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Ebola and Localizing the “Global Other” in the United States

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The outbreak of Ebola in Western Africa has spurred a great deal of anxiety among state and local public health officials in the United States. The initial arrival of the disease in the United States with a Liberian immigrant in Texas exposed the shortcomings of a response system that relied heavily on guidance and protocols from medical organizations emphasizing protective gear, isolation protocols, standardized questions, and other operational and technical details, but doing little to understand the patient as a cultural being. It also showed how even hospitals designated as “Ebola-ready” might have been able to treat the disease, but not the patient. The result was the nation’s first death from Ebola—a West African man who was first turned away from a thorough examination due in part, we suspect, to limited skills in providing culturally responsive services.

While the media focused on the handful of Ebola cases that have surfaced in the United States and provided a platform on which to debate the wisdom of mandatory quarantines for those potentially exposed to the virus, the crisis hit our nation in the few weeks prior to important mid-term elections. Ebola was no longer just a public health issue. It became highly politicized, driving much of the discussion towards partisan rhetoric that fed medically unfounded and alarmist ideas about preventing non-citizens

(that is, Black Africans) from bringing a plague to our shores. In previous elections, candidates were often accused of being “soft on crime.” In the 2014 mid-term elections, candidates were accused of being “soft on Ebola” and “putting our nation at risk.”

Despite the political and media-driven discourse about Ebola, cross-cultural health specialists and medical anthropologists viewed the disease from an intensely human perspective in real terms at the state and local level. Which immigrant populations and tribal groups were more vulnerable than others to Ebola? How was the disease linked to migration patterns of immigrants between West Africa and diaspora countries like the United States? What cultural patterns contributed to the spread of Ebola, and which could also help control it in an outbreak in the U.S.? What could we learn from the Texas experience from a cross-cultural health perspective to better prepare for the arrival of the virus in other hospitals and immigrant communities throughout the United States?

After Ebola arrived in the United States, we believed—naively—that the above questions were being widely discussed among state and local public safety and health officials around the nation. Instead, over the course of the past few months, we found reluctance and even resistance to discussing the Texas Ebola case from a cross-cultural health or medical anthropology perspective. To us, the case in Texas provided a classic example of how epidemiological models and protocols can sometimes remain aloof to, or neglectful of, the cultural aspects of disease transmission. We have heard many epidemiologists and physicians confidently state that culture and ethnicity do not matter in this case, and that everyone is equally at risk from the disease. Perhaps even more alarming around the country is that the very sub-populations that are most vulnerable to the virus—and a potential “gateway” population to contract the disease in the States—were not recognized or acknowledged. West African immigrant populations, as well as the health workers that care for Ebola patients, remain the two groups of people at greatest risk for contracting Ebola in the United States. However, the numerous small and large ethnic communities of West Africans in the United States remain largely unknown to many medical providers, health departments, and emergency planners. To make matters worse, few of these professionals realize that many of these West African immigrant populations themselves have been requesting assistance from public health professionals to educate their communities about Ebola and keep their own populations safe from potential spread of the disease through visitors arriving in the United States from back home.

We work with immigrant, refugee, and minority populations every day, and we respect that many of our colleagues in other fields may not be familiar with all the cultural sub-populations in their communities. But in the initial

response to Ebola, many of our colleagues around the country were shocked to learn that some 500,000 West African immigrants live in the United States, including significant populations in “unlikely” states such as Iowa or Rhode Island. Most importantly, from a cultural standpoint, these individuals maintain very close ties with family and friends in the Ebola “hot zone.” Many continue to have relatives and extended family members visiting them in the United States on a frequent basis.

From our perspective, this scenario exposed the over-reliance on medical protocols that screen for diseases in individuals, but often overlook the bigger picture of diseases in families and cultural communities. Patients are too often viewed as nameless “vectors,” not members of human cultures. In our subsequent efforts to inform this process, we have emphasized the basic anthropological concepts of “low” and “high-context” cultures (Hall 1976) . Clearly, the perspective, experience, and expectations of many of our colleagues in epidemiology around the country emerged from a “low-context” perspective that focuses on individuality. Disease screening too often looks just at the individual patient, and ignores broader family and community issues that are important to understand from a “high-context” group-oriented cultural standpoint. This assumption played itself out perfectly when the Centers for Disease Control announced to the world that the Liberian immigrant first diagnosed with Ebola in Dallas had only been in the company of, and therefore only potentially exposed, a handful of people living in his fiancé’s apartment. Within days, however, the high-context nature of Mr. Duncan’s culture revealed itself, and ultimately public health workers had to track up to 100 individuals for potential exposure from a single patient. (The public health implications for disease surveillance and control within group-oriented, high-context West African communities were also seen recently in Nigeria, where disease trackers had to investigate up to 1,000 potential contacts for every one patient with Ebola.) Likewise, the initial Ebola screening protocol in the United States focused almost exclusively on whether an individual patient had traveled personally to West Africa and did not take into account the fact that many West Africans in the U.S. live in closely knit neighborhoods and dense households, as is common with most “high-context” cultures around the world. The screening protocol did not account for the fact that a person might never have traveled to West Africa, but could have been exposed to an illness that was brought recently from an international visitor who had arrived in the household.

We believe part of the disconnect between these cultural experiences is exacerbated by the nagging insistence to frame Ebola as a disease of the “Global Other” and to assume that even if some of these people live in our communities, they didn’t bring their “otherness” with them. In many respects, Ebola provides Western health officials with a scenario that

accentuates racial and ethnic logic about disease and death. In the view of many Western providers, there are clear germ theory reasons why West Africans are victims of Ebola. These include, for instance, that the disease is most likely transmitted by infected bats that bite animals. This bush meat is then hunted and eaten by rural West Africans, who then migrate to rapidly growing mega-cities with significant overcrowding in their peri-urban shantytowns, where Ebola spread like wildfire from these infected humans. Many West Africans also routinely practice cultural rituals that can help spread the disease as well through body fluids, particularly when cleaning dead bodies of relatives before burial. Numerous West Africans, on the other hand, view the disease through a very different cultural lens. They are much more likely to believe the disease was deliberately introduced to certain African communities as a form of population control by the Western governments or companies as a way to ultimately gain their land, cocoa plantations, and mines. Others may attribute it to curses, evil eye, or negative energy being put upon them by enemy tribes or families, particularly if they are from ethnic populations with whom they fought during recent civil wars. Even West African health workers have been attacked and run out of some villagers, because they are sometimes viewed with suspicion that they are there to steal the patients and harvest their bodies for use in organ trafficking criminal networks. In light of historical, colonial, and current affairs in West Africa, it is not hard to understand the cultural context from where these health beliefs have come.

Our colleagues shake their heads at these perspectives and behaviors. But the good news, they argue, is that these behaviors are confined to Africa and couldn't show up here. Without saying so directly, some of medical providers we have spoken with suggest that the West Africans who come to the US are the lucky ones who have escaped the backwardness of Africa and can start anew. They have stopped being "African" and are now simply "Black." Surely, these lucky few have seized upon their new opportunity to leave behind the less desirable aspects of their cultures once they arrived in our country. Of course, the acculturation process is as strong one, but immigrants and refugees don't entirely stop being their cultural selves when they cross any border.

We recognize in this discourse a contrast between the well-intentioned efforts of public health colleagues as they encounter the "stubborn culture" of cultural newcomers. Crystal Biruk summed up critical aspects of stubborn culture this way: "Taken in bulk, the widely circulating conspiracy theories, violence, and rumors in times of health crises (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."

It could be argued that many Western medical professionals are also members of a “stubborn culture.” It is a culture that is based too often on clinical science over the social science of anthropology, and proceeds from its own set of cultural assumptions. As anthropologists, our job in the past few months has been helping members of both stubborn cultures come together, to reframe the experience and expectations of both sides, to make the knowledge that emerged from the process useful to one another. We had no doubts that many West Africans in the United States wanted to work with public health officials, and we definitely knew that public health and emergency response professionals have a vested interest in protecting everyone living in their communities, but both sides need help getting past their previous experience, suspicions and expectations.

Indeed, well before Ebola drew the attention of most Americans, the disease was ravaging West African communities. Many West Africans in the United States have already lost loved-ones to the virus. In response, many are forming organizations in immigrant communities here to raise awareness about the disease, generate funds, and mobilize resources. In Iowa, for instance, members of multiple West African countries and tribes got together to form a group called Africans in Iowa Fighting Ebola (AIFE). However, around the country, members of the media and politicians have largely ignored these organizations and requests for assistance, that is, until Ebola came to America. This just confirms the cynicism of many in West African immigrant communities that the West never really cares about anything in Africa until it affects them directly; this is perceived as tied to a need to provide the best care to white people. (This view has been further reinforced among many West Africans, given that the only two Ebola deaths in the U.S. were among black men, while the white healthcare workers here have all survived.)

Diseases like Ebola expose the cultural and economic fault lines that already exist in a global society. It feeds into the thinking of many health and emergency planners that as long as we can contain the disease in Africa, Americans can be sparred a major outbreak. This can be seen in the discourse about the cultural and political logic of quarantine and travel bans, despite the science to the contrary and the real need for health care providers to be able to get easily to the “hot zone.” For both West African immigrants in the United States and the public health and emergency management power structure, Ebola simply exposed “pre-sorted” social divisions. But these social divisions far exceeded ‘local’ versus ‘global,’ black versus white, or immigrant versus citizen. In cultural terms, the thousands of miles between the U.S. and West Africa may comfort Americans, but for the Liberians, Sierra Leoneans, and Guineans, the geographic distance is simply an inconvenience that is easily overcome. Interestingly, many West Africans in the U.S. are finding themselves in the

culturally awkward position of requesting assistance from local public health officials to quarantine or isolate their own relatives who have recently come from the homeland to here. However, they simultaneously request support against bias or discrimination against West Africans because of Ebola.

From our work connecting West Africans with public health, emergency management, public safety, and other professionals around the United States in the past few months, we have been emphasizing the need to "partner" to present a common message to the public, curtail negative stereotyping about Africans, share resources, and, most importantly, emphasize and engage the West Africans as the "front line" against Ebola in this country. Instead of ignoring the West African community, we are encouraging agencies to embrace them and engage their energy, concern, and intimate knowledge of Ebola in an effort to prevent its spread in the United States.

We have now seen this model of culturally responsive community engagement in emergency planning take effect in our own state of Iowa. As cross-cultural public health specialists and applied anthropologists, we have been actively providing training to state agencies and local organizations on West African immigrant populations, demographics, and cultural patterns. We have also helped identify the numerous Liberian, Sierra Leonean, and Guinean communities in our state and their association leaders, so that state organizations can connect with these folks themselves. Ultimately, we were able to bring together key players such as the Iowa Department of Public Safety, the Iowa Department of Public Health, local public health agencies, and the heads of multiple West African immigrant associations and Ebola organizations in a collaborative effort. Some of the activities that are being undertaken now by these state and county agencies include Ebola education for immigrants; outreach and partnership from the state agencies at the highest levels with the immigrant heads; meetings between state physicians, epidemiologists, and the West Africans; immigrant association surveillance and support of their community against the spread of Ebola; and ongoing identification of West African needs and concerns about Ebola in the state. Best of all, these activities are being undertaken before, rather than after, any sporadic Ebola case turns up in Iowa.

We suspect that one concern in replicating these kinds of community partnerships in other states will be how diplomatically African immigrants can point out the cultural shortcomings of the Western disease control and response protocols preferred by their epidemiological colleagues. The Africans have their own narrative that empowers *and scares* them. Their narrative makes a mockery of current and proposed efforts to slow the spread of Ebola of "closed borders" in the hot zone and current and

proposed travel bans and quarantines in the United States. Numerous West Africans that we have met in the United States have spoken openly about their concern over what can only be described as “Ebola refugees” – people fleeing West Africa not because of war or famine, but because of a deadly disease. They report many cases of families bribing their way past border guards in the hot zone, acquiring passports from other West African countries, flying out of airports in Europe or other African countries in order to get to the United States, and even taking Tylenol to keep low-grade temperatures under control long enough to get past airport screenings.

The competing narratives of control and response, versus how easily some West Africans can bypass Western protocols, will no doubt lead public health and safety professionals to blame the Africans’ cultural practices for the failure of Western medicine to curtail the disease around the world. They will note how placing family and tribe over everything else can ultimately put the greater society at risk. What we have seen, however, is that instead of welcoming cultural knowledge about how people get around our surveillance systems, or understanding how Western medical protocols need to be enhanced in order to take into account cultural patterns of the target populations they are meant to protect, often threatens or scares some in the emergency response field. These professionals are often more comfortable being operators of safety equipment, wearers of personal protective gear, or readers of closed ended questions, because that is far easier and less complicated than understanding humans as cultural beings. Ebola in America has helped expose the critical need to engage medical anthropologists and cross-cultural health specialists as partners, along with physicians, epidemiologists, and the immigrants themselves, in the urgent need to prevent the further spread of Ebola. These kinds of partnerships will become increasingly important not just to win the battle against Ebola in West Africa and beyond, but to address future pandemic threats in an age of unprecedented globalization.

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