Chapter 12: Ebola and the Ravages of History in Paul Farmer: A Catholic Theological Ethical Response to Global Health Inequity in Africa

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When Paul Farmer died in Butaro, Rwanda, on February 21, 2022, many people saw it as a fitting consummation of his selfless and sacrificial commitment to Africa and people of African descent. He died in the land that he loved so much. In the last decade of his life, Farmer spent a lot of time in Africa helping to build effective, affordable, and accessible health systems; providing safe and sustainable health care delivery for the most vulnerable among us; and training a new crop of African health care workers. Paul Farmer is rightly to be called an African ancestor. This is because he worked strenuously to the point of death to promote and protect the health of Africans. Through his selfless effort, he saved the lives of many Africans, while being an agent for building the systems, staff, spaces, and stuff—as he likes to summarize health care delivery—for promoting holistic health and human and cosmic flourishing in Africa and the world. It is remarkable that the last major book of Paul Farmer, *Fever, Feuds, and Diamonds: Ebola and the Ravages of History,* was dedicated to discussing global health inequity and its devastating impact in West Africa during the Ebola outbreak of 2013–2015.[1] The message of this book, forms the central themes around which I develop this essay.

Interestingly, *Fever, Feuds, and Diamonds* offers a synthesis of the development in Farmer's thinking as he and his colleagues in Partners In Health watched the destructive effects of COVID-19 playing out because

[1] Paul Farmer, *Fevers, Feuds, and Diamonds: Ebola and the Ravages of History* (NY: Farrar, Straus and Giroux, 2020), 192.

the lessons learned from Ebola about the reforms of the global health systems needed to prevent and respond to the next outbreak were not heeded by the world. These lessons from the 2013 Ebola outbreak in West Africa formed the focus of a course which Paul Farmer and the current COVID-19 White House coordinator, Ashish Jha, developed at the Harvard Global Health Institute, *Lessons from Ebola: Preventing the Next Pandemic*. I participated in this course. It was there that I encountered Paul Farmer and his passion for a common humanity and especially his commitment to Africa. This course also introduced me to the work of the Independent Panel on Global Response to Ebola by Harvard Global Health Institute and the London School of Hygiene and Tropical Medicine and the ten reforms of global health systems and structures that were recommended.[2] I believe that if these reforms had been implemented globally and locally before 2019, the world would have been in a much better shape to respond effectively to the COVID-19 pandemic.

In this essay, I explore with Farmer why Ebola has persisted in Africa and why it continues to kill so many Africans as we saw in the September 2022 outbreak in Uganda with the Sudanese strain. Farmer's appeal to social medicine and social context in understanding the *remote causes of the cause* of Ebola offers an important corrective to the disease control and treatment paradigm approach in global health amidst the devastating impact of health inequity. Farmer posed an important question and offers an answer that can help us locate the central concern of this essay:

> How did West Africa become a clinical desert—a place in which the rapid human-to-human spread of Ebola was not just possible but almost inevitable? The answer begins centuries ago, when pathogens and

[2] Suerie Moon, Devi Sridhar, Muhammad A. Pate, Ashish K. Jha, Chelsea Clinton, Sophie Delaunay, Valnora Edwin, Mosoka Fallah, David P. Fidler, Laurie Garrett, Eric Goosby, Lawrence O. Gostin, David L. Heymann, Kelley Lee, Gabriel M. Leung, J. Stephen Morrison, Jorge Saavedra, Mercel Tanner, Jennifer A. Leigh, Benjamin Hawkins, Liana R. Woskie, and Peter Piot, "Will Ebola Change the Game? Ten Essential Reforms Before the Next Pandemic. The Report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola," *The Lancet* 386, no. 10009 (2015): 2204–2221.

> pathogenic forces were linked to a worldwide web of maritime commerce that bound expansionist European economies to the Americas and Africa. This web began to take shape in the mid-fifteenth century, when Portuguese explorers and traders gave Port Loko, and indeed Sierra Leone and much of the Upper Guinea Coast, their names. The result would be violent conflict, recurrent disease, and rapacious extraction—of rubber latex, timber, minerals, gold, diamonds, and human chattel.[3]

I conclude my chapter by using Farmer's analysis of the causes of global health inequity in Africa to propose how theological ethics can serve the mission of churches and African communities in designing health care systems for health improvement and health protection in solidarity with the poor and the most vulnerable. I propose some effective strategies for global health partnerships in Africa against the current preoccupation with disease control and prevention, medical mission, and crisis intervention from outside Africa.

From Congo to West Africa: How Ebola Came to West Africa[4]

Between December 2013, when the outbreak of Ebola Virus Disease (EVD) was first reported, and September 2015, more than 27,000 cases were registered with 11,000 reported deaths. It was, according to experts, the worst Ebola outbreak in history because, in less than six months after the first case was reported, it had spread to the capitals of three African countries—Conakry, Guinea; Monrovia, Liberia; and Freetown, Sierra Leone. In terms of the recorded number of affected persons, countries involved, and longest persistent transmission, the West African strain of

[3] Farmer, *Fevers, Feuds, and Diamonds*, 192.

[4] Some of the material from this section was taken from my essay, Stan Chu Ilo, "Where Hands Don't Touch: A Biosocial Ethical Analysis of the Ebola Outbreak and Medical Intervention in West Africa," in *Bulletin of Ecumenical Theology* 31 (2019): 34–60.

the Ebola disease was the deadliest and the most destructive. The epicenter of the disease was Liberia and Sierra Leone.[5]

According to Roca, Afolabi, Saidu, and Kampmann, the first outbreak of Ebola disease occurred in Zaire (now Democratic Republic of Congo) in 1976 and was named after the Ebola River, the area where the disease was first found. That same year, a different strain of the disease occurred in Sudan.

> Since 1976, more than 25 known outbreaks of EV have occurred in Africa, and 5 different EV species have been identified. Currently, EV hemorrhagic fever remains a plague for the population of equatorial Africa, with an increase in the number of outbreaks and causes since 2000 … . The previous largest outbreak occurred in Uganda in 2000 and involved 425 persons, less than 2% of the affected subjects in the current outbreak [2013].[6]

In past outbreaks, according to Roca et al., the disease was confined to rural and isolated areas in Central Africa, without spreading to the urban areas. In the West African outbreak, it spread more in densely populated urban areas and then to some rural communities.

Ebola is a disease which is spread through contact with bodily fluids of a symptomatic Ebola patient. It is highly contagious and kills more than 90 percent of those who are infected with this lethal virus, particularly in the absence of supportive care and therapies. The case/fatality (CFR) rate ranges from 41 percent to 89 percent depending on the strain of the Ebola virus and the setting. Five main strains have been identified—Zaire, Sudan, Bundibugyo, Tai Forest, and Reston—with the Zairean strain being the

[5] Anna Roca, Muhammed Afolabi, Yauda Saidu, and Beate Kampmann, "Ebola: A Holistic Approach is Required to Achieve Effective Management and Control," *The Journal of Allergy and Clinical Immunology*, 135, no. 4 (2015): 856.

[6] Roca, Afolabi, Saidu, and Kampmann, "Ebola: A Holistic Approach is Required to Achieve Effective Management and Control," 856.

deadliest in terms of the number of fatalities.[7] The West African strain—a type of the Zairean strain—was not the deadliest, but the number of deaths was higher in West Africa because of failed health care delivery in the sub-region and failed and delayed humanitarian intervention by the international community. With limited access to primary health care and the slow response of the international community, the disease spread rapidly in the West African sub-region at the pace of between four and five hundred cases per week. As Boozary, Farmer, and Jha argue:

> If the Ebola virus surfaced in Boston or Toronto, there is little doubt that their health systems, despite shortcomings, could effectively contain and then eliminate the disease with far lower case-fatality rates than those reported now in West Africa. Why the disparity when there is no proven drug or vaccine available? The answer lies not with the virus, but in the collective failure to ensure availability of adequate health care, staff, resources, and systems required for the delivery of high-quality health care. The Ebola epidemic has placed this failure into stark relief, exposing the pathology of chronic neglect amid broad global inequities.[8]

This "chronic neglect" is often the result of short-sighted local and global response to diseases like EVD in Africa. It is also caused by reactionary measures to contain the infection, while neglecting steps to provide adequate, accessible, safe, and affordable care for the sick and prioritizing health protection and improvement.

At the onset of the Ebola epidemic in Sierra Leone, Farmer observed that local doctors were working with resources similar to those that were used by American surgical teams during the American Civil War![9] Farmer decried the painful condition of the health systems and health care delivery

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[7] Roca, Afolabi, Saidu, and Kampmann, "Ebola: A Holistic Approach is Required to Achieve Effective Management and Control," 857.

[8] Andre Boozary, Paul Farmer, and Ashish K. Jha, "The Ebola Outbreak, Fragile Health Systems and Quality as a Cure," *Journal of American Medical Association* 312, no. 18 (2014): 1859.

[9] Farmer, *Fevers, Feuds, and Diamonds*, 53.

in the most affected countries during the Ebola outbreak as medical, public health, and clinical deserts.[10] Many reasons could be attributed for this failure of humanity and health care delivery during the 2013–2015 Ebola outbreak. First, in terms of *staff*, Farmer and his colleagues argue that there was a shocking absence of trained health care workers—community health workers, nurses, and qualified physicians. A good example is Liberia, which had a broken health system before the outbreak and was recovering from over a decade of war and political and social upheavals. Statistics show that "even before the outbreak, Liberia's 4.3 million people were served by just 51 physicians—fewer than many clinical units in a typical major US teaching hospital."[11] Sierra Leone, on the other hand, had two physicians per 100,000 people and spent $96 per person a year on health, compared with 245 physicians per 100,000 people and $8895 in annual health expenditures in the United States in 2014.[12]

Second, there was the absence of health care resources—or, in Farmer's phrase, *stuff* and *systems*. Boozary, Farmer, and Jha strongly disagree with the claim that simply providing vaccines or monoclonal antibodies will help African countries fight EVD. Such success can only emerge when other systemic factors are addressed in African societies. One such factor, they argue, is the reform of the health care services and institutions. Health care services should prioritize quality of care and basic preventative measures like nutrition, water, and sanitation over the disease-control paradigm and other interventionist measures that focused on containing the epidemic rather than providing quality care. At the same time, "stuff" is not unimportant. According to the World Health Organization, "The lack of basic health care resources—such as protective gloves and gowns,

[10] Farmer, *Fevers, Feuds, and Diamond*, 4, 430.

[11] Boozary, Farmer, and Jha, "The Ebola Outbreak, Fragile Health Systems and Quality as a Cure," 1859.

[12] Statistics from WHO's *Global Health Observatory: Density of Physicians and Per Capita Total Expenditures on Health at the Average Exchange Rate*, in Annette Rid and Ezekiel Emanuel, "Why Should High Income Countries Help Combat Ebola" *Journal of the American Medical Association* 312, no. 13 (2014): 1297.

intravenous fluids, and straightforward protocols and guidelines—limited front-line health workers who risk their lives to care for those affected with Ebola."[13]

In addition, the absence of *spaces*, that is, good and safe health care facilities providing quality care for infected patients reduced their chances of survival. In fact, many Ebola patients who arrived in such facilities in West Africa during the outbreak

> received no intravenous rehydration and extremely limited monitoring of hematocrit and liver and kidney function. Other affected patients wait, and may die, outside the closed gates of overwhelmed facilities. Is it any wonder, then, that so many individuals are losing confidence in the ability of their health systems to care for them?[14]

As a result, there was a high case fatality rate in the isolated units of the hospitals at the peak of this outbreak. Many health care workers died from the disease because of intra-hospital transmissions. Thus, during the transmission phase of the disease, many people lost trust in the health care delivery because people feared that if the doctors and nurses could not shield or care for themselves against this disease, then it was unwise using the health care facilities under their watch.

Indeed, the pioneer Ebola doctor in Sierra Leone and Director of the Kenema hospital, Dr. Sheik Humarr Khan, who ran a special unit for treating febrile outbreaks like Lassa fever and later Ebola, died from EVD. Towards the end of his life, what worried him most was that if he died in an Ebola treatment center (ETC), it would discourage people from presenting themselves to the hospitals. In Farmer's view, Dr. Khan and thousands of West Africans who died of Ebola in the continent succumbed to the disease because "the variable virulence of pathogens is

[13] Boozary, Farmer, and Jha, "The Ebola Outbreak, Fragile Health Systems, and Quality as a Cure," 1859.

[14] Boozary, Farmer, and Jha, "The Ebola Outbreak, Fragile Health Systems, and Quality as a Cure," 1859.

pretty quickly swamped by the variable virulence of the world we inhabit. Giving all the credit to the virus is dubious when we humans have been the architects of the stunning inequities that characterize our shared world."[15]

Ebola is only a deadly disease if you live in Africa. Boozary and colleagues in their research show that there have been other major viral outbreaks in the world like the 1967 Marburg hemorrhagic fever, which occurred in Germany and the then Yugoslavia, or the Severe Acute Respiratory Syndrome (SARS) in Canada in 2003, or the Middle Eastern Respiratory Syndrome (MERS), the Avian influenza (H5N1), or Mad Cow disease, none of which spread like Ebola. The high fatality of Ebola disease, they argue, "is related to lack of adequate systems in which the health care staff and resources can be effectively deployed."[16] Most public health professionals know that the reason viral infections similar to Ebola that started to spread in other parts of the world before COVID-19 were contained was that "thanks to a mix of specific therapies (antibacterial, antiparasitic, antifungal, antiviral) and nonspecific therapies (supportive and critical care), we have made most formerly fatal microbial diseases eminently survivable."[17] The availability of these therapies outside Africa is the reason why American and European health workers who were infected with EVD and were flown back to the US or Europe survived the disease. They received the advanced care that Dr. Khan and his nurses and other health care workers did not receive in Sierra Leone.

However, a more comprehensive understanding of why Ebola ravaged West Africa in 2013–2015 and continues to flare up now and again in many parts of the Africa invites us to the realm of social medicine and public health. This lens can shed more light on global health inequity, helping to address why Africans and those in the global community interested in the health and wellbeing of Africans, must pay attention to

[15] Farmer, *Fevers, Feuds, and Diamonds*, 42–43.

[16] Boozary, Farmer, and Jha, "The Ebola Outbreak, Fragile Health Systems, and Quality as a Cure," 1860.

[17] Farmer, *Fevers, Feuds, and Diamonds*, 50.

health promotion and health improvement based on a social justice approach to addressing global health inequity.

Ebola, the Ravages of History: Why Africa?

But why is Africa home to Ebola, and why does this viral infection persist in Africa? Why do some Africans die from the disease and some live? Why do Westerners who get the disease survive from it, and Africans who get infected die? The answers to these questions have nothing to do with Africa's people, weather, climate, food, or environment. In addition, the nature of genomes of the Ebola variants circulating in West Africa between 2013 and 2015 and the hypovolemic shock that eventually killed many West Africans as a result of the disease had nothing to do with their genes or social life, as is often posited.

Rather, the answers to these questions, Farmer argues, can only be found in social medicine and in the history of the social determinants of health in the West African context. As he notes:

> If you want to explain wildly varying fatality rates among those infected with the same strains of a virus, you have to understand the social context in which care is given. The same is true of transmission: the setting determines what kind of care is available and how safely care is delivered. Similar points have been made regarding most communicable pathogens for well over a century. That century has also taught us that medical impoverishment and high fatality rates and untrammeled contagion can be radically and rapidly reduced by vigorous human countermeasures.[18]

Why are these human counter-measures not taken in Africa? This invites us to dig deeper into the history of the continent, racism, colonial medicine, and a concatenation of factors like religion, economies of scale, and past history. According to Farmer:

[18] Farmer, *Fevers, Feuds, and Diamonds*, 44.

> West Africa's economy had long been shaped by epidemics of all-pervading fever. These, in turn, were shaped by political economy, which in these parts is always both local and translocal. There can be little doubt that slavery and its disruptive machinery triggered raids and war while unleashing epidemics across the region and in the distant lands to which its sons and daughters were dispatched. Nor is there doubt that the racism underpinning and justifying slavery was rooted in an enduring belief that some lives matter less than others.[19]

Here, Farmer called the world to pay attention to "the synergy of several factors" which contribute to bringing or threatening the conditions for abundant life and human wellbeing. These factors with regard to EVD in West Africa were undermined by:

> a context of decades of civil war leading to a low level of trust in authorities, even when these are working hard to reconstruct the country; dysfunctional health services with a major scarcity of health workers, especially in Liberia and Sierra Leone; strong traditional beliefs in disease causation and even denial of the virus' existence; high-risk traditional funeral practices that amplify transmission, in addition to more recent healing practices in some churches where the bodies of patients with Ebola are touched; a slow and inadequate national and international response; and high population mobility across borders.[20]

This "synergy of several factors" can help us understand why the disease-control-and-treatment paradigm fails in public health in Africa. They also provide answers to the following questions: Why is Africa susceptible to certain kinds of diseases, and why do people who get infected with HIV/AIDS or Ebola, for instance in Africa, have less chance

[19] Farmer, *Fevers, Feuds, and Diamonds*, 205.

[20] Peter Piot, Jean-Jacques Muyembe, and W. John Edmunds, "Ebola in West Africa: From Disease Outbreak to Humanitarian Crisis," *The Lancet* 14 (2014): 1034.

of survival than their colleagues outside Africa?[21] What social, economic and environmental factors are at play in determining health and life outcomes for the poor in Africa which are differently aligned in other non-African settings? Why are African local knowledge and agencies still stigmatized in understanding the interaction of diseases and other non-biomedical factors in spreading infections in Africa and in the kinds of responses which Africans are making to these diseases? In the rest of this essay, I address one significant factor that has played an important role in the health of the poor and how its consequences continue even today to destroy the lives of Africans: colonial medicine and racism.

Colonial Medicine and Racism

Farmer begins chapter five of *Fevers, Feuds and Diamonds* with the question, "Why did West Africa become a clinical desert—a place in which the rapid human-to-human spread of Ebola was not just possible but almost inevitable?"[22] His answer is that "pathogens and pathogenic forces" that settled in the so-called West African "fever coasts" were linked to the worldwide web of mercantilist expeditions of the West that began the destruction and despoilation of Africa. The movement of peoples through the slave trade from Africa to the Americas and to Europe and back and forth was also accompanied with the spreading of diseases. It is significant to note that the two epicenters of Ebola disease in the 2013–2015 epidemic, Liberia and Sierra Leone, were countries that were founded by liberated slaves who were returned to the African motherland from the US, the UK, and Canada. The destruction of livelihoods, forests and fauna, and the displacement of peoples—an unintended consequence of the slave trade and after—turned West Africa into a fertile ground for the spread of

[21] See, for instance, Angus Deaton's analysis on "escaping death" in the African tropics and why infectious and non-infectious diseases which killed his Western ancestors in the seventeenth and eighteenth century continue to kill African babies, youth, mothers and the elderly today in *The Great Escape: Health, Wealth, and the Origins of Inequality* (Princeton: Princeton University Press, 2013), 100–106.

[22] Farmer, *Fevers, Feuds, and Diamonds*, 191.

infectious diseases. Thus, Farmer concludes that the fevers and feuds that destroyed Liberia and Sierra Leone prior to the Ebola outbreak were all linked to the slave trade in some ways. This is an important point to note because the ravages of African history that began in the slave trade all contribute to other factors that explain some of the lingering social determinants that produce sub-optimal health among a greater number of the population in these two countries.[23]

According to Quentin G. Eichbaum and his colleagues, "Colonialism directly impacted medical practice and education in Africa by using medicine as a tool for domination and control. Medicine provided a biological rationale for assigning racial superiority or inferiority. Thus, medicine was used to rationalize and justify inequities and excesses under imperial domination."[24] The argument here is that we must consider slavery, colonial medicine and its successor (global health), racism, and Western exploitation of Africa's vulnerability as some of the major factors that "*manufacture epidemics*" in Africa. It is therefore important to go back to the colonial origins of Western medicine and the Western negative framing of African bodies, spaces, and contexts in order to capture the complexity of how they combine in manufacturing epidemics and deaths in Africa. Farmer, building on the wisdom of Louis Pasteur—*le microbe n'est rien, le terrain est tout*—invites us to focus on "embodied disparities, social and economic terrains" and the desocialized and decontextualized epidemiology of disease pathogens and causality which deny history, politics, and local and structural violence of the global economy. Understanding microbial pathogenicity in people requires understanding their context and history. This understanding should take us deeper into world systems, including failed and failing democracies.[25]

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[23] Farmer, *Fevers, Feuds, and Diamonds*, 214.

[24]Quentin G. Eichbaum, Lisa V. Adams, Jessica Evert, Ming-Jung Ho, Innocent A. Semali, and Susan C. van Schalkwyk, "Decolonizing Global Health Education: Rethinking Institutional Partnerships and Approaches," *Academic Medicine* 96, no. 3 (2021): 330.

[25] Farmer, *Fevers, Feuds, and Diamonds*, 441–444.

To understand why the deeper roots of global health inequity trace back through slavery, racism, and colonialism in Africa and why where one is born determines how the person will die, we need "a broad-scope awareness of a diversity of stories" from communities and peoples.[26] Farmer argues that for people of African descent, the story goes back to slavery and colonialism, the original twin pilots of racism for peoples of African descent. Slavery and colonial medicine in Africa gave birth to the "control-over-care" paradigm of health. During the outbreak of Ebola in West Africa, more resources were put into safe burials, contact tracing, isolation, and social distancing over treatment and care of those who were afflicted, most of whom were left to die painful deaths without any form of therapies. This was a replication of methods of allowing the sick to die to keep the colonial masters protected from contact with the *doomed Africans*. For example, the French colonial authorities responded to outbreaks of diseases during the colonial era not with caring for the sick but rather with "the destruction of housing, highly restrictive and segregationist building codes, quarantine, isolation, fines, and other penalties for infractions. Disease-control algorithms were applied in discriminatory fashion, sparing Europeans—and their businesses—in a manner that rankled Creole elites."[27] What this example among many others show is that there were no efforts to integrate preventative measures and disease control with treatment and care for the sick in the colonial period and even today in Africa. It is important to demonstrate the strong link that exists between colonial pathologies and the epidemics they foster in today's Africa.

Second, colonial medicine "paid almost exclusive attention to the unitization of people in larger aggregates."[28] This tendency to define, distort, and label the *African other* as belonging to a pathological collective

[26] Susan Holman, *Beholden: Religion, Global Health, and Human Rights* (NY: Oxford University Press, 2015), 43.

[27] Farmer, *Fevers, Feuds, and Diamonds*, 261.

[28] Rijk van Dijk, "Foucault and the Anti-Witchcraft Movement: A Review Article," *Critique of Anthropology* 14, no. 4 (1994): 431.

is still prevalent today. The *African other* inhabits a strange and dangerous space, and diseases like EVD only shows why that dangerous space should not be shared by the rest of humanity in order to save that humanity from contamination. The African does not belong; the African is a stranger on the global stage and his or her life really does not matter.

Third, colonial medicine reinforced stereotypes and categorization of Africans and racial prejudice by the 'othering' of blackness as a collectivized contaminating identity characterized by death, decay, and traditional cultural and religious practices which promote diseases and deaths like burial rites, eating of bush meat, and ancestral traditions. This "community linked fate" seen in the objectification of those West Africans sickened by EVD fails to pay attention to distinctions and subsequently represses the subjectivation of Africans in the African continent which undermined agency and individual and group autonomy.

Megan Vaughan's *Curing Their Ills: Colonial Power and African Illness* helps us to understand how the dynamics of global health inequity are rooted in colonial history.[29] She demonstrates how power and politics with the health of people of African descent are tied to colonial medicine and knowledge construction. According to Vaughan, "Knowledge claims and constructions that provide ideological legitimacy to hierarchical systems and social structures" create health inequalities in Africa.[30] The primary thesis of Vaughan's book is that colonial biomedicine invented an image of Africa in Western medical and social discourse from the colonial period and beyond as "a repository of evil, death, disease, and degeneration."[31] Using a social constructionist approach, she argues that British medical personnel ascribed many diseases to the racial makeup of Africans. The diseases found in Africa were projected as reflective of the social reality of Africa, just like President Trump and his ardent followers

[29] Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford: Stanford University, Press, 1991).

[30] Janet K. Shim, "Bio-Power and Racial, Class, and Gender Formation in Biomedical Knowledge Production," *Research in the Sociology of Health Care* 17 (2000), 188.

[31] Vaughan, *Curing Their Ills*, 2.

referred to Coronavirus as the China virus, against the discontinuation of the health community of naming and associating a disease with the place where it was first found. Rather than looking at the scientific evidence for disease from the point of view of history and biology, colonial medicine saw the diseases in Africa as cultural; the way of life of the people, their cultural and social life and behavior were all contaminating. Colonial medicine, in this way, constructed the enduring imaginary of African society and blacks as unhealthy and pathological: "Medical discourse operated by locating difference and differences in the body, thereby not only pathologizing them but also naturalizing them."[32]

One implication of this construct, among many others, is what Farmer calls "control-over-care" paradigm.[33] This paradigm is the eternal preoccupation by Westerners with preventing the spread of diseases in the community or from the Africans to the Europeans rather than addressing the root causes of the diseases and improving the health and wellbeing of the people. Farmer gives many examples of this colonial paradigm which persists to this day in Africa. One particular example is the French approach in Africa. Two strategies were chosen by the French as external symbols of its 'civilizing mission' in Africa—public works and public health. For public works, the French built rail roads to connect its major colonial hubs in Africa like Dakar and Abidjan. For public health, the French introduced health reform through "sanitarians' grand plans."[34] The plan was to contain diseases and other forms of public health intervention on the people, which, according to Farmer, generated "fear and awe" among the people. Why? Because the plan to contain movement and control diseases was not about health improvement for Africans or improving the quality of their livelihood. Rather,

> disease control in West Africa had been linked under colonial rule to vigorous efforts to extract profits from these lands and their people. The

[32] Vaughan, *Curing Their Ills*, 13.
[33] Farmer, *Fevers, Feuds, and Diamonds*, 261ff.
[34] Farmer, *Fevers, Feuds, and Diamonds*, 261.

> quest, which continues, always sparks conflict. Every chapter of the history of West Africa under European rule seems to include yet another cataclysmic outbreak of disease or conflict (or both) followed by ineffective or repressive measures (or both) and linked to an unbroken chain of profiteering.[35]

There is also a racial component to the colonial disease-control-over-care paradigm. African-American writer Toni Morrison decries the global project "to metaphysically void Africa" of its beauty and assets through many contaminating narratives of Africa. She also writes of what she calls "the freighted and complicated emotions" and "disdain, mythology of passivity, and traumatized Otherness" with which African history and social realities have been consigned into an "unmediated estrangement."[36] Her account describes well how contaminating narratives of Africans function. This contaminating narrative of Africanism, Morrison argues, becomes a term for the "denotative and connotative blackness that African peoples have come to signify as well as the entire range of views, assumptions, readings and misreading that accompany Eurocentric learning about these people."[37]

According to Morrison, this propensity to reify and demonize blackness, to inscribe and erase, to historicize and render timeless, to exercise power over blacks and to exclude and to assign or withdraw value to blackness is how the predominant contaminating narrative of blackness has been developed and mediated through multiple White supremacist channels.[38] This is particularly evident in the way diseases and outbreaks like EVD or HIV/AIDS have been used to construct a negative representation of African bodies, societies, institutions, social agency, and an essentialized notion of race. One of many examples that Farmer gives is

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[35] Farmer, *Fevers, Feuds, and Diamonds*, 271

[36] Toni Morrison, *The Origin of Others* (Cambridge, MA: Harvard University Press, 2017), 101–102.

[37] Toni Morrison, *Playing in the Dark: Whiteness and the Literary Imagination* (NY: Vintage Books, 1993), 6–7.

[38] Morrison, *Playing in the Dark*, 8–9.

one tweet from then-candidate Trump who gave the impression that a total travel ban should be imposed on West Africa because of the possibility of spreading Ebola from Africa. According to Trump, "Obama won't send troops to fight jihadists, yet sends them to Liberia to contract Ebola. He is a delusional failure."[39] The truth is that for many non-Africans, the African continent is often portrayed as a repository of diseases and death with which they should not associate or from which they should escape. The African body was seen as a domain of maladies, and in many instances, African men who had protested against oppressive industrial, mining, or farm conditions were consigned to sanatoria as mental health patients.

Ebola and Global Health Inequity in Africa: A Theological Ethical Analysis

Michael Rozier argues convincingly that the Catholic Church has been less engaged in global public health discourse than one would have expected. However, the church is very active in providing health care in most parts of the world including Africa. For example, the Catholic Church has numerous health facilities in Africa. The Democratic Republic of Congo (DRC), with more than 2,185 facilities, has the highest number of Catholic health facilities in Africa. It is followed by Kenya with 1,092 and Nigeria with 524 facilities.[40] According to Rozier, the reason for this lack of engagement in public health discourse by the church is that the core motivation for Christian involvement in health care is to continue the ministry of the Lord Jesus to the sick. In Africa, this is particularly evident

[39] Cited in Farmer, *Fevers, Feuds, and Diamonds*, 34.

[40] For the latest statistics on Catholic health facilities in Africa, see Quentin Wodon, "Catholic Health Facilities in Africa: Achievements and Challenges," in *Handbook of African Catholicism*, ed. Stan Chu Ilo (Maryknoll, NY: Orbis Books, 2022), 540-544. See also Jill Olivier, Clarence Tsimpo, Regina Gemignani, Mari Shojo, Harold Coulombe, Frank Dimmock, Minh Cong Nguyen, Harrison Hines, Edward J. Mills, Joseph L. Dieleman, Annie Haakenstad, and Quentin Wodon, "Understanding the Roles of Faith-Based Health-Care Providers in Africa: Review of the Evidence with a Focus on Magnitude, Reach, Cost, and Satisfaction," *The Lancet* 386, no. 10005 (2015): 1765–1775.

in the fact that healing ministries are the fastest growing Christian movements in Africa.[41] As a result of this concentration on healing the sick and responding to their suffering, "the infrastructure of the Church was built largely to provide medical care to those who are ill."[42] Rozier helps us to understand why, particularly in Africa, both the local churches and their international partners focus more on providing medical supplies like drugs, diagnostic equipment, building hospitals, and sending medical workers to Africa rather than addressing health policies and public health issues like poor priority settings by local churches, failed government health programs that are reactionary, and the social determinants of health.

When Farmer invites us to pay greater attention to the multiple factors that bring about health, diseases, and death, he is inviting us to pay greater attention to the social determinants of health. These multiple factors he describes as "social drivers of epidemics," "the economic and social terrain," "therapeutic nihilism," particularly producing "differential virulence," seen everyday by "those who work in settings in which social determinants of exposure risk and access to care are thrown into relief—settings of poverty, war, or famine, or during natural or manmade disasters."[43] In order to offer hope to the sick in Africa and anywhere in the world and to build effective health systems and optimal health care delivery in Africa, one must pay attention to these social and commercial determinants of health. A good metaphor that is often used in public health to capture this point

> depicts illness as a river that people find themselves "pushed into" by adverse socio-economic conditions. They then float down the river until, if they are lucky, the health service intervenes and pulls them out. The

[41] See the analysis of the arguments of Paul Gifford and Bernhard Udehoven, "Searching for Healing in a Miraculous Stream," in *Wealth, Health, and Hope in African Christian Religion: The Search for Abundant Life*, ed. Stan Chu Ilo (Lexington, KY: Lexington Books, 2017), 46–55.

[42] Michael Rozier, "A Catholic Contribution to Global Public Health," *Annals of Global Health* 86, no. 1 (2020): 1.

[43] Farmer, *Fevers, Feuds, and Diamonds*, 447

> health service clearly performs a vital role in this scene, but the public health response is to look further up the river and address those circumstances that make people fall in to begin with: prevention being preferred to cure.[44]

What should be the response of the church and theological ethicist to the fact that millions of Africans are being pushed into the rivers of health inequity? What are the current responses of churches in Africa and theological ethics to global health inequity as it affects Africa?[45] The response of both the church and theologians in Africa to the burden of such diseases like Ebola, HIV/AIDs, malaria, and COVID-19 in Africa has followed the following patterns:

1. A conscious attempt is made to follow the instructions from the World Health Organization or the Vatican or the funding organizations from the West who are 'partners' with Africa's church health care delivery entities;
2. African churches do not produce their own knowledge regarding the kinds of interventions needed for health care emergency or health education nor have the churches and theologians worked on identifying and addressing the barriers to optimal health in Africa. As a result, there are no strategies or ethical frameworks designed to remove these barriers nor have adaptive steps been designed to build on the African context of health and abundant life in a creative way;
3. There is a lack of interest in identifying the assets and resilience of local communities and churches in order to strengthen cultural and communal agencies through community mobilization and advocacy for the poor; and

[44] Matt Egan, "Health Public Policy," in *Health Promotion Practice*, 2nd Edition, ed. Will Nutland and Liza Cragg (NY: Open University Press, 2015), 71.

[45] See for instance, Jim Keenan's recent summary of the focus of Catholic theological ethics in Africa in *A History of Catholic Theological Ethics* (New York: Paulist Press, 2022), 320–327. It shows that African theological ethicists have not focused on addressing agency, the rights of the poor to universal health coverage, food and human security, and environmental health, but rather on foundational issues around liberation and inculturation theologies.

4. Ethical reflection has largely centered around the adequacy of health care services and quality and ethics of care/prevention/control; the weaknesses and threats of healing ministries; the suffering of the sick person; and end of life issues. Sadly, little attention has been paid to health protection and health promotion which address the underlying remote and proximate social determinants of health including the worldwide web of commercial interests and neo-liberal capitalism that are really the drivers of global health inequity.[46]

More than eight years before the COVID-19 pandemic, a group of international public health specialists had warned that commercial interests that had inundated the food chains of low- and middle-income countries (LMICs) and poor people in high-income countries (HICs) with cheap unhealthy food were "manufacturing epidemics" in the world.[47] Sadly, while neo-liberal capitalism and its associated false accounts of global convergence continues apace within the context of increasing public health nihilism in many parts of Africa, the accounts of health and wellbeing in Africa are being written by the WHO and other foreign agencies with a certain determinism or fixation on particular diseases that need to be contained, like HIV/AIDS, and other random epidemics that reflect Africa's history. Sadly, there is no proactive plan and strategy to improve population health by improving the quality of life of Africans and the social conditions that manufacture sickness and death. As Farmer puts

[46] An exception has been the works of the recently deceased Jacquineau Azétsop, ed., *HIV & AIDS in Africa: Christian Reflection, Public Health, Social Transformation* (Maryknoll, NY: Orbis Books, 2016). See also his joint study with Michael Ochieng of the rights to health improvement and promotion in public health in Chad which emphasizes some of the concerns that I address here though his focus is on public health care providers and not private entities like the church: Jacquineau Azétsop and Michael Ochieng, "The Right to Health, Health Systems Development and Public Health Policy Challenges in Chad," *Philosophy, Ethics, and Humanities in Medicine* 10, no. 1 (2015): 1–14.

[47] D. Stuckler, M. McKee, S. Ebrahim, and S. Basu, "Manufacturing Epidemics: The Role of Global Producers in Increased Consumption of Unhealthy Commodities Including Processed Foods, Alcohol, and Tobacco," *PLoS Med* 9, no. 6 (2012): e1001235, doi:10.1371/journal.pmed.1001235.

it, "The control-over-care paradigm is now caught up in a broader neoliberal one: when everything is for sale and public goods are few, both prevention and care are at risk of becoming commodities."[48] In a special commentary on *The Lancet*, Ilona Kickbusch and colleagues draw attention to how these determinants function in global health:

> Health outcomes are determined by the influence of corporate activities on the social environment in which people live and work: namely the availability, cultural desirability, and prices of unhealthy products. The environment shapes the so-called lifeworlds, lifestyles, and choices of individual consumers—ultimately determining health outcomes.[49]

Global health is a creation of colonialism. Many factors that we have identified in Farmer's work on why Ebola kills many Africans are attributable to the structure of global health today that undermine the health of the poor in the world and particularly in Africa. Global health has been generally accepted and is now a common currency circulating even in theological ethics and bioethics. However, it is a term that is fraught with many contradictions. Global health is "an artificial construct" developed in HICs to describe the kind of health care practices in LMICs and how the HICs are designing and determining the health outcomes of the poor in the erstwhile territories of the colonialists.[50] The case being made here is that population health is determined not simply by the presence of pathogens but by the presence of widespread poverty and the absence of health care delivery and health systems that are resilient, accessible, available and affordable.[51] Many West Africans died from this

[48] Farmer, *Fevers, Feuds, and Diamonds*, 499.

[49] Ilona Kickbusch, Luke Alle, and Christian Franz, "The Commercial Determinants of Health," *The Lancet* 4 (2016): e895–e896.

[50] Eichbaum, Adams, Evert, Ho, Semali, and Van Schalkwyk, "Decolonizing Global Health Education," 329.

[51] See, for instance, Whitelaw's theory of setting-based approaches to health promotion: S. Whitelaw, A. Baxendale, C. Bryce, L. MacHardy, I. Young, and E. Witney, "'Settings' Based

treatable disease (EVD) because they were poor and forgotten and do not seem to benefit from the advances made in global health; rather, they are victims of global neo-liberal capitalism that bolsters inequity, poverty, exploitation, props up dictatorship, and violence. This is Farmer's conclusion as well:

> Ebola and other public-health calamities strike most often in places from which human capital and raw materials have been extracted for centuries. From the rural reaches of Haiti and Rwanda, from prisons of Siberia, and from the slums of urban Peru: for thirty years, I've been pointing out how the epidemics that people have suffered in these places have arisen because of the inequities—political, economic, and medical—that such extractions invariably worsen.[52]

We can talk of global health as an ideal to be pursued. However, in reality, global health as it exists today is sustained by asymmetrical power relations that negate the assets and agency of local communities. It is also built on a racist frame about Africa, for instance, that objectifies the sick and blames the poor, while reducing them to commercial objects, consumers of medication, and burdens to local and global economies. My contention here is that there is nothing really "global" in the health of the world given the glaring inequality in health care, health systems, and health structures across the globe and in particular nations. Indeed, we should be speaking of global diseases as a counterpoint to global health. This is so because the choices humans have made and the unjust structures in the world today have made the majority of people who live in the Global South and inhabitants of slums in our big cities in North America and Europe sicker and poorer. Our collective choices have also made the planet a less habitable home. So true are the immortal words of Thomas Berry that

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Health Promotion: A Review," *Health Promotion International* 16, no. 4, (2001): 339–353, doi.org/10.1093/heapro/16.4.339.

[52] Farmer, *Fevers, Feuds, and Diamonds*, 505.

"you cannot have healthy people in a sick planet."[53] In this kind of world, it is hard to realize the goal of "one health," a central direction for global health proposed by the US Center for Disease Control (CDC).[54]

Global health in Africa is represented through the systems of interventions from the West to Africa that Farmer calls "crisis caravans" who fly in for few hours, days, and weeks to provide medical missions, collect medical data, and provide temporary and unsustainable treatment of diseases or institute interventions for disease control. The improvement of the health of people in Africa and the courageous transformation of the medical impoverishment in Africa can only come about when the destructive chain linking the racialized global health practices and programs and virulent and persistent colonial policies that "neglected the destitute sick" are addressed. These sinful links have left intact as health orthodoxy some disastrous health policies and programs in global health today carried out by development institutions, UN agencies, and medical missions from the West to Africa, creating more crises and dislocation and worsening the health of the poor.[55] Alexandre Martins proposes a different understanding of global health from the top-down approach of international organizations, universities, and government and non-governmental agencies when he writes: "Global health is about justice in health care and incorporates the participation of individuals in the common good. A justice that fosters participation in the common good results from a collective engagement that promotes fair relationships

[53] Dennis Patrick O'Hara, "As Thomas Berry Concluded, It Is Not Possible to Have Healthy Humans on a Sick Planet," *The Irish News*, December 7, 2022, www.irishnews.com/lifestyle/faithmatters/2020/06/25/news/awakening-to-the-sacredness-of-creation-with-laudato-si--1982398/.

[54] 'One Health' is far from being realized. The One Health Initiative is "a collaborative, multisectoral, and transdisciplinary approach—working at the local, regional, national, and global levels—with the goal of achieving optimal health outcomes recognizing the interconnection between people, animals, plants, and their shared environment," Centers for Disease Control and Prevention, "One Health," www.cdc.gov/onehealth/index.html.

[55] Farmer, *Fevers, Feuds, and Diamonds*, 431.

among individuals."[56] Ultimately, what Martins points out is the need for community empowerment, assets, participatory practice, and self and community driven efficacy, agency and advocacy. Global health inequity and its colonial and racist roots as shown in the Ebola crisis call theology to an honest accounting of its own role in these roots as well as the ways it continues to function in colonialist and racist ways. How do the preaching in African churches and African theologies of healing, ancestral causes of diseases in Africa, and some forms of healing ministries *manufacture epidemics in Africa*?

Conclusion: Paul Farmer's Lessons for Theological Ethics

How can we think differently about the role of theological ethics in Africa going forward? Church health care agents in Africa have often provided logistic and professional support for the containment of diseases by international organizations in times of epidemic and humanitarian intervention. They have also provided health education. These agents and African theological ethicists have also raised cries for help to international community and led mission appeals and medical missions to Africa. But these efforts are not enough because they reinforce the undersides of global health—a reactionary interventionist approach that does more harm than good in the long run. Church health agents and pastoral agents in Africa have not been effective in addressing the structural violence in particular countries and designing an ethics for holistic health and a biosocial theological ethics of solidarity with the poor. There is the need for theological ethicists to pay greater attention to micro (individual), meso (national), and macro (international/global) factors in order to understand the African burden of diseases, of which EVD is only another layer in the ever-revolving cycle of disability and exposure to diseases and deaths for many poor people in Africa.

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[56] Alexandre Martins, "Ethics and Equity in Global Health: The Preferential Option for the Poor," in *Ethical Challenges in Global Public Health: Climate Change, Pollution, and the Health of the Poor: Global Theological Ethics*, ed. Philip J. Landrigan and Andrea Vicini (Eugene, OR: Pickwick Publications, 2021), 100.

In order to do this, I propose a biosocial ethics of holistic health as an ethical framework for understanding the complexity of African history, the sinful structures on which the social and commercial determinants of health are built in Africa and in global health, and the health of the poor in Africa. A biosocial ethics that is also capable of unmasking the structures of sin and injustice and power differential in Africa can make possible solidarity and the option with the poor by courageously confronting the convergence of local and global factors that continue *to manufacture death* in Africa and sustain the deceptive and destructive global health policies and interventions in Africa.

The biosocial theological ethics of solidarity is grounded on the intrinsic goodness of all lives and provides the foundational compass for interpreting how the choices being made by individuals, systems, structures, and institutions with regard to population health, especially of the poor and vulnerable, promote and harm holistic health as well as human and cosmic flourishing. This ethics reflects on and proposes what ought to be done by individuals, societies, nations, and all men and women for health protection and health promotion by addressing the social determinants of health as they manifest in local, national, and international settings. It pays particular attention to the index of deprivation in particular societies, what factors are generating it and how they vary from one society to another. Biosocial ethics of health focuses on all the factors which interact in the procurement of abundant life—nutrition, sanitation, water, clean air, quality of one's social relationships, cultural and spiritual traditions, politics, economics, religious beliefs and practices, traditional and modern knowledge about health, sickness, diseases and healing. It examines the adequacy of human actions, health and economic policies, and value preferences—cultural, religious, social, political, etc.—in hampering or advancing the proper interaction of these integrative factors, which all must work together in bringing about human wellbeing.

Paul Farmer, through his exemplary life and writings, synthesized his wisdom in his final book, *Fevers, Feuds, and Diamonds*. Through Partners In Health, Paul Farmer tried to invent a new approach to global health

equity, a partnership that places greater effort on building affordable, accessible, and available health care systems in Africa and training Africans to take care of the health of their own people. He could be said to have applied the principle of health *for* Africans *in* Africa *by* Africans. This is why he pioneered the building of the University of Global Health Equity in Rwanda, where he spent his last days here on earth.[57]

The future of global health partnership in Africa must be built on a biosocial model that aims at strengthening the capacity of local agencies, through individual and communal efficacy. Global health agents in Africa must adopt a respectful partnership with African peoples, health systems, governments, and private and religious entities. The priorities should be set by the Africans themselves, rather than by external forces and external interests; the goals should be health improvement and protection, rather than disease control and prevention.

A vital component of health systems in Africa that Farmer never addressed which is very important in concluding this essay is the role of faith-based entities. There is a growing recognition of the role of faith-based organizations in public health. In a special edition (March 2019), the *American Journal of Public Health* (AJPH) argues in an editorial that religious entities provide social capital for promoting population health particularly for vulnerable and seldom-heard communities. The editorial specifically identifies religion as a social determinant of population health, "providing leadership and capacity for service and social solidarity" in public health.[58] Joshua Williams and colleagues propose that the decisiveness of the role of faith-based entities is often seen in times of outbreak of diseases. According to them "Throughout history, faith

[57] The University of Global Health Equity, ughe.org/.

[58] Eileen Idler, Jeff Levin, Tyler J. VanderWeele, and Anwar Khan, "Partnerships Between Public Health Agencies and Faith Communities," *American Journal of Public Health* 109, no. 3 (2019): 346, doi.org/10.2105/AJPH.2018.304941.

communities and faith leaders have undertaken indispensable work to seek the good of their communities during contagions."[59]

Medical mission is still a very big business in Africa from faith-based agencies as well as other humanitarian organizations. Perhaps the churches with a strong sense of social justice and a new understanding of partnership that is different from tokenism, saviorism, and associated racialized thinking and acting towards Africa can be the new staging ground for a new ethical and life-giving partnership for holistic health built on the principles of social justice and option with the poor. Given the growing recognition of the importance of the leadership of faith-based health providers, Catholic ethicists could help develop some tools for measuring and assessing the effectiveness of the health care by church agencies so as to strengthen them in the service of improving and protecting the health of the population, especially the poor. Despite the significant contributions made by faith-based non-profit providers, Annabel Grieve and Jill Olivier note that "there is a distinct lack of robust evidence on their contribution, historical development, relationship with the public sector, and their contribution to UHC [universal health coverage] and to the strengthening of whole national systems."[60] In 2017, for instance, the World Council of Churches called for the mapping of faith-based health care providers in Africa in order not only to recognize their important contribution to public health but also to promote greater effectiveness and accessibility for these church hospitals.[61]

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[59] Joshua T. B. Williams, Adrian Miller, and Abraham M. Nussbaum, "Combating Contagion and Injustice: The Shared Work for Public Health and Faith Communities During COVID-19," *Journal of Religion and Health* 60, no. 3 (2021): 1437, doi.org/10.1007/s10943-021-01243-4.

[60] Annabel Grieve, and Jill Olivier, "Towards Universal Health Coverage: A Mixed-Method Study Mapping the Development of the Faith-Based Non-Profit Sector in the Ghanaian Health System," *International Journal for Equity in Health* 17, no. 97 (2018): 2, doi.org/10.1186/s12939-018-0810-4.

[61] Jill Oliver and Quentin Wodon, "Mapping, Cost, and Reach to the Poor of Faith-Inspired Health Care Providers in Sub-Saharan Africa: A Brief Overview," in *Strengthening Faith-*

Now is the time for churches to take seriously the need to provide effective, comprehensive, safe, affordable, accessible, and timely care to the sick, especially the poor through primary health care. Ultimately, we all must become the vanguard for a new biosocial ethical approach to healing the sick, improving health, and promoting the conditions for human and cosmic flourishing so that God's people may have abundant life. In this much needed movement, we are glad that we have Dr. Paul Farmer as our model and guide speaking to us from the communion of saints.

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Inspired Health Engagement, vol 3, ed. Jill Olivier and Quentin Wodon (Washington, DC: The World Bank, HNP Discussion Papers; 2012).