Introduction

The spatial navigation of risks of infection in Ebola Treatment Centres (ETCs) reveals the racialised non-equivalence of patient and healthcare workers' lives in a humanitarian setting. In ETCs spaces and mobilities are designed/used to protect the health and ultimately the lives of healthcare workers and patients. In international epidemic responses that intervene in formerly colonised countries, such as the British-led response to the 2013-16 Ebola Virus Disease (EVD) epidemic in West Africa, this spatial organisation intersects with colonial and racial hierarchies, a legacy of colonialism and the transatlantic slave trade. During the West African EVD outbreak, high numbers of European and North American healthcare workers volunteered in ETCs in West Africa to stem the outbreak of the disease and to care for Ebola patients. The majority of these volunteers (though not all) were white, caring for patients and managing local healthcare workers who were Black.

In this paper I show that although international healthcare workers worked in the same spaces as their Sierra Leonean and Liberian counterparts, they nevertheless experienced risks differently. Here I identify the risk of infection and risk of death, as two different sets of risks, with the former being largely shared and the latter falling disproportionately on Liberian and Sierra Leonean healthcare staff and patients. I show that the difference between these two sets of risks manifests spatially, both within the treatment centre and on a global scale and exposes the postcolonial and racial inequalities that underlie international epidemic interventions. The production of differentiated risk I analyse here is a result of living and working in an antiblack world (Wynter, 2006). While the spatial design of the international Ebola response did not intentionally produce this differentiation, it did nothing to counteract it. As a consequence, racist inequalities were reproduced spatially at different scales. Benton (2016a) especially has argued in favour of a more race-aware and race-critical analysis of humanitarian interventions and this paper contributes to this endeavour. However, while she proceeds using visual methods, my focus will be on the spatial reality of treatment centres and the controlled mobilities, and/or flows, that shape them. Hence, while I draw on anthropological and geographical analyses of risk in humanitarian settings (Fassin, 2007; Benton, 2014, 2016a, 2017; Gee and Skovdal, 2017) I do so while keeping the postcolonial context in which the epidemic and response played out firmly in mind.

Specifically I analyse the spatiality of navigating risk by drawing on Sharpe's (2016, p.35) theorisation of Black life lived in 'the possibility of always-imminent death'. Sharpe writes:

> What does it look like, entail, and mean to attend to, care for, comfort, and defend, those already dead, those dying, and those living lives consigned to the possibility of always-imminent death, life lived in the presence of death; to live this imminence and immanence as and in the "wake"?

In this paper I aim to take up Sharpe's (2016, p.35) challenge by looking at how during the West African Ebola outbreak risks were spatialised, yet always placed Black West African healthcare workers and patients closer to 'the possibility of always-imminent death' than their white counterparts. To show this I also draw on Ruth Wilson Gilmore's (2002, p.261) definition of racism:

> Racism is the state-sanctioned and/or extra-legal production and exploitation of group-differentiated vulnerabilities to premature death, *in distinct yet densely interconnected political geographies*. [emphasis added]

Here I show that the geopolitics of the Ebola response and the disparate access to strategies of removing oneself from the risks inherent in Ebola care reinforced differential vulnerabilities to premature Ebola death (Benton, 2014, 2017) in ETCs. These differential vulnerabilities depended on racism's 'distinct yet densely interconnected political geographies' (Gilmore, 2002, p.261) which shape global health and which underlie health interventions (Fassin and Pandolfi, 2010; Benton, 2017).

Combining qualitative analyses of risks in humanitarianism with critical sensibilities around the racial and spatial inequalities that characterise epidemic responses promises to open up new ways of both analysing and critiquing the latter. Overall I argue that international and local healthcare workers worked in a geopolitical environment shaped by antiblack racism in which spatial tools designed to protect them from EVD infection amplified and perpetuated existing racial inequalities. Unwittingly, these tools contributed to normalising premature death as a condition of Blackness (Gilmore, 2002, 2007; Bledose, 2019) and highlighted how in epidemic interventions racism manifests geographically at different scales.

Literature and methodology

The experiences of international healthcare workers during the West African Ebola outbreak have been explored with regards to their perception of risks (Gee and Skovdal, 2017) and their attitudes towards volunteering (Turtle et al., 2015; Greenberg et al., 2019, Gershon et al., 2016). Gee and Skovdal (2017) especially have paid attention to the importance of place in healthcare workers' perception and navigation of risk in ETCs. Here I build on their writing to argue for an analysis of risk navigation that takes the racial dynamics of global health interventions, such as the international response to the West African Ebola outbreak, into account. Following Benton's (2016a) call for increased awareness of the racial (and racist) dynamics of risk in humanitarianism, I here set out to show how the spatial navigation of risks by international healthcare responders in ETCs contributed to the racialised non-equivalence (Benton, 2016a) between (white) saviours and (Black) victims (Fassin, 2007). Specifically I explore how the techniques available to navigate the risk of death spatially to international healthcare workers exceeded those available to patients and local healthcare workers. In other words, I explore how working in an ETC contributed to reinforcing the ontological difference between white lives (to be sanctified) and Black lives (to be sacrificed) (Fassin, 2007) in an Ebola epidemic.

Fassin's (2007) work on the politics of life in humanitarianism draws on Michel Foucault's writings on biopolitics to argue that humanitarian interventions that rely on medical staff to volunteer in what are considered dangerous circumstances introduce an ontological distinction between the meaning of European lives and the racialised lives they set out to save.[1] While his analysis introduced an important critique of the current politics of humanitarianism and global health volunteering and management, it, like a high number of Foucauldian analyses, overlooked the distinctly racial and racist dynamics at play in our colonial and postcolonial world[2]. Fassin's (2007) analysis repeats Foucault's oversight, although he does turn to it in his analysis of South African biopolitics (2009). Fassin's (2007) analysis and its oversight of the racial politics of life are important to this analysis because Fassin identifies risk as one key differentiator between categories of life.

[1] Fassin uses the example of MSF's (Médecins sans frontiers – Doctors without borders) 2003 intervention in Iraq. MSF's first ever intervention in Western Europe occurred in 2015 when volunteers intervened to improve the health conditions in Calais' 'Jungle Camp' (MSF, 2015), thus continuing to intervene on the bodies of racialised others, rather than on non-racialised white Europeans.

[2] Ann Laura Stoler (1995) and Achille Mbembe (2003) have both paid attention to and critiqued the ways in which Foucault's analyses have neglected the reality of colonialism and more specifically of France's colonial empire.

In contrast, Benton's (2014, 2016a, 2016b, 2016c, 2017) work contributes a critical analysis of humanitarian politics and argues that race and racism shape the humanitarian encounter. Here I draw especially on her (2016a) work on 'race, non-equivalence and the humanitarian politics of life', which uses visual anthropological methods to show that, in the case of white or white-passing humanitarian actors, encounters with Black patients increase the perceived risk of humanitarian actions.

This paper extends Fassin's (2007) and Benton's (2016a, 2014) arguments by exploring the spatial navigation of risks in ETCs and thereby introducing a geographical focus to existing analyses. I introduce this spatial focus by engaging with Black geographies. Black geographies draw their interest in the politics of Black life and death in the wake of enslavement and colonialism from Black Studies and combine it with geographical methods and a focus on space and place. I argue, as I have done previously (Author, 2019), that drawing on Black geographical perspectives and sensibilities creates an opportunity to view postcolonial healthcare and the places in which it is administered as operating in the wake of antiblack violence that characterised colonialism and the transatlantic slave trade, which shaped Sierra Leone's geography and society (Shaw, 2002; Ferme, 2001).

Black studies recognise race, and Blackness in particular, as a political condition that leads to premature death (Gilmore, 2002, 2007; Bledsoe, 2019). The West African Ebola epidemic constituted an example of premature Black death. In the worst affected countries, Guinea, Liberia and Sierra Leone, 11,325 people died from infection with EVD (CDC, 2019). Because the epidemic took place in West Africa, deaths were not disaggregated by race/ethnicity. As Pierre (2013) has argued, and given the historical use of racism as a tool of colonialization, there is urgent need for analyses of race and racism in Africa.

In Black geographies, places are understood to be shaped by and in relation to past antiblack violence (enslavement, colonialism, racism). McKittrick (2006, 2011) writes about this in relation to the archetypical spaces of slavery: the plantation and the auction block and argues that in North America the spatial logic of the plantation extends into the city. Bledsoe (2019; Bledsoe and Wright, 2019) points to the a-spatiality of Blackness, its disassociation with place and perceived illegitimacy to claim it in 20th century America. Allen et al. (2018) aggregate Black geographical writings that analyse racism as taking shape in Black people's historical exclusion from placemaking processes. Importantly, I argue that the spatial organisation of ETCs unwittingly reinforced this exclusion. I have previously pointed to the importance of Black geographical analyses of health and places of care (Author, 2019, 2020).

Until now, the clinic, hospital or treatment centre have not been thoroughly analysed through the lens of Black Studies and such an analysis would exceed the confines of this paper. Here, I want to however draw attention to the ways in which Black studies and geographies can help us understand the spatial reality of Ebola care and its inherent risks in relation to Black life and death. Care practices and ethics are central to Black Studies (Sharpe, 2016) even if their engagement with health has been limited to the Caribbean and North America (Curran, 2011; Braun, 2014; Owens, 2017; Hogarth, 2017).

I draw on Black studies/geographies to offer an analysis of the spatial navigation of risks in and in relation to ETCs. I argue that such an analysis needs to exceed the place of the ETC in order to understand how the colonial and racist legacies that pervade modern geopolitics impacted international and local healthcare strategies for risk reduction. My analysis is aware of the fact that Black people in Africa and the diaspora have a different historical relation to places of biomedical care (Fanon, 1965; Spencer, 2015; Author, 2019), one that was often shaped by racism and colonial violence. Firstly, I suggest that engaging Black geographical sensibilities will direct our attention to the ways in which risks were spatialised during the Ebola epidemic and how this spatialisation coincided with postcolonial and racial hierarchies. Secondly it draws attention to the ways in which in ETCs, spatial strategies to minimise risks reinforced the association between Blackness and premature death and, once again, contributed to the non-equivalence between white and Black lives. In doing so I argue that Black Studies/geographies offer nuanced analyses of space and place that exceed traditional postcolonial analyses. They are founded in a thorough understanding of the tenuous relationship between medicine and colonialism and enslavement on the one hand, and the ways in which Black experiences are traditionally marginalised in analyses of space and place.

Building on Benton's (2016a) qualification of humanitarian risk as always being constructed in relation to the race of those to be saved and those doing the saving, I explore here how risk played out in relation to geographical origin and access. Specifically I argue that access to international mobility and the promise of better medical treatment in Europe or North America, spelled the difference between the risk of infection and the risk of death while working in ETCs. Consequently, I argue throughout this paper that the places in which Ebola care was delivered in Liberia and Sierra Leone and the risks associated with working there, depended on much broader postcolonial geographies of health and risk. In doing so I also draw on Sharpe's (2016) theorisation of Black people living in 'the possibility of always-imminent death' and on Gilmore's (2002) focus on the distinct yet interconnected geographies of racism.

Importantly, I argue that any geographical analysis of risks in relation to European health interventions in West Africa needs to take the region's historical framing as a racialised place of disease and health risk into account.

Methodologically this paper draws on in-depth, semi-structured interviews that I conducted with international, predominantly British-based, medical responders to the EVD outbreak in Sierra Leone and to a limited extent Liberia in 2017. Research participants were recruited through several medical NGOs, which either sent or prepared volunteers for work in ETCs in Sierra Leone and Liberia and subsequently through snowball sampling (Valentine, 2013). Interviewees worked as epidemiologists, nurses and doctors, logistical operators and NGO workers. Interviews were either conducted over the phone, skype or in person in the UK or Sierra Leone. All interviewees have been given pseudonyms. As I show, colonial legacies work their way through global health and humanitarian interventions. This made it easier for European and North American health responders to volunteer in the epidemic than healthcare workers from other regions. Here I refer to international healthcare workers, with the understanding that in this analysis they were predominantly of European descent. This representation is not intended to silence the participation of African, Asian and American volunteers (especially Cuban), whose narratives have been taken up elsewhere, but who are deserving of more attention.

Risking mobility

The geographies of the 2013 - 2016 Ebola outbreak concentrated risk in the region where the outbreak began: West Africa. Historically referred to by European travellers and settlers as 'the white man's grave' (Rankin, 1836), West Africa has, from a European perspective, long been framed as a place of disease and of risk to the white European body (Curtin, 1961; Frenkel and Western, 1988; Duffield, 2001). Colonial involvement - British in Sierra Leone, French in Guinea and US-American in Liberia - led to a continuous European and North American presence in the region from the 18th century onwards, although Portuguese settlers and traders started establishing trading posts in the 16th century (Rodney, 1980). European colonisation, at least in the case of Guinea and Sierra Leone, and the high mortality rates among European colonial officers that characterised it, contributed to a framing of West Africa as posing a risk to European health and as being 'unhealthy' (Manson, 1900, p.312). The perception of West Africa and tropical regions more generally as risky to European health, went so far as to

influence British government policy at the time (Haynes, 2001). In a circular to British medical schools in the 1890s for instance, Joseph Chamberlain, then Secretary of State for the colonies encouraged the latter to train medical officers in tropical medicine to 'diminish the risk to the lives and health of those Europeans who, as Government officers or private employees are called upon to serve in unhealthy climates' (Haynes, 2001, p.144). Speaking at the London School of Hygiene and Tropical Medicine in 1909, William Osler, one of the founding professors of Johns Hopkins Hospital, explained: 'It is no light burden for the white man to administer this vast trust. It is, indeed, a heavy task, but the responsibility of Empire has been the making of the race' (Osler, 1909, p.7). Even before the beginning of the West African Ebola outbreak in December 2013 then, West Africa's geography was associated with health risks and disease and framed as in need of (white) European interventions.

In Sierra Leone, the response on the ground was largely carried out by Sierra Leonean health workers, joined by international responders, in pre-existing and newly built treatment facilities. Before the beginning of the epidemic, Sierra Leone, a country of six million inhabitants, had 136 doctors and 1,017 nurses at its disposal (Tinsley, 2018), working mostly in government hospitals, community care centres (CCCs) and private clinics. Few of these existing structures were suitable for Ebola care, which requires a spatial flow system and infection prevention and control (IPC) protocols, including the capacity to spatially isolate Ebola suspect and confirmed cases from the general hospital population. Some existing clinics were refurbished to meet the standards required for Ebola care. The majority of previously existing clinics, however, were shut. This was due to a combined high risk of healthcare worker and patient infections and to them being unsuitable for Ebola care. To remedy the shortage of beds (WHO estimated in September 2014 that more than 500 additional hospital beds would be needed; WHO, 2015) the British military with local contractors and the Republic of Sierra Leone Armed Forces constructed 6 additional purpose-built facilities and supported 700 treatment beds (HM Government, n.d.; Bricknell et al., 2016). The vast majority of international healthcare workers worked in one of these NGO-run, purpose-built facilities, as volunteering in them was facilitated through the NHS (Jack, 2017) or international organisations. The inequalities I describe here are not the result of local healthcare workers being precluded from working in internationally-run facilities; local healthcare staff worked alongside international staff in purpose-built ETCs. However, given the poor healthcare infrastructure of affected countries, they also continued to work in less safe, pre-existing facilities and provided community care, which was not the case for the majority of international volunteers. For local healthcare

workers and international volunteers working in pre-existing or purpose-built facilities access to humanitarian mobilities contributed to the difference between the risk of infection and the risk of death from EVD (Benton, 2014, 2017). In Sierra Leone, 0.11% of the general population died from EVD in comparison to 6.85% of Sierra Leonean healthcare workers (Evans et al., 2015). For international staff the numbers were radically different (several contracted Ebola, but survived after receiving treatment in Europe and two Spanish priests died after caring for Ebola patients at the very beginning of the epidemic). Here I show that the difference between risk of infection and risk of death mapped onto postcolonial (and to a large extent racial) differences among local and international healthcare workers involved in the response.

Humanitarian disasters and the international responses designed to address them create their own geographies. While people, finances, skills and humanitarian technologies are mobilised to come to the aid of affected regions and people, the latter often find themselves immobilised, both within their regions, due to a breakdown in infrastructures, and internationally, due to travel restrictions (Sheller, 2012). Who would be able to leave should they get sick and who would be confined to the workings of West African healthcare systems and a variety of INGO clinics, shaped motivations for joining the response and the choice for staying in West Africa or returning to Europe (see also Turtle et al., 2015). Aimee, an NGO worker volunteering in a pre-existing facility in Sierra Leone exemplified this feeling:

> […] All the flights were due to be shut down and […] I remember my decision making being 'I could be trapped in this country. Am I ok with that?' No, of course I was not ok with it but I decided if I was trapped I just would be ok with it. It was a very strange place to be […]. And a lot of us had to think about that.

Impending immobility, the very real possibility of having to stay in West Africa until the end of the outbreak, increased the perceived risk for European workers and, momentarily created a space in which they and their West African compatriots faced the same risks and the same vulnerability to death and disease. However, as the response unfolded it also contributed to shaping an unequal geography of risk that disproportionately affected local healthcare workers and that centred around the possibility of being medevaced.

> A very legitimate point a lot of Sierra Leonean medical colleagues made was that I was likely to be medevaced. Officially the British government told me we

> would not be medevaced; explicitly we would not be, but we kind of thought that we might be. But we knew Sierra Leonean colleagues would not and we knew what the outcomes would be for them, so... And as much as we were facing - we were in the same PPE as our colleagues - and we were facing the same risk and it's a pretty deadly disease whether you are medevaced or not, the fact that we knew we'd be medevaced, was you know... (James, clinician working in pre-existing facility)

James' account reveals the postcolonial hierarchies at work during the response and his awareness of them. His discussion of facing, yet not quite facing, the same risk as his Sierra Leonean medical colleagues speaks to their respective relation to the risk of infection and of death inside the ETC. James' account also alludes to Gilmore's (2002) definition of racism by highlighting how international and local healthcare workers working in the same ETC were products of and exposed to highly different geographies of risk. James, who was relatively certain that him and his British colleagues would be medevaced could navigate the risk of infection differently than his Sierra Leonean colleagues, in whose case a lack of access to better healthcare facilities outside of Sierra Leone meant that the risk of infection and the risk of death were almost the same. Concerns around mobility – the ability to leave West Africa in case of exposure to or infection with EVD – was consequently central among both international and local volunteers in Ebola Treatment Centres. More importantly, it qualified personal risks within Ebola Treatment Centres along postcolonial and racial lines. This is important, given that as James' quote indicates, international and local healthcare workers in theory faced the same risks of exposure and could rely on the same material protections. However, who would or would not be medevaced shaped how risks were perceived and how they played out. Death and the risk thereof were, especially at the beginning of the epidemic, omnipresent.

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

> countries because we didn't know what would happen if they got sick. (Anton, NGO worker, Sierra Leone)

The ability to medevac staff or provide them with European-style medical treatment thus differentiated between the risk of infection and the risk of death. As Anton's quote also alludes to, the possibility of being medevaced aligned with coming from 'the right type of Commonwealth' country, that is to say it extended to white Commonwealth citizens.[3] In Sierra Leone, the British-led response also offered the opportunity of European-style medical treatment onboard the RFA Argus, a Royal Navy aviation support ship deployed to Sierra Leone in October 2014 (Royal Navy, 2014) and in one British military-run section of Kerrytown Treatment Centre (Reece et al., 2017). Both were provided to reassure British and international healthcare workers and protect them against the risk of death. There was however some confusion as to whether these would be available to local healthcare staff or Sierra Leonean patients.

> What would have been reassuring would have been that local health care workers could be treated in Kerrytown. And in the end they never confirmed [that this would take place], they just did it on the side. (Anton, NGO worker, Sierra Leone)

> Now it's called health worker treatment [centre] but it used to be white worker treatment [centre]. (Dina, epidemiologist, purpose-built facility, Sierra Leone)

These quotes illustrate that while risks of infection were borne equally by international and national staff, the risk of death was not, given the unequal access to well-equipped places of care that international and national healthcare workers benefitted from. Further to establishing a postcolonial and racialised 'politics of life' (Fassin, 2007) and placing local healthcare workers in a closer relation to risk of death than international ones even when working in the same treatment centre, the postcolonial politics of global health here meant that who could volunteer in the epidemic response without being exposed to the

[3] Gutiérrez-Rodriguez (2010) has drawn out how subsequent UK (Commonwealth) Immigration Acts gradually restricted immigration to white Commonwealth citizens (Australia and New Zealand, Canada and South Africa), while excluding their Black and Asian counterparts.

risk of death depended on their country's status as 'the right type of Commonwealth country' (Anton, 2017) or according to Dina, their race. The lives of Black healthcare workers who worked in ETCs were, due to the international politics of global health and the set-up of the British-led international Ebola response to Sierra Leone, at higher risk of death than their international counterparts. In other words, their lives were placed closer to 'the possibility of always-imminent death' (Sharpe, 2016, p.35).

Risk in place

As the previous section has demonstrated, risk was not shared equally and was distributed along postcolonial and racial hierarchies. Here I deepen this analysis by focusing on how risks were navigated spatially within ETCs. I explore the ways in which risks differed depending on the type of ETC that healthcare workers worked in. This again demonstrates the proportionately higher risk of death that healthcare workers working in pre-existing structures, the majority of whom were West African, found themselves in. I then focus in on how the spatial navigation of risks in ETCs reinforced the association between Blackness and the risk of death, while shielding (white) European and North American healthcare workers from it.

When medical responders spoke about their decision to travel to Sierra Leone and work on the Ebola epidemic, the risk they referred to mostly represented their own risk of infection, rather than someone else's risk. For many Sierra Leonean healthcare workers, risk was amplified by the possibility of spreading the virus to family and household members. While some risks were shared with Sierra Leonean healthcare workers, such as the risk of infection or the risk of quarantine, working in a purpose-built international treatment centre mitigated these risks considerably.

> When I was there at [international ETC], everything all the stuff was there supplied by the UK government, everything. Most of the medicines, generators, the staff cards all paid for by the UK government. (Cormack, nurse working in purpose-built international facility in Sierra Leone)

When analysing the risks that healthcare workers were exposed to during the epidemic, it then becomes important to differentiate between the navigation of risks in purpose-built, internationally-run facilities, in which the majority of international healthcare workers

volunteered and pre-existing clinics/hospital, which were adapted to care for Ebola patients and which were predominantly staffed by local staff.

> We knew that in practice the people who were getting infected were non-health care workers caring for family, were health care workers doing out of hospital work, were healthcare workers in government healthcare facilities, you know that. Actually, people working in international facilities were generally not getting infected. (Jack, paediatrician working in purpose-built facility in Sierra Leone)

Two healthcare workers who volunteered in a pre-existing facility in Sierra Leone, which had been adapted for Ebola purposes confirmed the added risk that came with working in such an environment.

> We tried to work with the hospital management and the supply [centre], so [for] like soap and gloves and just simple basic things like that […] the hospital would get supplies from like a national [centre], it is part of the government, and they would disperse medications […]. (Miki, nurse)

A doctor working in the same facility who was exposed to the virus when a glass vial crushed in her hands while trying to administer drugs to a delirious patient in the red zone, confirmed what she called the 'makeshift' nature of the ETC:

> We hadn't checked before we started to make sure the correct concentration of chlorine was available where it should be and it wasn't and so what you should do in that scenario is immediately submerge your hand into the chlorine, but we had to first mix it up, we couldn't find the things […] so the hospital would get supplies from like a national [centre], […] it is part of the government and they would disperse like medications or whatever. So there were all these delays and you know of that particular injury, the two people who'd been exposed before me one had got Ebola and one hadn't and so, like yeah that could have happened in any of the other units, but also working in a makeshift unit, where everything

> isn't working as perfect as you would want it means you're at higher risk of those kinds of things happening. (Layla, doctor)

Both accounts show that the pre-existing facility they worked in operated within the confines of Sierra Leone's political economy and thus was an entirely different environment from the one described by Cormack. The 'higher risk' referred to by Layla was due to logistical challenges and inferior quality of medical supplies. Her account also describes the reality the majority of Sierra Leonean healthcare workers working in government facilities were facing. Due to the set-up of the response, a majority of international healthcare workers were not exposed to injuries such as this because they worked in purpose-built ETCs with access to more reliable procurement and higher-quality equipment than possible within Sierra Leone's political economy. In both purpose-built and pre-existing facilities, navigating these risks took on spatial form.

Spatialising risk

Geographically, racism has translated into the inability of Black people to participate in placemaking (Allen et al., 2018) and a lack of control over the mobilities that impact their lives (Sheller, 2018). This inability was evident in the spatial organisation of purpose-built and pre-existing ETCs. Although ETCs were not designed to exacerbate racial and geographical inequalities, the nature of the Ebola response, the postcolonial context in which it took place and its racial make-up of white 'saviours' and Black 'victims' (Fassin, 2007; Benton, 2016a) nonetheless contributed to the creation of places of Ebola care in which these dynamics were perpetuated.

Patients' inability to control their movements became apparent in interviewees' discussions of flow management. Spatial flows were an integral part of working in an ETC. In medical terms, flow is the regulation of patient and staff movements through the hospital or treatment unit for purposes of patient and staff safety from nosocomial infection (infections occurring in hospitals). Flow was an integral part of Ebola care practices and shaped the way in which staff interacted with patients and the geography and built environment of the treatment centres or units.

> So there was a whole circle, a patient flow depending on the first outcome of the test. People would come to the emergency wards, they would be seen there by the health professionals, then if they would be admitted based on their admission criteria they would move into the suspect area. They would wait there until confirmation came, if they were negative they would either stay there if we couldn't transfer them into the hospital or they would be moved if they were confirmed into the confirmed area. (Maria, epidemiologist working in purpose-built facility in Liberia)

> We had a unilateral flow through the unit which meant you went from suspect to confirmed and you never went back again. We did have an exit from suspect so if we had a patient in suspect who tested negative twice we could take them out through suspect without having to go through confirmed and we had sort of a shower cubicle outside of suspect, […] where we could wash them down before taking them out and it was basically out the triage exit. (Laura, doctor working in pre-existing facility in Liberia)

Unilateral flows influenced the spatial design of treatment centres. Dina, an epidemiologist working in Sierra Leone drew a map of the treatment centre in which she volunteered, which illustrates this. Starting at the bottom right healthcare workers would make their way through corridors first into the suspect area (top right), through the clinic and then, after having put on personal protective equipment (PPE) into the confirmed area (top left, stretching from the clinic to the fence). They would leave through the disinfection tent (below confirmed zone) into the general yard.

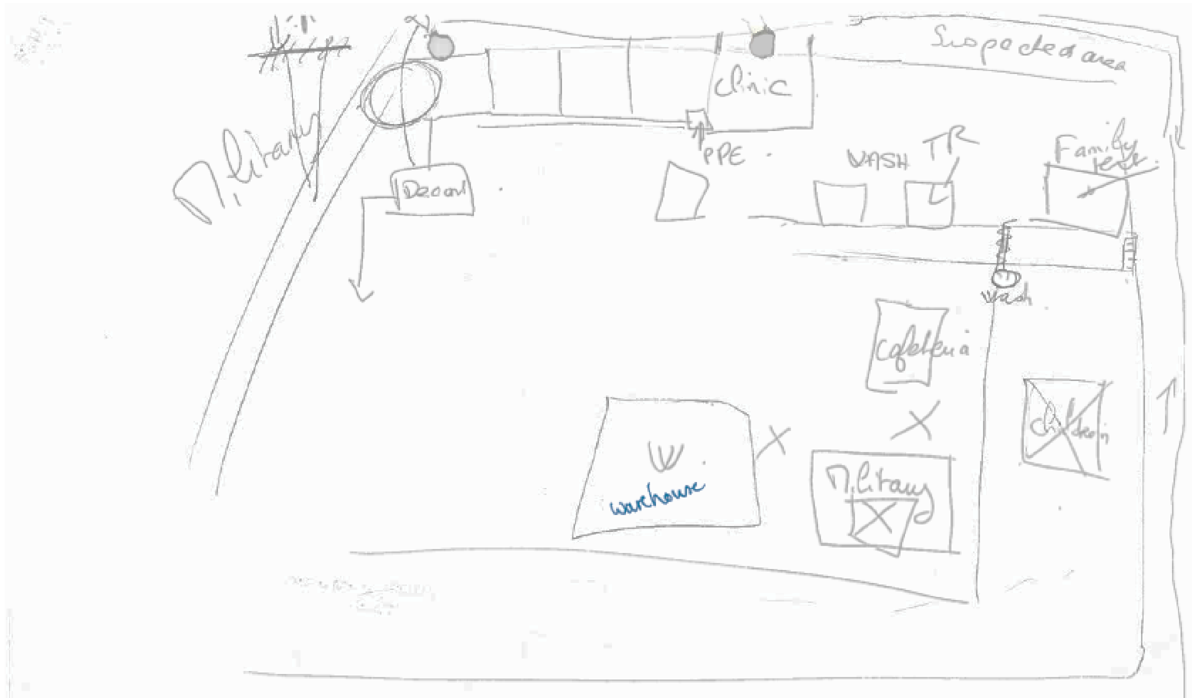

Figure1: Map of ETC drawn from memory by Dina. The red zone is in the top left corner, left of the clinic. The suspected area is to the right of the clinic. The arrows indicate Dina's flow through the treatment centre. The "white worker treatment centre", which Dina refers to above is in the bottom right corner designated 'Military'.

Flows worked to confine the risk of death to certain spaces. Patients' and healthcare workers' proximity to and risk of death was thus regulated and enacted through their movement through the treatment centre. Each movement moved the patient along a spatial and ontological trajectory closer to or away from the risk of death. Healthcare workers operated within the confines of this spatial logic and navigated it to minimise the risk of exposure to themselves and other patients (see figure 1). Being able to move freely through an ETC became a marker of life and an act of removing oneself from the spatialised risk of infection and death. Given the fact that the vast majority of Ebola patients in ETCs at the time were Black, these dynamics were necessarily reminiscent of Black historical and modern inabilities to claim space and control their own mobilities. Consequently, although not intentionally designed to reproduce the ontological proximity between Blackness and death, which is a product of antiblack racism (Gilmore, 2002; Sharpe, 2016), flow and the static zones it created, did exactly that: In the spatial dynamics of IPC, risk of death was enacted spatially and reinforced a colonial-racial hierarchy in which Black life was tethered ever more closely to the possibility of always-imminent death (Sharpe, 2016).

This racialised non-equivalence (Benton, 2016a, 2017) translated spatially through risk zones, in which spatial and temporal restrictions put in place to protect healthcare workers impacted

the care they were able to provide for their Black patients who were, due to the spatial management of risk, largely immobilised within zones of high risk of infection and death.

> The care that you would give people in terms of frequency of cleaning them isn't what you would want ideally because people would just be cleaned like when you went in and not in between […]. I remember once there was a young girl and just as we had to leave the red zone cause our time was up and it was like a hot day she fell onto the floor, but we couldn't really stay to help her back on, so she just had to stay there until the next people went in. (Anne, nurse working in purpose-built facility in Sierra Leone)

Care practices and their spatial organisation meant that some lives were considered more saveable and worthy of different standards of care – through access to European-style treatment facilities and the possibility of being medevaced – than others. Here the spatial navigation of risks contributed to the normalisation of Black suffering. Spaces were not designed to stop young Black girls falling to the floor, they were designed to protect and ensure the health of responders. Due to global health's colonial legacies and structural inequalities, predominantly white international healthcare workers were mobilised by the response and by the uses of flow. Black West African patients on the other hand were immobilised by it. Black West African healthcare workers, on the other hand, while mobile within ETCs, were still immobilised on an international level and thus occupied a space somewhere in between Fassin's (2007) lives to be risked and those to be saved. Although the spatial design and organisation of ETCs was not deliberately antiblack, the fact that they took place in a context shaped by colonial antiblackness contributed to the normalisation of Black suffering and premature death. In Anne's example above, the anomaly was not the girl falling to the floor. The anomaly would have been staying in the red zone and sharing the risk of infection a little longer.

Conclusion

In this paper I have attended to the spatialisation of risk in ETCs during the West African Ebola outbreak. I have argued that rather than being treated as a homogenous whole, risk should in the case of the international response to Sierra Leone and Liberia, be split between the risk of infection and the risk of death. Drawing on Black studies and geographies and critical analyses of risk in humanitarian encounters, I have argued for a differentiated analysis of risk that takes

the racial dynamics of mobilities and spaces in and in relation to ETCs into account. An engagement with Black Studies and their sensibilities reveals how international and local healthcare workers were similarly exposed to the risk of infection with EVD, not however to the risk of death. In doing so I have shown that an approach drawing on Black studies and geographies has the potential to unearth racial and postcolonial inequalities inherent in the spatial organisation of ETCs and can therefore contribute to Black geographical and postcolonial analyses of epidemic responses. Differential access to strategies of navigating risk on a local and global scale meant that Black life continued to be linked to 'the possibility of always-imminent death' (Sharpe, 2016, p.35). By examining this possibility in space and in relation to healthcare in postcolonial Africa, this analysis also contributes to dislocating Black Studies and advocates for their increased use outside of their traditional North American remit.

This paper also built on Benton's (2014, 2016a) and Fassin's (2007) analyses of risk in humanitarian settings and the (racial) politics of life. Analysing international healthcare workers' navigation of risk in relation to their West African counterparts also complicated Fassin's (2007) dichotomy of 'saviours and victims' by locating local health workers' somewhere in between a life to be saved and one to be risked. The analysis revealed the postcolonial power differential at play in global health and in epidemic and pandemic responses. Returning to Gilmore's (2002, p.261) definition of racism as the 'production and exploitation of group-differentiated vulnerabilities to premature death, in distinct yet densely interconnected political geographies' the paper also illustrated the differential power of white and Black healthcare workers to remove themselves from potential harm at different scales: in ETCs, in Sierra Leone and in the world. At a time when Covid-19 displays higher mortality rates for Black and Minority Ethnic populations in Europe and the Americas, race critical analyses of how we respond to epidemics should increasingly inform social scientific analyses of health. They allow us to reflect on a Black interpretation of spaces and mobilities; one that has meaning because it affects the global majority and which has been neglected in social scientific and medical analyses of the West African Ebola epidemic and response so far.

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