

# CURRENT HISTORY

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## COVID-19 in Ebola’s Wake: Safe Haven in Sierra Leone?

ADIA BENTON

In late December 2020, a colleague, Jonas, who conducts veterinary science and public health research in rural Sierra Leone, checked in by email to see how I was coping with months of COVID-19-related isolation. I was handling it as best I could. My book in progress about the 2014–16 West African Ebola outbreak—one of the reasons Jonas (a pseudonym) and I had become acquainted in the first place—was long overdue to its publisher. My plans to return to Sierra Leone to fact-check the book had been postponed indefinitely.

Jonas and I sent a few short messages back and forth. In late January 2021, he suggested that I travel to Sierra Leone for a break. “I don’t know. I’m worried about traveling so far and having to quarantine,” I responded. He urged me to throw caution to the wind and spend time in the rural southeastern part of the country, where there is little evidence of widespread transmission of COVID-19. “We really don’t have this problem in the provinces. Covid is only brought to our country by people coming from Europe and America. It affects a few people in Freetown and not us up-country,” he wrote. “We are safe.”

It’s hard to tell whether Jonas, a public health and zoonotic infections expert, was thinking wishfully or epidemiologically, or both. The same week as our email exchange, the government of Sierra Leone, in an effort to head off a “second wave” of COVID-19 infections, had imposed a national daily curfew from 10 p.m. to 5 a.m. on all residents and visitors, restricted travel between districts, and

closed restaurants and bars on the weekends. Masks would be required in all public spaces. Public transportation would operate with limited seating capacity to accommodate social distancing guidelines. Land and sea borders were also closed to travelers. Mosques and churches could hold services provided they did not last longer than 90 minutes.

The extent to which all of these rules and regulations would be enforced or enforceable was not clear, but the pronouncements were made nonetheless. I searched for visual clues on Sierra Leonean social media and news accounts to see how these measures were being enacted and observed. In a Freetown bank, customers wearing paper masks queued a few feet from each other as they waited for service; beachside, friends sunbathed, drinks in hand; aspiring models and designers wore masks that matched their *ankara* or African attire; families celebrated birthdays at a local restaurant. February events like art shows and performances were postponed “in consultation with the national COVID response center” and rescheduled for March.

With all these measures in place, numbers of infections and deaths have remained relatively low in Sierra Leone. As of March 7, 2021, the government had confirmed 3,918 cases of COVID-19 and 79 deaths since the pandemic began.

Cheered by all of this, I began to check the cost of air travel to Freetown. My university is not allowing its employees to embark on nonessential travel—even to places with low COVID-19 incidence like Sierra Leone. Would flights to Freetown through Paris and Amsterdam still be running? (The London route on British Airways was closed

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ADIA BENTON is an associate professor of anthropology at Northwestern University.

during the country's Ebola epidemic and never returned.) Or would I have to take the dreaded flight to Freetown via Brussels, with its terrible airport and flight attendants known for acting aggressively toward black travelers? (The diamond trade, along with humanitarian organizations' need to keep moving supplies and people in and out of Ebola-affected areas, kept this route operational back then.) Visa and immigration protocols had also changed due to COVID-19; would my multiyear, multiple-entry visa still be valid?

Jonas' words ring in my head: "We are safe."

## WARTIME CONDITIONS

The Sierra Leonean government has imposed stringent protocols for passengers entering the country via Freetown's Lungi International Airport. In addition to being required to provide a negative test result at the airport, arriving passengers are assessed for symptoms, and are offered two tests: a rapid diagnostic test requiring a blood draw, and a polymerase chain reaction (PCR) test, which entails a nasal swab and produces results in 1–3 days. Passengers' passports are held until the PCR results are received. Departing passengers must provide a negative test within 72 hours of departure. All of these tests are at traveler's expense: \$80 upon arrival; 500,000 leones upon departure. An additional fee is assessed if a traveler wants to have a test performed in the convenience of their home or hotel room.

These measures ensure proper surveillance and control at the country's most manageable border. Many other interventions—curfews, internal travel bans, and the like—might very well be epidemic security theater, the likes of which were also staged with great gusto in the United States, when then-President Donald Trump proposed cordoning off New York, Connecticut, and New Jersey from the rest of the Eastern Seaboard, and closed borders to travelers from China, but not to those from the European countries belonging to the visa-free Schengen Area. By the time the United States had provisionally closed its borders to visitors from the European Union, the viral strains originating in EU member countries had already gained a foothold in major US metropolitan areas and in the places EU residents traveled to thereafter.

Closing borders, as many had predicted, did little to slow transmission in the United States and

Europe, but it offered a small degree of solace for those of us living in what felt like a vacuum of public health leadership. Such arrangements also allowed countries like Sierra Leone to flex their diplomatic muscle—a role reversal remarked upon by citizens of African nations, who regularly undergo an extensive and often onerous process to obtain visitors' visas to enter the EU and the United States.

The Republic of Sierra Leone Armed Forces coordinates the country's COVID-19 emergency response. Elsewhere, I've referred to this as the militarization of epidemic response: the use of military assets, infrastructures, and expertise to carry out public health functions. These functions might include surveillance, containment, isolation, contact tracing, logistical support, and care. It remains an empirical question whether a martial logic—that is, the threat of "legitimate" use of force by the state—underpins the delivery of care and is experienced by communities as violent. I think it is clearer that the use of the military in this way reflects the limited scope of local public health expertise and capacity to address epidemics. It also

demonstrates the continuous investment in the professionalization of the military—at the expense of institutions and logics of care.

During the Ebola outbreak, many Sierra Leoneans said that the epidemic reminded

them of conditions during wartime. The political scientist Fodei Batty, for example, argued that the path of the Ebola virus from the Liberian border was remarkably similar to that of the Revolutionary United Front rebel forces in 1991. The Ebola virus has been described by anthropologist Sylvanus Spencer and others as "the invisible enemy" against which a war is waged.

I've argued against the salience of viral invisibility alone for explaining a martial approach to the Ebola epidemic—after all, viruses live in bodies. Efforts to "fight" Ebola would be a war waged against the people serving as hosts to the virus; the arenas for these battles would be marked by checkpoints established and staffed by members of the armed forces. During that epidemic, command centers of various kinds became sites where the movements of patients and their contacts were documented and traced, and through which emergency calls and other communications were routed. Isolation, containment, and treatment centers managed those suspected or confirmed to be infected.

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Early Ebola survivors whom I talked to often found themselves in the crosshairs of the state's epidemic response apparatus. They were hunted down and placed in isolation as they awaited a confirmatory diagnosis, interrogated about the people and places with which they were in contact, and listed in case files among "suspects," and they suffered the indignity of watching fellow patients, neighbors, and loved ones die from organ failure and neglect. As the coordinated Ebola response became more robust and oriented toward offering care, rather than containment, isolation, and an undignified death, the martial elements of public health subsided—or at least were hidden from view.

In placing responsibility for managing the COVID-19 epidemic with the ministry of defense, Sierra Leone's current president, Julius Maada Bio, took a cue from his predecessor, Ernest Bai Koroma, who was in office during the Ebola outbreak. Koroma deemed the response of the ministry of health and sanitation unsatisfactory and replaced it with the ministry of defense as the lead coordinating agency. Bio, in turn, appears to have bypassed the health ministry altogether. It would seem that he had little faith in the public health agency's capacity to coordinate the response to an epidemic crisis. It is not clear to me whether this is a fair assessment; was it too much to expect that the health ministry had been properly equipped to take on the logistical and managerial challenges of the pandemic?

## ELITE TRANSMISSION

Outside of Freetown, is Sierra Leone "safe," as Jonas insisted? I keep thinking of Jonas' earlier insight, that the earliest reported COVID-19 cases on the African continent were found among political and other elites who traveled internationally with some frequency. This appeared to be the pattern on the continent, raising questions about how global hierarchies shaped the transmission of the virus.

I learned about the first cases of COVID-19 in Mozambique, for example, through a series of forwarded texts to my partner, who had lived and worked as a surgery researcher in the country for two years. One of his former colleagues had included him in a group text that detailed the transnational movements of Maputo's mayor, who had been rumored to be the first case of the virus in Mozambique. Supposedly the mayor had been seated next to an infected member of the British royal family at a Commonwealth meeting in London. When I recited this story to the journalist Joe

Penney, he said that he had heard the same from Mozambican journalists.

Joe called me because he was writing a story about such African cases and how we should interpret them, in light of the patterns that were emerging from the data. In his research, he learned that "Senegal's first case, for example, was imported from France, while the Gambia's was from the UK, Angola's was from Portugal, and Suriname's was from the Netherlands."

I told him, "The colonial legacy lives in viral movements. . . . The 'knowing' is also a colonial symptom. There may have very well been an earlier case, but we know about the traveler. Their sickness registers."

Wryly, he replied, "On Facebook and in WhatsApp groups, some commentators have used the term 'coronized,' a play off 'colonized,' to describe this phenomenon."

The virus moved through elite networks, for sure, but many of us wondered about the drivers, cooks, cleaners, and others who work alongside, and for, these political and managerial elites that so preoccupied Jonas in his assessment of COVID-19 risk in Sierra Leone's provinces. What about all those Freetonians, both jet-setters and ordinary people, who often have family connections to the provinces? Was it really so safe out there?

## 'THANK GOD IT'S THEM INSTEAD OF YOU'

Every few months, in this long year of isolation and lockdown in the United States, national media outlets ask: How do we explain the relatively low number of COVID-19 cases and deaths in Africa and Asia? (The question came up in the *New York Times* again this morning, which is why I am revising this piece once again.) I don't like this question. It implies that African survival is not simply an anomaly but a perverse deviation from the natural order of things.

Without being able to look to Africa's failures for solace in the midst of our own misery and suffering, how do we define ourselves? What we have seen in the United States, for example, is that our racialized, class, and regional inequalities—and our demography, our austerity, our neoliberal governance of health care and public health—have shaped transmission dynamics in ways that have disproportionately sickened and killed the poor, the underinsured, the marginalized, the elderly, the black and brown, and people with disabilities.

But why had Sierra Leone (and much of Africa) been spared thus far? Is it an artifact of poor data

collection efforts and miscounting, of which many health systems are indeed guilty? Is it poor diagnostic capacity—a lack of the ability to test a broad swath of the population in a timely and orderly manner, and report the results? Pseudo-explanations for a relatively low pandemic toll in Africa flow from the morbid expectation that any divergence or deviance from the norm—African sickness and death—is about what Africans *are* rather than what they did (or failed to do).

Could regional differences in the pandemic's impact have some biological explanation? Some have argued that exposure to a range of pathogens over a short lifetime may have primed West African immune systems. Most of the deaths due to COVID-19 worldwide are clustered among people over 70 years of age. Could we then attribute Sierra Leone's case numbers to an accident of demography? Like many neighboring countries, its population skews relatively young. According to recent estimates, only 4 percent of Sierra Leoneans are over the age of 65—which may well have contributed to the low number of deaths.

Good ventilation in tropical homes and time spent outside have also been offered as explanations. But we know that many households are multi-generational, crowded, and packed in close to their neighbors; that running water and basic sanitation services may be scarce; and that mass transit, transportation hubs, and market areas tend to be crowded.

None of these factors can serve as a universal explanation. We may never know the reasons for the differences in case numbers. We are nowhere near the end of this global crisis.

But here's a look at what we do know.

Whatever is responsible for the relatively low number of cases and deaths in Sierra Leone—and in the region at large—the prevailing sense among regional health experts has been that the earlier Ebola epidemic prepared the country for the worst. Early coronavirus screening of passengers entering the country might have helped to reduce the numbers early on. Making sure that diagnostic tests were available and laboratories could process them was the next phase. Strides made during the Ebola epidemic surely mattered.

The type of pathogen also matters, however. Although the early symptoms of Ebola virus disease—fever, headache, and myalgia—are quite

similar to those of other common afflictions in the region, the virus is not easily transmitted by pre-symptomatic carriers; it is most likely spread during the disease's wet phase, which includes vomiting, diarrhea, and hemorrhaging. This makes Ebola relatively easy to control (despite the terror it causes) once it is known to be the causative agent of disease—and once responders are properly equipped with protective gear, and the physical environment accommodates proper ventilation and disinfection of surfaces. That is not the case for COVID-19.

Even a small number of severe cases could tax an already frail health system, so Sierra Leone might not be “safe” in the grand scheme of things. If we take seriously the idea that viruses move in bodies, and that how bodies move is largely rooted in the political, economic, and social reasons for crossing national borders with some frequency, then we should also be able to recognize that the distribution of opportunity to travel—the ease with which one travels—will shape early transmission dynamics. Bodies remember.

And if we take seriously the idea that the assemblage of agencies and organizations has been primed to respond to a disease crisis and can act accordingly, then it makes sense that these groups can

effectively mobilize workers to trace contacts, administer diagnostic tests, provide care, and educate individuals and communities to protect themselves and others. Institutions remember.

The Ebola outbreak ended in the region in June 2016. Ebola virus disease had infected nearly 30,000 people in Liberia, Sierra Leone, and Guinea, and killed around 11,000 of those infected. Many were left to mourn the Ebola dead. People with other health conditions died during the epidemic for lack of care. Many were buried as possible Ebola cases, irrespective of their diagnosis. The health system was also ravaged: many clinicians had fallen ill and died.

“It was hell,” a health official who had worked in Moyamba at the height of the epidemic told me in 2017, during my visit to a refurbished district primary health care clinic. “Pure hell.” And he wasn't even responsible for clinical care, but for the work of tracing Ebola contacts, managing the movements of sick people, and coordinating district-level efforts to bury the dead. These traumatic experiences surely shape how health

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workers have prepared for and responded to the current coronavirus epidemic.

## ROLLOUTS AND BUBBLES

During a virtual book club meeting in March 2021 to discuss a chapter in Paul Farmer's new book, *Fevers, Feuds, and Diamonds: Ebola and the Ravages of History*, I joined Paul and two of his Partners in Health colleagues, Jon Lascher and Bailor Barrie, both calling in from Freetown. Bailor, a medical doctor who trained in Sierra Leone during the country's civil war, and Jon, the senior administrator responsible for keeping the operations of the aid organization running smoothly there, described in passing the COVID-19 meetings they'd recently attended.

In the middle of the coronavirus pandemic, a new set of Ebola cases had emerged in Guinea. Fortunately, Jon told us, the government and the World Health Organization were following the carefully crafted protocol that emerged from the previous outbreak. Thanks to the decades of development of vaccine candidates and multiple clinical trials carried out during the 2014 outbreak, Ebola vaccines are ready to be rolled out in the area, just as the COVID-19 vaccination campaign is getting underway in the United States and the global North, amid debates about equity in global vaccine distribution.

Now Sierra Leoneans can see the fruits of their scientific and clinical labor. Now, rather than scrambling to stitch together a response to these new cases, public health officials can figure out how to distribute vaccines to known contacts of Ebola patients and educate communities about getting "suspected" cases tested and treated early.

What will a robust Ebola response look like this time? Will it prioritize containment and control, as a health security approach implies? Or will it balance such approaches with early detection and diagnosis for the purpose of providing

life-saving care? (A major criticism leveled by Farmer and Sierra Leonean clinicians working in public hospitals at groups like Doctors Without Borders was that they had limited the scope of care they offered to very sick Ebola patients. Intensive care was not the standard of care in humanitarian clinics in the early stages of that outbreak—they offered oral rehydration solution instead of intravenous drips, for example—which likely resulted in many lives lost.)

It was not lost on me that as I was sitting in my basement office, living through a pandemic, I was rehashing the lessons learned from an Ebola outbreak thousands of miles away, as leadership at every level in my well-resourced country failed to offer reprieve for those of us forced to live in isolation from each other, or in household "bubbles," for an indeterminate duration. Sierra Leone's government had yet to get a handle on COVID-19 everywhere in the country, but officials knew that they needed to prepare health personnel and communities to distribute and receive the 200,000 vaccine doses donated by the Chinese government, as well as more than 520,000 doses expected to be delivered by May through the international COVAX initiative.

Pondering whether Sierra Leoneans will remain "safe" from COVID-19 and its effects, I think some of the lessons from their two-year struggle against Ebola may offer clues. Vigilance and preparation—as well as adaptations made in previous crises—may have put the country's leadership in a good position from which to develop and implement its pandemic plan. Early action was key. Networks of solidarity and support have been important for ensuring the distribution of goods, services, and information at the subregional level. We saw glimmers of this in the United States. But on many fronts, we failed, thanks to fragmented leadership and inequitable, underresourced public health and health care systems. ■