The Jus Semper Global Alliance

In Pursuit of the People and Planet Paradigm

Sustainable Human Development

September 2021 BRIEFS ON TRUE DEMOCRACY AND CAPITALISM

Epidemic Response

—*The Legacy of Colonialism*

Jennifer Dohrn and Eleanor Stein

As we head into year two of the coronavirus pandemic, we ourselves are haunted by the spectre of the social dimension of what looks on the surface—and is presented to us by government and media—like a medical or health crisis. In reality, it is only a medical crisis on one level. The COVID-19 pandemic is at its root a crisis of globalisation, a crisis of racial capitalism, a crisis of colonialism, a crisis of the social organisation of our public health system. It is a crisis of treatment and care versus demonisation and wall building. And it is the latest pandemic in a long line of modern ones—from SARS to swine flu to HIV to Ebola—a predictable and predicted outcome, not the mysterious unforeseeable lightning strike as it is often portrayed. The United States has reaped the results of market fundamentalism and the neoliberal wars on government and public space, when hospitals in the richest cities in the world proved incapable of treating the tidal waves of COVID-19 sufferers or even handling the dead with dignity. No one living through COVID-19 in the United States can be unaware of the social construct of its toll: infections and deaths among populations of color nearly double that of

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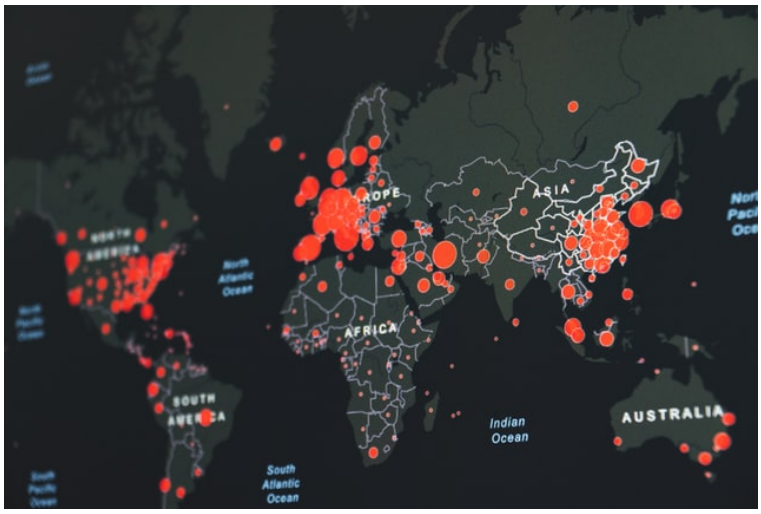

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white people. Indigenous people account for more than double (2.3 times) the number of deaths.[1] Whites in the United States have two to three times the vaccination rates of people of color, and still have far greater access to vaccines. Of those who have been vaccinated so far, two-thirds are white and only 2 percent are Black people.[2]

In this context, Paul Farmer's Fevers, Feuds, and Diamonds: Ebola and the Ravages of History is the book to read today, even though COVID-19 presents a very different medical crisis than Ebola. Farmer gives us an incomparable history of the social dimensions of disease and an analysis deeply steeped in an egalitarian, anticolonialist, and radical passion. His current exploration of the disastrous spread of Ebola in Sierra Leone, Guinea, and Liberia in 2014 leads him, as he says, down the rabbit hole, to uncover why in the twenty-first century these countries lack public health systems capable of meeting the ordinary health needs of their populations, to say nothing of meeting a crisis on the scale of Ebola. His exploration of the precolonial and colonial histories of the region and of the brutal British and French conquests both rival and draw on the methods and works of Walter Rodney and Adam Hochschild, as well as many African sources. Notwithstanding the tropes of the civilising mission of colonial conquest, these regions were systematically pillaged of wealth in all forms—but, centrally, of wealth in the form of women, men, and children in the centuries of the slave trade. It is slavery's legacy, most of all, that underlies the impoverishment of the region. As Farmer summarises:

> *What happened in previous centuries is not irrelevant to the study of today's epidemics and social responses to them.… Myths and mystifications, much of the vocabulary, and a good deal of armed conflict were brought to West Africa by colonial rule; so were martial disease-control efforts. What European colonialism didn't bring to the region was health care.… Natives of this part of West Africa might not be acquainted with modern medical care, but they are quite familiar with colonialism's primary purpose: to rip riches from the earth and export them for profit.*

As Farmer shows, the three most Ebola-affected countries, Liberia, Guinea, and Sierra Leone, remain caught up in the devastating aftermath of extractive colonialism.[3]

Farmer's narrative originates in his attendance at a global health conference in Sierra Leone in June 2014, just as what would become the largest Ebola outbreak in recorded history was gathering speed in West Africa. There he met up with his friend and colleague Dr. Humarr Khan, the first to recognise the presence of Ebola in Sierra Leone and, later, one of its tragic victims. Farmer returned in force with his nongovernmental organisation Partners in Health in September to "tackle Ebola," to take up a challenge that would consume him for years.[4] In this challenge, as in so much of his other work, his participation is wholehearted, passionate, and deeply personal. In fact, Farmer himself is a protagonist: he takes us on his own personal journey, on the ground, engaged, and changing from the beginning.

Farmer's primary source is essentially the oral history of Ebola survivors. As he says, much of his book is "a synthesis of other people's knowledge and an account of other people's suffering. But it's a synthesis informed by direct service to the afflicted…[and] by years of friendship with several people who have survived Ebola."[5] The book also draws on local

1 ↩ "Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity," Centers for Disease Control and Prevention, April 16, 2021.

2 ↩ Nambi Ndugga et al., "Latest Data on COVID-19 Vaccinations Race/Ethnicity," April 21, 2021.

3 ↩ Paul *Farmer, Fevers, Feuds, and Diamonds* (New York: Farrar, Straus & Giroux, 2020), xxii.

4 ↩ Farmer, Fevers, Feuds, and Diamonds, 49.

5 ↩ Farmer, Fevers, Feuds, and Diamonds, xxv.

knowledge, especially that of caregivers. Ebola, like COVID-19, is a disease of caregivers: family members, nurses, doctors, funeral providers. Caregiving is tragically the main source of contagion.

Families, communities, and local nurses are his authorities. At what came to be Farmer's favourite hangout, the war-scarred Sierra Leone café Mammy Yoko, we are introduced to one of Farmer's guides: Ibrahim Kamara, an Ebola survivor, 26 years old when we first meet him, who lost his mother and twenty-two other family members to the disease and grew into a care provider himself. He and Farmer ended up talking for a couple of years. Another is 38-year-old Yabom Koroma, who had lost her husband, two of her five children, her mother, and dozens of other relatives, and became the center of a community of care. Her story is also marked by the years of war, subsistence existence, and an almost total lack of available schooling—all the legacy of British colonialism and then corrupt independent government. But chief of these failures was the near nonexistence of a public health system. And these failures were all fuelled by the structural adjustment policies forced on Sierra Leone by international financial institutions discouraging public investment in education and health care.

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Farmer establishes with the devastating authority of his lifelong practice how outbreaks, epidemics, and pandemics happen differently in distinct societies: they invade and inhabit the social structures of how that country is governed and its very societal foundations. How did this disastrous state of affairs come about in Sierra Leone, Guinea, and Liberia? In West Africa, the legacy of colonialism, the global slave trade, and rule of power, profit, exploitation, and exclusion left countries bereft of public health infrastructure even remotely capable of meeting the Ebola challenge. And the global response to Ebola, Farmer reflects, always remained clinically paltry.

The priorities from the start were to stop transmission, then protect health professionals, and lastly save lives of those afflicted. Saving the sick became the lowest priority, in a historic inversion of basic public health clinical priorities, to say nothing of the social contract of the human right to health.

On top of the underlying paucity of health facilities, Farmer traces lethal flaws in the approach of governments and nongovernmental organisations, including Doctors Without Borders, that provided care in the region for several decades and arrived to facilitate control of the epidemic. Their approaches resulted in thousands of unnecessary deaths and continued the legacy of mistrust of modern medicine by the local population. The first of these was what he terms the prioritisation of containment over care. From the start, the priority was containment and control of infected populations to prevent transmission of the virus both within and, especially, outside of West Africa. The priorities from the start were to stop transmission, then protect health professionals, and lastly save lives of those afflicted. Saving the sick became the lowest priority, in a historic inversion of basic public health clinical priorities, to say nothing of the social contract of the human right to health.

Ironically, Farmer raises the profound question of "whether effective containment is possible without safe and effective care." His conclusion is that sound public health components are essential for a successful response: these include investment in a health system (clinics, hospitals) and a health workforce, all in the context of that society's culture. These are his lessons from previous work in Haiti, Peru, and Rwanda. And this was what was tragically lacking in West Africa. The containment emphasis had two perverse effects. First, local communities lost faith in the ability—or willingness—of

the existing health care facilities to care for them and their families, and therefore avoided containment whenever possible to try to obtain actual treatment. What drove sufferers underground was "the arrival of a vast machinery of disease containment." The control-over-care paradigm was the hallmark. Second, there was a failure to provide basic care for the acute dehydration Ebola causes. For over a century, the standard of care for replacement of fluids and electrolytes (essential to prevent organ shutdown) was established as intravenous fluid—a simple and inexpensive treatment provided by nurses. It has long been established that oral fluids simply do not rehydrate at the rate needed in critical situations. Farmer forces the realisation that the over thirteen thousand people who died did not all have to if sound medical practices of rehydration and replacement of bodily fluids had been followed. Indeed, Western doctors who contracted Ebola in West Africa and were flown home received this treatment. Those who did, survived.[6]

West Africa was indeed, as it was characterised, a clinical desert. Ebola patients first needed supportive care measures (fluid resuscitation plus prompt treatment of infections) and then, if necessary, critical care (ventilator support, kidney dialysis, monitors) delivered "primarily by skilled nurses."[7] Yet, most international aid organisations accepted and proliferated the socialisation of scarcity. This is part and parcel of the assumption that it is impossible to provide poor societies with the resources necessary to meet the crisis, and therefore other, less sophisticated methods must be relied on—even in the face of their epic failure. It took many months, even years, of fighting by Partners in Health, and many needless deaths, to win this argument.

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The third colleague and friend who haunts this book is the extraordinary Dr. Humarr Khan, one of the first generation of Sierra Leoneans to graduate from the country's only medical school, opened well after the end of colonial rule. From his Kenema Government Hospital in Sierra Leone, Khan called for investments in care delivery systems, hospital infrastructure, and a network of nurse-run public clinics. Such facilities as there were lacked what Farmer calls the necessary "staff, stuff, and safe space" to deliver effective care. With a network of colleagues from Tulane and Harvard, Khan was working to create advanced diagnostic laboratories across West Africa. His work included a study showing that Ebola was present in Sierra Leone long before it was clinically diagnosed—the study was only published after he and many nursing colleagues had died of Ebola. The first cases began pouring into and overwhelming his hospital, which had become the national referral center. Realising he was feverish and learning it was Ebola, he traveled east to an emergency treatment center just opened by Doctors Without Borders. That center was treating Ebola patients with oral fluids; efforts to get him to Switzerland or Germany failed when pilots and crew refused to take him, and he died there, an irreplaceable leader.

The book ends with Farmer, back in Boston, a year ago, already observing the legacy of Jim Crow reflected in the path of COVID-19 and the "rotten trap" of nationalism futilely closing borders, and fearing the shortages of oxygen and respirators that would soon collapse care for COVID-19 patients in all-too-many hospitals in the richest country in history. Another deadly virus is spreading in the context of a racist health structure with its history of exclusion and inferior health care for people of color and a poorly funded public health system. To read this book at this time is to see our own reality, multiplied a million-fold, through a glass, darkly—that of history's legacy.

6 ↩ Farmer, Fevers, Feuds, and Diamonds, 19.

7 ↩ Farmer, Fevers, Feuds, and Diamonds, 29.

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