



WHOSE HEALTH MATTERS?

Trust and mistrust in humanitarian crisis and global health interventions

Andrea Steinke

Sonja Hövelmann

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Abstract

Trust and mistrust are often highlighted when explaining scepticism and resistance to humanitarian health interventions. Mistrust, as manifested through rumours, resistance or violence against health workers, is often explained as a lack of knowledge and reason, which is countered through education campaigns or marginalisation of traditional healing methods. By analysing three case studies of global humanitarian health interventions – the Cholera epidemic in post-earthquake Haiti, the Ebola epidemic in West Africa and in the Democratic Republic of Congo as well as the Covid-19 pandemic – we argue, however, that political-economic origins, post-colonial continuities and neo-colonial practices are strong determinants that coin the relationships in global health interventions. By looking at historical, political, economic, and social aspects, we seek to explain that mistrust can also be interpreted as an experience-based, rational reaction shaped by previous atrocities. Normatively framing mistrust in humanitarian encounters as inhibiting the success of interventions avoids addressing more relevant issues able to explain multi-level and multi-dimensional mistrust as rooted in power asymmetries.

1. Introduction

Humanitarian health interventions are supposed to help people in need. Yet, they are often met with scepticism, reluctance and sometimes open resistance. In this article we argue that trust and mistrust are important variables in explaining various forms of opposition to global health interventions.

In an inter-connected, globalised world, where people and diseases travel easily between countries and continents, it is important to understand the drivers of resistance against global health interventions. The viruses Ebola and Covid-19, for example, have seen an increasing cross-border, cross-continental spread, that require international cooperation and, if national health system capacities are overstretched, also international assistance.

Trust has been defined as an important explanatory variable directly impacting political stability and economic success. A crisis in trust is proclaimed cyclically, in public institutions, in political parties, democratic systems and also aid institutions (Mühlfried 2019). Western medicine for example is often met with scepticism and mistrust in many post-colonial societies. While for some, this indicates a lack of education and reason, others interpret it as a “result of the instrumentalization of medicine during colonialism” (Mühlfried 2019, p. 7). By selectively providing health care – favouring certain groups or individuals over others – colonialists illustrated and manifested their power. Especially in contexts of foreign intervention or neo-colonial practices, the attribution of trust and mistrust are rich in history and inscribed in deeply rooted power asymmetries (ibid.). Yet, mistrust is mostly contextualised as a deficiency of the Other, which has to be tackled through educational campaigns and other means of trust-building. Thus, strengthening trust in health systems, especially in global health contexts, is often described in the literature as something that will be engendered through the replacement of local understandings of disease and healing via outreach and information campaigns (Chandler et al. 2015; Dhillon and Kelly 2015; Nuriddin et al. 2018).

While transparent communication on transmission and protection is central to fighting an infectious disease, it is certainly not an exhaustive measure. Our analysis aims to prompt a consideration that factors in political-economic determinants, post-colonial continuities and neo-colonial practices to understand the high levels of mistrust in global health interventions (Frankfurter et al. 2018, p. 536). Issues of trust in health systems are not limited to North-South relationships only but also tangible in doctor-patient relationships, people-and-public institutions in the Global North, as the current Covid-19 pandemic shows. What is more, erosion of trust in systems trickles down on relationships between individuals.

To illustrate our point, we look at three case studies – the Cholera epidemic in post-earthquake Haiti, the Ebola outbreak in West Africa 2014-2015 and in the Democratic Republic of Congo 2018, as well as some spotlight observations on the Covid-19 pandemic – where we examine the role of trust and mistrust.

From a humanitarian and global public health point of view, the lack of trust is paramount when discerning failure in health interventions. Research has identified people's belief in misinformation and low trust in institutions as reasons for the rapid and uncontained transmission of Ebola Virus Disease (EVD) (Chandler et al. 2015; Blair et al. 2017; Vinck et al. 2019). Communication and social mobilisation were promoted as key means to help contain the transmission of Ebola to counter the negative effects of traditional practices, misinformation and witchcraft. Mistrust in the health campaigns was portrayed as a result of misinformation, corruption or irrationality leading to an oversimplified causal explanation chain that a lack of trust was the reason for non-compliance and non-compliance with hygiene measures lead to contraction of EVD (Richardson 2019).

A similar dynamic unfolded when Cholera was detected in Haiti in 2010. The *Vibrio cholerae* bacteria was introduced to the Haitian immune system by United Nations (UN) peacekeepers. What first swept through the country as a rumour was soon corroborated by epidemiological analysis. In terms of transparency and accountability, the UN handled the situation exceptionally unsatisfying. The righteous anger and mistrust among big parts of the Haitian population lead to scepticism, resistance, even rejection of preventive and therapeutic measures against cholera and the overall presence of foreign organisations.

Additionally, the current Covid-19 pandemic provides an interesting opportunity to study trust and mistrust in global health interventions not just in the Global South but also in the Global North, in autocratic and democratic countries, in "low-trust" and "high-trust" societies alike. Covid-19 is no longer just a public health emergency but has turned into a global complex crisis.

Our analysis thus seeks to contribute to a broader understanding on the role of trust and mistrust by framing scepticism or resistance against humanitarian health interventions as a rational response rather than a lack of reason. We demonstrate that people may have well-founded reasons or stronger determinants that they chose to comply with than certain health interventions imposed by authorities or foreigners. Thereby, this article seeks to help address a critique voiced by researchers that a form of representation, which identifies lack of trust as a particular paradigm of causality why diseases spread, re-enforces and perpetuates ongoing structural inequities by omitting power relations, colonial history and contemporary extractive political economies (Somparé and Somparé 2018; Richardson et al. 2019).

2. Conceptual background

What is mistrust?

Trust and the absence thereof have been subjected to a rich variety of scholarly scrutiny in the past. Most prominently sociologist Anthony Giddens (1990) determines trust as a prerequisite for the functioning of modern societies in his seminal work "Consequences of Modernity". For Niklas Luhmann (2014), the spiritus rector of system theory, trust is one of many strategies to reduce

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complexities in human interaction. In a similar vein, for Diego Gambetta trust is “a device for coping with the freedom of others” (Gambetta 2000). Based on game theory concepts, trust is “conceived of as a belief that the other side is likely to be trustworthy and will therefore want to reciprocate cooperation rather than exploit it” (Kydd 2000, p. 326). Andrea Schmeier (2020) examines two types of trust in professional relationships: one manifestation is based on a shared identity whereas the other is experience-based. Notwithstanding, a common identity does not necessarily mean more trust. A high level of familiarity is not automatically equivalent to more trust. Being familiar in and with structures means being entangled and engaged and that means being susceptible to partiality. At least in humanitarian context this is considered prejudicial.

Mistrust then is marked by absence: the absence of reliability, control, faith, transparency and confidence. Corruption and clientelism reinforce feelings of mistrust at least for those parts of society not profiting from those systems. There have been debates whether or not mistrust is the opposite of trust. Mühlfried (2018) argues that mistrust is not the negation of trust, but rather that the qualities co-constitute each other. Also, trust and mistrust are not absolute categories. Trust is relative and not exhaustive. The term as it is commonly used does not refer to a 100 % margin of trust but to a subjective and relational dimension of human relatedness to societal systems and the individuals representing them.

Notions of trust and mistrust are largely dependent on context. This does not only refer to different conceptions between the “West and the rest” (Hall 1992), the relationships between state and society are inherently different in Euro-American contexts, too. Let us look at the USA and Germany for example: whereas Germany has established a relatively robust welfare system in the past centuries, the USA has put more emphasis on individual rights and freedoms. While the perceptions of a protective German Vater Staat and the US-American citizens defensive rights vis-à-vis the state especially coined in the constitutional amendment rights cannot be directly juxtaposed, preliminarily looking at the responses of the respective populations to Covid-19 measures, these structures relate to the level and extent of mistrust in public authorities and have to be factored in.

The anthropologist Florian Mühlfried (2019) proclaims a general culture of mistrust affecting contemporary societies. In his view, trust holds normative functions in society and societal relations: “The normative settings of trust – if not as a normality, then as an absolute necessity for the polity – turns mistrust into the main problem that must be made disappear” (Mühlfried 2019, p. 4). Accordingly, mistrust is framed as failure.

What is mistrust in humanitarian intervention?

Principle questions

Without a doubt, trust is crucial for the course of humanitarian intervention. Those on the receiving end of humanitarian assistance have to trust in the ones providing it, and in a way also vice versa. If one takes the humanitarian

principles seriously the people served by humanitarian action have to trust in humanitarians to uphold the principles, to act neutral, independent and impartial, overall guided by the shared humanity of everyone involved in the encounter. Essential for negotiations of humanitarian access and protection, parties in conflict have to trust in humanitarians not to side with or favour one conflict party, not to follow certain political agendas but base their actions on anything else than need alone. Those receiving assistance have to trust humanitarians to deliver quality programmes and that food, health and other goods provided are not substandard. Similar to doctors who take the Hippocratic oath, humanitarians commit to “do no harm”, while those affected can rarely hold them to account in case they do not.

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NGOs while not being profit oriented per se are dwelling in a world of capitalistic accumulation where they have to act as if they are profit oriented (Smillie and Minear 2004). The commodified nature of humanitarianism that marks contemporary interventions does not go unnoticed by the subjects of the intervention. The circulation of goods once set in motion sometimes overrides the primary intention of the intervention itself. In post-earthquake Haiti, for example, the import of transitional shelters (light-weight tent structures inadequate for longer-term housing) continued well into the recovery phase 1,5 years after the disaster, providing an easy win and photo opportunity to INGOs and satisfying Northern contractors that sold the shelter structures. Many Haitians publicly criticised this practice as evidently self-serving and driven by capitalist motivations more than by humanitarian ones. Similarly, “Ebola business”, referring to the profiting of a few from the allocated financial resources, was a main source of mistrust in West Africa and the DRC.

What is more, NGOs take over governmental responsibilities, yet they are not legitimised democratically in a similar way as elected governments are. Communities and sometimes even local authorities have little to no agency and control over the presence and programmes of aid organisations. Yet, transparency and agency are fundamental to notions of trust. Mistrust in NGOs as public institutions often is based in alleged and sometimes proven acts of corruption, fraud and a general lack of accountability. Evidently, the effectiveness in public authorities is another crucial factor: “people’s trust in the police is related to the legitimacy of police actions and ultimately, to the effectiveness of the police” (Osland 2019, p. 194). Especially in Haiti where so many aid interventions have failed, part of the disapproval of international NGOs and UN actors is grounded in their perceived ineffectiveness.

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Multidirectional mistrust

Furthermore, mistrust as a signifier in humanitarian action is mutual and not unidirectional (Slim 2019). “What is if the mistrust is our own?”, the humanitarian DuBois (2019) rhetorically asks. Not only do the targets of the intervention often mistrust humanitarians, humanitarians also mistrust the recipients of assistance. The latter have to prove their suffering and misery, physically through humanitarian techniques or in the form of testimonies and accounts to be eligible for humanitarian services – not least because of the bureaucratic procedures and donor accountability, but also as a signifier of interpersonal trust.

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The mutual mistrust is tangible also in the relationships between expatriate and national staff of international organisations. Representatives of international organisations show high levels of mistrust vis-à-vis their national colleagues (Schuller 2016). In Mali for example, MINUSMA expatriate employees “convey a level of mistrust in Malians working for the mission and how they interpret the country’s conflict dynamics” (Sandor 2020, p. 920). Beyond that, mistrust in the humanitarian sector is not limited to NGO - beneficiary relations but is to be found in a multitude of relationships: between NGOs and donors, between INGOs and national or local ones, between governments and NGOs, the military and NGOs, the UN and NGOs, between NGOs (Schneiker 2020).

Embodied mistrust

Mistrust in the global health context is often determined by the different ontological conceptions of the body encountered in different settings. Especially the discipline of medical anthropology has considered the varying limits, demarcations and connections of people’s bodies to the outer world, related also to perceptions of purity (Farmer 1988). This is relevant as in the global health sector, mistrust is widespread, even more so when it comes to vaccinations and injections. Here, information campaigning should not only be directed at communities affected, but also at humanitarians involved.

A study on the use of injection in Uganda in the context of the HIV/Aids epidemic for example has shown that a large part of the population was deeply mistrustful of governmental health care (Birungi 1998). Infectious disease, especially in the form of an unknown or novel life-threatening epidemic like Ebola or Covid-19, is very susceptible to emotions of uncertainty, fear and neglect not least because of a lack of ad hoc expert knowledge on the origins and spread of those diseases. The course of health interventions is therefore susceptible to misinformation and misunderstandings. The enemy is literally invisible and the trust of the population in health authorities’ measures is vital to contain it.

Normative power

When it comes to humanitarian action, the absence of trust is often framed in normative terms. Mistrust, especially coming from the recipients of aid assistance is framed as a failure. In this article, we argue that the standard framing of mistrust is not productive, because it is mostly analysed taken out of its political and historical contexts. To really understand mistrust especially in humanitarian relationships it is paramount to factor in the historicity of the relationship. Bruce-Raeburn notes that white exceptionalism is also inherent in the aid system because the idea that poor people are in need because of bad choices or because of their lifestyle overlooks racism, colonialism and the legacy of slavery that put them in that position in the first place (The New Humanitarian 2020a).

All that points to a general misreading of mistrust when the real question is about power and sovereignty. “A lack of public reflection on power can hamper a serious moral discussion with health professionals as important participants of various institutional forms of their relationship to others” (Grimen 2009, p. 17). Grimen (2009) points out to the fact that power as a con-

cept is only rarely factored in when it comes to relationships in health care provision. The evaluation of global health interventions, marked by profound inequalities in access, resources and protection certainly is a case in point for including power into the equation. These asymmetric relationships of power are deeply rooted in the histories of colonialism and inscribed into the DNA of humanitarian intervention. As Agier (2010, p. 989) notes “humanitarian workers have taken over from colonial administrations [...] to represent the new form of white presence and domination.” The unequal relationships are the main reason why the humanitarian sector is highly susceptible to abuse of power may that be in the form of corruption, sexualised violence, harassment, or fraud or more subtle forms like the prioritisation of technical expertise and the devaluation of local capacities. Trust between people requires vulnerability to the possibility that trust can be broken (van Praag 2019). Yet, the unequal power dynamics in the humanitarian space result in one-sided vulnerabilities of affected people, who need to compensate uncertainty and anxiety by hoping that they will not be let down (ibid.). “Power asymmetries implicitly translate into levels of interpretational sovereignty: those who diagnose pathological mistrust are the (helping) experts; those being diagnosed are the (needy) patients” (Mühlfried 2019, p. 7).

Colonial roots

Mistrust/trust is experienced based, as Schneiker (2020) pointed out. This is key to deciphering the profound lack of trust of communities in the Global South towards international interventions. To understand the presence of global health interventions one has to look back into the colonial history and its present-day continuities.

First of all, colonisers have intentionally infected people with pathogens to rob them of their territories and resources. Furthermore, colonies have served as laboratories not only for various kinds of economic and military interventions, but also for medical experiments. The colonised have been used for testing drugs and vaccines which were ultimately meant to protect the health of the colonisers (Gathara 2020).

These practices are by far not a ghost from the distant past as exemplified by the testing and use of the contraceptive drug Depo Provera. The USA had tested the contraception injection, first on Haitian women, the descendants of the victims of most atrocious forms of colonial crimes (Maternowska 2006). Later on, the largest US Depo-Provera trial was explicitly targeting US women of colour on welfare. To control the sexuality, fertility and last but not least reproductive capacities of poor women of colour was the primary objective of the usage of that particular drug. Finally, in the 1990s, Depo-Provera was used to temporarily sterilise Haitian refugee women intercepted at international waters and illegally incarcerated in Camp Bulkeley, Guantanamo Bay Naval Base, often without their knowledge and consent (Hannabach 2015)¹. Similar examples are found in the South African apartheid era: “Since 2003, for example, polio has been on the rise in Nigeria, Chad and Burkina Faso because many people avoid vaccinations, believing that the vaccines are con-

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¹ The Tuskegee Syphilis Experiment, taken place in the US between 1932-1972, is yet another case where the health of people of colour was seriously hampered with.

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taminated with HIV or are actually sterilization agents in disguise. This would sound incredible were it not that scientists working for Dr. Basson's Project Coast reported that one of their chief goals was to find ways to selectively and secretly sterilize Africans².

These are not isolated singular cases but have to be embedded into a wider web of colonial and racist continuities. Recently, two French doctors have triggered public outrage about racism when they suggested on television to "test Corona virus vaccine in Africa"(BBC News 2020). "How are Africans expected to not react to yet another attempt to use them as guinea pigs to develop drugs that would serve the Global North, whose well-funded health systems can afford the hefty-priced lifesaving medication that Africans themselves often die without?", the humanitarian and lawyer Karsten Noko asks³.

It is not by chance that contemporary aid practices especially in the form of development projects, came to life parallel to the decline of colonial states. Global health institutions in many places are perceived as a continuation of colonial administrations and logics. The divisive effects of colonial indirect rule are still tangible in post-colonial contexts in the form of a profound mistrust in educated elites (Somparé and Somparé 2018, pp. 138–139).

In that sense, people's scepticism of the motives of foreign interventions is not uninformed ignorance but might as well be an expression of a very rational, evidence-based assessment. It is not due to a lack of information but the opposite that people express mistrust in health interventions.

3. Methods

Research for this article is based on a triangulation of methods, ranging from extended ethnographic research in Haiti during the Cholera epidemic 2011 over literature review focussing on academic and policy output and expert interviews with health professionals on the Ebola response in West Africa to assessing recent observations on issues of trust connected to the Covid-19 response.

While preparing for and writing this article a highly infectious Corona virus spread around the globe. On 11 March 2020, the World Health Organisation (WHO) declared the Covid-19 outbreak a pandemic. Issues similar to those we were studying at the time became manifest in Germany and elsewhere. The sudden uncertainty and vulnerability that befell countries not accustomed to such a state of emergency created an opportunity to observe in real time the effects that complex public health crises can have on citizen-state relations and those affected by versus those responding to a health crisis. While the majority submitted to state ordered distancing measures, other reactions ranged from scepticism about the severity of measures to conspiracy theories on the role of the Gates Foundation in the crisis to physical attacks on

2 <https://www.nytimes.com/2007/07/31/opinion/31washington.html>

3 <https://www.aljazeera.com/indepth/opinion/medical-colonialism-afri-ca-200406103819617.html>

health care workers. We were able to connect our research to recent observations and first analysis on a global public health crisis, connect the dots between issues of trust and health intervention on the one hand and issues of colonialization and statehood on the other hand⁴.

4. Case studies: Trust and mistrust in humanitarian health interventions

4.1 Cholera in post-earthquake Haiti – colonial continuities, denial and resistance

In October 2010, *Vibrio cholerae*, the bacteria initiating Cholera, was identified in Haiti for the first time in more than a century. After the massive earthquake hitting the Caribbean nation in January of the same year, the outbreak of Cholera was the second major disaster affecting the Haitian population in 2010. The waterborne pathogen was introduced to Haiti by United Nations (UN) soldiers at a Nepalese battalion near Mirebalais in the centre of the country. Failure in wastewater management infused infected faeces into the Artibonite River, one of the country's water lifelines. It took the bacteria little less than three weeks to reach the camps of Port-au-Prince, established after the earthquake to house the more than 2.3 million internally displaced people (IDP) (Walton and Ivers 2011). Hurricane Thomas, the third disaster of that year, provided ideal conditions for spreading the bacteria. The epidemic was a major setback in the post-earthquake recovery efforts. Overcrowded encampments with next to no sanitary structure provided fertile grounds for the disease to spread. Medical anthropologist Paul Farmer (2012) has called Cholera the worst nightmare of a doctor working in a camp.

Cholera is an intestinal infection that provokes acute diarrhoea. The body loses fluids and electrolytes so quickly, that they often cannot be replaced without essential medical infusions (Farmer 2012). It can degrade a healthy adult in mere hours, even faster with the more vulnerable: children, the elderly, pregnant women and those with a weakened immune system due to tuberculosis and HIV/Aids. (Farmer 2012) While Cholera is generally treatable, in rural Haiti, with its lack of medical infrastructure, this acted as a death sentence in many cases. A lack of knowledge about Cholera as well as traditional burial rites amplified the expansion of the bacteria in rural regions.

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Despite all evidence – including independent epidemiologist research as well as research commissioned by the UN itself that proved the Haitian Cholera strain to be a perfect match with one found in Nepal 2009 (Piarroux et al. 2011), – the UN up until today has not taken full responsibility. In 2013, several institutions and individuals filed a lawsuit against the UN for neither testing nor treating its Nepalese soldiers for Cholera, nor taking care of correct water waste management during mission. The Southern District of New York dismissed the case in 2014, claiming the UN cannot be sued due to its immu-

⁴ This paper was written in July 2019 and represents early analysis of the global Covid-19 pandemic at that time.

nity. Then, in 2016, six years after the introduction of Cholera and five years after the study, UN Secretary General Ban Ki Moon acknowledged that the UN “simply did not do enough with regard to the Cholera outbreak and its spread” (United Nations 2016). This was too little – as he did not take the responsibility for introducing the disease in the first place, allegedly to impede indemnity claims, and too late – as the harm was done and trust in the UN as the representative of the international system in Haiti was lost. The last case of Cholera was reported in January 2019. Until then the disease had killed 9,792 people and affected over 820,000 people more⁵, the UN having left “Haitian lives destroyed by the very people sent to protect them” (Katz 2013, p. 225).

Just like the earthquake, the epidemic hit Haiti unprepared. There were no sufficient mechanisms and structures in place to react to a disease unknown to the current Haitian population its structural and physical immune system. Internationals alike were unable to respond quickly, for a variety of reasons, a few of them are touched upon below.

Lack of trust

There is a socio-political dimension to infectious disease in general and to Cholera in particular. Cholera has its “own preferential option for the poor” (Farmer 2012). The chances to get infected, having access to treatment and eventually recovering from the severe intestinal infection are largely dependent on the patient’s socio-economic status. In Haiti, it mainly affected people in the countryside, those without access to clean drinking water, sanitation and hygiene equipment. Due to the lack of infrastructure, health care provision, roads and transportation, many could not get to the next treatment facility in time (Koski-Karell et al. 2016). Drivers of moto-taxis, the primary means of transport, often refused to transport sick people because they were afraid of getting infected themselves. The mistrust of Haitians was not only directed towards foreigners it also went against other Haitians. Especially in the early months after the outbreak representatives of Vodou have been attacked because people conceived them of having poisoned communities with poud kolera, Cholera powder.⁶

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NGO fundraising mechanism started swiftly after the outbreak. Lack of money was not the problem for setting up mobile clinics, treatment centres and community programs. The problem was elsewhere: people did not trust foreign NGOs. CNN quoted Stefano Zannini, former head of mission at Médecins Sans Frontières (MSF) in Haiti, saying “there are a lot of misconceptions and rumours flying around, which has caused panic in the population,” Zannini said. “Some people are staying away from the Cholera treatment centres or are afraid to have them in their neighbourhoods because they think they help spread the disease. We’ve been trying to explain that the opposite is true: The closer a centre is to a population, the better.”⁷ As a result of community resistance, MSF had to discontinue one newly installed 400-bed treatment cen-

5 https://www.paho.org/hq/index.php?option=com_content&view=article&id=15684:haiti-reaches-one-year-free-of-cholera&Itemid=1926&lang=en

6 <https://lenouvelliste.com/lenouvelliste/article/87087/Sensibiliser-pour-sauver-les-vodouisants>

7 <http://edition.cnn.com/2010/WORLD/americas/11/15/haiti.cholera/index.html>

tre. The fact that it was situated in the vicinity of two schools fuelled protests by parents fearing for the lives of their children (Frerichs 2017). Especially in light of the way in which the disease entered the country these concerns cannot be easily dismissed. Focus group discussions on community beliefs on Cholera brought questions and scepticism about the establishment of Cholera treatment centres (CTC) to the forefront. People asked about disinfection, water waste management and the handling of dead bodies at the centres (Grimaud and Legagneur 2011). In another case, aid workers “were prevented physically from approaching children, or to make a list of beneficiaries of the nutrition programme, because some people whose name had been registered on a list, had died of Cholera” (Grimaud and Legagneur 2011, p. 31).

Other rumours that the UN was the source of the epidemic started to spread quickly after the first cases were identified. Protests took place all over Haiti, especially in the North of country. Violent confrontations led to several protesters being fatally shot, at least one by UN soldiers, as well as half a dozen injured peacekeepers.

Spreading the message – the role of rumours in the Cholera response

In Haitian society, like in many others, gossip and rumours are a widespread phenomenon and often serve as an unofficial communication channel and a means of sense-making. After the 2010 earthquake for example, a disaster unfathomable in its effects that killed roughly 300,000 people, theories surfaced that the tectonic shifts leading to the quake were caused by a subterranean bomb fired either by the USA or by Venezuela that accidentally went off halfway. Another theory determined the earthquake as resulting from illegal gold mining activities of the USA in Haiti. Considering the geopolitical turf war over the Caribbean as well as the debates surrounding the extraction of mineral resources in Haiti show that certain parts of rumours are always rooted in reality.

More recent examples of rumours spreading after the Cholera outbreak refer to the UN’s involvement. One reading accused a UN helicopter of ejecting black powder, *poud kolera*, into the Artibonite river, a sorcerer’s poison causing death or zombification (Katz 2013). Other rumours circled around UN soldiers contaminating the river, too. “The first thing said was, ‘They put something in the river’... No one knew who the ‘they’ were. MINUSTAH was mentioned later on”, a community representative was cited (Guillaume et al. 2019).

Rumours about foreigners in Haiti are nothing new. Prior to the Cholera epidemic, many stories circulated about the UN. One common misnomer often heard on the streets of Port-au-Prince was *vole kabrit*, goat thieves, blaming UN soldiers to have stolen and sodomized goats. Throughout the 13 years presence of the United Nations Stabilization Mission in Haiti (MINUSTAH), making fun of UN soldiers by referring to them as goat thieves and making ‘goat sounds’ was common practice. In this case rumours serve social functions and can also be interpreted as a “weapon of the weak” (Scott 1985). Amidst accusations of the UN’s partiality, human rights violations, sexualised violence, or sheer ineffectiveness of the UN mission, ridiculing a 10,000 soldiers strong foreign armed force can be interpreted as an act of resistance.

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Rumours not only relate to post-colonial configurations of power, they are also accelerated by the absence of transparency in communication. The rumours that the UN had actually 'put something' into the river became more and more plausible when investigative teams found the water waste management to be faulty at the Nepalese base, with broken pipes and sewage water being dumped in close vicinity of the river. While MINUSTAH press officials were quick to denounce the accusations of the disease originating from one of their bases, their official communication was not flawless. Associated Press correspondent Katz described asking the UN spokesperson how many soldiers were tested after a CNN story claimed Nepalese soldiers had been tested for Cholera, the spokesman was quoted saying "CNN hadn't gotten it quite right. It wasn't that the soldiers tested negative. It's that none of them tested positive. Because they have never been tested" (Katz 2013, p. 233). When Katz pointed out a puddle of brown liquid resembling faeces next to the UN base at the Artibonite River, the UN spokesman said: "It doesn't mean it is from the base. The people here they swim in the river. They bath in it. You know how they are." (Katz 2013, p. 234). Ironically, especially the last sentence is a point in case for identity-based trust as pointed out by Schneiker (2020). The UN spokesperson assumes a shared identity with the journalist, both being white expatriates vis-à-vis the Haitian population and therefore entrusts him, the journalist, with a derogatory comment about his perceptions of Haitians and "how they are".

Next to having jeopardized trust in international institutions, the UN's initial neglect to trace the source of the bacteria has also slowed down the response

Without a doubt, next to having seriously jeopardized trust in international institutions, the UN's initial neglect to trace the source of the bacteria has also slowed down the response. "That sounds like politics to me, not science. Knowing where the point source is – or source, or sources - would seem to be a good enterprise in terms of public health", medical anthropologist and former UN special envoy Paul Farmer was cited in October 2010 (Katz 2013, p. 237). The report commissioned by the UN, even though it found the *Vibrio cholerae* strain in Haiti to be a perfect match with the one from the current outbreak in Nepal, closed with "The source of Cholera in Haiti is no longer relevant in controlling the outbreak". Yet, exactly that was fundamental for regaining public trust.

Mistrust inflicted by post-colonial wounds

The well-known proverb *mikwob pa touye ayisien* – microbes do not kill Haitians – forms the basis to a generalised mistrust in the existence of the *Vibrio cholerae* bacteria in general. After having survived most brutal forms of colonial enslavement, a revolutionary war, dictatorship and foreign occupation, plus having the majority of the population currently living in unsanitary conditions, people thought of themselves as resilient and immune and did not believe they could be killed by microbes. Ergo, the reason why so many people were dying must have been poison for which health education and Cholera treatment centres are not a cure.

Similarly, focus group meetings conducted between November and December 2010 unearthed a range of theories on the background of the disease. Interviewees felt that because they had already gone through so much suffering, the earthquake being the latest event in a long line of hardships, Cholera could not have a natural origin. Furthermore, respondents suspected the

blan, the foreigners, to be involved in the spread of the bacteria “to divide us” or “to exterminate us and take our land”. Others thought it was brought by NGOs “in order to get more money” (Grimaud and Legagneur 2011, p. 27). The mistrust in NGOs goes even to the point that people have suggested that as hygiene campaigns have been organised before the introduction of the pathogen, NGOs must have known the disease would come (Grimaud and Legagneur 2011). Decades of foreign interference have made Haitians very distrustful of the motives of foreign organizations and individuals in Haiti. The wounds inflicted by colonial oppression run deep in Haiti and heavily influence inner-Haitian relationships as well as those to other nations. “People want a future outside of those colonial relationships”, NGO worker and anti-mining activists Nixon Boumba recently explained (Maurer and Pollmeier 2020, p. 1).

During a focus group discussion with Cholera victims in July 2016, the majority of participants voiced concerns about the way the epidemic was handled and the lack of accountability from those responsible for the situation. In essence, the critique is one of unequal relationships of power: “If that would have happened to Americans, people would have to go to prison for it. But Haitians don’t have the same worth like other nations”⁸, one man said. While there are reparation claims that are backed up by a series of human rights organisations and even a group of UN experts, including Philip Alston, special rapporteur on extreme poverty and human rights who stated: “Compensation is ordinarily a central component of the right to an effective remedy, and development projects are simply not a replacement for reparations.”⁹, there is more to it than just financial reparation. “For me, it is not about money and compensation in the first place, it is about an honest apology and being treated with dignity”¹⁰, one victim claimed. In his statement in December 2016, UN Secretary General Ban Ki Moon took partial moral responsibility for “not having done enough”¹¹, yet, the UN never took legal responsibility. His successor Antonio Guterres “has systematically avoided addressing that crucial issue in any way” since taking office, Alston said.¹²

Shortly after the outbreak of the epidemic, media reports portrayed protesters as playing the blame game and looking for scapegoats for what was basically their own fault because of poor sanitary conditions and cultural beliefs (Mallon Andrews 2015). In hindsight, looking at the mishandling of the outbreak including intransparent communication on their own wrongdoings, the outrage was a well-founded, evidence based and logical response. “We know they didn’t bring the disease here on purpose”, one Cholera victim said, “but that does not mean that they shouldn’t take responsibility for it”¹³.

Decades of foreign interference have made Haitians very distrustful of the motives of foreign organizations and individuals in Haiti.

8 Interview with cholera victim on the role of the UN, Haiti, Saut d’Eau, July 2016

9 <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25851&LangID=E>

10 Interview with cholera victim on the role of the UN, Haiti, Saut d’Eau, July 2016

11 <https://news.un.org/en/story/2016/12/546732-uns-ban-apologizes-people-haiti-outlines-new-plan-fight-cholera-epidemic-and>

12 <https://www.miamiherald.com/news/nation-world/world/americas/haiti/article242412291.html>

13 Interview with cholera victim on the role of the UN, Haiti, Saut d’Eau, July 2016

The Cholera epidemic is but one example of the sector not living up to its own standards, especially its guiding principle to “do no harm”.

The UN’s handling of the epidemic aggravated the already delicate relationship between Haitians and international organisations: “I do not trust MINUSTAH anymore. I won’t be taking any of the medicine they will give to us.”¹⁴ This was also connected to a sentiment of not being given the right kind of treatment: “they don’t give us effective medicine”¹⁵, referring to the fact that antibiotics were given only to people in severe condition (the rest was treated with fluids and electrolytes intravenously) and secondly to the scarce use of vaccination in the first years of the epidemic.

The criticism of the Cholera response then developed into a reckoning of the overall merits of international intervention in Haiti: “All of their efforts are not effective, all of what they do doesn’t really help us. Those things do not come to an end”¹⁶, one Cholera victim explained. Haiti, being the “patient zero of development”¹⁷ after 70+ years of development, humanitarian and peacekeeping intervention still checks most of the boxes in terms of per capita income, food insecurity, child mortality, etc. The criticism raised showed that it is not only about not being effective, it is also about doing more harm than good.

Many view the Cholera interventions by the UN as somewhat cynical: rat mode w soufle – the rat that bit, now tends to the wound – a commonly used proverb described the situation. The Cholera epidemic is but one example of the sector not living up to its own standards, especially its guiding principle to “do no harm”. When in 2018, the so-called Oxfam scandal about expatriate NGO employees’ involvement in several acts of sexual abuse and exploitation was made public, the allegations were no surprise to anyone who had spent a decent amount of time in post-earthquake Haiti. The events described align with earlier wrongdoings by foreigners in Haiti, like the misappropriation of post-earthquake funds, the more than hundredfold cases of sexual abuse and violence against children committed by UN peacekeepers in the 2000s, or the high numbers of civilian casualties in anti-gang operations (Müller and Steinke 2020).

Rumours and especially those confirmed to be true had a negative impact on other international organisations capabilities to provide assistance in the fight against Cholera. Thus, many NGOs reacted by sending out community health workers for information campaigning and awareness raising. The Haitian Red Cross for example tried to be as respectful as possible to people’s beliefs. “Dismissing people’s ‘subjective truth’, beliefs and perceptions on the grounds that they are based on ‘rumours’, ‘ignorance’, or ‘lack of education’ could, in the current Haitian context, actually lead to more distrust and resistance and can also generate strong, even violent, reactions.” (Grimaud and Legagneur 2011, p. 31)

In short, the resistance to Cholera treatment centres and the protests against the presence of UN peacekeepers are all manifestations of a profound lack

14 Interview with cholera victim on the role of the UN, Haiti, Saut d’Eau, July 2016

15 Interview with cholera victim on the role of the UN, Haiti, Saut d’Eau, July 2016

16 Interview with cholera victim on the role of the UN, Haiti, Saut d’Eau, July 2016

17 <https://geschichtedergegenwart.ch/the-afterlives-of-development-interventions-failure-as-an-opportunity/>

of trust of Haitian communities in the international system itself. Short term fixes in policy and adaptations in NGO programming can only be fig leaves if those measures are not connected to a more profound engagement with the sectors colonial forbearers and past failures. Wounds do have to be acknowledged for what they are for them to heal and make room for a more honest engagement of the people involved. Only then can meaningful trust be established. Until then the majority of acts of resistance and mistrust can only be framed as an appropriate, experience-based and rational reaction towards earlier atrocities.

4.2 Ebola in West Africa and the Democratic Republic of Congo – It takes two to trust

Ebola virus disease (EVD) is a lethal, infectious haemorrhagic fever that occurs in outbreaks across equatorial Africa. The Ebola outbreak in West Africa 2014-2015 is considered the largest outbreak to date and triggered a humanitarian health intervention of global scale. The epidemic encompassed about 28,000 documented cases and resulted in 11,000 deaths in Guinea, Liberia and Sierra Leone (Blair et al. 2017). The national health systems of the affected countries were unprepared to deal with the quickly escalating outbreak of a novel disease. The international response was similarly unprepared and with hindsight critiqued for being too slow and too uncoordinated.

Three years later, in 2018 the Democratic Republic of Congo (DRC) faced a large-scale Ebola outbreak in the Eastern part of the country. It is to date the second deadliest Ebola outbreak with about 3,400 cases and 2,240 deaths as of July 2020 (HPN 2020). In contrast to West Africa, Ebola is not a novel disease in DRC and the 2018 outbreak is considered the 10th since the 1970s.

In both contexts – during the West Africa and DRC outbreak – public health measure to prevent the spreading and transmission of the disease were met with scepticism, non-compliance or open resistance. While contributing factors to high transmission rates include active or post-conflict contexts, mass migration and high density of population, social resistance against containment measures and health responses was also cited as a reason (Masumbuko Claude et al. 2019).

Lack of trust if “Ebola was real” quickly became a dominant explanation of resistance against health regulations during the West Africa Ebola outbreak and was perpetuated by many newspapers, research and humanitarian actors. It framed the spiking transmission rates of the EVD because of people’s belief in witchcraft, sorcery, the low levels of literacy and their belief in misinformation and conspiracy theories framed as an overall “backwardness” or “uneducatedness”. The same narrative of mistrust was also quickly picked up for the Congolese context when there was similar resistance or violence against health workers. Since 2018 eleven Ebola workers have been killed in more than 400 attacks in DRC (Freudenthal 2020).

The solution to tackle mistrust was to organise extensive community engagement wherever there was reported resistance against the health inter-

Public health measure to prevent the spreading and transmission of the disease were met with scepticism, non-compliance or open resistance

Do neo-colonial practices and historical, economic and political determinants in a postcolonial context significantly shape factors of trust and mistrust?

ventions. This was done by sending in a team of trained social anthropologists or community workers as skilled interlocutors who could translate the technocratic approach into local languages and build bridges between local customs, practices and rites and the full force of the international health intervention. A crucial element was the introduction of safe and dignified burials that take account of traditional burial ceremonies while not placing mourners at risk of contracting the virus by placing the deceased in plastic body bags with a transparent “window” (Bledau 2019). The narrative about adaptation to local context and extensive community engagement was framed as a success by humanitarians in the West Africa Ebola outbreak, and subsequently, the outbreak in DRC was approached, by incorporating “lessons learnt” from the former intervention.

However, we suggest a more complex reading, namely that people were not necessarily uncooperative because they are “backward” or “uneducated” as a frequent representation by media and others suggested but we stress the necessity to contextualise resistance or non-compliance also with a range of other determinants such as social, economic, political and historical reasons. Arguably, neo-colonial practices and historical, economic and political determinants in a postcolonial context significantly shape factors of trust and mistrust.

Public communication strategies to establish the narrative that “Ebola is real” aimed to show that Ebola is caused by a virus, not caused by a curse or witchcraft and that medicine and science are the only cure and not traditional practices (Chandler et al. 2015). But as Chandler et al. (2015) conclude such messages follow an epidemiological framing and pay little attention to historical, political or economic contexts in which they are delivered. Thus, they reinforce external perceptions that local beliefs and practices are barriers to be overcome through persuasion or counterbalanced with incentives. This side-lining of traditional practices is also demonstrated by the fact that traditional healers and staff of private clinics, who provide a considerable proportion of health services and are at high risk of contracting the virus or spreading it to others, were not included into the list of eligibility criteria of receiving the vaccine in DRC (HPN 2020, pp. 5–6).

In fact, to perpetuate the narrative of “backwardness” as a reason for harbouring mistrust denies people rationality and neglects the fact that their experience of longstanding misrule, political tumult and indirect rule¹⁸ may in fact provide a reasonable explanation for mistrust in global humanitarian health interventions. Rationality of mistrust is framed as an irrationality, denying mistrust as a valid critique of the colonial legacies and obscure how power dynamics factor into contemporary public health emergencies (Frankfurter et al. 2018; Somparé and Somparé 2018; Masumbuko Claude et al. 2019; Richardson et al. 2019; Richardson 2019).

Political and historical dimensions

Social resistance to EVD control can also be explained by looking at political

18 Indirect rule refers to a governance system developed by Frederick Lugard, where colonialists ruled the colonies by relying on local rulers to execute their affairs.

and historical determinants. Mistrust in public authorities and formal power structures result from civil war, a volatile security situation and overall complex political configurations in the respective countries. Several studies point to the fact that in the affected regions, community mistrust is rooted in decades of conflict and government neglect (Frankfurter et al. 2018; Somparé and Somparé 2018; Bledau 2019). These have resulted in the destruction of social fabric and allow for an instrumentalisation of political communication. In Sierra Leone and Guinea, rumours spread that EVD was introduced as to establish a political blame-game that can be instrumentalised by the opposition. As interviewees reported in a context of strong bipolarisation of political life reflecting ethnic divisions these rumours fed into old ethnic prejudices and stereotypes from the 14-year civil war era¹⁹. Another rumour frequently spread proposed that the whole epidemic was a conspiracy by the government to secure funding from the West and that ergo the Ebola outbreak was not real (Bledau 2019, p. 68). Politicisation of the response has also been evident in DRC. Due to the outbreak, presidential elections were delayed in 2018 in the Eastern provinces Kivu and Ituri. Suspension of voting in the Ebola-affected areas and ongoing violence contributed to an increased popular scepticism and rumours that Ebola was a political tool denying people their right to vote (HPN 2020, p. 12), emphasising a perception of lawlessness and impunity in the Eastern provinces.

A low level of trust in public institutions can also be attributed to mismanagement during colonial and post-colonial governance or long periods of state weakness, absence or predation. For example Wilkinson and Fairhead (2017) showed that citizens who distrusted their government were less compliant with EVD protection measures but were not more or less likely to hold false beliefs about EVD transmission. This shows that citizens refused to comply not because they did not understand the measures but because they did not trust the capacity or integrity of government institutions. In fact, several studies underline that a legacy of neglect of public health priorities by the state and international agencies was mentioned as a reason of mistrust, ultimately leading to non-compliance or resistance (Frankfurter et al. 2018; Masumbuko Claude et al. 2019).

Similarly, lower trust in public health measures and medicine today can also be traced to earlier medical experiments. Lowes and Montero (2020) examine the effects of historical colonial medical campaigns on present-day trust in medicine, vaccination rates of children, and the success of World Bank health projects. Their findings demonstrate that negative historical experiences with the health sector can affect health-seeking behaviour in subsequent generations and that these campaigns were not isolated incidents but relevant in many sub-Saharan African countries where millions of individuals were forcibly treated for sleeping sickness. Medical tests and treatments for sleeping sickness included an effective compound of arsenic, which left 20% of patients blind (Lowes and Montero 2020). Perhaps these historical determinants explain why MSF staff had to temporarily close an isolation ward to infected patients because rumours accused the international medical staff of having brought the virus to Guinea (WHO 2014).

Mistrust in public authorities and formal power structures result from civil war, a volatile security situation and overall complex political configurations.

¹⁹ Telephone interview with health worker in Sierra Leone, June 2020.

Arguably, mistrust in medical experiments on treatments or vaccines, which were also carried out during the West Africa Ebola outbreak, can be interpreted a rationale response. For example, patients were hesitant to go to the Ebola Treatment Centers (ETC) because survival rates were low and the ETCs were “inhospitable and frightening” (HPN 2020, p. 7). However, because few survived and the dead were wrapped in plastic body bags without means of identification, people suspected that the bodies of the deceased were used for medical experiments or that their organs were trafficked (Somparé and Somparé 2018, p. 138). Thus, sick patients avoided the ETCs unless the disease was already very advanced, while chances of survival are higher when the disease is detected and treated early.

In fact, the WHO decided to deviate from its standard practice to allow for “monitored emergency use” of experimental interventions including medicines given the high fatality of EVD. Similarly, MSF engaged in clinical trials. Researchers tracing their engagement with experimental interventions quote that “not only was [MSF] willing to assume greater risks from unproven treatments than in previous research, but actually felt an obligation to maximize access to these treatment” (Rid and Antierens 2017, p. 134). Similarly, during the outbreak in DRC a vaccine was still in an experimental stage and an unregistered product. Over 300,000 people got vaccinated during the time span of the tenth EVD outbreak, mainly contacts of EVD cases, contacts-of-contacts and frontline workers active in the response (ECHO 2020).

Economic dimension and “Ebola business”

A large factor for mistrust in the Ebola interventions was profit. What has been coined as “Ebola business” describes the manifold practices of how individuals, elites or foreign agencies have been suspected to profit from the epidemic for personal gain. In all countries rumours spread that Ebola had been deliberately propagated as a ploy to pocket money. Audits and operational reviews in DRC revealed systemic corruption including payments to security forces, kickbacks and renting vehicles at inflated prices (Kleinfeld 2020). This unearths amidst a massive aid diversion scandal in DRC estimated to be around six million US-dollars, which heavily undermined trust in international actors (Kleinfeld 2020; The New Humanitarian 2020b).

“Ebola business” has not only undermined a trustful relationship between population and international actors but also impacted on trust among community members and national health workers. Ebola workers were frequently seen as opportunists because their engagement coincided with a huge improvement of their economic situation (Somparé and Somparé 2018). In DRC referred to as “strangers in our midst”, national response teams were assumed to be “well paid, displayed visible wealth, took minimal risks and rarely quit” (Masumbuko Claude et al. 2019, p. 13). Millions of dollars were paid by the WHO as per diem to security forces, triggering resistance against health workers and the ‘Ebola business’ they depended on (Freudenthal 2020).

Likewise, during the West Africa outbreak, “all sorts of interest groups mushroomed overnight to collect cash from the Health Ministry” (Masumbuko Claude et al. 2019), placing health workers under general suspicion of oppor-

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tunism unless proven otherwise. The profiting of few came at a time when the economic pressure due to the epidemic was high. What is often coined as a 'shadow epidemic' refers to the unintended consequences of containment measures such as lockdowns, curfews, and closures of factories or schools. Hikes in food prices, loss of informal jobs and disruption of trade due to closed borders impacted negatively on food security and livelihoods of people (Huber et al. 2018).

Research by Frankfurter et al. (2018) demonstrated a relationship between the Ebola outbreak in Sierra Leone and the political economy of diamond mining. It demonstrates how indirect rule by foreign entities in collaboration with local chiefs have great resonance with the original colonial-era practice aiming to politically pacify the rural population and maintain power. In making paramount chiefs central coordinating figures of the health response in Sierra Leone, they had access to enormous financial resources, which were distributed through patronage systems. In 2015 an audit demonstrated that one third of Ebola relief funds were unaccounted for (Frankfurter et al. 2018, p. 535). The overall public opinion is that significant amounts of resources were diverted by inventing or exaggerating Ebola risks and funnelling them through political patronage systems, with foreign entities indirectly profiting. "When a political system that for 120 years has enabled the subjugation of rural Sierra Leoneans as well as the extraction of critical financial resources is tasked with orchestrating a complex and at times draconian outbreak response, it is no wonder that patients may prefer to remain in the care of the families and loved ones rather than call for an ambulance directed by the paramount chief" (Frankfurter et al. 2018, p. 536)

The political economy surrounding the Ebola response has fuelled mistrust of its motives. Resources were diverted for heavily securitised interventions, rather than strengthening overall health care systems.

International humanitarian health intervention and neo-colonial legacies

Rid and Antierens (2017) suggest that only after a volunteer returning from Liberia to the USA fell sick and was diagnosed with EVD, did the USA start to deploy medical and military personnel as well as providing financial resources to support the health systems of affected countries. When cases were spiking in West Africa in August 2014, the WHO declared the outbreak "a public health emergency of international concern" (DuBois and Wake 2015). While the infection rate was already spiralling out of control in May 2014, it took until mid-September for the international community to become active, which some have coined as "criminally late" (DuBois and Wake 2015, p. v).

Furthermore, the designation "of international concern" was not only framed as a humanitarian or global health crises but also a threat to international security and stability (DuBois and Wake 2015). Several countries sent troops, for example the USA deployed troops to Liberia; United Kingdom to Sierra Leone because of former colonial relations but also China, Germany, France and Canada sent military personnel (Benton 2017, p. 30). However, international assistance was "mainly [busy] to protect themselves; in a zero risk, zero casualties approach" (Benton 2017, p. 33). The securitisation of the response begs the question whose security matters and security from what is of actual concern?

The securitisation of the response begs the question whose security matters and security from what is of actual concern?

A comparison of the Ebola outbreak with the scale of other diseases reveals that while EVD's rapid spread and high mortality rate caught international attention, other diseases are arguably more deadly in terms of total numbers of fatal cases. For instance, in DRC 6,000 people died of measles in 2019 (WHO 2020a). "Cumulatively in the past four decades, Ebola has claimed less than 3,000 lives. By contrast, the death toll in sub-Saharan Africa was 547,322 from diarrhoeal diseases and 222,767 from pneumococcal pneumonia in 2010 alone; many of these deaths could have been prevented through access to basic health care, including cheap vaccines and improved sanitation (Rid and Emanuel 2014, p. 1896). While massive international aid operations swallowed up resources, more people were dying from other diseases which are receiving almost no funding (Arie 2019).

It is hard to justify interventions against a single disease while at the same time more people die from measles, meningitis, polio or diarrhoea.

For the population living in those countries, it is hard to justify interventions against a single disease while at the same time more people die from measles, meningitis, polio or diarrhoea. For example, interviewees reported that a severe outbreak of Cholera in Sierra Leone in 2012 attracted hardly any international attention or financial support²⁰. But when travellers were infected with EVD and thus the risk of EVD spreading into Western nations increased, a response was quickly initiated. While originally framed as a tropical or African disease, WHO and states of the Global North became active when non-Africans started to be infected and it was taking a toll on the economy.

Mistrust in international aid workers, their interventions and prioritisation could also be read as a critique of whose priorities and whose security matter most. It can be interpreted as questioning the sincerity of the response because health interventions were not only perceived to be based on need alone, as the humanitarian principle of impartiality would stipulate. Especially in the DRC locals "have a lifetime of experience watching outsiders – from the capital, the UN, international aid groups – arrive with cash and promises that they can't keep" (Brown 2020). The same notion is also visible in what Adia Benton has coined the "politics of flight and rescue" (Benton 2017, p. 27). Who gets flown out of the affected areas was based on citizenship evacuation procedures meaning that previous development programming sponsored and implemented by foreign NGOs ceased their operations at the peak of the disease exacerbating unemployment and creating food shortages.

Heavy protection through biohazard suits and armed protection of health workers did not foster trust but rather inspired further acts of defensiveness.

Overall, containment measures were very militarised with punitive measures against indignant individuals violating burial or lockdown regulations (DuBois and Wake 2015). The securitised approaches to communities in distress resembled colonial approaches and sponsored acts of resistance rather than an acknowledgement of their fears (Benton 2017). Heavy protection through biohazard suits and armed protection of health workers did not foster trust but rather inspired further acts of defensiveness. By employing "field teams" who explained measures in the local language, sat down to talk to communities and tried to break this circle by establishing trust.

The lack of communication and adaptation of information into local languages has been stressed by several researchers as a source of animosity. The

²⁰ Telephone interview with health worker in Sierra Leone, June 2020.

use of language and concepts that people do not fully understand bred fear and suspicion. People were afraid that Ebola was a weapon to kill them or that misunderstandings would result in a misdiagnosis because information were often provided in official languages which in most cases are colonial languages. According to Somparé and Somparé (2018, p. 139) the use of colonial languages triggered notions of elitism, paternalism and coloniality and awoke “latent mistrust towards educated people that has been present in many African countries since colonization”. “Ebola people” were suspected of using their cultural capital to take advantage of the situation and impose measures on illiterate people that only they could understand (ibid). However, in a scenario where patient and medical personnel do not understand each other, imagining a trustful relationship is very difficult.

Examples and experiences taken from the two largest humanitarian health interventions to fight Ebola demonstrate that resistance against them are arguably a rational response or valid critique of power dynamics in public health emergencies. The continuous Ebola epidemic in Eastern DRC is taking place amid conflict and political unrest. Populations have lost patience with both external actors who have been present in the region for decades while life conditions have not much improved as well as their governments who are incapable of containing conflict in the region and regularly accused of corruption, questioning their overall effectiveness of interventions.

A way of furthering trust is by bolstering general health care systems. Many communities questioned the sincerity of the response teams that assured that they are there for their health but only helped them with Ebola but not with other diseases such as malaria, measles or pneumonia, which they were more likely to suffer from. While the Ebola humanitarian care apparatus is receding and funding declining, public health systems are as weak as before, leaving people wondering where “all that Ebola money went”.

A way of furthering trust is by bolstering general health care systems.

4.3 Covid-19: Turning the tables in global humanitarian health emergencies

The global spread of Covid-19, a Corona virus disease, has generated a medical and public health response unprecedented in scale. Covid-19 is an infectious disease triggering a mild to moderate upper respiratory tract illness. From the first detection in Wuhan, China, the virus quickly spread within the country and beyond its borders. Frequent air travel in a globalised world resulted in a rapid transmission around the globe since February/March 2020. WHO declared the spread of Covid-19 as a pandemic on 11 March 2020. While Europe, especially France, Spain and Italy developed into the hotspot of the disease in March, currently the majority of registered infections are located in the USA, India and Brazil. As of 11 September 2020, 28,202,363 people have been infected, 910,140 died with the virus.

To slow down transmission rates and reduce the burden on national health systems, shelter-in-place and social distancing measures have been recommended, imposed and enacted all over the world. Travel restrictions, closure of borders and lockdowns of entire countries have severely impacted pub-

lic and private life as well as national economies. However, compliance with public health measures and containment policies must have large support by the population to be efficient. While still in the middle of a constantly evolving crisis, we offer preliminary reflections on the disease and its relationship to mistrust both from previous epidemics such as Cholera and Ebola and from their own perceptions of exposure to the Covid-19 pandemic as it continues to unfold. We will highlight some recent observations²¹.

Multidirectional and multi-level trust

Trust in governments is an important determinant of citizens' compliance with public health policies, especially in times of crisis. Looking at emergent practice of grappling the pandemic it seems that those countries who harbour a strong public trust in governance and public institutions are better equipped to deal with the Covid-19 pandemic than other countries. In most countries, special legal and judicial powers for an apparent humanitarian cause have been enacted to prevent the spread of the disease. The use of state powers over the lives and bodies of its citizens brings up questions of ethics and human rights. If citizens mistrust authorities to act in their best interest these measures can ignite non-compliance or resistance. For example, in Germany, anti-vaccine activists organised several 'anti-corona' protests to express their fear that their right to bodily integrity would be violated by mandatory vaccinations and the mandatory wearing of facemasks in certain contexts.

Trust in fellow citizens, the healthcare or welfare system or the government has been determined as a crucial factor of how people respond to the pandemic.

Trust – or the lack of trust – in fellow citizens, their healthcare or welfare systems or their governments has been determined as a crucial factor of how people respond to the pandemic. Early survey data shows that German citizens trust in their neighbours, institutions and authorities (Schulze et al. 2020). Of the survey respondents, 79% indicated their trust in the German health system and 91% stated that they trust in doctors and medical personnel (Schulze et al. 2020, p. 58). German virologist Hans-Georg Kräusslich determines that strong public trust in government and authorities is a reason why Germany's fatality rate in Covid-19 cases is relatively low: "Maybe our biggest strength in Germany is the rational decision-making at the highest level of government combined with the trust the government enjoys in the population" (Bennhold 2020). Germany's chancellor Angela Merkel, a trained physicist, has communicated "clearly, calmly and regularly throughout the crisis, as she imposed ever-stricter social distancing measures on the country. The restrictions, which have been crucial to slowing the spread of the pandemic, met with little political opposition and are broadly followed" (Bennhold 2020). While the trust in public health authorities is stronger in contexts with reliable health care systems (Birungi 1998), Germany and its citizens are notorious for their obedience of and trust in authorities and Vater Staat in general as portrayed earlier.

Yet, in a pandemic of global scale not just domestic but international and multilateral trust play an important role (Ng 2020). International cooperation requires trust between countries but also in international organisations. When the pandemic was unfolding within the European Union (EU), many

21 This paper was written in July 2019 and represents early analysis of the global Covid-19 pandemic at that time.

countries prioritised domestic affairs over international or multilateral approaches. Survey findings indicated that only half (52%) of the respondents trusted their fellow citizens living in Europe to cope with the situation (Schulze et al. 2020, p. 58).

On 31 January 2020, WHO declared Covid-19 a “public health emergency of international concern” (WHO 2020b), this being the sixth emergency given that declaration since the founding of the WHO. Despite the fact that the first case in Europe was identified six days (25 January 2020) earlier in France, WHO’s warning went unheeded in many countries outside of Asia and preventive measures were not put in place to slow down or stop the spread across borders. As most Western countries were rather unscathed from the previous five emergency declarations, they defied the threat. Public authorities clearly could not imagine the pandemic to affect their systems in a way similar to what was happening in China. Arguably, a lack of trust in the WHO might be a reason why the warning was not taken seriously, too.

Rumours and conspiracy theories

As with Cholera and Ebola, rumours and conspiracy theories around the Covid-19 pandemic are impacting on effective responses. Misinformation ranges from a plot developed by Bill Gates jointly with the WHO to vaccinate and implant digital microchips to control the world’s population to blaming 5G networks for the global spread of the virus (Lynas 2020). Similarly, there is a whole range of rumours on how to protect against contracting or curing the disease. These include, for instance, drinking cow urine or eating garlic (ibid.). Social media and sensationalist reporting of the outbreak have generated panic and mistrust in the general public. Because these are so imminent, WHO has dedicated an entire webpage to falsifying rumours and conspiracy theories regarding Covid-19 (WHO 2020c) and is working with social media providers to help filter out such misinformation (Smith et al. 2020).

While these examples seem easy enough to detect as misinformation, trust in official communication and scientific evidence is vital for compliance health measures. The use of the anti-malaria drug hydroxychloroquine as a prophylactic against Covid-19 is not substantiated by clinical studies, but has been recommended by state governments and public health authorities such as Brazil’s President Jair Bolsonaro, US President Donald Trump or India’s health ministry, while the US Food and Drug Administration (FDA) has revoked emergency use of the prophylactic because emergent research shows it could do more harm than good (The Guardian 2020). Trump even suggested that ingesting household bleach might help counter the virus. The misinformation was vehemently countered by experts, however, the harm was done and people died from consumption of chloroquine (Krause et al. 2020).

Especially in the early weeks it was difficult to know what to believe with the media coverage of Covid-19 because the pandemic was rapidly unfolding with few scientific evidence-based information to rely on leaving a lot of room for speculation. Even though research and evidence have started to emerge, it is increasingly difficult to differentiate between fake and factual news, between targeted misinformation and politically instrumentalised knowledge. The “misinfodemic” (Krause et al. 2020) increasingly spreads along bipartisan

It is difficult to differentiate between targeted misinformation and politically instrumentalised knowledge.

political geographies complicating trust in the communicator. The politicisation of health issues thus contributes to a progressive erosion of trust in health institutions, media reporting, and government authorities, furthering the spread of fears, rumours and speculations.

Prioritisation and what about-ism?

Prioritising Ebola responses over other diseases such as the endemic measles outbreak has been identified as a source of mistrust for the Congolese context. Similarly, in the beginning of the Covid-19 pandemic, people compared the lethality to seasonal influenza, claiming that the latter has killed more people in the past and that hence containment measures were excessive. European health systems overwhelmed by the pandemic in fact often did prioritize Covid-19 response over other crucial medical treatment, like chemotherapy for example. This form of unidirectional response was problematised early on in the pandemic.

The current pandemic does not only juxtapose different health emergencies, focussing on disrupted consumer economy and summer holiday plans, but also revealed how much this pandemic is a crisis of the neoliberal paradigm. By pitting economy against health, ethically difficult and controversial decisions had to be made. The recent mass outbreak of the virus in the German meat-packing industry among migrant workers forced to work and live under horrendously inhumane and unsanitary conditions is but one example for this flawed dynamic. It also emphasises that the narrative of Germany doing so well to protect people is only partially true. The pandemic reflects the profound inequalities in German society and shows that certain lives are less protected than others.

Politicization and geopolitics

The Covid-19 pandemic is unfolding against a backdrop of growing nationalism, populism and anti-multilateralism (Krisch 2020). How much international institutions and multilateral trust are under stress is demonstrated by the recent example of the US withdrawal from WHO. President Trump announced his decision to stop funding and end cooperation with the WHO because he accused the agency of becoming “a puppet for China during pandemic” (Cohen 2020).

Also, within the EU, there was little trust in a multilateral response to the crisis. Instead, each country invoked a “my country first” mentality. For example, Italy asked Germany repeatedly for support when their health care system was stretched beyond capacity. Their request proved futile as it was China not Germany ultimately providing much needed personal protective equipment (PPE). As Mohamedou (2020) argues: “Italy [was] similarly finding itself at the receiving end of coded ‘cultural weak link’ criticism, incriminating the country’s poor response and underperforming healthcare system”.

Ebola and Corona virus are both zoonoses, meaning that the pathogen originated in wild animals and was supposedly transmitted via consumption of their meat to humans. In Western depictions, Ebola was framed as a tropical or African disease and the consumption of so-called bushmeat, as an origin of the disease, demonstrated the supposed “backwardness” of rural popu-

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lations. By referring to their sanitary conditions and cultural traditions the countries' responsibility of causing the crisis were thus invoked.

With Covid-19 the same trope was amplified: A widespread sense that the threat of the virus originated abroad – a threat coming from afar – and that the West had to deal with something created by others (Mohamedou 2020) fuelled anti-internationalism and mistrust in foreigners. In the beginning of the spread of Covid-19 people suspected to be Asian were met with heightened levels of racist aggression. Similarly, China's international assistance in form of medical equipment such as PPE was discredited as trying to divert attention away from the fact that it had "caused the crisis". Can the boy from rural Guinea that is considered 'patient zero' be blamed for causing the Ebola crisis in West Africa? Naming and blaming of the sources of the disease as a political tool rather than as an epidemiological strategy to help answer the call seems a recurring factor in health emergencies.

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Western exceptionalism in question and colonial wounds re-infected

During the Ebola outbreak, Cholera outbreak and many other humanitarian health emergencies, usually countries of the Global North provided expertise, resources or funding. Covid-19 has somewhat questioned this traditional distribution of roles in the beginning of the pandemic. Due to frequent travel, Northern European states were earlier and heavier affected by the pandemic than for instance African states. These reversed roles of Europeans asking for advice from African experts in tackling public health emergencies and managing a triage of multiple crises simultaneously including crucial knowledge in setting up emergency and decontamination systems sparked jokes and gloating. While most of Europe was still in denial over the severity of the disease and its spread, many countries in Africa had already set up emergency procedures at airports, hospitals and public institutions. Western media seemed bewildered that African countries have not been impacted more severely and Western humanitarian INGOs braced for the worst while seizing opportunities for funding to mitigate the potentially devastating effects that Covid-19 could have on refugee camps, densely urbanised spaces and already strained health systems toppled with the triage of multiple health emergencies. Yet, successes of countries such as Ghana and Senegal to implement containment measures early were ignored, while Sweden's risky public health approach – counting on the reasonable behaviour of its citizens rather than imposing strict measures – was commented as "exceptional and gutsy" (Mohamedou 2020).

The juxtaposition of Europe and Africa in terms of Covid-19 response has also triggered jokes and dark humour (Tadesse Shiferaw and Mucchi 2020). Especially, the general contain-and-control attitude towards African mobility to Europe is momentarily reversed with regards to changes in who poses a threat to whom. Many airports were closed for European travellers, who usually travel with ease and 'visa-upon arrival'. Anecdotes emerged of Italians being sent back because they refused to stay in quarantine in Tunisia and others overstaying their visas in Ethiopia (Tadesse Shiferaw and Mucchi 2020).

While dark humour, scapegoating and gloating around Covid-19 being a “disease of the white and rich” (Büchel 2020) are often accurate portrayals of the infection routes, they also point to post-colonial continuities. To many former colonised states foreigners bringing infectious disease is reminiscent of a historical trauma; a colonial wound re-infected (Irons 2020; Böhm 2020). Accordingly, rumours, for example in the DRC proposed that Covid-19 is yet another ploy to further a global humanitarian appeal to raise money which will not reach the people in need or introduced as a strategy of neo-colonisation where Western or Chinese companies acquire land or resources (Büchel 2020).

Also, strict containment measures triggered painful collective memories. For example, in imposing the strict lockdown for Covid-19, the Indian government invoked the very same Epidemic Diseases Act of 1897, originally passed by the British government during plague outbreaks. This was a unique act, designed specifically to control an epidemic outbreak, giving special powers to the state, which is partly why it has appeared relevant for Covid-19 (Chakrabarti 2020). Gathara (2020) criticised that the Kenyan president Kenyatta simply copied advice from WHO on Covid-19 measures and thus repeated the dictates from global elites taking a Western lifestyle as a template for life rather than consulting with citizens how to ensure containment measures in densely urbanised spaces where social-distancing, self-quarantine and other hygienic measures are next to impossible. He argues that the tendency to issue directives rather than consult with citizens has been inherited by the current government from colonial authorities, mimicking containment measures of a twentieth century plague epidemic. As with plague and influenza pandemics it is the privileged few bringing in the disease and being equipped with better means to survive, while the poor take the toll.

Grounded planes and evacuated Western aid workers shed a new light on localisation in humanitarian health emergencies.

In sum, Covid-19 exposes fault lines and inequalities around the world. As the West falls into crisis blinded by historical sentiments of Western supremacy and exceptionalism and profoundly unable to learn from others, Covid-19 could also provide a moment of reflection. Grounded planes and evacuated Western aid workers shed a new light on localisation in humanitarian health emergencies. By addressing structural inequalities and acknowledging racism, colonialism and neo-colonial continuities, there is a momentum to rebuild trust through truthful communication and honesty of motifs. A way to rebuild trust of the population is strengthening public health institutions and fostering equal access to quality health care.

5. Conclusions

If mistrust is a symptom, trust is not the panacea

Examples from the Ebola epidemic in West Africa, the Cholera epidemic in Haiti and the spotlights from the current Covid-19 pandemic have shown that rumours and resistance to global health interventions are manifestations of profound mistrust. Mistrust also correlates with weakened state institutions of health care (Birungi 1998), which most certainly holds true for Haiti and the Democratic Republic of Congo.

Trust building measures in the form of community engagement and, to some extent also the codification of humanitarian principles and standardisation of humanitarian action are aiming at (re)building ties within the humanitarian community and in relationship to its stakeholders to ultimately render humanitarian assistance more efficient. Regulations have been implemented that are necessary but did not sufficiently create meaning and accountability to function as a pillar of trust in relation to the people served by the intervention. Trust in humanitarian assistance is important. It is vital for relationships between people and institutions. But perfunctory trust building measures alone will not be the panacea reforming an institutionalised system built on unequal relationships of power. Colonial continuities and contemporary atrocities will not be overcome by new sets of standardisation and compliance systems as continuously promoted in think pieces and policy briefs. To really turn the corner, the humanitarian community has to look deep into the mirror of its history, the continuities deriving from it and not shy away from what is staring back. Power is the key to deciphering the question of mistrust that many humanitarians face, especially in global health contexts.

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In case of non-compliance, humanitarian health workers should not blame the citizens by assuming that they do not understand health-related messages, but rather acknowledge that they may have stronger determinants that they chose to comply with. Trust in humanitarian health interventions means that affected people have to trust humanitarian health workers to act in their best interest. This relationship is not unburdened but tainted by complex historical, political and economic determinants. Trust building measures are no one-way street. Humanitarians need to listen and reflect, be themselves part of educational campaigns to overcome barriers to global health.

Further, it has been shown that mistrust in global health encounters is not the result of an individual flaw, neither of the humanitarian nor the one s/he assists. Mistrust may not be the main issue after all. Normatively framing mistrust in humanitarian encounters as inhibiting the success of intervention overrides and avoids putting more relevant and pressing issues related to power imbalances at the forefront: protection, accountability and last but not least, structural racism and racist discrimination.

The colonial wound is an open wound and it quite literally gets re-infected via contemporary outbreaks of Cholera and Ebola or novel diseases such as Covid-19 and subsequent international measures. The demand for financial reparations brought forward by Haitian Cholera victims and supported even by representatives of the UN system themselves is but one example for a possible way to tend to that wound. Otherwise, global health assistance in Haiti and DRC, like the one currently underway to counter the Covid-19 pandemic, risk being rejected by the population. Addressing these underlying structural conditions as “the original objects of mistrust” (Mühlfried 2019, p. 7) will help improve the sectors response to global health crisis and interventions.

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ENDNOTES

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Dr Andrea Steinke is a Research Fellow at the Centre for Humanitarian Action (CHA), Berlin, Germany. andrea.steinke@chaberlin.org

Sonja Hövelmann is a Research Fellow at the Centre for Humanitarian Action, Berlin, Germany. sonja.hoevelmann@chaberlin.org

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CHA - Centre for Humanitarian Action e.V.

Wallstrasse 15a

10179 Berlin

+49 (0)30 2864 5701

info@chaberlin.org

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