african centre for biodiversity

MULTIPLE SHOCKS AND THE EBOLA AND COVID PANDEMICS IN WEST AND CENTRAL AFRICA:

EXTRACTION, PROFITEERING AND SHATTERED FOOD SYSTEMS AND LIVELIHOODS

SUMMARY

DECEMBER 2020

Multiple Shocks in Africa Series

The research for the discussion papers of this series was conducted under challenging conditions created by the COVID-19 pandemic and the consequent lockdowns and travel restrictions. As such, ACB researchers were not able to travel to the case study countries for on-the-ground research. We are therefore deeply grateful to our local partners who provided the necessary support in the focus countries (but who were also limited by lockdowns and other restrictions in their own countries) and to other key informants who provided invaluable information. The discussion papers are therefore aimed at providing a broad scoping of the shocks being experienced by the people of the focus countries and an initial dive into the interconnections between the processes driving these shocks. The ACB has a long track record of producing high quality and reliable research, but any potential errors or blind spots in this research series are those of the ACB. We welcome further input as we advance our collective knowledge and change project.

The African Centre for Biodiversity (ACB) is a research and advocacy organisation working towards food sovereignty and agroecology in Africa, with a focus on biosafety, seed systems and agricultural biodiversity. The organisation is committed to dismantling inequalities and resisting corporate industrial expansion in Africa's food and agriculture systems.

www.acbio.org.za

PO Box 29170, Melville 2109, Johannesburg, South Africa.
Tel: +27 (0)11 486-1156

Researched and written by Sasha Mentz-Lagrange

Copy editor: Liz Sparg

Cover image, design and layout: Xealos Design Consultants

Acknowledgements

The ACB thanks Sasha Mentz-Lagrange for researching and writing this paper, with the invaluable support of Common Front for the Protection of the Environment and Protected Spaces (FCPEEP) team members from the Democratic Republic of Congo: John Ciza Byerungu, Alain Bisimwa Kaouchu, Dr Jospin Uzima Vumi, Dr Christian Mirhuho, Dr Samuel Tambwe, Francine Bintu Makelele and Pascal Mugisho Mutabazi. Thank you to Andrew Bennie, Linzi Lewis and Mariam Mayet from the ACB for providing invaluable comments to improve this report.

The ACB gratefully acknowledges the financial support of several donors. The views expressed in this paper may not necessarily reflect the views of our donors.

The research shows how ecosystem collapse induced from extractive practices is linked to the emergence of the Ebola virus disease (EVD) and possibly many other emerging infectious diseases of a zoonotic origin.

The linkages between extractive practices and the emergence of disease

About 75% of novel human pathogens are thought to be emerging by spilling over from wild animals to local human communities (Rimoin et al., 2017; IPBES, 2020). The emergence of some of these zoonotic diseases is recent (Karesh et al., 2012) and correlates with the draconian changes in land use and ecosystem compositions in the Global South over the past three decades amidst ongoing poverty, extraction and economic subordination. The steady rise of deforestation over the past two decades has been linked to 31% of outbreaks such as the Ebola, Zika and Nipah viruses (WEF, 2020). But it could be more.

Changes in the mode and intensity of land use are scientifically recognised as being the driving force behind the emergence of zoonotic diseases (IPBES, 2020; UNEP and ILRI, 2020); yet the fact that this degradation is in a large part driven by multinational corporations predating over the Global South's resource endowments is insufficiently recognised (Wallace, 2016; Wallace et al., 2020). This greater zoonotic disease risk is in a large part exacerbated by the rising global demand for particular kinds of food (Karesh et al., 2012), be it through livestock farming, large-scale farming of "flexi" crops (such as oil palm) or wildlife hunting. All have in common that, because of the destructive processes they are associated with, they lead to a greater risk of contact with pathogens in circulation in the wild.

Ebola and a 'perfect storm' of compounding shocks

The world's first and second largest Ebola outbreaks (West Africa and DRC respectively) also happened in contexts of extreme deforestation and biodiversity destruction (IPBES, 2020). Globally, 71% of global forest loss has been driven by expansive agriculture – essentially cattle, cocoa, palm oil, sugarcane, rice and soya and timber (Lawson et al., 2014). In the DRC, the "national consensus" on the drivers of deforestation in the country (DRC, Ministry of Environment, Nature Conservation and Tourism, 2012) lead one to believe that subsistence slash and burn agriculture is, on average, the primary driver of deforestation. This, however, crudely disregards the underlying political, social and economic contexts (Liebman et al., 2020) in which these survival activities manifest and the role that multinational corporations play in the fortunes of Africa's tropical forests. In the DRC, large-scale plantations and industrial mining, which expand in a context of weak governance and brutal disregard for human rights, need to be deeply scrutinised for their role in disease ecology, as clearly demonstrated by Wallace's "neoliberal disease emergence" analysis (Wallace 2016; Wallace et al., 2020).

The story of the Ebola pandemic in West Africa and the Ebola epidemic in the DRC is therefore not just one of disease emergence. It speaks of much more fundamental causes, starting with the chronic divestment in public health infrastructure brought about by the lending policies of the International Monetary Fund

(IMF) and World Bank. The state of unreadiness of public medical health infrastructure in West Africa has been positively correlated with the fast-paced spilling over of the EVD between 2013 and 2016. The same can be argued about the state of public health in the DRC, which was under-resourced to deal with complex emergencies, due to chronic shortages in medical facilities and insufficient staff. In the context of this weak public health system in the DRC and the rampant armed conflict that has plagued eastern Congo for over 25 years, containing the epidemic has been hampered by people's reactions to the health response, which largely came from 'outside' in the form of the World Health Organisation (WHO) and international non-governmental organisations with few links to the populations (which a functioning public health system might have) and a disregard for local customs. This response has consequently fuelled a lack of trust and perceptions of neo-colonial intents to control or eliminate the populations, while the local elites enrich themselves.

Repeated armed conflicts, which have historically disrupted the functioning of local market systems, combined with the rise over the past few years of diseases affecting staples crops, including fall armyworm (FAW) and animal diseases, as well as recent flooding, have deeply disrupted the agricultural sector, making the DRC the most food insecure country in the world after Yemen (IPC, 2020). These cumulative shocks have been compounded by the Ebola epidemic and COVID-19 pandemic, which played a big part in precipitating chronic inflation of food prices and in increasing the dependence of the Eastern provinces on food imports, as well as hunting of wild meat. The undermining of livelihoods by the extractives sector and the virtual absence of support to small-scale farmers is leading increasing numbers of people into seeking sources of survival through unregulated, artisanal mining, combined with charcoal making, which is breaching forest boundaries and making spill-overs more likely, while farmer communities may be losing their ancestral agricultural knowledge and skills. These shocks are also happening in a context of a looming corporatisation of the DRC's seed sector, as the United States Agency for International Development (USAID)-sponsored development of new seed laws pave the way for the replacement and potential criminalisation of farmer managed seed systems (ACB, 2020).

But the dual challenge of EVD and COVID-19 hitting the country in a synchronous manner overshadowed another outbreak, which has caused a much higher death toll: measles. The current measles outbreak is the country's deadliest recorded to date (over 6 700 people had died at the time of writing) and the largest in the world today. The comorbidities associated with the management of the Ebola and COVID-19 diseases are not limited to measles. The WHO (2020i) also indicates that the continent is set to lose significant ground to the fight against malaria as attention and resources get diverted to fighting the EVD epidemic and the global COVID-19 pandemic. This illustrates how international responses to global heath threats direct and determine public health resource allocation, with little consideration given to bolstering sovereign public health systems.

Failing health systems, financialisation and corporate profiteering from the Ebola crisis

The demise of the DRC's public health and general infrastructure have created a vacuum for international organisations and private entities to move in to manage the country's Ebola outbreaks, giving way to disquieting levels of corruption. This has been with the implicit knowledge of the WHO, and, alongside politically motivated misinformation, has fuelled the stern resistance by local communities, sparked violence against those deployed to contain the spread of the virus and thereby further accelerated propagation of the virus. It has also created fertile ground for extensive profiteering on the back of the Ebola shock, with EVD vaccine developers cashing in on undisclosed subsidies (Freudenthal, 2019b) and novel anti-Ebola drugs being developed through the use of digital sequence information with no shared benefits for countries from which genetic information stems (Hammond, 2019). The Ebola shock also created further opportunity for financialisation, with the World Bank creating in 2017 the Pandemic Emergency Financing Facility (PEF), which saw the issuing of "pandemic bonds" (Sullivan, 2020). When Ebola broke out in the DRC, the PEF failed to materialise in any form of financial support, as the number of deaths proved insufficient to trigger pay-out; while investors were cashing in on coupons.

Although this instrument has since been quietly terminated by the World Bank as pay-outs to developing countries during the Covid-19 pandemic were delayed and investors bailed out, this system illustrates the abject commodification of disease and how the deaths of Africans became subject to global financial market algorithms.

Zoonosis, a Trojan Horse of "fortress conservation"

The DRC's deforestation rate is steadily increasing and the new president elected in 2019 seems to be doing little to reign in the rise

of illegal trade in industrial logging concessions in the country (Hecketsweiler and Freudenthal, 2019). However, this paper also cautions against the instrumentalisation of the growing awareness of wild ecosystems destruction, and its role in the spill-over of disease. This might become the next Trojan Horse of the "fortress conservation" agenda, characterised by the promotion of pure conservation approaches devoid of human presence, which often form a veil that covers unabated ecological destruction (WRM, 2020) – as is happening in two of DRC's protected areas classified as UNESCO world heritage sites (Global Witness 2018, 2019b) – while further disenfranchising communities that depend on the forest for their survival.

Towards systemic solutions

This research calls for structural changes in the global economy, which currently subordinates countries like the DRC. DRC's debt-driving ecological collapse and zoonotic spill-over brings to the fore the call for debt cancellation, without neo-liberal strings attached.

PHOTO CREDIT: BELEN B MASSIEU

Also, African countries must assume their share of responsibility in identifying and taking to task the plurality of actors involved in driving the deforestation that is leading to diseases emergence. Addressing pandemics, forest degradation and deforestation should be de-linked from financialisation and speculation and should be addressed through reinvigorated processes of internal democratisation, economic transformation and capacity building in state institutions and civil society.

What has happened to the DRC's (and many West African countries') health systems, and the link to the Ebola outbreaks, shows starkly the need for the Global South to find alternatives to the World Bank and IMF, who, despite their public relations efforts, have not moved beyond the neoliberal playbook. This, then, also requires governments to reject austerity and make the investments that are necessary to confront ecological and social crises. Divestment in public health systems therefore needs to be reversed, and support given to building their financial, human and institutional capacity. As the case of Ebola and its spread shows, public health systems are a crucial part of the ecological question. They cannot be left in the hands of aid organisations, the private sector, or global financial markets. Public health is a public good.

These shocks urgently call for a rethinking of interventions that would strengthen village level food systems, starting with supporting rural livelihoods so as make them more resilient to the influx of foreign capital that is so disruptive to local dynamics. This reorientation of the food systems needs to be brought about in a manner that places biodiversity at the heart of agroecology, to bring back the "lining" offered by nature. The shocks also strongly signal the need to overhaul the "conservation without people" agenda and to protect and strengthen the communal land rights of forest people, who have proven to be the best custodians of forests. At the same time, public awareness about potential reservoirs of emerging infectious diseases must be improved and capacity to track virus emergence bolstered; as well as the caring capacity of the public health sector.