

Ebola Crisis in West Africa as the Embodiment of the World. Arguing for a Non-conventional Epistemology of Disease Aetiology

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Abstract

The recent Ebola crisis in the Mano River countries in West Africa is not only a public health problem but a social problem which results from historical processes and socioeconomic arrangements that have subtly crippled people's agency, destroyed social cohesion and reduced opportunities for human flourishing. The embodiment of social ills as disease challenges biased-popular accounts which erase the link that exists between the spread of the virus and social structures. The national, regional and transnational tales of the Ebola epidemic cannot be undermined, because the human body disclosed the homicidal logic of social entities that have been entertaining the civilization of subtle violence in these postcolonial countries where populations are confronted with misery.

Keywords: *Ebola aetiology, critical epistemology, embodiment, structural inequality, political strife, global capitalism, social healing*

Résumé

La récente épidémie causée par le virus Ebola dans les trois pays situés près de la rivière Mano en Afrique de l'Ouest ne peut pas être réduit à un problème de santé publique, car elle laisse entrevoir un problème social profond résultant des processus historiques et des arrangements socioéconomiques qui ont subtilement endommagé handicapé la liberté de choix des individus, détruit la cohésion sociale et réduit les possibilités de développement économique. dans un tel contexte, il est possible que l'épidémie d'Ébola soit comprise comme une sorte d'incorporation

des maux sociaux, ce qui remet en cause des récits biaisés, souvent diffusés afin de cacher le lien qui existe entre la propagation d'un virus et les structures sociales. Les récits nationaux, régionaux et transnationaux de l'épidémie d'Ébola ne peuvent être compromis, car tant les corps individuels que le corps social ont révélé les logiques homicides des entités sociales and global qui entretiennent la civilisation de la violence subtile dans ces pays dont les populations croupissent dans la misère.

Mots clés : *Ebola aetiology, critical epistemology, embodiment, structural inequality, political strife, global capitalism, social healing*

"The age of anxiety we live in is characterized by tensions generated by the harshest inequalities ever known, inequalities that are also the most profoundly felt by the men and women who suffer them. It is also an age in which the sufferers are invisible to the men and women who profit from these inequalities" (Fassin 2007, 175).

Introduction

The Ebola virus disease (EVD) crisis started in Gueckedou, Guinea, in December 2013 when a two-year-old Guinean boy died from a mysterious illness near the border with Sierra Leone and Liberia, but it wasn't until late March 2014 that the disease was identified as Ebola, a pathology which had never been seen before in that part of Africa. It was officially recognized on the 22nd of March 2014 by the Guinean Health Minister (Moulin 2015). The later detection set a stage for the spread of the disease. Normally, anyone with Ebola typically will infect about two more people unless something is done to intervene. The sooner Ebola is detected and the faster the victim can be isolated, the smaller the number of people who will become infected. As of the 5th of December 2016, there were 10,666 cumulative cases in Liberia, resulting in 4806 deaths; 3804 cumulative cases in Guinea resulting in 2536 deaths; 14,122 cumulative cases in Sierra Leone resulting in 3955 deaths; 20 cases in Nigeria, resulting in 8 deaths; and one case in Senegal (WHO 2105a). While previous Ebola outbreaks were essentially confined to rural areas, the most recent outbreaks were widespread and unprecedented. The rapidity in which the virus spread and the failure of the local and global health communities to stop the transmission of a virus, which is not an airborne one, was frightening and calls for deeper reflection. The outbreaks' devastating effects were unprecedented. More people died than all the previous outbreaks combined (Boozary and Farmer 2014, 1859). It was broadcasted that the outbreaks were widespread due to populations' mobility, entrenched cultural practices, opposition to early interventions, dysfunctional health systems and inexperience in dealing with Ebola. Most of these factors are simply proximal causal factors while the fundamental causes are remote, rooted in a deep national-global malaise.

We contend with Andrew Boozary and Paul Farmer (2014), Annie Wilkinson, Melissa Leach (2015) and Landry Faye (2015) that the magnitude of the Ebola epidemic was essentially due to the violence embedded in social structures. The axes of this form of hidden and silent violence are at the same time social, cultural, economic, political and global. This social construct refers to violence embedded in ubiquitous social structures and normalized by stable institutions and regular experience (Winter and Leighton 2001, 99). If Ebola outbreaks were to occur in other locations, would they be as widespread as in Guinea, Sierra and Liberia? Why was Ebola in Nigeria and Senegal contained and eradicated quickly? The Ebola disease epidemic in West Africa was not just a mere public health crisis, but resulted from historical processes of sociopolitical and economic instability and violence sustained by the state's brutality and failures that crippled people's freedoms, destroyed social cohesion and reduced opportunities for well-being. Using the theories of structural violence (Farmer 2003, 29-50), postcolony (Mbembé 1992) and world systems (Wallerstein 2004) as hermeneutical tools, we intend to show how the instability and violence of everyday life shaped by a regional history of war, colonial and postcolonial oppression and socio-global inequality compounded by poor health systems and cultural practices have directly or indirectly contributed to the production of an epidemic of such a great magnitude.

The Context of the Epidemic

The EDV spread in weak countries with recent history of political unrest and violence while countries with a decent political stability were able to avert the crises. The context of the recent Ebola crisis is shaped by a regional history of war, economic failures sustained by neoliberal policies, a fragile global health leadership, a weak health systems and a poor political leadership.

Regional history of political unrest and violence

Before the first outbreak, Liberia was slowly recovering from the 1989-2003 bloody war rooted in ethnic conflicts that led to brutal murder of many Liberians, the displacement of around one million citizens and the destruction of infrastructures. Prior to the ethnic conflicts, Liberia was ruled for 133 years by freed slaves from the United States of America under a one-party system that successfully ostracized the Liberian natives. The domination of state power by former slaves came to an end in April 12, 1980 through a bloody coup d'état led by Sargent Samuel Doe. Doe's leadership was marked by acute ethnic-based segregation. The civil war which began officially in December 1989 is among others the corollary of the brutal retaliation of the Krahn-led Liberian Army against the Mano and Gio (Kraaij 2015). In December 1989, the Americo-Liberians, the Mano and the Gio people constituted in the National Patriotic Front of Liberia

(NPLF) invaded the country. Led by Charles Taylor, the NPLF weakened Doe's army which could only control a small part of the country (Kraaij 2015). Doe was killed on September 9, 1990 by Prince Y. Johnson and his men. Charles Taylor would then become the president of Liberia. Liberia was on the way to recovery from the hardship of 14 years of civil war when EVD struck (Al Paulus 2014).

As for Sierra Leone, the poor management during Siaka Stevens' regime (1967-1984) caused the complete collapse of the administrative system which was already facing serious challenges (Jang 2012). Sierra Leone would then be engulfed in a civil war that lasted 11 years (1991-2002), which resulted in around 70,000 casualties and 2.6 million displaced people. As previously stated, the causes of the unrest lay on the weakness of state authority in the context of globalization (Kaldor and Vincent 2006). The authoritarian and repressive one-party government of the 1980s with its pervasive corruption and mismanagement contributed to the state's economic downfall. The downfall was also triggered by pressures from the outside that sought structural adjustment (Kaldor and Vincent 2006). The country was still fragile, struggling to recover from this long history of unrest and violence when the Ebola crisis erupted.

For its part, Guinea endured about 50 years of authoritarian rule characterized by political violence and repression. Guinea earned its political independence from France in 1960. Being the first president, Sékou Touré opposed French neocolonial domination. The entire country was sidelined and received no support from the international community following Touré's affiliation with Marxism. Sékou Touré was a dictator who suppressed the political claims of all his opponents. Lansana Conté became the president of Guinea after a coup d'état in 1984. His regime was likewise autocratic. He died in 2008 and Captain Moussa Dadis Camara took hold of power in Guinea after a coup which aborted the constitutional succession of Somparé as interim president. The coup leaders overthrew the government arguing that Guinea's leadership was inefficient and corrupt (Arieff and Cook 2009). The leadership of Camara did not last long. On December 3, 2009, Camara was shot in the head and had to leave power. Then elections brought Alpha Condé, the sitting president, to power. Previous elections in Guinea led to the disruption of social cohesion and trust. Years of poor leadership and the neocolonial economic ambitions of successive French governments have not favored the economic progress of Guinea.

All the three countries are very poor: "Guinea is one of the poorest countries in the world, ranking 178 out of 187 countries on the United Nations Development Programme Human Development Index (just behind Liberia [174] and Sierra Leone [177]). More than half of Guineans live below the poverty line and about 20% live in extreme poverty" (Bausch and Schwarz 2014). A recent history of war, state collapse, and crises of governmental legitimacy were common to the Mano River countries. In the case of Sierra Leone and Liberia, an additional factor may be the role of multiple and diverse external humanitarian organizations in managing health care in the post-war

period, effectively removing more centralized local governments from the responsibility of monitoring and coordinating a single health care policy (Moran and Hoffman 2014). The rulers of affected countries inherited deeply broken nations, with devastated infrastructures, social mistrust, a legacy of communal tensions and crushing poverty. Reversing decades of economic regression and social tensions has not been easy. As the result of this legacy, the healthcare systems in the region were dysfunctional and under-resourced. In addition, affected countries have in common a colonial past that show similarities and differences.

Colonial regimes in place from about the last quarter of the nineteenth century to a decade or so after the Second World War, were, above all else, designed to extract Africa's natural resources in the most lucrative way. Social services that might have benefited the colonial subjects, such as healthcare and education, were, to save costs, kept to a minimum. This explains the profoundly undemocratic character of those regimes. The last thing the extractors wanted is for the subjects to give opinions about how they were governed and, hence, how their natural resources should be utilized. These were the arrangements that post-colonial elites not only inherited but readily embraced and deepened to advance their own narrow class interests. In the case of Liberia, a semi-colony of the USA, its elites, the descendants of repatriated slaves from America, ensured that Firestone Rubber would reap enormous profits from its operations there. Thus, the outrageously ironic situation today where, in one of the world's leading rubber producers, there are not enough rubber gloves to protect its citizens from the scourge of Ebola (Nimtz 2014). Sierra Leone followed a different trajectory. The British colonial indirect rule decentralized power which played out in peoples' responses to intervention teams during the crisis. In contrast to Guinea, defiant resistance was rarer in Sierra Leone. Anthropologists demonstrated that a comparison between Sierra Leone and Guinea suggests divergent political practice and lived experiences of the state, rather than cultural differences, may explain these patterns of social resistance. Resistance was rooted in the type of political and social structure that supported interventions (Wilkinson and Fairhead 2017). British colonial indirect rule allowed the Paramount Chief in charge of organizing social life in Sierra Leone. This was not the case in Guinea where the legacy of French direct rule and of post-independence Sékou Touré regime set an administrative system in which implementing authorities are external to the region and allied to the party in power (Wilkinson and Fairhead 2017). In the context of Ebola, the trajectories of these Sierra Leone and Guinea can be understood in relation to their contrasting political practices, a historical standpoint that may explain why Sierra Leone has seen less overt resistance and why much of the rumor in Sierra Leone has been about the corruption of government officials not ethnically motivated genocide which has been a preoccupation in Guinea (Wilkinson and Fairhead 2017). The fact that Forest Guinea, for example, was the main Ebola hotspot during the outbreak may not be accidental. This southeastern region has a long history of marginalization, which was

in part due to Sékou Touré's effort to modernize the country by outlawing initiation societies (Soumahoro 2017). It is a place where the "Central government agents are often seen as foreign elements all over the countryside, not only in the Forest Region" (Schroven 2014). Most of the evidence linking ethnic politics directly to the lack of decisive public response to Ebola came from Guinea. The land reform that accompanied this campaign "was experienced in the Forest region as a threat to indigenous land rights and as favoritism to rival Manding immigrants" (Wilkinson and Fairhead 2017). The Guinea Forest Region traditionally comprised small and isolated populations of diverse ethnic groups who hold little power and pose little threat to the larger groups closer to the capital.

Further investigations about these three countries show that Nigeria and Senegal stand in sharp contrast with them in regard to the social conditions that may have prompted the EDV epidemic. Senegal is known to be one of the exemplary democratic states in Africa which has enjoyed a multiparty political system since 1976. Since its independence in 1960, Senegal has never faced a military coup. In spite of the conflict in Casamance, years of political stability have favored the maturation of social institutions which has never been the case in Guinea, a former French colony just like Senegal. No need to mention that the French neocolonial politics was more favorable to economic progress in Senegal than in Guinea, led by the rebellious Sékou Touré; Senegal being one the flagship colonies to the French in Africa. The marginalization of communist Guinea by the international community during Sékou Touré determined, somehow, the fate of the Guinean people who still lack basic health and social infrastructures. As for Nigeria, the federal system which favors decentralization of power and services was also an important factor for the success against the Ebola epidemic. Just as Senegal, Nigeria is different from the three affected countries in that it has not experienced civil war since the end of the Biafra war (1967-1970). Absence of nationwide conflicts has helped Nigeria strengthen its political and economic set-up over four decades. The Niger Delta conflict and the battle against *Boko Haram* faced by the country were not civil wars *per se*. These two conflicts were only located in parts of the country. All these factors coupled with the support of external partners, the multi-sectoral government teamwork and community mobilization helped Senegal and Nigeria to prevent EVD transmission (WHO 2014c). Unlike the affected countries, Nigeria and Senegal were able to stir up local populations and external donors using existing social institutions to stop the spread of the EDV.

Political economy of suffering, neoliberalism and global health

A recent history of violent wars "in Liberia and Sierra Leone have involved powerful local interests that work at the behest of foreign transnational corporations. Diamond mining was one of the major causes of the civil war in 1991 in Sierra Leone" (Sanders et al. 2015, 648). Furthermore, "Large-scale mining is frequently experienced as the latest

form of exploitation, epitomizing the structural inequalities of deep-seated unequal global and society–state relations” (IDS 2015). It is shocking to know that gloves often used by medical professionals were lacking during the crisis in Liberia, a country which is home to the largest single natural rubber operation in the world called “Firestone Natural Rubber Company.” Although Liberian rubber is mainly used in Bridgestone car tires, the company also supplies rubber to companies manufacturing “vital medical components,” such as the latex gloves desperately needed in health facilities in the region” (Sanders et al. 2015, 649). It is hard to understand how countries with 40% of global iron ore exports at the time of the crisis lack the basic infrastructures to face an epidemic crisis (IDS 2015). When attempting to explain the root causes and peoples’ resistance to intervention teams, past and present relationships of domination and exploitation cannot be undermined. The Ebola epidemic is often portrayed as resulting from a virus that mysteriously and randomly emerges from the forest. This theory does not just work because the Ebola virus didn’t randomly spread in the Mano River countries. These countries are places where existing economy and public health system were destroyed by years of social strife, political upheavals, war and exploitative mining activities. Even in the times of war in Liberia and Sierra Leone, isolated areas which are often known to be the first sites of virus were “the centre of illegal logging and diamond mining linking these regions to regional and international economies. These so-called isolated and remote regions in Guinea, Liberia and Sierra Leone are now being profoundly transformed again with new resource extraction development, especially iron ore. Large-scale mining and its associated infrastructural development have a disruptive effect in terms of social and economic development in the region” (IDS 2015). It is well known that large-scale mining, through migration and demands for social services, may affect the ecosystem in ways that may prompt the emergence of zoonotic diseases.

The impacts of mining have contributed to EVD crisis in two ways. Firstly, large-scale mining creates social and ecological disruptions that could encourage the emergence and spread of disease. Local populations received so few benefits from external mining interventions. This has encouraged suspicion and rumors about Ebola response health teams and made it difficult for them to be trusted in the region. Early Ebola response teams were seen as government and/or mining companies’ accomplices. Secondly, accusations of sorcery and suspicion of Ebola intervention teams find a justification “in memories and discourses of the slave trade and before, and of recent foreign extractive mining relations—grounded not in traditional myths or timeless culture but history and political economy” (IDS 2015). Thus rumors and suspicion resulted from a long history of exploitation. At the time of the crisis, unemployment, widespread poverty, income inequality and social anger related to unequal distribution of mining gains shaped the social landscape in the affected countries. In spite of their enormous gains, mining companies failed to engage with local communities and health system in the region. Hence, “power and services have all been specifically developed and targeted at

the extractive operation almost to the exclusion of the surrounding communities and populations” (IDS 2015). To set up some of these companies, private investors often displace people’s livelihoods, undermine rural institutions and disregard cultural politics. The lack of respect for local communities and unmet social needs “have resulted in mistrust and suspicion of the government, including traditional chiefs and external companies, which are seen as manipulated by great foreign powers” (IDS 2015).

Although the Ebola virus has been in the region since 1976, no pharmaceutical company has been interested in launching research to find a remedy for diseases that affects people. In a world where profit tends to be the most important factor for medical research, afflictions endured by destitute poor become the focus of research only when people from the most privileged parts of the world are also affected. The people’s welfare is not a matter of concern in an era dominated by neoliberal integrists who work hard to exploit others. Neoliberal thought is central to modern development efforts and to global economy, the goal of which is less to repair poverty and social inequalities than to manage them. The global market produces affluence and innovation. However, in developing countries, the riches and the social benefits that arise from that wealth flow at substantially higher rates for owners than for workers (Kim 2014). The effects of structural adjustment programs (SAPs), for example, on the affected countries cannot be underestimated. The reduction of state spending on public services turned health into a commodity which led to the collapse of public health. With the growth of private health institutions and the decline of public health institutions’ performance, the urban poor and the rural population were condemned to access second-level and informal healthcare services. It is no secret that public health crises cannot be addressed by private healthcare institutions (Turshen 1999, 41-59). By favoring the development of for-profit health institutions and advocating minimal state interventions in healthcare and social services, development institutions and donors led these countries into a nightmare.

The transnational tale of inadequate development policies and poor governance can be forgotten in the dehumanizing poverty and disempowering violence that most people endure daily. The devastating effects of the EVD epidemic can then be understood as the obvious results of acceptable structural problems, the understanding of which seems to defeat analysis done from the ethnographically visible. Due to the de-politicization and the negation of state’s commitment to healthcare as a right, public health in most parts of the world was sacrificed through SAPs and a host of neoliberal incentives foisted on the world’s poor countries by the implementing agencies of rich donor countries in order to create a favorable climate for investment (Nguyen and Pestered 2003). The poor disproportionately suffer the consequences of such measures, resulting in the illness-poverty trap that spiraled entire societies into inhumane despair and unnecessary suffering. In many ways, the disastrous consequences of SAPs implementation perpetuated conditions that contributed to civil strife, extreme economic inequality and the systematic exclusion of rural communities and urban poor by urbanized elites

who hold pockets of resource wealth. Some of the hardships faced by rural populations expand in urban areas whose massive growth is a legacy of neglected rural development and displacement due to war in Liberia and Sierra Leone.

A failed global health leadership

The global response to the Ebola crisis will never be remembered as an example of good leadership, by neither national governments nor international health organizations (Tafirenyika 2014). Given that the affected countries could not have addressed the crisis by themselves, the reaction of global health institutions was strange, for it followed the patterns of global inequality which prevails in an unequal world where the need to intervene becomes an emergency only when it affects the developed countries. In order to privilege strategic or economic interests, financial aid was done bi-laterally for specific purposes (Wilkinson and Leach 2014). The epidemic has certainly “placed this failure into stark relief, exposing the pathology of chronic neglect amid broad global inequalities” (Boozary and Farmer 2014, 1859). The EVD epidemic was not just a common public health event, but reflected a crisis of leadership and governance mechanisms among global health institutions (Gostin and Friedman 2014, 1323). The restructuring that occurred within the World Health Organization (WHO) after the last financial crisis prompted a change of priorities towards non-communicable diseases. This change dismantled the agency’s core outbreak response team which resulted in a loss of institutional memory (Wilkinson and Leach 2014, 140). The WHO declared the outbreak an international emergency when the disease was already ravaging the affected areas. Severe funding cuts in recent years have crippled the WHO’s effectiveness in handling global health emergencies. The WHO has slowly lost its ability to act as a technical organization that takes care of health as a global public good. The increasing number of new actors and programs in global health created in spirit of competition that weakened the WHO’s global health governance role (Harman 2014). In the last fifteen years, poorly coordinated interventions and policing at the global scale have resulted in priorities and financing decisions that were not equipped to boost health systems.

To improve health after years of war and social strife, the strengthening of health systems was needed. Unfortunately, the global health community focused essentially on the three-disease program (AIDS, tuberculosis and malaria), giving pre-eminence to vertical programming over more horizontal interventions that solidify health systems and orient funds towards disease-specific interventions to the neglect of other diseases (Azétsop 2015, 141-142). The WHO has long emphasized the need to strengthen health systems but was never listened to. The WHO could not do it due to the lack of funding and staff (Gostin and Friedman 2014, 1323). In addition, the systematization of global health interventions in terms of goals to be achieved, targets to be reached and performance “created a results-based culture that is guided by investing in what can easily be measured” (Harman 2014) which showed serious strategic limitations when

these countries had to respond to the Ebola crisis. Hence, a sizable investment in the health systems would be a profound change of course for the region. As with other poor countries, the governments of affected countries have not spent enough money on health care to provide basic services, and the life expectancy of the populations has suffered greatly as a result. In 2013, Guinea spent \$7 per person on health services and the life expectancy was 52 years; Liberia spent \$14 per person and the life expectancy was 56 years; Sierra Leone spent \$11 and the life expectancy was 49 years; and in contrast, Norway spent \$7160 per person and the life expectancy was 81 years (WHO 2015a). These data demonstrate that countries that spend more on health expenditure are able to counter the effects of poor health on life expectancy (Ogungbenle et al. 2013; Akinkugbe and Mohanoe 2009; Heijink et al. 2012; Hitiris and Posnett 1992; Bokhari et al. 2007; Compah-Keyeke et al. 2013; Filmer and Pritchett 1999). Although the affected countries are poor, these data also reflect with the level of political commitment of their past and present leaders to work for people's welfare at the time of the crisis. It is common knowledge that politics is an important determinant of public health (Faret et al. 2013; Besley and Kudamatsu 2006).

Weak public health services and poor political commitment to public welfare

At the onset of the epidemic, "among every thousand people Guinea could count only 0.1 doctors, Liberia 0.014 and Sierra Leone 0.022" (WHO 2014a). These countries lack trained professionals, health infrastructure and well-organized structures. The health standard of the Sierra Leoneans has been and still remains one of the worst in the world. The 2008 Sierra Leone Demographic Health Survey revealed that life expectancy is 47 years. Infant mortality rate remains a deep concern, with 89 per 1000 live births. Under-five mortality rate is 140 per 1000 live births and maternal mortality ratio is 857 per 100,000 births (WHO 2014c).

Liberia emerged in 2003 from a long decade of a brutal conflict which had destroyed its economy, infrastructure, healthcare and education systems. As a result of war, most Liberian physicians had fled the country to get better jobs abroad, especially in the United States, but afterwards the government failed to re-establish the balance. Data showed that of Liberia's 550 pre-war health facilities, only 354 facilities were functioning by the end of 2003. Those facilities include 12 public hospitals, 32 public health centers, 189 public clinics, 10 private health centers and 111 private clinics. Strikingly, 80% of these were run by non-governmental organizations (Lee 2011). By the time the epidemic began in Liberia, the lack of specialists was particularly alarming since the country "had no pathologists, anesthesiologists, one psychiatrist, one internist, two pediatricians, and three obstetricians" (Al Paulus 2014). Furthermore, "in 2014, with a population of 4.2 million, Liberia had only 51 doctors, 269 pharmacists, 978 nurses and midwives, while Sierra Leone, with 6 million people, had 136 doctors, 114 pharmacists and 1,017 nurses and midwives" (Al Paulus 2014).

Guinea was already facing healthcare system challenges in 1986, due to deficient resources and the lack of good services at the peripheral level. Over the decades, public spending focused primarily on services in towns especially in Conakry marginalizing the Forest region where the epidemic started. A more alarming finding showed that in 1994, 48% of government expenditure in health benefited the richest 20% of the population, whilst only 4% of expenditure reached the poorest 20%. This questionable allocation of resources did not spare the expenditure for medical personnel, which are also amassed in Conakry. Over 60% of qualified health professionals are based in Conakry, a city which represents only 20% of the country's total population (African Region Human Development 2006). With a population of 11 451 000 in 2014, Guinea had 941 doctors and 4408 nurses and midwives (Munjita and al. 2015, 874). Weak health systems that failed to confront ordinary diseases could have coped with the Ebola epidemic.

By contrast, Senegal and Nigeria have managed to sail through and overcome the outbreak, due to the strength of health systems of the two countries and the political commitment of their respective governments. Senegal and Nigeria have demonstrated that African governments can face and address deadly and dangerous threats. Senegal's healthcare system is much more organized and equipped than those of the affected countries. By leveraging domestic resources and international assistance, both countries mounted a world class, rapid response strategy against Ebola.

In Senegal, public health governance is characterized by ongoing decentralization reforms in the public sector and by significant participation from a multitude of different actors from public and private sectors as well as foreign governments and organizations. The process of decentralization began in Senegal in the 1970s with a gradual transfer of administrative responsibilities to the local level, which brought significant changes.

Nigeria's healthcare system is much more organized and equipped than those of the affected countries. In addition, Nigeria has a central, coordinating command-and-control center to direct nationwide response activities and to manage technical relationship with external partners. As part of health policy, decentralization is also observed in Nigeria where the different states supported by the federal government manage the healthcare system. On this very point, Senegal and Nigeria contrast with affected countries where most healthcare infrastructure is concentrated in the capital city, making it totally vulnerable. The responsibility for the management of health facilities in Senegal was transferred to the regions, municipalities, and rural communities in the 1990s. In 1998, hospitals were given more autonomy, including control over their own finances and management. The budgets for regional hospitals and health districts were also transferred to local governments (Tine et al. 2014).

Containing the outbreak in Nigeria and Senegal was not the result of a mere gamble. The Nigerian federal system of administration, the awareness of what was happening in the three affected countries and the effective use of resources helped in preventing the transmission of the virus. Nigeria has executed a rapid response that efficiently

made use of the available public health resources. Nigeria benefited from a stronger and better-financed system of public health than Liberia, Sierra Leone and Guinea, the impoverished countries where the current epidemic began. Nigeria also took advantage of the infrastructure of a polio eradication program that had been active for years. A polio and HIV clinic in Lagos, financed by the Gates Foundation, was transformed into an emergency center for Ebola, with dozens of doctors available. Nigeria was also quick to welcome foreign help while foreign help was rejected in Mano River countries. There was remarkable co-ordination between every level of Nigerian government and global health organizations such as the WHO, the U.S. Centers for Disease Control and Prevention, and Doctors Without Borders. Private companies donated ambulances, disinfectant and other important supplies.

Nigeria got it right when a quick and aggressive attention was given to the index case: Mr. Jonathan Sawyer, who had left a treatment center in Monrovia. With the identification of the index case, Nigeria's public health officials launched an operation which helped identify 894 persons followed for Ebola symptoms due to the direct or indirect contact with Mr Sawyer. A total of approximately 18,500 in-person interviews in Lagos, Port Harcourt, and other regions of Nigeria was part of the isolation and contact tracing operation. From this operation, 20 confirmed cases occurred in Nigeria, along with one probable case, leaving only 11 dead (Freedman 2014). So, in the complex environment of Nigeria and even Senegal with their porous borders, the issue was quickly addressed. For instance, Nigeria made use of an Incident Management System (IMS) which helped contain the outbreak earlier (WHO 2014c). As part of the strategy, Nigeria Centre for Disease Control (NCDC) and the Lagos State Ministry of Health established an Incident Management Centre (IMC), which was the control tour of all the operations. The initial IMC was thereafter changed into a national Emergency Operations Centre (EOC) which together with the Incident Management System nomenclature and national structures aimed at emergency response (Shuaib et al. 2014). Interventions were organized in a way that all partner organizations, donors, and response teams would operate through the EOC structure, reporting to an Incident Manager. The IMs were, finally, responsible for sending accountable and transparent results to the NCDC and the federal Ministry of Health (IDS 2015). Additionally, Nigeria benefitted from the strategies and tools that were put in place to eradicate poliomyelitis.

The social behaviour of Nigerians and Senegalese also helped to win the battle. In Nigeria's social set-up, it is very easy for news to be spread even without the use of new technologies. With the efficient use of social media, this social behavior was instrumental in spreading prevention measures across the country, especially in Lagos State and other targeted states (Freedman 2014). Perhaps, one of the most important hallmark of the Ebola response in Nigeria was the implementation of nationwide continuous, comprehensive information, education and communication (IEC) campaign to alert citizens on the outbreak, methods of spread and high-risk behaviors. Print and

electronic media joined various levels of government in both countries to conduct IEC campaigns. Both governments also mobilized professional organizations, local opinion leaders, community organizations and religious institutions to further spread the IEC campaign against Ebola in remote parts of the country. In Nigeria, social mobilization teams went house-to-house to visit 26,000 families who lived within two kilometers of the Ebola patients. They explained Ebola's warning signs and how to prevent the virus from spreading. Leaflets and billboards, in multiple languages, along with social-media messages, were used to educate the broader Nigerian population. Nigeria also disseminated information over mass media, including setting up a dedicated website, on how people could avoid the virus, without stirring hysteria in the world's eighth-most-populous nation (Freedman 2014). Nigerians and Senegalese were well aware of the lethal effect of EVD, consequently, they granted no room for superstitions and the instrumentalization of the crisis for political benefits as it sadly happened in Guinea.

The commitment of President Macky Sall and Dr. Awa Coll-Seck, the then Health Minister, to the public health was exemplary. With the support of state's partners and local communities, Dr Awa led a quick response plan to stop virus transmission in a timely manner (WHO 2014c). This plan "included identifying and monitoring 74 close contacts of the patient, prompt testing of all suspected cases, stepped-up surveillance at the country's many entry points and nationwide public awareness campaigns" (Lynch 2014). The leadership of the Federal Ministry of Health, Prof. Onyebuchi Chukwu, and the instrumental role of the Nigeria Centre for Disease Control (NCDC) under the leadership of Professor Abdul Nasidi, were decisive in stopping virus transmission (Shuaib et al. 2014). What happened in Nigeria and Senegal shows how critical is the leadership and the commitment of the head of state and of the minister to control an epidemic of such a magnitude. In contrast this, President Ellen Johnson Sirleaf was rebuked by her own parliament when she requested extra-powers to respond to the epidemic and to delay upcoming elections. Sierra Leone President Ernest Bai Koroma reconfigured his country's response to the outbreak later, establishing a new response team that reports to the defense minister rather than the health minister. The governments of Nigeria and Senegal deserve ongoing global commendation for a resolute stand against the Ebola crisis.

Embodiment of National-Global Ills

The French physician and medical anthropologist, Didier Fassin rightly affirms: "the body is not only the immediate physical presence of an individual in the world; it is also where the past has made its mark. Or rather the body is a presence unto oneself and unto the world, embedded in a history that is both individual and collective: the trajectory of a life and the experience of a group" (Fassin 2007, 175). These words account well

for what happened in the Mano River countries, suggesting the need for choosing a theoretical device that best sustains our analysis and interpretation of elements that serve as evidentiary basis for our argument.

An embodied approach to EVD outbreak puts bodies back into society and society into the body, because there is a dialectical relationship between human embodiment and an inequitable social world. Biology plays an important role in that “it may impinge directly on the self, provide signals for identity construction, and act as a limiting factor on social action for the sufferer” (Williams and Monaghan 2013, 66). The EVD crisis is a social condition which reveals not only “pathologic process that attacks the body but also a historical truth that exercises the social body” (Fassin 2003, S5). The Ebola virus existed in the region for nearly four decades before the first animal to human transmissions took place. Poverty and the violence of capitalism pushed people to the forest, increasing exposure to Ebola virus and to other zoonotic pathogens. In fact, “Years of civil strife, largely fueled by competition over the control of very valuable natural resources, led to enormous displacements of the local population, consequently increasing the pressure on forest land, and accelerated migration out of areas harboring forest animals” (Sanders, Sengupta and Vera 2015, 648). Years of unacceptable suffering and violence progressively weakened the social body and paved the way to all sorts of catastrophes. The state of health systems reflects the recent history of affected countries. Infected people in Guéckédou who turned to the under-resourced healthcare institutions increased healthcare workers’ vulnerability to nosocomial transmission which, in turn, spread the disease to their neighborhoods. With the flow of people from one country to another, the virus spread from the Forest Region of Guinea to Liberia and Sierra Leone. The Ebola epidemic spread because people in the tri-country area, where the outbreak started close to Guéckédou, usually move across borders as unemployment is a major social phenomenon in this forest region. Most people rely on the informal sector to earn their salary, thus to ensure daily survival, people have to be willing to cross borders. In addition, due to the lack of social services and health facilities in the region, people often turn to major cities to look for help when they are desperate. The cultural beliefs about the nature of illness and remedy, about handling the sick, dying and deceased also contributed to the spread of the virus. The centralization of economic and political activity in the capital cities also served to hasten Ebola’s spread from villages and smaller towns to the cities. The rapid spread of the epidemic was then due to the weaknesses of the weak health systems.

Corruption is a public health risk factor, for corrupt practices in the health sector reduces the resources available to improve the health systems. Corruption also weakens public trust in the government healthcare system, trust which is essential in emergency situations. The affected countries are particularly endowed with natural resources: Liberia has been blessed with rubber, diamond and iron; Sierra Leone with diamonds, iron ore, mineral sand and gold; and Guinea with bauxite and diamond (Bermúdez-Lugo and Menzie 2015).

The exploitation of these resources has been entrusted to international investors who are supported by local authorities who grant them with all sorts of tax breaks. Exploitation of these resources has been done at the expense of local populations. The unlawful expropriation of the local peasantry from their ancestors' land shows how national resources become a curse instead of a blessing. This situation has increased resentment in these countries, reinforcing the accusation of the "white man" and the loss of confidence in the government authorities which result in difficulties in managing EVD epidemic through community participation and social mobilization. The strong reaction against government officials and local health staff indicated a clear loss of confidence in the health personnel involved in EVD intervention. In Forest Guinea, there were even rumors that political leaders were paid by the West to introduce Ebola in their region. The epidemic was fueled by the rejection of early interventions and government's action. Relations between the people of Guinea's Forest Region and the authorities have always been strained. Besides precariously weak public health systems, the Ebola crisis exposes the workings of a state apparatus that for decades has been basing itself on authoritarian governance by military and police force (Schovren 2014). Indeed, the management of funerals by institutions (MSF, Red Cross, and Prefectural Coordination) testifies to the crisis between the Guinean elites and the local population (Le Marcis 2015). Understanding the resistance to burial interventions framed on a vertical mode by Guinean authorities as reactions against the disrespect for their ancestral rituals would not help but redouble the violence by helping perceive local people as incommensurably others. The incommensurable otherness is another way of not allowing people to be radically different and maybe, not allowing them to just be human.

The anthropological literature usually presents funerals as social dramas in which relationships, alliances or conflicts, are made visible, distended for the former or resolved for the latter, in the context of Ebola funerals were silent, worse, the human beings were reified (Frédéric Le Marcis 2015). Anthropological research done in most places in Africa and in the diaspora emphasizes social and public relevance of funerals (Jindra and Noret 2011, 23). Burials in the context of the Ebola epidemic has trampled on the vital elements that make up the soul of a people, because to maintain a dead person in a position of anonymity amounts to denying his past and refusing him any future existence. The vertical solutions adopted by the Guinean authorities could only be misunderstood, since it ignores the rites that allow a deceased to transcend by offering the possibility of becoming an ancestor of the clan. Biological death does not mark the end of life, but opens up a new form of presence of the deceased in the world.

The intervention teams in Guinea's Forest Region simply ignored the culture and the ontological regime from which it emerges. Without accentuating the conflict of ontological regimes provoked by these interventions, we intend to underline that "the human person cannot be reduced to his or her biological life. For the people living in the Guinea's Forest Region, a dead person can remain a person to be pampered because he remains a person endowed with a capacity for action on the world and the destiny

of those who survive him” (Le Marcis 2015). Notwithstanding this anthropological argument, a more political hermeneutics of the crisis can be developed so as to uncover the social elements that patterned the crisis. The treatment of bodies imposed by the authorities shows the little concern that the elites carry for people. The rejection of local culture was equated to the dehumanization of people from the Forest Region, perceptible in the discourse of Guinean officials and transnational actors who understood people’s resistance to early intervention as being the consequence of ignorance and a lack of education, rather than recognising the importance of culture in people’s life and questioning the state’s and multinational corporations’ behavior in a region that has long been subject to exploitative logics (slavery, colonization and mining) and located on the outskirts of Guinea. Throughout the many years of suffering and socioeconomic exclusion, people in these countries have progressively developed a resistance against those who take care of public’s affairs. A past of violence and disrespect has driven people into fear and insecurity. Unfortunately, when Ebola struck, the rumors and resistance that these feelings generated were simply dismissed as ignorance and superstition. Instead, they are the product of longstanding experiences of relations with state and foreign actors who are seen as alien, oppressive, or self-serving.

In Liberia, the government has increasingly been accused of corruption and it is not altogether surprising that many thought Ebola was a ruse to make money (Faye 2015). Questions raised about the proper use of funds collected with the purpose of addressing the EVD epidemic increased suspicion and mistrust toward medical teams. In a context of growing mistrust, the implementation of quarantine by the government was massively rejected by local communities. In the Forest region of Guinea, intervention was simply understood as another instance of violence perpetrated by the Government on defenseless people. While the Ebola crisis was understood as an exceptional event by medical teams, local people saw it as a part of the ongoing process of violence prevalent in their country (Faye 2015).

The early interventions were culturally inadequate in that they forbade participation of relatives in funerals as was the case in Liberia until mid-September 2014. Thus, the initial response increased mistrust which prevented people from seeking help in government-run institutions and reduced the level of community’s contribution to relief efforts. Relief workers had to learn once again that effective intervention needed to be culturally acceptable. Interventionists thought that they could change long-standing and deeply-engrained burial and funeral practices which include washing of the body after death. These practices which involve close contact with infected corpses contributed to the spread of the disease. In Guinea, about 60% of cases were linked with traditional burial practices. Quarantine, social distancing, mandatory cremation of bodies, and other top-down solutions were used to avert incident cases arising from these practices instead of using credible individuals from the communities to reinforce health promotion messages that were tailored to local cultures. Early interventionists

did not only lack cultural competence—that is a set of abilities, skills, behaviors and policies that enables practitioners to work effectively in cross-cultural situations—as often required in public health interventions but also cultural humility, which is about acknowledging oneself as learner when it comes to understanding other’s experience, as an instrumental value for a successful intervention.

Approaches to medical intervention were essentially based on the so-called scientific rationality which saw cultural practices as irrational. Anthropologists played the role of mediators between the local population and medical teams which allowed medical teams to understand local culture and allowed people to understand the risks for infection. For an anthropologist, there is always a meaning and a rationale to cultural practices and norms; and, when there is a norm there is always an exception. Reliance on these two principles helps find alternative burial and cleansing rites after discussing with elders of local communities to avoid widespread transmission in Guinea (Scidevnet 2014). The EVD crisis highlighted the salient contribution of social scientists in providing an understanding of local beliefs, behaviors and customs to medical teams. Social scientists “can inform those who are at the front line, enabling them to better understand the context and work more effectively with communities to change behavior. This must become part of standing protocols and standards for health emergencies” (WHO 2015c). Social scientists may do this work while helping to understand endogenous and transnational logics that determine a much localized epidemic. This critical approach to ethnographic research, which informs Faye’s “symmetric anthropology,” demands to be distanced from a strictly culturalist and behavioral perspective in epidemiology. Instead, symmetric anthropology calls for an ethnographic approach that focuses on understanding actors’ daily attitudes and practices as embedded in a history that needs to be documented (Faye 2015). This perspective determines the understanding of disease aetiology and intervention to the connection that exists between the micro and the macro-picture, individual pathologies and social forces.

An Epistemology of Disease Aetiology and Management

The EVD crisis questions humans’ relationship with the social world and its material basis. The virus did not get out of the Guinea Forest Region and spread randomly. Prior to the crisis, economic and health systems had been devastated and disrupted by years of civil unrest fueled by large-scale mining and sustained by divisive way of ruling. Mining and war favored social and ecological disruptions which, in turn, favored a closer exposure to the virus (IDS 2015). Thus, focusing on embodiment to understand the social aetiology of an epidemic of such magnitude “helps bridge the structure-agency, micro-macro divide” (Williams and Monaghan 2013, 66), opening up a venue for discussing issues of justice. Daily life, community’s agency and individual biographies in affected

countries were deeply shaped by local cultures, socio-political unrest and large-scale mining. An inquisitive analysis of the embodied processes point to the structural factors that determined the spread of the virus, revealing another powerful pathway through which the negative effects of inequality take their toll (Williams and Monaghan 2013). Daily trajectory of people is affected by the violence generated by the social forces that structure risks for disease. The ethical inversion operated by this form of hidden and indirect assault on human dignity legitimizes what should not be accepted or tolerated. Violence prevents “individuals, groups, and societies from reaching their full potential” (Farmer et al. 2006, 1686). Thus, as a concept, violence “goes beyond physicality to include assaults on self-respect and personhood. The social and cultural dimensions of violence are what give it its force and meaning” (Bourgeois and Scheper-Hughes, 2004, 318). A theoretical lens, “structural violence” broadens the horizon of reading and analysis of disease aetiology and calls for a renewed understanding of emerging diseases.

A possible theoretical construct for disease aetiology

Structural violence can be defined as historically given and often economically driven processes and forces that conspire to constrain individual agency (Farmer 2003, 40). Violence is structural because it “is built into the structure and shows up as unequal power and consequently as unequal life chances” (Galtung 1969, 171). By structures we mean social relations and arrangements that shape how individuals and groups interact within a social system. These include broad-scale cultural and political-economic structures that daily life and constraint people’s agency assault their dignity and create a civilization of unjustifiable inequalities. These structures are violent because they result in avoidable deaths, illness, and injury; and they reproduce violence by marginalizing people and communities. Structural violence is largely invisible. Physical violence is direct and visible while structural violence is indirect and silent. The distinctive features of direct violence are the specific events where there is a clearly identifiable victim and a recognizable perpetrator of the violence (Galtung 1969, 170). Structural inequalities are often seen as a natural part of the social order (Galtung 1969, 173). Axes of violence include political oppression, economic marginalization, ethnically motivated violence and neoliberal oppression, to name a few. The history of Liberia, Sierra Leone and Guinea shows how structural violence has been normalized both by social institutions and international relations that shape daily life. Paul Farmer’s theory of structural violence calls a critical epistemology of emerging diseases which brings out features of disease production that are excluded by analytic frameworks used to explain disease aetiology. Structural violence is not just a concept but “a theoretical frame, a method of inquiry, and a moral/ethical imperative for the anthropological enterprise” (Green 2004, 319). Early interventionists thought the cases could be traced to failures to follow contact precautions and to the persistence of entrenched cultural patterns of burials. Beyond cultural factors, rejections of early interventions in Guinea, for example,

were not just an opposition to health measures that undermined people's customs, but they denoted an ongoing fight against a political establishment which has divided the country along ethnic lines and protected the interests of multinationals (Faye 2015). In order to explore the intelligibility of complex social phenomena and understand the unequal social positioning of individuals and groups within a larger ecology, a critical epistemology questions the veracity and pertinence of commonly accepted etiological theory and intervention practices. An embodied theory that includes both the world system theory (Wallerstein 2004) and the postcolonial theory (Mbembe 1992) can help construct this critical epistemology.

As an embodied theory, structural violence connects the human body with the body polity both at national and global levels. Understanding the human body, as deeply historicized and socialized enables a cross-cultural and multidisciplinary framework for grasping how social relationships shape disease patterns and, more broadly, collective affliction. By focusing on how the body is located within history, research can provide an important theoretical stepping stone to formulating a problematic that is more sharply focused on the relationship between national-global violence and disease. With the EVD epidemic, we witnessed a situation in which the violence of inequality is "transcribed into the body as biological difference and expressed as "risk" to be managed" (Nguyen and Peschard 2003, 448). As an analytic tool, structural violence allows a deeper depiction of the local and of the global, and shows how the global enters into the local through market profiteers and multinational corporations with the help of national leaders.

The location in the global economy is an important factor that influenced health and life chances. The world system theory explains how the dynamics of global economic structure risk for poverty and poor health (Barfield 1997). As a system, the world is bureaucratically organized with one political centre and an axial division of labor, but multiple cultures (Wallerstein 2004). Although this theory shows limitations and weaknesses, the hierarchical structuring of the world as core, semi-peripheral, and peripheral countries is an important element of a political economy analysis of health. The Ebola-affected countries exemplify peripheral countries which are characterized by their dependence on core countries for capital and their low level of industrialization and urbanization. The affected countries are essentially agrarian with low literacy rates and a lack of adequate infrastructures and technologies which means low-level productivity. These countries depend on foreign capital and investments to create jobs and produce goods. Governments sign contracts with multinational corporations through which all sorts of provisions are made in favor of these powerful entities. In fact, "corporations based in core nations exploit periphery and semi-periphery countries by extracting raw materials; employing inexpensive labor for assembly and other labor-intensive production; and using them as potential consumer" (Barfield 1997).

Economic projects designed by capitalists in affluent parts of the world generally have ripple effects in the countries where the production occurs. There is an economic order

which is nothing other than “a system of economic relationships, worldwide in scope and hierarchical in its distribution of resources” (Barfield 1997). Location in the periphery of the economic world system jeopardizes health in part because core and semi-periphery countries exploit the natural resources and labor of the periphery with the assistance of the local elite, without actively promoting the welfare of workers and protecting the environment. Economic violence operative in the mindset of those who run the mining industries in these countries will continue to spiral as the exclusion of poorer societies from global economy worsens their health. This form of exclusion is sustained by a global indifference. There tends to be a tacit agreement not to see that inequality and violence create opportunity for disease. Silence as a sign of support to violence tends to be the policy in an unequal world where sufferers are not only symbolically made invisible, but are also blamed for being a threat to others. The symbolic overtone of this viciously entertained silence consciously creates new identities, ideologically constructed from the poor-and-rich logic. This silence makes the suffering of others imperceptible while for the same health condition, intervention is rapidly carried out in well-off places. Imperceptibility is the divisive tool used by socio-global forces to silently create new subjectivities (Fassin 2007, 276-278).

Ebola is an embodiment of the present time, a process that transcends physical body and the local space because, in a globalized world, the boundaries of the local space are very porous. Colonization is one of the past events with which African countries are still struggling. Post-independent African leaders, who were carefully chosen for their complacency with former masters, inherited from the colonizers a brutal way of ruling and a corrupt administration which have not favored economic development. The logic of postcolonial power may help us understand how relatively stable countries were able to stop EVD transmission while the most affected could not. The contribution of local leadership to the production of misery and diseases cannot be undermined. Achille Mbembé’s theory of postcolony is meant to explain the social chaos that prevails in postcolonial Africa. Mbembé (1992, 3) states that: “...the postcolony is... made up of a series of corporate institutions and political machinery which, once they are in place, constitute a distinctive regime of violence”. This institutional bricolage is done through the meaning-making role of the state enjoys in society. Through its bureaucratic practices, the state not only gives meaning to everything in society on its own, but determines thinking patterns of citizens. An intimate tyranny links the rulers with the ruled in the postcolonial space. If subjection appears more intense than it might be, it is because the subjects of the commandment have internalized the authoritarian epistemology to the point where they reproduce it themselves in all the minor circumstances of daily life (Mbembé 1992, 25). Even if Liberia does not fall within the traditional colonial model due to its traditional connection with the USA, this country has nonetheless followed the dominant model of leadership proper to most African countries which Mbembé labelled as postcolony mindset which clarifies the reasons why the affected countries lack

appropriate institutions capable of responding to the crisis. The ongoing institutional bricolage and the pretence of fake and flattery transactions between state and society has silenced voices that demand accountability from the subsequent governments. On the aspects of governance and violence, these countries share some common features which can term “structural violence”. Shaped by all forms of brutality and neocolonial imperialism, the violence of postcolonial politics followed the path designed the colonial rule. The perpetuation of violence creates a culture of inequality that served the interests of the elite, former colonial masters and multinational companies (Wilkinson and Leach 2015, 137).

A renewed understanding of emerging diseases in resource-stressed countries

Just as for the Ebola crisis, biased accounts of disease production often focus one-sidedly on individual behavior or people’s culture. Such accounts de-contextualize and de-politicize the aetiology of public health crises that often claim many lives (Farmer 2004, 311-315; Faye 2015). The search for a thick meaning of such a crisis shows how socio-political strife and national-global inequalities came to be largely embodied as the Ebola disease. Looking exclusively into present features and people’s culture may erase the connections between present and past events that determine everyday life in affected countries. Hence, focusing only on the past to explain the ethnographically visible may mask the webs of living power and institutions that enmesh witnessed misery while scrutinizing only striking present-day events and actors to explain misery may hide the ways in which historical processes of violence have structured the likelihood to be infected. Although macro-social phenomena are not often the focus of social inquiries, integrating a broad body of knowledge to epidemiological data may lead us into a deeper understanding of the Ebola crisis as it is rooted in history, political economy and biology. For example, the lack of social capital in affected countries could have been foreseen as a potential barrier to public health intervention if a social analysis had been conducted to complement the epidemiological assessments (WHO 2015c). Thus, the analytic framework of the interventions should have been biosocial to avoid erasure of the social dimension of the epidemic. A biosocial approach combines epidemiological and social sciences tools to highlight the association between ongoing social strife that leads to the rejection of any form of Government’s intervention, issues of governance and the violence of modern capitalism with the magnitude of the epidemic. This association can be highlighted by connecting the hermeneutical ambition of critical anthropology with historicized understanding of macro-social forces and the political environment in which the Ebola risk were embedded (Farmer 2004, 309). In order to outline this association, we will bring out the following points: recent regional history of affected countries as a history of violence, the political economy of the Ebola crisis, the failures of global health institutions’ leadership and the limitations of local leadership.

Beyond the medicalization of the violence of inequality, a call for social healing

The use of an embodied analysis of Ebola aetiology has placed us in a favorable ground from which we cannot help but avoid the “pathologization” and, thus, the medicalization of the violence of inequality. Long before the latest outbreaks, inequalities have powerfully sculpted not only the distribution of infectious diseases, but also the course of life in affected countries and the risks of infection in those affected. Hence, just like other infectious diseases, Ebola follows the path of least resistance and the least resistance follows the path of inequality; it is a path laid down by a history of slave trade, colonialism, sociopolitical strife, imperialism and global indifference. So, the fight against Ebola was not just a battle against the virus, but also a fight against inequality. The knowledge and infrastructure to reduce transmission and treat the sick exists in richer counties, but they were not available in affected countries (Kim 2014). The pathogenic consequences of global inequality offers a stark reminder that the epidemic was more than just a health crisis because the same economic, political and xenophobic ideologies that encouraged global blindness at the onset of the crisis are the same forces that enable multinational corporations to exploit the resources (Chan 2015). The Ebola crisis challenges the global community to pay attention to disease in a new way. Medical interventions alone cannot replace a more systemic change that needs to happen locally and globally to ensure people’s well-being.

The global health community has learnt that, in spite of the wealth enjoyed by some, the world is not as secure as was thought. What happens in remote corners of the globe can affect those who live in its most visible parts. Strengthening national health systems therefore is an integral part of global health governance. Such a goal cannot be achieved without a sustained commitment to reduce global inequality through sound development policies since humanitarian response cannot ensure epidemiological surveillance in areas where zoonotic infections are possible. The global health community needs to reclaim the coordinating role of the WHO and rethink the presence of the other actors as complementary to that of the WHO.

Community-based initiatives are critical to prevention and development. Community mobilization was critical to the success of interventions in Nigeria and Senegal, while, prior to the crisis, countries in which the epidemic spread lacked social trust which happened to be an important barrier to EDV transmission. The notion of social capital refers to networks with shared norms, values and understandings that facilitate co-operation within or among groups (Adler and Kwon 2002, 18-19). Social capital is formed on the basis of generalized trust and obligations of reciprocity within social entities. Efforts to rebuild cannot be achieved without a certain level of community cohesion. Social capital provides the glue which facilitates co-operation on which development policy can be anchored. Social participation in health promotion and development demands decentralization of power from the central level to the district level and from the district level to the village or neighborhood level. Just as in West

Africa violence, community resistance or suspicion was reported in all previous EVD epidemics in other parts of Africa, suggesting that local communities should be involved in medical response and prevention interventions. In the context of epidemic, people need to be seen as allies and assets rather than enemies. Social trust and community participation are two values, among others, inherent to the public health perspective. In fact, “public health measures work only when authorities listen to the affected communities and involve them non-paternalistically, allowing confidence in the health system to develop” (Cohn and Kutalek 2016). The need of paying attention and giving a voice to affected communities indicates that EVD containment should not only be seen from a biomedical standpoint but also from a socio-cultural perspective (Cohn and Kutalek 2016). Affected countries are challenged to ensure social participation through a legal framework and accountability mechanisms that favor civil society’s control over government’s actions, so as to promote public institutions trust, socioeconomic integration and national unity as public values. In Sierra Leone, for example, the Local Government Act of 2004 provides for a democratic system of accountability at the local level. However, leaders never abide by it. Civil society should ensure that accountability structures function as expected. Thus, the government ought to empower local communities to know their rights and develop the skills to negotiate, participate, advocate, monitor and network according to their needs (Oxfam 2015). The improvement of the human welfare calls for important social interventions to eradicate ethnocentrism, corruption and the hegemony of mining companies. Efforts to rebuild and protect the public health require rethinking the activities of mining industries (IDS 2015). Each national government needs to design a corporate social responsibility law to hold mining corporations accountable. The lessons learnt from the crisis highlight the need for community engagement and an understanding of the link between governance and politics. Communities do not often collaborate when there are been issues of trust and accountability with public authorities. Social trust and public accountability that were lacking in these West African countries are important social virtues for national cohesion and state building. The lack of these virtues was detrimental not only to social cohesion but also to Ebola interventions. Therefore, understanding social dynamics is essential to designing robust interventions and should be a priority in public health and emergency planning. A critical step is to begin with a more realistic account of local social relationships. In addition, interventions should be informed by approaches which are sensitive to how social, political and economic interests interact in policy processes and local settings (Wilkinson, Parker, Martineau and Leach, 2017).

Conclusion

The recent West Africa Ebola outbreak has challenged local healthcare systems and many global institutions. The lesson learnt from this crisis is that an epidemic of such a magnitude is always shaped by important underlying causes. In the recent case of Sierra Leone, Liberia and Guinea, these distal causal factors were determined by structural violence which cannot be undermined when trying to understand the dynamic of the epidemic. It is not enough to look at the ethnographically visible to identify the causal link and the epidemic theory that may account for what happened, for proximal causal factors are engrained in a broader web of present and past social relationships and transnational interactions that transcend what is immediately seen and heard. From the apparently invisible location of the Forest Guinea Region where the EDV epidemic started, national and transnational brutality intersects and perpetuates economic poverty and political silence. Desperation of people in this isolated area that has been excluded from national politics and where large-scale mining takes place accounts for their opposition to early intervention team. The interaction of the multiple factors that give rise to the epidemic challenges researcher to move from an ethnographic research that focuses on culture and what is immediately visible to a thorough scrutiny of the interactions and behaviors of national institutions and multinational corporations with the local population in affected countries. The delayed global response to EVD, the distal causal factors of massive infection and poor national leadership underline how invisibly marginalized people from the peripheries of world are treated. The magnitude of the EDV epidemic was rooted in a wounded history and embedded in a national and colonial political economy fraught with mistrust and ethnic conflicts. There is no doubt that the violence, mistrust and suspicion found in affected countries shaped and determined the course of the epidemic. Hence, having a larger view of the EDV epidemic causation allows us to understand why countries such as Nigeria and Senegal managed to avoid the spread of the virus. A different colonial past coupled with quality social interactions and good political organization allows Senegal and Nigeria to avert the EDV crisis. Other countries of the continent should learn from the experience of the two countries. We learn once again that the determinants of health are essentially socioeconomic and political.

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