Grace Akello December 16th, 2019

Uganda did not export Ebola to the DRC despite porous borders

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Many livelihoods are reliant on frequent movement across the shared border of the DRC and Uganda, which can complicate procedures to prevent the spread of virulent diseases such as Ebola. Professor Grace Akello describes events surrounding Uganda's 2019 outbreak, and the effects of government health interventions that seek to remain partial to its citizens.

This article is part of the Public Authority blog series, with the Centre for Public Authority and International Development at LSE.

Uganda and the Democratic Republic of Congo (DRC) share porous borders, as well as social and economic links. With porous borders, it is

common for an individual to travel between Uganda and the DRC without being sure about their current country location – particularly when mobile phone networks oscillate between DRC and Uganda service providers. Even when the River Lhubhiriha marks one such border, people in this region wade through the river without thinking about its political significance.

One only appreciates the extent to which these two countries' borders are porous (or even imaginary) when conducting fieldwork in districts like Kasese, Bundibugyo, Nebbi, Zombo and Arua. It is said that the Bakonzo of Uganda speak the same language and have close kinship with the Kinande of the DRC. The same can be said of the Alur, Banyoro and Lugbara – ethnic groups living in both Uganda and the DRC. Noticeably, these border districts have market days whereby both Ugandans and Congolese small scale traders engage in the exchange of goods and services.

In 2018, the 11th Ebola epidemic was confirmed in DRC's border province of North Kivu. Different authorities, including the Government of Uganda's Ministry of Health, humanitarians and local leaders in high risk districts, devised strategies to keep Uganda Ebola-free. While at the national level Ugandans were depicted as faceless, nameless citizens living in a high risk border district, who must be protected from catching the virus from their risky Congolese neighbours, local leaders in Kasese knew that families cut across borders, and Ugandans farm and sell their agricultural produce in Congo, and vise versa.

In June 2018, an Ebola surveillance team from Uganda's Minister of Health (MOH) travelled over 15 kilometres into the DRC without realising they left their target citizens, whom they were sensitising to prevent Ebola's spread from the DRC. Their loudspeaker announcements advised Ugandan citizens to stop eating bush meat, wash their hands with chlorine, and if they saw anybody with signs such as bleeding from bodily openings – particularly if they have been to the

DRC in the recent past – to report immediately such persons to Uganda's Ebola Treatment Unit, located at Bwera hospital in Kasese district.

National vs local authority viewpoints

There was therefore a clash between national and local authorities' viewpoints concerning the appropriateness of preventive approaches. For instance, when the state viewed all Congolese as suspects who must be surveilled and forced (beaten even) into washing their hands and feet in chlorine prior to entering Uganda, local leaders viewed these approaches as divisive, aimed at bringing disharmony among families across borders – '*our relatives*', as mentioned in many discussions in Kasese. These leaders therefore disregarded such Ebola response activities and, at best, small Ebola checkpoints only targeted *unknown Congolese* and women for screening.

Indiscriminately ordering women to wash hands, for instance, on their way back from collecting firewood and water from the DRC was not useful. Even women exhibited what the Ebola surveillance team described as feigned compliance, sometimes hostility. In response, the Ebola team deployed security forces and heavy handedness, particularly on women who frequently crossed to the DRC side because, as Ebola surveillance officers and volunteers at checkpoints frequently argued, 'even animals there are infected and the bats must have nested in the gardens which Ugandans are tending while in Congo – and therefore they needed to be encouraged to adapt this habit of hand washing.'

Families and procedures across borders

In June 2019, a Congolese mother of five went to the DRC from Uganda as a caregiver for her sick father suffering from Ebola. Unfortunately her

father succumbed to death and together with her family they returned to Uganda after the burial. On hearing about these five high risk cases the MOH immediately ordered for their quarantining at an Ebola Treatment Unit. At the unit, some family members died (most likely of neglect).

After three days of quarantining the family, Uganda *exported* the high risk Ebola-affected family back to the DRC. During my interviews with some senior officers at the MOH, particularly about going against Standard Operating Procedures for Ebola by which they *exported* an Ebola case out of the country, there were mixed views. Ultimately it was agreed that no new infections resulted from the family being sent to the DRC, where further cases were contracted by people already within the country.

When these confirmed cases were discovered to have links with the DRC, Ugandan officials held cross border meetings with DRC officials on 11 June 2019. Agreed to transfer its Ebola-infected citizens back to its country, the DRC government stated that it had its own transport, perhaps assisted by humanitarians. Since Uganda's therapeutic protocols for the virus were still in review stage, Uganda 'allowed' the DRC to take back its Ebola cases. It is unfortunate that one of the sick persons was an 11 year-old girl who died before they reached at Ebola Treatment Unit in North Kivu. The mother who left her marital home in Uganda to do caregiving in the DRC was also deported.

I spoke to an officer at the Ministry of Health at the time who said:

> 'It was risky to refuse DRC Ebola citizens from going back. This is because DRC was looking at the amount of money which such cases attract. For instance, humanitarians would release money for surveillance, for treatment, for disposables and for Ebola staff. DRC could not let Uganda manage that money when it is DRC citizens who are affected.'

Ebola and indeed any virulent disease may force people into moral, social and political dilemmas. In 2019 Uganda was recognised globally as a state with the world's friendliest refugee policies, allowing in over two million refugees from neighbouring war-affected countries including the DRC into Uganda. Through such a policy, the government had gone further to give refugees land where they can carry out farming to improve their livelihood. This Ebola episode occurred only six months after this declaration, and here Uganda was at the brink of losing its credibility – to a great extent being depicted as a country going against its Standard Operating Procedures for Ebola control in order to keep its citizens safe, including breaking up harmonious families and kinship ties.

Such events force us to reflect upon the importance of humanitarianism in countries facing pandemics. We must ask ourselves: to what extent are humanitarians' contributions geared towards resolving the issue at hand, particularly if their interventions are guided by detachment, neutrality, seeing affected citizens as without a face, without a name, *sans* social links and kinships? These are pertinent questions whether within or across countries' borders.

Photo by Melissa Askew on Unsplash.

About the author

Grace Akello

Dr Grace Akello is a Visiting Professor at the Firoz Lalji Centre for Africa and a consultant at LSE's Centre for Public Authority and International Development. Dr Akello is also an Associate Professor in the Faculty of Medicine at Gulu University in Uganda.