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Ebola and emergency anthropology: The view from the “global health slot”

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By Crystal Biruk

Hoses spraying disinfectant, white spacesuits, and police roadblocks: these are the tangible technologies of expertise in West Africa. Amid images of ongoing efforts to contain Ebola, I find myself asking: What is the role of the medical anthropologist in a global health emergency? What expertise can we contribute? As of 1 October 2014, the World Health Organization (WHO) counts 7178 reported cases of Ebola, and 3338 deaths. On 8 August 2014, the WHO authoritatively declared the Ebola epidemic an “extraordinary event” and indicated that conditions for a public health emergency of international concern (PHEIC) had been met. The *New York Times* suggests that Ebola cases could top one million within four months. Meanwhile, Sierra Leoneans have been quarantined or put under lockdown and curfew to curtail the spread of the virus. The rhetoric of emergency, that familiar anchor of compassion, is not new, but nonetheless urgently calls upon us to do, to act, to document, and to intervene in this present crisis (Fassin and Pandolfi 2010:16).

By nature (or culture), however, anthropology is slow, tedious, and careful; these descriptors gain currency in their juxtaposition with the fast-paced and urgent nature of global health. Yet, our species of cultural expertise is in demand. The rise of a global health industry has furthered the institutionalization of medical anthropology in the past decade. The relatively large number of medical anthropology faculty jobs available in recent years and the demand for seats in our classes suggest that the sub-field is a “hot” one. We have carved a (small) niche as expert global health commentators and practitioners: our classes “enhance” and “complement” medical school or pre-med curricula by instilling in future scientists, doctors, and public health workers an anthropological approach to health, the body, and intervention. Anthropologists of global health have come to occupy a clear compartment in a wider discursive field: recalling Trouillot’s “savage slot” (1991), we might term it the “global health slot.” As anthropology emerged as a discipline, it established a monopoly over speaking about “primitive” people. Returning to Trouillot’s work, Joel Robbins (2013) argues that anthropological production today is driven by “suffering slot” ethnography, which centers the subject living in pain, in poverty, or under conditions of oppression. Celina Callahan-Kapoor reminds us that as medical anthropologists, our ethnographic accounts

emerge from and reinforce a kind of medicalized savage slot. Here, I use the phrase “global health slot” to draw attention to two things. First, the work produced by anthropologists of global health—even as it speaks to authors’ moral and epistemological commitments—attains value in a wider discursive and economic field, here, “global health.” Second, although the kinds of subjects (people) that appear in our work reflect our discipline’s investments, we might also consider how these subjects are always already illuminated against the objects they move through, negotiate, come up against, and are narrated by (here, global health and its anthropologists).

How might the turn to global health work to separate scholarly analysis from the specificities of local history and politics? What implications does our own embeddedness in the very offices and economies we critique have for the knowledge we generate? The unfolding Ebola epidemic sparks these questions for me, although I think they point to issues that anthropologists of global health face even in “non-emergency” times (if any remain).

The “global health slot”

The emergency of Ebola in West Africa, and the global health slot I have been describing, compels medical anthropologists, if not to “do” something, to “say” something. Rightly so, I think, anthropologists have long blurred the lines between these verbs, resisting the overwhelming pressures to “align, to be useful, to be active in regimes of intervention” (Marcus 2010:373). Yet, Ebola is a tragedy that cuts across almost all of the commitments shared by anthropologists of global health, science, and medicine: it exposes the political economy of health and illness; it illustrates flows and stoppages that direct the mobility of science and technology; it brings to light the shortcomings of “quick fix” or magic bullet solutions to structural problems; it draws attention to the health consequences of reconfigured social relations produced by health and development regimes of governance; and it tragically accentuates the racialized logics that have long determined which lives “count.” Some anthropologists are right now on the front lines of the epidemic, and Sharon Abramowitz recently compiled a concise list of ten real things anthropologists can do to fight Ebola in West Africa. Action-oriented approaches are crucial in times of emergency, and I concur that ethnographic expertise would likely improve the response in West Africa. However, my interests in this essay center on more humble and mundane kinds of “doing”: writing, thinking, and teaching about an unfolding epidemic to various audiences, including ourselves.

As a bystander in Ohio to an epidemic taking place in West Africa, I've been jotting down notes, collating articles documenting the unfolding events, following Twitter, and discussing Ebola with students and colleagues. In August, I sat down and spent a day trying to get some thoughts on paper; like many of you, I was horrified by both the epidemic's toll and media coverage of Ebola. I wanted to place accounts of riots, mistrust, and violence amid Ebola in historical context. I wanted to question the turn to "informed consent" as the bottom line of global research ethics through close analysis of the tragic decision not to give a Sierra Leonean doctor the Zmapp serum. I found myself balancing the compulsion I felt—as a medical anthropologist and a "Malawianist"—to say something, and my hesitance to graft theoretical frameworks I've been socialized into on to places I have never been to. I felt unsettled by: 1) My impulse to rely on comparative ethnographic data and theoretical packaging in my analysis; 2) My willingness to speak from a general position—as an anthropologist of global health—about particular places. The latter, especially, felt too "global health-ish." In other words, I feared that my reading might overlook the significance of small-scale organization and phenomena, in its emphasis of large-scale social patterns common to "Africa."

To probe my own discomfort, I thought it might be interesting to excerpt from the essay I wrote back in August in order to subject it to a critical re-reading. Maybe you can help. I imagined a general audience (of non-anthropologists), but it was precisely in re-reading what I wrote that I felt that sharing it publicly might generate more questions than answers, and might do injustice to what I see as the potential of an rigorous anthropology of global health. In staging a reading of my own words, I hope to encourage medical anthropologists to occupy the global health slot more ambivalently and to push forward readings that seem to apply everywhere and anywhere to more effectively capture the particularities of place. I hope my essay can serve as a platform for pondering what might be the goals of anthropology in an emergency, and for serious consideration of the promises and pitfalls of the global health boom for anthropology.

"Angry mobs" and "Ebola is not real!"

Let's look at an anthropological reading of violence leveled against doctors, clinicians, and those trying to manage and contain the epidemic in West Africa. This reading is symptomatic of my own occupation of the "global health slot;" you might imagine yourself or a colleague making similar points for a general audience (and certainly, many anthropologists have):

If you have been following the epidemic, you will recall that on 17 August 2014, BBC reported that an "angry mob" attacked a health center in Monrovia's densely populated West Point township, with some suggesting the protesters were unhappy that patients were being brought in from other parts of the capital, others shouting "There's no Ebola!," and still others believing that Ebola is a "hoax." "Ignorance is high and many people are reluctant to cooperate with medical staff," suggested health experts. In his depiction of the situation on the ground, Sierra Leonean journalist Umaru Fofana describes how his colleague watched relatives of Ebola patients "pelt the hospital with stones;" he goes on to bemoan conspiracy theories and denialism, and explains how locals are blaming medical workers for the disease. On 20 August 2014, journalist Norimitsu Onishi, writing for the New York Times, documented "clashes" in the same neighborhood where the patients escaped on 18 August, "hurling rocks" and "storming barricades."

These outbursts of anger and outrage, and the physical violence they engender, have largely been read in the mainstream press as spontaneous violent reactions to those "who are only trying to help" (cf. accounts of the protests and "clashes" in Ferguson, Missouri). Claims that "There is no Ebola!" or beliefs that medical workers are bringing rather than managing Ebola are read as tragic expressions of African ignorance and irrationality. Such accounts prompt even a critical reader to bemoan the persistence of irrational beliefs in conspiracy theories, witchcraft, and superstition; these beliefs are taken to be a major obstacle to the rational and scientifically proven interventions and efforts to contain and manage Ebola. "Culture" explains these beliefs, just as it takes up much space in WHO guidelines that emphasize "funerals and burials" and "misperceptions" and misinformation as issues to be dealt with in the ongoing fight against Ebola. (We should note that a recent Harvard poll shed light on "misperceptions' of the virus within the US: More than 25 percent of a sample of Americans said they were concerned than they or someone in their immediate family might contract Ebola in the next year, and 39 percent were concerned there would be a large Ebola outbreak in the US in the next year). While there are real transmission risks associated with funerary practices in West Africa, and with circulating "misinformation" about Ebola, I draw your attention to how, in all of the above statements, "culture" in the time of crisis is always already pathological, irrational, non-innovative, and bad.

As we consume representations of angry Africans hurling stones at

intrepid health workers, we must consider such events not as out-of-the-blue clashes between irrationality and rationality, but as symptoms of underlying tensions between insiders and outsiders, the researched and the researchers, the poor and the rich, and the immobile and the mobile. These interactions are not new, even if they are made more visible to us by the spectacular and horrifying real time documentation of Ebola's travels: blood soaked mattresses, angry mobs, and feces covered floors.

Anthropologists and historians have long taken conspiracy theories and rumors across sub-Saharan Africa (and elsewhere) not as mere silly "stories" but as reservoirs of information about the particular kinds of unequal and often exploitative relations between outsider-led projects and local people and places. In her book Speaking with Vampires: Rumor and History in Central Africa*, for example, historian Luise White (2000) documents and analyzes colonial-era rumors and conspiracy theories in East and Central Africa, viewing them as viable sources of historical insight about the fraught relations between ruler and ruled. These stories are not so different from those circulating right now in West Africa that accuse health workers of bringing Ebola; the 'rumors' White documents accused game rangers of capturing Africans, mine managers of keeping them in pits, or firemen of subduing Africans with injections. In 2007-08, I documented similar kinds of stories in rural Malawi that accused foreign researchers collecting survey data of being "bloodsuckers" (opopa magazi) who steal blood and information from them. Archival sources from 1930s Malawi (then Nyasaland) indicate that health campaigns, surveys, and vaccination efforts were often stymied by similar rumors, dismissed by colonial officials as "African superstition". The accounts of Liberians hurling stones at health offices also find corollaries in stories I heard about rural health posts and survey research vehicles in 2007-08 Malawi being vandalized by stone-throwing crowds of villagers.*

Taken in bulk, the widely circulating conspiracy theories, violence, and rumors in times of health crisis (notably not unique to Africa) that so effectively capture headlines bolster our imaginary of Africans as superstitious, in need of help and education, and ignorant of the wonders of science. These stereotypes are reinforced by imagery that feeds into pre-existing caricatures of Africans as hemmed in by their culture. They are closed off, not only to science, but to the western world; a recent Times headline *described a village ("a mud brick community of rice and cassava farmers deep in the forest") "frozen" by fear and death. In* its report *on the Ebola situation in Nigeria and Guinea, the WHO described*

> *26 villages as "highly resistant to outside help," until they were penetrated (saved?) by health workers and "opened" to the outside.*
>
> *It behooves us to remember that the "opening" of Africa to medicine and the arrival of western or western trained "health workers" was often concurrent with the violent opening of Africa to racialized capitalism. In south central Africa, for example, one of colonial medicine's main objectives was to ensure that black bodies remained fit enough to labor under poor conditions in mines in Southern Rhodesia or South Africa. Across Empire(s), health workers became "police" who toured villages to forcibly oversee vaccination; in early 20th century Uganda, Africans were forcibly moved from tsetse fly habitats (also important sites of fishing and hunting livelihoods) to prevent sleeping sickness (Vaughan 1991, Headrick 2014). In mid-nineteenth century Senegal, French colonial health authorities used yellow fever policy to justify forced removals that targeted the 'unsanitary' and 'uncivilized' indigenes, but left merchant families alone (Ngalamulume 2004). Of course, such instances of militarized and racialized medicine augment suspicions stoked by scandals such as the Trovan clinical trial in Nigeria and the perinatal AZT trials in South Africa, just two memorable examples from among many others that dot the landscape of an Africa that has long been the world's "living laboratory"(Tilley 2011).*

We recognize this account as anthropological because it asks readers to destabilize dominant representations of "African culture," to consider the historical circumstances and particularities that have produced these events, and to place them squarely in the long and still unfolding contexts and politics of intervention across Africa. These agendas are those we instill in our students and give to our universities (or other institutions) through our intellectual and other labor. They are valuable precisely because they contend with or complicate dominant narratives of well-intentioned global health or science encountering "stubborn culture." Anthropology establishes its legitimacy by drawing its objects into the global health slot, reframing them, and generating knowledge for interested parties (ourselves and others).

Now, I ask you: What do we really learn about Ebola *in a particular time and place* after reading the above? We learn, perhaps, that we should "historicize" so as to better understand the present. Rumors and irrational responses to health workers are not inexplicable or random: they are products of a long history of fraught encounters between insiders and outsiders. Yet, while my effort above to draw connections between a

constellation of historical examples (from Malawi, Uganda, Senegal) of similar phenomena is useful, a close examination of the relations and conflicts between various kinds of insiders and outsiders in the *specific* West African locales affected by Ebola would help us better understand the "clashes" between medicine and culture we witness *there.* To draw connections and comparisons is useful, but can also evacuate events of their particularity. Re-reading my own reading, I have so many questions, and maybe I just haven't looked in the right places for the answers: What sorts of projects (medical and otherwise, recent and in the distant past) have been working in the areas where these violent responses have occurred? How have they variously engendered trust, hope, frustration, suspicion, and fear? How might a particular history of these affects in these places help us to really understand this present moment of crisis? How, specifically, has "culture" been packaged and instrumentalized in state, development, and other projects, and how might this local politics of culture play into efforts to alter risky practices amid a health emergency? Though anthropologists these days focus on "NGOization", I wonder about the historical relations of trust and distrust between a citizenry (and all the different kinds of people who make up the citizenry) and its government. (I have found Ashoka Mukpo's reflections on the history of cynicism toward government in Liberia very useful in beginning to consider this question). Inevitably, we draw connections between what we know and what we wish to know: I work in Malawi, so I wonder whether Sierra Leone, Guinea, or Liberia are also over-researched or cross-cut by dense networks of NGOs and projects. (An aside: Of course, my reading is imprecise and broad strokes, you might say, because I don't work in West Africa. To assume, however, that a medical anthropologist not working in one of the countries most affected by Ebola has nothing of value to say about an ongoing epidemic is dangerous. My critique is less about the lack of "local color" than it is about how particularity might disrupt the narratives we—anthropologists—tell ourselves about global health or, in this case, a global health emergency).

Slow(er) theory?

Like any discipline, anthropology has its buzzwords, its pet theories, and its investments. We read accounts about other places in the pages of our journals and books and often what we remember most are the inventive interpretive concepts generated by their authors: therapeutic citizenship, scientific sovereignty, states of exception, pharmaceuticalization, humanitarian logics, and so on.[i] (Though I did not deploy any buzzwords above, my account is symptomatic of its machinery of production: the global health slot). I worry that anthropologists of global health, situated as they are in the global health slot, may fall prey to the very logics we are so

fond of critiquing. Even as we identify the portability of workshops, emergency responses, and health education programming –just a few of the trappings of 'global health'–as universalizing, imprecise, and ineffective, might we be guilty of overusing popular theoretical concepts that "travel well?"

Medical anthropologists are committed to excavating the structures and political logics that enable and fail to mitigate suffering amid Ebola. They have shed light on the question: Why is Ebola so out of control? Paul Farmer gets at the heart of the matter in pointing out that surviving Ebola is a matter of "care" rather than drugs. Others have drawn attention to massive brain drain and crumbling health infrastructure in the region. Yet, these explanations immediately raise more questions for me: Why have Liberian or Sierra Leonean doctors and nurses left for greener pastures (and how does this differ from the push and pull forces driving emigration of Kenyan or Malawian doctors)? How do the particular movements of people inevitable during conflict and post-conflict periods in Liberia play into the lack of healthcare personnel? Who are the people on the front lines of the epidemic? What are their dreams, hopes, and struggles, and how do their everyday lives influence the work they do (which has, finally, thrust them into a spotlight usually claimed by renowned researchers or foreigners)? We may agree that global health and epidemic containment efforts, in rhetoric and form, emerge from imperial (or militarized) humanitarian logics. Yet, how does this look in one place versus another? How do our readings across places reify—perhaps unhelpfully—a global health that looks different in all of its locales?

Ebola exposes the fault lines of global society, and brings to light the calculus that underlies questions of who can leave, who can access treatment, and who should be saved. This calculus maps onto 'pre-sorted' social divisions, but ones that far exceed "local" and "global" or black and white. In analyzing the hierarchies of value that propagate the uneven distribution of suffering and death, a nuanced consideration of how local bodies are marked by their position in matrices of power, class, gender, able-bodiedness *in a particular place* would be very helpful. How does a medical anthropologist navigate between the impulse to say something, and the glaring gaps she sees in her accounts? How can we convincingly connect structures to lives and theory to ethnography even, or especially, in times of emergency and for various audiences (and here I include fellow anthropologists)?

I am continually struck by the familiarity of stories I read about AIDS programming, knowledge production, NGOization, and so on in anthropological journals. I strain to see something I didn't see before, and hesitantly note the seeming commensurability between very different places (this is not to discount a wonderful body of work; I am being

somewhat polemical and sloppy). I have begun to wonder if the "sameness" I see all around me is difference dressed up in articles of clothing all anthropologists have in their closets: biopolitics, regimes of value, politics of ontology, traveling technologies, the politics of becoming, boundary objects, and multispecies ethnography (see Footnote xii). Anthropologists of global health take significant interest in how global standards and formalizing practices serve to fix, stabilize, and make "other" realities workable for scientists, policy makers, and development workers; so, too, do they operate in our own discipline.

In our willingness to graft theory or concepts onto places, do we mirror global health's own penchant for traveling toolkits and standards? It seems I have come round to calling for a more "particular" anthropology of global health. This surprises me, a bit. I think I am pushing myself—and all of us—to be open to the particular, to invite it in to the "global health slot" so as to mess up or slow down its machineries of production. Maybe, on the heels of Vincanne Adams and colleagues' (2014) recent call for "slow research" in global health, I am simply calling for "slow(er) theory." Even as we unpack rhetoric that casts culture as static, stubborn, and a stumbling block to health and science, might there be value in considering that, for the purposes of thinking, culture does have a certain stubborn—and productive–particularity? How do we not lose sight of this particularity, even in times or places where our usual toolkit of slow methods fails us because of urgency? The Ebola epidemic is a particularly good site for pondering these questions, precisely because plagues—long a favored topic of some of history's greatest novelists and writers—seem to look so similar across time and space: "The truth is that nothing is less sensational than plague, and by reason of their very duration great misfortunes are monotonous" (Camus 1991: 179). But, even as we recognize the suffering, the social fissures, and the narrative arc of Ebola as timeless and familiar, is it not anthropology's responsibility to illuminate something more, to carefully narrate a story that is nonetheless local in its universality? How do we move beyond "It's complicated," to unravel the particular strands that make it so?

I close by asking more questions, for which I have no solid answers, but which I look forward to discussing further (and maybe the role of anthropology in an emergency is to generate questions): What should anthropologists say about Ebola? How might what we say, and even our impulse to speak in the first place, be symptomatic of a certain culture of standardization across a sub-field that is currently riding a wave of popularity? I suggest that it might be helpful to think about ways to struggle against a "global health slot" that seduces us to: 1) Reify the global, and "global health" to achieve our own critical impulse or fit into ongoing conversations in our discipline; 2) Obscure our own complicity with the rise of global health as a powerful governance structure on a

global scale; and 3) Become swept up in a global health market—including our own discipline—that privileges those things it can most easily digest, commodify, and translate across difference. Moments of health crisis abroad urgently invite us into the global health slot. What is the nature of the knowledge we want to produce? What questions should we be asking? Who can speak? Isn't it time we theorize not only global health, but the "global health" anthropology has created for itself?

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Note

[i] These concepts are critically useful in my own thinking and writing. My point is not to single them out as colonizing forces of in the larger wordscape of anthropology. This essay is not adverse to "theory" but points, as others have, to how theory itself is a traveling technology that we learn to love, not unlike the good old Zimbabwe bush pump (deLaet and Mol 2000).

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