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> to the grave I will be able to photograph it, just know that it's her grave. "This is my mother's grave!" I'll be able to show my children and say, "This is your Granny's grave!" But I don't know.

Mark returned again and again to the fact that he never saw any of his mother's belongings after her death. This was certainly a result of infection-control protocols—all clothes, cell phones, ID cards, and other items are burned as soon as they enter an Ebola isolation unit—but Mark fixated on this fact as if it were the most uncomfortable sign of disrespect. His mother seemed to have disappeared without a funeral and without a trace. "A lot is on me now. . . . I'm responsible for my family. This is all bothering me now."

Soon after Nurse Mamie's death, the outbreak exploded in Kono District, with up to 27 new cases per day. A large surge in cases occurred in Kombeh village, where a well-known taxi driver named James had fallen sick after driving a seriously ill friend to the hospital in his taxi. Aware of his risk, James went to the hospital for screening and isolation but was turned away at the triage gate by confused and overwhelmed medical officers. He returned home, and died several days later with his family nearby. James's family notified the Ebola hotline that they had a corpse in the house that needed to be buried, but the village leaders reported that it took 36 hours for the epidemiological officers and burial team to arrive. All the while, James's corpse lay in the house until it was brought to the mosque nearby for pre-burial rituals. Some villagers reported that one third of the community wept over and cleaned the body. Ten days later, dozens of villagers were reported ill in their homes, and Kombeh became the most severe hotspot in Kono District.

Though transmission rates greatly declined in Kono after the alert hotline was improved and a series of small Ebola 'Community Care Centers' were constructed in remote villages for patients to be isolated close to their families, in 2015 all burials are still outlawed except for those run by the 'Safe Burial' teams. Even people who die in vehicle accidents or of old age are to be tested for Ebola and buried far from family members by the teams. Though in practice this probably means that the vast majority of ('unsafe') burials are done in secret, pickup trucks with masked men in white suits sitting in the open back shuttle back and forth from the hospital to villages to the burial ground all day long. Occasionally a lone vehicle trails with family members who wish to watch the body go into the ground from a distance.

The Ebola outbreak and the 'Safe Burial' process has clearly ruptured rituals and funerary practices, but some families continue to wash bodies of relatives who have died in their homes, resisting the instruction of health workers and Sierra Leonean law. But as these cases illustrate, the reasons why 'unsafe' burials have been practiced throughout the 2014 Ebola outbreak are entangled and ambiguous. Cultural practices, intimate expressions of affect and empathy towards the deceased and mourners, a desire among family members to maintain 'traditions,' and the pragmatic consequences of an under-resourced and ineffective Ebola response system unable to remove corpses promptly, have all contributed to the propagation of the disease through corpses. Ultimately, the optics of the 'Safe Burial' system—every dead body wrapped in an anonymous white bag, handled like a disease-threat by a team of men in biohazard suits—may actually be the most disruptive aspect of the outbreak. Ebola containment is atomizing and inherently counter-social. Dying, death, funerals, and burials have been turned from central, tactile, and intimate social processes to grave public health hazards: bodies are no longer the remnants of lives lived to be mourned at funerals but disease-carriers to be processed and removed. "They say 'Safe and Dignified,'" a Sierra Leonean colleague told me in Kono as we watched the burial team weave its way with a bagged corpse to the mass burial ground. " 'Safe,' maybe, but certainly not dignified. Where are the relatives at the back crying? Where are the hundreds of people paying their sympathies? This is what we here in Sierra Leone imagine for ourselves. No—safe and *undignified* burial is what this Ebola has done to us!"

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WHO 2014 How to Conduct Safe and Dignified Burial of a Patient Who Has Died from Suspected or Confirmed Ebola Virus Disease. Geneva, Switzerland: WHO. Accessed from http://who.int/csr/resources/publications/ebola/safe-burial-protocol/en/

Frankfurter shows us how the epidemic played out on the ground. Practitioners relied on local networks of intelligence. Health workers in dedicated vehicles drove into villages where there were suspected cases of Ebola, entering houses to dispose of the clothing, bedding, and other items of those who had died, and swabbing corpses to confirm cause of death. Oftentimes they neither explained nor gained consent for these procedures and protocols from family members. They left with dead bodies, again without appropriate consent, disposing of the corpses in body bags—white for children, black for adults—ignoring the conventional use of white for all corpses. Ambulance drivers and body handlers suffered the most collateral damage. Colleagues from WHO working in Sierra Leone at the height of the epidemic in 2014 reported that paramedics were excluded from entering the hospitals to which they delivered those who were ill; instead, they were secluded in sheds in hospital yards, subjected to extreme stigma from other health workers and from their own families. Reduced transmission and the potential end of the present epidemic have occurred, and this has been facilitated through extensive community engagement, the provision of health information so that people understand how transmission occurs, and social mobilization to support communities where emergency responses might be required. The experience from Ebola emphasizes the need for consultation between epidemiologists, health workers, and communities and the significance of local traditions in the care of the dead both in relation to disease transmission and in regard for the dead and bereaved.

In the following case study, the final of this volume, Peter Redfield takes apart the logic of MSF, an NGO that was originally conceptualized in the 1970s as a non-political, quick-response team that would provide medical care in war zones and other crisis situations. MSF has grown over the ensuing decades to a very large, multinational player in the global health scene; MSF's impressive successes and now-established worldwide reach are also its greatest challenges.

15.5 Doctors Without Borders and the Global Emergency

Peter Redfield

For the contemporary aid world, the category of 'humanitarianism' commonly designates short-term relief work—actions intended to rescue people from immediate peril and promote their survival. Perhaps no organization exemplifies this emergency orientation more fully than Médecins Sans Frontières (Doctors Without Borders or MSF), which casts itself as a central actor of frontline medicine in crisis settings worldwide. Rushing breathlessly from site to site, the group has expanded from a ragtag French alternative Red Cross of the 1970s into a well-established multinational NGO known for both a combative tradition and excellent logistics. Moreover, it largely funds itself through private donations, with a budget now in the order of $1 billion a year.[1] Relatively rich and independent, it can chart its own course to a greater degree than most aid actors. In conceptual terms the group identifies more strongly with humanitarianism than development, defining its commitments through present states of crisis rather than future goals. While its projects encompass a wide range of medical activities, many well beyond urgent care, MSF's sheer existence extends an ambulance ethos on a worldwide scale. The group's trajectory thus outlines both the possibilities and the limits of emergency medicine as a response to economic inequities and political violence. To illustrate its mode of urgent action, below I sketch a day in the life of one project, combatting a minor epidemic among civilians caught in a conflict zone.

A Case of Cholera

Near the end of 2004, I visited a cholera treatment center run by the Swiss branch of MSF in northern Uganda. The outbreak, focused in a displacement camp outside of Gulu, appeared to have run its course. Although the treatment center counted as an emergency project in the lexicon of the organization, the threat had subsided enough that there was little anxiety. Instead pressure came from

an internal source: in a few days MSF planned to close the center and move the equipment back to its local headquarters, with an eye toward redeploying it elsewhere. Due to this self-imposed deadline on top of their other work, the staff found themselves quite busy. After a morning meeting in Gulu that ran late, I joined a Dutch doctor, a Portuguese nurse and a Ugandan driver to travel to the camp. We threaded our way through the center of town, packed with a mix of storefronts and signs for aid agencies, and set off on the dusty and bumpy road. Along the way the doctor briefed me on the project. He was by now quite familiar with the disease, having seen it many times before, and was thoroughly comfortable with the prescribed treatment. "It's quick, so OK," he noted, and then added, "With rapid response it's easy."

Indeed, for MSF cholera treatment had become something of a routine. Over the second half of the twentieth century, the disease proved a common scourge of human displacement, regularly appearing in refugee settings where people crowded together with contaminated water and poor sanitation. Cholera outbreaks had helped inspire the group's development of a kit-based logistics system in the 1980s, with depots full of prepackaged equipment ready for deployment in emergency. Once on site, the cholera kit provided any medical team with the essential means to set up a sanitized treatment zone, and confine and rehydrate patients within it. Most of the time the approach proved quite reliable in quelling an outbreak and dramatically reducing mortality. The combination of assertive public health and basic clinical care transformed an exceptionally deadly disease into a relatively ordinary problem.

This particular case appeared a success as well. The compound, when we finally reached it, stood largely empty. Surrounded by a tall reed fence, with chlorine sanitation stations guarding its entrance and a large MSF flag flapping overhead, it resembled nothing as much as a minor colonial fort. Once through the sanitation barrier, we entered a set of large tents with beds set up for patients. Only a few were still occupied, and the patients and caregivers looked more bored than distressed. As the doctor explained, diarrheal cases continued to trickle in, including a few cholera patients, but the records for the last few weeks indicated the epidemic was at its tail end. Since this structure was a temporary outpost, they would refer patients to the local hospital and dismantle the center before the equipment started to disappear.

A bit later in a nearby government health center, we attended an impromptu presentation by a Ugandan doctor from the nearest hospital. The MSF team and the health center staff (along with a curious patient or two) gathered around his laptop computer as he shared a slideshow he had just prepared on the outbreak for an upcoming workshop. The slides told a triumphal story. Over the past two months the area had seen well over 200 cases of cholera, most from the camp we had just visited. Testing showed all the springs and borehole wells were contaminated, and early projections suggested as many as 3,000 people potentially at risk. However, once MSF staff had set up their center and authorities held an emergency camp meeting, the infection rate plummeted. In the end there were only eight deaths, far below what might have been. We congratulated the doctor on a nice presentation. While cautioning that at a larger research meeting the audience might want larger numbers, our team leader agreed that this appeared a successful case of quick response and prevention. Of course, he mused, MSF had never told him to calculate the cost; in contrast to other health projects, with emergencies that was never a priority. The Ugandan doctor quickly responded with dark humor. Maybe he should just tell the government to send all the displaced people back home. After all, in camp cholera kills them, and in the country rebels kill them. Same result, but the rebels are cheaper! This off-color joke provoked general laughter. It also acknowledged the larger context within which this small epidemic occurred: the long-running, low-intensity war in the surrounding region, and the government policy of concentrating civilians into crowded displacement camps. Neither the Ugandan doctor nor the MSF team could do much about these background conditions. They might stop the spread of cholera and save lives. They might further work to secure a better and more reliable water source for camp residents. The larger risk factors behind contagion, however, would remain.

That evening, on the way back to MSF's compound, we passed a car smashed on the side of the road, a crowd around it. We stopped to investigate and picked up one man, who was bleeding and holding his arm and finger. He appeared to be in shock and kept apologizing to anyone who will listen. The team did not linger to inquire about the accident; as one of them warned me, crowds can grow dangerous if rumors spread. Short on bandages in the first aid kid, the MSF nurse used a wad of tissue as a compress as our impromptu ambulance sped to the hospital where the Ugandan doctor worked. We transferred our unexpected patient to the emergency room, and then, having

effectively discharged him, we continued on home. By the next day the cholera treatment center had likewise folded its tents, its last occupants relocated to regular facilities, and its equipment dispersed to other projects.

The Medical Emergency

Popular media attests to the degree of entanglement between contemporary health care and dramatic moments of life-saving intervention. The heroic doctor of television dramas is very much an action figure: a master not only of diagnosis, but also of defibrillation, delicate surgery, and the administration of wonder drugs, all provided at the last minute with hope nearly lost. Yet the conceptual frame of the medical emergency, like the capacity to respond to one, is actually a relatively recent innovation. Michael Nurok (2003) has convincingly shown how terms like 'accident,' 'reanimation,' 'resuscitation,' 'shock' and 'trauma' only combined into their now-familiar 'epistemological alignment' early in the twentieth century, partly catalyzed by the First World War. The component parts of emergency care, from first aid kits and ambulances to emergency rooms staffed by dedicated specialists, emerged onto the landscape of wealthier countries in stages between the late nineteenth century and the late twentieth, with a particular boost in the decades after the Second World War. Details vary by national context, but at a general level—the level at which anthropologists usually engage the past—one might say that the medical emergency appeared alongside industrial society and biomedicine itself. Older strands extend deeper into traditions of experimentation and surgery, particularly forms associated with war.

This background history matters for three reasons. First, it recalls the extent that medical emergency reflects a particular cosmology of time and etiology—one that assumes human actors can and should influence outcomes at an immediate material level. This cosmology is formally secular, at least in the sense that it prioritizes a technical rather than a divine set of nonhuman actors. It also assumes a world of machinery, risk assessment, and accounting, compounded pharmaceuticals and electricity. The balance between life and death has moved away from concerns about spiritual transgression or proper burial and toward reverence for biological existence, purifying the value of 'saving lives.'

Second, the conceptual lineage of the medical emergency underscores the importance of exceptional moments, a time outside of ordinary life when special equipment might be deployed and actions taken. This sense of exception is not identical to the state of exception in legal and political tradition, being located in human bodies rather than a collective body politic. Nonetheless, it remains intimately (if not always consciously) attached to claims of legal exception as well as the longer legacy of war.

Finally, the history of the medical emergency recalls that one of the many ways to distinguish maladies is by the temporality of their potential treatment. In some cases the sense of crisis is immediate and every moment counts. Others feature a slower rate of progression, whether positive or negative, and care becomes a long-term proposition. By definition emergency medicine—from its conceptual framework to its tools, traditions and attitudes—has never oriented itself toward extended care. Rather, it concentrates on the present, minimizing both history and future for the sake of current need. Indeed, a patient may be unconscious: an incapacitated body of unknown provenance, one that displays worrying signs and requires immediate treatment. In effect, the practical logic of emergency sorts through symptoms as much as it does desires. It thus can operate even in the absence of a speaking subject or known history. Action, rather than dialogue or contemplation, remains paramount; not acting may have deleterious consequences. All three of these points grow significant when extended to the realm of medical humanitarianism.

Life During Wartime

Like all other human groups, nongovernmental organizations have their histories and habits. In the case of Médecins Sans Frontières, emergency plays a prominent role in both. Although not all forms of humanitarianism have emphasized immediate response, MSF descended directly from the Red Cross lineage of responding to war and disasters. By the end of the 1960s, its parent movement had expanded from its original concern with the battlefield suffering of wounded soldiers to encompass the plight of civilians. It had also moved well beyond its original focus on Christian Europe to engage in the fallout of decolonization and the Cold War. Thus the Red Cross found itself embroiled in the Biafran conflict in Nigeria, as well as the bloody birth of Bangladesh, two events that provided a catalyst for the formation of MSF. In this literal sense the organization was

born from war. Although it would never limit itself to responding to conflict, conflict established its most defining norms. The group likewise appeared in the wake of fast transport, global communication and standardized emergency care for civilians, which in the French variation sent doctors straight to the scene of the accident. Imagining an organization of 'borderless' doctors, in other words, required more than humanitarian sentiment. It also required a particular configuration of possibilities, and a problem around which they might cohere. For MSF that problem was what its 1971 charter termed 'populations in distress'—or in a formulation used in later publications, 'populations in crisis.'

In operational terms MSF realized this classic métier of refugee work in camps on the border between Thailand and Cambodia in the late 1970s. For some key members, that experience stoked their ambitions to provide more efficacious care, as well as to develop a logistics system that would support moving rapidly from site to site. In rhetorical terms the organization's first publicity campaign had already provided a revealing slogan for such ambitions, suggesting that for MSF there were "two billion people in their waiting room." Given that the group was then but a tiny French initiative, hardly capable of delivering much to anyone, the slogan bore little relation to actual practice. Nonetheless, it both defined a problem, and established an expansive frame of potential response. If populations experienced distress worldwide, then care should adapt accordingly. The medical emergency had found a global scale.

By the time I began conducting research in the early 2000s, MSF had greatly expanded in size and scope beyond these modest beginnings. The name now encompassed a factious family of national sections, undertaking a shifting range of projects and initiatives around the world. Many of these extended well beyond the most immediate frame of emergency in medical terms, including such things as vaccination programs, psychosocial counseling, health education, pharmaceutical advocacy and the provision of AIDS drugs. In Uganda, where I did much of my fieldwork, the organization was involved in all of these pursuits in one fashion or another, as well as conducting epidemiological studies of drug protocols and responding to emergent diseases like Ebola (which surfaced in the same general setting a few years after the cholera outbreak described above). It launched a spinoff NGO involving traditional healers, and ran a garage facility to maintain vehicles for the wider region. In practice, the concept of crisis proved elastic. From the perspective of MSF, that was precisely one of its values in the formulation 'populations in crisis,' permitting a greater degree of latitude than was true with 'emergency.' Still, the group regularly fretted over the limits of its mission, alternately launching new experiments and drawing back from them. What should it try to do, and what should it leave to others?

A Global Band-aid

A humanitarian organization like MSF often encounters the question of why it does not address root problems. Is not crisis response—particularly the theatrical, media-saturated international variety—like applying a band-aid rather than treating the underlying pathology? MSF's standard reply is staunchly realist. A crisis response remains limited by definition. Taking the medical metaphor seriously makes this clear: a band-aid, like an ambulance, seeks only to address an immediate problem, nothing less or more. For better or for worse that is precisely the temporal logic of emergency. To address chronic or future problems would require other equipment. It would also risk overlooking immediate needs, even as it might produce dependencies or new forms of domination, intended or not. For MSF lives cannot be exchanged, and a population should ultimately determine its own fate. Thus while the project of saving lives might have political implications and effects, it cannot substitute for a political plan or obscure political responsibility. From this perspective humanitarianism appears a limited, if vital endeavor, analogous to urgent care.

But the twin problems of scale and inequality pose other challenges. A billion dollars only goes so far, and charitable donations are not the basis of a viable, or sustainable, health care system. For this reason, the group issues regular moral exhortations and occasional denunciations aimed at those deemed responsible for the health of a given population. Governments and international agencies should do more, pharmaceutical corporations should charge less, problems should be solved at their roots. With this last point medical power reaches a limit. Violence, whether overt or structural, lies beyond a purely technical remedy. As MSF bitterly observed with regard to Rwanda in 1994, "you can't stop genocide with doctors."[2]

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Twenty years after the crisis in Rwanda, and a decade on from the cholera project described above, concerns about Ebola fill media headlines worldwide. Although the total number of dead has yet to reach the annual toll of cholera (let alone malaria or AIDS), the disease is extremely deadly and inspires fear in the manner of nineteenth-century outbreaks. Due to the mode of its transmission, the virus is unusually dangerous for health care workers, and ravages health care systems. Experimental treatment aside, biomedicine offers no cure for Ebola, only a reduction of mortality rates through supportive care. Amid the growing disaster in West Africa, MSF has received a new wave of attention, often cast in a heroic role as it struggles on the frontlines. Although overwhelmed and unable to offer treatment to those seeking it, the group recognized and proclaimed the severity of need earlier than most others, and its call for reinforcements have helped define a state of emergency. Its protocols for protective equipment have recently featured in discussions of shortcomings in the preparedness of US hospitals. As much as any official government body or intergovernmental agency, here an NGO defines a standard of action, however erratically and uncertainly life-saving. Yet at the same time, MSF has limited ability to actually solve the larger problem or rebuild health systems. An Ebola treatment center, just like one for cholera, is an immediate response, not a solution.

For all that emergency might offer humanitarians the allure of moral clarity—action as pure reaction—that clarity wavers when the frame widens. MSF continually opens programs in response to perceived crisis, and closes them when conditions return to a more ordinary state. In doing so, it confronts the fact that what counts as normal varies considerably from place to place, and that it cannot respond to all problems. Being 'without borders' the group continually struggles to define limits. The choices it makes factor in the work of other organizations and the larger realities of poverty and inequality, as well as its own relentless need to move on. Within the frame of a global emergency, there are always more lives to save.

Notes

1. *MSF International Financial Report 2013* gives the group's overall income as just over 1,000 million Euro in 2013, up from about 938 million the year before. Of this amount, 89.5 percent came from private sources, the vast majority derived from nearly 5 million contributors worldwide.
2. http://www.doctorswithoutborders.org/news-stories/field-news/new-msf-case-study-response-rwandan-genocide

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Unexceptional Moments

While groups such as MSF provide care to those in need during 'exceptional moments,' anthropologists often work at the other end of the spectrum of excitement—that is, they usually dwell in the most unexceptional of times and places—places like the aftermath of the Ebola epidemic. It is unexceptional in many ways: most volunteers and their attendant medical equipment have packed up and left West Africa for home; the press has moved on to other topics. It is unexceptional because the after-effects of the epidemic are chronic in nature and their cure is uncertain. At this writing (September 2015), we are just beginning to understand the long-term effects of having lived through the 2014 Ebola epidemic; survivors of the disease caused by the Ebola virus are now, six months to a year after the infection, suffering from intense joint pain, headaches, and PTSD-like symptoms of depression and anxiety. A quarter of the survivors suffer from eye problems and blindness as the virus continues to survive in the eye long after it clears from the rest of the body. Ebola virus also seems to survive in semen,