The publics of public health: learning from COVID-19

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Abstract

This commentary reflects on what has been learnt from government and public health responses to COVID-19, suggesting a tension between 'business as usual' forms of public health in the face of crisis, and the possibilities for a step-change towards a 'healthy publics' approach. We set out a range of ways that diverse, multiple publics have been implicated or brought into being during the COVID-19 pandemic, and we argue that these have generally been ignored or erased by agents or agencies of public health, keen to preserve certainty in their messaging and public confidence in their authority. We conclude with five principles for re-organising pandemic responses around a richer, more context dependent and diverse account of 'the public'.

Introduction

Advances in biotechnology prompted by the COVID-19 pandemic have exemplified the best of scientific promise. However, the ultimate success of these innovations will not depend so much on the efficacy of vaccines, their mass availability, or even the logistics of their distribution, but rather on the social and cultural aspects of risk communication, risk perception, and health practices. Public health is pluralistic and heterogeneous (Harvey, 2011). It covers a wide array of services, policies, and practices within an equally wide range of institutional and governmental entities. More importantly, it also describes a set of human and planetary conditions. While biomedical technologies and expertises are necessary to address challenges to public health, they are insufficient to disentangle the complex interplay between humans and other species, between public understandings of risk and people's participation in mitigation, and between the concerns of local authorities and those of national-level governments, including wider geopolitical constraints. The concept of 'healthy publics' (Hinchliffe et al., 2018) foregrounds 'dynamic collectives of people, ideas and environments that can enable health and well-being'. The efficacy of 'public health' thus relies as much on what 'publics' are up to, as it does on the policies and practices we group under 'health'. However, a shared situational awareness of this issue has been lacking over the first few years of this pandemic, as attention has fixated on advances in vaccinology and epidemic modelling (Rhodes et al., 2020). The result is a lack of investment in developing measures that focus on, for example, social dynamics (Jasanoff et al., 2021). While some national-level expert advisory groups have included social scientists, these have been in small numbers, with members often perceived as having less relevancy and legitimacy than their biomedical counterparts (Pickersgill & Smith, 2021). Worse, where government and public health responses to the pandemic have attempted to deploy social science, they have largely evoked behavioural techniques from bygone eras of contagion management (Armstrong, 1993) and have relied heavily on border closings and quarantines as mitigation measures. Indeed, not only has expertise from humanities and social sciences been side-lined, but critiques of the status quo in global public health policy and practice have been dismissed as little more than 'academic sparring' in the midst of crisis (Greenhalgh, 2020). Yet the current state of affairs also presents a singular opportunity to rethink the publics of public health. How can developments in this pandemic point to new ways of imagining the relationships between public health and its publics? And what can a critical social science and humanities perspective contribute in terms of rethinking how varied publics are constituted, mobilised, and acted-upon in public health policy and practice?

Public ignorance?

During the COVID-19 pandemic, international and national responses have relied on traditional public health response modes, with the 'public' largely engaged as the passive recipients of interventions, and not as a set of active partners who bring valuable insights and interpretations. Publics not conforming or complying with governmental and institutional expectations have been seen as misinformed, ignorant of science, and as easy prey for 'infodemics' of fake news from social media (see, e.g., Allington et al., 2021). Such a perspective has been institutionalized through health policy at the local, national, and international levels. This has led to dismissal, and even stigmatisation, of resistant or hesitant publics, with their perspectives seen as based on mere rumours, or as something to be supplanted with accurate information rather than understood or engaged. What should public health, as a public service, make of social media accounts that question vaccine safety or that link COVID to covert government programs? The response should not be to read these as irrational responses rooted in ignorance, to be simply countered with more information. The fact is that resistant or 'hesitant' publics do not see themselves as misinformed or making irrational decisions; rather, like everyone else, they are pursuing important epistemic and cultural commitments, making sense of the world based on what are necessarily partial views and limited standpoints. 'Hesitant' publics, no less than any other, are working to determine which claims ought to be understood as credible and why, how one ought to act, and what one ought to believe. Moreover, simplistic critiques of public opposition to scientifically accepted understandings of COVID-19 are not only a missed opportunity; they also gloss over what in other arenas we would have no difficulty seeing as well-founded and even democratically important scepticism of government communications, the motivations of large profit-seeking companies, and early-stage scientific information.

There is, of course, a reasonable anxiety for agencies and agents of public health that anything other than certainty, simplicity, and evidence-informed messaging risks undermining public confidence (Harvey, 2021). In the UK, the lessons of the MMR fall out – with measles vaccination rates falling to below those needed for official 'measles-free' status in 2019 – continue to resound. Nonetheless, public health messages that do not acknowledge uncertainty (for the sake of preserving scientific authority) can undermine the legitimacy of the information as well as the source – and can contribute to the production of even more sceptical publics (Green et al., 2005). The current pandemic has the potential to change this dynamic, if we learn from analyses of publics and pandemics in anthropology, history, and other disciplines. The contrast with Ebola is stark, where failures of the public health response in the 2014–16 outbreak led to close involvement of

anthropologists in policymaking (Martineau et al., 2017). Yet, while notable exceptions exist (for example, in Germany's early response to the crisis), there has been strikingly little involvement of social scientists (beyond the behavioural sciences) or humanities scholars in COVID-related policymaking, at least in Europe and the USA. Anthropologists' contributions to Ebola responses recognised that attention to 'culture' was essential for planning interventions that involved practices deeply embedded in social life, such as caregiving and burial practices. Rumours were approached as 'rational-in-context' – that is, as teaching us something about publics and their knowledge rather than as indicators of public ignorance (Wigmore, 2015; Wilkinson & Fairhead, 2017). One may ask why public health policies and practices are relatively comfortable with 'culture' operating in West African disease contexts but not in European COVID-19 disease contexts.

In any event, as COVID-19 spread, national public health responses in Europe and the United States often treated their own cultures as invisible and unmarked, with non-compliant behaviours seen as the result of misinformation rather than alternative explanatory models. One alternative analysis would be to think non-compliance' through the lens of 'bioprivilege'. Such an analysis would begin with a recognition that some bodies are considered to have attributes of autonomy, health, and able-bodied-ness, which affords those bodies the ability to make 'legitimate' claims to rights and recognition. However, such full-fledged 'biocitizens' stand in marked contrast to marginalized counterparts, who are systemically denied the category of 'at risk' because of unequal access to information, socio-economic inequalities, and other structural conditions (Harvey, 2012). The pandemic, interacting with wider structural and systemic inequalities, has thus given rise to pernicious new forms of 'bioprivilege', which demand that the personal preferences of some ('biocitizens') not only be officially recognized but that societal accommodations be made on their behalf, despite the public health risks that these choices present to the many.

This is just one example of how critical social science helps us to think more expansively about how different publics respond to epidemiological crisis, especially when information from authoritative sources is subject to revision and contest. Effectively communicating the advantages (or at least the 'precautionary and scientific principle' behind the medical guidance) in relation to maskwearing is one clear instance of such contest. At a point where transmission routes for COVID-19 were poorly understood, advice to wear masks in public was difficult for many people in countries such as the UK to follow, and not helped by a failure to communicate uncertainty effectively. As Martin et al. (2020) argue, in times of 'post-normal' science, a wider range of expertise should be

sought to maintain public trust instead of a narrow 'technical' range of sources to preserve a 'clear message'.

Public knowledge

Public knowledge – knowledges and epistemologies created, held, circulated, and valued by publics outside of or adjacent to formal spaces of knowledge production – is largely invisible in formal governance strategies or expert groups but has been crucial to the pandemic response. As expert knowledge around infection routes, transmissibility and vaccine response unfolded (and altered) in real time, diverse publics had to manage everyday infection control, making axiological (value) judgements and developing health protection practices under conditions of considerable scientific uncertainty. Social media was not simply a mediator of fake news in this moment: it was a key resource through which communities shared information about whether to sanitize shopping goods, how to distinguish COVID-19 from a cold, how to make home-made masks, how to manage household tensions (sometimes household violence) through periods of isolation, and how to establish systems of mutual aid (Fernandes-Jesus et al., 2021; Ortega & Orsini, 2020). In the face of official uncertainty, new explanatory models (Kleinman et al., 1978), public epidemiologies and public virologies, were built and held together as communities learned how to live and die with the virus, and how to reconfigure everyday routines and interaction around its management.

The work of Callard and Perego (2021) on the making of Long COVID is especially important in relation to the need to take such knowledges seriously. In their account of how patient activism brought Long COVID onto the public health agenda, Callard & Perego document how the perceived epistemic illegitimacy of lived experience limited acknowledgement among medical actors of the long-term effects of COVID-19 infection. In the face of official dismissal and condescension, the complexity and multiplicity of symptoms were collated by patients finding each other on social media. Epistemic work by patient activists was thus how the existence, trajectories, and impacts of the disease – which was an object of public knowledge long before reluctant formal authorities began to recognise it – came to be understood.

We might ask, then, what other important sources of evidence are excluded, as the lived experiences of publics continue to be positioned as anecdotal or subjective in the face of authoritative science. What kinds of expertise, and what publics, have been made invisible or otherwise excluded from response and recovery planning? How many countries have included those

most affected by pandemic responses – children and young people, chronically ill and disabled people, those living in residential care homes – in expert committees? How, indeed, have the communication and intervention efforts of public health policies and practices helped to create certain sorts of publics, including resistant ones?

Global and national publics

Pandemic publics are produced and evoked at a range of scales. For example, the pandemic has sharpened awareness of the emergence of 'planetary' publics (Hinchliffe et al., 2021), with the health of a global population and of the planet itself so clearly implicated in the increasingly global entanglements of species, environments, economies, and health. The most visible scale of publics evoked by pandemic response, however, has been not this planetary public, but national publics. Attention to the globalisation of health risks and the need for coordination has paradoxically generated a resurgence of the imagined salience of nation-states as places where defensible publics are constituted. As borders closed and migrants were stranded in 2020, the 'national' and often 'nationalistic' rhetoric of politicians and public health actors has consistently situated pandemic publics as populations divided by legal borders, even as the shared interests of publics in a globalising world have never been greater; this has also driven the unequal impact between nations, as actions explicitly protected the perceived interests of populations in the global north at the expense of those in the majority world (Kelley et al., 2020). The pandemic also revealed how the democratic promise of interconnected planetary publics can give way to the older reflexes of racism and xenophobia (Wang et al., 2021). Consider, for example, political references to COVID-19 as the so-called 'China Virus', and how this polarizing discourse worked to create scapegoats, apportion blame, and foment conspiratorial thinking.

These nationalistic and often xenophobic responses, including the exclusion of a 'global public' as a key referent in public health action, revert to traditional metaphors of risk as 'external', and health as an internal object to be defended. National responses have typically addressed overtly nationalised and often racialized publics, figuring their own desired public as citizens of a nation state, with epidemiological responsibilities to that state, and expectations of care and protection from it. From the UK's evocations of war-time cohesion (Fitzgerald, 2021), to the militarized anti-migrant rhetoric of Australia and the nationalized communitarian framing of New Zealand's Prime Minister (McGuire et al., 2020), political discourse has, across the world,

crafted pandemic response as primarily a matter of national character and interests, not international collective concern. Infections, mortality, and vaccine roll out are reported by nation state, while political rhetoric has resounded with evocations of the 'public' as a unified national public, whose duty it is to protect fellow nationals, and whose liberty can be curtailed by the state in the name of public health. This development has been in tandem with – and indeed often constitutive of – the unequal impacts of pandemic disease within and across global populations.

But if the nation is taken to be the primary scale for constituting pandemic publics, then citizenship becomes the organising logic of the health politics of the pandemic. With a sharpening of national borders, those with precarious claims to citizenship have largely been excised from COVID publics as anything other than risks (Alemi et al., 2020). People who are formally stateless, migrants, refugees, and those in occupied territories are particularly vulnerable to infection risk through material circumstances, cut off from familial sources of support, and given contingent access to nationalised prevention and care programmes (Watt et al., 2021).

The re-inscribing of national borders, and their control in the name of health, has also foregrounded both the securitisation of public health governance (Weir & Mykhalovskiy, 2010) and the status of citizens in relation to the state. Pandemic responses produce 'biological citizens', who not only look to the state to secure their own vitality, but also face renewed obligations to maintain their own and their communities' health (Rose & Novas, 2005). Notably, this also creates the conditions for critical or resistant publics, overtly or otherwise protesting these obligations, charging the state with failing to meet its own life-protecting obligations, and so on. As Jasanoff et al. (2021) note, a range of social 'compacts' frame such relations, which shape how public health is constituted and legitimated as part of a state apparatus. Such relations are rooted in national politics and histories, which in turn contour particular imaginary cultures of solidarity, collectivism, and individualism.

Public spaces

Media images of deserted city centres and closed public amenities during lock-downs starkly illustrated how the pandemic reconfigured the physical spaces of everyday conviviality. Local spaces of informal interaction with strangers (coffee shops, shopping centres, gyms) closed, while formal spaces of deliberation (the municipal committee or trade union meeting) moved online. Front-line workers, often in lower-paid and insecure delivery or retail roles, faced uncertain risks in a newly-dangerous public sphere, while the retreat to home working for others generated unexpected leaks

between the public and private spheres. The foreclosure of public space also brought renewed risks to some vulnerable people, not least those caught in abusive or marginal domestic situations, as the private home became more and more invisible to public authorities. This division between public and private space was sharpened by the erosion in many countries of those marginal spaces that were somewhere between the public and private – spaces neither of deliberation nor domesticity, but rather of liminality between work and home. Using public transport or buying a coffee were mundane opportunities to be part of a collective public through simple bodily co-presence – not always with entirely positive affect, but nonetheless granting an everyday reminder of belonging to some larger public.

As many disabled people have pointed out, the formation of public spaces has always excluded many from such possibilities, with little apparent disquiet. Indeed, for some people, the spatial restrictions of the pandemic brought about a new sense of equality in access to spaces of deliberation and interaction. Similarly, we should be wary of romanticising public spaces – parks, public transport, civic meetings – which have long histories of excluding people on the basis of race, gender, or disability. There is work to be done on renewing and reconfiguring spaces for interaction, deliberation, and political exchange postpandemic, and this work must centre the voices of people who have long been shut out from many avowedly public spaces. This remains deeply challenging: as Dolezal (2020) notes, social distancing, as an infection control response, aims at isolating individuals. Whatever the post-pandemic looks like, we have all 'become dislodged from the usual taken-for-granted fabric of embodied social relations', with significant effects on our everyday competence in intercorporeality as we integrate a view of others' bodies as risky. Telepresence, Dolezal notes, however sophisticated the platform, cannot reproduce the embodied affordances of being with others, and the health and wellbeing impacts of our enforced isolation from the co-presence of others are not yet known. Making up inclusive spaces for publics postpandemic will require more than mere attention to the technical possibilities of information exchange.

Conclusion

Taking healthy publics seriously entails recognising the fragility, heterogeneity, and emergence of both health and publics. In turn, this necessitates drawing on a wider range of evidence about health and wellbeing to inform interventions, as well as a more dynamic and relational approach to human and planetary cultures. We suggest that, to date, global pandemic responses have not done this. They have excluded expertise (including expertise through experience) on these issues, have failed to grapple with uncertainty, and have reverted to nationalistic responses to manage the emergency.

The ‘publics’ of public health have too often been evoked as either selfish territorial populations, dupes spending too much time on Facebook, or passive foils for an expert cadre of scientists. How might global and national public health systems respond better to pandemics through a more nuanced accommodation with the multiplicities we have gestured at here? We propose five principles as a starting point:

- Recognize the dynamic ways that cultural contexts interact with public health communication and intervention to produce different publics.
- Allow for transparency and clarity about uncertainty in the face of a crisis, as exaggerated certainty is counterproductive.
- Stop centring the nation as the space where publics become meaningful and move to thinking on a more explicitly planetary scale.
- Foreground social science and humanities expertise in national-level responses; this is not a ‘token anthropologist’ at the table but a commitment to serious epistemic parity.
- Develop comprehensive, participatory fora for bringing in greater multiplicity of lived pandemic expertise from outside formal expertise systems.

Throughout the COVID-19 pandemic, debates around managing communication on scientific uncertainty, struggles over the legitimacy of Long COVID, and the tensions between resurgent natio nalistic responses to a global crisis have brought the exclusion of participatory public expertise from response-planning into sharp focus. Beyond these acute questions, however, the pandemic has forced a rethink of who and where the ‘public’ is in public health. Many have lauded the informal and often hyper-local effectiveness of mutual aid groups, for example. But how do we maintain this new sense of a spatialized, ‘local’ public without accepting a more generally territorial account of public health, which can become sharply exclusionary when those territories run into legal and political boundaries?

Public health for the future will need a more sophisticated understanding of culture as the everyday contexts which shape our motivations, decisions, and desires, not as the set of beliefs and behaviours, which may be more or less congruent with current scientific evidence. Rather than seeing culture as an obstacle to health – a source of irrational beliefs and a barrier to effective treatment – public health practitioners need to start seeing the everyday practices of multiple publics as sources of dynamic and rigorous action in response to acute crises.

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References

- Alemi, Q., Stempel, C., Siddiq, H., & Kim, E. (2020). Refugees and COVID-19: Achieving a comprehensive public health response. Bulletin of The World Health Organization, 98(8), 510. https://doi.org/10.2471/BLT.20.271080
- Allington, D., Duffy, B., Wessely, S., Dhavan, N., & Rubin, J. (2021). Health-protective behaviour, social media usage and conspiracy belief during the COVID-19 public health emergency. Psychological Medicine, 51(10), 1763–1769. https://doi.org/10.1017/S003329172000224X
- Armstrong, D. (1993). Public health spaces and the fabrication of identity. Sociology, 27(3), 393–410. https://doi.org/10.1177/0038038593027003004
- Callard, F., & Perego, E. (2021). How and why patients made Long Covid. Social Science & Medicine, 268, 113426. https://doi.org/10.1016/j.socscimed.2020.113426
- Dolezal, L. (2020). Intercorporeality and social distancing: Phenomenological reflections. The Philosopher, 108, 18–24.
- Fernandes-Jesus, M., Mao, G., Ntontis, E., Cocking, C., McTague, M., & Schwarz, A., Semlyen, J., & Drury, J. (2021). More than a COVID-19 response: Sustaining mutual aid groups during and beyond the pandemic. Frontiers in Psychology, 12, 5809. https://doi.org/10.3389/fpsyg.2021.716202
- Fitzgerald, D. (2021). Normal Island: COVID-19, border control, and viral nationalism in UK public health discourse. Sociological Research Online. 13607804211049464. https://doi.org/10.1177/13607804211049464
- Green, J. M., Draper, A. K., Dowler, E. A., Fele, G., Hagenhoff, V., Rusanen, M., & Rusanen, T. (2005). Public understanding of food risks in four European countries: A qualitative study. European Journal of Public Health, 15(5), 523–527. https://doi.org/10.1093/eurpub/cki016
- Greenhalgh, T. (2020). Face coverings for the public: Laying straw men to rest. Journal of Evaluation in Clinical Practice, 26(4), 1070–1077. https://doi.org/10.1111/jep.13415
- Harvey, T. S. (2011, March). Maya mobile medicine in Guatemala: The “other” public health. Medical Anthropology Quarterly, 25(1), 47–69. https://doi.org/10.1111/j.1548-1387.2010.01135.x

- Harvey, T. S. (2012). Cyanobacteria blooms: Maya peoples between the politics of risk and the threat of disaster. Medical Anthropology, 31(6), 477–496. https://doi.org/10.1080/01459740.2012.658588
- Harvey, T. S. (2021). Make it plain, COVID-19 and how fundamental cultural misunderstandings about how viruses work can spread infection and hesitancy. Practicing Anthropology, 43(4), 19–22. https://doi.org/10.17730/0888-4552.43.4.19
- Hinchliffe, S., Jackson, M. A., Wyatt, K., Barlow, A. E., Barreto, M., Clare, L., Depledge, M. H., Durie, R., Fleming, L. E., Groom, N., Morrissey, K., Salisbury, L., & Thomas, F. (2018). Healthy publics: Enabling cultures and environments for health. Palgrave Communications, 4(57), 1–10. https://doi.org/10.1057/s41599-018-0113-9
- Hinchliffe, S., Manderson, L., & Moore, M. (2021). Planetary healthy publics after COVID-19. The Lancet Planetary Health, 5 (4), e230–e236. https://doi.org/10.1016/S2542-5196(21)00050-4
- Jasanoff, S., Hilgartner, S., Hurlbut, J. B., Özgöde, O., & Rayzberg, M. (2021). Comparative Covid response: Crisis, knowledge, politics. CompCoRe Network, Cornell University. https://www.unicamp.br/unicamp/sites/default/files/2021-01/Harvard-Cornell/20Report/202020.pdf
- Kelley, M., Ferrand, R. A., Muraya, K., Chigudu, S., Molyneux, S., Pai, M., & Barasa, E. (2020). An appeal for practical social justice in the COVID-19 global response in low-income and middle-income countries. The Lancet Global Health, 8(7), e888–e889. https://doi.org/10.1016/S2214-109X(20)30249-7
- Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. Annals of Internal Medicine, 88(2), 251–258. https://doi.org/10.7326/0003-4819-88-2-251
- Martin, G., Hanna, E., McCartney, M., & Dingwall, R. (2020). Science, society, and policy in the face of uncertainty: Reflections on the debate around face coverings for the public during COVID-19. Critical Public Health, 30(5), 501–508. https://doi.org/10.1080/09581596.2
- Martineau, F., Wilkinson, A., & Parker, M. (2017). Epistemologies of Ebola: Reflections on the experience of the Ebola Response Anthropology Platform. Anthropological Quarterly, 90(2), 475–494. https://doi.org/10.1353/anq.2017.0027
- McGuire, D., Cunningham, J. E., Reynolds, K., & Matthews-Smith, G. (2020). Beating the virus: An examination of the crisis communication approach taken by New Zealand Prime Minister Jacinda Ardern during the Covid-19 pandemic. Human Resource Development International, 23(4), 361–379. https://doi.org/10.1080/13678868.2020.1779543

- Ortega, F., & Orsini, M. (2020). Governing COVID-19 without government in Brazil: Ignorance, neoliberal authoritarian-ism, and the collapse of public health leadership. Global Public Health, 15(9), 1257–1277. https://doi.org/10.1080/ 17441692.2020.1795223
- Pickersgill, M., & Smith, M. (2021). Expertise from the humanities and social sciences is essential for governmental responses to COVID-19. Journal of Global Health, 11, 03081. https://doi.org/10.7189/jogh.11.03081
- Rhodes, T., Lancaster, K., & Rosengarten, M. (2020). A model society: Maths, models and expertise in viral outbreaks. Critical Public Health, 30(3), 253–256. https://doi.org/10.1080/09581596.2020.1748310
- Rose, N., & Novas, C. (2005). Biological citizenship. In A. Ong & S. Collier (Eds.), Global assemblages (pp. 439–463). Blackwell.
- Wang, S., Chen, X., Li, Y., Luu, C., Yan, R., & Madrisotti, F. (2021). 'I'm more afraid of racism than of the virus!': Racism awareness and resistance among Chinese migrants and their descendants in France during the Covid-19 pandemic. European Societies, 23(sup1), S721–S742. https://doi.org/10.1080/14616696.2020.1836384
- Watt, G., Giacaman, R., Zurayk, H., Bjertness, E., Holmboe-Ottesen, G., Ghattas, H., Nuwayhid, I., Leaning, J., Yudkin, J. S., Elessi, K., & Sullivan, R. (2021). COVID-19 vaccines for Palestinians. The Lancet, 397(10274), 579. https://doi.org/10. 1016/S0140-6736(21)00185-9
- Weir, L., & Mykhalovskiy, E. (2010). Global public health vigilance: Creating a world on alert . Routledge.WHO. (2021). COVID-19 Strategic Preparedness and Response Plan (SPRP 2021). https://www.who.int/publications/i/ item/WHO-WHE-2021.02
- Wigmore, R. (2015). Contextualising Ebola rumours from a political, historical and social perspective to understand people's perceptions of Ebola and the responses to it. Ebola Response Anthropol Platf, 4. http://www.ebola- anthropology.net/wp-content/uploads/2015/10/Contextualising-Ebola-rumours-from-a-political.pdf
- Wilkinson, A., & Fairhead, J. (2017). Comparison of social resistance to Ebola response in Sierra Leone and Guinea suggests explanations lie in political configurations not culture. Critical Public Health, 27(1), 14–27. https://doi.org/10. 1080/09581596.2016.1252034