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Race and the immuno-logics of Ebola response in West Africa

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By Adia Benton

On September 14, 2014, I woke up to the news that a fourth Sierra Leonean doctor, Dr. Olivet Buck, had died after having treated patients with Ebola. By then, there had been nearly 2,300 confirmed deaths, with about 150 of them being health care workers at the front line of the epidemic. All Ebola deaths are tragic, and many of them could have been prevented with better and earlier response by government and international health authorities. But Dr. Buck's death is all the more significant for what it represents in these months of sluggish response to the West African Ebola crisis. The government of Sierra Leone feared that Dr. Buck's death would further diminish an already understaffed health workforce and demoralize exhausted health workers. They arranged for her medical evacuation to Germany, where a hospital was awaiting her arrival. President Koroma requested assistance for Buck's transport from the World Health Organization (WHO), the international body coordinating the international Ebola response.

The WHO rejected the president's request. As Buck battled illness in a Freetown hospital, two Dutch doctors, fearing that they had been exposed to Ebola through patients they had treated for malaria, fled to the Dutch embassy in Ghana. There, they sought immediate evacuation to the Netherlands. The doctors — thankfully for the Ghanaians and others who surely crossed their path — had yet to experience symptoms and, therefore, were unlikely to have transmitted the disease to others. They have since been evacuated. The simultaneous unfolding of the stories of Dr. Buck and the two Dutch physicians raises important questions about the character of emergency response to this outbreak: How are we to interpret the Dutch doctors' evacuation and WHO's refusal to assist in Dr. Buck's? And what might be revealed by reading these two stories together?

Some have suggested that bureaucratic red tape was most likely to blame for this differential treatment; others have asked whether it was fair to evacuate *any* national health workers under the circumstances. As I have written elsewhere, for observers watching the outbreak unfold, these situations entail assessments about the value of life. These assessments are not isolated or neutral forms of triage (Sierra Leone's premier

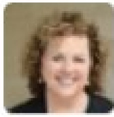
virologist also died amidst negotiations for his medical evacuation and possible treatment with an experimental drug, ZMapp). Rather, these assessments about the value of life lie at the core of humanitarian emergency response; they are part of its operating logic.

This operating logic has a racial dimension, which has for too long gone unexamined and whose impact has been woefully underestimated. Among West Africans living in or hailing from the affected areas and within the African diaspora, there is a sense that when it comes to decisions about who will live, who will die, and who will receive the best care, white Westerners who come to help will often — if not always — be the priority.

US Peace Corps volunteers, as well as employees from mining companies, international NGOs and foreign embassies, have been evacuated or placed on voluntary temporary leave from their posts. The Peace Corps evacuation is, perhaps, noteworthy because one of the organization's mandate for its volunteers is that they 'live in a manner similar to the local people in [their] community.' The simulation of local life appears to reach its limit when the threat of Ebola nears, despite the fact, as Kim Yi Dionne notes, that (1) avoiding contact with bodily fluids of infected persons and maintaining strict hygiene practices minimizes risk of infection and (2) volunteers are highly educated adults who can certainly understand and adhere to public health instructions. (This is not to say that volunteers *wanted* to be evacuated from the sites; in fact, many of them were reluctant to leave).

For the foreign doctors and technicians who stayed on and have fallen ill, no expense was spared, no form of care or protection was off-limits. Kent Brantly and Nancy Writebol, the two American missionaries who became sick in August, were evacuated to Emory Hospital in Atlanta and treated with the experimental drug, ZMapp. The racial *immuno*-logic to which I have been alluding rests on a critical assumption: that wealthy whites are not supposed to die or fall ill when they are helping 'others'; they are believed to be immune to the tragedies that befall black Africans. In some ways, it seems that falling ill is a failure to fully capitalize on protection of privilege. It is why we hear, "how could *this* have happened to *them*?" or "Why were they there in the first place?"

Former science journalist and senior fellow in global health at the Council of Foreign Relations pursues this line of reasoning in a tweet, couching it in terms of practical matters:



Laurie Garrett
@Laurie_Garrett

A third American missionary hlth wrker has contracted #Ebola. Isn't it time to examine infection contrl prax in mission clinics?

5:11 PM - 3 Sep 2014

The content of the tweet is not unique; nor does it really offer a useful suggestion. As many noted in their responses to Garrett, when any health worker gets sick with Ebola while treating others, it's usually because of a disruption in good infection control practices. When trained health workers become exhausted and use their protective equipment incorrectly, accidents can happen. When health workers live in a community of sick persons, they may contract the illness outside the clinic. Yet the question is regularly posed: "How did these foreign health workers get sick? Why did they get sick at this point in time?" (It's Evans-Pritchard all over again). To assert that the infection control situation must be investigated because three (white) Americans are sick is also to say that the thousands who fell ill *before the Americans* do not matter. (And that there are other expatriates — notably MSF — who get it right).

It is not easy being a clinician treating Ebola patients. At least half of your patients die. Working in the protective gear is uncomfortable and exhausting. The conditions in the hospitals are often sub-standard, leaving clinicians themselves worried about what would happen should they become sick from Ebola. A physician on twitter, Megan Coffee, recently wrote: "There is always that fear that if you're a doctor working with little there is nowhere to turn if you become sick." So it probably came as no surprise that the US Department of Defense, heeding MSF's call for military and civilian medical aid, pledged the rapid deployment of a military hospital to Liberia specifically for health workers.

We were soon to learn the terms of that pledge: $22 million for 25 beds in an unstaffed hospital. It was also reported that *only* foreign health workers — which many people read to mean "white" and not the African workers who have also been called to assist in the Ebola response — were to be the recipients of care in this hospital. Amidst a loud outcry amongst observers, the statement has since been "corrected" on Twitter; an official statement was expected during Obama's speech on September 16, but it never happened. These events cannot be undone; these words cannot be unspoken. It was only one of many messages about the value of West African lives that fanned the flames of distrust and anger directed at the international response to Ebola.

Earlier in September, two US-based clinicians eulogized Sam Brisbane, the first Liberian physician to die from Ebola. Since then, Liberia has suffered even greater loss of health workers than in Sierra Leone, where Dr. Buck died. The eulogy is a moving piece, sharing the authors' sense that despite the despair it causes for his family, friends and colleagues, Brisbane died a "good death." For all its poignancy, the idea of a "good death" rubs many of us raw, as we recognize that better care is possible — no, necessary — for those frontline West African doctors and nurses who put themselves at deadly risk and whose survival is essential for already fragile and overextended health systems.

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