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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

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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. FoucaultÕs (2007) concept of Ôcrises of circulationÕ 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 ÔsecurityÕ). Questions of public health have purchase beyond the practical management of epidemics: this project also intersects with concerns about mobility (e.g.

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 ÔFoucaultsÕ 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 ÔagencyÕ seriously (Walters, 2014) by considering ebola-as-actor.

My ambition is dual: I will be critically examining the WHOÕs response to the 2014-15 ebola epidemic, while simultaneously evaluating the theoretical strengths and limitations of of FoucaultÕs concept of Ôcrises of circulationÕ as a lens for examining the WHO response to ebola. Ultimately, I suggest that Ôcrises of circulationÕ are best deployed in tandem with the relentless questioning of discourse provided by both ÔolderÕ Foucault-inspired examinations of discourse, and Latourian commitment both to unpacking the construction of Ômatters of concernÕ and taking the characteristics of objects Ñ including disease Ñ seriously (Latour, 2004).

Foucault 3: Circulation, Security, Biopolitics

My starting ÔFoucaultÕ is the (mostly) later Foucault employed by Elbe et al (2014), whose investigation of European public health measures draws upon multiple volumes of FoucaultÕs work but ultimately centers upon his 1977-78 Coll•ge de France lecture series Security, Territory, Population, for which an English translation was published in 2007. FoucaultÕs 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:

Òwith 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 ÔgoodÕ from the ÔbadÕ circulation.Ó

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 Òthe material flows of the economy and the transportation and communication infrastructures that underpin them are increasingly the object of securityÓ. 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 ÔbadÕ 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 Òmanaging, monitoring and regulating itÓ.

Duffield (2011: 758) adds that the securitization of circulation Ñ i.e. the maintenance of Ôgood circulationÕ Ñ is primarily a strategy for protecting Northern material interests, in the form of Ôarchipelagos of privileged circulationÕ. 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 Ôcrises of circulationÕ has been circulating in studies of security for some time: Dillon and Lobo-Guerrero (2008: 282) assert that Òbiopolitical security apparatusesÓ in particular are ultimately for securing fanane fmate of Ôcm opoCCoionswen (228223 repnecm

including its relation to broader questions of security. Their article argues, among other things, that this stockpiling represented an attempt to Òsecure circulation pharmaceuticallyÓ Ñ a ÒÔpharmaceuticalizationÕ of securityÓ (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 Ñ including health governance (Fidler, 2004) Ñ 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 Ôcrises of circulationÕ is helpful in understanding the ebola response and questions of public health

established boundaries of surveillance knowledgeÓ (241). Weir and Mykhalovskiy describe GPHINÕs 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 Ôbunker mentalityÕ whereby the global South is neglected unless 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 ÔresilienceÕ, one of the WHOÕs post-ebola priorities and described by scholars variously as ÔacquiescenceÕ (Neocleous, 2013), Ôa dispositifÕ (Wakefield and Braun, 2014) and Ôneoliberal deceitÕ (Evans and Reid, 2014).

Returning to GPHIN: GPHIN also helped inaugurate the concept of ÔemergingÕ infectious diseases, which entails the representation of developing nations as Ôsources of infectious diseases and agentsÕ (245). This leads to my next section, as early FoucaultÕs concern with discourse is illustrative here.

Foucault 1: Discourse, feat. Said & scholars of ÔAfricanismÕ

As with the other themes, FoucaultÕs 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. FoucaultÕs concern with discourse Ñ though not his approach Ñ was shared with prominent Marxists and sociologists, collectively providing fuel for the social sciencesÕ Ôcultural turnÕ (Mitchell, 2000). Within the discipline of geography alone, FoucaultÕs analyses were translated for use in wildly varied contexts: emblematic examples included MatlessÕ (1998) work on the discursive construction of English landscape and SojaÕs (1989) Los Angeles-centric Postmodern Geographies. FoucaultÕs ÔdiscursiveÕ influen also entered geography indirectly, though GregoryÕs engagement with postcolonial scholar and literary theorist Edward Said, and I believe that this particular ÔFoucault effectÕ (Howell, 2007) is crucial to addressing the potential limitations of focusing on questions of circulation.

complementary visions of ÔdarkestAfricaÕ: ÒThe myth of the Dark Continent was largely a Victorian invention É shaped by political and economic pressures, and also by a psychology of blaming the victimÓ (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 ÔresilienceÕ as both the opportunity and responsibility of marginalized communities, and spatial imaginaries whereby intervening Northern (or ÔinternationalÕ) are cast as heroic (Orford, 2003).

These Africanist visions persist despite the WHOÕs 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 Ôself-sufficiencyÕ; I will demonstrate this rationality has not straightforwardly replaced the traditional interventionist narratives, despite their apparent irreconcilability. Africanist Ôvictim-blamingÕ is one of their common threads.

For its part, the ÔresponsibilizationÕ of individuals can be straightforwardly understood as a technique of liberal governmentality (Lšwenheim, 2007). ÔResilienceÕ usually frames understandings of groups (up to the nation scale) and acceptable group behaviour, whereas Foucault typically emphasised liberalismÕs individualization of its subjects. Despite differing scales, WHO (and other) demands for ÔresponsibilizationÕ and ÔresilienceÕ 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. FassinÕs (2004) examination of FranceÕs 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 ÔintegrationÕ) which far exceed those applied to the sedentary residents of European nations. Joppke (2007: 2) describes this Ôcivic integrationÕ as Ôan instance of repressive liberalism, which is gaining strength under contemporary globalisationÕ. In both Northern and Southern contexts, Southern actors are disproportionately expected to self-ÔresponsibilizeÕ, 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 Ôto make migrants independent of the stateÕ (Joppke, 2007: 4), it can be demonstrated that the WHOÕs continuing response to ebola seeks to cultivate West African self-sufficiency Ñ liberal subjectivity Ñ in the form of ÔresilienceÕ. In the context of infectious disease, discursive justification for these uneven responsibilities is supplied by skewed Ôgeographies of blameÕ (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 alÕs (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 manÕs 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 organizationsÕ ability to formulate effective preventative interventions Ñ while also resulting simultaneously in the pathologization of West African actors, social customs, and Ñ resonating with MalkkiÕs (1992) critique of ÔsedentarismÕ Ñ their very movement, which becomes conceptualised as a source of disease.

EbolaÕs construction as a Ômatter of concernÕ (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. WaltersÕ analysis of these factors in relation to drones Ñ the ways in which dronesÕ material properties and technical capabilities limit or inspire particular narratives about them Ñ offers a template for investigating these questions. According to WaltersÕ (2014: 101) materialist approach, objects Ômediate issues of public concernÕ. He cautions, however, that considering the role of objects in shaping security discourses must be done ÔreflexivelyÕ: materialism can supplement but should not replace other analytical approaches.

WaltersÕ dingpolitik connects with Anderson and AdeyÕs (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 Ôambient fearÕ. The epidemiological properties of ebola virus, and the resulting affects they inspire, play a role in shaping its uptake in security discourse. AndersonÕs (2010) study of anticipatory action and the overarching concern of ÔpreparednessÕ also proposes that anticipation of disaster Ñ and the fear associated with it Ñ is increasingly key to liberal approaches to security.

These questions of preparedness lead, in turn, back to the concept of ÔresilienceÕ (which, when concerned with the government of individuals, becomes ÔresponsibilizationÕ (Lšwenheim, 2007)). In the aftermath of ebola, the WHO have embraced resilience Ñ along with other troubling (neo)liberal strategies Ñ as a cornerstone of preparedness: outside of the Northern ÔbunkerÕ, Ò[r]esilience is the official response to the environmental terror embedded in the radically interconnected and emergent lifeworld that liberalism has created.Ó (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 ÕFoucauldianÕ 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

metaphorically). I can, however, analyse the WHOÕs 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 ÔRecovery/Resilience PlanningÕ or ÔTravel AdviceÕ 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 WHOÕs 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 WHOÕs extensive archive of ÔEbola situation reportsÕ. These were only initiated in

August 29, 2014, which the first report identifies as the epidemicÕs Ô34th epidemiological weekÕ. 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 WHOÕs understanding of Ebola

Fig.1 ÒEbola is RealÓ (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 WHOÕs technical account essentializes ebola as virus, and the consequences for potential action. The WHOÕs narrow, scientific definition of ÔebolaÕ 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, ÒEbola is realÓ Ñ but what is it?

I argue that the WHOÕs 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

This definition of the WHOÕs 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 Òsingle factor facilitating emergence for filoviruses: virus-infected monkeys shipped from developing countries via airÕÓ (262). Similarly, regarding the 1976 ebola outbreak in Zaire, Farmer finds that:

> Òmost 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 MobutuÕs Zaire, oneÕs likelihood of coming into contact with unsterile syringes is inversely proportional to oneÕs social statusÓ (Farmer, 1996: 262)

Though Farmer takes a rhetorically subdued position, the implication and force of his argument makes clear that that what he calls Ôstandard epidemiologyÕ 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 Ð even (or especially) at the level of scientific knowledge production Ð attempt to protect what they understand to be Ògood circulationÓ (in this case by making forms of Ògood circulationÓ invisible) while scapegoating Òbad circulationÓ (poor syringe hygiene, monkeys as disease vectors).

FoucaultÕs 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 WHOÕs 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:

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

FoucaultÕs refusal of nominalization is my analytical starting point. Meanwhile, Latour, if approached as a critic of social theory, helps to balance FoucaultÕs methodological neglect of material questions. FoucaultÕs early (2006 [1961]) account of madness, for example, is not interested in whether madness exists. However, critically evaluating the WHOÕs response to ebola also requires taking ebolaÕs material characteristics seriously. Latour, via Walters (2014), offers a way to re-consider the agency of ebola virus in critical context, countering FoucaultÕs 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 WHOÕs pathogenic emphasis. Fortunately, the WHO itself provides an opening for such consideration. In its 2015 Ebola Interim Assessment Panel Report Ñ ostensibly a critical examination of failings in the WHO and global response to ebola Ñ the WHO makes a rare admission that is worth quoting at length. It admits that:

> Òat 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 responsiblyÓ (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 WHOÕs 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 nationsÕ interest in maintaining their position within normal circulation was in direct competition with other nationsÕ interests in curtailing ebolaÕs circulation, and the affected West African nations would (and did) suffer disproportionately under efforts to contain ebola.

This may be because, as CowenÕs (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 ÔnodesÕ and a much larger area of the globe than ebola, ebolaÕs fatality rate is approximately five times that of SARS. Not only is ebola a much more dangerous disease to contract, but information about ebolaÕs normal effects on sufferers also tends to provoke visceral horror unmatched by any account of SARSÕ flu-like symptoms. EbolaÕs material characteristics and their affective implications render the disease Ñ in the scheme of recent epidemics Ñ uniquely offputting. The properties of the virus itself inescapably contribute to the ways in which it can be either downplayed or constructed as a Ômatter of concernÕ (Latour, 2004).

It is perhaps not surprising that, despite the WHOÕs rare if indirect criticism of the ÒdesirableÓ circulation of the global North, the interim report nevertheless suggests an intensification of capital flows as a potential solution to the ÒdisincentivesÓ to reporting outbreaks. Among the reportÕs recommendations, two in particular stand out:

1: ÒThe 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 RegulationsÕ core capacities as an important part of the post-2015 development agenda and the financing of global public goodsÓ (WHO, 2015)

2: ÒThe United Nations Secretary-GeneralÕs 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.Ó (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

compatible with the prerogatives of global capital and the member state countries that

the face of disease Ñ survival is self-determined. Resilience also ties neatly into what Farmer terms the Ôgeography of blameÕ, which places the blame for succumbing to disease at the feet of the (collective or individual) victim. The naturalization of ÔAfricanÕ 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 Ôgeographies of blameÕ: Farmer (1996: 263) identifies a frequent motif in public health discourse whereby it is implied that Òone 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.Ó FarmerÕs case study is tuberculosis, but both WHO documents and New York Times reporting similarly pathologise the most banal details of West African life.

Relatedly, Lšwenheim (2007) identifies ÔresponsibilizationÕ 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 (Lšwenheim, 2007), or for health via providing health advisories in lieu of trained medical professionals Ñ 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 illiberal 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 PanelÕs identification of the problems with the ebola response, thus rationalizing its proposed Ñ strictly liberal Ñ 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 WHOÕs proposed global scale solution for guarding against future epidemics, resilience at national and sub-national scales is a rational accompaniment.

In fact, ÔresilienceÕ 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 WHOÕs proposed strategy for epidemic preparedness and management further entrench DuffieldÕs (2007) distinction between ÔinsuredÕ and Ônon-insuredÕ life Ñ their purportedly global scope is limited to the protection of a Northern ÔbunkerÕ. EbolaÕs rapid spread should serve as an indictment of this approach. Rather than rethink it, however, the Interim AssessmentÕs strategic proposals double down on the liberal securitization of health (WHO, 2015). In this context, ÔresilienceÕ offers new moral and practical support (in the form of guidelines for disease containment) for what is essentially a spatially-determined program of Ôletting dieÕ (Foucault, 1978).

The WHO Intervenes: Surveillance and Biopolitics

By the time the WHO began to issue situation reports in late August of 2014 Ð estimated as epidemiological week 34 (see fig 3) Ð 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 WHOÕs six primary ÒinterventionsÓ in the Ebola crises: ebola treatment centres (ETCÕs), referring centres, laboratories, contract tracing, social mobilization, and safe burial. The presence Ð or more often, absence Ð 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 WHOÕs 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, Òincreases in demand for Ebola Treatment Centre (ETC) beds and referral unit places are continuing to outstrip capacity

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, ÒIn 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.Ó 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

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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

ÒSocial 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 countryÓ (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 WHOÕs 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 WHOÕs overwhelming effort to frame social mobilization in terms of empowerment, self-help, and ultimately an issue of the success or failure of West African ÒresiliencyÓ.

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 Òomens et singulatimÓ (all and each). Indeed, in its report, the WHOÕs Ebola Interim Assessment Panel suggested a need for comprehensive expansion of surveillance capacity. Ò In-country surveillance activitiesÓ it wrote, Òneed to be integrated with components of national health systems, not only for emergencies, but also for a broader array of diseases and conditions É Innovations in data collection should be introduced, including geospatial mapping, mHealth communications, and platforms for self-monitoring and reportingÓ (WHO,

Overall, surveillance is the WHOÕs 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 WHOÕs 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 WHOÕs 4th situation report illustrates the methodological importance of attending to such absences:

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

Here, the WHO lists Ôhealth workerÕ 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 Ñ particularly as a proportion of each category

of workers Ñ 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 Ñ and which are ÔinsuredÕ.

The Question of Circulation: Security, Economy and Air Travel

Debates over the effectiveness and costs/benefits of restricting air travel or imposing

celebration, in addition to popular journalism. On a methodological note, this is a clear example of the danger of ÔcirculationÕ 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:

ÒAdopting the policy of Òenhanced screeningÓ 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 UKÕs resources would be to immediately scale-up our presence in west AfricaÑbuilding 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.Ó

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 Ñ including nascent discussions of circulation Ñ 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 AfricaÕs 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 Ôpoor informationÕ without unpacking the material inequalities which determine the quality of health care, disease information, and monitoring.

Here, DuffieldÕs (2007, 2011) work can be brought in to balance that of Elbe et al (2014): specifically, DuffieldÕs distinction between ÔinsuredÕ and Ônon-insuredÕ life. Synthesising DuffieldÕs 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 Ñ both material and discursive Ñ which has culminated in contemporary spatial divisions between (economically) ÔproductiveÕ and ÔsurplusÕ 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 ÔDark ContinentÕ, ebola can be understood as an Ôinvisible epidemicÕ (Sack et al, 2014) which understandably escapes notice. Sack et al (writing for the New York Times) also foregrounds West African ÔdistrustÕ of health advice, reporting that communities continued to wash the bodies of ebola victims by hand Ñ spreading infection Ñ because it was Òa step considered essential to a dignified burial and a contented afterlifeÓ. Miller (1985: 39) argues that linking blackness with idolatry and superstition in precisely this fashion constituted Ò[a] key part of EuropeÕs understanding of Black AfricaÓ.

Of course social practices and suspicion (with justifiable causes) played a role in ebolaÕs transmission. However, centering ÔcultureÕ before or instead of the numerous and severe material constraints implies that ÔcultureÕ (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 ÔcultureÕ was not identified as problematic during local outbreaks of swine flu or CreutzfeldtÐJakob 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.

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 ÔdesirableÕ or ÔundesirableÕ forms of circulation requires attention to local and global historical developments which interact with but also exceed the development of contemporary global health ÔsecurityÕ discourses.

Even Elbe et al (2014)Ñ whose highly critical unpacking of ÔcirculationÕ and its governmental implications served as the inspiration for this projectÑ run afoul of the ahistoricism and spatial flattening which focusing on circulation (or ÔflowsÕ more generally) often facilitates. Other Foucauldian lenses for examining of liberal governmentality, such as ÔresponsibilizationÕ (Lšwenheim, 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 ÔdesirableÕ. In the case of ebola and (I believe) analyses of security more broadly, FoucaultÕs various accounts of governmentality also serve best as starting points for analysisÑ if supplemented by other critically demanding and historically-cognizant approaches.

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