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Communication practices in the context of the Ebola outbreak in Beni between 2018 and 2020: an interactive pragmatic analysis

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ABSTRACT

The Beni region in North Kivu, in the east of the DRC, was gripped by the Ebola virus disease health crisis between August 2018 and June 2020. Every available means, including communication, was deployed to halt the spread and transmission of this viral disease. In this fight – in which we ourselves participated as awareness-raisers – we witnessed conflictual communication at the reception end and dictatorial communication at the transmission end.

Foreign doctors who did not speak the local language were placed on the front line; people from other communities were also sent into the community to raise awareness amongst the local populations – mostly villagers – and the substantial material and financial resources contributed to this response only served to give rise to other problems that had to be tackled at the same time: rumours, misinformation and fake

news. These new 'diseases' then formed the basis of a conflictual communication environment, resulting in: a lack of community involvement in the fight against Ebola, the spread of the virus with its associated consequences, and physical violence directed at the response teams and their equipment.

The main problem raised by this study lies in the:

- The use of languages not spoken by the communities affected by the Ebola virus disease, which is thought to have been at the root of the communication breakdowns that prevented the rapid eradication of the Ebola virus disease in Beni.

- The use of foreign response personnel (those not belonging to the community affected by Ebola virus disease), which is said to have fuelled mistrust leading to physical attacks during the fight against this tenth outbreak in Beni.

Looking ahead, we have argued that the use of local languages for communication and the adoption of a peer-to-peer communication approach involving members of the affected communities would have enabled the affected communities to take ownership of the fight and foster community engagement.

This reminded us that the perception of the communicative content of such speech acts depends on the context in which they are used by the communicators; and the pragmatic theory of language, according to which the communicative approach is based on fundamental concepts: the implicit and the presupposition, and the interpretation of communicative value, which takes place through a set of values shared by the communicators, thereby ensuring mutual understanding of the messages.

This article aims, from an interactive pragmatic perspective, to examine the concept of 'verbal knockout' and the failure of communicative performance in the management of the tenth Ebola epidemic in Beni, North Kivu.

Keywords: verbal knockout, conflictual communication, response, Ebola, Beni, North Kivu.

Introduction

On 1 August 2018, the tenth Ebola virus disease (EVD) outbreak was declared in the Democratic Republic of the Congo (DRC) in North Kivu Province, specifically in the Beni region. The international response to the outbreak was massive, with an influx of over half a billion US dollars in international aid. A newly approved, highly protective vaccine was used, and new drugs were tested as therapeutic agents and proved effective in reducing the mortality rate from EV.

However, on 25 June 2020, the day the end of this outbreak was officially declared, the World Health Organisation (WHO) reported that the outbreak had caused two thousand two hundred and eighty-seven (2,287) deaths over a period of twenty-three (23) months. It turned out to be the most virulent outbreak to have affected the Congo and the second largest and longest-running response in the world to date. This alarming figure is the result of the community tensions caused by the response to this disease. In this article, we will focus on the communication aspects by examining the different ways in which local communities and the response team approached the prevention, treatment and monitoring of Ebola cases.

When it comes to risk communication and community engagement, language use and preferences regarding information vary from region to region; this would appear to be the case for the response to the tenth Ebola outbreak. Thus, during this study, we found the following regarding communication practices in the context of Ebola in Beni:

- People at risk of contracting the Ebola virus need information to protect themselves and their families. But information they do not understand is of no help to them. They need accurate information in clear language, in a local language, in a format they understand, and from credible sources.

- The use of French and Kiswahili – languages which many members of the local population do not understand well at all – has exacerbated mistrust between health workers and communities, thereby hindering awareness-raising efforts regarding response activities

- Language barriers pose the greatest challenge for women, older people and other vulnerable groups when it comes to accessing the information they need, yet these are the very people who are most vulnerable during a health crisis.

I. A brief overview of K.O.: conflictual communication

When we speak of communication, we generally think of a harmonious exchange. The very term 'communication' almost automatically conjures up a social reality in which information is exchanged that is understood, accepted and shared by all participants (Uli Windisch, 2007: 27).

The model of communication outlined by the linguist Ferdinand de Saussure clearly posits that communication is only possible or successful when the Sender, who transmits or communicates a Message, shares the same code with the Receiver. This enables the Receiver to decode the Message encoded at the time of transmission by the Sender.

If, on the other hand, misunderstandings arise during communication, the communication process is repeated until the information is understood. This presupposes a system of mutual understanding, to use the terminology of linguistics.

This conception amounts to acknowledging, at the same time, a social reality – and not merely a linguistic one – that is harmonious and consensual, that is to say, free from social conflict, struggles and antagonism.

Not everything is always harmonious when it comes to communication. Verbal altercations, rowdy exchanges, verbal warfare, polemics and verbal disagreements are social and linguistic phenomena just as real as the most harmonious and peaceful dialogues (Uli Windisch, 2007: 16).

Within the framework of our research, it is essential to distinguish between conflict — which refers to at least two people or two groups (social, political or other) who are in conflict — and conflictual discourse, which refers specifically to:

1. Firstly, to the specifically linguistic and discursive reality; and secondly, to that part of this linguistic reality which is permeated by conflict.

2. To the discourse of only one of the conflicting parties; to the discourse of the speaker who addresses another person due to a disagreement or a divergence of views. The person addressed becomes the adversary of the first speaker. This adversary may then respond, and this response may be followed by another utterance from the first speaker, and so on. These successive linguistic interventions constitute a series of conflictual discourses, each comprising a set of conflictual utterances. (Maingueneau, 1983:23)

In practical terms, a discursive conflict involves social actors who hold opposing positions on a particular issue. These opposing individuals or groups confront and clash with one another through discourse, as was the case during the response to the tenth Ebola epidemic in Beni. It is within such a crisis context that conflictual discourses unfold.

The author of a conflictual discourse has two targets: their opponent and the audience. The objectives of their discourse can be summarised in three parts:

1. To combat the ideas and arguments put forward by their opponent;

2. To ensure the triumph of their own ideas and arguments;

3. To share them with the witness audience, the public targeted by and affected by the issues at stake in the conflict. (Uli Windisch, 2007: 25)

It is, however, worth emphasising that, unlike actual warfare and physical confrontations, verbal wars and discursive clashes generally do not result in loss of life. The war remains symbolic, even if a verbal knockout disqualifies not only a speech but also a person and their identity. A verbal knockout, unlike a knockout in boxing, does not bring the fight or match to an end; a verbal knockout is momentary and temporary; it may be followed by further verbal knockouts. The person who has been knocked out will seek ways to knock out their opponent in turn. (Maingueneau, 1983: 27)

In the remainder of this study, we highlight the causes.

II. Of failures in the response to the tenth Ebola epidemic, precursors to discursive conflicts

The response to the tenth Ebola outbreak in the DRC was characterised by a very high level of mistrust of health workers amongst the affected populations. For some members of the community, the relief effort was simply a way for those in charge to make money. Responders faced unprecedented levels of violence: the WHO recorded more than 300 attacks on health workers involved in the response to the 2019 Ebola outbreak, several of which were fatal.

In a study conducted by Harvard Medical School, published in The Lancet[1] and based on a survey carried out in September 2018 among 941 people in North Kivu, only 349 (36 per cent) said they trusted the local authorities. Whilst 91 per cent said they had received information on how to protect themselves against the Ebola virus, 25.5 per cent stated that they believed the Ebola virus did not exist, 32.6 per cent said they thought the Ebola virus had been manufactured for financial gain, and 36.4 per cent stated that they believed the Ebola virus had been created to destabilise the region. Over 92 per cent said they had heard at least one of these rumours, and nearly 46 per cent said they had believed at least one of them. The study revealed that the less people trusted institutions and the more they

trusted rumours, the less likely they were to adopt preventive behaviours or accept a vaccine.

The inability of response teams to gain acceptance from local communities – a phenomenon known as 'community resistance' or 'community reluctance' – severely hampered their access to areas affected by the outbreak. The intensification of the conflict in North Kivu and Ituri in late 2019 further complicated key response activities, including the provision of healthcare, contact tracing, surveillance, vaccination and, of course, risk communication and community engagement.

Community resistance, often expressed either through a deliberate refusal to follow medical advice or through active rejection and acts of violence towards the response, had several root causes. Many interviewees, including some members of the Ebola response team, attributed the failures in community acceptance to decisions taken from the outset by the response's steering and coordination bodies, such as the lack of sufficient resources for the risk communication and community engagement component of the response, whilst underestimating the political dynamics of the affected areas.

The region had never experienced Ebola before, and many suspected that the outbreak was being deliberately spread as a genocidal attack against the Nande. Others believed that the outbreak had been fabricated with the aim of depriving millions of people of their right to vote in the national elections, scheduled for December 2018. These rumours were fuelled by politicians and others who exploited the outbreak for political or financial gain. (SSHA, 2019b)

Certain aspects of the response were also perceived as disrespectful. For example, Ebola treatment centres made from plastic sheeting made people feel as though they were refugees rather than part of a permanent, settled population, and when Ebola teams arrived without explanation to burn the mattresses of those who had been infected, the population was reminded of the armed attacks that plague the region (Oxfam, 2018a; Independent Monitoring Advisory Committee, 2019b).

Communities criticised the presence of response teams composed largely of security personnel and outsiders (from other countries or other regions within the DRC). Many did not understand or accept their exclusion from the local healthcare system, including people they trusted for their medical needs (Congo Research Group, 2020).

They were also resentful of the disproportionately high salaries that 'foreign' workers received compared with standard wages. This overt monetisation of the response gave rise to a widespread perception that staff from the Ministry of Health and Congolese people from regions other than Kivu benefited greatly, whereas few locals did.

Overall, at the outset of the response (in line with government policy), leaders deployed security forces regardless of the situation – 'almost a one-size-fits-all approach to security'. Security forces were deployed as a general protective measure, regardless of whether resistance came from communities or directly from armed groups. Whilst this might have been viable in a response lasting a month or two, it quickly became clear to many respondents just how damaging the single militarised model would be (Lamoure and Juillard, 2020).

III. Focus on discursive conflicts during the response to the tenth Ebola outbreak in Beni

'The first line of defence during a health crisis is information,' said Jérémie Soupou, an officer with the NGO Internews posted to Beni in 2019 as part of the Ebola response, as he launched a training workshop for journalists on communication during a health crisis. Effective communication with communities affected by a health crisis – or any other disaster – is essential to containing it. However, the communities affected by the tenth Ebola outbreak in the Beni region of North Kivu in the Democratic Republic of the Congo (DRC) did not initially have access to the information they needed. Even when they did have access to it, they did not necessarily understand it. And even when they did understand it, they did not always trust it.

Three factors had limited the effectiveness of communications about the Ebola virus disease in Beni, even though this region was the epicentre of the virus and at the heart of the surge in cases:

- The language used by response staff;
- The messages conveyed by response staff;
- The form of communication used by response staff (Elie Kemp, 2020:2).

At that time, the response coordination had overlooked the role of local stakeholders, community leaders, sociologists, anthropologists and communication specialists in the region, who speak the local languages and are familiar with local sensitivities. Yet their messages should have helped to improve understanding and acceptance of information about Ebola during the response.

In the event of a health crisis, communities need to be informed in the languages they speak and fully understand.

The difficulties encountered during the tenth Ebola outbreak in communicating with communities exacerbated the lack of trust faced by responders wherever the outbreak had been reported.

The importance of tailoring risk communication to the local context was then abundantly clear. In a 2018 findings study, conducted by non-governmental organisations and others, and published in the journal *Health Communications*, the WHO stated that one of the most important decisions regarding risk communication is to tailor the content to local populations, gender, circumstances and linguistic needs.

Unfortunately, at the start of the tenth Ebola outbreak in the DRC, official health communications were conducted primarily in French, the national language used in official documents. Whilst the response team had strengthened its capacity for community engagement and emphasised communication with communities, the Minister of Health and other stakeholders had recognised the importance of Swahili as the most widely spoken language in the region. Consequently, stakeholders began making information available in Swahili, the language spoken in the region covered by our study. However, the form of Swahili used in communication materials for the outbreak response was often a formal, international variety that was not understood by the communities, most of whom spoke local dialects of the language or did not speak it at all. As recently as September 2019, research by TWB revealed that risk communication materials were still largely in French and Swahili.

During the response to the tenth Ebola outbreak, several gaps in transparency regarding response activities were highlighted. These were at the root of the spread of rumours and misinformation, which only served to fuel the outbreak. This was partly due to the fact that communication took place in languages unfamiliar to the region's inhabitants: French and Kiswahili, languages that only those with a certain level of education can speak and read properly. Even when health communication specialists were able to speak to women, particularly older women, in Nande (or Kinande), the information and training materials on which they based their communication were in French and Swahili, which also meant that translations were less accurate.

In Beni, the local population speaks at least seven languages, whilst other affected regions in the east of the DRC exhibit similar linguistic diversity. Although Swahili is the national language spoken in the east of the country, this does not make it an effective language for communicating about a contagious and deadly disease with people whose main language is Nande, Kikonwo or Mbuba.

The use of languages and concepts that people do not fully understand breeds mistrust and fear. In Beni, an unstable security situation, combined with the presence of an alarming disease, has created this climate of fear and suspicion. During our reporting and awareness-raising activities on Ebola virus disease in the Beni region, most of our sources confided that, at the start of the outbreak, they interpreted the use of languages unfamiliar to them as a threat. Consequently, they believed that Ebola was a weapon sent to kill them. These prejudices only served to fuel conflictual communication between the response teams and community members.

Terminology that fuels fear and confusion lies at the root of the spread of rumours:

It is events that shape language, according to the sociolinguistic school of thought espoused by linguists such as Fishman, Labov and others… However, it is worth recalling that the choice of words is of the utmost importance in communication. During the tenth Ebola outbreak, residents of Beni said they were most concerned that medical staff did not speak their language; they were worried that they might be misdiagnosed with Ebola virus disease in the event of misunderstandings.

Some of the French words commonly used in the response to Ebola inadvertently fuelled suspicion. For example, community members interpreted the term 'riposte' (used as a synonym for 'response'), with its war-like connotations, as a battle or an attack, and 'vainqueur' (used to refer to survivors) as the victorious side. Previous observations by the *Social Sciences Research Group* (SSRG) of the United Nations Children's Fund (UNICEF) highlighted similar concerns that fuelled suspicion (Elie Kemp, 2020:2).

At the start of the outbreak, the people of Beni felt as though they had been stripped of their agency and free will. The fear of being taken to an Ebola treatment centre (ETC) or placed in isolation against their will was immense. This explains why it was not easy to transport patients to treatment and isolation centres. In Kasindi, for example, vehicles involved in the Ebola response were pelted with projectiles whilst transporting patients to the ETC in Beni; similar scenes were witnessed throughout the region (Serge, M: an immersive report on the causes of community resistance published on 12 September 2023 by Internews).

The supervisor of the communications teams in the Mutwanga health zone in the Rwenzori Mountains, Beni Territory, Mr Blaise Kilima, also explained to us that the population of the Beni region — mostly rural — associated terms such as 'ambulance' and 'isolation' so closely with death that it was best to avoid using them.

"Many parts of Beni are home to people who have not yet experienced modernisation. They harbour prejudices against certain rudimentary measures used in the Ebola response. There are practices they associate with distressing situations, such as ambulances, body bags, and isolation facilities like the CT or CTE. That is why we need to explain to them in advance the necessity of using these resources, which they had never used before," Mr Blaise Kilima explained to us in 2020.

Response staff used technical terms in French, even when speaking in Kiswahili or Nande. We found that the people of Beni had difficulty understanding certain seemingly simple French terms, such as 'allergy', 'virus' or 'molecule'. The use of English terminology such as '*swab*' or *'ring vaccination*' only added to the confusion. Abbreviations also complicated the message. Response staff commonly used 'CTE' for 'Ebola treatment centre', 'CT' for 'transit centre' and 'EDS' for 'dignified and safe burial', as these are practical acronyms. But their meaning was not always clear to the communities, especially when an abbreviation in English or French was used in a sentence in Swahili.

'The terms they (members of the Ebola response team) used confused us and filled us with fear. They would come to us using words we didn't understand. For example, they'd come up to you, examine the patient, and without any explanation, they'd say, 'We need to do the "swab", he needs to go to the "CTE"' '; they would stand in front of the body, showing no emotion, and say: 'He must be put in the body bag; we're going to carry out the EDS'," explained to 2022 one of the members of the Kawaya family, the first documented case of Ebola in Kasindi.

During a mass awareness-raising session on the importance of using body bags for safe burials, which I , personally led in the village of Thako, about ten kilometres from the border town of Kasindi in Beni territory, whilst I was working on the production of a newsletter called 'KOMA EBOLA' supported by INTERNEWS, the participants indicated that they would not object to these bags if the response team had first explained to them, in the local language, the importance of these bags, which, moreover, would not be used solely for deaths linked to Ebola.

Some expressions relating to the response are ambiguous, as their meaning takes on an entirely different dimension in the local context. The term 'case' is phonetic Cally similar to the diminutive 'ka' in Nande, and 'suspect' is associated with crime. The Nande speakers interviewed therefore understood 'suspected case' to mean a minor criminal, and consequently did not wish to be described in this way. Similarly, 'contact' is used in many contexts, ranging from a list of telephone numbers to sexual relations. Even health communication specialists were confused by its meaning in the context of the response.

As for women, they are particularly likely to misinterpret the message when communication is unclear. They were the first to provide care when someone fell ill, and were also often the first to take family members to the health centre. However, they were also less likely than men to have completed basic schooling. Consequently, their understanding of French terminology, Swahili posters and essential health information was often limited. A large number of women explained that they did not seek professional healthcare for fear of misunderstandings that could lead to an incorrect diagnosis (Elie Kemp, 2020:3).

Distorted or ambiguous translations of key concepts relating to the response, and local communicators' lack of proficiency in the language of the response:

Having identified these communication shortcomings, the national coordination team and international partners in the Ebola response subsequently opted for so-called peer-to-peer communication, which involved community members following basic training sessions on risk communication and community engagement. However, this approach was insufficient, as they were required to translate unfamiliar concepts from French into local languages, in a context of generally low literacy levels and without assistance. Many struggled to grasp these concepts.

They were sometimes forced to translate very direct or alarming terms by rephrasing them so that the population would not reject them because they considered them disrespectful or worrying. Indeed, the community frequently associates certain words used in the Ebola response with death and reacts negatively to them. Consequently, they had developed alternative expressions for terms with highly negative connotations, such as 'isolation', 'suspected case' and 'Ebola treatment centre'. These alternative terms adopted the patients' perspective. They replaced concepts of treatment (something doctors do to patients) with concepts of healing (in which patients are no longer the object but the subject) and referred to sick people as 'patients' rather than 'cases'. For

example, an explanation of contact tracing in Swahili literally reads 'the monitoring of all people who have been in close proximity to a sick person'.

This method would have been effective had these communicators been sufficiently trained. In the absence of guidelines, each communication specialist devised their own explanations. These varied from person to person, with a high risk of inaccuracies. For example, the 'Ebola treatment centre' was described in Nande as 'the place where people are cured'. Although positive, this translation could imply that all patients are cured there.

In 2020, the Paul G. Allen Foundation, in partnership with UNICEF and the JHumanitarian Patrice Network, published reports on the importance of language in responses to health crises in the DRC. These research networks reported that incomplete understanding, unguided translations and individual choices regarding the use of euphemisms by local communicators during the tenth Ebola outbreak in Beni led to inconsistencies and contradictions. They understood the local language and sensitivities, and were therefore able to find more respectful and acceptable ways of explaining key concepts. Nevertheless, their studies concluded that they did not have a perfect grasp of these concepts in the source language, French, and lacked support to ensure that their translations did not introduce errors or cause confusion.

IV. Practical suggestions for smooth communication during health crises or other widespread disasters

To provide a basis for smooth communication in future crisis management, we have proposed practical solutions that organisations responsible for managing crises such as Ebola can utilise to avoid conflicting communications that only serve to make matters worse. The study suggests ways to improve community engagement in responses to future outbreaks. Organisations involved in the response should, in particular:

- Provide information in indigenous languages, including their variants such as Swahili and Nande in the Beni region;
- Help health communication specialists to translate key concepts into accessible and accurate explanations in local languages;
- Involve community leaders and key stakeholders in all outbreak responses, as they have a thorough understanding of their peers' languages and cultural contexts;
- Adopt positive and reassuring terminology to avoid fear and mistrust amongst indigenous peoples;
- Use other forms of language as communication tools, provided they are understandable and socially acceptable.

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