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One Simple Chart Shows How We Can Stop Ebola From Taking Any More Lives, Business Insider
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'Assassination' of Public Health Systems Driving Ebola Crisis, Experts Warn, Common Dreams
Obama Has Been Fighting Doctors Without Borders For Years, Huffington Post
Oil palm explosion driving West Africa's Ebola outbreak, The Ecologist
Ebola Vaccine, Ready for Test, Sat on the Shelf, The New York Times
Every Single Flu Vaccine Myth, Debunked, i09
A Herstory of the #BlackLivesMatter Movement, Feminist Wire
A Paradise Built in Hell, Rebecca Solnit, Penguin Books, 2009.
Free Radicals: The Secret Anarchy of Science, Michael Brooks. Overlook Hardcover, 2012

Key points: Part One

- The current Ebola outbreak sprung up in places looted by capitalist industries, warfare among states, and the devaluing of African lives.
- The absence of health care systems for all produces daily death that dwarfs the current cluster of infections from Ebola.
- Despite popular perceptions, most of the care for people ailing from Ebola this year is being done by local community members and independently funded, modestly compensated volunteers.

Key points: Part Two

- Just as with the AIDS epidemic, grassroots movements can and should pressure state and corporate institutions to save lives today, while staying critical and building independent alternatives.
- A future stateless society can and must maintain systems to support human health. These systems are generally more complex than other systems anarchists have maintained during moments of revolt, but doing so is feasible.
- Too many anarchists offer critique and deconstruction under the banner of anarchism, but don't speak as anarchists when they put forward large-scale alternatives. This has contributed to the idea that anarchist solutions are only local, low-tech, and limited.
- On the other hand, health care systems, scientific research, and community systems of care reflect anarchist traditions of

mutual aid, free association, and care for all people regardless of status or class.

- Global recognition that #BlackLivesMatter means fighting back not just when Black lives are senselessly taken, but when insufficient value and material care are put forward to sustain them.

Visions and Questions

Anarchists are part of the global conversation on what's broken in the world, but when things really fall apart—like with the current Ebola outbreak—is the state the only answer? How might a stateless society respond to a challenge like this one? This article provides an anarchist response to these questions, while highlighting issues that require those of us with anarchist politics to carefully think through our position.

Anarchists have been leading critics of colonialism and its aftermaths, of militarism, capitalism, and economic policies made by and for corporations. Anarchists have built power in various bottom-up combinations ranging from labor unions in Spain (where anarcho-syndicalists ran the trolleys and the telephone system after the 1936 revolution) to the D-I-Y ethic of anarchists in punk rock communities since the 1980s, who stress that anyone can learn how to play a guitar or build a greywater system. Over the past two decades, we have been active and vocal parts of movements saying "no" to the worst aspects of state and corporate power, wars, police brutality, the WTO and IMF, clearcutting forests, and mountaintop removal.

Yet our voices have been less clear on issues that require collective recognition, large-scale organization, or widely shared services, like universal health care, ending second-class status for undocumented immigrants, or recovering from the 2008 economic meltdown. Too many anarchists offer critique and deconstruction

tion of society, asking what we need to re-think or clear up about our politics to engage seriously with issues like this.

Ebola is far from the most difficult problem we will face in our lifetimes. We anarchists are part of the world community that confronts such problems here and now. Our zeal to make the world just and free must lead not just to imagining an ideal society, but fighting for necessary care and wisdom in collective decisions today. We need to ask ourselves how to fight for the lives that are at risk when these decisions are made by institutions we rightly distrust.

About the authors

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Further Reading

Ebola: Capitalism's War Against Humanity, Anarchist Federation
Ebola: Five ways the CDC got it wrong, CNN
Aids: Origin of pandemic 'was 1920s Kinshasa', BBC
Special Collection: The Ebola Epidemic, Science
Ebola Is Coming. A Travel Ban Won't Stop Outbreaks, Forbes

munities willingly choose in service of helping others? Outside of crisis, how might the gross disparities in resources, preparedness, and necessary tools for caring for human lives be undone, erasing the vulnerability created by centuries of extracting wealth from Africa?

Vision Question 5: We know that capitalism overproduces private goods and services (for the wealthy) and underproduces goods and services that can be enjoyed by all. Yet despite some efforts to reclaim common spaces or provide free goods/services, there is a void in analysis by contemporary anarchists in the USA about redistributing social effort towards the collective needs or desires. How do we start talking about that kind of public goods anarchism?

Vision Question 6: What model of public organizations do anarchists see as becoming more commonplace in an anarchist social order? A vast, networked MSF? Expanded or reduced institutions like the CDC and the WHO? A National Health Service in every country, or in no country?

Vision Question 7: Are quarantines compatible with anarchist ideas about freedom from coercion? In a society without a state, who should consider themselves empowered to coerce someone else to save lives, and under what conditions?

In closing, the Ebola outbreak is a difficult problem, but a solvable one. The current outbreak thrives on conditions created by colonialism, capitalism, and war. Late in the day, governments and wealthy individuals have put themselves forward as the solution to this crisis, even though much of the hard work is being done by local community members and independently-funded, modestly compensated volunteers.

People curious or skeptical about anarchism are right to ask how a stateless society would handle a challenge like this one better than the current world order is. Those of us who envision a society that works differently ought to have serious answers to their questions. This article is meant to both sketch out that answer and prompt discussion among those striving for a radical transformation

under the banner of anarchism, but don't speak as anarchists when they put forward large-scale alternatives. Whether by silence or speech, anarchists have contributed to the idea that our solutions are only local, low-tech, and limited.

Part One: Where are we, and how did we get here?

The Ebola virus disease has been known for nearly four decades. Its devastating medical consequences (at least in the absence of prompt, high-level hospital care) have led to virulent, yet brief episodes that affected anywhere from a half-dozen to 500 people, killing most of them. Remote locations and the virus's origins outside of human society have kept previous outbreaks small, but no one doubted the risk of a widely circulating outbreak like the current epidemic in West Africa. The virus was characterized and necessary isolation procedures recorded, enough knowledge to slow down and contain future outbreaks, if sufficient resources are available. Researchers prepared a vaccine, and confirmed its effectiveness on monkeys—who also suffer from the disease.

That is where preparation stalled a decade ago. Capitalist biotechnology, the current system for funding large-scale public health research like clinical trials for vaccines in the West, saw too small of a market for an Ebola vaccine. Like many critical parts of our lives, protection from infectious disease is subjected to a test of profitability. Measured in dollar terms, African lives didn't matter.

The current outbreak struck a part of West Africa that was especially vulnerable. Two of the three countries at the heart of the Ebola epidemic lost much of their capacity to care for the sick, the newly born, and the dying through devastating civil wars. These wars in Liberia (1989–97, 1999–2003) and Sierra Leone (1991–2002) drew in parties and governments in all three states, were motivated

and sustained by converting resources like diamonds and timber into cash, and attracted outside military intervention. These wars were only the latest chapter in long and painful history. Since the Atlantic slave trade began, foreign money has altered the region, provoking war, claiming captives, and looting its mineral wealth. Guinea contains a quarter of the world's aluminum ore; Sierra Leone is a leading exporter of diamonds; and Liberia is home to vast palm oil and rubber plantations. These lands' integration into global circuits of capitalism has been repaid with grinding poverty.

In the 1980s, the capitalist countries that have benefited most from the resources of other lands came to a consensus on how the poorest countries should govern themselves. The so-called Washington Consensus, imposed through the International Monetary Fund, investment banks, and other transnational institutions, required poor countries to "structurally adjust" their economies to pay debts they owed to the countries that had long profited from their wealth. The effects on their health systems have been documented by the World Health Organization: "In health, SAPs affect both the supply of health services (by insisting on cuts in health spending) and the demand for health services (by reducing household income, thus leaving people with less money for health). Studies have shown that SAPs policies have slowed down improvements in, or worsened, the health status of people in countries implementing them. The results reported include worse nutritional status of children, increased incidence of infectious diseases, and higher infant and maternal mortality rates."

The severe shortage of medical staff extends across Africa. Among all countries in Sub-Saharan Africa, only post-apartheid South Africa has more than one doctor for every two thousand residents. This undersupply of medical services and health infrastructure is shared with a score of other countries marked by war (Afghanistan, Cambodia, Timor-Leste), recent colonialism (Samoa, Fiji, Antigua and Barbuda), and the global color line (Haiti,

that records the health of both patients and the public. How do we take these less glamourous and more factory-like and state-like roles seriously? If we envision a less factory-like and less state-like society, how do we maintain enough of these ways of working to maintain life-sustaining systems like health care for all?

An ongoing continuous effort to provide health support locally is the most vital, and most missing, ingredient in the region (and this explains why and how MSF has been able to step forward so decisively). Relief organizations like MSF, community- and neighborhood-level clinics, public health systems, and the scientific community are all examples of the type institutions we need to maintain. Likewise, most coordination among them is done a way that is voluntary, and based on mutual agreement rather than coercion and commands.

Dealing with an Ebola outbreak does mean taking some actions extremely quickly. Rapid mobilization of doctors, building of treatment centers, or supplying of sterile equipment this month is the equivalent of several times that effort next month. The current crisis demonstrates that no existing social system does this kind of acceleration very effectively.

Massive spare capacity to act logistically, and to supply medical personnel (currently expressed through the US military's capacity to build infrastructure, and the Cuban medical systems capacity to send doctors to any place on Earth) are other prerequisites for action. We envision a cooperatively-run economy to be capable of diverting these capacities from other uses more flexibly than either a capitalist or state-socialist order: if work is self-organized then any collective of workers might deploy to assist in a crisis, not just those that are part of the state or a purpose-built NGO. Imagine workers at FedEx being able to choose to dedicate some of their planes for sending vital supplies, or a builder's union in Nigeria erecting a dozen Ebola treatment centers. If profit were not the constant purpose of most labor, what other human priorities might be put to the fore? What compromises or hardships would individuals and com-

where everyone has to do some of the hard, undesirable, or dangerous work. "Nobody wants to, so everybody has to," can become a society-wide slogan, perhaps with a system of mutual confirmation, making sure things get done.

Public health, though, is a little more complex. First, public health systems are complex and interdependent. Doctors and nurses rely on fully stocked supply rooms, sterilized equipment, and carefully tested medicines. So, we're talking about multiple workplaces, coordinating together. On the model of worker-run cooperatives around the world and telephone and transportation systems during workers' uprisings across history, we envision people maintaining careful collaboration among themselves. Indeed, we suspect that excessive hierarchy, the profit motive, competition among private firms, and billing paperwork often get in the way of meaningful coordination.

In terms of recruiting people to step forward and treat a threatening illness, the current crisis shows that motivation is not the problem. Whether through independent initiatives like Doctors Without Borders, state-run cooperation agencies like Cuba's, or recruitment efforts like that recently carried out by Avaaz, a volunteer-based system is adequate to staff response during moments. Given the opportunity, many, many people are willing to take risks, do repetitive tasks, and apply the skills they have to common problems. Rather, the challenge is to make sure that needed skills are widely taught, that systems for healing people are kept in place, and that supplies are made to flow smoothly to where they are most needed.

Still, the effort to treat people with infectious diseases, take the necessary precautions to prevent infection, or administer immunizations to an entire population requires both detailed, onerous work and careful monitoring of populations at large. One face of a health system is the collective workplace of healers and caretakers, but another is factories that produce basic supplies and adequately cleaned rooms, and still another is a monitoring system

Guyana, Bolivia). Africa, of course, has been hit by all three. With this shortage and inadequate nutrition for the poorest, comes daily, senseless death.

Global recognition that #BlackLivesMatter means fighting back not just when Black lives are senselessly taken, but when insufficient value and material care are put forward to sustain them. Liberia alone (population 4 million) has about ten thousand unnecessary early childhood deaths and 1400 maternal deaths per year. The fact that Ebola in Liberia is "a crisis situation" but this hecatomb is "not a crisis" is part of the problem. A reallocation of health care resources towards the country would have happened a *long* time ago under non-capitalist/non-imperial conditions. If West Africa were adequately staffed to keep its youngest children and birthing mothers alive, it would have many of the resources it desperately needs now to prevent a disease that could spread outside the region.

This is the world that responded to the Ebola outbreak, and its largest institutions responded too slowly and too poorly. The outbreak spread from its first infection in December 2013 to around a hundred individuals before the role of the Ebola virus was confirmed in March 2013. Emergency coordination at the international level began in July.

It took the spread of Ebola mortality to more highly valued lives, by race and nationality, and the threat of an ongoing trickle of infected travelers to focus the attention of the wealthy world to the outbreak. Suddenly, it became a crisis. By the time this happened, both local health systems and independent efforts like Doctors Without Borders/Médecins Sans Frontières (MSF) pushed beyond their limits. Even pacifist and state-skeptical experts began calling for an all hands on deck approach, involving states and even militaries to scale up to the necessary level of response. The United States, the United Kingdom, and Cuban governments all made major commitments of resources, with the imperial powers deploying

their militaries to provide logistical support for new Ebola treatment centers.

Alongside its efforts to coordinate a medical response, the World Health Organization (WHO) has been explaining how the 2014 outbreak was propelled by broken features of the current world order. In blunt language, WHO Director-General, Dr. Margaret Chan, observed: "First, the outbreak spotlights the dangers of the world's growing social and economic inequalities. The rich get the best care. The poor are left to die. … decades of neglect of fundamental health systems and services mean that a shock, like an extreme weather event or a disease run wild, can bring a fragile country to its knees." At the same time, self-critical internal documents reveal that WHO's Africa regional office failed to comprehend the severity of the epidemic as late as June 2014. Politicized appointments within WHO, bureaucratic delays, and the difficulty of providing doctors with visas to travel where they are needed are all ways that the workings of government hampered rather than helped response.

Through mid-October, literally half of all Ebola patients in the current outbreak have been treated by Doctors Without Borders, a non-state entity funded mostly by 4.9 million individual donors, and staffed by volunteer medical professionals. Unlike the international state response, MSF was able to begin its work by March 2014. However, by August 15, the organization's capacity was nearly overwhelmed: "our teams in our Ebola medical centres in Sierra Leone and Liberia are stretched to the breaking point."

Part Two: Envisioning an Anarchist Alternative

Clearly the current epidemic is being made more severe by incompetent governments, agencies, public health organizations, international air travel, and people just reacting to it as frightened

ture of working together. To prevent the dangerous intersection of surveillance and public health, community-level clinics could choose to minimize the exposure of their patients. They could encrypt and anonymize health details before sharing them outside the local community, something that is much more unlikely in state and capitalist health systems. An anarchist society would also be one without any single organization or institution in control of the rest. Unlike the world we live in now, no one organization (even a workplace taking on an important task) would have the universal ability to inspect all records, much less the ability to back up such a demand with force. Instead, when a priority arises, the collective best prepared to address it would approach others for their cooperation.

Surprisingly, the situation with Ebola now foreshadows some of such a process. Truly effective response to Ebola requires community involvement and active participation in prevention education, treatment, and alterations to daily routines of life. None of the regional states are really strong enough to force that kind of compliance upon outlying rural communities or dense urban neighborhoods. As with many day-to-day necessities, consent and persuasion are the channels through which things actually get done. Anarchists strive to generalize that principle as much as is humanly possible.

How would a society without a state respond to Ebola?

A classic question about anarchism is "Who cleans up the trash in an anarchist society?" In contrast to capitalist society, where the answer is someone who needs the money more than they dislike the job, anarchists generally talk about either the absolute need to take responsibility locally, the possibility of rewarding people for doing undesirable tasks, or the creation of a rotational system

crobes respond to possible treatments, and monitoring the spread and decline of waves of infection are all accomplished through these decentralized mechanisms. They also all rely on permanent public systems.

However, the anti-authoritarian story of science, while embraced by many scientists, leaves out the ways that many scientific ways of looking at the world are intertwined with those of the state. Indeed many branches of science emerge out of the modern state's urgent desire to monitor, enumerate, and plan the future of its subjects—hence the word statistics, from science of state. Epidemiology depends on counting disease among locatable, traceable, identifiable patients in a landscape where everyone is visible. If one thinks of modern governance as the hardware and operating system through which one is "watched, inspected, spied upon, directed, law-driven, numbered, regulated, enrolled, indoctrinated, preached at, controlled, checked, estimated, valued, censured, commanded … noted, registered, counted, taxed, stamped, measured, numbered, assessed, licensed, authorized, admonished, prevented, forbidden, reformed, corrected, punished" (in the words of Russian anarchist Pyotr Kropotkin), then epidemiology is one of the "killer apps" that run on that operating system. Or rather, the opposite of killer. So, public health as a concept is inseparable from some of this apparatus of monitoring and responding.

Vision Question 4: Is anarchism about destroying not just the centralized state but the hardware and the operating system it has built to (over)see its citizens? About separating it from the control of any one entity? About fragmenting control into smaller pieces? About eliminating some but not all of these possible operations? About maintaining surveillance on microbes, for instance, while evading/anonymizing surveillance on individuals?

We imagine an anarchist society as one that is decentralized and which views the amassing of power and control as a risk that needs to be countered through the design of its institutions and in the cul-

humans. As we have seen in other crises, the state has failed to adequately prepare for or serve the people most in need, a situation that is reminiscent of Hurricanes Katrina and Sandy in the United States. After these disasters, activists-turned-recovery-agents created decentralized, horizontally organized response efforts. These efforts, limited as they are, make it possible to ask a larger question: If we lived in an anarchist society where there was no state, would it be possible to deal with a public health crisis?

Vision Question 1: Even if global anarchist revolution happened tomorrow, there would still be many decades of rebuilding and redistributing to undo the concentration of wealth and the racialization and continental distribution of poverty. These are the consequences of their property becoming our theft. How do we propose to concretely reverse imbalances like that in the number of trained medical professionals, which made this Ebola outbreak possible?

Vision Question 2: How do anarchists balance between celebrating the potential for volunteer, and horizontally organized responses to crises like the current Ebola outbreak and disruptively pressuring the state, capitalist, and vertical institutions that currently control much of the needed resources to do what they can? Or should anarchists maintain a partisan silence about the latter question?

What does confronting the Ebola outbreak mean?

The existing tools for dealing with Ebola, in the absence of a vaccine or more specialized treatment, are straightforward. Outside of careful protocols, Ebola is a particularly cruel disease, striking hardest at those who directly care for the sick, whether families, generous strangers, or dedicated health workers. With careful adherence to protective regimens, Ebola patients can often be sus-

tained through the disease, with much less additional spreading of the disease. But these routines are built on the ready supply of "staff, stuff, space, and systems"—the material, human, and physical components of health care provision. Health workers need materials to protect themselves and their patients, clean and well-stocked facilities to work in, and adequate replacements when they need rest or treatment. Treating Ebola only makes sense within a public service that is an ongoing part of society.

Like HIV/AIDS during the initial years of the pandemic, Ebola is a disease which is striking first and hardest at the lives of people who have been devalued by the global power structure. Like HIV/AIDS, it threatens the future of whole communities, even countries, while posing a less direct threat to the global public at large.

Three dangerous responses that played out with HIV/AIDS are relevant for how we confront Ebola. (The difference is that the Ebola virus disease can shift from a local to a global threat much faster.) First, that the disease has become an excuse for further stigmatizing members of large groups of people; we are already seeing disturbing overreactions associating Africans, West Africans, or Black people with Ebola. Second, the international community failed to prioritize responding to a disease until it affected high-status people. This response to an infectious disease leads to unnecessary deaths and greater ultimate costs. Third, new and existing solutions are only accessible at a high price, out of reach of much of the world. A vital struggle looms over who gets access to newly created treatments and prevention measures as these are rolled out for Ebola. Those with wealth and exaggerated fears must not be allowed to outbid those who are at greatest risk.

Fortunately, the response to the AIDS pandemic also taught some key lessons for today's crisis. AIDS patient-activists fought to have a seat at the planning table alongside doctors and pharmacologists. They also built community-centered health clinics, disrupted political life to win funding for treatment, changed the process of rolling out drugs in favor of dying patients, defied

global intellectual property law to make drugs available to the global south, and fought back against stigmatizing the disease and the people most vulnerable to it.

Vision Question 3: There have been many excellent grassroots public health efforts, from ACT UP to the Common Ground clinic after Hurricane Katrina, but they have suffered from limitations of infrastructure once they get beyond a certain scale. What organizing mechanisms can we put in place to make such efforts function at the scale of the problems they confront? What can we learn from non-horizontal institutions like Cuba's health service or from the formalized funding that powers Doctors Without Borders? If the scale of liberatory institutions is limited, how do we instill a capacity to multiply such institutions rapidly in response to urgent needs? How might we fund science, including medical research, and mass public services outside the current profit-driven system?

Public health and epidemiology: Public goods? State surveillance? Both?

We know about Ebola and how to treat it because of a chain of researchers and a larger framework of virology, medicine, and epidemiology that have traced the virus's incursions into human communities. Their work has taken us from nearly incomprehensible tragedy in 1976 to the ability to conceptualize and plan the urgent choices needed to bring to a halt a far larger epidemic today.

Such scientific systems are among the largest decentralized efforts humans have ever created. The scientific method operates through both collective memory and collective skepticism towards any permanently designated authority. At the same time, a permanently maintained collective memory of scientific facts is vital to the enterprise. So too is the continuous interchange of knowledge, training of researchers, health care workers, and public health specialists. Approaches to understanding disease, learning how mi-