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The post-colonialist condition, suspicion, and social resistance during the West African Ebola epidemic: The importance of Frantz Fanon for global health

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ABSTRACT

The scholarship of Frantz Fanon has been recognized across numerous disciplines as a unique and necessary intervention for critical analyses of the (post)colonial condition. Yet, thus far, his oeuvre has largely been ignored in global health research. In this article we introduce and demonstrate the relevance of Fanon's work for the field of global health. To illustrate, we draw from Fanon's conceptual framework and observations to analyze the 2014–16 Ebola Virus Disease outbreak response in West Africa. During this Ebola epidemic, although not necessarily as widespread as Western media made it seem, numerous instances of "resistance"—sometimes violent—were levied by members of the community toward foreign outbreak response teams. In this article, we argue that the keen insights proffered by Fanon more than half a century ago help facilitate a deeper understanding of some of the reactions of community members and public health officials during the Ebola response. In calling attention to colonial histories and structural relations of power, poverty, and violence, Fanon's work can help us to effectively move towards "decolonizing" global health interventions, thus providing a framework with which to better understand and more humanely intervene in future epidemic outbreaks in the Global South.

1. Introduction

> "Science depoliticized, science in the service of man, is often non-existent in the colonies." Frantz Fanon - *A Dying Colonialism* (1965)
>
> "For the native, objectivity is always directed against him." Frantz Fanon – *The Wretched of the Earth* (1961)

In a recent commentary in *The Lancet*, Richard Horton (2018) poignantly argues that a "myth" influences and informs global health in a pervasive yet tacit manner. It is a myth that effectively conceals power relations inherent in its analytic scope, thereby limiting the efficacy of the discipline as a whole. "It is a deception," he writes, "that erases important histories, marginalizes already neglected peoples, and prevents accurate understanding of why progress towards sustainable health improvements in some of the most resource-poor settings is so slow and erratic" (2018: 720). It may be justifiably noted that although much global health research does indeed focus on important dimensions of the plight of those in the Global South—e.g., poverty, dysfunctional health systems, and a lack of medical expertise—it does not adequately analyze the root source of these problems (Farmer, 1996, 2004). Consequently, global health research tends to omit from its remit uncomfortable truths about the integral role that power differentials and inequality play in the public health challenges faced in that region of the world, despite the recognition of these issues in the anthropological literature (Farmer, 1996; Abramowitz, 2017).

To address this analytical failing, Horton urges global health researchers to revisit the work of one of the most prominent and critical analysts of the colonial and post-colonial condition – Frantz Fanon. In this paper, we respond to this call by illustrating the utility of Fanon's work in gaining insight into the nature of the outbreak response that unfolded during the 2014-16 West African Ebola Virus Disease (EVD) epidemic. This epidemic is notable because it was the largest and most complex Ebola epidemic in history, and the response that emerged to halt the disease spread was characterized by a great deal of confusion, mistrust, and blame (Wilkinson, 2017).

One important aspect of Fanon's work is that it implores us to focus on the relationship between structure and agency. With reference to the context of EVD in West Africa, this involves a social structure that was informed by colonial and post-colonial ideology and practices that yielded a distorted and truncated agency for the formerly colonized.

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That is, for Fanon, personal agency was always in some direct or indirect way constrained by oppressive political, social and internalized mental processes - sometimes based on feelings of inferiority due to the dehumanizing effects of the (post)colonial circumstance. For Fanon therefore, the issue was how did the colonized and the formerly colonized react or work their way through these social and political constraints during the course of their lives? And what exactly were these constraints, and what form did they take? What were the practical consequences of these constraints? As we contend in this paper, addressing the types of issues raised by Fanon will be helpful for gaining a deeper and more nuanced understanding of the type of interactions and relationships that arise in the field of global health more generally, and those that arose during the West African EVD epidemic specifically. In particular, a Fanonian-inspired orientation will help address the question of why some people were hesitant to follow the public health directives of outsiders, and why on the other hand, outsiders were sometimes quick to label the actions of locals as "irrational."

Implicitly underlying our analysis and following naturally from our application of a Fanonian framework, is a critique of existing epistemological orientations towards the analysis of the EVD response. Epistemologically, existing approaches tend to be limited because they generally conform in some fashion to a rational-choice paradigm in which decisions are made in a somewhat socially and politically decontextualized way (Richardson et al., 2017). Consequently, an analytical gap forms because only the material conditions of existence are considered, to the neglect of the subjective dimensions of experience, in explaining the behaviours and interactions that unfolded during the EVD epidemic. The work of Fanon brings the subjective dimensions back into relief while at the same time not ignoring the material conditions of deprivation resulting from centuries of colonial neglect. Such an orientation shines a spotlight on how decision-making during the epidemic was an issue that must take into account both agency and structure within the specifically West African (post)colonial context. Although Fanon does not use the more contemporary sociological terms "agency" and "structure", his work is thoroughly engaged with the relationship between the two, hence his emphasis on the psychosocial dynamics of the postcolonial condition and the power relationships embedded therein. In line with this orientation, what we focus upon in our present analysis is a consideration of how the work of Fanon may serve as a broader framework for incorporating the analysis of the agency-structure relationship as central plank in the study of global health issues, including the EVD epidemic. In particular, we contend one important analytic advantage that such a framework provides, is that it enables the process of more formally synthesizing the *ad hoc* insights of a disparate set of critically-inclined global health researchers – many of whom we draw upon in this paper. As such, we rely on accounts from the existing literature on the EVD response to analyze – through a Fanonian lens – the relationships and interactions that were present in Liberia, Sierra Leone, and Guinea during the earlier stages of the EVD response from March to August 2014 when the so-called "resistance" and heightened tension were most evident (Hofman and Au, 2017: xv.)

We begin our paper with a brief introduction to Fanon's oeuvre, followed by an overview of the West African EVD response and a discussion of the postcolonial context in which the epidemic unfolded. We then provide our Fanon-inspired analysis of various aspects of the EVD response related to the "othering" and differential treatment of outsiders versus locals and how this contributed to the development of social "resistance" during the EVD response. In developing our analysis, we focus on issues related to conspiracy theories and rumors, public health messaging, disease containment versus the provision of care, the differential treatment of native versus international health care workers, and the securitization of the response.

2. Background and orientation

Fanon's work spans the gamut from individual-level to structural analyses. If we consider the book, *Black Skin, White Masks* (1967 [1952]), for example, we see that although Fanon never veers far from the political-economic and cultural effects of colonization, he focuses more on the complex psychic issues involved in the development of black identity under the social relations of colonization. In a similar vein, he develops a critique of ethnopsychiatry – a field that deals with the mental health of colonized peoples (Appiah, 2008: vii). In *A Dying Colonialism* (1965 [1959]), Fanon, moving from racial identity to a focus on national identity, uses his experiences as a psychiatrist during the Algerian war of independence to explore how national identity informs various aspects of the struggle against the colonizers. He investigates how, for example, national identity shapes people's relationship to everyday objects and groups, such as radios, women's fashion, Algerian Jews, and—most importantly for the purposes of this paper—medical treatment. In what is perhaps Fanon's most widely known work, *The Wretched of the Earth* (1961), Fanon uses insights from his earlier studies on racial identity formation, the analysis of colonialism, critiques of Manichean thinking, and narratives of liberation to analyze the effects that decolonization has on the psyche of the those living in recently-independent countries (Wyrick, 1998: 99). Taken together, these influential works have had a wide-ranging impact on perspectives that deal with revolutionary struggle, colonialism, racial difference, and distrust of colonizers, as well as in informing more contemporary perspectives on poststructuralism, post-colonial thought, and critical race theory. Considering his collected works, it could be argued that Fanon's overall objective was to provide awareness into the dehumanizing impact of colonialism in its various manifestations so that the oppressed would be in a better position to resist those effects (Ritzer and Stepnisky, 2018: 418). Notably for this paper, the dehumanizing impacts of colonialism were deemed pervasive and totalizing in ways that affected all aspects of social life, including the alienated relationship between patients and doctors. Thus, Fanon writes in *A Dying Colonialism* that:

> The colonial situation is precisely such that it drives the colonized to appraise all the colonizer's contributions in a pejorative and absolute way. The colonized perceives the doctor, the engineer, the schoolteacher, the policeman, the rural constable, through the haze of an almost organic confusion. (1965: 121)

As we shall discuss, such effects of the historical legacy of colonialism are enduring and may be seen in the relationship between some community members and both foreign and local outbreak responders during the West African EVD epidemic.

3. The Ebola epidemic response in West Africa

Over the course of the primary EVD epidemic period from approximately December 2013 to June 2016, Guinea, Sierra Leone, and Liberia collectively accounted for more than 28,600 cases and 11,325 deaths (Ripoll et al., 2018). Although the earliest EVD cases were identified in Guinea in 2013, it was not until the virus spread to other countries that the WHO officially classified the epidemic as a "public health emergency of international concern" on August 8, 2014 (WHO Response Team, 2014). At this point, military troops, humanitarian NGOs, and medical staff from different countries descended on West Africa to provide logistical support for the response.

During the early stages of the EVD response the Western media tended to focus on covering incidents of social resistance to public health interventions, in process rendering perhaps overly sensationalistic accounts, and making it appear that such incidences were ubiquitous (Wilkinson and Fairhead, 2017). At the same time, anthropological work also focused on describing such resistance to help characterize specific situational conditions in particular local field settings as part of the ethnographic record. Such wide coverage of social resistance in conventional media and academic venues may have inadvertently given the impression that resistance was widespread in West Africa. But this type of totalizing depiction was largely misleading as the vast majority in

EVD-affected areas welcomed epidemic control measures and sought assistance (Wilkinson and Fairhead, 2017:14). In this light, it is important to note Wilkinson and Fairhead's (2017) important observation that resistance from community members in EVD-affected areas took different forms, ranging in intensity from the passive rejection of public health control requirements to episodes of violent resistance, to more extreme instances including the killing of community outreach workers and police officers in Guinea, and clashes, riots, and the stoning of vehicles in Sierra Leone. They note further that the different types of social resistance observed in the three Mano River Union countries reflected the enduring effects of distinct styles of colonial rule found in each country respectively—e.g., French direct rule through external appointees in Guinea, British indirect rule through local Paramount Chiefs in Sierra Leone, and *de facto* indirect rule by U.S. interests through the support of the Americo-Liberians (i.e., manumitted slaves) in Liberia. As such, the political ramifications of the different ruling regimes could help account, at least partly, for the different kinds of resistance found in each country. We expand on these histories below and discuss afterwards how these acts of resistance may also be better understood through Fanon's insights on (post)colonialism and power relations - with the caveat that acts of resistance were not based on an all-determining shared psychology of all Ebola-affected people in West Africa (we would like to thank the reviewer for bringing bring to our attention the need to make this important qualification).

4. The (Post)Colonial context in West Africa

Although colonized by different powers, Guinea, Sierra Leone, and Liberia have similar backgrounds in terms of their experience of the post-colonial condition. As Howard (2017: 19) notes, they share comparable histories in relation to the domination by, and dependence on: extractive economies and structural poverty, foreign intervention, colonial rule, patrimonial regimes, and devasting civil wars in the case of Liberia and Sierra Leone. In various ways these developments resulted in weak states in which the respective governments did not have the resources and infrastructure to effectively manage the Ebola crisis. Most relevant in this connection was the decimation of the public health infrastructure that resulted from the imposition of structural adjustment policies, and in the case of Liberia and Sierra Leone the physical devastation that resulted from the civil wars. Moreover, all three countries had fallen prey to dictatorship, unbridled corruption, and recurrent military coups, leading to a host of subsequent issues such as: deepening rural impoverishment, burgeoning youth populations, rapid growth in cities and urban slums, and a high incidence of urban unemployment. Because of such events, to this day each nation's citizenry continue to suffer their own unique form of widespread distrust of government, youth disengagement and rebellion, and lack of popular participation (Abdullah and Rashid, 2017). The extant distrust—the product of years of alienation—was thus identified as a major factor involved in the tensions that arose during the outbreak response in West Africa (2017: 7).

Alongside past experiences of colonial rule—in direct or indirect form—many in West Africa today have been left with an "ambivalent" feeling toward state leaders and white people generally due to the extractive, exploitive industries confronting them (Wilkinson and Fairhead, 2017: 16). From human labor via slavery to a range of natural resources such as diamonds and other minerals, rubber, palm oil, biofuels, and various agricultural products—the forced removal of such resources by both foreigners and corrupt politicians has contributed to a prevailing logic of distrust and secrecy (Ferme, 2001; Shaw, 2002). Reinforcing this distrust was the refusal by colonial, then later post-colonial governments to invest in public infrastructure and social programs that would benefit the collective, while preferentially supporting private interests of foreign industries (Azétsop et al., 2020). Consequently, a commonly held perception in the three Mano River Union nations was that politicians were deeply detached from their publics and preoccupied by personal gain over societal benefit (Wilkinson and Leach, 2015: 143)—a case especially significant in countries whose political-economic trajectory is predicated on resource capture by foreign companies employing predatory capitalist practices. We do not have space to go into details about the many historical and contemporary deals and concessions made by political elites in Liberia, Sierra Leone and Guinea with foreign resource extraction companies that benefited private interests at the expense of the public interest. These instances are well documented by numerous historians – see for example: Howard (2017); Kieh (2017); Abdullah and Rashid (2017), in relation to the implications these arrangements had for structural adjustment policies and the decimation of the public health care systems, resulting in serious challenges in the Ebola response. In light of these circumstances, Leach (2015a, 2015b) argues that local people were justified in believing that, rather than having their best interests at heart, government and external actors were driven by corrupt practices that favoured personal enrichment. In the Liberian context, this was exemplified by former President Ellen Sirleaf Johnson's administration, which was repeatedly accused of corruption (Wilkinson and Leach, 2015). While in Sierra Leone, public suspicion concerning the misuse of government Ebola funds were confirmed when a report of the country's auditor general noted almost a third of the money was unaccounted for (O'Carroll, 2014).

It is in trying to gain greater awareness into this political-economic, cultural, and historical context that we believe Fanon has much to offer. For the purposes of our analysis, as alluded to in our introduction, a particularly important aspect of Fanon's work is his treatment of the relationship between what we now refer to as "structure" and "agency". As mentioned, this involves directing investigative attention to how social structure is informed by colonial and post-colonial ideology and practices that distort and truncate the agency of those colonized. For Fanon (1961: 235), an agency borne of colonial history results in a particular form of restricted agency. Specifically, political-economic oppression renders dehumanizing structural and cultural forces that influence internal mental processes.

Extrapolating these types of issues raised by Fanon may be helpful for gaining a more nuanced understanding of the type of interactions and relationships that arise in the field of global health generally and in (post)colonial societies particularly. For the purposes at hand, we consider how the structural legacy of colonialism in West Africa has influenced the way people interpreted events, processed information, and made decisions during the EVD epidemic. With this in mind, in what follows we use Fanon's work in a generative way – as a path to guide us towards looking into certain issues that arose during the epidemic, such as how conspiracy theories could be used to influence the interpretation of events and processing of information.

5. Conspiracy theories and rumors within the (Post)Colonial context

The social distrust stemming from past experiences of political and economic elites' corruption likely contributed to the popular local view that Ebola was a threat fabricated by politicians and their NGO allies to enrich themselves through the securing of international health funds – what Shepler (2014) refers to as "Ebola money." The perceived non-reality of EVD was further reinforced by other lived experiences of members of the community, and this also cast doubt on the official storyline proffered by public health officials. For instance, it was noted that the symptoms of what the government was claiming to be a new disease were very similar to other ailments endemic to the area, such as malaria and Lassa Fever (Frankfurter, 2014). Yet the government's reaction to this new disease was at odds with past experiences with similar diseases (Wilkinson, 2017). Why did Ebola cause an unprecedented response in the form of an enormous insurge of outsiders, it was wondered? Contradictory messaging during the early epidemic response contributed to even further confusion and laid the groundwork for

conspiracy theorizing. For example, the insistence that bush meat was causing the disease and should be avoided did not make sense to people for at least a couple of reasons (Wilkinson and Leach, 2015). People in the area have been eating bush meat since time immemorial, so why did the disease suddenly come now? Further, the eating of bush meat and the transmission of disease was not consistent with personal experience – the disease largely seemed to be spreading person to person, rather than from contact with, or by eating, animal meat. Furthermore, this messaging was not in accord with people's working logic. The message being promoted by sensitizing teams was that Ebola was deadly, that it would ultimately and swiftly lead to one's demise. At the same time, the sensitizing teams were telling people to seek treatment in ETUs. At a practical level, people questioned why they should visit an ETU when it was widely known that resources for care at such sites were lacking (Richardson et al., 2017)? Faced with those circumstances many felt it would be better to die at home where they could at least be cared for and surrounded by loved ones, rather than in a strange and alien place where family were prevented from being by one's side at the time of death (Frankfurter, 2014).

The perceived dubiousness concerning the reality of EVD also led to numerous other types of rumors and conspiracy theories. One popular rumor was that people were being killed when they were sprayed with chlorine by outbreak responders during transportation by ambulance to ETUs (Wilkinson and Leach, 2015: 138). Or that people were being infected by EVD at the ETUs. In both cases, what was felt to be the motivating factor behind such action was the alleged harvesting and selling of the body parts of the deceased for the enrichment of the perpetrators. Rumors also circulated that Ebola escaped a U.S.-based bio--weapons laboratory in Kenema Government Hospital in Sierra Leone (Bah, 2017), or that the disease was started by pharmaceutical companies in order to test new vaccines as was done in the past (Shah, 2007). Again, such conspiracies were based on the notion that the bodies of local people were being exploited for the financial gain of international and domestic elites. Conspiracy theories also spread in relation to the political implications of EVD. In Sierra Leone, some supporters of the national opposition party in that country argued that EVD spread was a ploy executed by the party in power to manipulate the voter census numbers for electoral advantage in the upcoming elections (Bah, 2017). Such a conspiracy was supported in some people's minds that the most EVD-affected areas were opposition party strongholds, where people would be prevented from voting because of the epidemic. In the context of (post)colonial distrust of foreign interests and corrupt local elites, rumors and conspiracy theories abound. For instance, Goguen and Bolten (2017) and Shaw (2002) point out that accusations that local and outside elites were slaughtering members of their community has a long history in West Africa. Such accusations can be traced back to the 18th century when local chiefs were known to have actively cooperated with European slave traders – hence, "eating" the profits of selling their own people (Shaw, 2002). Thus, for frightened community members, it did not seem all that outside the realm of possibility that history was repeating itself. This was perhaps an extreme example of a more generalized understanding of how local elites exploited others for personal gain. For instance, in the wake of the civil wars in Sierra Leone, some community members felt that educated people were creating their own local NGOs to attract more resources and funds thereby "eating" that money that was intended for the people (Shaw, 2002). Thus, it is not surprising to learn that the threat of Ebola was considered as a way to make money through this mechanism as well.

To outside observers, it may seem logical at first glance that the fear and distrust directed at officials during the earlier stages of the response were linked to the types of rumors and conspiracy theories reviewed above. That is, that "irrational" beliefs contributed to the climate of mistrust and misinformation experienced by response officials. In part, to dispel these rumors and conspiracies, the message "Ebola is real" began to be widely communicated and emphasized through media outlets and the work of "awareness" and "sensitization" teams (Farmer, 2020: 21). Not only was this done to address the ostensibly false basis of rumors and conspiracies but to encourage community members to then take the next step and seek care at ETUs. Such attempts did not appear to meet with success because as Paul Farmer notes:

> [As] the personnel of the international disease-control machinery soon learned, the majority of locals, whether in villages or cities or moving between them, did not wish to be contained, instructed, traced, controlled, managed, monitored, sprayed, quarantined, or buried safely – even in a culturally resilient manner. Nor did many desire to be guinea pigs. They did, however, want proper medical and nursing care and pragmatic assistance with food, water, and social services, especially when ordered to remain in place or formally quarantined. (2020: 19–20)

Further, quite understandably community members needed to have some reassurance regarding their chances to survive rather than simply receiving "lectures on the perils of bushmeat and brief workshops on faddish concepts like cultural resilience" (Farmer, 2020: 20). Farmer's observations are valuable and insightful precisely because in the Fanonian sense, he connects local people's subjectivity to the post-colonial context as experienced by people within the locality.

6. The postcolonial subject and the reluctance to believe

As a practicing physician and psychiatrist who worked in the hospital setting during the Algerian struggle for independence from France, Fanon was deeply familiar with the dynamics of the doctor-patient relationship within the (post)colonial context. In this context, where distrust and oppression ran rampant through all facets of society, in the eyes of the colonized, "the doctor always appears as a link in the colonialist network, as a spokesman for the occupying power" (Fanon, 1965: 131). The suspicion that ensues from adopting such a standpoint is not surprising for Fanon because it is conceived of as a natural outcome stemming from the totalizing and pervasive effects of colonialism. Thus, Fanon writes:

> In the colonial situation, going to see the doctor, the administrator, the constable or the mayor are identical moves. The sense of alienation from colonial society and the mistrust of the representatives of its authority, are always accompanied by an almost mechanical sense of detachment and mistrust of even the things that are most positive and most profitable to the population. (1965: 139)

In viewing the Western doctor as first and foremost a colonial interloper, the colonized subjects' rejection of medical advice appears reasonable from their perspective. And, when people refuse the advice of the Western medical practitioner, racist-inspired attitudes of othering become reinforced in the eyes of that practitioner (Wyrick, 1998). If we consider the role of the Western/international response official as akin to the Western doctor that Fanon writes about, we can discern a similar colonially informed dynamic between response officials and community members during the EVD epidemic.

In their pioneering work on Ebola and culture, Hewlett and Hewlett (2008: 108) observed that international response teams in East Africa were usually unaware of how the postcolonial structure of meaning and experience might inform how local people react to their presence. Tacitly and implicitly drawing upon Fanonian insights, Rosalind Shaw (2002) notes that analysts need to recognize that claims made, and information given, by those in power are always considered by the subaltern as value-laden and political in the post colonial setting —that what is taken as "knowledge" by the subaltern is interpreted through their social and political relationship to the bearer of that information and what they bear to gain by it. Therefore, messaging from officials—whether public health or otherwise—is always viewed through what Shaw (2002: 91) refers to as "a glass, darkly." This filtered interpretation of information takes on particular significance during an outbreak situation because the stakes are high, and in the case of EVD,

distrust of government and foreign officials is widespread. As Goguen and Bolten (2017) observe, Ebola communications from the government and NGOs were almost always automatically viewed with at least some level of trepidation. Members of the community were wary of the motives of health communicators and as such they did not view messages from officials as straightforward statements about risk (which was the way Western officials viewed such statements). Thus, to retain some agency in their decision-making community members were quite guarded in their interactions with response officials. And in one instance, it was for this very reason – that is, to combat fear and distrust and to address the tense relationship that formed between community members and response officials-that a community-based initiative was adopted in the informal settlement of West Point in Monrovia, Liberia (Ali et al., 2021). This type of community fear was especially poignant in Sierra Leone because widespread awareness of situations where villages came under the control of rebels during the recent civil wars was still fresh in people's minds. In the (post)colonial context, power relations seem omnipresent and malevolent, and in these pretexts white foreigners—even under the seemingly auspicious behavior of "humanitarian" efforts—can seem like an occupying power.

With Fanon's intricate explanation of the psychosocial dynamics of the postcolonial condition, we can also see how the rejection of the public health directives to go to an ETU during the epidemic was logical by the standards of a (post)colonial subjectivity—a move swiftly interpreted by Western observers and media as "irrational resistance" that required the mobilization of "sensitization" and "awareness" teams. To be sure, aside from the climate of distrust that was always in the background due to the extant politics of post-colonialism and predatory capitalism, there may be other valid reasons as to why people rejected going to the ETU (as reviewed above). Yet overall, we can understand from these experiences why some arrived at the conclusion that "Ebola is not real." From a Fanonian perspective, understanding this type of experience-based logic, or coming to terms with this type of contextual reasoning of community members, was likely difficult for outbreak responders. This was because they were likely to ascribe to Western understandings of medicine and the practitioner-patient model—especially during the chaotic early stages of the response. For Fanon, however, the distrust locals routinely expressed of medical treatment is understandable. "Psychologically, the colonized has difficulty, even here in the presence of illness, in rejecting the habits of his group and the reactions of his culture. Accepting the medicine, even once, is admitting, to a limited extent perhaps but nonetheless ambiguously, the validity of the Western technique" (1965: 131). Grounds for this type of suspicion of "Western technique" was undoubtedly shaped by peoples' experiences of what officials seem to prioritize in their response – namely, the emphasis on disease control rather than caring for those afflicted.

7. Securitization, control, containment: colonial-era medicine over the provision of care

In *A Dying Colonialism* (1965), Fanon argues that along with military and economic domination, Western medicine itself contributed to the oppressive situation faced by colonized peoples or those involved in the struggle for independence. Fanon contends that the colonized and formerly colonized tend to perceive Western medicine as an extension of colonial rule—that is, as yet another form of apathy, conquest, trickery, and dehumanization (Wyrick, 1998: 91). As discussed above, it is through this particular interpretive filter that West Africans' interactions with Western medical officials should also be conceptualized by analysts. Philosophically in line with the Fanonian orientation we are developing here, Hirsch (2021) contends that scholars need to be consciously aware that Black people in Africa (and the diaspora) have a different historical relation to biomedical care than white people in the West. This is because the former group's relationship with the latter has, and continues to be, shaped by the "wake" of racism and colonial violence. We can discern numerous indications of how bias against African patients was perceived and reinforced during the EVD response both at a systemic level and at the individual level of interaction between patients and health officials.

At the more systemic level of the response, the manifestation of this bias may be understood in general terms by considering Farmer's (2020) observations regarding the over-emphasis on disease control over treatment and care on the part of Western medical intervenors during the EVD response. "When we can't blame colonialism for the most recent developments, we can blame its successor regimes," Farmer writes. "The postcolonial world still suffers from control-over-care logic" (2020: 499). The control-over-care paradigm used in West Africa's EVD outbreak can be traced back to colonial-era medicine in the twentieth century, when European Pasteurians implemented it as standard, punitive public health practices (Farmer, 2020). Often based on racially inspired interpretations of findings in epidemiology or microbiology of the time – for example, the view that particular races were inherently more susceptible to infectious disease because of weaker constitutions – the endeavours of the Pasteurians met with vigorous resistance from the populations targeted. According to Farmer, this resistance was not motivated by ignorance on the part of the people, but rather from peoples' direct experience and knowledge that disease-control efforts instituted by physicians in the colonial medical services did not involve actual medical treatment – the "French and British Pasteurians pasteurized caregiving right out of their practice" (Farmer, 2020: xxvii). The legacy of this approach could still be seen—and felt—in the EVD response.

A lack of awareness by Western intervenors of the colonial foundations of a given society might have also contributed to the adoption of a "securitized" approach to the epidemic response. As Farmer keenly points out, "What motivated much resistance wasn't ignorance but the knowledge that disease-control efforts led by physicians in the colonial medical services are rarely linked to medical care" (2020: xxvii). Under such conditions, the securitized approach took on an exclusive logic of containment that was devoid of care and empathy, where disease control and containment were emphasized overall all else. We also see this in Benton's (2017: 31) observation that at times doctors and public health workers were required to act as "border guards" to ensure quarantine measures were abided by, while preventing relatives from visiting their loved ones. The exercise of force or the threat of force was also found in ETUs, which became places of imposed securitization (Richardson et al., 2017). For instance, although later removed, during the earlier response phase, some ETUs were constructed with high opaque walls sometimes with barbed wire placed on top, and this unquestionably raised suspicion (Richards, 2016: 133). The creation of this type of markedly inhospitable setting mitigated against the kind of "solidarity and mutual support" that Farmer (2001) notes is indispensable to bringing an epidemic under control. Further, the experiences in ETUs quite likely reinforced in people's minds a (post)colonized subjectivity in which people experienced a truncated sense of personal agency.

The overriding focus of the Western response was on measures taken for infection control, such as the provision of hazmat suits and the construction of ETUs consisting of open-air wards covered by canvas awnings. In addition, containment measures—such as quarantine, travel bans, border closures, and martial law—were part of this overall infection control focus. What was neglected in this emphasis on containment and isolation was the need to focus on care and empathy towards individuals suffering from Ebola and their families (Farmer, 2020: 18). As such, the primary purpose of the ETU was isolation rather than treatment. Consequently, although many outsiders were assigned to contain the outbreak, few were available for the messy and dangerous work of caring for those already afflicted (Farmer, 2020: xii). This misalignment meant that the real reason for the lack of success of the early response efforts tended to be obscured, as there was a refusal to recognize what the sick-poor really sought was *care*. Without first addressing this need there would be little buy-in from the community. For Farmer (2020:

498), this misalignment and lack of recognition of such was the ranking obstacle to success in the EVD response overall. Thus, it was not the arrival of doctors, nurses and other professional care-givers that was problematic for members of the community (but what *was* problematic was the drastic shortage of such staff); it was that once the WHO pronounced that the EVD spread in West Africa represented an epidemic of global concern, and international forces were finally mobilized, the arrival of this "vast machinery of disease containment" meant the control-over-care paradigm was officially ascendant (Farmer, 2020: 18). After awareness of this development became widespread, the impact was that it drove EVD sufferers underground while at the same time spurring on conspiracy theories and inadvertently encouraging resistance to health authorities (ibid). It was under these conditions that most of the violence had occurred – that is, during the earlier times of the response when the "care" provided was abysmal.

As Fanon has shown, because psychical and physical violence are embedded into every structure of colonial society, the dehumanization inherent in such a social structure—demarcated, as we have seen, with the securitization and control-over-care paradigms implemented during EVD—influences the very character of all possible social relations. As noted by Fanon in a chapter titled "The So-Called Dependency Complex of Colonized Peoples" in *Black Skin, White* Masks (1967): the subjective experience felt by the colonized, based upon a lack of being recognized as fully human, is one of trauma and pain, producing a psychology of inferiority and hate toward the colonizer that impacts the deepest levels of self, identity, and desire in the colonized. As the EVD response revealed over-and-over again, non-recognition of the concerns of community members by international response teams was seen throughout the epidemic response and likely reinforced the mistrust such members felt towards the international teams.

8. The differential treatment of outsiders versus locals

Over the course of the epidemic, it became apparent to local populations that there was a superior standard of care provided to foreign responders—doctors, nurses, and other personnel. This issue arose most notoriously with what Farmer (2020: 420 citing Polman, 2010) refers to as the "crisis caravan," the international containment teams—such as UN agencies and humanitarian and NGOs like Red Cross and MSF—that arrived in West Africa. While Farmer notes that this was not unexpected or surprising based on past experiences, nor did it lead to resentment, what was most startling for locals was that the lower standard of care became fixed as policy (or felt to be so) through exclusionary treatment programs adopted and implemented by the crisis caravan. For example, Benton (2014) reports that while $22 million (USD) was pledged by the US Department of Defense to purchase 25 beds and equipment for an unstaffed hospital, the terms stipulated that only foreign health workers (read as "white" and not African workers) were to receive care in this hospital. In another instance, donations from over two dozen Western countries were funneled to a handful of large international NGOs with little finding its way to local grassroots NGOs (Shepler, 2017: 467). While the worldwide budget for the epidemic was $3.3 billion (USD), most of the funding went to international staff instead of frontline health workers (Maxmen, 2015). Locals were doubtful about how the Ebola money was being spent. The journalist Amy Maxmen (2015) brought attention to an instance where graffiti was sprayed in an Ebola isolation unit in Kenema Hospital that read "Please pay us." As well, locals' suspicions increased when international staff were seen spending danger allowances in publicly ostentatious ways, such as enjoying themselves on the beaches—a practice that was also witnessed by residents when international peacekeepers were stationed in Sierra Leone during the civil wars (Shepler, 2017). As Benton (2017) concludes, these were only a few of several examples in which differential treatment of West African lives fanned the flames of distrust and anger directed at international response teams.

Moreover, as Farmer (2020) and Richardson et al. (2017) among others have noted, although the construction and operation of ETUs was lauded internationally by Western observers for the provision of humanitarian aid during a medical emergency. In actuality, the level of "care" provided in ETUs was grossly inadequate and would clearly be deemed unacceptable and unethical in Western health care contexts. The emphasis was not on "care" so much as it was on disease containment in terms of implementing quarantine and martial law, while at the same time encouraging increased donor money and acclaim for "care." In other words, the conflation of the "care" and "containment" conveyed the false impression to an outside public that care was being provided, and once again reflecting the inequities of the postcolonial condition (we gratefully acknowledge the reviewer for this insight).

In the case of Sierra Leone, differential treatment between locals and international responders also became strikingly evident in the high-profile deaths of local medical staff, most notably Dr. Sheik Humarr Khan—the only infectious disease specialist in the country (Bausch et al., 2014)—as well as Dr. Olivet Buck, both of whom treated Ebola patients. While infected international responders were able to be medically evacuated to receive effective treatment in other countries that had the resources available to treat EVD, local doctors were not provided a similar opportunity. The experimental drug ZMAPP developed by Canadian researchers was on offer to Dr. Khan, but the decision was made by the treatment team consisting of MSF and WHO officials to not use the untested drug on the ailing doctor. Yet the day after Dr. Khan's death, the drug was offered by Health Canada to two infected American aid workers in Liberia who were administered the drug and flown back to Atlanta, Georgia where they received adequate follow-up care and recovered (Crowe, 2014). In a similar manner, while Dr. Buck was battling the disease in a Freetown hospital, local officials arranged for this local physician to receive treatment in Germany. The President of Sierra Leone made a special request to the WHO (the agency coordinating the international response) to receive transportation assistance for Dr. Buck (Benton, 2014), but the request was denied. At the same time, however, two infected Dutch physicians were able to receive medical evacuation to the Netherlands (via the Dutch embassy in Ghana). The differential treatment of medical staff not only brought public awareness to specific issues pertaining to the preferential medical treatment for non-locals, but more generally it brought to the fore general issues of discrimination and neglect that locals have experienced from the very beginnings of West African colonial domination.

A consideration of working conditions during the EVD response also revealed differences in how international and local response staff were treated. Adia Benton (2014, 2017) observes that NGO-run, purpose-built facilitates (ETUs) were mostly operated by international healthcare workers. While locals may not have been precluded from working in such facilities—and in some instances international and local staff did indeed work side-by-side—locals were nevertheless more likely to continue working in extant facilities that had limited resources and poor infrastructure support. The differences were significant because as Hirsch (2021) points out, while both staffing pools faced the risk of infection, the risk of death for white personnel was much less due to an enhanced access to treatment and medical evacuation (as discussed above). For Hirsch (2021) and Benton (2016), the division of labor inside ETUs could also—even if inadvertently—reproduce a (post)colonial-inspired configuration and trope based on white "saviors" and Black "victims." While most healthcare workers were white, they were involved with caring for patients and managing local workers who were Black. As Hirsch argues, though the spatial design and organization of ETUs were not deliberately antiblack, "the fact that they took place in a context shaped by colonial antiblackness contributed to the normalization of Black suffering and premature death" (2021: 1). Thus, Hirsch (2021) concludes that there existed a patterned spatialization of risk during the EVD epidemic that coincided with colonial and racial hierarchies.

Fanon writes about the betrayal felt by locals when their own kind take up positions and responsibilities within the colonizer's ranks.

Distrust envelops such relationships, even in the case of medical doctors from the colonized population who work alongside the colonizers. The former, Fanon writes, are presumed "Europeanized, Western … [and] considered as no longer being a part of the dominated society" (Fanon, 1965: 132). "[H]aving acquired the habits of a master," therefore, locals in this situation become "tacitly rejected [by their own people] into the camp of the oppressors" (1965: 132). We see elements reminiscent of this sentiment during the EVD response. For example, tensions arose from perceived concerns over the cooption of locals hired to fill positions in the international response. Farmer (2020: 422) notes that many local experts, particularly West African clinicians, took up well-paid jobs within the crisis caravan as part of the disease control and containment efforts. But this meant that such local experts were diverted away from the important need to provide care. At the same time, those locals who were employed in the front-line of the response were left to deal with delicate and potentially explosive situations on their own in a direct face-to-face manner, while international responders were able to safely keep their distance from such confrontational circumstances. For instance, locals who were employed as contact tracers in Sierra Leone were sometimes confronted by angry neighbors and community members who resented the contact tracers for revealing to government officials the names of those in the household who were ill (Ali et al., 2022). They felt that this was a betrayal and as such sometimes this led to acrimonious confrontations. Such confrontations may have also been the result of how the contact tracing itself was taking place. Farmer (2020: 173) relates how contact tracing involved the unannounced arrival of local officials at households where they demanded information about suspected cases and contacts. If members of the household were reluctant to share such information the officers would then proceed to loudly yell out and announce the name of the suspected case – saying that this person was infected with Ebola. Farmer notes that this would put fear into the hearts of neighbors, and it also likely contributed to the stigmatization of those in the household.

In summary, differential treatment between locals (Black) and international response teams (white) provoked a sentiment of distrust, fear, and even resentment and anger at times. For Fanon, these issues stem from a lack of recognition of the humanity of (post)colonial subjects—a distinction between the human and nonhuman built into the very structure of European colonial civilization.

9. Concluding remarks

As Horton (2018) astutely points out, Fanon's work may help shed light on a missing element of conventional global public health analysis – namely, a neglect of how the foundation of many public health issues faced in the Global South is predicated upon relations of power. In this paper, we have tried to demonstrate that within the postcolonial setting of West Africa, a Fanonian approach provides certain analytical advantages to studying public health issues in general, and disease outbreaks in particular. First, it better enables us to contextualize the power dynamics—both historical and contemporary—that influence the nature of the response to public health issues faced in that setting. Second, a Fanonian perspective directs us to consider more seriously the lived reality of people within their local context, so that the plurality of factors that influence local people's agency are taken into account and not glossed over by the binary structure of Manichean thinking (for instance: "rationality"/"irrationality") that Fanon so opposed. Thus, in this paper we have seen that from a Fanonian viewpoint, what Western observers designate as "resistance" due to irrationality and a lack of "proper" education and understanding was not accurate and did not capture people's lived experiences. Decisions to follow or not follow public health directives were informed by other considerations that were perfectly rational within the local historical circumstances faced. Peoples' decisions were based on a complex of multi-faceted, practical, historically- and personally-informed concerns that cannot be simply reduced to the Manichean category of ignorance. In light of these Fanonian-inspired insights, analysts and global health advocates may be in a better position to reject salvific narratives based on the simplistic notion that Western humanitarian intervenors know best, and when their services are met with local "resistance" this must be "overcome" for the local people's own benefit. Third, a Fanonian framework enables analysts to understand how the legacy of (post)colonialism has an enduring impact on public health and disease outbreak response. Thus, in this paper we have demonstrated the utility of Fanon's work for analyzing phenomena such as: conspiracy theorizing and rumors, reluctance in accepting public health messaging, the bias towards containment and securitization rather than care, and the differential treatment of outsiders versus locals.

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