

Ebola, Emerging: The Limitations of Culturalist Discourses in Epidemiology

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Abstract

In this paper, I offer a critique of the culturalist epidemiology that dominates the discourse of Ebola in both popular and international health spheres. Ebola has been exoticized, associated with “traditional” practices, local customs, and cultural “beliefs” and insinuated to be the result of African ignorance and backwardness. Indeed, reified culture is reconfigured into a “risk-factor.” Accounts of the disease paint African culture as an obstacle to prevention and epidemic control efforts, at times even linking the eruption of the disease to practices such as burial traditions or consumption of bushmeat. But this emphasis is misleading; the assumption of African “otherness,” rather than evidence, epidemiological or otherwise, underpins dominant culturalist logics that “beliefs” motivate behaviors which increase the likelihood of Ebola’s emergence and spread. Conspicuously absent from both popular and official rhetoric has been attention to larger structural determinants of the course of Ebola epidemics. Yet global forces condition the emergence of Ebola far more than culture does. Inequality and inadequate provision of healthcare, entrenched and exacerbated by a legacy of colonialism, superpower geopolitics, and developmental neoliberalism, are responsible for much of Ebola’s spread. Certainly, structural force alone cannot account for the destruction Ebola has wreaked on the lives of victims and their families. Culture *does* matter. But the focus on culture comes at the expense of attention to sociopolitical and economic structures, obscuring the reality that global forces affect epidemics in Africa. In this paper, I seek to map the discursive contours of Ebola’s emergence, contextualize these trends within a larger debate about the role of anthropology in epidemiology, and question the simplistic link between culture and Ebola through a critical examination of structural-level forces.

Emergence

Ebola is a hemorrhagic fever of the filovirus family with a 50-90% case fatality rate. There is no effective treatment for ebola except for the euphemistically labeled “supportive therapy” (CDC, 2009). The virus is spread through contact with infected fluids, typically blood, and once it has infected a new patient, it rapidly attacks the internal organs and connective tissue, causes severe bleeding, vomiting, aches, mental impairment and dementia, and in severe cases, grand mal seizures. The typical cause of death is multi-organ system failure (Lashley & Durham, 2007).

The international community first became aware of Ebola in 1976, when the disease erupted in Yambuku, Zaire (now the Democratic Republic of the Congo, or DROC) and N’zara, Sudan (WHO, 2007). During these outbreaks, most of the world took only passing notice of this new disease. Scientists who had dealt with the disease and the Zairois and Sudanese touched by it would not soon forget the epidemic, but media focus was limited and Western concern was low. It was not until the late 1980s that Ebola would “emerge.” In 1989, Ebola was detected in a shipment of crab-eating macaque monkeys to a laboratory in Reston, Virginia, and media frenzy ensued (Associated Press, 1989). Here was an exotic and deadly disease with no cure, let loose for the first time on American soil. Ultimately, the particular subtype that had proven fatal to the monkeys was discovered to be harmless in humans (CDC, 2009), but fear of the virus had been sparked by the event and only grew with time. Within a few short years, Richard Preston published *The Hot Zone*, a best-selling book about Ebola and the Reston event, and *Outbreak*, a film starring Dustin Hoffman and Morgan Freeman, por-

trayed the potential scenario that an infected monkey shipped from Africa could cause a major epidemic within the U.S.

Despite media attention, the fear surrounding Ebola is in many ways overstated. The virus is indeed incredibly lethal—if you are infected. But in the course of over 30 years since its initial appearance, only 1,500 people have died in total (CDC, 2009). For comparison, twice as many children die of malaria each day (WHO, 2003). Yet Ebola looms far larger in the Western imagination. Why? Because the virus represents a threat to Western populations. It could travel from *there* and infect us *here*. It could mutate and spark a pandemic. It could be stolen by terrorist groups or weaponized by hostile forces. It has the potential to infect us in a way that malaria, conquered as an epidemic disease in the West and easily treated in resource-endowed hospitals, does not. A significant body of literature examines the discourse of “emerging and re-emerging” infectious disease. As anthropologist and physician Paul Farmer has argued, such categorizations are often limiting because they imply a change in the biological organism or pathogenicity, when, in fact, diseases emerge and re-emerge because of social forces (Farmer, 1999). Moreover, the terms mask where and for whom the diseases have emerged. Tuberculosis, for instance, never “disappeared,” as its label of “re-emerging” might indicate. But those who it continued to infect and kill in shocking numbers were people from the poorest countries. Consider that for OECD countries, tuberculosis has disappeared. It “re-emerged” only when it once again posed a threat to Western populations in the form of Multi-Drug Resistant TB, which was potentially untreatable.

Ebola is an example of such a disease, one that emerged into Western consciousness more than it did into the biological landscape. Media coverage of the epidemic in 1976 was virtually non-existent; a search through the *New York Times* archives indicates that only one article was written about the disease prior to 1989. But after the 1989 macaque monkey incident, media interest exploded. As Paul Farmer writes:

Modern communications, including print and broadcast media, have been crucial in the construction of Ebola—a minor player, statistically speaking, in Zaire's long list of fatal infections—as an emerging infectious disease... journalists and novelists wrote best-selling books about small but horrific plagues, which in turn became profitable cinema. Thus, symbolically and proverbially, Ebola spread like wildfire—as a danger potentially without limit. It emerged. (Farmer, 1999).

Toward a Culturalist Epidemiology

Ebola did not merely emerge; it emerged from Africa. Since its discovery, the mystery and intrigue surrounding Ebola has been linked to its foreign origins. The virus was exoticized, and the imagery invoked in many minds was that of an ancient evil surfacing from its hidden resting place in the darkness of the African jungle. CNN produced a special in 1995 with essentially this message, describing “a killer on the loose in the rainforest” (CNN, 1995). An article entitled “The Next Plague, and the Next” argues that “[in] the remotest tropics of Africa and South America lurk a coterie of viruses... [such as] Ebola” (Wade, 1994). A *New York Times* piece describes how “the rare and terrifying Ebola virus has emerged from its hiding place in the heart of the African jungle” (Editorial, 1995). The obsession with Ebola’s “hidden reservoir” in Africa runs through nearly every Western account of the disease in the media.

This connection between African culture and Ebola is more than mere rhetorical racialization of the disease. Culture itself is reconstituted as a “risk factor” for infection in light of assumptions about African “Otherness.” In both popular and official (i.e. WHO, CDC) accounts, African “beliefs”—often about disease etiology and transmission—are represented as ignorant and backwards, supposedly hindering or counteracting more enlightened epidemic control efforts. Africans are presumed to believe in spirits and witchcraft as the cause of Ebola, and reject biomedicine and the interventions it necessitates. These “beliefs” are sometimes even held to motivate cultural behaviors or “customs” that are responsible for initial outbreak of the disease and facilitate its spread. The Bushmeat Hypothesis, which posits that hunting, slaughtering, and eating infected gorilla or monkey meat is the primary cause of the virus’s entrance to a new population, is among the dominant explanations for Ebola outbreaks, and typically these accounts attribute bushmeat consumption to African culture (Fox, 2004). Rural Africans sometimes eat these animals; this fact is reconfigured into near-certain proof of a causal mechanism. Academic studies deploy a techno-scientific discourse to mask this simple cultural logic in advancing the hypothesis. “Despite efforts to change the eating habits of African villagers,” contends one article, “many believe occult forces are behind Ebola. They do not understand that they could limit their exposure by avoiding dead or sick animals” (Rizkalla, Blanco-Silva, & Gruver,

2007). Such arguments convey that Africans are both ignorant and stubborn in their misconceptions while supporting the notion that Ebola outbreaks are caused by a cultural tradition of bushmeat consumption. As I will show later, similar theories of causation link burial practices to outbreaks.

More generally, African culture is seen as an obstacle to overcome when implementing outbreak control. Locals are presumed to subscribe to alternative disease models rooted in “traditional healing,” believe in sorcery or the supernatural as the cause of the disease, or generally hold “misconceptions” about its etiology. Laurie Garrett’s description of the response to the Kikwit epidemic is telling:

[It was] something called a virus. Something called Ebola. These things gripped the estimated 400,000 people of Kikwit with a terror unlike any they had ever felt... The victims died fast, screamed incoherent phrases of apparent devilish origin. They seemed possessed... There were ancient ceremonies handed down by the ancestors that could purge evil spirits—they usually lifted the landa-landa [a local name]. But not this time. The magic was too powerful. Surely it must be the work of an exceptionally evil one, who was the potent fount of Satanism (Garrett, 2000).

These statements seem to suggest that Africans hold eccentric and primitive “beliefs” and may not accept the “truth” of modern biomedicine. Byron Good’s *Medicine, Rationality, and Experience* offers cogent analysis of the epistemology of medicine, which views itself not as a cultural construction, but a logical progression of objective knowledge into techniques designed to correct concrete biophysical abnormalities. Biomedicine, as a form of science, thus holds a privileged position in Western societies, as the arbiter of the divide between “knowledge” and “belief,” the first denoting universal truth and the latter a mere presupposition with a connotation of error (Good, 1994). In short, *they believe, we know*. The answer to the supposed barrier of culture, according to Western physicians and WHO teams, must be community education campaigns and anthropologically minded initiatives.

The Unhappy Marriage of Epidemiology and Anthropology

Susan DiGiacomo has argued that anthropology and epidemiology should be natural allies in the study of disease. But when anthropology is operationalized in bioscientific settings, “culture is reified as an ensemble of measurable ‘factors’ with deterministic power over specific aspects of illness” (DiGiacomo, 1999). Thus, anthropology has not truly been integrated into epidemiology. Rather, anthropology is “raided for bits of information about ‘culture’ which can then be plugged into a statistical model that generates correlations amenable to being represented as causal” (DiGiacomo, 1999). Randall Packard and Paul Epstein have advanced similar claims with respect to the experience of medical research on HIV/AIDS in Africa. They argue that scientists were inevitably influenced by assumptions of hypersexuality of African peoples and other peculiarities of culture, and constructed causal theories to match these assumptions. Anthropology quickly became viewed merely as a way to overcome culture barriers: “The medical research community defined the parameters of

the social science input in line with the dominant behavioral model. Specifically, they asked anthropologists and other social scientists to provide information about ‘risk behaviors’ that might facilitate transmission” (Packard & Epstein, 1991).

In short, anthropology has been employed as the handmaiden of epidemiology. Its role has been circumscribed to identifying “beliefs” in order to help design education campaigns and implement “culturally appropriate intervention strategies.” Medical researchers ask anthropologists to deal with the “cultural issues.” In this light, the discipline has become little more than a specialist in local beliefs and customs. Anthropologists are presumed to have knowledge of culture which they can package into discrete units for international health experts in order to make outbreak control more effective. Many anthropologists seem even to embrace this role. A recent book by anthropologists Barry and Bonnie Hewlett, *Ebola, Culture, and Politics: The Anthropology of an Emerging Infectious Disease*, effectively serves this purpose. After cataloging local disease models, customs, and beliefs, the book’s conclusion was that “anthropologists can help solve specific clinical, laboratory, epidemiological, and other problems that emerge during an outbreak, such as why people run away from the ambulance, why they refuse to seek treatment at the clinic, and... suggest ways to modify clinical and mortuary practices so they are culturally sensitive and appropriate” (Hewlett & Bonnie, 2008).

Certainly, there is a need for cultural awareness in any public health campaign or outbreak control. But anthropology discards its position as a contextualizing discipline by circumscribing its role to “explaining” the enigmatic beliefs of locals for use in a behavioralist epistemology. It implicitly reinforces the assumption that behaviors are culturally determined, ignoring social, political, economic, and historical factors that affect health outcomes and disease distribution. Epidemiology has almost always limited itself to an analysis of individual behaviors as “risk factors.” Indeed, these individualizing claims of causality may be useful for public health interventions because they allow for rapid targeting of risky behaviors or populations. Education campaigns, which in many cases are highly efficacious (e.g., Uganda’s “Zero Grazing” campaign, which has substantially reduced HIV/AIDS transmission rates), are easier to implement than wide-sweeping improvements to public health infrastructure. But anthropology cannot allow itself to be limited to serving as a handyman for “cultural problems” in outbreak control. It must reclaim broader role as a contextualizing discipline and lay bare the structural forces that influence disease patterns.

What’s culture got to do with it?

As I have argued throughout this paper, many official reports and news stories suggest that culture may be a causal agent of Ebola. Particularly striking is the lack of attention to structural forces, global, national, or local, which have conditioned the emergence and spread of Ebola. African political, social, and economic context is taken as a given, set aside in a “black box,” and untouched by outbreak control efforts. African “Otherness” overpowers the possibility of a non-cultural causality in the dominant discourse, and other factors are left unexamined as potentially causal or exacerbating. The focus

on culture at the expense of structure, however, is obfuscating. Take, for instance, the imagery of the village, which is almost universally deployed. Sub-Saharan Africa actually has one of the highest rates of urbanization (which is typically linked to industrialization) in the world. In fact, DROC and Gabon, the two countries with the greatest numbers of Ebola outbreaks, are the two most urbanized countries in Africa at 67% and 84%, respectively (Falola & Afolabi, 2007). Many depictions of Ebola victims invoke the idea of African “traditionalists” but a large number of those affected by Ebola live in cities, accept the biomedical model of disease, and are amenable to epidemic control efforts. In *Ebola, Culture, and Politics: The Anthropology of an Emerging Infectious Disease*, Hewlett describes “village life,” detailing family organization, social structure, and cataloguing local explanatory models of sorcery or supernatural causation (Hewlett & Bonnie, 2008). Yet the same source also notes that 60% of the cases were in urban, not rural areas (Hewlett & Bonnie, 2008). The Gulu district, where the epidemic occurred, was not some backwards and timeless village; it had three large hospitals, paved roads, nightclubs, restaurants, electricity, and numerous government offices. This was a modern city, though a poor one. The inhabitants generally accepted biomedical model and visited hospitals during illness.

The spread of the Ebola beyond the index case is, as I have argued, discursively linked to cultural modes of transmission. But the greatest amplifier appears to have been hospitals. Healthcare workers constitute one of the hardest hit groups. Other patients are also infected, some returning to their homes without knowing they are infected. They may then transmit the virus to the rest of their family or others in their community (Preston, 1994). In the Belgian missionary hospital in Yambuku, where the first case of Ebola (although it was not called that at the time) was reported, the nurses laid out 5 needles every morning, which they would use to give shots to between 300-600 patients each day (Garrett, 1994), a significant transmission risk for blood-borne virus. Nosocomial transmission was shockingly high in Yambuku, as it was in the N’zara outbreak, where Ebola spread rapidly through the staff and patients at the Maridi hospital (Garrett, 1994). Inadequate supplies and unsterile syringes have also been cited in the Uganda epidemic of 2000-01 and the Kikwit epidemic in 1995 (Hewlett & Bonnie, 2008). One report declares that “in-adequate [sic] and poor quality of protective materials, especially at the beginning of the outbreak, was a big problem and contributed to the transmission of Ebola virus within the health care setting” (Lamunu et al., 2006). The CDC Ebola Factsheet lists nosocomial transmission as one of the most serious causes of the spread of the disease (CDC, 2009). Yet despite the clear role of poor healthcare infrastructure, the focus in the literature has been on education and community mobilization campaigns, consigning inadequately funded hospitals to a status as an unalterable African condition in which epidemics play out. Poverty, inequality, and poor healthcare infrastructure remain outside the realm of conceivable intervention. The shift in emphasis from resources to culture masks the fact that improving the quality of health care and reducing inequality could significantly reduce the spread of Ebola epidemics.

In the 1995 Kikwit epidemic, hospital facilities had no running water, no electricity and no working waste-disposal system; there was a lack of disposable medical materials and protective equipment; nursing often involved invasive procedures and was usually conducted without protective gear (Hewlett & Bonnie, 2008). Further, the hospital was understaffed, overworked, and its workers had incredibly low morale—the overwhelming majority of Zaire’s physicians and nurses had gone unpaid since 1991 because of salary arrears (Hewlett & Bonnie, 2008). By the time Médecins Sans Frontières (MSF) had arrived in the country, 73% of the dead were healthcare workers, and almost all of the infected had been treated in the hospital and may have acquired infection there (Garrett, 2000). What stopped this mode of transmission? Mere supplies and additional manpower is one possibility. MSF helped institute a normalized routine and provided barrier nursing supplies and clean needles. “Exhausted, frightened healthcare workers make mistakes” writes Garrett. “Needles slip, bottles break, hands tremble, all creating opportunities to spread the virus.” Yet with appropriate supplies and additional nurses, “the hospital spread of Ebola came to an immediate and grinding halt” (Garrett, 2000). Transmission continued to occur in the community, albeit at a vastly lower rate, particularly in homes where family members cared for the ill. Since nearly every case of the disease was linked to the hospital, people had grown suspicious of the hospital’s efficacy, and many chose to treat patients at home.

So why are African hospitals so poor? This question is left largely unexamined in health policy reports. “It’s Africa” is the implication. “Of course it’s poor.” Poverty, inequality, and crumbling infrastructure are left untouched as a black box; rarely do health reports or newspaper articles suggest their causes or remedies. They are considered an unalterable and fundamentally African condition. Culture, conversely, another contextual factor, is considered easily “fixable” through education campaigns or community mobilization efforts. Yet while the assumption of cultural causation of ebola is dubious at best, it is clear that inequality, lack of adequate supplies, and short-staffed hospitals *do* spread Ebola. These conditions, however, do not merely exist. They are determined by larger structural, and often global, forces.

The persistence of African poverty is a topic too large to examine in the present investigation. But here I will suggest some of the ways in which larger global forces have caused or perpetuated inequality across the continent, and limited the resources available for healthcare provision. Numerous authors point to endemic corruption and the patrimonial tendencies of predatory and autocratic regimes as the cause of poor economic performance and low provision of public goods, including health care. Many development consultants contend that corruption is part of the “culture” in Africa (see Dambisa Moyo’s best-selling *Dead Aid*, for instance), yet it is possible to trace the phenomenon to a legacy of colonialism. Since colonial administrations never included Africans themselves, newly independent states had a dearth of qualified bureaucrats and significant competition for control of government. When the Belgians left the Congo in 1960, there were merely six indigenous college graduates in the country (Moss, 2007). Ruling the Congo required dispensing favors and positions in order to effectively gain political traction, which fostered a political environment of corruption and

clientelism. As historian Fred Hayward notes, the European powers left behind an economy based on commodity exports and state-controlled agricultural monopolies, which was highly susceptible to abuse (Hayward, 1986). Further, Africanist Mahmood Mamdani has cogently argued that the colonial state had an entrenched system of decentralized despotism in which the central government turned a blind eye toward chiefs demanding tribute as long as they produced profit (Mamdani, 1996). Corruption is not cultural, nor determined solely by the actions of individual African leaders. It is part of colonialism’s long shadow.

Shortly after DROC’s independence from the Europeans, the CIA assisted in the assassination of Patrice Lumumba, a suspected left-wing potential ally of the Soviets, and helped Mobutu Sese Seko secure the presidency of Zaire in 1965. Mobutu was a notoriously corrupt leader who amassed immense personal wealth—\$5 billion—by raiding public coffers, as the entire country had been in debt (Garrett, 2000). Mobutu’s rule was marked by blatant disregard for the health and well-being of his populace, inattention to improving infrastructure. The doling out of political favors and positions were required to stay in power. Decades of potential growth were stifled; hospitals languished, and healthcare providers, especially those in the poorest areas, were left unpaid. Journalist Laurie Garrett rightly argues that Ebola’s emergence in Zaire was the result of “greed, corruption, arrogance, tyranny, and callousness... [it was] the inevitable outcome of disgraceful disconcert—even disdain—for the health of the Zairois public” (Garrett, 2000). But she, like many others, doesn’t link these factors to a likely cause: U.S.-Soviet geopolitics, and the three decades of support and nearly unfettered U.S. military aid which allowed Mobutu to stay in power.

Structural Adjustment Policies (SAPs) and other forms of conditionality by the IMF or World Bank have also contributed to the poor quality of healthcare infrastructure in Africa. There is a vast literature base that details how fiscal liberalization components required cutbacks in public expenditure; healthcare was considered one of the most expendable programs. Healthcare spending dropped precipitously; needed hospitals were not built, necessary supplies were not provided, salaries went unpaid, hospitals were left understaffed, and many of the best and brightest doctors left the African countries because of the despicable hospitals and lack of opportunity (Schoepf, Schoepf, & Millen, 2002). The accompanying trade liberalization also diminished, indirectly, healthcare funding, because revenues from tariffs were a sizable portion of government budgets, and as this source dried up, spending had to be further cut. Moreover, by encouraging “outward orientation,” SAPs sought to increase production in the most profitable export sectors: agriculture and minerals. While well-intentioned, this served to entrench Africa’s position as a global commodity exporter. Global commodity prices are incredibly volatile, sometimes fluctuating more than 100% in a given year, and are vulnerable to U.S. and EU agricultural subsidies, causing a flooding of the market and lowering of the price. Relying on commodities and the whims of global prices was arguably a poor development strategy for DROC, making budgetary planning extremely challenging and diminishing its capacity to undertake long-term infrastructure projects (Mkandawire & Soludo, 1999).

To be clear, I do not wish to overstate the claim that global forces are responsible for the incidence and spread of Ebola

outbreaks. Ebola could have emerged even if Africa were more developed, and there are customs in Africa that may aggravate the spread of disease (for instance “love touches,” or ritual contact or kissing of the deceased at funerals). My goal has been to refocus attention to factors that influence the proliferation of Ebola epidemics that have traditionally been ignored. Inadequately funded and poorly supplied hospitals represent the single greatest transmission risk for the Ebola virus. Such conditions do not emerge in a “vacuum.” They have been caused by a long history of international intervention in Africa and perpetuated by actions in the West. We must unpack the “black box” of African poverty and poor health care and address it head-on, rather than try to awkwardly work around it. Too long have international “experts” and Western media maintained what I call “globalization doublethink.” There is intense fear that the Ebola virus could contribute mayhem and destruction were it to mutate and cross the Atlantic or Mediterranean. But there is little attention paid to the fact that in an increasingly interconnected world, global forces and interactions can also flow the opposite direction, propagate inequality, and alter disease distributions. We need to recognize that our actions and policies towards foreign countries, policies, agricultural subsidies, and geopolitical struggles can have grave consequences for global health outcomes.

Conclusion

In this paper, I have argued that the culturalist epidemiology that dominates the study of Ebola is limiting. It exoticizes the disease, and reconfigures assumptions about a vaguely monolithic African culture into causal explanations for the spread of infection. Culture becomes a “risk factor,” and the focus of journalistic accounts and official reports alike. Anthropologists are only called in to help correct the problem. They are asked to identify cultural “beliefs” with presumed deterministic power over behaviors that may spread Ebola. Anthropologists are tasked with designing education campaigns, explaining the actions of international health teams to locals, and designing “culturally sensitive” intervention strategies.

Anthropology does itself a disservice by agreeing to serve in this circumscribed capacity. It should not be a reduced study of culture or the exotic. It is the ultimate contextualizing discipline, and it ought to embrace its role as such. This means recognizing how social, political, historical, economic, and ideological factors affect patterns of disease emergence and proliferation. I have argued that in the case of Ebola, inadequately funded hospitals allow single index cases to explode into full-blown epidemics. We must now open up the “black box” of African poverty and ask *why* healthcare provision is so derisory, *why* Africa remains so poor and unequal. Neither is this an academic exercise in the assignment of blame. Exploring the answers to such questions can reveal what concrete steps we can take to limit disease outbreaks and improve the quality of lives of Africans who must endure economic stagnation, political turmoil and repression, and shockingly high mortality rates.

My principal argument has been that global structural forces, not cultural beliefs or practices, condition the emergence and spread of Ebola epidemics. But these forces are not unalterable. African poverty is not a permanent canvas on which the trag-

edy of Ebola and other human suffering is destined to play out. Our actions—the policies our governments enact, the decisions international financial institutions make, the agendas laid down by major actors on the world stage—all have an impact on inequality and subsequently disease distribution. But these factors are not set in stone. We can, and should, change them. Governments in Africa should increase the healthcare spending in order to improve the quality of healthcare infrastructure and provide adequate supplies. OECD governments should untie aid; currently about 60% of all aid to Africa is tied, meaning it must be spent on goods or services from the donor country (van de Walle, 2001). Foreign consultants financed by African debt are clogging the decision-making apparatus in Africa with uncertain benefits and substantial cost. The US, EU, and Japan should end their massive agriculture subsidies, which have unfairly flooded the market and lowered global prices, driving down African farmers’ incomes. The WTO should broker an agreement to provide trade protections to African manufacturers, particularly against China. Finally, Western donors must be prepared to fund costly infrastructure projects with few prospects for immediate benefit but the potential to vastly improve the productivity of the African economy and health of the African populace.

These suggestions alone will not stop Ebola outbreaks, nor will they end African poverty. My aim has not been to write a policy report but to highlight the limitations of such culturalist discourses of epidemiology and call for greater attention to the more salient features of Ebola epidemics in Africa. I call upon policymakers and citizens alike to recognize the globalized effects of their actions, shift their focus from cultural to structural factors in Ebola epidemics, and work towards diminishing inequality and poverty rather than altering a reified “culture” when implementing outbreak control efforts.

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Political Systems and Health Inequity: Connecting Apartheid Policies to the HIV/AIDS Epidemic in South Africa

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Abstract

South Africa's transition to a post-apartheid government marked a new era of liberation and equality for black South Africans. However, the notions of white supremacy and racial segregation, ideologies of apartheid government, continue to hinder the South African government's attempts to restructure its healthcare system. In addition, new economic drives toward privatization act as a new barrier to the achieving of equality in the South African healthcare system. The persistent inequality in the delivery of health care within South Africa is illustrated in the nation's distribution of HIV/AIDS; black South Africans bear the highest burden of disease. This paper argues that the current inability of the South African government to adequately address the HIV/AIDS epidemic is symptomatic of still-existing apartheid ideologies in the healthcare system, faulty public-private relationships, and structural gaps between health policy making and implementation.

Approximately 5.7 million people in South Africa are currently living with HIV, and of these people, 3.2 million are women and 280,000 are children under age 14. 17.8% of South African adults aged 15 to 49 are living with HIV, and there are almost 2 million South African children under age 17 who have been orphaned due to HIV/AIDS (UNAIDS, 2011). By overlapping historical analysis of apartheid health policies with current neoliberal discourse, we can witness patterns emerging between HIV/AIDS treatment and incidence disparities and South Africa's political and economic policies.

Starting in 1948, black South Africans became the target of exclusionary and exploitive laws that separated South Africans on the basis of race. The government forced black

South Africans to live in designated areas that were separate from areas inhabited by white South Africans. These areas, known as Bantustans, comprised of merely 13% of South Africa in size but were home to over 80% of the population (Price, 1986). In each Bantustan, a large number of which were situated in rural South Africa, health care was primarily provided by non-profit missionary hospitals and overseen by local elites. By giving control of the healthcare system to individual Bantustans, the national government of South Africa essentially removed its responsibility to monitor and account for the quality of health services in those areas. Due to little government regulation and oversight of privatized health care during apartheid, health services in Bantustans frequently ignored quality-of-care guidelines and became