UCL Migration Research Unit

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The WHO response to ebola: a discursive analysis

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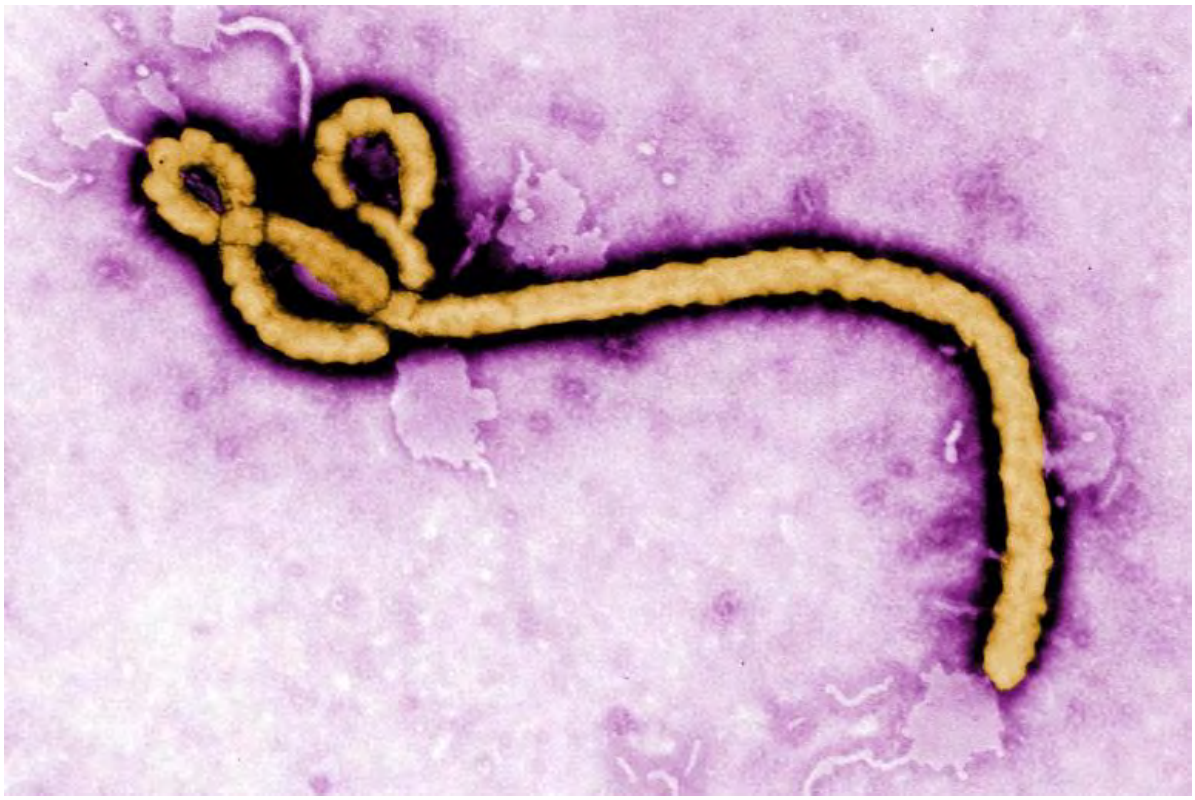
The WHO response to ebola: a discursive analysis.



Ebola virus. Image source: Wikimedia Commons.

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Abstract

This paper offers a discursive analysis of World Health Organization (WHO) archival documents as a case study to examine the construction of ebola as a global health concern. In particular, it aims to uncover how the particular properties of ebola interacted with international networks and pre-existing and emergent forms of governmentality to produce both understandings of ebola and responses to it: Did the delayed international response to ebola reflect the fact that ebola, due to a combination of its epidemiological properties and its geographical origins, initially appeared to pose little threat to most of the circuits of (economic) circulation upon which the global North depends? In any case, how did ebola come to be constructed as a 'matter of concern' (Latour, 2004)? How important was the question of circulation, and can it be disentangled from other factors? This project foregrounds the continuing role of colonial histories and representations in shaping both circulation and understandings of disease (Fassin, 2004).

Contents

Introduction

On the 13th of January 2016, the World Health Organisation declared Liberia free of ebola. Neighbouring Sierra Leone and Guinea, the other severely affected West African nations, had already been declared free of the virus (WHO, 2016). Several isolated cases have emerged subsequently (CDC, 2016), but as of approximately June 2016 the epidemic appears to have run its course. During the main outbreak — between 13 March 2014 (the first confirmed case) and 13 January 2016 — the WHO recorded 28,637 ebola cases, resulting in 11,315 fatalities. This represents five times more deaths than the total of all other known ebola outbreaks combined, even with both figures likely underestimated (BBC, 2016) and entirely excluding significant numbers of indirect deaths which continue to result from social devastation in affected nations. It is also the largest number of epidemic fatalities since 2009's outbreak of pandemic flu.

In addition to its enormous and ongoing human and material toll, the ebola epidemic has spurred extensive popular and academic debate about international responsibility and strategies for managing epidemic outbreaks, many of which are damning criticisms of primarily international but also domestic responses to ebola. This project contributes to those debates by bringing a critical Foucauldian analysis to bear on the WHO's part in the international response.

The WHO's initial response to ebola can be summarized as 'too little, too late'. A decade prior, the WHO was arguably *the* influential actor throughout the unfolding of the 2003-2004 SARS epidemic (Fidler, 2004). At that time, the WHO demonstrated its newly-acquired and formidable surveillance capabilities by using non-governmental mechanisms of surveillance to release information about SARS in China, defying the Chinese government in doing so. The WHO had consolidated and proven its surveillance-power and clout on the world state to the extent that SARS is widely understood as a pivotal moment in global security writ large — not only for the management of global health and the role of international organizations within it. The WHO's action against China is taken as emblematic of shifting security relationships and the declining power of nation states in relation to international organizations (Fidler, 2004). The WHO's late and poorly organized response to ebola is *less* understandable when examined in relation to only the recent history of public health. Explanations must be sought elsewhere.

In particular, I intend to interrogate the extent to which international responses to ebola can be understood as an attempt to curtail undesirable forms of circulation (i.e. disease spread) which in turn disrupt forms of circulation which are not only desirable but necessary to liberal governance. Foucault's (2007) concept of 'crises of circulation' may provide a fuller understanding of the ebola response, including its failings, while adding to the developing academic literature on contemporary security (including, but not limited to, health 'security'). Questions of public health have purchase beyond the practical management of epidemics: this project also intersects with concerns about mobility (e.g. travel and migration), national and international economies, and the role of international government and nongovernmental organizations in shaping international development.

The belated international response to ebola appeared to arise out of national concerns for the health of citizens in the Global North. UK Prime Minister David Cameron, for example, declared ebola to be his 'primary concern' as late as January 2015, and as a direct response to the infection and UK hospitalisation of a British nurse (Siddique, 2015). The delay in concern may reflect the fact that ebola, due to a combination of its epidemiological properties and its geographical origins, initially appeared to pose little threat to most of the circuits of (economic) circulation upon which the global North depends. This argument is seductive: certainly the nations initially affected by ebola are not typically understood as key nodes in chains of production or transportation for the goods or people of the Global North. Yet if the primary question is one of circulation, and if ebola was not initially understood as a problem for circulation, how did ebola eventually come to be constructed as a problem? Was ebola then constructed as a problem for circulation, or a different kind of problem?

In order to explore these dynamics, I have structured my research around the following research questions:

- **What is ebola?** How does the WHO understand ebola (and how else could it be understood)? How are its properties contrasted or compared to those of previous epidemic diseases? Which of ebola's properties have been highlighted in its construction as a problem? How did understandings of ebola as shift as the epidemic progressed?

- **What is the nature of the problem posed by ebola?** To what extent can ebola and other epidemic events be understood as problems of circulation, and how useful is this for understanding responses to ebola and the construction of ebola as a problem? What are the implications for ebola's relationship to broader questions of security and governance?

- **How is ebola being 'treated'?** What rationalities and practices have the WHO deployed in managing ebola as compared to previous epidemic events or altogether alternative approaches? What are their political implications?

Literature Review: Foucault(s)

My research is inspired and informed by Foucault and subsequent scholars of governmental rationality, particularly recent scholarship which has begun to examine the concept of 'crises of circulation' (Foucault, 2007). My dissertation partly seeks to clarify whether a Foucauldian approach is in fact useful for understanding the development (or stagnation) of global health, its foci and omissions. In particular, *which* Foucauldian approach(es) is/are most useful? Foucault's wide-ranging contributions provide numerous directions for analyses. This precludes a singular, holistic 'Foucauldian' approach, as focusing on one theme or lens pioneered by Foucault necessitates neglecting others.

Hannah (2007) identifies multiple 'Foucaults' (i.e. interpretations of his work) at large in Anglophone social sciences alone. In the same edited collection, Howell (2007: 292) argues for the existence of multiple 'Foucault effects': 'lines of influence … [or] avenues of enquiry', rather than straightforward derivations. Soja's (1989) inauguration of 'postmodern' geography claims Foucault for both postmodern and spatially-oriented theorizing, and Philo (1992: 146) agrees, adding that Foucault's spatial focus allows him to effectively 'circumnavigate essentialist modes of thought', or 'totalisation' in theory-building. Meanwhile, Hannah (2007), Driver (1985) and Gordon (1996: 259) all protest British academics' purported 'unilateral and active simplification' of Foucault's work. Throughout virtually identical complaints spanning more than two decades, these dedicated scholars of Foucault concur on one point: there is no unified, all-encompassing Foucauldian approach. I am inclined to agree, despite the distinctly non-Foucauldian consensus into which this homogeneous collection of complaints coalesces: an 'authentic' Foucault is produced, inevitably, even as the authors themselves argue against prescription. This overarching argument against definition also functions as a slippery defensive move, allowing Foucauldian scholars to dismiss critics of Foucault (or of their own work) as simply misunderstanding Foucault, simultaneously demonstrating their own privileged knowledge of 'authentic' Foucault in the process. (So Foucauldian scholarship does have one constant — competitive disavowal.)

Approaching my research questions through the lens of Foucault's early work, later work or the various emphases favoured by different disciplines could suggest any number of different starting points, and so this literature review attempts to outline only a handful

of relevant Foucaults (Legg, 2007; Elden and Crampton 2007). The main section of my dissertation incorporates more diverse scholarship on health (Farmer, 1992 & 1996; Fidler, 2004; Elbe et al, 2014; Hollingsworth et al, 2006) and security (Cowen, 2014; Duffield, 2007 & 2011; Braun, 2007; Dillon and Lobo-Guerrero, 2008; Lentzos and Rose, 2009; Rose, 2007), as necessitated by my empirical findings; meanwhile, I am using this consideration of various 'Foucaults' as a springboard to suggest other productive avenues. I will place particular emphasis on early Foucault-inflected postcolonial scholarship (Said, 1978; Brantlinger, 1988; Miller, 1985, Gregory, 2004 & 2014; Fassin, 2004; Orford, 2003). Finally, I will explore the possibilities of pursuing arguably complementary Latourian considerations of contingency and futurity (Anderson, 2010; Anderson and Adey, 2011), and argue for the methodological benefits of taking object 'agency' seriously (Walters, 2014) by considering ebola-as-actor.

My ambition is dual: I will be critically examining the WHO's response to the 2014-15 ebola epidemic, while simultaneously evaluating the theoretical strengths and limitations of of Foucault's concept of 'crises of circulation' as a lens for examining the WHO response to ebola. Ultimately, I suggest that 'crises of circulation' are best deployed in tandem with the relentless questioning of *discourse* provided by both 'older' Foucault-inspired examinations of discourse, and Latourian commitment both to unpacking the construction of 'matters of concern' and taking the characteristics of objects — including disease — seriously (Latour, 2004).

Foucault 3: Circulation, Security, Biopolitics

My starting 'Foucault' is the (mostly) later Foucault employed by Elbe et al (2014), whose investigation of European public health measures draws upon multiple volumes of Foucault's work but ultimately centers upon his 1977-78 Collège de France lecture series *Security, Territory, Population*, for which an English translation was published in 2007. Foucault's essential argument here is that maintaining circulation (of goods, people, information etc) is crucial to the maintenance of liberal order. Elbe et al. (2014: 448) assert that:

"with the rise of the era of governmentality, security policy becomes about more than just the traditional geopolitical games of territorial influence. It also becomes about managing circulation and sorting the 'good' from the 'bad' circulation."

Foucault was prescient. His analysis is even more cutting now, under advanced capitalism, than it was at the time of his lectures. Huge amounts of investment and planning have been devoted to securing the flows of goods discussed by Cowen (2014: 77); this is considered a *desirable* form of circulation, and so "the material flows of the economy and the transportation and communication infrastructures that underpin them are increasingly the object of security". Ebola, on the other hand, is an *undesirable* form of circulation, insofar as it has the potential to disrupt desirable or necessary circulation. Yet liberal government as understood by Foucault (2007) would not attempt to eliminate 'bad' circulation (e.g. disease) altogether. As Lentzos and Rose (2009: 246) argue in relation to bioterrorism, the goal is not to halt circulation, but to find ways of "managing, monitoring and regulating it".

Duffield (2011: 758) adds that the securitization of circulation — i.e. the maintenance of 'good circulation' — is primarily a strategy for protecting Northern material interests, in the form of 'archipelagos of privileged circulation'. Circulation itself produces uneven geographies. In the case of ebola, I suspect that questions of circulation will prove difficult to disentangle from other factors at play, including the colonial histories and representations which continue to shape both circulation and understandings of disease (Fassin, 2004).

The concept of 'crises of circulation' has been circulating in studies of security for some time: Dillon and Lobo-Guerrero (2008: 282) assert that "biopolitical security apparatuses" in particular are ultimately *for* securing freedom of circulation, while Cowen's (2014) research into logistics and the securitization of circulating goods presents a compelling argument for centering flows in considerations of security — which, for Foucault (2007) is the necessary corollary of liberalism, and is an increasingly key concern in global health discourse.

Elbe et al (2014) use Foucault's concept of 'crises of circulation' to understand European stockpiling of antiviral medicine (Tamiflu) in anticipation of pandemic flu,

including its relation to broader questions of security. Their article argues, among other things, that this stockpiling represented an attempt to "secure circulation pharmaceutically" — a "'pharmaceuticalization' of security" (Elbe et al, 2014: 452-453). European antiviral stockpiling, then, is ultimately an attempt to maintain some forms of circulation by curtailing others. This is a geographical question, but, as others have argued, security — including health governance (Fidler, 2004) — increasingly involves broader questions around the maintenance and protection of *flows* and not simply the protection of national borders (Cowen, 2014).

For my part, I hope to determine the extent to which the concept of 'crises of circulation' is helpful in understanding the ebola response and questions of public health security more broadly. It is my hope that investigating the extent to which ebola is a 'crisis of circulation' will pave the way for other considerations — e.g., if circulation is the concern, *which* forms of circulation (serving who?) are seen as requiring protection, with what geographical distribution of benefit?

Foucault 2: Surveillance, Space and Governmentality

Hannah's (2007) survey of fellow Foucauldian geographers found that *Discipline and Punish* (1975) was most geographers' route of entry into Foucault's work. (It was, incidentally, mine too.) Foucault's (1975) examination of the 'panopticon' — a model prison proposed by Jeremy Bentham, in which prisoners must assume that they are constantly surveilled — is particularly prevalent in introductions to the concept of surveillance or to Foucault's work. Writing in 1985, Driver lamented geography's already-conspicuous preoccupation with this discussion of the panopticon. Foucauldian analyses of various kinds of surveillance have burgeoned since then, and public health concerns are increasingly determined by ever more sophisticated techniques of epidemic surveillance.

Fidler (2004) cites the WHO's management of surveillance information during the 2003-4 SARS epidemic as a pivotal demonstration of the disciplinary power of surveillance at the international level, redefining both global health security and other overarching security concerns. Weir and Mykhalovskiy (2006) cite the development of the Global Public Health Intelligence Network, a collaborative project between Canadian government and the World Health Organization, as productive of a shift "in the

established boundaries of surveillance knowledge" (241). Weir and Mykhalovskiy describe GPHIN's automated harvesting of medical news reports globally (GPHIN brought SARS to WHO attention in 2002) as simultaneously weakening national sovereignty and also contributing to a model of global health governance which favours short-term interventionist response over longer-term investment in health development or security: aka a 'bunker mentality' whereby the global South is neglected *until* it poses a problem to the global North (Duffield, 2011). The defeatism of the neoliberal retreat to the bunker finds its mirror image in the defeatism of the recent valorization of 'resilience', one of the WHO's post-ebola priorities and described by scholars variously as 'acquiescence' (Neocleous, 2013), 'a *dispositif*' (Wakefield and Braun, 2014) and 'neoliberal deceit' (Evans and Reid, 2014).

Returning to GPHIN: GPHIN also helped inaugurate the concept of 'emerging' infectious diseases, which entails the representation of developing nations as 'sources of infectious diseases and agents' (245). This leads to my next section, as early Foucault's concern with discourse is illustrative here.

Foucault 1: Discourse, feat. Said & scholars of 'Africanism'

As with the other themes, Foucault's commitment to critical analysis of discourse is implicit throughout his work. However, a focus on discourse (often in the form of historical texts, archives, written materials) is most pronounced in early Foucault and scholars of early Foucault. Foucault's concern with discourse — though not his approach — was shared with prominent Marxists and sociologists, collectively providing fuel for the social sciences' 'cultural turn' (Mitchell, 2000). Within the discipline of geography alone, Foucault's analyses were translated for use in wildly varied contexts: emblematic examples included Matless' (1998) work on the discursive construction of English landscape and Soja's (1989) Los Angeles-centric *Postmodern Geographies*. Foucault's 'discursive' influence also entered geography indirectly, though Gregory's engagement with postcolonial scholar and literary theorist Edward Said, and I believe that this particular 'Foucault effect' (Howell, 2007) is crucial to addressing the potential limitations of focusing on questions of circulation.

Like Elbe et al (2014), my research is primarily concerned with the question of circulation. I am wary, however, of what I perceive as a conceptual flattening and historical evacuation in accounts which focus primarily on movement, flows and nodes. While explicitly concerned with the recent history of global health, Elbe et al's recent European case study runs the risk of ahistoricism on other fronts. To guard against this — and to understand *global* public health — it may be helpful to draw simultaneously upon earlier (scholars of) Foucault. Ebola is an ideal case study in this respect. In particular, both the spatial distribution of ebola and the delayed international response are suggestive of persistent spatial inequalities. Discourse both represents and plays a role in creating what Gregory (2004) terms the 'colonial present'. Continuing (and overall worsening) spatialized inequalities — colonialism's 'material' present — find their justification and inspiration in their persistent and flexible discursive counterparts: 'imaginative geographies', defined by Gregory (2009: 369-370) as:

"Representations of other places – of peoples and landscapes, cultures and 'natures' – that articulate the desires, fantasies and fears of their authors and the grids of power between them and their 'Others'."

In defining 'imaginative geographies', Gregory draws upon Said's (1978) account of what Said terms 'Orientalism' (i.e. the imaginative geographies of the 'Middle East'). Both Gregory and Said's analyses are in turn indebted to Foucault. Other scholars (Brantlinger, 1988; Miller, 1985) also draw upon Said — and by extension, a Foucauldian approach to discourse — to define and critique what Miller (1985) identifies as 'Africanism': the persistent colonial imaginary which informs European understandings of Africa and Africans in particular, and originates with European exploration in Africa. These imaginations can accommodate factual contradiction; they combine both fixity and fluidity. Kratz asserts that "[F]ew stereotypes change when more information or factual errors undercut them", and, accordingly, she argues that Africanism's underlying themes have altered very little since 16th century European accounts of exploration (Kratz, 2002: 109).

Brantlinger's (1988) genealogy of Africanism asserts a more recent genesis, while concurring with Kratz (2002) and Miller's (1985) understanding of the underlying themes. In Brantlinger's account, Africanism begins with 18th century exploration of Africa, over the course of which understandings of Africa as blank or empty space were joined by

complementary visions of 'darkest Africa': "The myth of the Dark Continent was largely a Victorian invention … shaped by political and economic pressures, and also by a psychology of blaming the victim" (195).

Brantlinger asserts that this victim blaming was largely cemented by humanitarian discourse in the form of the abolitionist movement, which successfully displaced the blame (& thus responsibility) for slavery onto Africans themselves. Abolition represented a turning point for Africanist visions, in that it both required and legitimised deeper involvement in Africa. Brantlinger asserts that before abolition, the withdrawal of British involvement was desirable; it was imagined that Africans would simply return to a Rousseauian state of nature once the colonial influence was removed. The struggle for and achievement of abolotion intensified the colonial (British) humanitarian self-imagination of saviourhood (Brantlinger, 1988). Spatialized victim blaming is a common thread in colonial discourse. It also underpins both the recent valorization of 'resilience' as both the opportunity and responsibility of marginalized communities, and spatial imaginaries whereby intervening Northern (or 'international') are cast as heroic (Orford, 2003).

These Africanist visions persist despite the WHO's apparent movement away from the more expansive ambitions of colonial humanitarian largesse (as understood by Lester, 2000; Lambert and Lester, 2004) and toward laissez-faire Southern 'self-sufficiency'; I will demonstrate this rationality has not straightforwardly replaced the traditional interventionist narratives, despite their apparent irreconcilability. Africanist 'victim-blaming' is one of their common threads.

For its part, the 'responsibilization' of individuals can be straightforwardly understood as a technique of liberal governmentality (Löwenheim, 2007). 'Resilience' usually frames understandings of groups (up to the nation scale) and acceptable group behaviour, whereas Foucault typically emphasised liberalism's individualization of its subjects. Despite differing scales, WHO (and other) demands for 'responsibilization' and 'resilience' can both be usefully unpacked, along with the imaginative geographies involved, via a Foucauldian critique of liberal governmentality: they deploy the same logic, transposed through different scales. Fassin's (2004) examination of France's child lead poisoning epidemic demonstrates, too, that these scales are more likely than not to collapse into each other if pushed: his research illustrated that the disproportionate blame leveled at French

West African parents was inseparable from popular and scientific (Africanist) imaginative geographies of West Africa.

From their very arrival, Southern (including African) migrants in Europe are also increasingly subject to intensified demands of liberal governmentality (under the rubric of 'integration') which far exceed those applied to the sedentary residents of European nations. Joppke (2007: 2) describes this 'civic integration' as 'an instance of repressive liberalism, which is gaining strength under contemporary globalisation'. In both Northern and Southern contexts, Southern actors are disproportionately expected to self-'responsibilize', transforming their selves and communities in response to ostensibly global problems. Much as certain contemporary European strategies of integration (in particular those of France and the Netherlands) aim 'to make migrants independent of the state' (Joppke, 2007: 4), it can be demonstrated that the WHO's continuing response to ebola seeks to cultivate West African self-sufficiency — liberal subjectivity — in the form of 'resilience'. In the context of infectious disease, discursive justification for these uneven responsibilities is supplied by skewed 'geographies of blame' (Farmer, 1992) which position the victims of disease as responsible for its spread.

Beyond Foucaults: Preparedness, Actor-Network Theory, and Matters of Concern

Sack et al's (2014) *New York Times* article exemplifies the practical value of following actors and centering the role of contingency: among other examples, the authors describe the transmission of ebola between multiple villages in Sierra Leone to Liberia and Guinea via one Liberian man's travel, on foot, to care for and then bury his ailing mother. In another, scientists were able to follow different strains of ebola to uncover routes of transmission. Information gained by following actors (whether human being or viral strain) has had direct implications for health organizations' ability to formulate effective preventative interventions — while also resulting simultaneously in the pathologization of West African actors, social customs, and — resonating with Malkki's (1992) critique of 'sedentarism' — their very movement, which becomes conceptualised as a source of disease.

Ebola's construction as a 'matter of concern' (Latour, 2004) is also shaped by its material properties as virus, i.e. the practical and affective considerations of managing an

extremely contagious and frequently fatal disease. Walters' analysis of these factors in relation to drones — the ways in which drones' material properties and technical capabilities limit or inspire particular narratives about them — offers a template for investigating these questions. According to Walters' (2014: 101) materialist approach, objects 'mediate issues of public concern'. He cautions, however, that considering the role of objects in shaping security discourses must be done 'reflexively': materialism can supplement but should not replace other analytical approaches.

Walters' *∂ingpolitik* connects with Anderson and Adey's (2011) argument for the importance of affect in security discourses. They follow later Foucault (2008) in drawing a connection between apparatuses of security and the cultivation of 'ambient fear'. The epidemiological properties of ebola virus, and the resulting affects they inspire, play a role in shaping its uptake in security discourse. Anderson's (2010) study of anticipatory action and the overarching concern of 'preparedness' also proposes that anticipation of disaster — and the fear associated with it — is increasingly key to liberal approaches to security.

These questions of preparedness lead, in turn, back to the concept of 'resilience' (which, when concerned with the government of individuals, becomes 'responsibilization' (Löwenheim, 2007)). In the aftermath of ebola, the WHO have embraced resilience — along with other troubling (neo)liberal strategies — as a cornerstone of preparedness: outside of the Northern 'bunker', "[r]esilience is the official response to the environmental terror embedded in the radically interconnected and emergent lifeworld that liberalism has created." (Duffield, 2011: 763)

Methodology: Discourse Analysis

In light of my theoretical concerns, my approach to discourse analysis is also inspired by Foucault. I have taken a 'Foucauldian' approach not only insofar as the expression of power through both discourse and practice is key concern, but also insofar as I have sought to unpack the internal logic(s) of my documents. Arguably Foucault himself did not present a coherent or unified approach to discourse analysis; his own accounts of his methods are often vague or opaque, and certainly not prescriptive, so I took more direct cues from explicit guides to methodology, while approaching my texts with questions of circulation in mind. I have found the work of Fairclough (2003; 2005) on critical discourse analysis and Rose (2012) on visual discourse analysis useful in providing concrete methods for unpacking the logics, implicit relationships and assumptions at play in these documents.

I devoted most of my attention to unpacking and considering rationalities which were conspicuously shared by a number of documents. Informed by Fairclough, (2003), I was also attentive to these documents' shared *absences*: Fairclough (2003) follows Foucault in claiming that what is said is always grounded against what is unsaid. Surprisingly, I did not find significant disagreement between WHO documents (with the exception of meeting minutes), despite an obvious collective pivot to favourably reframe the WHO's response toward the end of the epidemic.

Archival Materials

In accordance with both my research questions and the wealth of documents available online, I limited the scope of this project to analysis of the WHO's online, easily-accessible and public-facing archive — the materials most relevant to my research questions. It is worth noting that the type of archive available inevitably suggests some more appropriate forms of analysis, and precludes others. Effectively pursuing an Actor-Network approach, for example, would likely require access to interview participants and less readily-available archives, falling beyond the reasonable scope of an MSc dissertation. I have attempted to remain attentive not only to the omissions of the archive, but also to the blindspots generated by my methods. Without ethnographic fieldwork or interviews, I have limited insight into WHO practices and less ability to follow actors (either literally or

metaphorically). I can, however, analyse the WHO's *reporting* of its own role, its practices and its understandings of ebola.

I created a comprehensive archive of all 187 publicly-available WHO and WHO-recognised documents explicitly and primarily concerned with ebola and dating from 2014-2016 (which constituted the entire downloadable archive as of February 2016). These documents were written or transcribed by a number of individuals and groups both employed by or affiliated with the WHO, and are intended for a variety of audiences, resulting in different emphases between documents. As I read these documents, I sorted them into the categories below.

Document types:

- Disease Preparedness (22 items)
- Recovery/Resilience Planning (5 items)
- Strategic Documents (5 items)
- Misc meeting schedules, summaries and minutes (65 items)
- Development Assistance (3 items)
- Technical Guidance (54 items)
- New treatment research (10 items)
- WHO Advisory Group Meetings (13)
- Travel Advice (7)
- 2015 Assessment of Ebola Response (3)

Some of these categories are self-evident, e.g. the minutes from various meetings, while others were assigned according to the type of language used in a given document. Categories such as 'Recovery/Resilience Planning' or 'Travel Advice' arise directly from key words used in a number of WHO documents. The type and distribution between categories of documents found is indicative of the WHO's *explicit* rationale; at this stage I had not subjected the documents to interpretation. Of these categories, my analysis focused on strategic documents, meetings and the 2015 assessment of the ebola responses.

In addition to those documents listed above, I also undertook an in-depth examination of the WHO's extensive archive of 'Ebola situation reports'. These were only initiated in

August 29, 2014, which the first report identifies as the epidemic's 34th 'epidemiological week'. The epidemic was well underway by this point. These reports were typically issued every 2-5 days until the end of 2014, and subsequently issued weekly or fortnightly until June 10, 2016, which at the time of writing is the last date on which a situation report was issued.

Along with the academic literature cited earlier, I also found fuel for analysis in detailed reporting by *The New Yorker* (Higgins, 2014; Onishi, 2014, Sack et al, 2014). A handful of other reporting, also approached critically, informed my interpretation of my archival materials. I have cited these sources where appropriate. I also fact-checked key WHO claims against contemporary reporting (I did not find any inconsistencies).

Research Findings: Unpacking the WHO's understanding of Ebola

Fig.1 "Ebola is Real" (WHO, 2016a)

I will begin by addressing my first research question: *what is ebola?*

I begin with this fundamental question in order to unpack the ways in which the WHO's technical account essentializes ebola as virus, and the consequences for potential action. The WHO's narrow, scientific definition of 'ebola' structured both their response and popular imagination of *what can be done* concerning epidemic crises. As the WHO and other organizations constantly tried to communicate to affected populations, "Ebola is real" — but what is it?

I argue that the WHO's account of ebola essentializes the epidemic, reducing it to its molecular and pathogenic elements. This pathogenic reductionism neglects the material and social conditions which critical accounts might understand as coalescing into an *ebola assemblage*. Most pressingly, the WHO account of ebola evades those broader questions of political economy and international responsibility which cannot be addressed by

immediate epidemiological intervention; it neglects the material and social conditions which critical accounts might understand as coalescing into an *assemblage* of ebola.

The WHO also understands ebola only at the (arbitrary) scale of the epidemic itself, which is what allows their response to evade broader questions of political economy and international responsibility. This tendency to overlook political, economic, social and structures in the assessment and treatment of epidemics has a history described by Farmer (1996: 265) as "standard epidemiology," that is, an approach "narrowly focused on individual risk and short on critical theory [that] will not reveal deep socioeconomic transformations, nor connect them to disease emergence." I propose that the WHO's response to the 2014 Ebola crisis can be understood precisely as a non-critical "standard epidemiology". From the beginning of its response to the crisis, as can be observed through its weekly situation reports, the WHO understands the causality of the Ebola crisis primarily in terms of pathogenic transmission. This understanding is reproduced time and again in what I want to call the WHO's geography of Ebola (figure 2).

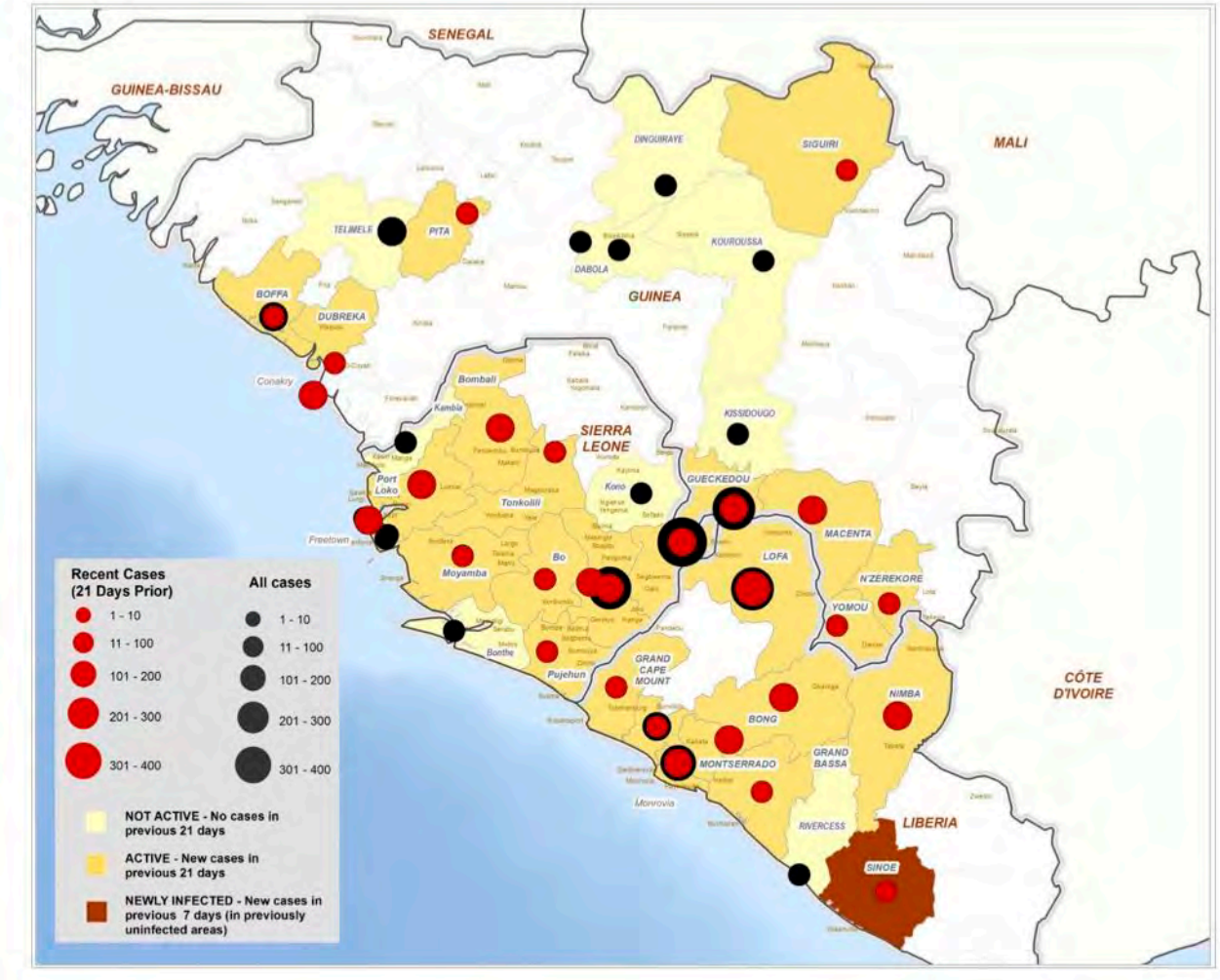

Fig. 2 WHO's Geography of Ebola (WHO, 2014a).

In its inaugural situation report or "sitrep" – a borrowed military term – the WHO makes several geographical categorizations concern the Ebola outbreak. Again, these definitions may seem trivial, but they do work not only to foreground a particular geographical understanding of the virus, but also to obscure competing understandings. The WHO suggests that

> "country reports fall into three categories: those with widespread and intense transmission (Guinea, Liberia, and Sierra Leone); those with an initial case or cases, or with localized transmission (Nigeria); and those sharing land borders with areas of active transmission (Benin, Burkina Faso, Côte d'Ivoire, Guinea-Bissau, Mali, Senegal) and those with international transportation hubs" (WHO, 2014a).

This definition of the WHO's geography of Ebola is consonant with its mapping in figure 2. I want to argue that this geographical understanding of the crisis reduces epidemic emergence to positivist causality that is arch-liberal in its approach, and collaborates to obscure political and economic power as causal forces. As Farmer argues, this imagination allows the Institute of Medicine to list a "single factor facilitating emergence for filoviruses: virus-infected monkeys shipped from developing countries via air'" (262). Similarly, regarding the 1976 ebola outbreak in Zaire, Farmer finds that:

> "most expert observers thought that the cases could be traced to failure to follow contact precautions, as well as to improper sterilization of syringes and other paraphernalia, measures that in fact, once taken, terminated the outbreak. On closer scrutiny, such an explanation suggests that Ebola does not emerge randomly: in Mobutu's Zaire, one's likelihood of coming into contact with unsterile syringes is inversely proportional to one's social status" (Farmer, 1996: 262)

Though Farmer takes a rhetorically subdued position, the implication and force of his argument makes clear that that what he calls 'standard epidemiology' has foreclosed perhaps the most pertinent lines of inquiry: namely, the causal roles of social inequality and transnational forces. As a rule, liberal approaches to security – even (or especially) at the level of scientific knowledge production – attempt to protect what they understand to be "good circulation" (in this case by making forms of "good circulation" invisible) while scapegoating "bad circulation" (poor syringe hygiene, monkeys as disease vectors).

Foucault's anti-essentialism (Philo, 1992) is useful for problematising such technical ideas of ebola; it provides a method for unpacking the ideological work performed by the WHO's *nominalization* of the ebola outbreak, i.e. its presentation as an agent rather than as process. According to Fairclough (2003: 12-13), nominalization proceeds as follows:

"instead of representing processes which are taking place in the world as processes … they are represented as entities … one common consequence of nominalization is that the agents of processes… are absent from texts. … [N]ominalization contributes to … a widespread elision of human agency in and responsibility for processes".

Foucault's refusal of nominalization is my analytical starting point. Meanwhile, Latour, if approached as a critic of social theory, helps to balance Foucault's methodological neglect of material questions. Foucault's early (2006 [1961]) account of madness, for example, is not interested in whether madness exists. However, critically evaluating the WHO's response to ebola also requires taking ebola's material characteristics seriously. Latour, via Walters (2014), offers a way to re-consider the agency of ebola virus in critical context, countering Foucault's lack of interest in material agency.

Circulation and critical geographies of the Ebola crisis

To challenge the nominalization of standard epidemiology it is necessary to offer alternative and critical accounts of the geography of Ebola which depart from the WHO's pathogenic emphasis. Fortunately, the WHO itself provides an opening for such consideration. In its 2015 Ebola Interim Assessment Panel Report — ostensibly a critical examination of failings in the WHO and global response to ebola — the WHO makes a rare admission that is worth quoting at length. It admits that:

> "at present **there are clear disincentives for countries to report outbreaks quickly and transparently, as they are often penalized by other countries as a result**. This was a significant problem in the Ebola crisis. Article 43 of the International Health Regulations (2005) requires all countries to behave with appropriate responsibility towards the international community in the adoption of travel and trade restrictions. However, **during the Ebola outbreak, more than 40 countries implemented additional measures that significantly interfered with international traffic**, outside the scope of the temporary recommendations issued by the Director-General on the advice of the Emergency Committee. As a result, **the countries affected faced not only severe political, economic and social consequences but also barriers to receiving necessary personnel and supplies.** These consequences constituted a significant disincentive to transparency**.** In this context, the private sector, especially those involved in international transport, must also act responsibly" (WHO, 2015a; emphasis added).

Though the passage ends with a call for greater responsibility from member states and the private sector, the report offers little in the way of assurance that goodwill from these quarters will prevail. The report does, however, point to larger issues of macroeconomic circulation that lie at the heart of the often-criticized decision of the affected countries to conceal their cases of Ebola virus. This account of the Ebola crisis suggests a partial causality that succeeds the pathogenic emphasis of the WHO's usual standard epidemiology. The panel suggests ways in which West African poverty, economic precarity and reliance on international capital flows created extremely strong disincentives for affected nations to accurately report of the ebola epidemic. Moreover, it suggests that a certain political economic rationality underwrote the decision of these countries not to disclose. Indeed, the ebola-stricken nations' interest in maintaining their position within normal circulation was in direct competition with other nations' interests in curtailing ebola's circulation, and the affected West African nations would (and did) suffer disproportionately under efforts to contain ebola.

This may be because, as Cowen's (2014) research demonstrates, under advanced capitalism it is crucial for national interests that nations remain nodes in networks of circulation; if other nations or international bodies impose travel bans, screening requirements, or even issue warnings, severe economic consequences are likely to result. SARS-affected nations suffered indisputable and significant tourism losses both during and after the epidemic (Wilder-Smith, 2006), and the WHO played a central role in producing that outcome. In addition, while SARS affected more prominent 'nodes' and a much larger area of the globe than ebola, ebola's fatality rate is approximately five times that of SARS. Not only is ebola a much more dangerous disease to contract, but information about ebola's normal effects on sufferers also tends to provoke visceral horror unmatched by any account of SARS' flu-like symptoms. Ebola's material characteristics and their affective implications render the disease — in the scheme of recent epidemics — uniquely offputting. The properties of the virus itself inescapably contribute to the ways in which it can be either downplayed or constructed as a 'matter of concern' (Latour, 2004).

It is perhaps not surprising that, despite the WHO's rare if indirect criticism of the "desirable" circulation of the global North, the interim report nevertheless suggests an *intensification* of capital flows as a potential solution to the "disincentives" to reporting outbreaks. Among the report's recommendations, two in particular stand out:

1: "The Panel recommends that WHO, in partnership with the World Bank, propose a prioritized and costed plan, based on reliable information on country systems, to develop the core capacities under the International Health Regulations (2005) for all countries. This plan should be submitted to donor agencies, Member States and other stakeholders for funding. It could include new types of financing mechanisms. Such financial support should be considered at the Third International Conference on Financing for Development in July 2015. The Panel supports the strengthening of Regulations' core capacities as an important part of the post-2015 development agenda and the financing of global public goods" (WHO, 2015)

2: "The United Nations Secretary-General's High-Level Panel on the Global Response to Health Crises should put global health issues at the centre of the global security agenda. In particular, it should identify procedures to take specific health matters to the United Nations Security Council and consider incentives and disincentives needed to improve global health security." (ibid)

In invoking both the World Bank and the UN Security Council, the WHO interim assessment ultimately prescribes further marketization and securitization as solutions to the problems to which these processes have arguably contributed. These unfortunate conclusions corroborate Cowen (2014) and Elbe et al's (2014) contention that (at least in international logistics and global health), the maintenance of circulation is an increasingly central security concern, and that the ebola crisis and response was prefigured by both national and global desires to secure (and maintain) circulation.

This account of the political, economic, and social pressures structuring the exacerbation of the Ebola crisis suggest that, far from being pathogenically reducible, the Ebola crisis was in part the result of larger flows of capital and people, and the consequences of what happens when that circulation is curtailed. This account therefore suggests a different account of the Ebola crisis, and suggests the possibility of exploring other critical geographies based on an analysis of other processes of circulation. Unfortunately, these critical trajectories were not pursued by the WHO in their response to the Ebola crisis. Instead I want to argue that the governing logic of the WHO response was one more

compatible with the prerogatives of global capital and the member state countries that oversaw the relief effort. It was a logic of *resilience*.

Resilience, not Prevention: Post-Epidemic Preparedness

The WHO archive hosts a handful of documents explicitly detailing the promise of resilience, all of which are very recent. By way of example, the abstract for their *Recovery Toolkit* reads as follows:

"The recovery toolkit is a library of guidance resources in a single place which can be quickly and easily accessed, to guide action. A key purpose of the Recovery Toolkit is to support countries in the reactivation of health services which may have suffered as a result of the emergency. These services include ongoing programmes such as immunization and vaccinations, maternal and child health services, and noncommunicable diseases. But in addition, and because the Toolkit contains core information needed to achieve functioning national health systems, it also supports countries to implement their national health plans during the recovery phase of a public health emergency." (WHO, 2016b)

It should be noted here that the idea of "resilience" functions not to ensure that disasters are prevented — which would require non-productive investment — but in making sure that populations can (in part) weather the disaster. With the benefit of consulting the WHO's broader archive, the emphasis on 'community mobilization' (discussed earlier) in many of the documents I examined also appears to be a function of the push toward 'resiliency', i.e. transferring costs to the affected populations themselves. At first this may seem like a fair deal, as liberal rationality proposes that communities should and will work to protect themselves out of self-interest/self-preservation — but, of course, it begins to seems less fair as it becomes clear that stopping Ebola in West Africa is also about securing the good circulation of capital while cutting off the undesirable circulation of Ebola, as evidenced by travel advisories.

The concept of 'resilience', whether the celebrated resilience of surviving Africans or of 'communities', is implicitly and unevenly defeatist. The 'normal' background condition of disease rates which would be considered intolerable in Northern nations is to be understood as immutable: the only variable, then, is individual or community *resilience* in

the face of disease — survival is self-determined. Resilience also ties neatly into what Farmer terms the 'geography of blame', which places the blame for succumbing to disease at the feet of the (collective or individual) victim. The naturalization of 'African' problems as immutable and arising internally is a cornerstone of Africanist discourse (Miller, 1985), and it works at a number of scales.

Resilience also connects with other geographical imaginaries, particularly 'geographies of blame': Farmer (1996: 263) identifies a frequent motif in public health discourse whereby it is implied that "one place for diseases to hide is among poor people, especially when the poor are socially and medically segregated from those whose deaths might be considered more important." Farmer's case study is tuberculosis, but both WHO documents and *New York Times* reporting similarly pathologise the most banal details of West African life.

Relatedly, Löwenheim (2007) identifies 'responsibilization' of the individual as a technique of liberal power, and one which is deeply discursive in nature. This could constitute e.g. shifting responsibility for risks of travel via travel advisories (Löwenheim, 2007), or for health via providing health advisories in lieu of trained medical professionals — i.e. placing responsibility for the self with the self, and rejecting the idea of *societal* responsibility. I submit that responsibilization as colonial technique has operated at a variety of scales (continent, nation, region, community), and is equally useful in bolstering liberal and *il*liberal governmentality: colonized peoples must be *taught* self-improvement, justifying intervention; or, colonized peoples would be capable of self-improvement if they so chose, but they have *chosen* otherwise, and therefore there is no moral obligation to treat them equally or even humanely. Thus resilience possesses a colonial history.

The limited imaginative horizons of liberal rationality (discussed above in relation to air travel) reappear in stark relief in the Ebola Interim Assessment Panel's identification of the problems with the ebola response, thus rationalizing its proposed — strictly liberal — governmental solutions (WHO, 2015). If increased penetration and securitization of global capital flows and their attendant regulatory organizations (in particular, the World Bank) is the WHO's proposed global scale solution for guarding against future epidemics, resilience at national and sub-national scales is a rational accompaniment.

In fact, 'resilience' is required: properly global, long-term and/or holistic approaches to ebola/disease management (as advocated below by Mabey et al, 2014) are incompatible with neoliberalism and the governmental logic of securitization. Instead, the WHO's proposed strategy for epidemic preparedness and management further entrench Duffield's (2007) distinction between 'insured' and 'non-insured' life — their purportedly global scope is limited to the protection of a Northern 'bunker'. Ebola's rapid spread should serve as an indictment of this approach. Rather than rethink it, however, the Interim Assessment's strategic proposals double down on the liberal securitization of health (WHO, 2015). In this context, 'resilience' offers new moral and practical support (in the form of guidelines for disease containment) for what is essentially a spatially-determined program of 'letting die' (Foucault, 1978).

The WHO Intervenes: Surveillance and Biopolitics

By the time the WHO began to issue situation reports in late August of 2014 – estimated as epidemiological week 34 (see fig 3) – the Ebola epidemic had already spread extensively in Sierra Leone, Liberia, and in parts of Guinea.

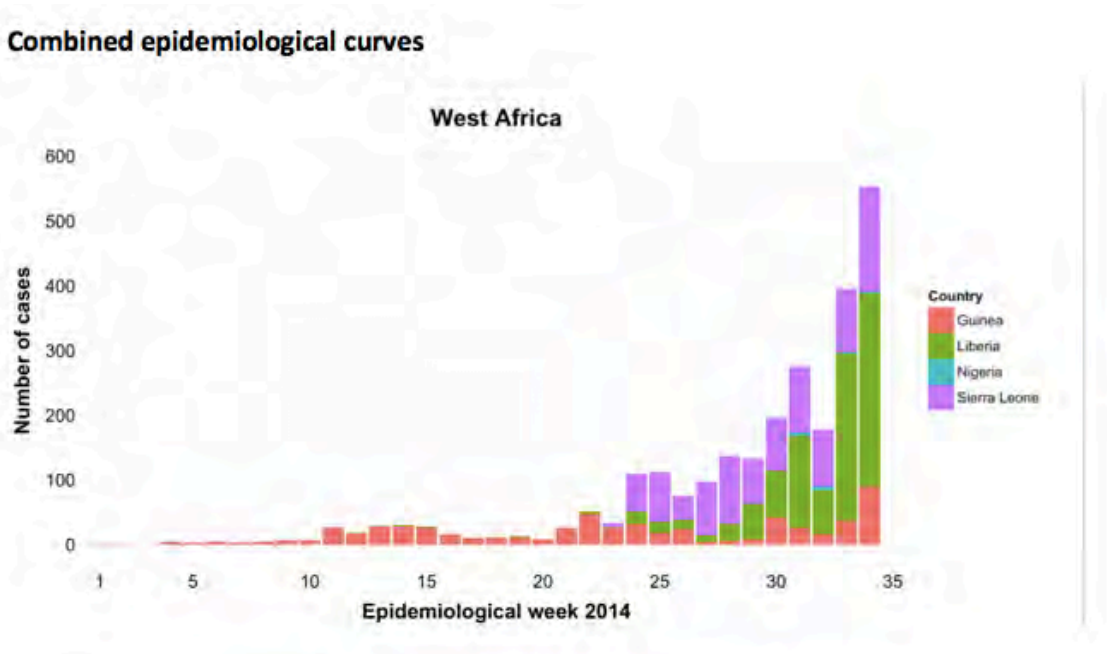

Fig. 3, Epidemiological Curves (WHO, 2014a)

As WHO situation report 1 shows (figure 4), the WHO produced a specific geographical understanding of the Ebola crisis, reproducing the categorization of Ebola into regions with new instances of Ebola transmission, regions with intense or active transmission, and without an instance of transmission in the past 21 days (red, orange, and yellow respectively). Again, this framing of the geography of Ebola is one that is in line with WHO technocratic governmentality, and one that understands the causes and solutions of Ebola in the immediacy of the transmission crisis.

A major of function of the WHO situation reports, which were published on a weekly and sometimes bi-weekly basis, was to map the presence of the WHO's six primary "interventions" in the Ebola crises: ebola treatment centres (ETC's), referring centres, laboratories, contract tracing, social mobilization, and safe burial. The presence – or more often, absence – of these interventions is colour coded and specified by region. As can be seen from the first such situation report, most intervention strategies were either non- or partially functioning at the time of the WHO's declaration of emergency. Closer analysis of these strategies of intervention reveals a deep governmental logic pervading the WHO strategy of intervention, and in what follows I outline these strategies and provide a discussion of each.

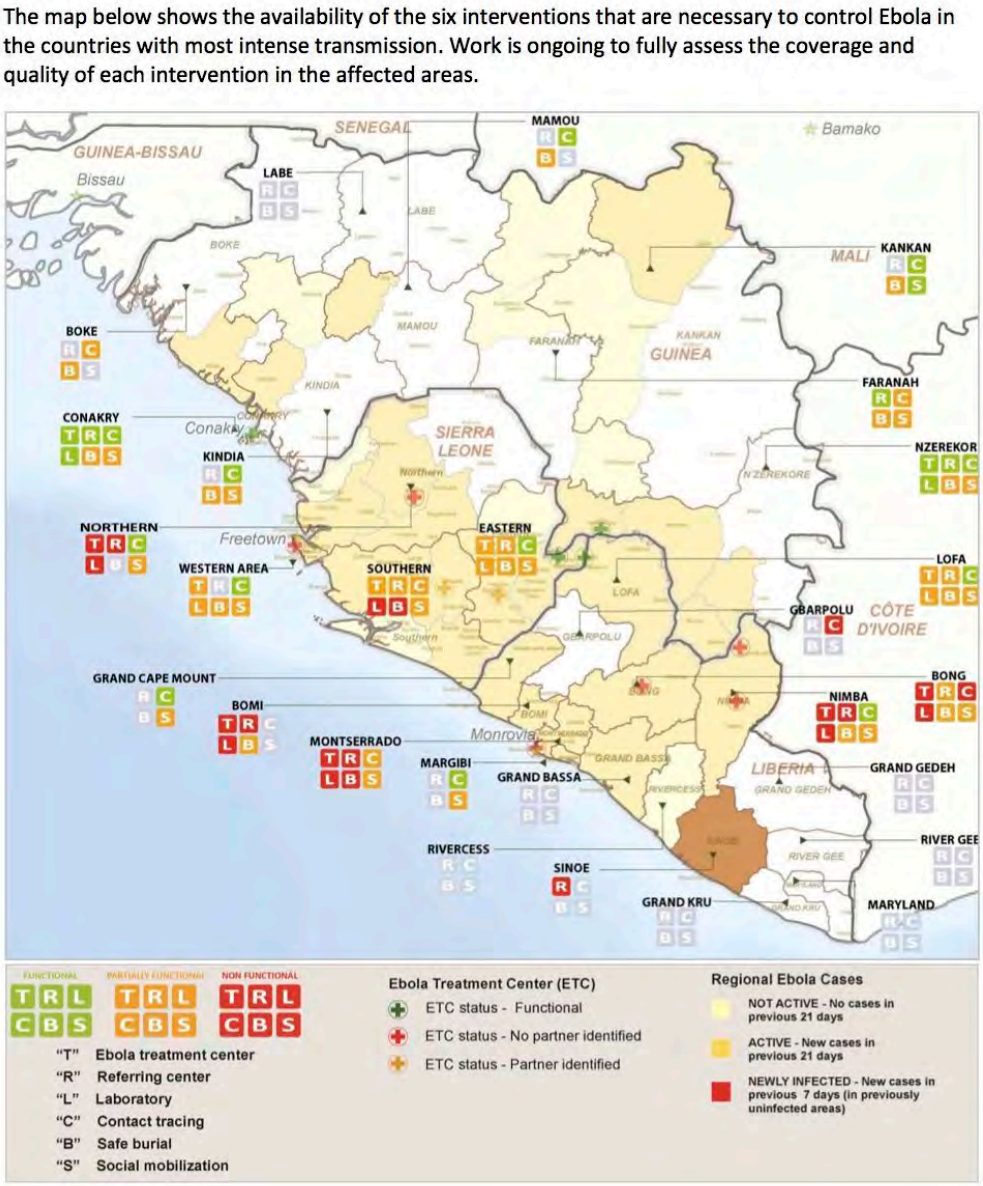

Fig 4. Strategies of Intervention (WHO, 2014a)

Treatment, Referral & Laboratories: coordinating a technocratic response

Perhaps more than any other strategy of intervention, the establishment of Ebola Treatment Centres (ETCs) offered the affected countries potential for relief from the exacerbation of crisis. ETCs were places were quarantines could be maintained, treatment such as intravenous rehydration could be administered, symptoms mitigated, and fatalities reduced. Unfortunately, the widespread unavailability of functional ETCs was a major impediment both to reducing the human misery of the Ebola crisis and to curbing its spread. Perhaps more than any other strategy of intervention, the lack of functioning

ETCs reflects the structural inequalities and deprivations faced by the affected countries. Again, though the WHO response frames the Ebola crisis as a one of pathogenic circulation, the structural conditions for the Ebola epidemic precede the outbreak itself.

As WHO situation report #4 (WHO, 2014c) reveals, "increases in demand for Ebola Treatment Centre (ETC) beds and referral unit places are continuing to outstrip capacity in Guinea, Liberia, and Sierra Leone." Though Médecins Sans Frontières (MSF) provided support as primary international partner with both national and international staff, in September of 2014 there were only five ETCs in the three primarily affected countries: two in Guinea, two in Liberia, one in Sierra Leone.

Figure 5. Ebola Treatment Centres in the three most affected countries

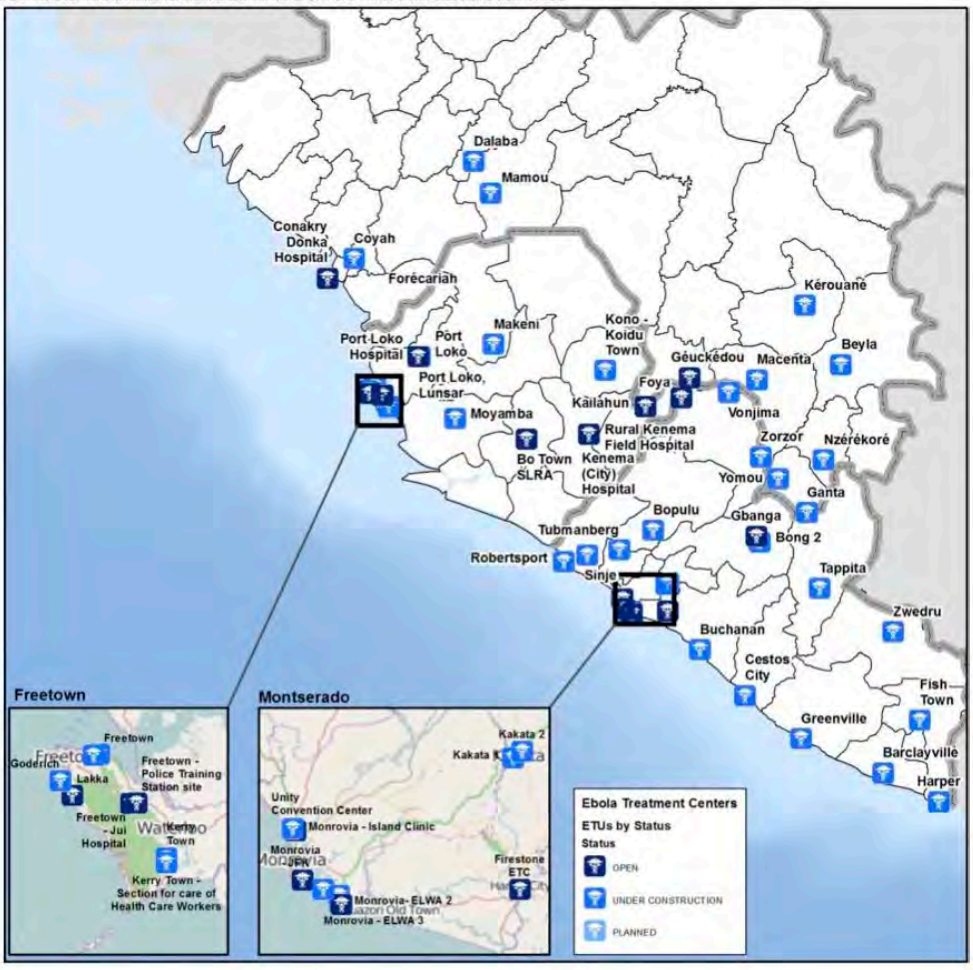

Fig. 5 ETCs in Affected Countries (WHO, 2014b)

In Guinea, ETC capacity in September 2014 stood at 130 beds. In Liberia the capacity was 315, less than 20% of demand. The WHO sit rep continues that, "In Monrovia alone, 1210 beds are required; the current capacity is 240 beds. In Sierra Leone there are currently 165 beds for patients with EVD, meeting just 25% of national demand." In Dakar there was a total of nine beds for the treatment of Ebola at the University Fann hospital (WHO, 2014c). As fig. 5 shows, as late as October 10, 2014 there was an extreme shortage of ETCs, despite the numerous instances of those categorized as "under construction".

In connection with ETCs, regional laboratories played a crucial role in WHO intervention. Laboratories allowed for testing of suspected cases of Ebola and worked in coordination with local referral centres, where patient were encouraged to get tested if they showed symptoms of the virus. Much like ETCs, however, the availability of laboratories was sparse at best, and overwhelmingly relied on western "partners" with the capacity for testing.

Figure 6. Laboratories in the three countries with widespread and intense transmission

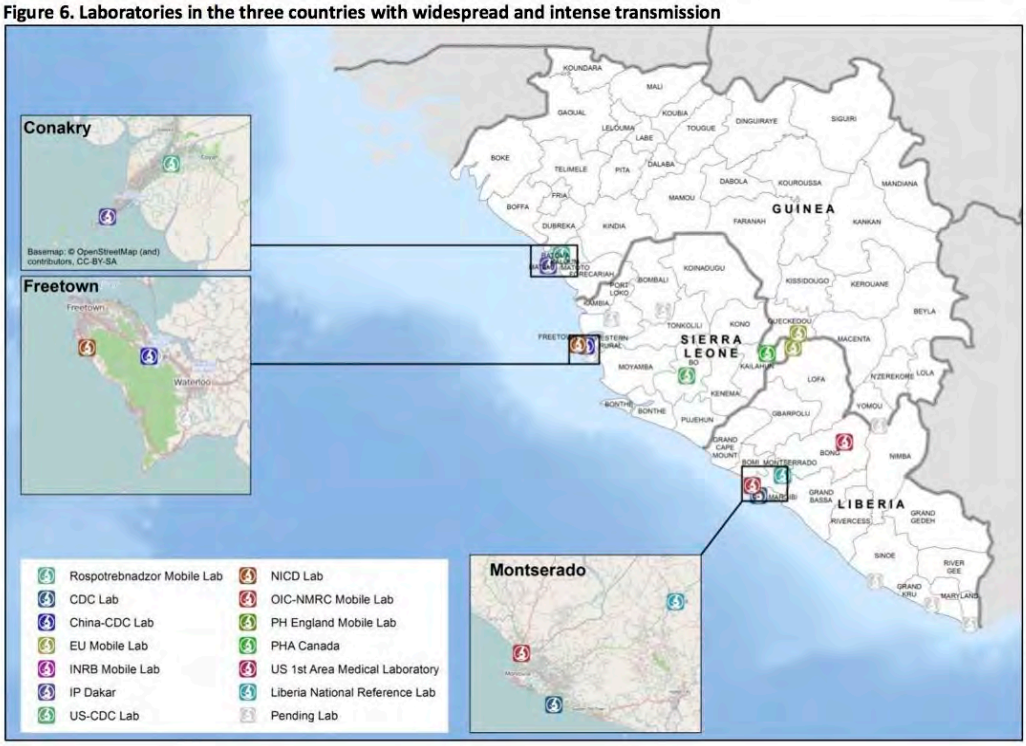

Fig. 6. Laboratories in Affected Countries (WHO, 2014b)

Rapid response testing was made difficult by the paucity and geographical dispersion of laboratories (fig. 6). When the crisis broke, only Guinea had adequate laboratory capacity, and this was only possible through collaboration with the Pasteur Institute Dakar in Conakry, the European Union Mobile Laboratory in Gueckedou, and the WHO itself (WHO, 2014a). In Liberia, some specimens from the Lofa region were able to be tested in Guinea, through this put an extra burden on already strained Guinean capacity. Similarly, specimens from other counties far from Lofa were sent to Monrovia where the international partner capacity of the United States Army Medical Research Institute of Infectious Diseases, US National Institutes of Health, and US Centers for Disease Control and Prevention were also strained (ibid).

If the securitization of disease is a feature of contemporary governmentality, it should be noted that international military presence, especially that of the United States, provided a great deal of the laboratory capacity. As with the Liberian case above, in Sierra Leone laboratory support, though woefully inadequate, was provided but he US Department of Defense Critical Reagent Team, as well as a mobile laboratory from South Africa that was deployed to Freetown. In Nigeria, as well, the pattern of "international partners" providing laboratory capacity continued with the Lagos University Teaching Hospital virology lab and the Lagos University Laboratory are being supported by WHO and an EU mobile team from the WHO Collaborating Centre in Hamburg, Germany (ibid).

Social Mobilization & Contact Tracing: Surveillance & Biopolitics

If the network of ETCs, referral centres and laboratories formed the front line of the WHO's approach to treatment of the ebola crisis, the intervention strategies of "social mobilization" and contact tracing similarly attempt to make the populations of the affected countries into objects of political strategy, though the modality of power is in these twin approaches is somewhat different. Whereas the ETC-laboratory intervention strategies required the coordination of networks of (often insufficient) resources to treat and assess the pathogenic characteristics of the Ebola crisis, the strategy of "social mobilization" attempted to intervene not on the bodies of individuals, but upon the social networks and lived lives they comprise. An early WHO situation report outlines the strategy:

"Social Mobilization teams continue to be actively engaged in implementing Ebola response strategies in the three intense-transmission countries. In Sierra Leone, the focus is on providing intense training to outreach teams (about 28,500 people) that will be going house-to-house covering 1.5 million households between 19 and 21 September 2014, to listen to community concerns, provide appropriate knowledge about Ebola transmission, prevention, care and treatment, and to encourage families to take sick patients to treatment or observation facilities.

In Liberia, the renewed focus is on community engagement strategies as part of the planned Ebola/Community Care Units that will be set up at a district and sub-district level. The social mobilisation teams are also assessing common indicators to monitor and map related activities in each country" (WHO, 2014c).

Both situation reports and WHO literature after the fact emphasize the incalculable importance of social mobilization for combating the spread of Ebola. In contradistinction to the chronic and structural under-capacity of the affected countries in the provision of ETCs and Laboratories, the strategy of social mobilization, though a labour intensive process, involves neither the administration of treatment or tests. Rather, it involves securing willing and active participation from members of the population. Insofar as the efficacy of social mobilization depends upon the consent of the governed, it represents more closely the kind of governmental power Foucault identities as breaking with sovereign regimes of obedience.

Amidst the criticism that the WHO faced for its slow and poor response to the Ebola outbreak, especially in the provision of treatment and supplies, it is interesting to consider the extent to which the WHO's special emphasis on the importance of social mobilization can be understood as an effort to diffuse responsibility for the outbreak among the population itself. If this suggestion sounds cynical, it is perhaps balanced by the WHO's overwhelming effort to frame social mobilization in terms of empowerment, self-help, and ultimately an issue of the success or failure of West African "resiliency".

Fig. 7. Building Together (WHO, 2016c)

When twinned together with its strategic counterpart, "contact tracing", the intervention strategy of social mobilization appears as an archetypal form of what Foucault (2007) calls "pastoral power": that is, the paradoxical relationship inherent in strategies of governmentality wherein strategies aimed at the population (the flock) must also account for each individual member (the sheep). Contact tracing, as the WHO defines it,

> "is the process of identifying, assessing, and managing people who have been exposed to a disease to prevent onward transmission. People who may have been exposed to EVD are systematically followed for 21 days (the maximum incubation period for the disease) from the date of the most recent exposure. This process allows for the rapid identification of people who become symptomatic" (WHO, 2015b).

The twin intervention strategies of social mobilization and contact tracing reflect the pastoral paradox insofar as the health of the entire population is dependent upon the specific actions and behaviours of its individual members as such. WHO emphasis on issues of, for example, hygiene emphasize the unique way in which strategies of population management simultaneously become strategies of managing the conduct of individuals.

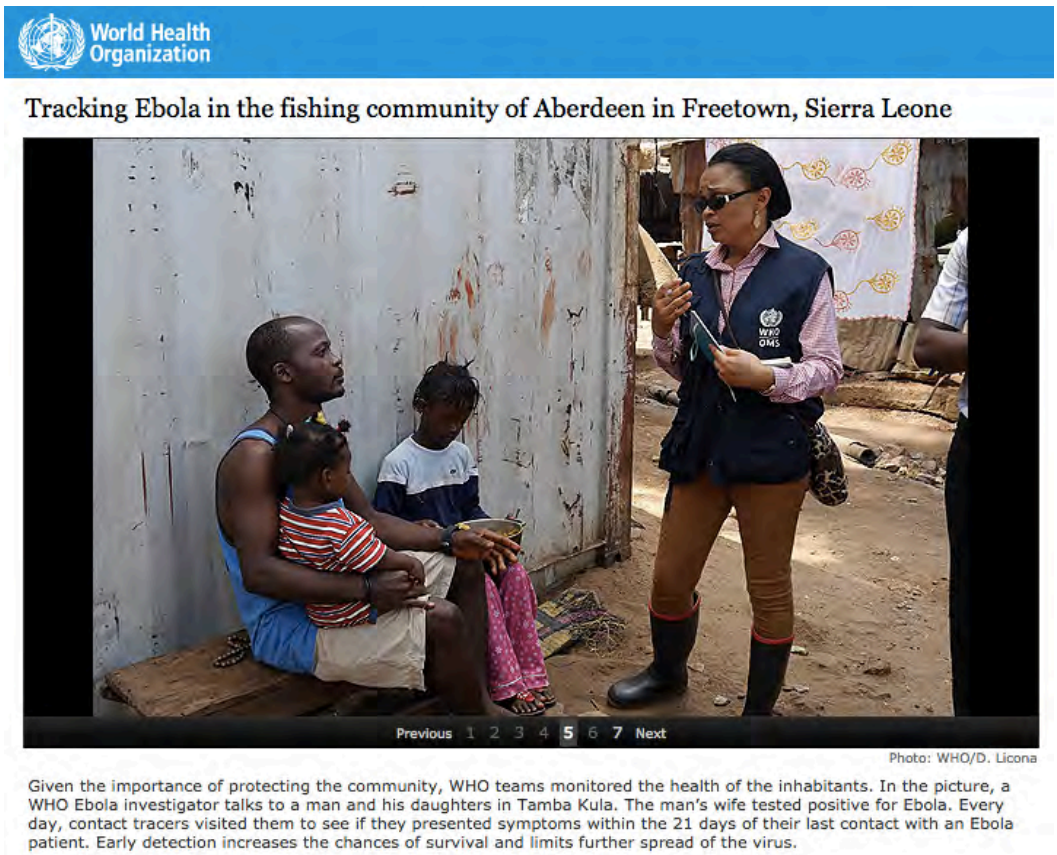

Fig. 8. Tracking Ebola (WHO, 2016d).

Contact tracing, then, must be understood as a technique of pastoral surveillance, an administration of power governed by the structure of what calls "*omens et singulatim*" (all and each). Indeed, in its report, the WHO's Ebola Interim Assessment Panel suggested a need for comprehensive expansion of surveillance capacity. " In-country surveillance activities" it wrote, "need to be integrated with components of national health systems, not only for emergencies, but also for a broader array of diseases and conditions … Innovations in data collection should be introduced, including geospatial mapping, mHealth communications, and platforms for self-monitoring and reporting" (WHO, 2015a).

Overall, surveillance is the WHO's main governmental technique. The SARS epidemic demonstrated that the WHO can exercise significant power by publishing information without national consent, as they did with China. There are limits on the WHO's influence: the WHO is, for example, unable to prevent nations releasing information. However, the WHO *can* exercise power in shaping discourse by withholding its own information. The WHO's 4th situation report illustrates the methodological importance of attending to such absences:

Table 2: Ebola infections in healthcare workers as at end 14 September 2014

Country	Case definition	Cases			Deaths
		Total	Last 21 days	Last 21 days/total cases (%)	
Guinea	Confirmed	52	9	17%	22
	Probable	8	0	0%	8
	Suspected	1	1	100%	0
	All	**61**	**10**	**16%**	**30**
Liberia	Confirmed	66	3	4%	56
	Probable	85	18	21%	26
	Suspected	21	0	0%	3
	All	**172**	**21**	**12%**	**85**
Nigeria	Confirmed	11	2	18%	5
	Probable	0	0	0%	0
	Suspected	0	0	0%	0
	All	**11**	**2**	**18%**	**5**
Sierra Leone	Confirmed	71	1	1%	30
	Probable	1	0	0%	1
	Suspected	2	0	0%	0
	All	**74**	**1**	**1%**	**31**
Total		**318**	**34**	**11%**	151

Data reported are based on official information reported by Ministries of Health. These numbers are subject to change due to ongoing reclassification, retrospective investigation and availability of laboratory results.

Fig. 9. Infections of Healthcare Workers (WHO, 2014c).

Here, the WHO lists 'health worker' infections without differentiation between local and international health workers. It is reasonable to assume that the WHO is capable of providing more detailed information. I provide this only by way of example; without over-ascribing importance to a single situation report, it is worth noting that differentiating local and international health worker infections — particularly as a proportion of each category

of workers — would likely reveal stark inequalities in health care provision. The chosen presentation, instead, implies uniform risk. If considering the role of better safeguards and procedures to prevent infection, it is important to consider which populations are, in fact, at most risk — and which are 'insured'.

The Question of Circulation: Security, Economy and Air Travel

Debates over the effectiveness and costs/benefits of restricting air travel or imposing additional screenings accompany every major epidemic: after SARS, Wilder-Smith (2006) argued that the cost of investing in airport entry point screening measures outweighed their usefulness, particularly in the context of already-declining travel due to a combination of pre-departure screening and widespread fear. Disruption of air travel in the wake of ebola can be largely attributed to action taken by both individual nations and airlines, rather than WHO initiatives; the Interim Assessment (WHO, 2015a) expressed considerable frustration with WHO member states in this matter, exemplifying tensions between Northern 'class' interests, as pursued by the WHO (i.e. maintaining circulation) and the security interests of individual nations (its member states).

In debates around air travel as it relates to the ebola epidemic, there is interplay between at least two kinds of circulation: the circulation of disease, and the circulation of health workers. Widespread disruption of normal air travel can hamper international responses to epidemics by preventing aid workers from reaching affected areas. Writing for the *New York Times*, Higgins (2014) reports that Doctors Without Borders' separate but related complaint that difficulties in securing international hospital transportation for foreign aid workers who contract ebola have the knock on effect of discouraging foreign health workers from volunteering to work in West Africa in the first place. If health workers can't be flown to US or European hospitals quickly, they've a much greater risk of dying from ebola.

Of course, Neither Higgins nor Doctors Without Borders mention the far greater numbers of local health workers contracting ebola; this is a question of insured life. Accordingly, it should be noted that foreign health workers assume unquestioned and arguably disproportionate importance in WHO strategy, evaluation and post-epidemic

celebration, in addition to popular journalism. On a methodological note, this is a clear example of the danger of 'circulation' as sole analytical focus: if these questions around air travel, in particular health worker transportation, are taken as-read as *fundamentally technical* problems of circulation, the political work of such discourses goes unchallenged. In fact, it should be argued that the fundamental problem here is not one of circulation but of global (health) inequality. The absence of this question from WHO and media (Higgins, 2014) analyses constructs a myopic imaginary whereby possibilities for addressing ebola which are incongruent with liberal governmentality go unacknowledged and unexplored.

Writing for the BMJ, Mabey et al (2014) challenge this elision as it manifests in discussions of airport entry screening:

"Adopting the policy of "enhanced screening" gives a false sense of reassurance. Our simple calculations show that an entrance screening policy will have no meaningful effect on the risk of importing Ebola into the UK. Better use of the UK's resources would be to immediately scale-up our presence in west Africa—building new treatment centres at a rate that outstrips the epidemic, thereby averting a looming humanitarian crisis of frightening proportions. In so doing, we would not only help the people of these affected countries but also reduce the risk of importation to the UK."

Grounding Circulation: (Non-)Insured Life

Understanding dilemmas relating to air travel and the transportation of health workers as *technical* problems of circulation suggests *technical* solutions rather than a problem with the underlying relations of power. Theorizing which centers flows and movement — including nascent discussions of circulation — can flatten or evacuate space, and in doing so runs the risk of buying into the rationality it attempts to critique. The failure of the ebola response and the historical (colonial) specificity of ebola as case study provides ample evidence that there is always *more* than liberal rationality at play. West Africa's poor health infrastructure is a direct consequence of colonial dispossession and uneven development. Both WHO situation reports and media accounts (Sack et al., 2014) attribute the delayed response to ebola to 'poor information' without unpacking the material inequalities which determine the quality of health care, disease information, and monitoring.

Here, Duffield's (2007, 2011) work can be brought in to balance that of Elbe et al (2014): specifically, Duffield's distinction between 'insured' and 'non-insured' life. Synthesising Duffield's work with that of Elbe et al, I wish to propose that the issue at stake is the maintenance of *uneven circulation*: unevenly secured forms of circulation, differentiated for reasons which can reflect but may also exceed liberal rationality. These follow from existing spatially-differentiated valuations of life, which are typically unexamined and reified by both WHO documents and media reports. Even if the management of circulation is purely a question of rational economic government by Northern nations (an interpretation continuing colonial *imaginaries* did not shape the ebola response, or played a negligible role, it is colonial history — both material and discursive — which has culminated in contemporary spatial divisions between (economically) 'productive' and 'surplus' life. Furthermore, elision between economic worth and moral worth is a hallmark of contemporary capitalism.

Grounding Circulation: Africanism

Geopolitical-economic considerations clearly *are* a principal determinant of global health strategy, including the ebola response, and Africanist narratives can serve to conceal the colonial origins of the global distribution of wealth, in addition to minimizing or naturalizing the failure to anticipate or respond to ebola: if Africa is the 'Dark Continent', ebola can be understood as an 'invisible epidemic' (Sack et al, 2014) which *understandably* escapes notice. Sack et al (writing for the *New York Times*) also foregrounds West African 'distrust' of health advice, reporting that communities continued to wash the bodies of ebola victims by hand — spreading infection — because it was "a step considered essential to a dignified burial and a contented afterlife". Miller (1985: 39) argues that linking blackness with idolatry and superstition in precisely this fashion constituted "[a] key part of Europe's understanding of Black Africa".

Of course social practices and suspicion (with justifiable causes) played a role in ebola's transmission. However, centering 'culture' before or instead of the numerous and severe material constraints implies that 'culture' (problematic social practices) is a uniquely or exceptionally West African phenomenon. In actuality, ebola would likely spread faster in most (denser) European or North American contexts due to their greater

density and no doubt aided by any number of equally superstitious social practices. European 'culture' was not identified as problematic during local outbreaks of swine flu or Creutzfeldt–Jakob disease, although consumption of animals (aka European dietary habits) is an extremely direct cause of the latter and a root cause of the former. The framing of West African social organization as problematic does not necessarily correspond with the most significant factors facilitating disease outbreak, and may in fact serve to obscure them.

Conclusion

At the international scale, Fidler (2004: 803) finds that the public health of nations is increasingly used as a measure of their 'good governance'. This understanding of public health as a reflection of national government is an example of the inescapable 'geography of blame' characteristic of liberal approaches to security. Problems such as epidemics are seen as arising from local factors, while their (often more significant) international causes drop from view. Inappropriate solutions follow. Similar geographical imaginaries underpin, for example, the concept of 'ungoverned spaces'. Increasingly, the rationality of global health reflects its incorporation into broader metrics of security — what Duffield (2011) terms 'total war' — whereby 'global' initiatives primarily serve the Northern bunker. My case study of ebola ultimately supports Duffield's understanding of the political economy underpinning circulation.

Furthermore, in response to scholarship which stresses the continuing importance of Northern interventionism — such as Braun's (2007) work on biosecurity — I submit that the WHO's non-interventionist approach is a more representative example of the liberal rationality governing contemporary approaches to global security. Non-interventionism has not totally replaced interventionism, but intervention can be *best* understood as a last resort, pursued only when (good) circulation is threatened.

As to my concurrent evaluation of circulation-as-analysis: my examination of the WHO response to ebola demonstrates effectively that understanding circulation is *necessary* for understanding liberal government, including the management of disease. My research also demonstrates, however, that analyses of circulation alone are both radically insufficient and potentially

counterproductive if not supplemented by other analytical lenses, insofar as uncritical application would likely serve only to reify the imaginaries underpinning liberal government. In the context of global health, understanding what separates 'desirable' or 'undesirable' forms of circulation requires attention to local and global historical developments which interact with but also exceed the development of contemporary global health 'security' discourses.

Even Elbe et al (2014) — whose highly critical unpacking of 'circulation' and its governmental implications served as the inspiration for this project — run afoul of the ahistoricism and spatial flattening which focusing on circulation (or 'flows' more generally) often facilitates. Other Foucauldian lenses for examining of liberal governmentality, such as 'responsibilization' (Löwenheim, 2007), also offer little if deployed in a purely descriptive fashion. In particular I have demonstrated the necessity of understanding historical-contemporary discursive constructions such as Africanism for elucidating how and why some forms of circulation come to be understood as 'desirable'. In the case of ebola and (I believe) analyses of security more broadly, Foucault's various accounts of governmentality also serve best as starting points for analysis — *if* supplemented by other critically demanding and historically-cognizant approaches.

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