BRIEFING: EBOLA – MYTHS, REALITIES, AND STRUCTURAL VIOLENCE

ANNIE WILKINSON AND MELISSA LEACH[*]

TEN MONTHS AFTER THE FIRST INFECTION, Margaret Chan, Director-General of the World Health Organization, described the Ebola epidemic in West Africa as the 'most severe acute public health emergency in modern times'. The disaster, she said, represents a 'crisis for international peace and security' and threatens the 'very survival of societies and governments in already very poor countries'.[1] As of October 2014, the disease had killed 4,951 and infected 13,567.[2] It has crippled families, health systems, livelihoods, food supplies and economies in its wake. These numbers are likely to be vastly underestimated. How did it get to this? Why has this outbreak been so much larger than previous ones? The scale of the disaster has been attributed to the weak health systems of affected countries, their lack of resources, the mobility of communities and their inexperience in dealing with Ebola.[3] This answer, however, is woefully de-contextualized and de-politicized. This briefing examines responses to the outbreak and offers a different set of explanations, rooted in the history of the region and the political economy of global health and development.

To move past technical discussions of "weak" health systems, this briefing highlights how structural violence[4] has contributed to the epidemic. Structural violence refers to the way institutions and practices inflict

[*]Annie Wilkinson (a.wilkinson@ids.ac.uk) is a researcher at the Institute of Development Studies; Melissa Leach (m.leach@ids.ac.uk) is Director, Institute of Development Studies.
1. Nick Cumming-Bruce, 'WHO chief calls Ebola outbreak a "crisis for international peace"', *New York Times,* 13 October 2014, <http://www.nytimes.com/2014/10/14/world/africa/ebola-virus-outbreak.html?mabReward=RI%3A16&module=WelcomeBackModal&contentCollection=Africa&region=FixedCenter&action=click&src=recg&pgtype=article&_r=0> (14 October 2014).
2. World Health Organization, 'WHO: Ebola response roadmap update', 31 October 2014, <http://apps.who.int/iris/bitstream/10665/137424/1/roadmapsitrep_31Oct2014_eng.pdf?ua=1> (4 November 2014).
3. World Health Organization, 'WHO statement on the meeting of the International Health Regulations Emergency Committee regarding the 2014 Ebola outbreak in West Africa', 8 August 2014, <http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/> (13 October 2014).
4. See Johan Galtung, 'Violence, peace, and peace research', *Journal of Peace Research* 6, 3 (1969), pp. 167–91; for structural violence in health see Paul Farmer, *Infections and inequalities: The modern plagues* (University of California Press, Berkeley, CA, 1999).

avoidable harm by impairing basic human needs. Damage is done unequal-
ly and often in a manner which comes to be taken for granted. The Ebola
crisis has emerged from the meeting of long-term economic, social, tech-
nical, discursive, and political exclusions and injustices, now shown to be
dramatically unsustainable. These multiple impairments have fed into
three additional areas of "weakness", which are discussed here. They are
the failure of outbreak response and global health governance, compro-
mised health systems and development policy, and misleading assumptions
and myths.

Structural violence in this case must be understood in the context of a re-
gional history and global economy that have cultivated inequalities. It is no
coincidence that Guinea, Liberia, and Sierra Leone are three of the poorest
countries in the world; their rich natural and human resources have long
been extracted for elite and foreign profit – as opposed to being developed
for the benefit of the majority of their populations. The result has been leg-
acies of distrust and governments that are unable to provide basic services,
health included. It is not simply that global inequalities leave some citizens
and healthcare workers exposed; it is that they produce these vulnerabilities
and shape the institutions of global health so that they are unable to patch
over them. These structural and related socio-cultural conditions are not
quickly or easily addressed, but we suggest that a greater focus on inclusive
institution building and knowledge making is needed in both short- and
long-term planning in order to build trust and resilience.

Outbreak timelines and storylines

It took at least three months for 'Guinea haemorrhagic fever' to become
Ebola. From December 2013 a mysterious fever sickened residents of
Eastern Guinea's forest region but it was not until 22 March 2014 that tests
confirmed the Zaire Ebola virus strain.[5]

As an outbreak-prone pathogen of high consequence, the International
Health Regulations are clear: a single case counts as an outbreak and the re-
sponse must be swift.[6] However, seven months later, this rapid response
model had clearly been compromised. The actions of Guinea's Ministry of
Health and the World Health Organization were uncoordinated, compounded
by the epicentre's proximity to the borders of Sierra Leone and Liberia, which
meant that there were three countries to prepare and coordinate.[7] Health

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5.   *Ibid.*
6.   WHO, 'International Health Regulations, second edition' (World Health Organization,
Geneva, 2005).
7.   Sheri Fink, 'Cuts at WHO hurt response to Ebola crisis', *New York Times*, 3 September
2014, <http://www.nytimes.com/2014/09/04/world/africa/cuts-at-who-hurt-response-to-ebola-
crisis.html?_r=1> (14 October 2014).

promotion messages in all countries focused initially on not eating bushmeat, and a consumption ban was put in place in Guinea.[8] This message was highly misleading, since although "spillover" from Ebola's natural reservoir in fruit bats may have been responsible for the first case, subsequent transmission has been entirely human to human. The inaccurate sensitization, which jarred with people's experiences, met with suspicion. As one Liberian man reasoned, 'The government said nobody should eat bushmeat. If Ebola was here, a lot of people would be dead.'[9] Rumours circulated that medical teams were responsible for the deaths of patients. Some communities shut themselves off, saying 'Wherever those people [the medical teams] have passed, the communities have been hit by illness.'[10] Patients were removed from health facilities[11] and treatment centres were attacked.[12] Many patients avoided isolation units altogether. The governments of Liberia and Sierra Leone declared states of emergency and put large areas under quarantine.[13]

Internationally very little happened until the disease began to fulfil what Priscilla Wald has called the 'outbreak narrative'.[14] In this story, a disease emerges in a remote location and spreads across a world highly connected by globalization and air travel to threaten "us all" – read the globally powerful North. Evidence seemingly appeared when a man infected with Ebola travelled from Liberia to Nigeria and infected medical staff there. The threat of exponential growth and subsequent infections of aid workers, a case in Senegal, and transmission in both Spain and the US turned Ebola from a newsworthy but exotic disease into an international security threat. On 8 August, the World Health Organization finally declared the epidemic to be a public health emergency of international concern.[15] Citing 'global

8. Saliou Samb and Alphonso Toweh, 'Beware of bats: Guinea issues bushmeat warning after Ebola outbreak', *Reuters,* 27 March 2014, <http://www.reuters.com/article/2014/03/27/us-ebola-bushmeat-idUSBREA2Q19N20140327> (13 October 2014).
9. *Vice News*, 'Monkey meat and the Ebola outbreak in Liberia, 26 June 2014, *YouTube*, <http://www.youtube.com/watch?v=XasTcDsDfMg> (10 October 2014).
10. Adam Nossiter, 'Fear of Ebola breeds a terror of physicians', *New York Times*, 27 July 2014, <http://www.nytimes.com/2014/07/28/world/africa/ebola-epidemic-west-africa-guinea.html?module=Search&mabReward=relbias%3Ar%2C%7B%222%22%3A%22RI%3A16%22%7D&_r=0> (10 October 2014).
11. Umara Fofana, 'First Ebola victim in Sierra Leone capital on the run', *Reuters,* 25 July 2014, <http://in.reuters.com/article/2014/07/25/health-ebola-africa-idINL6N0Q03FK20140725> (14 October 2014).
12. Saffa Moriba, 'Sierra Leone news: Insane MCH nurse sends Kenema into a turmoil', *Awoko,* 31 July 2014, <http://awoko.org/2014/07/31/sierra-leone-news-insane-mch-aid-nurse-sends-kenema-into-turmoil/> (2 August 2014).
13. Donald G. McNeil, 'Using a tactic unseen in a century, countries cordon off Ebola-racked areas', *New York Times,* 12 August 2014, <http://www.nytimes.com/2014/08/13/science/using-a-tactic-unseen-in-a-century-countries-cordon-off-ebola-racked-areas.html?_r=0> (14 October 2014).
14. Priscilla Wald, *Contagious: Cultures, carriers, and the outbreak narrative* (Duke University Press, Durham, NC, 2008).
15. World Health Organization, 'WHO statement'.

security' President Obama followed this by sending 3,000 US troops to Liberia to build hospitals and establish a regional command centre.[16] The UK sent 750 troops, a ship, and helicopters to Sierra Leone, focusing on treatment and isolation units.[17]

As Wald points out, at times outbreak narratives are distorting and conceal aspects of the dynamics at play, especially the scope of the risks posed and the identity of the vulnerable. The securitization[18] of Ebola, in which the virus has been interpreted as a global existential threat, is one such plot twist. There was a gap between the crisis rhetoric and resources committed. The US and UK governments have balanced their attention and resources between ground interventions and those to protect their borders, including checks at airports. Hysteria over the virus's routes into the global North saw airlines halt flights, making it difficult to get people and essential goods into the affected areas. On the ground in West Africa new cases far outstripped available health workers, burial teams, contact tracers, laboratory staff, and personal protective equipment. Furthermore, increased pressure to speed up the "pipeline" of treatments and vaccines, conforming to the epidemiologically managed happy ending of typical outbreak narratives, was balanced against improving the "pipeline" of healthcare workers and effective care and humanitarian strategies in West African countries.

Amidst these outbreak narratives and responses, another set of storylines – of Ebola as personal tragedy for rural and urban women, men, and children – must not be forgotten. It is also a tragedy to the social fabric in Sierra Leone, Liberia, and Guinea, where everyday intimacies are now feared and where doing the social and moral good of caring for the sick and dead brings likely sickness and death. Beyond this, Ebola presages a set of livelihood tragedies as food and trade routes break down.

Another less discussed perspective highlights structural violence. In this case, the spread of Ebola is caused by a combination of interacting institutions and the multiple inequalities and vulnerabilities they produce. Focusing on this form of structural violence, the following sections look at three ways in which particular conditions and processes amplified the epidemic.

Failure of outbreak response and global health governance

From the outset, the international Ebola response lacked leadership, funds, equipment, and human resources. To be clear, this was an avoidable

16.   Jeff Mason and James Harding Giahyue, 'Citing security threat, Obama expands US role fighting Ebola', *Reuters,* 16 September 2014, <http://www.reuters.com/article/2014/09/16/us-health-ebola-obama-idUSKBN0HB08S20140916> (17 October 2014).
17.   'RFA Argus deploys to Sierra Leone', *GOV.UK*, 17 October 2014, <https://www.gov.uk/government/news/rfa-argus-deploys-to-sierra-leone> (18 October 2014).
18.   Stefan Elbe, 'Haggling over viruses: The downside risks of securitizing infectious disease', *Health Policy and Planning* 25, 6 (2010), pp. 476–85.

disaster. Despite warnings that the epidemic was unprecedented and 'out of control',[19] the reaction, especially from the World Health Organization, was disastrously ineffective. Poor communications, delayed visas and payments, and complacency meant that the agency called the first regional meeting on the disease three months after Ebola's detection.[20] It was not until 28 August that it announced a roadmap for containing the outbreak.[21]

This delayed response has to be understood in the context of long-standing challenges in global health governance. The World Health Organization had been through dramatic restructuring and cuts as a result of reduced contributions after the financial crisis. For example, 2011 saw a loss of $1 billion in core funding and 300 jobs.[22] One manifestation of these cuts, which was also facilitated by a general shift in priorities towards non-communicable diseases, was a dismantling of the agency's core outbreak response team, resulting in a loss of institutional memory.[23] Increasingly, the World Health Organization has become a technical organization, rather than one taking responsibility for health as a global public good.[24] Its role has been complicated by the increasing number of actors and special programmes involved in global health.[25] New players, some with substantially larger budgets, have pursued policies at odds with the agency's goals. For example, the World Bank's focus on structural adjustment and cost recovery undercut promotion of 'Health for All'. Vertical programmes, such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria, have undermined commitments to horizontal health system strengthening. Practically, the majority of the agency's money is donated bilaterally for specific purposes and is not available for use during emergencies.[26] Furthermore, the World Health Organization has long been beset by intra-organizational challenges whereby headquarter, regional, and country offices are disjointed and politicized. In the current crisis the inaction of the Africa regional office has been attributed to political appointments, which

19.   Médecins Sans Frontières, 'Ebola in West Africa: Epidemic requires massive deployment of resources', 23 June 2014, <http://www.msf.org/article/ebola-west-africa-epidemic-requires-massive-deployment-resources> (15 October 2014).
20.   Jason Gale and John Lauerman, 'How the world's top health body allowed Ebola to spiral out of control', *Bloomberg,* 17 October 2014, <http://www.bloomberg.com/news/2014-10-16/who-response-to-ebola-outbreak-foundered-on-bureaucracy.html> (17 October 2014).
21.   Lawrence O. Gostin, 'Ebola: Towards an international health systems fund', *The Lancet* 384, 9951 (2014), pp. e49–e51.
22.   Sarah Boseley, 'Ebola: Government cuts to the WHO aided delays in dealing with outbreak', *The Guardian,* 9 October 2014, <http://www.theguardian.com/world/2014/oct/09/ebola-who-government-cuts-delays-in-dealing-with-outbreak> (15 October 2014).
23.   Sheri Fink, 'Cuts at WHO hurt response to Ebola crisis'.
24.   Lawrence O. Gostin and Eric A. Friedman, 'Ebola: A crisis in global health leadership', *The Lancet* 384, 9951 (2014), pp.1323–5.
25.   Charles Clift, 'The role of the World Health Organization in the international system' (Centre on Global Health Security Working Group Papers, Chatham House, London, 2013).
26.   *Ibid.*

left it technically weak and resistant to acknowledging the severity of the problem.[27]

The constraints within the World Health Organization were exacerbated by the paucity of international donations. The Ebola relief fund set up by the United Nations with a target of approximately $1 billion had received only $100,000 by October 2014.[28] As the United Nations, the World Bank, and the World Health Organization have increased their targets, routinely donations have lagged behind. The limited capacity of the World Health Organization is matched by limited national-level capacity. Ebola is notifiable under the International Health Regulations, which bind countries to core requirements for managing disease outbreaks. However, many resource-poor countries are unable to meet these requirements, and there is no effective governance structure for resolving the disconnects between policy and reality.[29] The weakness of this architecture has been acutely exposed by this outbreak. In the absence of an international contingency fund for emergencies, states intervened only when their security was sufficiently threatened.

Given the significance of large mining, agriculture, and biofuels operations to the Mano River economies, corporate social responsibility might represent an alternative response model. However, anecdotal evidence suggests a weak response here, too. For example, when the outbreak was already in full swing in July 2014, London Mining, a London-based firm operating in Sierra Leone, pulled their expatriate staff out of the country and donated only 115 million Leones (approximately $26,497). Addax Bioenergy, also in Sierra Leone, donated a vehicle and an even smaller sum of 35 million Leones (approximately $8,032).[30] On another front, British Airways and other airlines stopped flights. Any faith that the private sector would provide significant resources, either to protect direct business interests or as corporate social responsibility, was ill-founded.

Compromised health systems and development

These international governance failures interacted with national and local health, socio-economic, and political systems deeply compromised by the lack of development over the last few decades. Domestic governments and institutions have allowed and even worsened these failures, watched over by donors and aid organizations. The facts are well known. Liberia and Sierra Leone

27.   Sarah Boseley, 'Ebola: Government cuts'.
28.   Michelle Nichols and Lesley Wroughton, 'UN Ebola trust fund gets $100,000, almost $1 billion needed', *Reuters*, 17 October 2014, <http://uk.reuters.com/article/2014/10/16/uk-health-ebola-un-idUKKCN0I51XO20141016> (17 October 2014).
29.   Gostin and Friedman, 'Ebola: A crisis in global health leadership'.
30.   Personal communication.

suffered a decade of civil war, and Guinea too has struggled with political instability. Even before Ebola killed hundreds of health staff, the three countries all had acute shortages: among every thousand people Guinea could count only 0.1 doctors, Liberia 0.014 and Sierra Leone 0.022.[31] All rely on the aid industry to deliver basic health services. There is a pervasive lack of equipment, from ambulances through to gloves. Inadequate resources are compounded by corruption; for example, allegations of high-level fraud saw donors suspend funds to the Ministry of Health and Sanitation in Sierra Leone in 2013.[32] These are the obvious ways in which the health system is weak and consequently has enabled the virus to flourish. But to understand how and why, it is necessary to explain people's interactions with this health system.

In practice, the health system is something of a façade. Policies like the Integrated Disease Surveillance and Response speak of clear pathways of people and information.[33] However, such linkages are more often disjointed and irregular, as the three-month delay in identifying Ebola shows. Sharon Abramowitz has written of Liberian health reforms that created health sector functions, which, due to chronic underfunding, exist in name only.[34] In public health facilities up and down the three countries the presence of a nurse or drugs cannot be assumed. Despite the introduction of the Free Health Care Initiative in Sierra Leone in 2010, fees are often charged for things that should be free.[35] Now there are Ebola hotlines to call when people are sick or dead, but it can be days before assistance arrives, if at all.[36] People's experiences of these realities beneath the façade, both before and during Ebola, are drivers of the epidemic. These experiences, in turn, were a hangover from internationally promoted structural adjustment programmes in which state spending on public services was curtailed and health became a commodity and an individual responsibility. The constraints imposed on Africa in the 1980s and 1990s by the IMF, the World Bank, and many Western donors led to a health and development policy characterized for a generation by privatization on one hand and a reliance on aid organizations to deliver services to the poor on the other.

31.   WHO, 'Global Health Observatory Data Repository' (density per 1000, by country), <http://apps.who.int/gho/data/view.main.92100> (20 October 2014).
32.   GAVI Vaccine Alliance, 'GAVI review of health system strengthening in Sierra Leone', 11 April 2013, <http://www.gavi.org/library/news/statements/2013/gavi-review-of-health-system-strengthening-in-sierra-leone/> (25 October 2014).
33.   Ministry of Health and Sanitation, 'Technical guidelines for integrated disease and surveillance and response in Sierra Leone' (Ministry of Health and Sanitation, Government of Sierra Leone, Freetown, 2008).
34.   Sharon Alane Abramowitz, 'How the Liberian health sector became a vector for Ebola', 7 October 2014, Cultural Anthropology Online, <http://www.culanth.org/fieldsights/598-how-the-liberian-health-sector-became-a-vector-for-ebola> (8 October 2014).
35.   Amnesty International, 'At a crossroads: Sierra Leone's free healthcare policy' (Amnesty International, London, 2011).
36.   Ibid.

However, in these countries, reforms were not accompanied by stable economic growth or the promised "trickle down" from the few who did benefit from these policies to those who did not.

"Up country", as the interior of Sierra Leone is known, consists mostly of farming villages linked by bush tracks. Distances to health facilities are great, and private transport or hammocks may be required to carry the sick. In the rainy season many paths are impassable. Government services are associated with money making in Sierra Leone, with services often denied until payment. For many, the economic and logistical struggles mean that formal health facilities are not a plausible or attractive option.[37] Instead, a variety of "informal" health practitioners provide a substantial portion of healthcare, using a mix of biomedical and non-biomedical treatments. The legitimacy of these providers is often greater than that of government health workers and is based on demonstrated compassion and their blending of holistic approaches to health and aspects of biomedicine.[38] In practice, people approach healthcare not through specific biomedical disease categories, or distinct concepts of traditional and Western therapeutic systems, but in a plural way. Salient categories are about more or less manageable diseases, gender, and forms of expertise offered.[39] Importantly in the case of Ebola, governments that have long been experienced as deeply detached from their publics, and perceived not to act in their interests, are now the enforcers of biomedicine at its most authoritarian.[40] The much-reported fear and suspicion of healthcare workers and response teams often express a rejection not so much of biomedicine, as of its sub-standard and heavy-handed provision by sources perceived to be illegitimate. Ebola has also been used as a vehicle for party politics and reactions to Ebola response teams are, in turn, deeply politicized. Seen in this light, the murders of an outreach team in Womey, Guinea stemmed not from a dismissal of modern medicine but from the stoking of tensions in the context of a cut-throat electoral politics that has exploited economic, ethnic, cultural, and religious animosity in the forest region.[41]

37.   Mariane Ferme, 'Hospital diaries: Experiences with public health in Sierra Leone', 7 October 2014, *Cultural Anthropology Online*, <http://www.culanth.org/fieldsights/591-hospital-diaries-experiences-with-public-health-in-sierra-leone> (8 October 2014).
38.   Amara Jambai and Carol MacCormack, 'Maternal health, war, and religious tradition: Authoritative knowledge in Pujehun District, Sierra Leone', *Medical Anthropology Quarterly* 10, 2 (1996), pp. 270–86.
39.   Melissa Leach, James Fairhead, Dominique Millimouno, and Alpha Ahmadou Diallo, 'New therapeutic landscapes in Africa: Parental categories and practices in seeking infant health in the Republic of Guinea', *Social Science and Medicine* 66, 10 (2008), pp. 2157–67.
40.   Kate Thomas, 'Mistrust of government spurs Ebola spread', *The Analyst*, 3 September 2014, <http://news.analystliberia.com/index.php/news/266-mistrust-of-government-spurs-ebola-spread> (25 October 2014).
41.   'Drame de Womey – La nécessité de désamorcer la poudrière (1ère partie)', 30 September 2014, *Guineenews*, <http://guineenews.org/dossier-ebola-et-la-poudriere-de-la-guinee-forestiere/> (25 October 2014).

Sustaining these inadequate health-system conditions are post-conflict models of development based on internationally backed private-sector schemes to annex land for mining, palm oil, biofuels, and agriculture. These schemes generate foreign direct investment and kickbacks for the politicians who broker these deals, but in the process often displace people's livelihoods and undermine state functions and rural institutions. In many ways, this perpetuates conditions that contributed to Sierra Leone's civil war – extreme economic inequality and the systematic exclusion of youth and rural communities by urbanized elites who hold pockets of resource wealth.[42] This is a world where Sierra Leone and Liberia can have some of the highest growth rates internationally, while most people living there still experience continued or worsening poverty.[43] These patterns of profit and deprivation are embedded as much in international tax laws and donor policies as they are in national and local institutions, chiefdoms, and the workings of William Reno's 'shadow state'.[44]

Deepening the problems are precariously expanded urban areas whose massive growth is a legacy of neglected rural development, and displacement due to war. Many unemployed or underemployed young people now live in cities underserved by basic services and planning. Ebola has powered through the dense urban areas and slums in Monrovia and Freetown.

Lack of inclusion also drives fear and insecurity in more subtle ways. Rumours and resistance, dismissed as ignorance and superstition, are the product of longstanding experiences of state and foreign actors who are seen as alien, oppressive, or self-serving. In Liberia, Ellen Sirleaf Johnson's government has increasingly been accused of corruption – and it is not altogether surprising that many thought Ebola was a ruse to make money. "Sensitization" efforts have lined many a pocket already and KPMG have pulled out of accounting for Sierra Leone's Ebola Fund over questions of mismanagement.[45] In Sierra Leone much early denial of the outbreak was fed by rumours that the government was trying to depopulate an area known to be an opposition stronghold. Conspiracy theories may ebb and flow, but for those who do believe Ebola is real, reports of appalling conditions and lack of food at treatment centres are a sufficient reminder of the structural violence in play.

42.   Paul Richards, *Fighting for the rain forest: War, youth and resources in Sierra Leone* (International African Institute, London, 1996).
43.   International Monetary Fund, 'World economic outlook – recovery strengthens, remains uneven' (International Monetary Fund, Washington, DC, 2014).
44.   William Reno, *Corruption and State Politics in Sierra Leone* (Cambridge University Press, Cambridge, 1995).
45.   *Salone Post*, 'KPMG pulls out of management of Ebola fund', 9 October 2014, <http://www.salonepost.com/sp/news/articles/article200.asp> (25 October 2014).

Myths and assumptions

Discursive inequalities are woven into material ones. A number of incorrect
assumptions informed key aspects of the response to Ebola, with negative
consequences. The idea that a containment strategy, which had worked in
single countries in Central and East Africa, would work on highly mobile
border areas is one example. Conceiving of the epidemic as something that
could be contained through national borders was naïve. The movement
patterns that matter are along social networks and trade routes, shaped
through centuries of mobility for trade and kin visits across borders in a
region that was a vital pre-colonial trading empire.[46] The geographies of
spread differ between Sierra Leone, Guinea, and Liberia, reflecting their
different political-economic histories. But in all cases they reflect deep con-
nectedness internally and with a wider world. This region is not the global
backwater that outbreak imagery has projected.

Another set of myths relate to the initial "spillover". Many of the official
truths about Ebola – the bushmeat connection, and its jump from bats to
people due to supposed regional deforestation for the first time[47] – are in-
accurate.[48] People and bats have long co-habited in this ancient, anthropo-
genic forest landscape with its mosaic of forest, bush, and savannah, shaped
by settlement and farming, war and trade, and everyday social and ecologi-
al life. The idea that deforestation is bringing people and bats together for
the first time misconstrues regional landscape history as dangerously as it
lays the blame for the epidemic at the feet of the rural people now suffering
from it. Misguided exhortations against eating bushmeat have not just
denied people vital sources of protein and livelihood, but have contributed
to the deluge of misinformation that has undermined local trust in what
officials say about Ebola.

Elsewhere, it took too long to consider alternatives to the centralized
treatment model. Despite early evidence that large numbers of sick people
were staying in communities, whether fearful or unable to access hospitals,

46.   Paul Richards, Joseph Amara, Mariane C. Ferme, Esther Mokuwa, Prince Koroma,
Idara Sheriff, Roland Suluku, and Maarten Voors, 'Social pathways for Ebola virus disease in
rural Sierra Leone, and some implications for containment', *PLOS Neglected Tropical Diseases,*
forthcoming; James Fairhead Tim Geysbeek, Svend E. Holsoe, and Melissa Leach (eds),
African-American exploration in West Africa (Indiana University Press, Bloomington, IN, 2003).
47.   Terrence McCoy, 'How deforestation shares the blame for the Ebola epidemic', *The
Washington Post,* 8 July 2014, <http://www.washingtonpost.com/news/morning-mix/wp/2014/
07/08/how-deforestation-and-human-activity-could-be-to-blame-for-the-ebola-pandemic/>
(15 October 2014).
48.   For earlier evidence of Ebola in the region, see Randal Schoepp, Cynthia Rossi, Sheik
H. Khan, Augustine Goba, and Joseph Fair, 'Undiagnosed acute viral febrile illnesses, Sierra
Leone', *Emerging Infectious Diseases* 20, 7 (2014), <http://wwwnc.cdc.gov/eid/article/20/7/13-
1265_article> (1 November 2014). For a critique of deforestation, see James Fairhead and
Melissa Leach, *Misreading the African landscape: Society and ecology in a forest-savanna mosaic*
(Cambridge University Press, Cambridge, 1996).

there was official resistance to exploring community-based care. Belatedly this has been partially rectified, with community-based triage and isolation now central to the response strategy in Sierra Leone,[49] underpinned by more realistic epidemiological and social analysis, especially of community concerns.

Feeding into top-down responses is a final problematic assumption that public health experts and scientists possess the knowledge needed to stop the epidemic and that local populations do not. This has led to an insistence on protocols and procedures that deny valuable input from communities. Funerals are one such area. The failure to engage with why burial rites are important to communities led to offensive interventions. The mass cremation of corpses in Liberia, for example, is feared to be encouraging families to hide their sick.[50] Yet, examples of creative adaptations to burial rites demonstrate that mutually acceptable solutions can be reached.[51] In a Kissi community a response team ran into opposition over the burial of a mother and her unborn baby.[52] For the community it is forbidden to bury a woman with a foetus inside her; this represents a transgression of socio-ecological orders which could harm those left behind. For the medical teams the removal of the foetus was too risky. Village discussions brokered by an anthropologist revealed that the transgression could be mitigated with a reparation ritual. The World Health Organization provided resources for the ritual and the woman was safely buried. This example shows that with respectful dialogue it is possible to navigate both public health and community concerns.

Conclusion

In pointing to structural violence, we are not talking of a single social institution, but of overlapping institutions and practices that have produced interlaced inequalities, unsustainabilities, and insecurities. This has occurred in a set of localities long interconnected with a global world through colonial and post-colonial political and economic relations, and more recently with aid and "development". The terms of these relationships have been culpable in

49. Chris Whitty *et al.*, 'Ebola: Difficult choices to reduce transmission in the community', *Nature,* forthcoming.
50. Tristan McConnell, 'Some people would rather die of Ebola than stop hugging sick loved ones', *Global Post,* 10 October 2014, <http://www.globalpost.com/dispatch/news/health/141010/familes-cant-mourn-ebola-victims-liberia> (10 October 2014).
51. Paul Richards and James Fairhead, 'Burial/other cultural practices and risk of EVD transmission in the Mano River region' (Briefing Note, Ebola Response Anthropology Platform, London, 2014).
52. Sylvain Faye, 'How anthropologists help medics fight Ebola in Guinea', *SciDevNet,* 24 September 2014, <http://www.scidev.net/global/cooperation/feature/anthropologists-medics-ebola-guinea.html> (14 October 2014).

producing, or at least failing to tackle, structural violence. It is also a product of the discourses of global health that emphasize networks and shared vulnerabilities, but in practice neglect dire inequalities, allowing a virus like Ebola to devastate a country in the absence of the most fundamental public health and state capacities. History has shown that dramatic gains in life expectancy and reductions in the burden of disease come from improved living standards, sanitation, nutrition, prevention, and not from medicine alone.[53] Yet this has been consistently overlooked in favour of quick wins. In parallel, the need for international governance systems that conceive of health as a properly funded global public good, enabling rapid response to crises when they do emerge, has been undervalued. The creativity and knowledge of people on the ground has also been overlooked. Excluding people from having a say in the management of their own healthcare has vitiated the response.

The Ebola crisis should be a "game changer" for development. The inequalities that created and deepened this crisis are not sustainable. Talk of rebuilding weak health systems and fragile states must now be accompanied by talk of tackling these multiple inequalities. Resilient health systems are not just ones that are well equipped and staffed; they are built on foundations of inclusive economies and inclusive institutions. They are well equipped with locally managed resources, not just with donated goods and services. The epidemic is neither bad luck nor inevitable. It should be understood as the human-made result of international extraction and local exploitation. These forces have played interacting roles in hollowing out national and global governance capacity and creating stigmatizing discourses. The real damage has come from underestimating the damage done by inequality, which has allowed activities that exclude and extract to go unchecked.

The underlying stories about the Ebola crisis, which are emerging from social science, and from people on the ground, reveal a complex, historically embedded picture with multiple dimensions. Both the crisis response and efforts to address its structural underpinnings are strengthened by the inclusion of these perspectives. They suggest that there is no single model that can be applied to stop the spread of the disease. Instead, a strong public health effort needs to be integrated with local and community-driven approaches. The idea that there are impenetrable cultural mysteries to overcome is ill-founded. Community engagement must be two-way. Bending the epidemic and "trust curve" needs collaboration, local involvement, and joint solution finding that meets both socio-cultural needs and infection-reducing protocols. The Ebola Response Anthropology Platform[54] has

53. Angus Deaton, *The great escape: Health, wealth, and the origins of inequality* (Princeton University Press, Princeton, NJ, 2013); Thomas McKeown, *The role of medicine: Dream, mirage or nemesis?* (Blackwell, Oxford, 1979).
54. See <http://www.ebola-anthropology.net/>.

been set up to network anthropologists and other social scientists across the world with field workers and communities, and to provide an interface with those planning and implementing the Ebola response. The Platform is developing evidence and guidance on collaboration to achieve locally appropriate disease control. It will be a valuable resource in ensuring that the principles and sensitivities laid out here are considered in Ebola efforts now, as well as in the post-Ebola era that we all hope is soon to come.