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Sylvanus N. Spencer

### **“INVISIBLE ENEMY”:**

TRANSLATING EBOLA  
PREVENTION AND CONTROL  
MEASURES IN SIERRA LEONE

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# **“INVISIBLE ENEMY”:**

TRANSLATING EBOLA PREVENTION AND  
CONTROL MEASURES IN SIERRA LEONE

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## INTRODUCTION

The Ebola virus disease (EVD) was first discovered in 1976 in the Democratic Republic of the Congo. It first appeared in West Africa in December 2013, in the forested region of south-eastern Republic of Guinea. In May 2014, it crossed the border into the Kissi Teng Chiefdom of Kailahun District in the eastern region of neighboring Sierra Leone. This region was to become one of the epicenters of the disease. From there it spiraled into other parts of the country.

Using the concepts of travelling models and translation (Behrends, Park and Rottenburg 2013), this paper seeks to examine why time-tested scientific measures of contagious disease prevention and control recommended by international health experts and promoted alongside various Sierra Leonean actors (including health practitioners, politicians and media practitioners) have been slow in yielding the desired results and instead have in many cases led to unintended outcomes with very tragic consequences. The prescribed biomedical Ebola prevention and control measures primarily seek to break the chain of transmission of the virus by, among other things, discouraging contact with dead or living victims of the disease and their body fluids, undertaking contact tracing, quarantining victims or suspected victims, providing symptomatic or supportive treatment and safely disposing of the corpses of those infected<sup>1</sup>.

In this paper I suggest that a broader notion of translation is necessary to understand the chains of Ebola translation in Sierra Leone. The notion of translation cannot be reduced to the linguistic translation of biomedical measures into local idioms to counter people's denial of Ebola and the misinformation about its origin (see also Chandler et al. 2014; Abramowitz et al. 2015). While this translation work is without doubt important, it is better understood as a vernacularization, as Sally Engle Merry points out (Merry 2006, 44), which constitutes only one form of translation.

Following Paul Richards and others, my analysis of the dramatic spread of Ebola in Sierra Leone uses translation as an analytic which emphasizes that social and material factors are "important to understand the epidemic and [the] ways in which it might be stopped, [although] these factors have so far been little analyzed." (Richards et al. 2014, 1).

The process of translation described in this article shows that these social factors are far more heterogeneous than the conventional representations in popular discourse, which narrowly focus on traditional beliefs. Instead, I argue that a full understanding of the Ebola epidemic has to capture the heterogeneity of social factors and the multiplicity of actors, inserting agency in the translation of Ebola intervention measures. For some, Ebola was a result of witchcraft, claiming that its pathogenesis is of a spiritual and not a physical origin. For others it was another ploy by mischievous politicians to attract donor funds and to reduce the population of the south-eastern part of the country – the stronghold of the main opposition Sierra Leone Peoples Party – thereby reducing opposition votes in the much anticipated 2017 General Elections. This conspiracy theory gained credence from the fact that a National Population Census, which often informs the drawing up of constituency electoral boundaries, was to take place in the latter part of 2014.

Again, others claimed that Ebola was a ploy by Western conservationists who wanted to discourage local inhabitants from depleting the dwindling stock of wildlife in the nearby Gola Forest and therefore came up with the story that fruit bats and monkeys, which are eaten by some inhabitants of the forested region, are known carriers of the Ebola virus<sup>2</sup>.

The presenter of a popular local radio program called *Monologue* argued that the main reason for the initial spate of denials was that the community members in the epicenter of the disease

initially learnt about its spread into Sierra Leone from politicians who are generally discredited as deceitful.<sup>3</sup> The lack of confidence in the credibility of the messengers, he maintained, led to denials, misinformation and conspiracy theories. However, even when players other than politicians came on the scene with the same message, denials continued. It was mainly the sheer number of deaths, including deaths of health workers, like the country's only virologist, coupled with massive awareness raising campaigns that the level of denials was reduced.

As people gradually accept that Ebola is real and deadly, the drive to get them to know and practise the scientifically approved Ebola prevention and control measures gained momentum. There was also the task of providing the required medical treatment for those infected with the virus in order to save their lives and prevent them from infecting others. For this, the health delivery system of Sierra Leone and the other Ebola affected countries proved to be grossly inadequate even in terms of basic amenities (Park and Umlauf 2014). Although Sierra Leone made some strides in health and medical research during the colonial period, the post-independence period witnessed a gradual decline even in basic bio-medical research, which nonetheless often promises results that could be utilized as effective tools in the prevention and control of diseases threatening public health and socio-economic viability (Gbakima 2000).

## **TRAVELLING MODELS and TRANSLATION**

Among the international translators of Ebola prevention and control measures in Sierra Leone and other Ebola affected West African countries are the World Health Organization, the French charity, Médecins Sans Frontières (MSF) and the American Center for Disease Control (CDC). They work with several local NGOs, health workers, civil society groups and governmental agencies among others. In the light of Rottenburg's (2009) analysis of global entanglements, the recommended biomedical control measures could be viewed as constituting a travelling model. This model was formulated out of years of scientific investigations and observations of mainly Western scholars based on their experiences with Ebola in Africa and other infectious diseases they have had to contend with. In the process of tackling the unprecedented scale of the EVD outbreak in West Africa, the model had to travel from the context in which it was developed to a new receiving context where it is usually translated by local and international actors with quite different interests and strategies.

Translation as an analytical concept is useful in explaining how ideas conceived in one place "travel" through the agency of different actors to another corner of the globe where they may be adapted, transformed, appropriated or even rejected based on certain contextual realities different from the source from which the idea was originally conceived (Rottenburg 2008). Translation does not simply imply transfer of a model from one place to another but its transformation in the face of new logics and realities in the receiving contexts. The new context into which the model travels is not merely made up of passive recipients who would simply accept the model lock, stock and barrel. Instead, the recipients are actively involved in assessing and reacting to the model in the light of their own peculiar worldview, experiences and socio-cultural realities. In the end, this may result in unintended outcomes or even futile and counterproductive efforts to reproduce what obtains in a model's place of origin. This is very much evident in national and trans-national endeavors to translate travelling models of

governance and development like free expression, decentralization and gender mainstreaming in post-war Sierra Leone.

The translation process involves several players or actors (international and local) who package and present what is being translated in such a way that it may become acceptable to the receiving context. The translator seeks to build bridges between the giving and the receiving contexts. This may involve, among other things, pointing out similarities and drawing parallels between what is being translated and the experiences, thought forms, cultural values and practices available on the ground in the local context (Merry 2006; Lewis and Mosse 2006). It is along this line of thinking that Prah (2011) states that "no ideas however lofty, well-meaning and humanitarian can resonate with the broader classes [of Africa] unless these ideas find interpretable entry points into the cultural familiarities of the people." Being familiar with the historical experiences, local customs, traditions, folklores and values of the receiving contexts, the local translators are expected to be very valuable in bridging the gap between the two different contexts and outlooks.

In the absence of a cure for Ebola, the World Health Organization and the American Center for Disease Control, among others, recommended certain precautionary measures which include avoiding physical contact with a person suffering from Ebola, and with their bodily fluids as well as with the corpses of Ebola victims. All Ebola patients should be isolated or quarantined until they are declared by health professionals as Ebola free. These preventive measures were based on the scientific observation that the Ebola virus is mainly transmitted through contact. For the virus to be controlled it was necessary to break the chain of transmission by avoiding direct contact with victims, screening and isolating them in centers where treatment is provided. Upon failure to recover, the corpses should be safely disposed of. Safe disposal of corpses often involves disinfecting and burials without the usual funeral ceremonies or a large gathering of mourners.

It is now generally agreed that Ebola is a national enemy and should be defeated at all costs if individual and national survival is to be assured. As translators of Ebola prevention and control point out, breaking the chain of transmission is crucial if Ebola is to be defeated. As the disease claimed the lives of more and more unfortunate victims, increased emphasis was placed on the need to cut down on the risk of contracting the disease by minimizing human body contact. "Don't touch" became a popular slogan and the abbreviation, "ABC" (Avoid Body Contact) was used to drive home the message. Even the abbreviation of the ruling political party – APC (All Peoples' Congress) – was now cynically converted to stand for Avoid Peoples' Compound. People started refraining from handshaking and hugging, and began avoiding public gatherings and sitting at close quarters in public transports (usually overloaded well beyond the stipulated capacity of the vehicles). But in these close knit communities where not much fuss is made about maintaining what the American Anthropologist, Edward T. Hall (1963) calls "personal space", one could barely avoid close bodily contact in the daily dealings with people especially in the often crowded or even *overcrowded* homes and public facilities of urban centers. Furthermore, scrambling as opposed to queuing for goods and services tends to be commonplace at bus stops, market place, entertainment houses etc.

In connection with the desire to break the chain, a public health emergency was declared. This, among other things, put a ban on public gatherings and reduced the number of passengers allowed in commercial vehicles. Okadas (motor cycle taxis) which are the fastest means of transportation in urban centers were to operate only between 7.00 am and 7.00 pm. It was hoped that these measures would cut down on the risk of new infections and transmission of the disease. Another move in the fight to contain the Ebola virus was the strategic placement of

buckets of chlorinated water in public places for the washing of hands. Overnight, the market for detergents, disinfectants and hand sanitizers experienced a boom. Plastic gloves and in some cases, face masks became part of the arsenals used in the battle against the "invisible enemy".

Efforts to break the chain of transmission by diligently observing the prescribed precautionary measures run into conflict with certain long-cherished traditional beliefs, cultural practices and social values. Such conflicts are strikingly evident in the way some communities and individuals respond to the caution to refrain from touching corpses of Ebola victims and Ebola patients or anyone suspected of being infected. Breaking the chain of transmission as a travelling model for Ebola prevention and control ultimately aims at preventing new infections and transmissions but the way the model is received and implemented in the Sierra Leone context has resulted in unintended and counterproductive outcomes in that room is inadvertently created for many new infections. In many cases, the belief in traditions and the respect for social values appear to be stronger than the fear of the Ebola virus disease. Hence, an interviewee expressed the view that it is not Ebola that is killing people but the fanatical attachment to age-long traditions.

## **GLOBAL AND LOCAL MODELS: BREAKING THE CHAIN OF TRANSMISSION**

### **TRANSLATION I: VIRUS vs SPIRITS/WITCHCRAFT — "THE INVISIBLE ENEMY"**

Since the 1970s, and the outbreak in the Democratic Republic of the Congo, the scientific community of mainly Westerners has been involved in studying the Ebola virus and through laboratory investigations valuable knowledge has been amassed about EVD. However, in Sierra Leone, there was no previous experience with Ebola or a similar deadly epidemic. While Lassa Fever (a similar hemorrhagic fever disease) is endemic in Sierra Leone, it occurs much smaller scale, has a higher survival rate and has never reached epidemic proportions in the country. Thus, the closest experience people could compare the outbreak with was the civil war of 1991–2001. In translating what Ebola is, its destructive impact, the prescribed scientific measures of prevention and control and the need to put up a strong and united front against it, many local translators refer to the popular local sayings, "well bodi na gentri" ("health is wealth") and "sickness na we worst enemy" ("ill health is our worst enemy"). They often find it appropriate to link the epidemic with the sad experiences of the decade-long civil war which is still fresh on the minds of many Sierra Leoneans and which has so far posed the greatest threat to the existence of the nation. Some translators talk of "Ebola War" or simply "another war". The enemies of the civil war were human rebels while the enemies of the epidemic are the Ebola viruses which some refer to during the translation process as "invisible rebels" or "invisible enemy" since they cannot be seen with the naked eyes, and, like the Revolutionary United Front (RUF) rebels, pose significant threat to the lives and livelihood of unfortunate victims.

Indeed, one can find many parallels with the rebel war in terms of what was the initial epicenter of the conflict, the lack of preparedness and generally slow official response, the atmosphere of insecurity and uncertainty generated, the destructive capacity of the rebels, the humanitarian crisis that attended their onslaught and the fact that the capital city became the final scene of battle. Although the two situations are certainly not identical one could not help

but see the parallels. As Professor Jimmy Kandeh aptly puts it on his Facebook page, "Parallels between the war in Sierra Leone and the current Ebola outbreak are unmistakable and instructive: both threatened national security and the very survival of our people; both emanated from across the border but found fertile ground in our country; the government was caught off guard and unprepared in each case, with some even denying the gravity of the threat posed."<sup>4</sup>

It is often pointed out that although similarities exist, the Ebola crisis has the potential to be worse than the civil war in that the unseen nature of the "new enemy" makes it elusive and very deadly, putting a check on development strides. As one health worker puts it, "You cannot see the enemy so you cannot easily run away from it or enter into some form of negotiations with it."<sup>5</sup> The invisible nature of this new and vicious enemy has also given it the fatal advantage of being attributed to witchcraft in some of the communities which it ravages. Such superstitious belief is considered very unfortunate by mainly international actors since it implies that the solution to the epidemic lies in the spiritual and not in the biomedical realm. Since the country has a high level of poverty and illiteracy, it is apparently easy for a disease like Ebola to be attributed to the whims and caprices of witches and demonic spirits. Literature abounds which show the relationship between poverty, marginalization and disease. For instance, Farmer (1999) who is both a medical practitioner and anthropologist has argued that there is a strong relationship between poverty and disease.<sup>6</sup> Stories of the supernatural that built up around the disease were so prevalent that in the rural areas, in particular, traditional rulers and constituency representatives were urged by the government to use their authority to dispel such stories among their subjects. In Kissi Teng where the Ebola virus disease first emerged in the country, the death of a female traditional healer was not attributed to Ebola but to the displeasure of a mysterious snake which she allegedly owned. The creature was not supposed to be seen by her husband who accidentally set eyes on it and incurred its anger which saw it going on the rampage killing wife, husband and relatives residing in the house.<sup>7</sup> The belief in the existence of witches and spirits is strongly maintained in traditional religious beliefs and practices of different ethnic groups and is also reinforced by Islam and Christianity, especially Pentecostal Christianity.

Pentecostal Christianity fuels supernatural claims through its engagement in "spiritual warfare" which maintains, among other things, that the disease is a curse from God because of His annoyance over the gross sinfulness of Sierra Leoneans. It is also maintained that it has a demonic origin. In this connection, a popular Freetown evangelist pointed out in one of his radio programs aired over "God's Air Force Base" (FM 97.7) that the disease was named after the Ebola River in the Congo where it was first discovered and since rivers are the abodes of "marine spirits", whenever the name Ebola is pronounced some undue recognition is given to the demonic spirit inhabiting the river.<sup>8</sup> Believing that it is of a spiritual nature, the only remedy was divine intervention which can be expedited by engaging in spiritual exercises like fasting, speaking in tongues and engaging in all-night prayers. It was however pointed out that while Jesus is the master healer and can heal all diseases, this does not rule out the observance of the universal precaution against the disease.

When the disease first appeared in Lunsar Town in the north of the country, it was initially maintained that it was the result of a curse issued by a patient who was treated in one of the hospitals. It was claimed that the patient — a businessman — had been carrying a large sum of money which was then stolen by four nurses who were caring for him. On recovery, the patient enquired about his money but to no avail. He then pronounced a curse on the culprits which resulted in their deaths within a short time.<sup>9</sup> In Mapoto in Port Loko, the disease was attributed to witchcraft, as well as in Mount Aureol in Freetown. In the latter, where almost a dozen people perished within a week, it was claimed that these Ebola victims were witches whose "witch



[aero]plane" developed engine trouble and crash landed early in the morning as they were returning home to the physical after a night of mischief.<sup>10</sup>

The belief in supernatural origin and divine intervention, "inspired" several "revelations" of miracle remedies like bathing in the early hours of the morning with consecrated water and salt, lime or wood ash. For instance, in the early hours of August 2 2014, a "divine revelation" purportedly coming from the renowned Nigerian evangelist, Prophet T.B. Joshua, went viral with the help of the social media. It required those who believed to wake up from their sleep and bathe with hot water and salt over which they should have offered prayers. Many, both Christians and Muslims, diligently followed the "divine revelation" only to later discover that it was a hoax.

From the above it can be seen that while the bio-medical model assumes that everyone makes sense of the epidemic by learning about its invisible bio-medical viral nature, many in Sierra Leone and West Africa as a whole see it as a threat of war-like dimension which appears from nowhere and cannot be seen. Thus witchcraft became a common go-to explanation.

## **TRANSLATION II: QUARANTINE AND THE LOGICS OF CARE**

Quarantining is one of the strategies used in the fight against Ebola. Although its use is based on sound bio-medical observations going far back in human history, some international actors, like the WHO and MSF, strongly argued against employing large scales quarantine measures requiring the isolation and policing of whole communities. The human rights implications were immense, especially bearing in mind the authoritarian tendencies of some African regimes. There was also the possibility that there might be violent backlash from the public against coercive measures, thereby creating an unstable climate which would hamper the implementation of other Ebola prevention and control measures. However, governments in the affected West African countries carried through their determination to employ quarantine, since enforcing compliance was apparently the most obvious weapon available to them.

Sierra Leone has a long history of using quarantine to combat contagious diseases. In the colonial period, isolation/quarantine hospitals were set up for patients suffering from contagious diseases like small pox and tuberculosis. In 1826 the British Governor, Sir Neil Campbell, established a waterfront shelter off the village of Kissy on the eastern outskirts of Freetown, for patients with what was considered to be dangerous and contagious diseases. Out of this waterfront quarantine shelter developed the Lower Kissy Hospital. In the late nineteenth century this incorporated a Small Pox Hospital, a lunatic asylum and a Male Incurable Hospital. Because patients with small pox and incurable diseases had been quarantined or isolated at the Lower Kissy Hospital since the colonial period, the word "quarantine" was in the Western Area of the country corrupted into "Korontine" and it came to assume a very negative connotation as an act of abandoning people with incurable diseases in a place where they are left to suffer and die in the absence of human care and affection. The negative connotation gained strength when in the 1930s the King George VI Home for Paupers was set up on the compound of the Lower Kissy Hospital. The locals used the word "Korontine" when referring to the paupers' home and the medical facilities of the Lower Kissy Hospital. Thus quarantine became associated with being poor, incurable, demented, isolated and abandoned.

The rationale behind isolation/quarantine was apparently difficult to appreciate as the practice was generally viewed as restrictive and unkind. Hence, quarantined patients were robustly guarded (Clarke 1843). However, that did not prevent the escape of one hundred and fifteen

carrier inmates of smallpox in 1901 despite the fact that the hospital walls were heavily guarded by nineteen armed policemen.<sup>11</sup> The long-standing negative perception of quarantine among inhabitants of the Western Area and beyond made it difficult to get cooperation from the public, especially when rumors of torture and the extra-judicial killing of patients were being circulated in the early days of the outbreak.

The medical advice not to touch an Ebola patient or anyone showing signs and symptoms of Ebola but to quarantine them in their homes or confine them to isolation centers runs contrary to the prevailing socio-cultural value of care and support which people hold with regard to the sick and dying.

When the disease initially broke out, it was emphasized that there is no cure for it. In the absence of a cure, it was taken by many citizens that health centers and professional health services cannot in anyway contend with Ebola, and if there is any remedy at all, it should be sought elsewhere. For many Sierra Leoneans, elsewhere in this case means resorting to traditional methods of healing which may involve use of local herbs, magic portions, invocation of spirits, offering of sacrifices and ritual bathing, among other things. This may help to explain the initial aversion to seeking medical attention from hospitals and health centers. The resort to traditional forms of healing often resulted in the death of both the patient and the healer as in the case of Agba Kuduku of Kroo Bay in Freetown who, in spite of his fame in dealing with health matters which have baffled and defied Western medicine, lost his life after attempting to treat an Ebola patient, and ended up jeopardizing the lives of his neighbors.<sup>12</sup>

It was later realized that this initial information – that there is no cure for Ebola – was discouraging people from seeking professional medical services. Public health information was therefore modified into saying that although there is no medical cure for Ebola, symptomatic treatment is available for those seeking medical help at the early stage of the disease. Information was provided about the signs and symptoms of the disease and the populace was encouraged to report to health centers or call the Ebola emergency hotline, 117. This would be simple, were it not for the fact that the signs and symptoms of Ebola are almost identical to that of malaria and typhoid – fever, headaches, joint pains, diarrhea and vomiting – which in Sierra Leone are almost commonplace diseases that people are used to self-diagnosis and self-medication with over-the-counter drugs or local herbs.

Therefore, when signs and symptoms of Ebola manifest themselves, many people think it is business as usual, try to self-medicate and all too often resort to seeking professional medical help only at a late stage of the disease. This tendency already exists under normal circumstances, but is particularly tricky with a highly infectious and deadly disease like Ebola. Although the financial implications involved in seeking professional medical services often contribute to this inclination, the attitude is also stimulated by a general lack of confidence in the country's inadequate health system which rapidly crumbles under the weight of the sudden outbreak of Ebola.<sup>13</sup> Over the years, people developed a preference for receiving healthcare at home from the hands of family and community members. Although these often lack professional medical experience, the patients are often assured of a more compassionate treatment in less complex and familiar surroundings, and with no bureaucratic demands. Perhaps this is connected to the observation that the hospital is a place which is so routinized that the human body becomes an object and complex emergencies become routine (Chambliss 1999).

The preference for treatment at home was to gain ground when it was realized that relatives taken to hospitals and treatment centers in the early days hardly recovered and their bodies were not returned to those left behind but were safely disposed of in order to avoid new infections and transmissions. Rumors quickly developed that those taken to the treatment centers were

not treated at all but were given a lethal injection and then hurriedly buried in an undignified manner without a final bath, tributes from relatives and friends, prayers for the repose of the soul or the presence of loved ones to say farewell as demands by tradition. Therefore, in order to avoid this perceived nightmare and inhuman treatment, people seemingly strengthened their resolve to self-medicate with the help of loved ones. Since this is an obvious way of spreading the infection, the government passed an emergency legislation that criminalizes knowingly keeping or hiding an Ebola patient at home. A two-year mandatory jail sentence was prescribed for anyone found guilty. This only helped to compound the situation. The corpses of patients who had been receiving treatment at home were either secretly buried at night or abandoned in the streets expecting one of the Ebola burial teams to dispose of them.<sup>14</sup> Considering that the viral load has been found to be very heavy in corpses, these clandestine actions create avenues for new infections and transmissions via contact with the deceased.

The action of secret burials and abandoning of dead bodies in the streets is motivated not just by the effort to escape the two year jail sentence imposed for harboring an Ebola or suspected Ebola victim but also the fear of the entire household (or even the neighborhood) being quarantined in order to trace those who had contacts with the deceased and may be infected. During the isolation period of 21 days (the incubation period of the virus) those that test positive are transferred to treatment centers where they are isolated and treated with some chance of survival. The fear of being quarantined at times resulted in villagers scurrying into nearby bushes at the sound of sirens of ambulances or the sight of contact tracers. In some cases, people temporarily abandoned their homes when they got wind that a quarantine order is about to be effected. This has hindered contact tracing exercises, which are vital to help identify victims and potential victims of the disease in order to break the transmission chain.

There were reports of some quarantined inmates escaping from their homes into the communities with the potential of spreading the infections. It was claimed that the desire to find food was one factor leading people to break quarantine orders since many have been used to living on a day-to-day basis and were therefore not able to stock up food for the twenty one day period. In order to address this situation, World Food Program (WFP) and some charitable organizations took it upon themselves to provide some amount of food for quarantined homes.<sup>15</sup> However with no pipe-borne water running into most of the homes, some inmates were forced to defy quarantine orders by joining other community members to fetch water from community stand pipes, water wells or streams. Lack of commitment and discipline among the inadequate number of police officers charged with enforcing the quarantine orders also made comingling between infected and uninfected persons possible.

The recommended measure of quarantining Ebola patients and depriving them of direct human contact is at variance with the general healthcare-giving practices in Sierra Leone where direct physical contact is usually the case. Quarantining is generally viewed as treating patients as prisoners or outcasts through no fault of their own. Apart from the restrictive act of sealing off quarantined homes from the rest of the community, there is also the tendency to forcefully whisk away people, like criminals, from their homes to healthcare centers. Furthermore, there is also the tendency to stigmatize Ebola sufferers even when they are medically certified as having fully recovered. The same fate applies to Ebola-suspected individuals who have gone through the 21 day period of quarantine and come out clear of the disease. They are likely to suffer from stigmatization in the form of ostracization or being called derogatory names. Even Ebola health workers have complained of being teased and discriminated against in their communities. A member of the Ebola Burial Team disclosed in a radio interview that he was forced to make the hospital his home because of the aspersions being cast on him by some

community members who consider him a potential source of the virus in spite of the regular safety precautions he took.<sup>16</sup>

Accusations of witchcraft are another source of stigmatization which Ebola victims and those suspected of being infected with Ebola have to put up with because in some communities, multiple deaths taking place within a short space of time is at times attributed to the crashing of a "witch [aero]plane" on board which were the deceased and others who are sick and are about to die. It is considered a great disgrace for one (or one's relatives) to be declared a witch, and the "witch plane" narrative carries the implication that the victims may also be witches for which they could be taunted and shunned.

The report of an Ebola perception survey released in September, 2014 and carried out by Focus One Thousand in collaboration with UNICEF and the Catholic Relief Services, recorded 96% for discriminatory attitude towards people suffering from Ebola and 76 % indicated that they will not welcome Ebola survivors into their communities.<sup>17</sup> Efforts to escape the scourge of stigmatization saw some people migrating at times in the dead of night from where their health status is known, to another community, where friends and relatives hosting them are placed at risk of contracting the disease through contact with them. Because of this, it was advised over many radio programs that people should be wary of accommodating strangers or relatives especially those coming from areas hit hard by the disease. Chieftdom anti-Ebola by-laws prohibit, among other things, the harboring of strangers without permission from the chieftdom authorities. With this some communities became xenophobic. For instance, it was reported that because the small village of Kalia in Bo District, Southern Province, suffered massive loss of lives in early September, its inhabitants were being denied entry into neighboring villages in spite of cultural ties. This was considered contrary to cultural norms and the patronage framework within which these communities operate.

This piece of advice given in the process of translating Ebola prevention and control measures is, in the view of some interviewees, contrary to the traditional spirit of hospitality, which calls for warmly welcoming and accommodating visitors even when the visit is unannounced. In light of this, an elderly interviewee who had travelled from the interior of the country to visit a son-in-law in Freetown, lamented, "Could you imagine being refused entry into the home of my son-in-law who insisted that I should first allow myself to be quarantined for twenty one days and produce a certificate from the health authorities declaring that I am Ebola free. Curse be upon him several times over!"<sup>18</sup> The measures implemented against Ebola Virus Disease drove a wedge between family members, relatives, friends, and neighbors. It seems to kill peoples' inclination to show love and compassion to the living, sick and dying. As Hale (2014) observes, "The disease threatens humanity by preying on humanity." Although in the final analysis the "invisible enemy" is the Ebola virus, an infected victim becomes an embodiment of the enemy just as in the Dracula movies, and the victim is treated as such until delivered from the deadly grips of the virus. The epidemic therefore blurs the boundaries between enemy and victims. This ambivalence is also seen in the way health workers at times come to be seen as dangerous and inimical to the communities where they work and live guided by the view that they are responsible for the spread of the disease.

Since the measures prescribed by the model appear to be a challenge to long-cherished traditions and social values, accepting and implementing them call for tough decisions, emotional adjustment and a reorientation of thinking. This demands fundamental changes in attitude and behavior, which does not normally happen overnight. Apart from cultural impediments, the mass of the citizenry is not well informed about the nature of the disease and there is a general lack of confidence and trust in the fragile health care system of the country which is seen to be

crippled by inadequate medical facilities, riddled by corruption and starved of funds. They also express doubts about the level of commitment of their politicians who are suspected of exploiting an unfortunate situation either to enrich themselves or to make political gains as was evident in the civil war. Hence, following the huge cash flow of anti-Ebola funds into the country (added to funds generated internally), some citizens started raising concerns about the need for such funds to be judiciously used and strictly accounted for. The Anti-Corruption Commission, the local media, civil society groups and opposition political parties were at the forefront in calling for accountability and transparency in the use of Ebola funds. The ruling government added its voice to this and promised stringent penalties against those found culpable of misappropriating what the President of the country referred to as "blood money."

It became quite clear that the concerns raised were not unfounded when the Auditor General's report released in March shows that there had been massive misappropriation of Ebola funds to the tune of 84 billion Leones (12 million British Pounds). This severely battered public trust in the government's determination to quickly and successfully conclude the Ebola campaign.

Hence, lack of commitment in the anti-Ebola campaign, the fragile healthcare system and the practice of quarantine exist under a thick cloud of distrust which opens the way for self-medication, recourse to idealistic interpretations of EVD and the adoption of a non-scientific response.

### **TRANSLATION III: TOUCH NOT THE DEAD and SAFE BURIALS**

Apart from the injunction to Avoid Body Contact ("ABC") with an Ebola victim or suspected Ebola victim, the bio-medical model also demands refraining from direct contact with Ebola corpses and advocates for swift and safe burials as a way of minimizing the risk of contracting EVD.

The health precaution not to touch corpses of Ebola victims as a measure of prevention and control has not been well received by a large part of the public mainly because of cultural and sentimental reasons. Therefore, many infections were discovered by contact tracers to be linked to direct contact with Ebola corpses or involvement in communal or public funeral rites.<sup>19</sup> There is a general belief that the dead should not only be disposed of safely but also respectably. The very first aspect of this respectful disposal is that the corpse should be washed and anointed as if in readiness for a journey. In this connection, the elders maintain that water has an important part to play for both the living and the dead in that it is used for the first and last hygienic acts — at the birth of a baby and at death. To be buried without receiving your last bath is considered an act of disrespect. It is also considered a source of special blessing or favor to be involved in the performance of this last duty for the dead. In the small village of Kalia, Bo District, efforts were made to share the special blessings springing from the bathing of the corpse of an Islamic cleric who had unknowingly died of Ebola in early September 2014. The bathwater was collected and shared among some villagers who used it to wash their faces and soon began showing signs of the disease.<sup>20</sup> In less than a week, over twenty of them passed away. This is unsurprising, since the viral load is known to be very heavy in the corpses of Ebola victims.

Washing of corpses is usually done by close relatives and friends. For those who can afford it, it is done in funeral homes where at times relatives request to be involved in this intimate exercise which is considered to be a demonstration of affection and compassion. Muslims ensure that the corpse is enshrouded in a particular way and Christians often dress up the corpse in

his or her favorite colors. The laying out ceremony often sees an outpouring of grief which may result in the kissing, shaking, fondling and embracing of the body. In some secret societies, only fellow initiates are allowed to touch, wash and prepare the corpse for burial. In some others, when an initiate dies the corpse is "seized" by fellow initiates; they take possession of it and, behind closed doors, sing and dance with the corpse. They also perform certain rituals which, it is claimed, temporarily bring back the body to life. It is only after this closed ceremony (which involves physical contact with the dead) and the payment of a ransom will the corpse be handed over to family members.

It is believed that in the absence of a proper funeral ceremony, the ghost of the deceased cannot gain entry into the community of the spirit world, and in their frustration may resort to hunting homes of family, relatives and friends through apparitions and poltergeist activities. Therefore, since funeral rites are believed to be vital in the process of transition to the heavenly realm and for ritual links to the living, they are generally considered obligatory. This is especially so since the dead is seen to have no control over them, and yet so much is believed to be dependent upon them (Ray 1976; Imasogie 1983).

A look at the traditional beliefs and practices of the Mende who are the main inhabitants of Kailahun and Kenema (two of the epicenters of the epidemic) would show that as Little (1954; 1967) observes their social values are predicated upon their cosmological outlook and this finds expression in their ritual practices. For instance, this is evident in their beliefs and practices connected with the dead. They believe that the dead constitutes a link between the living and Ngewoh, their supreme being, who is the source of all authority. Prayers of the living are conveyed to Ngewoh through the dead by virtue of their proximity with him. It is believed that the community is ever under the watchful eyes of their ancestors. This contributes to social control and helps to cement kinship bonds. Hence, Saez, Kelly and Brown (2014) observed that changing burial practices is not only a matter of improving hygiene but is also a matter of disrupting of the social fabric of kinship. The dead therefore occupy an important place in the worldview of the Mende and they therefore reason that they should be given the respect they deserve, starting with the manner in which corpses are handled and interred. This is also true of the Kissi who together with the Mende co-habit the eastern part of the country. The anthropologist, James Fairhead, says that the Kissi believe that "a properly conducted funeral helps the dead to relocate to the village of the dead where they live a similar life to those on earth and continue to participate to those on earth."<sup>21</sup> The acceptance of Islam and Christianity has modified – but not eradicated – such metaphysical outlook. In the case of Christianity, scholars have pointed out the parallels between the Christian belief in "the communion of Saints" and the centrality of the Ancestors in African traditional religious beliefs and practices (Parratt 1996).

That which the health authorities consider to be safe burials is generally viewed as gross disrespect for the dead especially with regards to the way the burial teams are reported to carelessly dump corpses into graves without any sign of sympathy. In the view of an interviewee, the dead are treated like "sacks of rice".<sup>22</sup> The hurried and un-ceremonial disposal of Ebola corpses does not only deprive the bereaved of the opportunity to undertake what they consider to be dignified burials but in the early days of the disease it also deprived them of identifying the grave spot of their dead. For many, a marked grave is like a sacred ground to which relatives periodically retire to pour libation and communicate with the dead especially when in distress and in need of what they consider to be supernatural support. Although this could be done without visiting the graveside, acts of necromancy around the grave space apparently generate more emotional attachment and underscore intimacy with the dead. It is for this reason that in some rural communities graves are found just in the frontages or backyards of homes.

At the start of the outbreak, Ebola treatment and burials of victims took place in the Ebola epicenters of Kailahun and Kenema found in the eastern part of the country. These were far away from many other communities. This means that the dead were being buried miles away from their homelands when people traditionally frown on being buried as strangers in a strange land. As a result, under normal circumstances, when migrants to cities and other places die, relatives and friends who have some financial means often go to great extent to ensure that the corpse is transported to the homeland of the deceased for burial.

The displeasure over handling of the dead which apparently contributed to secret burials of corpses at night generated much public outcry. This saw a coalition of civil society organizations calling for a review of Ebola burial practice on 26<sup>th</sup> September 2014. According to the head of the coalition, the burial practice was "in conflict with our social, cultural and religious beliefs" and needed to be looked into in order to elicit more cooperation from the public.<sup>23</sup>

Translation of the biomedical injunction not to touch the dead and to practice safe burial became a site for the manifestation of cultural disconnect which in the view of many citizens determines the slow gains of the fight against Ebola.

## **MILITARIZING EBOLA**

Sierra Leone is in the grips of several figurative military campaigns against specific social problems. Hence, there is a War on Corruption, War on Poverty, War on Indiscipline etc. The civil war saw specific military assaults bearing code-names like Operation Final Push and the despicable Operation no Living Thing. Following this war-time pattern, the struggle against Ebola has seen the declaration of war-like operations like Operation Ose-to-Ose [House-to-House] Ebola Campaign, Operation Watch Your Neighbor and Operation Western Area Surge. Waal (2014) examines the tendency to militarize Ebola and public health in general which he considers "a strategic error."

This tendency saw the deployment of foreign military expertise which was reminiscent of the civil war and helped to create a heightened sense of uncertainty and the need for vigilance. In connection with their deployment, an elderly interviewee remarked, "These [soldiers] are not here to help us build hospitals and treat the sick; they surely have a hidden agenda to build barracks and engage in real combat to prop up the ruling regime and gain unimpeded access to our natural resources."<sup>24</sup> Militarizing Ebola also saw the involvement of local troops and the presidential appointment on 4<sup>th</sup> November 2014 of a retired army major and former Minister of Defense as Head of the National Ebola Response Center. A "military approach" was declared for the enforcement of the Ebola control measures. This had implications for human rights and was reminiscent of colonial coercion in the name of promoting hygiene.

Although foreign intervention brought considerable resources to the fight against Ebola, it soon became clear that the real battlefield was not just the erection of well-equipped medical facilities manned by highly trained, experienced and motivated foreign military medical personnel. Rather, there was the need for a more fundamental campaign against negative attitudes, misconceptions and slavish attachments to culture and tradition which were resulting in daily increases in new infections. This implies that in spite of the rapid expansion in Ebola-related health care facilities and services brought about by international support, it was the Sierra Leoneans themselves who should exert more effort towards winning the "Ebola War" by

adopting what is considered the right attitudes and behavior which align with the anti-Ebola precautionary measures. But as argued by Wilkinson and Leach (2014) and Beisel (2014) there is also need to address structural underpinnings and work out a response that takes into account both socio-cultural needs and the translated infection-reducing protocols.

The Operation Ose-to-Ose [House-to-House] Ebola campaign which aimed at, among other things, encouraging what is considered the required attitudinal and behavioral change. During the three-day lock down, citizens were supposed to stay at home where they were visited by teams of trained volunteers who explained to them how the disease is contracted and how to prevent it. Opportunities were given for questions to be asked and households were encouraged not to take care of the sick at home but to seek professional medical help very early. It was hoped that this exercise will dispel many misconceptions about the disease and elicit more cooperation in the fight to break its chain of transmission. Illustrated leaflets were distributed to drive home the message and a bar of soap was provided as a symbol of the importance of personal hygiene.

In spite of logistical constraints, the exercise was generally considered to be successful in revealing that in spite of the massive sensitization that had preceded it, the disease was still enshrouded in rumors and myths and there was still a lot to be done to change the perceptions of many citizens and win their confidence in the efficacy of the prevention and control measures. The exercise might have been useful in identifying and dispelling some of the myths and misconceptions surrounding the disease but even as this was being done, it was widely rumored that the soap distributed by the volunteers was laced with Ebola virus, with the aim of deliberately infecting a large number of people, in order to fulfill an earlier prediction from the United Nations that by the time the epidemic is brought under control it would have claimed the lives of twenty thousand West Africans.

This conspiracy theory was widely circulated in the main opposition stronghold, suggesting that mischievous politicians and supporters of the opposition party may be involved in the propaganda as a way of discrediting the ruling party and their international supporters in order to make political gains out of an unfortunate situation.

By September 2014, the capital city of Freetown and its environs had become the new front-line or epicenter of the disease. It was hoped that as in the case of the civil war, the city would become the final battle-field. Prior to its appearance in West Africa, Ebola outbreak had been confined to rural areas. Since it had never been fought in built up areas, there is hardly any blueprint of how the virus will manifest itself in a densely populated urban setting like Freetown, where the problems of congestion, sanitation and urban waste management are yet to be fully tackled.

As the number of confirmed deaths and new infections increased and decreased with no end in sight, the government out of desperation declared Operation Western Area Surge in December 2014. Unlike Operation Ose-to-Ose, this two week exercise sought not only to dispel misconceptions but also to identify all sick occupants of homes visited in the Western Area (which includes Freetown) and then call on the medical team to forcefully convey them to health centers for testing if necessary. After fourteen days, the exercise yielded 337 new Ebola cases. This was apparently an indication that the call for people to voluntarily report at medical centers or take their sick there for early diagnosis and treatment was yet to be fully heeded and the eradication of the virus was still a long way off. This failure to seek early medical treatment and the fanatical commitment to socio-cultural beliefs and practices became formidable barriers to defeating the "invisible enemy".



## CONCLUSION

From one small village in the Republic of Guinea, Ebola has spread into Sierra Leone and other parts of West Africa making it not only a national but also a regional affair. By the end of the year (2014) the disease had claimed over seven thousand West African lives and well over one thousand and five hundred Sierra Leonean lives, including those of eleven doctors. This "invisible enemy" caught the ruling government with "its pants down" in that no adequate preparation had been made to contend with an epidemic which became a source of considerable strain on the country's limited health facilities and fragile economy. As in the case of the civil war, the international community responded to the need for massive support in helping to combat this unprecedented health menace which in an increasingly globalized world has the potential to grow into a global nightmare (Kaplan 1994), as some of the more pessimistic (or arguably unrealistic) international commentators have predicted.

In the absence of a cure for Ebola, scientific measures geared towards breaking the chain of transmission of the virus were recommended and circulated in the affected West African countries with the help of local and international actors. The recommended measures constituted a travelling model; conceived mainly in the Western World, it was transported into a new context with its own peculiar historical experiences, realities and logics. The measures prescribed by the model present tough choices between an individual's own survival on the one hand, and on the other hand, displaying traditional affection and hospitality in ways that may compromise their health and that of others.

Some local translators have likened the struggle against the Ebola virus disease to the experience of the rebel war which ended in 2001. These translators point out the need for a similar level of commitment, determination, courage and national unity in fighting off the Ebola virus by breaking the chain of transmission. However, it is generally agreed by many Sierra Leoneans that some of the measures required by the model are at variance with local socio-cultural beliefs and practices. This disconnect together with other contextual realities like a dysfunctional health system, logistical constraint, poverty, ignorance, illiteracy and a largely idealistic outlook have helped to bring about an increase rather than a decrease in the level of infection. Hence, in accounting for the scale of the Ebola epidemic in West Africa, Peter Piot (the Director of the London School of Hygiene and Tropical Medicine) who co-discovered the Ebola virus, attributed it to "...a perfect storm of a lack of trust in authorities, in Western medicine, dysfunctional health services, a belief in witchcraft as a course of disease and not viruses, traditional funeral rites, and a very slow response both nationally and internationally."<sup>25</sup>

The receiving context has realities and logics that are quite unlike the context from which the model originated. As it has been observed, the community in Africa tends to be more important than the individual whose will is subsumed to that of the community (Mbiti 1970; Menkiti 1984). This tends to discourage the adoption of changes in behavior and attitudes that the community frowns upon. Hence, although from an Olympian distance, it may be difficult to understand why in spite of its scientific rationale the biomedical model is not easily accepted and implemented, it should be noted that translation is not simply a matter of rational choice because in a new context the model is confronted with new and competing rationalities often based on firmly rooted and long cherished socio-cultural values, beliefs and practices. Expert interventions are often met with local constraints and redefinitions. As it has been argued, although a model can travel into a new context, the rationalities behind its formulation do not automatically travel

with it nor does the institutional set up that is supportive of the model in the site from which it originates (Behrends, Park and Rottenburg 2014; Hoinathy and Behrends 2014).

The Sierra Leonean context has realities which make the ready acceptance and practice of scientific rationalization for the prevention and control of Ebola costly with regard to social relations and social life in general. Chief among these are the deep-seated and highly entrenched beliefs and practices that constitute basic trust between individuals and groups and so are fundamental to organizing social life. These are coupled with lack of faith in the country's statesmen and an underfunded frail healthcare system. Hence, well-intentioned efforts of international translators and local partners have been slow to yield the expected dividend in full measure. I argue these that these have to be understood not merely as the result of ignorance or of outdated or 'not yet modern' beliefs, but as a different ontology: a different way to organize social life. It is these more fundamental disconnects that needs to be addressed and incorporated in the biomedical model of Ebola prevention if the translation is to be successful.

## NOTES

1. See European Center for Disease Prevention and Control, Rapid Risk Assessment: Outbreak of Ebola Virus Disease in West Africa, 8<sup>th</sup> April 2014. Stockholm: 2014.
2. Interview: Foday Pessima, indigene of Kailahun, on 4-8-14.
3. Monologue radio program presented by David Tam Mbayoh on 6-9-14.
4. Quoted in Titus Boye-Thompson, "Ebola – Myths and Misconceptions Abound", New Citizen, 5-9-14, p. 9.
5. Interview: Fatmata Sesay, health worker, Freetown, 12-9-14.
6. See also Deaton, Angus. 2013. *The Great Escape: Health, Wealth and the Origins of Inequality*. Princeton: Princeton University Press.
7. Interview: Paul Ngobeh, an indigene of Kailahun, 9-10-14; also see 'Snake, Witch Plane, now well Poisoning', Awareness Times, 30-9-14, pp. 1; 8.
8. Radio preaching of Evangelist Victor Ajesafe on "God's Air Force Base" (FM 97.7), 11-9-14.
9. Interview: Musa Kanu, Resident of Lunsar Town, 18-8-14.
10. Interview: KanuTuray, A resident of Mount Aureol, 6-8-14.
11. See 1901 Minute Paper no. 1–100: Report of Sub-Inspector Sawyer on the Escape of 115 Inmates of the Kissy Lazaretto (Sierra Leone National Archives); see also Clarke, Robert. *Sierra Leone: A Description of the Manners and Customs of Liberated Africans*. London: B.White, 1843, pp. 71–73; see also Spencer, Sylvanus N. *Kissy: Looking Back at Two Hundred Years of History, 1812–2012*. Freetown: Entabuy Agency, 2011, pp. 15–18.
12. Interview: Momodu Sesay, a Trader at Kroo Bay, 28-11-14.
13. See "Ebola: Sierra Leone Hit by Lack of Treatment Units." Accessed from <http://news.yahoo.com/ebola-lack-treatment-units-sierra-leone> on 10-11-14.
14. See for instance, Augustine Samba, "Dead Bodies of Ebola Patients Abandon on Streets", Awareness Times, 11-9-14. p. 8.
15. See "Ebola Victims Break Quarantine in Hunt for Food," Sky News, 5-11-14; "Food Deliveries in Sierra Leone to Fight Ebola." Accessed from <http://news.yahoo.com/food-deliveries-sierra-leone-fight-ebola> on 23-11-14.
16. FM 98.1 Radio interview with a member of the Ebola burial team, 11-8-12
17. Focus One Thousand, Report of Survey on Misconceptions and Stigma Associated with Ebola Disease, September 2014.
18. Interview: Madam IyeSesay, Kissy Dockyard, 24-9-14
19. SidiYayah Tunis (Communications Director, National Ebola Response Center) on radio discussion program (Independent Radio Network), 2-11-14.
20. Paul Tucker reporting for Culture Radio (FM 104.5), 14-9-14.
21. See Dan Mullin, "Some would Rather Die of Ebola than Stop Hugging Sick Loved Ones", The Pluto Daily, 13-10-14.
21. Interview: Saidu Bangura, Freetown, 6-7-14
22. See Augustine Sankoh, "CSOs Call for Review of Ebola Burial Policy", Premier News, 30-9-14, p. 2. Following numerous complaints about disregard for traditional funeral rites and the discovery that a large percentage of infections were traceable to contact with corpses, the contested Ebola burial practice was later reviewed. The state now assumed the responsibility of burying the remains of all citizens who die at home without first determining whether Ebola is the cause of death or not. This action eliminates the embarrassing delays of up to three or four days which had been occasioned by the desire to first determine the cause of death before the Ebola Burial Team can

- undertake interment. Under the new arrangement, the bereaved can now invite a Pastor or Imam to offer prayers and a limited number of the bereaved family can now accompany the corpse to the cemetery where interment can be watched from a distance. This helped to eliminate some unfounded allegations that had militated against public support in the fight against the epidemic.
23. Interview: Pa Sorie Kargbo, Looking Town, 11-8-14.
24. See "The Man who Discovered Ebola on Why this Epidemic Spiral Out of Control", Vox Media, Monday, 29-9-14.

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