot of misunderstandings among the populations and led to errors of judgment on their part from the start of the process.

When they arrived in the Beni territory, the agents assigned to the response did not have time to contact the populations and explain to them why they were there and what their mission was. They immediately

began to circulate and work, regardless of the ignorance of the disease by the populations concerned. Certain facts required that they speak beforehand to the populations before anything else, and the fact of not having done so did not fail to raise doubts towards these new people, which had negative repercussions in the good management of the epidemiological crisis:

The presence of foreign teams as the front lines in the response: at the start of the epidemic in Beni territory, it was necessary to bring in doctors who had already had to deal with this disease in other regions or other countries , so that they can pass on their experience to local doctors who had never had to deal with this disease; but as this had not been well explained to the populations, very quickly they perceived it badly: "they had doctors who had come from such and such a part, from such and such a country, we wondered if we did not have doctors here. with us; These foreigners did not want the locals to take ownership of the response, given the salaries they were receiving."

4.4.2. Availability of vaccines at the start and in the middle of the response

At the start of the response, vaccines were in very limited quantities, only people likely to contract the virus, who had been in contact with an infected person, were vaccinated. But once the vaccine was available in greater quantity, it could be administered to a greater number of people. This change of situation, not having been the subject of a preliminary explanation, to create judgments among the people supposed to receive it, and all of a sudden, there displayed a manifest resistance: "Before, we asked of ourselves to be vaccinated, but we were refused it, saying that the vaccine is expensive, now, what has changed so that suddenly there is enough and that it is imposed on everyone? suddenly we are afraid, we fear that this vaccine is intended to kill us."

4.4.3. The different signs attached to the disease

At the beginning of the awareness campaigns, the sensitizers, as they could not speak the local language, distributed leaflets and hardly spoke; on these flyers, the sign striking a person with Ebola was bleeding; this is what the people remembered, and for them, there could only be Ebola if there was bleeding. With such a conception, when a family had a patient, who was diagnosed with Ebola without him showing any bleeding, they concluded that the doctors wanted at all costs to increase the number of people with the disease in order to have funding. and declared sick those who were not: "When someone dies in a center, no bleeding, they say he died of Ebola, and that we have to burn the body and the house and everything. the rest, how to explain? All it takes is a fever to diagnose a patient with Ebola; however, when you have sick children at home, water on your head is enough to lower the temperature in case of fever; but only you call for a response, directly he will be declared affected, and there it is his death if he goes to the CTE "

The populations had not taken cognizance of all the warning signs of the disease, they were in a defensive position for any assertion of cases which did not present the symptoms as they had retained them and were quick to reconsider. cause the results of testing centers.

From the burial procedure for the dead with Ebola:

To avoid any risk of contamination, the burial of the Ebola dead was very special and required maximum rigor. We were talking about a dignified and secure burial. This practice does not join the culture of the populations. It took a strong awareness to enable them to fully understand the reasons why this type of burial was inevitable; but due to lack of good communication, there was incomprehension: "People were dying as if they were in the parks, we were not informed. During the funerals, instead of cooperating with the families, they imposed their way on us, which did not match our culture; we didn't

even associate a family member, people revolted. Some of us would even check after we buried whether the body was really still there, as there were rumors that something was being removed from the body of the dead body before it was buried, which is why they only wanted to. 'none of us is present'.

4.4.4. Communication of results

Several times people complained about the slowness observed in the communication of Ebola test results; they lamented the fact that even announcing negative results took a long time, and nothing was communicated to them to appease their impatience. They could reach up to 3 days in complete uncertainty; what led them to conclude that if the results were dragging so long, it was because the doctors intended to change the results and have a large number of positive tests to justify the funds they were using.

These examples illustrate how the lack or poor communication of the teams has provoked a kind of apprehension of the response by the populations, which has aroused generally negative perceptions of them.

4.5. Medical ethics

Regarding the lack of medical ethics, the populations had not stopped complaining about the attitudes of the nursing staff assigned to the response; they reproached them for several facts. For example, in hospitals where care was free, given the neglected treatment that was reserved for them, they chose to go to private health centers: “free care did not encourage people to go early to the hospital. hospital, because the doctors in these centers neglected the patients; and suddenly, for us, free care implies the poor quality of care of which we are wary and prefer to go to private health centers”.

Foreign doctors tended to display a certain superiority in front of their patients; for example, they pronounced the names of patients with great contempt on the pretext of linguistic incompatibility. For a native, there was no worse insult to him than this gesture, which immediately broke any trust he could have in his caregiver.

4.6. Foreign connotation in the response process

When the epidemic began in the territory of Beni, the first teams to be deployed on the front line were all from elsewhere and therefore foreign to the local populations. This made the start of the process very difficult, as the teams were not accepted on the pitch. People did not understand why, even for awareness raising, locals were not involved, who could better express themselves and convey the message well. In some neighborhoods, the response teams could not set foot there without being accompanied by locals, otherwise they were stoned: "luckily you came with someone from our region, why are foreigners coming?" make us aware? We have no shortage of people capable of doing it here”. Indeed, taking into account the political situation that was going through the territory of BENI, bringing in foreigners for such a delicate mission, without having previously prepared the local populations to receive them, was a very great awkwardness, which risked to handicap the success of the response process, by the refusal of the populations to collaborate because they had the impression of feeling invaded and perceived this phenomenon as a new incursion coming to exterminate them again. The solution to this problem was nothing more than a reshuffle of the teams, it was necessary that the natives feel represented to give a certain credibility to the teams of the response.

4.7. From the integration of the premises to the response teams

From the moment when the response teams realized that only foreigners could not succeed in making the local populations adhere to the cause for which they were present in their territory, they felt obliged to introduce among they create new local units both within the frameworks and the grassroots staff. This adaptation did not fail to produce very positive effects within the communities, who were not only satisfied by the fact that their complaints were finally taken into account, but above all by the fact that the sons and daughters of the community could also access these positions and guarantee territorial representativeness within healthcare teams. This considerably increased the degree of confidence of the populations, and their level of ownership of the response against the Ebola virus. As soon as this was acquired, things changed completely, we witnessed a change in the behavior of the populations, who became involved in a strong sensitization on barrier measures, and an awareness of the risks of contamination of the disease; this resulted in a gradual drop in the contamination rate, until the situation was fully under control.

From the above, we understood that the perceptions of the populations towards the response teams, most often started from the fact that they caused a crisis of confidence in the populations, through the behaviors and attitudes manifested towards them... Likewise, it emerged that the success of such a crucial mission is the result of close collaboration between parties, where each feels considered, represented and respected. The fact of being foreigners can in no way impact the consideration of the local populations with whom we are called to work, if on our part we are open, transparent, collaborative and especially if we take into account the possible susceptibilities of the environment in which we are called to work on while taking care of a non-negligible aspect of local involvement.

5. Ebola Business: an implacable pitfall in the Ebola response mechanism

The Ebola virus disease response has been marked by significant episodes of violence. Several reasons, some as relevant as the others, are given to explain it. We note, for example, that the area of prevalence of this epidemic has long been a space of violence. Until the day the first case of ebola virus disease was discovered, attacks and killings carried out by members of the Allied Democratic Forces-National Army for the Liberation of Uganda (ADF-NALU) remained a grim reality for the population of the region. Already frightened and weakened, this population was in a psychological state which could not allow it to believe in anything, if not in another cruel plot against it. In any case, we can also learn from this statement from a grassroots authority, when he reports the opinion of the population about the escorts organized by agents of the response mechanism to recover a suspected case: “They are from Boikene, from Paida. When the population sees them they are afraid, they say that: it is the president [Kabila] who sent them to kill us "

The exasperation of the population was such that it wondered whether the government was incapable of stifling the two plagues at the same time, the massacres committed by the ADF-NALU, on the one hand, and the cascading deaths caused by the ebola virus, on the other hand: “that the government attack both massacres at once; the money we commit for Ebola, that we also commit for insecurity "

The population criticized health workers for taking advantage of the Ebola epidemic to enrich themselves at the expense of the population. Shenanigans and other small arrangements known locally

as "Ebola business" are said to be at the origin of the perceived resistance and the violence manifested. An official from a United Nations agency contacted on this matter noted:

This rumor stems from the fact that there is a lot of money surrounding this disease, but as a humanitarian I don't think it's business. Maybe it's business for some, but for us who are in international humanitarian organizations there is no business. "

Beyond that, the local business world which, accustomed to a cheaper workforce, has seen a good part of its workforce slip away in favor of occupations that are certainly precarious, but better paying in the gigantic machine than is the retort. Everything appeared as if the epidemic had opened up various economic opportunities to everyone except the local business and intellectual elites and, far from it, a significant portion of the poor population in the area. It should be mentioned that the poverty rate in North Kivu is 73% while the national average is set at 71%. In a context of mass unemployment, it is easy to understand that the difference in perception depending on whether or not one is integrated into the response system could lead to a surge of jealousy and antagonism that is difficult to stop. Wanting to know what people are saying about the ebola virus, young people gathered in Mambasa (Ituri) for group discussions replied: "Some people say it's just a strategy to find the money"

The objective of this section is to identify the various aspects likely to shed light on the business spirit which characterized the response system and to show how it makes it possible to understand the great resistance which prevailed throughout the period of the epidemic. Among other things, the ostentatious behavior of the agents, the disorientation of the local labor market, the diversion of vehicle rental opportunities, but also the logic of remote-controlled recruitment, so many revealing signs of the busyness that would have irritated the local collective conscience and if necessary, handicapped the response mechanism.

5.1. Ostentatious behavior of the agents

One of the identifiers of a company is its way of consuming. The area that has been shaken by EVD is very characterized by discretion and sobriety. That way, we don't show off our wealth and we hardly talk about it. The Nande people are known as such. Nande magnates are generally ordinary people both in their experience and in their consumption. They are very unnoticed and unsuspected. In this context, the consumption behavior of personnel, medical or not, engaged in the response departs from local tradition. Some have found it scandalous, ostentatious.

It was not uncommon that one evening in a pub, an official of the retaliatory system paid for beer by presenting a one hundred US dollar bill (us $ 100.00). This ticket is of very high value and is only used in large orders. Using it to buy a bottle of beer, worth less than a dollar, is an incredible display of wealth. Such a demonstration attracts curiosities, arouses jealousy especially since these officials have come from elsewhere. They are taken for "strangers" who enjoy a resource that could have gone to local children, the local experts. On this subject, a local authority, in Beni, mentions: “according to my analysis, the response was envied by everyone, it gives rise to well-paid work. These foreigners did not want the locals to take ownership of the response given the [high] salaries they were receiving ... the people working in the response did not want the epidemic to end "

This same perception is confirmed by the young people of Mambasa met for a group discussion about the prevalence of EVD in their environment: “given the way the response works we think that some of them do not want the disease ends because the response agents receive a lot of money. "

Besides, this opulence inspires more than one. Some officials in the response had become debauchery, going so far as to court married women at the risk of incurring the wrath of their husbands. Because, in the region, the married woman or in cohabitation is sacred: “The behavior of the agents of the response

has changed. Out of pride, they even take married women, educate the population with large telephones, they do not know how to demean themselves" (FG communautaire-Beni).

As this quote indicates, ostentation was at its height: debauchery, the display of high-value goods such as telephones, self-importance and pride, all vices that scandalized the population day in and day out.

5.2. Ebola, mistrust of young people and frustrations of business owners

The city of Butembo and Beni are very commercial. Butembo is particularly well known as a hub in the eastern part of the Democratic Republic of the Congo. One meets their innumerable traders, representatives of important industrial houses of the Middle and the Far East. For ages, Butembo has in fact remained a large market for eastern DRC, one of the country's most prosperous towns. This prosperity is built on a very young and underpaid workforce. Basically, this is generally a family workforce that is paid on a voluntary basis, without any reference to the requirements of the law in this area. In most stores in Butembo and Beni, the monthly salary per employee rarely exceeds the amount of thirty US dollars ($ 30.00). In some cases, the remuneration is limited to a simple daily payment of the food ration and a promise of other favors (not clarified) in the future life of the worker.

With the advent of the Ebola virus disease response system, many of these young people saw a much better paying job opportunity. For those who could be enlisted there, they could earn up to five times the salary they obtained from their former business owners: "we recruit young people in all the communes of Beni, it is a way to us to be able to integrate young people into the community"

Despite the precarious nature of the employment obtained, it could guarantee the young people recruited at least one hundred dollars (us $ 100.00) each. These young people could be recruited as sensitizers, landscapers, etc. Two consequences emerge from this reality. On the one hand, many young, former shopkeepers recruited into the response system found themselves relatively richer in a few weeks of work compared to the many years spent in the service of their former bosses. They thus built up capital which, at the end of their contract, could allow them to orient their professional destiny differently. On the other hand, this socio-economic rise of the lucky young people created envy among those who remained to manage the stalls so that they could exert pressure on their bosses in order to obtain an increase in remuneration. Business owners are thus under a double pressure: it is impossible for them to bait and bring back their experienced staff to their treads, on the one hand; they face the discontent of the staff still at their service in order to improve their working conditions. Also, traders accumulated frustration while young people developed mistrust of them and sometimes challenged them.

5.3. Ebola virus disease, a missed income opportunity for the Nande bourgeoisie

The Butembo-Beni area is one of the landmarks for wealthy people in the Kivus. It is a commercial empire whose notoriety has gone beyond the Congolese borders. Open to the outside by the border of Kasindi in North Kivu and Arua in Ituri, all makes of vehicles, as far as they can drive on the rocky roads of the area, are present there. The response system has hired a lot of land vehicles for its operation. All stakeholders should have them to deliver effectively in the area. From Mandima to Kayna, via Mangina and Katwa, the roads are impractical and require the use of suitable machinery. It turns out, however, that most of the vehicles engaged in the response system are owned by Goma or Bukavu. Butembo is distant from Goma and Bukavu, approximately 400 km and 600 km respectively.

A day's rental vehicle costs at least one hundred US dollars (us $ 120.00). A jackpot. And, in the general opinion, in Beni and Butembo, it is not understandable that for a misfortune which strikes the local community, all the deals, in particular that of car rental, are concluded outside these two towns. Offers for which the answers can be found locally should be reserved for them. Ebola virus disease was a business opportunity that local businessmen wanted, at least in part, to seize.

5.4. Staff recruitment

5.4.1. Errors in the process…

Upon notification of EVD by the ministry, the recruitment of personnel for the Mangina response appeared to have been criticized. However, the coordination seems not to have learned the lessons of this experience to adapt the recruitment later in Butembo.

In Mangina and Beni, non-local experts, doctors and epidemiologists were favored. The approach adopted revealed an uncooperative and sometimes even authoritarian aspect from the start. The experts said "do this", "do that" instead of "do this" or "do that". It made the population feel like they were facing strangers. The coordination of the response did not initially involve influential local actors in the development of the strategic response plan. The decision to implement the zonal approach, that is to say to use the structures of the health zones where community mobilization is strong, was taken late. The late-recruited teams subsequently denounced the discrimination to which they were subjected. The press release n ° 06/2018 of the inter-union health coordination in the health district of Butembo of September 05, 2018 is proof of this. In this open letter, calling on the Congolese government, financial partners and the coordination of the fight against the epidemic, the nurses threatened to withdraw from the response process from the start. This discontent must be located not only among nurses but also doctors in Far North Kivu who felt left out. Although the coordination in Beni tried to take this dissatisfaction into account, the approach had already produced effects on public opinion.

In its beginnings, the response used the politico-administrative approach with the help of national coordination, whose key players in raising alerts were the mayors, the heads of districts and cells. Civil society organizations seem to have been forgotten. However, the latter are closer to the population than the heads of districts and cells who are appointed not on the basis of skills but on the basis of political calculations. The zonal approach consists of strengthening the existing health system.

While the team should gradually adapt the approaches, they seem to have accumulated more errors especially in the Katwa health zone. During the research carried out in Rughenda, participants decried the errors in recruitment and processing. The population claimed to be frustrated and to have adopted a self-defense strategy in the face of those it qualifies as “invaders”. Indeed, in Katwa the participants kept saying: "We have nurses and doctors whom we know well here at home and who treat well. Where are they? They send us young girls who are friends of these people without any medical training”.

These statements are corroborated by an interview with an agent assigned to the transit center managed by the NGO Alima in Katwa, who noted that "out of 32 agents working at this center, at least 28 had come from Beni and Oicha. The team from Oicha would be recruited through a girlfriend of one of those responsible for the response. " Another outreach officer said he overheard one of the Butembo sub-coordination officials on the phone saying, “I'm disappointed that in Butembo there is no epidemiologist. Send me 6 people from Kinshasa”.

In fact, when recruiting in Butembo, 11 positions were opened to recruit epidemiologists at WHO. Over 10 applications have been received and all applications received show that the recipients have studied at local universities. But curiously 4 were selected and the rest recruited in Kinshasa. Some hygienists

and drivers have also recruited in Kinshasa. Which explains why were considered foreigners. The business character appeared more in the remuneration of agents

5.4.2….to its commodification

The “business” character appears in recruitment when the recruited staff did not meet the required conditions and especially when setting the remuneration and payroll. For some, each end of the month, their salary was cut by 10 to 15 or even 20% for a few months to stay in the response. This has been observed for agents imported from elsewhere. A lady from Beni who was a customs declarant found herself involved in the response as a hygienist in Butembo since her cousin involved in the recruitment was a zone chief doctor. Since she had another job in Beni, she had to look for someone to replace her for 3 months. She received the salary of $ 600, leaving it up to her to give half to the person who actually worked. Examples of this kind are numerous to show how the fight against EVD has been a business that exacerbates violence at the community level.

5.4.3. Recruitment of experts or logic of intra-sibling redistribution

The prevalence of Ebola virus disease has been a demand for various types of expertise as well. Controlling this disease didn’t only need doctors or nurses. Hygienists, sensitizers, housekeepers, builders, drivers, etc., all of these skills that the system so badly needed to face the evil. The nobility of this objective contrasts however with the observed recruitment method. Indeed, for some positions, the profile of their occupants manifestly reflects a certain clientelism, if not a certain clientelism: drivers in the place of masons, cooks in place of hygienists, a communications officer daughter of the Minister of health, sensitizers formerly carpenter or plumbers, etc. And, when it comes to recruiting a doctor, the recruit is known even before the recruitment process is complete. A nurse from Malepe (Beni) mentions on this subject: "The other problem is found in the recruitment of so-called experts who do not know their work who do not know how to communicate with patients, in the field it is still us who have to show them how to do this or that. There was a bad recruitment, when you integrate someone in a team only because it is the child of an uncle or an aunt who has no experience in the matter, just so that he could benefit from the salary. This is a situation that we are experiencing on the ground (...) We are recruiting agronomists, veterinarians who have nothing to do with doctors or nurses. "

This manifestation of clientelism reflects a logic deliberately adopted in order to allow members of the siblings of decision-makers or their friends to access the precious windfall presented by the epidemic: “(…) sometimes we wonder why it is doctors from elsewhere who deal with the disease. "

In Some and Makoko, in Ituri province, where there was already such discrimination in access to employment opportunities, a nurse said curtly: “that they integrate the local experts into the awareness and think about the rehabilitation of all response agents without discrimination. "And to a victim family, met in Makoko, for a discussion to add:" normally, it is the community relays who should raise awareness, but they bring other people that the community did not know "Makoko, FG, family victim

In addition, it was noted that when for a post, the individual who occupies it is a local expert, his remuneration is 10 times lower than that which would have been obtained for an expertise coming from Kinshasa or Goma. An institutionalization of discrimination which is denounced by most of the people contacted. This is what emerges from the discussion with some nurses in Beni: "And even if the population integrates the team, we find a big difference in the payment, we are not paid in the same way, yet we will all run the same. risk". A grassroots authority in the city of Beni also mentions: "It's EBOLA business, we must avoid making the disease economic, how to reconcile the two hypotheses, the one who has studied and teach somewhere he earns 10 dollars a day but an illiterate earns $ 100 a day, that's how people don't understand how it creates conflict (…) it's business.

It goes without saying that this practice is likely to shock the conscience given that the expertise in need could be found locally and at much less cost. It is believed that one of the main reasons for the violence that characterized the onset of the ebola virus disease episode in eastern DRC is the frustrations induced by the method of recruiting response personnel. This is confirmed by a grassroots authority from Beni when she said: “when the second, third and fourth cases were observed and we started recommending that the response team employ local people so that they could 'there is no resistance;

5.4.5. Coined deaths

In the local sense, a funeral should not be secret and hasty. The burial process is a ritual that begins with the visit of the body of the deceased by the participants in the burial. This ritual provides for a cross to be placed on the grave, at least for Christians. For the Muslim, women cannot take part in the funeral. In either case, the funeral is accompanied by a funeral oration presented by a "man of God".

At the start of the epidemic, all these actions were abandoned, without any explanation to the population. Someone could come and inquire about their sick relative's condition and be surprised by a response like, "Ha! The one in room number died yesterday and was entombed last night. Sorry! ". A brutal response, indelicate and responsible for many cases of violence in Beni, Butembo and Mandima, in particular. A Unicef official whom we contacted for an interview said while commenting with us on a poster to raise awareness of the population about the disease: “with EVD, everything is violent here, the context is violent, the disease itself. Even is violent, the escorted recovery of a patient for the hospital, the destruction or the ashing of the effects of patients all this translates to violence; and... even the gestures of those accompanying the dead in the cemetery are violent.”

The establishment of the dignified and safe burial team was intended to reduce this characteristic brutality of funeral ceremonies. The burial is said to be dignified if, without necessarily being carried out according to the tradition of local use, it reflects a certain respect for the corpse so as not to offend local practices in this matter. In times of epidemics like EVD, this is a conflict sensitive burial. Among other burial practices in the region, there is a brief funeral oration said by a "man of God", the placing of a cross on the grave, the visit of the body by at least the head of the family of the deceased. , etc. Long at the start of the epidemic, burial teams were wary of these practices. And, as a result, many families hid their dead or fled with their macabé to go and bury with dignity elsewhere. It goes without saying that this behavior has been the basis of many cases of contamination.

But when it comes to deaths, an unusual practice had taken hold. It is for EDS agents to pay the dead to families to justify the extension of their contracts. Indeed, if a family has just lost a member as a result of any disease (not necessarily EVD), an informed EDS agent could offer payment to the grieving family so that they accept that the deceased died of disease with signs of EVD. This is what is reflected in this quote obtained from a focus group organized in Beni, Mubolyo: "the more deaths you report the more chance you have of being returned, this is what is said in the response meetings. »FG-Beni

Additionally, funding to the response team was observed to increase with the number of deaths. The agents involved could therefore inflate the death toll to attract more generosity from donors. Two explanations can be given for this behavior. On the one hand, a high number of deaths is an indicator that the disease is not yet under control and its control still requires additional funds; On the other hand, it can be unethical behavior whereby agents, in order to perpetuate their windfall, declare a high number of deaths. Either way, it is as if donors are buying the dead during an epidemic. This is what deplored the participants in the group discussions organized in Mukulya, in Beni: "if there is a death it is that the funding increases, we should reverse, the more deaths the more the fund decreases" (FG-Blessed)

5.5. The logistics business and procedural violation

Two areas can be identified to illustrate this business character in logistics: transport and the real estate sector.

5.5.1. Transportation

Several organizations that were involved in the response needed to use state-of-the-art vehicle transport adapted to the DRC's transport infrastructure, the roads of which are mostly dilapidated.

The choice of these vehicles was made taking into account the aspect of terrain facilitation, that is to say, all-terrain vehicles. These cars are among others generally Toyota brand: Land Cruser, HILUX, TX, etc. Strategically, some cars were used because of their strength and availability in the field. This is the case with TOTOYA RAV4 cars. Indeed, for most of them, the selection of vehicles should follow a process described as "transparent" but which, in fact, was not.

As part of the rental of vehicles during the period of the Ebola epidemic, NGOs had a logistics service or department. In their manual of procedures, for a need requiring a sum below 50 dollars, this is expressed by request at the cash desk to be served. A need that requires an amount equivalent to 50 dollars, the beneficiary must complete a purchase request. On the basis of the latter an evaluation is made before being served. Between 50 and 2500 dollars, the beneficiary proceeds to a price quotation. From $ 2,500 to $ 19,000, it is necessary to proceed with a tender to have at least three quotes. It should be noted that for a quotation, the technical aspects are essential and a price comparison is necessary to select the best bidder. As soon as these aspects have been documented, it is then necessary to proceed to an argumentation.

However, as the response required an urgent nature, most organizations used special exemptions for these different procedures on the grounds of intervening quickly for the sake of saving lives. The confusion between urgency and haste paved the way for the violation of procedures. For vehicles, the following procedure has been used generally

- The establishment of a state of need, indicating the period during which the vehicles will have to be of service. This step is qualified as a description,
- The validation stage: at this stage, the procurement office first validates and indicates the period to be displayed or indicates the deadline, the address and contacts of the people from whom to receive information. These items relate to the call for tenders. The latter is a document addressed to the general public in order to respond to the need felt within the organization itself, with the smallest possible details concerning a good or a service that we need.
- Call for tenders: the various candidates are invited to apply by depositing their files in a closed box, generally with two padlocks, the keys of which are held by various officials of the organization.
- Analysis of files carried out by a representative committee. A report should be dilapidated after the scan.
- Check-in: This is a technical step which consists of analyzing the quality and the brand of the different vehicles. This is done by appreciating the wreckage (exterior view), the engine, the tires, the dashboard but also the interior comfort and that for each company that applied. Another report is also signed after this check

- Price study: before deciding which company to use, the organization proceeds by analyzing financial documents containing various proposals. A letter of invitation for the price negotiation is drawn up and sent to the vehicle owner and again a price negotiation report is signed.
- Award of contracts: The price having been concluded, the contract is awarded to each company which has been selected which will sign the contract. This is done after re-checking the files. Hence the quality department plays an essential role in the analysis. Thus, the framework contract served as a guide, it includes the unit price, the brand of vehicles, the number of days to be performed, the responsibilities of the parties involved. etc. The contract was renewed according to the increase or decrease in need. Each time the contract was renewed, an evaluation was carried out.

While these steps were followed by some, others took the opportunity to make money. The first three stages were often violated. Indeed, it should be noted that in this market there have been cases of information asymmetry. Only informed those who had connections within the process. They had either friendly, professional or family relations. Others have been outright agents of the response or politico-administrative authorities who have used their influence to line up vehicles using figureheads. Some providers had access to information that others did not, which allowed them to prepare in advance for the conditions. This also allowed others to line up several vehicles in the response. In an interview by an economic operator from Butembo, the latter first lined up 5 vehicles at the start of the response and was able to import 5 more in the following three months. This brought him to 10 vehicles in the system in Butembo and Beni. These friendly and even family connections explain why many of the vehicles were supplied by economic operators based in Goma. Community resistance was explained in part by a grumbling from local economic operators who sometimes manipulated young people to rise up against the process. Regarding the technical control or check-in stage, the authorities having used nominees lined up vesicles without going through technical controls

The income generated by the sector attracted people known as commissionaires. These are individuals who have established themselves as commercial intermediaries acting in their own name but on behalf of other people. These brokers would have to funnel all vehicles into the process since no one could bid individually anymore. This enabled the agents to collect commissions varying from 10 to 20% of the rental price. In an interview with a woman who provided a vehicle for six months to the response, the latter claims to have signed a waiver in favor of the person who facilitated the selection of her car in the response. In this discharge we can read "I admit having a debt of xxx to pay for six months at the rate of 600 dollars per month". To renew her contract, which should be a full year, she was asked to pay in advance the value of two months, or $ 4,800 to hope to benefit from a contract, something she refused since he was not sure. let the response last for another year.

5.5.2. The real estate and hotel sector

This sector was in great demand during the response. These are the houses and hotels that have been requisitioned either as offices or as accommodation for national or expatriate staff working in the response. These houses or hotels were useful for meetings and conferences in the response to Ebola. While for most of the hotels that obtained the contract, it was the response team that often came itself to negotiate with the owner without proceeding with a call for tenders, residential houses were the subject of intermediaries who should receive commissions for putting certain organizations in contact with owners.

Most hotels have rates ranging from US $ 30 to US $ 100. Billing has also been a boon for the response officers. Some rooms have seen their prices doubled.

6. Conclusion and recommendations

This research highlighted the negative perceptions that the populations of the areas affected by the tenth episode of the Ebola virus had on the quality of care, the behavior of the response teams and on the economic dimension of this response.

The DRC has experienced nine epidemics which it has managed to overcome; and the tenth, that which occurred in the Beni region, was extremely violent, marked by strong resistance and presented with a relatively high death rate. The purpose of this report is to present some results of research carried out in the area affected by Ebola virus disease, in the province of North Kivu, in the Democratic Republic of Congo (DRC). This research was entirely qualitative and focused on a sample of towns / villages including: the town of Beni, Mangina, Mandima and Kayna.

Focus groups with people selected for their relevant position in the epidemic area were held and semi-structured interviews were held with a few stake holders in the region. The discussion groups could concern women traders, members of the health staff, young journalists, young people, motorcycle taxim, etc. Interviews were held with key players in the response mechanism. These could be medical doctors, communications officers, grassroots authorities, religious leaders, etc. A total of 124 individuals took part in the survey.

The data was mainly collected on the basis of a recorder and hence resulted in the transcription. If the data could be in Swahili or French, all the transcripts were done in French by a specialized team.To ensure the quality of the data, it was the subject of two workshops, in Goma and Berlin. The Goma workshop made it possible to come out, on the basis of first data, the emerging themes, and that of Berlin served not only to complete the list of emerging themes of the data, but especially to the writing of some projects of articles that the data itself might suggest.

Among the themes that may have emerged from different phases of data analysis, the perception of the quality of care, the perception of the behavior of agents, and the economic dimension of the response to the Ebola virus disease are the subject of this article. report. In this regard, it emerges that the fact that the public authorities of the time no longer had the confidence of the population was a stumbling block to the response to EVD. Any initiative taken by the public authority to bring about a change in the behavior of the population was outright rejected by it. The WHO-Ministry of Health partnership could not therefore be easy in a context where the population was already exasperated by the leaders of political power at the time.

In this perspective, some key informants met at the time of data collection, completely rejected the existence of the disease, others thought it was a creation of whites in collusion with the power of Kinshasa to exterminate the Nande population, very opposed to Kabila's regime; still others thought that it was a fabrication of NGOs to be able to earn enough money; it was not uncommon to hear in the streets of Beni and Butembo, the concept of "No Ebola, No Job".

Still on the subject of the perception of care, there was a fearful behavior among the population. She was afraid of everything; she had the disease, the patient care procedure, and reception facilities and even disease survivors. The fear of the disease is explained by the fact that it is new, serious and without a plausible cause in the experience of the population. It is as if the disease is part of a conspiracy (conspiracy theory) against a known people, the Nande. The fear of the care procedure stems from the fact that to recover a suspected patient, a convoy of several vehicles, escorted by police officers, is mobilized. And it was with real brutality that everything that a patient had touched was destroyed. Fear

of structures, the well-known CTE, CTT, CT etc., new concepts on which the fate of patients depends. He said to himself that we are going there with no hope of getting out. In other words, these structures are real dying places that should be avoided. We die there, not of the disease, but of other fiddling that a curious creature comes to do on the patient. A curious creature, not otherwise presented, who is in fact the nursing staff, dressed in protective suits to the point of resembling an astronaut. We don't know any astronauts in this land, and even if we did, we wouldn't know any who care for the sick.

It emerges from this development that the fear inspired by the response to Ebola in North Kivu and Ituri, and the ensuing psychosis, is a communication system that has simply failed. Some of the response staff, especially those in charge of communication and outreach, were not even able to properly explain the symptoms of the disease. Had it been well designed and relating to all the components or stages of the Response, fear would have given way to appropriation; the administration of care is said to have had enormous success

Finally, the business-like behavior of the many actors involved in the response is another pitfall in the response. This behavior is such that, in some cases, recruitment to certain positions is paid for and does not take into account the requirements of the position. Some interviewees confirmed that instead of sensitizers, we saw drivers or masons. We ourselves had to meet at the CT of Beni a hygienist trained as a lawyer. To let a relative or friend benefit from the windfall generated by the Ebola Response, one could ignore the job requirements. Moreover, it is known that for the same reason, the then Minister of Health, Mr. Ilunga, had hired his own daughter as the communications officer for the entire program.

While some Ebola Response agents said "no ebola, no job", local traders in Butembo and Beni were embarrassed to be missing out on the economic opportunity presented by the epidemic in their area. Most of the markets (vehicle rental, medicines, other equipment, etc.) were carried out in Goma, Bukavu or Kinshasa. During this time, the agents involved in the response lived their lives lavishly in Beni, Butembo, Kayna... For example, it was not uncommon to learn from our interviewees that to buy a beer of less than a dollar, he presents a hundred bill. In many ways this state of affairs has been the source of frustration and, perhaps, the resistance observed in the region.

Based on our results, we can make the following recommendations, based on the lessons learned from the tenth Ebola outbreak in eastern DR Congo:

a. Ebola was just one of the emergencies in northeastern DRC
   In the hope of gaining the trust of the community, the approach focusing only on a public health crisis like Ebola and ignoring other community issues is not effective. Efforts must be made to ensure that the medical response goes beyond the fight against the disease, the care provided must be comprehensive
b. Community engagement must be the cornerstone of any response, otherwise mistrust, anger, protest and violent conflict can undermine the response:
   The involvement of local leaders and actors who trust communities is crucial to ensure that communities adhere to protection measures and accept the response.

c. Care should be decentralized:
   Decentralization of care for suspected Ebola patients is not only an effective medical strategy to quickly identify and treat infected people, but is also proving to be an important tool in building community confidence.

d. Respect for patients is fundamental:

Even in situations requiring urgent actions and having major public health implications, Ebola patients (suspected and confirmed cases) should be treated and respected like any other patient, and not treated as biological threats.

e. staff recruitment and contract award:

e.1. the recruitment of staff who will work in the response should be done with the greatest transparency by proceeding through all the traditional stages of the selection process: for a country with a high unemployment rate, the transparency of such a process constitutes a guarantee confidence and reduce the tension that emerges in such circumstances. For some positions that do not require great skill and expertise, favor local or community recruitment.
e.2. With regard to the organization of markets for orders or vehicles for hire, it is recommended to take into account the contextual aspects. For orders of drugs or heavy and delicate equipment, proceed by calls for tenders at the national level; but for cars for rent, fuel, calls for tenders can be provincial or even local