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Mother of All Labour

Vulnerability and Immunity in Times of Ebola

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Abstract

Wonkifong Ebola treatment unit was unique at the time of the outbreak that hit the Guinea in 2014. Contrary to other infrastructures run by Western workers, Wonkifong mainly employed personnel from Guinea, the Democratic Republic of Congo, and Cuba. Even so, the unit constituted a racialised landscape where proximity to white agencies granted privileges to certain groups of racialised people while excluding others. In a humanitarian infrastructure aimed at empowering knowledge of epidemics in the Global South, Black children were quarantined without their parents and left mostly unattended. After many months, former patients were hired as nannies to remedy the infrastructure's blind spot. These women were employed to care for the children thanks to their immunity to the virus. Building on the concept of a 'politics of life' and exploring how these women were exploited as 'medical superbodies', my article sheds light on how the humanitarian infrastructure produced a gendered labour that mirrors other economies exploiting female Black bodies such as the colony or the plantation. Relying on an ethnography of practices of care and mobility within the unit, this piece underlines how the postcolonial segregation at play during the outbreak operated not strictly in terms of skin colour, but in terms of gender and closeness to white power.

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Humanitarian Aid, Race, Ebola, Gender, Immunity.

> There is a code of conduct in emergency situations, women and children first. The most vulnerable among us should be rescued before all others. In reality, this code of conduct is white women and children first. Black women, black children, they are not afforded the luxury of vulnerability. (Gay 2015)

Little girl exits the quarantine zone. Wonkifong Ebola treatment unit, 2015.

Black Motherhood: race and segregated care in an Ebola quarantine unit

We are in Wonkifong Ebola treatment unit in May 2015. For more than a year, Guinea has been fighting an unprecedented Ebola outbreak. Today, there are about 10 people in the unit. Among them, a woman is sitting on a plastic chair. At a glance, she might be mistaken for a patient. While she looks tired, however, she does not seem to be sick or in pain. The woman, Madeleine, is a former patient of the unit.[1] She has been recruited a few days earlier, along with four other volunteers, as a *nounou* (nanny) to care for unaccompanied children quarantined in the unit.

I am a little confused when I first register Madeleine's presence within the quarantine zone. She is not a patient. Yet neither is she wearing personal protective equipment like the rest of the medical staff. She stands out as a liminal figure in this space where, before her enrollment, people were either waiting to be screened for Ebola, already diagnosed as sick with Ebola, or dressed in top-to-toe waterproof gear to protect themselves from Ebola. Yet Madeleine survived the virus a few weeks ago. Thanks to her new immunity, she can be in contact with infected patients. Since yesterday, Madeleine has been caring for a three-year-old girl. While the medical tour of the staff never exceeds one hour, Madeleine has been staying in the quarantine zone for more than 24 hours, eating and sleeping with patients suffering from Ebola. Today, the child has tested negative for Ebola. Madeleine helps the girl undress and prepares her for the chlorinated shower that ends every quarantine. The little girl is very excited by this new adventure breaking the monotony of quarantine. She runs everywhere and giggles when Madeleine asks her to stay calm.

Before Madeleine was hired, the quarantining of children regularly led to dramatic situations. The usual role of parents in African medical wards, care, could not be played (Jaffré and Olivier de Sardan 2003; Livingston 2012). As biosecurity protocols dictated that medical staff only entered the entire quarantine zone one or two times during an eight-hour shift, patients were left alone most of the time. As it was extremely hot, the constant vomiting and diarrhoea caused by Ebola increased the risk of fatal dehydration. Yet, there were no specific procedures to take care of children who could not feed or drink by themselves. Consequently, sick infants and children were often left close to death, as no health worker was on hand to feed and rehydrate them.

[1] All names in this article are pseudonyms.

Families could only visit from outside. Wonkifong Ebola Treatment unit, 2015.

The treatment of children within the Ebola unit resonates with Fassin's work on humanitarianism. Through the concept of a 'politics of life', Fassin addresses how different values are given to different types of lives within the humanitarian project (2007, 2009). While Western saviours are recognised, and treated, as 'political lives', the victims of epidemics, catastrophes, and wars—those who benefit from humanitarian aid—are equated with 'biological lives': they may be sacrificed for the greater good. Accordingly, within the Ebola unit, younger patients were deprived of the privilege of being recognised politically as children and therefore needing special care to survive Ebola. But the 'politics of life' as explored by Fassin, while enlightening the binary mechanism between 'us'—the valuable lives—and 'them'—the disposable ones—fails to call by their names two fault lines that shape and reproduce social injustice within humanitarian aid: race and gender.

Hiring Madeleine and other former patients substantially improved children's survival rate within the unit. Nonetheless, it also signals the enduring entanglement of race and gender in the field of modern medicine (Peiretti-Courtis 2021;

Washington 2006) since its beginnings. In African colonial territories as on American plantations, Black bodies were commodified through medical experiments. Organs, blood, body parts, and tissues were treated as resources in the same way as land or rivers (Gomez-Temesio 2023) and contributed to the capital of the colony or the plantation. The Black female body was essential, as it constituted the vessel to reproduce human resources (Owens 2017). Regarding contemporary medicine, while the issue of racialised access to health care has been addressed by scholars in the context of medicine in the United States (Bridges 2011; Davis 2016), race until recently has resisted scrutiny in humanitarian medicine (Benton 2016a, 2016b; Hirsch 2021a), seeming to embarrass the researcher's gaze (Beliso-De Jesús and Pierre 2020), particularly when Africa is in focus (Pierre 2013). Regarding gender, women are invisible in Global Health policies and are imagined almost exclusively as mothers (Harman 2016), whose work as carers is treated by aid institutions as a natural female labour, a task that does not deserve to be paid.

Through the figure of the survivor nanny, I propose to revisit the concept of a politics of life through the notion of 'medical superbodies' (Owens 2017). Indeed, Black mothers used as immune vessels to care for children invoke the concept proposed by Owens (2017) when addressing how Black female bodies were exploited in plantation hospitals. If Owens recognises a certain 'messiness' and lack of definition in the notion, used in different contexts to address the racialisation of Black bodies, she defends its relevance in addressing how, while white doctors dismissed Black bodies as completely other, they still exploited them as guinea pigs in medical experiments because they thought they could endure more pain than white bodies—pictured as more fragile and vulnerable. Madeleine's journey in the unit and her recruitment as a surrogate mother illustrate this concept's relevance to a critical revisitation of the concept of a politics of life through an intersectional analysis (Crenshaw 1991). Building on Fassin's work (2007, 2009, 2018), my article will show how women who survived Ebola were exploited as 'supermedical bodies' (Owens 2017) during the outbreak.

Madeleine was quarantined in the unit after having lost her husband to Ebola. She was not the only person contaminated by him. The day Madeleine was quarantined, she had a very sick baby crying in her arms. In quarantine, no one helped her care for her baby. Health workers found him one morning. Madeleine was so feverish she did not even realise her child was dead next to her. Madeleine ultimately survived the virus, but while she was recovering, a female relative came to be quarantined. She died quickly, leaving behind her a baby who was also sick. Louis, a European nurse working in the unit, decided to give Madeleine the baby. Thanks to Madeleine, he survived. Feeling ambivalent about Madeleine's story, I asked Louis who took the initiative of reallocating the baby; whether Madeleine

had agreed immediately to care for another child after losing her own a few days earlier. ‘Of course, she did!’ he answered. ‘For her, it was fated. God gave her another child to replace the one who died.’

It wasn’t clear whether this was Louis’ perspective or hers.[2] But Madeleine was the incarnation of what later became the standard practice of hiring survivors to care for children. Her story was very popular among the workers of the unit. She appeared as both the inspiration and the archetype for hiring surviving patients to care for children. Was it appropriate to hire a woman who just went through traumatic events within the unit? The staff did not question Madeleine’s grief when she was hired. For the personnel, it seemed clear that Madeleine was an exceptionally caring woman, and therefore a perfect nanny for sick children. As such, even before her hiring as a nanny, Madeleine’s journey is emblematic of the gendered care economy through which women act as ‘shock absorbers’ in times of crisis and deliver unpaid work (Harman 2016). Humanitarian policies expected women to perform gendered tasks that are often conflated—as Louis does—with natural mothering. Their exploitation as nannies underlines how humanitarian politics of life reproduce social injustice at the intersection of race and gender.

Wonkifong is an interesting place to write about race and gender in humanitarian aid. Inaugurated in December 2014 and built thanks to funding from the World Food Program, Wonkifong was designed as a South/South collaboration under the auspices of the World Health Organization (WHO) aimed at empowering Guinean health workers and sharing lessons learned from previous Ebola outbreaks. The unit was emblematic of the ‘Africanisation’ of aid (Issoufou 2018; Redfield 2012) as it employed almost no Western worker. Inside its walls, Guinean paramedics worked with a Cuban medical brigade as well as Congolese health workers sent to Guinea by the African Union and the Economic Community of Western African States (ECOWAS). The unit was supervised by two Guinean directors, and inhabited by two small ‘pockets of whiteness’: European workers employed at the lab and Louis, a nurse hired by the WHO to outreach on biosecurity protocols.

The segregation of tasks within the unit underscores how race did not operate strictly in terms of skin colour, but also in terms of closeness to white power. Indeed, while most workers were Black people, there was nevertheless a strict segregation of work depending on the citizenship of the worker. While foreign workers holding contracts with international agencies were hired as doctors or nurses, Guinean workers were mostly hired as *hygiénistes* or paramedics and performed the tasks most exposed to a risk of contamination, such as handling

[2] On mentions of God between Western health workers and Muslim patients as well as practices of ‘cultural othering’ during medical encounters, see Kehr 2018, 665–66.

dead bodies and cleaning biohazards.[3] Therefore, the unit constituted a racialised landscape where proximity to white agencies granted few privileges to certain groups of racialised people while excluding some others; even though these privileges were not the same as those enjoyed by Western/white workers in the aid industry (Benton 2016a, 2016b; Hirsch 2021b; Redfield 2012). At the bottom of these (more or less) privileged positions, were Guinean women who survived Ebola and were relegated to a stereotyped *imaginaire* of Black motherhood.

The question of privileges and mobility were pertinent to my own position in the unit. I came to be involved in Wonkifong as part of a team of anthropologists assisting in a clinical trial in Guinea. Being a white woman born and raised in Europe, I was identified by the directors and the personnel as a Western expert like Louis. Nevertheless, both my parents were Uruguayan and fled the military dictatorship during the seventies for political reasons. I was therefore warmly welcomed by the Cuban brigade. They saw me as someone belonging both to a country that was perceived as a friend of Cuba and to a far-left family. Being a French and a Spanish native speaker, I occupied an interesting place at the crossroads of the different contingents: I could translate. After my arrival, I joined the psychosocial commission which oversaw most of the paramedical tasks of the unit. Being allocated to a specific team allowed me to participate in the unit's daily life. I entered the quarantine zone to visit patients. I assisted doctors at the triage of admissions. I welcomed the families coming for visits and I accompanied them to identify the bodies of their deceased relatives. Being a woman, though, the Guinean directors were more demanding with me than with Louis. They regularly asked about my schedule or summoned me to tell me they thought I wasn't careful enough with the protocols. While this was appropriate to their position as directors, I noted that Louis wasn't held to similar standards. While my whiteness allowed me to move within a medical unit with ease even though I was 'only' an anthropologist, my gender slightly limited the privileges I was granted through my skin colour.

After considering the issue of race and locality in the context of the Africanisation of aid—and how, in a unit aimed at empowering African practice and knowledge of epidemics, Guineans were allocated the most dangerous tasks, I shall address the intersecting features of race and gender that characterise the work of Madeleine and her coworkers. Using the historical figure of the wet nurse (West and Knight 2017), I show how the humanitarian infrastructure eventually produced a gendered labour that mirrors other economies exploiting female Black bodies (Cooper and Waldby 2014; Owens 2017). I move then to consider the notions of mobility and immobility within the unit through the issue of immunity. I show how

[3] During the last weeks of the epidemic, when Cubans and Congolese were sent home, the unit was eventually operated only by local doctors and nurses.

survivors were put at risk of contracting diseases through their immobilisation in the quarantine quarters, unlike the rest of the staff whose daily practice was characterised by their mobility across the borders of the unit.

South meets south: the Africanisation of aid in times of Ebola

The inequity of life is at the core of humanitarian deployment in the Global South (Erikson and Wendland 2014; Gomez-Temesio 2020a; Gomez-Temesio and Le Marcis 2021). The concept of a politics of life is not limited to the interaction between humanitarian actors and victims of catastrophes or wars. It also addresses the inequities between Western employees and their national colleagues, often hired in positions such as drivers (Fassin 2007, 2009; Gomez-Temesio 2022). International NGOs and agencies have been reflecting on inequity among their employees (Redfield 2012). In this climate, Wonkifong unit was created in December 2014. The unit's aim was hence to allow local and regional professionals to reappropriate the epidemic and gain skills. Until then, the Ebola units in the country were run by international NGOs like Doctors Without Borders or the French Red Cross and employed mostly Western workers to fill the administrative and medical positions. Wonkifong was created as a translation of the 'Africanisation' or 'localisation' trend within humanitarian aid that saw NGOs and international agencies hiring more African workers to work on projects on African soil. But, beyond local reappropriation, hiring African workers eventually led to hazardous work being 'outsourced' to local employees. Hence the localisation trend translated into protecting white lives more than empowering Black ones (Duclos et al. 2019; Issoufou 2018).

Wonkifong constitutes a decisive case study within which to revisit the concept of a politics of life in terms of race, as the isolation unit precisely challenges the postcolonial division between white and Black people (Gomez-Temesio 2022). Wonkifong shows how human resource management in the unit did not operate in terms of skin colour so much as proximity towards Western agencies and the privileges they might grant to different groups of racialised people.

Indeed, for Guinean personnel, locality meant being remote from white power and privileges and translated into hierarchies between them and their African/Caribbean colleagues. Cuban and Congolese people were hired with most of the privileges of expatriate workers. They got the less risky jobs as they were employed exclusively as doctors and nurses with pay rates and per diems exceeding what they could earn in their own countries. Guinean staff were mostly hired as hygienists or paramedics and had to deal with the 'two sides of pollution', the care for hygiene and the non-respect of social conventions (Douglas 2003).

They cleaned patients and furniture with chlorinated water. They incinerated belongings from deceased and recovered patients. They managed corpses at the morgue. They hand-washed all personnel uniforms with chlorinated water. They were paid less than their colleagues and had no access to the usual expatriate benefits such as per diems, and paid residence even though many of them had to rent a room in the proximity of the unit. Local workers undertook the most dangerous tasks with fewer privileges than their expatriate colleagues. In February a convoy of workers was attacked by a mob near the unit. Consequently, security was increased within the unit and around the hotels where foreign workers were quartered. Guinean workers did not benefit from any of these measures. The use of local staff during the outbreak underlines a family link between the unit and colonial containment sites that always needed local personnel to perform the dirtiest tasks to preserve more valuable lives (Lachenal 2010; Gomez-Temesio and Le Marcis 2017; Le Marcis 2015).

Within the unit, the segregation of tasks translated into the segregation of spaces. Cuban and Congolese workers occupied the same space, reviewing medical dossiers, preparing drugs for the medical tour, or chatting and relaxing at the med tent. Guinean workers occupied a vacant tent that was initially used by the staff to serve as a space where different teams could communicate information to each other. The segregation of space was emphasised during mealtimes. There was a cafeteria in the unit that was open to everyone, but was only used by Guinean workers who had no other lunch options. Cubans went back to their hotels, as did most of the Congolese. Europeans at the lab enjoyed free meals delivered daily by the World Food Programme, which were originally delivered for the patients. I was also offered those meals after my arrival. Among those eating in the cafeteria, collective diarrhoea cases were frequently reported. While all the workers of the unit were officially required to observe a ‘no-touch’ policy, Guinean workers, who shared cutlery and dishes, were much more susceptible to contamination if Ebola was to spread among the staff.

Though Cuban and Congolese workers earned more than their Guinean colleagues, still their salaries were ridiculously low compared to the pay cheque earned by Western staff employed at the WHO headquarters in Conakry. In the same vein, the pockets of whiteness within Wonkifong—the lab, the European nurse, me—underlined that for Black workers the full privileges granted to the white side of the ‘racial contract’ (Mills 2014) were still denied. European workers at the lab made their own schedules, and had their own cars and residences. Though Louis was a nurse, he had a much more dominant role than Cuban and Congolese doctors, challenging as such, thanks to his whiteness, the traditional hierarchy that rules almost every hospital in the world. Expertise is hence equated with whiteness (Benton 2016a). Louis made his own schedule, directly advised the Guinean

directors on good hygiene practices, and when unsatisfied with the result, he made his own flyers and plastered them all over the unit's walls. Louis had daily altercations with those he thought were not ‘robust’ or ‘dedicated’ enough. For example, dishwashing gloves were available for Guinean paramedics in charge of handling dead bodies. Nevertheless, out of fear of Ebola, the rest of the paramedics also started using them for other tasks, as the gloves were more resistant than the medical ones. But Louis forbade the paramedics to use the dishwashing gloves, declaring that they were spending resources unnecessarily. While Cubans mostly ignored him—all Cuban doctors were used to such missions and only responded to their brigade leader—Congolese doctors generally followed Louis’ instructions. As for me, I had my own car and, as already mentioned, I could circulate among the unit as I wished. The unit reproduced the power dynamic at play in the Coordination nationale de lutte contre Ebola (National Coordination against Ebola). Formally led by a Guinean high officer, Dr. Sakoba Keita, the organisation gathered international partners such as medical NGOs, the Centers for Disease Control and Prevention (CDC), the WHO, and UNICEF, to produce a coordinated response. But as recounted in Dr. Keita’s memoirs, most of the time foreign agencies ended up doing whatever they thought best (Keita 2021). Following work on race by Benton (2016a, 2016b) and Hirsch (2021a), the management of human resources in Wonkifong sheds light on humanitarianism’s continuation of colonialism’s relationship with anti-Blackness.

Surrogate care: survivors’ superbodies

From December 2014 to May 2015, there was no specific protocol to take care of children quarantined without family. If this situation sometimes embarrassed the staff, when I repeatedly asked how an infant or child could cope alone, I was always given the same answer: African children are used to taking care of themselves. The children quarantined in the unit were racialised as medical superbodies (Owens 2017) even by Black people with a closer proximity to white authority. The treatment of children within the unit resonates with research on foetal prematurity in the United States and the way Black infants are treated by contemporary medicine. Often, they are identified as ‘strong babies’ who are better equipped to ‘make it’ compared with white ones (Bridges 2011; Davis 2019). These perceptions of invulnerability eventually translate into a dramatic increase in mortality rates, as these infants do not receive the same medical care as white infants (Parker Dominguez 2011). In the unit, children sick with Ebola were assumed to be—and treated as—stronger and more resilient, in continuity with colonial-era conceptions of Black bodies (Packard 1993; Peiretti-Courtis 2021; Sharpe 2016).

In May 2015, almost six months after the inauguration, the directors of the unit announced that thanks to a grant from UNICEF, former patients would be trained to work inside the unit as childminders. The obvious benefit of such an arrangement was that Ebola survivors, thanks to their immunity, would be able to stay inside the quarantine zone without any kind of protective equipment. They could therefore stay longer and offer better care than non-immune carers. Nevertheless, such hiring interrogates which kind of labour is promoted by humanitarian aid. Hiring survivors, qualified by virtue of their immunity, to care for children who until then had been unattended was an improvement for the children. Still, this improvement could not be detached from the moral economy that racialised the politics of life of the Ebola response in Guinea. Here, the management of immune personnel revisits the concept of politics of life at the intersection of race and gender.

Five survivors were hired: three women, Madeleine, Touré, and Rokhia, and two men, Prof and Bob Marley. They were all officially hired as *nounous*, or nannies. The term in French usually designates female employees. Here, the fact that among the five recruits, there were two men, might suggest that being a nanny was not considered a female job. Still, exactly why these particular individuals were chosen is important. The former patients were all selected at the suggestion of Sory, a Guinean paramedic who had kept in touch with many former patients. He was asked by one of the directors to come up with five profiles. He specifically chose the two men because he thought they would be great additions to the health team in general.

The first man was a Guinean doctor who had become unemployed after contracting Ebola. Sory chose him to give him ‘a chance to earn a bit of money’, and took the opportunity to add a doctor to the staff without having the budget to pay for one. The man was nicknamed ‘Prof’ by the staff, and was treated with deference. The second man’s nickname, Bob Marley, had been given to him by the staff during his stay in the unit up to a few weeks earlier. His nickname designated him as a cool young guy. Indeed, Bob Marley was known as one of the ‘success stories’ of the unit, described by Sory as a former ‘recalcitrant’ patient. During the first days, Bob Marley had tried to escape, and threatened the staff many times before finally submitting to the rules. He ultimately survived. Sory, therefore, thought that he could help potentially noncompliant patients in the future. So Prof and Bob Marley were hired less for their suitability as nannies than for their supposed skills in helping patients as a doctor and a community mobiliser. The three women hired were described radically differently by Sory. Madeleine, Touré, and Rokhia were all presented as ‘mothers’ and as such suited ‘to care for children’. None of them was introduced to me as having any particular skill outside of mothering. The way surviving women came to be employed as nannies

underlines how a powerful male bias still influences health policies both at the global and local level. Women—mothers and non-mothers alike—were used in the first days of the outbreak as natural carers by humanitarian forces. At the micro-local level of Wonkifong, Sory's choice underlines that men were hired as childminders only because they were thought to be more valuable than that. Madeleine, Touré, and Rokhia were the true nannies of the unit. Their hiring was emblematic of how in global health policy women are only made visible through motherhood.

While they were hired as surrogate mothers, Madeleine, Rokhia and Touré's own journeys as mothers had been difficult, even tragic, due to the outbreak. As stated earlier, Madeleine was a former patient who had lost a baby in the unit due to Ebola, but due also to the lack of care her baby received while she was too sick to help him. The two other female recruits had also experienced traumatic separation and grief within the unit. Touré was a young woman in her twenties. She was the single mother of a newborn when she became contaminated with Ebola. When Touré felt sick, the paramedics who had been sent to fetch her with the ambulance decided to leave the infant, as he showed no symptoms of infection. The baby boy was left in the care of Touré's brother. When she was admitted into isolation, there was no mention in her file that the medical team had left a breastfeeding newborn behind. Her brother came later to the unit asking for help. He had no money to feed his nephew. The uncle was sent away but kept coming back, insisting that he was afraid the baby would starve. He told me, 'You know, an adult, he can take upon himself and not eat, but a baby, you cannot reason with him, he needs it. All day, my nephew is crying, he is so hungry.'

Touré spent more than two weeks in the unit separated from her baby without any financial help to feed him during her quarantine. Were it not for her brother's insistence—he kept harassing the staff for formula, sitting in the entry and pleading his cause at every opportunity until they gave him a box—Touré's baby would have been left to starve. When she was eventually discharged, doctors explained to Touré that she should not breastfeed her baby because the virus might have stayed in her milk. A single mother without a job, Touré faced a new financial burden. When she heard a few weeks later from Sory that there were some job openings at the unit, she told him she was interested. Working as a nanny allowed her to buy baby food—while once again separating her from her son.

Mothering other children while experiencing grief and separation from one's own recalls the figure of the wet nurse. According to West and Knight, 'wet-nursing is a complex and contingent process that has commonly involved women in unequal power relationships in a variety of different regimes' (2017). Wet nursing constituted a unique gendered bodywork, where the female body is used by a

dominant system such as slavery or capitalism. Madeleine, Touré, and Rokhia were not hired for their lactation. Still, they were used as uniquely mothering bodies thanks to another specific body substance: their immunity to Ebola. By hiring survivors as nannies, Ebola units across the country inaugurated a newly gendered bodywork. Immune mothers were taken into the isolation quarters to help children who were not theirs. The parallel between the exploitation of the bodies of lactating women and the exploitation of the immune bodies of female survivors was made more apparent by their conditions of work. Unlike the rest of the staff, the survivor nannies did not benefit from any work contract. They were paid on call, and had no job security, unlike the rest of the health workers, who had monthly wages.

The third female worker, Rokhia, reveals the entanglement of enrollment, risk, and economic pressure to work in the unit as a survivor. Rokhia was the only person among the newly recruited who had not been quarantined in the unit. Still, she too had a terrible experience with the place, as her husband died there. He and Rokhia were working together as lab technicians in a private clinic near Forécariah when the outbreak started. One day, her husband became feverish. Due to budget restrictions, gloves were not available at the clinic. He probably became contaminated while doing his job. He died in Wonkifong. A few days later, Rokhia felt sick. She was quarantined in another unit in the capital. She survived Ebola but when she tried to resume work at the clinic she was fired. Her employers feared she might be contagious despite her recovery. For the same reason, her landlord evicted her from her home. Rokhia had two young daughters for whom she needed to provide, and came to work in Wonkifong not as a lab technician but as a child minder. Rokhia was a trained lab technician but—unlike Prof—there was never any mention among the staff of her having skills beyond those of a nanny. She had to leave her children at her mother’s place in Conakry. Nevertheless, facing the discrimination attached to her survivor identity, it was the only job that was available to her at the time. Rokhia explained, ‘I was fired from the clinic. I tried other places but now the economy is down due to the outbreak, and I am scared if I get a job elsewhere, they will find out I had Ebola and fire me again.’

Writing on volunteers working at the frontline of testing centres for COVID-19 in the US, Oyarzun notes that many of them were Black people without proper medical insurance. Their participation in the epidemic response, more than a noble gesture, reflected their need to work, even if it endangered themselves. Rokhia said of her decision: ‘I want to work to feed my children, because I don't have someone anymore, someone who could help me, so I have no choice but to fight for my daughters. Nobody will help me now; my only hope is to work.’

Enrolling in the unit could be equated with what Kingori (2015) describes as an ‘empty choice’ in her discussion of how the discourse of choice relative to informed consent may create an illusion of individual freedom and power, without consideration of the structural factors which constrain those choices. Madeleine, Touré, and Rokhia constituted a pool of vulnerable women who had to deal with terrible sequels after their contamination. Indeed, they were all in need of money after recovering from Ebola. Loss of a husband, of economic support, of a home and jobs—they faced what Petryna (2013) designates ‘the full cost of recovery’ in times of Global Health. In the unit, the employment of survivors was celebrated by the humanitarian staff as demonstrating the stereotypical African capacity to help each other. As Rokhia’s statement makes clear, these women enrolled not to help others but to help themselves. They took on this work to recover from the disastrous consequences of the disease. Their labour sheds light on a structural intersectionality of race and gender at the core of humanitarian practice where to enroll constitutes an empty choice.

Race, mobility and immunity

As COVID-19 made us aware during its global irruption in early 2020, the dynamics between mobility and immobility are at the heart of the spreading of a virus, as well as the efforts to stop it (Gomez-Temesio 2020b). And as such, mobility and immobility were already in play during the Ebola outbreak that hit Guinea in 2014. Circulation along borders was heavily impacted while contaminated people were quarantined. For people employed in the aid industry, mobility shed light on a racialised landscape and eventually translated into life expectancy. For example, while local workers took disproportionate risks in comparison to their foreign colleagues, they were not guaranteed the same conditions in case of their contamination by Ebola. Indeed, while repatriation was guaranteed for foreign workers, Guinean personnel, on the contrary, had to be treated in a unit within their country. The Ebola mortality rate was around 70 percent in the Mano River countries, but fell to under 20 percent for repatriated humanitarian personnel (Farmer 2015). The life expectancy of an aid worker could not be determined only on biological grounds (Canguilhem 1966) but was also dictated by racial dynamics within humanitarian aid, which, as noted by Hirsch (2021b), immobilised Black lives while allowing essential mobility to white ones. Black bodies were again treated as supermedical bodies (Owens 2017) who could be submitted to more risks without the protection enjoyed by white bodies through their employment by humanitarian organisations. A member of the Cuban brigade died unexpectedly from a malaria crisis. His body was not allowed repatriation and he was buried in the vicinity of Wonkifong.

While transnational mobility played an important role in maintaining racial lines during the outbreak (Hirsch 2021b), in this section, though, I focus on micromobility inside the unit. The recruits went through immobility while being sick—an immobility that had dramatic consequences such as losing a child or being separated from a breastfeeding newborn without the guarantee that he would survive. And then they were hired to be immobilised inside the quarantine unit, unlike other health workers who entered and exited with much freer frequency.

The protocol for starting the shift was the same for the recovered patients as for their colleagues. The recruits arrived through the staff entrance, had to disinfect their hands and shoes with chlorinated water, had their temperature taken, and finally signed the register, recording their time of arrival. They would go to the tent reserved for the paramedics, where Sory would give them updates about the situation, and how many children there were. Then they would be lent clothes that were usually allocated for patients, as no objects can exit the quarantine zone. Only a naked person after a chlorinated shower, or else someone with protective gear after undergoing the disinfection protocol, is allowed to exit the isolation quarters. Everything else remains behind for incineration so as not to risk bringing the virus to the staff quarters. After these first steps, the practices of mobility within the unit diverged drastically. Unlike the rest of the staff who were very mobile—and specifically mobile inside the isolation zone, where they never stayed put for more than a few minutes in the same spot, and never remained for longer than about an hour in total—the recruits were immobilised for shifts that could last for 48 hours without a break.

Equipment drying in the sun after disinfection. Wonkifong Ebola Treatment unit, 2015.

Nevertheless, as they did not have to use protective equipment, the child minders' exit protocol was much easier and quicker than that of the rest of the staff. While others had to wait for a coworker trained in disinfection to help them through the multiple steps of a safe exit, Madeleine and the others just had to take a chlorinated shower and then dress in new clothes. The recruits' in-and-out protocol was also less costly, as protective equipment included face masks, gloves, and tip-to-toe gear that had to be incinerated within the isolation unit. Still, the childminders were not allowed to take a break, while other workers underwent complex and expensive protocols to enter and exit the isolation unit many times a day. So, the recruits had to sleep and eat in the same space as patients endured their agonies, and in the same place where most of them had themselves undergone traumatic events. The recruits were emblematic of the transformation of a Black humanitarian worker into a medical superbody. Because they had overcome greater hardship than others—surviving Ebola—the unit, through its protocols, inflicted upon them more of the same duress (Sharpe 2016).

Disinfection protocol. Gloves, masks, and gear are incinerated afterward. Wonkifong Ebola treatment unit, 2015.

The first time Madeleine and Touré shared a shift, they cared for four children waiting to be screened. After more than 48 hours inside the red zone the children were discharged, and the women were allowed to exit the isolation unit. They tried to grab some food at the unit's cafeteria. Complaints from other workers were immediate. Guinean workers did not want to eat alongside them. Foreign workers refused to see them wandering among the unit. Feeling unwelcome, Madeleine and Touré went for a rest inside the staff quarters, but many workers again expressed their uneasiness at sharing a space with them, fearing they might still be contagious or that they could have neglected to wash properly in the shower. A Guinean worker told me: 'This is not safe, these people, we are not sure even if they are not contagious anymore. And they are not educated, I am sure these women are going to smuggle their phones in and out of the quarantine zone to call their children when they get bored. They cannot stay in our quarters.'

To avoid a crisis, the director eventually decided that former patients could not stay inside the unit before or after their shifts. Their presence was segregated within the quarantine space, where they seemed to belong. This disturbing and disturbed micromobility sheds light on how the Ebola survivors were not considered as being proper workers with the same rights as the rest of the staff. Rokhia, Madeleine, and Touré's journey thus revealed the dialectical interplay between race and capitalism from colonial times to the era of Global Health (Lachenal 2010). While Black lives had to be isolated due to the risk of contagion, their access to low-paying employment still had to be guaranteed (Gomez-Temesio and Le Marcis 2021). This racialised injustice within humanitarian spaces, incarnated in the perceived superbodies of the childminders, is also gendered. Indeed, as in the quotation above, the staff's complaints were mostly directed at the women. They did not fear that Prof and Bob Marley might bring the virus outside the isolation quarters, but that 'these women' would 'call their children'. Mothering was the skill Madeleine, Touré, and Rokhia were hired for. But being the mothers of children who remained outside the unit led to suspicion that they might breach the protocols.

The staff's demands for protection against the threat posed by surviving patients were ultimately legitimised by the director, but there were no procedures to protect these recruits against the risks posed by their immobilisation within the quarantine zone. The nannies were sometimes given face masks and gloves to protect themselves against tuberculosis, but wearing them was not compulsory.[4] There were no mosquito nets to protect them against malaria, and the patients' tents were wide open during the day as well as at night. They also were not protected against Ebola itself, as there was no blood test before their involvement that checked their immunity against the virus. This additional precautionary check might seem unimportant. Still, as research published by Desclaux and Barranca shows, about 10 percent of the participants in a study on the sequels of Ebola in Guinea, who identified as Ebola survivors, had no antibodies at all (2020).[5] It thus seemed that, contrary to their claims, they had never contracted the virus. Investigating this puzzling result, Desclaux and Barranca concluded that among this 10 percent, only in exceptional cases had people concealed their non-survivor status voluntarily, or just to gain benefits. The authors argued that the gap between claiming to be an Ebola survivor and lacking antibodies was explained by possible human error both in testing and in informing patients of the results during the epidemic. If one extrapolates the results of the study to the whole country, there are potentially

[4] It happened many times that patients quarantined in the unit were suffering from Ebola as well as from tuberculosis, or that patients waiting to be screened in fact had tuberculosis, its symptoms confused with those of Ebola.

[5] The study included 800 participants, among them adults and children, and included therefore two thirds of all survivors of Ebola in Guinea. Among them, 32 participants had no antibodies at all.

many people in Guinea who are erroneously convinced that they have survived Ebola and hence gained immunity, although they have not.

Rokhia was treated in another unit in the country. There was no check of her medical records, nor blood testing before she was sent into the quarantine zone. Immunity to Ebola was assumed by the fact that the recruits were known by the staff or because they claimed to be recovered patients. Following Cooper and Waldby (2014), the hiring of survivors within humanitarian infrastructures mirrors enrollment in clinical trials. Both happened in the same grey zone where Black or working poor people consent to do risky jobs because they have no other options for recovery, whether economic or medical. In both cases, these people are pictured as 'volunteers' who participate for the greater good—advancement of science, ending an epidemic—and therefore receive compensation, rather than real wages (Abadie 2010; Fisher 2008). Using the gift rhetoric, the trial industry confines test subjects to benevolent volunteers who 'give' something for the greater good (Sharp 2000). Hence, they do not benefit from the same protections as common workers. Consequently, Waldby and Cooper describe clinical trials as regimes of 'exceptional labor' that justified exemptions from the standard protections of common employment law (2014). In the same vein, the sudden need to save quarantined children allowed the unit management to hire survivors, put their alleged immunity to good use, and make them work without any kind of protection or medical background check.

While the issue of having gained (or not gained) immunity was ignored in the case of the recruits, their presence shed light on suspicions shared by the rest of the staff about the protection survival conferred when confronted by a potential new infection. Among the rest of the staff there were few Ebola survivors. Once, as we looked at Touré getting ready to enter the isolation unit, a Congolese doctor challenged a Guinean paramedic: 'You could just go like her and save all the time dressing and undressing. You had Ebola, you have nothing to fear.'

The paramedic answered, 'Come on! Science changes all the time. We are not sure yet, we have no distance, what we know today is not what we will know tomorrow, there is no certainty—so I will never ever go there without protection.'

Hence, who had the right to protective equipment did not depend strictly on being an Ebola survivor or not, but also on which kind of worker you were. The regular staff of the unit had the privilege of doubting science and being careful. The segregation between mobility and immobility, protection and lack of protection, translated into female survivors, or poor working people without a job, used as immune vessels—with no background check. They were vessels that could help in saving lives that were not important enough to justify endangering the most

precious staff lives, the foreign ones. Life expectancy inside the unit shed light on a postcolonial rearrangement of race at the intersection of locality and gender.

Epilogue: 2015–2018, recovering from the past?

‘The real-life phenomenon of patient recovery’, writes Petryna, ‘entails much more than a right to access medical goods or a right to health; it entails a right to exit from disease.’ (2013, 75). The journeys of Madeleine, Touré, and Rokhia ask the question of the price of survival after Ebola (Gomez-Temesio 2018). They all outlived the virus in 2015. Two of them lost their husbands and therefore their primary emotional and financial support. One of them lost a child in quarantine, while the other two had to deal with providing for offspring who stayed outside. Adding to their pain and losses, getting out did not translate into recovering their health fully. Like many other survivors, they had to live with physical and psychological sequels. Madeleine suffered from back pain and an unexplained amenorrhea; Touré, vision difficulties; Rokhia, chronic insomnia, nightmares, and frequent anxieties. When they left the unit, no medical aid was offered to deal with these sequels. There was also no solution to help them provide for themselves and their children. While they survived, they were not offered an easy path to recovery. In contrast, to find a way to bear the full consequences the virus imposed upon their lives, they enrolled as surrogate mothers in the unit.

Their journey illuminates how issues of intersectionality remain absent from Global Health and humanitarian aid debates so that women deliver on specific targets (Harman 2016), in this case, caring for Black children for whom no foreign life had to be risked. Because they are believed to be less sensitive to pain, warns Sharpe (2016), Black people are forced to endure more pain. The childminders occupied the lowest scale of Wonkifong’s internal hierarchy. They had more difficult work conditions and no protection against multiple threats. For the three women, they were specifically asked to mother within the aid infrastructure while the same infrastructure jeopardised the lives of their own children, whether they stayed in quarantine with them or were left at home. Madeleine, Rokhia, and Touré’s journeys illustrate the unattended challenges of the Africanisation of aid, or how humanitarian aid, despite its commitment to decolonising its ranks, remains a dangerous place for Black lives (Gomez-Temesio 2022). While Wonkifong was created with the explicit aim of letting the region have appropriate management and epidemiological skills, nevertheless, the unit remains a segregationist space in the way it treated local personnel. This postcolonial reconfiguration of race operated not according to skin colour—most of the unit’s staff was Black—but according to a sense of local belonging and distance to white humanitarian elites.

The use of former patients hence allows a critical discussion of the concept of the politics of life in the light of race and gender (Fassin 2007, 2009; Benton 2016a, 2016b; Gomez-Temesio 2018, 2022). Humanitarian medicine is exceptional by definition, as it applies to exceptional circumstances, operating with exceptional means and during an exceptional temporality. Due to this extraordinary condition, humanitarian aid tends to be governed by its own sovereignty (Fassin 2007; Redfield 2013). Nevertheless, the ethnographic journey of the former patients forces us to consider humanitarian aid not as an altogether exceptional topic but, on the contrary, as sharing the racialisation features exhibited more generally by modern medicine (Bridges 2011; Davis 2019; Parker Dominguez 2011). Madeleine, Rokhia, and Touré constituted a pool of vulnerable women who were exploited because they were considered as being able to endure more than their coworkers. From colonial and plantation medicine to humanitarian intervention, we must conclude, an enduring racialisation of African workers shapes Black bodies as 'medical superbodies': lacking the intellectual skills to perform 'white' tasks while being physically superior and not suffering from the same vulnerabilities as white bodies (Gomez-Temesio 2018; Owens 2017; Packard 1993; Sharpe 2016).

The recruitment of former patients also mirrors contemporary enrollment in clinical trials. Writing on bodily contributions, Cooper and Waldby note that human research subjects appear 'as an already available biological resource, as res nullius, matter in the public domain' (2014). Following this, in Wonkifong the alleged immunity of the childminders constituted an expandable resource that could be used by humanitarian aid within a narrative of help and humanitarian sacrifice. Madeleine, Touré, and Rokhia were employed as immune vessels that could mother vulnerable children and work at the frontline while protecting more valuable lives: in the unique context of Wonkifong, these were not white lives but Black or Caribbean lives close to white power. The all-permeating presence of race is even more apparent when considering that the former patients were hired for children who, before their recruitment, were left to die of dehydration and other forms of neglect. In other words, biological lives for whom real political lives should not be put on the frontline. The enrollment of women who survived Ebola as surrogate mothers then shed light on the way medicine constituted a tool through which the white gaze has been othering the Black body, from colonial to contemporary times, according to race, locality, and gender.

In 2018, I went back to Guinea and visited Rokhia in Conakry. When the unit closed in 2015, she lost her income for a second time. Rokhia feared violence and exclusion in Forécariah, where she used to work with her husband. She decided to move back to her mother's home in Conakry. Sharing memories of the unit, Rokhia told me about Madeleine, with whom she had kept in touch. She said Madeleine had been lucky enough to marry again, but unfortunately, after two

years, she had been unable to conceive a baby. As in the cases of many other female survivors I had kept in touch with since 2015, fertility seemed to have been targeted by the virus. Madeleine feared that her new husband would divorce her. The sequels of Ebola remind one that recovery is not simply a biological process, but one shaped by social factors including dramatic gender inequality.

Still, visiting Rokhia at home, in the aftermath of the catastrophe, I found the endurance of social life. Rokhia told me she owed her current existence neither to doctors nor to drugs, but to her mother and her sisters. They never told anyone Rokhia was sick with Ebola, nor that her husband had died of the same disease. One day, she just moved back there as a widow usually did. The love of her mother and sisters not only protected her but also created a space where life could be rebuilt. Indeed, as noted by Le Marcis (2012) on people living with HIV/AIDS, while recognition is denied in society, it can eventually be deployed in the intimate sphere. Recognition is thus embodied in acts of care. While we talked in the living room, Rokhia's sister was cooking in the yard. Around her, Rokhia's daughters played, misbehaving as little children do. While we were chatting, another person was keeping us company in the living room, Rokhia's husband. Although dead since 2015, he was seated beside his wife. When she moved back to her mother's compound, Rokhia had a frame made to carry a giant portrait of him. She thought it was important for her daughters to keep seeing their father. She didn't want to allow him to be forgotten. As I asked how the girls were coping a few moments before, she went to her bedroom and took the framed picture off the wall. There he was, a 'dis/appearance' of him (Sharpe 2016). While having passed a few years previously, he was still there, embracing the recognition he continued to be given by the people who loved him. Rokhia was given recognition by her family, and thanks to her, her husband outlived his condition. Still, Rokhia's will transcended the domestic sphere. As she explained to me, she wanted more than what Ebola made of her. For the last few months, she had been applying to study medicine in the US and Russia. So far, she had been unsuccessful. But, she told me, 'I will try until something works out. It will.'

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