Political Economy of the 2013/14 Ebola Outbreak in Sierra Leone

The Political Economy of the 2014/2015 Ebola Outbreak in Sierra Leone

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Abstract

Despite more than 25 recorded outbreaks of Ebola since its discovery in 1976, little in the way of social scientific research has been conducted to explore the social, political, and economic forces that promote its spread. The 2014-15 Ebola outbreak in Sierra Leone has been linked to a dysfunctional health infrastructure, lack of trust in public institutions, funerary ritual, and the provision of unsafe care to infected individuals. In the following study, I conduct a biosocial analysis of the 2014-15 Ebola outbreak in Sierra Leone by situating the biographies of survivors in a deeply historical, political economic analysis. I conclude that biomedical and culturalist claims of causality have obscured more distal determinants, including the trans-Atlantic slave trade, exploitative colonialism and subsequent patrimonial rule, enabled civil war, and resource extraction. Ultimately, I conclude that investments in health systems strengthening, critical reflection on the crisis caravan, accountable taxation on resource extraction, and a commitment to social justice are necessary to prevent future outbreaks.

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Introduction

The devastating Ebola epidemic in West Africa resulted from dysfunctional health services, low public trust in government, and burial practices that involved contact with contagious corpses. The epidemic occurred in the wake of centuries of shared history between the West and this region of Africa, which involved the slave trade, colonialism, the exploitation of natural resources, support for corrupt leaders and military coups, enabled civil war, and unethical pharmaceutical trials on African children [1]. Despite recognition of the socio-cultural elements involved in the response, little in the way of anthropological research has been conducted to help situate local responses within international efforts at containment.

Because of the profound biosocial impact of Ebola on families and communities, anthropology and other social sciences have been used to understand previous epidemics of the disease. The epidemic of Ebola in West Africa in 2014 has been the worst in history and has had a far-reaching social and political impact on families, communities, and countries and on the world stage. In this outbreak, 28,601 confirmed cases and 11,300 deaths have been reported in West Africa, and in Sierra Leone alone 14,112 confirmed cases and 3,955 deaths were reported [2]. In Sierra Leone, the cause of the epidemic is tied to the weak health system, which impacted both infection control and treatment as well as the community's trust of the system. Much of this weakness and its aftermath is linked to decades of brutal civil war and the oppressive history of colonialism, which have been internalized in social and political structures that impacted the emergence, spread, control and aftermath of the epidemic.

In this study, I recorded biographies and the lived experiences of Ebola survivors to understand the impact of the disease on them and their families. I also documented the barriers to

care and social economic context of their lives. By linking this ethnography to a historically deep political economy, I answered the following questions:

- How have years of civil conflict shaped the current Ebola epidemic in Sierra Leone?
- How do some of those most affected by Ebola understand the cause of the epidemic?
- How do individuals and communities understand quarantine?
- What factors affected decisions to seek treatment?
- How have daily life decisions changed during the epidemic?
- How has mobility changed during the epidemic?
- What is the status of survivors in the community?
- What were the factors that led to such an anemic initial response?
- Is there trust of government institutions or foreign NGOs?

By answering these questions, this study illuminates the political economy of the 2014-2015 Ebola epidemic.

Study Setting

This study was conducted in three districts in Sierra Leone: Freetown, the capital city, Kono, and Port Loko, and involved the interview of 30 survivors, 10 from each district. Sierra Leone is a country in West Africa, bounded by Guinea in the northeast, Liberia in the southeast, and the Atlantic Ocean in the west (as illustrated in Figure 1). The country covers an area of 71,740 square kilometers and has a population of 6.1 million people. The Gross Domestic Product (GDP) per capita is 809.1 USD. There is a life expectancy of 45.6 and 45.1 for females and males respectively. The country's maternal and child mortality is the worst in the world. In 2015, maternal mortality was estimated to be 1,360 per 100,000 live births and infant mortality was 116.7 per 1000 [3]. Sierra Leone rates again as one of the world's worst in another crucial diagnostic of health system strength: as of 2010, there were only 0.02 physicians per 1000 people [4].

Figure 1: Map of Africa

Freetown is situated in the western region of Sierra Leone and has a population of 981,000 people and an area of 357 square kilometers [5]. Freetown borders the Port Loko district to the northeast, Moyamba district to the south and the Atlantic Ocean to the west.

Port Loko district is in the northern province of Sierra Leone; it has a population of 500,992 [5]. The district of Port Loko borders the Western Area to the west, Kambia district to the north, Bombali district to the east, and Tonkolili district to the south. The district occupies a total area of 5,719 sq. km and comprises eleven chiefdoms. The population of Port Loko district is predominantly Muslim, and Temne is the largest ethnic group in the district.

Kono district is a diamond-rich district in the Eastern Province of Sierra Leone; it has a population of 352,328 [5]. Kono district borders Kenema district to the southwest, The Republic of Guinea to the east, Koinadugu district to the northeast and Kailahun district to the southeast. The district occupies an area 5,641 square kilometers and is divided into fourteen chiefdoms. Kono district is one of the most ethnically diverse districts in Sierra Leone and is home to a large

Figure 2: Map of Sierra Leone with district

population of many of Sierra Leone's ethnic groups although the Kono tribe form the largest. The district population is religiously diverse among Muslims and Christians.

In what follows, I give an in-depth history of Sierra Leone and the three districts in which the research was conducted. By doing so, I will lay the foundation to understand the political economy of the 2014-2015 Ebola outbreak in Sierra Leone.

15th Century: European visit and slavery

In 1462, Pedro da Cintra, a Portuguese explorer sailing down the coast of West Africa, founded Sierra Leone. He named this new country "Sierra Lyoa," which meant "Lion Mountains." It may have been the shape or the climate that influenced the name. In the sixteenth century, English sailors called it Sierra Leoa and, in 1787, the British adopted the name Sierra Leone [6].

Archaeological studies show that Sierra Leone has been inhabited for thousands of years [7]. Traditional historiography customarily presented it as a country that was occupied by successive waves of invaders. However, the language pattern suggests that the coastal Bulom (Sherbro), Temne, and Limba have been continuously settled for a long time, with sporadic immigration from inland Mende-speaking people including Vai, Loko and Mende, as well as the successive movement of people from other parts of Africa [8]. The use of iron and the practice of agriculture were established as early as 1000 AD [9], and the country's dense tropical rainforest isolated it from pre-colonial cultures and the spread of Islam [10].

Portuguese sailors, Alvaro Fernandez (1447) and Pedro Da Cintra (1462), were among the first European explorers to detail their adventures along the coast of Sierra Leone. Located near present-day Freetown, the Rokel estuary was established as an important source of fresh water for sea traders and explorers. Over the next 30 years, sea traders opened a bay for trading goods such as swords, kitchen and other household utensils in exchange for beeswax and fine ivory works. By the mid-1550s, slaves replaced these items as the major commodity. Though the Portuguese were among the first in the region and their language had formed the basis for trade, their influence had diminished by the 1650s. English, French, Dutch and Danish interests in West Africa had grown. Trade was established by coastal African rulers who prohibited

European traders from entering the country without first offering gifts in exchange for gold, slaves, beeswax, ivory and cam wood [8].

The Portuguese and Spanish dominated the early Atlantic slave trade. If the Europeans had a well-founded fear of what lay inland and east or north of the Guinea Coast, the Africans—who also suffered the "flaming sword of deadly fever"—also learned to fear what lay beyond the coast to the west and south. "Well before the arrival of Europeans," notes Rosalind Shaw, "the people of the Upper Guinea Coast has organized themselves into commercial networks that connected their coast and rivers together and linked them to long-distance trade routes leading to the Mande kingdoms of ancient Ghana and Mali to the northeast" [11].

The most significant of the population movements from the north has been termed "the Mane invasion," which Walter Rodney noted (according to Portuguese sources) dates to about 1540. But the "invasion" was more likely the gradual process of conquest and integration through marriage and acquisition of new languages, customs and land. This invasion (regardless of its pace) led to the establishment of small political units of independent kingdoms, or chiefdoms, whose rulers were checked by councils, "their form of kingship on local peoples such as Temne, Bullom, and Loko-speakers [12]." Secret societies, notably the Poro society, also exercised political power as well as instructed initiates in the customs of the country. These terms did not signify tribes, as Europeans would later have it, but referred to languages. Then, as now, Africa was by far the most linguistically diverse of the continents [13].

Walter Rodney also looked at the Portuguese literature on the kind of slavery practiced before the European invasion in the region and found only one. Rodney says that the Portuguese were detailed especially concerning trade. If slavery had been an important local institution, it is unlikely that the reports would have been silent about it. The one particular type of slavery that

they mentioned was this: “a person in trouble in one kingdom could go to another and place himself under the protection of its king, whereupon he became a ‘slave’ of that king, obliged to provide free labor and liable for sale” (such a person would likely have retained some rights and had some opportunity to rise in status as time passed). However, the Portuguese were interested in acquiring slaves (as did the Dutch, French and English who arrived later), but the Africans were not. The Portuguese initially lay in wait near the harbors and bays of the region's rivers, conducting raids and kidnaping when the opportunities arose. Soon, though, they began to have some chiefs as local partners who were willing to part with a few of the desirable members of their tribes for a price. A slave would be sold for a fortune in European rum, cloth, beads, copper or muskets [14].

Walter Rodney’s history of the Upper Guinea Coast detailed the era when the Portuguese established Port Loko and other trading towns, but these towns had been long-settled rice-farming and fishing areas. These rivers “whether used for good or ill, were the autobahn of the Upper Guinea Coast” [15]. By the time Port Loko got its new name, they were increasingly used for ill. “The ocean-going slavers remained in the coastal bays and estuaries,” notes Rodney, “while the boats of the Lançados—the Portuguese who ‘launched’ themselves into the local social world—hovered like vultures in every river, waiting to take hold of the victims of the struggles” [15]. The struggles in question may have been described as “local” or “longstanding” and “tribal” or even “religious.” But with the launch of the slave trade, they were of epidemic proportion. “So numerous were the unfortunates that the boats sometimes rejected further offers of slaves after they had gorged themselves full” [14].

Paul Farmer, in his review of the history of Sierra Leone, suggests that part of Portuguese dominance may be attributed to prudence: they hewed to the coast. The slave trade was a

lucrative business and many of its traders became rich, especially the Creoles who also lived on the coast (though the Portuguese rarely succeeded in penetrating the hinterlands). They had no reason to invade the interior because they had sparked a trade that would spark a war in the hinterland. And war, Walter Rodney observes, was "the most prolific agency for the recruiting of captives" [16]. Because the business was lucrative, other means of recruiting slaves were employed, such as the failure to repay, often trivial, debts to justify seizure and sale of debtors—mostly young ones—as chattel. Other justifications included accusations of witchcraft, petty squabbles and accusations of adultery from chiefs with numerous wives. All served as important excuses or justifications for the capture and sale of many from the Upper Guinea Coast who were highly valued in the American colonies [16].

Anthropologist Joe Opala offers us one reason why. The planters of South Carolina and Georgia were willing to pay more for slaves who came from the Rice Coast, as is clear from nineteenth-century newspaper advertisements and auction posters, because they wanted to grow rice: "The South Carolina and Georgia colonists had no experience with rice cultivation, and they depended on African know-how and technology" [17]. As Farmer highlights, fever became a means of witchcraft accusations as the trade become the most important commerce in the region and put it this way: "accusation of witchcraft reach a fever pitch, leading one agent of an English slave trading firm to diagnose as an addition to such accusations" [16]. Slaves became the diamonds of the day, along with gold, ivory, kola nuts, peppers and rice. These were bought with iron bars, salt, guns, alcohol, glass beads and trinkets.

The Europeans could not go into the hinterland fearing "the flaming sword of deadly fevers" [16]. Instead, they relied on local middlemen. As the Atlantic slave trade grew more profitable and drew in the major maritime powers of the day, writes Walter Rodney, "No one

challenged the fact that the Jihad was the greatest recruiter of slaves in the latter part of the eighteenth century" [18]. Rodney, drawing on Portuguese sources, describes the relationship between the trans-Atlantic slavers and their on-shore agents, whether European or African, as a "harmonization of cupidity" [18].

Slavery and its machinery triggered not only raids and war, but also epidemics across the region and in the distant lands to which its sons and daughters were dispatched. The historian Emmanuel Akyeampong states that, "West Africans responded to their disease environment by striving to attain ecological balances that kept local diseases at a lower level of endemicity. Folk environmental knowledge promoted the control of vegetation and game, which kept trypanosomiasis and other epidemics and epizootics at bay. Warfare—which intensified with the rise of the Atlantic slave trade—destroyed these balances and endemic diseases then became epidemic in various parts of Africa" [19].

Farmer further describes how the depopulation of the Americas was never simply the story of the introduction of new pathogens by unwitting and immune Europeans. In the first century after contact, much of it brutal and associated with seizure of land, anomie and demoralization—even then associated with decreased fertility and alcoholism—were widespread [16]. Farmer also discusses the contradictions laid by William McNeill and Akyeampong: Akyeampong casts doubt on overly deterministic accounts by fellow historians. For William McNeill, the heavy burden of disease, "more than anything else, is why Africa remained backward in the development of civilization when compared to temperate lands" [20]. But "defining 'civilization' from the Western perspective has always been a messy business," Akyeampong counters. "This statement also creates the erroneous impression that the only factor Africans have had to battle with in the quest for their development is the environment, eliding

the pivotal role that people—including outsiders—have played in the political economy of Africa [21].

Local slavery became very popular and profitable. Chiefs also enslaved people by waging wars and forcing captives into bondage. However, because not all war captives offered for sale would have been bought by the Portuguese, their captors would have to find something else to do with them. Rodney believes that executing them was rare and therefore they are used for local labor and there is also a time lag between the time they are captured and the time they are bought. Therefore, a lot of slaves awaited sales, and while they waited they were put to work [22]. There are additional reasons for the adoption of slavery by locals such as the example provided by the Europeans. Once slaving in any form is taken up it may smash a moral barrier to exploitation, and make its adoption in other forms seem a relatively minor matter. Export slaving entailed the construction of a coercive apparatus which could have been subsequently turned to other ends, such as policing a captive labor force and the sale of local produce, e.g. palm kernels, to Europeans opened up a new sphere of economic activity. In particular, it created an increased demand for agricultural labor; slavery was a way of mobilizing an agricultural work force [23].

However, local slavery was less harsh and brutal than the slavery practices by Europeans on, for example, the plantations of the United States, West Indies and Brazil. The anthropologist McCulloch described African slavery: "[S]laves were housed close to the fresh tracts of land they cleared for their masters. They were considered part of the household of their owner, and enjoyed limited rights. It was not customary to sell them except for a serious offense, such as adultery with the wife of a freeman. Small plots of land were given to them for their own use, and they might retain the proceeds of crops they grew on these plots; by this means it was possible for a slave to become the owner of another slave. Sometimes a slave married into the

household of his master and rose to a position of trust; there is an instance of a slave taking charge of a chiefdom during the minority of the heir. Descendants of slaves were often practically indistinguishable from freemen [24]. Abraham confirmed this claim as he described: "Slaves were sometimes sent on errands outside the kingdoms of their masters and returned voluntarily" [23]. Speaking specifically of the era around 1700, Fyfe relates that, "Slaves not taken in war were usually criminals. In coastal areas, at least, it was rare for anyone to be sold without being charged with a crime" [25]. Slavery was still present in the 19th century but in another form described by Abraham as "pawning": "A freeman heavily in debt, and facing the threat of the punishment of being sold, would approach a wealthier man or chief with a plea to pay of his debts 'while I sit on your lap'. Or he could give a son or some other dependent of his 'to be for you', the wealthy man or chief. This in effect meant that the person so pawned was automatically reduced to a position of dependence, and if he was never redeemed, he or his children eventually became part of the master's extended family. By this time, the children were practically indistinguishable from the real children of the master, since they grew up regarding one another as brothers" [23].

Some observers consider the term "slave" to be more misleading than informative in describing the local practice. Abraham says that in most cases "subject, servant, client, serf, pawn, dependent, or retainer" would be more accurate [26]. Domestic slavery was abolished in Sierra Leone in 1928. McCulloch reports that at that time, amongst Sierra Leone's largest present-day ethno linguistic group, the Mende, who then had about 560,000 people, about 15% of the population (i.e., 84,000) were domestic slaves. He also says that "Singularly little change followed the 1928 decree; a fair number of slaves returned to their original homes, but the great

majority remained in the villages in which their former masters had placed them or their parents" [27].

Export of slavery remained a major business in Sierra Leone from the late 15th century to the mid-19th century. According to Fyfe, "it was estimated in 1789 that 74,000 slaves were exported annually from West Africa, about 38,000 by British firms." In 1788 a European apologist for the slave trade estimated the annual total exported from between the Rio Nunez (110 km north of Sierra Leone) and the Sherbro as 3,000 [28].The British banned the transatlantic slave trade in 1807, but illegal slave trading continued for several decades after that.

1600 -1787: The fight for supremacy

In the 17th century, in Sierra Leone as Portuguese imperialism waned, the British rose to power. By 1628, the British had a "factory" in the vicinity of Sherbro Island. They traded in camwood, a hard timber, from which a red dye is obtained. In 1663, King Charles II of England gave a charter to a company called Royal Adventurers of England Trading into Africa to build a fort in Sherbro and on Tasso Island in the Freetown estuary. They were robbed by the Dutch in 1664, the French in 1704, and pirates in 1719 and 1720. After the Dutch raid, the Tasso Island fort was moved to a nearby Bounce Island, which was more defensible [29].

But at this time the military advantage lie in the hands of the Africans; according to a report form 1714, a local king seized company goods in retaliation for a breach of protocol [29]. In 1728, an aggressive company governor united the Africans and Afro-Portuguese in hostility to him: They burnt down the Bounce Island fort. It was not rebuilt until about 1750, only to be wrecked again by the French in 1779 [29].

During this period, the fight for supremacy amongst the locals also existed. The Temne ethno linguistic group was expanding. Around 1600, a Mani still ruled the Loko kingdom (the area north of Port Loko Creek) and another ruled the upper part of the south shore of the Freetown estuary [29]. The north shore of the estuary was under a Bulom king, and the area just east of Freetown on the peninsula was held by a non-Mani with a European name, Dom Phillip de Leon (he may, however, have been a subordinate to his Mani neighbor). By the mid-17th century, this situation had changed: Temne, not Bullom was spoken on the south shore, and ships stopping for water and firewood had to pay customs to the Temne king of Bureh who lived at Bagos town on the point between the Rokel River and Port Loko Creek. (The king may actually have still considered himself a Mani—in fact Temne chiefs to this day are called by Mani-

derived titles—but his people were Temne. The Bureh king in place in 1690 was called Bai Tura—"Bai" is a Mani form). The Temne had thus expanded in a wedge toward the sea at Freetown, and now separated the Bullom to the north from the Mani and other Mande speakers to the south and east [29].

In this same period, during the 17th century, Muslim Fula, the tribe to which I belong, came from the Upper Niger and Senegal rivers in an area called Futa Jalon in the mountainous region north of present day Sierra Leone. They had an important impact on the people of Sierra Leone because they increase trade and also produced secondary population movements into Sierra Leone. The Muslim Fula at first cohabited peaceably with the Susu, Yalunka, and non-Muslim Fula were already at Futa Jalon; but around 1725, they embarked on a war of domination over them. As a result, many Susu and Yalunka migrated [29]. Susu—some already converted to Islam—came south into Sierra Leone, in turn displacing Limba from north-west Sierra Leone and driving them into north-central Sierra Leone where they now are. Some Susu moved as far south as the Temne town of Port Loko, only 60 km upriver from the Atlantic. Eventually a Muslim Susu family called Senko supplanted the town's Temne rulers. Other Susu moved westward from Futa Jalon, eventually dominating the Baga, Bulom, and Temne north of the Scarcies River [29].

As for the Yalunka in Futa Jalon, they at first accepted Islam, then rejected it and were driven out. They went into north-central Sierra Leone and founded their capital at Falaba in the mountains near the source of the Rokel. It is still an important town, about 20 km south of the Guinea border. Other Yalunka went somewhat farther south and settled amongst the Koranko, Kissi, and Limba [29].

Besides these groups, who were more-or-less unwilling emigrants, a considerable variety of Muslim adventurers went forth from Futa Jalon. A Fula called Fula Mansa (Mansa means king) became ruler of the Yoni country 100 km east of present-day Freetown. Some of his Temne subjects there fled south to the Banta country between the middle reaches of the Bagu and Jong rivers, where they became known as the Mabanta Temne [29].

In 1652, the first slaves in North America were brought from Sierra Leone to the Sea Islands off the coast of the southern United States. During the 18th century there was a thriving trade bringing slaves from Sierra Leone to the plantations of South Carolina and Georgia where their rice-farming skills made them particularly valuable.

Britain and its seafarers – including Sir Francis Drake, John Hawkins, Frobisher and Captain Brown played a major role in the transatlantic trade in captured Africans between 1530 and 1810. The Treaty of Utrecht of 1713, which ended the Spanish War of Succession (1701–1714), had an additional clause (the Asiento) that granted Britain (among other things) the exclusive rights over the shipment of captured Africans across the Atlantic. Over 10 million captured Africans were shipped to the Caribbean Islands and the Americas and many more died during the raids, the long marches to the coast, and on the infamous middle passage due to the inhumane conditions in slave ships. Britain outlawed the slave trade on 29 March 1807 with the Slave Trade Act 1807 and the British Navy operating from Freetown took active measures to stop the Atlantic slave trade [30].

1787-1789: The founding and creation of the province of Freedom

In 1772, it was declared that slavery is illegal in England thanks to a five years advocacy and fight in the high court of England by Ganville Sharp and William Wilberforce [31]. After 1772 the problem of poverty replaced the abolition of slavery. The "Black Poor," the name given to the free slave in the street of London, most of them lived in impoverished East End parishes, or in Seven Dials and Marylebone [31]. They formed part of the broader Black British community employed at menial urban jobs. While the broader community included some women, the Black Poor consisted mostly of men, some of whom had relationships with local white women and often married them.

Grandville Sharp and others in London started to think about a settlement in Africa and by 1787 West Africa and in particular Sierra Leone had become their focus. Henry Smeathman presented a proposal to the Committee for the Relief of the Black Poor, for the establishment of such a colony in Sierra Leone [32], quotes a contemporary commentator who called them "indigent, unemployed, despised and forlorn," saying that "it was necessary they should be sent somewhere, and be no longer suffered to invest the streets of London" [33]. Thus they founded the "Province of Freedom," or Grandville Town, on the land purchased from local Koya Temne subchief, King Tom, and regent Naimbana – which later became Freetown, a British crown colony and the principal base for the suppression of the slave trade. The chiefs signed the agreement, but it was clear they did not understand what is in it and, consequently, could not abide by it.

About 500 settlers set sail from London in December of 1786, aiming to reach Freetown before the rainy season started, but they were delayed in Portmouth, England by bad weather until April 1787. Fifty passengers died of fever and several others were put off the ship. The final

count for the voyage was 411, of which about 300 were Black men, 40 Black women, a few White officials and 70 White women who were likely wives and girlfriends of the Black men but who were alleged to have been London prostitutes [31].

On 15 May 1787, the settlers put ashore at what is now Freetown. Their number had been reduced by about another score of deaths on the voyage. The first months of the settlement were traumatic. The torrential rains began soon after the settlers' arrival. They could not grow food and were soon starving. Disease and hostility from the indigenous people eliminated the first group of colonists and destroyed their settlement. The 64 remaining settlers, under the leadership of St. George Bay Company leader, Alexander Falconbridge and the St. George Bay Company, went on to establish a second Granville Town. This settlement was founded in 1792 by Lt. John Clarkson and the Nova Scotian settlers under the auspices of the Sierra Leone Company. By early 1788, there were only 130 people left in the settlement. Undeterred, the colony raised funds to send for 39 more settlers, most of whom were white. These reinforcements only followed their predecessors into the slave trade [34].

By 1792, 1200 freed slaves from Nova Scotia joined the original settlers, the Maroons. Another group of slaves rebelled in Jamaica and travelled to Freetown in 1800. Through the efforts of men such as William Wilberforce, Thomas Clarkson and Granville Sharpe, Lord Mansfield formed an administration in 1806, which was instrumental in the British Empire's abolition of the Trans-Atlantic slave trade in the following year. The British established a naval base in Freetown to patrol against illegal slave ships. A fine of £100 was established for every slave found on a British ship [31]

1792-1800: The Freetown Colony

Thomas Peters, an African American and a member of the Black Pioneers (an African American military unit during the American Revolutionary War), settled in Nova Scotia as part of the Black Loyalists (a British American of African descent who joined British colonial forces during the Revolutionary War) [35]. Graham Russell Hodges, Susan Hawkes Cook and Alan Edward Brown started the basis of colonialism in Freetown in 1771. It was here Peters met with leaders of the Abolitionists in London to report grievances of the Black Loyalists who had been given poor land and faced discrimination [35, 36]. He met the directors of the Sierra Leone Company who were eager to start allowing Nova Scotians to build a settlement in Sierra Leone. The London-based and newly created Sierra Leone Company had decided to create a new colony but, before Peters', arrival had no colonists. Therefore, Lt. John Clerkson, with the help of Peters, recruited and registered 1,196 American slaves from Nova Scotia to Sierra Leone. Most of these slaves were escapees from Vagina and South Carolina plantations. They set sail in fifteen ships from Halifax, Nova Scotia and arrived in St. George Bay between 26 February and 9 March 1772. [37]. 64 settlers died on their way to Sierra Leone and even Clarkson fell ill. These settlers were to build a settlement in the former Granville town that had been razed in 1789. This is, however, was not a rebirth of Granville Town that was re-established in Fourah Bay in 1791. The men cleared the land until they reached a large cotton tree, then everybody disembarked and marched to the cotton tree singing:

"Awake and Sing Of Moses and the Lamb

Wake! Every heart and every tongue

To praise the saviors name

The day of jubilee is come

Return ye ransomed sinner home"

On 11 March 1792, a white preacher Nathaniel Gilbert preached under the cotton tree, and Rev. David George preached the first recorded Baptist service in Africa. The land was dedicated and christened "Free Town," per the instruction of the Sierra Leone Company directors. This was the first thanksgiving service in the new christened Free Town and was the beginning of the political entity of Sierra Leone. Eventually, John Clarkson would be sworn in as first governor of Sierra Leone. This cotton tree still stands in the center of present day Freetown. Small huts were erected before the rainy season started. The Sierra Leone Company surveyors and the settlers built Freetown on the American grid pattern, with parallel streets and wide roads, with the largest being Water Street [35, 36].

On August 24, 1792, the Black Poor or old settlers of the second Granville Town were incorporated into the new Sierra Leone Colony but remained at Granville Town [37]. It survived French pillaging in 1794, and was rebuilt by the Nova Scotian settlers. By 1798, Freetown had between 300-400 houses with architecture resembling that of the American South with 3-4 foot stone foundations with wooden superstructures. Eventually, this style of housing (brought by the Nova Scotians) would be the model for the 'bod oses' of their Creole descendants.

The British, after the abolition of slavery, stationed a British Naval Squadron in Freetown in 1807 to intercept and seize slave ships participating in illegal slave trade. Slaves held in these ships will be released into Freetown and were called 'Captured Negroes,' 'Recaptives' or 'Liberated Africans' [28].

1800 -1961: Colonial era

I will start this section by highlighting Paul Farmer's reference to Crowder's periodization of the colonial era in West Africa. According to Crowder, the "proto-colonial period" lasted from 1880 to 1885. In his view, the Colonial Era began in 1885 in the midst of the Berlin Conference, and he subdivided the era in to four periods: 1885-1900-"Conquest and Occupation"; 1900-1919-"pacification and elaboration of systems of administration"; 1919-1939 -"Colonial Rule Proper"; and 1939-1945-"Watershed between Colonial Rule and Decolonisation". Decolonization, a consequence of World War II (among other factors), began at its close and ran its course in West Africa by 1960 [16].

But far back in the 1800s when Sierra Leone was still a small colony extending a few miles up the peninsula from Freetown, the majority of the territory that makes up present day Sierra Leone was still governed by the Temne and Mende and was not affected by the colony. This soon changed over the course of the 19th century: the British and Creoles in Freetown got involved in trade, treaty making and Military expeditions with the surrounding territory- trade being the driving force; the treaties and military expedition were undertaken to promote and increase it [38]. In order to secure local peace to enable commerce to proceed without interruptions, the British government agreed to pay a chief a stipend in return for a commitment from him to keep the peace with his neighbors, keeping roads open, allowing the British to collect customs duties and submitting disputes with their neighbors to British adjudication [38]. The treaties sometimes also required chiefs to desist from slave trading in the decades following the prohibition of slave trade in 1807. Because the war thrived because of the slave trade, suppression of slave trade went hand in hand with suppression of the wars. Thus, the commercial reasons for pacification could be added to anti-slavery ones [38].

When friendly persuasion failed to secure their interests, the British were not above (to borrow Carl von Clausewitz's phrase) “continuing diplomacy by other means.” By the mid-1820s, the army and navy went from the colony to attack chiefs whose behavior did not conform to British dictates. In 1826, troops led by Governor Turner went to the Bum-Kittam area, captured two stockaded towns, burnt others and declared a blockade on the coast as far as Cape Mount in Liberia. This was partly an anti-slaving exercise and partly to punish the chief for refusing territory to the British. Later that year, acting-Governor Macaulay sent out an expedition that went up the Jong River and burned Commenda, a town belonging to a related chief. These excursions were typical of those that continued throughout the century: army or frontier police, with naval support if possible, would bombard a town and then torch it after the defenders had fled or been defeated. Where possible, local enemies of the party being attacked were invited by the British to become allies [39].

The scramble for Africa became an intense competition between European powers for territory prompted the British to invade the hinterland in the 1880s. A rivalry with France led the British to renew efforts to finalize a boundary agreement with France. On 1 January 1890, they instructed Governor Hay in Sierra Leone to get treaties from chiefs in the boundary containing a clause forbidding them to trade with another European power without British consent [40]. Therefore, in 1890 and 1891, Hay and two travelling Commissioners, Garrett and Alldridge toured what is now Sierra Leone obtaining treaties from chiefs. “These treaties were not of cession: they were in the form of cooperative agreements between two sovereign powers,” Fyfe said. Even so, the treaties favored the British and not the chiefs [40].

In January 1895, an arbitrary boundary agreement was signed in Paris, roughly fixing the line between French Guinea and Sierra Leone. These borders were arbitrary because they were

not based on evidence; in fact, a surveyor would not determine these lines until much later. As Fyfe notes: "The delimitation was made almost entirely in geographical terms—rivers, watersheds, parallels—not political. Samu chiefdom, for instance, was divided; the people on the frontier had to opt for farms on one side or villages on the other" [41].

More generally, the arbitrary lumping together of disparate native peoples into geographical units decided on by the colonial powers has been an ongoing source of trouble throughout Africa. These geographical units are now attempting to function as nations but are not naturally nations, being composed in many cases of peoples who are traditional enemies. In Sierra Leone, for example, the Mende, Temne and Creoles remain rival powers between whom lines of fission easily emerge [40].

In August 1895, an Order-in-Council was issued in Britain authorizing the colony to make laws for the territory around it, extending out to the agreed-upon boundary (which corresponds closely to that of present-day Sierra Leone). On 31 August 1896, a proclamation was issued in the colony declaring that territory to be a British "Protectorate." The colony remained a distinct political entity; the Protectorate was governed from it. This indirect form of rule was not welcome by the chiefs, but they were forced to accept it. As Fyfe describes it: "Most of the Chiefs whose territories the 'Protectorate' subsumed did not enter into it voluntarily. Many had signed treaties of friendship with Britain, but these were expressed as being between sovereign powers contracting with each other; there was no subordination. Only a handful of Chiefs had signed treaties of cession, and in some of those cases it is doubtful whether they understood the terms. In remote areas no treaties had been obtained at all" [42]. And he further argues that: "Strictly speaking, a Protectorate does not exist unless the people in it have agreed to

be protected. The Sierra Leone Protectorate was more in the nature of a unilateral acquisition of territory by Britain" [42].

The chiefs of Sierra Leone responded with armed conflict, though they were defeated by the British's superiority in military might. In 1896 and 1897, the British passed a Colony Protectorate Ordinances that abolished the title of King and replaced it with "Paramount Chiefs." While kings had formerly been selected by the leading members of their own communities, now all chiefs, even paramount ones, could be deposed or installed at the will of the Governor; most of the judicial powers of the chiefs were removed and given to courts presided over by British "District Commissioners." The Governor decreed that a house tax of 5 shillings to 10 shillings was to be levied annually on every dwelling in the Protectorate. To the chiefs, these reductions in their power and prestige were unbearable. When, in 1898, attempts were made to actually collect the tax, they rose up, first in the north, led by a dominant Temne chief called Bai Bureh, and then in Mende country to the south. The two struggles took on quite different characteristics, and both uprising are what is referred to as the Hut Tax War of 1898 [43].

While Bai Bureh's forces conducted a disciplined and skillfully executed guerilla campaign which caused the British considerable difficulty: the Mende war was a mass uprising, planned to commence everywhere on 27 and 28 April, in which almost all "outsiders"—whether European or Creole—were seized and summarily executed. Though more fearsome than the Bia Bureh's, it lacked a definite strategy and therefore suppressed in most areas in two month, while Bureh's lasted longer. Some of the Mende rebels were not beaten until November. Mende king Nyagua's son, Maghi, formed an alliance with some Kissi and fought on in the extreme east of the Protectorate until August 1899 [44]. The leaders Bai Bureh, Nyagua and Be Sherbro (Gbana

Lewis), were captured and sent into exiled to the Gold Coast on 30 July 1899; a large number of their subordinates were executed.

Freetown was the center for the British Colonies in the early 19th century; the Governor of the Gold Coast (now Ghana) and the Gambian settlement lived in Freetown, also served as the educational center of British West Africa. Fourah Bay College, established in 1827, became Athens of English-speaking Africans on the west coast. For more than a century, it was the only European-style University in western Sub-Saharan Africa [44].

After the Hut Tax war, Sierra Leone entered into a period of relative peace with minimal military resistance to colonialism. However, resistance and dissent continued and took the form of riots and strikes. The Creoles, who had enjoyed a period of considerable political up until the mid-19th century, found the government less accessible to them by the late 19th century. In response, they openly and verbally opposed the government [45]. They continued to press for political rights. They operated a variety of newspapers, which the governors considered troublesome and demagogic. In 1924, a new constitution was put in place, introducing elected representation (3 out of 22 members) for the first time. But in addition to the political discussion, Sierra Loene opened an active trade union movement whose strikes were often accompanied by sympathetic rioting among the general population [45].

The British transformed the chiefs into functionaries in the colonial systems of indirect rule. Their role to provide policing, collect taxes, and obtain corvée labor for colonialists put into and maintain them in a privileged position over other Africans. Chiefs not willing to play this role were replaced by more compliant ones. According to Kilson, the attitude of Africans towards their chiefs became ambivalent: frequently they respected the office but resented the exactions made by the individual occupying it. Of course, from the chief's point of view, the

dilemma of an honorable ruler faced with British ultimatums cannot have been easy [46]. This rule by patronage was a legacy the British left with Sierra Leone and even in presented day Sierra Leone this is how we are ruled.

Throughout the 20th century, there were numerous riots directed against tribal chiefs. These culminated in the Protectorate-wide riots of 1955-1956, which were suppressed only by a considerable slaughter of peasants by the army. After those riots were reforms introduced: the forced labor system was completely abolished and reductions were made in the powers of the chiefs.

In 1924, Sierra Leone was divided into a Colony and a Protectorate with separate and different political systems constitutionally defined for each. Antagonism between the two entities escalated to a heated debate in 1947, when proposals were introduced to provide for a single political system for both the Colony and the Protectorate. Most of the proposals came from the Protectorate. The Krio, led by Isaac Wallace-Johnson, opposed the proposals, the main effect of which would have been to diminish their political power. It was due to the astute politics of Sir Milton Margai that the educated Protectorate elite was won over to join forces with the paramount chiefs in the face of Krio intransigence. Later, Sir Milton used the same skills to win over opposition leaders and moderate Krio elements for the achievement of independence.

In November 1951, Sir Milton Margai oversaw the drafting of a new constitution, which united the separate Colonial and Protectorate legislatures and—most importantly—provided a framework for decolonization [47]. In 1953, Sierra Leone was granted local ministerial powers, and Sir Milton Margai, was elected Chief Minister of Sierra Leone [47]. The new constitution ensured Sierra Leone a parliamentary system within the Commonwealth of Nations [47]. In May 1957, Sierra Leone held its first parliamentary election. The Sierra Leone People Party (SLPP),

which was then the most popular political party in the colony of Sierra Leone, won the most seats in Parliament. Margai was also re-elected as Chief Minister by a landslide.

Independence: 1961

Sierra Leone gained independence on 27 April 1961. The government leadership turned over to Sir Milton Margai. But how did Sierra Leone achieve independence? I will start with the process.

On 20 April 1960, Sir Milton Margai led a twenty four-man delegation at the constitutional conference that was held with Queen Elizabeth II and British Colonial Secretary Iain Macleod in the negotiations for independence held at the Lancaster House in London [48]. Among the Sierra Leone delegation was lawyer Sir Albert Magai, Milton's younger brother, and outspoken trade unionist Siaka Steven, as well as other strong SLLP members [49].

The meeting ended with Britain agreeing to grant Sierra Leone independence on the 27 April 1961; however, the declaration was signed by all but the outspoken trade unionist Siake Steven, on the grounds that there had been a secret defense pact between Sierra Leone and Britain. He also had a problem with the Sierra Leonean government's position that there would be no elections held before independence, which would effectively shut him out of Sierra Leone's political process [50]. When they returned to Freetown on 20 May 1960, Steven was promptly expelled from his political party, the People's National Party (PNP). Therefore, he and several prominent northern politicians like Mohamed O Bash-Taqi, Ibrahim Bash-Taqi and C A. Fofoana formed their own political party called the All Peoples Congress (APC) in opposition of the SLPP government. The SLPP is predominantly comprised by people from the South, so Steven took advantage of the dissatisfaction with the SLPP's ruling along with other prominent politicians from the north [50].

Sir Milton Magai led Sierra Leone to independence from Britain on 27 April 1961, and became the first Prime Minister. Sierra Leone retained a parliamentary system of governance and

was a member of the Commonwealth of Nations. In May 1962, Sierra Leone held its first general election as an independent nation. The SLPP won a majority of seats in Parliament and Sir Milton Margai was re-elected as prime minister [51, 52]. The years after independence were prosperous with money from mineral resources being used for development and the founding of Njala University [52].

Sir Milton was neither corrupt nor did he make a lavish display of his power or status. Sir Milton's government was based on the rule of law and the notion of separation of powers with multiparty political institutions and fairly viable representative structures. Milton Margai used his conservative ideology to lead Sierra Leone without much strife. He appointed government officials with a clear eye to satisfy various ethnic groups. Milton Margai employed a brokerage style of politics by sharing political power between political groups and the paramount chiefs in the provinces [53]. Sir Milton died in 1964.

His brother Sir Albert Magia was appointed Prime Minister by Parliament. However, the Foreign Minister John Kerefa-Smart questioned his succession to the SLPP leadership position, but received little support in Parliament and challenged leadership. Soon after Sir Albert Magai was sworn in as Prime Minister, he immediately dismissed several senior government officials who had served under his elder brother Sir Milton's government, as he viewed them as traitors and a threat to his administration [54].

Sir Albert was very unpopular, unlike his late brother, and resorted to increasingly authoritarian actions in response to protests, including the enactment of several laws against the APC in an attempt to establish a one-party state. Unlike his late brother Milton, Sir Albert was opposed to the colonial legacy of allowing the country’s Paramount Chiefs executive powers and he was seen as a threat to the existence of the ruling houses across the country. In 1967, riots

broke out in Freetown against Sir Albert's policies. In response, Albert Margai declared a state of emergency across the country. Sir Albert was accused of corruption and of a policy of affirmative action in favor of his own Mende ethnic group [55].

In 1967, a free and fair election was held and the APC led by Siaka Stevens won narrowly. Stevens was sworn to power as Prime Minister on 21 March 1967. Within hours after taking office, Stevens was ousted in a bloodless military coup led by the commander of the army, Brigadier General David Lansana, a close ally of Sir Albert Margai who had appointed him to the position in 1964. Brigadier Lansana placed Stevens under house arrest in Freetown and insisted the determination of office of the Prime Minister should await the election of the tribal representatives to the house. On 23 March 1967, this action was overrode by a group of senior military officers in the Sierra Leone Army led by Brigadier Andrew Juxon-Smith who seized control of the government, arresting Brigadier Lansana, and suspending the constitution. This group called itself the National Reformation Council (NRC) with Brigadier Andrew Juxon-Smith as its chairman and Governor-General [56].Then a group of another senior officers who called themselves the Anti-Corruption Revolutionary Movement (ACRM), led by Brigadier General John Amadu Bangura, overthrew the NRC junta. The ACRM juntas arrested many senior NRC members. The democratic constitution was restored, and power was handed back to Stevens, who at last assumed the office of Prime Minister [57].

Stevens took power with a great deal of hope and ambition in 1968, but before I talk about his rule I want to highlight some of the things that occurred during colonial rule. During colonialism as Farmer describes, there was a conference held in Berlin during World War II in which colonial leaders talked about founding their colonies. Both the government of France and Britain had by then long embraced policies to ensure that local surpluses be used to finance both

administrative expenses and infrastructure projects [16]. This covered basic functions of the police, justice, railway ports, rudimentary roads sanitation and primary school education. There was little in medical care or post primary education [16]. The British treasury was more stubborn in regard to self-financing, and that is why the size of its bureaucracy in West Africa is smaller than the French. The production of palm oil, rubber, groundnuts, coffee and other tropical products had been able to generate surpluses, but this was impossible without forced labor. But when this failed they relied on taxes to generate these surpluses. This created resistance from the hinterland and an uprising erupted, the Hut Tax War a described earlier [16].

Creole political power, as Farmer describes it, was never strong as many abolitionists account it; and it was further diminished after the Scramble, which called colonial powers to show their might by ruling tribes far inland from the long Creolized costal settlements--hence the Hut Tax war [16]. He further elaborates that, "By the turn of the century, most rural people, regardless of "tribe" or creed, had seen precious little in the way of health care, education, roads, or other tangible benefits of belonging to the world's most powerful empire… The sun set on generations of Sierra Leoneans who lived and died in the manner of their remote ancestors" [16]. He also describes the patrimonial form of rule, a legacy inherited by the leaders post-independence by citing an example: 'The British had a tiny Frontier Police force, founded in 1890. Four years later, it consisted of about 500 African rank-and-file soldiers led by precisely one dozen British officers. This pattern—white officers leading African rank and file—would leave a poisonous legacy after independence, by which time the Sierra Leonean army would be widely despised as a threat to democracy" [16]. This is seen with the various military coups denying Stevens power when he was first elected. "The establishment of the Protectorate implied an arbitrary work of political unification. If political unification remained a consummation

devoutly to be wished, social unification was even less likely in such circumstances, since the British made even less effort in this regard. The colonial record is replete with instances in which the occupiers are unable to understand their subjects, sought to compose British notions of law and order with little to show for it beyond mutual incomprehension and dead bodies," Farmer writes [16].

Colonial Health systems

By the end of the nineteenth century, the opposition of European occupation slowed down, if not stopped. For the French civilian administrators largely based in Dakar, their civilizing mission began. In the first decade, their mission was to advance through railroads and public health (then known as hygiene and sanitation, but to a far lesser extent, medical care). Senegal had boasted a bacteriological laboratory since 1896. With the advent of federal power across all of French West Africa, colonial authorities promised to "make hygiene the second key to bringing material improvement to Africans" [16]. But, in spite of the arrival of eager Pasteurians (as the wave of French experts in communicable disease termed themselves) and an ability to enforce sanitary regulations unmatched in Europe, deadly outbreaks of yellow fever and African sleeping sickness erupted across the region. Indeed, a new capital of the Ivory Coast, Abidjan, was established after a 1903 epidemic of yellow fever killed thousands in Bassam, the old capital. "Bassam's yellow fever epidemics occurred in 1899, 1902, and 1903, the last one killing nearly all of Bassam's European inhabitants," writes physician-anthropologist Vinh-Kim Nguyen. "The latter outbreaks led to near panic among the settlers, and a mounting rhetoric of epidemiological catastrophe produced by colonial administrators finally convinced metropolitan authorities that the administrative capital would have to be moved." In the setting of French conquest, colonial officials "conjured up a local capital from which rule could be exercised, and it materialized as a biopolitical fortress shaped by a double threat: a potentially rebellious population and tropical disease" [58].

Although other pathogens new to West Africa emerged (cholera, plague due to Yersinai and influenza), these were not reported in Sierra Leone at that time [59]. But malaria was a big problem in Sierra Leone. The chief obstacle to settling in the tropics was malaria, and

conquering malaria require an integration of preventive and curative measure, as well as careful surveillance for reintroduction. At the time of this writing, this has not changed, even though it might have without timid, defensive policies [60].

Ronald Ross in 1902 won a Nobel Prize for laying out the life cycle of the Malaria parasite plasmodium. In 1907, Dr. Laveran, a French military veterinarian working in Algeria, was awarded the Prize for his discovery of the parasite two decades earlier [60]. Before the discovery of malaria, the dominant theories of causality were, as with cholera, miasmic. Malaria, as the Italian name suggestes, was caused by bad air—"marsh miasma"—and environmental filth [16]. In brisk competition with a team of Italian researchers, Ross headed in 1899 to Sierra Leone, "reputedly the most malarious place in the British Empire," [61] to continue his research on the life cycle and how to interrupt it. The *British Medical Journal* reporting on the malaria expedition stated that "Freetown is a charming town built on and between small richly-wooded hills, sloping abruptly to the sea. The houses are mostly made of wood, and are generally of two storeys. They are however small, and in the town over-crowded. There is an excellent water supply, and dysentery and typhoid are comparatively scarce—the latter, indeed, being said to be absent. Nevertheless, the place is certainly very unhealthy to Europeans" [62]. Ross did not agree that Freetown was charming—he termed the place "pestilential"—but no one disputed its danger to Europeans and other expatriates, including West Indians of African descent. He showed that soldiers in the West Indian regiments posted to Freetown, who numbered close to a thousand even in at the turn of the century, also suffered regular attacks of malaria (presumed or confirmed), many of them fatal. The real dispute, Ross implicated, was the female *Anopheles*, a nighttime feeder; therefore, he regarded policies that focused attentions on the Europeans rather than on the vast majority [63].

Sierra Leone still had a deserved reputation as the "White Man's Grave" with death rates among British civilians and soldiers posted there remained far higher than in other tropical outposts, including India and the West Indies. Fevers had long dogged even the highest-ranking officials. "Up to the year 1885," according to the historian Goddard, "no less than ten Governors (in addition to eight Acting Governors) died on the coast, or on their way to England" [64]. But it was the natives, and especially children, who suffered most. Although quinine was long known to have effect against malaria, it was not widely used by the British (to say nothing of the Africans) as prevention or cure, even though a number of mid-century expeditions deep into West Africa were deemed a mortality-free (and thus exceptional) success thanks to daily doses of quinine. But a revolution in discovery was not readily translated into a revolution in delivery, as Akyeampong has observed: "knowing the disease cycle, or the potential effectiveness of quinine, did not alleviate the devastation of malaria wreaked on Europeans and Africans in Africa" [65]. Farmer further elaborates that "staff, stuff, space, and systems were required to make a difference, as well as an effort to convince physicians in Britain and in its malarial colonies that quinine worked. These all took time, and changes in health policy. Some of these changes came to pass in the French colonies sooner in part because authorities there enjoyed a power unknown in Europe" [16].

Outbreaks of yellow fever, smallpox, cholera and bubonic plague joined the chronic insult of malaria, and all were met with a host of restrictive or punitive measures, including the destruction of housing, highly restrictive building codes, quarantine, isolation, and fines for infractions. These were all applied in discriminatory fashion, sparing Europeans in a manner that rankled Africans, including the Creole elites. Farmer adds, "It's not as if the sanitarians didn't know the vastly differing life cycles of the pathogens, some zoonoses and some not. When the

first major outbreak of bubonic plague hit Dakar in 1914, locals were offered rewards of cash or kola nuts for rats and mice" [16]. The bounty, according to a French medical officer, sympathetic to the Africans paraphrased by Myron Echenberg "produced poor results because the Africans feared that discovery of an infected rat would bring down on their property and homes the fire and brimstone of the sanitary brigades" [65].

The impact of similarly punitive policies was eventually felt in the British colonies, but at a slower pace, and more unevenly because of the nature of British rule. "In attempting to explain the uneven success of health reform measures in British West Africa in this period," observes historian Raymond Dumett, "it is worth recalling that the Colonial Empire did not function as a centralized system. The keynote of British rule, in contrast to that of other European overseas empires, was decentralized improvisation" [66].

But one feature of British colonialism was growing stronger and more standardized: racist and discriminatory policies. As regards "urban segregation, discrimination, and the metaphoric equation of disease with so-called inferior races," observes historian Festus Cole, "policy and practice bore the peculiar badge of consistency" throughout British West Africa. [67]. These policies and practices included the exclusion, in the first years of the twentieth century, of Creole (increasingly termed, as was the lingua franca, Krio) and other African physicians, even those trained in England's best medical schools, from work in the colonial health service.

One dogged, if minority, critic of the neglect of the natives and the exclusion of African physicians from the colonial medical service was Sir William McGregor, Governor of Lagos. McGregor, himself a doctor, believed that "the primary aim of tropical medicine should be to treat people who lived in the tropics—that is, Africans—and that the employment of African

taxes to develop luxurious segregated areas for Europeans was indefensible" [68]. A number of expert panels and a Royal Commission disagreed, as did, more vehemently, Sierra Leone's Governor, who drew heavily and selectively on emerging medical knowledge to advance a doctrine of social segregation. Such segregation had long been the pursued in India and elsewhere in the Empire, but this was well before the parasite and the mosquito replaced miasma as the presumed etiology and vector. As John Cell notes, the "medical justification for segregation as a protection against malaria emerged quite suddenly in 1900 in West Africa," and "only afterward was the proposal made in India." [69].

It is not clear that Major Ross, widely viewed as the Empire's expert on malaria, intended to give comfort to hardliners like Sierra Leone's Governor. On leaving Freetown in December, 1899, Ross recommended four steps: "obliteration of the breeding pools of Anopheles by drainage," "the employment of kerosene or of an agent (i.e., a person) to destroy the larvae of Anopheles," and, failing vector extermination, the installation of "wire screens to the windows" and the use of mosquito nets. Finally, Ross added the following fateful line (in the words of Cell "only briefly and well down on the list of several recommendations"): "Houses of Europeans should be built on elevated sites" [70]

Freetown had something most other coastal towns and cities in West Africa did not: hills. Ross's first three suggestions, as the medical geographers Stephen Frenkel and John Western noted in a review written almost ninety years later, would protect all British subjects; the fourth, of course, would, if effective, protect only the colony's white minority: "Unlike the distribution of quinine, provision of mosquito netting, or draining mosquito breeding ponds, it bears repeating that the construction of segregated bungalows visibly demonstrated government resolve to protect their *European* employees" [70]. This was precisely the point, in the view of

Sierra Leone's Governor. Taking a segregationist leaf from the British Raj, which hadn't bothered with medical justifications for its social practices, the Governor and others in his administration proposed to move the white population and part of the West Indian regiment up to a "hill station" on Mount Aureol, 800 feet above the mosquito-infested coast. In 1902, when a Commission of the Royal Society investigating malaria reported that "no 'puddle' or 'ditch' had been drained" [67], the British built a small train line to carry them (the Britons, not the mosquitoes) back and forth from the Hill Station to the lower reaches of the city, where the commercial districts were clustered around the port, Farmer writes.

Akyeampong sees this decision, made in order to protect the colonists from the natives, as part of the entrenchment of colonial hierarchies: "The separation of Europeans from African carriers of malaria—that is to say, segregation—was adopted as the official policy of British West African colonial governments at the beginning of the twentieth century" [71]. Akyeampong reflects the views of most medical historians, included those cited in the course of this review. Festus Cole is withering ("Segregation institutionalized a pernicious colour bar which excluded Africans from Hill Station Club and discriminated against blacks on the mountain railway"), as are Leo Spitzer (who writes of "the feelings of betrayal and bitterness with which Sierra Leoneans came to view the Hill Station"), Raymond Dumett (who describes segregation as just one of many manifestations of "the tendency to slight the welfare of Africans for the benefit of Europeans"), John Cell (commenting on the analogy drawn by the Royal Commission between cattle as reservoirs of a disease transmitted by the tsetse fly and children as reservoirs of malaria, Cell notes that the "implied strategy was the elimination, at least from proximity to the sleeping quarters of Europeans, of such wild species as African children"), Odile Goerg (as "fundamental changes in race theories were occurring," the opposition between "Whites" and "Natives" not

only had “many legal consequences, such new definitions for census purposes or the acquisition of citizenship, but . . . also served as a basis for actual spatial exclusion”), and the geographers Stephen Frenkel and John Western (who observe that the attribution of malaria transmission to the Anopheles mosquito, then widely accepted in British medical circles, was “taken by Colonial Office medical authorities and reinterpreted in a racial context, that is, in order to promote and justify racial segregation”) [72,73,74].

Even among British officials, the Hill Station and its military barracks were soon seen as a failure by all but the most hardened propagandists. In 1904, Major F. Smith and Major A. Pearse of the Royal Army Medical Corps reported that “Mount Aureol is not healthy.” The cause remained “fevers,” which each year led to an “admission rate” of 1,955 per 1000 Europeans and 1,329 per 1000 West Indian troops—meaning that most non-natives were hospitalized more than once a year for febrile illness. Blood smears conducted in the Hill Station—and during the course of repeated admissions to military sickbays—showed the fevers were still due largely to falciparum malaria. Their inquiry further suggested that *Anopheles* and other mosquitos had little trouble crossing an open space between the bungalows and barracks and the shores of a nearby stream; they also fed on residents as they (the humans) went about their business elsewhere in the city. “This sanatorium is more or less a reproach to us,” concluded Smith and Pearse. “With a wave of the hand, so to speak, crowded West African towns have been (we are told) rendered salubrious. Meantime health in these barracks is unchanged.” The dynamic of colonial policies and reactions to them further deepened an urban social apartheid that was rivaled, within this colony and others, only by the neglect and abuse of the rural poor.

By the start of World War I, when German merchants were expelled from Liberia, the U.S. Navy transformed the port of Monrovia and its contractors into an important coaling station

for American ships. The great powers further tinkered with the map, fixing new boundaries between the three countries. World War I may have afforded, in Crowder's words, "an opportunity for revolt to many peoples only recently subjugated" [75]. But the impact of the war in West Africa's colonies was profound and largely dire. The Liberian trade was diminished immediately following the expulsion of German merchants, and soon the war slowed all legitimate commerce and sped up smuggling and other illicit trade [76]. Similarly, Farmer compared this to Sierra Leone as "contractions were registered across Sierra Leone and Guinea. The revolts of people only recently subjugated led to sharply limited victories, such as the rights of Senegalese citizens—a small majority of Senegalese subjects—to prevent the seizure and destruction of their properties in the face of outbreaks of plague" [16]. The global conflict also unleashed or worsened epidemics of smallpox, yellow fever, sleeping sickness, malaria, and (devastatingly) influenza. The war further weakened already fragile public health systems, which were largely focused on restrictive and punitive measures, and offered precious little in the way of care for the afflicted. "In Sierra Leone, the arsenal of these measures sounds eerily familiar to those seen in the recent Ebola response" [16]. As for healthcare infrastructure, this was already so weak (or altogether absent) in the colonies, as in Liberia, as to hardly merit being termed a health system. The West African Medical Service continued to exclude African physicians, even when overstretched British health officials were in 1914.

The quarantine was neither strict nor effective, as events were to prove. But it was typically British. In the words of the Sierra Leonean historian Festus Cole, "the approach by successive colonial governments to public health remained largely authoritarian, revolving around quarantine measures, enacting ordinances and punishment for Africans who breached sanitary regulations" [77]. Such measures were often honored in the breach when it came to the

British and their beloved ships, which ruled the waves in order to rule trade. By 1913, according to Cole, colonial health authorities suspected that Sierra Leone's 1910 outbreak of yellow fever could be attributed to its maritime commerce with the Guineas (French and Portuguese) and with Liberia. "It was clearly necessary to examine all ships calling at Freetown (as most were rarely disinfected before coaling), to protect laborers employed on or in their vicinity." It wasn't entirely clear how best to protect the stevedores and other dockworkers, although Cole maintains that the "most effective way of disinfecting a ship then was by using Clayton gas, which Freetown's harbor lacked [77]. It is unlikely that all the Clayton gas (whatever that was) in the Empire, or the enforcement of strict quarantine, would have made much of a difference in the days to come. At nine-forty on the morning of August 15th, "coal-lighters came alongside" His Majesty's ship. Twenty minutes later, according to the log, "native labour" from the Sierra Leone Coal Company commenced coaling. The sick list reached 132, and a young merchant marine, Patrick McFarlane, died "from pneumonia." The only other event of note that day concerned the transfer of a medic from a famous British battleship docked in Freetown: "one sick bay rating joined ship from *HMS Brittania*" [77].

The number on the *Mantua's* sick list continued to mount: 159 on the second day in harbor; 164 on the third; 176 on the fourth; 170 on the fifth. On August 20th, Able Seaman William Sutton, Church of England, died of pneumonia. The next day, it was William Glazzard, of the Royal Marine Light Infantry, and Ordinary Seaman H. Tilling, both of pneumonia, followed a couple of days later by Petty Officer Gilbert Francis Brown. On August 24th, events of note included the death of three more of the crew, whose bodies were off-loaded ("landed" in the terse jargon of the Royal Navy) while the *Mantua* took on 48 boxes of gold bullion. Before they left for Plymouth, on August 26th, the ship's crew had buried ten of their mates in

Freetown's King Tom Cemetery, but they had gotten the gold. The *Mantua's* sick list continued to decline as the ship steamed back to Plymouth, but not before losing more crew, their bodies "committed to the deep." On September 2nd, the *Mantua* fired its Howitzers for practice and sent medical staff and supplies to the *SS Chepstow Castle*, a cargo ship transporting troops from New Zealand, also laid low by influenza. By September 5th, the sick list had dropped back to five. No more deaths were noted [16].

Inside its boom defenses, the enormous Freetown harbor was packed with converted ocean liners, battleships, destroyers, corvettes, and hundreds of smaller craft. Within a week, more than 500 employees of the Sierra Leone Coaling Company reported in sick. Without "native labor," the ships' crews had to shovel their own coal. Leaping from person to person, influenza spread like fire in a laden ship's hold from the busy port to the rest of the compact city. Within three weeks, four percent of Freetown's citizens were dead [78].

In the absence of a vaccine, which would not come along until the 1940s, the sanitary measures of the day could not stop pandemic influenza, not during world war and not in Africa. Two medical geographers, analyzing patterns of spread several decades later, concluded that "influenza seemed to rage through sub-Saharan Africa as though the colonial transportation network had been planned in preparation for the pandemic" [79]. Sierra Leone was no exception. The novel strain spread from the port city to the railway system as rapidly as had the recent smallpox epidemic. If British health authorities couldn't have stopped influenza, they could have done a far better job organizing relief efforts. Caregiving did not, however, fit readily into the conceptions of the sanitarians of the day. Obsessed with disease control, they paid scant heed to supportive care. This may have been especially true of British authorities in Britain, whose "nihilism infected some, but not all, of their representatives in the colonies," Farmer writes [15].

Although the colonial sanitarians were obsessed with disease control, that didn't mean they were effective at controlling diseases other than influenza, even when the necessary tools were available elsewhere in the era's empires.

In 1915, yet another outbreak of smallpox began in Guinea, which had supposedly been the setting of widespread vaccination. This was clearly not the case, since smallpox—readily prevented by vaccination—spread throughout the French colony's southern reaches, and thence across the ill-defined border with Sierra Leone. This was of course precisely the border later ignored by Spanish influenza, trypanosomiasis, drug-resistant malaria, HIV, and Ebola [16]. It was also by largely ignored by traders during the course of five centuries.

In light of these lengthy history, it seems almost absurd that the world not prepared for Ebola. During the 2014/2015 outbreak practices from colonialism were still employed – quarantine and isolation with no treatment. We did not learn from these outbreaks and never tried to build our health care systems.

The misery would have been worse without local objections to British medical nihilism. In what will remind many of conditions within the misnamed "Ebola Treatment Units," attempts to isolate suspected Ebola cases were met with stiff resistance and attempts to flee. This was not to be attributed to native ignorance or superstition, according to the *Lagos Standard* of 2 October 1918, but to an awareness of "the reckless disregard for human Native life displayed by the authorities . . . people are hustled out to practically certain death in a building where . . . those sent are obliged to lie on bare cement floor. It is not a wise thing to depend on Force as the most essential weapon for stamping out an epidemic. The cooperation of the people is vital and cannot be ensured with the present methods, which make people run away not from fear of the disease, but fear of officials and their ways."

Paul Farmer asked what accounts for this harmonization of indifference to the suffering of those already sick with influenza and its complications. As with Ebola, the medical nihilism of public-health Luddites, who dominated Britain's response to the Spanish flu, played a noxious role. "Influenza was," Tomkins claims, "completely impervious to the methods and practices of European—or any other—medicine." But this wasn't entirely true: good nursing care, fluid and electrolyte replacement, and "pulmonary toilet" were increasingly recognized as proper supportive care in the absence of specific therapies such as antibiotics. These were, along with nutritional and social support, the mainstay of many organized medical responses to the epidemic [16].

Ebola is not the first transborder epidemic that started in Guinea. The 1916 smallpox epidemic was thought to begin in Guinea, just across the border from Karene. It wasn't the first serious transborder epidemic registered during the war, and not all of these epidemics afflicted humans directly. Although northern and eastern Sierra Leone were linked to through ties of kinship and commerce—the Karene district had an especially busy marketplace dedicated largely to trade across that border. This included trade in cattle and other livestock from Guinea, rich in grasslands compared to the more thickly forested and swampier colony to its south. Although the noises from Freetown were more insistent this time, the colonial health service was too weak to enforce its regulations fully, nor did it enjoy enthusiastic cooperation from chiefs or other local authorities. Within a few months, all of Sierra Leone's 51 chiefdoms were reporting cases of smallpox [16]. The tardy imposition of quarantine and travel restrictions, along with the toll taken by the disease itself, worsened food insecurity by making it harder to tend fields and paddies, harvest the rice crop, and bring it to market. In Rashid's view, and in that of Susan Tomkins and other historians, epidemics of rinderpest and smallpox and, most significantly,

influenza sounded the death knell of docile accommodation to colonial administration among people already weakened by conscription, taxation, forced labor, and food shortages due to war [80].

Sierra Leone's post-conquest administrative attempts to manage unruly people in the hinterland offer a case in point. In 1924, the Colony (ruled by the British and inhabited by the Creoles and many others, including Syrians traders and a "black native" majority) and the Protectorate people (the descendants of those who'd settled in the region over several centuries) were formally recognized to have different administrations. Within the Protectorate, divide-and-rule remained the order of the day. These political and social arrangements meant that the Creoles, vastly outnumbered by others living in the colony, lost much of their influence with the British [81]. Creole influence declined further as Britain dispatched more white colonial officials, who pushed aside Creoles in government positions within the Colony and across the territory. Social interactions between Creoles and white Britons still included commerce and congress (the occasional marriage, if far less frequent than among the Portuguese, was of course complemented by less formal arrangements). To impose indirect rule, the British farmed out chores to Paramount Chiefs, while further limiting these powers.

This was the health systems they left us with. At independence in 1961, in Freetown, apart from the Connaught hospital, there was another one at Murray town; there was one Government Hospital per district located in the district headquarter towns of Bo, Kenema, Kambia, Magburaka hospital and Port Loko Government hospitals. Makeni, the Provincial Headquarters of the North had a Health Centre until recently when a modern Government hospital was built. Kabala too had a Health Centre. The Colonial Government had their own specialist hospital at Wilberforce (commonly called Hill Station) where they and British officials

received medical attention. But thankfully, there are now Missionary hospitals such as Segbwema, Rotifunk, Kamakwie Wesleyan hospital, the Serabu Catholic mission Hospital, St John of God Hospital Lunsar, Ahmadiyya Hospital at Rokupr in Kambia district, the Masanga Leprosarium outside Magburaka which acquired fame for quality attention and now a Chinese Hospital.

Post-independence

Siaka Steven assumed power after Sir Milton and his brother, Albert Maggia, with a great deal of hope and ambition. Much trust was placed on him as he championed multi-party politics. On his campaign, Stevens promised to bring the tribes together under socialist principles. He built hospitals in the provinces and roads that connected the city to the provinces.

However, Steven's rule grew more and more authoritarian and his relationship with his ardent supported deteriorate. On 23 March 1971, soldiers loyal to the executed Brigadier John Amadu Bangura staged a mutiny in Freetown and other parts of the country in opposition of Stevens' government. Several soldiers were arrested for their involvement in the mutiny, including Corporal Foday Sankoh (who would later lead the civil war in Sierra Leone) was jail for seven years at the Pademba Road Prison, after he was convicted of treason. Guinean troops requested by Stevens to support his government were in the country from 1971 to 1973 [82]. In April 1971, a new republican constitution was adopted under which Stevens became President. In the 1972 by-elections the opposition Sierra Leone Peoples Party (SLPP) complained of intimidation and procedural obstruction by the All People Congress (APC) and militia. These problems became so severe that the SLPP boycotted the 1973 general election; as a result the APC won 84 of the 85 elected seats [83].

In 1977, a nationwide student demonstration against the government disrupted Sierra Leone politics. However, the demonstration was quickly put down by the army and Stevens' own personal Special Security Department (SSD) security forces, which he had created to maintain his hold on power. A general election was called later that year in which corruption was again endemic; the APC won 74 seats and the SLPP 15. In 1978, the APC dominant Parliament approved a new constitution making the country a one-party state. The 1978 constitution made

the APC the only legal political party in Sierra Leone [84]. This move lead to another major demonstration against the government in many parts of the country but again it was put down by the army and the SSD police. Stevens is generally criticized for dictatorial methods and government corruption, and reduced ethnic polarization in government by incorporating members of various ethnic groups into his all-dominating APC government. This further strengthen the patrimonial way of governance.

Siaka Stevens, who had been head of state of Sierra Leone for 18 years, retired from that position in November 1985, although he continued his role as chairman of the ruling APC party. In August 1985 the APC named military commander Maj. Gen. Joseph Saidu Momoh, Stevens' own choice, as the party candidate to succeed Stevens. As head of the Sierra Leone Armed Forces, Major General Momoh was very loyal to Stevens who had appointed him to the position. Like Stevens, Momoh was also a member of the minority Limba ethnic group. Momoh was elected President in a referendum on 1 October 1985. A formal inauguration was held in January 1986, and new parliamentary elections were held in May 1986 [82].

At this point I want to pause and discuss the theories put forward for the cause of the civil war that ravaged the country for 11 years, starting in 1991 and ended 2002.

The Civil War and Diamonds

Greg Campbell wrote, "It wasn't until diamonds were discovered in the 1930s that Sierra Leone's course toward self-destruction was set" [85]. Farmer also summarized the issues that lead to war in Sierra Leone in one paragraph as "Any history of Freetown from underneath—the Trade going on under the noses, or prows, of British interdiction ships, the Scramble, the punitive policies of the sanitarians, the attempted segregation of Freetown in order to protect Europeans from malaria, the forced labor regimes when Britain was on war-footing, the hoarding of rice by Syrian merchants—would suggest that Freetown never lived up to its name, or to the majestic cotton tree that loomed over Stevens Square, a silent witness to long years during which Freetown failed to be truly free. But the hastening of the country's decline by the discovery of the century is heart-wrenching enough without quibbling over metaphors or hyperbole" [16].

Sierra Leone's civil war was launched, with Taylor's and Gaddafi's material support, on 23 March 1991, when the RUF—a tiny group of Sierra Leoneans and mercenaries from Burkina Faso and Liberia under Foday Sankoh's (who was jailed by Siaka Steven in 1971) orders—invaded Kailahun, the teeming and ruined refugee camp where my best friend Humarr Khan drew his last breath from Ebola. Back then Kailahun was a forest village with fewer than a thousand inhabitants, most of them farmers and petty traders serving the diamond trade. They did not know what was about to hit them, but neither did the government of Sierra Leone. Then, at the helm of the battered state, there was President Joseph Momoh the head of the All People Congress. He naturally sought to continue the patrimonial clientalism of his mentor and predecessor Siaka Stevens. But this was in the heyday of the austerity measures peddled by the powerful development banks—powerful because of the cash, but also through policies that influenced institutions ranging from private banks to aid organizations—as structural adjustment.

This meant structurally adjusting many of Momoh's client's right out of a job and dashing the hopes of those who hoped for one, as William Reno reports: "State payouts to clients were already declining with implementation of a harsh structural adjustment program after 1991, which laid off 15,000 workers, 40 percent of the country's civil service. Much of the savings went to debt service" [86].

Momoh and his cabinet, and also the more astute officers of the Sierra Leonean Army, were well aware of the threats posed by these austerity measures, which almost halved the size of an already modest civil service but also meant that already malnourished health-care and educational systems were left to starve. Faced with rebellion in the east, which threatened income from mining, Momoh was also aware that he would need both credits and aid in order to beat back the rebels and regain the diamond fields, the key to his government's survival. In the end, and like most leaders of African countries caught in the web of neoliberal development, Momoh was obliged to follow the dictates of the International Monetary Fund and other creditors, which squared with mainstream opinion within much of the aid industry, increasingly vocal about corruption and clientalism. "Revenue collection decreased," reports Reno, "from 30 percent of GNP in 1982 to 20.6 percent of a lower GNP in 1992 as part of creditor-sponsored efforts to reduce corrupt state intervention in the economy" [86].

Paul Farmer describes the situation as "Among the corrupt clients to suffer most were school children and patients. By 1992, spending on basic services such as education and health care plummeted to less than a fifth of the already meager levels of the early eighties. Many of the neglected patients soon became the deceased. But the children, whether in or out of school, were soon to become enrolled in other activities, as first the rebels and then the army targeted them as recruits throughout the conflict. The latter force, always difficult to control, became more so as

the president and his entourage, many of them military men, also neglected the grievances of the underpaid and poorly equipped troops sent east to fight the RUF, which through terror and rapid recruitment and modern weapons, controlled more than half of the country within a year of their initial, unpromising incursion. They'd learned well from the Charles Taylor playbook" [16].

Several governments in Sierra Leone and Liberia were brought down by the war, and coup attempts are likely too numerous to count, Farmer further elaborates. But it is worth going through the exercise of at least learning about the changes in government. In the former British colony alone, the conflict led directly to three completed military coups within five years. In 1992, a group of young army officers, hammered in the east by the superior weaponry and woodcraft (and perhaps witchcraft, as we shall see) of the RUF and ignored by Freetown's paymasters, marched on the State House to demand back pay and better provisions and supplies. When the young soldiers scared off Momoh and the APC without firing a shot, they changed their game plan. They announced coup number one against the APC and established, as if by accident, the National Provisional Ruling Council. The NPRC was led by Captain Valentine Strasser, at age 28 suddenly the world's youngest head of state.

A second palace coup, by one of Strasser's military deputies, occurred in 1996 as popular sentiment turned against the NPRC in favor of democratic elections. Miraculously, these were held in February and led to the installation of Ahmad Tejan Kabbah, a UN bureaucrat turned politician. Coup number three, the "most destructive" (in the view of Gberie and most Sierra Leoneans) took place in 1997, when "a bloody putsch" sent the newly elected government into exile. It was coup the third that led, in Gberie's words, "to a complete normative collapse" [87]. The collapse—of social norms and institutions—was certainly complete, Farmer argues [16].

Farmer tries to make sense of the senseless war and he suggested that: The worst misfortune of all, at the height of the Atlantic trade was the conflagration that came to consume much of the Upper Guinea Coast in the last decade of the twentieth century. But even a brief history of the region necessarily includes more than mere mention of the region's civil wars, which set the stage for the epidemic to follow. The worst violence spread west from the trizone area to the coast, following the same route as Ebola would two decades later. It further recalls the epidemic in that it started small—both civil wars were launched by forces numbering no more than about one hundred rebels and mercenaries—and yet came to engulf three countries, and throw lethal tendrils into a dozen surrounding nations. As with the battles, skirmishes, raids, and sieges that accompanied the European occupation of West Africa.

The rise and fall of scores of warlords and factions were clearly tied to control of the extractive trades (diamonds, hardwood and other timber, bauxite, iron and rutile ores). As these were commodities for an international market, the warlords and rebels and sobels required airports and seaports and overland routes; but, they also required middlemen and foreign contractors. Finally, the creation (or recreation) and maintenance of extractive enclaves—which came to include the capital cities of Sierra Leone required modern weapons. None of them were manufactured locally.

Many have struggled to make sense of "senseless" brutality, which is rarely as senseless as claimed. Perhaps the best way to make sense of these civil wars—the immediate backdrop for the epidemic that began in 2013—is to link first-hand accounts to broader political-economic analyses, such as those offered by William Reno, who shows how, during the height of civil conflicts so marked by brutality that all who could fled, "external polities are central to an understanding of internal shifts." These external polities included not only all of the surrounding

states and Nigeria and Libya, but the era's superpowers and the Western democracies allegedly boycotting trade with the warlords. Much of the warlords' playbook was copied from the first governments to rule independent Sierra Leone. "Just as postcolonial state rulers manipulated economic policies to buttress elite political networks," contends Reno, "rulers continue to rework the logic of markets and manipulate the interests of external agents. This rational pursuit of power can translate into extortion from aid organizations, manipulation of drug and diamond trades, profit from forced labor, 'official' looting operations, and control of markets through alliances with new foreign commercial partners" [86].

As Mary Moran trying to analyze the cause of war in the sub region writes: "Anthropologists insist on returning local histories of conflict, and their relationship with global political and economic forces, back to the center of the analysis" [88]. Paul Farmer also argues that "these histories of conflict, whether deemed local or global, were fundamentally social processes with deep roots in the colonial era, but they were also economic and political" [16]. Scholars from other disciplines have offered similar analyses. The economist Paul Collier posits a greed-versus-grievance framework in order to better understand these and other African wars, which erupted across the continent, from Horn to Cape, during the last quarter of the twentieth century. None of these conflicts can be understood without casting the net widely, and far back in time. Emmanuel Akyeampong summarizes rather handily some of the immediate triggers of the West African wars: "The decline in world prices for African primary exports from the 1960s placed African governments in a weakened financial position, unable to deliver on the promise of rapid economic growth and good health care. Criticism elicited political repression, and in the mid-1960s a wave of military coups overthrew the first democratically elected governments in Togo, Ghana, and then Nigeria. Military adventurism and ethnic tensions have resulted in a

current state of political fragility with civil wars having been fought in Nigeria, Liberia, Sierra Leone and Côte d'Ivoire, the last three of them largely post-1990 phenomena, drawing in countries from the entire West African region either as collaborators or as peace-keepers" [89].

Paul Farmer writes: "The West African wars were not simply interconnected conflicts; they were interlocking ones. Even though Guinea managed to avoid all-out war, it was drawn deeply into it, as was Nigeria, the regional superpower, then under military rule. Like the conflicts spawned by the slave trade, this was always a war with many fronts. Without its international supply lines, purchased in part with diamond receipts, the RUF would not have long survived a determined counter-attack. Still less would it have become a major player in a global conflict involving some 50,000 combatants in Sierra Leone alone, as well as, eventually, more than 20,000 UN troops, assorted Nigerian forces, and shadowy terrorist groups operating not only across West Africa but in Kenya, Lebanon, Afghanistan. The global struggle centered in, of all places, the region around Koidu, Kailahun, Bo, and Kenema, the very towns familiar to anyone who has read about (or responded to) Ebola—even if the non-Sierra Leonean responders are unfamiliar with why the settings in which they now toil are so bereft of the tools of our trade, while mining machinery abounds and the earth still shakes with subterranean explosions" [16].

The Sierra Leonean war, as the RUF alleged, even as its forces twice swept west to loot and burn Freetown as they had countless villages and towns to the east? Or did these conflicts have more to do with control of the diamond fields to the east, where the kimberlite pipes had done their spewing. But there was plenty of greed and grievance on all sides. Several of these competing claims of causality were challenged by those who were able to reflect later in the course of the war, when the greed-versus-grievance debate was subjected to new information about the ethnographically invisible: the global market, estimated in 2010 at $72 billion, in

glittering diamonds. In the first years of the war, few of these greed-versus-grievance hypotheses received much play in the international press. By the late twentieth century, the default logic in attempts to "explain" most African conflicts was all about ethnicity and tribe, even when it wasn't.

Rwanda offered the case in point: in spite of all the talk of Hutu and Tutsi, Rwanda's fast-paced killing was a struggle to control the gatekeeper state established by colonial governments. Liberia was also held to be in the grips of ethnic conflict, even though the war was largely about looting: portable diamonds were a warlord's best friend, and there were other valuables under the earth, and timber on top of it. That did not mean that the looters-in-chief couldn't use tribal fig leaves along with others' grievances to advance their aims. "The war easily took on an ethnic character," observes Mary Moran, "with the Gio and Mano peoples rallying to Taylor's NPFL (even though Taylor himself was a member of the Americo-Liberian elite), and the Krahn and Mandingo peoples rallying to Doe. Ethnic violence and massacres became a commonplace, and by the mid-1990s, the war had killed tens of thousands of Liberians, almost all of them civilians targeted largely because of their ethnicity." The conflict continued, drawing in Nigerian troops, ostensibly as peacekeepers in a multinational force known as the Economic Community of West African States Cease-fire Monitoring Group, or ECOMOG. The force, mustered in 1990 in response to Taylor's attempt to overthrow Samuel Doe—and on-hand when another warlord did the job—was known for its heavy-handed tactics, which in Liberia had included aerial bombardment and shelling of towns and cities. It would use precisely the same methods in the defense of Freetown during RUF incursions that cause over 50,000 deaths and displaced over 2,000,000 people [16].

The war in Sierra Leone ended in 2002, rebuilding started but was slow despite the extraction industries. Taxes from the diamond industry and other extractive industries were not transparent and leaders were not accountable.

In August 2007, Sierra Leone held presidential and parliamentary elections. They had a good turnout and were initially judged by official observers to be "free, fair and credible." However, no presidential candidate won the 50% plus one vote majority stipulated in the constitution on the first round of voting. A runoff election was held in September 2007, and Ernest Bai Koroma, the candidate of the APC, was elected president and sworn in the same day. In his inauguration address in front of thousands of cheering supporters at the national stadium in Freetown, president Koroma promise to fight corruption and against the mismanagement of the country's resources.

By 2007, there had been an increase in the number of drug cartels, many from Colombia, using Sierra Leone as a base to ship drugs on to Europe. It was feared that this might lead to increased corruption and violence and turn the country, like neighboring Guinea-Bissau, into a narco state. However, the new government of president Ernest Bai Koroma quickly amended the laws against drug trafficking in the country, updating the existing legislation from those inherited at independence in 1961, to address the international concerns, increasing punishment for offenders both in terms of higher, if not prohibitive, fines, lengthier prison terms and provision for possible extradition of offenders wanted elsewhere, including to the United States.

In 2014 the country was impacted by the 2014 Ebola virus epidemic in Sierra Leone.

Methods

This thesis used qualitative methods and ethnographic design. I conducted multiple in-depth interviews of Ebola survivors in the three districts of Sierra Leone. Ten survivors from Kono, ten from Port Loko and ten from Freetown were interviewed in order to learn about their biographies and experience with Ebola and survivorship.

Survivors of the current Ebola epidemic (defined as discharged from an ETU with a negative Ebola PCR after being confirmed PCR positive for Ebola) were living in Freetown, Port Loko or Kono districts. They were members of Partners in Health survivor program. They all were greater than 16 years old and were able and willing to give consent.

I also conducted an in depth literature review on the history of Sierra Leone, focusing on slavery, colonialism, post-independence, the war, post war and the Ebola outbreak.

Data Analysis

I conducted a qualitative analysis of:

- Participants Biographies
- Participants lived experiences with Ebola and
- Post Ebola experiences

I qualitatively analyzed the participant's biographies, lived Ebola experiences and post Ebola experiences. I used both content analysis and a grounded theory approach. I used open coding to identify themes related to the biographies, lived Ebola experiences and observations that help illuminate the political economy of the 2014-2015 Ebola epidemic.

I link this ethnography to a historically deep political economy as well as the epidemiology of Ebola in Sierra Leone and the west, which I hope helps us answer the following questions:

- How have years of civil conflict shaped the 2014-2015 Ebola epidemic in Sierra Leone?
- What are potential causes of the gendered epidemiology of the outbreak?
- How do some of those most affected by Ebola understand the cause of the epidemic and how has their understanding changed?
- How do individuals and communities understand quarantine?
- What factors affect decisions to seek treatment?
- How have daily life decisions changed during the epidemic?
- How has mobility changed during the epidemic?
- What is the status of survivors in the community?
- What are the extrinsic and intrinsic motivators (e.g., Ubuntu, hazard pay) for national health staff?

- What are some potential avenues for health systems strengthening during the Ebola crisis?
- What were the factors that led to such an anemic initial response?
- Is there trust of government institutions? Foreign NGOs? How can this be strengthened?
- What are some of the broad historical reasons that explain the highly significant difference in Ebola mortality between Sierra Leone and the west?

Results

Demographics and Ebola related results of survivors interviewed

I interviewed 30 survivors from three districts, which included ten each from Port Loko, Kono and Freetown. All thirty survivors are older than 15 years with a mean age of 34 years (See Table 1). I interviewed 16 men and 14 women. Eighteen were married and one was separated. Among the 18 married, 14 of them lost their wives or husbands to Ebola.

Age	**Port Loko**	**Kono**	**Freetown**	**Total**
15-19	1	2	0	3
20-24	1	0	3	4
25-29	1	1	4	6
30-34	1	1	1	3
35-39	3	2	1	6
40-44	0	0	1	1
45-49	1	1	0	2
50-above	2	3	0	5
				30

Table 1: Showing age distribution of those interviewed per district

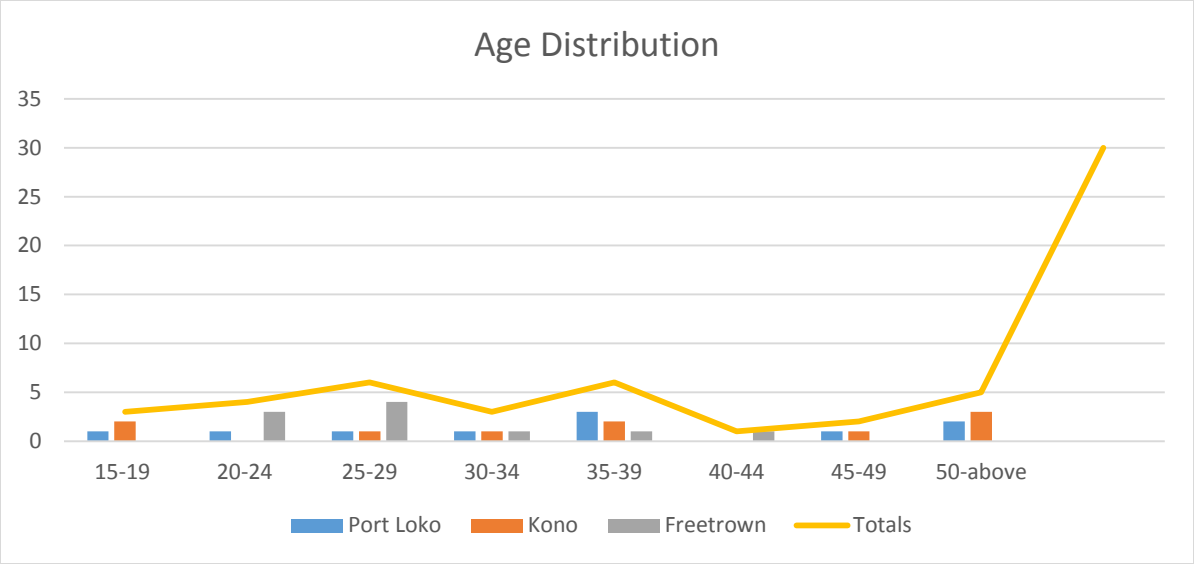


Figure 3: Showing age distribution per district

Sex	**Port Loko**	**Kono**	**Freetown**	**Total**
Male	4	6	6	16
Female	6	4	4	14

Table 2: Showing sex per district and total

Marital *Status*	Port *Loko*	Kono	Freetown	Total
Married	7	8	3	18
Single	2	2	7	11

Table 3: Showing marital status per district

As shown in Table 4 and Graph 2 below, 10 of the participants never went to school and three from Port Loko and Kono had primary school education. 3 from Freetown had university education, which shows the disparity in education between rural and urban settings. Of those with training and a college education, 3 of them were health care workers and 2 were teachers. 2 of the healthcare workers were Community Health Officers (CHO) and 1 was a Community Health Nurse (SECHN). One CHO from Kono became infected while working in his health post

at Jaima Sewafe. The other one from Freetown became infected in Magburaka Government Hospital. The SECHN as infected in Freetown while working at the Hastings Treatment Center (PTS).

Education level	**Port Loko**	**Kono**	**Freetown**	**Total**
University	0	0	3	3
Training colleges	1	1	3	5
Senior Secondary	2	1	4	7
Junior Secondary	0	2	0	2
Primary	2	1	0	3
None	5	5	0	10
				30

Table 4: Showing education level of participant by district

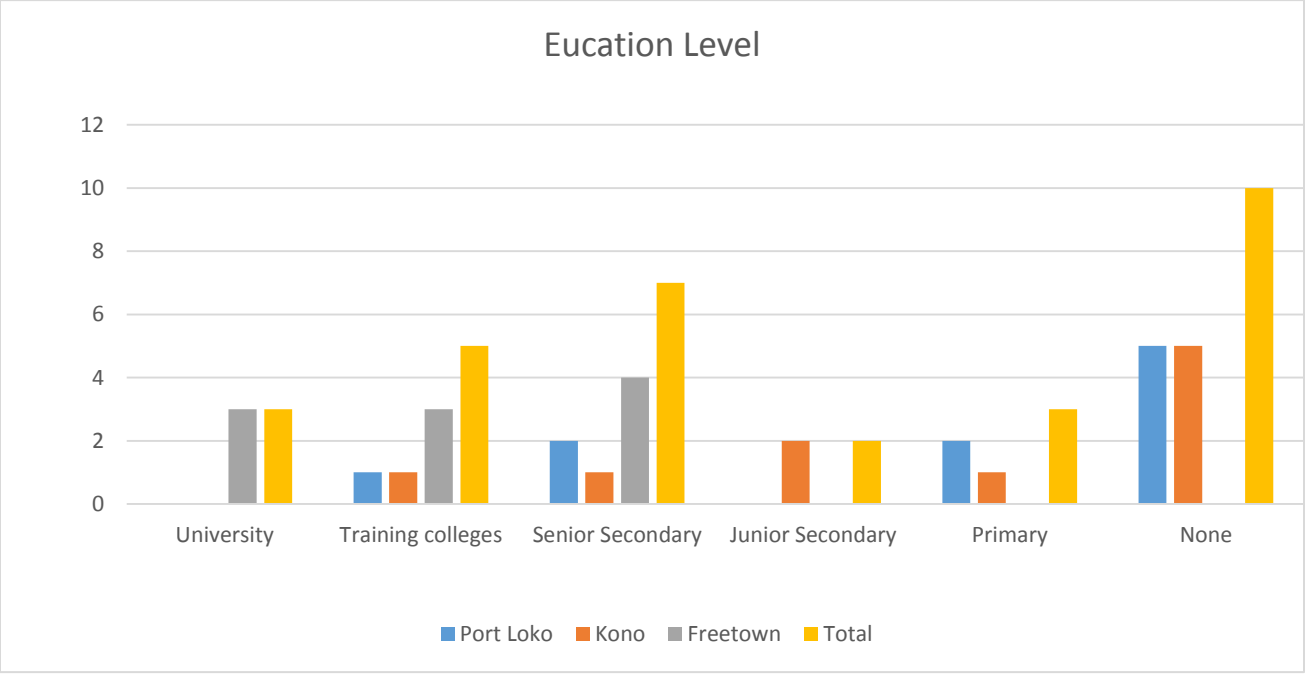


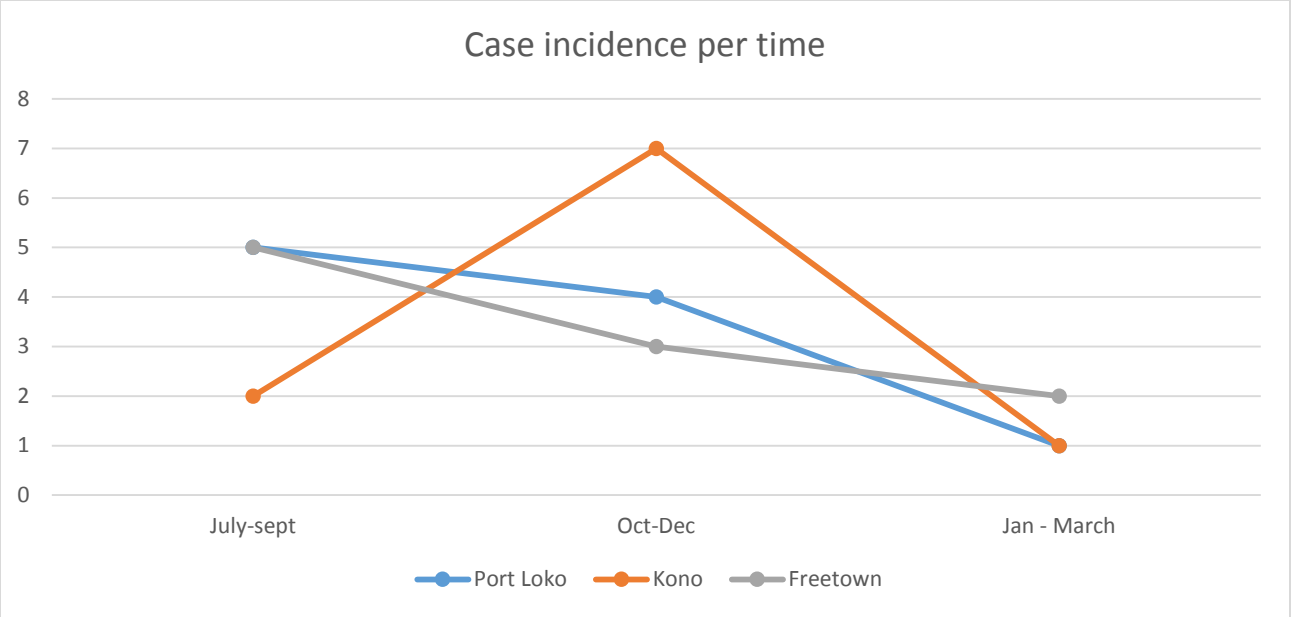
Figure 4: Graph showing education status per district

Table 5 and Graph 3 shows the time of the year in which the survivors interviewed were infected. The outbreak peaked between September to December 2014, when there were more

than 100 cases reported every week. Port Loko and Freetown were on fire in the months of September, October and November; Kono peaked in November, reporting 20 to 30 cases per week. At that time, bed capacity and care for patients was limited to a few ETUs. Neither Port Loko nor Kono had ETUs. Even Freetown had limited bed capacity. Most cases were referred to Kenema and Kailahun, the epicenter of the disease. Ambulances were limited in number and thus 5 to 7 patients were carried in each ambulance. Surveillance, burial teams, and social mobilization efforts were just starting to be set up. Many district had one or two ambulances and one or two burial teams, which put constraints on the response at the beginning of the outbreak (from May to September). The government set up the Emergency Ebola response centers in each district by June, which were charged with the responsibility of responding to the outbreak. A hot line was set up (117) and people were asked to call when they or their family member were sick or dead. However, it took an average of 5 days for a call to be responded to, because there were limited numbers of ambulances and burial teams. The government employed the Ministry of Defense to take charge in August and set up the National Ebola Response Centers (NERC) and District Ebola Response centers (DERC), which were headed by the military.

Time of patient infections	**July-Sept**	**Oct-Dec**	**Jan - March**
Port Loko	5	4	1
Kono	2	7	1
Freetown	5	3	2

Table 5: Showing rate of incident



Graph 3: showing case incidence over time.

The survivors I interviewed were treated in different centers, most of them in Kailahun and Kenema, as shown in Table 6 and Graph 4. Because there were no ETUs in their district, they had to be transported to Kenema and Kailahun of Bo for treatment. Most of them were transported with 4 to 6 others in an ambulance. However, some of those I interviewed were treated in their district after treatment centers were built, which in some cases came late in the response. The interviews will speak to the challenges encountered in the beginning of the outbreak.

In the treatment centers, different forms of treatment were given, including sometimes but not always IV fluids. At the beginning, the ETUs were without a T, which meant no treatment. Rather, they served as a place to isolate people from the communities.

ETU where admitted	**Port Loko**	**Kono**	**Freetown**
Kenema (Govt hosp)	2	1	2

Kialahun(MSF)	2	3	2
Kenema (IFRC)	1	3	1
Freetwon (PTS)	1	0	5
Bo (MSF)	2	2	0
Portloko (Marforkie)	1	0	0
Kono (IFRC)	0	1	0
Portloko (Goal)	1	0	0

Table 6: Show ETUS to which patients were admitted and treated

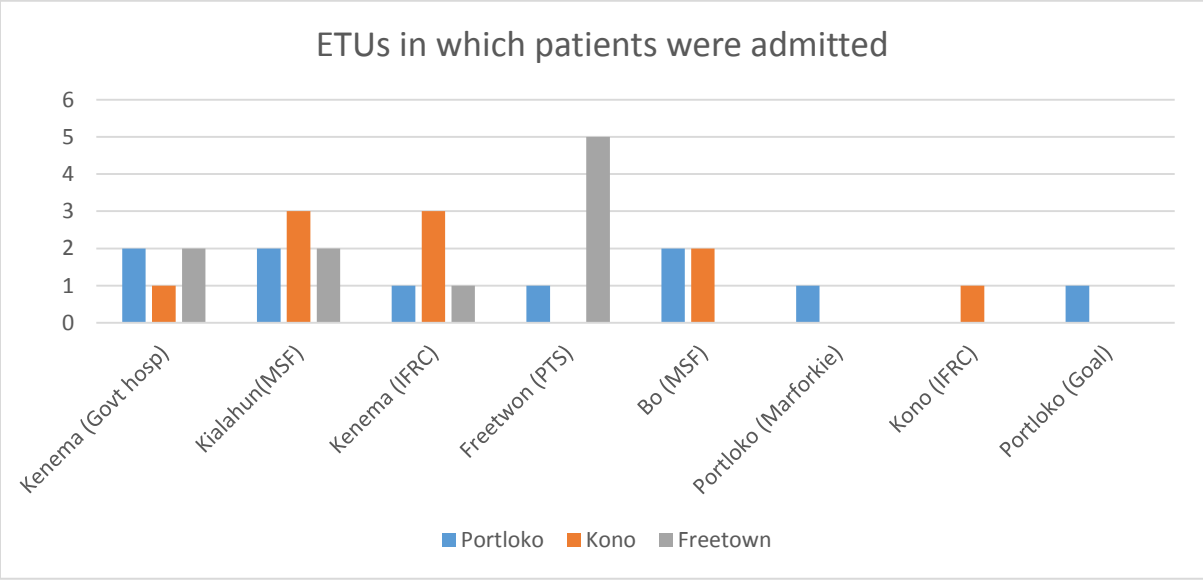


Figure 5: Graph showing where patients were admitted

ETU Built	**Time**	**Total No. of patients admitted**
Kenema (Govt hosp)	May-14	5
Kialahun(MSF)	Jun-14	7
Kenema (IFRC)	Sep-14	5
Freetwon (PTS)	Oct-14	6
Bo (MSF)	Oct-14	4
Port Loko (Maforkie)	Oct-14	1
Kono (IFRC)	Dec-14	1
Port Loko (Goal)	Jan-15	1

Table 7: Showing where ETUs were built and ready and the total patient interviewed who were admitted to those ETUS

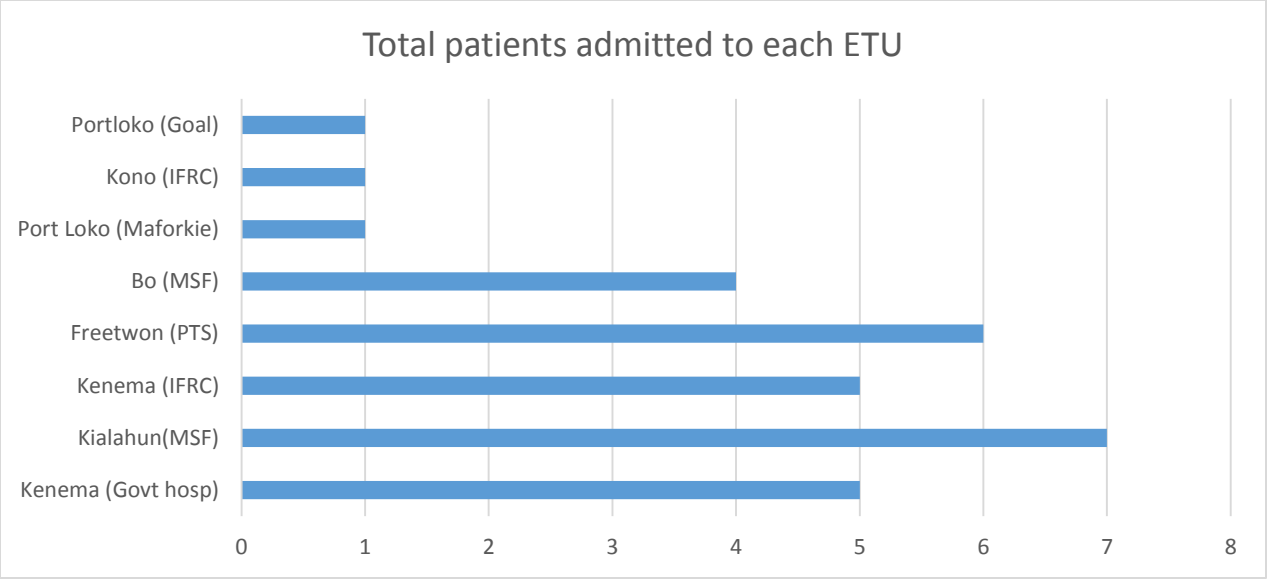


Figure 6: Graph showing total patient admittance in each ETU

Table 7 and Graph 6 show the time the ETUs where built. Most of the survivors interviewed were admitted in Kenema and Kailahun, because at the time they were the only ETUs available.

Most of the participants interviewed lost more than six family members to Ebola during the outbreak, as shown in Table 8. Ebola is a disease that affects families. Most of the people interviewed got the disease because they needed to care for their loved ones in the absence of a strong health care delivery system.

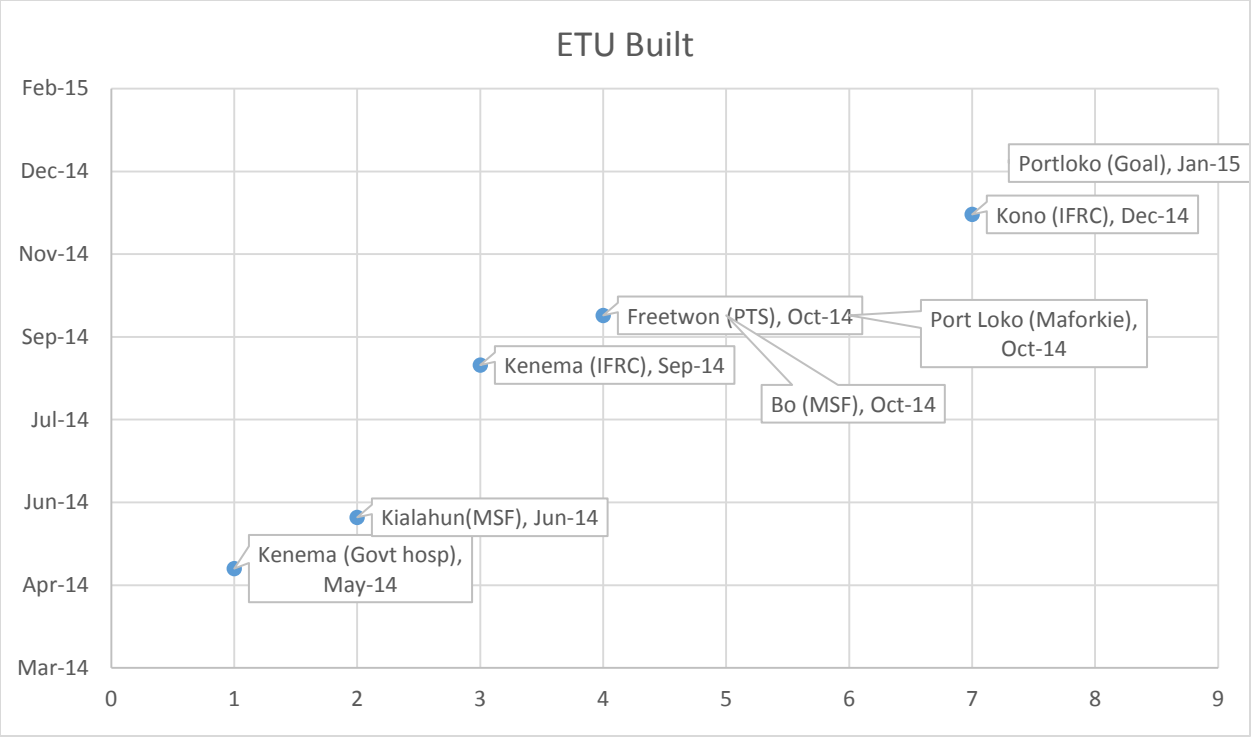


Figure 7: Graph showing time ETUS were set up

Mortality	Port Loko	Kono	Freetown
less than 1	1	0	0
1--3	2	1	2
4-- 6	2	3	2
7---9	3	2	4

Table 8: Showing the number of family members each participants lost to EVD

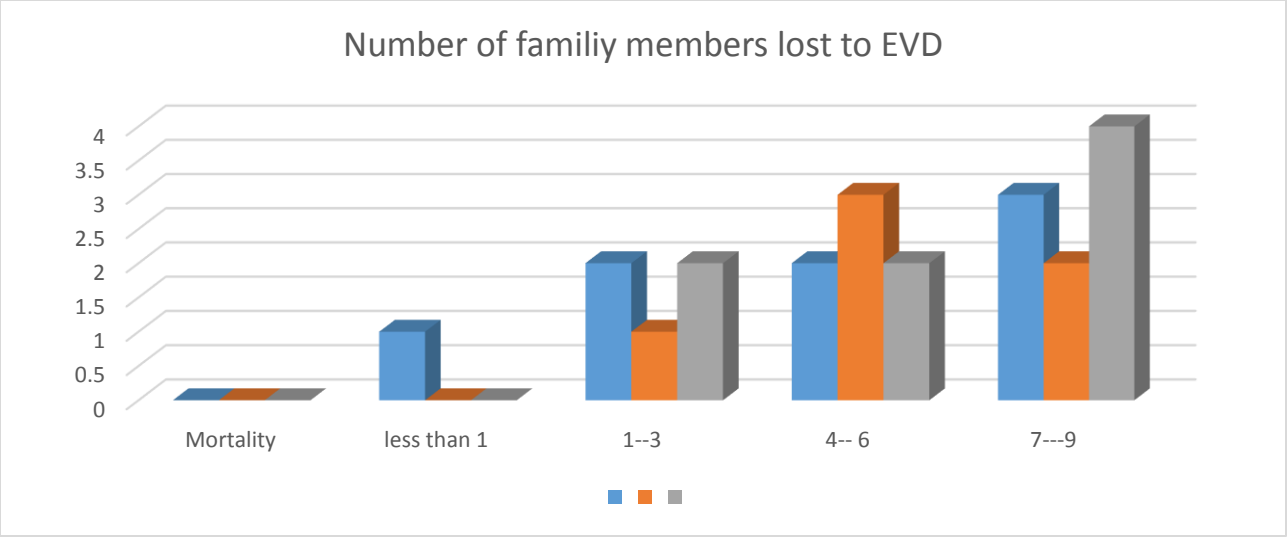


Figure 8: Graph showing number of family members lost to EVD

Interview results

The experiences of the participants differed based on the time of their infection. At the beginning of the outbreak, there were very few Ebola Treatment Units (ETUs) (there was one in Kailahun and another in Kenema). People infected with Ebola in other districts needed to be transported to the ETU in these districts. There was only one laboratory to test for Ebola in the country and it is located in Kenema. Around August, another one opened in Freetown. Blood from all over the country had to be taken to these labs for testing.

Ambulances were limited in numbers. There were only one to two ambulances per district and most of them were used for responding to obstetrics emergencies. Government and NGO's developed messages targeting the general population and set up burial teams. They also created an emergency number (117) to be called if someone had a fever or appeared sick. The emergency response centers (EOC) were developed in June to help in the response, which were led by the MoHS. In October, the National and District Ebola Response Centers (NERC and DERC), which were led by the Ministry of Defense, were instituted, which replaced the EOC.

More international NGO's came in around September through December in response to a statement released by the CDC in September, "Estimating the future number of cases in the Ebola Epidemic-Liberia and Sierra Leone, 2014-2015," which estimated the future number of Ebola cases based on then-current trends. The projected numbers were adjusted to account for under reporting of cases. Without additional interventions or changes in community behavior, the CDC estimated that there would be a total of approximately 550,000 Ebola cases in Liberia and Sierra Leone by January 20, 2015, or 1.4 million if corrections for underreporting were made. In June Doctors without Borders (MSF) announced that Ebola was out of control and called for massive resources. With the influx of more international NGO's and more ETU's, community care centers were built, the lab capacity increased, more ambulances were brought in and more burial teams were established and community mobilization improved.

Messages

The main sources of information in Sierra Leone, at the start of the outbreak, were the Ministry of Health and Sanitation. In April 2014, MoHS developed public health messages for the prevention and control of Ebola in collaboration with stakeholders and partners under the National Advocacy and Social Mobilization Committee. The aim of the messages was to educate communities and districts bordering Guinea and Liberia that already confirmed cases about the nature of Ebola and the necessary containment measures to avoid the expansion of the virus into Sierra Leone. These messages included:

- Washing hands with soap and plenty of water at key times
    - After coming home from work, school, market
- Practicing good food hygiene
    - Washing fruit and vegetables thoroughly under running water

- **Avoiding eating wild animals especially monkeys, chimpanzees and bats**
- Avoiding eating fruits that bats or wild animals have partly eaten
- Avoiding eating animals found dead

- Maintaining good personal and environmental hygiene
  - Not sharing sharps such as needles and razor blades
- **No hunting, handling or consumption of wild animals such as monkeys, gorillas, chimpanzees, bats, etc. and sick or dead wild animals**
- Handling suspicious cases of Ebola during an outbreak
  - **Report/go to the nearest health facility or stay at home and inform the nearest health facility, when you have any of following signs:**
    - a sudden high fever;
    - diarrhea;
    - vomiting;
    - body weakness;
    - headache;
    - sore throat;
    - Abdominal pain;
    - Skin rash; and
    - Internal and external bleeding may be seen in some patients.
    - In pregnant women, abortion (miscarriage) and heavy vaginal bleeding are common Ebola symptoms.
- **Knowledge about free Ebola treatment in all government health facilities**
- **Handling a suspicious patient/corpse**

- Handling suspicious patients/corpses with gloves, glasses and masks
- Disinfecting clothing and beddings with bleach after handling the patients/corpses
- Washing hand with soap after touching the patients/corpse
- Do not wash their body
- Quick burial of suspicious corpse
- Avoiding funerals especially for the suspicious patients

- **Practicing "no-panic led" behaviors**
  - No hiding sick persons
  - No hiding dead bodies
  - Collaborating the monitoring of persons and families in contact with suspicious patients
  - Collaborating to the case tracking and management
  - No fleeing from the area

Lack of trust of the health care system and denial

The messages were aired on radio, loud speakers and TV in an unclear and inconsistent form by health officials saying that "Ebola kills" and that these steps should be taken to avoid getting Ebola. There was mistrust of a dysfunctional public health care system. Patients sought care from traditional healer and private clinics. This was compounded by misconception and denial of Ebola that spread through local media, which relayed the population's belief of Ebola as being witchcraft, a hoax from the government or that international organizations and health workers were somehow responsible for the outbreak [90]. One woman (50 years old) said: *"I do not trust the government hospital, I seek care with a traditional healer in the village. I did not believe that Ebola was real, I thought it was just the white man and government who are*

finding ways to make money. So when I started having fever and generalized body pain I went to the traditional healer who gave me some medicine. Not until I started vomiting and got diarrhea and my condition got worse that my daughter brought me to Kiodu Government Hospital."

Another 36 year old man said: "*When my father first experienced the disease we thought it was witchcraft, so we took him to the village to one traditional healer for treatment, he died two days later. We performed the burial ceremony and buried him. After two days, my Aunt, brother and sister started showing symptoms we still believed it was witchcraft that is sent to the family so we still continued with the traditional healer and they died too, the entire family 14 in total died. When I started showing symptoms, my wife decided to take me to the hospital, Port Loko Government Hospital, where I was admitted and transferred 4 days later to Kialahun"*

Fear

The negatives messages generated fear among the communities, especially with the messages that essentially said "there is no treatment for Ebola and it kills." But also people saw health workers in space suits come into their community and take away a sick person and that sick person never returned. No effort was made to educate the community about the process or why they were dressed in space suits, which generated fears and refusal to call 117, and led to hiding their sick loved ones. One of the participants explained how she felt and why she went into hiding when she was infected: "*When my neighbor got sick, they came dressed in white suits, their faces were covered, they talk to nobody, took her away we never heard anything back. They quarantine our house, we were afraid and terrified. When I started having fever, I did not tell the contact tracer, I took Paracetamol whenever they are coming. After two days I decided to run away, at night I escaped and went to the bush, they looked for me but could not find me. I*

stayed at the bush for two day when I started having diarrhea and vomiting and did not have food I came back and reported myself to the health center in the village."

Another 25 year old man said: *"I was afraid to go to the hospital because they say Ebola don't have treatment and when you catch it you will die. So when I started showing symptoms, I decided to stay at home and die there were my family would see me, rather than taken to Kialuhun or Kenema and die there where nobody will see me."*

Condition at the Holding Center

At the start of the outbreak, Port Loko and Kono had holding centers but no treatment centers. When patients were brought in or came for themselves, they were called suspect cases and admitted at the holding center. In Kono, the male medical and male surgical wards at Kiodu Government Hospital were converted into a holding center. In Port Loko, the maternity and surrounding center at PLGH was used as holding center and Maforkie later was also used as a holding center. In Freetown Connaught Hospital the main referral hospital, King College from England were working there, they had a room in the outpatient that they converted into a holding center. And many clinics around Freetown were used as holding centers. There was no lab capacity in Kono and Port Loko, so when a suspect case was admitted nurses would draw blood and send it to Kenema, Kialuhun or Freetown. At first only Kenema had a laboratory to test for Ebola. Patients would have to wait for days to weeks before their result come back; by then, some would have died. General care at the holding centers was typically miserable and nothing in the way of medical care as one of the participant in Kono described: "*It only God that made me to survive, because at the holding center were I took 6 days, we were treated like animals. We were given no medicine, they gave us food only once a day, they come and put the food at the door and whoever is able to go take it good for him. People die and lay on their vomitus or pop,*

they come once a day to take out the copses. Every day 5 to 6 people die in the holding center. They took my blood and send it to Kenema it took 4 days for the result to come back, I was positive and it took 2 day for the ambulance to come take me to Kenema."

Another participant from Freetown said: *"When I was admitted at the holding center at the Macualey Street Health Center, I was not given any medicine. They took my blood and send it to a Lab that I don't know. It took 2 days for the results to come back positive, I was transported to the Hasting Treatment Center the following day. But at the holding center we lay on a plank of wood place on top of four-cement block. Nobody checked on us, the food was not good and they bring it only one time and throw it at us in the room. Some of it will spill, no body want to come near us or talk to us. We were given no ORS even to drink, it like we are isolated to die."*

However, towards the end of the outbreaks, things started improving, as more staff came from around the world to help. The local staff received more training and more confidence and they started going into to the holding centers and started taking care of patients as one of the participant who got infected in December in Port Loko described his experience: *"When I was brought into the holding center, I was triaged, registered and placed into the suspect ward in the holding center. They took my blood for testing and the result came 2 days later- I was positive. The two days I spent there-they feed us 3-4 times a day, the nurses will encourage me to eat, drink a lot of ORS, and I saw them giving people drips, but I did not need a drip. When my result came positive, they transferred me to the confirmed ward. They will come check on us three times a day, they are both white and black nurses."*

Transporting Patients to the Treatment Centers

Ebola patients should be transported individually. If this is not possible, they must be transported so that they are not touching each other and do not come into contact with the bodily fluids, such as vomit or diarrhea, of other patients.

However, in the initial phase of the outbreak, there was minimal availability of ambulances. Therefore, five to eight patients were transported at a time in an ambulance to the ETU. To compound the problem even further, the ETU were often located in faraway districts like Kailahun and Kenema. In the case of my participants, it would often take 4 to 6 hours to transport a patient from Kono to Kenema and Kailahun on a bad road with potholes, which was true of most of the routes to the ETU.

The conditions under which patients were transported are horrible as one participant described his transport to Kialuhun from Kono: "*I was transported to Kailahun when my result eventually came after 6 days, positive. 8 of us were put in the ambulance, one old woman is among us. When we left Kono we were all alive, but when we arrive in Kailahun only 3 of us were alive. I was weak and almost getting unconscious, the old woman died on the way because the driver was not careful he enter in a deep pothole and the old woman hit her head on the roof of the Ambulance where there was an iron that injured her head, she bleed to death. The other patients were vomiting and having diarrhea in the ambulance. We were thrown back and forth bumping into each other, falling on the pop and vomitus on the floor. It was the most horrible transport I have ever experienced in my life, before we arrived all of us were just laying on each other some dead and some alive. I even don't want to remember that."*

Another participant from Port Loko shared his experience of traveling from Port Loko to Kenema: *"I was transported with other 5 patients three of us confirmed the other three were just*

suspect cases. The ambulance was hot inside we cannot open the windows, we were sweating and restless, two people died on the way. The driver did not talk to us even when we tried to tell them that we have dead people in the ambulance. It took us 5 hours to get to Kenema and the journey was really tough for us. When we arrived in Kenema, we stayed in the ambulance for another 4 hours before they open the ambulance and got us out. We were tired, weak and two of my colleagues fainted. We were registered and triage then I was sent to the confirmed ward the other three in the suspect ward because the other two confirmed cases died on the way."

When more support arrived, each district had 10 to 20 ambulances and more ETUs were built in each district. The patient experiences changed because they no longer had to travel long distances to the ETU; however, they had to travel from the communities to the ETUs. This participant's experience was different, as she explains: "*I was transported alone in the ambulance when I got sick, a nurse was at the back with me, encouraging me and explaining what I will face at the ETU. She made me comfortable and ready to get to the ETU. I was given ORS at the Ambulance. She was nice but dressed in white covered all over. I was afraid at first but before we get to the ETU, I was already relaxed and comfortable."*

Conditions at the treatment center (ETUs)

At the start of the outbreak there weren't many Ebola Treatment Units. There was one in Kenema opened in late May, which was managed and run by the WHO and the MoHS. The MSF opened a second ETU in Kailahun in late June. The outbreak started slowly and silently in late May and early June. Cases increased drastically and exploded in October and November. Kenema had a laboratory and old isolation ward, which was set up to manage cases of Lassa fever. The laboratory diagnosed the city's first Ebola cases, but the poorly maintained isolation ward was soon overwhelmed with Ebola patients and services collapsed. At Kenema's

government-run hospital, two wards were converted into Ebola-designated treatment facilities. Unfortunately, eight nurses became infected in July, adding to the problem of finding sufficient staff willing to work under life-threatening conditions. As the year went on, that number grew to more than 40 deaths among doctors and nurses in the single district hospital, which dealt a huge blow to the country's already overstretched health system. On 29 July, Dr. Sheik Humarr Khan, the country's only expert on viral hemorrhagic fevers and who led the efforts in Kenema, died of Ebola.

In August, the WHO urged the three country's governments and the international community to step up in the three affected countries. The staf'fs motivation decreased when a WHO-deployed epidemiologist working in Kailahun became infected; then, three staff at a hotel where foreign medical teams were staying also became infected. These events caused most foreign staff to suspend their operation in Kailahun and Kenema, which led the WHO to deploy a team of logisticians and experts in infection control to investigate why health care workers were infected and ensure a safe working environment.

To make matters worse, healthcare workers went on strike in late August in Kenema over unpaid salaries and poor and dangerous working conditions. Burial teams complained that they were forced to use one broken stretcher to transport bodies as well as patients. As more healthcare workers died in Kenema, more deaths began occurring in the community as patients fled to avoid the hospital undermining the effectiveness of treatment in isolation as a control measure.

Throughout July and August, Kenema and Kialahun were the only treatment unit. Patients were transported from Kono, Port Loko, Freetown, and across the country to Kenema and Kailahun. Quickly, they were overwhelmed. The care provided at these facilities was sub-

optimal—no IV fluids were given, patients were left to die in the treatment center. One of the participants shared his story at the ETU: *"Only God knows how I survived, because I received no better treatment at the ETU compared to the holding center. The main difference was we were given food and ORS at the ETU, but I was weak to eat, received no treatment other than the ORS, at some point I gave up, people were dying all around me, taking a day for them to be picked up from the ward just for their bed to be occupied by another dying man. I just lay there breathing waiting for my time to die, but something happened to me on the 5th day, everybody in my ward died about 8 of them, when they came to pick them up I laid still just breathing slowly they thought I was dead too, they were about to cover me with the sheet when one of them said he is alive, I opened my eyes turned around everybody in the ward was gone. I decided I am not going to die, so I started to force myself to drink the ORS and eat some food, after two days a started to getting strong, walking around the ward holding onto the beds, then miraculously I started improving. An in two weeks a retest of my blood came negative. When I was told, I could not believe that I survived Ebola under those horrible condition."*

Another participant said: *"After a long trip in an ambulance so hot and stuffy we arrived at Kenema there was no bed for us, they called Kailahun they were full too so we stayed in the ambulance for 4 hours. When I was admitted at the confirmed ward, I was given 4 pills and a cup to drink ORS with. We received no IV fluid even though I was vomiting and had diarrhea, just ORS. I don't blame the nurses, they did their best, but the motivation and resources were absent so they will come only once in the ward to check who is dead or who is alive and the burial team will come in once to take out the dead ones. I was determined to survive from the time I arrived, I was forcing myself to drink the ORS though I will vomit each time I drink it, but I kept on forcing myself until it started staying in my stomach. I stopped vomiting on the 4th day*

at the ETU, and was drinking, drinking, drinking the ORS, that's all I did, because that's all I have. People were dying in the ward like 'fish' but I kept the faith. In 12 days they took my blood again for testing and the result came back negative, when I was told that I am negative, I was really happy but when I thought about the place I am returning, I cried, because I will meet nobody home all have died from Ebola, I lost 18 of my family members including my wife and 4 children, from Ebola."

As more ETUs were built and opened from the end of October to December, the situation changed in at least in two of the facilities, Freetown and Port Loko. Even Kenema and Kailahun started to improve the care they provided. They started giving IV fluids and caring for patients. The mortality started to decline and more survivors were discharged. One of the participant shared his experience: *"At the ETU we were well taken care of. When we arrived at the treatment center in Hasting, I was taken to the confirmed ward, escorted by two nurses who held me by my side because I could not walk by myself I am so weak from vomiting and diarrhea. They pass an IV line immediately and started giving me drips. The nurses were nice, they will talk to us, encourage us to take our medications and will feed us 4 times a day. When I was there I felt comfortable, we will birth, and they gave a new set of clothing to change into. Though a lot of people still died but a lot survive too. I was there for 11 days. They took my blood on the 11th days and the result came back the next day negative, when I was told that I am free from Ebola, I was so happy to go back home and meet my family."*

Another participant from Port Loko said this about his experience at Maforkie: *"I was picked up from the community by an ambulance and brought to Marforkie. There were two of us in the ambulance, when we arrived we were received by the nurses at the triage, some are white and some were black. They triage me and put me in the suspect ward where my blood was taken*

for testing, the result came the next day. I was positive and was transferred in to the confirmed ward. But at the treatment center they gave me drips, medicine and a lot of food. We will eat like 4 times, we will get fruits. The nurses were so nice they will talk to us encourage us to take the medicine and also to eat enough. They will come in like 4 times a day to check on us. So my experience at the ETU was good, though I never wanted to be there. One the 9th day my blood was take and tested negative, and on the 11th day it was taken again and tested negative, so I was discharged home, but don't have a home to go to because I have lost my entire family to Ebola, 7 of them, my Mother, Father, brothers and sisters and my aunt and cousin. So I was happy that I survived but sad for my family."

Quarantine, Burial and By-laws

The President declared a national state of emergency on 6 August. The military enforced a quarantine, which was imposed on the areas and households hardest hit. At the same time, the government passed a law that imposed a jail sentence of up to two years on anyone found to be hiding a patient. And yet cases escalated in September through December. Teams were soon struggling to bury as many as 30 bodies a day in Freetown alone. If they were not buried by family members, dead bodies often remained at home for 4 or 5 days. There were no laboratory or treatment beds in Freetown at that time, so all cases were transported to Kenema and Kialahun, which led to the overwhelming capacity. But South Africa deployed a mobile lab and the construction of the treatment center was on the way.

In the community, chiefs and community leaders imposed by-laws on people for hugging, shaking hands, hiding sick people, failing to report a visitor (family member or friend), and for leaving a quarantined house. A fine of 100 to 500 thousand leanes was levied to whoever broke the law.

The military and police manned checkpoints across the whole country to check for fever and discouraged traveling. Whole districts were quarantined, like Kenema, Bombali, Port Loko, Kono, where people were asked not to travel from or to these quarantine districts. The government took these steps to stop Ebola from spreading. With a weak health care system in Sierra Leone would these interventions work? Despite these measures to control the spread of the outbreak, cases still surged, especially in Freetown and Port Loko. In mid-October, Freetown was reporting 400 cases a week.

Homes where a patient confirmed for Ebola was found were quarantined. However there was little in terms of food supplies and water was provided for the people living in those homes. As this participant said: *"They pass their laws but it for themselves, because if you quarantine me and did not give me what to eat or get me water to birth, drink or cook with, I will definitely go out to look for food. People were told not to bury their dead, but no alternative was provided for them as the burial teams will take four to five days to arrive.*"

Another participant said: *"They told us to call 117, but when my uncle died, we called them over 20 times, all they say we will come for three days they did not show up and the body was going bad, so we had to bury him. The family buried him in the community."*

People were asked not to touch their sick loved ones and instead they should call 117. But the ambulance took three to four days to come after persistent calls. This participant said: *"We understood, we heard the messages, but would I sit a see my mom lay on vomitus or pop for 3 to 4 days waiting for an ambulance? No I cannot stand that site, I will take the risk and will care for her.*

Discussion

Poor infrastructure

Sierra Leone is under-developed: poor road networks, limited clean water supplies and almost no electricity are the norm. Only about 20% of houses have running water in the city and almost none in the provinces. People have to walk up to several miles to fetch water both in the capital city and in the provinces. The health care system is weak and dysfunctional. There is a huge shortage of staff: Sierra Leone is one of the worst countries with a doctor to patient ratio of about 1 to 45,000. Vehicles including ambulances take hours to travel short distances. The education system is dilapidated and weak. This under-development is deeply rooted from slavery and colonialism.

I want to put forward two arguments for why the underdevelopment of Sierra Leone is deeply rooted from colonialism. Daron and colleagues write, "weakness or lack of capacity of states in poor countries is a fundamental barrier to their development prospects. Most poor countries have states which are incapable or unwilling to provide basic public goods such as the enforcement of law, order, education and infrastructure" [91]. Others use the word 'weak' to refer to states that lack capacity [92]. Mann instead breaks down the concept into two dimensions distinguishing between *infrastructural power* which is the "institutional capacity of a central state to penetrate its territories and logistically implement decisions" and *despotic power* which refers to "the distributive power of state elites over civil society. It is derived from the range of actions that state elites can undertake without routine negotiation with civil society" [93]. Mann would see the state elite in Sierra Leone as possessing despotic power but lacking infrastructural power (a situation he calls 'imperial/absolutist').

Young argues that the authoritarianism of the colonial states set role models and political practices which transferred to post-colonial politicians [94]. Cooper proposed that the typical colonial state was a "gate-keeper state" that sat on the coast and was only interested in ruling and extracting natural resources, not building the institutions required to develop the colony. Such states persisted after independence when they were taken over by Africans [95].

Sierra Leone's modern state weakness is a legacy of the type of "indirect rule" created by the British. Indirect rule was a system where colonial powers used traditional rulers ('chiefs') as the local level of government, empowering them to tax, dispense law and maintain order. Chiefs often maintained police forces, prisons and were in charge of providing public goods like roads and garnering the resources and manpower necessary to build them. Mamdani's argument was that indirect rule, by making chiefs accountable to the colonial power, rather than local people, made them much more despotic. This despotism persisted after independence, influencing both local and national governance. It also played a significant role in the collapse of democracy in post-colonial Africa [96].

Daron and colleagues examine the specific mechanisms via which indirect rule persisted in Sierra Leone and the sense in which it created or contributed to the weakness of the post-colonial state. "They argue that indirect rule persisted in Sierra Leone because the post-colonial state was the 'bottom up' creation of the traditional rulers who ran the indirect rule system. They formed the first political party and dominated late colonial and post-colonial politics. Thus in Sierra Leone, the institutions of indirect rule created a political movement that captured the central state at independence in 1961. The system persisted, however, because even when the central state was captured by new movements after 1967, indirect rule mutated into a generalized form of incumbency bias [91].

The state that indirect rule created was weak in several well defined ways. First, indirect rule by traditional rulers has made it difficult for the state to establish a monopoly of violence both because it created an underclass of lumpen youths alienated from the society and because it mitigated against the construction of a national identity so that politics stayed local and parochial. Second, as emphasized by Mamdani, traditional rulers were relatively unaccountable and thus able to extract rents and under-provide public goods. This feature was not compensated for by other types of accountability, for example via a representative national parliament, in large part because of the role chiefs played in managing these higher level elections. Third, the fact that the local state was based on lineages and ruling families made it an intrinsically patrimonial and non-bureaucratized structure—a defining property of weakness. These factors interacted with others to create huge negative economic consequences from state weakness. For example, the nature of the traditional instruments of control, such as their role as custodians of the land, led to large economic distortions. Contrary to what the British did in Uganda, the post-colonial chieftaincies in Sierra Leone were smaller and directly linked to pre-colonial polities. This enabled post-independence leaders, even those like Siaka Stevens who had no connection to traditional rulers, to control traditional rulers [91].

Patrimonialism is, at its root, a method of organizing power and exercising control over society. In any society, some rule and some are ruled, but the practice and methods of rule can take many forms, including the extent to which the ruled can participate in decision-making. These forms have huge consequences for economic development. If society is organized in a patrimonial way, then the rulers become patrons and the ruled become the clients of the patrons. Patrons typically control scarce resources that they allocate at their discretion to clients in exchange for services and particularly loyalty and support. If a client gets access to resources,

such as a job, a school place for their children, essential medical treatment, this does not happen on the basis of some well-defined criteria. Rather, it comes because one's patron has access to the resources. It comes as a reward for loyalty.

For the British, indirect rule was a low cost method for pacifying the periphery of Sierra Leone. The colonial state had little interest in providing public goods or developing the country. However, it did need a way of guaranteeing order and stability, and of collecting enough taxes for the state to be self-financing (recall, for example, Cooper's "gatekeeper state"). The institution of the paramount chief achieved this without entailing any investment in the construction of a national state [91]

The most obvious evidence that Sierra Leone lacks a monopoly of violence is the civil war started in 1991 and ended in 2002. The national army was incapable of fighting this war and thus the war ravaged the country. Keen reproduced a quote from Abu Turay, explaining the extent to which central authority had collapsed in the late 1990s [97]: "by the end of Momoh's [President of Sierra Leone from 1985-92] rule he had stopped paying civil servants, teachers and even Paramount Chiefs. Central government had collapsed, and then of course we had border incursions, 'rebels' and all the automatic weapons pouring over the border from Liberia. The National Provisional Ruling Council (NPRC), the 'rebels' and the 'sobels' [soldiers-turned rebels] all amount to the chaos when government disappears. None of them are the causes of our problems, but they are symptoms [91]."

As Abu Turay highlights, these were symptoms of the problems in Sierra Leone and the problems were long standing. Siaka Stevens lost the trust of the Military and thus created a special security force called the Special Security Division (SSD), which was composed of marginalized youth as professional thugs [91]. These lumpen youth were "specialists in political

violence" readily called upon by patrons to intimidate (or eliminate) opponents, raze uncooperative villages, and cow voters during elections [98].

This lack of the monopoly of violence is indirectly linked to the nature of indirect rule in two ways. Paramount Chiefs had the responsibility for local order and maintaining police, and yet the way that they achieved this and the nature of traditional institutions played an important part in marginalizing youths. As argued by Fanthorpe, this system—whereby rural dwellers depend on a highly exclusionary set of traditional institutions if they want to access property and gain political rights—has historically created a large class of people (mostly young, low-status men) who are practically obligated to become rural drifters or join marginalized populations in the cities. That is, they cannot access political rights by appealing to the modern state, for it is nearly non-existent in rural areas. But for all intents and purposes, they also cannot do so by appealing to traditional authorities if they lack patronage by those higher up in the chiefdom hierarchy [99].

Indirect rule does seem to have made the state weak in other well defined ways as well. As emphasized by Mamdani, traditional rulers were and still are relatively unaccountable. They are able to extract rents and under-provide public goods. Acemoglu and colleagues, argue that Paramount Chiefs in Sierra Leone are more powerful in situations where they face less competition and this occurs when there are fewer ruling families. Using this idea, they show that in places with fewer ruling families and more powerful paramount chiefs, a whole series of development outcomes are significantly lower. This includes all levels of educational attainment, the proportion of people working outside agriculture, child health and different measures of asset ownership. The likely mechanism is that more powerful chiefs can extract greater rents to the detriment of public good provision [100]. Acemoglu and colleagues, also present evidence that a

potential channel is through the extra ability of powerful chiefs have to control people's access to land. This feature was not compensated for by other types of accountability, for example via members of the national parliament, because of the role chiefs played in managing these higher level elections. And many appointments in the bureaucracy appear to have been made on the basis of dispensing patronage, and they often feature the relatives of powerful people [100].

The second point about how colonialism was responsible for the under-development of Sierra Leone is focused on how the colonial power developed the country. The most dismal performance of the Colonial administration was on our roads. In the majority of cases the administration--instead of building bridges and carrying out road expansion--preferred the cheapest form of dangerous river crossing, namely the use of ferries which depended on a team of ferry workers pulling the river carrier and crossing from one end to the other. The British colonial administration were so concerned with their exploitation of resources and profits that they deliberately ignored the welfare of the peoples they governed. The only bridge they built was the single lane Magbele Bridge on the Rokel River in 1955, and that was the result of the sinking of the ferry one fateful day that year in which over 50 lives were believed to have been lost. Reluctantly, they managed to build the first single lane bridge in a deep and dangerous curve on entry. That Magbele Bridge is 60 years old today with no repairs ever being carried out on it to this day. We can see anytime vehicles meet, one has to wait until the first crosses the bridge before the other can do the same.

What about the state of British colonial cities? No colonial city in British West Africa is worthy of admiration. As badly planned as Freetown is, so too are Lagos and Ibadan in Nigeria, and Accra in Ghana.

In terms of healthcare, how many hospitals did they build? At independence in 1961, in Freetown, apart from the Connaught hospital, there was another one at Murraytown. There was one government hospital per district located in the district headquarter towns of Bo, Kenema, Kambia, Magburaka hospital and Port Loko Government hospitals. Makeni, the Provincial Headquarters of the North had a health center until recently when a modern Government hospital was built. Kabala too had a health center. The colonial government had their own specialist hospital at Wilberforce (commonly called Hill Station) where they and British officials received medical attention. But thankfully, we now have Missionary hospitals like Segbwema, Rotifunk, Kamakwie Wesleyan hospital, the Serabu Catholic mission Hospital, St John of God Hospital Lunsar, Ahmadiyya Hospital at Rokupr in Kambia district, and the Masanga Leprosarium outside Magburaka, which acquired fame for quality attention, and now a Chinese Hospital.

A specialist government maternity hospital, the Princess Christian Maternity Hospital (PCMH or better known as COTTAGE), was opened along Fourah Bay Road shortly after independence. There was also the Baptist Mission Eye Clinic in Lunsar to help with eye sight problems. Everywhere, the colonial government was found wanting. But if not for missionaries, our population today would have been halved due to poor health facilities. Our people sought quality medical attention by going to these private mission hospitals.

In 1975 and 1976, after nearly forty years of extorting our minerals, iron ore and diamonds, and realizing that the mining of such minerals required huge capital, they packed up and quit the SLST (later DIMINCO) diamond mines and left the country. A similar situation took place at the iron ore mines at Marampa with DELCO shutting down with the explanation that the iron ore industry had become too difficult and needed huge capital, and that they were no longer deriving any profits. They too packed up and left, paying the workers their miserable

benefits. Lunsar town almost became a ghost town as all the immigrants into the town including South easterners returned home frustrated. Diminco and Delco Companies shortened the lives of the people dependent on those mines for their livelihood.

The post-colonial government tried to develop the country. But with a long legacy of patrimonial rule, they too did little in providing public good for the general population. This is the state of the country under which Ebola struck. What outcomes will we expect? Absolutely bad ones. Hospitals where dilapidated with very minimal staff, stuff, systems and space. So we saw lots of deaths including health care workers and people not trusting the public health care systems because it has nothing to offer. This I will discuss in the next section.

Historic 'culture' of distrust

As I mentioned, the colonial history of patrimonial rule not only caused the underdevelopment of Sierra Leone but also created the culture of distrust of the public system. The long history of colonial and post-colonial patronage embodied a culture of distrust between the colonial masters, government and the general population, including extended families and elders in the community. People will obey leaders and elders, but will not respect them and doubt what they will have to say. This caused a complete distrust of the public sector including the public health care system before the Ebola outbreak. People were not seeking care from the public hospitals or clinic, but were instead seeking care from private hospitals or clinics, as well as traditional healers.

When the Ebola outbreak occurred, government official and health care workers went to the radio and delivered messages, and asked people to go to the hospitals or clinics if they got sick and not to bury their dead loved one. Because people perceived the situation as a ploy of the government to make money, they did not think Ebola was real and did not yield to the warnings.

Other theories included government and aid agencies wanting to sell the blood of Ebola patients, or that they would remove patients' limbs for ritual purposes; health workers would inject suspects with Ebola; the ubiquitous chlorine disinfectant spray would give them the disease; or simply that the virus is an invention to help the government bring in donations [101]. Thus, at the initial stages of the outbreak, people were not going to the hospital as requested by government but used alternative means to seek care with traditional healers, or hide when they started showing symptoms. These caused the transmission to increase in the community and leading to increased mortality.

Even though there is a strong culture of distrust in the health care government, the public health care systems did not have much to offer. When aid came in and more Ebola treatment centers were built and care at these centers improved, people responded positively to this developments. People were going to the centers on their own without someone having to call an ambulance. This tell us that culture of distrust can be changed if an investment is made to develop the health systems. People are not static; they respond to the good that will help them. They do want to get better and want to be treated in a humane and empathic way. If they cannot get good care at the health facilities, they will not go there. People will call the emergency line (117) if they know that they will get an immediate response either for their sick or their dead loved one. But at the initial stage of the response it will take 2-5 days for an ambulance to come when called. Instead, in an effort to get care, they would go to traditional healers or beg someone to care for them at home.

The lack of trust coupled with the weak health care system caused the outbreak to spiral the way it did in Sierra Leone.

Lack of supplies

Now, I want to turn to an economic argument. The hospitals lacked supplies such as personal protective equipment, such as gloves and gowns. This caused a lot of healthcare workers to become infected and many died. More than 200 health care workers perished in this outbreak. This is as a result of the lack of protective gears, and in Sierra Leone most of the death occurred in Kenema and Kailuhun districts. Because these districts had the only two treatment centers in the country at the start of the outbreak, they were quickly overwhelmed and over stretched, which led to infections. We lost the only hemorrhagic fever specialist in the country, Dr. Sheik Humaar Khan, at the Kenema treatment center.

The greatly diminished health care workforce during this outbreak also has economic relevance. The lost investments in the training of health care workers who died need to be included in estimates of health systems strengthening versus the crisis caravan of epidemic response economic arguments. In short, cost-effective analyses need to use a wide lens when justifying the pulling of funding post-outbreak, as is currently happening at the time of this writing.

Competing logics: the context of public health messaging

During the outbreak, messages were developed both by partners and government on the radio, mega phones mounted in vehicles and at community gatherings. These messages were nicely constructed and were delivered in a way that people understood them. They asked people to change their behavior, such as ‘no touching’, call 117 if you have a sick person or dead person at home, obey quarantine, and don’t leave the home when you are quarantined. They aimed at preventing transmission of the disease at the home and within the community. However, people did not obey them completely. The question is why.

There is this myth with public health interventions that if you develop the right messages and deliver them with the right strategy, people will heed them and change their behavior. However, what about when people do not have the *means* to follow messages? In the case of this outbreak, people heard the messages and understood them, but they lacked the resources to obey them. For example, for many of those quarantined, there was little food and water provided in addition to other necessities. Therefore, we saw people leaving quarantined homes in search of food or water or some of the things they needed like cigarettes.

Also people called 117 when they had a sick or dead family member, but the ambulance would not come for two to five days. Therefore people started caring for their loved ones at home or burying their dead themselves without protection. In addition, there is no treatment at the treatment center initially, which caused a high mortality rate and made people fear going to the hospitals or clinics. Therefore, they will hide or hide their loved ones when they got sick.

This changed as help arrived towards the height of the outbreak. When there are more treatment centers that provide care, mortality decreased with more people surviving and eventually discharged. Once there were more ambulances, the time to pick to pick up patients from the community became much shorter, and dead bodies where picked up more quickly. In quarantine, food and some water was now provided. People started obeying the messages, calling 117, staying in quarantine homes and thus the outbreak was contained.

When people had the means to obey messages, they did. With the messages alone, though, they heard them and understood them, but did not have the means to obey them. Therefore, while developing messages we also have to consider the means for people to obey them.

Culturalist claims of causality

Ebola was originally identified in 1976 in Yambuku, Zaire (now Democratic Republic of Congo) and is caused by an RNA virus in the filovirus family. "Ebola"—named after a river in Zaire—has five species: *Zaire*, *Bundibugyo, Taï Forest, Sudan* and *Reston.* The fatality rates of an outbreak is 25% to 90% in humans without treatment and less than 10% with treatment [102].

As Gilbert noted, "Outbreaks probably originate from an animal reservoir and possibly involve additional intermediary species. The most likely reservoir appears to be a fruit bat, although that linkage has not been confirmed" [102]. Anthony Fauci suggested that "transmission to humans may have occurred through direct contact with tissue or bodily fluids from an infected animal. Notably, Ebola virus is a zoonotic pathogen, and its circulation among humans is uncommon, which explains the intermittent and unpredictable nature of outbreaks." There have been more than 25 outbreaks since its identification in 1976, but less than 1600 deaths before 2014 [103]. In West Africa, there were more than 28,000 cases and over 11,000 deaths.

Public health messages in Sierra Leone were centered on eating bush meat and bans on the consumption on bush meat were put in place. As Annie Wilkinson and Melissa Leach stated "this message was highly misleading, since although "spillover" from Ebola's natural reservoir in fruit bats may have been responsible for the first case, subsequent transmission has been entirely human to human"[104]. Bush meat is the source of protein for most of the communities in Sierra Leone. Putting a ban in eating bush meat will lead to malnutrition. And a ban also has an economic impact on hunters who depend on hunting as a source of income.

Another culturalist claim made during the outbreak is related to burial practices. It is true that contact with those who died of Ebola increases the risk of transmission, but people often did

not have the choice whether to bury their dead or not, given that when they call the burial team it sometimes took two to five days for them to come. Laying emphasis on the culture of 'funerary ritual' blind us to the distal causes of the epidemic (i.e., slavery, colonialism, resource extraction, enabled civil war) and thus deflects blame from transnational relations of inequality.

Crisis caravan of donor funding

Most donors move from crisis to crisis, investing when there is one and removing their funds when it is over. For example, monies dedicated to Ebola containment have been moved to the fight against Zika [105]. It like a caravan following crisis around the world. They do not identify the root cause of an outbreak and try to invest in solving that problem. Instead, they just try to combat the emergency situation. When it's over, they leave.

There is no doubt that the Ebola outbreak in West Africa is as a result of the poor health care system in these countries. But instead of donors focusing on strengthening these systems, they just combated the emergency. However, these countries have been in health emergencies well before the Ebola outbreak. Sierra Leone has the worse maternal and child mortality in the world with a life expectancy of 46 years. The outbreak served as a lens that magnified the problem. The health care systems is very weak and dysfunctional. Government institutions need support in strengthening its health care system with staff, stuff, space and systems.

Conclusion and Recommendations

As I have discussed, the 2014/2015 Ebola outbreak in Sierra Leone and West Africa is a result of dysfunctional and weak health care systems that have a political, social, and economic history, which started from slavery to colonialism and neocolonialism. The health systems from colonialism were weak and post-colonial leader made little efforts to correct them. The legacy of patrimonial rule left by the colonial powers was continued by the post-colonial leaders whose focus was to reap the country from its minerals. Thus, those young individuals had few if any jobs and little education, which set the stage for civil war in 1991. But the warlords became greedy and changed their mission to smuggling diamonds and other mineral resources. This further crumpled the health systems. It is within this historical context that Ebola struck.

I will therefore recommend the following:

- Focus on health systems strengthening; Sierra Leone was in health emergency before Ebola, and thus investing in the health system with staff, stuff, space and, systems is cost effective than waiting for another outbreak to come.
- Accountable resource extraction taxation; leaders should be accountable and transparent with taxes paid by the extraction industry. The mineral industries should perform legal and transparent mining practices and should cease under the table deals with chiefs or government officials. Government official should use taxes to invest in developing the country.
- Focus in community engagement using community health workers. Invest in community health workers as they play a vital role in engaging the communities and understanding their problems. Thus they will be able inform the government thus improving public sector trust.

- Broader country development: Building roads, improving clean water supply, and providing electricity to all in the country is vital to the country's broader development and will prevent other outbreaks.

Limitations:

I interviewed only survivors, since most people perished in the outbreak, but I did not interview their families to understand their perspective. I also failed to interview international NGOs and government official to understand their perspectives while developing intervention.

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