Antiblackness and global health: placing the 2014 - 15 Ebola response in the colonial wake

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I, Lioba Assaba Hirsch confirm that the work presented in this thesis is my own. Where information has been derived from other sources I confirm that this has been indicated in the thesis.

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Abstract

This thesis draws on Black Studies to explore how antiblackness is entangled in the field of global health. Drawing on 'the wake', a theorisation of Black life in the aftermath of enslavement and colonialism articulated by Christina Sharpe, it argues that the British-led, international response to the Sierra Leonean Ebola epidemic (2014-16) worked through colonial infrastructures and colonial imaginations of Sierra Leone as a de-historicised landscape, unaffected by transatlantic antiblack violence. It enhances existing analyses of the response by showing that historical entanglements of care and antiblackness signal 'the wake' as an epistemic and geographical reality. In Sierra Leone this reality is largely normalised and was, despite its ubiquity, given little consideration in the international Ebola response. The thesis takes the form of a multi-sited, non-linear, geographical study of the international response. It shows that 'the wake' underlies the international Ebola response; that it can be traced in Freetown's cityscape, in the mobilities connecting Sierra Leone and the UK, in British archives and in colonial and contemporary expert accounts. Methodologically the research draws on interviews with international health responders and members of the Sierra Leonean diaspora involved in the Ebola response, fieldwork in Sierra Leone and London, and archival research on British colonial disease control. The empirical chapters examine the response in relation to 'the wake' in terms of the following themes: material and atmospheric traces of colonialism and enslavement in and around Freetown; disease control-related aeromobilities; colonial and postcolonial expertise; and care and care practices. The thesis demonstrates the value of placing contemporary global health in 'the wake' in order to rethink where and how we study the colonial present. In conclusion, it shows how ideas from Black studies should inform further research on global health in terms of unpacking postcolonial silences, centering Black perspectives and highlighting the endurance of colonial infrastructures.

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Unless otherwise indicated, the photos reproduced in this thesis were taken by me in the course of this PhD research. Photos of Sierra Leone were taken in March 2019, the photo of the mind-map in chapter four was taken in July 2019.

Figures 6, 18, 19 and 21 were made especially for this thesis by Miles Irving.

List of Acronyms

AIDS – Acquired Immunodeficiency Syndrome

ARVs - Antiretroviral drugs

CDC – Centres for Disease Control

DERC – District Ebola Response Centre

DFID – Department for International Development

EHU – Ebola Holding Unit

ETC – Ebola Treatment Centre

EVD - Ebola Virus Disease

HIV - Human Immunodeficiency Virus

IMATT - International Military and Advisory Team

INGO – International Nongovernmental Organisation

IPC – Infection Prevention and Control

MSF – Médecins sans Frontières

NERC – National Ebola Response Centre

NGO – Nongovernmental Organisation

NHS – National Health Service (UK)

PHE – Public Health England

PPE – Personal Protective Equipment

UNMEER – United Nations Mission for Ebola Emergency Response

WHO – World Health Organisation

Impact Statement

This is a thesis about a global health emergency and the subsequent medical, political and logistical response to it. As such the analysis I present is valuable both in terms of academic knowledge production as well as in applied global health practice. Taking the 2014-16 Ebola Virus Disease outbreak in West Africa as my case study, my research analysed colonial continuities, violent historical geographies and medical practices in postcolonial Sierra Leone. In 2015 the UK government created the Global Challenges Research Fund (GCRF), a £1.5 billion fund directed at improving the lives of populations in developing countries. My research responds directly to the GCRF core criteria in that it builds the basis for more effective (health) partnerships across a North-South divide, includes new perspectives and departs from traditional methodologies and, most importantly, builds knowledge that has the ability to improve the international management of epidemics in developing countries.

The ongoing Ebola outbreak in the Democratic Republic of Congo has illustrated, once again, that international health care workers respond in environments in which historical and contemporary violence is rife. Local distrust and violence directed at national and international health workers delay medical care and, despite advances in Ebola vaccines and medication, contribute to the spread of the virus. My thesis contributes to a better understanding of the political and historical environment in which epidemic responses take place. It offers an alternative explanation for the reluctance of local communities to seek medical care in government and international health centres. As such it constitutes the basis for new approaches to gaining communities' trust and containing deadly epidemics faster. This has two important potential impacts: on the one hand it can contribute to saving more lives by improving contact tracing, isolation and treatment techniques. The faster Ebola suspects are isolated from the community or are cared for in safe environments, the lower the risks of the spread of infection. On the other hand Ebola epidemics and epidemics more generally damage local and national economies. The World Bank estimated that due to the West African Ebola epidemic, $2.2 billion was lost in the combined GDP of Sierra Leone, Guinea and Liberia (CDC, 2019). As such epidemics constitute additional strains on already weakened economies and socio-political structures. My thesis constitutes an original piece of interdisciplinary work, connecting the field of global health to that of postcolonial and Black studies, which carries implications for how health responders analyse, assess and respond to disease outbreaks in postcolonial societies.

chapter ONE

1 Introduction

1.1 Preamble

The Ebola cemetery in Waterloo is located on an overgrown field, less than five kilometres from the main road connecting Waterloo and Freetown, Sierra Leone's capital. There are segregated sections, demarcated by cement pillars, each bearing a letter. We walk past sections E, F, J, L and K, each of which contains rows and rows of identical cement headstones, inscribed with the words 'In loving memory of' followed by a name, a burial date, the age of the deceased and a cemetery reference number. In many cases the deceased is unknown and the graves are marked with the phrase 'Known unto God'. Funded through official UK development assistance, *Concern Worldwide*, an international NGO in charge of burials in the cemetery, put up signs showing the layout of the cemetery and of individual sections (Figure 1). These signs are bleached by the sun and barely legible. I can hardly make out the official name of the cemetery, 'Paloko Road Cemetery, Waterloo' at the top and, more clearly visible, a British flag over the words 'UK aid' in the lower right-hand corner. The rows and rows of reference numbers, corresponding to the graves on the cemetery, are illegible. The flag and logo are still visible because they alone were printed in colour, the logo mirroring the blue and red of the British flag. The blue metal frame has begun to rust and reddish-brown streaks of colour have seeped onto the sign. A thin layer of dust has settled on it and someone (a visitor?) has run their fingers through it, making lines and a star-like shape at the bottom, next to the 'UK aid' logo, which has been wiped clean of dust. Without any protection from the sun and rain the sign will soon be completely illegible. No doubt the Union Jack and 'UK aid' will be the last things that remain.

Like the sign, the cemetery has become almost invisible. We approach it from the back and are directed to a large wild field. All I can see is tall meadow grass and hedges and trees, growing so closely together that they obscure what lies behind it from view. Two soldiers in civilian clothing tell me to watch where I step as they lead us through the thicket. There is no clear path and until I see the headstones I am unaware that the cemetery is right here. Here, on the edge, the grass is taller than me. Thin light brown

Figure 1: Map of Paloko Road Cemetery, Waterloo

shafts and low trees make it almost impossible to make out the gravestones. To our left, dry tall grass has taken over and it is impossible to walk between the headstones. To our right a field opens up (see Figure 2), similarly overgrown, but here with shorter plants: brown stalks crowned with white, pillowy heads. They remind me strongly of cotton and it feels as if these graves were dug in a cotton field, as if this cemetery is a reminder of cotton fields across the ocean and the antiblack violence that has shaped both sides of the Atlantic. It feels as if I am standing at the edge of a cotton field, interspersed with the same light grey uniform headstones that I see everywhere else on this cemetery; a reminder of the thousands of people who died from Ebola, but now also a reminder of the millions of Africans who were forcefully enslaved and transported across the Atlantic to work on cotton fields and rice and sugarcane plantations. The violence of the Ebola epidemic and the centuries old antiblack violence that characterises enslavement and colonialism in Sierra Leone appear to me, on this meadow, in muted form. The gravestones are visible, yet obscured by the cotton-like plants, which have grown taller and dense in places, making it more difficult to make out names and dates. At the same time the plant growing here is not cotton, and a closer look confirms this, but the association with cotton is strong, so strong that one of my companions notices it too. Yet a cotton field does not automatically conjure the transatlantic slave trade. In this particular

location, however, and for me, a Black researcher, having conducted months of research on antiblackness and Ebola, it is reminiscent of Sierra Leone's long, forceful integration into the transatlantic world through the transatlantic slave trade and British colonialism. In this cemetery, as in my research, antiblackness underlies what is immediately tangible. The rows of graves, holding hundreds of bodies, are more tangible than the cotton-like plants. Yet to me, in this place, both evoke Black death and antiblack violence. At times this antiblackness takes careful work to discern or prior knowledge to understand. Like in the cemetery, in my research I actively foreground antiblackness through associations, I infer it from silences and trace its marginalisations.

In the Ebola cemetery in Waterloo, the faded sign, the still colourful Union Jack and the cotton-like plants between rows of headstones are evocative of the themes and methods I explore and draw on in this thesis. They suggest that landscapes contain the possibility of multiple realities, of layered histories and geographies. If we explore such associations and connections further, we can also detect the persistence of antiblackness and the ambiguous nature of British involvement in relation to the Ebola epidemic in Sierra Leone. Doing so requires a researcher aware of the ways in which legacies of colonialism and the slave trade continue to hold Black life in the present.[1] They also signal the non-linear methodology that this thesis takes, warranted, I argue, by the marginalisation and elusiveness of antiblackness in the colonial present.

[1] I define the concept of the hold (Sharpe, 2016) in more detail in section 1.3 of this introduction. Here I use it to describe how Black life is lived and understood in reference to the antiblack past. The direct impact of this past can, like a hold, be firm or loose. To say that the past 'holds' Black life in the present accounts for this range of grips.

Figure 2: Ebola Cemetery 'Cotton Field', Waterloo

1.2 Thesis Rationale

This thesis speaks to how antiblackness is entangled in the field of global health. It explores how historical antiblackness and colonial infrastructures underlie and are implicated in the international response to the 2014-16 Ebola epidemic in Sierra Leone.
In Sierra Leone, infectious disease control was historically bound up with the transatlantic slave trade, the British resettlement of freed slaves in the 18th and 19th century and the subsequent colonisation of Sierra Leone by the British Crown. These historic entanglements resurface, I argue, albeit in elusive, at times ambiguous ways, during the 2014-15 response. This thesis excavates these entanglements by analytically 'placing' the Ebola response in Sierra Leone in the wake of colonialism; that is to say, it considers the response *in* and *as part of* the aftermath of the antiblack violence that has shaped Sierra Leone historically and geographically. This 'placing' is done in two main ways. Firstly, relying on research conducted in British archives of colonial disease control and fieldwork in Sierra Leone, I analyse the international Ebola response with reference to historical infrastructures, landscapes, epistemologies and practices that are suffused by antiblack violence and which underlie present-day infectious disease control in Sierra Leone. I consider the international Ebola response in the midst of these material and epistemic traces and examine to what extent the antiblack violence that characterises this

past resurfaces around the response. By considering the past and present of antiblack violence in relation to infectious disease control in Sierra Leone, this placing questions the temporal linearity which constitutes one aspect of postcolonialism. It also opens up the possibility of 'different geographic stories' (McKittrick, 2006, p.x), stories in which the past and present coexist geographically. Secondly, relying on in-depth interviews with international health responders and members of the Sierra Leonean diaspora, I trace the discursive continuities, marginalisations and silences that acknowledge or deny antiblack entanglements in narrations of the 2014-15 response. This second 'placing' takes the form of unpacking absences and locating the colonial wake spatially and discursively. I present an account of the Ebola epidemic that foregrounds the echoes, resonances and associations between the colonial past and the 2014-15 British-led international Ebola response. Overall, the thesis argues that approaching the wake of colonialism and questions of health and disease through each other allows us to rethink how and where we study the colonial present.[2] Here, colonial health management is not studied as a past phenomenon, but as shaping Black ontology in the present. Simultaneously, I argue for an understanding of present-day antiblackness that exceeds police violence and the prison-industrial complex and includes aspects of health and health care provision as a field in which Black ontology is negotiated and contested.

Building on an exploration of these historic-contemporary entanglements, I show that antiblackness constitutes a geographical and epistemic reality, which has shaped Sierra Leone in the past and continues to shape it in the present. Drawing on my research, I demonstrate that this antiblack reality has been largely normalised within Sierra Leone's postcolonial landscape. Furthermore, as the thesis shows, antiblackness was given little consideration in the international Ebola response in Sierra Leone. Indeed, the extent to which antiblackness was normalised became evident in my research: if one looks closely, traces of slavery and colonialism are readily apparent in Freetown's built environment, in its toponomy and architecture. At the same time, acknowledgment of or reference to this reality was largely absent in responders' narrations of the epidemic. I argue that this disconnect between physical reality and individual sense-making evokes the colonial

[2] In this thesis I understand the colonial present as a time-space governed by colonial relations. The term has many similarities with 'the wake', but has more explicitly been used to critique ongoing colonial dynamics (i.e., Gregory, 2006), rather than the aftermath of slavery. This is largely due to the different disciplines from which both concepts emerge (postcolonialism vs. Black Studies). Given the specific Black focus of this research project I have predominantly drawn on' the wake', but have sought to bring the two concepts in conversation with one another and to show the relevance of an engagement with Black studies and concepts in postcolonial debates.

wake. It also elicits a normalisation of the antiblack violence that has structured how the UK has related to Sierra Leone and that has shaped Black life – and health - in Sierra Leone.

1.3 Antiblackness and health in the wake: conceptual framework and thesis contributions

To locate the antiblack violence I describe above, the thesis draws on Black studies and especially on Christina Sharpe's seminal work *In the wake: On Blackness and Being* (2016), which offers a critical framework for the study of Black life in the aftermath of enslavement and colonialism. Structured around the allegory of the slave ship, *In the wake* moves across Black studies' subgenres and disciplines to offer a careful methodology for the study of Black diasporic life and death. Sharpe (2016) engages Black writers, activists and artists to consider the ontology of Black life in the diaspora through chapters on 'the wake', 'the ship', 'the hold' and 'the weather'. This ontology, she argues, is framed by ongoing antiblack violence, but also by multitudes of resistance and a deep understanding (a 'wakefulness') of the structures and atmospheres that hold Black life and death. In this thesis, I tease out these structures and atmospheres with regards to the 2014-15 Ebola response in Sierra Leone to argue that similar currents of antiblackness underlie the past and present of health care interventions in Sierra Leone. Furthermore, by considering the wake through a study focused on health and disease, I argue that the antiblack dynamics that hold Black life in the diaspora also work their way through postcolonial encounters on the African continent. I show here that the wake and its geographies take on different forms in postcolonial Africa than they do in North America, the traditional site of Black studies. I argue that an analysis of the Sierra Leonean Ebola epidemic contributes to our understanding of the spaces and materialities that represent the colonial wake in Sierra Leone. Subsequently this thesis contributes to a differentiated understanding of the wake and Black geographies in relation to postcolonial Africa.

The wake, the central concept in Sharpe's (2016) work, is polyvalent. It designates at once the all-encompassing nature of slavery's political and temporal aftermath but also comes to stand in for specific aspects of Black life in that aftermath. Among other meanings and metaphors, the wake is the parting of water behind a ship, the watch over a dead body and the air current behind a body in flight (Sharpe, 2016). There are other elements to Sharpe's definition related to Black life and death in the diaspora.

Importantly, while the wake is all-encompassing, it is not totalising and Sharpe highlights Black life and resistance despite the antiblackness that surrounds it.

Sharpe's (2016) work functions as the main conceptual and methodological reference point for this thesis. I analyse my empirical data with reference to the conceptual advances she makes in *In the wake*. In particular, I draw on her discussion of 'the wake', which I defined above, and 'the weather' (below), which each constitute a chapter in her book, and to a lesser extent on her concept of 'the hold'. While ships and their mobilities play a role in my analysis on several occasions, I engage less with Sharpe's chapter on 'the ship'. I also draw in depth on her methodology of 'care' and the underlying concept of antiblackness, which constitute recurring pathways throughout the thesis. I will attend to 'care' in the methodology chapter of this thesis. In this section I explain how I use 'the wake', 'the weather', 'the hold' and antiblackness.

I focus on the wake as the aftermath of colonialism and enslavement and the wake as the awareness (wakefulness) of being in that aftermath. This awareness in turn encompasses the realisation that Black life (and death) is still 'held' by this aftermath, by the antiblack violence that has made the past and continues to shape the present. This thesis is an exploration of Black life and health in that present.

An important aspect of being in the wake in Sharpe's (2016) analysis and in this thesis is 'the hold'. Sharpe uses the hold to refer to both the physical hold (immigration camps, prisons) in which Black life is restrained and the immaterial violence of being held by the antiblack forces of the past, which structure Black diasporic life in the present, in other words, which structure the wake. In my analysis of the Ebola response I use 'the hold' to refer to the latter, that is to say the grip (tight or loose) which the wake had on Sierra Leonean life, rather than quarantines or curfews, which were used to spatially hold people, i.e. limit their movements and confine them during the epidemic. The thesis is an exploration of Black life and health in that hold.

To describe the conditions of Black life in the wake/the hold/the present, Sharpe resorts to the metaphor of the weather. She writes (2016, p.104): 'In my text, the weather is the totality of our environments; the weather is the total climate; and that climate is antiblack.' The weather or climate, terms which Sharpe uses interchangeably, signify the all-encompassing nature of the wake as experienced by Black people in the diaspora. Whereas racism is often seen in its components, as structural or institutional or systemic, antiblack weather points to the antiblack moods, attitudes and symbolic and material traces whose impact on our lives, like the weather, is at times easily discernible and at

times less tangible and more difficult to grasp. As such, the weather can seem both ubiquitous and elusive at once, depending on one's positionality and experience of antiblackness. These more elusive manifestations of antiblack violence, I argue, are as important in my study as the more tangible ones, such as police violence and disproportionate incarceration rates. Rather than being everything, I argue here that the wake and the weather can be located anywhere. As I will show throughout this thesis, the denial and marginalisation of antiblackness and interviewees' failure to take the wake into account contribute to making antiblackness and antiblack weather seem more elusive and are, ultimately, signs of being in the wake. Here I read silences in the wake, not as an explicit act of antiblackness, but rather as a reproduction of the marginal position which antiblackness occupies in development, humanitarian and global health discourses. I do not interpret the silences in and of themselves but suggest that they are symptomatic of an inability or unwillingness to speak to the history of colonialism and antiblackness and its entanglements with the present.

Antiblackness, as I use the term in this thesis, exceeds antiblack racism. Antiblackness encompasses at once distinct eras/events that exemplify antiblack violence such as colonialism and the transatlantic slave trade as well as the antiblack racism that contributed to their realisation.[3] It designates the structures, institutions and discourses, and the underlying attitudes, patterns and conditions that negate, or work to negate, Black life and humanity. Antiblackness characterises antiblack weather, as defined by Sharpe (2016), and manifests itself in the hold; it is a characteristic of the wake. My thesis deals with antiblackness because the Ebola epidemic in Sierra Leone affected predominantly, and almost exclusively, Black people, in this case, people of African descent and because antiblackness has shaped and been shaped by British health interventions in Sierra Leone historically.[4] At the same time, I see antiblackness as holding both Black and white life (Wynter, 2006). As a consequence my analysis does not seek to point to individual failings or instances of racism, but rather to point to the antiblack patterns, structures and repetitions in which the Ebola response played out.

[3] Antiblackness and antiblack violence are somewhat overlapping terms. Antiblackness exceeds physical antiblack violence, however antiblackness is always violent. In this thesis I predominantly use antiblack violence to refer to physical violence.

[4] Here I am adapting UNISON's Black members committee's definition of Black as 'Black with a capital 'B' is used in its broad political and inclusive sense to describe people […] that have suffered colonialism and enslavement in the past and continue to experience racism and diminished opportunities […]' (UNISON, n.d.). While Black can refer to people of African, Asian and indigenous descent, I focus here specifically on people of African descent.

Black studies, rather than seeking to essentialise skin colour, takes antiblackness to be one of the foundational experiences of people of African descent in the world. This does not mean that this is the only prism through which people experience the world. Indeed, as I experienced in my research, antiblackness is often not considered or does not feature in people's accounts and self-narrations, giving way to gender or class instead. These identities intersect in their expression and oppression (Crenshaw, 1991) and shaped how research participants experienced the Ebola epidemic. However, in the thesis I focus on participants' inability to speak to the antiblackness that was entangled in the response. I do so specifically because gender and disability are increasingly being considered in global health interventions and I argue that race and ethnicity should be too. As such I analyse the inability to speak to antiblackness as contributing to its discursive and analytical marginalisation in global health.[5] In other words, these silences contribute to the denial of antiblackness in the narrations and accounts I analyse here.

Following Sharpe (2016, p.7), this thesis 'proceed[s] as if we know this, antiblackness, to be the ground on which we stand, the ground from which we attempt to speak'. Paraphrasing João Costa Vargas (2018), I take antiblackness *and its denial* to be the 'foundational fact' of Britain's relationship with Sierra Leone; a fact, which is epitomised, as I will explore, in Britain's historical and contemporary health interventions in Sierra Leone. Indeed, antiblackness and health are intricately bound up with one another. As Costa Vargas (2018, pp.x-xi) writes:

> There is no better proof of structural, long-term antiblackness than continued vulnerability to disease and premature death by preventable causes, which includes homicide by the police but goes far beyond. The litany of disproportional incidence of cardiovascular ailments; AIDS/HIV infection; various diseases caused by environmental exposure to toxic chemicals as well as insects and pests; malnutrition; deficient and unavailable health care; and cancer, is evidence of how Black lives don't matter.

On a clinical level, Arline Geronimus has argued (1992, 1996, 2013) that the persistent reality of environmental stressors (including racism) contributes to an increase in health vulnerability among African American women in the United States. In Sociology, Jo Phelan and Bruce Link (2015) have proposed that antiblack racism is a fundamental cause of inequalities in health in the United States and as early as the 1950s Frantz Fanon ([1959]1965) examined the racist dynamics inherent in health care and medicine in

[5] As indicated above, marginalisation refers here less to an act of removing colonialism/antiblackness from the discursive centre and more to a reification of its already marginal position.

colonial Algeria, where healthcare was refused to Algerian independence fighters by the French colonial government. The racist and antiblack dynamics that work their way through health policies and interventions in the US or in colonial Algeria, that affect the lives (and deaths) of Black people, warrant an investigation with regards to the Ebola response in Sierra Leone especially because, as I show in this thesis, in Sierra Leone, humanitarian interventions long exhibited an entanglement of antiblackness and (health) care.

As I indicated above, early British health interventions in Sierra Leone were the result of two periods of intense antiblack violence. In a first instance, beginning in 1787, when Freetown became the place in which freed Black slaves were resettled, new arrivals were medically examined and quarantined in King's Yard – what is now the site of Connaught Hospital - before being released into the colony. Resettlement and freedom were restrictive, as they were characterised by a period of years-long compulsory unpaid apprenticeships in the new colony. In a second instance, British colonial medicine protected the health of European settlers by using principles of sanitary segregation. Colonisers turned Freetown into a city segregated along ethnic lines, in which the health of white settlers was protected from what was deemed to be an unsanitary Black population, confined to 'native' areas and forbidden from living in white settlements. This thesis extends existing literature on health and antiblackness by showing how the 2014-15 Ebola response in Sierra Leone epitomises ongoing entanglements of health and antiblackness.

By relying on Sharpe's framework, I bring Black studies, which are originally associated with the study of the Black diaspora in North America, to bear on research on the international response to the 2014-16 Ebola epidemic in Sierra Leone. More broadly the thesis brings Black studies into conversation with postcolonial analyses of global health and with geographies of health and care. I demonstrate that Black studies offer an analytical and methodological framework to conduct a non-linear study of the international response to the 2014-16 Sierra Leonean Ebola epidemic. Specifically, this entails going back and forth in time, shifting between sites (the archive, Freetown, London) and at times returning to previous moments to consider them in a new light. This non-linearity, I argue, is key, in grasping the intangible, fluctuating ways in which antiblackness and the colonial present manifest epistemically and geographically. At the same time, I challenge the geographical and disciplinary boundaries with which we study coloniality and the colonial present. Decolonial theory, subaltern studies and

Black/African-American studies counter Eurocentric, universalising epistemologies by developing theory from local, people of colour and non-elite positionalities. However, they often do so within specific geographical boundaries. As this study considers health in relation to Sierra Leone, the region's forceful integration into the transatlantic economy and polity, long founded on antiblackness, justifies an engagement with Black studies. Postcolonial analyses and Black studies both emerged from anti-racist and anti-colonial struggles. However, Black studies take enslavement to be a central force shaping the politics and geographies of the present. In the case of Sierra Leone, whose geographies and politics were deeply affected by both enslavement and colonialism (Shaw, 2002), Black studies offer an analytical lens that helps foreground the materiality of those geographies in relation to the British-led international Ebola response. Furthermore, my research is concerned with tracing antiblackness and its marginalisation in the international Ebola response in Sierra Leone. As I show in the literature review, Black studies, more so than postcolonial theory, place emphasis on antiblackness. As such, my work joins itself to existing explorations of antiblackness in humanitarianism (for instance Benton, 2016a, 2016b). Consequently, a key contribution of this research project is to foreground antiblackness as an underlying factor in contemporary global health management in relation to West Africa.

Through its non-linear, multi-sited study of the international Ebola response in Sierra Leone, the thesis also rethinks how and where we study the colonial present in relation to global health but more generally as well. Specifically, it addresses the following main questions:

- Where and how might it be possible to locate the wake in the Ebola response?
- How does the British-led international Ebola response relate to the colonial past and present?
- How might global health interventions benefit from an engagement with Black studies?

1.4 The 2014-16 Ebola outbreak and response: The case of Sierra Leone

As this research project analyses a recent global health event some context is necessary to situate it. Despite the transnational nature of the spread of the disease during the West African Ebola outbreak, I focus in my analysis on Sierra Leone. More specifically, I focus

on Sierra Leone's administrative region Western Area and its subdivisions Western Area Urban District (Freetown) and Western Area Rural District (Freetown Peninsula). I do so mainly for methodological reasons. Historically, the Freetown Peninsula corresponds to those areas that were first formally colonised by Britain (namely the Province of Freedom and the Crown Colony) and on whose shores the transatlantic slave trade left its most discernible traces. I argue that it is in this part of Sierra Leone that the antiblackness that has shaped Sierra Leone's past underlies the development of the Ebola epidemic and response most clearly. Additionally, the contacts I had in Sierra Leone were concentrated in and around Freetown. Furthermore, a majority of health responders I interviewed and those members of the Sierra Leonean diaspora who did travel back to Sierra Leone to work on the outbreak worked in Freetown and on the Freetown Peninsula.

1.4.1 The Outbreak

Ebola or Ebola Virus Disease (EVD), is a viral haemorrhagic fever characterised by case fatality rates between 25% and 90%. Ebola's human-to-human transmission relies on direct contact with infected bodily fluids and materials contaminated with these fluids (WHO, 2019). During the West African outbreak, caused by the Zaire strain of Ebolavirus, case fatality rates were approximately 70% (WHO Ebola Response Team, 2014).[6] Symptoms of EVD include fever, vomiting, diarrhoea and in later stages haemorrhaging and confusion. Patients are only infectious once they become symptomatic (between 2 and 21 days after infection) (WHO, 2019).

The West African Ebola epidemic spread from Guinea's South-Eastern region in December 2013 to the neighbouring countries of Liberia (in March 2014) and Sierra Leone (in May 2014) (WHO, 2015), but it was only on March 23rd 2014 that the World Health Organisation (WHO) declared an Ebola outbreak in West Africa (CDC, 2019). The epidemic was declared over in June 2016. Sierra Leone's outbreak, in turn, was declared over in January 2016 (Ross et al., 2017). [7] According to the American Centres for Disease Control (CDC), Sierra Leone saw a total of 14,124 cases, 8,706 of which were confirmed Ebola cases and 3,959 deaths from Ebola Virus Disease (CDC, 2019), making it the country with the highest number of infections.

[6] Case fatality rates varied depending on the date and location of measurements. While the overall case fatality rate of the West African Ebola outbreak according to this WHO study was around 70%, late stage Ebola was in Sierra Leone characterised by a case fatality rate of 46.8% (Jiang et al., 2017) and varied between 46-76% in one ETC in Port Loko, Western Sierra Leone (Rudolf et al., 2017).

[7] Consequently I speak of the 2014-16 Ebola epidemic, but only of the 2014-15 Ebola response, to coincide with the main dates of both the Sierra Leonean outbreak and international response

In Sierra Leone the outbreak started in the east of the country, in Kailahun District, spreading first to Kenema, a city (and district) to the South, and then in late June 2014 to Freetown, the capital city, and surrounding districts leading to the 'Western Area Surge' in early December 2014 (WHO, 2015). The course of the disease's spread is depicted in the maps below (see Figure 3). The 2015 Census recorded Western Area's population at 1,500,234 inhabitants with Freetown's population exceeding 1 million (Statistics Sierra Leone, 2015). Western Area Rural has, despite its name, a high number of towns and Waterloo (where the Ebola cemetery is located) is the district capital. The majority of these towns are part of the Freetown metropolitan area. High population density in Western Area led to a rapid spread of the disease. According to the WHO, at the end of the outbreak in December 2015, Western Area accounted for more than half of Ebola infections and deaths in Sierra Leone (Lamunu et al., 2017). According to the 2015 Household and Population Census, conducted by Statistics Sierra Leone, Western Area recorded 21.6% of total Ebola cases in Sierra Leone. This includes suspect, probable and confirmed cases (Amara et al., 2015).

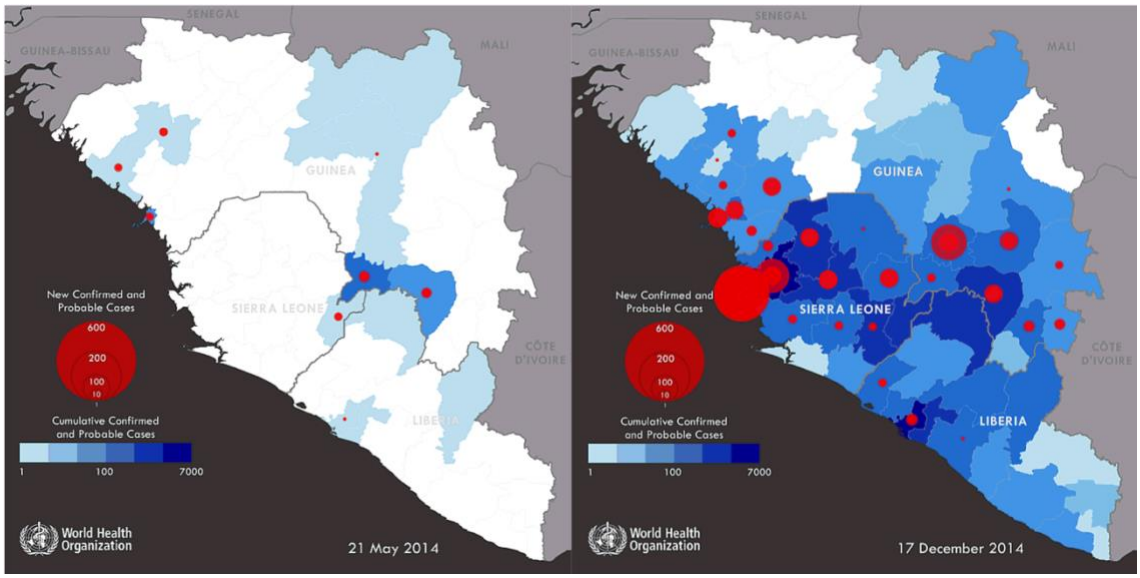

Figure 3: Spread of the Ebola outbreak from Kailahun District to Freetown May - December 2014 - Credit: WHO https://www.who.int/csr/disease/ebola/maps/en/, accessed 23/04/2019

1.4.2 The Response

This thesis focuses on the British-led international response to the Sierra Leonean Ebola epidemic and specifically on official and nongovernmental responses originating in Britain, rather than national or (other) international efforts. National and international efforts did, of course, intersect, but my focus lies on the work done by UK-based health workers and organisations working in national and internationally-run Ebola Treatment

Centres (ETCs) and Holding Units (EHUs) in Sierra Leone and the efforts by members of the Sierra Leonean diaspora residing in the UK.[8] My research also concentrates on formal care and treatment settings and therefore does not attend to community or household responses.

The British-led international Ebola response in Sierra Leone was multifaceted and multiscalar. From the beginning of the Sierra Leonean Ebola outbreak the British government and military were deeply involved in the command structure and operationality of the response. According to the Department for International Development (DFID) (2016, n.p.), '[t]he UK pushed for a leadership role in Sierra Leone, given strong historical and bilateral ties'. On the national level, and after failure to effectively tackle the early outbreak, responsibility passed from the Sierra Leonean Ministry of Health and Sanitation to the newly established National Ebola Response Centre (NERC), which was set up by a British 'Combined Joint Interagency Task Force', backed by UNMEER (the United Nations Mission for Ebola Emergency Response) and spearheaded by the Sierra Leonean Ministry of Defence in consultation with the government of Sierra Leone in October 2014 (DFID, 2016; Ross, 2017). The taskforce, a 'civilian-led command and control structure' (DFID, 2016), was headed by the DFID Director and included British military personnel and officials from the Foreign and Commonwealth Office and the Ministry of Defence. At the same time as the NERC, District Ebola Response Centres (DERCs) were established in each of Sierra Leone's 16 districts to coordinate local responses.

Financially, the UK government pledged £230 million, although in early December 2015, £125 million had been spent (PAC, 2015).[9] In addition, more than 250 UK aid staff were part of the response, over 1,500 military personnel were deployed to Sierra Leone to oversee and assist in the construction of six Ebola Treatment Centres around the country and train over 4,000 national and international healthcare workers (GOV.UK, 2016). As part of the British military response, one Royal Navy aviation support ship, the *RFA Argus*, with three Merlin helicopters was also deployed to Sierra Leone (Royal Navy, 2014). Through the NHS more than 150 health workers volunteered to work in ETCs around the country (GOV.UK, 2016).

[8] I also interviewed members of the Sierra Leonean diaspora living in Switzerland and Germany, but the vast majority of respondents were UK-based.

9 The total amount spent differs according to sources. In her update to the House of Commons on 12 March 2015 Justine Greening, the then Secretary of State for International Development, declared that the UK government's ongoing involvement would bring the 'total commitment to this response and the country's [Sierra Leone's] early recovery to £427 million'. (Greening, 2015)

While the NERC ensured the operational and technical aspects of the response, the response on the ground was largely carried out by Sierra Leonean health workers, joined by international responders, in pre-existing and newly built treatment facilities. Before the beginning of the epidemic, Sierra Leone, a country of six million inhabitants, had 136 doctors and 1,017 nurses at its disposal (Tinsley, 2018), working mostly in government hospitals, community care centres (CCCs) and private clinics. As I will show, few of these existing structures were suitable for Ebola care, which requires a spatial flow system and infection prevention and control (IPC) protocols, including the capacity to spatially isolate Ebola suspects from the general hospital population. IPC protocols include Personal Protective Equipment (PPE), such as gloves, goggles, suits, boots, as well as the capacity to safely dispose of contaminated materials. Some of the existing clinics were thus refurbished to meet the standards required for Ebola care. The majority of previously existing clinics, however, were shut. This was due to a combined high risk of healthcare worker and patient infections and to them being unsuitable for Ebola care. To remedy the shortage of beds (WHO estimated in September 2014 that more than 500 additional hospital beds would be needed; WHO, 2015) the British military with local contractors and the Republic of Sierra Leone Armed Forces constructed 6 additional purpose-built facilities and supported 700 treatment beds (HM Government, n.d.; Bricknell et al., 2016). British NGOs worked with the NERC to supply food to quarantined households and medical equipment, trained healthcare workers and burial teams, and funded community sensitisation officers. The Sierra Leonean diaspora in the UK in turn, raised funds, purchased and shipped medicines and medical equipment and trained NHS staff in Sierra Leonean cultural awareness before their deployment. Due to their engagement, the diaspora was heralded as 'an alternative model of international humanitarianism' (Purvis, 2014; Rubyan-Ling, 2019, p.218). My research analyses the response at both ends of the spectrum: I consider big purpose-built facilities run by British/international NGOs as well as diasporic efforts, through online petitions, to lobby British Airways to reinstate direct flights to Sierra Leone. At the same time, due to the complexity and size of the response, this thesis should not be seen as an exhaustive analysis of the British-led international response to the Sierra Leonean Ebola outbreak.

1.5 Chapter outline

In chapter two I offer an in-depth discussion of the literature that informs my conceptual framework: Black Studies and geographies and, to a lesser extent, ontopolitics and

mobilities literature. I show that Black studies and geographies offer useful tools to the study of global health in postcolonial Africa, but that my analysis challenges the discipline's traditional geographical boundaries and fields of analysis.

In chapter three I review the literature relevant to this research project, namely, literature on Sierra Leone, on biopower and biopolitics and the politics of (global) health including the West African Ebola epidemic. Existing literature on the 2014-16 Ebola epidemic and response in Sierra Leone, while taking the violent nature of the epidemic and of certain response mechanisms into account, does not relate this violence to the historically antiblack environment in which the epidemic occurred. The chapter highlights that despite valuable insights in existing academic work on Sierra Leone and its colonial past, Black geographies and critical approaches to global health have not been jointly considered with regards to the Ebola outbreak. This disconnect in the literature contributes to the marginalisation of antiblackness and to its normalisation in global health practice. It also leads to academic global health analyses of the epidemic that reproduce colonial imaginations of Sierra Leone as a de-historicised, apolitical space for health interventions. By critically summarising the different analytical fields, I show what each can contribute to my research project, while also demonstrating how a conceptual framework drawing on Black studies allows a centring of Black perspectives and a critical analysis of antiblackness in global health, which so far remain marginal.

In chapter four I explain my methodological approach to studying the British-led international response to the Sierra Leonean Ebola outbreak. I outline how studying antiblackness and the colonial wake requires a non-linear approach involving multiple sites and research methods. I summarise the scope of my research, from an ethnographic approach to studying archives of British colonial disease control in London, to in-depth, semi-structured interviews with healthcare workers and members of the Sierra Leonean diaspora, and fieldwork in Sierra Leone and ethnographic observations in the UK. Studying the response across a variety of sites and using combined archival, interview and ethnographic approaches responds to the elusiveness of both the wake and antiblackness in the Ebola response. The chapter also underlines the delocalised nature of antiblackness in global health and follows Sharpe's (2016) approach in adopting a methodology that attends to antiblackness in unexpected sites. My thesis follows Sharpe (2016, 2018) in advocating for a methodology of care for Black life in the wake that assumes 'antiblackness to be the ground on which we stand, the ground from which we

attempt to speak, for instance, an “I” or a “we” who know, an “I” or a “we” who care’ (Sharpe, 2016, p.7).

Chapter five ‘The wake and the weather: place, weather and disease control in (post-) colonial Freetown’ examines Freetown’s colonial present with regards to infectious disease control interventions. It takes as its framework two of Sharpe’s (2016) chapters, namely ‘The wake’ and ‘The weather’ to analyse the material and atmospheric traces of colonialism and enslavement that underlay health workers’ practices during the 2014-15 Ebola response. It argues that the weather, both meteorological and antiblack, underlay the response in a place in which meteorological weather has long been tied up with colonial medicine and antiblackness. This chapter draws on archival research on British colonial disease control in and in relation to Sierra Leone and on interviews with health responders who worked in two types of Ebola treatment facilities. The chapter shows the simultaneous presence of antiblack traces and remains in Freetown and surrounding areas and their absence in health responders’ narrations of the response.

Chapter six ‘Colonial mobilities and infrastructures: the production of (anti-)Blackness’ takes mobilities as its starting point to analyse the production and regulation of Blackness. I analyse how the mobilities linking Sierra Leone and the United Kingdom produce Blackness in reference to a colonial-racial hierarchy that holds both places and the mobilities that link them. In this chapter I study how antiblackness is entangled in routes, aeromobilities and the human and material infrastructures that support them. Specifically, I investigate how the regulation of flows between the UK and Sierra Leone historically, during and in the wake of the 2014-16 Ebola outbreak reflects the shifting production of Blackness as deviance or dependency. At the same time, I show that diasporic mobilities also contribute to imagining Sierra Leone as a place of economic opportunity and highlight the ambiguity of a Black mobile ontology.

Chapter seven ‘Wakefulness: epistemic spaces, flows and epigrammatic antiblackness’ explores antiblackness in relation to expert spaces and flows of expertise. Here I focus on expertise in order to foreground embodied epistemic hierarchies and spatial processes of knowledge production and exchange that reproduce and marginalise antiblackness in global health. Defining expertise as relative epistemic specialisation and authority, I examine how in the case of the Ebola epidemic and response, expert knowledge is tethered to and produced through colonial-racial hierarchies. Specifically I offer

ethnographic observations on how antiblackness is discursively marginalised and spatially enabled in two epistemic spaces that were part of my fieldwork. This is followed by an analysis of epistemic flows, which builds on my analysis in chapter six. I argue that mobility regulations during the epidemic deepened the coincidence between whiteness and expertise. At the same time, by showing how members of the Sierra Leonean diaspora became experts of both EVD and IPC I argue that aforementioned colonial-racial hierarchies were somewhat disrupted, all the while reifying the UK as epistemic centre.

Chapter eight 'Thinking and practicing care: violence, risk and the spatialisation of 'always-imminent death'' engages Sharpe's (2016, 2018) conceptualisations of care to analyse international responders and stakeholders' narrations of the Ebola response, and epistemic, emotional and spatial care practices in particular. The chapter explores how three factors (the absence of an Ebola cure, the highly infectious nature of the disease and the emergency setting in which the response took place) shaped how international responders practiced care in purpose-built and refurbished Ebola Treatment Centres (ETCs) and Ebola Holding Units (EHUs). This chapter draws on and grapples with Annemarie Mol's (2002) ontopolitics as both a research field and methodology to reflect on care's spatial and material reality. I extend Sharpe's (2016) writings on 'the possibility of always-imminent death' geographically to offer a critical Black analysis of care work in ETCs and EHUs during the Sierra Leonean Ebola epidemic. I also use Sharpe to reflect on research participants' inability to think the response otherwise, that is to say to think it outside of the confines of colonial relations of power.

Chapter nine, the conclusion, recalls the research aims, questions and findings of this research project. It reiterates the reasons for placing the 2014-15 British-led Ebola response in Sierra Leone in the wake and brings existing analytical threads together. It summarises how Black studies can contribute to an analysis of the British-led international Ebola response in Sierra Leone by enabling a foregrounding of the material, epistemic and symbolic persistence of antiblackness. It recalls that this thesis elicits a nuanced understanding of Sharpe's (2016) concept of the wake and extends it by presenting a 'geography of the wake' focused on West Africa's historical encounters with antiblackness. The thesis makes the case that analysing the 2014-15 British-led Ebola response in Sierra Leone in the wake of antiblack violence allows a rethinking of how and where we study the colonial present. Overall it proposes that ideas from Black studies should inform further research on global health in terms of unpacking postcolonial

silences, centering Black perspectives and highlighting the endurance of colonial infrastructures.

chapter TWO

2 Theoretical framing

In this chapter I outline the theoretical framing of my project by situating Christina Sharpe's (2016) work *In the wake: on blackness and being* amid relevant literatures from the fields of Black studies and Black geographies. I do not offer an in-depth reading of Sharpe (2016) here as I engage with her throughout the thesis. Here I show that although Black studies have so far rarely been used to analyse and critique international epidemic and humanitarian responses in formerly colonised countries, their focus on the ubiquity of antiblackness, unsettling of temporal linearity, focus on the aftermath of enslavement and colonialism and finally the spatialisation of the wake structure and shape my analysis in this thesis. In line with the thesis, which points to the absence and marginalisation of antiblackness as analytic lens in global health, here, and in the ensuing literature review, I show that global health remains marginal in Black studies and geographies. As such this is not an exhaustive overview of Black studies literature. Rather I present the literatures and analyses that are central in Sharpe's (2016) work and how I understand/relate to them in my thesis. This is followed by a short overview of secondary literature, which guided my analysis in select empirical chapters, notably work on mobilities and ontopolitics.

A word about race and ethnicity: I generally agree with Ramon Grosfoguel (2004) in arguing that rather than sticking to the traditional definitions of race as biological/pseudoscientific and ethnicity as cultural traits, the colonial present can only be transcended by recognising how these two categories work together as 'racial/ethnic identity'. However, in this thesis I largely speak of race, rather than ethnicity. This is due to the fact that I analyse Blackness as a shifting, racialised signifier, which, in the texts I analyse transcends ethnic identity. Here I follow Stuart Hall's (Hughes et al., 1997) lecture on 'Race – the floating signifier' in understanding the meaning of race as "relational and not essential". As Hall argues race can "never be finally fixed and is subject to the constant process of redefinition and appropriation." I explore this process of redefinition with regards to Blackness in the context of health and disease in this thesis.

2.1 Situating Black Studies, situating *In the wake*

Black studies, also referred to as Africana Studies or African American Studies, are concerned with the social scientific and literary study of people of African descent,

predominantly in North America as well as with the practice of establishing and teaching the subject in academia. The field is firmly rooted in and emerged out of North American and especially US American universities and is characterised by its interdisciplinarity and its historical focus. While both Africana and African-American studies nominally focus on the Black diaspora in the Americas, Black studies, nominally, affords a more universal scope to the study of the Black diaspora and has taken institutional forms outside North America, as in the Black Studies undergraduate degree at Birmingham City University, the first of its kind in Europe. However Black studies are still a marginal discipline and accessing a wide range of scholarly materials in a British university library was at times difficult.[10]

Black studies analyses of medicine and medical practice are limited. Rather than attending to them here, I discuss them, where relevant, in my literature review. Here I show that although Black studies and geographies have not explicitly dealt with issues of global health or health governance on the African continent, *In the Wake* (2016) and the works it is in conversation with offer a stimulating and innovative analytical framework for my study of global health. My thesis thus works to connect these varying fields and to fill the existing analytical gap. Here, I offer insights into those aspects of Black studies that are relevant in my thesis. Since my theoretical framework predominantly draws on Sharpe's (2016) work, a majority of the literature I introduce and make reference to here are works that Sharpe is in conversation with. I especially focus on the concepts of antiblackness, afro-pessimism and Black geographies and lay out how I interpret them in this thesis. While much Black studies scholarship is intersectional and considers the coproduction of race and sexuality, embracing Black feminism and Black queer scholarship, I do not address these in specific detail in my thesis and this is undoubtedly one of the main limitations of my work.

2.1.1 Antiblackness, Afro-pessimism and the aftermath

Although first emerging in the 19th century through the seminal works by George Washington Williams and W.E.B. Du Bois (Bobo et al., 2004; Banks, 2012) I focus here on more recent Black Studies literature. While early works often took the form of sociological and historical treatise of Black life in the United States, more recent work has increasingly dealt with the contemporary pervasiveness and ubiquity of antiblackness

[10] For an extensive list, LaToya Eaves (2016), a Black queer geographer, compiled a Black Geography reading list: https://twitter.com/spacedemands/status/776698987709194240

both in the US and globally. Sharpe for instance (2014, p.59) has called for Black studies 'to be […] a continued reckoning [with] the longue durée of Atlantic chattel slavery, with black fungibility, *antiblackness*, and the gratuitous violence that structures black being […]'. Here I begin by focusing on antiblackness. On the one hand antiblackness is a more focused concept than racism in that it relates to people of African descent exclusively; on the other hand it is more all-encompassing. In this thesis I follow Wynter's (2006), Gordon's (1993) and others' declaration that we live in an antiblack world. Indeed the aim of a majority of Black studies literature is to provide evidence of this continued antiblackness. Writing about the advent of Black studies, Sylvia Wynter (2006, n.p.) writes the following:

> You see, it's not just an intellectual struggle. […] It was an understanding that, as Lewis Gordon has been the first to keep insisting, we live in an anti-Black world – a systemically anti-Black world; and therefore whites are not [simply] "racists". They too live in the same world in which we live. The truth that structures their minds, their "consciousness", structures ours.

Here, Wynter, (2006) draws attention away from individualised instances of antiblack racisms, to the systemic, ubiquitous nature of the antiblack world that we live and think in. As such, a focus on racism, or even antiblack racism is too narrow and does not do justice to the ever-changing, persistent and pervasive nature of antiblackness. The works that I present here attest to the reality of the antiblack world, a world that is shaped by more than racism. Importantly, in Wynter's (2006) interview antiblackness does not only damage Black lives, but shapes the very possibilities of white alliance and solidarity. This is reflected in my thesis. My analysis is less focused on individual racism and rather on the antiblack world in which the British-led international Ebola response took place. As such, antiblackness, rather than racism constitute the conceptual centre of my work.

An important work that helped me articulate the argument at the centre of my thesis is João Costa Vargas' (2018) *The denial of antiblackness: Multiracial redemption and Black suffering*. Vargas' (2018, p.1) book explores 'the simultaneous acknowledgement of Black suffering and the denial of foundational and structural antiblackness' in Brazil and the US. Vargas (2018, p.28), similarly to Wynter (2006) argues that antiblackness exceeds antiblack racism, arguing that

> Antiblack racism – and more broadly, aversion to all that is related to and suggests blackness, antiblackness – is thus structuring and inescapable unless and until the very structures of our cognition and sociability are deeply transfigured, removed, destroyed.

Also similarly to Wynter he argues that antiblackness affects Black and non-Black life, although to differing degrees of implication. Importantly, Vargas studies the denial of antiblackness in the Americas. My project, while similarly framed, deals with the silencing and the marginalisation of antiblackness in global health in relation to West Africa. In global health, as I show, antiblackness is an under-researched phenomenon, whose consequences, in comparison to the police violence, urban war on drugs and prison-industrial complex, which lie at the heart of Vargas' work, have not been explored.

Black studies have focused on a variety of issues affecting people of African descent in North America and beyond. *In the wake* (2016) itself reads like a guide to and through Black studies, covering politics, history, art, sociology and media. Two major currents that structure and shape debates in contemporary Black studies are 'Afro-pessimism' and 'Black optimism' or 'Afro-optimism'. Afro-pessimism, which I focus on here, since it encompasses Christina Sharpe's work and thinking and, subsequently, my own, originated with Orlando Patterson's (1982) book *Slavery and Social Death*, an in-depth study of systems of enslavement across different times and continents. In afro-pessimism the idea of social death, which according to Patterson (1982) characterises the condition of the slave, is attached to and shapes ontological Blackness today. In afro-pessimism, the aftermath of slavery and the condition of social death constitute a Black diasporic reality (McMahon et al., n.d.; Sexton, 2012; Sharpe, 2016). Black optimism on the other hand argues that ontological Blackness precedes antiblackness (Moten, 2007, 2009). This is not to say that it disavows the veracity of the continuous reality of social death, but it, emphasises Black social life beyond criminalisation and resisting antiblackness (McMahon et al., n.d.).

Jared Sexton (2012) in his discussion of afro-pessimism, drawing on Lewis Gordon (2010) and on Orlando Patterson (1982) analyses the very ontology/ontological negation of Blackness in the post-slavery moment. He also interrogates the difference between black optimism and afro-pessimism. Contrary to Fred Moten (2007, 2009), a proponent of Black optimism, Sexton argues that Black social life exists and plays out *in* social death. Sharpe's (2016) work follows the same overarching logic in that her discussion of scholarly resistance, her appeal, following Sylvia Wynter, to undo the 'narratively condemned status' (Wynter, 1994, p.70) that Black life finds itself in, is embedded in a larger discussion of the ongoing forces of antiblackness, enslavement and colonialism.

Afro-pessimist literature is not limited to the fields of history, cultural studies and sociology, in which it can regularly be found, but encompasses other genres, such as the poetry of Dionne Brand, which Sharpe (2016) heavily draws on. Moreover, afro-pessimism, at its root, exceeds the Black Studies' focus on the ongoing violence of antiblackness in the Americas. Black studies scholars use the term to denote the ongoing effects of enslavement, racial and sexual violence and the commodification of Black life. The origins of Afro-pessimism are however more Africa-centric. The term originates in Congolese writer Sony Lab'ou Tansi's ([1990] 2007) '"An open letter to Africans" c/o The punic one-party state' in which he writes:

> In the present situation, our tragedy is that Africa does little thinking, trades badly, and is even worse at buying. To crown it all we use a simple and poetic expression to describe this tragedy: afro-pessimism, a terrible word used to conceal the greatest mess of all time. We accept smiling that history (which, incidentally has cuckolded us more than once) makes of us the victims of a shameful chill: the North-induced chill in the prices of raw materials that dooms us to construct and build garbage economies in the depths of the most cruel, unbearable, and inhuman form of indignity that humans can swallow without as much as a retch.

I focus on this 'African' origin of the concept of afro-pessimism because it is in line with my overall strategy of using Black studies, and afro-pessimist literature in particular, to analyse the 2014-15 British-led Ebola response in Sierra Leone. Toussaint Nothias (2012, n.p.) traces this 'original' use of afro-pessimism in relation to media coverage of Africa. He argues with Beverly Hawk (1992) and Martha Evans (2011) that racialisation is an integral aspect of afro-pessimism, stating that 'African as used in western media is a colonial label that encompasses the racial category of 'blackness''. In my thesis, African-ness and Blackness overlap. This is not the result of an analytical focus on skin colour, but rather a result of a historical framing of people of African descent both under chattel slavery in the Americas and colonialism in Africa as dependent, deviant and ontological non-being.

Sexton (2012, 2016), Moten (2009), Gordon (2010) and McMahon et al. (n.d.) point to the writings of Frantz Fanon, and notably *Black skin, white masks* as a foundational text in afro-pessimist literature. Especially Fanon's ([1952] 2008) theorisation of the pathologisation of racism and its concurrent internalisation (what Fanon calls epidermalization) influences contemporary afro-pessimist theorisations on Black ontology. Here the link between Black studies' take on afro-pessimism and early afro-pessimist foci on decolonisation and race in Africa, become visible. In my work I

bring these two variants of afro-pessimism, the Black studies critique and the geographical and historical field, back in conversation with one another.

While I do not centre Black analyses of gender and sexuality in my thesis, I nonetheless argue with Jared Sexton (2012, n.p.) that Black feminism is 'the ground wire of Black studies' and draw on a number of Black feminist authors. This is in line with Sharpe's (2016) work which engages with Saidiya Hartman, Hortense Spillers, Dionne Brand and Sylvia Wynter. Here I present those works that are in line with my analytical strategy with regards to their conceptualisation of the aftermath of slavery and colonialism by Hortense Spillers, Sylvia Wynter and Saidya Hartman, rather than Dionne Brand's poetry.

Spillers' seminal work 'Mama's baby, Papa's maybe: An American Grammar book' (1987) rethought the entanglements of race and sexuality to offer an overture for a Black feminist critique of post-slavery USA. Notably Spillers (1987) argued that the aftermath of slavery, the continuation of antiblackness, cannot be fully understood without coming to terms with the centrality of the subjugation of Black womanhood during chattel slavery and beyond and the key role that Black women were forced to play, through sexual and racial violence, in the production of slavery.[11] Spillers argues that Black women are, at the time of her writing, still made responsible for the marginalisation and ontological non-being of their Black children.

Wynter's complete oeuvre, which covers novels, plays and non-fiction essays interrogates humanness from an anti-colonial and Black studies perspective. As McKittrick (2015, p.2) writes: '[In Wynter's work] the question-problem-place of blackness is crucial, positioned not outside and entering into modernity but rather the empirical-experiential-symbolic site through which modernity and all of its unmet promises are enabled and made plain.'

Finally, Sharpe (2016) draws heavily on Hartman's work. Hartman, like Sharpe, is firmly rooted in the afro-pessimist tradition of Black studies. Her (2007) monograph *Lose your mother – a journey along the Atlantic slave route* examines Black identity and the loss thereof in the aftermath of the transatlantic slave trade through her personal journeys in contemporary Ghana. This theme builds on her (1997) seminal work *Scenes of subjection – Terror, slavery, and self-making in nineteenth century America*. In *Scenes of Subjection*, Hartman (1997) attends to the unfamiliar, normalised, humanity-affirming

[11] I refer here, as do Spillers (1987) and Sharpe (2016) to the legal principle of *partus sequitur ventrem*, which stipulated that the children of enslaved women would inherit the mother's legal status.

scenes of white dominance and Black subjugation to argue that the power relations they display work their way through the aftermath of chattel slavery and shape Black American ontology today. Similarly to Hartman's work, I locate antiblackness in global health/humanitarian interventions, a field which works to affirm and safeguard humanity and in which, as I show, antiblackness is normalised.

The intersectional making, construction and (non-) being of Blackness are at the core of much Black studies literature. The aftermath, and the antiblackness that continues to characterise it, are central themes in Black studies literature. My thesis is influenced by these themes: it follows the afro-pessimist tradition in that it accepts the continued structuring power of antiblackness in the aftermath of enslavement and colonialism. At the same time I use Black studies and Sharpe's (2016) work in particular to analyse a global health event that took place in West Africa, rather than on the Western side of the Atlantic. In the next section I explore geographical aspects of Black studies in more detail to show how they influenced and framed my work.

2.1.2 Black geographies

Apart from Sharpe's (2016) *In the wake* I draw in this thesis on Black geographical sensibilities. Black studies work is inherently geographical in that it spans different geographical areas, mobilities and spatial politics. For instance both Sharpe's (2016) and Hartman's (1997) work implicitly attends to the spatiality of antiblackness and Black life in different places (the plantation, the transatlantic, the slave ship, the city). My research however is more explicitly geographic. I researched and analysed global health-related mobilities, places of care and the spatialisation of the colonial wake in relation to the 2014-15 international Ebola response in Sierra Leone. In this sense, my thesis draws on work by Katherine McKittrick's (2006) and other Black geographers. While I am aware of the variety of Black geographical works both in the US and the UK and specifically a US focus on plantation geographies and the spatiality of the prison-industrial complex (Gilmore, 2007) or what Rashad Shabazz (2015) calls 'carceral power', I largely eschew analyses of these themes as they fall outside of the remit of my research project. Instead I follow Caroline Bressey's (2014a, 2014b) and Saidiya Hartman's (1997) approach in attending to Blackness, anti-racism and antiblackness in unexpected sites as well as Patricia Noxolo's (2006) lead in analysing places in relation to the places that constitute them. Here I focus on how Black geographies and McKittrick's (2011) 'black sense of place' shaped my thinking about space and antiblackness in Sierra Leone.

Black geographies work, among other things, to uncover Black mobilities and the a-spatiality of Black life. Adam Bledsoe and Willie Jamaal Wright (2019) for instance argue that capitalism relies on Black a-spatiality, the idea that spaces inhabited by Black people are open to be claimed and dominated. This, as I show, is a reality that shaped Sierra Leone during the Ebola epidemic, in which a majority of decisions about Sierra Leone were taken in London. This was also the case in the government of treatment centres which were predominantly run by international NGOS and agencies. It also serves to describe the Black (British-directed) colonisation of Sierra Leone, which barely took indigenous and /or prior land uses into account.

Similarly, McKittrick describes the 'ungeographic' nature of Black life (2013), that is to say the historical and contemporary lack of Black space-making power in North America. McKittrick (2013), shows how past antiblackness holds the present and shapes spaces of the future. Notably she (2013, p.11) argues that the city can be seen as the 'commercial expression of the plantation and its marginalised masses'. Following McKittrick's (2006, 2011, 2013) innovative work on Black geographies I adhere to her conceptualisation of a 'black sense of place' (2011) as a place that accepts that landscapes are not 'comfortably situated in the past, present or future' (McKittrick, 2006, p. 2). Geographies of the wake, which I analyse in this thesis in the case of Sierra Leone, enable an understanding of place that vacillates between past antiblackness and the postcolonial present in which the Ebola response took place. McKittrick (2011, p. 949) proposes various definitions of a black sense of place, but I concentrate on a 'black sense of place' as 'a sense of place wherein the violence of displacement and bondage, […] extends and is given a geographic future' (Hirsch, 2019b).

In *Demonic Grounds*, McKittrick (2006) lays the groundwork for Black feminist geographies. Importantly for my work, McKittrick (2006) explores and maps Black geographies that are not immediately tangible. She writes (2006, p.33)

> Reconstructing what has been erased, or what is being erased, requires confronting the rationalization of human and spatial domination; reconstruction requires "seeing" and "sighting" that which is both expunged and "rightfully" erasable. What you cannot see, and cannot remember, is part of a broader geographic project that thrives on forgetting and displacing blackness.
>
> The spatial dilemma – between memory and forgetfulness – produces what has been called a black absented presence.

Here McKittrick offers a guide to Black geographies and to the work I undertake in this thesis. While McKittrick (2011), similarly to Sharpe (2016), writes about Black being in the American diaspora, I extend her analysis of how past experiences of antiblack violence create a present understanding of and relation to place and geography in Sierra Leone. The particular relevance of placing the Ebola response in the wake comes from the spatial anchoring that entanglements of care and violence have taken in relation to Black life in Sierra Leone.

2.2 Other frameworks

In the second part of this chapter I briefly introduce other literature, which contributed to my thinking and writing throughout this thesis. Notably I attend to literature on mobilities and ontopolitics. Although they do not frame the overall conceptual contributions of my thesis, they nonetheless contribute to my argument and analysis in the empirical chapters. Furthermore I argue that my work contributes to debates in both fields.

2.2.1 Mobilities

To date Black explorations of mobilities are marginal at best (Nicholson, 2016; Nicholson and Sheller, 2016). Some mobilities authors have however pointed towards the importance of experiential accounts of mobility and mobility practices (Adey, 2006) or the colonial past of mobility infrastructures and methods (Sheller, 2016). My thesis developes these themes. Here I briefly introduce critical mobilities that take colonialism and race into account before introducing the field of emergency mobilities.

Critical Mobilities

The mobilities turn in social sciences has brought about an increasingly critical exploration of movement, flows and circulation in the making of modern societies. The new mobilities paradigm (Sheller and Urry, 2006) called for a progressively politicised reading of mobilities, especially in terms of spatial inequalities and mobility power. As Hagar Kotef (2015, p.4) points out, in the liberal tradition of mobility research, the close association of freedom and mobility came hand in hand with conceptions of some human movement as dangerous and undesirable. As I explore in the thesis, different conceptions of groups of people and their relation and entitlement to movement have been at the heart of imperial and antiblack justifications of colonisation and foreign intervention. These juxtapositions are still at work in contemporary disaster governance (Keil and Harris,

2009; Sheller, 2016). I argue that an understanding of how modern mobilities were conceived and remain entrenched in colonial ideas of who is allowed to move and who is not signals the colonial wake. By focusing on mobilities between Sierra Leone and the UK during the Ebola epidemic, I develop an analysis that shows that these mobilities are still shaped by colonial and antiblack dynamics

Doreen Massey (1992, p.61) comments on the unequal power that individuals hold over movement, how it affects, empowers or disenfranchises them, how some individuals are active in its enactment and others are passively mobilised or immobilised. The idea that mobilities can not only be governed, but are in themselves a powerful mode of governing and the making of human and spatial interaction (Adey, 2006; Baerenholdt, 2013) is at the core of my analysis. However, in my thesis I also exemplified mobilities' emancipatory power by analysing the Sierra Leonean diaspora's post-Ebola mobilities.

These themes evoke the concept of mobility justice (Sheller, 2018), namely the concern surrounding unequal access to and practice of movement and the legal infrastructures on which these rely. How mobility and spatial justice play out within (post)colonial health emergencies has only marginally been theorised and my study contributes a critical reading of the antiblackness and coloniality that continue to underlie global health mobilities.

Mobilising emergencies

Emergency mobilities make up a small yet critical part of the mobilities literature. This work predominantly analyses and examines relations between humanitarian catastrophes and the flows these generate and are subject to. In the case of epidemic emergencies, the movement of people is not the only movement of interest. A number of authors have studied emergency mobilities from the vantage point of biosecurity, focusing on disease vectors (Redfield, 2008; Adey, 2009; Dobson et al., 2013). These works spend little time centring the link between disease control, antiblackness and coloniality in practices of biosecurity. My writing explores, and to a certain degree filled, this gap, by drawing on approaches to emergency mobility literature that have more actively engaged with critical analyses of the colonial origin of disease control mechanisms and practices.

Mimi Sheller for instance argued (2016, p.16) that not only does a study of humanitarian mobilities of the 2010 Haiti earthquake need to take the historical constitution of the Caribbean into account, but also that 'postcolonial, biopolitical, and geo-ecological aspects of uneven mobilities' have been marginalised in recent and current

mobilities research. She therefore calls for a closer examination of the colonial and imperial pasts of mobilities and mobility technologies. Drawing on Black studies, I rendered an account of epidemic management in Sierra Leone that not only looked at the colonial history at work in the making of both the epidemic and its response, but that illustrated the need for epistemic and mobility practices and the technologies they rely on to be analysed in terms of their reproduction of coloniality and antiblackness.

An analysis of the use of mobility technologies and infrastructures in humanitarian emergencies is crucial for understanding the exacerbation of pre-existing mobility gaps. As Adey (2016) has pointed out, the role of foreign emergency interventions is to regenerate ordered movement. Sheller (2012) argues that information gathering tools that are used in the case of emergencies are often grounded in neo-colonial power relations, reinforcing a gap in which the Western responders' gaze ultimately relies on privileged technologies that were sometimes developed as tools of colonial governance. I follow a similar logic in my analysis of the material and human infrastructures that the British-led Ebola response in Sierra Leone relied on.

As Sheller (2016) points out in her research on emergency mobilities, this uneven mobility dynamic was worsened in the case of Ebola in West Africa. The widespread use of quarantine, isolation, cordon sanitaires and localised curfews, made the mobilisation of international responders and logistical supplies appear even more drastic, especially in light of severely reduced commercial airline traffic into and out of the region. I built on Sheller's critical accounts of mobility and their colonial implications yet have strived to study these mobilities not solely as reminiscent of colonial and slavery practices but as actively reproducing antiblackness.

2.2.2 Ontopolitics

The third theoretical orientation that I engage with in my research is ontopolitics. The term ontopolitics was coined by Annemarie Mol (1999, pp.74-75) in work that extended the concerns of actor-network theory. According to Mol (1999, p.78) performance and intervention 'suggest a reality that is *done* and *enacted* rather than observed'. In contrast with constructivism and perspectivism, the researcher deals with ontologies, rather than multiple perspectives on a single reality. Ontopolitics 'defines what belongs to the real, the conditions of possibility we live in' (Mol, 1999, pp.73-74) coupled with the awareness that only a few of these possibilities are enacted at any given time (Mol, 1999, p.80). As Mol (2002, pp.4-5) puts it, 'objects come into being - and disappear - with the practices in which they are manipulated. And since the object of manipulation tends to differ from

one practice to another, reality multiplies.' Knowledge and knowing become a matter of process and performance, rather than stable things, which in turn unravels fixed epistemic hierarchies. Ontopolitics' central focus is on practices, and the constitution of objects through practices and by doing so questions single, fixed hegemonic accounts of realities. This is in line with a critical Black studies approach, which questions the hegemonic white interpretation of reality. Mol's reading, which focuses on medical practice, is however delinked from race and/or colonial politics.

Mol (2002, p.151) recognises the complexities in studying diseases and consciously decides to exclude consideration of gender, race, or nationality of patients and carers from her study. The postcolonial context of my study, and the decision to place the Ebola response in the colonial wake however, means that this is exactly the point where my research starts. This political choice, which Mol avoids, is, I argue, crucial to an understanding of the multiple ways in which the Ebola response played out. Here I analyse a reality of the Ebola response in which antiblackness and colonial power relations still shape life in the wake.

2.3 Conclusion

Here I have outlined my theoretical approach as it frames my reading of other literatures, my methodology and my writing. I have started by presenting some of the works in Black studies that Sharpe (2016) draws on and is in conversation with. I have honed in on afro-pessimist literature and readings of Black ontology in the aftermath of enslavement and colonialism. Although Black studies have seldomly been used to study epidemic or humanitarian interventions in formerly colonised societies in Africa, I show throughout this thesis that they can enrich a reading of the 2014-15 Ebola response. At the same time, as I show in my empirical chapters, my thesis contributes to existing writings on Black studies and geographies.

In the second part of this chapter I have outlined literature on mobilities and ontopolitics, which influence my analysis in select empirical chapters. The mobilities turn has seen the emergence of more critical accounts that have engaged with the colonial and postcolonial dynamics of emergency mobilities in particular. However, existing analyses of Black mobilities are largely restricted to the US (Nicholson, 2016; Nicholson and Sheller, 2016). Ontopolitics offer a useful approach for studying medical practice, Despite Mol's (2002) apolitical conceptualisation of ontopolitics, her practice of reading multiplicity into ontology is in line with my research project in that it accepts the

existence of multiple ontologies. Here I politicise ontopolitics and use them to analyse the spatial realities of medical care practices in the colonial wake. Black studies especially influence my reading of the different fields of literature I present in the next chapter, my methodology and analysis.

chapter THREE

3 Literature review

3.1 Introduction

In this literature review I assemble and work through four bodies of literature that I believe can inform a critical examination of the 2014-15 British-led international Ebola response. Here I review social sciences literature on Sierra Leone, biopower and biopolitics, the politics of (global) health and the 2014-16 Ebola epidemic in Sierra Leone. I discuss these literatures to locate my research in relation to existing scholarship on these topics and in order to evaluate how they relate to my theoretical positioning and goals. As this is a geographical analysis, I highlight spatial analyses if and when they are written about. Overall I show that although critical accounts that take issues of race and postcolonialism into account exist in all four bodies of literature, few approaches have embraced Black studies or geographies, and antiblackness as a concept is largely absent.

3.2 Situating Sierra Leone

3.2.1 Overview

Sierra Leone has mostly been studied in terms of the transatlantic slave trade, colonialism and the civil war. In this section I work through aspects of this literature and provide some historical context for the study of the wake in Sierra Leone. I then focus on a number of studies in order to situate Sierra Leone in a more critical way in relation to questions of antiblack violence, modernity, power and spatial strategies.

The majority of literature on Sierra Leone that has considered the pre-colonial history of the country focuses on the slave trade. The most prominent study is Walter Rodney's (1980) PhD thesis, which can be read as a precursor to *How Europe underdeveloped Africa* (1981). Both focus on a political and economic description and critique of European involvement in Africa. Rodney's thesis, based on predominantly Portuguese archival sources, focuses on the early integration of the Upper Guinea Coast (including Sierra Leone) and its people into the global capitalist world and its economy by means of the slave and 'legitimate' trades (Goddard, 1970, p.626; Wallerstein, 1986, p.332). The

Portuguese archives are politically important, since they were the first Europeans to permanently settle on Sierra Leone's coast in the early 1600s. Incidentally, they named the country 'Sierra Leone' [from Portuguese 'Serra Lyoa' – Lion Mountain] Butlin, 2010, p.59), because they suspected lions in the mountains near the coast (Gberie, 1998, p.26).

Rodney (1980, p.332) describes the region's historical development from an early Portuguese settlement in the 16th century up to what he describes as its ultimate integration into the 'network of international capitalism' in the 1800s. His analysis of the trans-Atlantic slave trade is Marxist in nature. As such, he theorises the slave trade as being the result of 'the impact of imperialistic capitalism' (Hair, 1971, p.444) and the maintenance of a highly-classed society. This early integration into the global economy leads Rodney to question anthropological notions of a pre-colonial traditional Africa (Wallerstein, 1986, p.332).

Rodney argues (1980, p.95) that the Upper Guinea Coast is 'in many ways a classic region for the study of the Atlantic slave trade' and differentiates between two major episodes of the slave trade: 1562 to 1640 and 1690 to 1800. During the former period, the majority of slaves were destined for the Cape Verdes and the Iberian Peninsula, then on to Brazil and the Spanish Antilles and Americas. The latter period saw the prevalent Portuguese leadership in slave trading replaced by British, Dutch and French ships (Rodney, 1980, p.243). There was also a transition from raiding to trade as the main means to procure slaves (Rodney, 1980, p.253).

Between 1690 and 1800, the toll that the enslavement of thousands of people took on Sierra Leone was increasingly reflected in changes to demographic and housing patterns (DeCorse, 2015, p.206). According to Rodney (1980, p.243) the British procurement of slaves out of Sierra Leone, carried out by the Royal Africa Company (Shaw, 2002, p.29), only reached its peak 'at the beginning of and during the American war of independence (1776-83)'.[12] Coastal populations could no longer provide these numbers and the trade's outreach crept further inland. As a consequence, the northern regions of the country were now more forcefully incorporated into the Atlantic world providing ever increasing numbers of people condemned to being enslaved (Rodney, 1980, p.254)

The year 1787 saw the establishment by British philanthropists of the *Freedom Province*, later renamed Freetown, as a settlement for free poor Black people in British territories and freed slaves (Shaw, 2002, p.37). This land was subsequently taken over by

[12] Numbers vary between 4,000 and 6,000 a year (Rodney, 1980, pp.250-251; Shaw, 2002, p.29).

the Sierra Leone Company in 1791. The official abolition of the British slave trade did however only occur in 1807 and enslavement was effectively only terminated on Sierra Leonean territory by 1928 (DeCorse, 2015, p.303). When the Sierra Leone Company went bankrupt in 1808, the British government took over the political management of the Province by making it a Crown Colony. Following the Berlin Conference of 1884 -1885, 1896 saw the further transformation of the Sierra Leonean hinterland into a British protectorate (Ferme, 2001, p.34; Harris, 2012, p.40).

British colonialism was characterised by direct rule in Freetown and indirect rule in the protectorate. According to Migdal (1988) the constant and repeated 'fragmentation of social control' through the random attribution and detraction of the power of traditional leaders, created the basis for a 'weak state'. The *Hut Tax War*, a rebellion by Sierra Leone's Mende population against increasingly high taxes imposed by the British governor in 1899, constituted the main act of resistance against a progressively established colonial regime (Harris, 2012, p.40). This resistance lasted until independence was declared on April 27th 1961 (Momoh, 2011).

The period between Sierra Leonean independence and the onset of the civil war in 1991 has attracted little academic attention. A series of governments and attempted military coups led to the declaration of a one-party state under the presidency of Siakah Stevens' All People's Congress (APC) in 1978 (Gberie, 1998, pp.42-52). Protests against Stevens' government, which ultimately lasted until Stevens' retirement in 1985, also featured Foday Sankoh, the future leader of the Revolutionary United Front (RUF) (Gberie, 1998, p.51). It was Stevens' successor, President Momoh, who led the country back to a multi-party democracy in 1991 (Gberie, 1998, p.72) shortly before the beginning of the civil war.

The beginning of the civil war and its development have been studied thoroughly and in a number of different disciplines. Intricately interwoven with Liberia's civil war, it lasted between 1991 and 2002. Khan (1998), Clapham (1998), Gberie (1998), Duffield (2001a), Conteh-Morgan (2006) or Richards (2008) have all contributed in-depth studies to a contemporary understanding of the Sierra Leonean civil war and the varied factors leading to its beginning, development and its demise. While each focuses on one or several aspects of the civil war, almost all analyses adopt macro-level approaches to the study of politics and economics during the civil war, rather than seeing the civil war in the wake of enslavement and colonialism. Such an understanding of Sierra Leone's history would enable analyses of the Ebola epidemic and response that speak to the accumulation of violence and mistrust of authority.

Having provided a broad overview, I will now frame the question of Sierra Leone in a slightly more critical manner. I will do this particularly with everyday spatial and cultural practices and their relation to associational and dominative power in mind and how these have been thought of and conceptualised in the context of Sierra Leone.

3.2.2 Crises, violence and the everyday

Directly responding to and challenging this macro-level approach in the study of Sierra Leone specifically and West Africa more generally is the concept of 'crisis' as proposed by Achille Mbembe and Janet Roitman (1995) and used in a Sierra Leonean context by Daniel Hoffman (2007). It allows, in my opinion, for a more nuanced understanding of the region.

Mbembe and Roitman (1995) provide a useful critical framing for the study of West Africa. Their concept *geography of crisis* (1995, p.327) is, 'an attempt to treat crises as, above all, lived experience'; a theory of the West African everyday, a focus on the ways in which crises manifest themselves in banal, routine ways, in material and immaterial structures, relations and urban landscapes. These manifestations necessitate, on the part of the subject an acceptance and a simultaneous subversion of official rules and regulations in order to get by politically, socially and above all economically.

Mbembe and Roitman (1995, pp.348-351) point to the emergence of increasingly absurd and monstrous forms of violence, as a reaction to and expression of the breakdown of traditionally envisioned forms of state power and hierarchy in states in which citizenship is much more premised on the concept of redistribution than equality before the law. This understanding is politically useful, because it normalises modern West Africa and its populations in that it points to the emergence of new ways of conceptualisation of the everyday. In doing so it makes room for people's lived experience and consists in a theorisation of the everyday from below.

Hoffman (2007, p.401) has also critically used the idea of crisis. Cities in Africa, according to Hoffman, present an anthropological challenge and are part of what he terms 'crucial fields for the 'project of defamiliarisation' of postcolonial metanarratives'. For Hoffman, the theorisation of crisis in the context of Freetown, and Monrovia constitutes one such project of defamiliarisation. In Freetown, the crisis of uncertainty manifests itself above all else as capitalist overproduction, leading to the construction of 'fragmented and contradictory selves' (Hoffman, 2007, p.405). Hoffman thereby shifts

the conceptualisation of crisis from a deterministic understanding premised on violence and destruction to one imbued with participants' agency.

Paul Richards' (2008) account of the Sierra Leonean civil war is in line with Mbembe, Roitman and Hoffman's theorisations of the crisis and its routinisation. Richards specifically takes issue with the reductive and essentialist accounts by Robert Kaplan's (1994) *New Barbarism*. Richards' analysis of the civil war is much more critical. He takes a longer view of the different factors leading to the advent of the civil war and its development. The analysis of the development of the war is more fully substantiated.

As Richards describes, populations in Sierra Leone have regulated violence over an extended historical time period, contrary to Kaplan's interpretation of violence as anarchic. This regulation was part of a synchronisation of agricultural and social cycles. Precisely this means that wars between different groups were submitted to the agricultural calendar of sowing and harvesting without which neither the civil population nor the warring parties could survive for long. Violence is therefore to a degree normalised. In a continuation of this thought, Richards (2008, pp.24-25) interprets the extreme violence of the civil war as a disruption of this prior normalisation of violence.

These more critical accounts of crisis enable a historicised understanding of cultural and social practices, which looks beyond superficial and ethnocentric interpretations of postcolonial societies. There is, in my opinion, an advantage in taking account of the complex layering of pre-colonial, slave trade, colonial and civil war practices. An understanding of these can enhance the study of Sierra Leonean politics and society, but it should not be reduced to those terms.

3.2.3 Conceptions of space and spatial practice: the road and remoteness

This layering is evident in the multiple spatialities of Sierra Leonean society with which I would like to proceed; specifically, the reflection on two themes, which are in my opinion fundamental for a critical understanding of infectious disease control and its uses in the colonial wake; namely, the organisation of space exemplified in first, the road, both conceptually and practically and secondly spatial practices, such as remoteness.

A good example of the interconnectedness between mobility and spatiality with antiblackness and colonialism is the image of the road. Mobility and spatiality, as well as the symbolic representations of colonialism through the themes of modernity, progress and death are recurring themes in sub-Saharan African fiction and literature. The road is one instance in which these motifs come together.

Ben Okri's (1992) famous novel *The Famished Road* exemplifies this already in its title. A road, which is simultaneously located in the material and the spiritual world, lures Azaro, a spirit child, to walk on it into the spirit world, never to return. Its recurring appearance structures the novel's take on early postcolonial Nigeria. These themes, intersection and merger between past and present spaces, spirit and human worlds in an individual, a community or a place are also considered in Harry Olufunwa's (2005, p.51) discussion of Chinua Achebe's *Things Fall Apart* (1994 [1958]). Achebe's novel and its main protagonist Okonkwo, similarly to Azaro, invoke both the spirit and the material world. The same characterisation can be applied to Okri's or Teju Cole's writings.

More recently than Achebe or Okri, Cole's (2012) *Open City* foregoes the evocation of the spirit world. Characterised by Giles Foden (2011) as 'a novel about spatial relations' this novel, which is set in contemporary New York explores the historical, political and cultural layers that make up the city. The main protagonist, Julius, a Nigerian-German, evokes the violence inherent in postcolonial spaces, through nightly walks through the streets of New York (Krishnan, 2015, p.680). Julius', as much as Okonkwo's and Azaro's, lived impressions of (post) colonialism happen by way of the everyday. In the case of Okri and Cole, mobility, and specifically walking and getting lost are crucial elements in the development of both novels and the main protagonists' identities. Both the focus on the road, mobility and space as much as the focus on the everyday and ritualisation are reflected in some of the key works on Sierra Leone. Two authors, who allow us to explore these areas through scholarly literature, are Rosalind Shaw (2002) and Mariane Ferme (2001).

In Sierra Leone, cultural readings of the road are intrinsically linked to the slave trade, the civil war and colonialism. Coupled with each event, the road takes on critical meaning. Shaw (2002) offers an account of the process of memorialisation practices on the Western side of the transatlantic slave trade. She argues (2002, p.32) that in Sierra Leone, centuries of violently procuring slaves to be sent to the Americas have left their mark on the landscape and people's cultural, spatial and social practices. The roads inland as well as rivers in Sierra Leone's hinterland became, through the advent of the transatlantic slave trade places of danger best avoided.

This danger is exacerbated throughout colonialism, both with regards to colonial violence (Ferme, 2001, p.34) and the spread of diseases such as smallpox (Cole, 2015, p.255). The building of roads and railways coincides with the expansion of the British colony and its protectorate. Roads signify at once progress and European modernity, yet

are also seen as bringers of death. Thus, in Shaw's (2002, p.64) account of a discussion with a Temne diviner, the road is personified (*Pa Road)*, 'a malevolent entity', associated with death and 'an *immoral economy* of colonial and postcolonial commerce and transport'. In colonial times, the tension between the central government and rural communities manifested itself, once more in communities' dealings with infrastructure. As Ferme (2001, p.35) writes:

> Labour on roads and the railway tended to be a site of political contestation, thus situating communications and mobility at the very centre of local struggles and as a focal point in the search for autonomy from central authorities by rural peripheries.

Ferme's and Shaw's analyses of roads fall into a broader pattern of literature on the expansion of the colonial reach through urban and spatial planning and infrastructure development in West Africa. A good example of such literature is Liora Bigon's (2012) analysis of sanitary segregation in colonial Dakar and St. Louis du Senegal. Similarly to other writings, for instance Kalala Ngalamulume's (2004) analysis of the politics of prevention against yellow fever in colonial Senegal, Bigon draws upon urban planning documents to showcase the intersection between infrastructural segregation (i.e. roads, rivers, fences), a discourse of disease control and the expansion of the colonial realm.

I will now proceed by examining elements of resistance to both the encroachment of colonial power and the slave trade on the Sierra Leonean hinterland and examine how this dominative expansion of power was met with practices of power, which had particular spatialities.

3.2.4 Remoteness: security through spatial practice

As Black studies (and other) analyses of enslavement show, spatial practices (running away, hiding) were common features of resistance. The spatial dynamics of infectious disease control produced similar strategies of spatial resistance on the part of some Sierra Leonean communities. It is, in this geographic sense that the wake manifests for me. The slave trade, colonialism and the Ebola epidemic, although at different scales, control, limit, define, exclude from, grant access to and create or destroy specific spaces, places and mobilities and were met with spatial strategies of resistance.

Specific spatial practices are part and parcel of the cultural makeup of Sierra Leonean society. Both Ferme (2001, pp.26-31) and Shaw (2002, p.32) argue that these practices have developed over time as the region and its people were exposed to and became a key part of the transatlantic slave trade.

Remoteness, was, and still is, an important tactic to ward off unwelcome intruders, whether they be slave traders, colonial tax collectors, government officials or foreign health workers. Allowing paths to overgrow and neglecting the maintenance of access roads were as important in ensuring the remoteness of villages and communities as the places where these were built in the first place (Ferme, 2001, pp.34-35). DeCorse (2015, p.306), describes the development from open, dispersed settlements to remote, highly fortified settlements over the course of the transatlantic slave trade.

The safety inherent in remoteness and spatial isolation, especially of rural populations is also mentioned by Richards (2008, p.31). He argues that the opposition between ‘‘bush’ and town’ started in the early days of the Atlantic slave trade, when Freetown became the conspicuous link to the global powers beyond the Atlantic. This opposition only grew more accentuated during the civil war. As at the time of the slave trade, security could be found in remote camps, deep in the rainforest. Conceptually, the importance that space and remoteness played in the rural insurgency led by the RUF should consequently not be underestimated.

Remoteness cannot, however, be reduced to its manifestations in the landscape. An example for another practice is ‘spatial closure’, a practice in which the body, through rituals, is sealed off against negative spirits and influences roaming the landscape.

> The unconscious, accordingly, is not so much a region of the mind as a region in space, the inscrutable realm of night and of the wilderness filled with bush spirits, witches, sorcerers, and enemies (Jackson, 1989 [in Shaw, 2000: 30]).

Based on her fieldwork in Sierra Leone in the 1980s in rural Temne communities, Shaw (2002, p.6) theorises cultural and spatial practices, such as the practice of closure as reflecting memories of the slave trade. She argues that, different from Europe, where memorialisation practices are often externalised, in Sierra Leone these are incorporated into cultural practices and are transmitted through folk tales and the ever-present spirit world. Doug Henry (2006, p.383) adds that contrary to European practices of dealing with trauma individually, Sierra Leonean ways of overcoming trauma are much more collective in nature.

Similarly, rather than leading to an individualistic understanding of subjectivity, Shaw points out that spatial isolation and remoteness were only perceived as safe(r) when experienced in a group. This has implications on how we conceptualise personhood and agency. She argues (2000, p.27) against a Eurocentric understanding of personhood as individualistic as proposed among others by Mauss and Durkheim. Agency, in the Temne

and Mende communities of Sierra Leone is built relationally. This is captured in Mbiti's aphorism 'I am because we are; and since we are therefore I am' (Shaw, 2000, p.29).

Security during and after the slave trade was best achieved collectively and potentially by subordinating one's own agency to that of the community. This does not negate individuality. Rather, it offers an understanding of personhood that is developed in relation to the community and to the collective agency of that community (Shaw, 2000, pp.32-37).

3.3.5 Physical and spiritual landscapes

Shaw (2002, pp 50-62) lifts this interpretation of spatial practices and cultural inscriptions of rural landscapes onto a meta-level and puts it in relation with other landscapes influenced by centuries of the slave trade. In theorising the existence of physical, mental and spiritual landscapes, she draws on Édouard Glissant. His concept of memoryscapes theorises the impact that the enslavement has had not only on Caribbean people, but their landscapes.

> [T]he violence and terror of the centuries of slave raiding [are] remembered non-discursively through meanings, images, and practices that shape the landscape into a memoryscape (Shaw, 2002, p.62).

The relationship between spiritual and physical landscapes works both ways. It is not merely the physical landscape, which takes up space in spiritual rituals; as the concept of memoryscapes illustrates, the spiritual domain takes up space in the physical landscape too.

The inscription of violence onto the landscape, in the form of graves, remote villages, hidden away from slavers' routes and the purposeful neglect of roads to the seats of local governments, all indicate the complexity of a spatial and social analysis of the use of infectious disease control in Sierra Leone. The inscription of violence on human bodies constitutes another important analytical factor.

According to Shaw (2002) the long history of the slave trade has left society with the knowledge that bodies can become commodities. More obvious are the traces left on human bodies by the eleven years of civil war. Park (2007, p.584) argues that amputations became prevalent in Sierra Leone during the civil war, but were not widely spread beforehand. This is contrary to much international perception of Sierra Leone, in which the civil war and the practice of amputating limbs become conflated. It is in part this conflation that made the international community take notice of the civil war.

What Ferme and Shaw's analyses make clear, is that in order to sensitively 'read' these spatial practices and landscapes, one must look at 'the underneath of things', the title of Ferme's (2001) book. In order to do so, it is conceptually and analytically important to take account of the importance of secrecy in Sierra Leonean culture. The political and cultural prevalence of secrecy, similarly to other spatial and cultural practices I have evoked here, has been shaped by the country's violent past. It does occupy a central place in analyses of Sierra Leonean culture and history. Both Shaw (2000, 2002, pp.32-35) and Ferme (2001, pp.2-7), in their anthropological accounts of life in Sierra Leone, focus on the usage of secrecy as a political practice of protecting oneself against the powerful.

The key points that come out of this survey are the importance of historicised accounts and their bearing on a contemporary understanding of infectious disease control in relation to Sierra Leone as well as the cultural, political and spatial practices that take place within the region. It seems politically suggestive to reflect on the framing of Sierra Leonean modernity in only those terms though so as to avoid the risk of being overly historically deterministic. While I chose here to study Sierra Leone in the wake of its transatlantic past (and present) I am also aware that its present everyday is, by many Sierra Leoneans, experienced more or less independently of that past.

By focusing on the temporal and geographical reality of the wake, I aim to render an analysis of infectious disease control and the colonial continuity in the practices and mobilities that make them; one that transgresses an understanding of IPC as a mere technology of disease control and explores the underlying antiblack violence that has shaped both Sierra Leone and practices and mobilities of disease control. The literature on spatial practices to escape said violence in Sierra Leone that I have reviewed here indicates the appropriateness of such an approach for my project.

3.3 Biopower and biopolitics

3.3.1 Overview

Literatures on biopower and notably the writings of Michel Foucault and Giorgio Agamben have a lot to offer to the study of health, disease, disease control and the role of the human body in society. While they have contributed to Black studies, neither Agamben nor Foucault explicitly engaged with antiblackness. Both authors have written on a great variety of societal and philosophical issues and their influence on contemporary social sciences cannot be overstated. Hence, while I would originally characterise both as philosophers, their work has greatly influenced the fields of geography, sociology, anthropology, mobility studies, international relations, history and global health. This becomes especially clear when one examines the vast number of academics who have embraced their theories, either following in their intellectual wake or using them as an analytical basis (see for instance: Vaughan, 1991; Allen, 2003; Elbe, 2005; Gregory, 2006a, 2006b; Comaroff, 2007; Murray-Li, 2007; Ingram, 2010, 2013; Nguyen, 2010; Sheller, 2016). Thus, it is not simply Foucault's and Agamben's work on biopower which proves relevant for a study of postcolonial infectious disease control and which I will review here, but also that of other scholars who have adapted their theories for their purposes. Foucault's *History of Sexuality Volume I: The Will to Knowledge* (1998 [1976]) and his 1975 to 1976 (1976) and 1977 to 1978 (2009) lectures at the Collège de France are among the texts of particular relevance for my study.

An important point to consider for my project here is that when Foucault or Agamben write about racism or regimes of violence, they predominantly refer to Nazism and the genocide of the Jews and leave the colonial world and antiblack violence at the very margins of their analytical enterprise. Several authors have pointed to Foucault's and Agamben's silences with regards to the colonial world and I discuss them in a subsequent section. The marginalisation of the global South and of identity politics in their analyses is reminiscent of decolonial critiques of European knowledge production and underlines the relevance of my engagement with postcolonial writings and Black methodologies.

3.3.2 Foucault and Agamben

Foucault published *History of Sexuality Volume I*, in which he introduces the concept of biopower, in the middle of his academic career. Its publication coincides with the end of his *Society must be defended* lectures (1975 - 76) at the Collège de France. Foucault takes up the topic of biopower both in the last chapter of *History of Sexuality Volume I* and in the last lecture on March 17th 1976 (Stoler, 1995, p.55). He discusses this topic more thoroughly and with a more economic focus two years later in his lectures on *The birth of biopolitics* (1978 – 79 [2008]). Agamben is best known for building on Foucault's theories and expanding them in his genealogy of sovereignty and his analyses of states and spaces of exception. His most influential work, *Homo Sacer: Sovereign Power and Bare Life* (1998), is a discussion of Foucault's concept of biopower. Agamben has since written further books on the camp (2000) and the state of exception (2005).

There are two fundamental differences in Foucault and Agamben's approaches to the topic of biopower, or biopolitics, as Agamben refers to it. Foucault (1998, p.138) sees the emergence of biopower in the passage from the 'right to take life or let live' to the 'power to foster life or disallow it to the point of death', which he also characterises as the advent of modernity. Agamben (1998, p.6) on the other hand designates 'the production of a biopolitical body [as] the original activity of sovereign power'. Secondly, Foucault's analysis of biopower seems less pessimistic than Agamben's. For Foucault (1998, pp.142-143) the increased knowledge surrounding the political and biological human body led to a different form of power, one that fosters life and controls it on an individual and societal level. This 'political double-bind' is at the same time individualising and totalising (Agamben, 1998, p.5). Its general aim is, however, 'to ensure, sustain and multiply life, to put this life in order' (Foucault, 1998, p.138). In Foucault's analysis, biopower is intimately linked to the rise of economic and political liberalism. Hence, whereas Foucault sees biopower as partially productive, in Agamben's analysis it is entirely repressive (Ojakangas, 2005). The consequences of this distinction will be discussed in more detail in a later section. Where Foucault sees a development from sovereign to biopower, Agamben argues that these are one and the same. What is more, the repressive nature of power is for Agamben (1998, pp.8-11) exemplified in the figure of *bare life*, life that is included only through its exclusion from the political realm, or in other words, life that can be killed, but not sacrificed. For Agamben, the concept of bare life is expressed today in the figure of the refugee. Thus, despite a close identification with the concept of biopower and all that it entails, Foucault and Agamben's approaches

to it and their understanding of the ways in which (bio)power plays out in society are quite different (Ojakangas, 2005; Snoek, 2010).

For my project, relying on two aspects of Foucault and Agamben's works on biopower seems almost intuitive. First, a genealogical approach to studying power, sovereignty and knowledge offers perspectives on the historical and present-day governance of human health and infectious disease control, which are different from the dominant discourse on the topic, brought forward by the fields of epidemiology and disease control (i.e. Reynolds et al. 2008; Cliff and Smallman-Raynor, 2013). Secondly, an examination of life, death, health and disease and their regulation play vital parts in their analyses. I will discuss some key ideas in Foucault and Agamben a little further before turning to a few of the sites in which biopower, health and disease control come together.

Foucault sees traditional conceptions of power as based on territorial sovereignty (Snoek, 2010, p.49). Traditional European rulers' scope of power was determined by the land they governed, made explicit through the continuous waging, in the middle ages and their aftermath, of territorial wars. Power, in this period is deductive. It manifests itself in the right of the sovereign to seize goods, taxes, and labour and ultimately in the power to seize life (Foucault, 1998, p.136; Ojakangas, 2005, pp.5-6). This changes into its inverse with the advent of biopower whose explicit aim is to further life and regulate the body. Power rather than being deductive, becomes productive.

Agamben does not question the veracity of these historical developments; he does however disagree with the nature of sovereignty that Foucault attributes to this period of time. He invokes Carl Schmitt's paradox of sovereignty, that the sovereign is s/he who decides on the exception and is thus at the same time in and outside the law (Agamben, 1998, p.16; Ojakangas, 2005, p.8). In Agamben's (1998, p.18) own words: 'The rule applies to the exception in no longer applying, in withdrawing from it'. He argues (1998, p.8) that sovereignty has always relied on biopower and bases this assertion on the historical Roman figure of *homo sacer*, a 'human life [that] is included in the juridical order solely in the form of its exclusion (that is in its capacity to be killed)'. According to him, power has always been biopower and sovereignty has always relied on this, the production of bare life.

Foucault's account is different. He (1976, p.242) theorises that techniques of power, which emerged in this form at the beginning of the seventeenth and eighteenth century, were centred on the 'disciplinary technology of labour'. The latter consisted in 'the spatial distribution of individual bodies', 'techniques that could be used to take

control over bodies', 'and techniques for rationalising' (Foucault, 1976, p.242). These techniques are followed at the beginning of the nineteenth and twentieth century by a 'new non-disciplinary power […] applied to […] man-as-species' (Foucault, 1976, p.242). Foucault (1976, pp.242-243) states that

> To be more specific, I would say that discipline tries to rule a multiplicity of men to the extent that their multiplicity can and must be dissolved into individual bodies that can be kept under surveillance, trained, used, and, if need be, punished. And that the new technology that is being established is addressed to a multiplicity of men, not to the extent that they are nothing more than their individual bodies, but to the extent that they form, on the contrary, a global mass that is affected by overall processes characteristic of birth, death, production, illness and so on.

To Agamben the intersection between technologies of the self and technologies of power is missing from Foucault's theories. For him, this point of intersection is manifested in the production of *bare life* and its exceptional relation to sovereignty (Snoek, 2010, p.54).

At the heart of Foucault's concept of biopower lies the following question, taken up, among others, by Agamben: if biopower is productive, rather than deductive, how does sovereign power come to kill? Foucault's (1976, pp.256-258) answer, not Agamben's for whom sovereign power has always consisted in the power to *disallow life*, is state racism. Racism, Foucault (1976, p.259) states, 'justifies the death-function in the economy of biopower'. It does so by arguing that the death of some others will leave the general population stronger and purified. I attend to a critique of Foucault's concept of racism in a later section.

Agamben refers to the same historical period (World War II) in his theorisation of sovereignty and biopolitics. Further to disagreeing with the original differentiation between sovereign power and biopower, he argues against Foucault's theory around racism. To Agamben the essence of biopower is always 'to make survive', in other words the production of *bare life* (Snoek, 2010, p.50).

Foucault (2009, pp.87-115; p.389) describes government as 'the conduct of conduct'. Government is not an institution but an activity with the aim of shaping human conduct (Murray-Li, 2007, p.5). In contrast to sovereignty, government has an end that is external to itself and instruments that go beyond the formulation of laws (Foucault, 2009, pp.98-99). Increased knowledge of the state and of its population in the form of statistics, among other techniques, leads to a repositioning of the family as an entity to be governed within the broader population and to a focus on now qualifiable and quantifiable phenomena related to the population at large (Foucault, 2009, p.104). As Foucault (2009, p.105) writes, '[t]he family will change from being a model to being an instrument'. The

‘conduct of conduct’ refers thus both to the government of the self and the government of the multitude (Lemke, 2001, p.2). Foucault (2009, p.108) defines this all-encompassing logic and its material and procedural consequences as ‘governmentality’. The term ‘governmentality’ is composed of the French words for governing (*gouverner*) and mentality (*mentalité*) and indicates the intrinsic interdependency between techniques of power and the constitution of forms of knowledge, which is symptomatic of biopower, as Foucault (1998) shows. Governmentality, in opposition to discipline, has at its core the well-being of the population, rather than its surveillance and supervision (Murray-Li, 2007, 5p.). As Tania Murray-Li (2007) points out, in her study of development and governmentality in Indonesia, this conduct does not necessitate the conscious approval or awareness of the person being conducted. This corresponds well to Foucault’s understanding of power being immanent and as working indirectly through techniques and practices of self-regulation (Allen, 2003, pp.65-66).

3.3.3 The plague town and the panopticon

Foucault discusses the application of technologies of power and technologies of the self in a number of his works and makes reference to various sites or institutions (the asylum, the clinic, the prison). In the chapter on panopticism (Foucault, 1979) he discusses the example of the plague town in seventeenth century France.

The plague town is described as incorporating all the characteristics of the old technologies of power. Here ‘spatial partitioning’ and ‘the closing of town’ (Foucault, 1979, p.195) regulate the spatial distribution of bodies. This measure is accompanied by close surveillance of every street by a designated person. The plague town

> constitutes a compact model of the disciplinary mechanism […]. It lays down for each individual his place, his well-being, by means of an omnipresent and omniscient power that subdivides itself in a regular, uninterrupted way even to the ultimate determination of the individual, of what characterises him, of what belongs to him, of what happens to him. (Foucault, 1979, p.198)

Indeed Foucault (1979, p.200) locates the rise of disciplinary mechanisms in the fear of the plague. As he notes (2009, pp.8-11) by comparing disease control measures in the cases of leprosy, the plague and smallpox, however, rather than disciplinary power giving way to mechanisms of security, we are confronted with a ‘system of correlation’ between the different forms of power and related techniques. Foucault (2009, p.108) develops this point further: rather than a historical continuum, he argues we are faced with a triangle of governmental management, sovereignty and discipline with ‘population as its main target

and apparatuses of security as its essential mechanism'. As he argued, the disciplinary mechanisms deployed to fight against the plague in seventeenth century France were still present at his time of writing (1970s) and were being deployed around the 'other' and the 'abnormal'. However, Foucault also asserts that technologies of power and forms of government shift over time and space in response to events, meaning that the precise composition of any particular ensemble of government requires specific, contextually sensitive exploration.

Foucault's discussion of the panopticon, an ideal prison designed by Jeremy Bentham in the eighteenth century, is also relevant. Foucault argues that mechanisms of disciplinary power became more implicit over time. Designed as a circular prison in which each unit occupies the entire length between the outer wall and an inner courtyard, overseen by a circular watchtower, the panopticon is designed to ensure constant universal visibility. This constant visibility is meant to ensure that power works on its own by inducing in the inmates the urge to self-regulate. As Foucault describes, Bentham believed that the constant fear of being seen by a guard, in the guard tower, would create an effect of constant surveillance. It is thus the possibility of being surveilled, rather than actual surveillance, which is meant to assure normative behaviour and lead to the inmates' surveillance of themselves.

In comparing these two sites of analysis it becomes clear, that whereas the plague town epitomises old disciplinary mechanisms based on the sovereign's power over life and death, the panopticon is for Foucault (1979, pp.205-207) a paradigm of modern technologies of power. I especially highlight these two sites because Foucault's descriptions of the plague town resemble the spatial aspects of urban infectious disease control during colonialism and the Ebola epidemic in Sierra Leone, whereas the panopticon can be seen as representing a conceptualisation of power often pursued in medical and developmental behavioural change discourses. As Mbembe (2001, p.25) has argued, however, the colonies saw different forms of power than the European context considered by Foucault. My research project therefore requires its own context-dependent and genealogical analysis.

3.3.4 Space and power

Foucault and Agamben both analyse relations between space and power. While for Agamben sovereignty remains fundamental, Foucault suggests that the sovereignty-territory relationship has been displaced by government of population. Stuart Elden

(2010, p.809), however, argues that Foucault misinterprets territory. According to Elden, territory is also a political technology, which is realised and controlled through mapping and cartography among others. He states that 'in this sense cartography does not just represent the territory, but is actively complicit in its production'.

These 'calculative techniques' are accompanied by a shift in legal understandings of sovereignty, territory and the state. Territory then becomes a way of organising space, dependant on the social and political context, rather than a natural and geological given (Elden, 2010, pp.810-11). For Elden, then, territory is to be understood as a technology of government rather than something that precedes it and can be contrasted to it.

As other geographers have further demonstrated, power over space can take multiple forms and be conceptualised in varying ways. Power, as John Allen (2003, p.3) argues is 'inherently spatial and, conversely, spatiality is imbued with power'. He specifies that it isn't power that flows, resources do and thus power can never be separated from its effects. Space comes to be something that is practiced, not possessed. As Allen (2003, p.162) argues, in Lefebvre's theories on space, power over space is exercised by s/he who has 'the ability to *represent* space' in a way that excludes others and affirms domination. Derek Gregory (2006b) extends this understanding of power and space in his writings on military occupation. According to Gregory, spatial history needs to be taken into account when studying power's effects. Power operates as a network, which creates effects of proximity and distance in social relationships (Allen, 2003, p.195). I exemplify this relationship between power, space and resources with regards to the UK's humanitarian interventions in Sierra Leone.

Allen (2003, p.69) argues that geographic space as theorised by Foucault does not explain how technologies of power and self-regulation work on individuals. He contends that different forms of power (seductive, associational, dominative, instrumental) are constituted differently according to the time and space in which they are deployed. This in turn generates different forms of empowerment and room for resistance, which are often neglected in Foucault and Agamben's writings on power (Allen, 2003, p.197).

Jennifer Robinson (1996) also offers a differentiated analysis of forms of power. Similarly to Allen, she prefers the use of 'domination' or 'dominative power' to 'power' when it comes to studying the spatial politics and implications of the South African Apartheid system. To be even more specific, Robinson uses the concept of 'territoriality', as defined by Robert Sack (1983, p.56) as the 'strategic use of space […] to influence, affect, or control objects, people and relationships […] by delimiting and asserting control over a geographic area'.

Power over space is however not only limited to the delimitation of a certain area. Based on Foucault (2009), Steve Hinchliffe and Nick Bingham (2008, p.1536) focus on movements and circulation. They argue that, rather than being about containing all movement, biosecurity differentiates between good and bad circulation and furthers the good. They argue further (2008, p.1544) that, in biosecurity, sovereignty and power work to further and include the good life, a practice that is in line with biopower and the politics of improvement, but which can include the use of coercive mechanisms.

3.3.5 Limitations and critiques

John Allen (2003) critiques Agamben's understanding of power as only dominative and instrumental. Furthermore, what Allen (2003, p.196) terms associational power is not simply the mobilisation of forces in terms of resistance to a dominative power, but rather a form of empowerment that is independent of the powers it is directed at. This is in part, I think, what Gregory (2006b) points at in his article on Guantànamo Bay as a space of exception. Rather than being a space in which dominative power flows uninhibited, its very constitution is a political struggle, an occupation, which needs to be contextualised in order to gain an understanding of the different powers at work in the colonial present. Gregory (2006b, p.406) notes that Agamben, despite his knowledge of the colonial roots of the camp, decides to pass over them.

The work of Ann Laura Stoler is key to an understanding of the eurocentrism of Foucault. She states that, while students of colonialism have learnt a lot from Foucault's critical analysis of power and government and have benefitted from his methodology, his theories of biopower that so easily left out relevant developments in the colonial world need to be regarded critically. She questions 'whether issues of historiography and theory can be so neatly disengaged' (Stoler, 1995, p.5) as is the case in some critiques of Foucault's work in which his theories have been taken to be relevant for studies of the postcolonial world without taking the specific Eurocentric historical events they built on into account.

Writing about the nineteenth and twentieth century (and the two world wars), a period in which European powers claimed most of the African continent for themselves after having taken possession of the Americas and Asia, Foucault (1998, p.136) asserts that 'all things being equal, never before did regimes visit such holocausts on their own populations', thus neatly neglecting the genocides inflicted by colonial powers on indigenous populations.

Stoler's main point is that by pursuing a Eurocentric historiography, the ways in which European imperialism produced a colonial order and how this colonial order in turn impacted the making of European social relations has been neglected. In Foucault, racism, which justifies 'disallowing life' and killing, is a product of European history and especially the holocaust. Stoler (1995, p.200) criticises this view, arguing that, as a major manifestation of biopower, European racism needs to also be located in the European colonial enterprise. Foucault's concept of racism was conceived in the absence of his understanding of antiblackness or, possibly, his denial thereof.

Black studies scholars, such as Frank B. Wilderson III (2010) or David Kline (2017) offer critiques of Foucauldian and Agambean conceptions of power and ontology. Notably, Frank B. Wilderson (2010) questions Agamben's use of the Holocaust as the basis for his theorisation of bare life. Rather, he argues (2010, p.36) following among others Frantz Fanon, that the 'impossibility of Black ontology' cannot be conceived by way of analogy with the fate of the Jews during the Holocaust, nor consequently through Agamben's concept of bare life. He argues:

> The ruse of analogy erroneously locates Blacks in the world – a place where they have not been since the dawning of Blackness. This attempt to position the Black in the world by way of analogy is not only a mystification, and often erasure, of Blackness's grammar of suffering (accumulation and fungibility or the status of being non-Human) but simultaneously also a provision for civil society, promising an enabling modality for Human ethical dilemmas.

Afro-pessimist that Wilderson III is, he rejects an account of ontology in which Blackness is formulated/excluded in relation to humanness as is the case with bare life. Antiblackness then, in the afro-pessimist tradition, goes beyond Foucault's and Agamben's conceptualisations of racism and bare life.

Foucault, according to Stoler (1995), has considerably influenced critical methodologies used in the study of power and knowledge, methodologies which were part of the academic constitution of post-colonial studies. His very own methodology had at the time of Stoler's writing however seldom been used to question his omission of this primary site of European power and knowledge production: the colonial world (Stoler, 1995, p.14). She argues (1995, pp.205-208) that, while Foucault theorises biopower as an inherently bourgeois European phenomenon, it was also an imperial one and the analysis of biopower consequently needs to be extended to colonised states.

One author who has used Agamben and Foucault to theorise modernity in West Africa is Daniel Hoffman (2007). Writing on Freetown and Monrovia, Hoffman argues

that the barracks and not the camp are the paradigm of West African urban modernity and that the latter is characterised by the cohabitation of destruction and excessive production. He combines Agamben's theories on the camp and Foucault's conception of power as productive and argues that the military and rebel barracks, as remains of Sierra Leone's civil war, concentrate and organise subjects so that labour can be deployed easily in times of peace as well as war. Similarly to Mbembe's theorisation of African modernity or Richards' writings on the Sierra Leonean civil war, Hoffman (2007, p.403) writes that armed conflict is not the suspension of the normal social order, 'but one manifestation of the way economies and governmentalities are organized in the contemporary period'. This is exemplified by the permanence and ubiquity of the barracks. Hoffman's work therefore shows that, if employed critically with socio-political context in mind, the genealogical approach of Agamben and Foucault can be useful for placing the Ebola response in the wake. In my research I bring this genealogical approach into conversation with my focus on disease control-related mobilities and practices.

Foucault's theories have also been tested with regard to another academic and professional discipline that has the (post)colonial world as its main site: development. Tania Murray-Li (2007) explores what she calls 'the will to improve' in development initiatives in Indonesia. Improvement, according to Murray-Li, has been an intrinsic discourse and motivation for slavery, colonialism, post-colonialism and development. Improving, in her words, is to render technical and rendering technical often implies rendering apolitical or discarding a political challenge.

An interesting aspect of Murray-Li's work (2007, pp.18-19), which resonates with that of James Ferguson (1994), is the discussion of the prevalence and recurrence of development projects, despite their frequent failures. Their analyses differ in that Murray-Li dismisses dependency theory arguments that development interventions are designed to keep the poor locked in poverty. She studies the will to improve as just that: the will for improvement. Ferguson (1994, p.280) on the other hand, questions the benevolent, disinterested stance that many development agencies appear to take. Failures are what lead Murray-Li (2007, p.19) to question the concept of governmentality as an analytical tool. She argues that the will to improve the condition of subjects through national and international development initiatives needs to be questioned when confronted with the apparent failure of so many of these initiatives. In a situation in which the failure of one initiative legitimises the next, regardless of their success or failure, improvement takes on a circular character of self-generation reminiscent of Foucault's writings on sovereignty, not government. Furthermore, her analysis of self-organised improvement

and empowerment address a form of associational power that Foucault and Agamben's analyses leave little room for. Considering these critiques as well as the ones I turn to further down reinforces the relevance of engaging with theories that explicitly centre the global South and Black positionalities in my research of the mobilities, knowledges and practices that shaped infectious disease control during the Ebola epidemic.

Achille Mbembe goes further than other critics whose criticism mainly applies to the failure of theorists of biopower to apply or develop their ideas in relation to the colonial world. He questions the universality of the very theorisation of sovereignty by Agamben and Foucault (Murray-Li, 2007, p.13). According to Mbembe (2003), sovereignty in the colonial world is different from the European world. Foucault's theorisation of the balance between 'a liberal regime of rights' and the sovereign's power to kill did not apply to the way in which most colonies were governed. In the colonies, colonial sovereignty was entirely based on 'arbitrariness and intrinsic unconditionality' (Mbembe, 2001, p.26). Mbembe's (2003) main point is that, in opposition to biopower, the aim of the sovereign in the colonies was not to further the life and the well-being of the population. It was to destroy it. Thus, it is not life that is at the centre of the sovereign's relation to their citizens; it is death. He (2003, p.24) sums it up as follows:

> […] colonies are zones in which war and disorder, internal and external figures of the political, stand side by side or alternate with each other. As such, the colonies are the location par excellence where the controls and guarantees of judicial order can be suspended - the zone where the violence of the state of exception is deemed to operate in the service of 'civilization'.

The colonial world is thus framed as imperial exception.

My study of the Ebola response, the definition, evaluation and regulation of movements stemming from former colonies, in part assessed whether the Ebola epidemic reinforced the status of these regions and the people that inhabit them, as imperial or colonial exception. At the same time, I assessed to which extent the knowledges on infectious disease control displayed, vocalised and preserved in British archives, the diaspora and among practitioners built on an understanding of infectious disease control and Sierra Leone as (colonial) exception.

3.3.6 Summary

The examples I have shown demonstrate the versatility and wide applicability of the concept of biopower and its potential usefulness in a social scientific study of infectious disease control. However, ideas developed in relation to Europe cannot simply be applied

to the study of infectious disease management in relation to Sierra Leone. My review of the literature on biopower and its critiques has shown how authors have responded to the need for complex and differentiated perspectives on biopower, both in terms of who writes and who is written about. In my research, I forego a biopower lens in favour of a Black studies approach to the 2014-15 British-led international Ebola response. By doing so I highlight the importance of marginalised positionings, aim to centre these and thus seek to contribute to a more just politics of knowledge.

3.4 The politics of (global) health

3.4.1 Overview

According to Jones and Moon (1987, p.1) leaving the analysis of health and disease to biosciences implies that

> the causes of disease will be found in biomedical research and that the only effective treatment is intervention by chemical, electrical or physical means to restore the body to its normal biological functioning, that is technological medicine.

The literature on politics of (global) health encompasses a wide variety of academic disciplines, including anthropology, geography, sociology and cultural theory, all four of which I will focus on here.

Geographers have done a lot of critical work on the politics of health. Although these predominantly overlook Black approaches to infectious disease control, their contributions have questioned the imagined geographies underlying the neo-liberalisation of public and global health (Sparke, 2009; Laurie, 2015) and offered ontopolitical approaches to biosecurity (Hinchliffe and Bingham, 2008, Hinchliffe et al., 2013). They have undertaken Foucauldian explorations of infectious disease governance and its securitisation (Ingram, 2010, 2013; Parry, 2012; Brown, 2014; Taylor, 2016), interrogated the coloniality inherent in epidemiology (Craddock, 2008) and explored political implications in changes in the geographical distribution of chronic disease in the Global South (Herrick, 2014; Reubi et al., 2016).

A big part of the literature on politics of health under review here is informed by Foucault's writings on biopower and governmentality. As he illustrates, the health of populations and protection against infectious diseases has been a public concern since medieval times. Foucault (2009, p.11) founds parts of his analysis of governmental security mechanisms and technologies on a reading of medieval plague regulations.

Foucault (1998) also describes scientific knowledge about disease and public management of a population's health as technologies through which biopower is exercised.

Much recent social science literature on politics of health, and Black health in particular, has been written as a reaction to and an analysis of the emergence of HIV/AIDS in Europe and North America in the 1980s. Consequently, a majority of the literature I am reviewing here will have HIV and AIDS or the politics of HIV and AIDS as its subject matter. Ebola has until recently been more marginal to this scholarship. This marginality is reflected in this literature review.

Much of the literature, however, also deals with common themes such as new forms of sovereignty and citizenship, the exacerbation of socio-economic and health inequalities, and the role colonialism and biomedicine have played in defining each other. These themes will broadly structure this section of the review.

3.4.2 Biological citizenships and governmental technologies

Here I review literature that focuses on identity and the definition of health and disease, the different ways in which medical conditions and politics converge to uncover new forms of citizenship and thirdly how these can give rise to new governmental technologies and forms of sovereignty. I also demonstrate that its association with moral and cultural normativity renders infectious disease especially political for poor people of colour and other marginalised and stigmatised groups.

Foucault has, as I have shown in the previous section, written extensively on Western government's investment in the life and health of its populations. Nikolas Rose and Carlos Novas (2007, pp.439-440) have written about this 'biologization of politics.' They introduce the term 'biological citizenship' which broadly encompasses 'all those citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings'. One biological condition that has shaped these debates in recent years is HIV/AIDS. It exemplified to which extent citizenship was tied to normative cultures and behaviors.

Risk culture and behaviour

At its emergence in the United States in the early 1980s, HIV/AIDS was quickly explained through deviant non-heteronormative culture (Sontag, 1989; Berridge and Strong, 1993; Treichler, 1999). As Paula Treichler (1999, p.20) pointed out, during the early response to HIV/AIDS 'the major risk factor in acquiring AIDS is being a particular

kind of person rather than doing particular things.' The media and the scientific community quickly identified the '4-H'-group as responsible for transmitting HIV to the American public. 'Homosexuals', 'Heroin-users', 'Haitians' and 'Hookers' with haemophiliacs as an added group of people at particular risk of infection. The responsible citizen, according to Peter Baldwin (2005, p.14), was not framed as belonging to either of those groups.

Various authors have pointed to the importance of 'risk behaviour' in the political discourse surrounding HIV/AIDS (Gilman, 1988; Carter and Watney, 1989; Patton, 2002; Baldwin, 2005). This infection has accentuated the individual responsibility in keeping the nation healthy. Risk behaviour is here translated into a thoughtless act endangering the nation (Benton, 2015), wasting economic resources (Ingram, 2013, p.449) and squandering non-governmental efforts (Biehl, 2007, pp.394-396). As this review will show, risk behaviour and 'behaviour change' are common themes in health and development politics in West Africa generally (Nguyen, 2010) and Sierra Leone more specifically (Benton, 2015).

Another form of risk behaviour entirely is discussed by Adia Benton (2016a). Benton (2016b) has pointed to the absence of race and blackness as an analytical lens in anthropological accounts of humanitarianism, but used visual methods to explore the increased perception of risk when white subjects are involved in saving Black bodies. As she points out (2016a), these racial dynamics are underexplored and antiblackness is, as of yet, a largely absent analytical factor in the study of health interventions.

Infectious disease, citizenship and marginality

The powers of definition over health and disease constitute important techniques related to individual and national identity formation as well as citizenship. I draw on this perspective in order to illustrate the unequal power relations at work in scientific and cultural discourses about infectious diseases, which are written onto and read off of bodies that seldom dispose of the powers to define them (Treichler, 1999, p.19). Sander Gilman (1988, 1992) has written extensively on the relation between infectious disease and its association with otherness. Drawing on fiction and non-fiction Gilman (1992, pp.179-184) illustrates how, historically, disease has always come from somewhere else and has often been associated with a national minority. He (1988, p.236) takes the example of the construction of syphilis as a Jewish disease in late 19th century Germany and that of the American association of syphilis with black bodies; domestic black bodies before and foreign black bodies after the civil rights movement (embodied in Haitians, which are

predominantly of African descent and their inclusion in the 4-H group). A similar example, equally from the United States, is the construction of syphilis as a disease stemming from sex workers during the First World War. According to Cathy Waldby (1996, p.91) and Baldwin (2005, p.43) around 20,000 sex workers were systematically quarantined to reduce the threat of a syphilis epidemic among American soldiers.

Robert Crawford (1994, p.1347) calls the moral anxiety surrounding HIV 'a contestation over the meaning of the self'. He argues that health is at the heart of cultural and national imaginations of the self. It is, according to him, epitomised in middle-class heteronormative identity, which stands in opposition to everything that is 'other'. Infectious disease and very specifically infectious bodily fluids threaten this identity. Crawford (1994, p.1349) further argues that AIDS is understood as a ''spoiling' of identity, a fluidity that dissolves 'immunity'', which threatens the borders between healthy self and unhealthy other. This politicisation of disease within the state stands in stark contrast to the politics of health on the global level.

Blackness, disease and biomedicine

Like Jewish people and sex workers, Black populations in the US and the Atlantic world have long had a contentious relationship with biomedicine. Allan Brandt (1978) describes the Tuskegee Study, a government-run medical experiment to study the advancement of untreated syphilis in African American men between 1932 and 1972, which became an infamous example of the antiblack racism and 'othering' pervasive in medical practice.[13] Although race/ethnicity (similarly to age and income) has and often is an adjusting factor in medical studies on health, Black studies have seldom been used to analyse health-specific issues. The majority of books that link Black studies and medicine focus on enslavement. Examples are Lundy Braun's (2014) book on the spirometer and Nicole Rousseau's (2009) book on Black reproduction, as well as Deirdre Cooper Owens (2017) book and various articles on J. Marion Sims, the forefather of gynaecology, a Southern slave owner who pioneered gynaecological instruments and practices by experimenting on enslaved women without anaesthesia (Brown, 2017; Domonoske, 2018; Zhang, 2018). Rana A Hogarth's (2017) monograph *Medicalising Blackness: Making Racial Difference in the Atlantic World, 1780 – 1840* argues that 'the construction of racial differences and the medicalisation of blackness were mutually dependent forces, essential to the development of medical knowledge production in the Atlantic world.' Andrew Curran's

[13] Study participants were left untreated and at times treatment was actively withheld for purposes of the study, even after the wide availability and acceptance of penicillin as effective treatment for syphilis.

(2011) *The anatomy of blackness* traces the shifting classification of black Africans from black 'variety' to black 'race' in anatomy and human sciences among French enlightenment philosophers and argues that rather than revealing essential truths about Blackness or African-ness, they allow an insight into the making of European whiteness. More in line with my work is Singh et al.'s (2014) paper on African Kaposi's Sarcoma and antiblackness. Using the frame of antiblackness, Singh et al. argue that the marginalisation of extensive, pre-existing (colonial) African research on Kaposi's Sarcoma at the beginning of the European and North American AIDS epidemic constitutes an instance of antiblackness. It also reinforced racial conceptualisations of different AIDS strands in which 'European AIDS', differed from 'African AIDS', the latter afflicting people of African descent in Africa and North America. My thesis is situated between Black and postcolonial analyses of colonial health management in Africa, which I review below. I will now turn to a closer examination of citizenship and sovereignty in the context of infectious disease epidemics. Here again, the literature to date is mainly preoccupied with HIV and AIDS.

Sanitary citizenship, unsanitary subjects

As has emerged in the literature on citizenship and risk behaviour, who one is and what one does can easily become conflated. Charles Briggs (2003) elaborates on this in his ethnography of a cholera outbreak in Venezuela in the early 1990s. He (2003, p.xvi) introduces the concepts of sanitary citizen and unsanitary subject:

> We introduce the term sanitary citizens in drawing attention to the way that some people are credited with understanding modern medical concepts and behaving in ways that make them less susceptible to disease. Others get branded as unsanitary subjects; they are deemed to be incapable of helping themselves or taking advantage of medical services - and even presented as threats to the health of the body politic. The dramatic case that we describe shows not just the fallacies and injustices associated with designating people as unsanitary subjects but the way this label can justify denials of basic social and political rights.

Briggs examines the discourses through which cholera was established as a foreign disease and as one that was directly linked to indigenous culture. Consequently, unsanitary subjects bore the blame for the disease and the related morbidity and mortality rates. Briggs (2003, p.5) however identifies institutional and discursive racism rather than indigenous culture as the sources of disproportionately higher morbidity and mortality rates among indigenous populations. He concludes, as does João Biehl (2007, p.13) in his study of the politics of creating universal access to antiretroviral-drugs (ARVs) in Brazil

that access to drugs, services, medical care and infrastructures is rarely guaranteed for the 'marginalised [Black and indigenous] underclass.'

As several authors point out (Biehl, 2007; Nguyen, 2010; Benton and Dionne, 2015), life-sustaining drugs for HIV/AIDS were slow to be developed and once developed – a first efficient drug cocktail was made available in North America in the 1990s - their cost by far exceeded low and middle-income countries' health budgets. Not only that, racism and prejudice effectively obstructed marginalised populations' access to healthcare (Biehl, 2007, pp.388-389). Briggs (2003) refers to this as racial profiling.

Pharmaceutical citizenship

New access to technologies and drugs, instead of alleviating socio-economic and political inequalities has in certain respects further aggravated the situation for the most vulnerable to the point where the global health regime can at times reproduce social inequalities (Biehl, 2007; Briggs, 2003; Ingram, 2013). The example of potential drug resistance illustrates this. For ARVs to be effective, that is, to stop the virus from integrating and modifying cells and for the patient not to become drug resistant, they need to be taken consistently. As several authors have pointed out, one of the biggest dangers of drug shortages in the Global South is that patients were not consistently provided with a full ARV cocktail (Biehl, 2007; Nguyen, 2010; Benton, 2015). In these situations, prejudice and stigma towards poor and marginalised populations (poverty, homelessness, potential loss of insurance cover) often led doctors, nurses and administrators to discriminate racially and socially (Biehl, 2007). Only 'reliable' individuals were provided with full ARV cocktails, so as not to 'waste' the small amounts of available drugs on patients, who might, for one reason or another, not (be able to) follow continuous treatment (Farmer, 2001, p.3735). Thus, once more, socio-economic identity and related stigma have considerable impact on individual health outcomes.

Biehl (2007, p.379) argues however, that the widespread social mobilisation that these inequalities and related discrimination practices gave rise to in Brazil is one of the key factors leading the Brazilian government to ignore patents and buy (lower cost) generic drugs. This 'pharmaceutical globalisation' (Biehl, 2007, p.378) led to two distinct social phenomena: on the one hand, widespread social mobilisation led to new forms of citizenship and governance, altering the relation between civil society and government in Brazil and offering 'a small window of opportunity to intervene in global governance […] to try to recast an uneven correlation of forces' (Biehl, 2007, p.379). On the other hand, 'pharmaceutical humanitarianism' (Biehl, 2007, p.380) obscured the political and

economic marginalisation of the poorest and most racialised parts of society. These preceded the disease and the new forms of governance and citizenship it gave rise to.

Therapeutic citizenship

Vinh-Kim Nguyen's (2010) book is an ethnography of the local responses to national and international HIV/AIDS politics in Burkina Faso and Côte d'Ivoire. In it, he (2010, p.142) defines therapeutic citizenship as 'a form of stateless citizenship whereby claims are made on a global order on the basis of one's biomedical condition.' Therapeutic citizenship also emerges when a shortage in drugs forces an NGO, a hospital, an international organisation to resort to triage in order to determine who will receive the life-prolonging ARVs and who will not. The restoration to health through ARVs constitutes a form of citizenship in which life itself is at stake (Nguyen, 2010, p.101). Here, despite the emergence of new forms of citizenship, triage also leads to the unravelling of extant local solidarities (Nguyen, 2010).

Therapeutic citizenship has also emerged through participation in clinical trials (Nguyen, 2010, p.91). Using the example of two clinical trials targeting mother-to-child transmission of HIV, Nguyen (2010, p.97) argues that this therapeutic citizenship needs to be differentiated from the motivations that led North American AIDS activists to participate in similar trials. The motivation here is less one of solidarity and more the urge to gain access to life prolonging drugs, which were not widely available. Rather, similar to the Brazilian case, therapeutic citizenship developed in West Africa to overcome the lack of drugs and challenge the international regime that made obtaining them almost impossible. Patient activist groups formed and advocated for affordable universal access to drugs on a national and international level. As Alan Ingram (2013, p.438) has pointed out however, these novel international forms of citizenship remained fragile and provisional.

As Nguyen in particular has argued, the processes behind the formulation of new forms of citizenship also led to the emergence of new forms of sovereignty. I have alluded to some of them in the discussion of Biehl and Nguyen's works but will now discuss them briefly in more detail.

New technologies of government

The emergence of new technologies of government can be demonstrated in several ways. One is the emergence of new forms of sovereignty evident in patent laws. Throughout the late 80s and early 90s, a small number of North American pharmaceutical firms held the patents to most ARVs. At that time patent laws made it difficult for countries such as

Brazil, Burkina Faso or Côte d'Ivoire, where HIV/AIDS hit fragile health and infrastructure systems, to purchase lower-cost generic drugs (Biehl, 2007; Nguyen, 2010; Ingram, 2013). By breaking or threatening to break these laws, Brazil, for instance, exercised its sovereignty and opposed more powerful industries and governments (Biehl, 2007; Ingram, 2010). For citizens of countries in the Global South, which were faced with their government's inability to provide access to life-prolonging drugs, sovereignty shifted in part from governmental organisations to NGOs and INGOs (Biehl, 2007; Ingram, 2010; Nguyen, 2010; Benton, 2015).

In the conclusion to his book, Nguyen (2010) argues that in West Africa in the time of HIV/AIDS, triage has in fact become sovereignty. Drawing on Agamben's writings on sovereignty and the exception, he contends that triage ultimately is the decision over who lives and who dies. This decision has, as Nguyen (2010, pp.174-176) describes, to a large extent been taken out of the hands of states' governments. It has instead in certain key respects been transferred to non-governmental actors who decide upon the seropositive patients' right to live according to his or her adherence to normative technologies of the self (Ingram, 2010). A similar decentralised power dynamic could be observed during the Ebola response in Sierra Leone.

Didier Fassin and Mariella Pandolfi (2010) discuss the right to intervene as one of the big challenges to and paradoxes of modern sovereignty. They argue that the right to intervene and its subsequent 'duty to intervene', for the first time derive not from a political principle, but from a moral humanitarian imperative. This new humanitarianism, according to Fassin and Pandolfi, rejects state sovereignty in the name of human suffering and the duty to intervene. Foreign intervention becomes more and more often legitimised through humanitarian morality. What used to be an act of war – an army intervening on another country's territory - is today seen more in logistical than political terms.

In the context of the military-humanitarianism that Fassin and Pandolfi describe, the humanitarian logic is usually premised on two conditions: first, the power of the intervening army must by far exceed that of the 'host country'. Secondly, the intervention is carried out and presented in a context removed from all socio-political and historical bindings. What is more, this new humanitarian logic divorces military interventions from the national self-interest that usually accompanies them. Fassin and Pandolfi (2010, p.15) refer to this coupling of military and humanitarian logics and emergencies as 'globalised biopolitics' because of the exceptional legal status of some of these interventions.

Similarly, writing on the politics of polio eradication in Peshawar, a city on the border to Pakistan's Federally Administered Tribal Areas (FATA), Stephen Taylor (2016) examines the marginalisation of cultural and socio-economic factors in new, technical campaigns of disease eradication. He argues (2016, p.108) that the international pressure on Pakistan to comply with the global goal of 'the pursuit of zero', allows for the deployment of new disciplinary forms of governing peripheral communities.

What I find particularly relevant in this development is that this move away from state sovereignty, coupled with the increasing power of NGOs and INGOs, corresponds both to a technocratisation and depoliticisation of (global) health processes (Fassin and Pandolfi, 2010, p.14; Nguyen, 2010). Biehl (2007, p.384) illustrating the universalization of access to ARVs in Brazil argues that this was premised on 'finding new technical tools and cost-effective means to deliver care' leaving out pre-existing layers of violence and inequality. He argues:

> The civil and political violations that precede disease are apparently lost sight of in this pharmaceutical humanitarianism, and the economic injustices reflected in barely functioning health care systems are depoliticised.

The literature on citizenship and new technologies of government illustrates the extent to which infectious disease is always political. This is especially the case for marginalised groups. These diseases have also given rise to new forms of citizenship and forms of government, which themselves introduce new power dynamics and call into question previous forms of solidarity. What is more, the literature under review here has shown that global health governance has undergone a simultaneous de-politicisation and technocratisation. Ebola is transmitted differently and has been less framed as a sexual disease, but has evoked similar international reactions and dynamics to HIV/AIDS. What I will be exploring is how a Black studies approach can add new understandings to the international making of Ebola and its responses in a postcolonial context.

3.4.3 Discursive and conceptual framings of global health

Health, government and securitisation

Infectious diseases have often been framed as security threats. As Waldby (1996, p.1) puts it: 'Declarations of epidemic are declarations of war.' While historic concern with infectious diseases was often framed in explicitly economic terms (Allin, 1987, p.1046) recent discursive framings of epidemics are more diverse. Discourses now often make

active use of a vocabulary traditionally associated with warfare and national security threats.

Felice Batlan (2007) describes the similarities between the American government's stance on infectious diseases such as H1N1 and terrorism. Both, she argues, enable the government to deploy extraordinary powers that will rarely be questioned because both terrorism and infectious disease threats play directly to a nation's fear. She further argues (2007, p.55) that it is not only the epidemic threat that is now framed in security terms. On the contrary, she designates the detention of inmates in Guantànamo Bay as 'political quarantine'.

In a similar vein, anthropologist Jean Comaroff (2007) writes, among others, about the detention of seropositive Haitians in Guantànamo Bay in the early 1990s. The latter had fled Haiti after Jean-Bertrand Aristide's democratically elected government was overthrown in a violent military coup (Paik, 2013, p.155). Comaroff argues (2007, p.208) that their detention by the U.S. military 'foreshadowed' the subsequent extra-legal detention of inmates during the war on terror.

Stefan Elbe (2005, p.403) argues that one of the reasons for framing the HIV/AIDS epidemic in security terms is the epidemic's scale. Elbe explores the dangers inherent in the merging of epidemic and security vocabularies and discourses in the politics of HIV/AIDS. He argues further that the integration of population dynamics into global security deliberations constitutes an act of biopower. Using Foucault, Elbe (2005, pp.408-410) contends that one of the risks of securitizing AIDS is the development of a society in which racism works to dismiss life that does not contribute to the maximisation of health; in other words, a society in which the death of some is deemed beneficial for the strength and health of the society as a whole.

Elbe (2009, pp.4-8) expands on these ideas by arguing that the incorporation of HIV/AIDS into the contemporary global security paradigm poses the following questions: how does the meaning of security shift from the absence of war to national or human security? And how does this shift enable governments to expand the realm of security and surveillance within international relations? He subsequently answers these questions by arguing that 'the securitisation of HIV/AIDS is a contemporary manifestation of the governmentalisation of security' but that the majority of potential downsides of securitisation did not manifest.

Colin McInnes and Simon Rushton (2010, 2012) review the political development of the securitisation of HIV/AIDS. They (2012, pp.116-119) question the correlation

between HIV/AIDS and state stability that had been posited and assess the speech acts through which HIV/AIDS was placed high on the security agenda, whereas other deadly diseases, such as cancer or habits, such as smoking, were not.

Structural violence

A different way of understanding infectious disease politics is the structural violence approach proposed by physician and anthropologist Paul Farmer. Farmer (2001, 2005), who has extensive experience of working as a doctor and anthropologist in Haiti, points to barriers in accessing medication and health infrastructures as the main obstacles to eliminating infectious diseases worldwide. He (2001, p.3712) describes diseases as the 'biological expression of social inequalities'. Although also relevant to the Global North, this approach has found most traction with theorists focusing on countries of the Global South. For example, Biehl (2007, p.15) shows that the availability of medication in Brazil did not have an impact on big parts of the destitute (predominantly Black and Brown) population in Bahia, since the infrastructures, tasked with distributing it, were not functioning. I think it is important to keep Farmer's approach in mind when analysing infectious disease governance in relation to West Africa, because as Nguyen (2010) and Benton and Dionne (2015) have pointed out, the structural inequalities that shape West African modernity critically influence how politics of health play out locally.

Another important concept of Farmer's (2006) is what he calls 'geography of blame'. In his example, Farmer argues that, in the imagination of the United States, (Black) Haiti has always been a source of disease, unrest and poverty. Considering the designation of Sierra Leone as 'white man's grave' (Frenkel and Western, 1988, p.214), I explore in my research whether a similar racialised geography of blame influenced the international management of Ebola in Sierra Leone.

The making of postcolonial health

Craig Calhoun (2010, p.42) contends that 'emergencies are crises from the point of view of the cosmopolis'. This quote provides an apposite entry point for discussing global health and its relations to the (post)colony. Similarly to Treichler (1999, p.19), who argues that the power of definition over suffering and illness did not rest with the diseased body, the literature I review in this section contends that biomedicine and the discourse around infectious diseases continue to contribute to the definition of (post)colonial Africa.

Global health, according to Tamara Giles-Vernick and James L.A. Webb (2013, p.2), is an umbrella term, similar to 'economic development [which] likewise has meant

very different things to different people at different times.' The term's versatility, they contend, allows for an often uncritical examination of its dimensions, especially with regards to global health in Africa. They (2013, p.5) draw attention to the roots of modern day global health interventions on the African continent, their nature, and their similarities with colonial medicine. Disease-specific vertical campaigns, such as the ones described by Nguyen (2010) or Adia Benton (2015) with regards to HIV/AIDS in Burkina Faso, Côte d'Ivoire and Sierra Leone echo earlier mass vaccination campaigns or colonial concerns with malaria. Global health campaigns, no less than colonial medicine, therefore, should be questioned as to their motivation and apparent selflessness.

Colonial and tropical medicine

History and anthropology offer a wide variety of accounts of colonial disease control in Africa. These accounts focus on discursive techniques, urban planning and colonial governance. Luise White (2000, p.90) analyses vampire stories in East and Central Africa 'as a regional, colonial genre, the formulaic elements of which reveal an intimate history of African encounters with colonial medicine'. In terms of urban planning, Godwin R. Murunga (2005) analyses how colonial discourses surrounding bubonic plague in colonial Nairobi were used to justify spatial and racial segregation. Similarly, Stephen Frenkel and John Western (1988) study the politics of malaria prophylaxis and urban/racial segregation in colonial Freetown. Kalala Ngalamulume (2004) studies yellow fever and urban planning in colonial Saint Louis du Senegal and examines biomedicine as a tool of empire, as does Liora Bigon (2012, 2014, 2016) with Dakar, Lagos and Kumasi. Most authors focus on one site; Bigon (2016) however compares French and British colonial doctrine and disease control in different urban settings. Finally, concentrating on colonial governance, Guillaume Lachenal (2010) discusses the tensions between colonial medicine and bureaucracy in colonial Cameroon. He focuses on Haut-Nyong, a province whose political management was handed over to doctors in 1939.

A key theme in these articles is the finding that it was the disruption to economic activities as well as the threat to the colonial settler population that spurred the development of colonial medicine, often in combination with urban segregation policies. As Festus Cole (2015) points out in his analysis of the British medical policy in Sierra Leone around the turn of the 20th century, British colonial medicine was not concerned with indigenous health and the latter was only addressed when viral diseases threatened the colonial workforce and the colony.

Historian Megan Vaughan (1991, pp.8-9), in her historical analysis of medical discourses and the making of African subjectivities, tests whether Foucault's power/knowledge regime can apply to the African colonial context. She argues, similarly to Mbembe (2003), that in contrast to most European states, which Foucault theorised, power in colonial Africa was repressive. She continues by arguing that health and medicine were much less instrumental to the exercise of power in colonial Africa than they were in Europe and that, thirdly the emphasis in colonial Africa was much less on individualisation. Rather, as she explains (1991, pp.9-10), colonial subjects were counted and recounted in groups and these groups were associated with specific biological and social attributes. According to Vaughan (1991, pp.25), the power of biomedical discourses hence lay less in their ability to alter African bodies and more in their ability to normalise and pathologise them.

Margaret Lock and Vinh-Kim Nguyen (2010) focus on the relation between colonialism and modern biomedicine. One of their main arguments is the refutation of biomedicine as a Western science, which was subsequently exported to the colonial world. The contention that biomedicine is a neutral tool, applicable everywhere and not requiring local adaptation, is at the basis of many modern global health programs implemented on the African continent. Lock and Nguyen (2010, p.148) identify four crucial phases in the development of biomedicine and the colonial world: the imperial (before 1920); the colonial (1920 – 1960); the nationalist (1960 - 1980) and the NGO phase (1980 – today).

Writing about Louis Pasteur and the 'Pasteurian' influence on colonial medicine, they argue (2010, p.153) that biomedicine, and microbial approaches to understanding diseases disregarded local colonial ecologies despite their importance. Rather than focusing on a logic of improvement, something that would become more prominent during the colonial and subsequent phases, their approach targeted the human body, understood to be universally the same. Bruno Latour's (1993, pp.140-145) account underlines the crucial role that Pasteurian microbiology played in the French conquest of colonies in Asia and Africa. He emphasises the colonial logic, which Pasteurians claimed for themselves as well as the local conditions, which allowed them to implement their all-encompassing visions for colonial health. Nguyen and Lock (2010, p.153) agree that these approaches were successful because it was possible to 'enforce control measures on a pliant colonial society to stop the transmission of infection'.

Indeed, Pasteurian approaches to local ecologies offer interesting insights into colonial understandings of place. Although tropical diseases were very much understood

as being ‘proper to a place’ (Patton, 2002, p.34), an understanding of the dynamics and histories that went into the making of places was not taken into account. Hence, as Cindy Patton (2002, p.35) explains, despite the conceptual anchoring of certain diseases in the tropics, the latter would only qualify as diseases when infecting the colonial body. She identifies this as one of the mechanisms making the ‘first world body’ out to be the proper measure of health. This aligns with the writings on HIV, the nation state and identity, discussed earlier, in that it marginalises ‘deviant’ suffering. Patton (2002, p.38) concludes the following:

> These diseases, which are regulated by national medical establishments but which are also regulating - of those who have them - doubly but asymmetrically marked space: where there are tropical diseases, there must be lack of civilization (tropics), and where there is civilization there must be lack of (tropical) disease.

She further argues (2002, p.38) that ‘epidemiological narrative is most visible as it constructs movement, tropical narrative as it constructs place’. Comaroff (2007), in a similarly constructivist vein, extends this thought. Not only is tropical disease inherent to a place, but she argues in relation to HIV/AIDS, it is often deflected onto Africa.

An analysis of literature on biomedicine’s colonial and imperial role is an important foundation for analytically placing the British-led international Ebola response in the colonial wake. Specifically, it puts a reading of contemporary health interventions and programmes into perspective, by pointing to resonances between colonial and current periods. In chapter seven I assess whether the framing of movement and place in colonial and antiblack constructions of infectious disease is replicated in the 2014-15 Ebola response. I now turn to further aspects of how contemporary global health has shaped, and plays out in Africa.

Fragmentation

As Ruth Prince (2014, p.13) writes, social scientists have analysed global health and biomedicine as systems of power and knowledge contributing to coloniality. Prince argues that knowing about the colonial nature of public health on the African continent provides historical context as to the current fragmented state of African health care systems. She writes (2014, p.1) that public health in Africa has never been unitary or all encompassing. On the contrary, colonial medicine had a strong focus on urban areas rather than rural ones and changed in intensity depending on international politics or the threat of epidemics (Prince, 2014; Cole, 2015). Furthermore, colonial medical campaigns

were to a large degree conducted by missionaries (Vaughan, 1991; Nguyen, 2010; Prince, 2014).

As Giles-Vernick and Webb (2013, p.5) point out, the majority of contemporary health care programs are 'vertical and disease-specific' and constitute a 'portable universal good.' This conceptualisation of programs of disease eradication is in line with an understanding of biomedicine as developed during the colonial era. As Lock and Nguyen (2010, p.153) have pointed out an understanding of biology as universal allowed for the application of biomedical interventions without needing to know the local context. This seems to me to be one of the main features of contemporary health systems in postcolonial Africa. The application of supposedly universal solutions to medical or other problems is a common feature in global development politics, with Structural Adjustment Policies (SAPs) operating in a similar fashion.

In his ethnography of HIV/AIDS politics in Burkina Faso and Côte d'Ivoire, Nguyen (2010) identifies the layering of triage as one of the main phenomena in recent history. He argues that its use destroyed pre-existing local solidarities that had formed among people carrying the virus. Nguyen (2010, p.177) points to this current medical triage as being only one in a long line of triages. Starting with the colonial era, he contends that triage in the time of AIDS recalls colonial policies of ethnic division, i.e. the classification of human beings into different 'tribes'. In Côte d'Ivoire, as in many other countries, these divisions, together with an economic crisis induced by the imposition of SAPs throughout the 1970s and 80s, came back to haunt the independent republic and culminated in a coup in 1999 (Nguyen, 2010, pp.168-169). Nguyen (2010, p.174) thus sees contemporary AIDS politics and triage as the last stage in this slow erosion of sovereignty in Côte d'Ivoire.

New selves and others

Nguyen (2010) examines how the receipt of medication was in the 1990s often dependent on the performative nature of public confessions involving one's seropositivity. These confessions were introduced to West Africa by international NGOs, which imported them from North America. Nguyen argues that not only did these performances echo evangelical confessions introduced to the region by colonial missionaries, they effectively contributed to the making of a 'better' healthier self, by encouraging the patient to improve him or herself. Benton (2015) has pointed out that while these confessions and group sessions are a frequent requirement by INGOs, wealthier patients avoid participation by paying for medication in private practices. Thus, self-improvement

becomes a condition of survival only for those members of the society who cannot afford to pay for medication and are subject to the rules of national and international organisations. This making of new selves and the subsequent differentiation from others is one aspect of biotribalism.

Benton (2015) take this concept up in her ethnography on HIV exceptionalism in contemporary Sierra Leone. Biotribalism occurs in a society in which spaces and resources are attributed to individuals based on the presence or absence of a disease (Benton, 2015, p.16). According to her, the exceptional political and financial position attributed to HIV/AIDS within global health funding leads to fierce competition for available resources, which, as suggested by Nguyen (2010) can lead to the destruction of existing forms of solidarity. It poses real problems for people not afflicted with HIV, since less and less funding is reserved for other illnesses (Benton, 2015). Thus, similarly to Nguyen, Benton (2015, p.141) argues that the exceptional role of HIV/AIDS – HIV-Exceptionalism - has led to new forms of inclusion and exclusion within Sierra Leonean society.

Biotribalism is not only an effect of HIV/AIDS funding though. Prince (2014, p.5) contends that the African continent has seen a general shift in health regimes during the 60s and 70s as developmentalist politics had to make way for the neoliberal logic imposed on them by SAPs. The state remains, despite the increasing NGO-isation of health systems, an important player in African health politics. As Benton (2015, p.17, p.143) points out, many Sierra Leoneans look to the state for care and resources. The fact that they are increasingly being dispensed by international organisations does not remove expectations for service delivery and care. In the inverse logic, many Sierra Leoneans also feel responsible and are expected to care for the state by staying healthy.

Benton and Nguyen offer important and compelling accounts of the politics of HIV/AIDS and the interactions between civil society and national and international governmental and nongovernmental agencies more generally in West Africa. Their ethnographies strongly inform my analysis because of their topical relevance – the government of disease in an international postcolonial setting with a specific focus on West Africa.

3.4.4 Ebola in global health

Most articles on Ebola that have emerged during the course of the most recent epidemic are anthropological in nature, the rest adopting medical and political viewpoints. The majority of these articles worked to relativize fears and stigma surrounding the outbreak

and the disease, such as Paul Farmer (2014) offering medical and logistical reassurances as to the contagiousness of the disease and how to fight it or the articles on the Ebola Response Anthropology Platform (i.e. Wigmore, 2015) or the reports on Ebola Deeply (i.e. Honigsbaum, 2015) offering cultural context as to the local reluctance to engage in safe burials, community engagement and quarantine. Adia Benton (2013, 2014, Benton and Dionne, 2015) has analysed both the history, militarisation and racial politics of the West African Ebola outbreak.

Mary Moran and Daniel Hoffman (2014) have curated a series of short articles on Ebola. Including regional specialists such as Ferme, Richards and Nguyen, each article focuses on a different aspect of the disease. Common themes are local perceptions of the epidemic, a change in discourse as the epidemic worsens, the militarisation of quarantines and the reflection of people's mood through popular music. These articles offer interesting insights into the many ways in which Ebola has influenced and sometimes altered local norms and habits.

Another, more in depth account, of an Ebola outbreak was written by Bonnie and Barry Hewlett (2008), two anthropologists accompanying and advising a WHO team in Africa. Their book is based on two 'outbreak ethnographies', one in Uganda between 2000 and 2001 and on in the Democratic Republic of the Congo in 2003. Their work presents a cultural and social analysis of local populations and their relation to disease and foreign medical interventions. Theirs is also one of the first accounts based on interviews with people in communities affected by Ebola and one of the first to record their perspectives. Writing on the 2000-2001 Ugandan Ebola outbreak, they argue (2008, p.40) that a failure to understand differential kinship systems led to failures in infection tracking by international epidemiological teams. Hewlett and Hewlett (2008, pp.44-47) also illustrate how local interpretations of Ebola as bad spirits (*gemo)* served as an effective way of slowing infection. Locally, it was advised to avoid spatial proximity with persons possessed by *gemo*, since that makes it easier for it to 'catch you'.

Since the beginning of the outbreak, analyses of both the epidemic and response have multiplied. Paul Richards (2016, p.7) book *Ebola - How a people's science helped end an epidemic* studies Ebola as 'a disease of ignorance'. He notably argued that the international response, with its influx of workers, building of treatment centres and improved logistics, worsened the epidemic because it increased healthcare worker infections. Richards (2016) importantly highlights the community response and the level of human adaptation in ending the West African outbreak.

A number of books took sweeping, multidisciplinary approaches to studying the outbreak and response. Sam F. Halabi et al.'s (2016) volume assesses the meaning of the Ebola epidemic for public and global health management. Reuniting accounts by leading medical experts and global health practitioners, this books offers a detailed discussion of the challenges and ethical questions facing the future of global health. Ismail Rashid's and Ibrahim Abdullah's (2017) anthology *Understanding West Africa's Ebola epidemic – Towards a political economy* is unique in that it prioritises analyses by scholars from the region. Dealing with a number of socio-economic issues that shaped and resulted from the 2013-16 Ebola epidemic, it argues that neoliberalism created political and structural conditions that made it impossible for Guinean, Liberian and Sierra Leonean governments and health systems to respond appropriately and also points to the ways in which the delayed international response was symbolic of global economic inequalities.

Nicholas G. Evans et al.'s (2016) edited volume offers a nuanced and critical account of the international response, drawing on analyses by practitioners involved in the response and scholars familiar with the region. Calling the epidemic '[a] disaster […] of the developed world's making' (Evans et al., 2016, p.xi), the volume advocates for the importance of a multidisciplinary approach to the management of global epidemics. Importantly, it includes discussions about the racism inherent in and revealed by the framing of the American Ebola response, which I review further down. Commissioned and edited by MSF's Michiel Hofman and Sokhieng Au (2017), *The Politics of Fear – Médecins sans frontières and the West African Ebola epidemic* similarly draws on a multidisciplinary group of authors to discuss fear as a predominant factor shaping international and national response mechanisms. Finally, Sinead Walsh and Oliver Johnson's (2018) book on their involvement in the Sierra Leonean Ebola outbreak constitutes a deeply personal and instructive account of the Sierra Leonean response. Walsh, being Ireland's ambassador to Sierra Leone at the time, and Johnson, the director of King's Sierra Leone Partnership in Freetown, offer a thoughtful and reflective account of the development of the epidemic in Sierra Leone and their own experiences in Sierra Leone, trying to stop its spread.

A number of articles also focused on more specific issues related to the management of the epidemic. Due to the quantity of said articles I only review a few here and forego medical accounts. Greenberg et al. (2019) identify flexible work places, family support and reliable medical training as well as a duty to intervene as factors motivating US-based healthcare workers to respond to the West African Ebola outbreak, while negative media

coverage constituted a discouraging factor. Desclaux et al. (2017) argue that the continuous provision of accurate information, financial compensation for lost income and psychological support are essential for compliance among quarantined Ebola contact cases in Senegal. Finally Wilkinson et al. (2017, p.5) critically examine the notion of 'community' to argue that, despite increased awareness of the importance of including local communities in Ebola responses, frequent references to 'community' engagement continue to obscure social power dynamics and reify local communities as romanticised 'grass-roots collegiality'.

Few accounts have mentioned and analysed the racism that underlay reporting of the West African Ebola epidemic and elements of its management. Benton (2014) comments on the underlying racism in the WHO's decision not to medevac Sierra Leonean doctor Olivet Buck after she contracted Ebola working in a Sierra Leonean hospital. Meanwhile two Dutch volunteers were medevaced back to the Netherlands on the suspicion of having become infected with the virus. In Evans et al.'s (2016) volume several chapters are dedicated to the anti-Black and anti-African racism that shaped the American response and its framing. In one of them Benton (2016c) analyses Presidents Johnson Sirleaf and Koroma's public assurances that they would do all they could to prevent their citizens from spreading Ebola to the United States as an expression of internalised racial hierarchies, in which the well-being of the US populations is posited as more important than that of their own populations in Liberia and Sierra Leone. Kim Yi Dionne and Laura Seay (2016, p.95) meanwhile analysed the 'longstanding ethnocentric and xenophobic popular understandings of Africa' prevalent in the United States and argued that they shape epidemic responses in that they discourage people from following public health instructions. Finally, the only existing in depth analysis of Ebola and racism is Charles T. Adeyanju's (2010) study of the 2001 Ebola scare in Ontario, Canada in which a Congolese woman was suspected of bringing Ebola into the country. As Adeyanju (2010) writes, beyond the panic around the suspected Ebola case a deep-seated racism towards Hamilton, Ontario's Black community, transpired. As Gilman (1988) wrote with regards to the association of syphilis with the 19th century German Jewish community, Adejanyu (2014) points out that fear of disease, in the case of Ebola, has long been entangled with anti-Black and anti-African feelings.

3.4.5 Summary

The expansion of global health interventions in sub-Saharan Africa has given rise to new forms of sovereignty and citizenship in the context of increasingly fragmented health systems and services. The technocratisation of international health services has, at times also led to their depoliticisation by service providers. This is reminiscent of colonial medicine, whose dynamics and logics it thereby perpetuates. Ethnic, racial and sexual characteristics have long been entangled in marginalising and stigmatising ways with disease and medicine. Drawing on Christina Sharpe's (2016) work and Black studies more generally, I aim to extend the few existing accounts that examine Ebola and racism/antiblackness. By doing so I aim to contribute to the varied literature on the 2013-16 West African Ebola outbreak and to deepen the focus on the colonial continuities at play in global health practice and to analyse and rectify the absence and marginalisation of antiblackness in existing analyses of the response.

3.5 Conclusion

In this literature review I have attended to four fields of literature: literature on Sierra Leone, on biopower and biopolitics, on the politics of (global) health and, relatedly, on the West African Ebola outbreak. As I have shown, analyses that take antiblackness into account are rare, if not non-existent in all four fields. I argue here that an approach ignoring the implications of colonial medicine and infectious disease control for contemporary practice-focused understandings of space and health in a postcolonial context would ignore important signs of being in the wake. But assuming, as is often done with biomedicine by practitioners and policymakers, that infectious disease control is an immutable mobile (Latour, 1986) without history would be to ignore its entanglement with an antiblack and colonial past. Analysing whether and how these pasts of colonial infectious disease control influenced the 2014-15 Ebola response makes up an integral part of my thesis. An approach that engages with Black and postcolonial theories then aims not only to uncover the underlying antiblackness that continues to exist in global health, but also to understand how colonialism and antiblackness shape which realities are given prominence.

chapter FOUR

4 Non-linearity and care: researching antiblackness in global health

4.1 Introduction

In this thesis I drew on methodologies inspired by Black studies and decolonial sensibilities to study the 2014-15 Ebola response. As with the rest of this thesis I used Sharpe's (2016) *In the wake* to think through my research design and methodology. Sharpe (2016, p.13) describes her work as a methodological invitation:

> The work we do requires new modes and methods of research and teaching; new ways of entering and leaving the archives of slavery, of undoing the "racial calculus and…political arithmetic that were entrenched centuries ago" (Hartman 2008, 6) and that live into the present. […] With this as the ground, I've been trying to articulate a method of encountering a past that is not past. A method along the lines of a sitting with, a gathering, and a tracking of phenomena that disproportionately and devastatingly affect Black peoples any and everywhere we are. I've been thinking of this gathering, this collecting and reading toward a new analytic, as the wake and wake work, and I am interested in plotting, mapping, and collecting the archives of the everyday of Black immanent and imminent death, and in tracking the ways we resist, rupture, and disrupt that immanence and imminence aesthetically and materially.

For this research project I conceived a methodology that, to paraphrase Sharpe (2016, p.13) both analysed a past that is not past and contributed to mapping and collecting an archive of the everyday of Black death. As such my project situates the Ebola epidemic in Sierra Leone amidst an assemblage of historical and contemporary antiblack violence and Black death; it situates the response among a broader network of lines and spaces, ship voyages and plane journeys, vectors, viruses, infrastructures, people, matter and ideas that span the North Atlantic. My main focal points within this network are:

1. British colonial archives of quarantine and disease control
2. The present-day Sierra Leonean diaspora in Britain
3. International responders to Ebola who moved between Britain and Sierra Leone
4. Fieldwork in Sierra Leone and ethnographic observations in London

These focal points enabled me to explore the geographical, political and epistemic reality of the wake and to analytically place the 2014-15 British-led international Ebola response therein. My non-linear, multi-sited research design is one possible response to Sharpe's (2016) methodological invitation. My research design enabled me to explore the relevance of Black studies and geographies in understanding epidemic responses in postcolonial West Africa and global health politics more generally. Given the post-enslavement and postcolonial nature of British-Sierra Leonean relations I have also striven to maintain decolonial sensibilities. As Linda Tuhiwai Smith (1999, p.2) has pointed out, research is a 'significant site of struggle between the interests and ways of knowing of the West and the interests and ways of resisting of the other.' In recognition of this struggle, I considered how coloniality entered into and shaped the research process itself. A full list of primary sources I located and engaged with, many of which I cite in this thesis, can be found in Appendix 1.

Here I start by outlining issues of positionality and reflexivity and cover ethics, risk assessment and consent before explaining my approach to data gathering, analysis and writing.

4.2 Positionality and reflexivity

In this thesis I brought together two academic fields whose approaches to positionality and reflexivity are radically different. In much global health and medical research the positionality of the researcher remains unknown and unquestioned and when taken into account has at times been used to exacerbate health and power inequalities (Aronowitz et al., 2015). In Black studies however, the researcher's positionality, especially with regards to race and gender, is omnipresent. In this research project, my positionality as a Black woman researcher, a member of the West African diaspora in Europe and a European citizen influenced my research design and outcome in two ways, which I outline below: mobility privilege and intersectional vulnerabilities.

4.2.1 Researching while diasporic and Black: mobility privilege and intersectional vulnerabilities

I benefitted from my identity as a member of the West African diaspora with European citizenship. At the same time living and researching at the intersection of being a young,

mixed-race woman of African descent also put specific limitations on how I could conduct this research project.

Mobilities played an important role in my thesis in terms of studying (anti)Blackness and international infectious disease control. All four research sites are constituted through mobilities between West Africa and the UK, either professional, personal or material: I traveled to Sierra Leone on two occasions to conduct fieldwork, healthcare workers and members of the Sierra Leonean diaspora moved between the UK and Sierra Leone; government memos, letters and telegrams were shipped, flown and sent between Freetown and London, where they now constitute British colonial archives of disease control. Mobilities also shape my life as a member of the West African diaspora living in Europe. Despite my Black diasporic identity, my mobilities highly resembled those of British-based international health responders who decided to travel to Sierra Leone to work on Ebola in the sense that in the long term my livelihood and identity did not depend on travels to Sierra Leone.

In contrast to some members of the Sierra Leonean diaspora in the UK, I hold a European passport. This facilitated my research mobilities both within Europe and internationally. I did require a visa to travel to Sierra Leone, but received it without problems. The postcolonial politics of passports and international research, which I touch upon in my analysis, did not apply to me due to my German passport. It would have been much more difficult, maybe impossible, for an African researcher to conduct my research project. As several journalists and commentators recently pointed out, the UK Home Office denies visas to African researchers on prejudiced and arbitrary grounds (Grant, 2019). Yei-Mokuwa et al. (2019) discuss the implications for research of African researchers being twice as likely as researchers from other regions to see their visa requests to the UK denied. Both pieces (Grant, 2019; Yei-Mokuwa et al., 2019) describe the prohibitive nature of the UK's visa policies with regards to African health researchers working on Ebola. At the same time, a majority of documentation relating to early governmental disease control efforts in Sierra Leone are held by British archives in the UK and can only be accessed locally. As such, the ability to conduct critical research on antiblackness in global health in the colonial wake relied on my privileged position of being a European citizen with a powerful passport.

My Black and African diasporic identity has furthermore placed me in a very particular position with regards to my work in relation to sub-Saharan Africa. On the one hand, I believe that it allowed me to gain privileged access to diaspora communities by sharing

the characteristic of being part of the *here* while still retaining strong links to the *over there* (Smith, 1999). Laura Nader (1972) and Ulf Hannerz (1998) describe this process of studying one's own community as 'studying sideways'. I am a member of the West African diaspora in Europe, though neither Sierra Leonean nor British, which afforded me a certain level of inclusion and simultaneous distance in my research into the Sierra Leonean diaspora. Especially when it came to discussions of Blackness and race I think that my status as a Black woman influenced the information I received.

With regards to doing research, Smith (1999) however points to the difficulty of being between two worlds, in terms of negotiating politics of epistemic ownership and trust. As she (Smith, 1999, p.14) writes, sharing ethnic and/or cultural traits with the community one researches is not always an advantage. She argues that white researchers in comparison to researchers stemming from indigenous communities, can be seen to embody a higher form of authority and prestige. I have both experienced and written about the challenges of conducting decolonial research that is aware of colonial-racial power dynamics in sub-Saharan Africa while being a young woman of African descent (Hirsch, 2019a). As a young Black diasporic woman without male family connections, my presence and movements in Freetown were a source of sexualized advances and comments. Due to earlier experiences of intense sexual harassment and assault in sub-Saharan Africa, the time I spent in Freetown by myself was thus limited and my movements through the city were carefully regulated.

Colonial-racial and gendered professional hierarchies played out in different ways during my research in the UK as well. In my interviews with experts and practitioners who have worked in Sierra Leone and have now returned to the UK, I made use of my past work experience and identification as a development worker in sub-Saharan Africa. These identifications and my knowledge of the development community and of having worked in sub-Saharan Africa were useful in creating bonds and giving me legitimacy. At the same time, especially in my interviews with medical responders, my lack of a medical or health background at times left me feeling insecure. This was compounded by the fact that the majority of doctors I interviewed were men, while women made up a majority of nursing and non-clinical staff. Here my desire to appear knowledgeable clashed with my need to ask detailed, simple questions about basic medical practices and ask for detailed descriptions.

Although I am neither a health worker nor someone who was directly affected by the Sierra Leonean Ebola epidemic my personal encounters with European biomedicine

have at times been tinged by antiblack racism. When I was 17 an unaccompanied GP visit resulted in a German doctor misdiagnosing a rash on my leg to be a sign of AIDS (I presume he mistook it for Kaposi's Sarcoma), despite my well-documented medical history of dermatitis. Sitting alone in that doctor's office he told me of his suspicion: "I think that could be AIDS." More recently, after returning from Sierra Leone, my dermatitis, which flares up in times of stress, resulted in a British GP prescribing me medication for scabies. "It does not look like scabies", she said, "but as you've just come back from Africa…". These instances are small, the latter more so than the former, but have, consciously or unconsciously, heightened my awareness of medicine's entanglement with antiblack and anti-African racism, which I explore in this thesis.

When it comes to doing research in archives, I experienced how being Black did not go unnoticed and that it could, on the contrary, lead to instances of antiblack racism. Dealing with these instances in a way that allows me to pursue my research is challenging. As such, this thesis is necessarily a personal one, not only in the sense that I authored it, but also in the sense that the antiblackness I studied was in one instance directed at me.

4.2.2 Reflections on Black-inspired methodologies and decolonial sensibilities

The originality of my methodology lies in its non-linearity and multi-sited-ness and its translation of Black archival methods into a broader qualitative research project on global health. Here I first explain my non-linear and multi-sited research approach before delving into two principles of Black archival methods that I used to guide my overall methodology.

Rather than studying the Ebola response in one site and focussing on one type of interlocutor and timeline, I move between times, spaces and groups of responders: colonial infectious disease specialists, members of the Sierra Leonean diaspora and British-based international medical responders to the 2014-16 Ebola epidemic. This temporal non-linearity is derived from the Black studies imperative that the past is not past. As such, moving between archival accounts of colonial infectious disease control in Sierra Leone and contemporary accounts of international and diaspora responders to the 2014-16 epidemic, I draw out practical similarities and colonial continuities. By adopting this approach I argue that the colonial wake manifests not only in neo-colonial practices, such as military or political occupations (Gregory, 2004), but also in the uninterrupted use of or reliance on knowledges, infrastructures and places whose origin and historical use is entangled with antiblackness.

Similarly the multi-sitedness that characterises my approach suggests that the study of the colonial wake cannot be restricted to one geographical area. British colonisation of Sierra Leone relied on decision-making and political processes in the UK. The geographical presence of British colonial bureaucrats, governors and citizens in Sierra Leone was but one element of British colonisation. A similar dynamic manifested during the Ebola response, in which decisions were partially taken in the UK. In my research design I take this into account and study the Ebola epidemic in the colonial wake in four sites, three of them predominantly in the UK. Following Sharpe (2016, p.13) this serves to assemble a mosaic of the wake. It also serves to counteract the hierarchies at play in the Ebola response. The inclusion of members of the Sierra Leonean diaspora in the UK especially, at times provided a counterweight to a linear interpretation of the response in which white British doctors saved Black Sierra Leonean Ebola patients. Similarly, I put contemporary dynamics of this British intervention in Sierra Leone into perspective by comparing them to historical infectious disease interventions during the colonial period. Both this non-linearity and multi-sitedness serve to capture the complexity of both the Ebola response and the colonial wake. I now turn to describe how I used two principles of Black studies, largely used in archival research to shape my research design and process.

Two ideas derived from Black studies guided my thinking on methodology in particular: care and what I call 'foregrounding'. Following Sharpe (2018, p.174) care as a methodological principle corresponds to avoiding the reproduction of (accounts of) violence perpetrated against Black peoples. While this principle derived from Black studies' engagement with colonial and slavery archives (Hartman, 2008; McKittrick, 2014; Fuentes, 2018), Bressey (2011) asks similar question with regards to the use of photographic archives of Black subjects in asylums in 19th century London. I adopted care as an archival methodology but also extended it to my analysis of interviews and my writing process. Specifically this meant not reproducing the antiblack violence that I encountered in archival documents, but also abstaining from reproducing the Black suffering of Ebola patients that international responders relayed to me in interviews in this thesis. I adhere to this practice with one exception in chapter eight. Because the Ebola epidemic did not only take place in the wake of enslavement, but also colonialism, I follow McKittrick's (2014) suggestion, that decolonial or anticolonial research should not reproduce antiblack violence. So as not to reproduce Black suffering my focus in this

thesis was on silences, marginalisations and disconnects, rather than on the violence of the Ebola epidemic.

Similarly, what I term 'foregrounding' is a common archival practice in Black studies that brings to light the Black lives and experiences that are usually silenced in the archive. Foregrounding Black lives involves working with archival fragments, interpreting gaps in the archive and annotating what is left unsaid (Bressey, 2006; Hartman, 2008; Fuentes, 2018). Again, following McKittrick (2014, p.19) I relied on archival research as a way to examine how colonialism 'tells us about the ways in which the practice of [colonialism] set the stage for our present struggles with racism' in global health. At the same time I adopt 'foregrounding' as a methodology beyond my archival work to include my data analysis and writing process. I drew on examples of foregrounding (Hartman, 2008; Sharpe, 2016; Fuentes, 2018) to think through the unsaid, the silent reality of the wake. The silences I encountered were twofold: in colonial archives of infectious disease control these silences hid the Black life that colonialism sought to regulate. In interviews with international health responders and members of the Sierra Leonean diaspora in the UK the silences encompassed the history of antiblackness that characterised British involvement in Sierra Leone generally and in terms of health interventions specifically. At times, I filled these silences with accounts of the diaspora. At times I let silences stand to show the reality of the wake in which silences of past antiblackness and of the wake are normalised.

Finally with regards to the decolonial sensibilities that I highlighted in this chapter's introduction, I drew on Linda Tuhiwai Smith's (1999) seminal work *Decolonising Methodologies*. I set out to acknowledge the complexity of power relations at work in my research and worked to counteract the power dynamics that underlay my research encounters. I therefore endeavored to do two things: I engaged in what Smith (1999, p.15) has termed 'reporting back and sharing knowledge'. For this purpose I wrote short reports tailored to both the diaspora and British health responders that I shared and discussed with representatives of both groups. The emphasis lay on sharing knowledge in contrast to the mere sharing of information. At the same time, I was careful to protect my own – often precarious – position as a woman researcher of African descent. This meant for instance that I did not return to one particular archive after being subjected to antiblack racism.

4.3 Ethics and Risks

In this section I offer a description of the ethical issues that arose during my research and how I navigated them. Specifically I briefly discuss how I navigated intense emotional reactions and the narration of traumatic events and then in more depth the challenging and at times uncomfortable position of 'studying up' (Nader, 1972) in a multi-sited research project. My research was given the appropriate UCL ethical approval and is registered under the project ID number 9877/001. For the two field trips to Sierra Leone I completed risk assessments. All interviewees' names have been pseudonymised.

4.3.1 Navigating traumatic events

I was aware when applying for UCL ethics approval, that interviewing responders and members of the Sierra Leonean diaspora in the UK about their involvement in the Ebola response could potentially trigger intense emotions. In order to shield interviewees from reliving traumatic or sad memories, none of my questions related to family members, acquaintances or colleagues' infection with Ebola. Nor did I ask interviewees to describe the suffering they witnessed either directly or remotely or ask for identifying or general details about the development of EVD in patients. Instead my research focused on the spatial and material practices of being involved in the response, either as part of the diaspora or as an international health worker.

Nevertheless some interviewees volunteered detailed descriptions of suffering and death, of neighbours and family members dying. Nina, an IPC nurse, spoke to me about the benefits of speaking about the trauma of working in the response with others:

> It was really a traumatising experience. When you just carry on and you don't get a chance to actually absorb what's happened. And I had a lot of friends who had done the same as me like worked during the epidemic and stayed on and got jobs afterwards and every time we'd meet up we'd just talk about these traumatic things that happened and particular instances because… We just went over the same things again and again because we needed just to process it.

I think those interviewees who did speak about deaths and gave detailed descriptions of the suffering they saw wanted to talk about it and maybe, like Nina, saw it as a form of processing. In the 44 interviews I conducted, two interviewees started to cry. As I described in my ethics application, my plan, should such a situation occur, was to stop the recording, pause the interview, offer reassurance and sit with the interviewee. In both instances I offered to end the interview or to go for a walk, to talk about something else

or to take the interview up another day. Both interviewees declined all options and decided to continue with the interview. I told all interviewees at the beginning that they should take charge of the voice recorder and stop or start it as they saw fit, so as to give them control and autonomy over the interview process. I started the interview by showing them how it worked and how to start, pause, or stop the recording. Few did so and for the most part the recording device lay in the middle of the table, an alien object that they did not seem to want to be in charge of. In these two instances however I told the participants that we would just continue talking and they should switch the recorder back on once they felt compelled and composed to do so. Interestingly, neither of the two cried when describing deaths or suffering. In both instances it was feelings of helplessness, of wanting to help, but encountering structural or individual obstacles in their efforts to stem the spread of the epidemic. I checked in with both persons after the interview, asked how they were feeling and whether they were alright.

4.3.2 Studying up in a multi-sited research project

I now turn to discuss the ethical implications and complications of studying up (Nader, 1972) in a multi-sited research project. As George Marcus (1995) points out, multi-sited ethnographies carry the risk of putting quantity before quality and resulting in superficial research. In my research this problem was compounded by the differential and changing research power relations in which I found myself in relation to international health responders, to members of the Sierra Leonean diaspora and trips to Sierra Leone and the archive. Here I explain how I mitigated these risks and complications by first focusing on the challenges that come with conducting multi-sited research before focussing on the changing power dynamics and especially the issue of 'studying up' (Nader, 1972).

I did not conduct ethnographies. Although my field trips to Sierra Leone were structured around ethnographic sensibilities (keeping a detailed diary, taking photos), I did not engage in participant observation, nor did I hone in on people's social and cultural behaviours. Overall my research analysed the Ebola response through research participants' discourses, archival material and online research. In total I conducted 44 in-depth, semi-structured interviews. The interviews stand at the centre of my research and are complemented by archival and online research and my fieldwork in Sierra Leone. Secondly, as explained above, my multi-sited analysis serves the bigger political purpose of demonstrating the omnipresence of the colonial wake and to remove the study of the

colonial present from colonised or occupied regions. As such, the multi-sited-ness of my study also serves to assemble the wake geographically and epistemically.

The different sites in which I studied the Ebola response in the wake also required different approaches in terms of navigating power. Especially with regards to my interviews with international health workers I engaged in practices of 'studying up' (Nader, 1972). Lena Sohl (2018) and Sarah Becker and Brittnie Aiello (2013) explore the tensions between 'studying up' and anti-racist and feminist work, especially in positions in which the researcher does not share the race, gender or economic privilege of those they research. This tension was in my research distributed between different sites. With regards to interviews with the diaspora the power dynamics at play corresponded to what Ulf Hannerz (1998) has called 'studying sideways', that is the study of one's own community. I did not hide the fact that I was not Sierra Leonean, but some interviewees or members of the community did not ask and possibly assumed that I was Sierra Leonean. Through a chance meeting with the Sierra Leonean High Commissioner in London I was invited to a Town Hall Meeting with the Sierra Leonean president Julius Madaa Bio, which was directed at the Sierra Leonean diaspora in London. Thus my identity as a member of the West African, rather than the Sierra Leonean, diaspora probably got blurred at some point.

The research I conducted with and on medical and global health experts (including medical responders) corresponded the most to the idea of 'studying up', that is to 'study the colonisers rather than the colonised, the culture of power rather than the powerless, the culture of affluence rather than the culture of poverty' (Nader, 1972, p.289). The vast majority of international responders were white, as were all of the experts whose discourses I analyse in this thesis. This racial difference came in conjunction with a clear epistemic power differential – my knowledge of IPC practices, epidemiology and global health was theoretical, not practical. As such, by studying antiblackness in global health by studying international health responders' narrations of the Ebola response I did not only engage in studying up, but navigated the added power dynamic of studying white medical practitioners as a Black social scientist.

I have strived to conduct ethical, transparent and respectful research. All participants were given participant information sheets that clearly stated my interest in the colonial period and my intent to use historical data to put contemporary experiences into perspective. The format of my interviews however meant that interviewees' awareness of my interest in the colonial period varied depending on their engagement and

interest in this aspect of my research. I did not mislead interviewees, but the clear Black studies framework that I adopt in this thesis only emerged towards the end of my fieldwork as did my focus on antiblackness and postcolonial silences. Consequently, while my fieldwork led me to adopt this focus, my analysis has evolved from the analysis I set out to do and has undoubtedly become more critical. Following Caroline Knowles (2006) I tried to embrace the feeling of discomfort that comes with critical research, especially in terms of exploring contemporary antiblackness or racisms. At the same time I argue that in this case the political value of placing the Ebola response in the colonial wake balances out concerns around the critical nature of my research.

All interview data were pseudonymised to protect the identity of research participants. I transcribed the interviews as soon as possible after the event and wrote down ethnographic notes in my fieldwork diary. The data was also kept safely on an encrypted, password-protected external hard drive, which I kept in a safe location and uploaded and stored on secure UCL systems.

4.4 Data Gathering

By splitting my fieldwork among four sites, I have aimed to draw out the geographical and political unboundedness of the colonial wake and pointed to colonial continuities in infectious disease control. This move has not only created a more differentiated account of the epidemic; by putting the different perspectives in conversation with each other I have aimed to reduce my own bias in the analysis and focus on the political silences and marginalisations implicit in these accounts. In total, I have conducted 44 interviews with 46 people. Three people were interviewed twice, and I conducted two group interviews, one in Sierra Leone and one in London. Seven interviews were conducted during my first field trip to Sierra Leone in 2016, the remaining were carried out either in person in London, Berlin or Geneva during my main fieldwork in the summer of 2017 or over skype or on the phone, if participants lived outside of London/the UK. (A full list of interviews can be found in appendix one.) While I strived to conduct half of envisaged interviews with international responders and the other half with members of the Sierra Leonean diaspora, I ended up conducting 21 interviews with international responders, 16 interviews with members of the Sierra Leonean diaspora who took part in the response from the UK, one with a member of the diaspora who travelled to Sierra Leone from London to work in Sierra Leone's National Ebola Response Centre (NERC), one member

of the diaspora who was deployed as part of her work for a major international health organisation, six Sierra Leonean responders who lived and worked in Sierra Leone at the time of the outbreak and one Sierra Leonean historian who wrote about the history of infectious disease control in Sierra Leone.

4.4.1 British archives of colonial disease control

In order to place the 2014-15 British-led international Ebola response in the colonial wake I had to first acquaint myself with colonial infectious disease practices and the discourses accompanying them. The reports and documents on infectious disease control in colonial Sierra Leone are dispersed between different archives in and around London, the UK and Sierra Leone. Indeed, the accumulation of documents and materials on Sierra Leone in several archives in the UK is but one result of British colonisation of Sierra Leone. Sticking to one archive thus would have given me a partial view of practices and processes. While I drew a majority of the archival sources cited in this thesis from the National Archives in Kew, conducting research at the Wellcome Trust archives was valuable to garner an understanding of non-governmental, academic approaches to British infectious disease control practice and research in Sierra Leone. What is more, studying two archives illustrated how historical realities are generated through archival practices and how these practices derived from colonial circumstances. These circumstances make it however possible to conduct archival research on colonial infectious disease control in Sierra Leone while being in London. The key materials for my research were located in The National Archives and the Wellcome Collection in London. These collections contained a wide range of materials (including first person accounts, plans, maps and photographs) concerning infectious disease control in Sierra Leone, West Africa and the British Empire more generally.[14]

While British archives contain a wide range of materials through which colonial disease control can be explored, it is also necessary to recognise the coloniality of the archive itself. Following Stoler (2010, p.215) I researched the colonial archive 'along the grain', by studying the genre and discursive construction of official writings on infectious disease control and infrastructure developments, all the while keeping the practices that have produced and preserved these materials in mind.

[14] In this thesis, in-text references to archival materials replicate the archival code (TNA for The National Archives and WC for the Wellcome Collection) followed by the archival reference number. A majority of archival materials in this thesis are located in The National Archives Colonial Office collection and are thus named CO followed by the reference number.

Recent years have seen increased academic and analytic engagement with the practices and places that constitute contemporary archives (Schwartz and Cook, 2002; Stoler, 2002, 2010, Burton, 2003). The archive accordingly is not only to be understood as an archetypical place of knowledge production and conservation, but as an exemplary place of knowledge-power (Ketelaar, 2002). Foucauldian and Benthamian readings of the archive as Panopticon or as 'system of […] enunciabilities' (Stoler, 2002, p.94) have engendered new points of analytic departure that open the archive up to new forms of epistemological critiques (Schwartz and Cook, 2002). Central to these critiques is a focus on the practices and performances that enact the archive. Drawing on Judith Butler's (1993) theory of performativity, archiving – and the archive per se – are seen as constituted by acts and practices, which produce a reality (Cook and Schwartz, 2002).

These critiques have influenced and in turn been influenced by scholars of colonialism and imperialism. Several authors have made the colonial or imperial archive the focus of their academic work (Richards, 1993; Stoler, 2002, 2009, 2010; Burton, 2003, Elkins, 2015). As Stoler (2002, p.97) points out, the link between epistemic production and the holding of power 'has long been a founding principle of colonial ethnography'. Analysing the archive as to the coloniality of its epistemic positionings and productions thus became a part of the study of colonialism within historical anthropology, geography and history. A focus on making and performing the colonial archive also opens the archive up to decolonial and Black critiques. If the archive is being enacted, those who enact it occupy an epistemic positioning, one that can be analysed as to its coloniality and antiblackness. Viewing the archive through a Black lens thus becomes a next possible step in moving from the 'archive-as-source' to the 'archive-as-subject' (Stoler, 2002, p.93). The 'archive-as-subject', rather than being a neutral place of knowledge preservation in my analysis, becomes a set of practices, enacted through a particular politics of knowledge. I aimed to question this politics of knowledge as to its persistent antiblackness and coloniality. As I have indicated above, I did so by relying on Black practices of reading the archive, namely 'care' and 'foregrounding'.

In keeping with both the recent developments in archival studies and with the Black methods and decolonial sensibilities, which I engaged in my research, I followed an approach based on ethnographic methods in my study of the archive. Such an approach aimed to support a reading of the archive-as-subject (Stoler, 2002, p.93) and thus focused attention on the practices and processes which constitute contemporary archives and their entanglement with coloniality and antiblackness. Such an approach also entails questioning not only the document's content, but its form; seeing the archive as a site of

potential colonial knowledge production, not mere knowledge preservation. As Stoler (2002, p.93) writes: 'What constitutes the archive, what form it takes, and what systems of classification signal at specific times are the very substance of colonial politics.'

Approaching the archive through ethnographic methods thus aims for the archive to be understood as part of a politics of knowledge production whose analysis cannot be divorced from the colonial and antiblack context which produced it. Such a process also builds on existing analytical and methodological approaches. The archive becomes a composition of three dimensions, each worthy of analysis in itself and in its relation to the other two: (1) archival content, (2) the practices that make this content and (3) the physical place in which this content is being made. With regards to locating antiblackness in the archives I extended my analysis from documents to the space of the archive to show how its structures and regulations enable the further exclusion of people of colour.

4.4.2 Interviews with members of the Sierra Leonean diaspora in Britain

The Sierra Leonean diaspora's position in the response is one of political and geographical ambiguity. Their geographical distance to Sierra Leone, yet intense involvement in the country's development and well-being, have been theorised in more general terms in literature on the African diaspora and development (i.e. Hall, [1999] 2018; Mercer et al., 2008; Mercer and Page, 2010). As Katherine Purvis' Guardian article (2014) described, diaspora efforts during the Ebola outbreak in Sierra Leone contributed to governmental efforts to curb the disease. Her article was useful in tracing the main British-Sierra Leonean stakeholders and the different shapes their responses took. The diaspora thus constitutes an important case study in both the exploration of knowledge and mobility practices and the role that they played in curbing the spread of Ebola during the recent epidemic. I proposed that the diaspora is especially important because it complicates the North-South, white-Black power dynamics that characterised the 2014-15 British-led international Ebola response.

Tracing and analysing diasporic mobilities and practices in the context of Ebola informed how diasporic mobilities, practices and realities were altered through the epidemic. As Nira Yuval-Davis (2011), among others, has pointed out, diasporic belonging transgresses national boundaries. It is this in-between-ness that makes the Sierra Leonean diaspora community in the UK particularly interesting in terms of their physical and epistemic mobilities. I suggest that these, in the case of infectious disease control and the Ebola epidemic are imbued with prior colonial geographies and mobility

practices. As such I analysed diaspora (im)mobilities in the aftermath of the colonial regulation of Black mobilities between Sierra Leone and the UK. I suggest that this offers an insight into colonial continuities and diasporic lives in the wake of antiblackness and Ebola. Consequently my questions evolved around interviewees' roles and responsibilities in the response and their mobilities between Sierra Leone and the UK.

Prior to my fieldwork I conducted a stakeholder mapping of diaspora organisations that was structured around three criteria: the organisation's location in the UK, their participation in the Ebola response and their membership as predominantly composed of members of the Sierra Leonean diaspora. This exercise revealed about ten non-governmental organisations and charities committed to increasing diaspora involvement in Sierra Leone with specific commitments to the eradication of Ebola. Although I contacted all of them, in the end it was a chance encounter at a SOAS-hosted event entitled 'Is a vision enough? What can we expect over the next 20 years from the African diaspora?' that gave me access to the Sierra Leonean diaspora. I happened to sit next to a young woman, who when I told her about my research identified herself as a member of the Sierra Leonean diaspora. She invited me to an event series she hosted, which initiated a snowballing effect (Valentine, 2013). It was this connection and the connections that I developed with other members of the Sierra Leonean community that proved vital. Zaria, a member of the community, told me about the importance of personal reputation and social investments:

> […] there's this whole big thing of sharing respect in our community so if somebody asked you to do something, you have to, you know, you do it. At this point I wouldn't necessarily be here if it wasn't for the fact that Musa had asked and recommended [you].

Musa was Zaria's brother-in-law and I had interviewed him a few weeks previously. A lot of my interviews came about this way, through recommendations and people putting me in contact with one another. The personal note and effort was highly important, something I noticed when potential interviewees responded much more to my phone calls than emails. While five members of the Sierra Leonean diaspora belonged to one organisation that had formed to give the Sierra Leonean diaspora response an official form and a forum, the majority had loose associations with various organisations.

Following Kesby et al.'s (2013, pp.160-162) 'Deep Participatory Action Research', I became involved in one diasporic initiative and, at their request, conducted a small evaluation of the impact of their events. I also continued attending various

diaspora events, both cultural and humanitarian. This became especially important after the Freetown mudslide, which occurred while I was doing my fieldwork. I attended planning and response meetings and fundraisers, volunteered help and checked in with interviewees as to their relatives' well-being. Given the contained nature of the mudslide, which killed more than 1000 people in one of Freetown's suburbs, much less international media attention was paid to this disaster, which saw a smaller yet similar response from the Sierra Leonean diaspora in the UK as the 2014-16 Ebola epidemic.

4.4.3 Interviews with international medical responders

Thirdly I interviewed international, largely British-based responders to the 2014-15 Ebola epidemic in Sierra Leone. In my interviews I focused on medical practices and response-related mobilities, although as my interviews progressed I increasingly abandoned set questions and simply asked interviewees to tell me about their involvement in the Ebola response. The interviews were thus largely semi-structured and open-ended. Interviewees varied in their professional capacity from health practitioners, such as nurses, doctors, public health experts or epidemiologists, but also included volunteers with no medical expertise who found themselves in the midst of the epidemic and decided to stay and help.

In this thesis I analysed international responders' narrations of their involvement in the Ebola response. With this group of interviewees especially, silences and discursive marginalisations became an important part of my analysis. This was not something that I set out to do, but a phenomenon that revealed itself through the course of my research. Thematically I also focused on mobilities and practices. In contrast to diasporic movement and the mobility of people within Sierra Leone, the movement of experts and practitioners increased with the onset of the Ebola epidemic. Following Doreen Massey's (2004) further development of Arturo Escobar's (2001, p.143) contention that 'culture is carried into places by bodies', I suggested that colonialism too can be carried into places by bodies. Here I studied international responders in the aftermath of enslavement and colonialism, both of which were shaped by white expertise, mobilities and access to medical practice, from which Black Sierra Leoneans were largely excluded.

Furthermore, epistemic and mobility practices of international responders involved in the epidemic were important because of the unique stake that they had in the definition, declaration and the shaping of the international response. This is illustrated by the fact that it took Médecins sans Frontières (MSF)'s urgent call about the severity of

the epidemic in Guinea and neighbouring countries to mobilise international attention, monetary flows and professional skills and expertise to be directed towards the region.

I gained access to these organisations in various ways. My first strategy was to email international and British-based organisations that formed part of the response. This was largely unsuccessful. Big organisations such as MSF and Save the Children do not necessarily support research that they did not commission. As such my requests for my calls for participants to be distributed through their networks went largely unanswered. The only big organisation that responded to my email was UK-Med. UK-Med, a Manchester-based medical NGO, specialises in recruiting medical personnel for humanitarian disaster relief on a global scale. In 2014 they were commissioned by the UK government to recruit health workers from the NHS to participate in the Ebola response (Redmond et al., n.d.). Their administrator shared my call for participants and four former responders agreed to be interviewed. Through snowballing I managed to then interview a few more. The most successful method was to get in touch with smaller medical NGOs. Through a friend I was put in contact with a medical doctor who had worked with London-based Organisation X which supported a hospital in Freetown. The organisation's administrator shared my call for participants with their medical volunteers and I was able to conduct 10 out of 21 interviews with international medical responders with health workers who had formed part of this organisation's Ebola response. The small size of the organisation is one of the reasons why both organisations and names are anonymised and pseudonymised in my thesis. The rest of interviewees was recruited through personal contacts that I either made in Sierra Leone, where I lived on the Save the Children complex in Freetown during my first trip in 2016, or through acquaintances.

4.4.3 Fieldwork and ethnographic observation

While the three sites I have just outlined constituted my main research sites, these were complemented by some exploratory fieldwork and ethnographic observation. I attended several events in London, one of which I analysed in detail in this thesis. Most notably I conducted two short fieldwork trips to Sierra Leone: one in May/June 2016 and one in March 2019. These two trips framed my fieldwork temporally. While my thesis is an analysis of the British-led Ebola response in the wake, and as such a big part of my interviews took place in the UK, it is also an exploration of British infectious disease control in relation to Sierra Leone. As such it was important for me to travel to Sierra Leone to allow me to ascertain the geographical reality of the wake, but also to explore

Sierra Leone in the aftermath of accumulations of violent events that caused Black death (the transatlantic slave trade, colonialism, the civil war, the Ebola epidemic, the mudslide). I speak here of ethnographic observation, rather than ethnographies, because especially the second trip was framed by very specific research aims that arose out of the interviews and archival research that I conducted throughout my main fieldwork period. Overall, I engaged in various forms of data gathering: I travelled to sites in and around Freetown that were connected to the transatlantic slave trade and the Ebola epidemic and response and took photos. I had conversations with Sierra Leoneans and internationals living in Sierra Leone on the Ebola response and life in Sierra Leone in general and on the transatlantic slave trade and British colonisation. These conversations were not recorded, but I wrote about them in my field diary. During the events I attended in London, I took notes and wrote down reflections, but did not engage in systematic ethnographies. Due to the challenges of conducting research in Freetown/Sierra Leone as a young mixed-race, diasporic woman, I undertook most of my travels by car (Figure 4). I hired two taxi drivers, Barri and Alhaji, to drive me around Freetown and the Freetown Peninsula, rather than take public transport, such as minibuses or motorbike taxis. Driving around with Barri and Alhaji also made it easier to navigate unknown environments and find places outside of Freetown.

Figure 4: One of the two taxis in which I drove through Freetown and surroundings

4.4.4 Gathering of documents

Finally, the data I gathered from my archival research and interviews was supplemented by the gathering of technical reports, newspaper articles, online petitions and more. Some of these related directly to the Sierra Leonean Ebola epidemic and international response, some provided crucial background information on Sierra Leone, global health or IPC practice.

4.5 Data analysis

In this thesis I drew on Black studies and geographies to analyse the 2014-15 Ebola response in Sierra Leone. Such an approach, I argue, reflects Sierra Leone's history of foreign interventions, the racial dynamics and antiblackness that underlay these interventions and shaped Sierra Leone's modern history. Here I aimed to reintroduce complexity as an analytical gesture, to complicate the colonial wake in which the Ebola response took place. By drawing on Black studies and geographies in my study of global health I aimed to create an analytical and methodological approach that encourages understandings and realities of Sierra Leone, of global health interventions and of IPC practices that are entangled with the colonial and antiblack histories in which they originated. My analysis aimed to contribute to an understanding of infectious disease-related practices that foreground the reality of the colonial wake and of Black life therein; an understanding that cared about histories and presents of antiblackness and about the postcolonial silences that have shaped and continue to shape infectious disease control and the politics of knowledge that contribute to it.

In my data analysis I aimed to forego one of the main threats to research rigour identified by Baxter and Eyles (1997): the misinterpretation of statements made during an interview. In order to avoid misinterpretation, an important part of my analysis was devoted to the convergences, gaps and ambiguities that emerged when multiple narrations, realities and practices emerged. Importantly, after I concluded my fieldwork I identified four themes that wove through my archival research and interviews: colonial and antiblack traces, mobilities, expertise and practices of care. These themes are reflected in my chapter structure.

In terms of analysing the documents and materials I have found in the archives, I employed two strategies. Following Stoler (2009), I analysed materials by reading 'along the grain' in an active effort to familiarise myself with the colonial logic of the time and how it transpired into infectious disease management. A reading along the grain actively worked to uncover 'the power in the production of the archive itself' (Stoler, 2002, p.102). It thus worked to acknowledge and familiarise myself with the colonial power intrinsic in the genre of official documents and correspondences of the time.

This was complemented by Black archival strategies, which place a focus on the silencing of Black populations in archives of the slave trade and colonialism (Hartman, 2008; McKittrick, 2014; Fuentes, 2018). This strategy is similar to the practice of reading 'against the grain', pioneered by the Subaltern Studies Collective (Guha et al., 1983; Chaturvedi, 2000). Black archival methods and reading against the grain actively engage with the author's silences, their contradictions, the limits of the text and how these reflect back on the historical context in which both author and text are situated.

I agree with Claire Dwyer and Gail Davies (2007, p.258) that the nature of research is inherently performative. Consequently, the analysis of interviews was not only about singularity or clarity and rather about the exploration of ambiguity within and without the research context. In order to capture the interpretative nature of research, my analytical tools aimed to apprehend the context as well as content of interviews and interviewees. Narrative analysis lends itself well to such a task, because it focuses on the way in which the interviewee constructed their answers to the interview questions. This was especially important as my interviews were loosely structured and invited participants to guide the interview process and tell me what they thought was important. Following Jane Ritchie and Jane Lewis' (2011) work, I wrote down short descriptions with each interview including on setting, environment and spatial attributes, but also interviewees' demeanor and facial expressions. I drew on some of these descriptions to enrich my analysis, especially when interviewees' silences and pauses became suggestive of an inability or unwillingness to think about the colonial wake or if they displayed feelings of discomfort.

In the evaluation of data generated through interviews I placed special emphasis on the analytical treatment of silences. Both Baxter and Eyles (1997) and Dwyer and Davies (2008) point to the political value of silences in interviews or research participants' refusal to talk. They recommended the use of ethnographic accounts in order to give room to these silences in the interpretation of data. In the analytical exploration of aforementioned silences or refusals to talk, I aimed to explore how to '[fold]

uncertainty into the act of producing an account' (Dwyer and Davies, 2010, p.94). One of the consequences of this strategy is the foregrounding of postcolonial associations and coincidences, rather than a strict focus on causality. In terms of studying antiblackness in global health, I foreground these silences and interpreted them as a productive discursive practice.

To assist me in my analysis I made use of NVivo. NVivo facilitated the coding of textual and audio data and thus made it easier for me to classify, organize and analyse collected data and to develop thematic areas and the structure of this thesis. Following Ritchie and Lewis (2011) I first indexed and then coded the data. Indexing is here used to describe the early stages of analysis whereas coding indicates a later level of analytical precision. I engaged in several rounds of indexing before settling on the codes that led to the thematic areas I analyse in this thesis.

I identified this chapter structure and the internal organization of information that I delivered in chapters through mind-mapping exercises, such as the one depicted below (Figure 5). Working my ideas out on paper brought clarity into the mass of data that I gathered during fieldwork. It also allowed me to 'assemble' my analysis of the Ebola response. This was particularly important since I often juxtaposed data from different sites in individual chapters. Rather than having one chapter for each site, I decided to bring the different sites directly in conversation with one another. This allowed me to foreground the colonial continuity of the wake in practices, discourses, geographies, infrastructures and epistemes. Proceeding this way in my analysis also corresponded to the non-linear methodology that I set out and described at the beginning of this chapter. Putting the different elements of my research on paper also allowed me to establish hierarchies and to determine how different findings related to each other. I worked with different colours to indicate importance and orderings in the multitude of data that I assembled. Mind-mapping allowed me to establish connections and work out themes and sub-themes in the organization of my thesis.

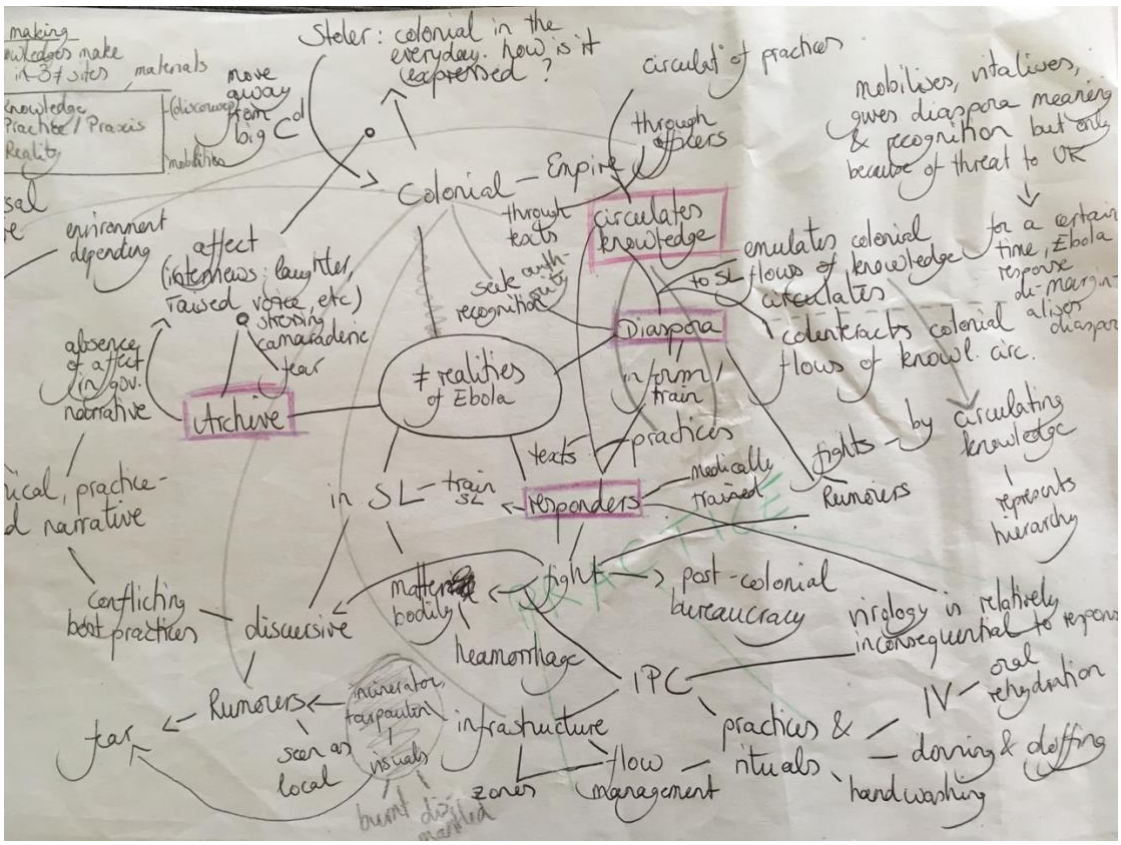

Figure 5: A thesis mind-map circa January 2018

4.6 Conclusion

In this methodology I have laid out my approach to studying the 2014-15 British-led international Ebola response in the wake. I have drawn on Black studies and decolonial sensibilities to develop a methodology that takes the ubiquity and simultaneous marginalisation of antiblackness into account. Specifically I approach the wake as a multi-sited, non-linear reality, which requires a sensitivity to silences and gaps in interviews, archival material and secondary literature. I have reflected on my own positionality and questions of power between researcher and researched both with regards to issues of gender and race and with regards to epistemic, postcolonial and professional hierarchies. The methods and reflections I have laid out here structure the way I conducted my research; the results of which are presented in the ensuing empirical chapters.

chapter FIVE

5 'The wake' and 'the weather': place, weather and disease control in (post-)colonial Freetown

5.1 Introduction

In this chapter I analyse the 2014-16 Sierra Leonean Ebola epidemic as an event that took place in the wake of global health and medicine's political and scientific entanglements with antiblackness. Here I approach the study of antiblackness as Christina Sharpe (2016) does in the concluding chapter of *In the Wake*, 'The weather'. Echoing Sylvia Wynter's (2006, n.p.) statement that 'we live in an anti-Black world' and seeking to confront the shifting tangibility of this antiblack world, Sharpe innovates a conceptual reading of weather. She (2016, p.104) writes: 'In my text, the weather is the totality of our environments; the weather is the total climate; and that climate is antiblack.' For Sharpe weather and climate are conceptual devices for thinking and writing about how antiblackness manifests in the wake. Focusing on Freetown and the Freetown Peninsula, this chapter explores the more or less conspicuous environments in which the Sierra Leonean Ebola epidemic and response took place. Specifically I foreground remains of Sierra Leone's colonial and antiblack past and show how these created a spatial, epistemic, atmospheric and structural environment of antiblackness, reminiscent of Sharpe's antiblack weather. [15]

Sharpe (2016, p.102) bases her conceptualisation of weather on the Oxford English Dictionary (OED) definition of the term:

> Weather: The condition of the atmosphere (at a given place and time) with respect to heat or cold, quantity of sunshine, presence or absence of rain, hail, snow, thunder, fog, etc., violence or gentleness of the winds. Also, the condition of the atmosphere regarded as subject to vicissitudes. *Fig*. in and in figurative context; *spec. (lit.)*, applied to an intellectual climate, state of mind, etc. […]

While Sharpe draws on the OED definition of weather and its meteorological elements (atmosphere, weather event, storm, etc.), she uses the term figuratively for poetic and aesthetic purposes. To illustrate Sharpe's conceptual use of weather, I reproduce her

[15] Throughout the thesis I often refer to/describe things as 'colonial and antiblack'. In my text I understand colonialism to be a manifestation of antiblackness. Consequently, I do not see the two as separate, but as a specific and general attribute of the phenomena I describe and analyse.

partial retelling of Toni Morrison's (1987) *Beloved*. Morrison's protagonist Sethe is inspired by the story of Margaret Garner. Born into slavery, both the fictional Sethe and the real life Margaret Garner kill their daughters to prevent them from being re-enslaved. In *Beloved* (Morrison, 1987), Sethe and her surviving daughter Denver are haunted by the spirit of Sethe's dead child and by the past. Sharpe (2016, pp.105-106) writes that

> [Sethe] wants to keep Denver from being overtaken by the past that is not past. Sethe wants to protect Denver from memory and from more than memory, from the experience, made material, of people and places that now circulate, like weather. […] What Sethe remembers, rememories, and encounters in the now is the weather of being in the wake. […] Slavery is imagined as a singular event even as it changed over time and even as its duration expands into supposed emancipation and beyond. But slavery was not singular; it was, rather, a singularity – a weather event or phenomenon likely to occur around a particular time, or date, or set of circumstances. Emancipation did not make Black life free; it continues to hold us in that singularity. The brutality was not singular; it was the singularity of antiblackness.

Sharpe describes slavery as a weather event. In this chapter I argue that antiblackness, in the case of Sierra Leone, circulates and manifests, not solely as a thing of the colonial and slave past, but because this past continues to hold Black Sierra Leoneans in the present. I argue that the Ebola epidemic is one example of the ways in which Black life is held and shaped by antiblackness; it too is a weather event.

The figurative use of weather and climate, two terms Sharpe largely uses interchangeably, contributes to the poetics of *In the wake.* In this chapter I follow Sharpe in using her conceptualisation of weather to think through antiblackness. Like the weather, antiblackness is sometimes experienced intensely, sometimes barely noticed and I point to instances of both in this chapter. To avoid confusion between conceptual and meteorological weather, I write about 'antiblack weather' to designate the former and 'meteorological weather' to designate the latter. Sharpe's conceptualisation helps to analyse present-day antiblackness, which, like meteorological weather, can be more or less conspicuous. In this chapter I analyse the antiblackness that characterises the wake in its varying degrees of conspicuousness.

Specifically I do three things. I consider how traces of antiblackness manifest in and around Freetown. I also extend Sharpe's work by considering antiblackness *and* meteorological weather both in British 19th and 20th century colonial literature on infectious disease control in Sierra Leone and during the Ebola epidemic to show how

antiblackness works its way through historical and present-day global health interventions and the scientific knowledge they rely on. Finally I show that though the response presented itself as a response to Black death and suffering, antiblackness and its silencing work their ways through it in sometimes conspicuous, sometimes inconspicuous ways. Although Vargas (2018) writes about the denial of antiblackness, I show here that, rather than being outright denied, antiblackness is disregarded, silenced and marginalised. My aim in this chapter is to analyse the Ebola epidemic and response in light of various remains of antiblackness in Sierra Leone; in other words I highlight the antiblack surroundings in which the response took place. Attending to the Ebola epidemic in this way can be seen as an instance of keeping watch with the dead, an analytical wake, so to speak.

In this chapter, I interpret the wake in its spatial and physical, temporal and atmospheric form in relation to health and disease management in Sierra Leone. I draw on archival material, maps, a field visit to Sierra Leone in 2019 and interviews with international and diaspora responders conducted in London in 2017. I demonstrate how, with regards to the Sierra Leonean Ebola epidemic, colonialism specifically and antiblackness more generally were present in material and discursive manifestations as well as taking more abstract, fleeting forms. The wake, in this chapter - as in the entirety of this thesis - is both visible and invisible, both tangible and intangible. It appears as both obvious and spectral (like weather) and I trace its presences as well as absences as politically symbolic of an enduring climate of antiblackness.

The chapter illustrates the interplay of (in)conspicuous, material and atmospheric dimensions of the wake. In the first part (4.2) I consider the meaning and materiality of antiblack traces and colonial landscapes in contemporary Freetown and surrounding areas (4.2.1) before focusing on the physical coexistence between colonialism and care, grounded in the Freetown cityscape (4.2.2). This material and geographical coexistence, I argue in this chapter, contributes to the coloniality of care in relation to Sierra Leone. I bring Stoler's (2013) work on colonial ruination into conversation with Sharpe's (2016) work on surfacing the antiblackness of our political climate, i.e. exposing antiblackness. The second part of this chapter focuses on colonial and antiblack atmospheres (4.3). I explore atmospheres both in their environmental and affective dimensions. Specifically, I attend to antiblack climate and weather. Drawing on Sharpe's (2016) analysis, I see events such as the Ebola epidemic as manifestations of antiblack weather. I rely on archival research to establish a link between colonial and scientific writings on infectious

diseases in the colonies, meteorological weather and antiblackness (4.3.1). In the next section (4.3.2) I focus on interviews with responders to the Ebola epidemic and their accounts of how the hot weather that they experienced negatively impacted their ability to care for Black life. In the final section (4.3.3) I draw on Luise White's (2000) monograph on rumours to analyse the hold the colonial past had on present places of care during the Sierra Leonean Ebola epidemic. This section draws on interviews with international responders to the Ebola epidemic and on my analysis of physical remains (4.2) to suggest that antiblackness and colonialism endure in places of care and contribute to feelings of mistrust towards foreign healthcare workers.

Overall, this chapter draws on Sharpe's (2016) discussion of antiblackness as weather to analyse how colonial and slave-trading remains in and around Freetown signal the endurance of antiblackness and subsequently the wake. This endurance takes both material and atmospheric form and is, like meteorological weather and climate, at once startlingly present and actively inconspicuous.

5.2 Spatial Remains

5.2.1 Naming and the creation of the postcolonial cityscape

I start the analysis with a discussion of the spatial remains of colonialism and antiblackness (including the slave trade) on the Freetown Peninsula. This discussion illustrates the weather-like antiblack backdrop against which the Ebola epidemic and response played out. Sierra Leone, which became independent from Great Britain in 1961, still bears the traces of having been a British colony. As Sierra Leone's biggest development partner, the UK played instrumental roles in ending Sierra Leone's 1991-2002 civil war (Kamara, 2018), but also in curbing the spread of the recent Ebola epidemic by sending healthcare workers and pledging £230 million to the Ebola response (PAC, 2015). As such, Great Britain is present both in Sierra Leonean political and economic life, but also in more subtle and permanent ways in architecture, in Freetown's urban form and in street, landmark and place names. These spatial and architectural markers, their prevalence and what their modern existence can tell us about Sierra Leone's current relationship to its colonial past are the subject of my analysis. While some authors focus on the long-lasting mental and physical impact of the civil war and its atrocities (Henry, 2006; Park, 2007; Basu, 2008), others have looked at practices of

discursive and spatial memorialisation of the transatlantic slave trade (Ferme, 2001; Shaw, 2002; Argenti, 2007 for a similar exploration in the Cameroon Grassfields). While Ferme (2001) and Shaw's (2002) accounts focus mostly on spatial memorialisation practices in rural contexts, my analysis is concerned with the Freetown peninsula and how the colonial aftermath and legacies of antiblackness manifest materially in signs and naming practice.

Doreen Massey (1994, p.67) famously called for the adoption of a progressive sense of place as 'a place which is extraverted, which includes a consciousness of its links with the wider world'. This means thinking Sierra Leone through its transatlantic relations and being attentive to the ways in which these relations shape Sierra Leone as a place. Hence, my focus lies here on spatial naming practices in Freetown and how they create or rather recreate the Freetown cityscape and surrounding areas as colonial. I focus on place and street names to argue that, in Freetown, official street signs and location markers exhibit the colonial and antiblack past and its reach into the present. Here I draw on archival materials, maps, photographs and interviews with members of the Sierra Leonean diaspora in the UK to show that street names and location markers are part of what I call geographies of the wake. I show that though the Freetown Peninsula is marked by the colonial and slave trade past, this antiblack past is largely inconspicuous and normalised in Sierra Leone. This normalisation, I argue, contributes to a silencing of the history and presence of antiblackness in analyses of the British-led Ebola response, which I have outlined in chapter three. Here I use Stoler's (2013) writings on ruins and processes of ruination as signs of imperial power's tenacity. Stoler and the authors contributing to her anthology locate the imperial past in unexpected sites and ruins of the present. Drawing on Stoler's (2013, p.3) analytical language, I argue that in the case of the Freetown Peninsula, a geography of the wake reveals the ubiquitous and structuring nature, rather than 'the occluded, unexpected sites', of colonialism's afterlife.

The study of place names, or toponymy, has contributed to analyses of colonialism's space-making power during colonial periods, as well as presented useful insights into colonialism's afterlife. Brenda Yeoh (1992) illustrates the racial, nostalgic and nepotistic politics that went into street naming decisions in colonial Singapore, as well as local Chinese strategies to either subvert or adopt these. As she details, streets were often named for colonial officials or the places that represented the colonisers' home, such as names of towns, regions, landmarks or royalty, in an effort to 'escape the impress of the tropics and native culture and symbolically to exist in British settings' (Yeoh, 1992,

p.316). Mcebisi Ndletyana (2012) has analysed the renaming of colonial and apartheid street names, cities and provinces in post-Apartheid South Africa. He argues (2012) that colonial toponymy was used both as a means of legitimisation for colonial-settler presence as well as a strategy of rupturing the relationship between indigenous populations and the spaces they have long inhabited. Describing the temporal and political unevenness with which South African political authorities went about changing colonial and Apartheid place names, Ndletyana (2012) demonstrates that renaming practices also depend on a conducive bureaucratic and political climate, the forcefulness and violence with which colonial policies were implemented in different regions, and how, in the case of the settler colonialism of South Africa, racial groups were targeted differently by the spatial and housing policies of the Apartheid government.

Unlike the South African case, in which settler colonialism came with explicit notions of racism and white supremacy, Sierra Leonean colonialism was characterised by notions of humanitarianism and benevolence (Frenkel and Western, 1988). Freetown was established as a settlement in 1792 on an initiative of the Sierra Leone Company, created by British abolitionists, such as William Wilberforce and Granville Sharpe (Ingham, 1894). After the American war of independence in 1783, Free Black Nova Scotians, Black loyalists, Jamaican Maroons and poor urban Blacks from London and other cities across the British Empire were settled in the new territory. An early company report from 1791 described the beginnings of the enterprise as follows:

> About five years since, the streets of London swarming with a number of Blacks in the most distressed situation, who had no prospect of subsisting in this country but by depredations on the public, or by common charity, the humanity of some respectable Gentlemen was excited towards these unhappy objects. They were accordingly collected to the number of above 400, and, together with 60 Whites, […] they were sent out at the charge of government to Sierra Leone. (Sierra Leone Company, 1791, p.3)

Following this first settlement, the Sierra Leone Company took it upon itself to gather funds to relocate more destitute Blacks and to support the beginnings of their livelihoods in Sierra Leone. This brand of colonialism was described as ‘humanitarian imperialism’ by Stephen Frenkel and John Western (1988). In a later ‘Report from the Committee on the Petition of the Court of Directors of the Sierra Leone Company’ from 1802 (TNA - WO1/532) in store at the National Archives in Kew, the aim of the establishment of the Sierra Leone Company and the subsequent establishment of the settlement of Freetown

are described thus: ‘The general object of the founders of [the Company] was the introduction of civilisation into Africa.’

A number of street and place names in Freetown commemorate this early period of British colonialism. The name Freetown, to begin, dates back to this time period and was chosen by the Sierra Leone Company. Based on the diary of Sierra Leone’s first governor, Governor Clarkson, the then Bishop of Sierra Leone, Right Reverend E.G. Ingham (1894, p.10) described the process which led to the creation of the settlement on Sierra Leone’s coast: ‘The land was cleared in a few weeks, and the town was named Freetown, in consequence of an instruction to that effect sent out from home’. ‘Home’ in this case refers to England, from which both Governor Clarkson and Reverend Ingham came.

The story of Freetown’s creation is told differently in the city itself. A mural at the government-commissioned Sierra Leone Peace and Cultural Monument celebrates Thomas Peters, a slave born in the North American colonies, who joined the British fight against American Independence and was freed and resettled in Sierra Leone, as the ‘True Founder of Freetown’ (fieldwork, 2019). This discrepancy in Freetown’s founding story, between the version recorded at the National Archives in Kew and the one etched into stone in Freetown’s Peace and Cultural Monument, is indicative of the multiple histories and interpretations that coexist in the wake.

Regardless of who Freetown’s true founder was (both histories leave out indigenous Temne tribes living on the Freetown Peninsula), Freetown became in the late 18th century the British repatriation destination for Black people freed from slavery. As such, Freetown was the first settlement of freed slaves from the Americas and the Caribbean established on the African continent (Olusoga, 2016). This is reflected in the toponymy of the colony and its capital. Mariatu, a young member of the Sierra Leonean diaspora in Britain, described the importance of Sierra Leone in Black history:

> Our country in particular is very very key to the liberation of Black people full stop. You know it was one of the first places that Black people were free […] in that context of post-slavery you know with the freed slaves in Britain being sent there […]. Our capital is called Freetown. There’s nowhere else called Freetown.

Here, Freetown’s name is synonymous with the liberation of Black people and Mariatu singles it out in time and space, emphasising its uniqueness: “it was one of the first places […] There’s nowhere else called Freetown”.

The importance that this singularity conveys is reflected in both Freetown's cityscape and naming practices throughout the peninsula. Freetown, as the first settlement of freed slaves, has maintained a theme of Black, British-managed, liberation throughout the naming of streets, waterways and landmarks. Streets in Freetown bear names that recall British abolitionists, colonial officials and early settlers: Wilberforce Street, Wilkinson Street, Macaulay Street, to name just a few, have been highlighted on the map of Freetown below (Figure 6) and bear the names of British colonial governors, abolitionists and officials. Wilberforce Street (Figure 7) and the Wilberforce neighbourhood are named after William Wilberforce, the famous abolitionist and one of the co-founders of the Sierra Leone Company. Wilkinson Road, one of the main roads in Freetown's West End in turn recalls the name of Moses Wilkinson, a former slave and Black Nova Scotian who arrived in Sierra Leone in 1792 (Clifford, 2006). Macaulay Street too is named after colonial officials: second cousins Zachary and Kenneth Macaulay both served respectively as Governor and Acting-Governor of the colony, the first between 1794 and 1795 and 1796 and 1799, the second in 1826. A stream near the old boundary of Granville Town, one of the first settlements established by freed slaves and free Blacks on the coast of Sierra Leone is called Granville Brook, after Granville Sharpe, co-founder of the Sierra Leone Company.

Figure 6: The wake in Freetown's cityscape: colonial toponymy and research location

Figure 7: Street sign in Freetown's historic centre

Some of Freetown's colonial place names have changed over time. As Ndletyana (2012) has indicated, postcolonial name changes occur at different times and for various reasons. A comparison of Freetown street names from 1913 and 2019 below (Figure 8) shows the general nature of name changes. I have selected these streets because they form part of the old heart of Freetown, the location from which the initial settlement spread to take the urban form that it has today. In Freetown, some street names have changed, whereas others have remained the same. I have not been able to obtain official documentation stating the reason and date of these name changes, but they indicate a 'nationalisation' of the urban sphere; a move in which some street names change from British names to names that reflect the Black history of Sierra Leone. The big avenue that runs through Freetown's north from West to East was called Westmoreland Street in 1913, recalling the historic district in the North-West of England. Today it is called Siaka Stevens Street, after the second Prime Minister of independent Sierra Leone. Water Street, fittingly named for its location on the edge of the Atlantic Ocean was renamed Wallace Johnson Road after I.T.A. Wallace-Johnson (1894-1965), a Sierra Leonean labour leader, political activist and editor of the *Negro Worker*, a journal for Black workers around the globe (Adi and Sherwood, 2003). Oxford Street, parallel to Wallace Johnson Street, is now called Lightfoot Boston Road. Henry Josiah Lightfoot Boston, a member of Sierra Leone's Krio ethnic group and descendant of freed slaves, served as the first Black director of Fourah Bay College, West Africa's oldest university.

Other street names have remained unchanged. Bathurst Road, Bathurst being the former name of Banjul, capital of The Gambia and Pademba Road are still the same, as is Liverpool Street. Out of the 21 streets that make up the grid system between Kroo Bay and Susan's Bay in Freetown's North End and Siaka Stevens and Garrison Street to the South, Waterloo Street to the West and Little East Street/Malama Thomas Street to the East, six have changed (see Figure 8 below). In this corner of Freetown the cityscape is still marked by the colonial past, its material presence evident in street signs. References to British geography also remain, but they are interspersed with regional references to people and institutions. In this part of Freetown, Wilberforce Street remains as an example of the longevity of humanitarian imperialism (Frenkel and Western 1988) and its normalisation.

1913 Street Name	**2018 Street Name**
From East to West	
Little East Street	Malama Thomas Street
East Street	Ecowas Street
Wilberforce Street	Wilberforce Street
Rawdon Street	Rawdon Street
Howe Street	Howe Street
Charlotte Street	Charlotte Street
Gloucester Street	Gloucester Street
George Street	George Street
Trelawney Street	Lamina Sankoh Street
Walpole Street	Walpole Street
Pultney Street	Pultney Street
Percival Street	Percival Street
Liverpool Street	Liverpool Street
Bathurst Street	Bathurst Street
Wellington Street	Wellington Street
Waterloo Street	Waterloo Street
From South to North	
Pademba Road	Pademba Road
Garrison Street	Garrison Street
Westmoreland Street	Siaka Stevens Street
Oxford Street	Lightfoot Boston Street
Water Street	Wallace Johnson Street

Figure 8: Evolution of Freetown Street Names 1913 – 2018 (Source: TNA - CO 270/45; google maps)

One final example of the normalisation of the colonial and slave trading past that has marked Freetown and surrounding areas is this sign:

Figure 9: Kent Slave Port

I took this photo in Kent, a small fishing village about an hour from Freetown on my way to Banana Islands. Kent's history, as its name evokes, has long been entangled with the British presence in and influence on Sierra Leone. Kent, like many other villages on the Peninsula, was implicated in the slave trade in two ways: Portuguese slavers kept enslaved Africans here before transporting them on small boats to nearby Banana Islands, in whose surrounding deep waters their slave ships could safely anchor. Later, after the abolition of the British slave trade, freed slaves founded the village of Kent and settled here (Leigh, 2016). Some material remains, such as the old St Edward's Church, remain of the slave trade, but today Kent is mostly known for its sandy beaches and proximity to Banana Islands, both of which are attractive tourist destinations. The sign indicates the normalisation of colonial and slave histories that have shaped the Freetown Peninsula. On the one hand it identifies Kent as a 'Slave Port', thereby attesting to the village's

history in the transatlantic slave trade. On the other hand it assures tourists that this is a safe parking spot, should they wish to leave their cars here before crossing over to Banana Islands or going to the beach. The fact that it is located right by the port, at the drop-off point for tourists wanting to cross to the Bananas, underlines this fact. Here, antiblack legacies are leveraged and explicitly signalled to attract tourists interested in the history of the transatlantic slave trade in Sierra Leone. Simultaneously the mention of Kent's historical reality as a slave port, next to the words 'Safe Car Park' normalises and trivialises the importance and long lasting consequences of the transatlantic slave trade.

The aftermath in Sierra Leone takes on political as well as spatial form. The colonial implications of the international response to the Ebola epidemic in which each former colonial power intervened in the country it had once colonised (Chaulia, 2014) fell, in Sierra Leone, on spatially fertile ground. In Freetown and surrounding areas, places were already marked by the antiblack violence of the slave trade and the British intervention which ended it. In street signs and place names the abolition of the slave trade and founding of the Sierra Leone company are framed in philanthropic terms and are largely commemorated divorced from British involvement in the preceding slave trade. I suggest that it is the decidedly humanitarian and philanthropic framing of British colonial and imperial interventions in Sierra Leone that has led to its memorialisation and normalisation in street signs and place names. As I argue in the next section, the environment in which care, and medical care especially, are provided matter if we are to understand the relation of the epidemic and subsequent response to the antiblackness of the wake.

5.2.2 Care and Colonial Remains

Racial and Sanitary Segregation

After having discussed the toponymical form the colonial wake takes in Sierra Leone, I want to, in this section, further focus on spatial remains and how they exemplify the wake in correlation to contemporary disease management in Freetown. I see these material remains, following Stoler (2013; 2016), as 'ruins' or 'debris'. These terms do not describe an actual state of physical disrepair, but suggest colonial and imperial durabilities present in the physical remains and capable of shaping contemporary life. In the introduction to her book Stoler (2013, p.12) describes her work on ruins and ruination as follows:

> Here we envision colonial histories of the present that grapple with the psychological weight of remnants, the generative power of metaphor, and

> the materiality of debris to rethink the scope of damage and how people live with it.

I argue here that, in the case of Sierra Leone, colonialism's spatial remains are intricately linked to the notion and history of care and medical care especially, and that this link, as I will suggest throughout my analysis, had repercussions on the Ebola epidemic and response. Historians, geographers and anthropologists have written about the colonial history of medical care in Africa and in Europe (see for instance Latour 1988; Vaughan 1991; White 2000). My research engages with these accounts but seeks to ground care and colonialism in the spatial remains that contribute to making Freetown's urban present. I will now turn to focus more explicitly on the link between colonialism's spatial remains and disease management.

Figure 10: Excerpt of Freetown Map 1913. The Colonial Hospital is situated in the top centre, just off Oxford Street (TNA - CO 270/45)

As the excerpt from the 1913 map of Freetown (Figure 10 above) shows, street names are not the only feature through which the colonial past is visible in Freetown today. As Stephen Legg (2008) has pointed out, colonial urban design both translated and masked the urban realisation of racial and class segregation. In Freetown's urban form, especially the colonial-style architecture (Figure 11 below) scattered across the city (Stone, 2012; Akam, 2012) and its grid system (visible in Figure 10), are reminders of the colonial origins of the city and the racial segregation that was inherent to its spatial logic. The grid system according to which Freetown's city centre is organised is a typical example of British colonial town layout, as it afforded easy military access and administrative governability (Brockett, 1998). The centrality of military barracks (Figure 10) and the spatial and physical difference between settler and native towns (Fanon, 1961) is also observable in Freetown. As such, colonial houses were built in enclaves, often located on hills and away from downtown Freetown, visible on the map above. Two of these enclaves, Wilberforce and Hill Station, have been highlighted on Figure 6. The location of the settler towns is traceable through prevailing colonial-style architecture in Freetown. A high number of colonial homes are still situated in the Wilberforce and Hill Station neighbourhoods. (Stone, 2012; Akam, 2012; Doherty, 2014). These remains, like Stoler's (2013) ruins, give the colonial past a material present in which life in Freetown plays out. In Freetown, a history of health care is intricately interwoven with these colonial ruins.

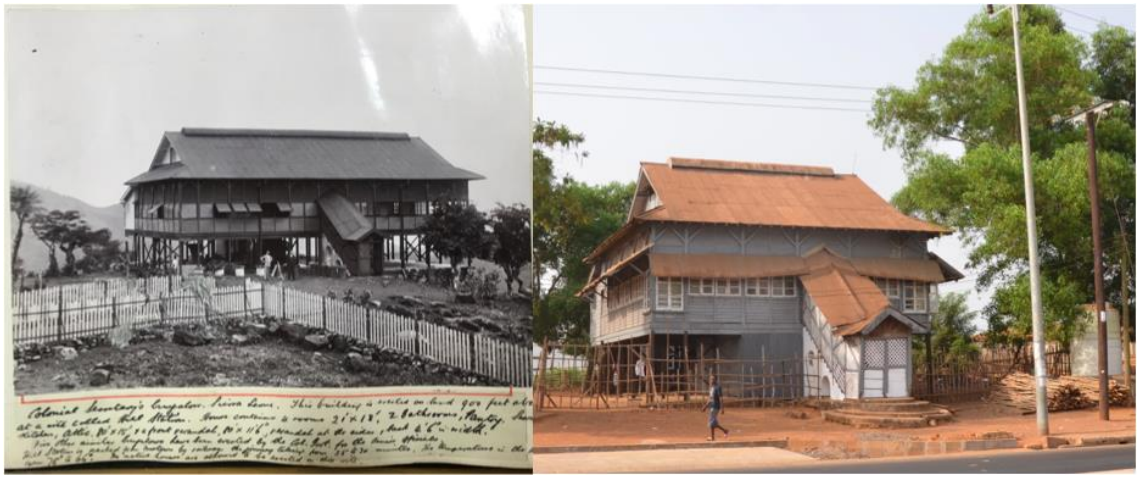

Figure 11: Example of British colonial architecture in Hill Station, Freetown in 1871 and 2019 – Right photo taken by author, left photo (TNA - CO1069/88). The bottom line of the description reads 'No native houses are allowed to be erected in this site.'

Hill Station in Freetown, named after the Indian model of sanitary segregation (Cole, 2015) was built for colonial officers and their wives in what was considered to be a cooler, healthier climate than downtown Freetown (Frenkel and Western, 1988). (The caption

below the 1871 photo of a Hill Station House - Figure 11 - mentions the temperature varying between 77 and 68° Fahrenheit, i.e. 20-25° Celsius, which was cooler than downtown Freetown. The temperatures in Hill Station are still on average lower than in the city centre.) The relocation of white colonial staff to the higher-lying parts of colonial cities, was practiced in Freetown thereby introducing racial segregation masked as sanitary segregation. Hill Station's origin – it retains this name to this day - is one of racial segregation and medical racism. To protect colonial officers from becoming infected with Malaria, they were encouraged to sleep away from native populations who were deemed to be harbouring disease. What is more, 'native houses' were not considered to be sanitary, but rather were seen to be host to mosquitoes and other organisms capable of transmitting tropical diseases to colonising populations (Frenkel and Western, 1988) thereby confirming Fanon's (1961, pp.37-39) declaration that 'the native town […] is a place of ill fame'. At its inception, no native houses were allowed to be erected in Hill Station.

In the annual medical reports, in which data on the health of the colony was collected and which were then sent to London, a special section was dedicated to Hill Station. In a 1910 report by the medical department in Sierra Leone the general health of the site is discussed as follows:

> The health conditions of Hill Station have during 1910 continued to be quite satisfactory. […] The total number of cases on the sick list was 18. Of these 6 were due to climatic causes: -
>
> Malarial Fever … … … … … 5
>
> Yellow Fever (suspected) … … … 1
>
> In three of the cases of Malaria Fever, infection was contracted during visits to out-stations in the Protectorate. Two of the cases occurred in the Military residents who worked in Freetown daily. The suspected case of Yellow Fever occurred in a newly arrived official who frequently had to remain in his office overtime, owing to extra work, and was not, in consequence, able to leave Freetown until late in the afternoon. […] The only non-official residences up to the present are the General's Cable Company's and the Wesleyan Mission's, none of the Mercantile firms of Freetown having so far taken the advantage of the undoubted claims of Hill Station as a healthier place of residence for Europeans as compared with the climatic and present sanitary conditions prevailing in the town. (TNA – CO 270/45, p.16)

Here, Freetown, meaning downtown Freetown, is constructed as a (Black) 'native' place of disease, whereas Hill Station is a (white) 'European' place of health. Neither the name Hill Station, nor the medical report stored at the National Archives, indicate the racial component of both urban and sanitary management of Freetown and the role that Hill Station played in both. Rather the report painstakingly lists the places of infection with Malaria and Yellow Fever as having occurred in places other than Hill Station: in downtown Freetown, the protectorate and among those who worked in Freetown daily, thereby reinforcing the link between race, place and health/disease. I argue that the imaginaries underlying Freetown's urban layout are largely unchanged. Although not an exclusively white neighbourhood anymore, Hill Station is still a highly coveted living space. When the British-led IMATT (the International Military and Advisory Team) moved to Freetown to advise the Republic of Sierra Leone Armed Forces at the end of the civil war in 2001, they moved to Hill Station (Gberie, 2017). This further consolidated Hill Station's status as a secure living space for elite Sierra Leoneans (Akam, 2012; Gberie, 2017), an impression further cemented when the Americans built a $40 million dollar embassy on the site (Gberie, 2017). The elite status conferred upon Hill Station by British colonial officers who settled here for health reasons and turned it into a white only area, lives on in the wake of colonialism: in preserved colonial houses, but also in British and American military presence and elevated real estate prices.

Freetown's urban form displays an uneasy and complex relationship with colonialism, which lays the groundwork for an uneven urban landscape and in which life occurs in the midst of colonial ruins. Similarly to Stoler (2013), I argue that, although not technically in ruins, Hill Station exemplifies the hold the colonial past has on the present in that it continues to embody the exclusivity that colonial officers intended for it. Its de facto exclusion no longer operates on the basis of racial and ethnic characteristics, but today takes on a more classed and capitalist character.

Biomedicine and Antiblackness

I now focus on a different corner of Freetown to illustrate the relationship between spatial remains, antiblackness, disease management and care. To do so, I trace the history of Connaught Hospital, Freetown's main adult referral hospital (KSLP, n.d.). The hospital is named after the Duke of Connaught, who visited Freetown shortly before the hospital was completed at the beginning of the 20th century. Specifically I suggest here that the antiblackness that has long been entangled with care in this site, has been physically erased, enabling a reading of Sierra Leonean history that valorises British

humanitarianism and care. I draw attention to how continued practices of medical segregation along racial lines, which occurred during the Ebola epidemic, embody the wake and discuss analytical possibilities, which take the spatial coincidence of antiblackness and infectious disease control seriously. I argue that in order to understand how the Ebola response played out in the colonial wake, we need to think antiblackness as 'the ground on which we stand' (Sharpe 2016, p.7). Connaught Hospital, as this section shows, quite literally stands on grounds that have long been shaped by antiblackness. Writing about medical care, as I have laid out in the methodology, involves caring about the antiblack violence that has shaped this corner of Freetown in particular. For centuries colonialism and the resettlement of slaves in and around Freetown have been framed as philanthropic gestures of care, obscuring how antiblackness took place here.

The site on which Connaught Hospital is located, on the Northern edge of Freetown, has long been a place in which care and violence have coincided. In the period from 1690 to 1800 between 440,000 and 660,000 enslaved Africans were shipped to the Americas from the coast of Sierra Leone (Rodney, 1980, pp.250-51; Shaw, 2002, p.29). The majority of slave ships sailed under a British flag (the Trans-Atlantic Slave Trade Database, 2019). With the abolition of the British slave trade in 1807, the British navy patrolled the coast of West Africa, captured slave ships, and brought the enslaved to King's Yard, an enclosed space on the site that Connaught Hospital now occupies and which used to be the location of the Colonial Hospital (TNA - CO 270/45). In King's Yard, the enslaved were registered and medically examined by British Navy doctors and officers. If necessary they were cared for in the adjoining Royal Hospital and Asylum (Olusoga, 2016, pp.309-310) and at times isolated there, to protect the health of the colony, before being resettled in and around Freetown.[16] Thus for many freed slaves Western biomedicine marked the transition from enslavement to resettlement and the promise of liberation.

The only physical remains of King's Yard is one of two original gates, which stands on the grounds of Connaught Hospital (Figure 13). Erected in 1817 by Governor McCarthy, the gate marked the boundary to King's Yard. The gate still opens up into a yard, albeit a small one, leading to an eye clinic and the grounds of Connaught Hospital. An inscription at the top of the gate (see Figure 12 below) references the Royal Hospital and Asylum that was constructed to provide care to 'Africans rescued from slavery by

[16] Interview with Sierra Leonean historian Dr Sylvanus Spencer in Freetown, 30/05/2016

British valour and philanthropy' and thereby attests to the history of British care in this site.[17] King's Yard forms a spatial and political marker of the transition from enslavement to resettlement in Sierra Leone. As I was told by my guide when I visited the site in March 2019, the enslaved would step up to the gate, their name would be called and only then would their shackles be released and they would be free to leave the yard to be resettled. However resettlement did not mean freedom. It often entailed further unpaid labour for up to fourteen years under the so called 'apprenticeship system' (Olusoga, 2016 p.314). In this site physical and structural violence both precede and follow biomedical care.

Figure 12: Original plaque on top of King's Yard Gate

Figure 13: Connaught Hospital and King's Yard Gate

[17] The full inscription on the plaque reads: 'Royal Hospital and Asylum for Africans rescued from slavery by British valour and philanthropy Erected AD MDCCCXVII His Excellency Lieut[t] Col[l] MacCarthy, GOV'

King's Yard functioned as a reception centre for enslaved Africans until 1870, shortly after which the Colonial Hospital was erected on this site (Sierra Leone Heritage, 2019). The Royal Hospital and Asylum was torn down in the early twentieth century. A 1913 Annual Medical Report on Sierra Leone describes the plans for its demolition and for the subsequent construction of Connaught Hospital, which was built on the site in the 1920s, after the Colonial Hospital burnt down (TNA – CO270/45, p.97; TNA - CO1071/323, p.21). Today the only physical remains of the histories of enslavement and liberation in this site are reminders of British care: Connaught Hospital itself and the gate to King's Yard. Following Stoler (2013) I argue that what remains (Connaught Hospital, King's Yard Gate) after colonial domination offers insights into the strategic tenacity of colonialism's afterlife. I extend Stoler's argument by suggesting that these remains also show the conscious erasure of histories of antiblackness. The reminder of 'British Valour and Philanthropy' atop King's Yard Gate on the grounds of Connaught Hospital obscures the antiblackness that made Britain a major benefactor and proponent of the trans-Atlantic slave trade in the first place. It also erases the antiblack sentiment that led to the stipulation in the 1807 Act for the Abolition of the Slave Trade that

> His Majesty, His Heirs and Successors, and such Officers, Civil or Military, as shall, by any general or special Order of the King in Council, be from Time to Time appointed and empowered to receive, protect, and provide for such Natives of Africa as shall be so condemned [to slavery], either to enter and enlist the same, or any of them, into His Majesty's Land or Sea Service, as Soldiers, Seamen, or Marines, or to bind the same, or any of them, whether of full Age or not, as Apprentices, for any Term not exceeding Fourteen Years.[18]

Antiblackness structured the Act for the Abolition of the Slave Trade, in that it kept the possibility for further Black servitude alive. This is reminiscent of what Mbembe (2001, p.13) has termed European 'doubt of the very possibility of [African] self-government'. As during the colonial period whose onset, in Sierra Leone, neatly coincided with the abolition of the slave trade, Black people, after leaving King's Yard Gate, were not free, but had to serve as apprentices to Black and white settlers (Fyfe, 1961). These histories of antiblackness are invisible in the physical remains of Connaught Hospital and King's Yard Gate. Making sense of these geographies of the wake, in which what remains and what is obscured extends colonial logics of Black dependency and British care, requires a consciousness of the versatile continuity of antiblackness today and an acceptance that we live and care in the wake of colonialism and antiblackness.

[18] 47° Georgii III, Session 1, cap. XXXVI An Act for the Abolition of the Slave Trade, retrieved from https://www.pdavis.nl/Legis_06.htm, accessed, 16/08/2019

I now turn to show that, although not visible in the physical remains of King's Yard, antiblackness continued to structure medical care in Sierra Leone. In the years following the abolition of the slave trade and the colonisation of Sierra Leone, care continued to be associated with this site in the form of the Colonial and then Connaught Hospital. Medical care, was a crucial component of colonial governance in Sierra Leone. Within the Colonial Hospital, the sanitary segregation that characterised Freetown's racialised residential organisation, took hold as well. In 1910 Freetown experienced a Yellow Fever epidemic. A 1910 annual report by the colonial medical department details the isolation arrangements that were made to prepare the colonial hospital for infectious disease control:

> Owing to the outbreak of Yellow Fever in the town during the month of May, it was found necessary to make arrangements for the isolation of patients suffering from, or suspected of suffering from this disease.
>
> For this purpose the Matron's Cottage in the [Colonial] Hospital enclosure was divided into two rooms containing one bed each and was set apart for Europeans […]. For the purpose of isolating natives at the Hospital, eleven beds on the male side and five beds on the female side were provided with mosquito netting. (TNA – CO 270/45, p.19)

Thus a century before the onset of the Ebola epidemic, biomedical care was characterised by racial segregation in this site. What is more, the standards of care varied starkly between those provisions taken to protect Europeans against Yellow Fever and those put in place for the Black 'native' population. Similarly to residential segregation at Hill Station, medical racism led to the establishment of a parallel yet unequal system of disease management. During the 1910 Yellow Fever epidemic, the mortality rate in the Sierra Leonean part of the hospital was higher than in the refurbished matron's cottage reserved for Europeans. Of fourteen European patients isolated at the Colonial Hospital, nine 'recovered and returned to work. Four recovered and were invalided. One died (Yellow Fever)' (TNA – CO270/45, p.19). On the 'native' ward, on the other hand 'four cases admitted into these beds were diagnosed as Yellow Fever, three of them died […]' (TNA – CO270/45, p.19).

In 2014, as in 1910, Sierra Leoneans were cared for separately from European patients.[19] One of my interviewees pointed to the racial segregation she observed in care arrangements during the Ebola epidemic. Sara, a French epidemiologist who volunteered

[19]See for example the video Inside RFA Argus – the British ship on course to battle Ebola': https://www.youtube.com/watch?v=IPXZh6xsu3A, retrieved 07/09/18 DATE LAST ACCESSED

in a purpose-built ETC on the Freetown Peninsula, commented on one section of the treatment centre, which was reserved for (predominantly white) expat healthcare workers. Commenting on the exclusivity of this part of the ETC she said [sarcastically]: "Now it's called health worker treatment [centre] but it used to be white worker treatment". Sara thereby acknowledged the underlying racial segregation in treatment facilities.

Anton, a manager for Organisation X, a British medical NGO, expanded on this in his interview by commenting on the impossibility of caring for Sierra Leonean health care workers infected with the virus in that same ETC:

> What would have been reassuring would have been that local health care workers could be treated in [ETC]. And in the end they never confirmed [that this would take place], they just did it on the side.

Although Anton's remark "they just did it on the side" indicates that local-international, or black/white, segregation was not strictly observed in this ETC, the official policy of international/national segregation recalled health policies of the colonial era.

The decision to dedicate one ETC to the care of international health care workers was not motivated by racism or antiblackness (Davies et al., 2014). However, in the historical context of British medical and sanitary segregation on racial grounds in Sierra Leone, present-day practices evoke the antiblackness of the past. At the same time, as I have shown using the example of Connaught Hospital, places of biomedical care have in Sierra Leone spatially coincided with antiblackness. I further explore this spatial coincidence towards the end of this chapter. As I have shown, in the wake, the antiblackness that permeated (medical) care in Sierra Leone, in terms of racial segregation and forced labour, has left no physical mark and takes work to unearth.

In the first part of this chapter I have analysed how colonial remains continue to shape Freetown's urban form and how they contribute to making the wake a spatial reality. Drawing on archival and present day maps and photographs I have shown how the colonial wake takes on physical reality on the Freetown Peninsula and in Freetown's urban design and street names. The colonial rationale which influenced the street layout (Brockett, 1998) and the division between settler and native towns (Fanon, 1961) are still visible in Freetown's urban organisation yet the racial segregationist rationale that characterised colonial Freetown often remains obscure. The colonial past is normalised in street names and location markers that obscure the often violent and antiblack nature of the colonial enterprise in Sierra Leone behind discourses of care and humanitarianism.

Like the weather, the antiblackness that characterises the wake is in Freetown's urban form omnipresent, yet also inconspicuous.

Discourses asserting Sierra Leone's founding as the first free Black settlement and as a place of Black liberation obscure the violence of the trans-Atlantic slave trade in which British interests played a crucial role. As exemplified in the physical remains of King's Yard Gate, colonial durabilities can be interpreted as leaving selective spatial and, as I will explore in the next section, epistemic and atmospheric traces.

5.3 Atmospheric Antiblackness

After attending to colonialism's spatial remains in the first part of this chapter, I now focus on what might be called atmospheric remains. Thinking with Sharpe's framework, I argue that antiblack weather is pervasive yet difficult to grasp and affects Black life in direct and indirect ways. In this section I link my analysis of antiblack weather to 19th and early 20th century writings on disease, and meteorological weather in Sierra Leone to show the epistemic and antiblack entanglement of race, disease and place. The second section further focuses on meteorological weather, this time in the context of the 2014-15 Ebola response. Specifically I explore how meteorological weather conditions were one factor that made care for Black life during the epidemic difficult for international and national healthcare workers. Finally, I close this chapter by analysing how reported rumours around ETCs and infection prevention practices can be interpreted as antiblack and postcolonial hauntings.

Reading this section requires an understanding of the polysemy of the concepts of weather, climate and atmosphere. As I stated in the introduction, I refer to Sharpe's (2016) figurative use of weather to think through antiblackness in the wake as antiblack weather. When referring to meteorological weather, climate or atmospheres I refer to them as such and understand weather as a short-term condition and climate as a long-term condition. In this section atmospheres denote two things: first, miasmata, the diseased airs and breezes that were thought to spread disease in the 19th and early 20th century, and secondly affective atmospheres (Anderson, 2009), such as postcolonial spectres and hauntings (Coddington, 2011; cf. Bressey, 2014a).

5.3.1 Race, place, disease

> In what I am calling the weather, antiblackness is *pervasive as climate*. The weather necessitates changeability and improvisation; *it is the atmospheric condition of time and place*; it produces new ecologies. […] The weather [transforms] Black being. […] When the only certainty is the weather that produces *a pervasive climate of antiblackness*, what must we know in order to move through these environments in which the push is always toward Black death?[20] [emphasis added] (Sharpe, 2016, p.106)

In this section I adopt Sharpe's definition of antiblack weather as 'a pervasive climate of antiblackness'. However, for Sharpe antiblack weather also has atmospheric connotations and atmospheres play an important role in this section. While highlighting how the perceived relationship between race, disease and place changes in scientific developments from miasma to germ theory, I highlight the roles attributed to meteorological weather and to diseased atmospheres by the 19th and 20th century writers I analyse here. Miasma theory, a medical theory that stipulated that diseases were caused by bad airs and breezes, was prevalent until the advent of germ theory propagated by Louis Pasteur and Robert Koch in the mid-late 19th century. Here I trace antiblackness in scientific publications, specifically the work of Sir Rubert Boyce, from the mid-19th to early 20th century to show the continued yet shifting link in the scientific imagination between Blackness meteorological weather and climate and disease. I argue that Boyce's texts on infectious disease control in Sierra Leone contribute to epistemic antiblackness by framing analyses of disease and weather through an antiblack lens. While I take epistemic antiblackness to also be anchored materially in books and paper documents, I consider the circulation of the texts and knowledges at the time of their publication as contributing to antiblack atmospheres or weather (Sharpe, 2016). Given the colonial context in which these texts were published (and which facilitated the research they were based on), this knowledge circulated between Sierra Leone and the UK, between colonial officers and academic researchers, and thus contributed to an imagination of Sierra Leone as a place of Black disease and underdevelopment.

Rubert Boyce (1863-1911), a pathologist and tropical disease expert, dedicated his career to researching the origin and prevention of infectious, vector-borne diseases, most commonly appearing in the tropical regions of the British Empire, such as West Africa and the West Indies as well as the Southern US and South America. A considerable

[20] Again, Sharpe's (2016) weather does not correspond to or abide by meteorological principles. She also does not define the relationship between climate, weather and ecologies and at times uses the terms somewhat interchangeably.

number of his publications draw on his expeditions to those regions and in the next two chapters I will analyse the link between colonial mobility and the constitution of infectious disease-related epistemology. For now, my focus lies on the writing of Boyce and others on yellow fever and malaria prevention in Sierra Leone.

In his book *Yellow Fever and its prevention: a manual for practitioners*, Boyce (1910, p.49) discusses yellow fever and malaria, two of the main diseases threatening the health of Europeans in West Africa, and places them in relation to Blackness and to the transatlantic slave trade.

> In the case of the sister disease, malaria, we do not discuss whether it was imported into West Africa or whether it was endemic. We regard it as a disease essentially endemic to those peoples living among *Anophelines* [mosquito transmitting malaria]. […] In the eighteenth century the slave ship was no doubt one of the most powerful factors in the distribution, not only of yellow fever but of all other racial and endemic diseases and of the insect carriers peculiar to them. Not only did the slaveship [sic] carry human beings in whose blood might have been the virus of yellow fever, malaria, sleeping sickness, relapsing fever, filariasis, plague, etc – it equally well served as the means of transport of the various species of mosquitoes, fly, or flea. […] The "slaver" [slave ship] was a floating native village, in which the worst features of the native village were reproduced, white and blacks living jammed together in hot stifling quarters, providing the ideal conditions for the multiplication of the Stegomyia [a subgenus of the aedes aegypti, the mosquito transmitting yellow fever] and the spread of yellow fever.

Several points are worth analysing here. First, malaria and yellow fever are explicitly depicted as 'racial diseases'. Both are attributes of the 'native village', that is, associated with Blackness. Second is the link between disease, place and race. Boyce makes clear who he means by 'those peoples living among Anophelines': In an article published in the *British Medical Journal* in 1911 (p.181) Boyce states 'as regards the West African continent, […] yellow fever was in all probability a disease endemial to the native races of the coast.' In Boyce's writings, yellow fever and malaria are associated with Blackness in two ways: they are anchored in Black places (West African coast) and bodies (on slave ships). The 'native village' is depicted as the ideal breeding place for mosquitos transmitting both diseases. Boyce (1910) points to the detrimental qualities of 'native' villages and how they are conducive to the spread of disease. Properties of place, in Boyce's writings, become attributes of the people living in said place. Lack of racial segregation and the climatic conditions provide, according to Boyce (1910), 'the ideal conditions for the multiplication of the Stegomyia and the spread of yellow fever.' In Boyce's writing, the slave trade is only critiqued insofar as it led to the dissemination of

infectious diseases across the British Empire and although captured Africans are described as human beings, their humanity is qualified by the conditions in which they choose (the native village) and are forced (the slave ship) to live.

Sierra Leone, from the beginning of Black and colonial settlements is, in Boyce's writing (1910), firmly imagined as a place of racialised disease. In this Boyce is not alone. In his writings (1911, p.181) he makes reference to other scientists and researchers who have described Sierra Leone thus:

> French writers have taken it for granted that Sierra Leone was the home of yellow fever on the West Coast, on the natural ground that it was more thickly peopled, and had wider relations with the outside world.
>
> The origin of the [1835 yellow fever] outbreak was ascribed to importation from Fernando Po [Bioko, an island belonging to Equatorial Guinea], and by others to the town of Sangara, 400 miles distant. It was seriously proposed to build a high wall to keep out the pestilential breeze which, it was alleged, came from this town [Freetown].

Thus from the very beginning Freetown is both imagined as a place of disease and as a place in which local atmospheres, people and the environment carry disease. At the same time, Freetown's transatlantic connections are seen as having contributed to the spread of yellow fever. His reference to 'a pestilential breeze' (Boyce, 1911, p.181) is a reference to miasma theory. At Boyce's time of writing germ theory had replaced miasma theory as the acceptable rationale explaining the causes of disease. However, some of the authors Boyce (1910) draws on in his analysis made use of it.

When describing the history of yellow fever in Sierra Leone, Boyce (1911b) draws on F. Harrison Rankin's (1834) *The white man's grave: A visit to Sierra Leone*. In one chapter, Rankin, a member of the Royal Geographical Society (RGS, 1842) discusses the health and climate of Sierra Leone. Therein his references to infectious atmospheres and noxious weathers are frequent, as are his association of weather, atmosphere, disease and antiblackness in relation to Sierra Leone. For instance:

> An idea is extant that disease has originated in malaria brought thence by the north wind. When this idea was in vigour, various suggestions were offered for repelling the future intrusion of death from that quarter. […] rather than detain the infectious air, [the natives] would rejoice in facilitating the greatest possible importation of it into the white man's settlement (1834, pp.147-148).
>
> It is not easy therefore to discover in what manner or by what inlet the miasmata of the low country can enter to poison Sierra Leone. […] Whatever detriments to health exist in Sierra Leone must arise from its own internal chemistry (1834, p.149).

> As the only possible point of offence, these Maroon [resettled Jamaican maroons] grounds demand particular, if brief, notice. Noxious damps are considered to reach the European residences from it; […] Assuming the origin of a foul atmosphere on this ground, Freetown has an advantage in its remote situation, and in the nature of the intervening space. (1834, p.153)

In Rankin's writing, atmospheres, breezes and bad airs surround Black life in Sierra Leone and threaten the white colonial settler presence. The belief that diseases were caused and spread by bad airs are here inextricably linked to Sierra Leone as a diseased space. Miasma theory was equally applied in writings on Europe. In the case of Rankin's writings on Sierra Leone however these atmospheres are entangled with antiblackness. In his writing (1834, pp.147-48) 'the natives' 'rejoice' in threatening the health of white Europeans. The 'noxious damps originating from 'Maroon grounds' also establish an epistemic link between Blackness, diseased atmospheres and place.

Boyce (1911, p.1) disavowed miasma theory and praised the onset of bacteriology and epidemiology. This scientific onset signals a shift in the relation between race, place and disease. While in Rankin's (1834) writings Black people were seen as living amidst unhealthy airs and constituting a threat to white health by propagating their spread to white settlements, Boyce (1910, p.49) qualifies malaria and yellow fever as 'racial diseases'. Discussing endemicity, Boyce (1910) follows Sir Arthur Havelock, former governor of Sierra Leone, in discussing racial differences in yellow fever's infectious cycle. Boyce (1910, p.58) quotes Havelock who in 1884 sent a report on typho-malarial fever to the Secretary of State as saying:

> a noticeable feature was that as the disease assumed a more virulent type, it became more and more restricted to Europeans. The natives seemed to have complete immunity from its attacks, there not being a single authenticated case amongst the negro population.

Boyce (1910, p.62) added to this that '[t]he endemial remittent fever of the native was a source from which the *Stegomyia* [mosquito] obtained its infection.' Here scientific facts around malaria's endemicity in West Africa are entangled with an understanding of Black people as diseased. The health threat they constitute to European settlers is also assessed. The endemic nature of malaria and yellow fever among indigenous and resettled Black Sierra Leoneans was then used to justify the politics of sanitary segregation along racial lines in Freetown discussed above. In a paper on yellow fever in the *British Medical Journal*, Boyce (1911, p.181) argues that

> If the mining managers and merchants will forearm themselves by adopting the rational precautions of segregation […] they need not fear the awful setbacks to commercial progress […].

In a further shift, Logan Taylor, like Boyce a member of the Liverpool School of Tropical Medicine, saw the behaviour of Sierra Leoneans more than the climate as the justification for racial segregation. He wrote (1902, pp.853-854) that

> It is little wonder that Europeans and also natives living in the hot and damp West African climate, under conditions which favour the spread of malaria and other fevers, are taken ill, and it is these insanitary conditions more than purely climatic influences that are to blame for the unhealthiness of the West Coast. […] Natives do not see the necessity for cleanliness, being quite content to remain as they are.
>
> When suitable ground can be had I think it better for the Europeans to live away from the natives. In Accra the Government officials have good bungalows away from the native town, forming a proper European quarter (Victoriaborg), and this arrangement is found to work well, and Accra is the healthiest town on the Gold Coast. At Freetown a suitable site for a European quarter has been fixed on in the hills, and the proposed hill railway to it has been already surveyed.

Taylor's writings and their publication in the *BMJ* exemplify the widespread support for sanitary segregation on racial grounds at the beginning of the 20th century. His writings also exemplify that at the beginning of the 20th century the association of disease and place was in the case of colonial Sierra Leone still characterised by antiblackness. The causes for the 'unhealthiness' of Sierra Leone is here linked to both the local meteorological climate and to the behaviour of 'natives'. As a consequence, only spatial distance from Black people and grounds can protect European settlers from infection.

In this section I have shown how in the case of infectious diseases and their prevention in Sierra Leone, the perception of diseased atmospheres and antiblackness combined to inform sanitary segregation policies in Freetown. With regards to Sierra Leone, knowledge of infectious diseases and infectious disease control has long been characterised by epistemic antiblackness. In the analysed texts the speculated relation between Blackness and disease is threefold: first disease stems from 'native grounds' and is spread through bad airs, second Sierra Leone's climate and environment is one in which 'racial diseases' are endemic and finally the insanitary behaviour of the native Black population produces and spreads disease. This epistemic antiblackness contributed to the imagination of Sierra Leone as a place of disease and danger for white colonisers. During

the Ebola epidemic, the idea of Sierra Leone as a place of disease and as a place which threatens white European health was reaffirmed.

5.3.2 The weather

International responders to the Ebola virus outbreak in Sierra Leone also found themselves in what they encountered as challenging climatic conditions. In this section I explore discussions of meteorological weather by international healthcare workers during the Ebola response in the wake of the epistemic association between weather and antiblackness that I have discussed above. I also consider how, during the 2014-15 epidemic, meteorological weather contributed to accelerated forms of Black death.

Meteorological weather featured in several interviews with international doctors and nurses who deployed to Sierra Leone to work against the spread of the Ebola virus and almost always in relation to their capacity to care or not care for Ebola patients. Weather conditions varied according to treatment centres, with the majority of British-based international health workers working in purpose-built ETCs, which were generally hotter than pre-existing facilities. A lack of qualified doctors and treatment beds prior to the outbreak (WHO, 2015; The Global Fund, 2017; Tinsley, 2018) constituted one major reason for the construction of purpose-built ETCs, a majority of which were tent-structures, which afforded little protection from the sun and heat of Sierra Leone's weather. Here I briefly show the colonial and explicitly antiblack mechanisms that, though not the main reason, contributed to Sierra Leone's lack of adequate health infrastructure prior to the outbreak, before exploring the relationship between working in purpose-built facilities and hot weather.

As Festus Cole (2015, p.239) explains, British colonial health and sanitation policy 'was largely designed to meet the needs of the white, expatriate community'. As such, few efforts were made to sustainably cater for the health of the colony beyond its white settlers (Cole, 2015). Despite British parasitologist and tropical disease specialist Ronald Ross's (Anonymous, 1901) urging to sustainably improve Freetown's health conditions by draining its streets and swamps to reduce breeding grounds for mosquitos, thereby lowering the risk of malaria for all residents, the colonial government opted for racial sanitary segregation instead.[21] One of the reasons for not investing in sustainable health

[21] Ronald Ross went on to win the Nobel Prize in Medicine or Physiology for his research on anopheles mosquitos and malaria transmission in 1902

care in Freetown was the transitory nature of colonial officers, who, according to Spitzer (1968), only stayed for a short number of years before returning to the UK. Eventually however, to make the West African colonies 'healthier' and attract a bigger medical work force, the West African Medical Service (WAMS) was created in 1901 and tasked with supplying medical doctors to serve in the six West African colonies. The WAMS formally excluded Black West African doctors from applying (Johnson, 2010).

As a result of racist recruitment and health and sanitation policies, 'native' health and well-being, especially outside of Freetown, were drastically underfunded (Cole, 2015). 'Native' Freetown and the West African coast more generally were in colonial times seen as detrimental to European health in virtue of their racial and environmental constitution rather than as a result of colonial policies that considered Black health as at once irrelevant and threatening to white settlers. Due to the absence of medical facilities of the kind available in the 'European' section of the town and meteorological weather conditions that British settlers and scientists considered toxic, Black health was only minimally cared for and the risk of death from diseases was high (Cole, 2015). British colonial policy laid the groundwork for an underfunded health infrastructure, both in terms of medical staff and places of care.

In 2014, the lack of permanent healthcare facilities, combined with insufficient numbers of trained Sierra Leonean medical staff to respond to the epidemic, created another kind of antiblack climate, in which conditions would once again be experienced as dangerous for international personnel. While lacking the openly racist framing of the colonial period, the 2014-15 response was enacted in conditions that were reminiscent of the groundwork laid in the colonial period and thereby continued to be entangled with antiblackness.

Meteorological weather, as it was described by international health workers who worked in the international Ebola response in Sierra Leone, impacted working conditions in Ebola treatment centres. In Sierra Leone day-time temperatures vary between 26°C and 36 °C (Blinker, 2006). The interviewees quoted here worked either in purpose-built ETCs or in pre-existing facilities that were adapted to constitute safe working environments and serve the purposes of isolating sick patients. Both types of facilities were impacted by Sierra Leonean weather. For Ebola, which at the time had no proven cure, the best method of treatment was aggressive re-hydration through the administration of either ORS (Oral Rehydration Solution) or IV (Intravenous therapy) (Farmer, 2014). The time required to administer as many of these treatments as possible became a crucial factor in treating

EVD and the weather played an important role in health care workers' ability to care for patients. Charlotte, a British nurse who worked in a new purpose-built ETC, described the weather and working conditions in the following way:

> It was brimming hot when we were there. Hot and humid. It was the hottest time of the year, so yeah I spent relatively little time in the red zone of all the time I was out there. […] We were there at the hottest time of the year, so […] only at night could you be in there for longer, but during the day we were only allowed to be in the red zone for 40 minutes. […] If people are hot and if you need to go you need to go, so you're half way through a job and you just left it on the side.

The red zone in ETCs was the area of the hospital or treatment centre in which confirmed, and in some instances suspect, cases awaited results. In order to enter the red zone, health care workers had to wear full personal protective equipment or PPE. PPE was put on or 'donned' according to strict rules and involved several layers of protective equipment to avoid potentially contagious bodily fluids from being transmitted from patients to carers. Charlotte described the process thus:

> You would start with one pair of gloves and then you would go and take off your outer stuff, your normal clothes, wash your hands to start with and then you would put on your suit and you would put on your mask first or hood first, we had slightly different PPE to the others but then you'd put your outer gloves, […] but you're sweating by the time you've put it on you know, so then it's this very ritualistic, ordered thing […].

The impenetrability of PPE contributed to making the hot temperatures even less bearable. Gareth, an infectious disease specialist who worked in Hospital X, a pre-existing adapted brick facility, compared the work he had to do there, to occasions on which he had to work in a purpose-built facility, in this case a tent:

> The tents were incredibly hot. Phenomenally hot. […] I have an image of a meeting in a tent and everyone was wearing PPE and you can just see one of the army guys in uniform and they're just drenched all the way through, because the tent was actually baking. And […] when you're working in a brick environment it's actually reasonably cool. […] I think generally when we went in to do the work in the unit, we'd be in there for about two to three hours and that was reasonably comfortable.

According to Gareth working in a brick environment made the heat and working in PPE more bearable. Unlike those who worked in a tent-like purpose-built facility, like Charlotte, health care workers in brick units could stay in PPE for up to three hours. Pre-existing, durable units thus seemed to allow health care workers to provide longer and more thorough care for patients in the hot weather. Layla, a doctor, worked in the same facility as Gareth and described the sensation of wearing PPE in the heat:

> In these crazy suits, it's really really fucking hot, like you can only be in there for a certain time because otherwise you actually physiologically can't sustain it. Some people handle heat better than me. I found the heat that was the most difficult part. You get to the end and your boots are filled with water and you're not sure what it is. Is it your own sweat, did you spill something on yourself? [laughs] What is this sensation of water in your gumboots? What's going on? So yeah it was very hard and difficult.

Layla's statement illustrates both the constraints meteorological weather exerted on the organisation of care work during the Ebola epidemic as well as the emotional toll it took on both care workers and patients. Although she laughed when recounting the sensation of working in PPE in hot conditions, she continued to describe the oppressive atmosphere to which the heat, in her opinion, contributed:

> It's a terrifying scenario to be in, cause it's really hot, there's these people in big white suits coming at you, no one is really talking to you, you don't know what's happening, people around you are dying.

Meteorological weather and the high contagiousness of EVD in combination with a lack of adequate medical infrastructure contributed to affective atmospheres of fear and stress. As interviewees demonstrated, the weather did play a role in how and how much care could be administered. Moreover, as the comparison between Gareth and Charlotte's statements indicates, pre-existing brick facilities allowed health care workers to stay in the unit in full PPE for longer. During the epidemic, meteorological weather had little to do with the antiblackness or antiblack weather (Sharpe, 2016) that has shaped Sierra Leone's healthcare system since colonial times. I have argued here however, that the historical lack of investment in medical care for all Sierra Leoneans and the structural underfunding that resulted from it, led to safe medical care predominantly being located in purpose-built ETCs. In these ETCs, tents for the most part, meteorological weather conditions made caring for Sierra Leonean patients much more difficult than in pre-existing brick facilities.

As my exploration of antiblack weather and epistemic antiblackness with regards to health and disease management in colonial Sierra Leone has shown, Black health was, during colonialism, mostly seen in terms of its potential to harm white settler colonisers. Consequently little attention was paid to Black health and to the structural foundations that would ensure that the latter was in good condition. Racially segregated health facilities and medical racism have left their trace on Freetown in material form. This had, as I have shown, repercussions on the conditions in which the Ebola response could operate. More precisely, it impacted the possibilities to care for and save Black lives. In

the final section of this chapter I focus on atmospheres and the colonial spectres they invoke in places of care in Sierra Leone.

5.3.3 Atmospheres of (colonial) haunting

I finish this chapter by writing about affective atmospheres (Anderson, 2009) and specifically about affective atmospheres that border on hauntings and spectres. I suggest that places of care were, during the Ebola epidemic also places of colonial haunting. I suggest that in Sierra Leone the wake encompasses more than the physical remains of slavery and colonialism. I suggest that the rumours around places of care, which abounded during the epidemic, can be interpreted as a processing of past antiblack violence that occurred here, but which has left no tangible trace. Here, studying places of care in the wake relies on a sense of place attuned to the antiblack practices and discourses that have shaped care in relation to Sierra Leonean life, enslaved, colonised and free, in Freetown. Here I focus on fears and rumours around Ebola's origins and its supposed political purpose and its association with places and practices of care.

Luise White's (2000) historical exploration of East African rumours and vampire stories locates their origin in colonial medical practices, such as forced trials or medical experiments. Relying on archival sources and oral histories, White (2000, p.106-107) describes a Kenyan woman who in 1920s Nairobi related the violence of Kenyan encounters with medical practitioners:

> [they] used to come in the night, they would come into your room very softly and before you knew it they put something in your arm to draw out the blood. […] Medical practitioners come to Africans, unannounced and unwelcomed, and do not heal, but silence and kill.

Similar concerns abounded during the Sierra Leonean Ebola epidemic. As Jonah Lipton (2017) explains, during the Ebola epidemic white Western biomedicine became a force regulating the lives and deaths of Freetonians. He describes (2017, p.808) 'the imposing presence of the novel biomedical order honed to eliminate the virus' and argues that this biomedical order, characterised by standardised, non-traditional, impersonal burials, was perceived as white. A number of writers (Richards, 2015; Spencer 2015; Lipton, 2017) have described the importance of traditional burials in Sierra Leone, which are seen to ensure the well-being of deceased relatives in the afterlife. White biomedicine disrupted these practices and endangered the 'deceased' eternal fate' (Lipton, 2017, p.808). As such, seeking care in a hospital equalled subjecting oneself to white biomedicine and the

perceived risks associated with biomedical care, such as non-traditional burials, risking one's eternal fate and as I show now, violence that mirrors White's (2000) accounts.

Interviews with Sierra Leonean and international responders revealed that many Ebola patients were reluctant to seek help in internationally-run treatment centres. This was confirmed by media reports. In a BBC interview published on August 1st 2014, Dr Oliver Johnson, a British doctor standing in front of the isolation unit at Connaught Hospital, stated:[22]

> There's fear and concern among the patients who either don't believe that the disease is real or don't trust the hospitals to treat them. So they're staying away from the hospital, they're refusing to be isolated here.

The fear and concern that Dr Johnson describes, found expression in rumours. Here, I treat rumours that circulated around medical care and care places as a representation of past experience and a way of processing present events through that past. I argue that the reluctance to seek care in 'white' treatment centres is indicative of the wake and its geographies and that an analysis of the latter can offer insights into places of care and medical responses in postcolonial contexts. Following Coddington (2011, pp.146-7), I take hauntings as 'aspects of social life which appear to be not there, concealed yet important; aspects which *seethe*, *acting on* or *meddling with* present-day realities in a violent or disturbed manner; and finally, aspects that by seething, unsettle taken-for-granted realities.' These hauntings, like weather, are at once present and at times hard to notice. I suggest that hauntings, rather than appearing to Sierra Leoneans but not international health workers, emerge between the two and shape and unsettle their relation with regards to Ebola care.

The Ebola epidemic spread from the border region of South-Eastern Guinea to Sierra Leone and Liberia in the first half of 2014 and by 1st August first Ebola cases were reported in Freetown. As Dr Johnson told the BBC, patients were reluctant to be treated in hospitals and treatment centres. The health care responders I interviewed confirmed facing similar problems when working in ETCs around the country. Anne, a British nurse who worked as the clinical lead in an ETC outside of Freetown, talked about patients' reluctance to visit their facility thus:

[22] https://www.bbc.co.uk/news/av/world-africa-28613885/ebola-patients-refusing-isolation-sierra-leone-doctor, last accessed 30/06/2018

> […] they were a very resisting community, like lots of rumours. It was challenging for our psychosocial team to work with the community there, for people to accept to come to Ebola treatment centres and they were often hiding sick people.

What was at stake was convincing Sierra Leoneans suspected of carrying the virus to come to hospitals or treatment centres. Anne's statement that "they were a very resisting community" and that "they were often hiding sick people" indicates that rather than seeking medical care in their vicinity, some Sierra Leoneans tried to put individuals infected with the Ebola Virus outside of the reach of biomedical care and the clinic. Emmanuel, a Sierra Leonean nurse, worked for an international organisation in Sierra Leone during the epidemic. He explained that

> there was a lot of conspiracy theory about how Ebola was spread, so the local people did not have any confidence in international organisations. So because of that lack of trust, we needed to convince people that this was a medical response, it wasn't political, you know there was no ulterior motive.

As Emmanuel pointed out, conspiracy theories and rumours were a sign of mistrust in international organisations. Here I show that this mistrust extended to places of biomedical care. Anton, a British NGO worker working at Hospital X in Freetown related a common rumour:

> I heard rumours about people getting killed in those places [hospitals and ETCs] or that it was all a big conspiracy, but considering the availability of information and the sort of context I am not gonna say they're unreasonable.

Thus, responders were aware that relations between hospitals and local communities during the Ebola epidemic were, from the beginning, fraught with tension and mistrust. Patients did not trust the hospital as a place in which to receive care. I suggest that this mistrust constitutes an instance of postcolonial haunting. As I have shown throughout this chapter, historically, (white) biomedicine and antiblack violence coincided in Sierra Leone in places of care. Here I interpret this historical relationship as '*meddling with* present-day realities' (Coddington, 2011, p.147) in a way that shaped the ability of international health workers to care for Sierra Leonean lives during the Ebola response. Anne's statements mirrored Anton's description of mistrust. When describing the spraying of chlorine for disinfection purposes she told me that:

> Some people would think you were trying to kill them essentially. Cause they can report that to their family and say "they're trying to gas us". That was one of the fears with the spraying of chlorine when people were

> getting into ambulances. [It's] like you're being gassed basically. […] [That was] a rumour point.

Similarly to Anton and Anne, James, a British doctor who had worked in Sierra Leone before the onset of the epidemic, described the rumours related to Hospital X, where he worked and their consequences for national and international health workers, working in the Ebola unit:

> A lot of our early problems were not so much that Ebola was a curse, not a virus, it was that Ebola was a conspiracy. So there was a belief that we were taking patients into the unit to kill them, inject them to kill them or there was another belief, I read a quote from someone, an interview [we] had done [with] one of our patients who […] talks about how, his belief before he got sick was that they wanted our blood, people who didn't have blood had come to take his blood. And when he got sick a nurse he had known from his community for many years treated him in the Ebola unit and […] rather than believing her he simply believed that she had been kind of co-opted and they'd come to take his blood and you know that must have been September/October [2014] time.

This shows that between White's (2000) research in East and Central Africa and the Ebola outbreak in Sierra Leone, rumours remained consistent in their content and in relation to the same practice (drawing blood). While there is no way of directly linking these rumours back to colonial biomedical practice, they can be interpreted as resulting from similar colonial histories. James' account also indicates how deeply entrenched and resistant these beliefs were ["rather than believing her he simply believed she had been co-opted"]. His statement illustrates, as do those of the other interviewees quoted above, that rather than solely a medical phenomenon, Ebola, the environment in which it took place and the practices necessary for medical care were a social phenomenon haunted by the colonial past. This had repercussions for patients' readiness to seek care from international (and predominantly white) health care workers and to seek help in places of care that were associated with (white) biomedicine. James continued:

> Certainly in the early time, there was unrest, patients were trying to escape, family members were trying to break their family members out, […] soldiers were deployed to our unit, there was a big question around should we forcibly restrain patients from leaving? Patients were very unlikely to be referred, you know they didn't want to come […] And we had families, rioting the hospital believing that Ebola was a conspiracy intended for us to kill their family member. You know Dr Smith once was chased up the stairs by family members and she locked herself in our office with us and we were worried they might set the building on fire. It was quite a real challenge and you know the idea of physical harm became quite real.

Both Anne and Anton made sense of these rumours by tracing them back to a specific health context or medical practice. They did not link them to the violence with which the provision of care in Sierra Leone has historically been entangled. Like White (2000), I take these rumours as meaningful sources for analysis and interpret them in light of the colonial and slave-trading past of Sierra Leone. Rather than anchoring these rumours and the fears they express only in present day practices, I argue that they, and the practices they refer to, also emerge from the places and affective atmospheres described in this chapter.

Here hauntings, and the antiblack past they evoke, shape postcolonial presents and environments. Rumours provide discursive anchoring for haunting atmospheres. Following Coddington (2011) I suggest that the colonial past haunts present reality and lived possibilities for Black life and health in Sierra Leone. This haunting, although it often occurs in relation to colonial medicine, both epistemically and spatially, is difficult to grasp and almost impossible to pin down. When considered in relation to existing literature on rumours, haunting and colonial medicine (White, 2000; Coddington 2011) however, the importance of recognising these spectres of colonial medicine and the violence that characterised it, become clear. The violence of the slave trade has left its marks on the Sierra Leonean landscape and is remembered in cultural and mundane practices (Ferme, 2001; Shaw, 2002). During the Ebola epidemic, I suggest, those memories materialised in rumours and hauntings surrounding places of (white) biomedical care.

5.4 Conclusion

The colonial wake, in which the Ebola epidemic took place, manifests, as I have shown, in more or less conspicuous remains. Now, in 2019, life in Sierra Leone is itself in the wake of the Ebola epidemic. According to one interviewee, being in the wake of Ebola also gave rise to a sense of haunting. Rather than a postcolonial haunting, the place of care that this responder described was haunted by the epidemic itself. Charlotte, a British nurse, was part of the last deployment that was sent out by the NHS to Sierra Leone in January 2015. She worked in one of the purpose-built ETCs erected by the British army to cope with high numbers of infections at the height of the epidemic. Charlotte describes the treatment centre when the last patient left:

> One of the most surreal experiences was actually when they shut, when the last survivors left and […] I think I was on the shift or some of us volunteered and we went in and sorted it out, because it was chaos in there, because people go in and you know everything that goes in can't come out so you had just like chaos of stuff and rubbish […] and being in the red zone without patients and I really felt that from some of the staff, it was like the ghosts of the people that had died there then rose up to meet [you], like you could then process it because you weren't in there looking after patients, you were... yeah the red zone without patients in it, it's a very very odd and ghostly place. And it felt haunted, it really did feel haunted […].

Charlotte's statement is instructive in several ways. On the one hand she demonstrates that although the presence of international health care workers fuelled the rumours that circulated around places and practices of biomedical care, hauntings were not only experienced by Sierra Leoneans ("It felt haunted, it really did feel haunted"). She also illustrates how the wake of Ebola is composed of physical remains ("the red zone"), materials ("chaos of stuff and rubbish") and ghosts ("the ghosts of the people that had died there then rose up to meet you"). Charlotte's account interrogates places of care and their remains and how these places influence the relationship between patients, health care workers and medical care. Similarly to the ways in which colonial medical practices have left their traces on the development of the Ebola epidemic and the possibilities of care within the response, the epidemic itself will likely haunt, positively or negatively, future relations between Sierra Leoneans, medical interventions and the places in which care is provided.

With this chapter I have set the scene and have positioned the Ebola epidemic and this research project firmly in the wake. I have shown that the environment in which the Ebola epidemic took place is shaped by a colonial and transatlantic past, which in the case of Sierra Leone is not yet past. The wake is visible in Freetown's urban form and toponymy, yet the antiblack violence on which both the transatlantic slave trade and the British colonial project were built remain inconspicuous. Instead in Sierra Leone, foreign interventions during colonialism, the civil war, and now the Ebola epidemic, have always been framed as projects of humanitarian care. This, as I have shown, has both analytical and political implications for care and medical care in particular. Care, in the case of Sierra Leone, occurs in the wake of antiblack violence in the form of medical racism, racial segregation in the health care sector and the historical irrelevance of Black Sierra Leonean health.

Hauntings, like the weather, like affective atmospheres, like the wake are not always immediately tangible or visible. Antiblackness, like meteorological weather, shifts and circulates and, depending on one's perspective and experience, is more or less conspicuous. Both require a sensitivity towards the pervasiveness of colonial and antiblack violence and the tenacity of colonial space-making. As I have shown in this chapter, the wake, and the antiblackness that characterises it, assume various forms – material, epistemic or atmospheric – and are present in and through places, spaces and practices. They hold the possibilities in which Sierra Leonean life exists today and came sharply into focus during the Ebola epidemic, many aspects of which were reminiscent of Sierra Leone's colonial past.

chapter SIX

6 Colonial mobilities and infrastructures : the production of (anti-)Blackness

6.1 Introduction

The Ebola epidemic and response revealed dynamics that have long been at the heart of colonialism and enslavement: the regulation and politics of Black mobilities. Sharpe (2016) uses the slave ship as a way of thinking through Black life in the wake. Her second chapter is entitled 'The Ship - The Trans*Atlantic' with the asterisk representing 'a means to mark the ways the slave and the Black occupy what Saidiya Hartmann calls the 'position of the unthought'. The asterisk […] holds the place open for thinking […]' (Sharpe, 2016, p.30; Hartman and Wilderson, 2003). In this chapter I want to follow Sharpe's (2016) invitation to think through transatlantic mobilities and the production of Blackness.[23] Specifically I analyse how the mobilities linking Sierra Leone and the United Kingdom produce Blackness in reference to a colonial-racial hierarchy that holds both places and the mobilities that link them.

In order to think through transatlantic mobilities and the production of Blackness I draw on Achille Mbembe's (2017) work, which points to the importance of various mobilities (slave trade, colonialism, Black migration and travel to Europe and Africa) in the development of both 'Western' and 'Black' consciousnesses of Blackness. He (2017, p.30) explains the importance of mobilities in the making of 'the modern Black imaginary': 'Ideas circulated within a vast global network, producing the modern Black imaginary. The creators of the imaginary were often people in motion, crossing constantly from one continent to another.'

In this chapter I trace the mobilities that link Sierra Leone and the UK to reveal their entanglements with the production of Blackness. These, I argue, build on enduring infrastructures that signal colonial continuity and the colonial wake in which the Ebola response took place. Building on Mimi Sheller's definition of 'mobility injustice' as 'the process through which unequal spatial conditions and differential subjects are made', I argue that the British-led international response to the Sierra Leonean Ebola outbreak

[23] When referring to the transatlantic, I do not refer only to Atlantic crossings from East to West, which have largely been in theorisations of Blackness, but also on crossings from North to South and South to North. These signal colonial and postcolonial mobilities, which form the basis of my analysis in this chapter.

constitutes a site of colonial-racial 'mobility injustice'. I extend her work to argue that the Ebola epidemic and response exacerbated and exhibited a process in which the mobilities that contributed to the making of unequal spatial conditions were linked to the production of Blackness.

Blackness is not a monolith. As Sheller (2018, p.57) has pointed out, 'racial boundaries are formed, reformed and transformed through mobile relations of power.' I suggest here that the mobilities linking Sierra Leone and the UK and their regulation allow the tracing of various aspects of Blackness as produced through the transatlantic slave trade, British colonialism, Sierra Leonean independence and the Ebola epidemic. In doing so I draw on Mbembe's (2017) genealogy of Blackness as defined by 'the West' and Black people respectively. Crucially I argue, building on Mbembe (2017) and Sheller (2018), that the Ebola epidemic and response allows me to think through the longstanding tensions at the heart of what I call a 'Black mobile ontology'.[24] I show that mobilities are a central factor in the production of Blackness as the 'ontological negation of being' (Sharpe, 2016, p.14) through commodification, subjection, criminalisation and in the case of the Ebola epidemic, disease and death. At the same time mobilities also contribute to the making of Black diasporic ontologies as mobile, sovereign selves. The contemporary infrastructures that underlie these mobilities are evocative of Sierra Leone's colonial past and the colonial-racial hierarchies that shaped it. By analysing mobilities and the production of Blackness I develop a theme that Sharpe (2016) evokes, but does not explicitly address. While her work examines how the transatlantic journey transforms Black ontologies, she does not examine the mobilities and colonial infrastructures that underlie this transformation.

My analysis also shows, that in the wake, Sierra Leone exists as multiple places and has multiple mobile ontologies (Sheller, 2018), which depend on the existence and framing of British-Sierra Leonean mobilities and infrastructures. Following Patricia Noxolo (2006, p.265) I formulate an analysis of these ontologies that depends on a critical geography of Sierra Leone as a place 'that comprises all the places that have contributed and continue to contribute to its history and culture.' The flows connecting Sierra Leone to the UK, I argue, play a particularly important role in this geography and they are the ones I focus on here.

[24] Sheller (2018, p.21) defines a mobile ontology as 'an ontology in which *movement is primary as a foundational condition of being, space, subjects, and power* […] [an ontology that] connects multiple scales and performative sites of interaction'

The chapter focuses on maritime and aerial mobilities. Aerial transport technologies, such as planes or helicopters are modern forms of mobilities that became highly relevant during the Ebola outbreak because of the apparent threat their speed and global connectivity posed to the containment of viral agents. The threat of the spread of disease was most often associated with infected airplane passengers coming from Sierra Leone, Liberia and Guinea. All accidental introductions of EVD into Western countries involved flights carrying infected passengers from affected West African countries into Europe and via Europe into the United States.

The discussion illustrates the conceptual propositions of the chapter in the following way: I begin with an analysis of historical British-Sierra Leonean mobilities (5.2). Here, I take routes, directionality and material and human infrastructure as three instances to analyse how, during the transatlantic slave trade, colonialism and the moment of independence, mobilities linking the UK and Sierra Leone produced Blackness as absence, deviance and dependence.[25] As I show too, whiteness, without being named, is predominantly produced as antithetical to Blackness and white and Black spaces are framed and shaped differently through these mobilities. The second part of the chapter looks at contemporary mobilities and the making of diasporic and Sierra Leonean mobile ontologies (5.3). I argue that postcolonial mobile ontologies, both of people and places, are still produced in relation to the UK as colonial centre and that this was exacerbated during and after the Ebola epidemic and response. The suspension of direct flights between Sierra Leone and the UK at the moment of the Ebola epidemic, I argue, not only shows the entanglement of modern diasporic lives with what Mbembe (2017) calls 'Western consciousness of Blackness', but also the Black diasporic production of Sierra Leone as a place of opportunity or what Mbembe (2017) defines as an aspect of 'Black consciousness of Blackness'. I draw on archival research on aeromobilities in the National Archives, online advocacy efforts and interviews with international health responders and members of the Sierra Leonean diaspora in the UK who were involved in the 2014-15 Ebola response.

Overall I show that for Black Sierra Leoneans and white British colonial/contemporary responders, mobilities between the two countries have always been different and have construed the country and themselves as different people and places. I argue that the loss felt by the Sierra Leonean community in the UK when faced with the discontinuation of

[25] When speaking of 'human and material infrastructures', I use the term material to denote inert objects, such as buildings or roads and consequently as distinct from human infrastructures.

direct flights (which I analyse in 5.3) needs to be seen as part of a long history of Black immobilisation and mobile disruption (which I analyse in 5.2). From the British point of view, economic profit calculations always underlay mobilities to and from Sierra Leone, whereas for Sierra Leoneans they came to be an expression of a privileged postcolonial relationship with the former colonial centre. Here as in the rest of the thesis, my aim is to point out concurrences and continuities in mobilities and their regulation. This does not automatically indicate causality, but instead foregrounds associations and patterns that indicate the wake.

6.2 Colonial mobilities and infrastructures

Here I analyse the colonial entanglements of Sierra Leonean-British mobilities. I consider the establishment of routes, regulations and infrastructures as suggestive of the shifting production of Blackness. By looking at present day airline routes I briefly argue that the way in which transatlantic mobilities currently play out is based on a disregard for the commodification of Black life at the very heart of the establishment of transatlantic mobilities. Further I suggest that this disregard frames British colonial mobilities towards Sierra Leone as mobilities of care, rather than exploitation. I then show that commercial aeromobilities into Sierra Leone were part and parcel of the colonial enterprise and that white mobilities into the Empire were implicitly encouraged and normalised, whereas Black mobilities towards the UK were explicitly discouraged and criminalised. This differentiation, I argue is evocative of the production of Blackness as deviance and risk, whose circulation colonial governance aimed to control. Finally I analyse human and material colonial infrastructures, with the latter referring to the built environment and show that these were in part designed to guarantee continued British access to Sierra Leonean resources after independence. This, I argue, signals the colonial wake. In this part I base my analysis on archival research on colonial mobilities conducted at the National Archives in Kew and the Wellcome Collection and on interviews with health responders.

6.2.1 The establishment of routes

I suggest that current aeromobilities are built on a history of transport mobilities that disregards Black mobilities and the violence of early transatlantic population flows. This disregard, I suggest, can offer a possible explanation for current passenger aeromobilities which largely leave Africa off the map. I use this disconnect between present-day

aeromobilities and the historical Black mobilities that underlie them as a starting point to think through the dynamics of contemporary transport mobilities linking West Africa to the UK. For this purpose I start by contrasting two trans-Atlantic population flows: one historical, one contemporary.

Figure 14: Global flight connections 2009. Created by Josullivan.59. Source: https://commons.wikimedia.org/wiki/File:World_airline_routes.png, accessed, 23/05/2019, no changes made.

The above map shows global passenger flight connections based on available airline routes in 2009. Displayed in dark blue, the map shows that flight connections are densest between Europe and North America. Less visible are the flight connections linking Africa, and West Africa in particular, to the world, indicating a scarcity of routes. Eric Sheppard (2002, p.319) explains this disconnect historically by arguing that early efforts of connecting London with New York were first enhanced through transport technologies, the steamship, the airplane or the telegraph, along routes on which 'large shares of commodities and information already flowed'. He contrasts this example with that of 'major African cities' (Sheppard, 2002, p.319), which are still poorly connected both to each other and to European hubs. His analysis suggests that African cities were disconnected from the flow of commodities and capital he describes. I argue that Sheppard's (2002) analysis disregards the role the trade in African lives played in establishing modern capital and transport flows across the Atlantic.

For 400 years the slave trade shaped the transatlantic region, connecting Africa's western coast to Europe and the Americas. According to the Trans-Atlantic Slave Trade Database (2019) 33,822 voyages were made on ships transporting close to 10 million enslaved Africans across the Atlantic. As Mbembe (2017, p.14) has pointed out '[b]etween 1630 and 1780, far more Africans than Europeans disembarked in Great

Britain's Atlantic colonies.' Despite the total volume of journeys, ships, enslaved and cargo transported from West Africa across the Atlantic, West Africa today scarcely features on a global map of transatlantic flight connections. Taking contemporary transport mobilities to be anchored in historical capitalist flows also marginalises the considerable wealth generated by European and North American individuals and nations through the slave trade. Money from the slave trade contributed to the establishment of British banks, universities and private fortunes and significantly enriched British Victorian cities such as London, Bristol or Liverpool (Hall et al., 2014). However in the subsequent establishment of transatlantic passenger and cargo shipping, telegraph and airplane routes, Africa was largely left off the map. Consequently, early transatlantic flows manifested for the Black populations of Africa as violent extractive mobilities while founding the wealth which built contemporary transport mobilities. In the present, African lives are still largely left off this map. This disparity is indicative of the racial-colonial 'mobility injustice' (Sheller, 2018) in which the Ebola epidemic took place.

As the map below shows (Figure 16), both the UK and Sierra Leone constituted major regions involved in the transatlantic slave trade. Ships from the UK, in particular from London, Bristol and Liverpool ports, carried 34.2% of all enslaved across the Atlantic. Approximately 12,000 slave voyages were undertaken by ships sailing under British flags and Sierra Leone was the principal place of slave purchase on 1,153 voyages.

During the trade, Sierra Leone became a geographical hub of importance at least twice, first in becoming a location from and via which enslaved Africans were shipped on European vessels from sub-Saharan Africa to North and South America and the Caribbean, thus enhancing transport mobilities both in terms of establishing naval routes and the infrastructures required for maritime navigation (see Figure 15, below – Bunce Island was the site of an important slave trading post. Its location in the Sierra Leone River made it accessible for slave ships. Enslaved Africans were transported to Bunce from Sierra Leone's mainland before being shipped across the Atlantic).

Figure 15: Old landing dock, Bunce Island, Sierra Leone

The second time Sierra Leone became a geographical hub was in disrupting these very routes and mobilities, after the abolition of the British slave trade, when slave ships were stopped by the British Navy and returned to Sierra Leone, the nearest British port, to free recaptured slaves (Olusoga, 2016; for both flows see Figure 16). With regards to the transatlantic slave trade in Sierra Leone, ships became a metaphor of both violence and liberation.

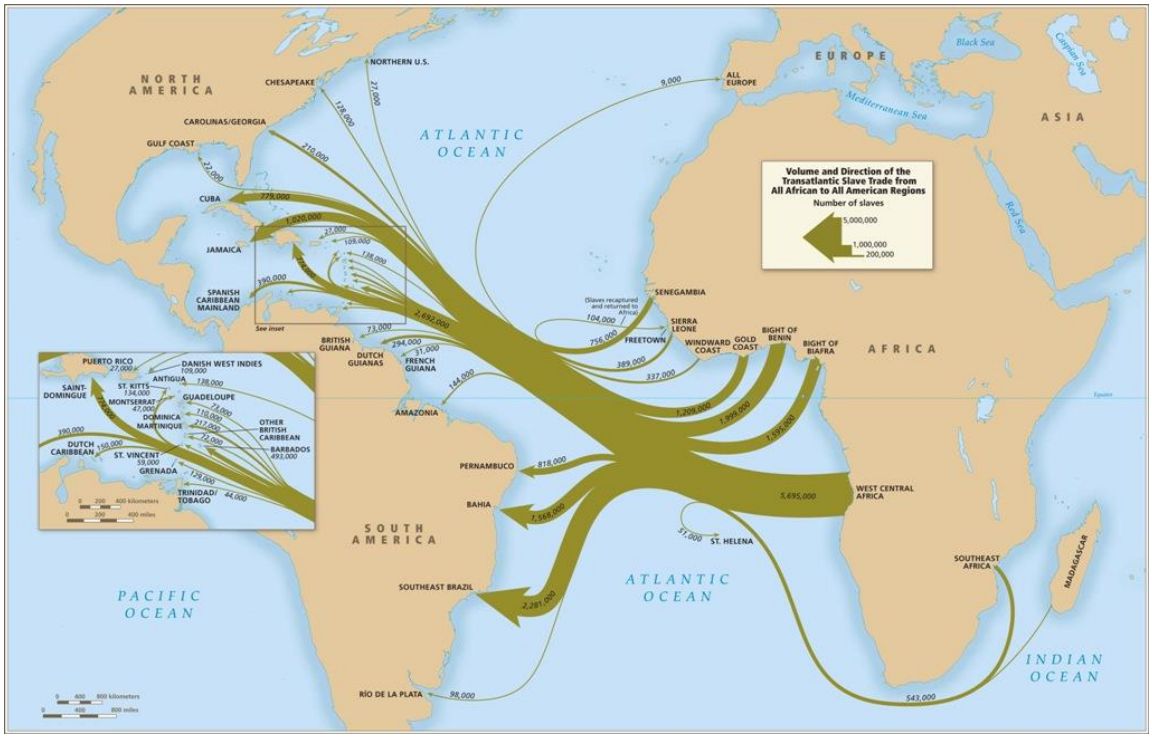

Figure 16: Map of the transatlantic slave trade: Volume and direction of the trans-Atlantic slave trade from all African to all American regions. JPEG. Voyages: The Trans-Atlantic Slave trade Database. Introductory Maps, accessed 24/05/2019

As I have shown in the previous chapter, this liberation framed Sierra Leone's subsequent colonisation by the British crown as an act of care. In the remains of King's Yard Gate, Britain's hand in the commodification of Blackness is erased and what remains are reminders of mobilities of care. Both flows shaped Sierra Leone to differing degrees. The contemporary disregard for the Black mobilities that both fuelled early capitalism and produced Blackness as an 'ontological negation of being' (Sharpe, 2016, p.14) by turning Black bodies into '*bodies of extraction'* (Mbembe, 2017), necessitates a reading of present-day mobilities in which Blackness is absent or dependent. This mobility injustice is indicative of being immobilised and left off the map, of Blackness as marginal to the flows of capital and power. This marginalisation, as I will show, plays an important role in the aftermath of the Ebola epidemic. I now turn to a more in-depth exploration of the regulation of Sierra Leonean mobilities under British colonialism. A closer look at colonial mobility regulations lays the basis for my analysis of contemporary UK-Sierra Leone mobilities during the 2014-15 Ebola epidemic that I attend to in the second part of this chapter.

6.2.2 Colonial mobilities: Directionality

In this section I stipulate that the production of Blackness as deviant and risky can be observed in the differential framing of directionality between Sierra Leone and the UK. Mbembe (2017, p.35) argues that 'race is what makes it possible to identify and define population groups in a way that makes each of them carriers of differentiated and more or less shifting risk.' During British colonialism, predominantly white mobilities from the UK to Sierra Leone were encouraged, blurring the line between colonial officers and British civilians, whereas Black Sierra Leonean mobilities towards the UK were discouraged, producing Black Sierra Leoneans as risky subjects and criminalising their movements. The mobilities linking the two countries have thus long been entangled with the production of racial difference. The regulation of mobilities and the politicisation of directionality shaped constructions of Britain and Sierra Leone as colonial centre and dependent respectively. These dynamics extend into the present, shape Black Sierra Leonean mobility and impacted the international Ebola response in Sierra Leone. I argue that Sierra Leone's status as colony was reified and upheld through a regulation of its people's mobilities and that it is not only Sierra Leone as a place that was colonised, but Sierra Leonean mobilities too in that they were imbued with colonial-racial hierarchies. Stoler (2016, p.117) offers a definition of colonies that places the regulation of mobilities at its very centre:

> A "colony" as a common noun is a place where people are moved in and out; a place of livid, hopeful, desperate, and violent *circulation*. […] A "colony" as a political concept is not a place but *a principle of managed mobilities*, mobilizing and immobilizing populations according to a set of changing rules, for resettlement, for disposal, for aid, or for coerced labour and those who are forcibly confined.

Stoler's (2016) definition conceptualises the colony as it exists for European settlers. However, her definition is useful in that it draws attention to several aspects which I argue are reflected and can be traced in the history of colonial mobility regulation in Sierra Leone. Stoler defines the colony as a place of violent circulation. As I have shown in the previous section and chapter, for several hundred years Sierra Leone was a place of violent antiblack circulation. In this section I turn to its nature as colony and specifically to colonial Sierra Leone as 'a principle of managed mobilities' (Stoler, 2016, p.117). Speaking of Sierra Leone as a British colony in that sense allows for an analysis of how colonialism, through the regulation of mobilities, laid the basis for the relatively free global mobility afforded to predominantly white European and North American citizens compared to the relative immobility of (predominantly Brown and Black) former colonial subjects. This racial differentiation became visible during the Ebola outbreak. How the colonial management of mobilities intersected with the management of infectious diseases historically becomes apparent in the following section.

The material, human and epistemological flows linking Freetown to London have always been subject to different rules and regulations than those linking London with Freetown and have shaped the respective cities at differing degrees of domination/immersion. Mobilities towards Sierra Leone and within British West Africa were actively encouraged, at least for colonial officers. The coordination of medical and sanitary policies relied actively on these inter-colonial and inter-imperial mobilities, first undertaken by ship and later by plane. After the onset of a yellow fever outbreak in Freetown in 1913, Rubert Boyce, an infectious and tropical diseases expert, was summoned from England. A Yellow Fever Report (WC, GC/59/A), written for the West African Yellow Fever Commission in 1913 describes his arrival as follows:

> Sir Rubert Boyce, who had sailed from England on June 1st with additional medical officers to render assistance in the Gold Coast and Sierra Leone, arrived at Freetown on his outward journey to Secondee about June 13th, a few days after the death of a European (Case 11) from Yellow Fever. After consultation with the Senior Sanitary Officer, he decided to continue his journey to Secondee, leaving behind him two of the medical officers to assist in carrying out the preventive measures.

> Quarantine was raised from Freetown at the end of June, all necessary anti-mosquito measures being continued.

This passage shows several things. It shows that West African intercolonial and British-Sierra Leonean mobility was seen as instrumental for the coordination of infectious disease control in Sierra Leone. Boyce's journey from England also indicates that the knowledge and expertise deemed necessary to combat the yellow fever outbreak was not local but had to be summoned from the UK, a point I return to in the next chapter on expertise. As with the liberation of freed slaves, these mobilities framed British-Sierra Leonean mobilities in terms of care and as a response to a local health emergency. It also draws attention to the contradictory mobility dynamics that characterised British epidemic interventions in Freetown and West Africa more generally. The mobilisation of British expertise in the form of several medical officers stands in stark contrast to the quarantine imposed on Freetown according to the report. This foreshadows similar dynamics visible during the 2014-16 Ebola epidemic in which lockdowns were imposed on the entire Sierra Leonean population (BBC, 2015) whilst international health responders travelled to and within Sierra Leone to assist in the response. As in 1913, the 2014-16 Ebola epidemic was characterised by the simultaneous mobilisation of European-based expertise and immobilisation of Freetown under quarantine or quarantine-like measures.

The ships on which Rubert Boyce travelled from England to Sierra Leone and then on to Ghana were, in the years following the yellow fever outbreak, replaced by airplanes. White British mobility continued to be encouraged. As with the management of diseases, the British Empire relied on mobilities between the different colonies and with the UK. The rapid propagation of air travel at the beginning of the 20th century also extended to colonial Africa. Aeromobilities played an active role in making territories accessible for colonisation and developing them according to colonial doctrines. As Peter Adey (2010, p.87) argued in relation to early aerial surveys 'the aerial view revealed a reality that demanded improvement and development.' With the aeroplane, the British Empire could be tied together as new flight routes were discussed and new geographical perspectives could be developed (Zook and Brunn, 2006). During a discussion on imperial air routes at the Royal Geographical Society in 1920, attended by Winston Churchill, the then Secretary of State for Colonies, it was stated that 'the importance to the empire of the development of aviation is obvious' (Prince of Wales et al., 1920, p.264). Aeromobilities did not only serve to connect different ends of the empire, aerial mapping technologies

also increased the epistemic advantage of the UK over the territories that constituted its empire.

In the increasing availability of commercial flights, colonial expansion and aeromobilities came together. This is illustrated by the cover of an Imperial Airlines flight schedule from 1931 (Figure 17). Imperial Airways, a precursor of the British Overseas Airways Cooperation (BOAC) and British Airways (Deal et al., 2018) offered flights connecting London to India and Egypt, Sudan and East and South Africa, as part of its 'Empire Service' as early as 1931. On this Imperial Airways flight schedule, the aerial view that Adey (2010) described is depicted graphically. The view is that of an airplane approaching Africa and India from the south. The Empire in this image is laid out in front of the viewer who can trace the airline's route from Cape Town to London. Although the British colonial dream of a railway connection linking Cape Town to Cairo failed, aeromobilities achieved exactly that by opening the Empire up commercially through speedy trans-imperial connections. For the British traveller, the empire here becomes a place of boundless mobility and circulation.

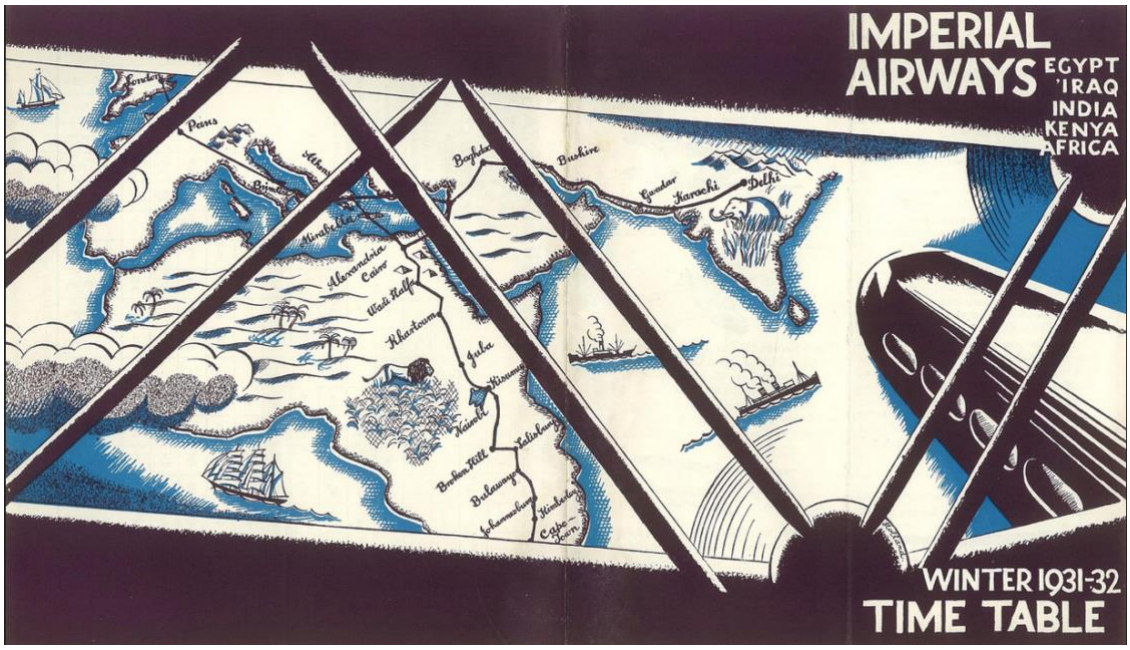

Figure 17: Cover of Imperial Airways Schedule 1931-32, October 1931 'Empire' (African and Indian) routes taken from the collection of Björn Larsson, www.timetableimages.com, accessed 28/05/2019

West Africa was added to Imperial Airways' schedule in 1937 with connections to Nigeria and Ghana.[26] From 1948 the West African Airways Cooperation (WAAC), jointly co-owned by British West African colonies, started offering flights to Freetown as part of its intercolonial service.[27] To advertise these mobilities to the British public,

[26] http://www.timetableimages.com/ttimages/iaw.htm, accessed 26th May 2019
[27] http://www.timetableimages.com/ttimages/wt1/wt48/wt48-2.jpg, accessed 26th May 2019

WAAC advertisements were placed in targeted publications, such as *West Africa*, a weekly news magazine, published in London, highlighting West Africa's commercial and resource importance to the British Empire and to Britain because of its geographical proximity. One such advertisement encouraged readers to 'Fly by the airmail routes' and promotes 'a comprehensive network of routes to 25 centres within West Africa' (TNA, CO1045/515). As such the WAAC encouraged white British civilians to explore West Africa through existing colonial air routes, contributing to the blurring of British colonisers and civilians. Through aeromobilities, British civilians could take part in the Empire.

Freetown was linked through the WAAC to the capitals of other British West African colonies, such as Banjul, Accra and Lagos. In a 1951 article published in *Flight* magazine, a British journalist, Geoffrey Dorman (1951, pp.38-40) describes this 'inter-colonial route' as having first been devised to facilitate the regional mobility of British colonial administrators and link West African colonies to Dakar and Khartoum. Although not explicitly racially segregated, the cost of an airline ticket prevented the vast majority of Black Sierra Leoneans from flying within West Africa, let alone from flying to the UK. In 1948 a WAAC single fare from Freetown to Lagos cost £34 corresponding to approximately £1,255 in today's money.[28] In 1950 a second-class service was added to 'tap the African 'man in the street' for their future potential' (Dorman, 1951, p.39), but not on routes connecting Freetown to other cities. In 1951 a single fare from Freetown to London via Dakar cost £96 (= £2,990 today).

WAAC received technical advice from and acted as agent for BOAC (Dorman, 1951, pp.38-40). Here West African aeromobilities were both devised and ensured by British expertise and colonial interests. They were largely organised around linking smaller colonies to West African colonial centres in Nigeria and Senegal. A direct route to London only operated to and from Dakar and Kano (Northern Nigeria) (Dorman, 1951, p. 40). Starting in 1951, BOAC added Freetown to its world route.

Through the airplane, access to and within Britain's colonies was facilitated. White mobility to and within West Africa was encouraged. The economic costs of airline tickets precluded widespread Black mobility. I now show that through mobility regulations, Blackness was construed as risky and deviant and independent Black mobility from Sierra Leone to the UK was actively discouraged.

[28] https://www.in2013dollars.com/uk/inflation/1948?amount=34, accessed 27th of May 2019

In the case of Black Sierra Leoneans wanting to travel to London, mobility regulations applied to the 'native' population. Writing about a (white) western conceptualisation of Blackness, Mbembe (2017, p.28) argues that

> its function first and foremost [was] to codify the conditions for the appearance and the manifestation of a *racial subject* that would be called the Black Man and, later, within colonialism, the Native (*L'indigène*).[29]

In colonialism, I argue 'Blackness' and 'Nativeness' become akin in the sense that both are antithetical to whiteness. In the shift from enslaved to colonial mobilities, the regulation of Black mobility is framed through the figure of the native. An advertisement in the 1911 Sierra Leone Royal Gazette (TNA, CO271/17, p.55) reads as follows:

> Warning
>
> Natives of this Colony and Protectorate who may be desirous of proceeding to England in search of employment are warned of the impossibility of obtaining employment there, and the danger which they run of getting stranded in that country if they go without insufficient funds. They are further warned that they are likely to find themselves in trouble unless they have work assured to them on their arrival, or have the means to take them back if they fail in their object.
>
> 9th of February, 1911

With the exception of those movements sanctioned by an existing work contract, it is made clear that 'native' mobilities towards the UK, and their subsequent presence in Britain, is undesired. Here Black or native mobility towards the UK is framed as risky and is criminalised. This is in stark contrast to the aeromobilities I have discussed in the previous section, which invited British civilians to 'fly by the airmail routes'. The warning also signals what Mark Duffield (2008, p.143) describes as the containment of the 'circulation of underdeveloped and non-insured life', a marker of the difference between 'developed' and 'under-developed' nations. Although Duffield (2008) sees this modern differentiation as largely biopolitical, he contends that it is often racialised. In the case of Sierra Leonean-British mobilities, Blackness is produced as risky and its mobility as deviant.

Today, the directionality of mobilities is still unevenly immersed in postcolonial geographies and power dynamics. This became obvious during the Ebola epidemic,

[29] 'The Black Man' or 'Black' is the English translation of what Mbembe in the original French version calls 'le nègre'.

during which postcolonial visa and health regulations precluded the majority of mobilities from Sierra Leone to the UK. This impacted the capacity of Sierra Leonean and African healthcare workers to take part in the epidemic response. Anton, a British NGO worker, explained the constraints that his organisation was subject to in recruiting healthcare workers to the Sierra Leonean response:

> What would have helped would have been if they [the British government, WHO] confirmed that medevacs were gonna be available for any nationality and how that was gonna be sorted. That wasn't done. So we knew British people would get out, we knew someone from Spain would be alright, we didn't know if any of our Kiwi staff were. To be honest we were told pretty clearly if they were from the right type of Commonwealth country they'd be alright. Like that was the indication […]. I think we did not take volunteers from other African countries because we didn't know what would happen if they got sick.

Anton's quote illustrates the entanglement of postcolonial mobility politics and the organisation of an epidemic response. His statement that medevacs [aerial evacuations to specialised hospitals] would not be made available to African healthcare workers or staff originating from 'the wrong type of Commonwealth country' was mirrored in newspaper articles (Harker, 2014; Benton, 2014). His differentiation between "the right type of Commonwealth country" and "other African countries" indicates (post)colonial-racial hierarchies that underlay the response, but for the most part were not openly addressed. Apart from the reproduction of colonial mobility dynamics themselves, these politics also led to a reification of both Sierra Leone and Africa more generally as unable to care for itself, as not possessing qualified healthcare workers and as having to rely heavily on the mobilisation of white European and North American volunteers.

Sheppard (2002) argues that the positionality of cities plays an important role in determining aeromobilities. I would argue that control over the directionality and nature of movements was and is as important in the determination of aeromobilities. The control over mobilities shapes and was shaped by Britain's understanding of Sierra Leone as an extractive, non-settler colony. Economic interests played an important role in this control. The warning published in the Sierra Leone Royal Gazette, seemed to be targeted largely against the 'threat' of homeless, jobless Africans in the streets of Britain, the very undesirability of which had contributed to the foundation of the colony of Sierra Leone (and their subsequent resettlement in Sierra Leone) (Olusoga, 2016).

Present aeromobilities, of course, are highly dependent on economic calculations as well. British Airways' decision to suspend the Freetown-London route during and after the Sierra Leonean Ebola epidemic, which I analyse in the second part of this chapter, was purportedly based on financial grounds. At the same time, Europe's current visa policies, which made the repatriation of non-European (non-white) healthcare workers so difficult, is also motivated by fears of foreign beneficiaries of the welfare state.[30] Migrants (and refugees) are still 'warned that they are likely to find themselves in trouble unless they have work assured to them on their arrival' (TNA, CO271/17, p.55). The continuation of these dynamics is indicative of being in the wake. The directionality of mobilities is imbued with antiblackness and produces Blackness as deviant and risky. I now focus on the material infrastructures that have made these aeromobilities possible.

6.2.3 Colonial Infrastructures

Sharpe (2016) writes about the *Zong*, a British slave ship that threw 142 enslaved Africans overboard on its way to Jamaica in 1781. Due to navigational errors, the ship had run out of potable water and the crew reduced the number of enslaved Africans to ensure the survival of the rest of the 'cargo'. In her analysis Sharpe (2016, p.37) distinguishes the figure of the slave from that of the ship. Upon arrival in Jamaica a local newspaper commented on the ship's distress (navigational errors, prolonged journey) rather than that of the enslaved. She writes: 'Here, if not everywhere, as we will see, the ship is distinct from the slave.' It is this distinction that I want to take up here. In the case of the *Zong* this distinction is a further sign of antiblackness, of personifying the ship yet denying the enslaved personhood. I argue here that a focus on the ship as distinct from the slave enables a focus on the ship as an infrastructure on which the slave trade and colonialism relied. These infrastructures, the routes and materials they rely on, endure and can be analysed as continually producing Blackness as dependency and as signalling the colonial wake. To see 'the ship [a]s distinct from the slave' allows a focus on ships and airplanes as constituting colonial and antiblack infrastructures after slavery and colonialism. In the wake, these infrastructures produce Sierra Leone and its population as dependent on British aid and expertise. In this section I focus on British colonial considerations in the building of and investment in material mobility infrastructures in Sierra Leone. Then, borrowing AbdouMaliq Simone's (2004) concept of 'people as infrastructure', I show that human infrastructures were an instrumental part in British efforts to remain a central

[30] The majority of African countries are currently excluded from visa-free travel to Europe (Passport Index, 2019).

player in the development of West African aeromobilities post-independence. Both types of infrastructures played important roles during the 2014-15 Ebola epidemic and carry the colonial past into the present, thereby contributing to and constituting the colonial wake.

Adey (2010, p.87) points to the importance of infrastructures in the development of colonialism and the crucial role aeromobilities played in it. The economic and social development of colonial regions was seen as a central justification for investing in and building aeromobile infrastructures:

> The infrastructure of air-routes and pathways necessary to conduct aerial photography would have to be built, constructing a symbolic and material presence in colonial regions – the aerial survey as harbinger of development. Requiring considerable infrastructure to support the mobilities and maintenance of aircraft, air survey was a conduit through which development could be piped. The infrastructure necessary for air-routes and commercial services could already be in place for colony development.

In the case of Sierra Leone, I would like to extend Adey's (2010) argument to argue that further to establishing a colonial presence in Sierra Leone, the infrastructures that supported colonial mobilities endure into the present. I use the example of the building and extension of Kenema and Lungi airfields, situated in Eastern Sierra Leone and the Freetown area respectively, towards the end of British colonialism, to analyse how infrastructures contribute to shaping the colonial wake. Specifically I show the extent to which the building of aeromobile infrastructures in Sierra Leone was entangled with colonial governance and the control of the Black Sierra Leonean population.

At the eve of independence, in 1960, the colonial government invested in aeromobile infrastructures. In 1960, it proposed the construction of a new, bigger airfield in Kenema, in Eastern Sierra Leone to be funded through the Colonial Development and Welfare fund. The following excerpt is from internal communications between the British Treasury, the Colonial Office and the Communications Department regarding the construction of said airfield and the extension of Lungi airport:

> Mr Wallace also mentioned that Kenema was of importance from an internal security point of view since it was the nearest possible point to the diamond mining areas, and if trouble occurred there it might be necessary to organise an airlift of troops or police. In that event a runway of conventional length which would take fairly large sized aircraft was necessary (TNA, CO937/510).

Thus, one year prior to independence, security concerns around diamond mining in Eastern Sierra Leone were an important matter for the colonial government, which could be addressed through improved aeromobilities. The building of a new airstrip here, which, in the internal communications was discussed in financial and temporal terms (the airstrip having to be financed from local funds from the day of independence on the 21st of April 1961), enabled (post-)colonial access to Sierra Leone's diamond-rich eastern region. Here aeromobile infrastructures were seen to grant police and military speedy access to and from Sierra Leonean diamond fields, which at the time were controlled by the British colonial government and London-based British-South African firm De Beers (Smilie et al., 2000) which operated a diamond field near Kenema. The 'trouble' anticipated in this communication imagines Blackness as an internal security threat, to be controlled through aeromobilities.

As with Kenema, infrastructure investments for Lungi airport's extension are discussed in British colonial communications. Lungi airport, situated across the estuary from Freetown is presently Sierra Leone's only international airport. It was converted from a pre-existing RAF base into an airport in the 1950s by the British colonial government (TNA, CO 937/262). Similar to Kenema airport, the airport's expansion by British colonial powers was linked to security concerns. In 1953, a communiqué between the Air Ministry and the Colonial Office revealed the following:

> The War Office has asked us [Air Ministry] to prepare a plan for the reinforcement of Sierra Leone in the event of civil disturbances as part of Operation "Weary" which covers the West African Colonies. [31]
>
> Unfortunately the only airfield of any size in Sierra Leone (Freetown/Lungi) has, according to our latest information, an all-up weight limitation of 50,000 lbs and hence appears to be unsuitable for Hastings, which would be operating at 70/75,000 lbs.[32] In all other respects however the airfield is acceptable, and Transport Command would be willing to operate Hastings from it in an emergency, provided the weight limitation could be temporarily raised. […] If smaller aircrafts had to be used, we should need to have more of them or to make more journeys, or both, and this would involve greater expense and possibly some delay in completing the operation. (TNA, CO937/262)

In both cases – the construction of Kenema and Lungi airfields – security concerns are written into material and financial calculations around airplane types and weight, landing strip length and weight limitation. What is discussed here are the technological

[31] I was unable to find additional information on Operation Weary anywhere else.
[32] At the time of its construction in 1946 the Hastings was the biggest RAF troop-carrier and freight transport aircraft of its kind (IWM, 2010)

requirements to clamp down on political protest, framed as 'civil disturbances'. The reinforcement of Lungi and Kenema airfields were discussed to grant speedy access to parts of the empire that needed to be controlled and in which political and socio-economic uprisings needed to be quelled. The excerpt indicates one more point: until the late 1950s and until the political situation on the ground seemed to demand greater security, British colonial officers in Sierra Leone did not deem a proper airport necessary. Existing infrastructure was sufficient to ensure colonial mobilities (always in relatively small numbers) throughout the region and on to London. Sierra Leonean aeromobilities were not designed for popular Sierra Leonean use. This reinforces an image of Sierra Leone as a place of resource extraction, which was (and is) largely ensured by ships. Sierra Leonean mobilities were organised around a British understanding of Sierra Leone as a dependent place. This echoes the production of Blackness as dependence, which was used as a justification for British colonisation (Mbembe, 2001, 2017). I argue that in the conception of Sierra Leone's aeromobilities Sierra Leoneans' mobilities were barely considered. Rather, I argue in the next section, the conception of colonial aeromobilities was designed to ensure the continued protection of British interests. To show this I draw on Simone's (2004) concept of 'people as infrastructure'.

Writing about inner-city Johannesburg, Simone (2004) offers 'people as infrastructure' to think through the ever-moving, socially heterogenous dynamics of urban Africa. He argues (2004, p.411) that

> *people as infrastructure* describes a tentative and often precarious process of remaking the inner city, especially now that the policies and economies that once moored it to the surrounding city have mostly worn away.[33]

Here I want to extend Simone's (2004) concept to think through colonial mobility infrastructures in Sierra Leone. I propose that at the moment of independence the material infrastructures, put in place by Sierra Leone's colonial government, which would allow the future of aeromobilities into Sierra Leone, were supplemented by human expertise and skills in the form of seconded BOAC advisors and experts. This reliance on white 'people as infrastructure' reiterates the colonial-racial mobility injustice at the heart of British-Sierra Leonean relations. White expertise is mobilised to shape the future of Sierra Leonean mobilities according to British interests. To illustrate my argument I return to the moment of Sierra Leone's independence.

[33] While I use Simone's terminology of 'people as infrastructure', I apply it to colonial infrastructures, rather than the fragmented, marginalised 'people as infrastructure' that Simone writes about.

The independence of participating states in the late 50s and early 60s saw the end of the WAAC and the emergence of national carriers. A 1960 British government report on civil aviation in Sierra Leone, discussing future Sierra Leonean aeromobilities, focusses on how the impending independence of Nigeria led to fears of a disruption to flight services linking Sierra Leone to the rest of the region and to the UK (TNA, CO937/544). Colonial governance had ensured continued British aerial access financially, materially and politically in West Africa through the joint ownership of WAAC by British West African colonies. At the moment of independence this access and the economic advantages that it promised were thrown into question. While the report states that it is politically 'impracticable for either the French or ourselves to make any direct attempt to re-assert our control over traffic rights in this area', it also encourages the possibility of 'avoiding the placing of unnecessary restriction on the freedom of our respective airlines' (TNA, CO937/544) in the development of West African aerial routes. Similarly as with WAAC, the newly emerging national airlines such as Sierra Leone Airways, Ghana Airways or Nigeria Airways relied largely on expatriate BOAC workers and their skills in the establishment of their national carriers and the maintenance of existing equipment (TNA, CO937/544). UK representatives in Sierra Leone encouraged this involvement. The report argues the following:

> The U.K. High Commissioner felt that it was very much in BOAC's interest to ensure that there was complete liaison between themselves as partners with the airlines in West Africa and BOAC (AC) Ltd. as shareholders in these airlines. The best men available should be nominated to serve with the West African associates. […] there are also some grounds for believing that [West African] Ministers and officials are genuinely appreciative of the help so far received from BOAC even although they are chary of expressing such sentiments which would ill accord with the popular idea of independence. (TNA, CO937/544)

This passage shows how aeromobilities and the future access of BOAC, which would later become British Airways, were negotiated at the moment of West African independence (1957-1965) and the extent to which the maintenance of close links was deemed important to fulfil British interests in West Africa. A shift from WAAC, an airline directly immersed in inter-colonial routes and infrastructures, to national airlines in which British ownership and control was less direct can be observed here. To maintain British influence and with regards to securing continued access to West African countries, 'the best men available should be nominated to serve with West African associates.' (TNA, CO937/544).

In order for the material infrastructures in which the colonial government had invested to ensure British aeromobilities (in the form of British airlines, such as BOAC), British negotiators built on human expertise and skill. The shift from outright British government control to BOAC shareholder-ship necessitated the skilled negotiation techniques of BOAC representatives in coordination with UK government representation on the ground. To be able to convince newly independent states that existing aeromobile infrastructures should guarantee continued British access, the political atmosphere had to be read and carefully manoeuvred. The following passage from the same report makes this clear (TNA, CO937/544):

> […] the position of BOAC nominated directors and of skilled managerial and technical staff seconded by BOAC is extremely difficult. It is often apparent to them that government intervention or support will be necessary to secure the adoption of sound policies or the correction of abuses but if they approach Ministers or officials they are vulnerable to the charges that they are going over the heads of the board or that they are intriguing behind the backs of government appointed directors. Occasionally this risk can be avoided by arranging for the approach to government to be made by a visiting representative of BOAC, not holding office in the local airline, where BOAC can allege a legitimate interest in the matter at issue because of its bearing on the prospects of the partnership between BOAC and the national airline […].

This passage shows the importance of human infrastructure in the bid for continued British aeromobilities throughout West Africa. The material infrastructures put in place in the 1950s, such as the building of Kenema and the extension of Lungi airfields, depended on skilled negotiators and political ruses to continue to be useful for British aviation. In other words, British interests rested on material *and* human infrastructures. The fears that Britain was to be excluded from West African aeromobilities here led to deception and strategizing both of which relied on Britain's vast network of governmental and commercial representatives. By drawing on Simone's (2004) terminology of 'people as infrastructure' I have shown that colonial future-making depended on material as well as human infrastructures. This becomes relevant in a reading of the 2014-15 British-led Ebola response, which mobilised a similar network of material and human infrastructure and in which (im)mobilities were similarly entangled with racial differentiation.

At Lungi airport, built under British colonial rule, baggage handling and security have since 2012 been managed by Westminster Group PLC, a British private security firm with a mandate to combat crime and increase efficiency (Bangura, 2015). In a 2019 interview, their chairman Sir Tony Baldry stated that:

> We started operating in Sierra Leone in 2012 when the country was in dire need of a professional company to handle the ground handling of the Lungi airport. At that time we sent in 30 experts to work with Sierra Leoneans. (Thomas, 2019)

Through these material and human infrastructures – the 'experts' that Tony Baldry speaks of – the dependency which characterises colonialism is extended. In the wake the management of Lungi airport depends on British experts traveling to and from Sierra Leone to regulate and enable mobilities in and out of the country. Before and after independence, Sierra Leonean aeromobilities are ensured through British governmental and private interests taking the form of material and human infrastructures. Here, colonial continuities and concurrences work their way through the wake.

In the first part of this chapter I have attended to the production of Blackness in the framing and regulation of colonial mobilities. I have taken, routes, directionality and infrastructures as three points to explore how mobilities constitute the colonial wake and contributed to shifting definitions of Blackness. Rather than demonstrating explicit causality, I have tried to present a picture of the sweeping intersection of mobilities, antiblackness and British colonialism in Sierra Leone. As in the previous chapter, the colonial wake here does not take exclusively material form. Aeromobilities relied and continue to rely, as I show going forward, on colonial infrastructures, which in Sierra Leone take both material and human form.

This serves as a backdrop against which I analyse British-Sierra Leonean mobilities during the 2014-15 Ebola response. While I explore contemporary mobilities, I draw attention to the political and geographical concurrences and disruptions whose colonial basis I have mapped out here. As per Stoler's (2016, p.117) invitation to think about a colony as 'a principle of managed migration' I have examined UK-Sierra Leonean colonial relations through an analysis of the politics of mobility. In the next section I suggest that mobilities during and after the Ebola epidemic continue to shape Blackness as dependency and were themselves perceived as multiple. These multiple mobilities create multiple Sierra Leones, on which in turn a contemporary Black diasporic ontology depends.

6.3 Contemporary mobilities and mobile ontologies

In this section I attend to contemporary mobilities and the multiple mobile ontologies they create. I argue that the suspension of direct flights between London and Freetown and reactions to it recall the careful production of Black Sierra Leoneans and Sierra Leone itself as dependent on the UK and on white expertise, which I have illustrated in the first part of this chapter. Here, mobilities, their flow and interruption, their regulation and experience, signal the precarious postcolonial condition that shapes Black being and Sierra Leone in the wake.

Mbembe (2001, p.13) argues that

> the slave trade and colonialism echoed one another with the lingering doubt of the very possibility of self-government, and with the risk, which has never disappeared, of the continent and Africans being again consigned for a long time to a degrading condition.

Following Mbembe (2001) I argue here that an analysis of the changing aeromobilities linking Sierra Leone and the UK during and after the Ebola epidemic reveals a continuing dependence and 'lingering doubt of the very possibility of self-government'. In the wake, Sierra Leonean mobilities still depend on white British expertise and material infrastructures. Black Sierra Leonean diasporic lives both depend on and invoke these (post-)colonial flows and use them to subvert the construction of Sierra Leone as a place dependent on the UK. This, I argue, signals the wake and the ongoing injustice at the heart of Sierra Leonean mobilities. As per Sheller's (2018, p.21) definition of mobility injustice I close this chapter by attending to the 'differential subjects', which the unequal, colonial and antiblack mobilities I have described here have created.

6.3.1 Aeromobilities in the colonial wake

Figure 18: Pre-Ebola (early 2014) international flights to/from Freetown's Lungi Airport

The direct flight between London and Freetown has long been a focal point in Sierra Leonean-British aeromobilities. In post-civil war Sierra Leone only Brussels Airways' direct Freetown-Brussels international connection preceded BA's Freetown-London route, the former starting in 2002 and the latter in 2008. The British Airways route connecting Freetown to London was launched by bmi (British Midlands International) in 2008 and taken over by British Airlines after the airlines' merger in 2012 (Maslen, 2012). Gambia Bird, a subsidiary of German airline Germania, launched services in 2012 linking Freetown to London and to other regional capitals. Other routes gradually joined in the 2010s (Figure 18). During the Ebola epidemic however, all airlines with the exception of Brussels Airways and Royal Air Maroc suspended flights to Sierra Leone (see Figure 19). I offer a detailed chronology of the onset and disruption of flight routes in and out of

Sierra Leone around the beginning of the Ebola epidemic in Appendix 2. While most airlines resumed their flights after the outbreak, British Airways CEO Alex Cruz declared the routes to not be ‘commercially viable’ in 2016 (Massaquoi, 2018).

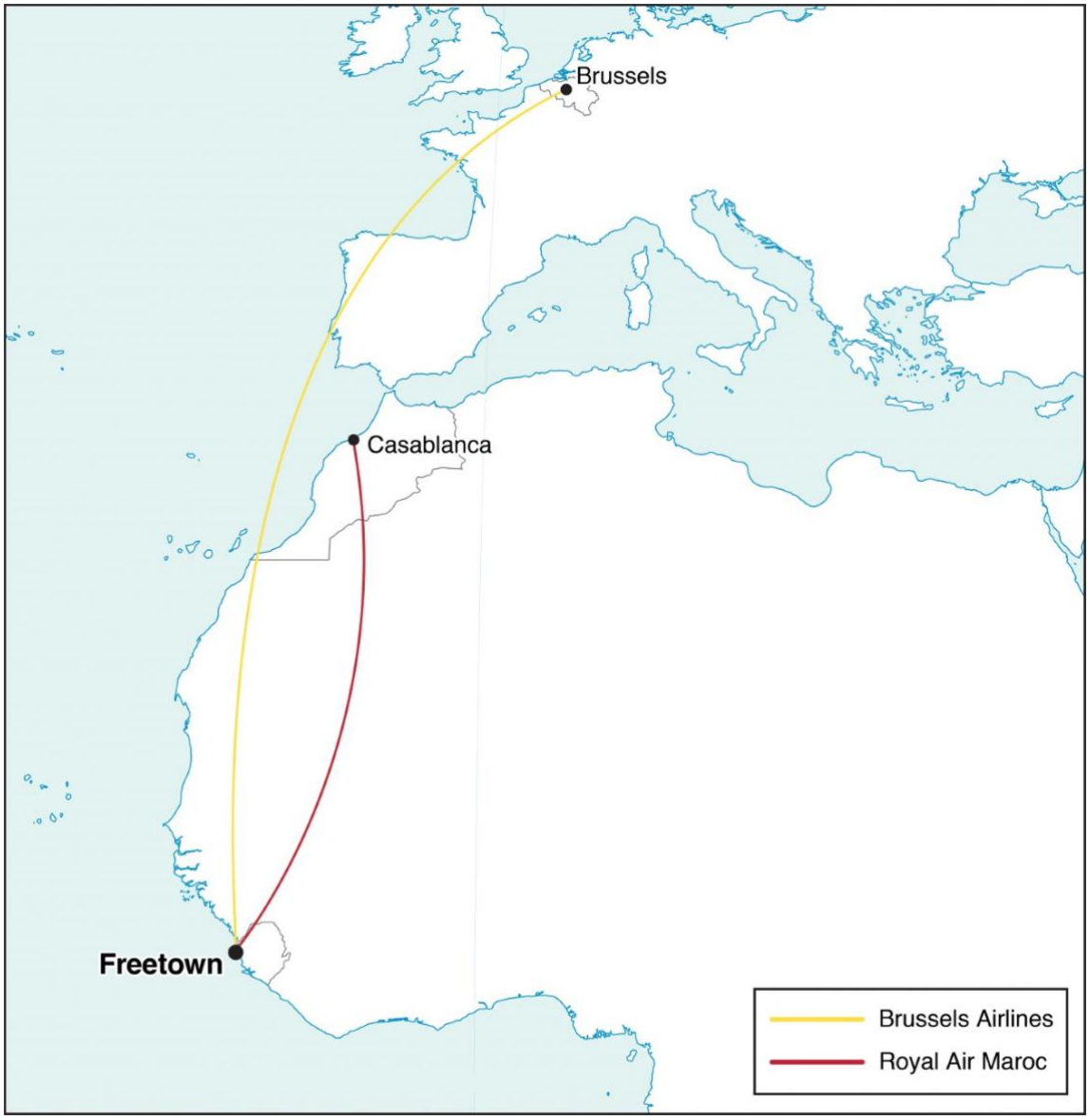

Figure 19: International flights connecting Freetown's Lungi Airport during the Ebola epidemic

The direct flights between the UK and Sierra Leone were an important part of diasporic lives. David, a member of the Sierra Leonean diaspora in the UK, described the importance of the direct connection and the lengths to which he went to have direct flights connecting London and Freetown reinstated. He also described how the suspension affected the diaspora in the UK:

> Actually the suspension, interesting case, because I remember working on an advocacy effort to ask the UK government to lift the ban because the ban, we assumed that it was imposed by the UK government even though they denied it, and so I remember getting back a response from the

> Minister of Transport writing me back that the ban has actually been lifted. But then it was lifted in theory, but in practice there was still no direct route between the two because BA, which was flying directly, stopped during Ebola citing health issues, but then once the ban was lifted they never went back and that had some impact and that was the motivation for me to start the advocacy drive in the first place because a lot of Sierra Leoneans that I talked to especially those that had business interests in Sierra Leone, and also those that wanted to help out from a humanitarian point of view, didn't have an opportunity to fly from here to Sierra Leone and instead they had to go to a different country and some weren't even able to make it. So, it deprived the response as well from a humanitarian angle not just from a business perspective.

David's account signals the diaspora's quotidian reliance on direct flights, but also their desire to be involved in the Ebola response. His statement that "some weren't even able to make it" indicates a feeling of dependence, which weaves its way through this chapter and which is echoed by other members of the diaspora further down. I now turn to show that the direct route was perceived by some Sierra Leoneans in Sierra Leone and in the diaspora as an appreciation of Sierra Leone by the former colonial power.

Upon the inauguration of Gambia Bird's Freetown-London route a Sierra Leonean journalist reported the following:

> While urging the airline to ensure that they give the British Airways a run for their money with their new route to London via Freetown, Minister Koroma [Minister for Transport and Aviation] pointed out that London is a preferred route for Sierra Leoneans because of the rich colonial ties between the two countries (Tarawallie, n.d.).

These rich colonial ties were often invoked by members of the Sierra Leonean diaspora too. After speaking to David about the advocacy effort he had been involved in, I analysed two online petitions, one on *change.org* (Figure 20) the other one on *38degrees.com* urging British Airways, not Gambia Bird, to resume direct flights to Sierra Leone. The texts of both petitions made explicit links to Sierra Leone's colonial past. Tony Rogers, a British healthcare worker who was part of the British response to Sierra Leone launched the *38 Degrees* petition in 2015. In his petition he quotes an editorial from Sierra Leonean newspaper *Torchlight* (Rogers, 2015):

> Sierra Leoneans felt abandoned by the former colonial masters when even an attempt by Gambia Bird Airlines to resume direct flights was met with stiff rejection from the British government.

Similarly, Martha Massaquoi, who set up the *change.org* petition in 2016 stated that

> As a Commonwealth country, we feel that the link to the UK provided by British Airways represented an important bond between the countries (Massaquoi, 2016).

Britain's colonial history in Sierra Leone was also taken up by some of the signatories who commented on the *change.org* petition. Out of 701 signatories, 266 people commented, some only signing their names, others writing lengthy explanations as to why they want BA to resume flights. A 'direct' route or flights were mentioned 81 times, making it the prime reason why people signed. Allusions to Britain's colonial past in Sierra Leone took different forms. Here I present some of the comments to show how members of the Sierra Leonean diaspora, who made up a big portion of signatories, used the colonial past to demand flights be reinstated. I argue that a direct route between Britain and Sierra Leone is seen as a sign of a privileged relationship due to the countries' shared colonial past. At the same time I argue that this reflects the careful construction of both Blackness and Sierra Leone as a colony as a place/race whose autonomy is perpetually in doubt (Mbembe, 2001, 2017). Some comments made direct reference to colonialism, while others wrote about the commonwealth or shared history:

> Sierra Leone was British Colonized until our independence in 1961. In light of that, Britain should be more sympathetic to Sierra Leoneans especially in time of devastation (EBOLA, MUDSLIDE etc.). I am doubtful as far as their loyalty to Sierra Leone when our people are abandoned during their time of crises by a country that colonized them for so long. They stopped all flights to Sierra Leone, it was only SN Brussels that stuck with us during these difficult times and I commend them for their patriotism. […] (Seray Dumbuya, 2018)

> Because Sierra Leone is a former British colonial country. And families are suffering to travel to Freetown or London. (Mohamed Amara Samba Mustapha, 2016)

> Direct flights to Sierra Leone is a necessity. Britain needs to stand by Sierra Leone. (Rebecca Yongawo, 2016)

> Ebola is now finished and all their fears have proved wrong. Royal Air Maroc & SN Brussels flew through out [sic] the whole episode and no lives were put at risk. In addition we have a long history with BA and UK as Sierra Leone is an old British Colony. (Frances Fode, 2016)

> I wholeheartedly support this long overdue request for a vital service that is not only financially beneficial to the countries but also cements the historical bond between our countries and peoples (Saeley Johnson, 2016)

> I believe it benefits the company, the two states and above all it cements the ties between us as a common wealth country. (Patrick Lebbie, 2016)

> There is a huge diaspora of Sierra Leoneans in the UK and a long history of links between the countries. […] Direct air travel between the UK and this commonwealth country is essential. (Douglas Laurie, 2016)

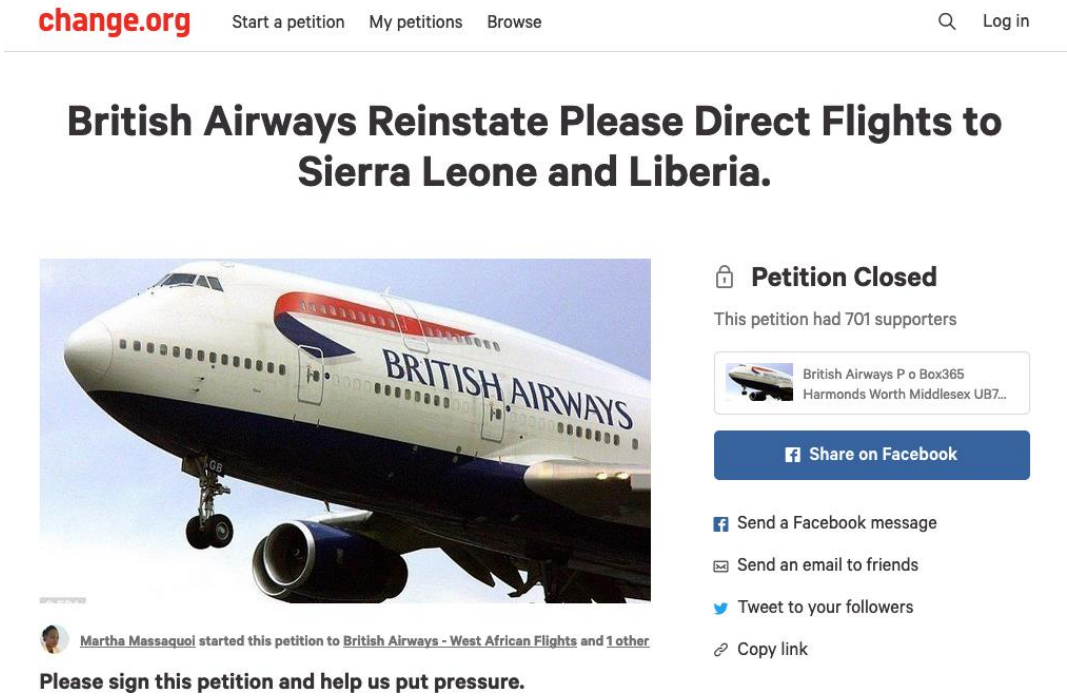

Figure 20: Screenshot of change.org petition, https://www.change.org/p/british-airways-p-o-box365-harmonds-worth-middlesex-ub7-0gb-british-airways-reinstate-please-direct-flights-to-sierra-leone-and-liberia, accessed 29/05/2019

This selection of comments shows several things. First, current direct aeromobilities are seen as 'cementing' historical ties and bonds between the two countries. Furthermore, the former colonial relation between Sierra Leone and the UK is expressed emotionally. 'Britain needs to stand by Sierra Leone', 'I am doubtful as far as their loyalty' or 'their fears have proved wrong' all indicate that for the people commenting on the petition, BA's decision to suspend flights during the Ebola epidemic and to extend the suspension affected them emotionally. I argue that these emotions signal the colonial present; a present in which the colonial past translates into a privileged special relationship between Britain and its former colonies. Here the colonial and antiblack violence that has characterised Britain's role in Sierra Leone for so long is relegated or invoked to form an emotional bond that would lead BA to reinstate a flight connection, which for them was no longer profitable (Massaquoi, 2018). The comments indicate a sense that Britain 'owed' Sierra Leone, or that it should 'care' about Sierra Leone and the ways in which this suspension affected Sierra Leonean lives in the diaspora and at home. This sense was

confirmed by Brima, a prominent member of the Sierra Leonean community in the UK. When speaking to me about the flights he said the following:

> British Airways […] have still not resumed flights to Sierra Leone which to me is kind of a lesson to us Sierra Leoneans. I think we tend to think the British care about us; they don't even know we exist until something like Ebola happens.

For Brima, the suspension of direct flights was revealing of British attitudes towards Sierra Leone. Taken in conjunction with Minister Koroma's statement, which framed Sierra Leonean-British aeromobilities as an expression of "rich colonial ties", Brima's statement suggests the following: in the case of Sierra Leonean-British aeromobilities, a direct connection was seen by many Sierra Leoneans in terms of British appreciation of Sierra Leone, whereas a suspension of the direct route was seen as a lack of care and loyalty. By contrast, no online petitions were directed towards Gambia Bird to resume flights connecting London and Freetown.

Brima's statement also makes clear that, for him, the Ebola epidemic had revealed the extent to which these feelings were one-sided and belonged to the past. The British had reduced Sierra Leone and the mobilities which tied it to the UK to the Ebola epidemic and the threat the virus posed to the UK population. Mobilities were reconfigured to fit the Ebola aftermath, one in which the threat of infection had subsided, but in which pre-Ebola conditions were not reinstated. Ebola had thus made it harder for Sierra Leoneans in the diaspora to travel to Freetown, not only because of the virus, but because of a new postcolonial power geography in which Sierra Leonean-British mobilities had been further marginalised. 'The British', in other words, did not care about 'rich colonial ties' or the longstanding mobilities between London and Freetown. In the wake of colonialism and Ebola, Black mobilities between the two countries were once again made more difficult and the contribution and exploitation of Black life in creating these very mobilities in the first place were marginalised. At the same time, Brima's disillusionment reflects his inability, and that of the diaspora, to hold sway over places increasingly drawn together through airlines and those left aside.

6.3.2 Multiple mobile ontologies

In the last section I argue that the disruptions experienced by members of the Sierra Leonean diaspora in the UK in comparison to narrations by international health responders indicate Sierra Leone's multiple 'mobile ontologies' (Sheller, 2018). As a

reminder, Sheller (2018, p.9) defines mobile ontologies as ontologies 'in which *movement is primary as a foundational condition of being, space, subjects, and power* […].' I argue here that the ways in which mobilities between the two countries, their flows and disruptions, were understood by interviewees, show Sierra Leone's multiple mobile ontologies. Whereas (predominantly white) international health responders described the disruption through its effects on the organisation of the response and consequently construed Sierra Leone as a place in need of foreign intervention, members of the diaspora (entirely Black) construed it as a place of economic opportunity. This last point is especially indicative of a Black diasporic mobile ontology which infers British-Sierra Leonean mobilities that differ from the mobilities of extraction and intervention that have characterised the colonial period and the Ebola epidemic. Whereas throughout this chapter I have pointed to the production of Blackness as ontological negation, deviance and dependence, here I point to Black sovereign mobilities, which occur in the wake, but subvert historical dynamics.

The diaspora experienced the suspension of flights differently than international responders did, many of whom did not comment on it at all because it did not affect them. For the diaspora, the suspension of flights was concerning for reasons that went beyond Ebola and the humanitarian emergency that unfolded in Sierra Leone. This is not to say that they were indifferent to Ebola, rather at the time of our interviews the threat of Ebola had passed and the reality of there being no direct air route between Freetown and London, with all the economic and social implications of this, was still present. From their perspective, suspending the flights disrupted quotidian mobilities that connected their lives in the UK and Sierra Leone. Despite the availability of new (indirect) routes connecting London and Freetown and Freetown to the world, offered by a variety of regional and international airlines in the aftermath of the Ebola epidemic (see Figure 21), members of the Sierra Leonean diaspora focused on the lack of direct flights.

Figure 21: Post-Ebola flight connections in/out of Freetown's Lungi Airport

For members of the Sierra Leonean diaspora direct flights represented an opportunity to live mobile lives and to conduct business in an environment in which their Sierra Leonean-British identities conferred a higher status than they did in the UK. These self-initiated mobilities are, I argue, an important aspect of the Black diasporic experience and identity. Anxieties around the flights' suspension were articulated in terms of a loss of business opportunities. Among the 15 members of the Sierra Leonean diaspora in the UK (and Europe) I interviewed, 12 had been to Sierra Leone in the last 5 years or had immediate plans of visiting. Some, such as Aminata, owned businesses which operated entirely in Sierra Leone. Aminata's identity as a successful female Sierra Leonean-British entrepreneur depended on her social enterprise, which in turn depended on speedy flight connections linking her life in London, where she moved with her parents during the civil war, and her desire to uplift marginalised women in Sierra Leone.

> It was so easy for me because when I am taking my products, like when we done the pilot I just filled up all my suitcases instead of shipping, which I know I wouldn't have gotten it on time. And the BA was so good for me, straight direct flight, straight into Lungi [Freetown's Airport], cross over, easy. So that was out, even up to now BA is not flying there, I don't know, so we currently don't even have direct flights going into Sierra Leone. And that affects loads of businesses. Because when BA was flying, people were going in and out, making deals, staying a couple of days, coming back. That was about 6 and a half hours and you're there. So that affected just kind of infrastructure to do business in Sierra Leone.

Her opinion was echoed by David, whom I have quoted above, but also by people signing the online petition to reinstate flights. Living between Sierra Leone and the UK was an integral part of Aminata's life and that of other members of the diaspora. 'Business' was mentioned numerous times in the reasons people gave on the petition to want a direct flight connection reinstated. These are just some examples:

> I'm signing this petition, because BA is missing a great economic opportunity in West Africa. The UK is Sierra Leone's most important market, and Sierra Leone is full of opportunity for UK businesses, especially in travel and tourism. (Benjamin Carey, 2016)

> I travel to Freetown and Monrovia for business and with a direct flight would make this journey more frequently, increasing business for my firm and for Sierra Leone (Victor Benjamin, 2016)

> I am signing because I love my country and I want British Airways to continue running and it's good for business investment for Mama Salone [colloquial name for Sierra Leone] (Abu Fofanah, 2016)

Similarly, 'family' and 'home' were mentioned numerous times as well:

> I am signing because i want the flight to be going to Sierra Leone please as I will be very grateful to be visiting my family thank you (Katie Dauda, 2016)

> It makes my family life easier and safer to travel back home (Ahmad Allie, 2016)

> I'm singing because it difficult for Sierra Leonean to get a direct flight back home from United Kingdom. And this have resulted for few people to travel back home. (Osman Vandi, 2016)

On the other hand, on the rare occasions that they spoke about the suspension British-based health responders, who were predominantly white, saw the interruption in terms of its effects on the Ebola response. They too were opposed to it, but on medical grounds. Furthermore, in contrast to members of the Sierra Leonean diaspora their narrations

construct mobilities towards Sierra Leone not as quotidian but as emergency mobilities. Tom, a British doctor working in Freetown stated that

> BA still isn't flying direct, Gambia Bird shut down as a result, especially the early days you know Royal Air Maroc and Brussels [Airways], good on them, if we'd waited for the UN response to be doing all the transport, then, the country would have collapsed.

Gareth, a doctor who worked for the same organisation as Tom, confirmed this sense:

> So there wasn't much option in terms of flights. So I flew with whoever was flying on the day I needed to fly. I went from Heathrow and I went via, I think I went via Brussels. Although I didn't disembark. The flight was quite interesting because it wasn't a commercial flight. It was a - well it was a commercial flight but it wasn't a typical commercial flight insofar as that everyone on the flight was going there for a specific reason so it had a very different feel to it from a normal commercial flight.

Anton, an NGO worker, explained the decision to suspend flights as one motivated by public perception:

> The British government I think got a call from the Daily Mail I think at some point querying "why are there still direct flights?" So they stopped them. Immediately. […] And what we understood at the time is that the health leadership in the UK was strongly pushing to allow direct flights and actually said it would be safer to only have direct flights between the two countries, because then you can monitor who is coming in and out. If everyone is having to change through Brussels or through Casablanca then you have people going all over Europe, and people mixing [in] all kinds of airports everywhere, whereas if you got direct flights you know what you're doing, but the optics of having direct flights, people coming, people being one flight away from the UK was too great for the government to risk going with.

These quotes show several things: on the one hand they indicate that the suspension was perceived as being motivated by British public opinion. Anton's explanation that the health leadership in the UK sought to maintain direct flights is significant. Whether this is true or not, it is a further sign of the dependence of Sierra Leonean aeromobilities on UK public and private interests. Tom's emphasis that without Royal Air Maroc and Brussels Airways "the country would have collapsed" shows the health emergency framing through which he perceived Sierra Leone, whose salvation was, once again, dependent on mobilities of British care. Similarly, Gareth's statement construes the aeromobilities connecting London and Freetown that he experienced as not "normal". Their narrations indicate that their mobile relations to Sierra Leone were temporary and based on the idea of Sierra Leone as a place in need of intervention. This temporariness is reminiscent of white colonial mobilities into Sierra Leone, which were, in opposition

to settler colonies, such as Australia or South Africa, always temporary. In contrast to the diaspora's narrations their mobilities were not quotidian, but emergency mobilities.

By opposing reactions to the suspension of direct flights between London and Freetown I have shown that the lives of members of the Sierra Leonean diaspora in the UK seem to be more dependent on mobilities connecting the two countries than those of international health responders. Their relation to Sierra Leone is a long-standing one, whereas for the most part international responders' engagement was temporary. I argue that these differences contribute to Sierra Leone's multiple mobile ontologies. Here mobilities into and out of Sierra Leone have construed Sierra Leone as multiple places: as a place of economic opportunity or one in urgent need of foreign intervention on the brink of collapse. The mobilities of the diaspora differ from those of international health workers. Their mobilities construe Sierra Leone as a place of opportunity and as a place which has always existed in close relationship with the UK. For them the disruption of direct flights was perceived as a disruption of this long-standing relationship. For international health responders, on the other hand, Sierra Leone was a temporary place of crisis in need of temporary intervention. Here the mobilities that connect Sierra Leone and the UK and the place they create are multiple.

In the second part of this chapter I have attended to contemporary mobilities, their disruptions and Sierra Leone's multiple mobile ontologies. As during colonial times, the mobility and immobility, the flow and its disruption that connects and characterises British-Sierra Leonean relations is implicitly racial. In the long term, members of the Sierra Leonean diaspora suffered more from the disruption of direct flights than international health responders, for whom the initially temporary suspension did not have long-lasting effects. In the aftermath of the Ebola epidemic British Airways interrupted a flight connection that for members of the diaspora (and the Sierra Leonean Minister for transport and aviation) was perceived as an appreciation of Sierra Leonean-British relations and a shared past. It also constituted a crucial component of Black diasporic lives and signals a contemporary Black mobile ontology, still characterised by mobility dependency, but also living mobile lives that counteract the colonial wake. Calls for reinstating the flights were subsequently addressed to the British government and British Airways, signalling the persistent role that British actors and infrastructures play in ensuring Sierra Leonean aeromobilities. In the wake, and mirroring colonial and imperial dynamics, African communities are still forced to appeal to British private and

governmental entities to move freely. Though nominally independent, Sierra Leone's mobilities towards the UK are a representation of postcolonial mobility injustice and the colonial-racial hierarchies that it entails.

6.4 Conclusion

In this chapter I have explored how the mobilities that have shaped Sierra Leone historically, during and in the aftermath of the 2014-16 Ebola epidemic are representative of and linked to the shifting production of (anti-)Blackness as described by Mbembe (2017) as 'Western consciousness of Blackness'. By tracing these shifting meanings through the mobilities and infrastructures that have linked Sierra Leone and the UK I have sought to build on the importance that Sharpe (2016) places on the Trans*atlantic. Sierra Leonean-British mobilities, in reproducing racial-colonial hierarchies, are, I argue, constitutive of the colonial wake. I argue that the establishment of routes, control over the directionality of flows and investment in colonial infrastructures has been entangled with the production of Blackness as ontological negation, deviance and dependence. Whereas British colonialism encouraged white quotidian mobilities between the UK and Sierra Leone, Black post-Ebola mobilities are increasingly made difficult and framed as exceptional. Sierra Leone's resulting mobile ontologies (Sheller, 2018) are, I argue, multiple and the mobilities are largely still dependent on the UK. Mobilities linking the two countries have been violent extractions of Black life and framed as mobilities of care; they have construed Sierra Leone as on the brink of collapse and in dire need of foreign aid but also as a place of economic opportunity.

The British-led Ebola response took place amidst and exacerbated the mobility injustice at the very centre of Sierra Leonean-British mobilities. As I have shown in this chapter, public health regulations and aeromobile infrastructures led to a situation in which Black Sierra Leonean immobility was set in opposition to white European and North American mobilisation towards Sierra Leone. At the same time I also see this analysis as a starting point to think through the inherent mobility of Black life. The case of Sierra Leone shows the extent to which mobilities linking Britain as imperial centre with its colonies were instruments of racial differentiation and laid the basis for a modern postcolonial mobility regime in which Black African mobility towards the UK (and Europe) is largely criminalized. At the same time, analysing the mobilities of members of Sierra Leonean diaspora in the UK has shown that a Black mobile ontology is also positive and self-

initiated, and that it constitutes and depends on Sierra Leone as a place of economic opportunity. This echoes Sharpe's (2016, p.16) recurring adage that

> To be in the wake is also to recognize the ways that we are constituted through and by continued vulnerability to overwhelming force though not *only* known to ourselves and to each other *by* that force.

The contradictions at the heart of this Black mobile ontology, are, I suggest, deserving of future attention. In a post-Ebola world, Sierra Leone as a place of economic opportunity has been further relegated to the margins of British interest. The mobilities linking Sierra Leone to the UK have been further marginalised too, shaping and changing the lives of UK's Sierra Leonean diaspora. As during British colonialism, Sierra Leone's mobilities reify it as a place of underdevelopment and in need of (British) philanthropic care, underpinning its (post)colonial relationship of dependency.

chapter SEVEN

7 Wakefulness: epistemic spaces, flows and epigrammatic antiblackness

7.1 Introduction

In this chapter I continue my geographical analysis of global health and antiblackness by focusing on the politics and performance of knowledge. Specifically, I analyse the production and circulation of expertise in relation to global health, the Ebola epidemic and antiblackness. I focus on expertise in order to foreground embodied epistemic hierarchies and spatial processes of knowledge production and exchange. I argue that these reproduce and marginalise antiblackness in global health. This chapter deals with experts, here defined as producers and/or recipients of academic knowledge and discusses how expertise coincided with colonial-racial hierarchies. I argue that both experts and the aforementioned hierarchies influenced the Ebola response but also attend to the partial disruption of colonial continuities by members of the Sierra Leonean diaspora.

Here I treat expertise as relative specialisation and authority in global health knowledge and practice. As such I oppose it to what Paul Richards (2016) has termed a 'people's science', that is to say local, bottom-up knowledges and approaches to ending the Ebola epidemic. In my analysis I also treat expertise as geographically tethered to European knowledge production. This is not to say that I consider Europe as the origin of modern knowledge production or indeed 'European knowledge', if it can be so geographically distinct, as universal. Rather I show that European experts, the knowledge they contributed and institutions located in Europe, came to play an important role during the British-led response to the Sierra Leonean Ebola epidemic. Following Harry Collins and Robert Evans (2008 p.3), I take expertise to be 'a matter of socialisation into the practices of an expert group'. However, while I attend to groups of British-based scholarly experts, healthcare workers and members of the Sierra Leonean diaspora, I take epistemic spaces and flows to be of utmost importance in my analysis of epistemic politics during and in relation to the Ebola epidemic in Sierra Leone. As I show in this chapter, these point to the simultaneous entanglement and marginalisation of antiblack processes and effects during and in the response's aftermath and reify Europe as epistemic centre.

Knowledge is a theme that winds itself through *In the wake*: '*Wake: the state of wakefulness or consciousness*' (Sharpe, 2016, p.81). Knowledge of the wake and of being in the wake and the knowledge of the hold past violence has on Black life in the present are for Sharpe (2016) thoroughly embodied experiences. She (2016, p.12) argues that our knowledge 'is gained from studies […] [and] through the kinds of knowledge from and of the everyday.' In this chapter I attend to knowledge on global health and antiblackness both in its studied and personally experienced form. As such I follow Caroline Bressey's (2014b, p.103) invitation to 'put before readers what might be considered more personal aspects of our research practice'.

At the same time Sharpe, (2016, p.12) argues that consciousness of the wake, studying the wake, requires attention to the marginalisation and silences in which antiblackness and Black life manifest in the wake:

> Those of us who teach, write, and think about slavery and its afterlives encounter myriad silences and ruptures in time, space, history, ethics, research, and method as we do our work. […] Again and again scholars of slavery face absences in the archives as we attempt to find "the agents buried beneath" the accumulated erasures, projections, fabulations, and misnamings.

In this chapter I look at the processes which produce the epistemic erasures and misnamings that Sharpe (2016) describes in relation to the Ebola epidemic and response and in relation to the process of conducting the research on which this thesis is based. As in preceding chapters I show the accumulation of marginalisations of Black life and historical antiblackness that underlay the British-led Ebola response in Sierra Leone. I also show how antiblackness manifested itself to me, a Black researcher of global health and geography in my own process of becoming an expert, i.e. of conducting academic research, in a space of epistemic production. Overall I show, following Adia Benton (2016b, p.270), that in the case of the international Ebola response, the realities of antiblackness and of the colonial wake were 'epigrammatic', that is to say 'situated in a space peripheral or marginal to the main text, hovering over it in ways that make it easy to deny its centrality and significance'. In doing so I extend her work on race and humanitarianism by focusing on colonial continuities, which she, writing from a Black American perspective, largely leaves out.

Apart from Sharpe's (2016) work and Benton's (2016a, 2016b) work on race and humanitarianism, which illuminates the interconnection between whiteness and expertise, I also draw on work on archives by Caroline Bressey (2006) and Marisa J Fuentes (2018). Both highlight the methodological efforts required to unearth Black lives from archives

designed to erase them. Finally the work of Joseph Morgan Hodge (2007) has helped me think through expertise and colonialism. His work on agrarian doctrines highlights the role that a network of technical experts played in late British colonialism. He argues (2007, p.9):

> In many ways then, late British colonial imperialism was an imperialism of science and knowledge, under which academic and scientific expertise rose to positions of unparalleled triumph and authority.

Building on his work I argue here that in light of the historical role scientific experts and practitioners have played in the establishment and maintenance of colonial rule, something I have begun to explore in the last chapter on mobilities, the epistemic marginalisation of that colonial past by present-day experts warrants close attention. In the wake, I argue, Britain's epistemic power vis-à-vis formerly colonised countries manifests itself by side-lining and ignoring the colonial experience (and antiblackness that characterised it), rather than dominating it.

This chapter is structured as follows: in the first part I analyse antiblackness in relation to epistemic places (7.2). I show that in my research, knowledge around antiblackness was both actively marginalised and manifested itself as a reaction to me, a Black researcher. Drawing on ethnographic observations I analyse two events that occurred during my fieldwork. The first was an expert panel discussion on the international Ebola response held by a British think tank at a London learned society that I attended in October 2015 (7.2.1). The second was an incident that occurred while I was conducting archival research on colonial infectious disease control in Sierra Leone at a London archive (7.2.2). In the second part of this chapter I focus on epistemic flows (7.3). Specifically, I argue that specialisation and authority, key markers of expertise, were, during the Ebola epidemic entangled with the colonial-racial mobility injustice that I discussed in the previous chapter. This, at once, furthered white mobility and deepened the coincidence between whiteness and expertise (7.3.1). On the other hand, I show how epistemic flows originating from the Sierra Leonean diaspora in Europe both relied on and disrupted the racial-colonial dynamics of expertise and epistemic production that I describe (7.3.2). By attending to diasporic efforts to produce, share and translate knowledge for friends and family in Sierra Leone, I show how the diaspora came to occupy a position of epistemic authority in relation to friends and family in Sierra Leone. However, this perception of expertise and the impact their knowledge had on the behaviours of friends and family in

Sierra Leone is, I argue, in part due to their relative positioning in the UK, strengthening the latter's position as (post-) colonial epistemic centre.

This chapter builds on the two preceding chapters. Here I continue to show how the Ebola response took place in the wake, yet largely marginalised the knowledge of antiblackness in the response and in discussions thereof. This chapter also especially builds on my analysis of mobilities in that it deepens my exploration of the co-constitution of expertise and white mobility.

In terms of methodology, I draw on ethnographic and autoethnographic observations, and on interviews with members of the Sierra Leonean diaspora in Europe and international health responders to the epidemic in Sierra Leone.

7.2 Epistemic Spaces

In the first part of this chapter I attend to epistemic spaces. Specifically, I analyse two different kinds of spaces that actively contribute to producing and shaping knowledge on the colonial wake and the Ebola epidemic. I analyse awareness of the colonial wake and antiblackness among global health experts. 'Experts' here signifies both the producers and guardians of specialised knowledge. In my analysis of global health and antiblackness, spaces and their location and set-up play an important role in regulating access and conveying epistemic authority. The spaces I analyse here are promoted as producing and guarding knowledge and as prestigious places of scientific innovation. In the first section I analyse an event that took place at the Royal Society in London. According to its website, 'the Royal Society is a Fellowship of many of the world's most eminent scientists and is the oldest scientific academy in continuous existence' (Royal Society, 2019). In the second section I relay an autoethnographic account of an event that took place in the archives of the Wellcome Collection, also in London, where I was conducting archival research for this thesis. Founded in 1936 after the death of Sir Henry Wellcome a pharmaceutical entrepreneur, the Wellcome Trust and Collection derive their funding from the profits of Sir Henry Wellcome's company, which merged with Glaxo plc. in 1995 to become GlaxoSmithKline in 2000. According to its website, (Wellcome.ac.uk, n.d.) 'Wellcome exists to improve health by helping great ideas to thrive.' In the UK, the Wellcome Trust and Collection is one of the major funders, producers and collectors of medical and health-related knowledge. In this part I draw on

(auto)ethnographic accounts of conducting archival research to analyse how global health knowledge and antiblackness coexist in epistemic spaces, yet how the latter remains largely epigrammatic (Benton, 2016b, p.270).

7.2.1 Expertise and the marginalisation of the colonial wake

In this section I show how the issue of colonialism was, in a public discussion on the Ebola epidemic and response, treated as 'epigrammatic' (Benton, 2016b, p.270). Building on Benton's (2016b) work, I argue here that the epigrammatic treatment of colonialism in the panel discussion I analyse below signals the wake and the marginalisation of the knowledge that antiblack dimensions of Britain's colonial past in Sierra Leone, which constitute a focus of this thesis. This encounter reveals how contemporary European epistemic power is manifested by side-lining, rather than dominating, the colonial experience.

In November 2015 I attended a meeting on the global Ebola response in West Africa taking place at the Royal Society in London. The event invitation specified that this was an interactive expert panel discussion presenting the findings and recommendations of an independent panel convened by two major academic institutions in the field of global health and tropical medicine, in the US and the UK. The event was hosted by an influential British think tank and the report they were presenting was being published in a major international medical journal. In terms of institutional set up, this event reflected the predominance of British-American expertise and epistemic production in the field of global health. In order to attend the event, I had to register online, provide personal details and an institutional affiliation and await confirmation of my registration. At the venue, I had to sign in and was issued with a name tag and folder containing relevant information. In a small room at the Royal Society, about forty people were listening to a series of global health experts, some academic, some professional, some European or American, a few West African, talking about the organisation, development and failures of the global response to the Ebola epidemic. Their expert status was conferred to the panellists due to their seniority in the field of global health, their experience and the institutions they represented.

While some people of colour (mostly West African) spoke, the majority of panellists were white British and North American, as was the majority of the audience. The spatial and racial set up is noteworthy for several reasons. Firstly, the fact that the event took place in a small room in London, rather than one of the West African countries

affected by the Ebola outbreak. This reinforced a dynamic in which the countries in which the epidemic took place were a geographical and political 'borderland' (Duffield, 2001b, p.309), 'an imagined geographical space' governable from a distance and in which the international (health) community could and felt compelled to intervene due to the catastrophic conditions prevailing there. Playing out in West Africa and predominantly affecting Black bodies, the response was nevertheless thought of and analysed in Britain, by a small handful of (predominantly white) British and American experts. As in the previous chapter, I emphasise that expertise on the management of Ebola (and other tropical infectious diseases) resides outside of West Africa, in this case, the UK and is predominantly accessible to a British, not West African public.

The exchange I want to focus on here occurred in the second part of the meeting, entitled 'How to rebuild trust in the global system, including the World Health Organisation?' This panel consisted of the editor of the medical journal and a professor of global health governance who was also a member of the independent panel. It was moderated by the health editor of a major liberal British newspaper. The moment I analyse here occurred during the Q&A when a member of the audience who identified himself as a belonging to a London university, asked a question. Because the transcript of the exchange is quite long, I have divided it into segments, which I will analyse in turn.[34] Here I trace the marginalisation of colonialism in the Ebola response in panellists' words and their demeanour. The exchange started as follows:

> Member of the audience: When the outside world became seriously engaged in this West African outbreak of Ebola, the USA helped Liberia, France went into Guinea and the British went to Sierra Leone. Do you think this neo-colonial division of responsibility is helpful or harmful?
>
> Moderator: [chuckles] That's fascinating. So, who wants to talk about neo-colonialism? [panellists laugh]
>
> Editor: [laughing] Oh god!
>
> Moderator turns to Professor: [Professor], do you dare? [laughs; everyone laughs]
>
> Professor: [laughing] Maybe I'll start with the other question [laughs] give [Editor] some time to think about… [laughs, everyone laughs]

[34] I rely in my analysis on the video recording that has been made available online. As such I had the opportunity to revisit the event, listen carefully to people's tone and look at their faces as they speak, something which was impossible for me to do in such detail, as I was sitting at the back of the audience.

> [proceeds to answer another question that was asked by someone in the audience on institutional trust]
>
> [turns to the editor] So [Editor] on the… [implied: matter of colonialism] [laughs]

The question and the initial reaction to the question, laughter and discomfort, as well as a sense of being overwhelmed ["Oh god"; "do you dare?"] distance the panel members – and the audience more generally – from the topic of colonialism or in this case neo-colonialism. The tone in which the question was asked is earnest, as was the tone of the panel discussion and the questions asked beforehand. The reaction – laughter - seems disproportionate and out of touch; the general atmosphere is awkward, given that the question was asked seriously. The question itself did not contest the neo-colonial nature of the international response; it asked if this characteristic was helpful or harmful. The question in itself was not new or unanswered. Sreeram Chaulia (2014) for example has pointed to the imperial continuity with which former colonial powers intervened in the three countries affected, countries in which they often still hold considerable economic stakes and over which they 'feel a sense of entitlement and privilege' (Chaulia, 2014, n.p.). As Bernadette O'Hare (2015) has pointed out, incidentally in the same journal whose editor-in-chief sat on this panel, the Ebola epidemic was exacerbated by structurally underfunded health care systems. This, she argues was partially also due to tax exemptions given to British firms operating in Sierra Leone.[35] The consequences and implications of Britain's continued economic and political influence in Sierra Leone should not have been something to laugh at, on a panel debating the international Ebola response.

To return to the discussion: the experts on the panel and the moderator delay answering the question as much as possible. The professor, a woman of colour, does not answer it at all. She directs it to the editor. The exchange continues as follows:

> [Editor]: Oh my God [Moderator laughs] So just on the, dodging the last question a bit [he proceeds to answer the same question the professor answered]. Now on the neo-colonialism. Ahm boy [audience laughs] I mean it's certainly true that the system as run in global health today retains a lot of features of the colonial system. But that said you know [pauses] I think the countries that went in were trying, I certainly know this from the UK's point of view, I can't speak for the other two [countries], went in to

[35] According to estimates, between 2014 - 2016 the Sierra Leonean government lost an estimated $131 Million US dollars in tax incentives to firms in the mining and agricultural business (Curtis, 2014). The vast majority of these losses are attributable to tax incentives granted to two London-based mining companies, African Minerals and London Mining. An agreement between the government of Sierra Leone and London Mining prior to 2013, for instance saw a reduction in the statutory income tax from 30% to 6% (Curtis, 2014).

> create effective partnerships and if that was driven by history [shrugs] you know let's be careful not to condemn the present because of the sins of the past. I think that we did go into Sierra Leone with the best of intentions – sorry [Senior Fellow]? [turns to the head of global health security and senior fellow at the think tank co-hosting the event]
>
> [Senior fellow – from the audience]: It really worked!
>
> Editor: Yeah, yeah and so I prefer to believe that those relationships we have in countries are terribly, terribly important and need to be strengthened.

Again, the editor delays having to answer the last question by concentrating on the question previously already answered by the professor of global health. Here the question of neo-colonialism is pushed aside in favour of another question on institutional trust. He admits to doing so when he says "again dodging the last question a bit". "Dodging a question" expresses feelings of avoidance and discomfort. No one on the panel wants to answer the question, which they shorten to "neo-colonialism", a move, which somewhat strips the question of the complexity with which it was asked. The editor's answer does not state "Neo-colonialism, in the case of the UK's intervention in Sierra Leone, was helpful", although this is the message that his response conveys. Rather the answer shifts to intentions and motivations ["the countries that went in were trying"; "[they] went in to create effective partnerships"] and, importantly, separates the past from the present ("let's be careful not to condemn the present because of the sins of the past."). The editor, is aware of colonialism's problematic nature, referring to it as "the sins of the past". These sins, however are moved aside, the colonial past is literally shrugged off to make way for "effective partnerships". Lastly, his admission that he "prefer[s] to believe" that existing relationships between former colonial powers and West African countries need to be strengthened and are "terribly, terribly important" again indicates a choice: the colonial past and its enduring hold can be taken seriously or they can be relegated to the epistemic margins. Here they are relegated to the epistemic margins.

The senior fellow's remark from the back of the audience that "it really worked" is both pragmatic and outcome-oriented. It does not question whether neo-colonialism played a factor in the outcome of the response. Here the outcome overrides the neo-colonialism that the audience member asked about. Global health is, given the setting in which this conversation took place and due to the nature of its work, outcome-oriented. Global health management is largely taught this way too, to come up with clear,

implementable findings that will save human lives.[36] As such, global health and medical experts, as were present during this panel discussion, measured the helpfulness or harmfulness of the neo-colonial nature of the global response in whether or not the epidemic – and the death toll associated with it - could be brought to an end. In this discussion, pre-existing colonial relations allowed a swift deployment of the British-led response. The conversation continued with a remark from the moderator:

> Moderator: In fact there is public buy-in too, isn't there? That's the other factor, actually the British are more likely to support Sierra Leone because we had a role there once, I guess.
>
> Member of the audience [nods]: and being francophone or anglophone helped. […] [The moderator wants to move on, but the Senior Fellow cuts in]
>
> [Senior fellow]: Look the Americans at the beginning of September said "We really want to help Liberia", which was never an American colony, so you can't describe that as neo-colonialism. And President Obama contacted President Johnson-Sirleaf and said "what do you want?" She said what she wanted, the Americans responded. They said to us "We have to work inside a multilateral envelope, we created the biggest health mission we've ever done, we've never done one before". The British came along very quickly afterwards, particularly Philip Hammond and together with the Prime Minister said, "We have to help Sierra Leone". The French came in after that with Guinea. Again very strong. Thank Goodness! Supposing this had been in countries that did not have Godparents like these, who just take these amazing decisions. (LSHTM, 2017)

When the senior fellow speaks, the camera pivots to the audience, where he stands, rather than remain focused on the panellists, which we were able to see before. Some members of the audience nod vigorously throughout his statement. The member of the audience who asked the question smiles and listens intently to the senior fellow. The mood is one of quiet acquiescence; no one asks a follow up question or visibly disagrees. This might have something to do with the setting in which this event takes place and the format of the discussion. The experts are sitting at the front of the room and the audience, many of which identify themselves as having worked on the Ebola epidemic themselves (they may be considered experts in their own right) are invited to ask questions. The time for questions however is limited and throughout this exchange the moderator keeps reminding people to be quick in their contributions and answers.

Two more things are noteworthy here. The first is the moderator's statement as well as her overall role. By responding with a chuckle and an amused "that's fascinating"

[36] I draw here on my personal experience of following courses of the UCL MSc in Global Health and Development during a Cross-Disciplinary Training Scholarship I was awarded in 2018/19.

she sets the tone in which the question is answered. Her statement about "British buy-in", is telling. She does not specify the nature of this buy-in or Britain's "role", nor does she ask whether colonial nostalgia or guilt played a role in Britain's humanitarian concerns. As a 2014 YouGov survey found, 59% of British people interviewed thought that the Empire was 'more something to be proud of' than ashamed (19%) (Dahlgreen, 2014). As such, I suggest that 'public buy-in' in foreign global health interventions ought to be critically examined. As I have alluded to in the previous chapter, a significant motivation for Britain (and other countries) to get involved in the response was also the fear that Ebola could spread to the UK.

Finally I turn to the point made about Liberia. While it is technically true that Liberia was never an American colony, this statement obscures two things. Firstly, Liberia was founded by the American Colonization Society (ACS) in order to remove freed slaves and free African-Americans to territories in Africa. The founding idea of the ACS was that Black Americans would have better chances at freedom on the African continent, rather than in the US, and it was tinged with racist ideas around a white America and partially expressed the explicit interests of slave holders (Seeley, 2016; Mbembe, 2017). Lands for colonisation in Liberia were in part procured at gunpoint (Seeley, 2016). As such, stating that Liberia was never an American colony obfuscates the real entanglements between enslavement, the resettlements of freed slaves and African colonisation. What is more, such a statement limits the identity of colonisers to white settlers and administrators. Black colonisation often operated along the same lines as white colonisation. As the history of Liberia and Sierra Leone in the years following the creation of the initial settlements shows, in both societies Black settlers established hierarchies typical of white colonial societies, placing themselves at the top (Kandeh, 1992; Shaw, 2002). Secondly, this statement adopts a very restrained definition of colonialism as the political and administrative authority over an overseas nation or territory. Such an interpretation negates the wake in that it limits the social, epistemic and psychological effects of colonialism as explored for instance by Fanon (2011) or members of the modernity/coloniality group. It also negates the wake in that it ignores (or chooses to ignore) colonialism's afterlife and the spatial and political dynamics that continue to shape British-Sierra Leonean relations.

Overall the answers distance the experts increasingly from the premise of the question. Neo-colonialism is only acknowledged – before being repudiated – at the very beginning by the editor, when he starts to answer the question asked by the member of the audience.

The negative long-term effects of colonialism are never acknowledged. From then on, all answers explain how Sierra Leone's colonial past was helpful in the organisation of the response. The word 'neo-colonialism' is mostly dropped. The last statement "Thank Goodness. Supposing this had happened in countries that did not have Godparents like these" is particularly disturbing. It obscures the violence and exploitation that have characterised British colonial relations to the countries that were forcefully made part of the British Empire. At the same time, such a statement implies that countries without colonial godparents would be left to themselves, a twist on the Euro-American 'duty to intervene' (Calhoun, 2010), which has characterised the hegemonic nature of humanitarian interventions' outside the Global North in past decades. The fellow's statement also obscures the history of colonialism, which often is at least partially to blame for the structural deficiencies (Rodney, 1981), which made the Ebola epidemic worse and the response more difficult and which I have begun to analyse in previous analytical chapters.

In this section I have analysed the epistemic marginalisation of the colonial wake among global health experts discussing the international Ebola response. By attending to the spoken and unspoken reactions of a handful of British-based global health experts, I have shown how the reality of the colonial present, in the form of a question on neo-colonialism was both discursively marginalised and not addressed seriously. Contrary to Sharpe's (2016) analysis of the wake, which emphasises historical continuities of antiblackness, 'neo-colonialism' presupposes an old form of colonialism, a rupture and colonial discontinuity. I argue that when thinking global health governance and the Ebola response in the wake, a continuous and pervasive understanding of colonialism allows for a more critical analysis of the context in which the Ebola epidemic and subsequent response took place than was evidenced during the panel discussion. This has repercussions on how global health is taught and how emergency and humanitarian interventions are conceived. As I have shown here, the casual treatment of the colonial past and the 'neo-colonial' implications this past brings with it, are epigrammatic (Benton, 2016b). The marginalisation and side-lining of past colonial experiences are worrisome tendencies among experts in charge of managing global health in the postcolonial world. The editor's and senior fellow's statements, and the general way in which the discussion around neo-colonialism was conducted, further contribute to the marginalisation of non-Western experiences of antiblack violence and underscore the reasons why they should be considered in contemporary international disease management.

I also want to draw attention to the spatiality of this event. Hosted at and by some of London's most influential scientific institutions, the unchallenged epistemic and discursive marginalisation of the colonial reality by some of the UK's leading global health experts, far from the populations most affected by the epidemic, signals their refusal to acknowledge the reality of the colonial wake as the setting in which the Ebola epidemic and response played out. It also signals their refusal to acknowledge the role European experts play in perpetuating colonial epistemic dependencies between West Africa Europe and North America today. In the following section I pursue my analysis of epistemic spaces and the interplay of global health knowledge and antiblackness.

7.2.2 Archives and antiblackness

In this second section I draw on an autoethnography of conducting research on colonial infectious disease control in Sierra Leone at the Wellcome Collection archives in London. Here I consider the archive, and the Rare Materials Room at the Wellcome Library specifically, as a place of historical and medical expertise due to the exclusivity of materials in storage, their historical value and the steps one has to take to access this knowledge. I show that apart from being present in archival materials (texts, documents, photographs), the archival space, its layout and regulations, can itself become a space in which antiblackness is enabled. As Caroline Bressey (2006) has pointed out, Blackness is, in archival materials, difficult to trace and at times invisible; it requires attention and care. Marisa J. Fuentes (2018) similarly argues that archives work to silence and erase Black agency, especially that of Black women. While this was also true in the archival materials I studied, I point here to a different experience of 'silencing' both Black women and antiblackness in an archival space. Here I show that as a Black researcher, my analysis of global health and antiblackness is necessarily also influenced by my positioning in and access to places of epistemic production, especially those that pertain to health and medical knowledge.

The Mayor's Commission on African and Asian Heritage 'Delivering shared heritage' report (Barrow et al., 2005, p.23) called on archives (among other epistemic bodies) to be 'equally accountable to ensuring greater inclusion of African and Asian practitioners'. Since then other writers and historians have described the experience of conducting archival research 'while Black', of feeling out of place and being encountered with surprise and at times being subjected to increased surveillance (Robinson, 2017; Farmer, 2018). The experience I narrate here demonstrates that antiblackness is enacted

in archives of global health. I argue that its enactment contributes to further silencing Black women in archives, those doing research and those represented or silenced in texts. This enactment also signals an inability to responsibly deal with the colonial and antiblack content contained in archival collections of health and medicine.

In 2017, as part of my fieldwork, I was conducting archival research on colonial infectious disease control efforts in Sierra Leone at the Wellcome Collection Library in London. The Wellcome Collection library and archives focus solely on the history and practice of medicine and as such were an important location for my research. Located in the Wellcome Collection, which houses a museum and library, the collection's archives are accessible for researchers and visitors in the Rare Materials room on the second floor of the library. As with the event held at the Royal Society, the Wellcome Library's access is restricted. In order to access the Library one needs to register and bring proof of identity and permanent address. The library photocard, according to the library rules needs to be carried at all times and shown to 'Library or Security staff whenever it is asked for' (Sabovic, 2016). Rare items can be ordered to the Rare Materials Room to which access is secured with a card reader. In order to access the collection's rare materials one has to electronically sign in and out of the room. The room itself is small with a row of desks against the wall and groups of tables, maybe four or five, throughout the room. To the left is a counter behind which the archivist-on-duty works and which gives access, behind a glass door, to the archives themselves, which are inaccessible for visitors.

On the day in question I was working at the Library and went to the Rare Materials Room to inspect the documents I had ordered that morning. After handing my library card to the archivist he retrieved the first set of documents and gave them to me wordlessly. It is generally very quiet in the Rare Materials Room. Conversations, if held, are only held at the counter and with the archivist on duty in hushed tones. No one speaks while doing their research. After I finished reading through those materials I returned them and, handing my card over again, requested to see the second set of documents I had pre-ordered. This time the archivist held on to my card. "Hirsch", he said, "that's a German name. Why do you have a German name?" I told him that this was because I was German. "But your first name does not sound German", he said. I cut him off and told him that it was. "Where are you from?", he then asked and I told him about my parents' heritage. "Do you speak German?", he asked and I confirmed again. This made him switch languages and he started speaking to me in German.

Before continuing the description of this event I would like to draw attention to two things: most Europeans of colour will be familiar with their belonging being

questioned by strangers. This was not a new experience for me. It was however the first time that this happened in an archive in which I felt even more compelled than usual to remain silent. The Wellcome Library's conditions of use stipulate the maintenance of 'a quiet and friendly environment' (Sabovic, 2016). In this situation, respecting the conditions of use meant submitting to the questioning of my identity. The graphic that accompanies Ashley Farmer's (2008) article 'Archiving while Black' in the Chronicle Review illustrates this feeling of being kept under surveillance by the archive, of being questioned (Figure 22). In this archive, this place of knowledge production, where I had come to question existing and produce new knowledge on colonial health practices and antiblackness, what I knew about myself was being questioned and probed, not by the documents I was reading, but by the guardian of this knowledge and of my access to this knowledge, the archivist.

Figure 22: Screenshot of 'Archiving while Black' headline and illustration, www.chronicle.com/article/Archiving-While-Black/243981, accessed 14/06/2019

The archivist retrieved my documents and laid them on the counter. Looking at the colonial office stamp on the document on top of the file he was holding in his hands he commented, in German now, "You study colonialism. Where we try to help the savages and they throw spears at us." He laughed. I pretended to laugh too, hoping he would give

me my documents so I could retreat to my table. He didn't. After telling me about his uncle's missionary work in Africa and encountering American missionaries when he grew up he explained to me that the word 'Neger' (the German version of the N-word) in his native language was not pejorative at all, because it was the Latin word for 'Black'. Then he proceeded by telling me a joke about German people of African descent, referring to them using the N-word and laughed. I pretended to laugh with him, again, hoping he would give me my documents and let me leave. After asking me some more questions about myself he gave me the documents I had requested. I sat down. The Rare Materials Room at the Wellcome Collection, as I have described above, is small and the table where I had been working was not far from the archivist's counter. I averted my gaze and made sure not to turn my head in his direction. After about a minute he left his place behind the counter and came to my table. "Ms Hirsch", he said, "I am sure you will appreciate this joke." He told me two more jokes, one of which repeated the N-word multiple times. Shaking with silent laughter he left. In order to leave the room I needed to return all documents to the archivist. I finished looking through what I had ordered and stayed in my seat, waiting for his shift to be over and for another archivist to come on duty, so I could return my documents without another encounter and leave.

This archive of colonial health and medicine became for me a place in which I was subjected to antiblackness. While mainly due to the archivist's behaviour, the spatial regulations in place to ensure the safety of rare materials compounded my feelings of helplessness and of being silenced. Due to the security-controlled exit of the Rare Materials Room I could not leave without risking being subjected to antiblackness again. The Wellcome Collection, a place of epistemic production and expertise, had also evidently not trained their archivists in how to interact with non-white visitors and researchers. Nor had they trained them in how to interact with the colonial materials that they have in store. Apart from the many mentions of the N-word, the archivist's reaction to seeing the Colonial Office stamp on one of the documents I had requested was inappropriate, although he found it funny. Antiblackness manifested itself in this space of health and medical expertise while the spatial regulations (quite typical for archives) left me with little direct recourse to remove myself from the situation. Like the Black people in the archives I was researching, I was, in this moment, silenced. Antiblackness, in my research, surfaced not just in the historical and contemporary materials on global health I studied, but also as a result of 'researching while Black' in spaces of epistemic production. The silencing of antiblackness experienced here is, I argue, double. Firstly,

my silencing increases the accumulation of 'silencings' that Black people in British (and other) historical archives have been subjected to (Bressey, 2006; Fuentes, 2018). Secondly, the fact that the archivist felt able to display such behaviour is, I argue, an indication that the historical existence of antiblackness in global health – both in materials and practice – is not taken into account by places of epistemic production in their effort to shape widely accessible, inclusive places of learning.

In the first part of this chapter I have attended to epistemic places. I have analysed two discursive encounters between the production and/or guarding of global health knowledge and expertise and colonialism and antiblackness respectively. The colonial wake and the awareness of colonial and antiblack violence that it entails, are, I argue, largely marginalised in global health knowledge. The increased encounters with antiblackness that come from being a Black researcher point however to the more than epigrammatic presence of antiblackness in places of epistemic global health production. As such, antiblackness and colonialism are epigrammatic, in that they are barely taken into account, and highly present in that they manifest for researchers of colour. This further underlines Sharpe's (2016, p.81) argument that the wake is 'a state of wakefulness or consciousness' to the continued hold of past antiblack violence on the present. As I have shown, this consciousness is in the examples I have encountered in my research, not present. Furthermore, the spatial regulations of the epistemic places I have analysed here actively made access to both the materials and discussions for the people most affected by antiblackness in global health difficult. In the first instance, the analysis of the international Ebola response took place in London, far away from the populations of Sierra Leone, Guinea and Liberia. This reinforced London's role as epistemic centre and the continuation of colonial power dynamics in which Sierra Leone depends on British expertise, which I have begun to analyse in the previous chapter. In the second instance, archival spatial regulations, designed to protect historical materials of high epistemic value, made it more difficult to confront the antiblackness I encountered and contributed to the further silencing of Black women.

7.3 Epistemic flows: the mobilisation of expertise

In the second part of this chapter I attend to two contrasting types of epistemic flows: the embodied epistemic flows of international, largely white, British-based health responders who travelled to Sierra Leone to work in the Ebola response and the epistemic flows

(through communication technologies) that allowed members of the Sierra Leonean diaspora to share relevant knowledge on Ebola prevention with their friends and family in Sierra Leone. A big part of the aeromobilities that I have discussed in the previous chapter consisted in flying experts from their places of work and residence to the countries in which Ebola was spreading. In other words, aeromobilities were used to connect expertise to the places in which it was needed. The geographical distribution of Ebola expertise - predominantly centred in the global North - is an important hurdle to overcome in the African fight against Ebola (Nsofor, 2018). In this part I analyse the geographical divide between the places in which expertise 'resides', two of which I have analysed in the previous section, and the places in which, in the case of the Ebola response, it is needed. I argue that the postcolonial mobility injustice that characterises mobilities between the UK and Sierra Leone shaped the production and embodiment of expertise along colonial and racial lines.

7.3.1 Expertise and mobility

As I detailed in the previous chapter, Sierra Leone's 1913 yellow fever outbreak led to a British infectious disease expert, Rubert Boyce, being sent from London. Like the 1913 outbreak, the 2014-2015 Ebola response necessitated the mobilisation of British health experts and practitioners to Sierra Leone. In this section I explore how expertise's conflation with whiteness was, in the case of the international Ebola response, reinforced through unequal mobility regulations. Here I draw on interviews with international responders to the Ebola response and online materials. I show how colonialism and the antiblack effects of the contemporary mobility regime that enables the marginalisation of Black expertise remain largely epigrammatic in conversations with medical responders to the 2014-15 Ebola epidemic. Building on the previous sections, the wake here manifests in the continuation of Sierra Leone's epistemic dependence on the UK.

Adia Benton (2016b, p.268) describes how whiteness, in humanitarian interventions, is a placeholder for 'expertise, intellectual capacity, and bureaucratic efficiency and rationality'. As Yuka Suzuki (2018) has exemplified using the case of white Zimbabwean farmers' 'claims of technocratic expertise', this conflation builds in part on racially exclusionary education policies that barred Black Zimbabweans' access to education. In colonial Sierra Leone, Black Sierra Leonean access to medical careers was, as I have described in chapter four, in part prohibited (Johnson, 2010). My intention here is not to establish a causal link between the colonial exclusion of Black Sierra Leoneans from obtaining medical expertise and the need for white medical expertise

during the Ebola response, but rather to point to the long history of the exclusion of Black Sierra Leoneans from becoming medical experts and the concomitant conflation between whiteness and expertise in colonial Africa.

In the UK the NHS, the Department of Health and Public Health England (PHE) put out a call to healthcare workers to volunteer by supporting the UK's Ebola response on the 19th of September 2014 (Davies, et al., 2014). Nongovernmental organisations and bodies had in some instances issued calls for volunteers independently. However, which health experts and practitioners could volunteer for the response depended heavily on repatriation and visa policies. In the recruitment process the antiblack effects of the regulation of mobilities, which I have analysed in the previous chapter, became visible. Ruba, the Ebola response administrator at Organisation X, a medical NGO with offices in London and Freetown oversaw the organisation's cooperation and compliance with both DFID and PHE, managed volunteers and staff in Sierra Leone and oversaw their return to the UK. She spoke about the politics of mobility and expertise that came into play in the organisation's recruitment of international volunteers:

> Actually, privileged people got to go, special people. It was like clinicians or like epidemiologists that were like quite famous and excited by Ebola. They were like [sounds excited]: "Oh my God this is the new thing since HIV and AIDS!" It was really interesting because it kind of showed me the division. There was people applying who had experience in Ebola that were from DRC [Democratic Republic of Congo], Sudan, Kenya, Uganda that previously worked on other outbreaks but we couldn't recruit them because of repatriation.

Ruba's statement alludes to several things. First, the prestige associated with working on the Ebola response by career clinicians. According to her statement, some clinicians interpreted Ebola as an event furthering their expertise on infectious disease control, outbreak management or tropical diseases. Secondly, she alludes to the visa politics that shaped the organisation of the response, which meant that some health workers and medical experts who had experience of working on haemorrhagic fevers could not deploy to Sierra Leone because it was not certain whether their countries of origin would take them back. While Ruba speaks of African citizens, I draw attention to the underlying Blackness, which, as I have shown in the previous chapter, has long regulated Sierra Leoneans' international mobility. She continued by explaining:

> At the time that the Ebola outbreak happened there was only some countries that would repatriate their citizens if they had Ebola. So certain countries wouldn't repatriate their citizens and certain countries would. So

> for example America, Canada and most of Europe would whereas some of the other countries would not. Let's say we recruited someone from DRC, if they got Ebola we couldn't send them back to their home country so therefore we couldn't recruit them.

Here Ruba attests to the differential mobility potential of health experts and practitioners who wanted to volunteer in the Ebola response. In both statements Ruba opposes European and North American countries like the UK or Canada to African countries, like the DRC, Sudan or Uganda. Two things contributed to differential mobilities during the Ebola epidemic: the first being health infrastructures in experts' countries of origin. Fearing their inability to contain potential outbreaks of their own, many African countries refused to repatriate health care workers who volunteered in the Ebola response. Secondly, and relatedly, health care workers from these countries could not be repatriated to the UK, even if they volunteered for a British organisation, such as Organisation X. Anton, who worked for the same organisation alluded to this when he explained that medevacs were not going to be made available for all nationalities of volunteers. I have quoted him more extensively on this in the previous chapter, but part of his statement is worth repeating. He confirmed Ruba's statement by saying that "I think we did not take volunteers from other African countries because we didn't know what would happen if they got sick."

Layla, a white South African doctor who volunteered with Organisation X explained her personal experience with this:

> When we had that conversation if I needed to be evacuated, they [Organisation X] said I would have the choice: UK or SA [South Africa], but they recommended that I should go to the UK and I - my father is from the UK, so I actually have two passports - and so I quarantined in the UK because SA wouldn't let me come back home afterwards […]. It was a little bit annoying because I actually had some stuff I needed to do back home [laughs]. I was advised to go to the UK, because someone else had been sent back from SA and then sent back to Freetown and so I was like, I felt like I might get stuck in this loop.

Layla's quote shows that volunteering one's expertise and experience in the Ebola response was dependent on having a powerful passport, but also that this influenced one's chances of receiving high quality medical treatment in the case of an infection. Layla, a South African, was able to participate in the response because her British passport allowed her safe repatriation in the case of infection. This possibility was not available to a majority of African health experts and practitioners. Indeed, as Benton (2014) has argued, repatriation regulations were subjected to racial/national differentiation. As such, the WHO declined to provide funds for the repatriation of Sierra Leonean doctor Olivet

Buck who died in Freetown after contracting the virus while caring for patients. In the same week two Dutch healthcare workers were repatriated after coming into contact with the virus (Barbash, 2014; Benton, 2014). In the quotes I have analysed here the marginalisation of Black expertise takes two forms. On the one hand it consists in restricted mobilities, which made it difficult or impossible for Black African experts to safely participate in the Ebola response. On the other hand, as in the case of Dr Olivet Buck, Black medical expertise and the capacity to care for Sierra Leonean patients infected with Ebola is marginalised, not to say eliminated, through death. Simultaneously this led to an Ebola response in which the conflation between whiteness and expertise was exacerbated.

Ruba spoke to this in her interview:

> We [Organisation X] were sending Sierra Leoneans to the UK to be trained or to conferences across the world to be able to share their experience or upscale [increase their skillset] people because of the number of healthcare workers that died. So there were definitely positives and negatives. However, because of the lack of mobility of being Sierra Leonean that also sometimes became problematic, like trying to get visas to send someone to Turkey or a Sierra Leonean to South Africa was quite problematic because you had a Sierra Leonean passport, whereas if you have a UK passport I'll most probably be able to blank [reserve] you a space in a UN flight. Like, the privilege that comes with the locality of your passport, changes everything. And that became apparent in the outbreak. Who could be sent, who could not be sent. Which countries we would repatriate, which ones [we] wouldn't.

Here Ruba explains a direct link between expertise and mobility injustice. She details that upscaling Sierra Leoneans' knowledge was dependent on the access their passports granted them to various countries. Ruba opposed this to the possibilities for humanitarian mobility that came with a UK passport and how this inequality intensified during the Ebola outbreak. Infectious disease control intersected with postcolonial mobility regulations and laid the unequal access to global mobility bare. This unequal access largely operated along colonial-racial lines, making it once again more difficult for Black Sierra Leoneans/Africans to get involved in the response and build their expertise.

At the other end of the spectrum were British medical professionals who volunteered with Organisation X in Freetown. Tom, a clinical doctor, told me how he ended up working there:

> I was then in [region] doing my masters on [infectious disease] and there were no rains, the [rainy] season did not come in [region] and therefore there were no [vectors] and therefore there was no [infectious disease] and

> then I saw that there was another viral haemorrhagic fever happening and decided that I'd go. Didn't really know much about what the job would entail, but yeah, I guess felt like I was doing something worthwhile and decided to stay.

Tom's statement alludes to what Ruba, the recruitment manager, critiqued about the recruitment process. It is somewhat at odds with the social justice motivations that some other volunteers displayed in statements such as, "I've never volunteered before, always wanted to" and "I've always wanted to help people who are less fortunate than us" (Cormack, 2017); and "I really wanted to go […] I guess that's the symptom of people who want to save the world" (Sara, 2017). As a white British clinician, Tom chose where to study infectious diseases and where to work, how long to stay (he ended up staying in Sierra Leone even after the end of the epidemic) and where to intervene in medical emergencies. After finishing work on the Ebola epidemic he worked on the refugee crisis in Europe, before taking up a more permanent post in Freetown.

The furthering of Tom's expertise and experience was dependant on his ability to move without constraints. He was not the only volunteer whose career had involved travel and experience of working in a medical context in a different country. According to Ruba, Organisation X actively recruited people with experience working in "low-income settings". Many volunteers thus had previous experience of working in settings outside of the UK. This contributed to their recruitment. Gareth for instance, an infectious diseases doctor who volunteered with Organisation X spent two months living and working in Malawi while at medical school. Sara, an epidemiologist who worked for a different organisation, had experience of working in Senegal. At the same time this form of expertise was, like the clinical expertise of treating haemorrhagic fevers, at times seen as universally applicable. One responder with previous work experience stated, "I worked in Malawi for a year. I am familiar [with] what an African town looks like" (Hector, 2017). Such a statement reflects the belief that European knowledge and experience are universally applicable, but also minimises the cultural and political diversity of sub-Saharan Africa. The postcolonial politics of mobility led to a situation in which the association between whiteness and expertise was exacerbated. Though not intentionally racialised, the effects of the regulation of mobilities during the Ebola epidemic coincided with the mobilisation of predominantly white European and North American expertise and a marginalisation of opportunities for (Black) African involvement and upscaling.

In this section I have shown how the association of whiteness and expertise that is discussed by Benton (2016b) or Suzuki (2018) intersects with the regulation of

postcolonial mobilities during the Ebola epidemic. Though not intentionally racialised, the effects of this regulation nevertheless led to a situation in which Black expertise was marginalised at the same time as white expertise was mobilised. This inequality relied largely on European passports affording their carriers far more mobility and the reassurance of repatriation than those of African and especially Sierra Leonean responders. As I have started to illustrate in the previous chapter, here the wake manifested in intensifying Sierra Leone's dependence on the UK (and Europe more generally) in terms of medical expertise and capacity while further marginalising Sierra Leoneans' ability to build up their capacity to contribute to the response.

In the final section I focus on the making of expertise in the wake by considering the efforts of members of the Sierra Leonean diaspora in the UK to communicate and share knowledge relevant to the response with their friends and families in Sierra Leone.

7.3.2 Making knowledge in the wake

The Sierra Leonean diaspora in the UK was actively involved in the British-led Ebola response (Parvis, 2014) and its members became Ebola experts in their own right. To underline their epistemic authority they gave interviews to major news outlets, advised the NHS and RedR (the organisation tasked with preparing NHS volunteers to be sent out to Sierra Leone, RedR, n.d.a) on cultural norms and provided briefs about dos and don'ts in Sierra Leone more generally. Some members of the diaspora travelled back to Sierra Leone to work in either governmental, nongovernmental or international organisations on the ground. As David Rubyan-Ling (2019) has illustrated, big parts of the diaspora were at the onset of the epidemic unaware of the existence and the medical and societal implications of Ebola. Other authors have analysed the diaspora's use of technology (Abdullah, 2017) and while I touch on the means of communication that were used by the diaspora to communicate with their families and friends back home, I focus on the processes and dynamics that turned members of the Sierra Leonean diaspora into experts. Building on Rubyan-Ling's (2019) work on social remittances and the ascription of expertise and authority to expat Sierra Leoneans, I aim to show that expertise is both relative and relational and that it is tied in with geographical location and postcolonial positionality. At the same time, I want to show how the diaspora created expertise and how this at once relied on and surpassed colonial power structures and colonial epistemic flows. I start by exploring the juncture between expertise and race, the role that it played in the Ebola response and how it was navigated by members of the diaspora. I then focus

on localised examples of the creation of Ebola-related expertise by members of the diaspora.

I also return more explicitly to Sharpe's (2016) work. Sharpe posits *In the Wake* as a book that explores the Black lives that are lived 'in excess' of the violence and hold that produce and shape the wake. While she focuses on literary and visual representations of Black life that survives the wake, I want to examine how the diaspora 'made' expertise in the wake or how they came to be experts in a humanitarian and epistemic environment in which, as I have shown in my discussion of the Ebola panel discussion, Black expertise and the antiblack reality of the colonial present were largely epigrammatic.

Interviews with members of the diaspora illustrated how far expertise correlates with authority and how authority intersects with nationality and race. I have drawn on Benton's (2016b) analysis of the conflation between expertise and whiteness in the previous section, but show here to which extent this conflation came to play a role in international responders' pre-deployment training.

This racial-epistemic hierarchy became visible when interviewees spoke about the training that British-based healthcare workers attended before being deployed by the NHS. Members of the Sierra Leonean diaspora in the UK were involved in the design and delivery of these training sessions. In the UK, RedR UK, an organisation which 'provides training and technical support to NGOs, aid workers and communities responding to natural and man-made disasters all over the world' (RedR, n.d.b) was responsible for training NHS healthcare workers for their deployment to Sierra Leone to work in Ebola treatment centres (RedR, n.d.a). Cormack, one of the white British NHS volunteers I had interviewed, told me about his experience in these training sessions:

> Before we went out, a week before we went out they said that Sierra Leoneans have a lot of respect for white people and I found that a really strange thing for someone to say, but they told us that a couple of times, even the Sierra Leonean people that came to talk to us about culture and language.

Cormack reacted with bewilderment to this statement. So much so that he felt it necessary to raise it with me, when I asked him about the training in our interview. I asked him to elaborate:

> So we were told that a couple of times, I don't know [pauses] white people, British people and I think it's probably a lot to do with the civil war. Or it might not be. But I met people there who wanted Britain to take Sierra Leone back as a British colony. Oh yeah. I don't know, I might have a picture, some of the buildings along the way to Kerry Town [ETC], had

> Union Jacks painted on them stuff like that, yeah I'm not joking! [see Figure 23 for a selection of Union Jacks in and near Freetown] […] And people said to me as well "We need the British back, we need you to come back!" And the thing was, it was a long-term British colony a long, long time ago and […] freed slaves were settled there and there was a lot of - back in the 1800s - of philanthropy and people set freed slaves up in their own town and all that. [...] But we were actually told on the first week that you know that they look up to British people or white people and I found that really strange. But I don't know. I don't know if I saw that really. Working with Sierra Leoneans I saw that… I think there was a lot of acknowledgment of our skills, they wanted to learn, but that's not looking up to someone, is it?

Figure 23: Union Jacks on the Freetown Peninsula

Several things are important in Cormack's statement. On the one hand, he makes reference to the history of British involvement in Sierra Leone. This, he qualifies as important while also distancing himself from it ("It was a long-term British colony a long, long time ago"). Cormack's statement shows the tension or unease that can surface when talking about colonialism. He seems to underline the importance of colonialism ("It was a long-term British colony") while at the same time placing it in the distant past, which strips it of some of its importance ("It was a long, long time ago"). He does not make the connection between his knowledge of the colonial history of Sierra Leone and what he was told by Sierra Leoneans during his RedR training about whiteness and authority. His detailed description of the pre-colonial philanthropic era - more detailed than that offered by most of the people I interviewed – was followed by "I don't know if I saw that [respect/deference towards white people] really. […] that's not looking up to someone, is it?" He also seemed to hesitate, which group – white people or British people or both - he was told was highly respected. While he was aware of Britain's history in Sierra Leone he did not see the colonial continuity that characterises the wake.

I asked members of the Sierra Leonean diaspora who had been involved in contributing to and delivering the training sessions about the sessions too. Isata, a young Sierra

Leonean-British woman, who had worked on the presentation used in the training sessions, confirmed that they had included a segment on whiteness and authority in the trainings (Fieldwork notes, 2017). So did Brima, a senior member of the Sierra Leonean diaspora in the UK. When I asked him whether whiteness was generally associated with authority in Sierra Leone, he stated the following:

> It's unfortunately true [laughs] […]. When I was at the BBC I was the person making the program, [but] they [Sierra Leoneans] kept going to my producer to speak to and he had to keep saying "He's my boss, go and speak to him." It's one of the things that annoys me that you could send two people to Sierra Leone one black and one white and they'd pay more attention to the white person. […] So there's - it's really bad in Sierra Leone. I can't stress how bad it is, but that is true, they give a sort of respect and kudos to a white person that they would just not give to a black person that is of equal or higher authority, but it's true, it's unfortunately true.

Brima's statement and the personal example he gave illustrate how, as Benton (2016b) states, whiteness, expertise and authority interact with one another. Brima does not give any background information on the racial and epistemic hierarchy that he sees playing out in Sierra Leone and that he has experienced himself, but he emphasises it at several points ("It's really bad in Sierra Leone. I can't stress how bad it is"). His statement also alludes to the complicated politics of race and authority. In his interpretation, the objective nature of authority is subjected to the reality of being Black and the lack of expertise that is often associated with Blackness.[37] Brima continued his statement about deference towards whiteness by speaking explicitly about how he advised healthcare volunteers who were deploying to Sierra Leone as part of the Ebola response:

> [...] I'd also say to them [trainees] because of that [unquestioned deference towards whiteness] be careful of what you say because you could be talking rubbish and they won't challenge you because you're white. They'd challenge me because I'm black, but they'd let you go ahead talking absolute garbage and not say: "Hm, sorry but that's not correct." And so be very careful about what you say, how you say those things because people will be nodding at you and then take you down the wrong ally when they should be saying "No! Stop and turn back". And they won't and that's something as I said it's something that really annoys me. […] It's a fact of life.

Brima's concluding remark "It's a fact of life" is telling about the reality of being Black and working alongside white colleagues in Sierra Leone. Brima cautioned volunteers who participated in the training to think carefully about their whiteness and their expertise. As

[37] This assumption has a long history, linked to antiblackness, which is touched upon among others by Grosfoguel (2013), Mignolo (2011) and other members of the Coloniality/Modernity Research Group.

he states, and this is again in line with Benton's (2016b) analysis, whiteness and expertise are in Sierra Leone often perceived to go hand in hand. This becomes especially clear in his statement that "you could be talking rubbish and they won't challenge you because you're white." Cormack confirms Brima's training, unwittingly perhaps, when he states that "there was a lot of acknowledgement of our skills", although he does not interpret this to be deference or undue authority. As such, the cautioning that Brima expressed and that Cormack heard did not necessarily translate into the same sense of understanding of expertise and authority. Despite the association of whiteness, authority and expertise that Brima warned trainees about, Cormack, in his interpretation, questions whether the deference he experienced had anything to do with whiteness. I would argue that their differential interpretation is linked to their different experiences of the wake. For Brima, a Black British-Sierra Leonean man living and working in the UK, the conflation between whiteness and expertise/authority was a fact that he had experienced in his own life. For Cormack this information was new (and possibly uncomfortable). In comparison to Brima, Cormack was not 'awake' to the reality of colonial-racial hierarchies that permeated (and continue to permeate) knowledge in the wake.

The epidemic and response were however also a time in which the diaspora was placed in a position of authority with regards to their Ebola-related knowledge. This authority especially played out in relation to the diaspora's communication with friends and family back home. In these instances, the Sierra Leonean diaspora were geographically closer to and seemed to have more authoritative access to Ebola-related knowledge than the Sierra Leoneans they communicated with back home. This was illustrated in an interview with an older member of the Sierra Leonean diaspora living in Germany. Solomon had read up on the origins of Ebola in the Congo, how it spread and that there was, in early 2014, no cure. He told me the following:

> So I called my village. I told my village – I am the village elder – 'Stay at home. Be careful and have little contact with others. Let them say that you are conservative, but this is how it should be done. Ebola is a disease that is transmitted easily.' [imitates villagers' scepticism] 'Yes, but brother we are safe here.' I said: 'No, no one is safe. No one is safe from Ebola' [own translation].

Solomon's quote illustrates the role of expert and adviser that some members of the diaspora took on. Solomon used his authority of being both a village elder and a member of the diaspora living in Germany. In this case, Solomon gave the people in his village in Sierra Leone direct instructions on how to behave. He did not give them any information

that they could not have gotten from local officials. In fact, as Richards (2016) and Piot (2012) have pointed out, rural African communities have long known how to establish basic protection against infectious diseases, such as smallpox. However, the fact that Solomon called from Germany to warn them against the Ebola virus added authority to his directive. Here, as in relation to whiteness, expertise and authority are linked to living in Europe. In Solomon's case this authority stretches so far as to be able to contradict and overrule the opinions of the people in his village in Sierra Leone ("Yes, but brother we are safe here" – "No, no one is safe").

Solomon also used his position to try and transmit the knowledge he had accumulated by speaking to friends and drawing on the sources of information available to him. This involved some form of epistemic translation. He described this to me in the following exchange:

> Solomon: I also really tried to explain to them in my language, not in Krio, in the language that they understand. Because the vocabulary differs. But in my language, although there is no name for Ebola […] we developed a name for it.
>
> Lioba: What is the name?
>
> Solomon: *Tumbu*. *Tumbu* means maggot. […] It looks like a maggot [both laugh]. So we said *tumbu* und we tried to explain what it means in our language. And you know in our language this *tumbu*, the maggot can enter people and when that happens, then it can draw out blood. So we tried to speak in this way. And then they understood. It was not fearmongering. It was the reality of what we could transmit in the language's vocabulary. [own translation]

Here, Solomon translates his knowledge of Ebola into knowledge that has local currency. His translation of EVD into 'maggot' and his exclamation 'It looks like a maggot' rely on his knowledge of Ebola being a filovirus and his acquaintance with the appearance of the virus under a microscope. He states, "It was the reality of what we could transmit in the language's vocabulary", a statement which acknowledges both Ebola's microbiological nature as well as the necessities of making the disease intelligible for the people living in his native village. Here expertise becomes a practice of both linguistic and epistemic translation.

Solomon's statement echoed that of another member of the diaspora, Musa, a Sierra Leonean doctor working in London. Musa stated that when communicating with fellow members of the diaspora or with family and friends in Sierra Leone, his emphasis was less on whether or not Ebola was real, but rather that even if it was not real it still had the potential to kill:

> You know you would also during those conversations [with family and friends in Sierra Leone] sometimes hear that: "Oh is this real?" […] I think there is a difference between, you know, "Is this real?" and actually "Do I believe that if I got this it could kill me?" […] But people who were still certain it [Ebola Virus] was 'man-made' towards the end and whatever their reason for it being 'man-made' whether it had just been imported by other people or whether it was not really a virus, but they still believed "Ok it may have been man-made but actually if I got it, this time it's real, it can do damage." So there was that shift there and for me actually that was the more important thing, not whether you think it's man-made or not, but whether you thought this is dangerous and that I should stay away from crowded areas, not go to funerals, etc., all the things that they were advising.

By focusing on the reality of danger, rather than the reality of the virus, Musa's attention was less focused on whether his interlocutors could understand expert microbiological and epidemiological knowledge and more on how to get them to observe safe practices. His acknowledgement that the deep-seated mistrust towards biomedical explanations of the disease would harm prevention efforts, led him to initiate a shift in how he shared knowledge pertaining to Ebola. This effort at epistemic translation, I argue, is a form of expertise that did not rely on Sierra Leoneans' understanding of Ebola's aetiology, but rather took its desired impact into account. In the wake of colonial medical campaigns and accumulations of distrust (Coultas, forthcoming), effective Ebola expertise required taking this distrust into account and adjusting the way in which public health advice was communicated. In other words, it required a 'wakefulness' (Sharpe, 2016) to the entanglement of biomedical expertise and colonial and antiblack violence.

Other conversations with members of the diaspora evidenced similar practices, if not of translation, then of communication. They were similarly imbued with authority. Aminata told me how she communicated with her cousins back in Sierra Leone:

> Like my cousins I was always calling them in Sierra Leone: "You guys better listen to what they're telling you. Don't go out when they're giving you a curfew." Because some of them wanted to be going out because they thought "Oh no it's not…". I was calling them religiously every single week. Getting my mum to call her sisters to tell them. To say: "This is what we're hearing. You guys need to stay home! Don't go near this area. This is where it's coming from!" And so even doing that, calling them and telling them and they were saying "No we know now how serious it is." I said, "For now you pray at home, because you shouldn't be in big crowds" and stuff. But they, they listened.

Aminata's tone, when she describes calling her cousins is authoritative. Aminata was not telling her cousins anything that they were not being told in Sierra Leone at the time. In fact she told her cousins to listen to local authorities ("You guys better listen to what

they're telling you. Don't go out when they're giving you a curfew.") She also told them what she was hearing on the news and in the UK. At the end of her statement her cousins, it seems, had understood the seriousness of the situation. Whether this was due to her repetitive calls or due the development of the epidemic in Sierra Leone is unclear, but Aminata's authority is evident in her concluding remark "They listened". Like in Solomon's case, Aminata's location in Europe imbued her knowledge with authority and made it expertise. This coincides with Rubyan-Ling's (2019) analysis of health expertise as a form of social remittance during the Sierra Leonean Ebola outbreak. Building on his (2019) argument, I would however stress the continued colonial implications that these remittances carry in that here, expertise is performed along colonial lines. The authority that in the first section of this part accompanied whiteness is here embodied through a European location and increased access to European information and expertise. Europe is still reified as epistemic centre.

At the same time, due the diaspora's relative epistemic authority on Sierra Leone in the UK, their involvement in the response also signals a more subversive use of epistemic power. The diaspora's role during the Ebola response, their making of expertise, is an example of living in and working against the colonial wake. On the one hand, their geographical position and the authority that is conferred upon them by people in Sierra Leone reproduce the UK and its residents as a powerful epistemic centre. On the other hand, acknowledgement of the intersection between whiteness and expertise by members of the diaspora and the active role they took on in training NHS volunteers deployed to Sierra Leone challenges the traditional epistemic hierarchy between former colony and former coloniser and between Black and white. This challenge is somewhat mitigated by the admission of perceived white epistemic superiority. At the same time, members of the diaspora took it upon themselves to communicate with friends and family in Sierra Leone and to transmit knowledge and concepts that would lead to a reduction in new Ebola infections.

7.4 Conclusion

In this chapter I have analysed epistemic hierarchies and the marginalisation of the colonial wake and antiblackness in global health. By looking at epistemic places and flows I have analysed how epistemic hierarchies work along embodied and geographical colonial-racial lines. This, I argue, revealed Sierra Leone's continued epistemic

dependency on the UK. As in the previous chapter I suggest that this is a sign of the colonial wake and the ways in which the Ebola epidemic took place in its midst, yet was not taken into account in high-profile analyses of the response, such as the Ebola response panel at the Royal Society I have discussed here. Throughout the chapter I have explored various ways in which antiblackness and colonialism were treated as epigrammatic (Benton, 2016b) while also manifesting in places of epistemic production. This I have argued, signals a lack of 'wakefulness' (Sharpe, 2016) to the importance of the colonial wake in global health research and practice. Drawing on work by Bressey (2006) and Fuentes (2018) on the silencing of Black people in historical archives I have sought to extend their analyses to the physical space of the archive. Overall I argue that the unchallenged existence of antiblackness in places of epistemic production echoes the spatial, epistemic and practical entanglements with antiblackness that characterised British medical interventions in Sierra Leone during colonial times.

I have extended my analysis of (aero)mobilities from chapter six by focusing on the interplay between mobility and expertise and attending specifically to the links between postcolonial 'passport privilege' (Ruba, 2017), whiteness and the making of expertise. Focusing on the role of the Sierra Leonean diaspora in the Ebola response, I have analysed how race and expertise intersect and explored how members of the Sierra Leonean diaspora translated information and knowledge to their families and friends in Sierra Leone. While my analysis in this chapter drew especially on work by Benton (2016b), I have extended her analysis of race as epigrammatic in humanitarian interventions by taking the colonial wake into account. While the marginalisation of race in humanitarian interventions deserves attention, I have here sought to highlight the convoluted interplay of colonial-racial hierarchies in the production and circulation of global health knowledge, that signals, or so I would argue, the colonial wake.

chapter EIGHT

8 Thinking and practicing care: violence, risk and the spatialisation of 'always-imminent death'

8.1 Introduction

In this chapter I attend to care practice in the context of the international Ebola response. Practice is an inherent part of medical care in fact the OED defines practice as 'the carrying out or exercise of a profession, esp. that of medicine or law; [an] activity or action considered as being the realisation of or in contrast to theory' (OED, Online, 2019). In this chapter I focus on care practice as the individual exercise of medicine which, depending on practitioners, reflects a differential understanding of medicine's political or apolitical nature. A focus on care, its various manifestations and conceptualisations, extends the historical entanglements between care and antiblack violence which I have analysed in chapter five and introduces novel understandings of what it might mean to care for Black life in an Ebola epidemic. Here I consider the reality of the wake and of the Ebola epidemic through practices and feelings of care. Christina Sharpe (2016) argues, and I have shown throughout this thesis, that practices of medical care occur in the context of broader regimes of antiblack violence. Discussing the U.S military intervention in the aftermath of the Haitian earthquake, and the airlifting of a small Haitian girl to the US military hospital ship *USNS Comfort*, Sharpe (2016, p.50) writes

> "US," "military," "comfort," and "allopathic medicine" – each and together being terms whose connection in the lives and on the bodies of Black people everywhere and anywhere on the globe – warrant at least a deep suspicion if not outright alarm: from those experiments on board the floating laboratory of the slave (and migrant) ship, […] to the dubious origins and responses to the crisis of Ebola […].

Sharpe (2016, p.50) sees the Ebola epidemic and response, similarly to the 2010 earthquake in Haiti, as an aftermath of transatlantic violence. Questions of medical and institutional, epistemic and emotional care, antiblackness and the wake circle around one another in Sharpe's (2016) work. Indeed, one of the aims of *In the wake* is to model a practice of care for the (Black) dead and the dying. Sharpe (2016, p.35) writes:

> What does it look like, entail, and mean to attend to, care for, comfort, and defend, those already dead, those dying, and those living lives consigned

> to the possibility of always-imminent death, life lived in the presence of death; to live this imminence and immanence as and in the "wake"?

Although I see this as the central question of her work, Sharpe does not offer a concrete definition of care. Rather care is a variety of practices. The Oxford Dictionary of Human Geography defines care as 'The act of looking after dependents such as children or people with health conditions to ensure their well-being' (Rogers et al., 2013). For the purposes of my analysis and following Sharpe (2016, p. 35) and Rogers et al. (2013) I argue that care is *the act of looking after Black life, 'those already dead, those dying, and those living lives consigned to the possibility of always-imminent death' epistemically, emotionally and in practice*. I use Sharpe's (2016, 2018) approach to care to analyse international responders' and stakeholders' narrations of the Ebola response, and epistemic, emotional and spatial care practices in particular. Care, in this chapter can be personal and institutional and how responders practiced care is, I argue, indicative of their understanding of the wake.

During the epidemic care was shaped by three central factors. First, the absence of an Ebola cure. At the beginning of the West African Ebola outbreak in December 2013, no certified medicine or vaccine slowing or hindering the progress of EVD in the human body had been approved by the U.S. Food and Drug Administration or similar national bodies. Second, the highly infectious nature of the disease and, third, the emergency setting, which required a makeshift approach to care materials and spaces. This chapter explores how these three factors shaped the caring practices available to and required by (clinical and non-clinical) international medical responders during the Ebola epidemic. That is, how international responders practiced care in such an environment and how they conceived of and navigated the risks involved in their care work. In line with my central argument, I use Sharpe's work to make the wake and the antiblackness which has shaped it visible in responders' care practices.

This chapter also builds on work by Annemarie Mol (2002) on ontopolitics in medical practice. Sharpe's (2016) work provides the theoretical framework for my analysis in this chapter, but the contents that I analyse are very much derived from a research focus modelled on Mol's work on ontopolitics and practice. While I draw on ontopolitics as a methodology and as an analytical concept, there are some marked differences between Mol's (2002) analysis and mine. For one, Ebola is an infectious disease, not a chronic condition (like atherosclerosis) and this has, as I will show, consequences for how its ontologies are enacted. Secondly, I explore how the ontologies of Ebola are enacted

entirely within the international Ebola response to Sierra Leone, which constitutes an '(extra)ordinary event', in comparison to the everyday hospital setting in which Mol (2002) studies the ontopolitics of atherosclerosis.[38] Thirdly, while my focus lies on practices of care, the nature of my research means that I explore these practices through the narrations of interviewees, not through participant observation, which forms the basis of Mol's (2002) work. Lastly and relatedly, Mol (2002) makes a distinct differentiation between perspectives and realities. According to her (2002, pp.10-13), perspectives, which are inherently personal, do not grasp the multiplicity of ontologies, but ''merely' interpret them'. Here I challenge this statement and its implicit hierarchy. I argue that historical antiblack violence (the slave trade, colonialism) shapes embodied perspectives along racial-colonial lines to different degrees and that those perspectives, in turn, shape the ontologies of the wake.

Mol (2002, p.55) raises the importance of geographical context by stating that 'ontology in medical practice is bound to a specific site and situation'. However, her analysis does not take the political history of such sites into account. This chapter speaks to my grappling with Mol's (2002) method: My approach adopts an ontopolitical approach in the study of medical practice, while also centring perspectives. This centring of perspectives is important, because as I have demonstrated, who practices care, and where, matters, given the colonial-racial legacies of health and disease management in Sierra Leone (see chapter five).

As such, I extend but also qualify Mol's (2002) analysis by bringing it into conversation with Sharpe's (2016, 2018) work on Black life and care in the wake. Both Mol (2002) and Sharpe (2016) invite us to consider reality by focusing on practice. Throughout the thesis I have worked to convey the geographical and political reality of the wake during the Ebola epidemic. Consequently, this chapter engages with practice as an act of reading the reality of the Ebola response to Sierra Leone to analyse how the wake is enacted spatially and materially in the Ebola response.

I foreground the materials and flows that practices of care relied on during the Ebola response in Sierra Leone. Here I predominantly analyse interviews that were focused on Infection Prevention and Control (IPC) practices with international responders to the Sierra Leonean Ebola epidemic in one specific location: Hospital X, a hospital in

[38] I lean here on Sharpe's (2016, p.132) '*ordinary* note of care' to denote an event that is extraordinary in terms of its logistical and political complexity, yet ordinary in terms of the structural, bodily and discursive violence that has characterised Black life in the Wake.

Freetown. A considerable number of international volunteers from London-based Organisation X worked in the hospital's Ebola Holding Unit (EHU) in conjunction with Sierra Leonean healthcare staff. [39] In practice this meant that volunteers worked within the confines of the existing hospital and within the confines of the Sierra Leonean political economy. As I show in this chapter, this had repercussions on the materials and infrastructures on which care practices relied.

The first part of this chapter explores care epistemologically. Here I present Sharpe's (2016, 2018) meanings of care to show how care is an important marker of the wake, both in terms of the conflation between institutional care and colonial violence, as well as a methodology with which to study Black life in the wake. In 8.2.1 I relate Sharpe's (2016) writings on 'care as violence' to local attitudes towards government and international care institutions during the Ebola epidemic. I argue that international responders' awareness of the historical conflation between care and violence indicates an awareness of working in the wake, even if antiblackness and the colonial present largely continue to be epigrammatic. In 8.2.2 I subsequently show that international responders and experts displayed an inability/unwillingness to think the Ebola response both in and outside of the wake. This, I argue, demonstrates the ambiguity of being in the wake and the difficulty of accepting the wake as a reality. In the second part of this chapter my analysis focuses particularly on care practice and the spatialisation of the possibility of death. In 8.3.1. I demonstrate that Ebola was enacted both as process and as status in ETCs and EHUs and that this shaped the spatiality of places of care. Simultaneously, I argue that the management of the risk of infection was navigated through spatial and material care practices and resulted in the creation of 'realms of always-imminent death'. In 8.3.2 I continue exploring the spatialisation of always-imminent death but shift to analysing international responders' perceptions of risk inherent in care practices and institutions. I show that risk was, again, localised and that it was unequally distributed across postcolonial and medical hierarchies. Finally I close by considering the sharing of risk. Here I draw once again on Sharpe (2016), who argues that sharing risk constitutes a way of caring for Black life in the wake. I consider one extended account in which an international healthcare worker narrated her experience of sharing risk as a political act of counteracting the neo-colonial dimensions of global health.

[39] EHUs were part of existing hospitals, whereas Ebola Treatment Centres (ETCs) were standalone facilities.

8.2 Thinking care, thinking the wake

8.2.1 Thinking care and violence

I start by establishing the connection between care and the wake. Historical uses of care as violence are a marker of the wake and awareness of care's historical uses in the wake is a practice of care. I proceed here by briefly outlining the multiple uses of care that Sharpe (2016) identifies both in her own work and in the lives of Black people in the diaspora and focus particularly on her concept of *care as violence*. Following Sharpe, I argue that the historical and contemporary conflation between care and violence is one of the realities of living in the wake. However, in the interviews with international health responders I analyse here, antiblackness remains largely epigrammatic. In this section and throughout this chapter I highlight the historical and political awareness - particularly around colonialism's legacies - that did exist among some research participants. Building on Sharpe's (2016) work I argue that how responders related to historical entanglements of care and violence had direct implications for how they understood care as well as how they conceived of and practiced medical care during the Ebola epidemic. The wake influenced the response but only a few interviewees were able to articulate this. In this section I relate one interviewee's understanding of the conflation between care and violence, which shaped Sierra Leonean hesitancy to seek care during the early stages of the epidemic to Sharpe's writings on care as violence.

Sharpe (2016, p.5) writes:

> I want to think "the wake" as a problem of and for thought. *I want to think "care" as a problem for thought. I want to think care in the wake as a problem for thinking and of and for Black non/being in the world.* Put another way 'In the Wake: On Blackness and Being' is a work that insists and performs that thinking needs care and that thinking and care need to stay in the wake. [emphasis added]

In this passage, Sharpe (2016) lays out her intention for thinking care in/into the wake. I follow her lead by thinking care, as she conceptualises it, into the Ebola epidemic. This contributes to my overall aim of placing the Ebola response in the wake. Sharpe identifies care's multiple uses. In her own work, care is a methodology that structures her writing and her analysis of the literary and visual representations she attends to. In her analysis of Black life in the wake care is a shifting analytical field that encompasses both violence and the sharing of risk, a theme I return to in the second part of this chapter.

As a methodology, care encompasses Sharpe's efforts not to expose Black lives to more violence. She writes (2018, p.174):

> I recognized then and recognize now that care is a difficult word and concept; it is freighted with all kinds of raced, gendered, and colonial histories. So let me try again to distinguish between what I am calling care and state-imposed regimes of violence and surveillance. The work of what I imagine, theorize, and activate as practices of care is not to extend suffering or to make the one suffering at one with the nation-state or institution inflicting that suffering.

Here care translates into an awareness of the wake and of the histories of institutional 'care as violence' that shape the present. This chapter follows Sharpe (2016) in attending to Black life and death with care, that is to say to depart from the reproduction of Black suffering for analytical purposes. This practice, maybe unwittingly, was also observed by a majority of the international responders I interviewed (whose accounts appear in this chapter) who largely refrained from describing the details of dying from Ebola. I adhere to this methodology with one exception in section 8.3.1, which I thought necessary to allow readers to fully comprehend the meaning and practices of care and what I call the 'realm of always-imminent death'.

Care as an analytical field becomes visible in the multiple instances of care that Sharpe demonstrates throughout her book and which I turn to now. Broadly, Sharpe (2016) distinguishes between analyses of, on the one hand, institutional care and its entanglement with antiblack violence, and, on the other, sharing risk as a care practice. Her (2018, p.174) recognition of the 'raced, gendered and colonial histories' that contribute to the entanglement between institutional care and antiblack violence places care in the wake, a reality in which linear time and space are unsettled. I build on her analysis to argue that the unsettling of time and space allows for an analysis of care in which care and antiblack violence not only coexist but contribute to the reality of the Ebola response. I have drawn out a similar argument in Hirsch (2019b) and in chapter five in which I wrote about the wake and the weather in relation to disease control and care in Sierra Leone.

The entanglement between care and regimes of violence, according to Sharpe (2018, p.175), has a long history.

> […] saving and killing often look a lot the same as far as black people are concerned. (There are too many examples of this kind of care-as-violence to name, from tortures in the Congo under Belgian rule and in Kenya under British rule to […] recent news stor[ies]

Here Sharpe moves from an entanglement between care and violence to care-as-violence. That care can be violence is visible in the history of Sierra Leone at least twice: after the abolition of the British slave trade in 1807 the British Navy intercepted slave ships off the coast of West Africa and resettled freed slaves in Sierra Leone where they were enrolled in schemes of unpaid labour as 'apprentices' (Olusoga, 2016, see chapter five). The apprenticeship scheme upheld a regime of servitude from which the enslaved had officially just been freed. The motivation for this, as I have detailed in chapter five, was 'British care and philanthropy'. The second instance is what Frenkel and Western (1988) have described as 'humanitarian imperialism' wherein British colonisation of Sierra Leone was understood to be for the benefit and development of local populations. The historical overlap between discourses of care and the colonial violence that I have analysed with regards to infectious disease control in colonial Sierra Leone further speaks to care and its entanglement with antiblackness. In the aftermath of care as colonial violence, thinking care is about remembering and tending to Black death in the past and in the present and to consider what Sharpe (2018, p.175) calls the 'longue durée of Atlantic chattel slavery', the continuity of colonialism, the wake.

Thus, in the wake, to think care in a postcolonial context is to remember its use as violence. In other words, the reality of the wake includes a past entanglement of care and violence or 'care as violence'. The majority of my interviewees did not consider how past experiences of violence could influence the behaviours of Sierra Leonean communities during the Ebola epidemic. For most, antiblackness and the colonial past were epigrammatic in their narrations of the response and of care practices. A few interviewees did however mention the colonial past. James, a white British doctor who had worked at Hospital X since 2013 spoke about the entanglements of violence and care. He acknowledged the reality of working in the wake of historical conflations of care and violence (albeit not in those terms). In his interview he referred to the hold that past experiences of violence have on Sierra Leonean attitudes to seeking medical care:

> I don't know if it's a true story but I was told, I think Siaka Stevens as president got a doctor to kill someone in his government, so you know… and there was a belief that this [the Ebola epidemic] was a US military experiment, well [the] US army had a research station at Kenema looking at viral haemorrhagic fevers, so these rumours are not sort of… they often have a seed of truth and reality was pretty far-fetched as well. So I don't feel dismissive or blame people for having these beliefs and what's really sad is that a lot of the time they were desperately trying to do what they thought was the right thing to do for their families and we were, the response saw them as a problem and they were acting out of compassion and sacrifice and heroism and that, that I find hard.

James' narration displays feelings of empathy. James recognised that Sierra Leone's historical and political landscape played an important role in shaping individual and communal attitudes to government and international care institutions. Medical care is here associated with violence, both in the belief that one of Sierra Leone's presidents had used a doctor to kill someone, but also in the belief that the medical research conducted by Americans in the east of Sierra Leone was at the origin of the epidemic and consequently, of thousands of deaths. Importantly, James acknowledged that rumours on Ebola were based on historical and present realities. He recognised the reality of the epidemic occurring in the wake of violence. Here care's entanglement with violence is a reality that needs to be acknowledged in the management of the response. Speaking about community perceptions of associating institutional care with violence he continued:

> […] the person seems certainly healthy, they're being dragged away by persons in space suits and then they all end up dead, and I think this is another thing that they experienced before, and you know what's more unrealistic? The truth? Or their belief? Actually the truth sounds pretty far-fetched if you don't come from a biomedical tradition

Again, James' statement attests to the hold that past violence has on present perceptions of care. His statement "this is a thing they experienced before" echoed another statement he made during the course of our interview. Speaking of the east of Sierra Leone, where the epidemic first entered the country and where the first treatment centres were set up (MSF established an ETC in Kailahun District in June 2014) he said: "People did not in the east trust foreigners you know and there's lots of historical reasons why that is understandable."[40] James cared about these realities, even if they were not his own because they shaped the lives (and deaths) of his patients and influenced the extent to which he could provide medical care. He also acknowledged that care's entanglements with histories and past experiences of violence were not taken into account in the response.

> I think that was a challenge from […] some of the Sierra Leonean and international leadership who did not have enough insights and I think particularly when it came to understandings of death and burials, [you] know people would just say "Why are these people so crazy? Why are they putting their lives at risk for the sake of a burial?" It just doesn't seem to make sense. I think only when I started to understand the belief among some Sierra Leoneans about the afterlife and haunted afterlife and [that] there is actually worse things than death. There's worse things than death that is not something that exists in my view of the world. Without understanding that - and I think there was a general lack of empathy of

[40] The civil war started in the East of Sierra Leone, sweeping over from neighbouring Liberia.

> really putting ourselves in their shoes and asking the right questions about those things. And I think we did learn those lessons, but too late.

In James' account two meanings of care are present. On the one hand he attests to care's entanglement with historical violence and while he does not centre the antiblackness that has characterised colonial and slave-trading violence in Sierra Leone, he acknowledges how past experiences of violence shaped Sierra Leonean communities' responses to institutional care during the Ebola epidemic. On the other hand James' awareness of his patients' realities, that their reality of the epidemic differed from his, corresponds to Sharpe's (2016; 2018) invitation to think about the wake and Black being in the wake with care. James' account, I argue, is an instance of thinking care in the wake.

Here I have outlined the meanings of care that Sharpe (2016, 2018) identifies. I have shown that thinking care in the wake involves an acknowledgment of care's history of antiblack violence especially with regards to Sierra Leone. I argue that to care about Black life means recognising the reality of the wake and of past violence and their hold on the Ebola epidemic and response even if antiblackness remains epigrammatic. The repetition of Black 'un/survival' (Sharpe, 2016, p.131) that Sharpe describes and which I analyse in this thesis with regards to infectious disease control, warrants a centering of perspectives, rather than enactments (Mol, 2002) and an effort to care beyond the objective unembodied realities of Ebola-related care that Mol invites.

8.2.2 Thinking the response otherwise

Building on from the previous section I further explore care and turn to what Sharpe (2016) calls 'the inability to think Blackness otherwise'. I show how care can be analysed as being linked to the inability to think the Ebola response otherwise. In order to show this, I analyse two instances during my fieldwork in which people involved in the response analysed and reacted to being challenged on the neo-colonial implications of the response. I suggest that the inability or unwillingness to think the response and medical care that was provided outside of the normalised reality of colonialism and the structures of (post-)colonial dependency between Sierra Leone and the UK, illustrates the epistemic hold of the wake on thinking care and thinking the Ebola response. At the same time this inability/unwillingness further shows how colonial conflations of care and colonial/antiblack violence were epigrammatic in conversations about the response. Care here becomes an expression of continued dependency that extends, rather than counteracts the colonial present.

Sharpe writes about teaching a course on memory and trauma. She describes structuring her course around the trans-Atlantic slave trade and the Holocaust and narrates how her students reserved their empathy and care for discussions on the Holocaust, rather than the trans-Atlantic slave trade and enslavement. She (2016, p.11) analyses their reactions as follows:

> […] students would say things about the formerly enslaved like, "Well, they were given food and clothing; there was a kind of care there. And what would the enslaved have done otherwise?" The "otherwise" here means: What lives would Black people have had outside of slavery? How would they have survived independent of those who enslaved them?

Sharpe's description of students' lack of care and her subsequent analysis of this reaction is important on several levels. It reaffirms that in her work care has multiple meanings and that it can be violence. But she also introduces a discussion on her students' capacity to imagine Black life outside of enslavement and colonialism. As Sharpe (2016) states, her students' 'inability to think blackness otherwise' is a fundamental characteristic of being in the wake.

Some responders displayed a similar inability or unwillingness to think the response and African-ness 'otherwise'. As I have shown in the previous chapter, antiblackness and the relevance of the colonial past to the development of the West African Ebola epidemic and subsequent international response was largely epigrammatic in the discussions I observed or had with experts and responders to the Ebola epidemic in Sierra Leone. Rather postcolonial dependencies were taken for granted, left unquestioned and used to reinforce ideas of British care for Sierra Leoneans.

In order to illustrate how this inability to think otherwise manifested in my research, I return to the expert panel discussion on the Ebola response that I analysed in 7.2.1. I focus here on just one of the statements made during this discussion, which was, as I described, hosted at the Royal Society in London. Towards the end of the discussion in which a panel of global health experts reacted to a question posed on the neo-colonial nature of the Ebola response, I presented the words of a senior fellow, who was not part of the panel, but joined the discussion from the side of the room. In the previous chapter I focused largely on his remarks on Liberia-US relations and his assertion that they could not be qualified as neo-colonialism. I take my analysis up where I left off and focus in the following analysis on his statement on godparents.

> [senior fellow]: Look the Americans at the beginning of September said "We really want to help Liberia", which was never an American colony, so you can't describe that as neo-colonialism. And president Obama

> contacted President Johnson- Sirleaf and said "What do you want?" She said what she wanted, the Americans responded. They said to us "We have to work inside a multilateral envelope, we created the biggest health mission we've ever done, we've never done one before". The British came along very quickly afterwards, particularly Philip Hammond and together with the Prime Minister said, "We have to help Sierra Leone". The French came in after that with Guinea. Again very strong. *Thank Goodness! Supposing this had been in countries that did not have godparents like these, who just take these amazing decisions...* (LSHTM, 2017) (emphasis added).

The statement "Supposing this had been in countries that did not have godparents like these, who just take these amazing decisions…" exemplifies, I argue, what Sharpe (2016) calls an 'inability to think blackness otherwise'. The speaker does not detail what the response would have looked like in countries that do not have 'godparents' as do Liberia, Guinea and Sierra Leone, nor does he go into detail on the nature of the godparents he refers to. His "supposing" is open ended and it is this open-endedness that signals most of all his inability or unwillingness to think the Ebola response otherwise. This inability to think the response otherwise is reminiscent of Sharpe's description of her students' inability to think blackness otherwise. Here I take "what would the enslaved have done otherwise?" (Sharpe, 2016, p.11) and "supposing this had been countries that did not have godparents like these" (LSHTM, 2017) to illustrate how our thinking and imagination is framed by being in the wake. The underlying question asked by the senior fellow, reminiscent of Sharpe's students, is: how would Sierra Leoneans, Guineans and Liberians have survived independent of those who colonised them? The violence of the colonial past is in this reasoning obscured to make way for an interpretation of colonialism as care and colonialism as blessing.

At the same time, the fellow's choice of words is an (unanswered) invitation to imagine a non-colonised Africa. "Supposing this had been countries that did not have godparents like these […]" (LSHTM, 2017) invites us to think of Sierra Leone, Guinea and Liberia without 'godparents', that is to say without the experience of colonisation and colonial violence as care. To think the international Ebola response in a non-colonised setting requires care, as does the realisation that our ability to think and theorise postcolonial Africa is constrained by being in the wake.

An inability to think the response otherwise was also present in the following account. Anton, whom I have quoted previously and who worked for Organisation X and I had the following exchange when I relayed the senior fellow's remarks:

> Anton: [flinches] I think it is really, it is a very difficult one. And so, our understanding of Ebola comes from a bit of colonial history like Peter Piot going out into Congo, even though that wasn't a British colony -
>
> Lioba: [interjects] Yeah but he's Belgian.
>
> Anton: yeah you know [it] comes from colonial aspects of that. I don't know how these decisions were made in terms of how these countries were gonna get involved there. I mean it's really interesting to see the differences of how that happened really. The US came in and just took over Liberia, they just took over and that's the US way of doing things, but also they have this strange paternalistic relationship with Liberia […] they kind of care what's going on, but it's odd. It's a little bit odd. The British relationship with Sierra Leone is something that I get very conflicted about. Now Sierra Leone is one of the few countries in the world that like genuinely loves Tony Blair. [Lioba laughs] No! People call their children Tony Blair, they think he's wonderful because he ended the civil war. It was one of the few scenarios in which British military involvement ended up with something relatively near to good. I don't know if I can say that [looks hesitant], relatively good. So really bizarrely like actually quite made sense for the British government and the British military to get involved and actually there were people who wanted - there were newspaper columns, and I don't know if I could find them but I could try - there were newspaper columns in Sierra Leone calling for Sierra Leone to be recolonised by the British. It got to that kind of level. […] On the one hand I'm like, oh did it really have to do it [did the UK really have to get involved]? If it's against everything that I believed, that you have these colonial [relations]...on the other hand it's like, where else is it [help] going to come from? In the situation?

Anton's physical reaction when I summarised the moment at the expert panel discussion is telling. He flinched when I recounted the characterisation of British-Sierra Leonean relations. Anton was fully aware of the colonial aspects of the discovery of Ebola and they made him uncomfortable. As the quote shows, he was also aware of the long history of British post-colonial involvement in Sierra Leone. He hesitated when stating that the UK should get involved in Sierra Leone and seemed uncomfortable ("So really bizarrely like actually quite made sense for the British government […] to get involved"). Anton's narration finishes, like the quote I asked him to comment on, with the inability to think the response otherwise: "On the other hand it's like, where else is it [help] going to come from? In the situation?" Anton's questions are open-ended. His relation to colonialism and the role it played in the development of the international Ebola response is radically different from that of the senior fellow speaking at the expert panel event on the Ebola response. In comparison to him, Anton recognises the colonial implications of the past for the present and recognises the problematic reproduction of dependencies. Yet his analysis ends with a similar inability to think the response otherwise, to think Sierra

Leonean life otherwise in the wake of British colonialism. Here, caring and thinking about care with regards to the Sierra Leonean Ebola epidemic are suggestive of the epistemic constraints of the wake.

In both accounts the meaning of care displays colonial relations of dependency. In the senior fellow's remarks this dependency is lauded and the colonial past interpreted as the reason for European and North American involvement in the West African epidemic. Anton views this relationship much more critically, but similarly finds himself unable to think the response outside of the constrains of the colonial wake. Again, I argue that how global health practitioners and analysts think about care and the wake has implications for how they conceptualise epidemic responses.

In this part I have explored the epistemological dimensions of thinking care in the wake. Drawing on Sharpe's (2016; 2018) writings about thinking and practicing care, I have argued that the way international responders and experts conceptualised care and understood it in relation to the Sierra Leonean Ebola epidemic was symptomatic of how they related to the reality of the wake. Though antiblackness and the wake still remained largely epigrammatic, I have started to show that some responders had awareness of the colonial implications of Britain's intervention in Sierra Leone, a theme that I further explore in the second part of this chapter. The wake manifested, for international responders, in Sierra Leonean communities' association of institutional care with violence and their subsequent hesitation to seek care in government and international treatment centres. As James suggested during his interview, rather than seeing communities' attitudes as a problem, care should take their realities into account. I argue that Sharpe's approaches to care offer a useful starting point to think about broader definitions of care in epidemic interventions. I have further argued that an unwillingness and/or inability to think the Ebola response otherwise hinged on responders and experts' un/awareness *of* the wake and thereby placed the response and analyses thereof firmly *in* the wake. Here (white) unawareness of continuous antiblackness becomes a feature of the wake. The inescapable nature of the colonial wake is not only due to the historical fact of colonialism, which I have described in previous chapters, but also due to our inability to think the present and the future otherwise.[41]

[41] Much afrofuturistic work engages in imagining Black futures free of colonialism and the remnants of enslavement. Asif and Saenz for instance (2017) explore afrofuturistic literature and thinking to critique medical practice and doctorhood.

8.3 Practicing care: the spatial management of the possibility of always-imminent death

8.3.1 The ontopolitics of Ebola and care as flow

I continue in this section with a focus on Ebola care practices and the spatial (and to a lesser extent temporal) management of the possibility of death. Following Mol (2002) and drawing on interviews with medical responders working in a variety of makeshift and purpose-built Ebola Treatment Centres and Holding Units I analyse how Ebola's ontologies were enacted as condition and as process. Then, drawing on Sharpe's (2016, p.35) concept of 'the possibility of always-imminent-death' I further conceptualise how the risk of infection was managed spatially, and how the way in which Ebola's ontologies are enacted contributed to this spatialisation. I argue that how Ebola IPC was enacted shaped the organisation of ETCs and EHUs spatially and led to the creation of 'realms of always-imminent death' inside ETCs and EHUs.

To explain what I mean by realms of always-imminent death I return briefly to one of Sharpe's (2016, p.35) quotes that I presented in the introduction. There Sharpe asked what it looked like to live 'consigned to the possibility of always-imminent death, life lived in the presence of death' in relation to Black life in the wake. Here I propose that during the Ebola response this possibility took spatial form in the red zones/ confirmed wards of ETCs and EHUs for Black patients teetering between life and death, but also for healthcare workers whose care practices were shaped by the constant possibility of infection and subsequent death. In Sierra Leone, 0.11% of the general population died from EVD in comparison to 6.85% of Sierra Leonean healthcare workers (Evans et al., 2015). Though for international staff the numbers were radically different (several contracted Ebola, but survived after receiving treatment in Europe and two Spanish priests died after caring for Ebola patients at the very beginning of the epidemic) death was, especially at the beginning of the epidemic, omnipresent. Nina, a British IPC nurse who worked for Organisation X in Freetown confirmed this. She described the situation in the hospital at the height of the epidemic as such:

> […] because we had like dead bodies all the time, […] people were dying every hour and the system was, because they're so infectious, they're the most infectious, because the viral load is so high that it killed them, so they couldn't go to the normal mortuary in the hospital, because it just wasn't possible and the burial teams would come a couple of times a day or whenever they could or usually just once a day and pick up all the bodies, but they couldn't come every day because they just didn't have enough

> staff and we basically had bodies piling up in the corridor and it was really grim, really really grim and some of them would be there for days and stuff and they start to smell, they start to leak, it was really really dangerous and like sometimes […] and sometimes there would be like 13 bodies like in a pile. It's also really like disrespectful, you know what I mean, it's also not very right, I mean these are people, and it's horrible for the other patients because they can see it [...]

Here I argue that this 'possibility of always-imminent death' was in ETCs and EHUs localised and managed through flows that reinforced the difference between those living (and moving) and those consigned to the realm of imminent death. Here the wake manifests once again along racial lines in that for IPC reasons Black patients were spatially confined to the realm of imminent death, whereas predominantly white staff, whose narrations I draw on here, could move freely through the centre and were often in charge of patient and staff flows. Here I start by analysing the spatial coincidence between two realities of EVD before analysing how the possibility of infection and of death was managed spatially and through patient and staff flows.

Mol (2002, p.104), writing about the enactment of atherosclerosis in Hospital Z in the Netherlands, notes that atherosclerosis exists both as process and as condition. Writing about the reality of the disease for vascular surgeons and internists she writes:

> Here, atherosclerosis is enacted as a present condition, there, as a process that has a history. Tensions between these ways to enact the reality of the disease are articulated. But it does not come to a full-blown fight. Instead, the differences between the condition atherosclerosis and the atherosclerotic process are distributed.

The tensions that arise due to the multiplicity of atherosclerosis, according to Mol (2002), do not escalate, because they are spatially distributed between the outpatient department and the department of internal medicine. Similar distributions structured Ebola's ontopolitics during the international response in Sierra Leone, albeit in a more restricted space. The spatial dimensions of ETCs and EHUs allowed for some degree of distribution of Ebola as condition and Ebola as process, but on a smaller scale than was the case in Mol's (2002) case study of Hospital Z. Whether treatment units were located in existing hospitals or were purpose-built, they were generally separated into zones with increasing risk of infection: the green zone, the orange zone and the red zone, with the latter corresponding to what I call the realm of always-imminent death. These spatial zones structured the material practices of Ebola care. Sara and Maria, two epidemiologists who

worked in different purpose-built ETCs both spoke to this in separate interviews and how these zones shaped their practices spatially and materially:

> Sara [indicating map, Figure 24]: Here that would be the green zone, meaning low risk, so you would have to wash your hands. And we [epidemiologists] were in the orange zone, so the kind of thing that is not the wards is orange […] and the red zone is inside the wards, but the clinic is orange [suspected cases] with like super high risk. So you would have to go in PPE in the red zone. We had scrubs for the orange zone.
>
> Maria: As the epidemiologist we were not allowed to go in the red zone so […] the patient would have to be ambulatory to be able to […] do the interview so we would be in the orange zone and we would have the distance between us like the three, four meters and through the distance we would talk to the patient and use a simplified questionnaire to see who the contacts were. [...] And these we would then transmit to the local authorities [...] and there was another organisation responsible for the contact tracing.

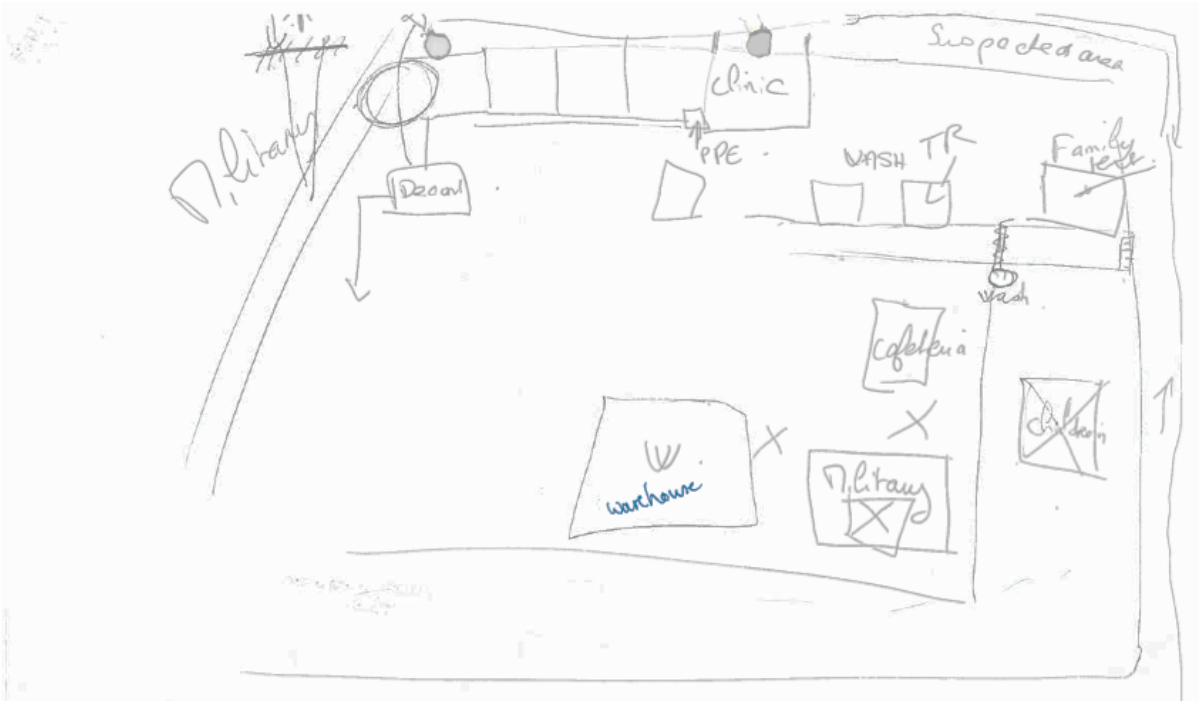

Figure 24: Map of ETC drawn from memory by Sara. The red zone is in the top left corner, left of the clinic. The "white worker treatment centre", which Sara spoke about in 5.2.2 is in the bottom right corner designated 'Military'.

Several things are worth noting here. As epidemiologists, Sara and Maria are not directly involved in patient care and their movements are thus constricted to the green and orange zones. They do not enter the realm of always-imminent death. Even when interacting with patients they do not cross into the red zone. The spatial distance between themselves, suspected and confirmed cases becomes one of the cornerstones shaping their movements as well as how they can do their work, how they obtain their data and what they wear. In

Maria's account Ebola is both a condition that determines which patients she interacts with ("so I was in contact […] with only […] the cases that were suspects and then negatives of course") and a process that needs to be interrupted through contact tracing.

Both epidemiologists, when speaking about the disease in their work spoke about it as condition or in their words, status. Describing her daily work to me, Sara said the following:

> So basically trying to collect data about patients there and trying to create a database and follow the epidemic. […] so I was entering data, and if they [the forms] were missing data I would go back to the clinicians and […] so I was basically checking if they had lab results and what was the Ebola status, [pauses] it was supposed to be positive. Yeah and I was chasing data about their Ebola status, what were the symptoms and things like that. And chasing that the clinicians were actually filling the forms.

Sara's description of her work allows me to further analyse Ebola's ontologies during the international response. For Sara, Ebola is a status and specifically a positive status on a form that comes in with the patient, is filled in by the doctor (but not always) and then transformed into data by her. What Sara describes is a process of transforming Ebola from one (or multiple) thing(s) into another. Her statement "I was chasing data about their Ebola status, what were the symptoms and things like that" indicates the multiplicity inherent in turning Ebola from a list of possible symptoms into a status, to translate several things into one. In Sara's case all patients who arrived at the treatment centre were supposed to have a positive status, but her subsequent description ("I was chasing data about their Ebola status […] and chasing the clinicians") indicates, that obtaining a clear status was at times difficult. At the same time, her statement also shows the tensions for practice in Ebola's enactment. For clinicians filling in a form, according to Sara, seemed secondary to catering to other elements of the ontologies of Ebola, such as administering pain medications (pain) or cleaning or feeding patients (vomiting, bleeding, diarrhoea and dehydration). For Sara obtaining these forms constituted the basis of her work and allowed her to "follow the epidemic" (Sara, 2017). Following the epidemic took different forms of practice. While Sara did this through the forms and data available to her on a computer, contact tracers, who Maria mentioned above, followed the disease in the community.

Having a negative or positive Ebola status became one of the cornerstones of the way treatment centres operated. As Sara stated above, only patients with positive Ebola results were admitted into the centre in which she worked. Simultaneously as Maria and Sara's descriptions of treatment centre zones indicate, Ebola status also shaped the spatial

arrangements of treatment centres and units. The difference between a positive or negative status had important repercussions on mobility in the centre, with positive statuses confined to the red zones, the realm of always-imminent death. However, in the status too, we can find tension. Laura, a British doctor who worked as medical director in various treatment centres described the Ebola testing process to me:

> Testing wise we used to get results usually that night but we faced a lot of opposition from a man who was running the lab at the time and he would often refuse to do our 72 [hours] repeat samples on people who initially tested negative and we'd have to really fight for it. We weren't getting CT values or anything like that we just got a positive or negative.[42] There were some interesting things happening like we had a guy referred to us at one point who, he was a doctor, had potentially been exposed in his hospital, where there had been several healthcare worker infections. He didn't really have many symptoms, but he had some low-level symptoms so they tested him and they tested him on a Monday, they called him on a Monday to inform him his test was negative. They called me on the Wednesday to inform me that his test was positive and he was coming to us. So, when he arrived he said to me - I didn't know that part - he just said to me "Tell me, is my test now positive or…?" and I said "I don't know but what I've been told is it is positive" and I called the lab or our lab tech several times to speak to the lab and I was told no it's definitely positive.

In Laura's account the simple binary of an Ebola status, so important in structuring the spatial organisation of treatment centres and units, gets complicated and turned into a contested reality. A result is first negative and then positive. Due to the absence of CT values, which indicate a numeric continuum, not a positive or negative status, Laura could not be sure whether this was a low or a high positive value. At the same time, the tension here partially stems from the personal politics that characterised the treatment centre's relationship with the laboratory running their tests. Laura's statements "we faced a lot of opposition from the guy running the lab", "we'd have to really fight for it" indicate tension of a different nature, not due to different enactments of the disease but caused by outside factors.

When we spoke Laura had come up with an explanation for the inconsistency in test results:

> But I think what happened at that point because of the management at [laboratory] being a problem […] I think maybe they were reviewing previous results and they probably went "That's positive" and it maybe was

42 Hartley et al. (2017) define a CT value in Ebola testing as follows: 'the cycle threshold (CT) value was used as an inverse proxy for viral load and a cut-off of 40 was used to discriminate between positive and negative values.' As such the lower the CT value, the higher the viral load and the higher the viral load, the higher the mortality rate.

> a low level positive, so yeah and so we admitted this guy to our confirmed ward but we didn't really know what to do because he wasn't sick so we gave him a mask and some gloves, he was a doctor, we basically said "do not help anyone, do not touch anything if you can avoid it" and you know he never became any more symptomatic with us, he didn't have a fever. We tested him again three days later and he was negative and we discharged him.

Laura is able to explain the tension in the lab result through problems in management at the laboratory. In her analysis the result's ambiguity is brought about through inconsistencies in laboratory practice. In Mol's (2002) account tension is distributed geographically in Hospital Z, here tensions between the lab and the clinic collide and disrupt the spatial segregation of treatment zones. The patient is admitted to the confirmed ward, but told not to touch anything. The accuracy of his Ebola status is in doubt. The spatial zone (the confirmed ward/red zone) that the patient is committed to does coincide with his lab result but not his symptoms. As Laura describes "he never became any more symptomatic with us". Despite Laura's hesitation ("we didn't really know what to do") and her affirmation that "he wasn't sick", the patient is sent to the confirmed ward in which patients in various stages of EVD are cared for and in which the risk of infection is highest. The patient is placed in the realm of always-imminent death.

Laura's account also gives an insight into the hierarchy of medical evidence at work here. In this example, laboratory test results (in form of numbers based on the patient's viral load) are translated into a condition and trump bodily evidence ("he never became any more symptomatic with us") and Laura's professional assessment that "he wasn't sick". The disease's laboratory status cancels out the patient's symptoms, or lack thereof, and also his entitlement to be in a ward more distant to the realm of always-imminent death, such as the suspect ward. Here, the realities of Ebola Virus Disease are hierarchical with Ebola as positive or negative status at the top. This leads to a higher risk of infection for the patient than if Laura's assessment or his bodily symptoms were at the top of the epistemic hierarchy. Laura knows this, but abides by this hierarchy. In this example Ebola is enacted in two ways, not only in two different locations, but in one body, whose lab results produce a (seemingly temporary, low level) positive Ebola status without returning corresponding bodily symptoms.

As this example also illustrates Ebola care is subjected to spatial and temporal rhythms. Spatial and temporal flows are an integral part of working in an ETC or EHU. In medical terms, flow is the regulation of patient and staff movements through the hospital or treatment unit for purposes of patient and staff safety from nosocomial infection

(infections occurring in hospitals). Flow was an integral part of Ebola care practices and shaped the way in which staff interacted with the geography and built environment of the treatment centres or units. Tom, a British doctor working in Hospital X during the outbreak described flow as one of the basic components of setting up effective Ebola care ("Safety around Ebola units requires a couple of things. One of them is the appreciation of flow." - Tom, 2017). Maria, the epidemiologist, whom I have quoted above described the flow that shaped the rhythm of work in the unit in which she worked. She based this flow largely on an understanding of Ebola as a condition (or status) that is either positive or negative:

> So there was a whole circle, a patient flow depending on the first outcome of the test. People would come to the emergency wards, they would be seen there by the health professionals, then if they would be admitted based on their admission criteria they would move into the suspect area. They would wait there until confirmation came, if they were negative they would either stay there if we couldn't transfer them into the hospital or they would be moved if they were confirmed into the confirmed area.

Here flows enact a treatment centre in which distances and spaces work to navigate the possibility of infection and death. Each movement that Maria describes, from patient arrival at the hospital to testing to suspect and possibly confirmed areas moves the patient along a spatial and ontological trajectory closer to or away from the possibility of death. These movements are represented in the following flowchart (Figure 25) that depicts the patient flow in the EHU of Connaught Hospital in Freetown and reiterates the importance of Ebola as status but also as process.

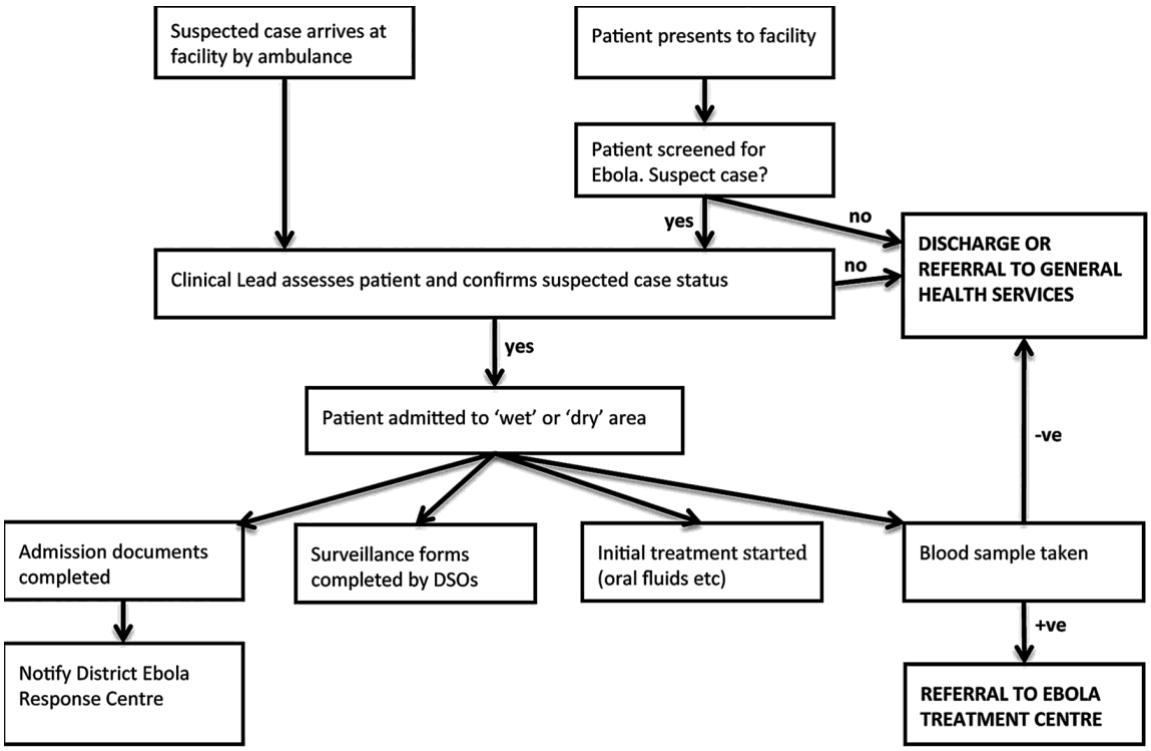

Figure 25: Simplified patient flow within an Ebola Holding Unit (EHU). DSOs, disease surveillance officers. Reproduced from Johnson et al, 2016, https://gh.bmj.com/content/1/1/e000030#article-bottom, accessed 28/06/2019

Laura, whom I have quoted above, described the organisation of flow in the treatment centre in which she worked. Her account reifies Ebola as a status, but also attests to the possibility of infection and death inherent in flow management:

> We made it very clear at the beginning of every day that the only way into the treatment facility was through the door of suspects from donning [putting PPE on] and the only way out was through doffing [taking PPE off] and that we had a unilateral flow through the unit which meant you went from suspect to confirmed and you never went back again. We did have an exit from suspect so if we had a patient in suspect who tested negative twice we could take them out through suspect without having to go through confirmed and we had a sort of a shower cubicle outside of suspect, well not outside, outside the ward, but still within the high risk zone where we could wash them down before taking them out and it was basically out the triage exit and we tried to keep that area sprayed clean with chlorine all the time if someone had come through there. If there were any spills [of bodily fluid] we treated them with chlorine and absorbing matters, we were following MSF protocols.

Laura's description indicates the importance of movement in the conception of treatment centres and units and the spatialisation of the possibility of always-imminent death. As with green, orange and red zones, the flow established in the refurbished hospital in which Laura worked, worked to confine the possibility of death to certain spaces. These spaces overlapped with the confirmed or suspect zones or wards, whose demarcation was based

on Ebola as condition. Simultaneously the passages from zones in which death was imminent and those where it became more distant were clearly marked and demarcated through practice and materials. The patients' proximity to death is regulated and enacted through their movement through the treatment centre. Chlorine kept the exit from the suspect area clean from bodily spills. She continued:

> If a patient was deceased their body was decontaminated with chlorine and then they were placed in a wrap and then in a heavy duty body bag although we didn't have those at the beginning in [hospital 1], they weren't available for a bit of time but we would decontaminate them, wrap them in this sort of shroud, and then put them in the heavy duty body bag, or some form of plastic body bag and carry them out to the morgue.

A shroud, heavy duty or plastic body bag were the materials used to confine and demarcate death. Here, IPC measures extend beyond the death of a patient. Given that Ebola patients are most infectious at the time of and shortly after their death, the patient's dead body is subjected to similar spatial and mobile constrains as the patient was in life. If anything, those constrains are intensified materially and spatially to ensure the reduction of risk of infection. The dead body leaves the realm of always-imminent death but not through the same exits or routes taken by those living. Again, I argue that in the spatial dynamics of IPC, the possibility of always-imminent death is enacted spatially and reinforces a colonial-racial hierarchy in which Black life is tethered ever more closely to the possibility of always-imminent death.

In some instances, this link between movement and death or life was enacted nominally too. Describing the flow system, Tom stated the following:

> Tom: So the flow from clean to dirty or what is sometimes called green to red zone. So creating a flow, which means that you need normally free doorways you know free entry points, so one is an entry for staff from the clean zone, one is an exit for staff from the patient area and one is a dirty exit which is where either corpses or Ebola positive patients come out of.
>
> Lioba: And it's called dirty exit?
>
> Tom: Ahm no I guess that's in my head. In my head you got a clean exit and a dirty exit.

Tom's description both speaks to the importance of regimented flows through an ETC or EHU for general safety and reveals how safety from infection was linked to the built environment. In order for Ebola care to take place in a safe environment (in other words to guard carers against the possibility of Ebola death), movement through that environment had to be carefully planned and the environment at times adjusted by freeing

doorways or changing the layout of existing wards. His account also speaks to the way in which movement through the treatment centre or holding unit marked patients and staff as distinct groups. Ebola's contagiousness led to the segregation and directionality of movements. Patients moved through the treatment centre or unit in ways that were different from staff. At the same time, the directionality of movements was also imbued with meaning. Tom's description "the flow from clean to dirty" resonates with Laura's description of the unidirectionality of flows. In both instances the further a patient or member of staff moved along established flows through the treatment unit, the closer they came to the realm of always-imminent death. As a consequence, these differentiated movements enacted Ebola as contagious and deathly possibility.

Tom also reveals how the movements through various exits marked individuals not only as patient or staff, but as moving through and temporarily inhabiting clean and dirty zones and exits. His admission "In my head you got a clean exit and a dirty exit" indicates how space and movement in EHUs and ETCs are themselves imbued with meaning even if that meaning was, for Tom, somewhat divorced of negativity. He seemed surprised when I asked him to clarify whether "dirty exit" was the official name for it, whereas I was surprised by his choice of words.

As Tom's and Laura's accounts show movement and flow were imbued with meaning and signalled one's proximity to the realm of always-imminent death. Simultaneously flows could also be life-affirming. Laura explained the procedure of discharging patients who had tested negative twice:

> If we were going in that day, we wouldn't check on any other patient, we'd go straight to the patient we were discharging so we hadn't contaminated ourselves and then discharge them and then discharge another if there was more than one and then dress them in clean clothes that we'd also brought in with us.

Here, changes in flow and material signal survival. The usual flow is interrupted to protect the life of the patient who is about to be discharged. Clean clothes are brought in from the green or clean zone to signal the patient's imminent passage back to life. At the same time her statement "so we hadn't contaminated ourselves" indicates the high risk of infection and the careful spatial and practical planning that characterised Ebola care and made it sustainable.

Ebola care was not only subjected to spatial flows and zones, but also to temporal ones. The flows throughout the wards, from suspect to confirmed patients, had to be carried out

in full PPE, as lighter PPE and scrubs were only allowed in the green zones. Due to local weather conditions this limited the time that staff could spend on rounds through the ETC or EHU. Time spent attending to patients in the confirmed ward varied from treatment centre to treatment centre but interviewees reported they would on average spend between one and three hours in the red zone in full PPE. Jack and Hector, two British doctors who both worked in purpose-built facilities stated that they spent between 45 minutes and one hour in the red zone on each round (Jack, 2017; Hector, 2017). In Laura's case this was different. She stated:

> We had the white suits at the beginning and we weren't supposed to be in for longer than an hour and a half in the white suits. Then we became increasingly concerned by the white suits […] so then we moved to the yellow suits and then we said you shouldn't be in for longer than an hour. But I think I was probably in a white suit at one point for just under three hours and I was probably in a yellow suit for at least two if not more hours.

PPE in conjunction with the weather conditions in which Ebola care was practiced contributed to determining the temporal rhythms of Ebola care. This has implications for how care was given and what responders felt they were able to do without putting themselves at risk. Laura and her team moved from lighter white suits to heavier yellow suits, which decreased the time they were able to actively care for patients on the confirmed ward. Anne, a British nurse who worked as the medical lead in two ETCs, described the implications of spatial and temporal regiments for Ebola care:

> The care that you would give people in terms of frequency of cleaning them isn't what you would want ideally because people would just be cleaned like when you went in and not in between […]. I remember once there was a young girl and just as we had to leave the red zone cause our time was up and it was like a hot day she fell onto the floor, but we couldn't really stay to help her back on, so she just had to stay there until the next people went in.

Anne's regret at the altered standard of care and her team's decision to leave the girl lying on the floor does not negate the reality of violence and care and care as violence that characterised aspects of working in Ebola treatment centres and that Sharpe's (2016) work is about. Anne's quote also brings my discussion of spatial and temporal flows back to care in the wake. Her story indicates how, for clinical staff, Ebola was enacted in the realm of always-imminent death and how care with violence became part of medical practice.

In this section I have analysed how care practices enacted Ebola as two distinct realities: status and process. These two realities together with the high risk of infection shaped the spatiality of ETCs and EHUs and the ways in which international health care workers managed 'the possibility of always-imminent death' (Sharpe, 2016). As in previous chapters, the colonial-racial dynamics that shaped the Ebola epidemic and response materialised in differentiated movements and access to spaces, resulting in diminished chances of infection for (white) international staff in comparison to (Black) Sierra Leonean patients.

8.3.2 Care and (shared) risk

An antidote to care as violence, which I have discussed in the first part of this chapter, is, Sharpe (2016, 2018) argues, care as sharing risk. In her work sharing risk in the face of structural and epistemic violence constitutes an emotional and practical act of care. As I will show here, sharing risk became important during the Sierra Leonean Ebola epidemic and the organisation of its response. Focussing on shared risk as an element of care enables an analysis of care practice that is aware of and acts in spite of the possibility of imminent death, which I have discussed in the previous section. And it is this awareness coupled with the awareness of the wake and Black death repeating itself that Sharpe (2016) opposes to care's entanglements with violence. In the interviews that I conducted, awareness of the possibility of imminent death was widespread. As I have shown in the previous chapter, awareness around the repetition of the wake was however largely epigrammatic.

My research suggests the following: Caring for Ebola patients, who effectively lived with the possibility of always-imminent death, meant embracing an element of shared risk however the level of risk depended on the treatment centre or holding unit that international responders worked in. First, I analyse how responders perceived risk to be distributed along medical and postcolonial hierarchies and how they shielded themselves against it. Then I turn to analyse the narration of sharing risk by one international responder, Layla, a white South African doctor who worked in Hospital X, in depth.

Effectively risk was not shared equally and was distributed along medical and postcolonial hierarchies. When medical responders spoke about their decision to travel to Sierra Leone and work on the Ebola epidemic, the risk they referred to mostly represented their own risk of infection, rather than someone else's risk. While some risks were shared with Sierra Leonean Ebola patients (risk of infection, risk of quarantine and ultimately,

risk of death), working in a (purpose-built) international treatment centre mitigated these risks considerably. Jack, a British paediatrician who worked in an international purpose-built facility in Sierra Leone, confirmed this:

> We knew that in practice the people who were getting infected were non-health care workers caring for family, were health care workers doing out of hospital work, were healthcare workers in government healthcare facilities, you know that. Actually, people working in international facilities were generally not getting infected.

James, who worked at Hospital X spoke to how risk was shared or not shared in his EHU:

> A very legitimate point a lot of Sierra Leonean medical colleagues made was that I was likely to be medevaced. Officially the British government told me we would not be medevaced, explicitly we would not be, but we kind of thought that we might be. But we knew Sierra Leonean colleagues wouldn't and we knew what the outcomes would be for them, so...and as much as we were facing - we were in the same PPE as our colleagues - and we were facing the same risk and it's a pretty deadly disease whether you are medevaced or not, the fact that we knew we'd be medevaced, was you know...

James' account reveals the postcolonial hierarchies at work during the response and his awareness of them. His discussion of facing, yet not quite facing, the same risk as his Sierra Leonean medical colleagues speaks to their respective proximity to the possibility of infection and of death inside the EHU. James, who was relatively certain that him and his British colleagues would be medevaced could navigate the risk of death differently than his Sierra Leonean colleagues. While the message in James's statement is clear, James finds himself unable to articulate the deadly consequences this colonial-racial inequality could have. He trails off and does not finish his sentence instead finishing with "you know…".

Jack, spoke to how risk was distributed along medical hierarchies:

> We also went out with lots of paramedics and the paramedics, were terrific and by far my favourite staff group to have in the response. […] They're much more used to dealing with personal risk, you know they're out in the community dealing with risk all the time, whereas we're [doctors] all ensconced in hospitals where we manage that much more effectively.

Jack's comment indicates that different medical staff groups handled the risks involved in participating in the Ebola response in different ways. His statement about paramedics "They're much more used to dealing with personal risk" and his subsequent comparison to doctors and their relationship to risk ("we manage that much more effectively") also

indicates that care practices outside of a traditional hospital setting seemed to him more risk-prone in comparison to care practices occurring in hospitals, where he had experience working as a doctor. Here, spatial settings are differently imbued with risks. In a hospital, according to Jack, risks can be navigated more effectively than in the public, where the paramedics he encountered worked.

Ruba, Organisation X's Ebola response manager, also spoke to the association between the care practices needed in the international response and different staff groups. Her statement placed a heavy emphasis on the necessity for care, as opposed to other work:

> There was a higher demand for nurses because there was no cure for Ebola and a lot of the work around Ebola was around cleaning, feeding, changing bed covers […] So sending doctors was quite problematic, because […] they're not trained in how to care for people.

Together Ruba and Jack's comments emphasised that the work needed in Ebola Treatment Units was care work, that the risk of infection was high and that specific staff groups, such as paramedics and nurses, were traditionally associated with carrying out these types of work. More importantly this risk was especially high outside of international, purpose-built ETCs and EHUs. Overall risk seemed to operate along medical, spatial and postcolonial hierarchies and was distributed unequally among people involved in the response.

I now turn to my analysis of care as shared risk. The hierarchical dynamics I described above were somewhat lessened at Hospital X on which I focus in my subsequent analysis. Among the people I interviewed who worked at Hospital X, the hierarchies around care work that usually permeate medical practice were broken down. Gareth, a Welsh infectious disease specialist who went out to work in Hospital X, described the sharing of tasks (and risk) in the Ebola Holding Unit of Hospital X:

> One person would be assessing patients for their suitability to be admitted to the unit, someone else would be going to the unit to make sure the people inside were ok, someone would be dealing with discharges, there was cleaning and cleaning of the patients and the room and dealing with dead bodies and administration of drugs, so all those tasks were split up between whoever was on the shift. […], when you were working in the unit everyone was considered the same level […].

The Ebola Holding Unit of Hospital X thus became a place in which medical hierarchies were, to a large degree, suspended. The practices described by Gareth (cleaning bodies, administering drugs, cleaning the room) were practices of medical care shared by other

doctors and nurses working in Hospital X. At the same time, Hospital X was not a purpose-built facility. As I will show in more detail in the following paragraphs, the spatial and resource constraints of Hospital X considerably increased risks of infection. Here the flattening of medical hierarchies was accompanied by a heightened possibility of death for international and national staff in comparison to purpose-built facilities. Nevertheless, as James pointed out above, for his Sierra Leonean colleagues the risk of working with Ebola patients continued to be higher.

I now turn to Layla, a white South African doctor I quoted in chapter five who worked in the EHU at Hospital X during the response. I use her narration to analyse how a specific incident at Hospital X manifested as 'care as shared risk' (Sharpe, 2016) and how she conjured the possibility of imminent-death by talking about the materials her care practice relied on. Layla told me about an incident she had when administering the drug diazepam intravenously in the EHU of Hospital X. Diazepam, more commonly known as Valium, is a drug that when administered at a low dosage, produces a calming effect, often used to treat anxiety, and when administered at a higher dosage puts patients to sleep (ASHP & SCCM, 2002). The onset of Diazepam's calming qualities differs depending on the way it is being administered. Through oral administration, the effects materialise between 20 and 40 minutes (Dym & Ogle, 2011). When administered intravenously (through an IV) the medication takes effect between two to five minutes (ASHP & SCCM, 2002). This information is important when analysing the incident that Layla recounted. Speaking about the atmosphere in the Ebola Treatment Unit and patients' fears, she told me how she injured herself in the red zone, the area of Hospital X that comprises the EHU, which is the most infectious area of the hospital:

> It was a difficult choice where one of my patients was very unwell and quite delirious and agitated and so what you want to do for the individual patient is sedate them so they can be more relaxed. […] You want them to calm down and so what I wanted to do is give him some diazepam, but obviously with every additional intervention that you introduce into that red zone you put yourself at additional risk. But I had decided that it made sense and we had those little plastic things to open the vials with, but because the quality of the vials we got were quite poor, the distribution of the plastic, or actually of the glass across the vial was suboptimal and two people before me had gotten this same injury in the red zone. So I broke off the cap and the cap itself was very thick and even though I used all the right protective gear, the vial itself crushed in my fingers and went through three pairs of gloves and pierced my finger in the red zone.

Layla's account is rich in materiality and suggestive of a few things. Layla, like the other responders I quoted, spoke about risk, although she linked it more directly to medical practice and specifically to caring for her patient. Her statement shows that it is her patient's state of agitation and ill health that motivates her to act. Her decision to administer the medication intravenously can be interpreted as, on the one hand signifying a high level of care, due to the much faster onset of Diazepam's calming effects, or on the other hand could be conditioned by the progress the disease had made in the patient, rendering him "unwell", "quite delirious" and "agitated" which possibly meant he was not able to swallow the medication, when administered orally. Thus the patient and the patient's body and mental state shape and motivate Layla's practice. Her next words "[…] obviously with every additional intervention that you introduce into that red zone you put yourself at additional risk" show that Layla was well aware that calming her patient and making him feel "more relaxed" directly increased her risk of exposure as does her admission "But I had decided that it made sense". Similarly to Sharpe's (2016) accounts of shared risk, Layla cared for her patient in an environment in which care came with increased risks and took the risk of infection to ease her patient's suffering.

Layla's description of how the injury itself occurred is suggestive of the ontopolitics of Ebola care (and the concomitant risk) in Hospital X during the outbreak. In her account risk of infection is enacted through the practice of opening a vial containing diazepam. It materialises through low quality materials, the precedence of the occurrence of this injury linked to the particular practice of opening this type of vial and the protective measure of wearing three pairs of gloves to protect oneself against infection.

As in Mol's (2002) account of atherosclerosis, Ebola is never one thing, but rather appears in materials and practices. The way Layla speaks about the incident indicates that the quality of the materials in use did not compare to the standard of materials in medical practice that she was used to. While Mol's (2002) writings on the multiple ontologies of atherosclerosis take an in depth look at the materiality of medical practice, the tensions she describes, arise from a multiplicity of materials and practices and the realities they produce, not from low quality materials as is the case in Hospital X. Similarly, Layla's description of the vial's shards piercing through three pairs of gloves speaks to the specificity of medical practices during an Ebola response. The additional material barrier between the Ebola Virus and a yet uncontaminated organism that is provided by two extra pairs of gloves enacts Ebola as highly infectious, but also points to the disease's exceptional nature, which requires material distance through improvised barriers. The risk of infection is not only the result of the virus, but results from the structural and

material contexts of postcolonial Sierra Leone. Hence, risk is here enacted as something that is close by, ubiquitous and against which the body of the doctor should ideally be 'ensconced'.

Layla continued to speak about this experience by linking it to the broader context of working in, what she called, "a makeshift unit", as opposed to a purpose-built facility:

> We hadn't checked before we started to make sure the correct concentration of chlorine was available where it should be and it wasn't and so what you should do in that scenario is immediately submerge your hand into the chlorine, but we had to first mix it up, we couldn't find the things… we tried to work with the hospital management and the supply so like soap [laughs] and gloves and just simple basic things like that […] so the hospital would get supplies from like a national [centre], I can't remember what they're called, it is part of the government and they would disperse like medications or whatever. So there were all these delays and you know of that particular injury, the two people who'd been exposed before me one had got Ebola and one hadn't and so, like yeah that could have happened in any of the other units, but also working in a makeshift unit, where everything isn't working as perfect as you would want it means you're at higher risk of those kinds of things happening.

Layla's continued description of this incident further reveals the materiality of Ebola care in an emergency setting. Chlorine, which, as I have written in chapter five, was at times perceived as deadly by members of the community, is here in its concentrated and liquid form in a bucket in the red zone of Hospital X, a sought after remedy. At the same time, its remedying characteristics, as Layla describes, depend on the correct concentration and placement of chlorine and its availability in the correct location. In Layla's account, the risk of infection, the unavailability of materials and the low quality of tools all contribute to making the possibility of infection and death from infection more probable. In the red zone, Sharpe's (2016) 'possibility of always-imminent death' is spatialised.

Layla also makes an important point about the spatial arrangements in which her care, and the Ebola care of Hospital X took place. Her analysis of the incident ("that could have happened in any of the other units, but also working in a makeshift unit, where everything isn't working as perfect as you would want it") places her comments on the absence of correctly mixed chlorine and low quality vials in a political context. One of the reasons the risks of working in Hospital X, a government hospital, were higher was because of the lower quality of materials available from local supply chains. Miki, one of the British IPC nurses working at Hospital X and I had the following exchange with regards to Hospital X's supply chains:

> Lioba: How did you try to make your work sustainable?
>
> Miki: We tried to work with the hospital management and the supply [centre], so [for] like soap and gloves and just simple basic things like that […] the hospital would get supplies from like a national [centre], it is part of the government, and they would disperse medications […].

The process that Miki describes here differs from the supply chains that purpose-built ETCs relied on. Cormack, who worked in a newly-constructed, purpose-built treatment centre stated: "When I was there at [ETC], everything all the stuff was there supplied by the UK government, everything. Most of the medicines, generators, the staff cards all paid for by the UK government." Miki's description of Hospital X's supply chain together with Layla's description of materials and conditions in the hospital's EHU indicates the reality of care work in Sierra Leonean hospitals as not working "as perfect[ly] as you would want". The reality of shared risk in Hospital X materialised in low quality vials and momentary unavailability of correctly mixed chlorine concentrations. For Layla, the decision to take on these added risks and work in a makeshift environment was a political one. She finished the description of her near-exposure as follows:

> It was ideologically feeling like this [working in a pre-existing unit] is definitely the best way to do [it], to respond without a doubt, I didn't support the model that a lot of other NGOs were engaging in [temporary purpose-built facilities] for all kinds of reasons but also at the very same time, what felt to me like the additional personal risk was also not nothing. I mean when it happened, when stuff went wrong everybody stuck together and it was a fantastic team [...]

Layla closes the analysis of her near-exposure and links her acceptance of shared risk to the environment in which she chose to work and care for Ebola patients. She also justifies her decision by clearly opposing the less risky model of working in a purpose-built facility Here, as in Sharpe (2016), shared risk or as Layla put it "additional personal risk" become a political act of caring for Black life in the wake of colonialism. Layla stated:

> [The experience] certainly made me think about global health and like neo-colonial agendas of global health in a very different way to how I had before even though that was always a big question for me […].

In Layla's account, awareness of neo-colonialism and its implications for global health shape her care practice and influence her theorisation and acceptance of shared risks. For her, shared risk was a political decision, which largely depended on the organisation and infrastructure available in Hospital X. Here, I offer her account as one possible kind of care; an answer to Sharpe's (2016, p.35) question on how to care for 'lives consigned to

the possibility of always-imminent death' in the midst of the Sierra Leonean Ebola epidemic.

8.4 Conclusion

In this chapter I have attended to thinking and practicing care in the midst of the 2014-16 Ebola epidemic in Sierra Leone. Building on Sharpe's (2016, 2018) work I have undertaken epistemological and ontological explorations of care. Specifically I have argued that the reality of the wake manifests in an entanglement of care and violence, and that this conflation became relevant during the Ebola response. Drawing on Sharpe's (2016) concept of care as violence I have shown that, in the case of Sierra Leone, care has indeed been violence. By bringing her conceptualisation of care in relation with international responders' narrations of the Ebola response, I have argued that care in the wake needs to include an awareness of its historical entanglement with antiblackness and of the hold experiences of this conflation had on care recipients in postcolonial Sierra Leone during the epidemic. The inability or unwillingness to recognise that the Ebola response took place in the wake of colonialism, together with the widespread inability to think the response and Sierra Leonean communities outside of the (post-)colonial constrains that hold them, is, I have argued, a sign of being in the wake. In the second part of this chapter I have extended Sharpe's (2016, 2018) work by analysing care practices, risks and the way in which international responders managed the possibility of death spatially and in material practice. By demonstrating how Ebola was enacted spatially and materially, I have also shown that, although antiblackness remained epigrammatic in conversations with international responders, IPC practices reinforced colonial-racial dynamics of placing Black life ever more firmly in the realm of always imminent death and that care as shared risk can counter the continued violence of the colonial wake. Overall, I argue that to interrupt (post-)colonial dependencies, care practices during the Ebola response could go beyond traditional medical care, such as dispensing medicine, cleaning and feeding patients, to include a political awareness of the entanglement of care and violence and the spatial reproduction of the possibility of death as immanent to Blackness.

chapter NINE

9 Conclusion

In this thesis I have analysed antiblackness in global health. Using a multi-sited, non-linear methodology, I have placed the 2014-15 British-led international Ebola response in Sierra Leone in the wake of colonialism and antiblack violence. Drawing on Black studies and on Christina Sharpe's (2016, 2018) work in particular I have set out to offer an account of the historical and contemporary environment in which the Ebola epidemic and response took place. My focus has been on the various epistemic and ontological forms the colonial wake takes in relation to infectious disease control in Sierra Leone and on the location, production and marginalisation of antiblackness in global health. At the beginning of this thesis I set out to answer the following research questions:

- Where and how might it be possible to locate 'the wake' in the Ebola response?

- How does the British-led international Ebola response relate to the colonial past and present?

- How might global health interventions benefit from an engagement with Black studies?

The answers to these questions are complex and difficult to synthesise. I provide short answers here before elaborating and expanding on them in various ways as I discuss the main findings and contributions in the following sections.

- Where and how might it be possible to locate 'the wake' in the Ebola response?

The wake can be located spatially, epistemically and in practice in many different locations and in the in-between places and mobilities that connect Sierra Leone and the UK: the transatlantic, Freetown and the Freetown Peninsula, archives of colonial infectious disease control in the UK and others. In this thesis I have located the wake outside of its conventional American geography to argue that in and in relation to postcolonial Africa the wake takes specific spatial, epistemic and atmospheric forms that influenced the British-led Ebola response in Sierra Leone. I have undertaken this act of locating the wake by relying on multiple methods, moving between different places and

between the past and the present. To show the simultaneous ubiquity and inconspicuousness of the wake I have argued that studying the wake requires an awareness of the hold that past antiblack violence has on the present. This awareness, as I have shown, varied depending on respondents' positionality and their experience and/or knowledge of the colonial and antiblack entanglements that characterise Britain's involvement in Sierra Leone.

- How does the British-led international Ebola response relate to the colonial past and present?

Despite a number of important differences, the colonial past was entangled in the international Ebola response in Sierra Leone to varying degrees of conspicuousness. As I have shown, nominal independence did not disrupt the dependency and power differential that characterised British-Sierra Leonean relations. Rather the British-led Ebola epidemic reproduced some of the colonial-racial dynamics that characterised formal British rule over Sierra Leone and thereby contributed to the colonial present. As I have suggested, the past surfaced in colonial infrastructures, hauntings and affective atmospheres around places of care and contributed to local communities' distrust towards foreign healthcare workers and biomedical practices. Sharpe's concept of the wake constituted an important lens which allowed me to think through and highlight the continuities, similarities and disruptions between the colonial past and present with a special focus on medical care related knowledge, mobilities and practices.

- How might global health interventions benefit from an engagement with Black studies?

Black studies enable a focus on the structuring and pervasive power of antiblackness and its hold on Black and white life in the wake. Black studies explicitly challenge how we study antiblackness and offer approaches to locating and foregrounding it in silences and the margins to which it has often been relegated. Here I have used Black studies to think about how (medical) care and antiblackness have been and continue to be entangled in global health. Rather than focusing on individual racism or prejudices, Black studies add an important lens to the study of global health interventions, which challenges the (a)political stance of global health and medicine and examines the continuing prevalence of its own colonial and antiblack past. Specifically this allows for a broadening of

perspectives and a re-centring of issues of colonialism and antiblackness in contemporary analyses of global health interventions, both of which were, in my research, largely epigrammatic.

In the following sections I summarise my research findings and contributions and restate how this thesis contributes to existing fields of literature. I discuss my findings and reiterate the originality of my research project and methodology and close by considering avenues for further exploration that this project suggests.

9.1 Research findings and contributions

In this thesis I have shown that the wake is a geographical and epistemic reality in which Blackness is produced as dependency, deviance and ontological negation while antiblackness is marginalised. Located at the intersection of Black studies and Black geographies, critical global health and postcolonial geographies, this thesis contributes to a variety of academic fields both conceptually and methodologically. Here I start by reviewing my conceptual findings in relation to the research questions before discussing the methodological ones.

In this thesis I started from the premise that placing the Ebola response in the wake could reveal colonial legacies and the structuring power of antiblack violence in the present. I developed three main strands of argumentation throughout my analysis of the British-led international Ebola response in Sierra Leone. Firstly, that the wake is ubiquitous and that it manifests as a geographical and epistemic reality. Secondly that antiblackness, which I have, following Sharpe (2016), identified as a key marker of being in the wake, is deeply entangled in global health and that it was simultaneously marginalised and reproduced in the Ebola epidemic and response. And thirdly that an analysis of the Ebola response that highlights both the wake and the antiblackness which underlies global health interventions in formerly colonised societies can contribute to critical analyses of the politics that shape medical practices and global health in particular.

The wake as geographical reality

The analysis of the wake that I have undertaken in this thesis, especially in chapters five and six, introduced a Black geographical focus on geographies of antiblack violence and their normalisation to the study of postcolonial Sierra Leone. While violence and spatial

practices to navigate it are recurring themes in analyses of Sierra Leone (Ferme, 2001; Shaw, 2002; Richards, 2008), to date no analysis has approached health in Sierra Leone through the prism of Black studies or geographies. My thesis has contributed to remedying this omission in that I have actively foregrounded how antiblack violence has shaped health practices and medical care in Sierra Leone historically and how this history influenced the British-led Ebola response.

Black studies and geographies, while putting a heavy emphasis on antiblack violence and place, have largely limited their analyses to the violence of the transatlantic slave trade and the prison-industrial complex in the US and the Black diaspora in North America, the Caribbean and Europe (McKittrick, 2006; Bressey, 2011; Shabazz, 2015; Sharpe, 2016, 2018). In this thesis I have argued that in postcolonial Africa the wake constitutes a specific geographical reality and that the Sierra Leonean Ebola epidemic and international response took place in its midst. Sierra Leone, and the Freetown Peninsula in particular, are, as I have shown, places in which the remains of colonialism and the transatlantic slave trade take spatial, material and atmospheric form. These remains, I have suggested, are particularly relevant to an analysis of the Ebola response because they endure in places of and in relation to medical care practice, for instance in the site of Connaught Hospital/King's Yard Gate. I have analysed the latter as both a modern place of care, which came to play an important role during the Ebola epidemic and a marker of the transition from enslavement to (partial) liberation. In this spatial and ontological transition, as I have explained, care was and continues to be framed as British philanthropy and as medical examinations and potential quarantines to protect the health of the newly established colony. In this place, knowledge of antiblackness both wove its way through care in the continuation of indentured labour that liberated slaves were subjected to and is thoroughly silenced, in the negation of Britain's role in the slave trade and the continued legality of slavery as an institution, which continued to be upheld in British colonies until 1833.

Importantly, I have argued that the wake is not restricted to Sierra Leone. My spatial analysis of the wake extended from the Freetown Peninsula to the mobilities, traversing the Atlantic Ocean, linking Sierra Leone and the UK historically and during the Ebola response. It encompassed meetings in British learned societies and manifested in British archives of colonial disease control. In this thesis I have shown that the colonial wake manifests and is reproduced in the (spatial) relations between Sierra Leone and the UK. I have contributed to an understanding of the colonial present that exceeds the geographic boundaries of formerly colonised countries; a present that is produced and

negotiated in the in-between spaces, the transatlantic, and the racialisation of mobilities linking the UK and Sierra Leone. In the historical and contemporary mobilities linking the two countries, Blackness is (re)produced as dependency, as deviance and, in the case of the Ebola epidemic, as the possibility of death. This possibility of death was, as I have shown, spatially confined in treatment centres during the Ebola response. While this is standard IPC practice, the racial dynamics of the Ebola response mirrored colonial mobility dynamics in that white mobility (in treatment centres and globally) was encouraged, whereas Black mobility was restricted.

However, there is a hopeful counter-current in diasporic mobilities, which, while still centred on the UK, produce Sierra Leone as a place of economic opportunity. Diasporic demands for the reinstating of direct flights connecting Sierra Leone and the UK were, and continue to be, addressed to the UK. However, these demands are used to develop and sustain self-determined mobile lives. As I have argued here mobilities, both forced and self-determined, are inherent to Black modern mobile ontologies. Here I have contributed a Black and postcolonial reading of mobilities. While mobility studies increasingly take Black and postcolonial realities into account (Adey, 2010; Sheller, 2012, 2016, 2018; Nicholson & Sheller, 2016; Nicholson, 2016), I have here suggested that mobilities not only reproduce antiblack and colonial dynamics (by encouraging white and discouraging Black mobility), but that they contribute to the production of antiblackness in the colonial wake. I have shown in this thesis that during the Ebola epidemic and response the regulation of mobilities emulated racialised regulations of international travel during the British Empire and have argued that these similarities were a further sign of being in the wake.

The Black geographical focus that I have brought to the study of infectious disease control highlights the colonial continuities that characterise the Ebola response in the wake. Here the wake also takes more mundane forms than it does in Sharpe's writing, for instance in signs and street names, in the spatial coincidence between medical care and the incomplete transition from slavery to liberation. Antiblackness here manifests as the continued production of Black African dependency on the UK in terms of mobilities and the infrastructures they rely on.

Antiblackness and colonialism are marginalised and normalised in global health and in the Ebola response

A second thread that I have woven through this thesis is the epistemic marginalisation and geographical normalisation of antiblackness. This issue has been addressed in anthropology and Black studies (Benton, 2016a, 2016b; Sharpe, 2016; Vargas, 2018) but not in the field of global health. In this thesis I have researched how the historical fact of antiblackness was navigated and negotiated by British health responders and experts during Britain's colonisation of Sierra Leone and during/in the aftermath of the 2014-15 Ebola response. This, I have argued, is an important contribution to Black studies, in that it extended existing analyses of the marginalisation of antiblackness to include global health practice and recognised colonial medicine as an important site for the study of antiblackness. It is also an important contribution to the field of global health in that it shows how antiblackness underlies global health practice. This is especially important given the colonial origins of global health practice and the medical racism that characterised early health interventions in West Africa.

I have contributed to Adia Benton's (2016b) conceptualisation of the 'epigrammatic' nature of race in development interventions by positing that during the Ebola epidemic colonialism was side-lined, silenced and marginalised. As I have shown, this was certainly the case in interviews with international responders and transpired during expert events that I attended. At the same time interviewees also attested to the presence of British remains in Sierra Leone (such as Union Jacks on houses and cars) or renewed calls for British colonisation at the height of the Ebola epidemic, when it seemed as if the national response would fail. What interviewees described was the political reality of the colonial wake. Despite this awareness however, the colonial continuities of the British-led international Ebola response, the reality that the Ebola epidemic took place in the wake and that the way in which the response played out exacerbated (post-)colonial dependencies were not thought of by global health experts and practitioners. This is not a testament of individual shortcomings, but rather a testament to global health's apolitical self-perception/stance. This apolitical stance has seldom been challenged with regards to antiblackness. Singh et al. (2014) offer a rare and critical account of antiblackness in AIDS expertise and medical management. Here my thesis contributes to the small but critical pool of writings on antiblackness in global health. As Singh et al. (2014) do, I argue that in global health antiblackness is hidden in plain sight. On the one hand, as I have shown, antiblackness characterised and shaped the slave trade and colonialism, two

periods in which the spread of disease through Black people and in Black spaces became an issue of imperial (that is to say global) importance. On the other hand, this historical entanglement of the development of global health and the antiblackness that shaped these periods politically, epistemically and socially still underlies global health today. In other words, contemporary global health is in the wake of antiblackness.

Colonial infrastructures endure and shape global health in the wake

My thesis also contributed to writings on (post-)colonial infrastructures. Specifically I argued that the Ebola response and knowledge on infectious disease control in Sierra Leone relied on colonial infrastructures. In my thesis these infrastructures were material, epistemic and human. I started out with an analysis of material infrastructures and their colonial entanglements. With the examples of Connaught Hospital and Freetown's Lungi airport I showed that material infrastructures were essential to the international Ebola response, that they were built during colonial times and that their history was entangled with antiblackness and colonial future-making. I then argued that the racial segregation in treatment centres and the aeromobile dependency on UK infrastructures (in the form of airlines, staff and a British-built airport) which originated under British colonialism resurfaced throughout the Ebola epidemic and response.

Drawing on Simone's (2004) 'people as infrastructures', I argued that people can constitute colonial infrastructures. Specifically I drew out similarities between colonial and contemporary health experts in terms of their mobilities and the continued epistemic dependency on the UK that characterises health management in Sierra Leone. Under British colonisation, infectious disease outbreaks required health expertise to be summoned from England in the form of tropical health experts. The Ebola response similarly required the mobilisation of hundreds of health experts from the UK to Sierra Leone. As I have shown, British-based experts were actively involved in the management and evaluation of the international Ebola response in West Africa and their accounts largely marginalised antiblackness and attested to the unwillingness or inability to think the colonial wake and to think West Africa outside of colonial relations of dependency. Again, however the Sierra Leonean diaspora complicates this account and presents a counterweight to these colonial continuities. While their status as experts depended largely on their location in the UK, their quotidian mobilities to Sierra Leone were interrupted by a breakdown in aeromobile infrastructures. At the same time the diaspora played an essential role in translating biomedical knowledge to their friends and families

in Sierra Leone and of Sierra Leonean norms and values to biomedical responders in the UK. As such they constituted an important instance of people-as-infrastructure on which the Ebola response relied. In the case of the diaspora, epistemic hierarchies work along colonial lines but also subvert them.

I argued that a similar dependency characterises Sierra Leone's aeromobilities, which still to a large extent depend on British expertise in the form of British security experts. I have shown that expertise is embodied and constitutes human and epistemic infrastructures, which contributed to the effective management of the Ebola epidemic and which ensure Sierra Leone's aeromobile connections to the world. The interplay of material, human and epistemic infrastructures, I have shown enacts the colonial wake, not just in Sierra Leone but in Sierra Leonean power relations. Other accounts, such as Paul Richards' (2016) analysis of the Sierra Leonean response offer an important counter-narrative to my analysis of the Ebola response in the wake. I argue however, that valuable as it is, a focus on local and informal responses to the epidemic, obscures the colonial power dynamics still at stake in global health management, which I have sought to foreground in this thesis.

Finally, I drew attention to one last form of infrastructure, which I refer to as epistemic infrastructure. These were both embodied and material and took the form of 'people-as-epistemic-infrastructure' in the form of the Sierra Leonean diaspora and healthcare workers, but also archives. Black women's approaches to archival work (Bressey, 2006, 2014; Robinson, 2017; Farmer, 2018), while honing in on the careful work that is required to uncover Black histories in archives that have predominantly recorded white history, have so far not focused directly on how archival spaces themselves take part in reproducing antiblackness. Archives, I have argued constitute two forms of infrastructure: the space of the archive is material; its doors and walls granting and regulating access to the archives within, which, while largely contained in material form in books, papers documents, CDs, etc. is also abstract in that the knowledge contained within circulates independently of the materials that hold them. Throughout this thesis I have drawn on archives of colonial British disease control. I have analysed both the antiblackness contained within these documents and the ways in which the archival space, an epistemic infrastructure in and of itself, allows the reproduction of such antiblackness.

Politicising practices of care

Throughout this thesis I have argued that in order to disrupt the colonial and antiblack continuities that make and shape the wake, understandings of medical care need to exceed clinical care practices. Following on in that logic I have adopted an understanding of care that takes care's political entanglements into account. I have argued that this is particularly important in the study of Black life. As such, this thesis has dealt with various interpretations and realities of care. The historical and spatial entanglements of care and antiblack violence and care's uses as violence, I have argued, were marginalised in the Ebola response. For most responders, care was conceived as modified clinical care, subject to IPC regulations and safeguards. This is in line with medicine and global health's self-conception as distinct from politics. Technically, to save lives in ETCs and EHUs, medical responders did not need to know of the wake. Even without their knowledge however, the spatial reality of IPC and medical care in ETCs and EHUs enacted Ebola and Ebola patients as the possibility of always-imminent death (Sharpe, 2016) along colonial-racial lines. Here, the spatial management of IPC reinforced the conflation of Blackness and the possibility of death.

Very few responders had an awareness of care as violence and consequently could not include this in their approach to the response. However, as I have suggested, knowing of care's coincidence and conflation with violence, placing the response in the wake of such violence, could have changed the response and addressed urgent issues of community distrust. Postcolonial and feminist approaches to geographies of care (Lawson, 2008; Raghuram et al., 2009; Raghuram, 2009; Bartos, 2018) while paying attention to the transnational and gendered power dynamics inherent in care work, neglect a focus on spaces and places of care and how care as violence might be present in these spaces. Here I have contributed to place-based analyses of care work in formerly colonised societies (Street, 2012) that highlight the manner in which colonial-racial dynamics work their way through hospitals and treatment centres and shape these places in the colonial present.

Sharpe's (2016) call to see care differently, to extend its meaning and to infuse scholarly projects with care for Black lives and deaths, has guided me in this project. However, Sharpe does not only see care in its conflation with institutional antiblack violence. Rather she offers the sharing of risks as a care practice, which looks after and defends Black life in the wake. Here I have contributed to a reading of care in the wake that examines

medical care practices. While Sharpe's (2016) analysis is focused on care in the face of antiblack violence, I introduce a more nuanced argument here. Specifically I argue that while medical care can be entangled with violence, during the Ebola response, it was also a site in which Black life was being defended by international health care workers.

Care as methodology

My methodology was also influenced by Sharpe's (2016, 2018) writings on care. In my thesis I took care to attend to Black life and the postcolonial silences in which Black agency tends to disappear. Placing the Ebola response in the wake has required an active effort of foregrounding. As in the introduction, in which I wrote about the Ebola cemetery in Waterloo and the historical layers that it evokes, my analysis of the Ebola response has paid attention to what is marginalised, unsaid and normalised. Black women geographers have long paid attention to these necessary acts of foregrounding whether it be in the archive, in landscapes or geographies of development (Bressey, 2006; McKittrick, 2006; Noxolo, 2006; Fuentes, 2018). Here I have continued in this vein. Paying attention to the reproduction of antiblack violence and colonial continuities and the silences that they inhabit has been, I have argued, an act of care.

To care in this way has warranted the adoption of a non-linear methodology. My methodology has included researching antiblackness in global health in various sites. To do so has enabled me to conduct a study of the colonial present that is geographically unbound. As with Sharpe's definition of antiblack weather, in relation to global health the colonial wake is pervasive. At the same time, by combining interviews and archival research, I have been able to present an analysis of the wake that takes the disconnect between historical antiblackness and contemporary (un)awareness thereof among health responders into account. Thus, while the wake is pervasive, the colonial continuities and antiblackness that characterise it are also hidden and marginalised. This, as I have shown, contributes to, and is itself a marker of, being in the wake. I have further diversified my methodology by interviewing both international health responders and members of the Sierra Leonean diaspora. While the diaspora is increasingly a focus of research in global health interventions (Parvis, 2014; Rubyan-Ling, 2019), my methodology has allowed me to explore postcolonial hierarchies beyond the decolonial binary of colonising and colonised (Grosfoguel, 2007; Mignolo, 2011).

Finally, in conjunction with accounts of Sierra Leone by research participants and by British colonial infectious disease control experts, my two field trips to the Freetown

Peninsula have allowed me to assemble a composite, contradictory geography of Sierra Leone in the colonial wake. I have uncovered similarities and disruptions in accounts of Sierra Leone between international, largely British, health responders now and at the turn of the 20th century, members of the Sierra Leonean diaspora in the UK and my own impressions of Sierra Leone. At the same time my methodology acknowledges the mobility inherent in a Black modern ontology. Black lives, as I have shown, have long been shaped by forced and more recently, self-determined movements. To conduct research on the international Ebola response in this way also recognises that Sierra Leone and Black Sierra Leonean lives have long been shaped by outside forces; that their past and present ontologies depend on forced and self-determined transatlantic mobilities, a fact that was echoed and reinforced during the international Ebola response.

9.2 Originality

In the thesis I have developed four original concepts/approaches that I revisit here. While these concepts emerged out of my theoretical reflections and fieldwork, I propose that they can be of use to researchers within the fields of Black and postcolonial geographies and beyond.

1. Geographies of the wake

Throughout this thesis I have sought to give Sharpe's (2016) concept of the wake a geographical foundation. While *In the wake* concerns itself with the geography of the present-day Black diaspora, it is McKittrick (2006, 2011, 2013) who attends to the aftermath of slavery in the material object of the auction block or the spatial organisation of the plantation. In the case of Sierra Leone these geographies of the wake take different forms. Sierra Leone was never a plantation economy and while my fieldwork led me to auction blocks on Bunce Island, the latter are not at the centre of my analysis.

In Freetown, the wake materialises in the place-making power of the slave-trading and colonial past, in the spaces marked by slavery and colonialism, their physical presence, ongoing ruination, or absence influencing our understanding of colonialism's spatial tenacity. I refer to both this place-making power and the material and non-material structures and affective atmospheres that result from them as geographies of the wake. Geographies of the wake are geographies of the present. They are part of the continued hold the colonial and slave-trading past has on the spatial, material and affective

entanglement of places with that past. Geographies of the wake are geographies of past encounters, framed by violence and Black subjugation in and in relation to Sierra Leone. The contemporary uses to which these structures are put need not replicate or intend to replicate colonial and slave-trading practices in their original form to constitute the wake. Rather, the wake manifests through architectural and atmospheric remains, through buildings whose initial function supported colonialism and the slave trade, but whose current usage may be largely disassociated from that past.

In my thesis I have done this work of foregrounding in relation to places of care, such as Connaught Hospital, Freetown's urban layout and toponomy, but also in relation to the material remains, their normalisation and commodification on the Freetown Peninsula. Furthermore, I have extended this geographical focus on the wake to encompass the historical and present-day mobilities linking Sierra Leone and the UK. Such an analysis enables geographers of global health to rethink how we theorise and relate to places and mobilities of care in the colonial present, how the colonial past is given a spatial future and how different communities' experience might influence their relation to places of care.

2. A Black mobile ontology

The theme of mobilities winds itself through chapters six and seven. Specifically I have engaged with material, human and epistemic mobilities. One of the key concepts that emerged from these reflections was the concept of a Black mobile ontology, designating the centrality of forced and self-initiated mobilities in a Black modern ontology and, importantly, the ambiguity that these tensions encompass. This concept builds on Mimi Sheller's (2018) theorisation of a mobile ontology. Sheller (2018, p.21) defines a mobile ontology as 'an ontology in which movement is primary as a foundational condition of being, space, subjects, and power […] [an ontology that] connects multiple scales and performative sites of interaction.' In this thesis I have developed a Black mobile ontology on several levels. Firstly I have shown that mobilities between the UK and Sierra Leone have long been instrumental in the production of (anti-)Blackness for instance through the transatlantic slave trade and the colonial regulation of Black/native mobilities within Sierra Leone and the British empire. During the Ebola epidemic and response, the regulation of mobilities was reminiscent of earlier colonial and antiblack regulations and shaped Sierra Leonean and diaspora Sierra Leonean lives. At the same time present-day

mobilities remain an integral part in making diasporic lives. As I have shown, these lives and the mobilities they rely on, depict Sierra Leone as a place of economic opportunity and members of the Sierra Leonean diaspora as entrepreneurs, thus changing and challenging the (post-)colonial mobilities constructing Sierra Leone as a place of dependency. It is this ambiguity that lies at the heart of a Black mobile ontology. While this ambiguity and the tensions it incorporates are by no means unique to Black lives, they continue to play an important role in how Blackness is conceptualised in the reporting of urban crime, international migration and infectious disease outbreaks like the 2014-16 Ebola epidemic. Importantly, I would argue, it is antiblackness and (post-colonial) violence that are powerful factors holding and determining the mobilities of Black life and its ontologies. Such an interpretive lens enables innovative analyses in scholarly fields concerned with racial justice, mobilities and migration studies.

3. Colonial Infrastructures

I have also worked in this thesis to develop a concept of colonial infrastructures. These take various forms. On the one hand I have explored the material infrastructures that facilitated and accompanied British colonisation in Sierra Leone, such as Lungi airport, continued flight connections on the eve of independence or Freetown's colonial hospital. On the other hand, I have shown that people can constitute colonial infrastructures in that the material realisation and continued use of such infrastructures relied on embodied knowledge, on personal relationships and on human interactions between British officials and the newly-independent governments on the ground. Lastly, writing about archives, I have suggested that archives can be seen as a form of epistemic colonial infrastructure, incorporating human, material and epistemic infrastructure elements. All three elements designate aspects of infrastructures that support the colonial wake and link the colonial past, nominally, but also politically, to the colonial present.

Importantly, colonial infrastructures differ from Stoler's (2013) imperial debris, in that they were actively built for colonial future-making, as in the case of Lungi airport. They do not merely remain, but reinforce relations of dependency between Sierra Leone and the UK today. This is not their sole function, and that they are put to other uses obscures the colonial wake and makes it less tangible and more ambiguous. As with the wake more generally, it is the interplay of continued coloniality, the aftermath of antiblackness and the role of human, material and epistemic infrastructures in that aftermath that reinforce the coloniality of the infrastructures I have described. Colonial

infrastructures have the potential to contribute to research on infrastructures in that they highlight the continuity between past and present (post)colonial infrastructures and the role of people as active agents in (re)making these continuities.

4. A Black geographical approach to studying the archive and global health

Lastly I would like to highlight a methodological innovation that is linked to my research of and in the archive. In my ethnographic approach to studying the archive, I have focused on its spatiality and the ways in which this spatiality enables antiblackness. Ethnographic approaches to studying the archive are not new. I have however focused on centring my experiences as a Black woman researcher and studying the archive with regards to antiblackness and its intersection with patriarchal power dynamics. This approach has revealed the ubiquity of antiblackness in archives as spaces of epistemic production. This antiblackness is, I would argue, always present, but is revealed upon entering the archive as a person of colour. With this approach I have drawn attention to the differential ways in which the archive is experienced and how it perpetuates power dynamics along colonial-racial lines.

As I have begun to show in the previous section, my methodology introduces a novel approach to studying a global health event. The non-linearity of my research approach reflects the non-linearity of time and space in the wake, the way the past of antiblackness continues to hold both Black patients and white responders in the present and the geographical ubiquity of the colonial wake. Using Black studies and geographies to analyse the British-led international Ebola response in Sierra Leone served to foreground silences, marginalisations and normalisations of antiblackness in global health. The multi-sited-ness of my approach, including archives, diaspora and international responders in Sierra Leone and Europe (especially the UK) and fieldwork in Freetown and the Freetown Peninsula, reflects some, but not all the places that shaped the multiple ontologies of Sierra Leone that I present here. These ontologies are ambiguous, ever-shifting and represent the complicated and contradictory power relations that shape and make postcolonial Sierra Leone. This approach has the potential to inform further research on (colonial) archives and critical geographies of global health.

9.3 Further research

I see my thesis as constituting a starting point for further research into global health practice. Anthropologists have long been involved in the management of infectious disease outbreaks (Hewlett and Hewlett, 2008). Rather than merely seeing culture and society as unknown norms that need addressing in the successful management of Ebola (or other) epidemics, I argue that the historical and affective environment in which epidemics play out needs to be taken into account in formerly colonised societies. The ongoing Ebola outbreak that started in the DRC in 2018 unfortunately shows that distrust and violence continue to structure local reactions to international health responses and to international and national healthcare workers. This distrust slows down the speed with which national and international responses can provide care and accelerates and extends the spread of disease. As I have suggested using the example of the Sierra Leonean Ebola epidemic, awareness of the historical entanglement of care and violence in expert discussions, places of care and among medical responders, can lead to epidemic responses that are better equipped to deal with high levels of local distrust. I would here like to suggest two future research projects. This projects are evidently not exhaustive, but I consider them as a methodological and theoretical starting point to continue thinking through the colonial present and how it affects epidemic responses and global health management overall.

Firstly I would like to suggest deeper research into histories and accumulations of distrust in relation to medical care and governmental and international health workers. Building on Coultas' (forthcoming) work on community accumulations of distrust in Tanzania, White's (2000) work on the local and regional transmission of rumours and vampire stories reflecting the association of white colonial violence and institutional biomedicine in central and east Africa and Nuriddin et al.'s (2018) work on community trust during Ebola epidemics, I propose the following: More research into postcolonial African perceptions of foreign medical interventions is urgently needed in order to design health interventions that do not aggravate fear of institutional medical care, especially during deadly epidemics. This would involve extending conceptualisations of care in epidemic responses to more than biomedical care, that is to say to an awareness of the historical coincidence of western biomedical practice and colonial or antiblack violence. It would also involve drawing on indigenous conceptions and practices of care to further decolonise medical practice. As I have shown in this thesis, some international responders

exemplified an awareness of operating in the wake of violence, although this violence was often, in the case of Sierra Leone, perceived to be a remnant of the traumas of the civil war. I do not negate such an interpretation, but argue that more thorough and expansive research into the roots of this conflation and how it impacts local behaviours during epidemic outbreaks can be useful. Building on this thesis, such research could then be used to directly impact the design and management of health interventions and could contribute to policy discussions around the benefits of investing in long lasting health development in comparison to ad hoc interventions such as the ones we have witnessed during the West African and current DRC Ebola outbreaks. To persuade policy makers and donors of such an approach however, more research into local attitudes is urgently needed. While I have begun to explore how colonial and antiblack violence shapes an Ebola response in this thesis, more specific research is needed, especially research that hears from people who live in communities affected by Ebola and through which knowledge pertaining to institutional care and violence is transmitted. Here, I would argue, a qualitative ethnographic approach in an area in which Ebola has become endemic is key. While the multi-sited approach which I have employed here has been useful in showing both the ubiquity of the wake and has sought to challenge the places in which we study the colonial present, this future research project, focussed on trust or the lack thereof, requires a different, more spatially fixed approach. Such research would contribute to conversations on postcolonial emotional geographies, on critical global health interventions and geographies of care.

A second way forward is to further analyse the relation between the coincidence of violence and biomedicine and places of care. I have begun to develop an argument for the inclusion of Black studies in an analysis of Connaught Hospital in Freetown as a place of care in which care and antiblack violence coincided (Hirsch, 2019b), but argue that this topic requires further research. Building on work by Alun Joseph et al. (2013) on 'Re-Imagining psychiatric asylum spaces', Virve Repo's (2018) work on spatial control in care homes, Alice Street's (2012) work on postcolonial landscapes in one hospital in Papua New Guinea or Jonah Lipton's (2017) work on the racialised perception of biomedical practice and death during the Sierra Leonean Ebola epidemic, I propose an ontopolitical approach to studying places of care in formerly colonised societies. Building on this thesis, I propose an in-depth analysis of medical practice and community perceptions thereof in one hospital so as to better understand the relation between medical care, place, and the wake. I envisage this research to be conducted in a place such as

Connaught Hospital in Freetown, that is, a place which was built as a colonial hospital and which maintains its medical care function today. As I envisage it, such a research project would emulate Annemarie Mol's (2002) comprehensive work on the ontopolitics of medical practice in a teaching hospital in the Netherlands, however it would do so with a focus on the political and postcolonial environment in which care is provided and with the clear understanding, which I have built in this thesis, that care and medical practice are always political, an understanding which Mol (2002) eschews. Specifically I would argue that such a research project can contribute to a body of knowledge on the afterlife of colonial violence in places of care, the very specific geographical configurations that that afterlife might take and whether and how it would intersect with medical care practices.

There is more future research to be derived from this thesis both in Black geographies and in critical global health. My thesis invites further research on the power of the diaspora to effect behavioural change in medical emergencies, on Black mobilities and colonial infrastructures, both human and material. This thesis has analysed the 2014-15 British-led international Ebola response at the intersection of critical geographies of global health and antiblackness. However, the colonial-racial hierarchies that underlay certain aspects of the Ebola response (its mobilities, infrastructures and expertise) also work their way through medical practice in the UK. This year's UK General Medical Council commissioned report (Atewologun et al., 2019) on the disproportionate referral for investigation, sanction and disbarment of Black and Ethnic Minority doctors in comparison to their white peers, attests to the colonial-racial hierarchies that shape medical practice in the UK. At the same time, this report should not be seen as divorced from the ethnic differences in health that characterises the UK population and which disproportionately affect members of Black and Ethnic Minority groups. Both, I would argue need to be considered as a result of Black life being held by the antiblackness that characterises the wake.

In this thesis I have placed the Ebola epidemic in Sierra Leone in the colonial wake to analyse the production and marginalisation of antiblackness, which I have argued, underlies global health practice. By doing so I have drawn on and contributed to works on the wake, the aftermath of colonialism, slavery and antiblack violence. As such this work seeks to challenge the apolitical stance which remains prevalent in medicine, to open up discussions on health and care in the colonial present and to encourage the critical

exploration of postcolonial silences and how they shape and hold Black life in the wake of antiblack violence.

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Appendix ONE: List of primary sources

Interviews

2016 (interviewed in their official capacity as part of the response in Sierra Leone)*

Name	Affiliation	Interview Date	Number of Interviews
Valerie VanZupthen	Welthungerhilfe	03/06/2016, 13/07/2016	2
Erin Poehlich	International Rescue Committee	22/06/2016	1
Victoria Parkinson	ISAT	08/06/2016, 05/07/2016	2
Water, Sanitation and Hygiene Network Team (3 people)	Water, Sanitation and Hygiene Network Team	03/06/16	1
Brima Kargbo	Chief Medical Officer Western Area	02/06/16	1
*Sylvanus Spencer	Historian, Fourah Bay College	30/05/2016	1
Sahr Gbandeh	Lead Ebola Response Team, Cline Town Hospital	30/05/2016	1

2017

Pseudonym	Interview Date	Diaspora/intl' responder	Affiliation	Number of interviews
*Sara	22/05/2017	Intl' responder	Organisation Y	1
*Aminata	31/05/2017	Diaspora	-	1
Hawa	05/06/2017	Diaspora	-	1
*David	06/06/2017	Diaspora	Organisation A	1
*Ruba	12/06/2017	Intl' responder	Organisation X	1
*Solomon	25/06/2017	Diaspora	-	1
Malia	26/06/2017	Diaspora	-	1
Bridget	02/07/2017	Diaspora/intl' responder	Organisation T	1
*Cormack	10/07/2017	Intl' responder	Organisation Y	1
*Brima	10/07/2017	Diaspora	Organisation A	1
*Isata	12/07/2017	Diaspora	NERC	1
Amina	20/07/2017	Diaspora	Organisation A/B	1

* Names and references marked with an * are cited/referenced in this thesis.

*Gareth	25/07/2017	Intl' responder	Organisation X	1
*Anton	25/07/2017	Intl' responder	Organisation X	1
*Nina	26/07/2017	Intl' responder	Organisation X	2
*Musa	01/08/2017	Diaspora	Organisation A	1
*Tom	02/08/2017	Intl' responder	Organisation X	1
Aimee	03/08/2017	Intl' responder	Organisation X	1
*Layla	04/08/2017	Intl' responder	Organisation X	1
Joseph, Jonah, Frances and Guy	06/08/2017	Diaspora	Church A	1
Catherine	07/08/2017	Diaspora	Organisation C	1
*Hector	09/08/2017	Intl' responder	Organisation Z	1
*Zaria	10/08/2017	Diaspora	Organisation A	1
*Maria	14/08/2017	Intl' responder	Organisation U	1
Carolina	15/08/2017	Diaspora	Organisation B	1
Robin	16/08/2017	Intl' responder	Organisation X	1
*Anne	17/08/2017	Intl' responder	Organisation Z	1
*Miki	17/08/2017	Intl' responder	Organisation X	1
*Jack	22/08/2017	Intl' responder	Organisation Z	1
*Emmanuel	22/08/2017	SL responder	Organisation V	1
*Charlotte	24/08/2017	Intl' responder	Organisation Y	1
*James	24/08/2017	Intl' responder	Organisation X	1
*Laura	05/10/2017	Intl' responder	Organisation W	1
*Mariatu	03/11/2017	Diaspora	Organisation D	1

In total I conducted 53 interviews with 46 interviewees. Two interviews were conducted in groups of 3-4 people, the other interviews were conducted individually. The majority of these interviews were conducted in the UK, with two conducted in Germany, one in Switzerland and five in Sierra Leone.

Archival Sources

The National Archives in Kew

Archival Reference	Item Description
CO267/655	Sierra Leone original correspondence: various matters
MPGG 1/33	Sierra Leone: Bonthe. 'Sketch plan of house occupied by the district medical officer and plan, 1910
CO271/16	Government gazettes 1910
CO272/87	Blue book 1910: statistics
CO267/525	Despatches: includes photographs depicting Sierra Leone sanitary conditions, elimination of mosquito larvae
CO267/686	Sierra Leone original correspondence
CO267/681	Sierra Leone original correspondence
CO267/684	Annual Reports of the Medical and health Services for the years 1942-45
CO267/677	Mr A Creech Jones, MP poses further questions about the detention, trial and imprisonment of Wallace Johnson
CO267/671	Sierra Leone original correspondence – Secretary of State 1938-41
CO267/172	Dr Madden's report on Sierra Leone, 1841
CO267/695	Sierra Leone original correspondence – Secretary of State 1945-49
CO267/676	Sierra Leone original correspondence - Secretary of State 1939-43
CO267/629	Sierra Leone original correspondence – Secretary of State 1929
CO267/461	Officers: Medical Adviser, board of Trade, Treasury, War and Miscellaneous 1901
CO267/614	Offices and Individuals 1926
CO267/649	Sierra Leone original correspondence – Secretary of State 1934-1947
CO269/4	War and Colonial Department and Colonial Office: Sierra Leone Acts 1883-1891
CO269/8	War and Colonial Department and Colonial Office: Sierra Leone Acts 1912-15
CO269/7	War and Colonial Department and Colonial Office: Sierra Leone Acts 1906-11
CO269/6	War and Colonial Department and Colonial Office: Sierra Leone Acts 1900-05
*CO937/510	Applications and descriptions of the development of Lungi and Kenema airports
CO937/337	Sierra Leone correspondence: regards merchants shipping legislation
INF10/301	Sierra Leone photographs
DT18/481	Connaught Hospital, Freetown: Nursing training at Connaught Hospital, letters and descriptions
*CO1045/515	Sierra Leone correspondence and papers

CO267/698	Sierra Leone: original correspondence – Secretary of State 1950-51
FCO141/14324	Sierra Leone: correspondence with the Secretary of State for the Colonies under the membership (Ministerial) system
CO267/694	Sierra Leone: original correspondence 1947-51
CO554/1160	Governor's Reports 1955-57
CO554/356	Sierra Leone Railway Development 1952
CO554/1405	Transport Communications in Sierra Leone 1956
*CO937/262	Development of Lingi Airport at Freetown, Sierra Leone, 1953
*CO937/544	Sierra Leone. Colonial Office and Commonwealth Office: Communication Department: Original Correspondence. Civil Aviation. 1960
CO272/96	Blue books of statistics, 1919
CO554/2551	Passport Procedures, Sierra Leone, 1960-61
*CO271/17	Government Gazettes, 1919
CO272/90	Blue books of statistics, 1913
CO272/88	Blue books of statistics, 1911
CO272/100	Blue books of statistics, 1923
CO272/98	Blue books of statistics, 1921
*CO1071/323	Sierra Leone colonial reports, 1906-24
ADM101/82/2	Medical and surgical journal of His Majesty's Steam Ship *Albert* for 16 September 1840 to 11 October 1842 by J O McWilliam, MD, Surgeon
CO270/57	Administration Reports, 1926
*CO270/45	Administration Reports, 1910-13
*WO1/352	Africa and the Atlantic Islands. iv. Sierra Leone. Sierra Leone Company, 1800-1807
INF 10/301/3	Sierra Leone. 'Social Services: health services. Photographs, 1959
INF 10/301/10	Sierra Leone. 'Social Services: health services. Photographs, 1959
INF10/313	Sierra Leone: 28 photographs compiled by the Central Office of Information depicting architecture, 1946-64
MPH 1/896/22-24	Sierra Leone: Freetown. (22) 'Plan of Free-Town': shows Fort Thornton, hospital, parade ground, King Tom's Point. Reference table to military buildings, 1827
*CO 1069/88/20	Sierra Leone. Photograph No 19: 'The Colonial Hospital, southern view', 1871
CO 1069/88/12	Sierra Leone. Photograph No 11: 'Cathedral from the north western angle. Water Street', 1871
CO1069/92	SIERRA LEONE 5. Photographs of Sierra Leone, 1908-1911.
*CO1069/88/22	Sierra Leone. Photograph No 21: 'The Colonial Hospital, eastern view', 1871
*CO1069/88/181	Sierra Leone. Photograph No 48: Colonial Secretary's Bungalow
MPD 1/112/2	Sierra Leone. 'Plan of the Liberated African Department Offices at Freetown', 1838

CO 1069/88/241	Sierra Leone. 'Visit of Their Royal Highness's The Duke and Duchess of Connaught to Sierra Leone, 15th December 1910'.
FCO141/14346	Sierra Leone Freetown riots, 1955

Basler Mission Archives (Basel, Switzerland)

Reference	Description
D-10.4,19	Afrikanische Stationsapotheken nach Vorschlag v. Dr Mählig, 1886
G. IV. 1a	Tropische Krankheiten
G. IV. 2	Die Malaria und deren Bekämpfung nach den Ergebnissen der neuesten Forschung
G. IV. 1b	Tropische Krankheiten
G. IV. 1c	Tropische Krankheiten
G. IV. 1d	Tropische Krankheiten
D. Sch-2, 10	Agogo Hospital 1931-1981
G. V. 5	Agogo. Schwester Erika Kaith erzählt
G. V. 4	Willst du gesund warden? Bilder aus der ärztlichen Mission
G. V. 8	Zeitschrift für Balneologie. Klimatologie und Kurorthygiene
G. V. I	Malaria – Winke für Laien
G. V. 6. aa	Sonderabdruck aus der “Kolonialen Rundschau” 1913
G. V. 6. b	Sonderabdruck aus der “Kolonialen Rundschau”, 1913
G. V. 6c.	Sonderabdruck aus der “Kolonialen rundschau”, 1914. Tropenhygienische Rundschau
G. V. 15.	Die geographische Verbreitung der Tropenkrankheiten Afrikas
G. V. 22.	Archiv für Schiffs- und Tropenhygiene, 1905
G. V. 27.	Archiv für Schiffs- und Tropenhygiene, 1908
GI. II. 1-4	Land, Leute und ärztliche Mission auf der Goldküste

The Wellcome Trust Archives

Reference	Description
WC530 1913Y43f	First Report / Yellow Fever Commission (West Africa)
K27702	Report on the sanitation and anti-malarial measures in practice in Bathurst, Conakry, and Freetown
WC530 1915-Y43r	Reports on questions connected with the investigation of non-malarial fevers in West Africa
b21366093	[Statutes: Sanitary laws & Quarantine Act, 1825]
.b28740397	A practical medico-historical account of the western coast of Africa, 1831

GC/59/A/15	Weekly reports from J M Dalziel, Freetown, Sierra Leone, to the Medical Secretary of the Commission, Sept, 1913-Jan 1914
*GC59/A	Yellow Fever (West Africa) Commission 1913
GC215	Blacklock, Professor Donald Breadalbane (1879-1955): malaria in West Africa
GC/215/1	Malaria in ships in West Africa
*.b21355113	Yellow Fever and its Prevention: a manual for medical students and practitioners by Rubert W. Boyce
*LA/BOY	Mosquito or man? The conquest of the tropical world by Rubert W. Boyce
*EPB RAMC	The white man's grave: a visit to Sierra Leone in 1834 by F. Harrison Rankin (1836)

British Medical Journal Archives

*Anonymous. (1901). The Liverpool Malaria Expedition. *The British Medical Journal*, *2*(2119), 363–363.

*Boyce, R. (1911b). The History of Yellow Fever in West Africa. *British Medical Journal*, *1*(2613), 181–185.

*Taylor, L. (1902). Sanitary Work in West Africa. *The British Medical Journal*, *2*(2177), 852–854.

Royal Geographical Society Archives

*Royal Geographical Society (Great Britain). (1837). *The Journal of the Royal Geographical Society* (Vol. 7).

*Prince of Wales, Salmond, G., Churchill, W., Colonel Amery, Haig, E., & Trenchard, H. (1920). Imperial Air Routes: Discussion. *The Geographical Journal*, *55*(4), 263–270.

Flight Magazine Archive

*Dorman, G. (1951, July 13). West African Wayfarings. *Flight*, 38–49.

Fieldwork and ethnographic observation

Description	Dates	Location	Description
*Findings of the Independent Panel on the Global Response to Ebola – interactive expert panel discussion	23rd of November 2015, 9:30 – 12:30	The Royal Society, London	I observed this event as a member of the audience. In addition to taking notes during the event I also reviewed a video of the event that was posted online, analysing body language and listening to participants' statements in detail. My focus was on panelists, rather than the audience, a majority of which was made up by health workers and academics.
Fighting Ebola	19th of January 2016, 19:00 – 21:00	Imperial War Museum, London	I sat in the audience and took notes on people's statements and their behaviour (laughter, awkwardness, body language).
Learning from the Ebola Crisis: Civil-Military Cooperation & Future Interventions	04th of February 2016, 18:30 – 20:00	King's College London	I sat in the audience and took notes on panelists' statements and their body language, non-verbal behaviour. I also spoke to two of the panelists after the event.
*Sierra Leone Fieldwork	26/05/2016 – 07/06/2016	Freetown	On this preliminary field visit to Sierra Leone I took and notes of my time in Freetown, conducted interviews and spoke to members of the public and British health responders involved in the Ebola response
*Wellcome Trust Archive	February 2017	London	Apart from conducting archival research I also took notes of the spatial layout of the archives, of the security regulations in place and the interactions with staff.
The National Archives in Kew	February 2017 – March 2019	London	Apart from conducting archival research I also took notes of the spatial layout of the archives, of the security regulations in place and the interactions with staff. I also

			spoke to staff about how to approach the study of colonial infectious disease control.
Community Meeting on Freetown mudslide	19th of August 2017, 15:00 – 17:00	Walworth Methodist Church, London	I attended this meeting on the invitation of one of my contacts in the Sierra Leonean diaspora community in the UK. I took detailed notes and volunteered to help during the event.
*Sierra Leone Fieldwork	08/03/2019 – 21/03/2019	Freetown Peninsula	On this fieldtrip I spent time in Freetown and on the Freetown Peninsula, visited sites of relevance in the transatlantic slave trade and sites connected to the Ebola response, such as Hastings and Kerry Town Ebola Treatment Centres, Connaught Hospital, and the Ebola Cemetery in Waterloo. I spoke to members of the public and Sierra Leoneans and international health and charity workers involved in the Ebola response, took photographs and kept a detailed fieldwork diary.

Appendix TWO: A chronology of regional and international flight suspensions affecting Sierra Leone during the Ebola outbreak

This table is organised according to dates of suspension of flights during the Ebola outbreak (third column from the left). Airline schedules in the region seem to be subject to relatively frequent change. This table is up to date as per May/June 2019.

Airline	**Route started in**	**Route disrupted in**	**Route resumption**	**Direct connection with**
Arik Airlines	June 2009	**27th July 2014**	23 February 2016, discontinued as of early 2019	Accra
Asky Airlines (Ethiopian Airlines)	March 2010	**29th July 2014**	November 2017	Banjul, Accra, Lomé
British Airways (then bmi)	November 2012 (2008)	**5 August 2014**	N/A	London
Air Côte d'Ivoire	November 2013	**11th August 2014**	20 October 2014	Abidjan, Monrovia
Gambia Bird	2012	**15th August 2014**	N/A	London
Kenya Airways	July 2007	**16th August 2014**	25th September 2015	Accra, Monrovia
Air France	2011	**28 August 2014**	30 June 2015	Conakry, Paris
Brussels Airways	2002	**Continued service throughout epidemic**	Brussels, Monrovia	
Royal Air Maroc	2013	**Continued service throughout epidemic**	Casablanca	
Turkish Airlines	February 2017		Istanbul, Dakar	

Mauritania Airlines	August 2017			Conakry
Air Peace	December 2017			Lagos
Africa World Airlines	October 2018			Accra, Monrovia